New Hampshire

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 11/16/2015 4.04.11 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State DUNS Number

Number	011040545
Expiration Date	3/12/2013

I. State Agency to be the Grantee for the Block Grant

Agency Name	New Hampshire Department of Health and Human Services
Organizational Unit	Bureau of Behavioral Health
Mailing Address	105 Pleasant Street
City	Concord
Zip Code	03301

II. Contact Person for the Grantee of the Block Grant

First Name	Nicholas
Last Name	Toumpas
Agency Name	New Hampshire Department of Health and Huuman Services
Mailing Address	129 Pleasant Street
City	Concord
Zip Code	03301
Telephone	603-271-9446
Fax	
Email Address	ntoumpas@dhhs.state.nh.us

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/1/2015 11:37:27 PM
Revision Date	11/16/2015 4:03:17 PM

V. Contact Person Responsible for Application Submission

First Name	Beth Anne
Last Name	Nichols
Telephone	603-271-5075
Fax	603-271-5040
Email Address	beth.nichols@dhhs.state.nh.us

Footnotes:

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State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal 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 award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions 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. §§4728-4763) 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 Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) 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. §§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. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination 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 nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title 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. §§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. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§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 wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§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. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
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. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 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 the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. 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. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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 residence, 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 civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Kathleen A. Dunn, RN, MPH

Signature of CEO or Designee[1]: Kathleen A Dunn

Title: Dir., Community Support & Long-Term Care

Date Signed: 07/28/2015

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State of New Hampshire
DEPARTMENT OF HEALTH AND HUMAN SERVICES
129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9200 FAX: 603-271-4912 TDD ACCESS: RELAY NH 1-800-735-2964

NICHOLAS A. TOUMPAS
COMMISSIONER

July 28, 2015

Her Excellency, Governor Margaret Wood Hassan
State House
Concord, New Hampshire 03301

RE: Mental Health Block Grant

Dear Governor Hassan:

Since the early 1970s, federal legislation requires states to designate a state agency to coordinate service development and to receive and manage federal funds for mental health services. The NH Bureau of Behavioral Health (BBH) serves as the State Mental Health Authority (SMHA) and the Director of the BBH serves as the Single State Authority (SSA) in NH. BBH prepares annual applications and reports for the Mental Health Block Grant. The Substance Abuse and Mental Health Services Administration (SAMHSA) awards New Hampshire approximately $1,900,000 annually.

While a large portion of the transactions required for the Block Grant applications are submitted electronically, the assurances and certifications are submitted in hard copy format. These documents require your signature or the signature of your designee. Please authorize the current SMHA or the Associate Commissioner who oversees the SMHA, or any one officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG). I have attached the text for the letter of designation for your review and signature.

Please send your signed copy of the attached letter to:

Beth Anne Nichols, State Planner
Bureau of Behavioral Health
NH Department of Health and Human Services
105 Pleasant Street
Concord, NH 03301

If you have any questions regarding this application, please contact Kathleen Dunn, Associate Commissioner and Medicaid Director, at (603) 271-8421.

Sincerely,

Nicholas A. Toumpas
Commissioner

Attachment: SAMHSA.MHBG.Appl_GovernorsDesignation

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

MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

August 3, 2015

Ms. Virginia Simmons
Supervisory Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Ms. Simmons:

I delegate authority to the current Bureau Chief and Administrator of the Bureau of Behavioral Health, New Hampshire Department of Health and Human Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Administration's (SAMHSA) Mental Health Block Grant (MHBG).

With every good wish,

Margaret Wood Hassan
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.nh.gov/ • Email: governorhassan@nh.gov
TDD Access: Relay NH 1-800-735-2964

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

III: B. Planning Step 1:
Assess the strengths and needs of the service system to address the specific populations.

NH's 2014 estimated population is 1,326,813 people. In State Fiscal Year (SFY)14, 46,749 individuals, including adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED), were engaged in the public mental health system, a decrease of 4.7% (n= 49,064) from FY13.

As the SMHA, BBH's responsibilities include planning, coordinating services, contracting, regulating, and monitoring New Hampshire's system of public mental health services for BBH-eligible adults with a serious, or a severe and persistent, mental illness (SMI/SPMI) and children with a serious emotional disturbance (SED). These are the statutory populations the State MH system is required to assist. BBH oversees new program development and provides training and technical assistance to the community mental health system.

(1) Comprehensive Community-Based Mental Health Service Systems

The New Hampshire Department of Health and Human Services (DHHS) is the largest agency in New Hampshire state government, responsible for the health, safety and well-being of the citizens of New Hampshire. DHHS provides services for individuals, children, families and seniors and administers programs and services such as mental health, developmental disability, substance abuse and public health.

New Hampshire, in compliance with the Social Security Act Title XIX §1900, has established a system of care for individuals with mental illness in a comprehensive system of care. The NH Department of Health and Human Services is the agent for the variety of Departments and Bureaus that ensure these functions.

A. Health and Mental Health Services

1. System Integration: Section 1115 Medicaid Demonstration Waiver

The State of New Hampshire Department of Health and Human Services (DHHS) as the single state Medicaid agency is seeking Section 1115 Demonstration Waiver authority from the Centers for Medicare and Medicaid Services (CMS) to support the comprehensive reform of its Medicaid program. The initiatives proposed within this "Building Capacity for Transformation" section 1115 Demonstration Waiver will include improvements to the delivery of mental health, physical health, substance use disorder (SUD), oral health, and population health programs and services. New Hampshire requests authority to recognize costs not otherwise matchable from local and state health expenditures to implement these programs. The freed-up state and local funding would provide needed financial assistance to pursue meaningful delivery system reforms that will help improve the New Hampshire health care system. Details of the proposed waiver are included in Section C:1 The Health Care System and Integration.

1. Regional Public Health Networks (RPHNs)

In July 2013 the New Hampshire Department of Health and Human Services, through the Bureau of Drug and Alcohol Services (BDAS) and Division of Public Health Services (DPHS) established a strategic partnership to align multiple public health priorities into one integrated system. The partnership aims to increase efficiency through single contracts with 13 agencies to serve as the host entity for a Regional Public Health Network (RPHN). The purpose of the RPHNs is to integrate multiple public health initiatives and services into a common network of community stakeholders. The RPHNs include every community in the state.

B. Rehabilitative Services

Of particular interest within the context of this grant application, New Hampshire's mental health service system is administered by the Department of Health and Human Services (DHHS) Bureau of Behavioral Health (BBH), authorized as the State Mental Health Authority (SMHA). The BBH maintains and coordinates policies governing New Hampshire's system of care for severely mentally ill (SMI) adults and the severely emotionally disabled (SED) youth. This governance ensures the comprehensive, effective, and efficient system of services for persons with mental illness intended to reduce the occurrence, severity and duration of mental, emotional, and behavioral disabilities, and prevent mentally ill persons from harming themselves or others.

Behavioral health services are provided to BBH's priority population through three different provider types/settings.

1. Inpatient Care

Inpatient services are provided through general hospitals with inpatient psychiatric capacity, New Hampshire Hospital (NHH), one community based Acute Psychiatric Residential Treatment Program (APRTP), and (2) Designated Receiving Facilities (DRFs): treatment facilities designated by the Department of Health and Human Services Commissioner to accept for care, custody, and treatment adults involuntarily admitted to the state mental health services system.

New Hampshire Hospital (NHH) is a fully accredited public state-operated adult and youth-serving psychiatric facility. It is operated independent of the SMHA. Its capacity has fallen from 252 certified beds in 2010 to 130 today as state budget cuts required it to close parts of the facility serving children 14 and older, and adults. It is the only freestanding psychiatric facility in the State. It is managed in clinical partnership with Dartmouth Medical School. The objective of all programs is the reintegration of all persons into the community. New protocols, mandated by the CMHA, are being structured to strengthen the discharge transition planning process.

The Philbrook Center, a residential treatment program for troubled youth, was named for Dr. Anna Philbrook, a longtime child psychiatrist at the state hospital. Budget cuts closed the center in 2010, with juvenile patients moved to the Anna Philbrook Unit within the state hospital itself.

2. Long-Term Care Rehabilitative Services

Glencliff Home for the Elderly serves Adults with SMI 60 years of age or older who meet the requirements for Long-Term Care that identifies GHE as the least restrictive environment and providing the level of medical care the person requires.

3. Community Mental Health

Rehabilitative services are provided through 10 regional community mental health centers and other community-benefit organizations. These are private, non-profit providers that contract with BBH as providers of designated behavioral health services in specific geographic regions.

State Eligibility for Community-Based Services

New Hampshire's current statutes and administrative rules detail the Bureau's authority. Through its provider network, BBH maintains responsibility for the determination and redetermination of the eligibility of individuals for community-based mental health therapeutic and rehabilitative services which are covered under New Hampshire's Medicaid State Plan Rehabilitation Option and Targeted Care Management Option (see attached He-M document).

Per New Hampshire Administrative Rule and State Medicaid Plan, a Community Mental Health Program (CMHP) shall provide the following, either directly or through a contractual relationship:

►Intake assessment ►Case management ►Individual service plan development and monitoring ►Discrete employment services for adults with mental illness, including evidence-based supported employment ►Protection of consumers' rights ►Mobile, psychiatric emergency services ►Planning, coordination, and implementation of a regional mental health disaster response plan which shall specify responsibilities and procedures ►Outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system and providing non-office-based diagnostic and treatment services ►Services to emergency shelters and providers of services to homeless persons ►Collaboration with state and local housing agencies and providers to promote access to existing housing and the development of housing for persons with mental illness, including home ownership and rental options ► Individual, group, and family psychotherapy ►Medication services, including psychiatric and nursing assessment, medication prescription and monitoring, oral and intravenous administration, and education▪ Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support ►Evidence-based illness management and recovery services, including those services provided in community settings ► NHH census management services, including a staff liaison who has NHH privileges and participates in NHH treatment and discharge planning meetings on a regular basis and ►Specialized treatment services to eligible persons with mental illness and a concomitant alcohol and/or substance use disorder, including assessment of alcohol/substance use disorders, as part of the clinical evaluation process and provision of treatment for both the substance use disorder and the mental illness, as necessary.

C. Employment Services

a. Public and Private Employment Services

NH's Medicaid for Employed Adults with Disabilities Program (MEAD) allows adults with disabilities, including mental illness, to work without losing their Medicaid eligibility, as does the SSI (Supplemental Security Income) PASS program (Plan to Achieve Self Support).

The state has a number of employment services available through the New Hampshire Department of Employment Security (DES) and NH Works.

Additional services are available through the Division of Vocational Rehabilitation (DVR), of the NH Department of Education (DOE).

Vocational Rehabilitation is a joint State/Federal program that seeks to empower people to make informed choices, build viable careers, and live more independently in the community.

Work Incentives Coordinators at Granite State Independent Living (GSIL), a statewide private non-profit and New Hampshire's only Center for Independent Living, provide assistance to disabled persons interested in working while retaining their Medicaid eligibility. They are able to speak and think with authority on behalf of the people we serve and support because we are led by a board of directors and staff of which over 51% are people with disabilities.

b. Supported Employment

For at least 10 years all Community Mental Health Centers (CMHCs) have provided the Evidence-Based Practice (EBP) Supported Employment (SE), based on the Dartmouth model. Now, the CMHA calls for the State to expand, through its community mental health providers, its delivery of supported employment services, which include providing individualized assistance in identifying, obtaining, and

maintaining integrated, paid, competitive employment: the Agreement calls for the State to increase its penetration rate of individuals with SMI receiving supported employment services to 18.6 percent of eligible individuals with SMI by June 30, 2017. By June 30, 2017, the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable, and, to the extent it has not already done so, develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future.

Supported Employment is emphasized in the CMHA as an integral part of the Assertive Community Treatment ("ACT") program and is embedded in the requirement for improved discharge and transition planning from Glencliff Home and New Hampshire Hospital.

4. Housing Services

a. Community Residences

New Hampshire has two community mental health programs that deliver residential services and supports to adults, located in two regions of the State in community residences. A "Community residence" means either an agency residence or family residence, exclusive of any independent living arrangement, that: (1) Provides residential services in accordance with state administrative rule for at least one consumer with a mental illness; (2) Provides services based on the needs identified in a consumer's individual service plan (ISP); (3) Is operated directly by a community mental health program, a community mental health provider, or by contract or agreement between a community mental health program and another entity; (4) Serves consumers whose services are funded by Medicaid-billable rehabilitative services; and (5) Is certified pursuant to He-M 1002.

b. Transitional Housing Services (THS)

THS serves the clinical, medical, vocational and residential needs of adult men and women with mental health issues. The goal is to help individuals successfully transition from New Hampshire Hospital into the community as well as maintain their independence in the least restrictive environment possible.

Transitional Housing Services offers the following:

- Services that are designed to be responsive to the unique needs of the individual and to effectively engage natural and community services support systems so that community integration is wholly obtainable.
- Psychiatric services, medication management, clinical services, medical services, residential, case management, specialized and co-occurring treatment services, vocational and day treatment services.
- Support for community connectedness and family involvement.
- Open communication with families and individuals.
- A comprehensive approach to service delivery driven by consumer involvement.
- Evidence-based practice approaches that include Illness Management and Recovery and IPS/Supported Employment.

c. Supported Housing

According to the CMHA Supported Housing in New Hampshire includes housing supported by subsidies from any source, including State-funded rental subsidies through the State's Bridge Subsidy Program or funding from the U.S. Department of Housing and Urban Development ("HUD"), coupled with other ongoing mental health and tenancy support services provided by ACT, case management, and/or a housing specialist.

