



State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



TABLE OF CONTENTS

I. COMMON REQUIREMENTS OF THE APPLICATION AND ANNUAL REPORT

- 1.1 Letter of Transmittal
- 1.2 Face Sheet
- 1.3 Table of Contents
 - 1.4 Overview of the State
 - 1.5 The State Title V Agency
 - 1.5.1 State Agency Capacity
 - 1.5.1.1 Organizational Structure
 - 1.5.1.2 Program Capacity
 - 1.5.1.3 Other Capacity
 - 1.5.2 State Agency Coordination

II. REQUIREMENTS FOR THE ANNUAL REPORT

- 2.1 Annual Expenditures
- 2.2 Annual Number of Individuals Served
- 2.3 State Summary Profile
- 2.4 Progress on Annual Performance Measures
- 2.5 Progress on Outcome Measures

III. REQUIREMENTS FOR APPLICATION

- 3.1 Needs Assessment of the Maternal and Child Health Population
 - 3.1.1 Needs Assessment Process
 - 3.1.2 Needs Assessment Content
 - 3.1.2.1 Overview of the Maternal and Child Health Population Health Status
 - 3.1.2.2 Direct Health Care Services
 - 3.1.2.3 Enabling Services
 - 3.1.2.4 Population-Based Services
 - 3.1.2.5 Infrastructure Building Services
- 3.2 Health Status Indicators
 - 3.2.1 Priority Needs
- 3.3 Annual Budget and Budget Justification
 - 3.3.1 Completion of Budget Forms
 - 3.3.2 Other Requirements
- 3.4 Performance Measures
 - 3.4.1 National “Core” Five Year Performance Measures
 - 3.4.1.1 Five Year Performance Targets
 - 3.4.2 State “Negotiated” Five Year Performance Measures
 - 3.4.2.1 Development of State Performance Measures
 - 3.4.2.2 Discussion of State Performance Measures
 - 3.4.2.3 Five Year Performance Targets
 - 3.4.2.4 Review of State Performance Measures
 - 3.4.3 Outcome Measures

IV. REQUIREMENTS FOR THE ANNUAL PLAN

- 4.1 Program Activities Related to Performance Measures
- 4.2 Other Program Activities
- 4.3 Public Input
- 4.4 Technical Assistance

V. SUPPORTING DOCUMENTS

- 5.1 Glossary
- 5.2 Assurances and Certifications
- 5.3 Other Supporting Documents
- 5.4 Core Health Status Indicator Forms
- 5.5 Core Health Status Indicator Detail Sheets
- 5.6 Developmental Health Status Indicator Forms
- 5.7 Developmental Health Status Indicator Detail Sheets
- 5.8 All Other Forms

1.4 Overview of the State

Geography: New Hampshire shares a boundary 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 size (square miles) among the states and 19th in population density. New Hampshire is a state with just over 1.2 million people, 49% of whom reside in areas classified as rural and 51% classified as urban (of those in urban areas 30.6% are in urbanized areas and 20.3% live outside urbanized area) (Office of State Planning). The areas of the state classified as urban and near urban are located in the south east and south central part of the state with the western, central and northern portions of the state all considered primarily rural. Seventy-seven percent of New Hampshire towns are considered non-urban or rural.

New Hampshire citizens living in rural communities face geographic barriers to health care including lack of transportation and increased travel time to health care providers and hospitals (The State of Health in Rural New Hampshire).

Demographics: New Hampshire's estimated population has increased by approximately 1% annually over the past five years, exceeding the growth rate of all other New England states except Vermont. During this same time period, there has been an increase in immigration from other states with an average 6,250 new residents per year. This exceeds growth due to natural population increases (New Hampshire Vital Statistics Report, 1992-1997). Population projection estimates are that the state population will be 1.35 million by the year 2010.

The birth rate in New Hampshire has declined 19.8% over the last eight years with the total number of births in 1997 totaling 14,275. The peak number of resident births recorded was in 1989 when there were 17,801 births. The current birth rate is the lowest ever recorded in the state and at 12.2 per 1,000 population is the fifth lowest in the nation and lower than the U.S white rate of 13.9. (New Hampshire Vital Statistics Report, 1997)

The population estimates for the number of women of childbearing years (ages 15 to 44 years) for the year 2000 is 262,799 comprising 21% of the total population. Population projections estimate decreases of 1% in 2005 and again in 2010 so that women in this age group are predicted to comprise 20% and 19% of the total population for those years (Calculated from Office of State Planning Population Estimates).

Given the trend in birth rates and the population projections for women of childbearing age, it is not surprising that the demographics of the population of New Hampshire are changing. The state is experiencing an aging of its population. Today children under 18 years comprise one-quarter of the population. But by 2020 it is estimated they will constitute just over one fifth of the population. Between 1995 and 2005 decreases in the percent of children under the age of 6 and 6-11 years are anticipated but the percent of middle school children between 12-14 years is expected to remain stable. By 2005 it is estimated these three groups will respectively comprise 6.5%, 7.5% and 4% of the population (Kids Count New Hampshire 2000, Child Care in New Hampshire –Five Year Plan, January 1999).

The population of New Hampshire remains a largely homogeneous one with 96.5% estimated to be white, non-Hispanic in 1998. The remaining 3.5% of the population is: 1.4% Hispanic, 0.7% black, .2% American Indian/Eskimo, and 1.2% Asian/Pacific Islander. The minority populations are concentrated in the southern and southeastern portions of the state in the counties of Hillsborough (which includes the states two largest cities Manchester and Nashua) and Rockingham. The county share of the total minority populations for Hillsborough and Rockingham are respectively: 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%. (Office of State Planning Population Estimates by Race and Hispanic Origin, 1998). The community health agencies in these two counties are becoming increasingly aware of and making adaptations to respond to the linguistic and cultural needs of the minority populations. Becoming culturally competent is more difficult for community agencies in rural and non-urban areas where the concentration of racial and ethnic minorities is smaller. For example, in Nashua it would be easier than in many rural northern communities to find bi-lingual Hispanic staff or to justify the hiring of interpreters for the growing number of Hispanic families being served in the community

New Hampshire is home to an estimated 5,000 refugees, 80 % of whom reside in the southern tier of the state. One third of these individuals come from Southeast Asia, 30% from the former Yugoslavia and the remainder from the former Soviet Union, Romania, and Africa. While these new residents experience a range of health issues including poor nutrition, parasites, exposure to tuberculosis and increased lead levels; maternal and child issues predominate. Case management, outreach and interpreter services are all in high demand for this population (Governor's Office of Energy and Community Services).

Current Socioeconomic Indicators and Racial and Ethnic Health Disparities by Population: New Hampshire finds itself at the top of many lists of health and socioeconomic indicators. Data from 1997 is presented here for the purpose of comparison with available 1997 national data. More recent New Hampshire data is reported on in pertinent performance measures and outcome measures later in this document. The 1997 state infant mortality rate of 4.4 per 1,000 is the lowest ever in the state and the lowest overall and white infant mortality rate in the nation. Similarly, the state ranks third nationally for low birth weight rates, with a rate of 5.9 in 1997 compared with the U.S. white rate of 6.5. Additionally, New Hampshire is among the top three states in measures related to access to adequate prenatal care. In 1997, the proportion of women who did not receive adequate prenatal care (no care or care that commenced in the third trimester) was 1.5% of all births compared with the national white rate of 3.2%. New Hampshire's teen birth rate is second only to Vermont at 28.6 per 1,000 females aged 15-19, 38.2% below the U.S. white rate of 52 per 1,000 (fact sheet family planning program).

There are a number of trends in maternal and child health indicators that are less favorable and bear mention. In 1997, 7.8% of all births were to teen mothers, an increase of 5.4% from the previous year and an increasing trend since 1992. An increase in non-marital births occurred across all age groups in the state and was highest among adolescents less than 18 where 95.9% of births were to single mothers. Along with the rise in teen births, was a concomitant increase in low birth weight and very low birth weight babies in the state, highest among the adolescent age group. The health risks for teen mothers and their infants and the long-term negative socioeconomic implications are well known.

Maternal smoking, a major risk factor identified as affecting the health of babies during pregnancy is a concern for New Hampshire. Contrary to a national and statewide decline, New Hampshire experienced a slight increase in the maternal smoking rate from 16.3% in 1996 to 17.4% in 1997 and a slight decline in 1998 to 17.1%. This change is strongly influenced by an increase in smoking among teen mothers from a 1992-1996 five-year average of 34.3% to 37.9% in 1997 (New Hampshire Vital Statistics Report, 1997).

New Hampshire's overall economic profile is one of prosperity. The state unemployment rate in April 2000 of 2.5% is a near record low. On average, wages in New Hampshire in 1997 rose more rapidly than the cost of living. But many families and 10% of our children, (30,000) are living at levels below the official poverty line. For the time period of 1985-1996 the percentage of children in the state living in poverty increased by 25% while the national percentage of decreased by 5%. During that ten year period, the percentage of families with children headed by a single parent (24%) increased by 41% in the state, an increase three times that of the nation. While the percentage of children living with parents lacking full-time, year round employment dropped by 11% for the country, in New Hampshire this percentage increased by 15%. (Kids Count New Hampshire 2000). These figures signify a disturbing trend for our state's children. The negative impact on the health and well being of children living in poverty is well documented. Thus, these data cannot be ignored.

It is also imperative to note that while many of New Hampshire's overall health and economic indicators rank high, there are tremendous disparities within the state. The Kids Count New Hampshire 2000 report, in its fifth volume, analyzes data related to children and families grouping towns into five economic clusters ranging from poor to wealthy. In so doing, the report is able to explore how child health and well being varies depending upon a child's residence in a wealthy or poor community. Thus, even for those indicators for which New Hampshire as a whole excels, there are dramatic differences among communities. For example, the rate of inadequate prenatal care is three to four times higher in the poorer communities than in the wealthiest cluster. Births to teen mothers are four times higher in the poorest communities than in the wealthiest ones. In the wealthiest towns, one in nine births are to single mothers versus, one in three births to single mothers in the poorest cluster of towns. These data and those explored in more detail in the needs assessment will assist the Office of Community and Public Health, Bureau of Maternal and Child Health to assess its current programming and resource allocation to work towards the improvement of maternal and child in the areas of greatest need.

At the current time, little information is available regarding the health disparities among racial and ethnic populations in the state. Through our State Systems Development Initiative (SSDI) grant we are optimistic that we will learn more in this area. Two grants are being awarded to the cities of Nashua and Manchester specifically to study health disparities and barriers to access among racial, ethnic and socioeconomic minorities in the maternal and child health population. This work will be done over the next year in partnership with the Bureau of Maternal & Child Health and with assistance from our newly hired maternal and child health epidemiologists.

The number of New Hampshire children receiving SSI cash benefits has decreased from 1,860 reported as of December 1998 to 1,630 reported as of December 1999 (Social Security Administration, Office of Research, Evaluation and Statistics). This represents a -12.4% change. The decrease is attributed to continuing economic prosperity in the state rather than welfare reform. New Hampshire is a 209(b) state whereby eligibility for SSI does not automatically qualify a child for Medicaid benefits.

State Based Issues Impacting on Women and Children

Welfare Reform and Child Care

The current economic climate in the state and its potential impact on the health and well being of women and children has been previously discussed. Two related issues are welfare reform and child care. The annual average number of TANF (Temporary Assistance to Needy Families) cases open on the last day of the month has declined 40 % from 1994-1998 from 9,071 to 6,123. (New Hampshire Economic/Social Indicators) The number and percent of children receiving TANF assistance has also declined with marked differences among the economic clusters described earlier. The wealthier communities saw a decline of 45% during the five-year period of 1995-1999, while in the poorer communities the decline was 33% (Kids Count New Hampshire 2000). The numbers of children in the poorer cluster towns receiving food stamps and Medicaid benefits is four to five times that of the wealthiest cluster.

If TANF is to be successful in achieving one of its stated goals, moving women into the workforce, than the need for quality child care with adequate capacity to serve all the children in need throughout the state is paramount. A 1997 report estimated that 56 percent of preschoolers requiring out of home care were in regulated child care settings, leaving the remainder in unregulated settings or without care at all (New Hampshire Child Care Supply Statistics, Child Care Resource and Referral Network of New Hampshire, January 1997). In New Hampshire, women's participation in the work force has always been higher than the national rate and in 1996 was 62.9%. (Child Care in New Hampshire –Five-Year Plan, January 1999).

These figures are likely to increase as TANF roles decline. As one key component of quality child care is health and safety, the Bureau of Maternal and Child Health is working to improve the health and safety of child care environments through its' Healthy Child Care New Hampshire initiative. Further a goal of this initiative is to engage child care providers to assist in helping families obtain access to health care through Healthy Kids Gold (Medicaid) and Healthy Kids Silver (CHIP).

Welfare Reform and Medicaid

New Hampshire's Medicaid caseload dropped less than 1% between 1995 and 1997, perhaps because New Hampshire's delinking of TANF with Medicaid kept eligibility for Medicaid aligned with TANF eligibility requirements (*Access to and Participation in Medicaid and the Food Stamp Program, Final Report*, Mathematical Policy Research, Inc., March 2000). With results of current outreach efforts for Healthy Kids Gold (Medicaid) and Silver (CHIP) programs embedded in Medicaid numbers, however, any conclusions about caseload trends are tentative.

New TANF-supported outreach to Medicaid eligible individuals was initiated in 2000 through 8 community-based Family Planning agencies (supported in part by Title X) working in 25 sites. Approximately \$300,000 of TANF funds per year fund direct outreach in district welfare offices, Employment Security, and other relevant sites such as workplaces employing high numbers of low-paid part-time workers. Outreach efforts also target teen parents and teens at risk for pregnancy in school and community settings.

Health Insurance Status

In 1999, the Department of Health and Human Services sponsored the New Hampshire Health Insurance Coverage and Access Survey (NH –HICAS), a population-based, probability sample telephone survey, which revealed that 96,000 or 9% of New Hampshire residents remain uninsured. An estimated 25,000 or 26% of the uninsured are children. The survey also estimated that 74% of uninsured children or 18,500 were eligible for publicly sponsored programs such as Healthy Kids Gold and Silver but not participating. Data gathered since the survey by New Hampshire Healthy Kids suggests that some of these children may now be insured through CHIP. Efforts to improve participation in these programs can be found below.

The highest uninsurance rates in New Hampshire are among the young adults ages 18 through 29 (14%) followed by those 30 – 44 years of age (10%)., When examining the uninsured population by gender, it is estimated that nearly 75% of the uninsured women in the state are of child-bearing age. An estimated 30% of all uninsured women or approximately 10,500 were ages 18-29 and 43% or roughly 15,500 women were ages 30-44. Half of these uninsured women ages 18-44 are not eligible for Medicaid. Thus there are large numbers of women in the state who may have difficulty accessing reproductive or perinatal care due to a lack of health insurance.

Regional disparities in uninsurance rates were also found, with higher rates of uninsurance in the north and central eastern parts of the state. Yet the more urban areas, Manchester, Nashua, Concord and Portsmouth account for 70 % of currently uninsured individuals. A subcommittee involving a partnership between the Department of Health and Human Services, the Legislature, representatives of health care providers and businesses in New Hampshire and the Healthy Kids Corporation (sponsor of Healthy Kids Silver) are focusing on strategies to reduce the rate of uninsurance on the adult population.

Medicaid and CHIP

New Hampshire CHIP is a unique partnership between the New Hampshire Department of Health and Human Services and the New Hampshire Healthy Kids Corporation. The New Hampshire Healthy Kids Corporation administers CHIP health insurance programs outreach and coordination. Healthy Kids Gold expands coverage for infants at 185-300% of poverty level. Children ages 1 through 18 (greater than 185-300% federal poverty level qualify for Healthy Kids Silver with premiums based on income. New Hampshire Healthy Kids estimates that within its first fifteen months of operation CHIP has reduced the number of uninsured children by one third. (NH Healthy Kids Quarterly Report, 1st Quarter 2000). In 1999, 6,100 children obtained health insurance coverage through its services. The new mail-in unit at New Hampshire Healthy Kids has processed applications for over 4,100 children who have been screened as income-eligible for Healthy Kids Gold coverage. These applications are passed on to the

DHHS District Offices for final processing and enrollment. Cumulative enrollment in Healthy Kids Silver, including the self-pay program hit a record high in the five-year history of Healthy Kids Corp. with a total of 2,346 children as of December 1999. Subsidized enrollees totaled 2,050.

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 due to access to basic medical services through safety net providers such as community clinics, or preference not to enroll due to administrative difficulties associated with eligibility determination and enrollment procedures. Efforts are underway to streamline the eligibility determination process and continue outreach, exploring creative options to encourage enrollment.

Medicaid and Prenatal Care

In New Hampshire, pregnant teens up to age 19 may be covered by Healthy Kids Gold (<185% of poverty) or Silver (186-300% of poverty.). Pregnant women age 19 and over with incomes up to 185% of the federal poverty level are eligible for Medicaid. During 1998, Medicaid was the payment source for 21% of all births in the state. Eighty percent of women obtaining prenatal care through Title V funded community agencies are enrolled in the Medicaid program. These women are entitled to enhanced prenatal services which include social services, nutrition services, care coordination and client education provided during a home or clinic visit.

New Emerging Statewide Agenda

Healthy New Hampshire 2010. DHHS is using the HP2010 process to establish the prevention agenda for the state for the next decade. MCH staff have been actively involved in the process, and will commit to aligning MCH program goals, and resource allocation with the leading child health status indicators as articulated in the Healthy New Hampshire 2010 report, forthcoming in January 2001.

Quality Improvement Initiative

DHHS sees performance management as a major strategy to improve the capacity at the state and local level to deliver core public health services, and to improve the quality of those services. Our vision is to promote science-based practices and standards by defining and measuring quality, establishing quantitative expectations for performance, and then holding the state and local health systems, contracted community agencies, and other service providers accountable for meeting those expectations through performance-based contracting. The specific initiative is an integrated Medicaid and Public Health collaboration to create an effective system for clinical quality assessment and improvement across Medicaid, categorical and primary care contracted services, with a strong link to prevention, and to population-based services. A major activity has been the creation of a post-doctoral Clinical Quality Fellowship program funded by DHHS with Dartmouth Medical School's Family Practice Residency, Dartmouth's Center for Evaluative Clinical Sciences, and the Concord Community Health Center. Post-doctoral fellows will be assigned to support DHHS as it plans for, develops and implements its clinical quality improvement

programs; and to support community health agencies and other providers to effectively partner with the state in implement clinical quality improvement programs.

Strengthening the Safety Net

Another top DHHS priority is to preserve and strengthen our community-level infrastructure of agencies that serve low income and uninsured populations. Like all states, we have evolved a patchwork of health centers and categorically funded agencies; from MCH, prenatal, well child, WIC, family planning, STD and HIV, refugee, homeless, rural health clinics, FQHCs and look-alikes to name but a few. Not only do these agencies provide access to health care services, but these agencies are quite successful in integrating public health and prevention into clinical practice, providing true population-based care. They also provide invaluable non-medical social services through case-management and so-called wrap around activities. These agencies leverage far more in services than what the state and federal funds actually pay for, and their survival is critical to the continuing health of our communities. DHHS activities include: financial assessment and market analysis of safety net providers, development of a Medicaid reimbursement strategy to offset the adverse financial impact of BBA 97, develop a strategy to provide coverage for uninsured adults.

Enhanced public health benefits for Medicaid recipients

DHHS intends to use the Medicaid program to expand such needed services to the MCH population as home visiting, enhanced prenatal services, substance abuse treatment and oral health care. In addition, DHHS plans to contract with a Pharmacy Benefits manager for Medicaid recipients to help improve access to and management of prescription drugs.

Managed Care, Medicaid, and Public Health

With a changed political climate, and with a rapidly changing health care market; the privatization of Blue Cross/Blue Shield, and the financial failure of two of New Hampshire's largest health plans, Tufts and Harvard-Pilgrim; the state has re-evaluated its proposed transition to a fully capitated Medicaid Managed Care program. Instead, DHHS is pursuing a Primary Care Case Management Model.

New Hampshire's vision is to create a comprehensive integrated system of health care for its citizens who lack the resources to purchase private health care coverage. This system would integrate population-based, prevention oriented, public health into traditional medical care. To accomplish this, DHHS must make the transition from payer of claims to value-based purchaser of services for its Medicaid beneficiaries. Like payers in the private sector, DHHS is attracted to the outcomes and performance measurement, and the cost and utilization management that managed care has to offer. Thus, regardless of what state Medicaid policy may ultimately look like, with respect to fee-for-service versus voluntary managed care versus primary care case management, the Department is actively pursuing the development of an improved capacity to support its evolving role as a value-based purchaser. This capacity includes improved analytic capabilities, as well as a disease management program.

DHHS is involved with two active collaborations between the public and private sectors. Within New Hampshire, DHHS partners with the Medical Directors of all the state's Health Plans through its participation in and support of the Foundation for Healthy Communities. The Foundation has taken on a number of high priority MCH activities, including: the development of state-wide child health status indicators, development of universal prevention guidelines, asthma management protocols, advocacy for newborn hearing screening, 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 Regional Director of the US Public Health Services. Priority areas include development and dissemination of joint Managed Care and Public Health asthma, diabetes, smoking and immunization guidelines with a goal of improving health care and health status.

The Political Climate

The political climate as it relates to the health of women and children is promising at this time. There are a number of statewide initiatives focusing on children and families, which should prove to have a synergistic effect in improving the health and well being of this population. In 1998, Governor Shaheen assembled a Kids Cabinet comprised of the Commissioners of the Departments of Health and Human Services, Education, Employment Security, Safety, and Corrections; the Attorney General; the Coordinator of the New Hampshire Highway Safety Agency; the Adjutant General and the Administrative Justice of the District and Municipal courts. The purpose of the Kids Cabinet is to act as an overseer to improve coordination and effectiveness of children's programs to improve life for New Hampshire's children and families.

The priorities of the Kids Cabinet are:

- To improve the quality, affordability and availability of child care and after-school care;
- To increase the number of children who have health coverage
- To reduce rates of youth substance use and sexual activity
- To help parents help their children through parent support activities.

As part of the fourth priority, the Title V program has been charged with the responsibility of implementing a statewide home visiting program for pregnant women and their young children. The goals of this program are to: improve pregnancy outcomes, to improve the health, safety and well being of children, and to enhance the family's life course.

The Kids Cabinet is one of several entities that is examining data relative to the health and well-being of children and their families for the purpose of driving public policy and evaluating public programs. 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 of the group is to develop a tool kit of community-level health status indicators so communities can better use data to assess their needs, advocate for resources and evaluate their efforts.. The group has identified key indicators based on available data of child health and well-being to utilize as a road map for understanding local health needs of children by communities.

Additionally, the Children's Alliance of New Hampshire (CANH), a child advocacy group, which annually produces Kids Count New Hampshire, reports on key indicators of child health and well-being by five economic clusters. CANH also recently published The Children's Agenda 2000, an plan for the legislature, state agencies, the business sector and local communities to focus attention on the needs of children in New Hampshire and to build support to meet those needs. Both the Kids Count data book and the agenda set forth priorities for public policy and identify gaps in available data which is needed to adequately describe and monitor how children and families fare in New Hampshire.

These collective efforts place a high priority on children and families and thus the climate is ripe for collaboration among many stakeholders to work towards improving the health of children in New Hampshire.

Statewide Health Care Delivery Systems:

Primary Care, Maternal and Child Health and Perinatal Services

The current service system in New Hampshire for pregnant women, infants, and young children, needs differs throughout the state. Most of the state is designated as medically underserved. These designations are used to assist communities to apply for status as federally qualified health centers to improve access to health care. While New Hampshire's two largest cities have public health departments, there is no statewide network of local health departments.

Instead, agencies within the New Hampshire Department of Health and Human Services, including the Bureau of Maternal and Child Health, contract with community-based, non-profit safety net providers including: six prenatal, eight family planning, eight primary care and fourteen child health agencies targeting low-income, uninsured and underinsured pregnant women, children and men and women of all ages. Services provided by these non-profit agencies are comprehensive and include direct medical and reproductive health care and enabling services, such as; case management, nutrition, social services, home visiting, transportation, and translation services as needed. The locations of these agencies assure that most services are available throughout the entire state. Other services, such as HIV and STD testing and counseling and breast and cervical cancer screening are also delivered by state-contracted agencies. This patchwork of agencies along with private providers' offices and specialty clinics for those with special health care needs comprises the primary care health care service system for the state.

High Risk Newborn Facilities

New Hampshire is divided into twenty-six hospital service areas. Dartmouth Hitchcock Medical Center (DHMC), located in the western central part of the state provides tertiary care in virtually all specialties for much of the state. This and one other New Hampshire hospital, the Elliot Hospital, located in southern New Hampshire, are in-state alternatives for high-risk newborn care. In some areas, patients may choose to seek specialty and tertiary care in Massachusetts to the south, or Portland, Maine, to the north and east. The majority of high risk births are delivered at DMHC. A regional perinatal outreach program is administered out of DMHC. Staff from this program conducts transport conferences with the 26 birthing hospitals throughout the state for the purpose of continuing education and to monitor the appropriateness of transfers of high risk mothers and infants to the facility. In addition, the perinatal program provides continuing education on best practices to all maternal and child health hospital nurse managers.

Mental Health Services

One serious lack in the infrastructure of health care in New Hampshire is access to mental health services. While community mental health services are available in some areas, they are unable to meet the need. Additionally, sliding fee scales utilized by community mental health agencies tend to be such that low-income and uninsured families cannot pay. While Medicaid does cover mental health services for children, it is necessary for children to be diagnosed with severe emotional disturbances to receive services. Similarly adults must have serious mental illnesses to utilize Medicaid as a source of payment for mental health services.

There is also a dearth of providers throughout the state who specialize in mental health services for very young children and families. Initiatives to address this issue are being undertaken by the DHHS Division of Behavioral Health and the New Hampshire Infant Mental Health Association.

Oral Health Services

Improving access to oral health services for the most needy and vulnerable populations is among the highest priorities within the DHHS. Keeping children pain and disease free is the top oral health priority. There are many obstacles to overcome to realize this priority. There are only 21 pediatric dentists in the state located primarily in the central and southern regions (population centers). The rural North Country has no pediatric dentists. Only 43% of children enrolled in Medicaid have seen a dentist in the last year. Less than 20 dentists in the state see new Medicaid patients and few are willing to treat uninsured and underinsured clients.

The DHHS, oral health program has recruited a senior Dentist to provide leadership across four key components of an oral health initiative to address the challenges at hand. These four components, along with some examples of activities are listed below.

- **Public Health/Prevention**
 - Promotion of community water fluoridation..
 - Epidemiology, surveillance and program evaluation.
- **Medicaid**
 - Improve fee for service program.
 - Integrate dental services into voluntary managed care program benefits.
 - Improve provider participation in Medicaid Program.
- **Community-Based Dental Programs**
 - Exist in two primary care clinics with plans for expansion.
 - Currently five school-based preventive programs providing screenings, cleanings, fluoride treatment and health education.
- **Workforce Development**
 - Designation of Dental Professional Shortage Areas.
 - Recruitment of dentists and hygienists.
 - Loan repayment program to include dentists and hygienists.

It is anticipated that these combined activities will contribute to greatly improved oral health services for children and other vulnerable populations.

Services for Children with Special Health Care Needs

In particular, for children with special health care needs, a mutual 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 provide primary care for the large majority of New Hampshire's children with special health care needs and are, therefore, 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 the availability of pediatricians to care for this population of children.

New Hampshire appears to have an adequate number of pediatric subspecialty providers. There are pediatricians in the practice of allergy, cardiology, developmental medicine, endocrinology, gastroenterology, genetics, hematology/oncology, infectious disease, intensive care, neonatology, neurology, pulmonary medicine and rheumatology. In addition, there are several community-based pediatric ophthalmologists, pediatric orthopedists and a pediatric urologist. All the sub specialists practice with a few exceptions (pediatric orthopedist/ ophthalmologist) either at Lebanon, site of the Dartmouth-Hitchcock Medical Center, or in the greater Manchester area, the state's population center. A network of pediatric specialty outreach clinics, operated or supported by the Special Medical Services Bureau, ensures availability and access to community-based care.

One serious gap in the infrastructure for children with special health care needs in New Hampshire is access to mental health services. They are overburdened with simply caring for this population. Expertise in treating children and adolescents, and in particular children with special health care needs, is limited in the publicly funded mental health system. There are few other mental health resources 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 psychologist housed at DHMC whose specific expertise is management of children and adults with mental retardation and mental illness. A directory of mental health specialists with expertise in managing children and adolescents with chronic illness has been produced by the Hood Center for Care giving Families. The Division of Behavioral Health has been awarded a Federal \$5 million, 5-year care New Hampshire grant to implement systems of care for children with SED in two communities with a plan to go statewide with this initiative after the demonstration is completed.

For CSHCN, dental access issues are compounded. Children with special health care needs, like all children, need ongoing routine dental care, but yet sometimes their complex medical or behavioral situations requires 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 level of skill necessary to manage this group of children.

Title V Role in the State Public Health System and MCH Priorities

See page [129](#) for a list of the State's MCH priorities.

The MCH priorities were selected based on data presented in the needs assessment as well as on DHHS priorities. The state plan for Healthy People 2010 is under development. Several focus area workgroups are in the process of determining their top HP2010 priority objectives. The MCH work group chose five priority objectives. State priority need number 2, To decrease the use of alcohol, tobacco and other substances during pregnancy and number 9, To increase early access to prenatal care among vulnerable populations have corresponding NH Healthy People 2010 objectives.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Title V Program is located in the New Hampshire Department of Health and Human Services within the Office of Community and Public Health. Administration of the Block Grant is assigned jointly to the Bureau of Maternal and Child Health (BMCH) for services to women, infants and children and to the Bureau of Special Medical Services (SMSB) for children with special health care needs. The BMCH Health resides in the Division of Family and Community Health. Organizationally, the SMSB is placed within the Medicaid Health Management and Coordinated Care Unit. This became effective May 2000. This arrangement allows for the expertise of the Title V Children With Special Health Care Needs Program to be integrated within Medicaid operations for policy development, disease case management and quality assurance. Leadership opportunities for SMSB staff will be strategically enhanced within this structure.

Key staff changes occurring during the past year included the transfer of Jane Hybsch from her position of Director of Title V Children With Special Health Care Needs to the position of the Unit Administrator in the Medicaid Health Management and Coordinated Care Unit. Colin T. McHugh, MA, is the newly appointed Director of the Title V Children With Special Health Care Needs Program as of March 2000. See Section 1.5.1.3 for details of Title V staff.

Other changes occurring within the past year include moving the Newborn Metabolic Screening Program from SMSB to BMCH and the addition of the Universal Newborn Hearing Screening Program to BMCH. Since BMCH was undertaking universal newborn hearing screening, it was logical to move the screening and tracking component of newborn metabolic screening to BMCH as well. SMSB will continue to provide case management for any newborns identified with a metabolic disorder as the staff possesses tremendous case management skills and experience. Staff for the Universal Newborn Hearing Program will be hired this summer.

Also a new addition in the last year is the Folic Acid Project, a collaborative effort between the WIC Nutrition Program, BMCH, and the March of Dimes to promote the intake of adequate amounts of folic acid in women of childbearing age in order to decrease the incidence of neural tube defects via a media campaign. This project is also developing a Neural Tube Defects Surveillance System for the State of New Hampshire.

New Hampshire Revised Statutes Annotated (RSA) 125 describes the powers and responsibilities of the Division of Public Health. RSA 132 covers “protection for maternity and infancy”.

RSA 132.13 authorizes services to crippled children; RSA 137:G creates the Catastrophic Illness Program.

RSA 123:10A mandates newborn screening.

RSA 611 covers Sudden Infant Death Syndrome.

During the 1999-2000 legislative session, SB 456, An Act relative to testing newborns for deafness was passed. The bill requires the commissioner of the Department of Health and Human Services to develop standards for testing newborns and to produce a report with recommendations to the legislature and the Governor by November 2000. The BMCH will be responsible for producing this report.

See Figure 1 for State Government Organizational Chart relating Title V to the Governor.

See Figure 2 for State Health Agency Organizational Chart.

See Figure 3 for State Title V Organizational Chart.

See Figure 4 for relevant state statutes and dates.

1.5.1.2 Program Capacity

See Table 1 for State Title V funded programs with descriptions.

TABLE 1

Title V Funded Preventive and Primary Care Services/Programs for Pregnant Women, Mothers and Infants	
Program	Description
Primary Care Program	The Primary Care Program supports eight agencies throughout the state in the delivery of quality primary care to persons of all ages (including prenatal and pediatric care). These programs operate in the family practice model to provide comprehensive preventive health services. Many of these sites offer support services such as social services, nutrition counseling, case management, health education, transportation and translation services. 65,000 individuals are served through this program.
Perinatal Program	The goal of the Perinatal Program is to promote positive pregnancy outcomes for all New Hampshire women by reducing adverse outcomes that impact on maternal and infant morbidity and mortality. The BMCH helps support fourteen agencies in the provision of comprehensive prenatal care to over 1000 primarily low-income, uninsured or underinsured women per year. Services provided include: medical care, nutrition services, social services, nursing care, case management, home visiting and referral to specialty care as needed. Perinatal program staff assure that best practice models are carried out in the community and new science-based findings are put into practice, such as smoking cessation interventions.
Family Planning	The Family Planning Program provides quality comprehensive reproductive health care, through eight community health agencies at 25 sites throughout the state, to 29,000 individuals per year, regardless of age or income, with a particular focus on low-income women and teens. All services are confidential and include physical check-ups, screening tests, health counseling, reproductive health education, birth control, pregnancy testing and counseling, testing related to reproductive health, and community education programming. Ten teen clinics offer family planning services “for teens only” that are provided during or after school hours, by appointment or on a walk-in basis, and incorporate teen peer educators into available services. Family planning staff provide technical assistance to community programs relative to best practices in family planning service delivery. Family planning staff set direction and guidelines for family planning services statewide.
SIDS (Sudden Infant Death Syndrome) Program	The SIDS (Sudden Infant Death Syndrome) Program offers information, support and resources to family and care providers of infants suspected to have died of SIDS. In collaboration with the Office of the Chief Medical Examiner, referrals are coordinated to trained staff in community agencies to provide home visits. Information and training are provided to professionals and the general public upon request.
Home Visiting Project	The Home Visiting Project serves pregnant women and families with children up to the age of two. Goals of the program are to promote healthy pregnancy and birth outcomes, to promote a safe and nurturing environment for young children, and to enhance families’ life course and development. Presently there are three home visiting pilot projects, serving approximately 150 families across the State. Under the aegis of the Governor’s Kids Cabinet Title V staff are leaders in implementing a statewide expansion of home visiting. Title V staff are involved in training, data collection and evaluation relative to home visiting.
Universal Newborn Hearing Screening Program	The major objectives of the Universal Newborn Hearing Screening Program are to screen all newborns for hearing and to establish and maintain an automated tracking system to assure that infants identified receive appropriate follow-up and intervention. Started in 2000, it is anticipated that 80% of all newborns will be screened by the year 2004. An estimated 30-40 hearing impaired children are born in New Hampshire each year.