HUD-funded Supportive Housing Programs (SHP)

HUD-funded Supportive Housing Programs (SHP) are an essential service within New Hampshire's homeless Continuum of Care. They are specifically to serve individuals and families who are homeless and have a disabling condition that prevents them from living independently. Designed to provide comprehensive case management, these programs meet the needs of chronically homeless, persons with mental illness, dual diagnosis, Acquired Brain Disorder, and other disabling conditions. Providers include Community Action Agencies, Community Mental Health Centers, and several smaller non-profit organizations. Direct services include case management, assistance with acquiring essential life skills, housing, and other supportive services that will ensure their housing placement is permanent.

Shelter + Care

Shelter Plus Care (S+C) programs are designed to provide both housing and support services to individuals or families who are homeless and need support to maintain permanent housing. To be eligible, participants must be homeless and living in an emergency shelter, the streets, or another place not meant for human habitation and have a disabling condition. The program is designed to be flexible in meeting the needs of participants with housing options and varied support services that may include mental health treatment, healthcare, case management, substance abuse treatment, or assistance with other basic life skills. Three S+C programs are funded through the Balance of State Continuum of Care (BOSCOC), two through the Center for Life Management (CLM) and one through Southwestern Community Services (SCS).

Housing Bridge Subsidy

The BBH's Housing Bridge Subsidy program is proving to be highly successful, moving eligible persons out of the state hospital or transitional group housing into safe, affordable residences in the community. This program satisfies a key component of the CMHA. This program uses general fund dollars to provide rental subsidies to adults with SMI who are homeless or at risk of becoming homeless.

The program has established permanent or subsidized housing for over 300 individuals, while prioritizing individuals at New Hampshire Hospital, Transitional Housing and/or those being served by Assertive Community Treatment teams in the community who are homeless, or at risk of becoming homeless due to their economic circumstances, and/or individuals served community mental health centers currently in community residences who are ready to transition into the community.

The Housing Bridge Subsidy Program is available on a statewide basis, and individuals choose a location of their preference. All of the individuals served are referred to local community mental health programs that will help support them in maintaining their apartment, preventing a further episode of homelessness, and achieving their independence and personal recovery goals.

All new supported housing created pursuant to the CMHA will be scattered-site supported housing, with no more than two units or 10 percent of the units in a multi-unit building with 10 or more units, whichever is greater, and no more than two units in any building with fewer than 10 units known by the State to be occupied by individuals in the Target Population

The CMHA required the State to achieve a target capacity of 340 supportive housing units funded through the Bridge subsidy program by June 30, 2015 (see attachment). Below is a table illustrating the growth of this program:

SFY	Number of Placements
2010	36

2011	46
2013	28
2014	100
2015	100
2016 (planned)	100
TOTAL	**410**

5. Educational Services

a. SMI (Adults)

The CMHA directs the State to have an effective family support program to meet the needs of families of SMI individuals throughout the State. The family support program will teach families skills and strategies for better supporting their family members' treatment and recovery in the community. The family support program will include training on identifying a crisis and connecting individuals in crisis to services and supports, as well as education about mental illness and available ongoing community-based services and supports.

This type of educational service (psychoeducation) is increasingly included in treatment of individuals with SMI and their families and/or natural supports. For example, Illness Management and Recovery (IMR), an Evidence-Based Practice (EBP) part of the contracted service spectrum provided by Community Mental Health Centers contains an early module dedicated to psychoeducation.

Other services and programs to assist adults with SMI in improving or attaining their educational goals may be provided by Vocational Rehabilitation. The mission of New Hampshire Bureau of Vocational Rehabilitation is to assist eligible New Hampshire citizens with disabilities secure suitable employment and financial and personal independence by providing rehabilitation services.

Topical education on mental health and related issues, often provided by family members and consumers, is provided through entities such as NAMI-NH, the Office of Consumer and Family Affairs (OCFA), and the PSAs. These resources also serve to support consumers and their families in their interactions with educational providers.

b. SED (Children)

Mental health services to children may occur within individual school districts whose professional relationships with the CMHCs located within those may vary widely. Historically, there has been little formal coordination between the various public systems receiving state and local funding to provide mental health services to children. More recently, efforts have been made to establish Memoranda of Understanding (MOUs) between the CMHCs and individual districts or even schools.

Although schools may not contract with a CMHC for school-based services, the vast majority of schools have informal, yet frequent, contact with them to help facilitate the coordination of mental health treatment for students in need.

This public system of mental health care for children is funded by a myriad of sources, with over 80% of schools reporting the use of some local funds for providing mental health services, a significantly higher share than in national surveys of schools. This is not surprising given the state's historical focus on 'local control.'

Schools are providing mental health services to both special education and the general population, both of which categories may include SED individuals, through both CMHCs and private providers.

IDEA Services

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program.

These services will be discussed further in **Section (3) Children's Services.**

6. Substance Abuse Services

Substance abuse treatment and prevention services, including outpatient and clinically managed detoxification and residential services at several intensity levels are within the purview of the Department of Health and Human Services Bureau of Drug and Alcohol Services (BDAS), which is the recipient of a (separate) Substance Abuse Block Grant (SABG). Both BDAS and BBH serve individuals with co-occurring disorders, who may have a primary diagnosis of a substance use disorder (SUD) with a secondary and/or tertiary MH diagnosis, or, conversely, specific to the BBH population of adults with SMI and children with SED with a secondary/tertiary SUD. Several CMHCs employ Licensed Alcohol Drug Counselors (LADCs), Master's level Licensed Alcohol and Drug Counselors (MLADCs). The State of New Hampshire offers professional designation as a Certified Recovery Support Worker (CRSW). These roles have become increasingly important as evidence-based practices (EBPs) are implemented. Many EBPs, including BBH-contracted ACT and Supported Employment programs, incorporate substance abuse treatment components into their models.

The importance of the ability of the state to provide SUD treatment has increased because of the New Hampshire Health Protection Program (NHHHPP), the state Medicaid Expansion effort. As of May 26, 2015, over 40,000 New Hampshire residents have enrolled in the NHHPP. Medicaid is by far the largest source of payment for mental health services relevant to the Community Mental Health Agreement (CMHA) in New Hampshire. And, as Medicaid Expansion adds new enrollees, previously uninsured individuals will have increased access to needed mental health services. The Medicaid Expansion population will have access to new substance use service benefits, which could improve substance use service access and coordination opportunities for this group.

An assessment of substance use disorder (SUD) services was conducted by BDAS between May and July of 2014 and included the surveying of licensed substance use and mental health professionals and representatives from organizations within major service delivery systems relative to current and anticipated capacity to identify, treat, and support recovery from substance use disorders.

a. Substance Abuse Treatment

Many services are available to NH citizens, including:

a. **Withdrawal Management (Detoxification)** – Service aimed at managing acute substance dependence as defined by the presence of intoxication and withdrawal. This service helps stabilize and prepare an individual with a substance use disorder to enter treatment and may be delivered within an inpatient or outpatient setting.
b. **Outpatient Counseling**
    - **Individual Outpatient Counseling** – Service provided by a clinician to assist an individual to achieve treatment objectives through the exploration of substance use

disorders and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision making with regard to alcohol and other drug related problems.

- **Group Outpatient Counseling** – Service provided by a clinician to assist two or more individuals and/or their families/significant others to achieve treatment objectives through the exploration of substance use disorders and their effects, including an examination of attitudes and feelings, and considering alternative solutions and decision-making with regard to alcohol and other drug related problems.
- **Intensive Outpatient Programs** – Structured individual and group alcohol and/or drug treatment services and activities that are provided at least 3 hours a day and at least 3 days a week according to an individualized treatment plan.

c. **Partial Hospitalization** – Combination of 20 or more hours per week of group and individual sessions in conjunction with, either directly or through referral, medical and psychiatric services, psychopharmacological services, addiction medication management, recovery support services and 24-hour crisis services.

d. **Residential Services** – Program providing 24-hour support and services where an individual lives full-time at the program and receives individual and/or group counseling, educational sessions and introduction to self-help groups.

e. **Recovery Support Services** – Services provided to individuals and/or their families to help stabilize and support recovery. Services may include employment services, anger management, recovery mentoring/relapse prevention management, peer recovery coaching, care coordination, childcare, transportation, sober housing, and other supports.

f. **Medication Assisted Treatment** – Treatment that includes medication prescription, supervision, and management paired with counseling or other treatment services. Common medications include buprenorphine (Suboxone), Methadone, Naltrexone, Acamprosate, and Disulfiram. Currently the Bureau of Drug and Alcohol Services is pursuing a grant to assist with MAT programs in the state.

g. One CMHC offers an **Integrated Dual Disorders Treatment (IDDT)** program, an evidence-based practice treatment model, to its SMI clients. This is a standalone program not provided under the center's contract with the Bureau of Behavioral Health, but is supported through the Balancing Incentives Program (BIP) award granted the Department of Health and Human Services by the Centers for Medicare and Medicaid Services (CMS).

BDAS has launched the **Alcohol and Other Drug Treatment Locator Website** of NH providers offering withdrawal management, assessments, outpatient counseling, residential treatment, recovery supports and other types of services for people experiencing problems with alcohol and other drug use, including addiction.

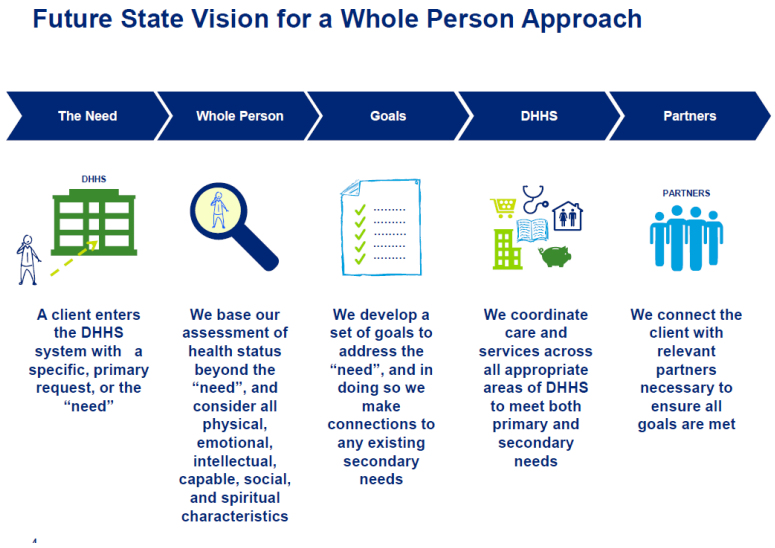
b. Substance Abuse Prevention

The BDAS Substance Abuse Prevention system, funded by the SABG, is comprehensive, consisting of several partners, stakeholders and investors at the state and community level. For a complete review of NH Substance Abuse Prevention Efforts and Services please review **New Hampshire's System for Substance Abuse Prevention Efforts and Services** (attached).

7. Medical and Dental Care

Case management programs embedded within Community Mental Health Centers and other human service programs across the state coordinate care for SMI and SED individuals through assessment, planning, linkage, and referrals to needed providers, including medical and dental providers and programs assisting SMI adults and SED youth.

The Department of Health and Human Services has adopted a whole-person approach to assist with navigation of the complex human services network.



a. Medical Care

The New Hampshire Division of Public Health Services (DPHS)

The New Hampshire Division of Public Health Services (DPHS) receives and distributes state and federal funds used to deliver essential public health services, especially the underserved. SMI and SED individuals often fall into this category. DPHS sponsors various health care programs; including, but not limited to:

> Grant-Supported Federally Qualified Health Centers are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).
>
> Sections within the Bureau of Community Health Services' (BCHS) fund Community Health Centers (CHCs) and other agencies that provide health services to individuals and families. In this way, the Bureau helps improve the health of New Hampshire's residents, focusing on access to care for vulnerable, underserved and rural populations.

The Primary Care Office (PCO) works with other agencies and stakeholders to support and improve access to comprehensive, culturally competent, quality, primary health care services for underserved and vulnerable populations. This is done through three program areas: 1) Statewide Primary Care Needs Assessment, 2) Shortage Designation Coordination, and 3) Technical Assistance and Collaboration that Seeks to Expand Access to Primary Care.

b. Dental Care

Oral Health Program

The Oral Health Program has contracts with agencies across the state to provide preventive and reparative dental services for NH's children and adults who don't have access to dental care. In cooperation with

NH's Medicaid program, community organizations, schools, private foundations and medical and dental professionals, the Oral Health Program is raising the public's awareness of good oral health as an important part of total health and wellness.

As part of the NH Community Dental Programs effort, twenty-one school-based dental programs and thirteen dental centers across the state offer a range of oral health services. Each program or dental center has its own eligibility rules to qualify for services. Generally speaking the client must live in the geographic area served by the program, fulfill financial eligibility requirements and fall within the patient population age criteria determined by the dental program.