Newborn Metabolic Screening Program	The Newborn Metabolic Screening Program coordinates the blood screening of all infants born in New Hampshire for 6 potentially serious disorders, and optionally, sickle cell disease. The blood specimens are analyzed at the University of Massachusetts Medical Center, New England Newborn Screening Program, and the abnormal results are reported to the infant's medical provider to assure immediate follow-up.
Folic Acid Project	The Folic Acid Project is a collaborative effort between the WIC Nutrition Program, MCH, and the March of Dimes to promote the intake of adequate amounts of folic acid in women of childbearing age in order to decrease the incidence of neural tube defects via a media campaign. This project is also developing a Neural Tube Defects Surveillance System for the State of New Hampshire.

Title V Funded Preventive and Primary Care Services/Programs for Children	
Program	Description
Child Health Program	Fourteen community health agencies receive funding to offer comprehensive preventive health care to approximately 13,000 low income children, birth through age ten, through clinic and home visits. Services include physical exams, health screenings, immunizations, anticipatory guidance, social services, case management and outreach. Title V staff provide technical assistance and to these programs and monitor them for quality assurance. Staff with expertise in child health participate in strategic planning relative to children's needs and work in collaboration with the SCHIP program.
Adolescent Program	The Adolescent Health Program currently supports one comprehensive primary care clinic for adolescents. Collaborative activities with the NH Injury Prevention Program, The Family Planning Program, and the Department of Education address issues pertinent to adolescent health. Additionally Title V staff participate in strategic planning, needs assessment and data collection activities relative to adolescent health issues.
Preschool Vision & Hearing Program:	The Preschool Vision & Hearing Program works with locally trained volunteers to provide approximately 40 screening clinics throughout New Hampshire for 2000 children ages 3 ½ to 6 years old. One retest day is held for each clinic site and follow-up is attempted for any child that does not pass either screening. All screening results are sent to the public school nurse in the community where the child will attend first grade.
Abstinence Education Program	The Abstinence Education Program seeks to reduce unintended pregnancies primarily among pre and young teens through a combination of community grants and a media campaign using an abstinence message.
Oral Health	The Oral Health Program receives Title V funds to improve access to oral health services for children and adults. Strategies to improve access include: establishing new dental clinics, assisting communities to organize to fluoridate water supplies, improve Medicaid reimbursement rates and policies, and to increase the number of dental providers through loan repayment and the designation of Dental Health Professional Shortage Area.
Injury Prevention Program	The goal of the Injury Prevention (IP) Program is to reduce morbidity and mortality associated with the leading causes of injury death and disability in NH, including MV crashes, suicide, and other intentional and unintentional injuries, with a focus on children and adolescents. The IP Program oversees the contract and collaborates with the Injury Prevention Center at Dartmouth Medical School, which provides IP

	services statewide, including coalition development, public education, training and legislative activities on injury-related issues. The IP Program leads and/or participates in a number of multi-disciplinary committees aimed at reducing motor vehicle crash related injuries and teen suicides, and has held several successful conferences and numerous trainings in the past year.
--	---

Title V Funded Services/Programs for Children with Special Health Care Needs	
---	--

Program	Description
Child Development Program	<p>The 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 of or at risk for altered developmental progress. The Network is comprised of five (5) Child Development Programs contracted through local community health agencies. The Dartmouth-Hitchcock Medical Center serves as both a local program and the tertiary referral center for more complex children. Although the University Affiliated Program (UAP) 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 submit service utilization data to the SMSB.</p> <p>The Child Development Services Network provides:</p> <ul style="list-style-type: none"> • A team evaluation consisting of a pediatric neuro-developmental examination, an assessment of current developmental functioning, a cognitive evaluation, and family assessment of needs and priorities. • A review of the child's current educational program is provided when indicated. • Post-evaluation recommendations for normative, therapeutic and/or educational services are made and progress monitored. These may include: <ul style="list-style-type: none"> ○ identification of the child's learning style and program needs; ○ referral for additional diagnostic testing or subspecialty services; ○ assistance in finding appropriate community support and educational resources; ○ follow-up monitoring and re-evaluation at clinic, home, school or early intervention program; ○ referral for child or family counseling. • Access to financial and medical resources of the SMSB is arranged by the local program coordinators as part of the regional clinic service.
Pediatric Specialty Clinics	<p>The SMSB assists families to access specialty care by organizing community-based multidisciplinary clinics which evaluate children with complex medical needs, and by helping to pay for medical and related services to treat these conditions. Each clinic has a Medical Director and a Clinic Coordinator. Additional professional staff, appropriate to the chronic conditions followed in the clinics, are specified for each clinic type. Consultant staff include physical therapy, nutrition, psychology and developmental pediatrics.</p> <p>Pediatric Specialty Clinics provide:</p> <ul style="list-style-type: none"> • A coordinated approach to assessment and management of a variety of complex medical conditions. • An opportunity for organized communication among specialty medical care providers to ensure efficient coordination of their services. • Comprehensive assessment and development of an integrated patient care plan. • A focal point for communication and coordination with community-based care providers and other community resources.

<p>Pediatric Specialty Clinics cont'd</p>	<ul style="list-style-type: none"> • Treatment that encourages parents/child to participate in care planning, allowing for timely feedback with opportunities to discuss medical questions and concerns with specialists. <p>SMSB-operated Pediatric Specialty Clinics are:</p> <ul style="list-style-type: none"> • Amputee/Limb Deficiency • Cleft Lip & Palate • Neuromotor Disabilities
<p>Nutrition, Feeding & Swallowing Program</p>	<p>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 regional nutritionists, and feeding and swallowing specialists who serve families with children who have nutritional or oral motor feeding issues.</p> <p>There are currently 15 Registered Dietitians providing nutrition services and 4 Occupational/Speech/Language Therapists providing feeding and swallowing services. Due to the complexity of the issues/concerns presented by these children, often time, the regional nutritionist and the feeding & swallowing consultant work together to assess and plan interventions. Providers work within their local communities in collaboration with other agencies and systems involved with the child, including the family, early intervention and school personnel.</p> <p>The Bureau offers ongoing specialized training for all network providers and monitors their quality of care to assure a coordinated and consistent, outcome-oriented approach that is family-centered and community-based.</p> <p>Parents, Physicians, Early Intervention Specialists, School Nurses, Day Care Programs, Specialty Clinics, WIC, Head Start, VNA or other agencies identifying nutrition or oral motor feeding issues generate referrals for the program.</p>
<p>Care Coordination Initiative</p>	<p>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.</p> <p>The Care Coordinator:</p> <ul style="list-style-type: none"> • Provides coordination of medical services with other community providers, including schools, to ensure continuity of care. • Provides teaching that will empower families to assume the role of primary case manager for their child. • Develops comprehensive health care plans that are responsive to the needs of the child and priorities of the family. • Maintains appropriate medical documentation. • Facilitates access to primary and specialty care services. • Attends clinics and ensures that medical documentation is available for the multidisciplinary team. • Conducts hospital/home/agency visits for the purpose of case finding and care planning. <p>Bureau Care Coordinators collaborate with other State systems and community agency personnel by sharing expertise and information about available resources.</p>

<p>Financial Assistance Services</p>	<p>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 incomes less than 200% of poverty are considered eligible.</p> <p>Payment is provided in accordance with an established fee schedule for diagnostic and treatment services related to the child’s chronic condition. Guidelines for flexible financing, enabling services are also established. All third-party resources must be utilized before SMSB funding.</p> <p>Also provided are referrals for counseling and support to assist families with the challenges of managing a special needs child and/or their child’s behavior.</p>
<p>Family Support Services</p> <ul style="list-style-type: none"> ➤ New Hampshire Family Voices ➤ Family Support & Resource Center ➤ Parent-to-Parent of NH 	<p>New Hampshire Family Voices New Hampshire Family Voices is a resource for parents who are in need of information regarding health care systems, both public and private, health care financing and delivery, and other community services. Family Voices acts as a resource to inform health professionals, policy makers and the broader community regarding children with special health care needs. Family Voices works within systems to promote family-centered policies and practices through the provision of information regarding the real life experiences of New Hampshire families who have children with special health care needs.</p> <p>Family Support & Resource Center The Family Support & Resource Center was established to enhance and strengthen access to information and resources by families and professionals caring for children with special health care needs. The Center maintains a database with over 3,200 entries of community, state, regional and national resources, as well as distributes fact sheets, brochures, periodicals and other printed materials. The centerpiece product of the Center is a quarterly newsletter entitled “Pass It On” which is mailed to over 1,800 individuals and organizations. Staff participate in training, educational forums and interagency collaborative initiatives around children’s issues to increase awareness of available services and resources.</p> <p>The staff of the Family Support & Resource Center are parents of children with special health care needs who can personally relate to the issues and concerns raised by individuals seeking their assistance.</p> <p>Parent-to-Parent of NH Parent-to-Parent of NH provides parent support services to all New Hampshire families who have children with special health care needs. Parent-to-Parent of NH receives calls from and makes matches for or referrals to new parents coming into the state, parents of newborn children, and veteran families who have new issues. They also make referrals to appropriate agencies and personnel. In the area of special health care needs, these referrals are most often made to support groups for specific illnesses (such as hypoplastic left heart syndrome, epilepsy) to national organizations or foundations for specific health conditions or to the Family Support & Resource Center at the SMSB. There is a toll-free 800 number, staffed five (5) days a week, from 8:00 a.m. to 4:30 p.m., with an answering machine available during non-staffed hours.</p>
<p>Injury Prevention</p>	<p>The Injury Prevention Center at the Dartmouth-Hitchcock Medical Center provides services to enhance safety in the childhood population at large. SMSB participates with the Center by displaying special car seats and having brochures available during the Annual Buckle-Up NH Campaign.</p> <p>The direct services component of SMSB has ensured safety by emphasizing in its Neuromotor, Epilepsy and Spina Bifida programs assessments and teaching specifically</p>

	<p>oriented to the needs of these special populations. Equipment, i.e., wheelchairs, are reviewed, helmets are provided for recreational activities, and safe Equipment Bank articles are available for use when families are trying out new technology.</p> <p>Information is distributed to schools to assure safe management of seizures, guidelines for guarding against injury to sensation-impaired extremities, as in the spina bifida population, is utilized. Our family support program has developed information regarding ensuring safe evacuation planning in the development of IEPs.</p> <p>While these activities have assured that safety concerns are addressed, there has been no special focus or plan developed to highlight this population's needs. As community-based care coordination efforts are enhanced, there should be an opportunity to assess information and resource needs in communities. It is hoped that the resources provided to the Injury Prevention Center could be channeled to meet the special needs population more directly, and in a more systematic and organized fashion.</p>
Outreach / Public Education	<p>The Title V CSHCN staff is primarily involved with direct care services for families through clinical programs and care coordination services--time to provide educational programs are limited. Still, staff have made themselves available to audiences of school personnel, early intervention staff, school nurses, day care providers, nutritionists, camp personnel, etc., to provide formal presentations about SMSB services as well as discussions about management of particular chronic illnesses such as Epilepsy, Spina Bifida and Cerebral Palsy.</p> <p>Special packets of information about services and poster sessions have been available at the annual NH Pediatric Society meetings.</p> <p>Poster presentations on materials created for use with families on the topics of Sexuality and Safe Transportation of Special Needs Children have been displayed at national conferences such as NPACE and AACPDm.</p> <p>Contracted personnel have reached audiences both in-state and out-of-state with presentations at NECTAC and SSI conferences. Teaching medical residents/students, other physicians, teachers and offering case presentations are expected activities. These opportunities give the Title V CSHCN Program visibility throughout the region and nationally.</p> <p>While the offerings made by the contracted consulting staff has remained steady, changes in direct care staff responsibility and capacity have limited the amount of outreach staff can provide. It is hoped that when staff capacity can be increased and direct service responsibility decreased, community-based activities will allow increased opportunities. Providing more information based on needs identified by the communities with which our agency will be working will be the goal during the next year. Additionally, with the movement of SMSB into the Medicaid Administration Bureau, it is expected that our audience will expand and more opportunities will occur in which we can share our expertise.</p>
Psychology Consultation Services	<p>Psychology services are provided via a triage consultation model. Services are available to any family regardless of Bureau financial eligibility. Coordinators will identify a problem that is then referred to the psychologist. He will speak with the family, talk about the concerns and develop a plan. This may include a face-to-face appointment to obtain more information, consultation with medical providers, a school</p>

	<p>observation, or a referral to a resource in the local area. The referral is made to a facility, which will be consistent with the available medical insurance.</p> <p>The Psychology Consultant provides the following services:</p> <ul style="list-style-type: none"> • School consultation. This may include a review of school records, class room observation, consultation with school staff about the educational coding, setting up a behavioral program, or providing information about the effect of the child’s chronic medical conditions on learning. This service has been developed to enhance the educational programs for CSHCN. This service is not duplicative of school psychology services because the school psychologists often do not have the advanced skill set to work with the CSHCN population. • Assessment Consultation. This service is a discussion with family and/or school personnel regarding the need for assessment of intelligence, achievement and/or school emotional development. The population served with this intervention is often those children not educationally coded or not coded appropriately. • Treatment Consultation. This is a service provided to parents which provides an opportunity to talk about a problem such as anxiety, adjustment to coping with a chronic illness, sleep disturbances, eating and soiling problems. A management plan is developed. It may be that a referral to a local community mental health service is needed for long-term intervention for the problem. • Staff Consultations with nurse coordinators are available as requested. These usually occur prior to an official referral to verify a coordinator’s or a parent’s concern and to select the correct approach to the concern. It also enables case management discussions to take place. • Staff Workshops/In-services. These are learning opportunities for the staff in which the expertise of the psychologist is offered in a lecture or discussion session about a topic of coordinators’ interest. Presentations on topics such as Child Adolescent Diagnosis and Pharmacology, issues in consultation with school staff, children with different temperaments, therapeutic adherence and behavioral treatment of Childhood Enuresis, Behavioral Treatment of Habit Disorders, and Ethical Issues in Pediatric Chronic Illness have been offered. • Tracking changes in mental health services is a valuable service, which allows for anticipatory problem solving regarding resource gaps and concerns. • Attendance in national, regional and local conferences is also included to maintain up-to-date standards in the program. <p>With the expansion of community-based coordination, future considerations may be given to offering presentations of interest to a group of parents in the local setting. These presentations have been offered or attempted to be offered centrally, but there has not been a good response from SMS parents. Better needs assessment locally may identify more popular topics.</p>
<p>Special Initiatives ➤ Medicaid Outreach & Enrollment (SCHIP)</p>	<p>A commitment at the State and National level to expand children’s health insurance coverage and a willingness by the Title V CSHCN Program to implement strategies to address barriers to enrollment has meant more CHSCN receiving Medicaid benefits. A trained case technician employed by SMSB reviews each application submitted and determines whether the child/family qualifies for Medicaid/SCHIP benefits. Assistance is offered to families to assure follow through with the application process, including home visiting to complete the required paperwork.</p>

1.5.1.3 Other Capacity

Key staff and parents working on Title V programs are listed in Table 2. Data capacity is addressed in Core Health Status Indicator #5

**TABLE 2
State Title V Key Staff and Parents (Total = 33.6)**

Senior Level Management				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Joan H. Ascheim, MSN, Chief Bureau of Maternal & Child Health Ms. Ascheim received a BS in nursing from Georgetown University and an MSN, PNP from the University of Virginia. She has worked in BMCH since 1983. Her particular areas of expertise are home visiting, health and safety in child care and other children's issues.	Oversees all programs in BMCH	1.0	P	
Jane M. Hybsch, RN,MHA, Unit Administrator, Medicaid Program Ms. Hybsch holds a BS in nursing and Master's in Health Administration from University of New Hampshire. She served 11 years as the Title V Children with Special Health Needs Care Director	Oversees Medicaid Health Management and Coordinated Care Unit	1.0	P	
Colin T. McHugh, MA, Title V Children with Special Health Care Needs Director as of March 2000 and planner of disease management programs for the Medicaid Program. Mr. McHugh holds a bachelor's degree from Plymouth State College and a master's from Univeristy of Connecticut. Prior to this Mr. McHugh spent five years in the managed health care industry at Anthem Blue Cross and Blue Shield.	Director of Children with Special Health Care Needs	1.0	P	
Title V CSHCN Program Manager	Community-based Care Coordination Initiative	1.0	P	0
Senior Physician	Pediatric Specialty Clinics and integrated services with Medicaid	1.0	P	0

Parents				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Title V CSHCN Program Parent Consultants	Family Support services	1.6	C	0

P = Paid, C = Contract, V = Voluntary

Programs/Services for Pregnant Women, Mothers, and Infants				
Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Audrey Knight, MSN, ARNP- Child Health Nurse Consultant	SIDS Program.	.3	P	
Lisa Bujno, MS, ARNP – Perinatal/Adolescent Program Chief	Prenatal Program	.5	P	
Patricia Tilley, MS Home Visiting Program Specialist	Home Visiting Program	1.0	P	
Paula Roberts, MS, Home Visiting Consultant	Home Visiting Program	.75	C	
Newborn Hearing Coordinator	Universal Newborn Hearing Program	1.0	P	1.0
Carol McDonnell, RN, Newborn Metabolic Screening Coordinator	Newborn Metabolic Screening Program	1.0	P	
Consulting Audiologist	Universal Newborn Hearing Program	.33	C	.33

Programs/ Services for Children

Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Audrey Knight, MSN, ARNP- Child Health Nurse Consultant	Child Health Program	.7	P	
Lisa Bujno, MS, ARNP – Perinatal/Adolescent Program Chief	Adolescent Health Program	.5	P	
Nancy Martin, RDH MS Chief, Bureau of Oral Health	Oral Health	1.0	P	
Marie Kiely, BS, MS - Injury Prevention Program Manager	Injury Prevention	.5	P	
Holly Wentworth, RN, Preschool Vision & Hearing Screening Program Coordinator	Preschool Vision & Hearing Screening Program	1.0	P	
Maureen McCanty, OB/GYN	Prenatal Program	2-5 days/year	C	

P = Paid, C = Contract, V = Voluntary
 Senior position, biography attached

Programs/Services for Children with Special Health Care Needs

Position Title/Category	Program	FTEs	P, C, or V	Vacant #FTE's
Developmental Pediatrician	Pediatric Specialty Clinics	1.25		
Psychology Consultant	Pediatric Specialty Clinics Community-Based Care Coordination	.54		
Nutrition Consultant	Nutrition, Feeding & Swallowing Program	.68		
Feeding & Swallowing Specialist/Consultant	Nutrition, Feeding & Swallowing Program	.54		
Physical Therapy Consultant	Pediatric Specialty Clinics	.50		
Care Coordinator	Pediatric Specialty Clinics	7.9		
Care Coordinator	Community-Based Care Coordination	2.6		
Care Coordinator	Community-Based Care Coordination Nutrition, Feeding & Swallowing Program	.40		
Medicaid Outreach Coordinator	Pediatric Specialty Clinics Community-Based Care Coordination Nutrition, Feeding & Swallowing Program	1.0		

Planning, Evaluation and Data Analysis

Program	Position Title * = Senior Position, Biography Attached	FTEs	P, C, or V	Vacant #FTE's
All programs, emphasis on maternal and child health needs assessment and performance measures and health disparities	Jenny Ruducha, DrPH MCH Epidemiologist *	.6	C	
All programs, emphasis on child health, medical homes, linking data sets	Ann Bracken, MD, MS* MCH Epidemiologist	.4	C	.4
All programs	John Zellers, Program Specialist	.5	P	
Universal Newborn Hearing Screening	To be hired, Information Specialist	.5	C	.5

Planning, Evaluation and Data Analysis

Program	Position Title * = Senior Position, Biography Attached	FTEs	P, C, or V	Vacant #FTE's
Nutrition, Feeding & Swallowing Program	Quality Assurance Evaluator of Nutrition, Feeding & Swallowing Program	.40	C	
Special Initiatives, Data Management, Quality Improvement	Special Projects Consultant	.60	C	

P = Paid, C = Contract, V = Voluntary

* Senior position, biography attached

1.5.2 State Agency Coordination

See Table 3 for all key associations with the Title V program.

TABLE 3
Key State Title V Relationships

Other State Human Service Agencies and Committees/Cabinets	Local and Federally Funded Agencies And Health Centers	Associations and Organizations	Tertiary Care Facilities and Universities
Healthy Child Care New Hampshire Steering Committee	The Title V agency funds a variety of community health centers, family planning, prenatal, adolescent health and child health programs child care health consultants. See Appendix E for listing.	New Hampshire Association for the Education of Young Children	Boston University School of Public Health , MCH Title V Regional Partnership Initiative – Advisory Committee
NH Home Visiting Network Steering Committee	Plus Time NH	NH Family Child Care Association	New England Newborn Screening Program, University of Massachusetts Medical School
Healthy People 2010 MCH Focus Workgroup	PTAN (Preschool Technical Assistance Network)	Association of Maternal and Child Health Programs	Early Connections – Policy and Practices Review Committee (Child Find Initiative),University of New Hampshire Affiliated Program
Perinatal Alcohol, Tobacco and Other Drug Use Task Force (Legislative Committee)	Community Health Institute	March of Dimes, NH Chapter	Dartmouth Hitchcock Medical Center, Department of Maternal-Fetal Medicine
STD/HIV Prevention Program, Infertility Prevention Project Committee	Crotched Mt. Rehab Center	State Adolescent Health Coordinators’ Network	Dartmouth Hitchcock Medical Center, Department of Neonatal Medicine
NH Department of Education	Parent Information Center	National Birth Defect Prevention Network	DHMC Injury Prevention Center
Diabetes Education Program, Disease Prevention and Health Promotion	Bi-State Community Health Center Association (Primary Care Association)	Bi-state Primary Care Association	New Hampshire Technical Institute

Other State Human Service Agencies and Committees/Cabinets	Local and Federally Funded Agencies And Health Centers	Associations and Organizations	Tertiary Care Facilities and Universities
Tobacco Prevention Program, Disease Prevention and Health Promotion	Parent Information Center	New Hampshire Dental Society	Harvard School of Public Health
Bureau of WIC Nutrition Services	Upper Valley Support Group	Area Health Education Centers (AHEC)	Dartmouth Medical School
Medicaid	Child Health Services	NH Safety & Health Council	Leadership Education In Adolescent Health Program, Children’s Hospital, Boston
Domestic Violence Fatality Review Team	Area Agencies	Education Development Center, Inc. – Newton, MA	Hood Center for Children and Families
Governor’s Domestic Violence Commission, Public Education Subcommittee	Cedarcrest -- ICFMR	Early Childhood Educators	University of New Hampshire – University Affiliated Program (UNH-UAP) Institute On Disability
Legislative Study Committee (SB 163) on Children and Guns		Organization of Day Care Providers	
State Children’s Health Insurance Program (SCHIP) Outreach Workgroup/Robert Wood Johnson funded “Covering Kids” Project State Coalition		NH Infant Mental Health Association	
State Children’s Health Insurance Program (SCHIP) Quality Assurance Workgroup (QCHIP)		NH Catholic Charities	
State’s Children’s Trust Fund Board of Directors		Manchester Child Care Committee	
Child Care Advisory Council – Title V Staff		Camp Superkids Advisory Committee	
Medicaid Dental Workgroup		The Title V agency is a member of the Rural Health Consortium charged to help identify barriers to care for New Hampshire rural citizens.	

Other State Human Service Agencies and Committees/Cabinets	Local and Federally Funded Agencies And Health Centers	Associations and Organizations	Tertiary Care Facilities and Universities
Title V staff participate in welfare reform planning efforts around home visiting to improve prenatal outcomes and decrease adolescent pregnancy. Additionally, the Family Planning Program participates on a Welfare Reform Advisory Council.		Greater Manchester Asthma Alliance	
NH Asthma Educators Coalition		The Title V agency participates as a member of the DHHS Children’s Care Collaborative, a consultative service to families with CSHCN and communities. Other partners include the Division of Behavioral Health and Division of Developmental Services.	
Title V staff participate in the Child Fatality Review Team.		The Title V agency participates as a member of the Firearm Safety Coalition.	
Division For Children Youth & Families Child Development Bureau and Child Care Standards and Licensing		New England Regional Genetics Group	
Region I Healthy Child Care American Grantees		New Hampshire Hospital Association	
Teen Workplace Safety Coalition (w/Dept. of Labor & Education & Others)		New Hampshire Pediatric Society	
The Title V agency chairs the NH Child Health Month Coalition.		New Hampshire Medical Society	

Other State Human Service Agencies and Committees/Cabinets	Local and Federally Funded Agencies And Health Centers	Associations and Organizations	Tertiary Care Facilities and Universities
Gov. Traffic Safety Commission		CL&P Legislative Initiatives Commission	
Buckle Up NH Coalition		New England SERVE	
Teen Motor Vehicle Legislation Committee		Children's Alliance for New Hampshire	
Youth Suicide Prevention Advisory Assembly (YSPAA)		New Hampshire Public Health Association	
NH Safe Kids Coalition		Early Intervention Network of New Hampshire	
Head Start State Collaboration Office		New England Regional Genetics Group (NERGG)	
Division of Behavioral Health's Children's Services		School Nurse Association	
NH State Library's Family Resource Connection		Early Education Intervention Network (EEIN)	
Division of Behavioral Health & Developmental Services – Part H ICC		New England Regional Genetics Group (NERGG)	
State Department of Education Special Education Advisory Committee			
State Independent Living Council			
Diabetes Advisory Committee			
State Children's Health Insurance Program (SCHIP)			
Council On Children and Adolescents With Chronic Conditions			
NH Childhood Lead Advisory Council			

II REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

Please refer to ERP Forms 3, 4, and 5.

Figure 2

2.2 Annual Number of Individuals Served

Please refer to ERP Forms 7, 8, and 9

2.3 State Summary Profile

Please refer to ERP Form 10

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.4 Progress on Annual Performance Measures

See Table 4 for Title V Activities by Level of the Pyramid for MCH Populations. All indicators are documented on Form 11.

TABLE 4

Title V Activities by Level of the Pyramid for MCH Populations

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
Infrastructure Building Services	Participated in NH Breastfeeding Task Force activities	Legislative efforts (teen driver safety) through the NH Teen Motor Vehicle Legislation Coalition, and the NH SAFEKIDS Coalition	
	Review and revision of the Prenatal Client Data Form for prenatal program reporting	Participated in Governor's Traffic Safety Commission (supported teen driver legislation)	
	Field Testing of electronic Client Data Form for Prenatal Program reporting requirements	Participated in Crash Outcomes Data Evaluation System (CODES) Workgroup (teen driver/risk factor data)	
	Participated in the state's Child Fatality Review Committee (CFRC).	NH hospital emergency department survey of referral practices/protocol for teens w/self-inflicted injuries	
	Issued revised and updated copies of recommended emergency department protocols for handling a suspected SIDS case and surveyed hospitals on past use of previously mailed protocols.	Initiated Child Fatality Review (CFR) Team teen suicide prevention activities	
	Involved in 2 surveys that had implications for future SIDS information campaigns: The New Hampshire Foundation for Healthy Communities' survey to women who delivered a baby in the state and the Behavioral Risk Factor Surveillance Survey (BRFSS), a telephone survey conducted by the University of New Hampshire for the New Hampshire Department of Health and Human Services	Improved data collection on teen suicide	
	Genetics Training for Prenatal Coordinators	Collaboration with TANF and Family Planning programs to plan teen-focused activities	
	Perinatal Alcohol, Tobacco and Other Drug Use Task Force monthly meetings	Participation in a rural community coalition to help prevent adolescent pregnancy in a small town	

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
		Participation in a community coalition to distribute knowledge about contraception in the community and to increase access to family planning services and information	
		Participation in a school-public health agency collaborative effort targeting middle school aged girls at risk for teen pregnancy	
		Received funds from the Child Care Development Block Grant funds and through a contracted agency hired two nurse consultants for the Healthy Child Care New Hampshire Project.	
		Established a healthy and safety in child care audiovisual library.	
		Worked with NH Immunization Program staff to update immunization component of the required services of the Title V –funded programs	
		Used CASA results from the NH Immunization Program in the Bureau’s Q/A efforts.	
		Worked with contract agencies and with representatives from the Healthy Kids Program, DFA, and the DHHS CHIP Program staff to increase the enrollment of children on the Healthy Kids Program, NH’s SCHIP program.	
		Participated in a state-level CHIP Outreach Workgroup and “QCHIP”, the state-level committee overseeing the quality assurance efforts monitoring the state’s CHIP Program.	

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
		Attended Healthy Kids Outreach breakfast meetings held throughout the state, sponsored by the Healthy Kids Program and DHHS	
		Required contract agencies to include objectives in their program workplan, which indicated outreach efforts to increase Healthy Kids and Medicaid (Prenatal) enrollment.	
		Developed and distributed child care health consultant work plans.	
		Developed a plan to expand the child care health consultant network.	
Population Based Services	Prenatal Outreach activities by BMCH Prenatal Programs	Provided information to public and media on prevention of MV crash injuries, child passenger safety	
	Displayed brochures on the NH SIDS Program, its services, and risk reduction strategies among maternal and child health information/resources in any conferences, trainings, or health fairs and included SIDS risk reduction strategies in any SIDS presentations or trainings	Coordinated Buckle Up NH Coalition Week activities	
	Promoted breastfeeding in any SIDS risk reduction outreach efforts including newsletter articles and presentations.	Bike safety and bike helmet promotion	
	Distributed breastfeeding resources and information from Breastfeeding Task Force and from WIC staff to Title V and 330-funded agencies.	Participated in NH Youth Suicide Prevention Advisory Assembly (YSPAA)	

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
	Provided financial support to the WIC Program's annual breastfeeding spring conference and encouraged attendance by Title V and 330-funded agency staff.	Continued efforts to educate the public about firearm safety, particularly around teen suicide issue	
		Development and facilitation of programs on creative abstinence	
		Sponsorship of "Sex is a Big, Big Deal" with Dr. Robert Hatcher	
		Development of an innovative curriculum on puberty	
		Co-facilitation of a program on "Stages of Change Behavior Theory"	
		Coordination with area Domestic Violence Centers to facilitate programs on sexual violence	
		Design of a sexuality course specifically for GED students by one educator	
		Appearances by educators at local schools on "Career Day" to publicize careers in human sexuality education	
Enabling Services	Individual Prenatal Program transportation services, translation services, health education services, case management services, and nutrition services	Added teen component to annual Buckle Up NH Week activities	
	Provided case management for all suspected SIDS cases referred by the OCME	Conducted child safety seat checks and parent education on child passenger safety	
	Individual Prenatal Program Pre-certification for Public Assistance Benefits	Provided technical assistance to community organizations and MCH contract agencies	
		Held 1 st NHTSA Child Passenger Safety Technician Certification Training	
		Coordinated Buckle Up NH Coalition Week activities	

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
		Completed the NH Bureau of Substance Abuse Services funded teen suicide prevention project	
		Exhibited teen suicide prevention materials at Annual Juvenile Justice conference (Nashua, NH).	
		Teen Clinic pregnancy prevention counseling and education	
		Held two networking and educational meetings for child care nurse consultants.	
		Encouraged agency enrollment of clients in both Healthy Kids Gold and Silver. Representatives from the DFA and the Healthy Kids Program were guest speakers at the spring '99 Child Health Coordinators' Meeting, sponsored by the Bureau's Child Health Nurse Consultant	
Direct Health	Partial funding to 6 prenatal agencies and 8 primary care agencies to provide comprehensive prenatal care	Specialized Teen Clinics at 8 sites funded by Family Planning Program within BMCH to provide reproductive health services	
Care	Title V and 330-funded agencies providing prenatal care assisted women in enrolling in WIC and encouraged the breastfeeding supports such as the Peer Counselors available through the local WIC agencies	Continued to support six child care health consultants in communities.	
Services	Provided case management for all suspected SIDS cases referred by the OCME	Continued to work with Title V and 330-funded agencies to assure that their knowledge of immunization requirements was current via information mailings and presentations.	
		Several Title V contract agencies hosted the CDC videoconferences on immunization updates	

LEVEL OF PYRAMID	Activities for Pregnant Women, Mothers and Infants	Activities for Children	Activities for CSHCN
		Several Title V-funded agencies which had previously held CDC Enhanced Immunization Outreach grants continued to provide their previously funded activities using local agency resources.	
		The 3 Title V agencies with CISS-sponsored home visiting grants and the 5 Title V agencies with CISS-sponsored Healthy Child Care America grants continued to assure that children and families they are involved with receive age-appropriate immunizations.	

NPM #1—The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

FY 1999

For purposes of this measure, “receiving rehabilitation services” is defined as the number of children identified on the SMS database as SSI recipients during the reporting period. The denominator is the number of children reported on SSI by SSA in December 1999.

Status of Annual Performance Indicator: 20.0% (Same number documented on Form 11)

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: SSI SDX tape and SMSB client database

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

We attribute this change to be reflective of a chart audit conducted of the care coordination program with many children having been discharged due to inactivity / lack of a coherent care coordination plan. It should continue to be noted that the reported diagnoses for SSI child recipients changes with the age of the child. Younger children (0-6 years) are less likely to be identified as having a psychiatric disorder or mental retardation. However, for older children (13-21), psychiatric disorders comprised 28.81%, and mental retardation comprised 51.94% of the total number of children receiving SSI benefits in 1996 (Institute of Child Health Policy, May 1997). Typically, these groups of children are not directly served by the Title V Program unless they have chronic illness/physical disability co mobility. Moreover, fewer children in New Hampshire are receiving SSI benefits.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 39. Programs to be reviewed/revised are in Table 40. See pages 132 & 133 for FY 2001 annual plan for this measure.

TABLE 5
Programs/Activities Contributing to Success for NPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The SMSB continued to receive SSI paper transmittals from the DDU, Vocational Rehabilitation Division, on new child SSI applicants.	D	A total of 292 referrals were received. Of these, 214 were new child applicants; 78 were children who had applied for SSI in the past and were now reapplying.
Planned efforts to expand outreach to SSI child recipients via MOU arrangements with Developmental Services were superseded by the reassignment of the SMS Bureau Chief to managed care systems development (MMIS) in Medicaid.	I	At this time, the Department of Health & Human Services was on an accelerated fast track to move its TANF population (n=54,000) into mandatory managed care via an 1115 Waiver. As such, dedicated subject matter experts were tapped from all areas of the Department (Elderly & Adult, Behavioral Health, Developmental Services, Public Health) to work on this project with OIS developers.