8. Other Support Services

a. Adults

No Wrong Door

The Affordable Care Act (ACA) establishes a 'no wrong door' enrollment policy that aims to enable people seeking coverage to complete one application to determine which health and social services programs they and their family are eligible for. The No Wrong Door initiative has as its core a goal of improving access to state human service and financial supports: a Single Entry Process.

For New Hampshire, the No Wrong Door concept has materialized with implementation of a statewide system to enable consumers to initiate access all long-term services and supports through any serving agency, organization, coordinated network, or portal. Goals include:

- Application assistance
- Streamline processes
- Uniformity in the application experience

- NHCarePath**,** a BIP-funded project. is designed to be New Hampshire's "front door" that quickly connects individuals to a full range of community services and supports. CarePath serves to educate and publicize No Wrong Door linkage efforts and state partners, including the ServiceLink assistance program.

- The ServiceLink Resource Center is a web-based product of the NH Department of Health and Human Services. Through contracts with local agencies around the state, ServiceLink helps seniors, adults living with disabilities and their families access and make connections to long term services and supports, access family caregiver information and supports, explore options and understand and access Medicare and Medicaid.

b. Children

- **NH Medicaid - Health Coverage for Children Under Age 19** provides comprehensive coverage, both medical and dental at no cost to your family. This includes many routine services such as well child check-ups and immunizations.

- The New Hampshire **Women, Infants and Children Nutrition Program (WIC)** provides nutrition education and nutritious foods to help keep pregnant women, new mothers, infants and preschool children healthy and strong.

- Other children-specific supports are described further in **Section (3) Children's Services.**

9. Case Management Services

Case management serves to assist SMI and SED clients, on a one-to-one-basis, in gaining access to needed medical, social, educational, and other services. Case management is the backbone of any Community Mental Health Program (CMHP) administered by the BBH. All evidence-based practices include case management; every SED and SMI client is offered case management by their regional Community Mental Health Center, and case management serves as the link between institutions and the community; as it is the means, by rule, to provide effective discharge planning from New Hampshire Hospital and/or Glencliff Home for the Elderly.

Case Management, as defined in NH Administrative Rule 426 and provided by authorized and contracted Medicaid providers, is an optional service, consisting of:

(1) Assessment and periodic reassessment of an eligible individual to determine service needs;
(2) Development and periodic revision of a specific and comprehensive care plan based on the information collected through an assessment or reassessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual;
(3) Referral and related activities to help an individual obtain needed services, such as scheduling appointments, but not including transportation, escort, and childcare services; and
(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual.

Case management services for an individual who has been admitted to a hospital or nursing facility include:

(1) Providing ongoing case management services on behalf of the client in order to ensure that services and supports are established and maintained within the community and within the community mental health system;
(2) Establishing and maintaining contact with community agencies and individuals to develop community resources, to foster access to services other than those offered through the state mental health system, and to encourage community support to the client when he or she returns to the community;
(3) Arranging, in collaboration with the hospital or nursing facility, community supports appropriate to the client's need;
(4) Participating in the service planning process, from initial treatment planning through discharge planning, and supporting the participation of the client, the family, and the guardian in the treatment planning process and, with the client's or guardian's consent, involving significant others;
(5) Providing information necessary for individual service planning, with the consent of the client;
(6) Participating in making discharge plans and in securing access to available community resources of choice in order to foster a smooth transition to the community; and
(7) After a client's involuntary commitment and conditional discharge, advising the administrators of the CMHP or provider and the hospital concerning the client's progress with, and suggesting revisions in, the discharge conditions.

Transitional case management is provided to individuals, under the age of 22 and over the age of 64, who are transitioning from a hospital or nursing facility to the community.

10. Activities Leading to Reduction of Hospitalizations

a. Adults

CMHA

The Community Mental Health [settlement] Agreement resulting from *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM* (attached) is driving major programmatic changes in the NH behavioral health system. Remedies are specific, and are based on the settlement language that states, "according to the United States Department of Justice's regulations, 28 C.F.R. § 35.130(d) in particular, the ADA requires, among other provisions, that, to the extent the State offers services, programs, and activities to qualified individuals with disabilities, such services, programs, and activities will be provided in the *most integrated setting* (italics added) appropriate to meet their needs."

"In order to comply with this Settlement Agreement", (the Agreement states) the State shall "develop and implement the services set forth below in this Settlement Agreement. The services may be provided directly by the State or through contracts with CMHPs.

The Target Population for the community services described in [the] Agreement is the subset of adults within the State who have SMI, and who are institutionalized or at serious risk of institutionalization
All of the services are designed in an effort to reduce unnecessary institutionalization":

- 24/7 Crisis Service System
  - Mobile Crisis Teams
  - Community Crisis Apartments
- Assertive Community Treatment ("ACT")
- Housing
  - Supported Housing
  - Community Residences
- Supported Employment
- Family and Peer Supports
- Transition Planning and Transition Plans for People in Facilities

BIP

The New Hampshire Department of Health and Human Services (DHHS) has used the Balancing Incentive Program (BIP) grant to establish NHCarePath to enable increased access to and use of long-term care services and supports in community settings. In partnership with community organizations throughout the state, these services and supports will allow more people to remain in their homes and communities rather than in nursing homes.

b. Children

Two CMHCs have children's Assertive Community Treatment (ACT) teams, managed by the BBH. There is a contract award awaiting approval for a third.

The child-serving system in New Hampshire has worked valiantly to ensure safety net and family support services for children. These will be discussed more fully in **Section (3) Children's Services.**

(2) Mental Health System Data and Epidemiology

The BBH-eligible population is the priority population to be served with BBH funding to the CMHCs, and BBH conducts annual eligibility audits at each of the CMHCs to confirm that the eligible population is receiving the required services. The Adult SMI rate is estimated by SAMHSA (2012) to average 4.1% of the adult civilian population of each state (source: Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings). The US Census Bureau estimates 2014 New Hampshire population at 1.327 million. Youth age 18 an under are estimated at 25% of the population; adults at 75%.

	NH	US	NH	US	NH INCR/DECR	US INCR/DECR	NH	US	NH INCR/DECR	US INCR/DEC	NH	US	NH	US
Measure	2011		2012				2013				2014		INCR/DECR	INCR/DECR
Community Adult Admissions	35,949	4732693	37,062	4917579	1.03%	1.04%	34,309	5154974	0.93%	1.05%	33,885	5179695	0.99%	1.00%
Community Child and Youth Admissions	12,452	1,850,777	12,622	1,917,317	1.01%	1.04%	13,511	1,985,979	1.07%	1.04%	12,864	1,964,382	0.95%	0.99%
TOTAL	*50,412*	*6,583,470*	*51,696*	*6,834,896*	*1.03%*	*1.04%*	*49,833*	*7,140,953*	*0.96%*	*1.04%*	*48,763*	*7,144,077*	*0.98%*	*1.00%*
Percent of SMI Clients	30	69.1	30	69.5	1.00%	1.01%	32	66.5	1.07%	0.96%	31	68	0.97%	1.02%
Percent of SED Clients	75	74.7	73	71.6	0.97%	0.96%	72	69.6	0.99%	0.97%	69	68.7	0.96%	0.99%

SOURCE: SAMHSA URS Multi-Year Output Tables

SFY15 (Estimated)

The total served in Community Mental Health Centers statewide in FY15 was 33,461 (estimated 3% state population).

Of clients served, FY15 data indicates that 13,225 adults: 40% of total served, and 53% of total adults served, were reported eligible (SMI + SPMI) for state-supported community-based services. While adult admissions have increased, New Hampshire SMI rates for proportion of SMI clients served have remained relatively stable and consistently below other states' reporting and the national average.

Of clients served, FY15 data indicates that 8,261 children and youth: 25% of total individuals served, and 87% of total children and youth served, were reported eligible (SED & SED-IA) for state-supported community services.

The New Hampshire State Epidemiological Workgroup

The NH SEOW is a multidisciplinary advisory group that works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance use and behavioral health issues in order to inform prevention and treatment policy, programs and services in the state (see attached Purpose and Objectives Statement).

(3) Children's Services

a. Community Mental Health Centers

Per New Hampshire Administrative Rule and State Medicaid Plan, a Community Mental Health Program (CMHP) shall provide the following developmentally appropriate services to children who are eligible pursuant to the applicable rules and shall give priority to children connected to the division for children, youth and families. Services provided to eligible children shall be community based, and shall include the following:

►Family support and education, including designation of a family liaison ►Psychiatric diagnostic and medication services ►Case management, including appropriate interagency involvement ►Individual, family, and group therapy ►Intake and assessment; Crisis intervention ►Individual service plan

development and monitoring ►Outreach support to children and their families, both in their homes and in community settings ►Functional support services.

The CMHA does not address the unmet needs of Children with SED. However, NH has an active Children's advocacy presence, and members of the Behavioral Health Advisory Council (BHAC)'s Children's Interest Group sit on the BHAC Executive Committee. The BHAC's Children's Interest Group is a dynamic group who supports and communicates with various stakeholders, including NAMI-NH and the Children's Behavioral Health Collaborative of New Hampshire. The latter group represents child and family organizations and agencies - more than 50 - focused on mental health and substance use disorders for children, youth and families.

In 2014, 12,864 children were admitted to the Community Mental Health Centers. The majority of these (69%) were determined to be SED, mirroring the proportion of SED children and youth served nationwide.

a. Division of Children, Youth, and Families

The NH Department of Health and Human Services Division of Children, Youth and Families (DCYF staff provide a wide range of family-centered services with the goal of meeting the needs of parents and their children and strengthening the family system. Services are designed to support families and children in their own homes and communities whenever possible.

The Bureau of Child Protection works to protect children from trauma, abused and neglect while attempting to preserve the family unit. Child Protective Service Workers help prevent further harm to children from intentional physical or mental injury, sexual abuse, exploitation or neglect by a person responsible for a child's health or welfare.

Other departments of the DCYF are described in Section III.C.18: Children's Services.

IDEA Services

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program.

In New Hampshire, the Department of Health and Human Services, Office of Medicaid Business and Policy (State agency), administers the Medicaid program. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P. L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act through a child's individualized education plan (IEP). The Department of Education funds the school system to provide services under the Individuals with Disabilities Education Act (IDEA) to children and youth with Individualized Education Program (IEPs), up to age 21.

The primary State guidance for administering and operating the school-based health program is the New Hampshire Medicaid to Schools Program Manual. In order to be eligible for this program, a student must be (1) identified as having an educational disability in his or her IEP, (2) younger than 22 years of age, (3) eligible for Medicaid, and (4) served by an SAU that is enrolled as a Medicaid provider. Covered services under the Medicaid to Schools program include:

- medical evaluation;
- nursing services;

- occupational and physical therapy;
- psychiatric, psychological, and mental-health services;
- speech, language, and hearing services;
- rehabilitative assistance;
- vision services; and
- transportation services.

Additional information about the child-serving system in New Hampshire may be found in Section III.C.18: Children's Services.

(3) Targeted Services to Rural and Homeless Populations

1. Rural New Hampshire

According to the 2010 US Census, 39.7% of New Hampshire's population qualifies as rural, and 92.81% of the total area of New Hampshire is considered rural. All home and community-based services are available to the eligible population, regardless of location. BBH contracts with community mental health centers in all areas of the state, which includes the provision of services via satellite sites to reach the most rural parts of the state.

As of the date of this application, 69 treatment centers in New Hampshire, including 20 mental health providers, are located in designated Health Professional Shortage Areas (HPSAs) (source: HRSA Data Warehouse).

The State Office of Rural Health (SORH) offers technical assistance to rural health care providers and organizations and provides healthcare-related information to rural healthcare stakeholders. SORH serves as a liaison between rural healthcare organizations and many DHHS programs.

The Workforce Development office works with each of the above program areas to increase or retain the supply of health professionals serving New Hampshire. There is a particular focus on those professionals whose service will meet the needs of rural and underserved populations. Workforce Development administers New Hampshire's State Loan Repayment Program, the J1 Visa Waiver (Conrad 30) program, and the National Interest Waiver program.

2. New Hampshire's Homeless

Community Mental Health Centers and Peer Support Centers are required by administrative rule to provide outreach to persons with mental illness who are homeless for the purpose of engaging such persons in the service system and providing non-office-based diagnostic and treatment services.

The State of New Hampshire Bureau of Homeless and Housing (BHHS) provides an array of statewide services, which fall under the Homeless Prevention/Intervention Service spectrum, which together with the emergency shelter system, act as a safety net.

The Projects for Assistance in Transition from Homelessness (PATH) program is funded through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) branch of the US Department of Health and Human Services with funds contracted to community mental health and Community Action Agencies.

The entities through which Housing and Urban Development (HUD) funds the Homeless Assistance Supportive Housing Programs are in the Continuum of Care (CoC). New Hampshire has three distinct CoCs, Greater Nashua, Manchester, and the Balance of State. The Bureau of Homeless and Housing Services (BHHS) coordinates the activities of the Balance of State Continuum of Care (BOSCOC).

(5) Management Systems

For purposes of block grant planning and reporting, SAMHSA has clarified the definitions of SED and SMI which were first identified in the 1993 Federal Register them (May 10, 1993; 58 FR 29422-29425). States may have additional elements that are included in their specific definitions, but the following provides a common baseline definition. Children with SED refers to persons from birth to age 18 and adults with SMI refers to persons age 18 and over; (1) who currently meets or at any time during the past year has met criteria for a mental disorder – including within developmental and cultural contexts – as specified within a recognized diagnostic classification system (e.g., most recent editions of DSM, ICD, etc.), and (2) who displays functional impairment, as determined by a standardized measure, which impedes progress towards recovery and substantially interferes with or limits the person's role or functioning in family, school, employment, relationships, or community activities.

The Department of Health and Human Services Bureau of Behavioral Health has established, through administrative rule HeM 401, New Hampshire's criteria for SMI/SPMI AND SED/SED-IA (attached).

a. Emergency Mental Health Services

Each CMHC has staff responsible for 24-hour emergency, or crisis, services. Services are required by administrative rule to: a. Be available 7 days per week, 24 hours per day; b. Include clinical/psychiatric evaluation and treatment, medication services, and referral to inpatient treatment; and c. Be available at the CMHP and other community locations including hospitals, homeless shelters, police stations, and residences.

All of New Hampshire's CMHCs are involved in regional planning, training, and drills in behavioral health emergency/disaster response. Administrative rule requires that Behavioral Health Disaster Response Plans provide: ► Coordination with other local and regional agencies that provide emergency management services including relief from a disaster► Identification of members of the community at large who are vulnerable to behavioral health crises during times of disaster► Provision of onsite crisis assessment and diagnostic and counseling services; and ►Addressing the acute psychiatric treatment needs of community members and assuring the availability of community support and treatment services to consumers of the state mental health system who are vulnerable during times of disaster due to the nature of their mental illness.

The BBH Acute Care Services Coordinator assists with, and advocates for, the mental health training for emergency health services, participates in suicide prevention activities, is the liaison to the Office of the Chief Medical Examiner (OCME) for the DHHS and for the New Hampshire National Guard, liaison to the CMHC Emergency Services Departments, the Designated Receiving Facilities (DRF), and is on the Advisory Board of the Disaster Behavioral Health Response Team (DBHRT) as well as being a member of DBHRT.

b. Grant Expenditure Manner

The majority of the MH block grant award for NH supports contracts with eight **Peer Support Agencies (PSAs)** at fourteen sites and two outreach programs, serving all 10 MH regions, sustaining statewide

access to peer support as an alternative and/or adjunct to clinical and medical models of service provision. PSAs provide an array of recovery-oriented services.

Peer Support Agencies (PSAs) are community-based private not-for-profit agencies that have contracted with BBH to provide peer-to-peer support by adults with mental illness, intended to assist adults with mental illness in their personal recovery.

NH has had a long commitment to mental health consumer peer support starting with both the establishment of the first Office of Consumer Affairs with a state mental health authority nationally and the first peer support agency (PSA) in NH, both in the late 1980's. The system continues to evolve, as evidenced by the support of the BBH Office of Consumer and Family Affairs, assisting with peer services and training for the state.

Federal block grant funds (57%) and state general funds (43%) comprise the NH peer support agencies' budgets, which are monitored by the BBH. In turn, the PSAs are the recipients of nearly 65% of the State's total MHBG award. Some peer support agencies have been successful at accessing additional funding through such sources as the United Way and the Community Development Block Grant.

For 2014, 681 PSA members and guests were served statewide.

The Peer Support Agencies are discussed more fully in Section 16: Recovery.

The **State Behavioral Health Advisory Council (BHAC)** is 100% supported by the grant, which, at a minimum, provides staff, operational support and cost-of-participation support for consumers and family members who would otherwise be unable to attend Council activities. The criteria for approving any additional funds include direct relevance to the duties of the Council, documentation of activity, and usually a tangible work product.

Modest projects (non-contractual) appropriate to system transformation across the age span are supported by the block grant, if approved and if funds are available, under the State Plan Advisory Project.

The grant also supports the **State Planner position** and activities of that office, which includes serving as liaison and subject matter expert to BHAC. The State Planner oversees the block grant, represents the Bureau at required national meetings, and provides or arranges the staff support, direct consultation, instrumental support, research materials and financial support for the Council activities and technical assistance for all block grant related initiatives. The Planner coordinates and collects multi-source data for the NRI National Profile and similar projects requested of the state, related to the SMHA.

New Hampshire's block grant expenditures are selected with an intentional emphasis on activities that are congruent with the **CMHA**, particularly in the areas of community tenure and alternatives to hospitalization. These planned efforts are described in Section 15: Crisis Services; and in Section 17: Community Living and the Implementation of Olmstead.

Although not included in the CMHA, the peer support model of Crisis Respite and its array of recovery supports for community inclusion may be contributors to reducing hospital

readmissions. Outcomes data for the Peer Support Agencies and further information about its Crisis Respite services are detailed elsewhere in the Application.

Services to **Children** are a focus of the State Plan. Two RFPs have releases planned:

1. First-Episode Psychosis training, and
2. MATCH training.

Planned efforts to support services to SED populations are detailed in Section 5: Evidence-Based Practices for Early Intervention; and in III.C.18: Children and Adolescents Behavioral Health Services.

U.S. DISTRICT COURT
DISTRICT OF NEW HAMPSHIRE

FEB 12 2014

FILED

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW HAMPSHIRE

Amanda D., et al., and others similarly situated, Plaintiffs, v. Margaret W. Hassan, Governor, et al., Defendants.	)	Civ. No. 1:12-cv-53-SM
United States of America, Plaintiff-Intervenor, v. State of New Hampshire, Defendant.	)	

CLASS ACTION SETTLEMENT AGREEMENT

I. Background and Introduction

A. This case involves the services, programs, and activities offered to thousands of persons with serious mental illness ("SMI") in the State of New Hampshire's mental health system. The State's mental health system includes the New Hampshire Hospital ("NHH") in Concord, NH, the Glencliff Home ("Glencliff") in Benton, NH, and services, programs, and activities at other sites, including but not limited to those offered by the community mental health programs and providers across the state.

B. In 2010 and 2011, the United States investigated the State of New Hampshire's mental health system to assess compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 *et seq.*, and its implementing regulations, 28 C.F.R. pt. 35, and Section 504 of the Rehabilitation Act of 1973 ("Rehabilitation Act"), 29 U.S.C. §§ 794 *et seq.*

C. On April 7, 2011, the United States issued its findings and conclusions in a letter sent to the State of New Hampshire.

D. The New Hampshire Disabilities Rights Center, Inc. ("DRC") had earlier conducted an investigation of the State's mental health system and sent its own findings letter to the State on November 2, 2010.

E. On February 9, 2012, six individuals filed a class action Complaint on behalf of themselves and others similarly situated (collectively, "Plaintiffs"), in the United States District Court for the District of New Hampshire, alleging New Hampshire's administration of its mental health system violates the rights of individuals with SMI under the ADA, 42 U.S.C. §§ 12101 *et seq.*, and the Rehabilitation Act, 29 U.S.C. §§ 794 *et seq.* In addition, the Plaintiffs alleged that the State and the other Defendant officials (collectively "the State" or "Defendants") have failed to comply with the requirements of the Nursing Home Reform Act ("NHRA"), 42 U.S.C. §§ 1396r *et seq.*

F. On March 27, 2012, the United States moved to intervene in the matter as Plaintiff-Intervenor, and on April 4, 2012, the Court granted its motion to intervene.

G. The State denies all violations alleged by the Plaintiffs and the United States. By entering into this Settlement Agreement, the State does not admit to the truth or validity of any claim or allegation made against it by Plaintiffs or the United States. Nothing in this Settlement Agreement shall be construed as an acknowledgement, an admission, or evidence of liability of the State under the ADA, the Rehabilitation Act, or the NHRA, or any federal or state law. This Settlement Agreement may not be used as evidence of Defendants' liability in any civil or criminal proceeding, except proceedings to enforce or implement this Settlement Agreement.

H. On September 17, 2013, the United States District Court certified a class comprised of:

> All persons with serious mental illness who are unnecessarily institutionalized in New Hampshire Hospital or Glencliff or who are at serious risk of unnecessary institutionalization in these facilities.
>
> At risk of institutionalization means persons who, within a two year period: (1) had multiple hospitalizations; (2) used crisis or emergency room services for psychiatric reasons; (3) had criminal justice involvement as a result of their mental illness; or (4) were unable to access needed community services.

I. The Joint Motion referenced in Section III will request that the certified class include all claims brought pursuant to the ADA, the Rehabilitation Act, and the NHRA.

J. In order to resolve ongoing issues between the Parties without the expense, risks, delays, and uncertainties of litigation, the Parties, have agreed to settle this matter on the terms and conditions set forth below in this Settlement Agreement. The purpose of this Settlement Agreement is to make a full and final compromise and settlement of any and all claims or allegations of the Plaintiffs and the United States set forth in the instant lawsuit.

II. Definitions

A. "Community mental health program or provider" or "CMHP" means an entity or its subcontractor that provides community mental health services to any individual with SMI in New Hampshire, pursuant to a contract with the State.

B. "Persons with serious mental illness" means individuals 18 years of age or older whom the State defines as having either severe mental illness or severe and persistent mental illness ("SPMI") pursuant to N.H. Code Admin. R. He-M 401, and those whom the State defines as "severely mentally disabled" pursuant to N.H. Rev. Stat. Ann. 135-C:2, XV.

III. Legal Foundation

A. The Parties agree to file this Settlement Agreement with the United States District Court for the District of New Hampshire along with a joint motion (the "Joint Motion") requesting that the Court enter the Settlement Agreement as an order of the Court. The Joint Motion will also request that the Court retain jurisdiction to enforce the Settlement Agreement, in accordance with Section X. The Parties will cooperate in drafting the Joint Motion and agree to provide their best efforts to support the Joint Motion at any hearing or argument.

B. The Parties acknowledge that the Court has jurisdiction over this case and authority to enter this Settlement Agreement and to enforce its terms in accordance with Section X.

C. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331; 28 U.S.C. § 1345; and 42 U.S.C. §§ 12131-12132.

D. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b).

E. This Settlement Agreement constitutes the entire, exclusive, integrated agreement of the Parties. It supersedes any previous understandings and agreements between the Parties concerning the subject matter of the instant lawsuit other than the Parties' Joint Stipulation Regarding Discovery and the Court-ordered Protective Order (Doc. 55).

F. The Parties represent and acknowledge that this Settlement Agreement is the result of extensive, thorough, and good faith negotiations. The Parties represent and acknowledge that the terms of this Settlement Agreement have been voluntarily accepted, after consultation with counsel.

G. Once entered by the Court, this Settlement Agreement is legally binding upon and judicially enforceable by the Parties, and it shall be applicable to and binding upon all of the Parties, including their officers, employees, successors, assigns, and agents, as well as the guardians of the class members (and their representatives, estates, next of kin, administrators, executors, and any other individual that has the authority to bring a claim or suit on their behalf regarding the claims and allegations raised in this lawsuit). Notwithstanding the foregoing, and any suggestion to the contrary, if any, in this Settlement Agreement, Defendants do not and cannot bind the New Hampshire General Court, which has the authority under the New

Hampshire Constitution and New Hampshire statutes to appropriate funds for the State's mental health system and to pass laws concerning the State's mental health system. Should the New Hampshire General Court enact laws or direct appropriations that limit the State's performance of any of its obligations under this Settlement Agreement, the provisions of Section X.F. shall apply.

H. Should the Court deny the Joint Motion, the Parties agree to work cooperatively and in good faith to modify any terms of this Settlement Agreement the Court may find objectionable and resubmit a Joint Motion and revised Settlement Agreement. If the Parties are unable to reach agreement on the issues raised by the Court through negotiation, the Parties agree to enter into mediation upon the request of any Party. If, after mediation, a modified Settlement Agreement is not reached and/or the Parties are unable to obtain the approval of the Settlement Agreement by the Court, this and any modified Settlement Agreement shall become null and void and the litigation shall proceed. This provision of the Settlement Agreement is binding and effective immediately upon all Parties signing this Agreement.

IV. Intent of the Parties

A. The Parties are committed to compliance with the ADA, 42 U.S.C. §§ 12101 *et seq.*, the Rehabilitation Act, 29 U.S.C. §§ 794 *et seq.*, the NHRA, 42 U.S.C. §§ 1396r *et seq.*, and related laws.

B. According to the United States Department of Justice's regulations, 28 C.F.R. § 35.130(d) in particular, the ADA requires, among other provisions, that, to the extent the State offers services, programs, and activities to qualified individuals with disabilities, such services, programs, and activities will be provided in the most integrated setting appropriate to meet their needs.

C. The Parties recognize and support the purposes of the ADA to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities. 42 U.S.C. § 12101(a)(7).

D. The general observations and statements of intent in this Section IV are made without prejudice to the right of any Party to assert either their support for or alternative interpretations of the relevant laws in the event the Settlement Agreement is vacated and/or this matter is reinstated on the Court's trial docket. The Parties also reserve their right to offer alternative interpretations of the relevant laws in any other matter, and none of the statements in this Section IV may be used as evidence in any other matter.

V. Substantive Provisions

A. In order to comply with this Settlement Agreement, the State shall develop and implement the services set forth below in this Settlement Agreement. The services may be provided directly by the State or through contracts with CMHPs.