Programs/Activities	Pyramid	Comments
New health policy directives necessitated a change in how outreach to SSI recipients would be managed.	E	With the implementation of a Medicaid expansion for children under 1 to 300% of OMB poverty guidelines and the creation of a state buy-in program for uninsured children (Healthy Kids – Silver) via SCHIP in January 1999, outreach became targeted to that group of children on SSI who had no source of health insurance. This change was concurrent with state RWJ-funded outreach initiatives for “covering kids”. Previously, SSI outreach was directed at children with medical concerns exclusively.

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Status of Annual Performance Indicator: 9

Indicator has: () Improved (X) Stayed the same () Not Improved
 Objective Met/Exceeded: (X) Yes () No

Source of Data: SMS Database, staff and contractor annual reports

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 41. Programs to be reviewed/revised are in Table 42. See pages 134 & 135 for FY 2001 annual plan for this measure.

The Title V CSHCN Program continues to provide a full complement of direct health services to income eligible/medically needy families. All nine (9) specialty and subspecialty services are provided or paid for by the state.

TABLE 6
Programs/Activities Contributing to Success of NPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The SMSB supported the continued operation of private sector, multidisciplinary pediatric specialty clinics (SMS prior privatization initiatives).	D	Diana Dorsey, MD, the SMSB pediatric consultant, attends DHMC outreach cardiac clinics in Berlin and Keene assisting with diagnostic work-ups in collaboration with DHMC pediatric cardiologists and facilitating referrals to SMSB for direct health care and enabling services.
Support to privatized services cont'd	D	Demands, however, on Dr. Dorsey's time to complete disability determinations for the Medicaid Program and provide pediatric coverage to the Lebanon Neuromotor Program due to an MD retiring resulted in termination of her attendance at the Dover, Concord and Nashua Cardiac Clinics (2/99, 9/98, 8/98 respectively). She was not replaced by either a Dartmouth physician or a community-based Hitchcock Clinic affiliated pediatrician.
	D	The nutrition component of the Manchester Cystic Fibrosis Clinic was provided by the SMSB contracted dietitians.
	E	The Title V CSHCN Public Health Nurse Coordinators attend the Spina Bifida and Manchester Cystic Fibrosis Clinics as team members accepting assignments for care coordination on behalf of families.

Programs/Activities	Pyramid	Comments
The SMSB continued to operate three (3) pediatric specialty clinics directly from the state level.	D	These are: Amputee Clinic Neuromotor Clinic Cleft Lip & Palate Clinic
Amputee Clinic	D	This clinic, operating out of Healthsouth Rehab Hospital in Concord, reported no changes in team composition or clinic operations. A total of 20 children were enrolled during FY 1999.
Neuromotor Clinic Operations	D	Community-based clinics operate in five (5) designated sites: Berlin, Lebanon, Concord, Manchester and Exeter.
Neuromotor Clinic: Team Composition	D	Recruitment for a pediatric orthopedist at DHMC was successful. Dr. Kathleen Moen began attending the Lebanon Clinic in August 1999. Team composition in other clinic sites remained unchanged.
Quality Assurance	I	Guidelines for comprehensive physical therapy assessments continue to be under development. The School Functional Assessment and Pediatric Inventory of Disability is strongly favored for its validity with respect to parental report. Toileting fact sheets were written and are being distributed to parents. A parent questionnaire to focus the clinic visit on parent concerns and facilitate planning based on parent needs was implemented.
Cleft Lip & Palate Clinic Operations	D	The clinic continued to operate in two sites: Manchester and Lebanon.
Support to parents of newborns	D	Fourteen (14) newborns were referred by birthing hospital staff for assistance, 8 more than last year. Parents of these infants received hospital and/or home visiting support by the State Title V CSHCN Nurse Coordinator.
Team Composition	D	It remained very difficult to organize a full team complement, particularly in Manchester where members, in addition to their participation in the clinic, also have other full-time jobs. Many team members are able to attend only a few clinics, which makes continuity of care difficult. The loss of a speech pathologist, the lack of audiology services at the Manchester Clinic site, and the lack of ENT coverage at half the clinics have impacted the quality of services offered.

Programs/Activities	Pyramid	Comments
Privatization Efforts	I	Discussions around transitioning the clinic to DHMC have been underway for one year. The process has been slow and arduous with no formal commitment from DHMC to move forward.
Quality Assurance	I	The new parent information packet was completed and is being distributed.
Child Development Clinics Operations	D	The SMSB-funded network of community-based child development clinics continued at six (6) designated sites: Lebanon (DHMC), Berlin, Concord, Laconia, Manchester and Nashua. Although no direct Title V dollars support the MCHB LEND clinical service at Durham, the clinic coordinator has continued to participate in monthly child development coordinator staff meetings.
Team Composition	D	The lack of a developmental pediatrician at DHMC forced the closure of the Berlin site in December 1998. Children were routed to the tertiary center at DHMC in Lebanon for continuing care.
Appointment Scheduling Waiting time for appointments as a result of demand and staff availability became problematic.	D	Because of staffing constraints, first time appointments for evaluation were upwards to 6 months (all sites). Requests for follow-up appointments are the greatest area of need, limited by both financial and personnel availability.
Team Development	I	A pressing need for all sites is having time to meet on a regular basis to review team issues, triage and plan.
Funding Levels	I	Attempts to join forces fiscally with other state agencies, specifically Education and Mental Health, have been unsuccessful. Only the Laconia site has been able to secure local dollars to support and expand the coordinator role (Hospital DSH funds). The only other sources of revenue are insurance/Medicaid billings, which are paltry. Medicaid pays the highest rate of reimbursement of all insurers as a result of special negotiated rates with the SMSB.
Development of quality improvement workplans	I	Each Child Development Clinic site has work in progress to address needs identified by the parent satisfaction survey.

Programs/Activities	Pyramid	Comments
Future planning efforts did not materialize due to staff and time constraints.	I	There is a recognized need for a State plan as well as ongoing Title V leadership, coordination and involvement in developmental evaluation services for children 0-21. Moreover, there is also a need for an integrated system that includes a supported community-based structure with processes that coordinate resources and consultative services for this population of children.
Payment on behalf of individual children and families.	D, E	A total of 1,000 children were served and a total of \$484,983 expended. Breakdown as follows: Family Support \$169,307 Direct Health Services \$315,676
Nutrition, Feeding & Swallowing Program The SMSB supported 15 community-based nutritionists to provide evaluation and follow up services to CSHCN.	D	A total of 1,257 service contacts were reported.
Ongoing staff development and competency assessments continued.	I	Ten (10) trainings were held. Two (2) staff were financially supported to attend national conferences. Collaborative/Training efforts continued with Children's Hospital and the Vermont LEND Program.
Quality assurance activities continued. • WIC / SMS chart audit completed	I	Focus was on implementing changes to internal administrative processes to improve timeliness of nutrition reports.
The SMSB supported one Feeding & Swallowing consultant to provide evaluation services to CSHCN. Demand escalated necessitating a decision to stop accepting new referrals.	D	A total of 495 service contacts were reported.
"Getting underway" with network development and expansion continued.	I	Three (3) providers were recruited, whose training is to begin July 1999.
Quality assurance activities continued	I	<ul style="list-style-type: none"> • Training and technical assistance to hospital radiology departments for VFSS • Standardization of data collection procedures • Informational handouts for primary care providers • Initiation of discussion around quality indicators to measure effectiveness of services
Psychology Consultation Services The SMSB supported parent access to a psychologist for discussion of needs and concerns.	D	A total of 167 parent consultations were reported.

Programs/Activities	Pyramid	Comments
School consultations by the psychologist to assist parents in addressing school programming issues and placements continued.	E	Total of 181 school meetings (not IEP) were reported.
SMS supported staff training and capacity building via access to a psychologist.	I	A total of 152 staff consultations were reported.
<p>Care Coordination A new community-based model was deployed as a pilot in using a nurse from a local public health department in Nashua.</p>	I	<p>This experience allowed the SMSB to validate the feasibility of this approach and identify the groundwork needed for successful expansion into other areas of the state.</p> <p>Where best to house these individuals, how to teach care coordination best practices, and how to measure effectiveness are still outstanding questions.</p>
<p>Family Support Services The SMSB continued to fund Parent-to-Parent of NH supporting continued access to information and support to families calling the 1-800 toll-free number.</p>	P	Family support continues to be the primary focus.
FY 1999 marked the sixth year paid parent consultants have been a part of SMSB operations.	I	

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”

FY 1999

For purposes of this measure, “medical home” is defined as children with access to a source of insurance for health care. Change is considered an artifact due to better data. Therefore, access to a source of insurance remains a proxy measure for medical home.

Status of Annual Performance Indicator: 91.7%

Indicator has: Improved Stayed the same Not Improved

Objective Met/Exceeded: Yes No

Source of Data: NH Insurance household survey and estimates of CSHCN.

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 43. See page 136 for FY 2001 annual plan for this measure.

No new program initiatives other than planned maintenance of effort can be reported.

The infrastructure building needed to support a medical home has not been fully conceptualized or universally operational. Medical homes resembling the AAP definition are the exception rather than the norm. There is little infrastructure in a physician’s office to track or monitor the health status of individual children or, for that matter, children with special health care needs as a population. The computer systems are for billing purposes and are not in general constructed in such a way to make data extraction or management easily possible.

TABLE 7
Programs/Activities Contributing to Success of NPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
One health maintenance office visit continued to be authorized yearly for low income, medically needy children under care of the SMSB to visit their primary care physician in an effort to encourage a medical home.	D	Family education is a critical component of assuring a medical home. A primary care physician may be listed on the Title V application, but contact with this individual may be sporadic, particularly if a child is seen regularly at a pediatric specialty clinic. Families repeatedly say: “We come to clinic, why do we need to see yet another doctor?”
The SMSB continued its \$15,000 grant support to the “Accessing Developmental and Psychological Training Project” (ADAPT) along with its other funding partners.	I	Project benefits have been identified as follows: <ul style="list-style-type: none"> • Early intervention providers have established working relationships with local pediatricians. • Early intervention programs use the ADAPT Project to obtain information and connect with health care professionals. • Community physicians participating in ADAPT now play a larger and more defined role in their communities. • Physician trainees are better able to handle individual cases and to make appropriate referrals to community services.

Programs/Activities	Pyramid	Comments
ADAPT cont'd		<ul style="list-style-type: none"> • The project has opened communication between early intervention services and the medical community. • Communication among providers—preschools, early intervention programs, medical professionals, developmental services—has been improved. • Information sharing among professionals and collaboration on problem solving has improved in participating communities. <p>In two regions (Keene and Concord), school districts now contract with ADAPT physician trainees for consultative services.</p>

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Status of Annual Performance Indicator: Cannot be reported

Indicator has: () Improved () Stayed the same () Not Improved
Objective Met/Exceeded: () Yes () No

Source of Data: Vital Records and Newborn Screening Program

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 44. See page 137 for FY 2001 annual plan for this measure.

Births by Occurrence: Data is not available from Vital Records. FY'97 & FY'98 data will be corrected and resubmitted in August 2000.

TABLE 8
Programs/Activities Contributing to Success of NPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The SMSB continued to financially support income eligible and medically needy families with infants with disorders identified through newborn screening testing.	D	During FY 1999, a total of \$7,820 was spent on services on behalf of nine (9) children.
Care coordination was provided by an assigned nurse coordinator to families with children with metabolic disorders. Payment for enabling services continued.	E	Five (5) new children were identified. A total of 20 families received services.
The Annual PKU Weekend was not held this year as either the NH Title V or the VT Title V programs nor Children's Hospital could identify staff to plan and organize this event.	E	
FY 1999 marked the 16 th year NH has contracted with the New England Newborn Screening Program for laboratory services.	P	Electronic linkage continued and a new database software program was deployed.
Sickle Cell screening continued to be offered on a targeted basis. No disease was detected.	P	The literature does not support universal sickle cell testing for populations at low risk as a cost effective intervention. Vermont, a state with a similar racial composition as NH, has been universally testing since 1990 with no disease. Monitoring of the Vermont experience continues.
Quality assurance activities continued: <ul style="list-style-type: none"> Hospitals continued to be urged to use the cumulative lists to match their birth rosters. The concept of a Hospital Report Card for newborn screening was presented to the Hospital Association and endorsed. Certified letters to the physician of record continued for repeat specimens requested, but not received. 	I	Report card format was developed, but data compilation did not occur as planned.

TABLE 9
Programs/Activities Needing Review/Revision for NPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Data reliability for the Home Birth Report was questioned and the need identified for revising the data collection process.	I	This entailed discussions with Vital Records, which are planned for FY 2000.

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Status of Annual Performance Indicator: 80.5%

Indicator has: () Improved () Stayed the same (x) Not Improved
Objective Met/Exceeded: () Yes (x) No

Source of Data: CDC National Immunization Survey (July, 1998 – June, 1999), NH Bureau of Vital Records

Population(s) served: (x) Pregnant Women, Mothers and Infants (x) Children () CSHCN

Narrative – The primary reason for the slight decrease of this indicator from the previous year is that the previous year’s rate did not include the 3 Hepatitis B doses having been given. It is still expected that there would be higher immunization rates achieved in those facilities that treat children on a regular basis for both well child and acute care visits, and especially in the Title V-funded contract agencies that see children on a regular basis for well child but not acute care. Reasons for not achieving a higher rate include problems with vaccines not being counted as the minimum age to be administered or minimum intervals between doses were not adhered to; drop out rates between doses of DTP and Hep B reflecting tracking/recall problems; and missed opportunities.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 45. See pages 138 & 139 for FY 2001 annual plan for this measure.

TABLE 10
Programs/Activities Contributing to Success of NPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Collaboration with NH Immunization Program staff to update immunization component of the required services of the Title V–funded programs	I	MCH provides a periodicity schedule, more detailed than that of AAP, to its contract agencies, which must be followed as a contract requirement. This schedule is updated annually to reflect current immunization requirements.
Use of CASA results for Q/A efforts	I	MCH used CASA results from the NH Immunization Program in the Bureau’s Q/A efforts. (Contract agencies with less than optimal CASA results are required to include activities to improve rates as part of their MCH grant proposal workplan. This is shared with the Imm. Program. At site visits MCH staff assess compliance with Imm. Program requirements sent in follow-up to agency’s CASA results.) As more and more of the larger TitleV- and 330-funded agencies and primary care centers are using Logician software, which includes tracking, and self-monitoring of age-appropriate immunizations, we would hope to see improvement in the rates of children served by Title V-funded agencies.
Kept contract agencies up to date with current immunization information	P, D	Bureau staff continued to work with Title V and 330-funded agencies to assure that their knowledge of immunization requirements was current via information mailings and presentations. . Imm. Program representatives presented at the twice-yearly Child Health Coordinators’ Meetings sponsored by the Bureau.

Programs/Activities	Pyramid	Comments
Hosted CDC video conferences	P, D	Several Title V contract agencies hosted the CDC videoconferences on immunization updates on behalf of the Imm. Program.
Continued immunization activities	D	Although 13 Title V-funded agencies that had previously held Enhanced Immunization Outreach grants from CDC funds via the Imm. Program had this grant funding source end, several continued to provide their previously funded activities such as nurse-run immunization clinics on a scaled-down level using community donations of local agency resources.
Activities by CISS-sponsored Home visiting and Healthy Child Care America grants	D	The 3 Title V agencies with CISS-sponsored home visiting grants and the 5 Title V agencies with CISS-sponsored Healthy Child Care America grants continued to assure that children and families they are involved with receive age-appropriate immunizations.

NPM #6 – The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Status of Annual Performance Indicator: 13.1 per 1,000

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: New Hampshire Bureau of Vital Records, 1998 Birth Data

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN
 Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 46.
 Programs to be reviewed/reviseed are in Table 47. See page 140 for FY 2001 annual plan for this measure.

TABLE 11
Programs/Activities Contributing to Success of NPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Teen Clinics	D, E	The BMCH receives federal, state and Social Service Block Grant (Title XX) funding to assist in its' efforts to provide quality family planning and health services to populations in need, especially low-income women, the uninsured and teens. Services provided to teen clients include: complete physical examinations; preventive health care(including contraceptive services); anemia screening, breast and cervical cancer screening; testing and treatment for sexually transmitted infections; immunizations; screening for substance abuse, domestic violence and sexual assault; health education; and treatment of selected health problems such as abnormal pap smears and amenorrhea. Specialized family planning teen clinics were provided through four agencies at eight sites in FY 1999. Each offered teen-friendly services that were confidential, affordable, available during evening or weekend hours on a walk-in basis, and staffed by teen peer educators. These sites provide extensive pregnancy prevention counseling and education to teen clients on topics such as abstinence, postponing sexual involvement, pregnancy prevention, decision-making, resisting peer pressure, risk taking, pregnancy options and behavior modification.
Teen Pregnancy Prevention Community Health Education	P	Thirteen family planning educators employed by the delegate agencies provided information and training on reproductive health issues to communities throughout the state. Some unique community education projects included: <ul style="list-style-type: none"> • The development and facilitation of programs on creative abstinence • Sponsorship of a program with Dr. Robert Hatcher entitled "Sex is a Big, Big Deal" • Development of an innovative curriculum on puberty • Facilitation of a program, along with JSI, on Stages of Change Behavior Theory • Coordination with area domestic violence centers to facilitate programs on sexual violence • Designing of a sexuality course specifically for GED students by one educator • Appearances by educators at local schools on 'career day' to publicize careers in human sexuality education • Production of "Teen Pregnancy Prevention Month" radio

		spots
--	--	-------

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Status of Annual Performance Indicator: 13%

Indicator has: () Improved () Stayed the same (X) Not Improved
 Objective Met/Exceeded: () Yes (X) No

Source of Data: 9 school-based preventive dental programs
3 hospital-based dental clinics
N.H. Healthy Kids Gold (Medicaid) Program
N.E. Delta Dental Program

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

We did not reach the goal set for National Performance Measure #7 because the numerator and percentage used for children receiving sealants was based on the national average of 21%. Before the Oral Health Program was established, N.H. sealant goals were set for 4 consecutive years based on the national average. While the demographics of New Hampshire make this seem reasonable, we know that there are pockets of populations in N.H. of low-income, underserved, and uninsured people with no access to dental care. FY 2000 will be the first year that the Bureau of Oral Health will adjust National Performance Measure target #7 to 15% to reflect a more realistic understanding of the number of N.H. children receiving the preventive benefits of protective dental sealants.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 48. Programs to be reviewed/revised are in Table 49. See page 141 for FY 2001 annual plan for this measure.

TABLE 12
Programs/Activities Contributing to Success of NPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Oral Health Program	I,D	Established in Nov. '98, the Oral Health Program funds community-based oral health programs in schools, hospitals, and primary care health centers. Nine school-based preventive dental programs provide screenings, cleanings, fluoride treatments, and referrals for restorative care and dental sealants. Three hospital dental clinics provide on-site preventive and restorative care to low-income families without access to regular dental services.
	P	Additional oral health initiatives included fluoridation campaigns in Nashua and Manchester.
	I	Designation of two Dental Health Professional Shortage Areas in the Upper Connecticut Valley and in the Berlin/Gorham areas will attract more dental providers to the most underserved areas of the state.
	I	Formation of the Dental Policy Advisory Committee initiated dialogue among dentists and advocates for children's oral health about improving the Medicaid program to enroll more dental providers.
	I	Participation in state and regional meetings promote the interchange of useful information among oral health stakeholders.
	I	Collaborative efforts with Bi-State Primary Care Association are underway to improve dental data collection and the development of a statewide dental surveillance system.
	I	The Bureau of Oral Health continues to promote the need for and to leverage more resources to further develop school-based and

community oral health programs.

NPM #8 – The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Status of Annual Performance Indicator: 2.0 (Same number documented on Form 11)

Indicator has: (x) Improved () Stayed the same () Not Improved

Objective Met/Exceeded: (x) Yes () No

Source of Data: death certificate (calendar year 1998, most recent data available)

If data are not available, state how and when data will be obtained for current application.

Population(s) served: () Pregnant Women, Mothers and Infants (x) Children () CSHCN

Narrative – Discuss why the objective was met or not met only if tables are not adequate.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 50.

See page 142 for FY 2001 annual plan for this measure.

TABLE 13
Programs/Activities Contributing to Success of NPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
* Child safety seat checks and parent education on child passenger safety	E	6 child safety seat checks @ 3 well child clinics in NH; several checks @ other NH sites. A total of over 375 seats were checked, 90% needed improvement
Technical assistance to community organizations and MCH contract agencies	E	
Provided information to public and media on prevention of MV crash injuries, child passenger safety	P	
* NHTSA Child Passenger Safety Technician Certification Training	I, E	IPC-Dartmouth (Title V funded) coordinated (with IP Program assistance) 1 st training event to 27 police, fire and rescue, nurses and others. In addition, certified 2 NH people as Instructors in order to develop a NH-based infrastructure for ongoing graining of CPS technicians, and capacity to routinely conduct car seat checks statewide.
Coordinated Buckle Up NH Coalition Week activities	P	IPC continued to lead BUNH Coalition (with IP Program participation) and coordinate MV/CPS material distribution statewide, mini-grants to NH communities for CPS events, annual kick-off public awareness events, and others.
Bike safety and bike helmet promotion*	P, E	IPC continued efforts to educate and train a state-wide team of safety advocates on bicycle and helmet safety: held training to a mixed audience of 25 on bike rodeo's; held a training for 25 on the NHBIKES curriculum; assisted with organizing the first Walk and Bike NH conference. Continue to publicize availability of reduced cost helmets. * The majority of bicycle injuries occur due to a collision with a motor vehicle.

* = programs/activities that are new within the past 2 years.

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Status of Annual Performance Indicator: Cannot be reported

Indicator has: () Improved () Stayed the same () Not Improved
Objective Met/Exceeded: () Yes () No

Source of Data: Vital Records and report by birth hospitals

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 52. See page 144 for FY 2001 annual plan for this measure.

Calendar year births for FY'99 data are not available. FY'97 and FY'98 data will be corrected and resubmitted in August 2000.

TABLE 15
Programs/Activities Contributing to Success of NPM #10
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Financial assistance with specialty medical care including purchase of hearing aids continued to be available to low income, medically needy families whose infant/young child is suspected of having a hearing impairment.	D	
Teachers of the deaf/hard of hearing infant specialists continued to be available on a consultation basis to early intervention programs contracted through the NH Division of Developmental Services under Part C to serve eligible children.	E	Interpreters for the deaf continued to be provided to all SMSB operated pediatric specialty clinics. Additionally, the SMSB provided funding for parents to either attend signing classes or purchase videos to enhance their ability to communicate with their child. Educational materials about hearing impairment/deafness remained available on loan from the SMSB Family Support & Resource Center library.
No additional New Hampshire hospitals began infant hearing screening programs.	P	
Representatives of the SMSB participated in the Task Force on Infant Hearing Screening convened by the NH Pediatric Society under the leadership of Judith Frank, MD. The purpose of the group was to provide a forum for discussion around issues such as equipment, standards and procedures, tracking systems and quality assurance.	I	The Task Force produced a report as a result of its work endorsing adoption of universal hearing screening and designated the Title V CSHCN Program as the lead state agency for tracking, monitoring and quality assurance of this initiative.

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Status of Annual Performance Indicator: Cannot be reported

Indicator has: () Improved () Stayed the same () Not Improved
 Objective Met/Exceeded: () Yes () No

Source of Data: _____

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 53. See page 145 for FY 2001 annual plan for this measure.

The report writer tool for the SMS database was erased during Y2K testing. It is currently being reinstalled. Data will be supplied in August 2000.

TABLE 16
Programs/Activities Contributing to Success of NPM #11
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Funding continued to be provided to low income, medically needy families who received COBRA assistance in order to maintain health insurance coverage for their child with special health care needs.	E	Families received assistance with COBRA insurance payments. A total of \$_____ was expended.
Families whose children may be eligible for Medicaid / SCHIP continued to be assisted through this process by the Title V CSHCN Program's Medicaid case technician.	E	A total of 164 families were assisted in this process.
The SMSB continued to routinely collect information at the time of initial application and annually, thereafter, about a child's health insurance status.	I	This information continued to be entered into the SMSB patient master file database and is easily retrieved for reporting purposes. Insurance data has been trended since 1991.
A project with Healthy Kids-Silver, the state's SCHIP product, to identify CSHCN applying for these benefits did not materialize.	I	

NPM #12 – Percent of children without health insurance.

Status of Annual Performance Indicator: 7.9

Indicator has: () Improved () Stayed the same (x) Not Improved
 Objective Met/Exceeded: () Yes (x) No

Source of Data: 1999 NH DHHS Health Insurance Coverage in New Hampshire Survey, March 1996 CPS, U.S. Office of the Census

Population(s) served: (x) Pregnant Women, Mothers and Infants (x) Children () CSHCN

Narrative - New data sources available providing more accurate information have indicated that we not only did not meet the desired objective of a decline in percentage from 4.8% to 4%, but have a greater percentage of children without insurance (7.9%) than was previously thought. Results from the New Hampshire Health Insurance Coverage and Access Survey released in November, 1999, by the NH Department of Health and Human Services' Office of Planning and Research show that of the estimated 96,000 residents that remain uninsured, 26%, or 25,000 are children under age 18. This is an approximate increase of 10,000 from previously held estimates for this age group. Healthy Kids is New Hampshire's State Child Health Insurance Program (SCHIP), with Healthy Kids Gold being the replacement for the state's Medicaid program, and Healthy Kids Silver being the partially subsidized buy-in program offering a sliding fee scale.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 54. See page 146 for FY 2001 annual plan for this measure.

TABLE 17
Programs/Activities Contributing to Success of NPM #12
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Encouraging contract agency staff to increase enrollment in SCHIP	I	The Bureau has played an active role in working with its contract agencies and with representatives from the Healthy Kids Program, DFA, and the DHHS CHIP Program staff to increase the enrollment of children on the Healthy Kids Program, NH's SCHIP program.
Participation in "QCHIP"	I	The Bureau's Child Health Nurse Consultant has participated in a state-level CHIP Outreach Workgroup, as well as "QCHIP", the state-level committee overseeing the quality assurance efforts monitoring the state's CHIP Program.
SCHIP outreach breakfast meetings	I	Bureau staff attended several of the four Healthy Kids Outreach breakfast meetings held throughout the state, sponsored by the Healthy Kids Program, DHHS, and the DFA which provided information and an opportunity to give feedback on the enrollment process.
SCHIP/Medicaid outreach objectives in contract agency workplans	I	Agencies applying for Title V funding in the spring '99 cycle were required to include objectives in their program workplan, which indicated outreach efforts to increase Healthy Kids and Medicaid (Prenatal) enrollment. This was a new requirement.

Programs/Activities	Pyramid	Comments
Monitoring contract agency SCHIP/Medicaid enrollment	I	Data/reporting information from the previous year, submitted to BMCH from its grantees in spring '99, were assessed for percentage of clients enrolled in Healthy Kids Gold, Healthy Kids Silver, and (Prenatal) Medicaid. Written feedback and composite information from all of the grantees was provided to the agencies from Bureau staff, along with suggestions for improvement, as indicated.
Public distribution of Healthy Kids (SCHIP) information	P	Bureau staff continued to distribute and display Healthy Kids information among its Maternal and Child Health material at any conference, training, or health fair, including the spring '99 display in the state's Legislative Office Building during Public Health Week (April). Bureau staff provided basic information and the toll-free number to any requests from the general public.
Facilitating contract agencies' enrollment of clients on Healthy Kids/Medicaid and Presumptive Eligibility	E	Bureau staff have continued to work with Title V and 330-funded agencies to encourage their enrollment of clients in both Healthy Kids Gold and Silver. Representatives from the DFA and the Healthy Kids Program were guest speakers at the spring '99 Child Health Coordinators' Meeting, sponsored by the Bureau's Child Health Nurse Consultant. This provided an opportunity for the local agency staff to share with state program level staff any problems or concerns they have experienced in trying to enroll clients at the local level. Training from the Department's Division of Family Assistance (DFA) has enabled these local agencies to do "presumptive eligibility" enrollment, and receive a \$11.91 payment for completing and submitting the Healthy Kids application to the local DFA office for processing.

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Status of Annual Performance Indicator: 78%

Indicator has: () Improved () **stayed** the same (x) Not Improved
 Objective Met/Exceeded: () Yes (x) No

Source of Data: Ad hoc report on FY'99 run by state Medicaid Program, 1999 NH DHHS Health Insurance Coverage in New Hampshire Survey

Population(s) served: (x) Pregnant Women, Mothers and Infants (x) Children () CSHCN

Narrative – Although the indicator of 78% was lower than last year’s indicator of 82%, and did not meet the objective of 85%, 2,243 more children received services paid by Medicaid in FY '99 compared to FY'98. The decline in the indicator reflected new information showing that the number of children eligible for Medicaid was higher than had been previously thought.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 55. See page 147 for FY 2001 annual plan for this measure.

TABLE 18
Programs/Activities Contributing to Success of NPM #13
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Monitoring and encouraging contract agencies' use of "Health Care Support" and "Prenatal Extended Care" services	I	Bureau staff reviewed Title V contract agencies' utilization of the "Child Health Care Support" and "Prenatal Extended Care" services. Bureau staff have periodically encouraged MCH contract agencies to utilize and bill for these Medicaid services created specifically for the Title V maternal and child health population. Agencies with low utilization rates are encouraged to provide these important services to the women and children they serve. These services, "Child Health Care Support" and "Prenatal Extended Care" enable agencies to provide supportive services such as nutrition counseling, social work services, case management, outreach, health education and home visiting to pregnant women and to families with children.

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Status of Annual Performance Indicator: 16.0

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: Consensus between Title V administration and parent consultants

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 56. See page 148 for FY 2001 annual plan for this measure.

TABLE 19
Programs/Activities Contributing to Success of NPM #14
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
<p>The SMSB has pledged a commitment to ensuring parent participation in its program and policy activities. Sustaining this effort, however, is not without certain challenges.</p>	<p>I</p>	<p>The SMSB has used parent leadership training as the vehicle to identify parents with interest in becoming involved on a program and policy level. Each year, one parent with a child with a medical condition is sponsored at the UAP Institute On Disability’s Leadership Training Seminar at a cost of \$1,000.</p> <p>Additionally, supporting parent training through Parent-to-Parent of NH has been a resource to identify parent leaders. Many of the graduates of this training program have gone on to paid staff positions in either community-based human services organizations or as paid parent consultants to special projects in other organizations.</p> <p>While it has been rewarding to see these individuals grow into new positions, constant turnover has prevented the SMSB from having a consistent pool of trained parent consultants from which to draw for expertise. Consequently, Title V CSHCN Program operations have fallen upon the SMSB paid parent consultants.</p>

NPM #15 – Percent of very low birth weight live births.

Status of Annual Performance Indicator: 1.1 %

Indicator has: Improved Stayed the same Not Improved
 Objective Met/Exceeded: Yes No

Source of Data: New Hampshire Bureau of Vital Records, 1998 Birth Data

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 57. See page 149 for FY 2001 annual plan for this measure.

TABLE 20
Programs/Activities Contributing to Success of NPM #15
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Agency	D, E, I	The Bureau of Maternal and Child Health provided partial funding to 14 agencies that provide comprehensive prenatal care services to pregnant and post-partum women with a special emphasis on adolescents and women from low-income families (less than or equal to 185% of the US Dept. of Health and Human Services Poverty Guidelines). 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 precertification for Medicaid eligibility. Bureau staff conduct periodic site visits to monitor compliance in the provision of acceptable care in accordance with their contract and national standards. Additionally, prenatal data submitted on each client enables monitoring of outcomes and service provision.
Perinatal Alcohol, Tobacco and Other Drug Use Task Force	I	This Task Force continued meeting during FY 1999. However, as the Prenatal Program Chief position was vacant during this period, the Bureau of Maternal and Child Health did not actively participate in this Task Force.
Prenatal Genetic Screening Training	I	Training on genetic screening in the perinatal population was provided for BMCH Agency Prenatal Coordinators during FY 1999, including instruction on the use of a Genetic Screening Tool.

TABLE 21
Programs/Activities Needing Review/Revision for NPM #15
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Client Data Forms	I	Client data forms, in both paper and electronic versions, need review regularly.
Low Birth Weight Rate	P, I	Analysis of the high LBW rate may highlight areas of concern and indicate programming priorities.

* = programs/activities that are new within the past 2 years.

NPM #16 – The rate (per 100,000) of suicide deaths among youths 15-19.

Status of Annual Performance Indicator: 17.1 (Same number documented on Form 11)

Indicator has: () Improved () Stayed the same (x) Not Improved
 Objective Met/Exceeded: () Yes (x) No

Source of Data: death certificate (calendar year 1998, most recent data available)

If data are not available, state how and when data will be obtained for current application.

Population(s) served: () Pregnant Women, Mothers and Infants (x) Children () CSHCN

Narrative – Discuss why the objective was met or not met only if tables are not adequate.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 58. Programs to be reviewed/revised are in Table 59. See page 150 for FY 2001 annual plan for this measure.

The number of teen suicide deaths fluctuates from year to year; annual rates are unreliable (based on fewer than 20 deaths). Analysis of data for the period 1992-1996, when compared to 1987-1991 showed a 30% reduction in the teen suicide rate.

TABLE 22
Programs/Activities Contributing to Success of NPM #16
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
NH Youth Suicide Prevention Advisory Assembly (YSPAA)	P, I	IPC chaired and coordinated YSPAA; IP Program active participant
YSPAA completed the NH Bureau of Substance Abuse Services funded project	I,E	BSAS-funded project conducted in 6 NH sites-a large resource manual of the newly developed materials is now available
* NH hospital emergency department survey	I,P,E	In conjunction with the NH Medical Examiner's Office, a survey was distributed to Hospital ED's regarding protocols/practices for follow-up of teens admitted for self-inflicted injuries. A large percentage of the ED's responded to the surveys which were then reviewed by YSPAA members. A follow-up letter was sent to all hospitals that responded with resource information.
Child Fatality Review (CFR) Team	P, I	The CFR (IP Program Manager participates) reviewed several teen suicides. The IP Program Manager and IPC-Dartmouth presented to the Team on teen suicide and prevention activities in NH. The CFR Team requested that YSPAA collaborate on an effort to develop a training/workshop on guidelines for working with the media around this issue that will take place in May 2000.
* Exhibited at Annual Juvenile Justice conference (Nashua, NH).	E,P	YSPAA exhibited and distributed resource and educational materials on youth suicide at this conference, to an audience of over 500
* Improved data collection on teen suicide	I	NH Medical Examiner, with YSPAA assistance, upgraded the data collection form used by NH field examiners reviewing a teen suicide death. This upgrade will allow the ME to collect additional information regarding potential risk factors and circumstances of the teen suicide.

Programs/Activities	Pyramid	Comments
Continued efforts to educate the public about firearm safety, particularly around teen suicide issue	P,E	The NH Firearm Safety Coalition, led by the IPC-Dartmouth, and composed of members from the IP Program, NH Medical Society, Department of Education, Gun Owners of NH, Sturm-Ruger (firearms manufacturer) and others continues to be active and develop educational strategies to reduce firearm suicides. FY99 efforts (funded in part by Title V) focused on continued distribution of firearm safety educational materials, and development of an educational video geared toward young teens and accompanying educator's guide, that will be distributed to NH schools, police, etc. Fund-raising, development of the script, guide and production of the video took place during this period. The video is to be released in November 1999.

- = programs/activities that are new within the past 2 years.

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Status of Annual Performance Indicator: 83.3%

Indicator has: () Improved (X) Stayed the same () Not Improved
 Objective Met/Exceeded: (X) Yes () No

Source of Data: New Hampshire Bureau of Vital Records, 1998 Birth Data

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 60. Programs to be reviewed/revision are in Table 61. See page 151 for FY 2001 annual plan for this measure.

TABLE 23
Programs/Activities Contributing to Success of NPM #17
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Perinatal Program, DHMC	E, I	The Bureau of Maternal and Child Health has not focused on specific activities addressing this objective. The Perinatal Program at Dartmouth Hitchcock Medical Center provides regular and comprehensive outreach and education to all state hospitals regarding the transfer of high-risk cases to DHMC for delivery.

TABLE 24
Programs/Activities Needing Review/Revision for NPM #17
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Staff	I	The Prenatal Program Chief position was vacant during the entirety of FY 1999. This position is now filled and examination of the prenatal program is underway.

* = programs/activities that are new within the past 2 years.

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Status of Annual Performance Indicator: 88.3%

Indicator has: Improved Stayed the same Not Improved

Objective Met/Exceeded: Yes No

Source of Data: New Hampshire Bureau of Vital Records, 1998 Birth Data

Population(s) served: Pregnant Women, Mothers and Infants Children CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 62. Programs to be reviewed/revised are in Table 63. See page 152 for FY 2001 annual plan for this measure.

TABLE 25
Programs/Activities Contributing to Success of NPM #18
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Agency	D, E, I	<p>The Bureau of Maternal and Child Health provided partial funding to 14 agencies that provide comprehensive prenatal care services to pregnant and post-partum women with a special emphasis on adolescents and women from low-income families (less than or equal to 185% of the US Dept. of Health and Human Services Poverty Guidelines). 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 precertification for Medicaid eligibility.</p> <p>Bureau staff conduct periodic site visits to monitor compliance in the provision of acceptable care in accordance with their contract and national standards. Additionally, prenatal data submitted on each client enables monitoring of outcomes and service provision.</p>
Perinatal Alcohol, Tobacco and Other Drug Use Task Force	I	<p>This Task Force continued meeting during FY 1999. However, as the Prenatal Program Chief position was vacant during this period, the Bureau of Maternal and Child Health did not actively participate in this Task Force.</p>
Prenatal Genetic Screening Training	I	<p>Training on genetic screening in the perinatal population was provided for BMCH Agency Prenatal Coordinators during FY 1999, including instruction on the use of a Genetic Screening Tool.</p>

TABLE 26
Programs/Activities Needing Review/Revision for NPM #18
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Staff	I	The Prenatal Program Chief position was vacant during the entirety of FY 1999. This position is now filled and examination of the prenatal program is underway.
Prenatal Programs	D, E	Review of Prenatal service areas need review to determine possible expansions of this program.

SPM #1 – Percent of pregnant women attending state funded prenatal clinics who have an HIV test.

Status of Annual Performance Indicator: 77.3%

Indicator: () is new (X) has improved () has stayed the same () has not improved

Objective Met/Exceeded: () Yes (X) No

Source of Data: Bureau of Maternal & Child Health

State Priority Need Being Addressed: Compliance with Current Prenatal Standards of Care

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 64. Programs to be reviewed or revised are in Table 65. See page 153 for FY 2001 annual plan for this measure.

TABLE 27
Programs/Activities Contributing to Success of SPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program	D	BMCH-funded agencies were required to counsel all pregnant women about the benefit of having an HIV test as a standard part of prenatal care, and to test those who consented. Data from BMCH-funded agencies revealed that 92.3% of prenatal clients were counseled and offered HIV testing prenatally. Since HIV testing is voluntary, prenatal clinics cannot require that women undergo testing. Clinic staff, therefore, have direct control over whether women are counseled, but no control over whether women consent and undergo testing. The Performance Objective for this Measure was increased from 60% to 95% between FY 1998 and FY 1999 and was not met. The Performance Objective for FY 2000, therefore is being adjusted to reflect a more reasonable goal. The objective for FY 2000 will be 80% and the objective for FY 2001 will be 85%.

TABLE 28
Programs/Activities Needing Review/Revision for SPM #1
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Coordinators' Meetings	I	Reinforcement of the goal to counsel all pregnant women about the benefit of having an HIV test will be reinforced routinely during biannual Prenatal Coordinators' Meetings

SPM #2 – Percent of women statewide who smoked during pregnancy.

Status of Annual Performance Indicator: 17.1 %

Indicator: () is new (X) has improved () has stayed the same () has not improved

Objective Met/Exceeded: () Yes (X) No

Source of Data: Bureau of Vital Records

State Priority Need Being Addressed: Low Birth Weight

Population(s) served: (X) Pregnant Women, Mothers and Infants () Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 66. Programs to be reviewed or revised are in Table 67. See page 154 for FY 2001 annual plan for this measure.

TABLE 29
Programs/Activities Contributing to Success of SPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Smoking Assessment/Counseling	D	BMCH funded Prenatal Agencies include assessment and education regarding smoking during pregnancy to each enrollee. Treatment is available for those who attempt smoking cessation
Perinatal Alcohol, Tobacco and Other Drug Use Task Force	I	This Task Force continued to meet during FY 1999, although BMCH did not participate due to a vacancy in the Perinatal Program Chief position.

TABLE 30
Programs/Activities Needing Review/Revision for SPM #2
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program	D, I	The Perinatal Program Chief position is now filled and the issue of prenatal smoking is being examined.

* = programs/activities that are new within the past 2 years.

SPM #3 – Reduce the rate (per 100,000) of motor vehicle crash deaths among youth ages 15-19

Status of Annual Performance Indicator: 18.3 (Same number documented on Form 11)

Indicator: () is new () has improved () has stayed the same (x) has not improved

Objective Met/Exceeded: (x) Yes () No

Source of Data: Death certificate (Calendar year 1998, most recent data available)

If data are not available, state how and when data will be obtained for current application.

State Priority Need Being Addressed: Motor vehicle injuries are the leading cause of death to teens aged 15-19 and should be reduced.

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN

Narrative – Discuss why the objective was met or not met only if tables are not adequate.

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 68. See page 155 for FY 2001 annual plan for this measure.

The number of teen motor vehicle crash deaths fluctuates from year to year; annual rates are unreliable (based on fewer than 20 deaths). Analysis of data for the period 1992-1996, when compared to 1987-1991 showed a reduction in the death rate.

TABLE 31
Programs/Activities Contributing to Success of SPM #3
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
* Legislative efforts through the NH Teen Motor Vehicle Legislation Coalition, and the NH SAFEKIDS Coalition	I,P	IPC leads Coalition, IP Program participates. Successfully advocated for changing the seat belt law to primary enforcement for ages 12-18
* Added teen component to annual Buckle Up NH Week activities	E,I	Coordinated Buckle Up NH Week 99 activities; added in 1999: development of an educational poster to publicize the importance of replacing bike helmets, car seats and seat belts following a crash, “Buckle Your Bod” contest for teens: mini-grants for teen seat belt education programs
Governor’s Traffic Safety Commission	I	Injury Prevention Program manager appointed member. Commission reviews and recommends traffic safety-related legislation and plans various public awareness activities
Crash Outcomes Data Evaluation System (CODES)	I	IP Program participates on workgroup. Data linkage project in 3 rd year, compiling data on traffic injury and risk factors

* = programs/activities that are new within the past 2 years.

SPM #4 – Percent of families whose infant is suspected to have died of Sudden Infant Death Syndrome who have received NH SIDS Program services. (Risk Factor)

Status of Annual Performance Indicator: 100

Indicator: () is new () has improved (x) has stayed the same () has not improved

Objective Met/Exceeded: (x) Yes () No

Source of Data: NH SIDS Program

State Priority Need Being Addressed: Families whose infant is suspected of having died from Sudden Infant Death Syndrome (SIDS) should receive services from the NH SIDS Program which can offer information and bereavement support to assist them in their grieving process.

Population(s) served: (x) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 32
Programs/Activities Contributing to Success of SPM #4
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Case management of all suspected SIDS cases referred by the OCME.	E, D	The Bureau's Child Health Nurse Consultant is the Program Coordinator of the NH SIDS Program. The NH SIDS Program offers information and bereavement counseling services to families and care providers who have suffered a loss suspected to be due to SIDS. Under the mandate of RSA 611, referrals are coordinated from the NH Office of the Chief Medical Examiner (OCME) through the Bureau's SIDS Program, to a network of trained SIDS counselors – nurses and social workers employed by local community health agencies. Contact with hospital staff, funeral homes, child care programs and police departments frequently is made by the Program Coordinator in order to obtain accurate information to make the referral. The community SIDS counselors provide information, support, and follow-up to families via telephone and home visits for up to one year, as indicated. The Program Coordinator initiated contact with all suspected SIDS families for an initial assessment and any crisis intervention needed.
Participation in the state's Child Fatality Review Committee (CFRC)	I	The SIDS Program Coordinator continued to participate in the state's (CFRC), a multidisciplinary group which reviews child fatality cases and issues recommendations for developing public health policy or systems changes to prevent similar deaths or improve the process for responding to such deaths. The committee issued its first report in November 1998, which was presented to the Governor at an annual Attorney General's Task Force on Child Abuse state conference. Committee members were responsible for assuring following up on recommendations pertaining to their particular discipline, for inclusion in the subsequent report, issued November 1999.

Programs/Activities	Pyramid	Comments
Hospital protocols and follow-up survey for handling a suspected SIDS case	I	<p>In October 1998, in collaboration with the Chief Medical Examiner, the SIDS Program Coordinator issued revised and updated copies of recommended emergency department protocols for handling a suspected SIDS case. These protocols and accompanying handouts had been developed and disseminated in 1997. Upon the recommendation of the Child Fatality Review Committee, a survey assessing use of the 1997 protocols accompanied the October 1998 mailing. The survey had a 96% response rate. 60% indicated that they were familiar with the protocols; 20% that they had used the protocols in some way; and 75% that now that they had received the new packet, they envisioned using them in their facility.</p>

SPM #5 – Percent of licensed child care providers, child care providers receiving state child care subsidy payments, pediatricians, obstetricians, and family practitioners who received information on SIDS risk reduction strategies.

Status of Annual Performance Indicator: 100%

Indicator: () is new () has improved (x) has stayed the same () has not improved

Objective Met/Exceeded: (x) Yes () No

Source of Data: NH SIDS Program

State Priority Need Being Addressed: Parents, child care providers, and all who take care of an infant should be aware of SIDS risk reduction strategies to lower the risk of an infant dying of SIDS. All professionals who interact with those who take care of an infant should be knowledgeable about SIDS risk reductions strategies and routinely pass this information on to their clients.

Population(s) served: (x) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 33
Programs/Activities Contributing to Success of SPM #5
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
2 surveys conducted with implications for future SIDS information campaigns	I	In 1998, the New Hampshire Foundation for Healthy Communities' survey to women who delivered a baby in the state found that only 61% of the respondents reported that someone discussed sleep position for their baby during their pregnancy. Similarly, the 1998 Behavioral Risk Factor Surveillance Survey, a telephone survey conducted by the University of New Hampshire for the New Hampshire Department of Health and Human Services, found that of the respondents who cared for an infant that slept in that household, only 62.9% usually placed the baby to sleep on its back. These results indicated a need to continue the "Back to Sleep" outreach effort, with special emphasis on those in contact with pregnant women. This information was used for planning SIDS risk reduction informational mailings for Fall '99.
Information shared at conferences, trainings and health fairs	P	Brochures on the NH SIDS Program, its services, and risk reduction strategies were displayed among maternal and child health information/resources in any conferences, trainings, or health fairs, such as the DHHS exhibit in the NH State Legislative Office Building during National Public Health Awareness Week (April, 1999). Any SIDS presentations or trainings performed during the July, 1998-June, 1999 period also included a review of SIDS risk reduction strategies.

SPM #6 – The percent of communities with oral health consortia

Status of Annual Performance Indicator: The number of communities with oral health consortia is 11. That represents 44% of the 25 N.H. communities with a population over 10,000 and has increased from 8 communities, or 33% of 24 communities in the previous year over 10,000 with oral health consortia.

Indicator: () is new (X) has improved () has stayed the same () has not improved

Objective Met/Exceeded: (X) Yes () No

Source of Data: Bureau of Oral Health Programmatic Activity

State Priority Need Being Addressed: Percent of communities with oral health consortia.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 69. Programs to be reviewed or revised are in Table 70. See page 156 for FY 2001 annual plan for this measure.

TABLE 34
Programs/Activities Contributing to Success of SPM #6
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Development of community oral health consortia	I	We surpassed our target of 33% of communities with populations over 10,000 by 11 percentage points. Eleven communities now have oral health consortia, up from 8 from the previous year. In the second year of a federal MCH fluoride systems building grant, the Bureau of Oral Health was established with 1 FTE in the Office of Community and Public Health. A part time consultant (.5FTE) was hired to oversee the fluoride grant. For the first time the state awarded ten oral health contracts to agencies to provide preventive and restorative oral health services to uninsured and underinsured children. Two communities with oral health consortia initiated fluoridation campaigns and the state successfully applied for two dental Health Professional Shortage designations. Input from the Dental Policy Advisory Committee initiated efforts to increase reimbursement rates and streamline claims processing in the Medicaid system to engage more dentists as Medicaid providers.

SPM #7 – The degree to which the State safeguards the quality of care for children with special health care needs enrolled in managed care plans.

Status of Annual Performance Indicator: Cannot be reported

Indicator: () is new () has improved () has stayed the same () has not improved

Objective Met/Exceeded: () Yes () No

Source of Data: Parent survey

State Priority Need Being Addressed: #5

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 71. See page 157 for FY 2001 annual plan for this measure.

No surveys were conducted which can be reported on in support of this measure.

TABLE 35
Programs/Activities Contributing to Success of SPM #7
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The Title V CSHCN Program staff continued to assist individual families in negotiating their HMO health benefits on behalf of their chronically ill/disabled child.	D	A formal reporting mechanism planned to collect information about the nature of HMO negotiations provided by Title V CSHCN Program staff and track subsequent outcomes did not materialize.
Emphasis remained on educating families about how to access the HMO system of care and how to maneuver around it properly.	E	Stressed is the need for families to read and understand the scope of benefits provided, how to obtain specialty referrals and when to institute a grievance.
Pass-It-On, a publication of the SMSB Family Support & Resource Center, continued to be the vehicle for disseminating information about managed care to families with CSHCN.	P	
The SMSB continued to be an active participant in the MCHB-funded New England SERVE Project, "Enhancing Quality: Monitoring the Impact of Managed Care and Health Care Reform on CSHCN and Their Families".	I	The goal of this project is the development of a proposed set of qualitative and quantitative indicators that can be used to evaluate the impact of managed care on CSHCN at the care delivery level.
The SMSB participated as a member of the core team for the Hood Center's "Partnerships for Enhanced Managed Care Project", another MCHB-funded initiative.	I	The goal of this project is to enhance the ability of primary care pediatric practices to deliver care coordination and to identify needed community resources for children with complex, chronic illness in managed care plans.

Programs/Activities	Pyramid	Comments
A pilot project was initiated with the Medicaid Managed Care Unit to identify CSHCN enrolled in the voluntary program and linking them to the Title V CSHCN Program.	I	Although not successful for casefinding for Title V, this pilot helped to inform policymakers quantitatively that CSHCN were being voluntarily enrolled in Medicaid Managed Care. EPSDT materials will be redesigned based on knowledge deficits identified by families through this process.
Policy development activities in managed care have been undertaken by the Institute for Health, Law & Ethics at the Franklin Pierce Law Center. The Institute's a component of the NH UAP funded by MCHB. Efforts are complementary to the work performed by the Title V CSHCN Program.		Institute activities include: <ul style="list-style-type: none"> • Bill of Rights for CSHCN • Regulatory Implementation of the Bill of Rights through the Department of Insurance rulemaking authority • Standards of Health Care for CSHCN • Public Policy Newsletter

SPM #8 –The percent of Title XX state contracted child care centers that have a health consultant on site.

Status of Annual Performance Indicator: 35%

Indicator: () is new (x) has improved () has stayed the same () has not improved

Objective Met/Exceeded: (x) Yes () No

Source of Data: Survey of Title XX state contracted child care centers.

State Priority Need Being Addressed: To improve the quality of child care by improving the health and safety of child care environments through the increased numbers of child care health consultants.

Population(s) served: () Pregnant Women, Mothers and Infants (x) Children (x) CSHCN

Programs likely to be contributing to performance improvement or reaching/exceeding the objective are in Table 72. See page 158 for FY 2001 annual plan for this measure.

TABLE 36
Programs/Activities Contributing to Success of SPM #8
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Healthy Child Care NH Project	I	Received funds from the Child Care Development Block Grant funds and through a contracted agency hired two nurse consultants for the Healthy Child Care New Hampshire Project.
	I	In collaboration with the New Hampshire Pediatric Society, developed a plan to expand the child care health consultant network including sending a pediatrician to the National Training for Child Care Health Consultants at the University of North Carolina
	P	Established a health and safety in child care audiovisual library. available for loan through the NH State Library.
	I	Developed and distributed child care health consultant work plans focusing on presenting health and safety education in child care..
	I,D	Continued to support six child care health consultants in communities
	E	Held two networking and educational meetings for child care nurse consultants addressing health and safety education and grant writing.

2.5 Progress on Outcome Measures

Please refer to ERP Form 12

Outcome Measure #1 – The infant mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 4.3 *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: 1998 State Vital Records

Outcome Measure #2 – The ratio of black infant mortality rate to white infant mortality rate.

Status of Annual Outcome Indicator: N/A *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: See notes for form 12 regarding this measure

Outcome Measure #3 – The neonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 3.3 *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: 1998 State Vital Records

Outcome Measure #4 – The postneonatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 1.0 *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: 1998 State Vital Records

Outcome Measure #5 – The perinatal mortality rate per 1,000 live births.

Status of Annual Outcome Indicator: 4.4 *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: 1998 State Vital Records

Outcome Measure #6 – The child death rate per 100,000 children aged 1-14.

Status of Annual Outcome Indicator: 11.2 *(Same number documented on Form 12)*

Indicator Has: Improved Not Improved

Objective Met/Exceeded: Yes No

Source of Data: 1998 State Vital Records

III. REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

Needs Assessment relative to preventive and primary care services for pregnant women, mothers and infants.

3.1.1 Needs Assessment Process

Methods

An effective needs assessment process produces information that contributes to a reformulation of existing or newly identified problems and leads to the development of strategies that improve health and well-being. In a relatively small state, such as New Hampshire, it is most pertinent to select appropriate health indicators that are sensitive measures of community health and have a high enough prevalence rate in order to detect variations in smaller geographical areas. Empirically grounded community level analysis is also an important focal point for the development and fine-tuning of intervention programs. Hence, the main objective of this needs assessment is to examine variations in regionally sensitive intermediate health status measures that will lead to a more thorough understanding of the potential differentials in factors associated with these health disparities and health services utilization patterns. This process will also inform health policy makers in adjusting data collection systems that will be more useful in targeting gaps in interventions, monitoring the progress in program implementation and more critically evaluating program quality and effectiveness.

Low birth weight is an ideal health status measure that is a sensitive indicator of the overall health of a community and is also a major cause of infant mortality and childhood morbidity (The Future of Children, 1995). Entering into the school age group, children who were low birth weight are also more likely than children of normal weight to have mild learning disabilities, attention disorders, developmental impairments and breathing problems such as asthma. The adverse consequences of being born low birth weight are still apparent in adolescents and experts believe that these abnormalities will be lifelong and will not improve as children enter adulthood (The Future of Children, 1995). The multiple dimensions of the low birth weight measure in its sensitivity, relevance, and its position as a broader indicator of the future health of a community has led the NH BMCH to use this indicator as a major focus in the needs assessment.

Data Source

The most comprehensive data that is available on the health and specific health services utilization patterns of New Hampshire residents is the Primary Care Access Data Report (1993-1997). This report is a combination of many data sources including: New Hampshire Department of Health and Human Services (NH DHHS) Office of Economic Services; New Hampshire, Department of Employment Security, Economic and Labor Market

Information Bureau; US Census Bureau; NH DHHS, Office of Community and Public Health, Bureau of Vital Records (birth and death records); and the NH DHHS, Office of Community and Public Health, Bureau of Health Statistics and Data Management. The Primary Care Access Data (PACD) provides information on a statewide basis and divides the state into twenty-four geographically defined hospital service areas (HSA) on which similar health measures are aggregated for analysis. The HSA is a more methodologically appropriate grouping of a set of towns representing contiguous and more homogenous communities as compared to a broader county level territorial designation. The HSA population has potential access to the same health care resources. However, the realized or actual access may vary by socioeconomic status, community characteristics, behavioral and cultural factors and type of health insurance.

Empirical Grouping Low Birth Weight by HSA

A state average for all health status and utilization indicators was identified. A system of clustering HSA into three distinct categories was developed for each individual indicator: below the state average, approximating the state average and above the state average (Table 1). In the low birth weight indicator, a further examination of available data of high-risk behavior variables was undertaken along with its relationship to low birth weight. An empirically grounded approach led to the development of a typology of HSA clustering that included: Group I: HSAs have higher state average low birth weight rates and higher than state average maternal high risk characteristics; Group II: HSAs have higher than state average low birth weight rates but lower than state average maternal risk characteristics; Group III: HSAs have lower than state average low birth weight rates but still have higher than state average maternal high risk characteristics. The latter category will lead to the exploration of factors beyond high risk maternal characteristics that may play a mediating role in reducing their impact on low birth weight.

3.1.2.1 Needs Assessment Content

Results for Low Birth Weight:

The state average low birth weight (LBW) rate was 5.2 low birth weight births per 1,000 births. The state range was 3.4 to 7.0. The distribution of HSA by three categories of low birth weight is listed below.

Table 1: Distribution of Low Birth Weight in New Hampshire by Hospital Service Area 1993-1997

<u>Lower than Average</u> <u>LBW <=4.9</u>	<u>State Average</u> <u>LBW >4.9<=5.4</u>	<u>Higher Than Average</u> <u>LBW 5.5-7.0</u>
Colebrook	Concord	Berlin
Conway	Derry	Claremont
Dover	Exeter	Haverhill
Littleton	Keene	Franklin
New London	Laconia	Manchester
Plymouth	Lancaster	Portsmouth
Rochester	Lebanon	
Wolfeboro	Nashua	
	Peterborough	
	Salem	

The next step involved a review of the Higher than State Average LBW Hospital Service Areas. Of the five areas in the category, Claremont, Franklin and Manchester also had a profile of higher than state average maternal high-risk behaviors and higher levels of late or no prenatal care. However, even though Haverhill and Berlin had a relatively lower level of late or no prenatal care compared to the state as a whole, their worse performance in the maternal behavioral and sociodemographic characteristics produced a high rate of LBW. The Portsmouth HSA is a definite outlier. Even though most characteristics were very favorable including earlier entry into prenatal care, Portsmouth had a higher LBW of 6.0 as compared to the state average. On the other hand, six other HSAs, Colebrook, Conway, Lancaster, Littleton, Rochester and Wolfeboro had varying degrees of high risk maternal characteristics and sociodemographic factors but nevertheless maintained lower than the State average LBW rate (Table 2).

Table 2: Distribution of Low Birth Weight Rate in New Hampshire by Levels of Maternal Risk Characteristics by Hospital Service Area 1993-1997

<p>GROUP I High LBW <u>High Maternal Risk</u> Claremont Franklin Manchester</p>	<p>GROUP II High LBW <u>Low Maternal Risk</u> Berlin Haverhill Portsmouth</p>	<p>GROUP III Low LBW <u>High Maternal Risk</u> Colebrook Conway Lancaster Littleton Rochester Wolfeboro</p>
---	---	--

A detailed analysis and presentation of Group I HSA, Claremont, Franklin and Manchester, results will follow (Table 3). Reference to the other two groupings will be interspersed in the discussion to highlight associated or different factors that may be contributing to an identified relationship.

TABLE 3: Distribution of Selected Sociodemographic Status, Health Provider, Health Behaviors and Prenatal Care Use by Claremont, Franklin and Manchester HSA

Characteristic (Health Provider)	State	Claremont	Franklin	Manchester
State of Hlth:Rural NH				
Miles - Ob/Gyn		<=10	10-15	<=10
% in poverty		+10%	5-10%	Less than 5%
% Medicaid births		15%+	15%+	15%+
Medically Underserved		MUA	MUP	Non (MUA/MUP)
Health Professional Shortage Area		Non-HPSA	Non-HPSA	Non-HPSA
Primary Care MD/100,000 pop		50-100	Up to 50	50-100
Hospital w/30 min. drive time		2	2	2+

Characteristic (Health Provider) State of Hlth:Rural NH	State	Claremont	Franklin	Manchester
BMCH Contracts (Provided by JA)		Valley Regional HealthCare (PC,BCC,HV)	Health First (PC, BCC,FQHC)	Manchester Com. Health (PC, BCC,330,FQHC) Child Health Services (CH)
BMCH funds MCH/PC		187,206	270,750 (PN/CH)	160,163 (PN)
BMCH funds Child Health				152,600
BMCH Home Visiting		50,000		
(SES) PCAD Report				
% Uninsured '99* Results from the NH HI Cov. & Access Survey	9.3%	11.8% *Central Western Region (Not listed as HSA '99)	12.6% *Central Eastern Region	9.1% *Central
% kids Medicaid	9.1%	15.0%	15.8%	11.3
% adults Medicaid	2.1	3.7	3.2	2.8
Medicaid Payment	20.7	40	42	21.3
Medicaid Pay 15- 17 y.o.	53.3	69.4	45.2	50.2
Medicaid Pay 18- 24 y.o.	46.7	56.5	63.1	43.8
Medicaid Pay 25- 44 y.o.	10.9	24.1	25.1	11.7
Economic Cluster Kids Count NH 2000		5	5	4
High School Cluster		5	5	3
(Demographics) PCAD Report				
Population		21,882	19,328	157,972
Mo. Educ. <12 yrs.	10.9	21.7	22.8	14.0
Mo. Educ. <12 yrs. 18-24 y.o.	24	29.7	34.5	27.8
Mo. Educ. <12 yrs. 25-44 y.o.	4.1	8.4	8.1	6.1
% Mo. Unmarried	22.3	34.7	42.9	26.5
% Mo. Unmarried 15-17 y.o.	93.8	89.2	87.1	93.8
% Mo. Unmarried 18-24 y.o.	51.3	48.4	65.8	54.7
% Mo. Unmarried 25-44 y.o.	10.5	18.6	20.8	13.5
Mo. Age < 20 yrs.	7.3	14.9	15.5	7.8
(Health)				

Characteristic (Health Provider) State of Hlth:Rural NH	State	Claremont	Franklin	Manchester
Low Birth Weight	5.2	6.8 N=86	7.0 N=51	5.6 N=622
LBW 15-17 y.o.	8.7	14.9	22.6	9.4
LBW 18-24 y.o.	5.7	7.0	6.8	6.3
LBW 25-44 y.o.	4.9	5.7	6.0	5.2
(Behavioral Risk)				
Maternal Smoking	17.6	27.7	29.2	18.1
Mat. Smoke, 15-17	35	41.9	45.2	35.4
Mat. Smoke. 18-24	30	33.5	38.1	29.1
Mat. Smoke. 25-44	13	21.9	20.8	13.4
(Health Care Use)				
Late/No PNC	1.7	2.5	3.1	2.7
(Health Care Use)	State	Claremont	Franklin	Manchester
Late/No PNC 15-17 y.o.	6.1	11.1	6.7	8.0
Late/No PNC 18-24 y.o.	3.0	2.0	4.9	4.5
Late/No PNC 25-44 y.o.	1.1	1.8	1.3	1.2

Sociodemographic Characteristics and Low Birth Weight:

Income:

The available measures of socioeconomic status reveal that Claremont, Franklin and Manchester have some of the highest poverty levels in NH. Computation of HSA comparable economic and high school clusters by the Kids Count NH, 2000 demonstrates that Claremont and Franklin consistently scored the most poor at level 5 and Manchester scored at economic level 4 and high school level 3. The ranking of towns as a whole instead of population based measures inflates the economic well being of Manchester because the surrounding communities in the cluster have much higher levels of economic well-being. A more detailed examination of Manchester shows that in some inner or center city census tracts close to 35% of the children may live in poverty (The Oral Health Status of the City of Manchester, New Hampshire, 1999).

Medicaid Enrollment, Birth Related Payment and the Uninsured:

The percentage of the HSA population that receives Medicaid and/or Food Stamps is a proxy indicator of poverty. Caution must be exercised in interpreting the meaning of levels of Medicaid enrollment and payment. Factors such as the cultural levels of community acceptability, attitudes of social workers or enrollment personnel and individual population characteristics may affect levels of Medicaid enrollment and utilization. Medicaid utilization is also affected by the ability of health providers to accept Medicaid patients in their practice. Provider acceptance is often a complex mix of financial status of their clinical operation, social and cultural elements and the provider to population ratio that affects the size of their practice and ability to incorporate lower payment level of patients.

This Medicaid measure is positively related to other measures of economic well-being, i.e., higher poverty areas also had higher Medicaid enrollment. All three HSAs had higher than state average percentage of kids and adults on Medicaid. The greatest level of departure from the NH State Medicaid enrollment was in the population of children. Claremont, Franklin and Manchester had 15%, 15.8% and 11.3%, respectively, of children enrolled in Medicaid as compared to the state average of 9.1%.

HSA aggregated information on health insurance status is not available. However, a 1999 NH Health Insurance Coverage and Access Survey estimates lack of insurance by region. Claremont, which is located in the Central Western Region of the state is listed as having 11.8% of the population without health insurance. The rate is similar in the Central Eastern Region where Franklin is located with 12.6% uninsured. The Central Region where Manchester HSA is located lists 9.1% uninsured in comparison to a state average of 9.3% .

Mother's Education:

The percentage of mothers in the three HSAs with an educational level below 12 years is much higher than the state average of 10.9%. The poorest levels of education (double the state average) include the two least populated rural areas in comparison to urban Manchester whose rate was 14%. Also the smaller HSAs appear to be catching up educationally with their urban , larger counterpart in the 18-24 year old group. However, the educational profile of younger mothers in Manchester is more similar to Claremont than Franklin. This pattern suggests that while areas of less populated more rural HSAs seem to be gaining in education, the current urban adolescent culture may negatively affect educational attainment. The greatest level of educational disparity between the three HSAs appears to be in the 25-44 year old age group.

Age of Mother:

Claremont and Franklin HSA had twice the percentage of mothers less than 20 years of age (14.9% and 15.5%) as compared to the NH State average of 7.3%. Manchester HSA had 7.8% of mothers under age 20. It is likely that the effect of maternal age is related to being in a lower socio-economic group. The stress of poverty along with the negative social consequences of an unplanned, and in many cases unwanted pregnancy creates increased pressure that has physiologic and behavioral consequences. They may include increased smoking, alcohol intake, depression, and other negative adjustments to stressful life events.

Marital Status:

Marital status is also closely related to socio-economic condition. Franklin HSA had the highest overall level of unmarried mothers, 42.9%. In the age sub-group analysis, this pattern continued in the over 18-year-olds. Even though Manchester had the highest percentage of unmarried mothers in the 15-17 year old age group, the older age group corresponded more closely to the state average.

Prenatal Care and Low Birth Weight:

All three HSA of Claremont, Franklin and Manchester had higher levels of Late or No Pre-Natal Care; 2.5, 3.1 and 2.7 respectively as compared to the NH State average of 1.7. An examination of pre-natal care by age groupings reveals a similar pattern but further confirms that young women (15-17 year olds) are at much higher risk for not receiving prenatal care than the older groupings of women. Actually, as age increases the level of late or no prenatal care decreases proportionately. The three areas also have a different ordering of which HSAs are the worst performers in prenatal care. This observation points to the complexity of health system, sociodemographic and cultural-sociological variables that may operate differently within each HSA as well as across HSAs.

Maternal Smoking and Low Birth Weight:

Since the 1970's, the Surgeon General has reported that cigarette smoking during pregnancy is linked to fetal growth retardation and infant mortality (US DHEW, 1973). Smoking during pregnancy has been associated with 20% to 30% of low birth weight births and 10% of fetal and infant deaths making it the largest and most important known modifiable risk factor known these outcomes (The Future of Children: Low Birth Weight, 1995).

Higher percentages of women in Claremont and Franklin smoked during their pregnancy as compared to the state averages. Manchester HSA closely resembled the state average in smoking. This pattern was consistent in all three age groups. Additionally, the smoking rates were inversely related to age and decreased as the age of the mother increased.

The Health System Context for the New Hampshire Population:

New Hampshire has a mostly private health care delivery system. The NH Department of Health and Human Services contracts with local not-for-profit agencies to deliver public health oriented services which include: well-child, WIC, prenatal, STD and HIV services, family planning and primary care services. The private nature of the health care delivery system reduces the ability to obtain health services utilization information including the scope and quality of care. A recent report on The State of Health in Rural New Hampshire (1999) geographically maps a set of health provider characteristics including three indicators for the medically underserved. They include the federal designations of medically underserved area, medically underserved population and health professional shortage area.