B. Target Population

1. The Target Population for the community services described in this Agreement is the subset of adults within the State who have SMI, and who are institutionalized or at serious risk of institutionalization at NHH or Glencliff (collectively, hereinafter "individuals"). SMI, as used herein, includes individuals whom the State defines as having either SMI or SPMI pursuant to N.H. Code Admin. R. He-M 401, and those whom the State defines as "severely mentally disabled" pursuant to N.H. Rev. Stat. Ann. 135-C:2, XV.

2. The first priority for receipt of services and supports will be given to individuals who reside at NHH or Glencliff.

3. The second priority for receipt of services and supports will be given to the following individuals within the target population due to their serious risk of institutionalization:

   (a) individuals who have been admitted two or more times to NHH within the last two years;

   (b) individuals who have used crisis or emergency services for psychiatric reasons within the last two years;

   (c) individuals who have had criminal justice involvement as a result of their mental illness in the last two years;

   (d) individuals who were unable to access needed community services within the last two years; and

   (e) individuals who reside at the Transitional Housing Services programs ("THS") or who have resided at THS within the last two years.

4. The State will allocate services and supports under this Agreement consistent with these priorities.

C. Crisis Service System

1. The State will develop a crisis system that:

   (a) is available 24 hours per day, seven days per week;

   (b) provides timely and accessible services and supports to individuals with mental illness (including those with co-occurring substance abuse disorders) who are experiencing a mental health crisis;

(c) stabilizes individuals as quickly as practicable and assists them in returning to their pre-crisis level of functioning;

(d) provides interventions to avoid unnecessary hospitalization, incarceration, and/or Designated Receiving Facility, Acute Psychiatric Residential Treatment Program, emergency room, or nursing home admission;

(e) provides services and supports at the site of the crisis, including at the individual's residence; and

(f) promptly assesses individual needs, identifies the services and supports that are necessary to meet those needs, and connects the individual to those services and supports in a timely manner.

2. Crisis System Components

(a) Mobile Crisis Teams

i. The State will develop and implement measures to ensure that mobile crisis teams:

a. are available 24 hours per day, seven days per week;

b. are composed of clinicians trained to provide behavioral health emergency services and crisis intervention services, and also include at least one peer specialist and one on-call psychiatrist;

c. are able to respond to individuals 24 hours per day, seven days per week onsite in their homes and in other natural environments and community settings where crises arise, including in crisis apartments described more fully below;

d. are able to offer services and supports via telephone and, whenever necessary, consistent with legitimate safety concerns, meet face-to-face to de-escalate crises without removing the individuals from their homes and/or community programs;

e. are able to provide services and supports until the crisis subsides, up to seven days following the onset of the crisis;

f. may provide, in their discretion, services and supports to individuals beyond the immediate crisis; and

g. are able to work with law enforcement personnel to respond to individuals in mental health crisis who come into contact with law enforcement.

ii. For individuals served by an Assertive Community Treatment ("ACT") team, described more fully below, the ACT team shall serve as their mobile crisis team.

iii. The State's network will have three mobile crisis teams that are able to respond onsite to any individual crisis within one hour from the time of contact within three Mental Health Regions, including Region 4 (Concord), Region 7 (Manchester), and Region 6 (Nashua). In all other regions, the State shall, at a minimum, maintain its current crisis system, including existing crisis beds or implement mobile crisis teams.

iv. By the time each mobile crisis team becomes operational consistent with the requirements of this section and the implementation timelines in section V.C.3 below, each team will have available to it at least four community crisis apartment beds, with no more than two beds per crisis apartment.

(b) Community Crisis Apartments

i. Consistent with its Ten-Year Plan, the State will develop and implement the measures set forth below to expand short-term community crisis beds and to involve peers in providing crisis services and supports. These measures are in addition to crisis apartments that already have been established, which will be maintained by the State.

ii. As an alternative to hospitalization and/or institutionalization, the State will expand its community network of crisis apartments in the regions served by the mobile crisis teams described above, where individuals can stay for a limited time to receive crisis services and interventions in the community before returning home. In all other regions, the State shall, at a minimum, maintain its current crisis system, including existing crisis beds, or implement mobile crisis teams.

iii. Crisis apartments will be operated with sufficient clinical support and oversight, and peer staffing, as is reasonably necessary to prevent unnecessary institutionalization. Each crisis apartment will have peer staff and clinical staff available to be onsite, 24 hours per day, seven days per week, whenever necessary, to meet individualized needs.

iv. Individual stays at a crisis apartment will be limited to seven days.

v. The crisis apartments will have sufficient dedicated staff capacity to meet the needs of the individuals served at each apartment.

vi. Each crisis apartment will provide transportation for individuals from the site of the crisis to the apartment, and to their home or other residential setting after stabilization has occurred.

3. Implementation of Crisis Service System

(a) By June 30, 2015, the State will add mobile crisis capacity and crisis apartments in Mental Health Region 4 (Concord) that meet the standards set forth above in Section V.C.2.

(b) By June 30, 2016, the State will add mobile crisis capacity and crisis apartments in Mental Health Region 7 (Manchester) that meet the standards set forth above in Section V.C.2.

(c) By June 30, 2017, the State will add mobile crisis capacity and crisis apartments in Mental Health Region 6 (Nashua) that meet the standards set forth above in Section V.C.2.

(d) The State shall maintain its current crisis services, or implement mobile crisis teams, in all other regions.

D. Assertive Community Treatment ("ACT")

1. Consistent with its Ten-Year Plan, the State will develop and implement the measures set forth below to expand ACT.

2. ACT Team Components

The State will develop and implement measures to ensure that ACT teams:

(a) are available 24 hours per day, seven days per week, with on-call availability from midnight to 8:00am, consistent with Section V.D.2(b);

(b) are able to deliver comprehensive, individualized, and flexible services, supports, treatment, and rehabilitation to people 24 hours per day, seven days per week in a timely manner as needed, onsite in their homes and in other natural environments and community settings, or alternatively, via telephone where appropriate to meet the needs of the individual;

(c) offer services, supports, treatment, and rehabilitation that are customized to an individual's needs and vary over time as needs change; these may include case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services, supports, treatment, and rehabilitation critical to allow the individual a reasonable opportunity to live independently in the community;

(d) are composed of a multi-disciplinary group of between 7 and 10 professionals, including, at a minimum, a psychiatrist, a nurse, a Masters-level clinician (or functional equivalent therapist), functional support worker, and a

peer specialist; the teams also will have members who have been trained and are competent to provide substance abuse support services, housing assistance, and supported employment; to accommodate geographic concerns in Regions 1, 2, and 5, teams may employ up to 12 members per ACT Team;

(e) ordinarily serve no more than 10 people per ACT team member (excluding the psychiatrist); if circumstances unique to New Hampshire require a team to serve more than 12 people per ACT team member, the State will create an additional ACT team to meet the need for services within six months, provided the team in question is, at that time, still serving more than 12 people per ACT team member; no more than 70 people will be served per 0.5 FTE psychiatrist;

(f) consistent with legitimate safety concerns, are able to offer services, supports, treatment, and rehabilitation face-to-face in a timely manner to de-escalate crises, until the crises subside, without removing the individuals from their homes and/or community programs; and

(g) are able to work with law enforcement personnel to respond to people in mental health crisis who come into contact with law enforcement.

3. Implementation of Assertive Community Treatment

(a) By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth above in Section V.D.2.

(b) By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team.

(c) By June 30, 2015, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2, with the capacity to serve at least 1,300 individuals in the Target Population at any given time.

(d) By June 30, 2016, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2, for an additional 200 people, with the capacity to serve at least 1,500 individuals in the Target Population at any given time.

(e) By June 30, 2017, the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but unavailable, specifying the Mental Health Region in which the individuals reside, and, to the extent it has not already done so, develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future.

E. Housing

1. Supported Housing

Consistent with its Ten-Year Plan, the State will develop and implement the measures below to ensure that supported housing meets individuals' needs:

(a) supported housing will be permanent housing with tenancy rights, where obtaining tenancy rights is not conditioned on individuals' participation in treatment or compliance with mandatory programmatic criteria; supported housing includes support services to enable individuals to attain and maintain integrated affordable housing, and includes support services that are flexible and available as needed and desired;

(b) all new supported housing created pursuant to this Settlement Agreement will be scattered-site supported housing, with no more than two units or 10 percent of the units in a multi-unit building with 10 or more units, whichever is greater, and no more than two units in any building with fewer than 10 units known by the State to be occupied by individuals in the Target Population;

(c) all new supported housing created pursuant to this Settlement Agreement will be single occupancy or single family housing unless the individual prefers to live with a roommate; if the individual chooses to live with a roommate, there will be a private bedroom for each person; the individual will be able to select his or her roommate;

(d) "supported housing," as used in this Settlement Agreement, includes housing supported by subsidies from any source, including State-funded rental subsidies through the State's Bridge Subsidy Program or funding from the U.S. Department of Housing and Urban Development ("HUD"), coupled with other ongoing mental health and tenancy support services provided by ACT, case management, and/or a housing specialist.

2. Community Residences

(a) Notwithstanding the provisions regarding supported housing set forth above, the State may prospectively transition individuals with mental illness and complex health care needs, who could not be cost-effectively served in supported housing, into a community setting serving up to four persons with complex health care needs where the community home provides or coordinates the delivery of needed health care services, supports, and treatments. Such community settings may include enhanced family care, supported roommate, or non-congregate community residences. Consistent with the provisions of subparagraph V.E.2(b) below, the cost of these community settings shall not exceed an annual budget of

$100,000 per person or $400,000 per community setting.[1] This paragraph does not require the State to remove individuals currently in community residences that house more than four persons. Utilizing the resources and expertise within the State Bureau of Elderly and Adult Services and/or any other appropriate agency, the State will develop and implement, consistent with the individual's or guardian's desires, individual transition plans, as set forth in this Settlement Agreement, for any individual placed in a community setting.

(b) The implementation of community residences for medically complex individuals described in subparagraph V.E.2(a) above and Sections V.E.3(g) – (j) below, may be accomplished through openings in or expansion of existing community service capacity or by a vendor selected after issuing a Request for Proposals ("RFP") in 2014. The service provider or RFP vendor shall have a budget cap of $100,000 per person served or $400,000 per community setting. If existing programs or acceptable vendors are not located through the 2014 RFP process, the State will, subject to the budget cap, continue its efforts to transition medically complex individuals to community settings through openings in or expansion of existing programs and will issue a second RFP in 2015. If, after the completion of the second RFP process, the State remains unable to develop the capacity to serve at least four individuals with SMI and complex health care needs by January 1, 2016, the State shall reallocate the General Fund share of the funding described above to fund additional supported housing, supported employment, mobile crisis, and/or ACT. The reallocation of funds shall be the General Fund amount of $50,000 for each of the 16 community settings described in Sections V.E.3(g)-(i) below, or the prorated share thereof, if some, but not all, of the community capacity is developed or utilized.

3. Implementation of Housing

(a) By June 30, 2014, the State will have 240 supported housing units that meet the standards set forth above in Section V.E.1.

(b) By December 31, 2014, the State will create an additional 50 supported housing units that meet the standards set forth above in Section V.E.1, for a total of 290 supported housing units.

(c) By June 30, 2015, the State will create an additional 50 supported housing units that meet the standards set forth above in Section V.E.1, for a total of 340 supported housing units.

(d) By June 30, 2016, the State will create an additional 110 supported housing units that meet the standards set forth above in Section V.E.1, for a total of 450 supported housing units.

[1] "Community setting" costs do not include routine medical, mental health, or waiver services provided under the State Medicaid program.

(e) By June 30, 2017, the State will make all reasonable efforts to apply for and obtain HUD funding for an additional 150 supported housing units for a total of 600 supported housing units.

(f) By January 1, 2017, the State will identify and maintain a waitlist of all individuals within the Target Population requiring supported housing services, and whenever there are 25 individuals on the waitlist, each of whom has been on the waitlist for more than two months, the State will add program capacity on an ongoing basis sufficient to ensure that no individual waits longer than six months for supported housing.

(g) By June 30, 2015, the State will have the capacity to serve in the community four individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing, consistent with the provisions set forth above in Section V.E.2.

(h) By June 30, 2016, the State will have the capacity to serve in the community six additional individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing, consistent with the provisions set forth above in Section V.E.2.

(i) By June 30, 2017, the State will have the capacity to serve in the community six additional individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing consistent with the provisions set forth above in Section V.E.2.

(j) By June 30, 2017, the State will identify and maintain a list of all individuals with mental illness and complex health care needs residing at Glencliff who cannot be cost-effectively served in supported housing and, to the extent it has not done so already, develop an effective plan for providing sufficient community-based residential supports for such individuals in the future.

F. Supported Employment

1. The State will, through its community mental health providers, deliver supported employment services in accordance with the Dartmouth evidence-based model. Supported employment services include providing individualized assistance in identifying, obtaining, and maintaining integrated, paid, competitive employment. Consistent with the Dartmouth model, supported employment services should be provided in the amount, duration and intensity to allow the opportunity for individuals to work the maximum number of hours in integrated community settings consistent with their individual treatment plans. Services offered should include job development, job finding, job carving, job customization, co-worker and peer supports, self-employment supports, re-employment supports, time management training, benefits counseling, job coaching, transportation, workplace

accommodations, assistive technology assistance, specialized on-the-job training, and, if not already provided, individually-tailored case management and supervision.

2. Implementation of Supported Employment

(a) By October 1, 2014, all individuals receiving ACT services will have access to supported employment services from employment specialists on their ACT teams.