Claremont was identified as a medically underserved area and Franklin HSA as a medically underserved population. Manchester was not designated as a MUA or MUP area. Additionally, all three areas were not identified as health professional shortage areas. Franklin continued to have the worst profile on existing measures of availability and accessibility of health care providers. In terms of primary care MD's per 100,000 population, Franklin had up to 50 in comparison to Claremont and Manchester whose providers rose to 50-100. Also, even though all three HSAs had at least two hospitals in the area, Franklin residents had to travel from 10-15 miles to the nearest Ob/Gyn provider. Claremont and Manchester residents traveled up to 10 miles.

Summary: Policy Implications of Low Birth Weight Hospital Service Area (HSA) Needs Assessment

The process of analyzing existing information on low birth weight differences by the lowest level of aggregation, i.e., the Hospital Service Area has led to the discovery of variation in multiple characteristics within HSAs of similar low birth weight levels . This suggests that sociodemographic, health provider characteristics, health insurance and maternal behaviors operate in very distinct ways in the different HSAs that were examined. To the extent that public policy researchers and decision-makers can identify these distinctions, more effective HSA level programs can be developed to meet individual population needs. The role of the state of NH can be one of facilitator of the procurement of new knowledge relevant to the health of the population and developer of strategies to work in partnership with the private sector. The existing private care delivery structure in NH is reflective of the general political philosophy, which values less government intervention and more reliance on a decentralized system to deliver health care services.

The Magic Bullet Solution: Adequate Prenatal Care

The cumulative results of studies of adequate prenatal care utilization indices have established widespread confidence in the ability of prenatal care to reduce the risk of low birth weight (The Future of Children: Low Birth Weight, 1995). The most likely known ways that prenatal interventions influence low birth weight is through smoking and nutrition counseling and medical care. The social and psychological elements of recognition of the pregnancy which may involve taking responsibility and sharing the information with significant others may play a role in the development of social support structures and promotion of healthy adjustments in lifestyle behaviors.

Although the only available indicator of prenatal care in the NH Primary Care Access Data was late or no prenatal care, a very strong pattern emerged that supported the positive influence of earlier prenatal care on low birth weight. If any one easily identifiable intervention had to be selected with proven results, prenatal care would be at the top of the list. The three HSAs, Claremont, Franklin and Manchester, that had higher levels late or no prenatal care also had much higher levels of low birth weight in comparison to the state average. These communities also had higher levels of other high-risk characteristics including sociodemographics, maternal health behaviors but a mix of results in the health provider indicators. In sharp contrast with these results, six other HSA communities with similar sociodemographic and high maternal risk factors produced better low birth weight rates that were lower than the state average. The HSAs in this category were Colebrook, Conway, Lancaster, Littleton, Rochester and Wolfeboro. Although it is not possible to specifically correlate the reasons why these HSAs had better birth weight outcomes, the one common factor appears to be earlier entry into prenatal care.

Strategies for Smaller Hospital Service Areas

Claremont and Franklin had similar populations of approximately 20,000. They also appeared to be more closely sharing similar characteristics on all the examined variables although Franklin was generally slightly worse off than Claremont. These two areas also had been categorized as being medically underserved and therefore may experience a more structural barrier to health system entry as well as the complexity of other financial, social and psychological barriers both from a provider and patient perspective. The mothers in both areas were generally less educated, had higher Medicaid enrollment which correlated to higher poverty indices and higher percentages of being uninsured and unmarried.

Public health strategies need to be based on the particular culture of the community, i.e., the dynamics of social and economic mobility, the interaction of the medical culture with poverty groups, the mix of public and private clinics and providers including perceptions of quality of each type of facility. More data needs to be gathered to fully understand this community dynamic. The development of intervention programs must be a collaborative process that involves the State and local community and health education messages must be well targeted to reflect the values of the community. For the adolescent group, the goal might be to reduce pregnancy rates. Early sexual education for both young men and women, counseling, development of youth programs to promote the engagement of youth, and creating safe dialogues about their prospects and visions for the future as well as ensuring early and easy access to family planning programs can be considered.

Strategies for Larger HSA (Manchester)

Manchester is the largest city in New Hampshire with a population of over 150,000. The size of the population makes it an important city to target for intervention because of the potentially large impact it could make. The size of the population also creates a need for a further in-depth analysis of the internal variations in health status and use of services. NH DHHS, Bureau of Maternal and Child Health is funding a study to more closely examine the changing population base and health differentials especially in the poorest center city or inner city areas. This extensive review will assist in redirecting strategies and resources to match defined needs.

The Manchester HSA has a medical system that from a structural perspective, is potentially capable of meeting the needs of the entire population. It is not medically underserved and is not designated as a health professional shortage area. However, anecdotal evidence of the last decade suggests that the ethnic and racial composition of the city is changing which may create complex cultural and economic barriers to receiving care. Since 1990, it is estimated that about 2,000 refugees have settled in Manchester from a range of countries including Vietnam, Russia, Bosnia, Iran, Iraq and South Africa. An additional 4,000 or so Hispanics have also migrated into the city. Based on data from the Manchester Health Department Surveys, certain access barriers specific to the center city of Manchester population have been identified including language barriers (10%), lack of a vehicle (29%), and no telephone (17%). The environment for childbearing is further polluted with 62% of the Center City residents

reporting that they or someone in their household smokes. Also almost 50% of the residents knew someone close to them that has had a problem with drugs or alcohol..

Comprehensive Assessment of the Health Care Delivery System in NH

New Hampshire has a private health care delivery system financed mainly by private health insurance in addition to Medicaid and a mix of state and federally funded initiatives. The interwoven and complex nature of service delivery is difficult to assess at the present time. However, the expansion of Medicaid and other social and political dynamics are changing the patterns of utilization of more publicly oriented services. A thorough assessment of the public-private provider networks in New Hampshire along with financing structures and utilization patterns will help to establish how health funds are currently allocated. This data driven analysis can promote the establishment of an explicit funding criterion by geographic region which can lead to a more equitable distribution of scarce public resources.

Data Needs and Revisiting the NH Data Collection Systems

Even though it seems that a lot of health data is collected in New Hampshire, most of the data does not lend itself to local analysis. This is mainly related to the relatively small population base in which major diseases and mortality events have a low enough prevalence rate and therefore cannot be analyzed at the community level. Many additional national surveys focus on obtaining state averages in whatever health problem is being studied. The small numbers used in the random sampling schemes are inadequate in assessing local variations in health status and related measures. At the community level, resources are scarce which prevent the development of studies that are methodologically valid and reliable. This deficit affects the level of confidence in advising decision makers about a wide range of strategies and issues to address local problems.

NH DHHS has established a data committee that has mapped all the data sources in New Hampshire and the particular indicators available at different levels of aggregation. This committee can extend its mission to assess data needs and deficits that can be used to redirect current efforts more effectively and efficiently resulting in improved data for decision making.

Birth Spacing

While it was not a part of the above needs assessment, the Title V agency considers births spacing an important issue which will be examined it more closely in time. Evidence suggests that birth spacing impacts on perinatal outcomes, in particular, low birth weight, preterm birth and size for gestational age. Delay of subsequent conception 18 to 23 months after delivery lowers the risk of adverse outcomes while conception within 6 months of a prior birth may significantly increase this risk. Additionally, delay of subsequent births in the adolescent population may greatly reduce poor outcomes for both mothers and babies. Thus, progress toward national performance measures 6 (rate of births to teens ages 15-17) and 15 (percent of very low birth weight births) may be enhanced by attention to this indicator of perinatal health.

The concept of birth spacing is now included as an objective in Healthy People 2010 with a published baseline rate of 11 % of females aged 15 to 44 years having given birth within 24 months of a previous birth in 1995 (National Survey of Family Growth, CDC, NCHS). In New Hampshire, examination of data from the Bureau of Vital Records revealed that of births with valid data in the field of previous live births, 24% were within 24 months of that previous birth in 1998. This is more than double the national percent and quadruple the Healthy People 2010 goal of 6%. Further analysis of this indicator could reveal regional variations affecting the analysis of low birth weight rates for the state and may suggest specific public health strategies. Both direct care and population-based interventions could readily impact this indicator and could thereby improve several national performance measures.

Prenatal HIV

As with birth spacing, prenatal HIV testing was not a part of the formal needs assessment but remains a priority. Today there are compelling reasons to make HIV testing a routine part of standard prenatal care for all pregnant women, regardless of perceived or identified risk factors. The American College of Obstetricians and Gynecologists (ACOG) now recommends universal testing with notification, promoting the concept of HIV testing in pregnancy as unexceptional. Advances in the prevention of perinatal transmission of HIV over the past decade have provided clear evidence that universal HIV testing in pregnancy improves outcomes, as early identification and treatment of HIV-infected women significantly decreases the likelihood of HIV transmission to the fetus. In New Hampshire, MCH funded agencies are required to counsel all pregnant women regarding HIV testing. New Hampshire state law, however, requires counseling and informed consent for HIV testing. This dichotomy hampers New Hampshire's ability to achieve universal prenatal HIV testing. The interventions to address this performance measure fall within all four levels of the pyramid. This measure is related to national performance measures 17 (percent of very low birth weight infants born at high-risk facilities), and 18 (pregnant women receiving prenatal care during the first trimester) due to the myriad possibilities for adverse outcomes to the fetus when HIV is undiagnosed. This measure is also related to outcome measures 1, 3, 4, 5 and 6 (relative to neonatal, infant and child death) because of increased mortality rates associated with this condition.

3.1.2.2 Direct Health Care Services

3.1.2.3 Enabling Services

Preventive Care Services for Pregnant Women, Mothers and Infants

Prenatal Care

The above detailed analysis of core health status indicator #04A, low birth weight and associated health indicators such as entry into prenatal care clearly point to the need for the BMCH to further examine the delivery system for prenatal care, particularly in the regions noted, Claremont, Franklin and Manchester. The BMCH does fund prenatal programs based in community health centers in both Franklin and Manchester and a prenatal program based in a Planned Parenthood agency in Claremont. The waiting times to access prenatal care; outreach to pregnant women; transportation; adequacy of nutrition, social work services, smoking cessation services and prenatal education in these agencies need to be assessed during the upcoming year. It will also be informative to assess similar measures in the group of HSAs with like sociodemographic and high maternal risk factors as these three, but better low birth weight rates to determine if there are strategies that could be replicated elsewhere to improve the prenatal system of care.

Additionally, as mentioned previously, a separate study in the Manchester area will be examining racial and ethnic health disparities among the maternal and child population. This information should assist us in describing linguistic and cultural barriers to obtaining care in the Manchester area and can inform us as we move to assess such barriers in other areas.

At the same time that we are examining how prenatal care is delivered in these communities, the BMCH will be reassessing how it currently allocates resources state-wide for the provision prenatal care as well as other maternal and child health services. The desired outcome is to design a funding methodology that more closely aligns resources with need.

Prenatal Care, Infant Care, Insurance and Medicaid

While it is imperative to examine the prenatal services delivered through Title V programs, it is not sufficient. Approximately, 11 % of pregnant women or 1,660, receive services through these programs. The recent NH-HICAS survey found that nearly 75% percent of women of child bearing years are uninsured and of those about half are not eligible for Medicaid. Clearly this has implications for women accessing prenatal care if they do become pregnant. As the DHHS serves on the subcommittee with legislators, businesses and health care providers focusing on strategies to reduce the rate of uninsurance, this population should be a priority. Further, it is important to ensure that all women eligible for Medicaid during pregnancy are aware of the program and their potential eligibility for it.

Assuring that all eligible women enroll in Medicaid is not, by itself, adequate to assure a healthy infant. When comparing the health status indicators of low birth weight and percent of pregnant women entering care in the first trimester for Medicaid and non- Medicaid pregnant women (Health Status Indicators #06 A &C), women on Medicaid fall short on both counts. The percent of low birth weight babies is 5.7% among Medicaid women and 4.9% among non-Medicaid women. Similarly, only 75.2% of Medicaid women enter prenatal care in the first trimester while 91.5% of non-Medicaid women receive early prenatal care. While low birth weight can be attributed

to a number of sociodemographic variables, it is probable that in this case it is influenced, at least in part, by the low percentage initiating early prenatal care. Thus the Title V program must examine barriers to accessing prenatal care for women on Medicaid in addition to exploring regional differences in women accessing prenatal care.

Of note is that while the percent of Medicaid babies born at low birth weight is higher than that of non-Medicaid babies, the rate of infant deaths is lower at 3.4 per 1,000 versus 5.4 per thousand (Health Status Indicator #06B). We do know that the percent of infants on Medicaid who received one well child visit in during the same time period was 76%. The same statistic is not available for non-Medicaid children.

The Medicaid program currently allows prenatal programs under contract with the Title V agency to bill for “prenatal extended services” for women enrolled in Medicaid. These services may be social work services, nutrition services, prenatal education, case management and home visiting. The Title V agency has been asked by a non-Title V Medicaid provider if they could bill for these services as well. As a result, the BMCH is currently assessing the use of these services by Title V agencies, the potential for utilization and associated costs by non-Title V Medicaid providers and reviewing the literature to determine the effectiveness of such services. Based on the findings of this information gathering, a determination will be made as to whether or not this should become a service available to all pregnant women on Medicaid.

Smoking and Pregnancy

The increase in maternal smoking in New Hampshire occurring when national rates are declining is troubling. Also troubling is that the increase is strongly influenced by smoking among teen mothers. The BMCH will work with the March of Dimes to distribute and promote the newly released prenatal smoking cessation guidelines to Title V agencies and private obstetrical providers. These guidelines will be integrated into the contractual scope of services for prenatal providers under contract with the Title V agency. Other partners will be sought in this initiative including the New Hampshire Chapter of the American College of Obstetrics and Gynecology, the New Hampshire Tobacco Prevention Program, the Foundation for Healthy Communities and the Perinatal Outreach Education Program at Dartmouth Hitchcock Medical Center. Targeted initiatives will be developed for pregnant teens and communities with high maternal smoking rates.

Home Visiting Services

During the upcoming year, the BMCH will lead an initiative to expand home visiting services from three communities to the entire state. This service will be offered to all pregnant women on Medicaid and their infants. Home visiting has been shown in some studies to decrease low birth weight, particularly among teens and to reduce smoking during pregnancy (a contributor to low birth weight). Both of these indicators will be measured for women in this program. Home visiting program can also assist in encouraging parents to take their babies to their well child appointments.

Decreasing Teen Births through Family Planning

The known association between teen births and low birth weight is supported in the above regional analysis with both the Claremont and Franklin HSAs demonstrating higher low birth weight rates and higher teen birth rates. It is likely that if the city of Manchester was examined separately from the HSA, a higher teen birth rate would emerge. The Title V agency houses the family planning program and will examine the distribution of family planning funds to deliver reproductive health care as it will with Title V funds.

3.1.2.4 Population-Based Services

Smoking and Pregnancy

In addition to the direct service initiatives to integrate smoking cessation into prenatal care delivery. The BMCH will work with the DHHS public information office, the Tobacco Prevention Program and the March of Dimes to explore a public education campaign aimed at decreasing smoking during pregnancy. Targeted initiatives will be developed for pregnant teens and communities with high maternal smoking rates.

Abstinence Education Program

The Title V also oversees a contract to carry out the goals of the Abstinence Education Program. The program is proposing a combined strategy of a media campaign and community-based grants to implement abstinence curricula geared towards children w-14 years. The Title Agency will work with the contractor to target these initiatives to areas with high teen birth rates.

3.1.2.5 Infrastructure Building Services

Needs Assessment/Quality Assurance

Results of the needs assessment relative to the maternal and infant population point to the need for further data gathering. As previously mentioned, the SSDI initiative in the Manchester area will assist us in describing what some of the cultural, linguistic and socioeconomic barriers exist which may prevent women from seeking early prenatal care.

Additionally we will examine, more extensively, the HSAs that had lower than state average low birth weights and high maternal risk characteristics and compare with those HSAs exhibiting high low birth weights and high maternal risk characteristics. Some of the factors to be explored are: whether or not private health care providers accept Medicaid clients, waiting times for women to access prenatal care, outreach activities, transportation issues, smoking cessation activities, nutrition education and more. Further analysis of HSAs with high low birth weight and low maternal risk characteristics is also needed. It may be that, as found in Massachusetts that these low birth weight statistics are due to multiple births due to the use of fertility technology. Regional analysis of birth spacing and its relationship to low birth weight is also needed.

It is also important to research why the percentage of women on Medicaid accessing prenatal care in the first trimester is so much lower than that of non-Medicaid women. A regional analysis of this information is needed.

The Title V agency and Medicaid are in the process of developing a coordinated approach to quality assurance. Many of the factors list above can be measured through quality assurance activities and will be considered priorities as this quality assurance plan is developed.

Needs Assessment Relative to Preventive and Primary Care Services for Children

3.1.1 Needs Assessment Process

3.1.2 Needs Assessment Content

Keeping with the needs assessment process undertaken for pregnant women and children, we set out to examine key health status measures for children at the community or regional level. Health status measures explored were immunizations, ambulatory care sensitive conditions, access to preventive care, access to oral health service and injuries. This component of the needs assessment is viewed as being under development. More time is needed to adequately research and analyze available data. These are described separately below.

Immunizations

Provision of preventive health care to young children is the most efficient and effective way to reduce morbidity and mortality as well as reduce the costs of medical care. The New Hampshire Department of Health and Human Services operates a statewide Immunization Program that has a varied method of delivery mechanism mainly grounded in the private sector. The majority (89%) of children receive their immunizations through private physician offices with the State Immunization Program supplying the free vaccines. The other approximately 11% of New Hampshire's children receive their immunizations through agencies that receive a varying range of public funding to provide these services. These agencies include Visiting Nurse Associations (VNA), three public health departments, federally qualified community health centers, or state funded primary care sites (The 1999 Immunization Assessment of Their Two Year Old Population, NH DHHS). New Hampshire also has fourteen federally qualified rural health centers that are more similar to private physician offices but are also considered 'public' based on the Center for Disease Control (CDC) criteria for clinic assessment purposes.

The New Hampshire DHHS, Immunization Program has been conducting comprehensive immunization clinic assessments on children 24-35 months of age in public and private health care settings since 1994. Approximately 42%, of the two hundred thirty eight individual medical offices and clinics that immunize children have been assessed during this time period. The majority of these agencies also had sequential assessments.

The Year 2000 National Immunization Goal is 90% coverage, at 24 months, with four doses of DPT, three doses of Polio, Hib, and HepB and one dose of MMR. In the most recent 1999 assessment period of publicly funded health providers, approximately 80.2% have achieved the recommended vaccine schedule for 24 month olds. This rate is the same as the information provided by the National Immunization Survey based on a random telephone survey of New Hampshire residents.

1999 Immunization Results by Type of Public Provider

	<u>No. Complete Immunizations</u>	<u>No. Records Reviewed</u>	<u>% Fully Immunized</u>
Community Health Centers	242	291	83.2%
Rural Health Centers	272	342	79.5%
Primary Care Centers	72	82	87.8%
Well Child Clinics	177	211	83.9%
Walk-In Clinics	82	128	64.1%

The Primary Care Centers, as a group, outperformed all the other types of public health providers. The private physician offices, based on 1996-1998 data, also had a similarly higher coverage of 85%. The Walk-In Clinics had the lowest rate of 64.1%.

Critical Issues in Understanding Immunization Coverage in New Hampshire

Information on childhood population based immunization coverage is not available at the local level in New Hampshire. The State average and public health provider oriented information system is focused on assisting providers in understanding and developing methods to improve the coverage of the children within their individual practice. Additionally, a private provider system reduces the level of oversight and possible public health interventions. An immunization registry know as ImmPACT is in the development and testing phase. Once it is implemented and fully functioning it will provide childhood population based immunization coverage information for all providers. While local data are currently not available in a useful format, the fact the New Hampshire on the whole fails to meet the Year 2000 National Immunization Goal, improved immunization coverage remains a priority. Additionally, data available does reveal that publicly funded providers, in the aggregate, achieve lower immunization coverage rates than do private providers. Thus we shall continue to work with in collaboration with the immunization program to improve immunization rates among those providers, many of which receive Title V funding.

Review of Ambulatory Care Sensitive Conditions for Children

Ambulatory Care Sensitive (ACS) conditions are medical conditions that are less likely to require inpatient hospitalization if timely and appropriate primary care is received. Utilizing the diagnoses from the Hospital discharge data, the Bureau of Health Statistics and Data Management of the NH DHHS use the International Classification of Diseases, ninth revision (ICD-9) to categorize specific conditions within the ACS defined guidelines. These conditions are then analyzed by Hospital Service Area which are used as an indicator of primary care adequacy and utilization. The ACS conditions are then compared to the state average and tested for statistical significance using a derivation of the Z-test.

In examining the ACS conditions across all the HSAs, only two areas were statistically different (95 % confidence level) from the state average. They were Concord and Lancaster, 351.8 and 774.5 respectively. Concord had a more outstanding performance in preventing children (1-14 years of age) from being hospitalized for conditions that could be effectively treated by primary care. Lancaster, on the other hand, had many more children admitted to the hospital for treatable conditions. The Franklin ACS conditions approached significance (705.1) in again having a worse indicator of adequacy of primary care in the area. For the other age group (15-17 year olds) included in the analysis, only Wolfeboro (745.7) had a significantly worse record in admitting children to the hospital with preventable or treatable conditions on an outpatient basis.

Given the few areas of the state for which these data hold statistical significance, their utility at the current time appear to be limited. More research will be done in the future to explore the use of ACS as measures of health for children at the national level and to determine if particular ACS diagnoses should be examined more fully.

Access to Preventive Child Health Services

As mentioned in the state overview, the New Hampshire Health Insurance Coverage and Access Survey reported approximately 25,000 children to be uninsured with an estimated 74% of these or 18,500 eligible for publicly sponsored programs. New Hampshire Healthy Kids enrolled 6,100 children during 1999, possibly decreasing the numbers of uninsured children by one-third. While the possession of health insurance can open the door to health care, it does not assure access. During the year 1999, the percent of potentially Medicaid eligible children who received a service paid by the Medicaid program was 78%. Similarly the percent of Medicaid enrolled children under the age of one who received at least one periodic screen was 74%. This information is currently not available by locality to determine if access is problematic in particular areas of the state. Nor do we currently have information about which providers of pediatric care accept Medicaid or other barriers families may face in trying to obtain health care for their children who are insured through the Medicaid program. Thus more information is needed before strategies are developed to improve these measures.

Some child health programs under contract with the Title V agency are reporting a decline in the numbers of children being served in well-child clinics. This decline can likely best be explained by the increase in children obtaining health insurance through New Hampshire Healthy Kids and a subsequent shift in where children receiving their health care towards the private sector. This has implications for how the Title V agency allocates its resources for child health services, with a possible decrease in funds for direct health care services and an increase in enabling or population based services. Two pilot projects are currently underway to inform decision making along these lines (see section below on infrastructure.)

Access to Oral Health Services for Children

It is known that there are pockets in New Hampshire of populations of low-income, uninsured and underinsured people with no access to dental care. Among children, 80 percent of dental caries are found in 25% of the children. Absent a statewide oral health needs assessment, it is useful to consider findings from several community oral health needs assessments. In a recent visual dental screening by local dentists in two Nashua elementary schools, 26% of screened children in grades K-2 had visible dental caries. Among 16 Nashua school nurses, dental care for uninsured children ranked as their top concern. After the five years in the Raymond and Newmarket area schools, one preventive dental program reported that of 559 children screened in kindergarten through sixth grade, 465 had visible decay and 98 (19%) had no established “dental home.” In school year 99/00 we have completed the first snapshot look at the oral health status of 2nd and 3rd grade children in 11 school-based preventive dental programs.

Childhood Injuries

Children Ages 0-14

A needs assessment for children would be incomplete without the inclusion of injury data. Injuries are the leading cause of death and years of productive life lost for children in New Hampshire and the nation. Motor vehicle crash injuries are the leading cause of death for children over age one, responsible for 6 deaths during the 5-year period, 1992-1996, and 21 inpatient hospital admissions during 1996. The death rate for the 1992-1996 period declined significantly from the earlier 5-year period (1987-1991) when 27 children 0-14 were killed in MV crashes. The decline no doubt resulted in large part from enactment and several upgrades of the child passenger safety law during that period, as well as increased public education efforts. NH will continue these efforts in order to maintain the reduced death rate and reduce serious injuries.

While these deaths are largely preventable with proper use of child safety seats and seat belts, many NH children are still not properly restrained. A 1996 survey of child restraint use showed 24% of children and teens ages 0-15 not properly restrained. Those riding in a vehicle with an unrestrained adult were far less likely to be restrained than those riding with a restrained adult. With NH still the only state in the US without an adult seat belt law, restraint use among adults remains low and thus affects child restraint use. Both NH and national data show that children ages 4-8 are not being properly restrained and current efforts focus on increasing booster seat usage in this age group.

Children Ages 15-19

Motor Vehicle Crashes

Motor vehicle crashes are the leading cause of death among NH teens ages 15-19 years old. Age-specific MV death rates increase dramatically in the 15-19 year age group, with a rate nearly 3 times higher than that of the 10-14 year olds. During the 5-year period, 1992-1996, 60 teens ages 15-19 died as occupants in a MV crash, for a rate of 14.5 deaths/100,000. This rate represented a nearly 50% decline over the previous 5 year period. Seat belt use is low among teens, compared to other age groups. That fact, combined with youthful risk-taking behavior and inexperience driving results in a high death rate in this group. Until recently, NH did not have a graduated licensing law for new drivers or a seat belt law covering anyone over age 12. It is hoped that recent changes in these laws and continuing public and professional education will impact future death and injury rates.

Suicide

A 1993 report revealed a dramatic increase in suicide deaths among NH teens ages 15-19, especially those by firearms. Release of this study prompted the formation of the Youth Suicide Prevention Advisory Assembly (YSPAA) and the NH Firearm Safety Coalition (activities described elsewhere in this document). While suicide in this age group declined in the most recent period studied (1992-1996), it is still a major public health problem; recent preliminary data does not indicate any further decrease. Teen suicide rates continue to equal the national rate, unlike death rates from other injury causes, which are significantly lower in NH. Some reasons for the higher than expected teen suicide rate may include easy access to firearms in a rural state such as NH, and/or a paucity of services available for teens needing mental health and substance abuse treatment, well documented risk factors for suicide. YSPAA and the Firearm Safety Coalition continue to address the above risk factors. Hospital discharge data revealed that for every teen suicide, there were 14 inpatient admissions and 25 emergency department visits for self-inflicted injuries. Females were more likely than males to receive hospital treatment for self-inflicted injuries, while males are more likely to complete suicide. National data on method of suicide suggest that this ratio may change in the future due to a disturbing increase in use of firearms by females.

Teen Smoking

The New Hampshire Youth Risk Behavior Survey is administered every two years in New Hampshire to high school students in grades 9-12. Over one third of surveyed high school students reported smoking cigarettes within the past 30 days in the 1999 survey. The percent of teen mothers who smoke during pregnancy is higher, and more alarming. Smoking cessation strategies, as a major public health initiative, have enormous potential in cost savings through prevention of subsequent morbidity and mortality.

3.1.2.2 Direct Health Care Services

3.1.2.3 Enabling Services

Immunizations and Access to Preventive and Primary Care Health Services for Children

Assuring that children have access to immunizations and preventive and primary care health services is a high priority and thus we aim to improve in both areas. A pilot study will be conducted over the next year in two regions of the state. In lieu of the provision of well child clinics, maternal and child health nurses will assist eligible families to enroll in Healthy Kids and Medicaid and will offer home visits and case management services to families who are enrolled and receive their child health care in the private sector. Measures such as immunization status, preventive visits to the primary care provider and emergency room visits will be examined for these children and compared with children enrolled in Healthy Kids and Medicaid but who do not receive these additional supportive services. Findings from this study will assist in determining whether or not to expand such services other regions of the state.

Home Visiting Program

During the upcoming year, three pilot home visiting programs will be expanded to become a state-wide initiative offered to all pregnant women on Medicaid. This service will continue through the infant's first birthday and possibly longer, dependent upon funding. Immunization status and use of preventive health care will be evaluated in this initiative as well.

Oral Health

The Bureau of Oral health will work to initiate a sealant component to school-based dental health programs.

3.1.2.4 Population-Based Services

Motor Vehicle Injuries

While death rates for motor vehicle injuries are declining, the Injury Prevention Program will continue to provide public education on the proper use of child restraints and to encourage the use of seat belts. Publicity around graduated teen licensing will continue.

Teen Suicide

The Injury Prevention Program in collaboration with the Injury Prevention Center at Dartmouth-Hitchcock Medical Center will continue to provide leadership for the Youth Suicide Prevention Advisory Assembly (YSPAA). The YSPAA will work to educate professionals and the public on issues relative to teen suicide through conferences and dissemination of educational materials and suicide prevention and intervention protocols.

Teen Smoking

The BMCH will work with the New Hampshire Tobacco Prevention Program to collaborate on strategies designed to reduce teen smoking. BMCH and the March of Dimes will also work together on smoking cessation strategies for the prenatal population. This measure is related to national performance measure 15 and state performance measure 2.

3.1.2.4 Infrastructure Building Services

Immunizations and Access to Preventive and Primary Care Health Services

Needs Assessment

The ImmPACT immunization registry now in the pilot stage will enrich the programmatic data now available on childhood immunization coverage and will be integrated into future needs assessments for children's health.

Additional needs assessment work is needed to determine why only about 30% of infants enrolled in Medicaid are, in fact, receiving services. Further examination of the data by regions, possibly by HSAs will ensue. Strategies to examine barriers to obtaining care such as provider and client surveys will be considered. Additional research on the utility and feasibility of using ACS conditions to assess the adequacy of primary care in various parts of the state will be conducted.

Quality Assurance

The Immunization Program shares reports produced following assessment visits to Title V funded community agencies relative to immunization coverage. The Title V funded community agency must produce a plan of action to improve low coverage rates. Title V staff review these plans and follow-up with the agency during quality assurance site visits. Additionally, Title V staff assure that agencies with lower than acceptable immunization rates have addressed this in their annual continuous quality improvement plan submitted to the Title V agency.

Injury Prevention

Teen Suicide

The YSPAA will be implementing a statewide plan to decrease teen suicide. A high priority is to explore opportunities to increase access to mental health and substance abuse services for teens.

Motor Vehicle Deaths – Ages 15-19

Continued success in decreasing deaths to teens from motor vehicles will require the ongoing collaboration the New Hampshire Teen Motor Vehicle Legislation Coalition led by the Injury Prevention Center (Title V funded). Current laws will be reviewed and recommendations made for improved and comprehensive graduated licensing laws for teen drivers. The Injury Prevention Program will continue to monitor data on teen motor injuries describe trends, identify risk factors and to evaluate progress.

Oral Health

Work will continue with the Oral Health Work Group to improve the Medicaid Dental Program in an effort to engage more dentists to care for children enrolled in the Medicaid program.

An epidemiologist from CDC has recently joined the Bureau of Oral health and will work over the next year to develop a statewide dental disease surveillance system.

3.2.1 Priority Needs

Maternal and Child Health Population – A Summary of Priority Needs

The majority of priority needs were identified through the needs assessment process. Some however were identified based on known data and programmatic priorities. In some cases priorities were developed into state performance measures, others relate to national performance measures.

Direct and Enabling Services

- To increase access to prenatal care for vulnerable populations by targeting women on Medicaid, women representing racial and ethnic minorities and regions of the state with poorer access.
- To decrease smoking among pregnant women and with a particular emphasis on teens.
- To increase the percent of pregnant women in publicly funded programs who are screened for HIV.
- To decrease the proportion of births occurring within 24 months of a previous birth.
- To improve access to child health primary care and improve immunization status.
- To increase the number of children receiving dental sealants.

Population Based Services

- To decrease smoking among pregnant women and with a special emphasis on teens and to decrease teen births through collaborative public education campaigns.
- To decrease motor vehicle injuries among all children through continued public education on the use of child safety seats, seat belts and graduated licensing.

Infrastructure Building Services

- To improve the ability to describe the health of the maternal and child health population through improved data collection and analysis and expanded needs assessments.
- To align maternal and child health needs resources with findings of needs assessments.
- To develop a system of quality assurance to monitor progress towards meeting priorities by community agencies receiving Title V funds and the state Title V agency.

- To reduce the rate of teen suicide through implementation of a statewide plan.
- To reduce deaths to teens by motor vehicle crashes by reviewing and revising graduated teen licensing.
- To improve children's oral health through community health consortia.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

3.1.1 NEEDS ASSESSMENT PROCESS

This past five-year period has built upon the initial needs assessment process in a more targeted manner and has focused on analysis and identification of priority needs in order to inform state planning and resource allocation. In the past **five years** the agency has concentrated on the following needs assessment activities building upon the comprehensive needs assessment conducted 8-10 years ago:

Direct & Enabling Services

- Integrated family needs assessment functions into existing Title V activities such as annual **parent satisfaction** surveys and collaborated with multi-disciplinary teams to derive indicators.
- Incorporated **provider needs assessments**, physicians and care coordination, early child education providers and child development, and school nurses into existing program evaluation activities

Population Based Services

- Collaborated with statewide parent **information and referral initiatives** to collect and trend family and provider information needs data
- Collaborated with the Department of Education, School Health Services, on a **school nurse survey** and analyzed questions related to CSHCN

Infra-Structure Building

- Concentrated on **assembling needs assessment data from a variety of state-wide and community-based health and related initiatives**. As a result of parent satisfaction surveys families wearily shared with us, "*We are being surveyed to death.*" This was the main reason we purposively chose to extract information from on-going initiatives that have exploded in intensity during the past few years in order to assist in determining gap areas for future direction of needs assessment activities and potential collaborators for the future.

The **strengths** of the current CSHCN needs assessment process is that, where appropriate, the needs assessment process is integrated into existing direct and enabling programmatic functions and builds upon the NH Title V- CSHCN agency long-standing commitment to working directly with families through on-site parent advocates and contracts with Parent Support agencies.

The **weakness** in the needs assessment process is the proliferation of simultaneous needs assessment projects directed at targeted groups that may repeatedly contact the same families due to overlaps depending upon the agency or concern of origin.

The final **constraint** is that not all families of all CSHCN in New Hampshire are identifiable or easily recruited to participate in needs assessment activities. This barrier relates primarily to infra-structure building limitations (staff numbers and expertise).

Existing needs assessment data and gaps in needs assessment data provided the documentation for prioritization of needs, state performance measures, and will guide future planning.

3.1.2 NEEDS ASSESSMENT CONTENT

3.1.2.1 OVERVIEW OF HEALTH STATUS

Children with special health care needs (CSHCN) are defined as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally (p. 138)."ⁱ National epidemiologic estimates based upon the National Health Interview Survey on Disability of 1994 suggest that 18% of children in the United States below the age of 18 years had a chronic physical, developmental, behavioral, or emotional condition and required health and related services of a type or amount beyond that required by children generally. Children at increased risk were not included in this analysis since that population group cannot be presently identified. This prevalence estimate is commonly accepted as the current operationalization of the definition of CSHCN.ⁱⁱ New Hampshire continues to lack a centralized registry to record incidence or prevalence statistics and continues to depend upon population estimates.