(b) By June 30, 2014, the State will increase its penetration rate of individuals with SMI receiving supported employment services by two percent over the 2012 penetration rate of 12.1 percent reported to the Substance Abuse and Mental Health Services Administration (SAMHSA), to 14.1 percent of eligible individuals with SMI.

(c) By June 30, 2015, the State will increase its penetration rate of individuals with SMI receiving supported employment services by an additional two percent, to 16.1 percent of eligible individuals with SMI.

(d) By June 30, 2016, the State will increase its penetration rate of individuals with SMI receiving supported employment services by an additional two percent, to 18.1 percent of eligible individuals with SMI.

(e) By June 30, 2017, the State will increase its penetration rate of individuals with SMI receiving supported employment services by an additional 0.5 percent, to 18.6 percent of eligible individuals with SMI.

(f) By June 30, 2017, the State will identify and maintain a list of individuals with SMI who would benefit from supported employment services, but for whom supported employment services are unavailable, and, to the extent it has not already done so, develop an effective plan for providing sufficient supported employment services to ensure reasonable access to eligible individuals in the future.

G. Family and Peer Supports

1. The State will have an effective family support program to meet the needs of families of individuals throughout the State. The family support program will teach families skills and strategies for better supporting their family members' treatment and recovery in the community. The family support program will include training on identifying a crisis and connecting individuals in crisis to services and supports, as well as education about mental illness and available ongoing community-based services and supports. Family supports can be provided in individual and group settings.

2. The State will have an effective peer support program to help individuals develop skills in managing and coping with symptoms of illness, in self-advocacy, and in identifying and using natural supports. The peer support program will train peers who have personal experience with mental illness and recovery to deliver the peer services and supports. Peer supports can be provided in individual and group settings, in person, or by phone.

3. Implementation of Family and Peer Supports

(a) By June 30, 2014, the State will maintain family support services statewide consistent with the provisions set forth in Section V.G.1. Notwithstanding anything to the contrary in this Agreement, the State's current contract with its vendor for the provision of family support services (or a substantially similar agreement with another entity offering similar services) satisfies the requirements of this subsection.

(b) By June 30, 2014, the State will have a system of peer support services, which are offered through peer support centers, open a minimum of eight hours per day, five-and-a-half days per week, or the hourly equivalent thereof, in each Mental Health Region in the State, consistent with the provisions set forth above in Section V.G.2.

VI. Transition Process

A. Transition Planning and Transition Plans for People in Facilities

1. The State, through its community mental health providers and/or other relevant community providers, will provide each individual in NHH and Glencliff with effective transition planning and a written transition plan as set forth below. The written transition plan may be incorporated into the individual's discharge summary and paperwork from NHH or Glencliff.

2. Transition planning will:

(a) begin with the presumption that with sufficient services and supports, individuals can live in an integrated community setting;

(b) be developed and implemented through a person-centered planning process in which the individual has a primary role and is based on the principle of self-determination;

(c) include persons who have the linguistic and cultural competence to serve the individuals;

(d) be based on each individual's needs and not on the availability, perceived or actual, of current community resources and capacity; and

(e) not exclude any individual from consideration for community living based solely on his or her level of disability.

3. The transition planning process will result in an effective written transition plan that:

   (a) sets forth in reasonable detail the particular services and supports, including their scope, frequency, and duration, that each individual needs in order to successfully transition to and live in an integrated community setting, whether or not a suitable community setting is currently available; such services and supports may include housing, transportation, staffing, mental health care, health care, and other professional services;

   (b) sets forth which persons and/or organizations have responsibility for delivering needed services and supports before, during, and after the transition;

   (c) sets forth the date the transition should occur, as well as the timeframes for completion of needed steps to effect the transition;

   (d) sets forth any barriers to transition to an integrated community setting and how to overcome them, if possible; and

   (e) sets forth a post-transition schedule of monitoring visits by community mental health providers to the new community setting to assess whether the needs of the individual are being met.

4. In developing the transition plans, the State will make all reasonable efforts to avoid placing individuals into nursing homes or other institutional settings. Before adopting a transition plan that places an individual in a nursing home or other institutional setting, the State must consider all possible alternatives and describe the steps it took to implement the alternatives. If the final transition plan results in placement of the individual in a nursing home or other institutional setting, the plan shall be used to identify the barriers to placement in a more integrated setting and describe steps the State will take to address the barriers.

5. Similarly, the State will make all reasonable efforts to avoid admitting persons with developmental disabilities to NHH, except where individuals' acute psychiatric needs cannot be addressed in a more integrated service or treatment setting. If such individuals are admitted, the State will document the basis for their admission and immediately begin transition planning on their behalf, consistent with the requirements of Section VI.

6. The State will create a central team to assist in addressing and overcoming any of the barriers to discharge identified during transition planning and/or set forth in the transition plans. The central team will include personnel with experience and expertise in how to successfully resolve barriers to discharge including ACT team

members, supported housing providers, and peers who work for community providers.

7. The State will design and implement a system for in-reach activities. The in-reach system will include meetings between individuals in NHH and Glencliff and the community mental health program or provider from their respective regions to develop relationships of trust and to actively support these individuals in transitioning to the community. The in-reach system will also include opportunities for meetings with the State and to obtain the State's assistance in identifying and addressing barriers to community living. In conducting in-reach:

   (a) the State, through the community mental health program or provider will, among other things:

      i. explain fully the benefits of community living, including ACT, supported housing, and supported employment;

      ii. facilitate visits to community settings and accompany residents of these facilities on these visits;

      iii. explore and work to address the concerns of any individuals who decline the opportunity to move to a community setting or who are ambivalent about moving to a community setting;

      iv. review with reasonable regularity (at least quarterly), these individuals' housing preferences and interest in community living; and

   (b) the State will:

      i. offer to meet with any individual and/or their guardian, if one has been appointed, that continues to express reservations about living in the community, to ensure that the individual and guardian fully understand the community living options; and

      ii. propose individualized strategies to address the individual's or guardian's concerns, provide opportunities to visit community programs, and facilitate conversations with providers about the services that will be available in the community and with individuals who have successfully transitioned from institutional settings to living in the community.

8. If an individual and/or guardian is opposed to a community setting, the State will document the steps taken to fully inform them of the community options and document the particular concerns that the individual and/or guardian has with moving to the community. The State will develop individualized strategies to address the individual's or guardian's concerns, to be discussed at future meetings. The State will

establish a system for re-contacting these individuals and/or their guardians regularly, and at least annually, regarding their interest in community alternatives.

9. The State will identify individuals at NHH or Glencliff within the Target Population who have a dual diagnosis of developmental disability and mental illness and provide each individual with effective transition planning and a written transition plan as set forth in this section, using services and supports available from both the developmental disabilities and mental health services delivery systems to meet their needs.[2]

10. Any individual referred to Glencliff, whether from the community, NHH, or any other facility or hospital, will be reviewed pursuant to Pre-Admission Screening and Resident Review (PASRR), to determine if the individual has a developmental disability and/or mental illness and whether that individual's needs could be met in the community with adequate and appropriate services and supports. These PASRR reviews will be conducted by qualified developmental disability and/or mental health professionals. If the PASRR review determines that the individual's needs could be met in a community setting, the individual will be referred promptly to the appropriate Area Agency and/or Community Mental Health Center. Providers of developmental and mental health services will discuss and develop community options with the individual and will offer the individual appropriate services and supports in an integrated community setting.

B. Implementation of the Transition Planning Process

1. By February 1, 2014, the State will begin implementation of the provisions set forth above in Section VI.A., to be substantially completed by June 30, 2014.

VII. Quality Assurance and Performance Improvement

A. The State will develop and implement a quality assurance and performance improvement system, emphasizing the use of client-level outcome tools and measures, to ensure that existing community-based services described in the Agreement are offered in accordance with the individualized transition process set forth above, and that the individuals served are provided with the State's services and supports they need to ensure their health, safety, and welfare. The goal of the State's system will be to ensure that all mental health and other services and supports funded by the State are of good quality and are sufficient to provide reasonable opportunities to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization.

[2] This paragraph is intended by the Parties to address the needs of individuals with intellectual and developmental disabilities and those with acquired brain injuries who also have SMI. Therefore, as used in this section, "developmental disabilities" means those individuals eligible for services under N.H. Rev. Stat. Ann. 171-A and 137-K, and their implementing regulations, N.H. Code Admin. R. He-M 503, 522.

B. Provider Network

1. The State will ensure an adequate network of qualified providers with the expertise and competency to effectively deliver the services and supports set forth in this Settlement Agreement.

2. Program specifications for the services and supports set forth above in this Settlement Agreement will be developed by the State with input from the Plaintiffs and the United States.

3. The State or Managed Care Organizations ("MCOs") will certify, and re-certify every two years, that providers of the community services set forth above are operating in compliance with all provider network requirements, and delivering services consistent with relevant program specifications. If a provider is not in compliance with these requirements, a corrective action plan will be developed, with timelines for implementation, oversight and monitoring by the responsible State agency.

4. The State will execute performance-based contracts with CMHPs, either directly or through its managed care agents, that specifically describe expectations with regard to the individual outcomes to be achieved and the services and supports to be provided to individuals consistent with the provisions of this Settlement Agreement.

C. Quality Assurance System

1. The State will develop and implement a quality assurance review system that will regularly collect, aggregate, and analyze data related to transition efforts, including but not limited to information related to both successful and unsuccessful transitions, as well as the problems or barriers to serving and/or keeping individuals in the most integrated setting. Such problems or barriers may include, but not be limited to insufficient or inadequate housing, community resources, mental health care, crisis services, and supported employment. The State will review this information and use it to develop plans to reduce the incidence of such problems or barriers and implement prompt and effective measures, utilizing the services developed through this Agreement and other existing services, to overcome, if possible, the problems and barriers identified.

2. The State will regularly review community providers and programs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, resource-targeting, and implementing needed remedies. The State will develop and implement effective measures that work to address any gaps or weaknesses identified.

D. Quality Service Reviews

1. As part of the Quality Assurance System outlined in Section VII.C., the State will use Quality Service Reviews ("QSRs") to evaluate the quality of services and supports.

Through the QSR process, the State will collect information through a sample of face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life, as well as through review of individual treatment plans. Through the QSR process, the State will evaluate, among other things, whether individuals' needs are being identified, whether services and supports are meeting individuals' needs, and whether services and supports are designed around individuals' strengths and meeting individuals' goals.

2. The State will work collaboratively with the Plaintiffs and the United States to design a process (or adapt an existing process) for implementing QSRs and reporting on QSR findings. The State will work in good faith to obtain and consider recommendations of the Plaintiffs and the United States, but will have final decision-making authority on the process to be adopted.

3. The State will conduct QSR reviews of services and supports provided under this Settlement Agreement at least annually. The QSR review process will ensure statewide review of each service provision during the term of this Agreement.

4. The State will collect and analyze data from the QSRs and then use it to identify strengths and areas for improvement at the individual, provider, and systemwide levels; this will include issues related to barriers to meeting individualized needs in integrated community settings. The State will use the data from the QSRs to identify gaps and weaknesses, as well as areas of highest demand, to provide information for comprehensive planning, administration, and resource-targeting, to consider whether any areas are in need of improvement including whether additional community-based services and supports are necessary. The State will further use this information to develop and implement prompt and effective measures to utilize the services and supports developed pursuant to this Agreement, and other existing services, to address any areas in need of improvement and to ensure individuals have the opportunity to receive services in the most integrated setting.

E. Reporting

1. The State will provide to the Expert Reviewer (described below in Section VIII) and the Parties, on an annual basis, information:

   (a) identifying the number of people served in each type of service described in this Settlement Agreement;

   (b) detailing unmet needs using data gathered through the process set forth above in this section or the State's other quality assurance/improvement programs; and

   (c) detailing the quality of services and supports provided by the State and its community providers using data collected through the State's quality

assurance/improvement systems, including any data gathered during the QSR process.

2. Nothing in Section VII.E.1 is intended to expand the Expert Reviewer's functions as set forth in VIII.F. and VIII.K.

3. The Expert Reviewer will periodically convene meetings with the Parties and members of the State's mental health services team at mutually convenient times and locations for discussions on implementation of the Agreement. Prior to the meetings, the State will provide the Expert Reviewer, Plaintiffs and the United States with data regarding implementation consistent with section VIII.I.

VIII. Expert Reviewer

A. The Parties will jointly agree on an Expert Reviewer within 90 days of the execution of this Settlement Agreement. The Expert Reviewer will be independent and no Party or any employee or agent of any Party shall have supervisory authority over the Expert Reviewer's activities, reports, and/or recommendations.

B. The Expert Reviewer will have three functions. The Expert Reviewer may provide technical assistance as requested by the State to implement the provisions of this Settlement Agreement and to improve the State's mental health care system. The Expert Reviewer will mediate disputes between the Parties in accordance with Section X.D. The Expert Reviewer will assess and issue a public report to the Parties on the State's implementation of and compliance with the provisions of this Settlement Agreement.