Applying National Estimates

Based upon national prevalence estimates **54,477 NH children** (total population, birth-17=302652 * 18%) **aged birth through 19 years would correspond to the new definition of CSHCN.** The major limitation is that the NH population is composed primarily of 96% white-non-Hispanic children and is not representative of the nation.

NH Office of State Planning: NH Health Insurance Coverage and Access Survey

The NH-HICAS was a random survey of the non-elderly population of New Hampshire residents conducted by the survey research firm Macro International, Inc. Interviews were conducted in English, and one adult who was most knowledgeable about insurance in the family, was asked the survey questions for him or herself as well as for other family members. Between June 16, 1999 and September 1, 1999, approximately 11,781 family-level interviews were

conducted, representing approximately 28,263 persons. A random sample of families in each hospital's market area – called a Hospital Service Area (HSA) – was interviewed.¹

A variety of methods were used to ensure the reliability of the data. The survey contractor (Macro International, Inc.) followed best-practice protocols that ensured appropriate interviewing and quality data collection. Moreover, Macro International developed weights to adjust for various factors that could, if left unadjusted, introduce bias into the estimates. Various adjustments were made to address the design of the survey (which sub-sampled hospital service areas), non-response (where individuals in certain groups were more or less willing or able to participate in the study), and under-coverage (including an adjustment for those without telephones)². Technical assistance was provided by the Robert Wood Johnson Foundation through the Alpha Center for review of important decisions regarding these methods.

Families were asked a series of questions regarding the health status of children from which estimates of children with chronic conditions were derived. The questions used to develop information on chronic conditions were:

Q74c. Is { he/she } restricted or prevented in {his/her} ability to do the things most other children of the same age can do?

Yes

No

Don't know

Refused

Q74d. Has it lasted, or is expected to last more than 12 months?

Yes

No

Don't know

Refused

If a parent reported that a child was limited in some fashion, they were then asked if this limitation lasted or was expected to last more than 12 months. If parents answered yes to both questions for a given child, that child was identified as having a chronic condition.

The NH – HICAS estimates that approximately 3.6% of children less than 18 years of age had a (severe) chronic condition lasting twelve months or more (See Table below). This 3.6% represented approximately 10,700 children. Since not every NH resident was interviewed, this is just an estimate of the true value. Given various characteristics of the survey design, however, we can be 95% confident that the true value of the percent of children with a chronic condition lasting 12 months or more resides within the range of 3% and 4.2%.

³ Hospital service areas are based on inpatient utilization data. Each hospital in the state has a non-overlapping market area that includes all towns in which a given hospital has the most admissions of any hospital in New Hampshire. Please contact the Department of Health and Human Services for a listing of each town in a hospital service area.

² Weights were developed which adjusted for age, sex, and race and ethnicity and the under-coverage associated with the fact that the survey was a telephone survey and missed households without telephones.

**Percent of the Population of Children Whose Parents Reported that the Child had a Limitation
lasting 12 Months or More**

	Estimate	Std Err	95% CI		Number of Children
			Low	High	
Child Has Chronic Condition	3.6%	0.31	3.0%	4.2%	10,694
Child Has No Chronic Condition	95.9%	0.35	95.2%	96.6%	283,696
No Response	0.5%	0.17	0.1%	0.8%	6,329

NH Department of Education: Early Intervention & Special Education Services

Cumulative service utilization data for children receiving special education for 1999-2000 was reported by the Department of Education as follows:

Population	Number of Children
Infants & Toddlers, Birth - ≤ 36 months	2,012
Special Education, 3-21 years, Part B, IDEA	26,404

A very gross estimate of the prevalence of children with special needs who also receive early intervention/special education services based upon eligibility is approximately 9% of the population of children age birth - 21 years.

NH Department of Education: NH School Nurse Survey, 1997 & 1998

The NH Department of Education, School Nurse Consultant Office, conducted a survey of all NH school nurses during school years 1997-8 (Pre-K-12, public schools) and 1998-9 (Pre-K-12, public & private schools). The purpose of this survey was to capture information about the variety of school nurse responsibilities. Information was collected related to number of students with chronic illness/disabilities, communicable diseases, amount of medication administration, screenings conducted, specialized care provided, visits to health office, and related activities. School nurses were also asked to describe their needs as well as the needs of their school population.

Methodological issues and data limitations are prevalent in these surveys and revision of this questionnaire is required, along with definitions, identification of source data, and reporting consistency before implications can be inferred. Furthermore, slightly more than 50% of the schools responded to these surveys.

With revision, this annual survey has the potential to capture significant needs data from a consumer (child) population level as well as a provider (school nurse) level. Potential gross prevalence estimates of CSHCN include children who may not be coded or receiving special education services since not all children with special health care needs receive special education services. Two tables are provided as an example of the type of data that could be useful for future Title V needs assessment activity.

Chronic, Diagnosed Conditions Requiring a School Nurse Assessment / Classroom Modification				
Dx	1997-98		1998-99	
	Number	Percent	Number	Percent
Allergy	7094	27.9%	8032	26.6%
Asthma	5407	21.2%	6527	21.6%
ADD/ADHD	3314	13.0%	4207	13.9%
Integumentary	1657	6.5%	1673	5.5%
Cognitive DD	1101	4.3%	1354	4.5%
Allergy/bee sting	952	3.7%	1091	3.6%
Migraine	762	3.0%	998	3.3%
Neuro/seizure	492	1.9%	620	2.1%
Psychiatric	489	1.9%	842	2.8%
Cardiac Condition	430	1.7%	473	1.6%
Child Abuse (report)	391	1.5%	362	1.2%
Hearing Imp	380	1.5%	433	1.4%
Vision Impair	384	1.5%	481	1.6%
Chemical Depend	354	1.4%	425	1.4%
GI condition	241	0.9%	250	0.8%
Mobility Impaired	232	0.9%	325	1.1%
Nutrition/Eating	202	0.8%	249	0.8%
Diabetes	188	0.7%	210	0.7%
GU chronic	190	0.7%	179	0.6%
Cerebral Palsy	140	0.6%	163	0.5%
Tourette's	96	0.4%	115	0.4%
Arthritis	82	0.3%	96	0.3%
Bleeding Disorder	73	0.3%	69	0.2%
Down Syndrome	85	0.3%	107	0.4%
Neuro/CNS	77	0.3%	97	0.3%
Immune disorder	50	0.2%	79	0.3%
Oncology	60	0.2%	86	0.3%
Muscular Dystrophy	39	0.2%	41	0.1%
Cystic Fibrosis	39	0.2%	28	0.1%
Spina Bifida	35	0.1%	50	0.2%
Other, not specified	416	1.6%	527	1.7%
TOTAL	25452	100.0%	30189	100.0%

School Population represented in survey*	70,056	80,967
Percent Special Needs per total reported population	36%	37%

* Note: Survey responses include slightly more than 1/2 of the school population in NH.

Number of Children Requiring Specialized Care/Procedures by School Nurse				
Special Care	1997-98		1998-99	
	Number	Percent	Number	Percent
Diapering	284	12.1%	233	13.0%
Personal Toileting	225	9.6%	250	13.9%
Nebulizer	222	9.4%	253	14.1%
Blood Glucose test	174	7.4%	193	10.8%
Bladder Program	129	5.5%	93	5.2%
Bowel Program	130	5.5%	89	5.0%
ROM Exercises	101	4.3%	167	9.3%
Feeding assist (oral)	78	3.3%	97	5.4%
SC meds	65	2.8%	54	3.0%
IM meds	36	1.5%	11	0.6%
Tube feeding	22	0.9%	36	2.0%
Self Catheterization	17	0.7%	20	1.1%
Oxygen Admin	16	0.7%	17	0.9%
Postural Drainage	14	0.6%	22	1.2%
Suctioning	14	0.6%	27	1.5%
Stoma Care	12	0.5%	22	1.2%
Cath by SN or aide	7	0.3%	16	0.9%
IV meds	6	0.3%	10	0.6%
Vent Assist care	2	0.1%	4	0.2%
Dialysis	1	0.0%	8	0.4%
Other, not specified	797	33.9%	172	9.6%
TOTAL	2352	100.00%	1794	99.90%

School Population represented in survey*	70,056	80,967
Percent Special Procedures / reported population	3.3%	2.2%

PRIORITY

Identifying CSHCN based upon a common operational definition, within any public or private health or educational system, continues to be a major barrier towards not only estimating prevalence of conditions but also accessing that population to capture information about health and related needs.

Health Status indicators for the population of CSHCN do not exist. Again, infra-structure building limitations of staff and resources have constrained development in this area.

3.1.2.2 DIRECT CARE SERVICES

3.1.2.3 ENABLING SERVICES

FAMILIES OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Special Medical Services Bureau (SMSB) has relied upon information derived from published studies of family needs (state of the art)^{iii iv v vi vii} and in-house efforts to develop, implement, and monitor the expressed needs of the families served by the Bureau to direct service prioritization and systems development. New Hampshire families of children with special health care needs have had numerous opportunities to identify and verbalize their needs, concerns, and priorities. The SMSB has incorporated **needs assessment as an ongoing systematic process** with the capacity to monitor trends versus a periodic event or project. Questions about family perceived needs have been incorporated into periodic **Parent Satisfaction** surveys that are conducted on a programmatic basis. **Over 500 families** have participated in surveys that concluded in 1996^{viii} and were summarized in the Parent Newsletter. Also, needs and concerns have been captured from related service systems such as Early Intervention and agencies who serve related populations of children and families.^{ix x xi xii xiii xiv} **Recurring themes from these studies over the past 10 years include finding out about services and help accessing them, paying for related medical needs, family support, and care coordination.** Families overwhelmingly report that the Title V-CSHCN is responsive to families, helps families find and get services, provides verbal and written information, provides referral to other agencies and parents groups and whose staff listen to families and communicate with their child's other providers.

Finding information about services and getting them includes family requests for verbal or written material about a variety of conditions and subjects. Service requests relate to helping families access primary and specialty medical care, dental care, providers who accept Medicaid, transportation to appointments, trained respite providers, child care, legal services, counseling/behavior management, and Medicaid / SSI application assistance. Families report that providers need to be educated how and when to refer and that information about services should be easily available. An associated **need for care coordination services** to assist families to deal with multiple agencies and providers and help transition from home to school to adult programs is also a recurring theme. A recent survey of families receiving Child Development Services (n=203) which included individual telephone interviews of 24 families indicated that families highly valued the developmental evaluation and felt empowered by the teams^{xv}. Families reported being referred to the program via pre-school teachers, primary care physicians, Early Intervention programs, other parents, Child Find, infant follow-up program, and a local public health nurse. Some families reported that their child was born with an identifiable condition, others that a pre-school teacher expressed concern about development, and still others reported that they also were concerned about their child's development. A small number of families interviewed indicated they received no direction, acknowledgment, or assistance from their primary care provider when they brought up concerns about their child's development. **A latent or unexpressed need that had not been clear previously is that families are reporting difficulty finding out about services in the first place.** As families become more "integrated" into private managed care delivery systems we anticipate that families will have more difficulty connecting to the support systems they say they need. A progress Report from the

State Children's Health Insurance Program (1999) also identified that **families learn about Healthy Kids Program through a friend or relative.**

Paying for services has been another broad category of concerns that families have repeatedly expressed although priorities have shifted with the changing marketplace. Paying for services used to be associated with residual bills after insurance and out-of-pocket costs, and with increased access to low managed care co-payments, is shifting to help paying for expensive medications, special dietary supplements, adaptive and durable medical equipment, and a variety of related supplies denied by managed care. There are still some families who require the traditional financial support due to inadequate or no health insurance.

In 1999, the Department of Health and Human Services sponsored the **New Hampshire Health Insurance Coverage and Access Survey**, a telephone survey of New Hampshire residents under the age of 65 designed to understand health insurance coverage, access to health care, and general medical needs. In spite of general economic prosperity, an estimated 96,000 New Hampshire residents (9%) are uninsured. Almost 84 % of residents are covered through the private sector which is significantly higher than the national average. 74% of the uninsured are Adults, and those ages 30-44 account for the largest share of the uninsured. Adults ages 18-29 account for 25 % of the uninsured individuals in the state. An estimated 25,000 children are uninsured, approximately 26 %. Approximately 74 % of these children live in families with incomes that would qualify them for existing state programs which translates into 18,500 children who are potentially eligible for publicly sponsored coverage and are not participating. Almost 73 % of all uninsured individuals have at least one family member who is working full-time. In addition, approximately 12 % of uninsured individuals live in families with at least one individual working part-time. Approximately 58 % of working uninsured adults indicated that they were working in firms that did not offer insurance coverage. An additional 18 % reported that their employer offered coverage but they were ineligible for that coverage as a result of the length of employment, the part-time nature of the work, or as a result of medical issues which restricted their access to employer-based insurance. The Northern part of the State has significantly higher rates of uninsurance than the Southern regions. Approximately 14 % of residents are uninsured in the North Country, the area north of 'The Notch.' Approximately 13 % of residents are uninsured in Central Eastern New Hampshire, including the Mt. Washington Valley and the Lakes Region. While the uninsurance rate is higher in the North Country and Central Eastern New Hampshire, the more urban areas of New Hampshire - including those centered around Manchester, Nashua, Concord and Portsmouth - account for approximately 70 % of the total number of currently uninsured individuals. Given that most job growth is in the retail and service industries - those least likely to offer insurance coverage - the uninsured may increase. The number of uninsured will also increase in the event that there is a downturn in the economic and/or insurance cycles.

Two current initiatives could have a significant effect on the lives of uninsured New Hampshire residents. A portion of the uninsured are children potentially eligible for existing programs. These children will benefit from private and state outreach efforts currently underway. The greatest share of the uninsured - adults - will be the focus of a subcommittee involving a partnership between the Department of Health and Human Services, the Legislature, representatives of health care providers and businesses in New Hampshire and the Healthy Kids Corporation. These two initiatives have the potential of significantly reducing the rate of un-insurance in NH.

Family Support, as identified by families, includes someone they can talk to, someone who will listen and understand, help siblings talk about their feelings; competent respite providers for children with high tech equipment, help anticipating future health care needs, and help families cope with grief and loss. Advocacy issues relate to school individualized education planning process and appeals for services to Medicaid, managed care agencies, and schools.

Market changes have resulted in the expansion of managed care services to a greater portion of the population improving access to primary care, especially preventives services, through lower co-payments. At the same time, the measures that allow **managed care** to be successful in containing costs may not work to the advantage of children with low prevalence conditions who demonstrate a wide variation in severity of needs. A New England SERVE survey^{xvi} of families of children (n=368) with special health care needs reports that families are moderately satisfied with medical and specialty care services (especially small co-pays), coverage for well child care, and decreased insurance paperwork. Families reported most dissatisfaction with mental health services and the ease of service delivery in their managed care organization. Mental health services families identified as having most trouble accessing were in-patient psychiatric care and counseling for child/family. Families were satisfied with their managed care organization relative to handicapped accessibility, waiting time to schedule appointments for primary care and access to timely specialty care referrals, however, were dissatisfied with grievance process and flexibility to use cost-effective alternative services. Questions related to satisfaction with other health services such as medications, equipment, medical supplies received a higher satisfaction rating than any other area with a few exceptions relative to special diets. Greatest levels of dissatisfaction were reported relative to communication and coordination of care. Information, including current research, access to a case manager or care coordinator, and helping the school understand child's needs were areas of greatest concern.

Comparison of New Hampshire respondents who comprised 47 percent of the entire New England sample demonstrated no significant differences in satisfaction. Parent responses to the open-ended questions about the suggestions parents would make to change the system of care was extracted from the New Hampshire portion of the sample. More than 50 percent of the families in the New Hampshire sample offered comments related to:

- direct access to specialists: allow access to out of network providers, eliminate need for follow-up requests for referral once need has been established,

- care coordination: record review, help families get services, work with schools, transition children, support, and
- managed care plan: expand service coverage to therapies, counseling, durable medical equipment / equipment, explanation of services, be knowledgeable about needs of children with special health care needs.

Generalization to the larger population of families is constrained by sample bias related to non-random sampling and lack of representation from minorities and low-income families. Sample selection is affected by recruitment of families from within existing services programs, ability and their willingness to respond to the survey, the severity of service needs indicated, and self-selection based on their experience with a managed care plan. However, information provided by these families does provide a baseline from which to proceed and interestingly, even with market changes, is echoing previous themes.

PRIORITY

Families are reporting difficulty finding out about services in the first place. They identify family and friends as informants related to a variety of resources versus primary care providers or professionals. This has important implications for the structure of the service systems that develops and determination of where resources are best allocated.

Families value and request assistance with coordinating their child's care. Care coordinators have the potential to improve access to a variety of primary and related services and financial supports. Determining the infra-structure for care coordination within the state is a current priority.

PROVIDERS OF SERVICES TO CSHCN AND THEIR FAMILIES

Providers have received minimal attention during the past 10 years compared to families. The 1988 Needs Assessment surveyed a variety of providers who represented all regions of the state in the areas of health, medicine, early intervention, and education. Participation was highest for those providers who had a direct working relationship with community-based clinic programs that were functioning at that time. Professionals who worked directly with the specialty clinics (medical sub-specialty consultants, child health programs and clinic team members) reported the highest "awareness" of services. Pediatricians, family physicians, Early Intervention programs, and Special Education programs were less aware of the range of Bureau services although may have been familiar with a particular program with which they have had contact and experience. Satisfaction with Bureau services was also reported to be high with appreciation noted for the following attributes of Bureau programs:

- Comprehensive, continuous care, quality of services and expertise of providers
- Care coordination, outreach, and follow-up
- Public Health-Private collaborative approach to service delivery
- Availability of a range of specialty care services
- Collaboration with local providers

Professionals also offered suggestions to improve services. These suggestions ranged from improving communication from specialty clinic services, expanding services to larger numbers of children by increasing frequency of clinics or expanding eligibility requirements (age, condition, income), increasing reimbursement to providers, billing third party payers/maximizing resources, and creating new resources for nutrition, psychology, and family support services. Ideas for policy changes included facilitating collaboration with other state agencies who serve children, monitoring quality of services, and developing systems for identification and tracking of children with special health care needs.

Professional perception of unmet service needs of the children and families they serve were grouped under health, financial, family support, and education categories. Access to a variety of primary care, specialty care, dental and allied health headed the list. This included availability of the service as well as financial means to access the service through private insurance or Medicaid. Family support needs included information, counseling, and assistance with coordinating care. Education needs were identified as availability of vocational services, school nursing, related services, and health information integration into family service and education plans.

The **role of the primary care provider** in coordinating the care of children with chronic illness/disability/special needs has been addressed in the literature^{xvii xviii xix xx xxi xxii xxiii} (even prior to the advent of the "new national agenda") and the role of the contemporary pediatrician is best articulated as the provider of a "medical home" for the child.^{xxiv} The need to move ahead and shift services to the community and discover how to bridge the gap between families who say they want these services and providers who could link families to services has led to a **recently initiated study of primary care provider needs related to care coordination services.**^{xxv} Since families are the key identifiers of their own needs, and they say they need care coordination, and they aren't connecting with the services because they aren't being referred we chose to focus on referral behaviors of providers and how we might influence those behaviors. At the same time we recognize that providers are also customers and partners in this endeavor and have unknown needs. Seven key informant interviews were conducted that explored physician knowledge, attitude, past behaviors, perceived consequences, future intent, and preferred information channels. Pediatricians who saw "many" children with special health care needs in their practice demonstrated specific awareness of community care coordination resources compared to pediatricians who reported seeing "fewer" children. Pediatricians have made referrals for care coordination services, furthermore, they intend to refer in the future. Knowledge of available resources is essential. Suggested information channels include resource directories, condition specific information packets, and face-to-face contacts. The referral decision is influenced by client, physician, and health system factors. Diagnosis, young age of child, and families in need of resources were the client factors identified. Personal knowledge of the provider, saving time, credibility of service, and feedback mechanisms were the physician factors. Reimbursement and paperwork assistance were the health system factors. This baseline information will be used to develop a survey tool for distribution to pediatricians, family practitioners, and nurse practitioners who provide primary health care services in New Hampshire. The purpose of broadening the scope of this study is to confirm these determinants as those that most influence pediatricians to refer for care

coordination services, compare responses for different audience segments, and determine which factors or combination of factors might be predictors of referral. Most critically, the results will be used to devise appropriate strategies that will guide the re-designing of care coordination services to be accessible and acceptable to providers and families, at the community level. This will constitute a segment of our needs assessment activity in the future.

As a result of the recent Child Development Program evaluation a decision was made to extend data gathering to **pre-school education providers** who work closely with local programs. Families especially identified pre-school personnel as identifying concerns about their child's development and/or suggesting resources to families. Families also identified that school personnel either highly welcomed Child Development Evaluation results and the information provided by the team or were hesitant to implement recommendations. In the latter case families reported a gap between what was recommended by the team and what schools were willing to provide for services. Key informant interviews were conducted to explore how school personnel interact with Child Development Programs, benefits of the evaluation to school districts, and barriers to service delivery. These interviewees provided very positive responses to the Child Development Program. *Key informants value the Child Development Team, their expertise & responsiveness, comprehensive & collaborative approach, willingness to see child in environment, receptivity towards discussing recommendations, knowledge of resources, community embeddedness, and long-term personal relationship.*^{xxvi}

Title V-CSHCN recently collaborated with the School Nurse Consultant in the Department of Education to revise a Department of Education survey tool that explores **school nurse involvement** with children with special health care needs. Narrative responses to questions related to needs of school nurses and of the student population related mostly to children with special health care needs. School nurses indicated that, during the past five years, their practice has changed in the following ways: complexity of diagnostic conditions (mental health, medically fragile, emotional/behavioral), need for medications, and psychosocial supports for families have increased. More attention is spent on care versus health education/prevention. A handful of school nurses reported that computerization has also been a change. Changes related to student needs include: increase in intensity, complexity, and comprehensiveness of care required from school nurse by students. A small number of school nurses also noted the increased use of the school nurse by staff and by families who do not have a regular source of primary care. School nurses also projected the **future changes in school nursing as: increasing involvement with more complex special needs students**, emphasis on health promotion and wellness activities, and need for school-based primary care clinics. School nurses identified the following needs related to their ability to perform their role: support and advocacy from State Nurse Consultant, educational opportunities/continuing education, communication and networking, policy and legal issues, and information about community resources.

Needs assessment activities from a variety of sources were reviewed to identify provider related needs and training:

NH, DHHS, State Office of Rural Health & Community Health Institute

The State of Health in Rural New Hampshire, 1999

Availability of Primary Care and other Health care Providers: challenge in recruiting and retaining sufficient professionals across spectrum of necessary disciplines.

Rural residents account for a greater proportion of the population with disabilities than urban resident yet receive fewer formal or specialized services, travel further to obtain health care services, pay a greater proportion of their income for health care and generally receive poorer quality of care than their urban counterparts. **The major problem is that specific disabilities are not prevalent enough in remote areas to support the development of specialized expertise (p. 29).**

Professional Training opportunities were also identified by the following groups:

- NH, DHHS, DMH & DS, Common Themes of Regional Interagency Network Initiatives, Infant Mental Health 1999 Conference Proceedings
- Early Education & Intervention Network of New Hampshire, Future Search Conference April, 1999
- NH, DHHS, Division of Developmental Services, NH Traumatic Brain Injury Needs Assessment Project, 1999
- NH, DHHS, Division of Behavioral Health, A Five-Year Plan for Behavioral Health Services in NH, 2000-2005
- The Union Leader, Monday April 13, 1998, pg. A1, A4 Immigrants Test City Schools. Although does not identify cultural competence directly, this reported study identifies the substantial growth of diverse populations in a historically homogenous state.

PRIORITY

Collaboration with providers is essential for families to access the services they say they need and requires development of a network of on-going communication with provider groups. Title V also has an opportunity to assist in addressing staff training and education needs.

3.1.2.4 POPULATION-BASED SERVICES

Population-based services and needs have been combined through Title V-CSHCN agency efforts to support family-based contracted service providers such as : **Parent to Parent of NH, Family Support & Resource Center, and the Family Resource Connection** through information and referral activities. Data from these activities is collected at the time of occurrence and analyzed annually^{xxvii}. The contact made by telephone callers allows the agency to monitor trends in needs of a population of children and families who are not currently being served by Title V-CSHCN. Over 5,000 requests for some type of information or assistance has been tracked over the past five years.

Requests for assistance continue to cover a variety of areas and are presented in high to low frequency order:

Support services include listening to parents, counseling, finding groups, sibling support, or generic supports related to parenting, divorce, single parenting, step-parenting, custody, difficult teens. **Support needs have replaced financial assistance as the most frequent overall request primarily due to increased financial assistance programs. This need is met through referral to appropriate support agency.**

Literature/Materials includes requests for specific publications, lending library books, condition specific information, for parents, professionals, or students in secondary and post-secondary schools. It also includes requests for agency informational brochures. This need is met at the time of contact.

Health care services / case management relate to finding and getting services for a wide variety of diagnoses or technical assistance related to a particular condition. **This need continues to remain towards the top of the list regardless of increase in financial assistance and parent support program development.**

Parent Matches are requests to link family with another family and are met within a month of request.

Financial Assistance relate to need for Medicaid, insurance, SSI, or money for medical bills. Some concerns related to assistance with accessing services.

Special education / School requests relate to help with advocacy for specific programs or services, transition to school, and job training opportunities and are handled by parent consultants or referral to appropriate agency.

Equipment / Medications / Daily Living Expenses include funding for special equipment, drugs, utility bills, clothing, special food/formula, transportation, and housing.

Phone Number Assistance inter-departmental transfer calls and callers seeking telephone numbers of specific agencies. The largest number of calls are from adults seeking a connection with Granite State Epilepsy Services.

The remaining requests are for respite, recreation, adoption information, training needs, advocacy, and legal assistance.

Many sources have created a proliferation of data about needs of targeted groups of NH citizens some of whom are indirectly related to CSHCN. Multiple methodologies have been employed (focus groups, questionnaires, telephone surveys, etc.) some of which employed rigorous collection and analysis methods and some that did not. Direct comparison is not possible. The variety and scope of the activities do provide an overview to the breadth of needs activities and underscores the importance of collaborating versus duplicating these initiatives.

The following information has been extracted from related major sources of needs assessment or planning activities that have been generated in New Hampshire during the past few years. Results of assessment are condensed for the sake of brevity. Some of these needs have been incorporated into direct and enabling services section where appropriate.

<p>NH, DHHS, State Office of Rural Health & Community Health Institute The State of Health in Rural New Hampshire, 1999</p>	<p><i>Access to Care:</i> insurance, transportation time, geographic barriers <i>Availability of Primary Care and other Health care Providers</i> <i>Organization of Services:</i> challenge of implementing integrated model of care to sustain broad range of services and survive in managed care environment. Rural residents account for a greater proportion of the population with disabilities than urban resident yet receive fewer formal or specialized services, travel further to obtain health care services, pay a greater proportion of their income for health care and generally receive poorer quality of care than their urban counterparts. The major problem is that specific disabilities are not prevalent enough in remote areas to support the development of specialized expertise (p. 29). <i>Sustaining Rural Health Infrastructure:</i> challenge to sustain locally available continuum of care with community hospital as the hub within current economy.</p>
<p>NH Healthy Kids (SCHIP) Progress Report, 1999</p>	<p>More than 4,000 children have been enrolled in Healthy Kids Silver program Outreach and marketing activities have resulted in increases in inquiries Families learn about Healthy Kids through a friend or relative as it becomes better known.</p>
<p>NH, DHHS Office of Planning and Research Insurance Coverage in New Hampshire, Issue Brief 1999</p>	<p>New Hampshire Health Insurance Coverage and Access Survey, a telephone survey of New Hampshire residents under the age of 65 designed to understand health insurance coverage, access to health care, and general medical needs. In spite of general economic prosperity, an estimated 96,000 New Hampshire residents (9%) are uninsured. Almost 84 % of residents are covered through the private sector which is significantly higher than the national average. 74% of the uninsured are Adults, and those ages 30-44 account for the largest share of the uninsured. Adults ages 18-29 account for 25 % of the uninsured individuals in the state. An estimated 25,000 children are uninsured, approximately 26 %.</p>

	<p>Approximately 74 % of these child live in families with incomes that would qualify them or existing state programs which translates into 18,500 children who are potentially eligible for publicly sponsored coverage and are not participating.</p> <p>Almost 73 % of all uninsured individuals have at least one family member who is working full-time. In addition, approximately 12 % of uninsured individuals live in families with at least one individual working part-time. Approximately 58 % of working uninsured adults indicated that they were working in firms that did not offer insurance coverage. An additional 18 % reported that their employer offered coverage but they were ineligible for that coverage as a result of the length of employment, the part-time nature of the work, or as a result of medical issues which restricted their access to employer-based insurance</p> <p>The Northern part of the State has significantly higher rates of uninsurance than the Southern regions. Approximately 14 % of residents are uninsured in the North Country, the area north of 'The Notch.' Approximately 13 % of residents are uninsured in Central Eastern New Hampshire, including the Mt. Washington Valley and the Lakes Region. While the uninsurance rate is higher in the North Country and Central Eastern New Hampshire, the more urban areas of New Hampshire - including those centered around Manchester, Nashua, Concord and Portsmouth - account for approximately 70 % of the total number of currently uninsured individuals. Given that most job growth is in the retail and service industries - those least likely to offer insurance coverage - the uninsured may increase. Two current initiatives could have a significant effect on the lives of uninsured New Hampshire residents: 1) outreach efforts to insure children through existing programs, 2) adults - partnership between the DHHS, Legislature, representatives of health care providers and businesses in New Hampshire and the Healthy Kids Corporation.</p>
<p>Children's Alliance of NH, Child Advocacy Network Children's Agenda 2000</p>	<p>Work of over fifty organizations and individuals who are partners and supports of the NH CAN. Agenda is divided into four categories.</p> <p><i>Education:</i> access to adequate, appropriate education & safe learning environments.</p> <p><i>Health & Wellness:</i> Access to health care, substance abuse prevention, prenatal care and parenting education. 25,000 children in NH have no health insurance; 18,5000 are eligible but not enrolled in state sponsored health insurance coverage. 15% of two years old were not fully immunized in 1997.</p> <p>Medicaid does not reimburse for school-based preventive health services</p> <p>Incarcerated youth have no resource (State or Medicaid) that funds medical needs of these youth. NH is among the seven least fluoridated states in the nation and fewer than 50% of Medicaid enrolled children received dental care in 1996. NH ranks 30th in the US among births to mothers who smoked during pregnancy and ranked</p>

	<p>among the bottom of 20 states among women of child-bearing age who report frequent drinking.</p> <p><i>Economic Security and Well-being:</i> Economic self-sufficiency, safety net, and affordable child care.</p> <p><i>Child Safety & Protection:</i> Coordination and funding of services that promote healthy children and families in community, training and assuring adequate staff, improving information systems.</p>
<p>Facilities and Equipment for the Care of Pediatric Patients in a Community Hospital</p> <p>Gladstone, G., Frank, J. E., Quinton, H. B. 1998-9</p>	<p>Survey conducted by the NH Pediatric Society of 24 NH community hospitals to define the current level of compliance with an AAP policy statement regarding equipping pediatric areas in community hospitals. All hospitals responded.</p> <p>Compliance with policy statement was reported as: 90% in 12 hospitals, 80-90% in 10 hospitals, <80% in 2 hospitals. Quality improvement needs identified were:</p> <p>Covered electric outlets, alarms for doors, and padding of sharp edges</p> <p>Designated areas for play, entertainment, education and child live activities</p> <p>Increasing the number of nurses were are Pediatric Advanced Life Support certified.</p>
<p>The American Pediatric Society sponsored research</p> <p>Metabolic/Hearing screening for early discharged infants: A population-based study.</p> <p>1996</p>	<p>In a study of approximately 15,000 births in NH, 50% increased risk of readmission to hospital and 70% to emergency room within the first two weeks of life for infants discharged less than 48 hours of life. In 1994, with 14,491 births, 42.5% of infants were discharged in < 48 hours (range of individual hospitals varied from 19.9% to 63.9% with an average maternal length of stay of 2.14 days.</p> <p>Despite State Health Dept. guidelines to screen <24 hr. old infants prior to discharge, 8 hospitals, which account for 20.1% of the early discharge infants, have no formal policy for screening at <24 hours. The number of repeat metabolic screening testing by the state lab has remained constant since 1992 despite the rise in early discharge and may be indicative of missed screening. Routine hearing assessment is currently not part of any NH hospital newborn protocol and is evaluated by only 5.9% of practicing physicians in the office.</p> <p>Frank, J. E, Flanagan, V. A., Ketterer, K. H., Dept. of Pediatrics, Dartmouth Medical School</p>
<p>NH, DHHS, DMH & DS</p> <p>Common Themes of Regional Interagency</p>	<p>Conference Proceedings:</p> <p>Improve Regional Network Communication and Coordination</p> <p>Staff Training</p> <p>Prevention Services & Comprehensive Early Childhood Outreach Program</p> <p>Universal home visiting to prevent need for costly intervention services</p>

<p>Behavioral Health</p> <p>A Five-Year Plan for Behavioral Health Services in NH, 2000-2005</p>	<p>populations such as children.</p> <p>Improve access to care for children with serious emotional disturbance, train staff, replicate comprehensive, community-based models, and treatment capacity.</p> <p>Promote a variety of social support services especially advocating for health insurance benefits for behavioral health services.</p> <p>Improve service system quality and cultural competence.</p>
<p>NH, District Court, County Human Service Administrators & UNH Cooperative Extension.</p> <p>NH Statewide Community Youth Profile, 1998,</p>	<p>Priority Area Key Issues</p> <p>Economic opportunity for improved quality of life.</p> <p>Business / industry role in supporting children, youth and families.</p> <p>Collaboration, coordination, and communication among service programs.</p> <p>Prevention, Intervention, and Treatment community-based programs <i>including those with developmental disabilities.</i></p> <p>Court and Juvenile services improvement.</p> <p>Positive activities for Children, Youth and Families (recreation, child care, summer youth programs, sports, music and arts).</p> <p>Preparation for life-long learning, workforce preparation, transitions from high school to employment.</p> <p>School/Education improvements</p> <p>Strengthening families including parenting education.</p> <p>Valuing youth as community resources</p> <p>Access to funding, transportation, programs and services.</p> <p>Accountability and sense of responsibility of the systems and of individuals.</p> <p>A report in <u>Pacesetter</u> (Winter, 2000, p. 8) indicates that the <i>percentage of youth and adults with disabilities in the justice system is about three to five times the number of youth served under disability law by public schools.</i> Between 25 and 75 %s of youth offenders have at least one identified disability, other are misdiagnosed unidentified, or have additional disabilities. The most common disabilities were reported to be attention deficit hyperactivity disorder, depression, learning disability, developmental disability, and conduct disorders.</p>
<p>The Governor's Business Commission</p> <p>Child Care and Early Childhood Education</p>	<p>General Findings:</p> <p>Cost (affordable) of child care is a barrier for working parents. Families spend approximately 18 % of annual income on child care</p> <p>Child care workers are poorly paid. Poor quality child care affects employee turnover. Businesses loose up to \$24 million because of child-care related absenteeism. Access to child care varies across the state.</p>

<p>New Hampshire's Child Care Challenge, 1998-9</p>	<p>Child Care programs (for profit or not-for-profit) face challenges in providing low-cost, high quality child care and shortages in availability harms business and industry. Commission charge is to develop partnerships and address supply shortages of child care.</p> <p><i>CSHCN are not mentioned as a group having special needs for child care.</i></p>
<p>The Union Leader, Monday April 13, 1998, pg. A1, A4</p> <p>Immigrants Test City Schools</p>	<p>An emerging issue for a largely homogenous state population:</p> <p>Fifty-two (52) languages are now spoken in Manchester public schools compared to 22 last May. Countries of origin include: Vietnam, Laos, Cambodia, Romania, USSR, Bosnia, Nigeria, Congo, Iraq, and others.</p> <p>Approximately 250 to 300 refugees arrive each year putting a strain on programs such as English as a Second Language (ESL).</p> <p>There are an estimated 3,000 to 3,5000 refugees in the state.</p> <p>Manchester (south-central) has the largest concentration of refugees however other towns also have concentrations of refugee populations: Newmarket (Laotian), Claremont and North Conway (Bosnian), Seacoast (Rwandans), scattered across the state are families from Somalia, Sudan, Nigeria, Romania, Albania, Vietnam and Iraq. Success in refugee resettlement programs is ascribed to high quality refugee resettlement programs, job opportunities, and only 3.5 % foreign born population compared to other states. State Refugee Coordinator for NH Office of Refugee Resettlement suggests that discrimination against foreign-born populations is low. Waves of migration among the Hispanic population had occurred in the 1950's, 1970's and 1980's relative to job recruitment in the mills. During the 1990's, scarcity of jobs resulted in this population moving to other states such as Florida.</p>

PRIORITY

A future plan is to concentrate on the population-based needs for care coordination / case management assistance that remains a consistent theme across population-based and direct services needs assessments and is not being met.