C. In the event the Expert Reviewer resigns, or the Parties agree to replace the Expert Reviewer, the Parties will: (a) confer within 30 days of the resignation or agreement by the Parties to replace the Expert Reviewer, and (b) select a replacement and notify the Court of their joint selection. If the Parties are unable to agree on a replacement Expert Reviewer, the Parties will each submit to the Court, within 14 days of the conference, the names and *curricula vitae* of up to four individuals (up to two from the State and two from the Plaintiffs and the United States) as candidates for the Expert Reviewer position. The Parties will request that the Court select the Expert Reviewer from among those nominated.

D. The Expert Reviewer will have the authority and responsibility to independently observe, assess, review, and issue public reports to the Parties on the State's implementation of and compliance with the provisions of this Settlement Agreement. The Expert Reviewer's assessments will provide the Parties with guidance on the State's efforts to implement the terms of this Settlement Agreement, ways to improve implementation, and other suggestions to enhance the State's mental health system. The Expert Reviewer's suggestions and assessments may not, however, modify any provision of this Settlement Agreement, absent an order of the Court. All Parties reserve their right to object to and contest any such order of the Court.

E. The Expert Reviewer will review the services and supports provided to individuals in the State's mental health system and will devote such time as is necessary to fulfill the duties and

responsibilities of the Expert Reviewer pursuant to this Settlement Agreement, consistent with the budget allocated for his or her services. The Expert Reviewer may retain consultants to assist in carrying out his or her duties and responsibilities, to the extent funds are available in the Expert Reviewer's budget. In no event will the State be obligated to reimburse the Expert Reviewer for any fees, costs, or expenses that exceed the amount of the Expert Reviewer's maximum budget, as defined in Section VIII.P., except that the Parties may jointly agree to an increase in the Expert Reviewer's budget. Upon the request of a Party, the Court may approve, in extraordinary circumstances, an increase in the budget if there is an issue related to noncompliance that requires an unanticipated degree of additional work by the Expert Reviewer, limitations on the availability of information from the State necessary for the Expert Reviewer to fulfill his/her duties and responsibilities for assessing compliance, or a request by the Court for additional assistance or information necessary to ensure compliance and enforcement of its orders. In the event that a request is made to the Court for an increase in the budget of the Expert Reviewer, any Party may object and request a hearing on the issue.

F. The Expert Reviewer will evaluate implementation of and compliance with the terms of the Settlement Agreement. These evaluations may include: onsite inspection of facilities and programs responsible for the delivery of services under the Agreement; interviews with staff, class members, guardians, and other stakeholders; data collection; and document and record review, including transition planning where the individual's team identified barriers to discharge or recommended placement in another institutional setting. The evaluations will include review and assessment of the status of individual transitions and the adequacy and quality of individualized services and supports.

G. The Expert Reviewer and consultants will have full access, with reasonable notice, to the people, places, and documents that are necessary to assess the State's compliance and/or implementation efforts with this Settlement Agreement, to the extent they are within the State's custody or control, including: (1) individuals receiving and/or offered services in the State's mental health system; (2) residences, facilities, buildings, services, programs, and activities in the State's mental health system, as well as the persons involved in providing services and supports at these locations; and (3) pertinent documents, records, and other materials, including departmental and/or individual residential medical and other records, associated with services, programs, and activities for individuals receiving and/or offered services in the State's mental health system. The Expert Reviewer shall exercise its access to State employees, facilities, and documents, in a reasonable manner in order to minimize disruption to State operations. The State has no obligation to require any individual or entity that is not a State employee, contractor, subcontractor, grantee, or provider of State-funded services to speak with the Expert Reviewer and/or his or her staff or consultants.

H. The Expert Reviewer may communicate *ex parte* with the Court at its request, or with any of the Parties, including counsel, employees, agents, contractors, and all others working for or on behalf of the State to implement the terms of this Settlement Agreement, as well as anyone else the Expert Reviewer and any consultants deem necessary for completing the duties and responsibilities of the Expert Reviewer pursuant to this Settlement Agreement.

I. The State will maintain sufficient records and collect sufficient data to document that the requirements of each element of this Settlement Agreement are being properly implemented, including data on the location and point of contact for individuals in crisis. The State will provide such data and records to the Expert Reviewer in a timely manner upon the Expert Reviewer's request. The Expert Reviewer may make requests for additional information that are reasonable and not unduly burdensome for purposes of evaluating compliance with the Settlement Agreement. All records and data shared with the Expert Reviewer will be provided by the State to the Plaintiffs and the United States in a timely manner.

J. The Expert Reviewer may confer regularly and informally with the Parties on matters relating to implementation efforts and compliance. The Expert Reviewer will have the authority to convene meetings at mutually agreeable times and places.

K. Twice a year, or more often if deemed appropriate by the Expert Reviewer, the Expert Reviewer will submit to the Parties a public report on the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

L. In accordance with Section X.D., the Expert Reviewer will mediate any dispute regarding the implementation or enforcement of, or compliance with, this Settlement Agreement.

M. The Expert Reviewer may testify in this case with regard to any matter relating to the implementation or enforcement of, or compliance with, the Settlement Agreement, including, but not limited to, the Expert Reviewer's observations, findings, and recommendations in this matter. Expert Reviewer testimony will be inadmissible in any other proceeding or matter, excluding any proceeding related to the implementation or enforcement of, or compliance with, this Settlement Agreement.

N. The Expert Reviewer shall not be subject to formal discovery, including but not limited to depositions, requests for documents, requests for admissions, interrogatories, or other disclosures.

O. Neither the Expert Reviewer nor any consultant shall be liable for any claim, lawsuit, or demand arising out of their activities under this Settlement Agreement. However, this paragraph does not apply to any proceeding for payment of contracts or subcontracts into which they have entered in connection with their work under this Settlement Agreement.

P. The Expert Reviewer's reasonable fees, costs, and expenses (including costs of consultants or subcontractors, if any) will be borne by the State, up to a maximum budget of $175,000 per calendar year. In the event the Expert Reviewer does not use all of the funds in a particular year, any unused funds may be applied in a future year. The Expert Reviewer will invoice the State monthly for his or her fees, costs, and expenses. The monthly statements shall include daily records of time spent and expenses incurred, and shall include copies of supporting documentation including receipts. Monthly statements shall be provided to all Parties. The State and the Expert Reviewer will agree in advance on the scope and cost of any technical assistance

that the State requests and the Expert Reviewer provides. Any objection to the monthly statement shall be submitted to the Court within 21 days of receipt of a monthly statement. The Court retains the authority to resolve any dispute that may arise regarding costs, fees, or expenses charged by the Expert Reviewer. The State shall make payment to the Expert Reviewer within 30 days of receipt of the invoice, or upon order of the Court in the event there is a dispute regarding the Expert Reviewer's fees, costs, or expenses.

Q. The Expert Reviewer shall not enter into or be offered any contract with the State, the Plaintiffs, the United States Department of Justice, or their counsel, in any litigation or investigation, while serving as the Expert Reviewer, unless agreed to by all Parties. If the Expert Reviewer resigns, the former Expert Reviewer may not enter into any contract with the State, or their counsel, in any litigation or investigation on a matter in New Hampshire during the pendency of this Settlement Agreement without the written consent of the Plaintiffs and the United States. Similarly, the former Expert Reviewer may not enter into any contract with the Plaintiffs, the United States Department of Justice, or their counsel, in any litigation or investigation on a matter in New Hampshire during the pendency of this Settlement Agreement without the written consent of the State.

IX. General Provisions

A. Each Party to this Settlement Agreement represents and warrants that the person who has signed this Settlement Agreement on behalf of his or her entity is duly authorized to enter into this Settlement Agreement and to bind that Party to the terms and conditions of this Settlement Agreement.

B. All individual Defendants are officers of the Executive Branch of the State of New Hampshire and are sued only in their official capacities.

C. The State has authority and responsibility for the operation of NHH, Glencliff, and the rest of its mental health system.

D. The Plaintiffs and the United States may make reasonable requests for documents or data not otherwise produced to the Expert Reviewer, provided the requests are not unduly burdensome to the State and are relevant to the implementation of this Settlement Agreement. Such requests will be made in the first instance to an individual identified by the State to serve as the point of contact for such requests. If that individual concludes such requests are relevant to the implementation of this Settlement Agreement and are not unduly burdensome, he or she will provide the documents or data in a timely manner. If that individual concludes the information is not relevant or is unduly burdensome, the request may be referred to the Expert Reviewer who will make a recommendation after conferring with the Parties. Nothing in this paragraph is intended to apply to document requests by, or production to, the DRC in cases of individual representation of class members or investigations.

E. The Parties and the Expert Reviewer will be responsible for maintaining the confidentiality of records in their possession. Submissions to the Court that contain identifying

information of individuals (such as their full name, address, or social security number) shall be filed with the Court consistent with the Protective Order already entered in this matter.

F. When necessary to fulfill their ethical responsibilities and monitor the implementation of this Settlement Agreement, the Plaintiffs and the United States will have reasonable access to relevant people, places, and information necessary to assess the State's compliance and/or implementation efforts with this Settlement Agreement, including: (1) individuals receiving and/or offered services in the State's mental health system; and (2) residences, facilities, buildings, services, programs, and activities in the State's mental health system, as well as the persons involved in providing services at these locations. The Plaintiffs and the United States will provide reasonable advanced notice of any monitoring visit or inspection. The Defendants may elect to have counsel present at any such visit or inspection in which the Plaintiffs or the United States intend to interview State employees for purposes of monitoring this Settlement Agreement. Where there is an emergency situation that presents an immediate threat to the life, health, or safety of individual(s), that is not being adequately handled by the State, the Plaintiffs and the United States will not be required to provide the State with notice of any such visit or inspection. Any request for documents or data under this Section not otherwise produced to the Expert Reviewer, shall comply with Section IX.D. Nothing in this Settlement Agreement shall limit access afforded to the DRC or the United States pursuant to any federal or state laws or other agreement(s).

G. The State agrees that it will not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the Plaintiffs' and the United States' investigations or in any monitoring activities related to this Settlement Agreement. The State agrees that it will timely and thoroughly investigate any allegations of retaliation in violation of this Settlement Agreement and, where necessary, take corrective actions for any retaliation identified through such investigations.

H. No person or entity is intended to be a third-party beneficiary of the provisions of this Settlement Agreement for purposes of any other civil, criminal, or administrative action. No person or entity may assert any claim or right as a beneficiary or protected class under this Settlement Agreement in any separate action. This Settlement Agreement is not intended to expand the right of any person or organization to seek relief against the State or their officials, employees, or agents.

I. The Court may modify this Settlement Agreement pursuant to Fed. R. Civ. P. 60, but all Parties reserve the right to object to any such modification. The Parties agree to first provide reasonable notice, meet and confer, and seek to reach agreement about any proposed modification. Any modification to this Settlement Agreement agreed to by the Parties shall be executed in writing by the Parties, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.

J. Upon full execution of this Settlement Agreement, all Parties agree that it may be filed electronically with the United States District Court for the District of New Hampshire, in conjunction with the filing of a Joint Motion as outlined in Section III.A.

K. During the pendency of this Settlement Agreement, the United States and members of the Plaintiff Class are barred from bringing a new action in federal or state court against the Defendants under the ADA, the Rehabilitation Act, or the NHRA for any claim or allegation set forth in the lawsuit. Nothing in this provision is intended to preclude individual appeals on PASRR decisions.

L. The United States and the State will bear the cost of their own fees and expenses incurred in connection with this case. The State agrees to pay Plaintiffs a total of $2,426,800 for all attorneys' fees, costs and monitoring in this case, except as provided in paragraph X.E. The total amount shall be paid in yearly installments in accordance with the following schedule: the first installment of $1,113,400 shall be paid 90 days from the Effective Date of this Agreement; the second installment of $1,113,400 shall be paid no later than 12 months from the due date of the first installment; the third installment of $75,000 shall be paid no later than 24 months from the due date of the first installment; the fourth installment of $75,000 shall be paid no later than 36 months from the due date of the first installment; and the fifth installment of $50,000 shall be paid no later than 48 months from the due date of the first installment. The Plaintiffs will file an assented-to motion for fees and expenses consistent with this paragraph and pursuant to Fed. R. Civ. P. 23(h) and L.R. 23.1(b)(4), and will not file any additional request for attorneys' fees in this matter except as provided in X.E.

M. This Settlement Agreement will become effective upon signature of all Parties and approval by the Court ("Effective Date"), except as provided by Section III.H. of this Settlement Agreement.

N. Provision of any information to the Expert Reviewer, Plaintiffs, or the United States pursuant to this Settlement Agreement will not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties. This paragraph is intended to confer the full protections offered by Fed. R. Evid. 502(d).

O. This Agreement may be executed in counterparts, each of which will be deemed an original, and the counterparts will together constitute one and the same agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.

X. Construction and Enforcement

A. Except where otherwise specified, the State will implement all provisions of this Settlement Agreement within 30 days of the Effective Date of this Settlement Agreement.

B. The Parties agree that insignificant or brief, temporary deviations from the requirements set forth in this Settlement Agreement do not constitute noncompliance with the Agreement.

C. Except as provided in Section X.F., and/or with the exception of a situation that poses an immediate and serious threat to the life, health, or safety of individuals covered by this Agreement to which the State is not adequately responding, if Plaintiffs or the United States believe that the State is failing or has failed to comply with any term(s) of this Settlement Agreement, the process contained in this Sections X.C.-E. constitutes the sole and exclusive

means to resolve disputes related to such claims of noncompliance with the terms of the Settlement Agreement.