3.1.2.5 INFRASTRUCTURE BUILDING SERVICES

In the past 10 years many external and internal forces have been shaping the way New Hampshire delivers services to this population of children and has affected relationships with providers. The shaping of a new national agenda (family-centered, community-based, culturally-relevant, coordinated care) initiated by Surgeon General C. Everett Koop, the broadening of the Title V mandate (PL 101-239) to improve service systems for *all* children with special health care needs was followed by policy changes which have helped to expand financial access to health care services for these children.^{xxviii xxix xxx} At the same time, market changes have resulted in more managed care organizations including children with special health care needs in their service populations. The most significant change in the New Hampshire program has been the transition of pediatric direct care multidisciplinary programs (cardiology, epilepsy, cystic fibrosis, spina bifida, and cleft lip & palate) to the tertiary-based private sector. While these modifications have allowed families to access specialty care services at times and places convenient for them and allowed Title V-CSHCN to expand services not previously available to families (respite, flexible financing, family support), there continue to be challenges.

A related change driven by the need to develop community-based systems of care has been the trend to de-centralize the provision of care coordination services from the state level to the local level. Although the medical services were shifted to the tertiary center, the care coordination services (enabling) were retained by the Title V agency. The shift of care coordination to the local level has been delayed by the need to develop structure, process, and outcome measures and training and monitoring support for these services as well as determine service placement. NH does not enjoy an abundance of community level infrastructures that have the capacity to assume these services--and building capacity at the local level includes assuring long-term sustainability. The agency has developed pilot contracts with local services to assume local case management activities as well as out-placed staff. The long-term plan is to work with each localities strengths, not duplicate efforts and build on existing community capacity.

The Title V-CSHCN program has experienced its share of staff freezes and loss of critical positions. Making the transition from a direct service agency, building infrastructure, and supporting the development and sustainability of local services requires different personnel expertise. Only two administrative positions at a graduate level have responsibility for planning and development, contracts management, direct service provision and direct service oversight.

SERVICE DELIVERY SYSTEMS

Up to this point, most all needs assessment activities have been focused on the known population of individual children with special health care needs who receive some type of Title V direct or contracted service. At the same time, effort has been expended with the support of prior SSDI funds to develop MIS system capacity to adequately track and monitor performance indicators as established by the MCHB and improve future ability to monitor needs and quality assurance though still at an individual level. The ongoing challenge to the state is to create the ability to

monitor needs of all children with special health care needs in the state and not just those served by the program. As more of the Title V programs become privatized the ability to track this population (as individuals) is diminished. We no longer know who these families are. New methodologies need to be developed and implemented on a population level that encourage participation from a variety of service delivery systems and secondary data sources. Sharing data across delivery systems will require the identification of a common set of data elements. New information systems should be able to combine eligibility determination, utilization review, service delivery process, and monitor outcomes of care. Furthermore, an operational definition of children with special health care needs also needs to be resolved. The capacity to aggregate data will be essential for the Title V agency to measure, monitor, and improve systems of care for children that focus on the core public health functions of assessment, policy development, and assurance at a population level. Assessment provides the foundation for problem identification, data to support policy decisions, and monitor progress (assurance). The system and personnel resources to do this will need to be secured.

Systems level assessment also implies multiplicity of program delivery systems and resources. The boundaries of the system whose needs are being assessed are determined by definition. The SMSB has struggled with identifying mutually beneficial public and private partnerships with existing delivery systems on a state or community level. Moving to a population based perspective implies looking at community in a broad sense and interacting with key stakeholders. A forthcoming challenge for the SMSB is to create working partnerships with agencies, provider systems, and organized groups. Strengthening alliances with the MCH Title V sister agency and the NH Pediatric Society will be the first steps in this long-term process. Systems level assessment and monitoring require a systems level response.

Finally, a systems level perspective needs to consider service integration at the direct service level. Current service delivery systems continue to be based upon a categorical, deficit-oriented, fragmented, rule-bound, and bureaucratic characteristics. Strategies to change the way the system operates is faced with many barriers: competition for scarce resources, overlap of federal, state, and legal mandates, agency "turf" issues, lack of interdisciplinary training and development opportunities and competing public-private value systems. It may be time to start sharing our vision for the future and solicit perceptions from related public and private agencies, (who may be perceived to have other agendas) as to their expectations of future Title V systems development initiatives. **Systems level initiatives, working with stakeholder groups / advisory committees have not been initiated due to current staffing constraints.**

PRIORITY

Securing staffing expertise (epidemiologist, graduate level staff) is an unrealized priority and directly affects the State's ability to develop collaborative relationships with the multiplicity of stakeholders who share concerns for this population.

3.2.1 STATE IDENTIFIED PRIORITY NEEDS FOR CSHCN

- Identifying CSHCN based upon a common operational definition, within any public or private health or educational system, continues to be a major barrier towards not only estimating prevalence of conditions but also accessing that population to capture information about health and related needs.
- Families are reporting difficulty finding out about services in the first place. They identify family and friends as informants related to a variety of resources versus primary care providers or professionals. This has important implications for the structure of the service systems that develops and determination of where resources are best allocated.
- Families value and request assistance with coordinating their child's care. Care coordinators have the potential to improve access to a variety of primary and related services and financial supports. Determining the infra-structure for care coordination within the state is current priority.
- Collaboration with providers is essential for families to access the services they say they need and requires development of a network of on-going communication with provider groups. Title V also has an opportunity to assist in addressing staff training and education needs.
- A future plan is to concentrate on the population-based needs for care coordination / case management assistance that remains a consistent theme across population-based and direct services needs assessments and is not being met.
- Securing staffing expertise (epidemiologist, graduate level staff) is an unrealized priority and directly affects the State's ability to develop collaborative relationships with the multiplicity of stakeholders who share concerns for this population.

NEEDS ASSESSMENT PLAN

FAMILY OBJECTIVES *(known CSHCN, survey, focus)*

1. Develop a profile of current family users of BSMS services based on geographical, socio-economic, diagnostic, and related indicators and segment audience in respect to the factors that influence help seeking behaviors such as financial stress, severity of condition, or geographic isolation.
2. Confirm factors that motivate families of children with special health care needs to seek information and/or services and identify product benefits and barriers through a social marketing survey.
3. Identify information and distribution channels that most readily capture the attention of families of children with special health care needs.

PROVIDER OBJECTIVES *(survey, interviews)*

1. Create a partnership with the NH Pediatric Society to assist in the development of family centered, community-based, culturally-competent, coordinated systems of care for children with special health care needs.
2. Validate factors that that motivate primary care physicians to refer children with special health care needs and their families for care coordination services as reported through key informant study.
3. Identify effective strategies for encouraging primary care providers to refer children with special health care needs for care coordination services and for the development of community-based systems of care.
4. Collaborate with Department of Education and revise school nurse survey relative to children with special health care needs.
5. Explore the benefits and barriers perceived by pre-school personnel in relationship to community-based child development programs and identify system needs.

SYSTEMS NEEDS ASSESSMENT OBJECTIVES

1. Collaborate with the BMCH to conduct a assets-based, community level, needs assessment that considers the needs of all (age) targeted children in a defined area. (facilitation, training, coordination, community development initiative)
2. Share Title V vision for future systems development and integration with related public-private agencies and invite feedback.

NEEDS ASSESSMENT FUTURE VISION (SOME IDEAS)

	PRIOR TO 2000	2001	FUTURE	OUTCOMES (VISION)
CHILD & FAMILY	<p>Focused on population served by Title V</p> <p>Many laundry lists of expressed & perceived needs from a variety of service perspectives</p>	<p>Using Soc Marketing framework determine strategies to connect families (benefit /barriers/ channels) to community-based services and re-adapt product/ price/ promotion/ placement</p>	<p>Consider use of an interview survey to establish prospective cohort needs assessment of ALL CSHCN (surveillance) / marker conditions.</p>	<p>Longitudinal vs cross-sectional data - can zero in on needs at specific developmental stages, do trends analysis, prioritize resources to targeted groups or situations</p>
PROVIDER	<p>1988 MD, Schools, EI, Direct providers to CSHCN</p> <p>1999 Focused on MD needs to support medical home concept</p> <p>1999 Focused on Pre-school personnel needs in relation to community-based CDP services</p>	<p>Using Soc Marketing framework determine strategies to influence MD's to refer families to community-based services and enlist their help in creating care coordination services at local level (Outcome: establish partnership with NH Ped Soc)</p> <p>School nurse survey - structure for on-going partnership</p> <p>Explore pre-school provider issues</p>	<p>Connect with pedi offices that are implementing MIS systems to track CSHCN</p> <p>Enhance capacity of contracted in-office care coordination service providers to develop similar MIS (materials)</p> <p>Secure agreement on common data elements and data sharing,</p> <p>ID method (networked or paper) that allows monitoring and tracking of population</p>	<p>Assuming each child will have a pcp can create access to the population of children (denominator).</p> <p>Use this captured population to conduct NHI(D)S, QA, & outcomes monitoring</p> <p>Ratio of pcp to CSHCN in NH</p>
SYSTEM	<p>Family needs: PIC, Part H, Hood Center (DHMC) but not system needs</p>	<p>MCH + CSHCN community-based needs assessment</p> <p>Dept of Ed, DMH & DS, DDC, EI, AA, Delphi re: future system needs id</p>	<p>Secure staff resources for MIS and analysis in Title V-CSHCN</p> <p>Develop/determine plan for future based upon Delphi results</p> <p>Explore secondary data sources: Medicaid, SSI, SPEDIS, SCHIP, UHDDS, etc. (HMO?)</p>	<p>Community level needs, targeted, population-based</p> <p>Service Integration</p> <p>Use of Secondary data sources for needs and performance indicators</p>

Please refer to Form 13 (the degree to which the State has established appropriate services for CSHCN).

3.1 Health Status Indicators

See Supporting Documents Core Health Status Indicators data.

See Supporting Documents Developmental Health Status Indicators data.

See Table 37 on Page 129 entitled State Identified Priority Needs FY 2001 – 2005. Please see ERP Form 14

TABLE 37
State Identified Priority Needs FY 2001 – 2005

STATE PRIORITY NEED	POPULATIONS
1. To increase the percent of pregnant women in publicly funded programs who are screened for HIV.	(x) Pregnant women, mothers and infants () Children () CSHCN
2. To decrease the use of alcohol, tobacco and other substances during pregnancy.	(x) Pregnant women, mothers and infants () Children () CSHCN
3. Motor vehicle injuries are the leading cause of death to teens aged 15-19 and should be reduced.	() Pregnant women, mothers and infants (x) Children () CSHCN
4. To improve children's oral health through community health oral consortia.	() Pregnant women, mothers and infants () Children (x) CSHCN
5. Monitoring the impact of managed care on children with special health care needs is essential to assuring quality care.	() Pregnant women, mothers and infants () Children (x) CSHCN
6. To maintain an infrastructure of safety-net providers to provide support services to vulnerable populations.	(x) Pregnant women, mothers and infants (x) Children (x) CSHCN
7. To assure safe and healthy child care environments	() Pregnant women, mothers and infants (x) Children (x) CSHCN
8. To improve access to mental health services for children including those with special health care needs, and their families.	() Pregnant women, mothers and infants (x) Children (x) CSHCN
9. To increase early access to prenatal care among vulnerable populations	(x) Pregnant women, mothers and infants () Children () CSHCN
10. To decrease smoking among adolescents	() Pregnant women, mothers and infants (x) Children () CSHCN
11. To decrease the proportion of births occurring within 24 months of a previous birth.	(x) Pregnant women, mothers and infants () Children () CSHCN
12. To improve the ability to describe the health of the maternal and child health population through data collection and analysis	(x) Pregnant women, mothers and infants (x) Children (x) CSHCN

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

Please refer to ERP Forms 2, 3, 4, and 5

3.3.2 Other Requirements

The state continues to exceed maintenance of effort requirements. The state FY89 Maintenance of Effort {Sec. 505(a)(4)} of \$2,872,257 is compared to the projected budget of \$6,738,989 of which \$4,482,204 are state funds.

Other sources of Federal MCH dollars as indicated on Form #2 include:

SSDI Grant \$100,000

These funds are being used to hire a full-time equivalent MCH senior health policy analyst and to provide grants to two urban areas to analyze data relative to health disparities.

CISS Grant \$70,833

This new grant will fund strategic planning in the area of adolescent health.

Abstinence Education: \$145,009

These funds will be used to conduct a public information campaign and a community grants program.

Universal Newborn Hearing Screening Program - \$125,000

These funds will be used to hire staff to establish a universal newborn hearing screening program with standards and a data-tracking program.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures

See ERP Form 11 for 5 year targets.

3.4.2 State “Negotiated” Five Year Performance Measures

See ERP Form 11, and 16.

TABLE 38

SPM #	Five Year State Performance Measures 2001 - 2005 Rationale	Related to State Priority Need #
1	Percent of pregnant women attending state funded prenatal clinics who have an HIV test Universal HIV testing in pregnancy improves outcomes and decreases transmission to the fetus.	1
2	Percent of women who smoked during pregnancy Smoking is known to have untoward effects on the fetus and infant including fetal death, low birth weight, and SIDS	2
3	The rate of deaths to teens aged 15-19 caused by motor vehicle crashes per 100,000 teens. Motor vehicle crashes are the leading cause of death among teens 15-19 and can be prevented.	3
6	Number of community oral health consortia Access to dental care for many children is poor. Community consortia can assist in bringing oral health services to their community for children.	4

SPM #	Five Year State Performance Measures 2001 - 2005 Rationale	Related to State Priority Need #
7	The processes that allow managed care to be successful in containing costs may not work to the advantage of CSHCN. Monitoring the impact of managed care on CSHCN is essential to assuring quality care.	5
8	Percent of Title XX state contracted child care centers that have a health consultant on site Studies have shown quality of many child care settings to be so poor as to jeopardize the health and safety of children. Health consultants have been found to improve the health and safety of child care environments	7
9	Percent of students who did not smoke cigarettes on one or more of the past 30 days. Over one-third of NH high school students reported smoking in the past 30 days. The long-term negative health effects of smoking are well known.	10
10	Families value & request assistance with coordinating their child's care. Care coordinators have the potential to improve access to a variety of primary and related services and financial support.	

IV. REQUIREMENTS FOR THE ANNUAL PLAN
4.1 Program Activities Related to Performance Measures

NPM #1 –The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

FY 2001

For purposes of this measure, “receiving rehabilitative services” will be defined as children receiving SSI benefits whose school districts are receiving supplemental Medicaid funding in support of an established IEP plus those children in SMSB who individually received a service.

This definition reflects the structural integration of Title V CSHCN services within Medicaid operations and serves as a better population-based proxy measure of service delivery to SSI child recipients.

Denominator will be data reported by SSA annually in June to correspond with school year.

Population(s): () Pregnant Women, Mothers and Infants () Children (**X**) CSHCN

TABLE 39
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The SMSB will continue to focus its outreach efforts on those families whose children are receiving and/or applying for SSI benefits, but are not receiving Medicaid/SCHIP.	E	This approach will target casefinding efforts to those low income children presumably in greatest need of linkage to a system of care and rehabilitative services due to lack of insurance. It will also make for the most efficient use of available staff time given two State nursing position vacancies and the implementation of a hiring freeze effective May 3, 2000.
The SMSB will continue to inform families applying for Title V CSHCN services about the availability of SSI and continue to disseminate and display public information about the benefits of SSI at statewide conferences.	E	Tracking of the number of public displays will continue.
The SMSB will continue to participate in the Benefits Planners Group convened through the Division of Developmental Services.	E	This group meets monthly and publishes a benefits guide for families with disabled children and/or disabled adult members. A section on SSI benefits is included in the guide.
The SMSB will continue to participate in the Annual Benefits Conference.	P	An annual conference is held for updating interested parties about changes in the service system and related changes affecting benefits offered by State and community agencies.
Discussions will be initiated with the Director of Developmental Services with the goal to establish a written interagency agreement around the release of the SSI paper transmittals to the Area Agencies and reporting of needs data/service utilization statistics back to the SMSB.	I	This represents a unique casefinding opportunity for the Division of Developmental Services. A data collection tracking system will be implemented to evaluate the outcome of this initiative should agreement be reached between the Division of Developmental Services and the SMSB.

TABLE 40
Programs/Activities to Be Reviewed or Revised
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
SMSB will improve its data collection and tracking methodology.	I	<p>The implementation of New Heights, the Medicaid Eligibility System, has impacted the ability of SMSB to obtain SSA data. No report writer functionality was built into this information system, which went into statewide production in 1999.</p> <p>Electronic database linkages will be explored between Federal SSA, SDX data transmission and the SMS database.</p> <p>Procedures for ongoing transmission of SSA data to SMS through OIS will be established.</p>
SMSB will designate a new State SSI liaison as point of contact.	I	The position of SSI liaison has been held by Jane Hybsch, who can no longer perform these duties.

NPM #2 – The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE 41
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
SMSB will continue to operate pediatric specialty clinics (i.e., Amputee/Limb Deficiency, Neuromotor, Cleft Lip & Palate) at the State level to the extent these services are not available in the private sector.	D	Discussions will continue with DHMC about transitioning Cleft Lip & Palate Clinic administrative operations to their institution. This opportunity is as a result of DHMC's interest in expanding its capacity by offering craniofacial surgical services. In the absence of the Cleft Lip & Palate Program infrastructure to build upon, DHMC would be unable to meet the standards of care set forth by the ACPA for this service. It is expected that this Clinic will be fully privatized by the end of FY 2001.
SMSB will continue to provide access to pediatric specialty medical care to income and medically eligible children through its network of contracted providers on a fee-for-service basis.	D	Financial assistance will continue to children receiving Medicaid benefits under care of the SMSB for those health services not covered by Medicaid, as well as for those children who have no insurance or are underinsured.
Continuation of pediatric nutrition/feeding & swallowing services and psychology consultation is planned.	D, I	A workshop for early intervention providers to enhance their skill in screening children for nutrition/feeding problems will be conducted during FY 2001. This training was specifically requested by the Division of Developmental Services, the lead agency for Part C.
State and contracted Title V CSHCN public health nurse coordinators will continue to work with individual children and their families. Services will include participation in the specialty clinics, linking families to community resources, providing ongoing support and advocacy. Home/Agency/School visits will continue as needed for the purpose of assessment, monitoring of status, service planning and education.	E, I	Emphasis will be placed on training contracted community-based nurses to provide care coordination with the goal to link all families with CSHCN with community providers locally. Core competencies needed to carry out care coordination functions will be identified. A curriculum will be developed and implemented, including a reading packet to supplement monthly trainings. A procedures manual also will be produced with a look towards future statewide deployment of local care coordinators.
Three contracted parent consultants will continue to be housed at the State Office operating the SMSB Family Support & Resource Center.	P	Coordination of these family support services with the Family Resource Connection, the Part C Central Directory, will continue via quarterly meetings. A new structure and relationship may need to be considered with the passage of the Family Opportunity Act.
The Department of Education, Transportation Coordinator, and SMSB staff will continue to work together to promote the safe transportation of children with special needs to school bus drivers as well as provide training and technical assistance on special needs restraint systems.	P	Participation in the annual "Buckle Up New Hampshire" campaign is planned. The SMSB contracted physical therapist has offered workshops to transportation providers to assist in the safe transportation of children to and from school.

Programs/Activities	Pyramid	Comments
State and contracted Title V CSHCN staff and consultants will continue to be available as speakers for local schools and community agencies on topics of interest concerning children with special health care needs.	P	Some funding will be set aside to allow the SMSB to sponsor statewide training initiatives and conferences as well as to support Title V CSHCN staff and parent participation in these events.
Shared staffing arrangements of a Pediatric Consultant (Diana Dorsey, MD) with the Medicaid Program will continue.	I	Her duties will include medical eligibility determination of children applying for Home Care for Children with Severe Disabilities (HC-CSD), approval of admissions to Cedarcrest, the State's only licensed ICF-MR, as well as annual review of the services provided to these institutionalized children.
Title V CSHCN staff will continue to be part of Medicaid's prior authorization/DME workgroup, the dental access workgroup, as well as the newly created Catastrophic Care Committee.	I	
It is expected that the Medicaid Program will continue to utilize the Title V CSHCN expertise in drafting policies concerning the definition and payment of medically necessary services.	I	

TABLE 42
Programs/Activities to Be Reviewed or Revised
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
The Network of Regional Child Development Clinics will undergo an extensive review process with the goal of establishing a plan for future directions.	I	Dedicated consultant time will be purchased to ensure completion of this task. Efforts will be directed towards bringing together key stakeholders to include DHMC, Crotched Mountain Rehabilitation Center, Child Health Services and the Institute On Disability/LEND, all of whom provide child diagnostic evaluation services. Key to the success of these planning efforts will be the ability of the respective parties to set aside their differences and collectively frame their planning from a statewide perspective, rather than from their own agency's interest.

NPM #3 – The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE 43
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
The SMSB will continue to authorize one primary care office visit annually to low income/medically needy children under care of the Title V CSHCN Program.	D	Payment eliminates a financial barrier to care.
Families will continue to be educated by Title V CSHCN staff about the importance of a medical home.	E	Families with children with complex medical conditions requiring the services of multiple subspecialists fail to recognize the need to maintain a community-based primary care provider connection.
SMSB will provide information about how sharing, linking or integrating data could be accomplished to better ascertain the number of children in the State with special health care needs as part of the DHHS Enterprise Data Warehouse Project.	I	Some new efforts hold future promise for identifying CSHCN. The Hood Center’s <u>Partners In Quality</u> , an MCHB-funded initiative, seeks to establish a two-step method of identification of childhood chronic health conditions in managed care plans using ICDA-9 coding from clams data. This methodology once refined could be applied to Medicaid claims data.
SMSB will continue to be a funding partner for the ADAPT Project.	I	This project blends community-based, family-centered consultation regarding health issues for early intervention and preschool providers with a mentored traineeship in developmental pediatrics for primary care physicians. Eleven NH communities have participated in this project, and two more will be identified in FY 2001.
SMSB will continue to act in an advisory capacity to the <u>Rural Medical Home Improvement Project</u> .	I	This MCHB-funded project fosters the development of community-based medical homes for children with special health care needs by equipping pediatric practices in New Hampshire (Exeter and Plymouth) and Vermont with a continuous improvement process, a partnership with parents, a linkage to community resources, and the capacity for office-based care coordination. SMSB will provide consultation at project retreats and direct financial support to enhanced care coordinators from those sites in NH. Additionally, this project is working on a Home Index, a tool to measure medical home infrastructure and quality, which if valid and reliable may be used for enhanced medical payments by Medicaid to practices.
SMSB will identify a mechanism to capture data from families about their medical home.	P	This initiative will be coordinated with the NH Pediatric Society.
SMSB staff, consultants and contractors will complete the medical home assessment tool prepared for public agencies by the AAP.	I	Findings will be used to develop a strategy for quality improvement.

NPM #4 –Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (i.e., the sickle cell diseases) (combined).

Population(s): (x) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 44
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Transitioning of Newborn Screening Program (NSP)	I	MCH will continue the transition of the NSP from Bureau of Special Medical Services to Bureau of Maternal and Child Health. Bureau staff will continue cross-training for full program coverage. The NSP has a new Program Coordinator and a new support staff person. The MCH staff providing back-up to the NSP has no prior experience with the NSP and is learning program coverage from previous NSP staff.
Quality improvement feedback to hospitals	I	An enhanced quality improvement plan for newborn screening is scheduled for implementation during FY 2001. Hospital report cards including breastfeeding rates and retrospective analyses of newborn screening compliance via birth records is planned.
NSP Advisory Committee to meet re: future expansion of screening services	I	There are plans to organize a meeting of the NSP Advisory Committee to discuss the present NSP activities and the current discussion being held nation-wide about expanding the program to include testing for other metabolic diseases. There is no plan currently to offer universal sickle cell screening; rather, screening will remain on a targeted basis for high-risk populations. This decision will be evaluated annually and in conjunction with the newborn screening data from the State of Vermont. Vermont initiated universal sickle cell screening in 1990 and is similar in racial composition to New Hampshire. Cost effectiveness of Vermont's approach will be analyzed.
Mailing to medical providers and hospitals re: changes in the NSP	P	A mailing is planned to all hospital maternity units, pediatricians, and family practice physicians. Included will be a letter from the Director of the Office of Family and Community Health with news of the change of the Newborn Screening Program (NSP) from the Bureau of Special Medical Services to the Bureau of Maternal and Child Health, and the news of the name of the new NSP coordinator, Carol McDonnell.
Presentation to hospital Perinatal Nurse Managers	P	The NSP Coordinator will present an information update/discussion session on the NSP at the fall meeting of the Hospital Perinatal Nurse Managers to improve communication between the nursery staff and the NSP and ultimately increase the number of newborns screened successfully and within an appropriate time frame.
Lab analysis contract continuation	P	There will be continuation of the contract with the New England Newborn Screening Program for laboratory analysis.
Care coordination	E	Care coordination and enabling services will continue to be offered to families by referral to Special Medical Services/Medicaid Administration Bureau (SMS/MAB). Care coordination and enabling services enhance the caretaking ability of the family.
Access to pediatric specialty medical care	D	Access to pediatric specialty medical care for low income/medically needy families with infants identified with disorders detected via newborn screening testing will be provided via referral to SMS/MAB

NPM #5 –Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

Population(s): (x) Pregnant Women, Mothers and Infants (x) Children () CSHCN

TABLE 45
New or Continuing Programs/Activities
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Use of CASA results for Q/A	I	In collaboration with NH Immunization Program, Bureau staff will utilize CASA results from Title V funded child health categorical and primary care agencies as the quality assurance component for this measure. This includes assuring that MCH contract agency proposal workplans include goals and activities to improve immunization rates and reduce problem areas such as immunization drop out rates. Bureau site visits will include assessment of immunization practices including tracking and recall procedures, decreasing the drop out rate of immunization series and increasing the follow up of missed immunizations. The Bureau is considering requesting its contract agencies to provide several universal clinical indicators as part of each agency’s quality assurance plan. Immunization rates would be among the pediatric indicators.
Hosting CDC Immunization Training Teleconferences	I	Title V funded agencies will work with the NH Immunization Program to host the CDC Immunization Training Teleconferences state-wide.
Immunization staff at Child Health Coordinators’ meetings	I	The Bureau will continue to invite NH Immunization Staff to the twice yearly meetings organized for representatives of the Title V contract Child Health and Primary Care (and 330-funded) agencies to present information updates. These Child Health Coordinators’ meetings are held Fall and Spring.
“ImmPact” activities	I	The NH Immunization Program will continue to work with the MCH Title V contract agencies in any pilot activities related to “ImmPact”, the NH Immunization Program registry as the opportunity arises. Immunization Registry activities are currently in the pilot phase.
Agency contracts with current immunization requirements	I	Bureau staff will work with NH Immunization Program staff to assure that the immunization contract requirements of the Title V contracts with local agencies for child health and primary care contain the current national immunization requirements.
Development of HCFA’s Government Performance and Results Act Immunization goal	I	The Child Health Nurse Consultant will work with the NH Immunization Program staff and Medicaid Administration Program in the development of HCFA’s Government Performance and Results Act Immunization goal. Immunization data obtained will be utilized by the Bureau to assess a pilot project being carried out in 2 Title V-funded child health categorical agencies that are providing support services to improve health outcomes.

Programs/Activities	Pyramid	Comments
Provision of currently recommended immunizations	D	Title V funded agencies offering primary and categorical child health care will continue to provide age-appropriate immunization services according to the current ACIP/AAP/AAFP “Recommended Childhood Immunization Schedule; United States” as required by their Title V contract.
National Immunization Week	P	Bureau staff will continue to assist the NH Immunization Program in endorsing any population-based immunization and outreach activities during National Immunization Week by distributing education material to the Title V contract agency staff.

NPM#6 – The birth rate (per 1,000 for teenagers aged 15 through 17 years.

Population(s): (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE 46
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Teen Clinics	D, E	These programs will continue during FY 2001. Clinical guidelines are currently in development and will be implemented during this year.
Teen Pregnancy Prevention Community Health Education	P	
Teen Pregnancy Prevention Coalitions	I	
*TANF Collaborations	D, I	Additional projects in collaboration with TANF are in process, including marketing and outreach activities, community education programs and access to emergency contraception for teens.
*Teen Subsequent Pregnancy Prevention Project	D, E, I	This project is a collaborative effort between TANF and DHHS to devise, implement and evaluate a program addressing subsequent pregnancies in teens. This project is in the design stage but will include home visiting, family resource centers and family planning constructs to prevent subsequent pregnancies.
*Abstinence Project	P	This project will implement a media campaign and community grants aimed at skills building for 9 – 14 year olds.

TABLE 47
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Adolescent Health Program	D, E, I	The Adolescent Program will undergo Strategic Planning during FY 2001 to identify opportunities for improvement in adolescent health for the State of NH

Use * for new program (<1 yr old)

NPM #7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Population(s): () Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE 48
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Bureau of Oral Health: Application of sealants in school-based preventive dental hygiene programs	E	The Bureau of Oral Health will work to improve the availability of dental sealants for children. Additional BOH funded school-based dental programs will initiate a sealant component to their preventive programs. Because most N.H. school-based dental programs don't involve a dentist in the schools to make a diagnosis required prior to the application of sealants, one day is selected when children are transported from school to private dental offices for the application of dental sealants. While this is not cost-effective and is time consuming, school-based programs have found that it is often the only approach to assure that children without access to regular dental care will have the benefits of protective dental sealants on their teeth.
Application of sealants in hospital-based dental clinics	I	A new hospital-based pediatric dental clinic will open 6/00 to provide preventive (sealants) and restorative dental care to children. Three established hospital-based dental clinics serving both adults and children will continue to provide sealants to children as part of comprehensive dental services.
Bureau of Oral Health/ Medicaid Administrative Bureau collaboration	I	A new collaboration between the Bureau of Oral Health and Medicaid Administration, the "Oral Health Work Group", will continue making improvements to the Medicaid Dental Program in an effort to engage more dentists as providers of care for children enrolled in the program.
C.D.C. Chronic Disease Epidemiologist will give ¼ of his time to oral health	I	On 6/19/00 a new C.D.C. chronic disease epidemiologist will begin working with the Bureau of Oral Health to develop a statewide dental data surveillance system

TABLE 49
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Bureau of Oral Health	E	The Bureau of Oral Health will continue to work with stakeholders to change Admin. Rules so that in school-based dental programs, hygienists will be allowed to decide which children would benefit from the application of preventive dental sealants and then, without the required diagnosis from a dentist, apply the children's sealants on site in the schools.

NPM #8 – The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.

Population(s): () Pregnant Women, Mothers and Infants (X) Children () CSHCN

Under comments discuss program highlights, the role of other agencies, and the potential influence of outside forces.

TABLE 50
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Increase availability of child passenger safety resources statewide	E,P	Injury Prevention Center at Dartmouth (IPC) (funded by Title V) conducts the bulk of CPS activities, in collaboration with the OCPH IP Program. Continue training a team of NHTSA-certified child passenger safety technicians, to conduct car seat checks statewide Make seats available to low income families through car seat check program Applying (through Chrysler) for 250-1000 booster seats to make available to low income families statewide, to increase usage among 4-8 year olds
Continue to lead the Buckle Up NH Coalition	I,E,P	IPC – Dartmouth leads the Coalition, OCPH IP health educator participates in all activities Coordinate activities to increase child restraint use statewide Continue to utilize fully equipped child passenger safety van (rec'd through GM settlement/ SAFEKIDS Coalition) at car seat checks statewide Continue to loan “buckle up” educational kits statewide for health fairs, presentations and other events
Professional education efforts in child passenger safety	P,E,I	Plan three 4-day NHTSA standardized CPS Technician programs Develop and provide at least one 1 day CPS training Continue CPS presentations at hospitals Work with NH Auto Dealers Association to develop appropriate training programs for their members In consultation with NH Highway Safety Agency and other partners, identify and implement other needed training in the field of CPS Identify interested individuals from Child Health Programs, law enforcement, loaner programs, health and child care professionals, business and other groups to attend the workshops

NPM #9 – Percentage of mothers who breastfeed their infants at hospital discharge.

Population(s): (x) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 51

Programs/Activities that are new or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Collaboration with WIC	I	Bureau staff including staff from the CSHCN Program will continue to work with the state WIC Program to support breast feeding educational and support activities, such as supporting breast feeding-related legislation, serving as a member of the state Breastfeeding Coalition, co-sponsoring the WIC annual Breastfeeding conference, and any other breastfeeding initiatives sponsored by WIC which may be carried out by Title V agency staff.
WIC presentations at Bureau-sponsored meetings	I	WIC Program staff will be invited to BMCH update meetings with representatives of prenatal, child health, and primary care agencies to share current breast feeding information and resources such as availability of trained breastfeeding peer counselors. The Bureau sponsors information update meetings for its agencies providing services to pregnant women and children twice yearly, fall and spring.
Inclusion in periodicity schedules	I	Bureau staff will distribute to its Title V funded agencies the new American Academy of Pediatrics' periodicity schedule which includes new emphasis on breast feeding and will include breast feeding in the Bureau's FY 2001 Preventive Services Schedule which is a component of the MCH contract, Exhibit A.
Monitoring breast feeding promotion by contract agencies	I	MCH staff will continue to monitor Title V contract agencies' promotion of breast feeding by observing for posters and educational material promoting breastfeeding while doing local agency site visits, requesting that agencies include in their annual workplan goals and activities supporting and increasing the number of clients who chose to breast feed. The Bureau is considering changing its quality assurance requirements for contract agencies to include some universal clinical indicators. The number of women breastfeeding in the early postpartum period, and the number of infants breastfed at six months would be among those included.
Promoting breastfeeding in any MCH – sponsored activities with the general public	P	Bureau staff will work with the state WIC program to disseminate information which supports breastfeeding such as in BMCH-sponsored meetings, publications, and health fairs and in any SIDS risk reduction trainings or activities.
Promoting breastfeeding in CISS grant-funded home visiting activities	D	The project director of the MCHB-sponsored CISS grant on home visiting will continue to provide training, support, and collaboration with grantees and with other home visiting programs state-wide to promote breast feeding activities
Promoting breastfeeding among contract agency clients	D	Title V-funded agencies will continue to encourage prenatal clients to breastfeed and support those who have chosen to do so.

NPM #10 – Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Population(s): (x) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 52
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
*Establishment of Universal Newborn Hearing Screening Program	I	During the summer of 2000 a program coordinator, .5FTE computer information specialist and consulting audiologist will be hired to comprise the staff of the NH Universal Newborn Hearing Screening Program.
*Universal Newborn Hearing Screening Project Advisory Committee	I	During the late summer, early fall 2000 the Universal Newborn Hearing Screening Project Advisory Committee will be convened to assist the project staff in the development of project standards and protocols. The advisory committee will be comprised of a wide range of professionals including the audiological community, parents of children who are deaf and hard of hearing, and others representing the deaf and hard of hearing community.
*Establish protocols for the Newborn Hearing Screening Program/File a report to the legislature and the governor.	I	A bill passed during the last legislative session requires that the Department of Health and Human Services file a report by November 2000 establishing standards and protocols for the Universal Newborn Hearing Screening Program. The report shall include standards for screening, equipment to be used and tracking and follow-up
*Research and Development of an Early Hearing and Detection Intervention data system.	I	The project computer information specialist shall research existing data systems to tracking universal newborn hearing screening, evaluation, tracking and follow-up. With input from the project advisory committee the information specialist shall adapt an existing system or develop a system to best meet the needs of New
*Assist hospitals to identify funds and choose screening equipment.	I	Research and share information on equipment costs and bulk purchasing arrangements.
*Develop a training and education plan for parents and professionals.		The project staff will develop a training and education plan that will include: educating parent and professionals on the need for universal newborn hearing screening and the availability of screening, training for hospitals, and training for audiologists to work with infants and young children.

Use * for new program (<1 yr)

NPM #11 – Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE 53
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Funding will continue to be provided to low income/medically needy families who require COBRA assistance in order to maintain health insurance coverage for their child with special health care needs.	E	Determined to be a cost effective strategy in preventing pre-existing conditions exclusions.
The SMSB's Medicaid Case Technician will continue to assist families to apply for Medicaid and SCHIP.	E	This service remains one of the most valued by families as noted through parent satisfaction surveys.

NPM #12 – Percent of children without health insurance.

Population(s): (x) Pregnant Women, Mothers and Infants (x) Children () CSHCN

TABLE 54
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Providing training and other efforts to increase SCHIP enrollment	I	Bureau staff will continue to work with other DHHS staff in providing training and information about, and working to increase enrollment in “Healthy Kids”, the state’s SCHIP program including the ability to do presumptive eligibility.
Contract agency workplan requirements to include enrollment activities	I	The Bureau will continue to require that its contract agencies include efforts to enroll eligible children on SCHIP as part of their agency workplan submitted annually.
Monitoring Healthy Kids contract agency enrollment efforts	I	The Bureau will continue to monitor Healthy Kids enrollment data from its own data sources and that of the Healthy Kids program to better target agencies needing technical assistance and develop strategies to increase overall enrollment. Increasing enrollment of eligible children in the state’s SCHIP program was identified as a priority for FY 2001 Office of Family and Community Health Strategic Planning Session. A workgroup was established to work on this goal which included representatives from the state WIC and Family Planning Program.
Removing barriers to SCHIP/Medicaid enrollment	I	The Child Health Nurse Consultant will continue to work with representatives from the Bureau of Vital Records and the Division of Family Assistance to explore and remove barriers for families enrolling in Healthy Kids, such as verification of age and citizenship.
Participation in SCHIP quality assurance and outreach efforts	I	The BMCH Child Health Nurse Consultant will continue to participate in the state’s SCHIP quality assurance project (QCHIP) and the state’s SCHIP outreach workgroup which has been combined with the Robert Wood Johnson-funded “Covering Kids Project.
Child Health agency pilot sites	E, D	Two Title V-funded child health categorical agencies will serve as pilot sites to explore whether additional social supports to families will facilitate and increase enrollment in the SCHIP program. Bureau staff will be analyzing data to assess the success of the pilot.

Use * for new program (<1 yr old)

NPM #13 – Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Population(s): () Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 55
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Improving utilization of “Health Care Support” and “Care Coordination” services	I, D	Bureau staff will continue to work with other DHHS staff in monitoring utilization of and providing technical to contract agencies regarding Medicaid services such as those covered under “Healthy Kids”, the state’s SCHIP program, the agencies with trained staff who are authorized to do presumptive eligibility, and use of the currently available fee-for-service “Health Care Support” and “Care Coordination” services. Health Care Support reimburses for psycho-social and educational services designed to improve a child’s health status and function within the family and community and is only for Title V-funded MCH contract agencies. Care Coordination reimburses Medicaid providers for services that assist a Medicaid eligible child to gain access to medically necessary medical or social care. Care Coordination is not limited to Title V-funded agencies.
Child health agency pilot sites	E, D	Two Title V-funded child health categorical agencies will serve as pilot sites to explore whether additional social supports to families will facilitate and increase enrollment in the SCHIP program. Bureau staff will be analyzing data to assess the success of the pilot.

Use * for new program (<1 yr old)

NPM #14 – The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

Population(s): () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE 56
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
SMSB intends to continue its contract with the Parent Information Center for the services of paid parent consultants. Parent consultation will be expanded to include Medicaid initiatives as well.	P	Should new planning efforts around CSHCN be convened in the Department, SMSB will assure family participation. Interested parents with expertise will be identified and offered mentor training and stipends to facilitate their full participation.

NPM #15 – The rate (per 100,000) of suicide deaths among youths 15-19.

Population(s): () Pregnant Women, Mothers and Infants (X) Children () CSHCN

Under comments discuss program highlights, the role of other agencies, and the potential influence of outside forces.

TABLE 57
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Continue to lead the statewide Youth Suicide Prevention Advisory Assembly (YSPAA)	I, P	IP Program manager will continue to provide leadership and coordination to YSPAA, through collaboration with the IPC-Dartmouth, the State Medical Examiner's Office, mental health and school professionals and others
Implementation of statewide plan developed at the June 2000 Regional Suicide Prevention Planning Conference	I, P	Begin implementation of the plan, including: exploring opportunities to increase access to mental health services for children and teens; continuing to be a statewide resource/referral network and identifying and coordinating resources statewide; public education/awareness
Hold 2 nd conference on media reporting of teen suicide, to build on success of 1 st event, increase collaboration between the media and community-based youth advocates and reduce suicide contagion risk	I,P	Repeat successful May 2000 workshop, entitled "Getting the Story Right" in 2 settings, one in fall 2000 for the Northern NH Press Association annual meeting, and again in Spring 2001 for a statewide audience
Continue with NH Firearm Safety Coalition efforts to reduce youth access to firearms	I,P	IPC-Dartmouth will continue to lead the Coalition, with participation from the OCPH IP Program Continue distribution and evaluation of the Coalition's 1999 Firearm safety education video and educators guide geared toward pre-adolescents Continue education of firearm owners of the risk of teen suicide
Continue surveillance of teen suicide as well as attempts to measure progress and ensure that effective strategies are in place	P	Monitor mortality and morbidity data through OCPH, as well as additional data on teen suicide risk being collected by the Medical Examiners office
Seek opportunities to develop and disseminate suicide prevention and intervention protocols fro a statewide community-based system of providers	P,E	
Continue to seek funding for community based prevention training	I	
Continue to educate the public and promote suicide prevention efforts by providing resources and materials at conferences and health fairs, through newsletters and presentations	P	

NPM #16 – Percent of very low birth weight live births.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 58
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Agencies	D, E, I	BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women.
Perinatal Alcohol, Tobacco and Other Drug Use Task Force	I	The Perinatal Program Chief is a member of this Task Force, which is currently focusing on Fetal Alcohol Syndrome in New Hampshire.
*Prenatal Program Coordinators' Meetings	I	BMCH-funded Prenatal Program Coordinators' meetings have been reinstated on a biannual basis as of April, 2000. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered at the 4/2000 meeting included: Prenatal Smoking Cessation Guidelines; Folic Acid counseling at pre-conception; data collection processes; and an MCH history and funding overview.
*Analysis of LBW/ VLBW birth rate	I	The VLBW rate in New Hampshire continues to exceed goals. An analysis of geographic incidence of this measure has been completed as part of New Hampshire's MCH Needs Assessment process. Further analysis into root cause will be undertaken in FY 2001.
*Prenatal Strategic Planning	I	The Prenatal Program will undergo a Strategic Planning process this fiscal year to identify program priorities and areas for improvement.
*Prenatal Performance Improvement	I	The contract for prenatal agencies will be reviewed, as will clinical guidelines, as the Office of Public and Community Health develops a performance-based contracting plan.

TABLE 59
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Client Data Form Work Group	I	A work group is forming to review and revise the BMCH Prenatal Client Data Form. Alternative methods of data collection will be discussed, as well as the status of electronic data submission by agencies.
Prenatal Extended Services	D, E, I	Since the late 1980s prenatal extended services have been reimbursable by Medicaid for BMCH-funded prenatal agencies in New Hampshire. BMCH is exploring evidence of the effectiveness of these services and the possibility of expanding these services to private providers in the state.
3. Prenatal Service Areas	D, I	Review and possible revision of the Prenatal Agencies' Service areas will be undertaken in FY 2001.

Use * for new program (<1 yr old)

NPM #17 – Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 60
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Perinatal Program, DHMC	I	The Bureau of Maternal and Child Health will continue to foster a collaborative relationship with the Perinatal Program at Dartmouth Hitchcock Medical Center.

TABLE 61
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Prenatal Program Data Analysis	I	The Prenatal Program will analyze data on low birth weight and very low birth weight infants during FY 2001 and attempt to identify causative factors influencing the deliveries of 16.7% of very low birth weight infants at other than facilities for high-risk deliveries and neonates. Intervention will be planned based on this analysis.

Use * for new program (<1 yr old)

NPM #18 – Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 62
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program Agencies	D, E, I	BMCH-funded agencies will continue to provide comprehensive prenatal care to low income, uninsured and underinsured women.
Perinatal Alcohol, Tobacco and Other Drug Use Task Force	I	The Perinatal Program Chief is a member of this Task Force, which is currently focusing on Fetal Alcohol Syndrome in New Hampshire.
*Prenatal Program Coordinators' Meetings	I	BMCH-funded Prenatal Program Coordinators' meetings have been reinstated on a biannual basis as of April, 2000. These meetings provide a forum for Coordinators to network with their peers and discuss issues pertinent to prenatal care delivery. Topics covered at the 4/2000 meeting included: Prenatal Smoking Cessation Guidelines; Folic Acid counseling at pre-conception; data collection processes; and an MCH history and funding overview.
*Prenatal Strategic Planning	I	The Prenatal Program will undergo a Strategic Planning process this fiscal year to identify program priorities and areas for improvement.
*Prenatal Performance Improvement	I	The contract for prenatal agencies will be reviewed, as will clinical guidelines, as the Office of Public and Community Health develops a performance-based contracting plan.
*Early Prenatal Care Promotion	P	BMCH is collaborating with the NH March of Dimes on a campaign to promote early prenatal care

TABLE 63
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Client Data Form Work Group	I	A work group is forming to review and revise the BMCH Prenatal Client Data Form. Alternative methods of data collection will be discussed, as well as the status of electronic data submission by agencies.
Prenatal Service Areas	D, I	Review and possible revision of the Prenatal Agencies' Service areas will be undertaken in FY 2001.

- Use * for new program (<1 yr old)

SPM #1 – Percent of pregnant women attending state funded prenatal clinics who have an HIV test.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 64
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Program	D, E, I	The Prenatal Programs will continue to be required to counsel and educate prenatal clients regarding HIV testing. HIV testing will be addressed at least yearly at Prenatal Coordinators' Meetings.

TABLE 65
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Collaboration with NH HIV Program	I, P	Discussions have been initiated between staff of the Prenatal Program and the HIV Program regarding strategies for increasing prenatal HIV testing.

Use * for new program (<1 yr old)

SPM #2 – Percent of women statewide who smoked during pregnancy.

Population(s): (X) Pregnant Women, Mothers and Infants () Children () CSHCN

TABLE 66
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Prenatal Smoking Cessation Guidelines	D	New prenatal smoking cessation guidelines are being rolled out this week and the prenatal coordinators had a preview of these at the April 2000 Coordinators' Meeting. Final guidelines will be distributed to providers when available.

TABLE 67
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Prenatal Data Analysis	I	Analysis of statewide prenatal data will allow the Prenatal Program to target sub-populations for smoking cessation. The NH March of Dimes is interested in working collaboratively on such an issue.

Use * for new program (<1 yr old)

SPM #3 – Reduce the rate (per 100,000) of motor vehicle crash deaths among youth ages 15-19

Population(s) served: () Pregnant Women, Mothers and Infants (X) Children () CSHCN
Under comments and review/revision, discuss the role of other agencies and outside forces.

TABLE 68
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Begin development of a comprehensive approach to legislation and regulations re: teen driving	I, P	Collaborate with the NH House of Representatives Transportation Committee, IPC-Dartmouth and the NH Dept. of Safety to review current laws and regs and recommend improvements; develop a comprehensive graduated licensing law for new teen drivers
Continue to lead the NH Teen Motor Vehicle Legislation Coalition	I	IPC-Dartmouth (Title V funded) leads and coordinates this statewide coalition of legislators, state agencies and advocates for teen driving safety, which will meet as needed in FY01 to review and recommend legislation
Continue Buckle Up NH teen driver component	I,P	IPC-Dartmouth leads the Coalition with participation by the OCPH IP Program; Coalition will continue to include activities during the annual Buckle Up NH week to support youth programs to educate their peers on seat belt use
Continue to monitor data on teen MV injuries in order to monitor trends, identify risk factors and evaluate progress	I	IP Program routinely analyzes injury data from the Dept. of Safety incident reports and OCPH data (death certificate and UHDDS)

SPM #6 – Percent of communities with oral health consortia.

Population(s) served: (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE 69
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Bureau of Oral Health	I	New consortia will be developed in Exeter through Exeter Hospital and in Southern Carroll County as the Dental Task Force of the Health and Wellness Council. Established consortia across the state will continue their efforts to increase access to oral health care for underserved children and adults.

TABLE 70
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Bureau of Oral Health	I	Efforts are underway in the Office of Community and Public Health to define a system of performance management that will improve the capacity at state and local levels to deliver core public health services and to improve the quality of those services. Promoting science-based practices, defining and measuring quality, establishing expectations for performance then holding contracted community agencies accountable will make performance-based contracting the means by which the Bureau of Oral Health will be assured of delivering quality oral health services. We expect to make changes in the choices of agencies that the Bureau will contract with in the future based on their performance.

* Use * for new program (<1 yr old)

SPM #7 – The degree to which the State safeguards the quality of care for children with special health care needs enrolled in managed care plans.

Population(s) served: () Pregnant Women, Mothers and Infants () Children (X) CSHCN

TABLE 71
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Title V CSHCN Program staff will continue to assist individual families in negotiating health benefits via managed care plans.	D	
Education to individual families about the “ins” and “outs” of managed care will continue.	E	Consumer-friendly information about managed care will continue to be compiled and disseminated through the SMSB Family Support & Resource Center and New Hampshire Family Voices. Additional channels for information dissemination will be identified and utilized.
Title V CSHCN participation in the New England SERVE Task Force on Managed Care and CSHCN, and the Hood Center’s <u>Partnerships for Enhanced Managed Care</u> will continue.	I	SMSB will continue to track issues in managed care from its direct experience and monitor outcomes of these two MCHB-funded projects. Data compiled and lessons learned will be shared with State policymakers and used for PCCM program design.
EQRO Medicaid Managed Care Project for FY 2001 will focus on CSHCN.	I	New England SERVE will provide consultation in project design.
The Title V CSHCN Program will continue to monitor the work of the Institute on Health, Law & Ethics.	I	Implementation of policy recommendations into Medicaid / Title V CSHCN operations will be considered as appropriate.

SPM #8 – The percent of Title XX state contracted child care centers that have a health consultant on site.

Population(s) served: () Pregnant Women, Mothers and Infants (x) Children () CSHCN

TABLE 72
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
*Training will be provided to create a network of at least 20 child care health consultants available to Title XX child care centers.	I	A team of consultants 3 out of 5 whom attended training in North Carolina will present a training in fall 2000 to create a network of a minimum of 20 child care health consultants who will provide in-kind consultation to a child care facility for at least one year. Materials from the national training will be shared.
Technical assistance and support for the child care health consultant network.	I	The state child care nurse health consultant will be available as a resource to the network of consultants via an 800 number. Child care health consultants from around the state will have access to the Healthy Child Care New Hampshire audiovisual library which houses useful materials for training child care providers. A web site and list serve are being explored. Networking meetings for consultants will occur at least annually
Provision of resources to child care health consultants	I,E	All child care health consultants will receive copies of the New Hampshire child care licensing regulations and the Healthy Child Care America Blueprint for Action. They will be made aware of standard resources such as Caring for Our Children and Stepping Stones. Additionally, each consultant will receive a New Hampshire developed Child Care Health and Safety Curriculum which is nearly complete. The curriculum provides a standard resource which can be used by consultants to educate child care providers on health and safety issues.
Creation of child care consultant database	I	All Title XX child care centers will be periodically surveyed to determine the number of child care health consultants actively consulting to child care.

* Use * for new program (<1 yr old)

SPM #9 — Percentage of high school students who did not smoke cigarettes on one or more of the past 30 days.

Population(s): (X) Pregnant Women, Mothers and Infants (X) Children () CSHCN

TABLE 73
Programs/Activities that are New or Will Continue
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Comments
Primary Care/Child Health/ Prenatal Programs	D, E, I	The MCH contract agencies assess risk factors for children and adolescents and anticipatory guidance during regular health maintenance visits.

TABLE 74
Programs/Activities that Will Undergo Review or Revision
(Pyramid level = I, P, E, and/or D)

Programs/Activities	Pyramid	Review Process or Expected Revisions
Adolescent Health Program	I, P	The Adolescent Health Program will undergo a strategic planning process during the next year and identify priorities for public health intervention. Smoking among adolescents is a state priority and consideration of this measure will be included in the planning process.

Use * for new program (<1 yr old)

4.2 Other Program Activities

The Title V Program in New Hampshire has a long history of utilizing limited financial and human resources through the developing of partnerships and coalitions. It is no coincidence that New Hampshire leads the country in many national outcome measures. Through the development of common goals and objectives, Title V has greatly expanded our “reach” in both the State family and the community. Coordination of program activities takes place through joint efforts by Title V and the Department of Health & Human Services on topics of mutual interest and concern. The Department planning document sets the tone for cooperation. Community health concerns, national health issues and Vital Records data drive the Department and Title V to investigate, analyze and develop strategies to respond to Public Health/Title V concerns. In addition to the previously mentioned activities the following is planned for FY 2001:

TANF and Family Planning Collaboration: The TANF and Family Planning initiative coordinates efforts in our Family Planning Program with the Division of Family Assistance, which administers our Temporary Assistance for Needy Families (TANF) funds. New or expanded programming has focused on two areas: (1) Approximately \$300,000 of TANF funds per year will be used to *expand outreach and community efforts targeting Medicaid-eligible women and teens at risk for pregnancy*. The 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 multidiscipline planning committee is crafting a targeted intervention for preventing subsequent births to teen mothers. Preliminary strategy includes using existing home visiting programs and family resource centers in combination with local family planning agencies and other categoricals such as WIC, prenatal programs, Head Start.

Teen Clinics: Four family planning agencies sponsor specialized teen clinics, which provide comprehensive reproductive health services, including clinical services, counseling, and community education. Two new teen clinics are scheduled to open by July of 2000. Teen clinic services provide innovative, teen-centered care to an often hard-to-reach population, serving impressive numbers of teens (agencies with long-standing teen clinics average teen caseloads 20 percent higher than agencies without teen clinics. These teen clinics are characterized by extensive community collaboration; by teen involvement in all aspects of program planning and delivery, including outreach, marketing, evaluation, and education (peer education); and by innovative outreach and marketing strategies carefully targeting the most vulnerable teens in the community.

Oral Health: Title V works with the Oral Health Program to keep vulnerable children free from oral disease and dental pain. The promotion of community water fluoridation is an ongoing population-based approach to oral health promotion. Preventive and restorative dental care is provided to uninsured and underinsured children through school-based dental programs and community and hospital-based dental clinics. Cooperative efforts with the Medicaid program have raised reimbursements to providers and streamlined claims processing in an effort to engage more dentists from the private sector to improve access to oral health care.

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.

WIC: Title V works with the WIC program through a shared knowledge of community agencies and a shared vision of services for women and children. Coordination of immunization, nutrition breast feeding promotion and injury prevention strategies are shared across programs both in the state office and in the communities we serve. Lacking an MCH nutritionist, it is critical that BMCH obtain consultation from the WIC nutrition staff regarding key nutrition issues that impact on women and children. Currently BMCH staff are collaborating with WIC and other staff to develop a public education campaign regarding folic acid and prevention of birth defects. Additionally, collaboration will center around implementation of the new growth charts in community agencies now that they are available.

Birth Defect Surveillance System: Through a cooperative agreement with CDC, the Bureau's of Maternal & Child Health and WIC Nutrition Services are collaborating on the development and implementation of a birth defect registry. This system will begin collecting data on neural tube defects this year and hopes to expand to additional defects over the next three years.

Home Visiting Network The Home Visiting Network and Development Project, began as a CISS grant in 1996 with funding from MCHB. It funds home visiting model programs in three diverse geographic areas of the state. The programs provide a combination of nurse, social worker and paraprofessional home visitors to pregnant women throughout their pregnancy and through her child's second birthday. Services provided in the home are a combination of education, support and linking families to other services and strive to accomplish a broad range of health and well being goals. Grant funds were augmented with funds from the Division of Family Assistance (DFA). The project is currently evaluating outcomes and obtaining feedback from clients and key stakeholders in the project community.

Home visiting is one of the top agenda items of the Governor's Kids Cabinet. Planning is underway to expand the three pilot programs to a statewide initiative for all pregnant women enrolled in the Medicaid program. Implementation is anticipated for January 2001. The BMCH has been chosen to be the lead agency for this implementation and will work closely with the DHHS commissioner's office in doing so.

Child Health Month Coalition: The Bureau will continue to be a primary member of the state's Child Health Month Coalition. The coalition is a collaborative effort between DHHS (BMCH and Bureau of Health Promotion Injury Prevention Program), NH Pediatric Society, the Injury Prevention Center at Dartmouth, Safe KIDS Coalition, CHaD, and DCYF. The coalition sponsors a yearly mailing of seasonal information to over 2,000 health and social services professionals, schools, hospitals, and agencies who work with children and families, and a yearly toll-free hot line for questions regarding children's health care and parenting issues, and a web page hosted by the New Hampshire Pediatric Society.

Shaken Baby Campaign: In FY 2001 BMCH will continue to support statewide effort to educate residents about the dangers of shaking babies. The leadership is shared between the Injury Prevention Program and Prevent Child Abuse NH. The coalition targets new parents and pregnant women, providers, school aged children including baby-sitters, college aged students entering health or social work related professions, young men, child-care workers etc.

Integration with the State Systems Development Initiative (SSDI) – Funds from the SSDI grant enabled the BMCH to hire two part-time MCH epidemiologists to increase the data analysis capacity of the BMCH. Jenny Ruducha, DrPH produced the needs assessment for this application and will continue to develop components of the needs assessment. Ann Bracken, MD, MS will work on: the child health evaluation described below, refining the definition of the medical home and exploring the feasibility of linking maternal and child health data sets. Other funds from this grant will be contracted out to the cities of Manchester and Nashua to assist them in analyzing health disparities among racial, ethnic and socioeconomic minorities.

Evaluating the Use and Allocation of Title V Funds Used for Child Health Services: Due to the success of aggressive outreach of NH Healthy Kids, the state's SCHIP program, some contracted Title V agencies are noting declines in their well child clinic enrollment. The Title V agency must therefore reassess how and for what purposes it allocates resources for children's health. In the short-term the Title V agency has granted requests from several child health providers to shift the focus of their grants from direct care to support services. Two current child health contract agencies are serving as pilot sites to determine if use of their Title V funds for supplemental, non-medical services such as case management, support, education, counseling, and transportation services can improve health outcomes in children compared to those not receiving these services. Dr. Bracken will be evaluating this initiative. The results of this study and additional needs assessments will assist the Title V agency in determining long-term goals for child health services.

State Toll-Free Number

The State maintains a toll-free number for all services provided by the Department of Health and Human Services. The system is a computerized, menu driven system that links callers directly with the program area best qualified to respond to the callers question (MCH, CSHCN, WIC, Medicaid). The toll-free number is backed up by an operator for callers using non-touch-tone telephones or needing operator assistance. MCH Programs may also be accessed by TTY/TDD Relay by persons with hearing impairments. Supplementing the State toll-free number are several regionalized information and referral systems with the capacity to refer callers to the appropriate state programs for Maternal and Child Health, WIC, Medicaid services and other services.

4.3 Public Input

Application Development

A meeting was held on July 7, 2000 for individuals and agencies who have an interest in the maternal and child health activities of the maternal and child health block grant. Attendees were provided with a summary document and a presentation describing the priorities for the application. Their feedback on the application was elicited and incorporated.

CSHCN Application Development:

On June 16, 2000, a meeting was held with parents to discuss the CSHCN needs assessment document and priority needs for the State. Seven (7) families were in attendance to offer advice and guidance. Of note, one participant was a father of a child with special health care needs. Specific input was requested regarding dental access issues as perceived by parents. Parents were offered the opportunity to read the Block Grant application, but only one parent agreed to do so. The SMSB intends to bring one of its parent consultants to the Region I Block Grant Review Meeting as a member of its administrative team.

Title V CSHCN Implementation and Evaluation:

Consumer involvement has been a guiding principle within SMSB operations. Once the Region I Block Grant Review is completed, parents will again be convened and asked to identify next steps and an action plan based on feedback we receive on our application.

Evaluation of SMSB services by consumers is completed primarily through report of parent satisfaction with delivered services. Even as SMSB transitions from a direct service provider to building infrastructure and supporting the development of local services, monitoring of parent satisfaction will continue to assure quality of delivered services.

4.4 Technical Assistance

The technical assistance request is deferred to a later date.

See ERP Form 15.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educators. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;

- (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
- (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;***
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms

5.9 National “Core” Performance Measure Detail Sheets

5.10 State “Negotiated” Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

-
- i McPherson M., Arango P., Fox H., Lauver C. McManus M., Newacheck P. W., Perrin J. M., Shonkoff J. P., Strickland B., Wang Q., Khoury M. J. James L. M., Olney R. S., Pauloizzi L. J., Erickson J. D. (1998). A new definition of children with special health care needs. *Pediatrics*, *102*(1 Pt 1), 137-140.
- ii Newacheck, P. W., Strickland, B., Shonkoff, J. P., Perrin, J. M., McPherson, M., McManus, M., Lauver, C., Fox, H. & Arango, P. (1998). An epidemiologic profile of children with special health care needs. *Pediatrics*, *102*(1), 117-123.
- iii Center for Children with Chronic Illness and Disability. (1997). *Brave new partnerships: children with disabilities, families, and managed care*. Center for Children with Chronic Illness and Disability, University of Minnesota.
- iv Garwick, A.W., Kohrmon, C., Wolman, C., Blum, R.W. (1998). Families' recommendations for improving services for children with chronic conditions. *Archives of Pediatrics & Adolescent Medicine*, *152*, 440-448.
- v Horner, M.M., Rawlins, P., & Giles, K. (1987). How parents of children with chronic conditions perceive their own needs. *Maternal and Child Health Nursing*, *12*, 40-43.
- vi Walker, D.K., Epstein, S.G., Taylor, A.B., Crocker, A.C. & Tuttle G.A. (1989). Perceived needs of families with children who have chronic health conditions. *Children's Health Care*, *18*(4), 196-201.
- vii Diehl, S.F., Moffitt, K.A., Wade, S.M. (1991). Focus group interview with parents of children with medically complex needs: an intimate look at their perceptions and feelings. *Children's Health Care*, *20*(3), 170-178.
- viii Special Medical Services. (1996). *Report of family satisfaction and perception of quality of care in BSMS programs*. NH Department of Health & Human Services. Concord, New Hampshire. (n=502).
- ix Special Medical Services. (1993). *New Hampshire families of children with special health care needs (and providers) speak out: needs assessment report*. NH Department of Health & Human Services, Concord, NH. (n=626)
- x Hood Center for Family Support, Dartmouth-Hitchcock Medical Center. (1995). *New Hampshire partners in health family forum summary report*. Prepared by Special Medical Services, NH Department of Health & Human Services, Concord, NH. (focus groups)
- xi New Hampshire Infants & Toddlers Program (Part H). (1996). *Summary report of early intervention services community reviews*. Prepared by Special Medical Services, NH Department of Health & Human Services, Concord, NH. (Regional focus groups)
- xii Parent Information Center. (1997). *Summary report of New Hampshire (community) needs assessments*. Parent Information Center, Concord, NH. (focus groups)

-
- xiii Special Medical Services. (1994, 1995, 1996, 1997). *How Can We Help? Annual Report*. NH Department of Health & Human Services, Concord, NH. (n=800)
- xiv Special Medical Services. (1998). *Quality and access of managed care services for NH children with special health care needs*. NH Department of Health & Human Services, Concord, NH. (n=172 NH families) (Extracted from: *Assessing the quality of managed care for children with special health care needs*, summary of a regional survey of families, primary care providers & managed care organizations in New England, New England SERVE, 1997.)
- xv Special Medical Services (1999). *Parent satisfaction with child development program services*. NH Department of Health & Human Services. Concord, New Hampshire.
- xvi New England SERVE (1997). *Assessing the quality of managed care for children with special health care needs, summary of a regional survey of families, primary care providers and managed care organizations in New England*. New England SERVE, 101 Tremont Street, Suite 812, Boston, MA 02108.
- xvii McNerny, T. (1984). The role of the general pediatrician in coordinating the care of children with chronic illness. *Pediatric Clinics of North America*, 31(1), 199-209.
- xviii Hurley, R.E. (1986). Toward a behavioral model of the physician as case manager. *Social Science Medicine*, 23, 75-82.
- xix Like, R.C. (1988). Primary care case management: a family physician's perspective. *Quality Review Bulletin*, 14(6). 174-178.
- xx Battle, C. (1972). The role of the pediatrician as ombudsman in the health care of the young handicapped child. *Pediatrics*, 50(), 916.
- xxi Brewer, E.J., McPherson, M., Magrab, P.R., & Hutchins, V. (1989). Family-centered, community-based, coordinated care for children with special health care needs. *Pediatrics*, 83(6), 1055-1060.
- xxii Johnson, C.P. & Blasco, P.A. (1997). Community resources for children with special healthcare needs. *Pediatric Annuals*, 26(11), 679-686.
- xxiii Anonymous. (1998). Managed care and children with special health care needs: A subject review. American Academy of Pediatrics Committee on Children with special health care needs. *Pediatrics*, 102(3 Pt 1), 657-660.
- xxiv American Academy of Pediatrics. (1999). Managed care and children with special health care needs: creating a medical home. (On-line). Available:
<http://www.aap.org/advocacy/mmcfllhom.htm>
- xxv Kruger, B. J. (1999). *Determinants that influence pediatricians to refer children with special health care needs for care coordination services*. Unpublished paper.
- xxvi Special Medical Services. (1999). *Child Development Program Key Informant Interviews with Pre-School Personnel*.

-
- xxvii Special Medical Services. (1995,1996, 1997, 1998). *Annual information and referral report*. NH Department of Health & Human Services, Concord, NH. (Total n= 4,192)
- xxviii Carpenter, M.B., Kavanagh, L. (1998). *Outreach to children: moving from enrollment to ensuring access*. Arlington, VA: National Center for Education in Maternal and Child Health. (On-line). Available: <http://www.ncemch.or/policy/outreach.html>.
- xxix Ireys, H.T., & Nelson, R.P. (1992). New federal policy for children with special health care needs: implications for pediatricians. *Pediatrics*, 90(3), 321-327.
- xxx Koop, C.E. (1987). *Surgeon general's report: children with special health care needs, campaign 87, commitment to family-centered, coordinated care for children with special health care needs*. U.S. Department of Health and Human Services, Government Printing Office.