1. Should an issue regarding the implementation or terms of this Settlement Agreement arise, the Party asserting the issue will confer with the other Parties and the Expert Reviewer in good faith in an effort to cure the issue. If informal resolution does not lead to complete and timely resolution, the Parties shall utilize the procedures set forth in Sections X.C.2-5.

2. A Party asserting a failure of the State to comply with this Settlement Agreement ("Complaining Party"), will give written notice ("Notice of Noncompliance") to the State that, with specificity, sets forth the details of the alleged noncompliance, including the specific provisions of this Settlement Agreement alleged to have been violated, and the reasons why the Complaining Party believes the provisions were violated.

3. Upon issuance of a written Notice of Noncompliance, the State will have 30 calendar days from the date of such written notice to respond, and to describe any steps that the State will take, if any, to cure the alleged noncompliance.

4. Following the State's response to the Notice of Noncompliance, the Complaining Party may either accept the State's response, or may request a conference to resolve the disagreement. A conference will be held within 14 calendar days of the request. At the conference, which may take place in person or, if any Party requests it, via telephone, the Parties agree to confer in good faith in an attempt to resolve their differences.

5. If these steps do not resolve the differences between the Parties, the Complaining Party may petition the Court to enforce the Settlement Agreement, in accordance with Section X.E.

D. With respect to any dispute or other matter regarding the implementation of the Settlement Agreement, any Party may request that the Expert Reviewer mediate this dispute or make a recommendation to address an implementation matter. The Parties agree that upon the request of any Party for mediation by the Expert Reviewer, all Parties will participate in mediation in good faith.

E. The Court shall have the power to enforce the Settlement Agreement and issue further orders as needed to ensure compliance. The Plaintiffs and the United States agree that they will not seek to enforce compliance with the terms of this Settlement Agreement through a motion for contempt, nor seek damages or penalties, in the first instance for any particular instance of alleged noncompliance. Any attorneys' fees or costs requested by Plaintiffs in connection with a petition to enforce the settlement will be reasonable. Such fees or costs will not be automatically awarded, but only after a hearing as to the propriety of such an award and its reasonableness. Defendants retain their rights to object to any such request.

F. The Governor and the other individual Defendants agree to request from the New Hampshire General Court, and make their best efforts to secure, the funding they believe is necessary to implement the terms of the Settlement Agreement. In the event the New Hampshire General Court fails to appropriate the requested funds and precludes the Defendants from substantially complying with one or more provisions of the Agreement, the Plaintiffs and the United States may withdraw their consent to this Settlement Agreement, and revive any claims otherwise barred by operation of this Settlement Agreement. In the event of a failure to appropriate requested funds, nothing in this paragraph is intended to prohibit Plaintiffs or the United States from enforcing, consistent with this Agreement, those provisions, and only those provisions, of the Settlement Agreement that have been adequately funded by the General Court, but with which the Defendants are nevertheless not in compliance.

G. Within 30 days of the filing of this Settlement Agreement with the Court, the State will identify for Plaintiffs and the United States an individual within the State to serve as a point of contact for the Plaintiffs, the United States, and the Expert Reviewer for purposes of implementation of this Settlement Agreement.

H. All provisions of this Settlement Agreement will have ongoing effect until the final dismissal of this action.

I. The Court shall retain jurisdiction of this action for all purposes until the State has complied with all provisions of this Settlement Agreement and maintained compliance with all provisions for a period of one year. The Parties anticipate that the State will have complied with all provisions of the Settlement Agreement within six years of its Effective Date and that the case will be dismissed with prejudice if compliance is achieved, consistent with this paragraph. The Parties may agree to jointly ask the Court to terminate the Settlement Agreement and dismiss the case with prejudice prior to the end of the six-year term. If the State asserts that it is in compliance and the Plaintiffs and/or the United States disputes the claim, the State will bear the burden of demonstrating that it has complied with all provisions of this Settlement Agreement and maintained compliance with all provisions for one year. The Parties may agree jointly at any time to allow for additional time to resolve compliance issues. Upon a determination of the Court that the State has demonstrated compliance with all of the provisions of this Settlement Agreement, including the provisions in this paragraph, the case shall be dismissed with prejudice.

J. Failure by any Party to enforce this entire Settlement Agreement or any provision thereof with respect to any deadline or any other provision herein shall not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Settlement Agreement.

K. The Parties will promptly notify each other of any court or administrative challenge to this Settlement Agreement or any portion thereof and shall defend against any challenge to the Settlement Agreement.

L. The Parties agree that, as of the date the Court enters an order granting the Joint Motion, for purposes of the Parties' preservation obligations pursuant to Fed. R. Civ. P. 26, state and federal law, and the litigation hold letter sent to the State on June 17, 2011, the Parties are no

longer required to maintain any litigation holds. The State's outside counsel will maintain the data already collected from the State, in the manner in which it currently exists, or archived, until this case is dismissed with prejudice. With regard to the data and documents produced by the State and held by the United States and Plaintiffs, the United States and the Plaintiffs will abide by Section 16.f. of the Joint Stipulation between the Parties concerning electronically stored information.

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The undersigned AGREE to the form and content of this Settlement Agreement:

FOR THE UNITED STATES:

/s/ John P. Kacavas
JOHN P. KACAVAS
United States Attorney
District of New Hampshire

/s/ John J. Farley
JOHN J. FARLEY
New Hampshire Bar No. 16934
Assistant United States Attorney
United States Attorney's Office
District of New Hampshire
53 Pleasant Street
Concord, NH 03301
Telephone: (603) 225-1552
john.farley@usdoj.gov

/s/ Jocelyn Samuels
JOCELYN SAMUELS
Acting Assistant Attorney General
Civil Rights Division

/s/ Eve L. Hill
EVE L. HILL
Deputy Assistant Attorney General
Civil Rights Division

/s/ Jonathan M. Smith
JONATHAN M. SMITH
Chief
Special Litigation Section

/s/ Judy C. Preston
JUDY C. PRESTON
Deputy Chief
Special Litigation Section

/s/ Richard J. Farano
RICHARD J. FARANO
District of Columbia Bar No. 424225
DEENA S. FOX
New York Bar Registration No. 4709655
KATHERINE V. HOUSTON
California Bar No. 224682
ALEXANDRA L. SHANDELL
District of Columbia Bar No. 992252
Trial Attorneys
United States Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, NW
Patrick Henry Building
Washington, DC 20530
Telephone: (202) 307-3116
richard.farano@usdoj.gov
deena.fox@usdoj.gov
katherine.houston@usdoj.gov
alexandra.shandell@usdoj.gov

FOR THE PLAINTIFF CLASS:

/s/ Amy B. Messer
AMY B. MESSER
New Hampshire Bar No. 8815
C. ADRIENNE MALLINSON
New Hampshire Bar No. 17126
AARON J. GINSBERG
New Hampshire Bar No. 18705
Disabilities Rights Center, Inc.
18 Low Avenue
Concord, NH 03301
Telephone: (603) 228-0432
amym@drcnh.org
adriennem@drcnh.org
aarong@drcnh.org

/s/ Steven J. Schwartz
STEVEN J. SCHWARTZ
Massachusetts Bar No. 448440
KATHRYN L. RUCKER
Massachusetts Bar No. 644697
Center for Public Representation
22 Green Street
Northampton, MA 01060
Telephone: (413) 586-6024
sschwartz@cpr-ma.org
krucker@cpr-ma.org

/s/ Ira A. Burnim
IRA A. BURNIM
District of Columbia Bar No. 406154
JENNIFER MATHIS
District of Columbia Bar No. 444510
Judge David L. Bazelon Center for
Mental Health Law
1101 15th Street, NW, Suite 1212
Washington, DC 20005
Telephone: (202) 467-5730
irab@bazelon.org
jennifern@bazelon.org

/s/ Daniel E. Will
DANIEL E. WILL
New Hampshire Bar No. 12176
ELAINE M. MICHAUD
New Hampshire Bar No. 10030
JOSHUA M. WYATT
New Hampshire Bar No. 18603
Devine, Millimet & Branch, P.A.
111 Amherst Street
Manchester, NH 03101
Telephone: (603) 669-1000
dwill@devinemillimet.com
emichaud@devinemillimet.com
jwyatt@devinnemillimet.com

FOR THE DEFENDANTS:

/s/ Joseph A. Foster
JOSEPH A. FOSTER
New Hampshire Attorney General

/s/ Anne M. Edwards
ANNE M. EDWARDS
New Hampshire Bar No. 6826
REBECCA L. WOODARD
New Hampshire Attorney General's Office
New Hampshire Bar No. 17176
33 Capitol Street
Concord, NH 03301-6397
Telephone: (603) 271-3650
anne.edwards@doj.nh.gov
rebecca.woodard@doj.nh.gov

/s/ John-Mark Turner
JOHN-MARK TURNER
New Hampshire Bar No. 15610
JAMES Q. SHIRLEY
New Hampshire Bar No. 2332
DAVID W. MCGRATH
New Hampshire Bar No. 9347
Sheehan Phinney Bass + Green. P.A.
1000 Elm Street, PO Box 3701
Manchester, NH 03105
Telephone: (603) 668-0300
jturner@sheehan.com
jshirley@sheehan.com

WHEREFORE, the Parties to this action having agreed to the provisions in the Settlement Agreement set forth above, and the Court being advised in the premises, this Settlement Agreement is hereby entered as the Order and Judgment of this Court.

It is so ordered, this 12th day of February, 2014, at Concord, New Hampshire.

HON. STEVEN J. McAULIFFE
United States District Judge

New Hampshire Community Mental Health Agreement

Expert Reviewer Report Number Two

June 30, 2015

I. Introduction

This is the second semi-annual report of the Expert Reviewer (ER) under the Settlement Agreement in the case of *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM.* For the purpose of this and future reports, the Settlement Agreement will be referred to as the Community Mental Health Agreement (CMHA). Section VIII.K of the CMHA specifies that:

> Twice a year, or more often if deemed appropriate by the Expert Reviewer, the Expert Reviewer will submit to the parties a public report of the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

The ER was mutually appointed by the parties effective July 1, 2014.[1] The first six months of ER activity was the "orientation phase"; ER activities focused on meeting state administrators and visiting inpatient and community-based service providers throughout the state to: (a) gain an understanding of the structure and functioning of important elements of the mental health system; (b) introduce to these entities the functions of the ER vis-à-vis the CMHA; and (c) begin to formulate a baseline status assessment of the mental health system as a foundation from which to identify and document future progress in implementing the CMHA.

In the second six-month time period, from January 1, 2015 through June 30, 2015, the ER has concentrated on:

1. Working with the parties and state officials to identify data elements and sources to be used to track and document progress and performance related to the CMHA;
2. Beginning to work with state officials on the implementation of Quality Management (QM) and Quality Service Review (QSR) provisions in the CMHA; and
3. Working with the parties to develop collective understandings of how the data tracking and QM/QSR activities will be used to provide the most accurate and timely

[1] Implementation efforts related to the CMHA had been underway prior to the appointment of the ER, and to the extent possible, those activities were reflected in the first ER report.

information to the ER and the parties with regard to attainment of the performance targets, outcomes, and quality requirements of the CMHA.

The ER has continued to make regular visits to New Hampshire, both to observe the implementation of certain key service elements of the CMHA, and to continue discussions with relevant parties related to implementation efforts and the documentation of progress and performance related to the CMHA. Thus far, the ER has:

- Completed visits to peer supports programs in each of New Hampshire's 10 regions. Seven of these were conducted during the first six-month period;
- Conducted on-site reviews of Assertive Community Treatment (ACT) teams/services in Manchester, Nashua, Concord, Laconia, Keene, and Berlin;
- Conducted on-site reviews of Supported Employment (SE) services in Nashua, Concord, Laconia, Keene, and Berlin;
- Met with officials, administrators, and staff at New Hampshire Hospital (NHH) (twice) and Glencliff to discuss and observe transition planning functions;
- Met with the peer supports group at Glencliff;
- Met with NHH staff and the liaisons to the Community Mental Health Centers (CMHCs) to discuss discharge planning issues;
- Met with Ken Norton, Executive Director of NAMI New Hampshire;
- Participated in one CMHC Director's meeting;
- Met with representatives of the Nashua Police Department;
- Met with representatives of the Emergency Department of Androscoggin Valley Hospital in Berlin;
- Participated in three meetings of the Department of Health and Human Services (DHHS) Mental Health Coordination Team;
- Participated in several meetings with representatives of the Plaintiffs and the United States (hereinafter "plaintiffs");
- Conducted numerous meetings with DHHS officials to discuss QM/QSR, data tracking, and data elements and reporting related to the CMHA; and
- Conducted in-person meetings with the parties in Concord on January 26, 2015, March 3, 2015, and June 10, 2015.

Information obtained during these on-site meetings has, to the extent applicable, been incorporated into the discussion of implementation issues and service performance below. The ER will continue to conduct site visits going forward, even outside the context of QSR reviews, to observe and assess the quality and effectiveness of implementation efforts and whether they achieve positive outcomes for people per CMHA requirements.

II. Data

As indicated above, a key priority for the ER during this second six-month period has been working with DHHS to further identify and access data that can be used to routinely track progress related to each element of the CMHA. Data includes participant-level service access and encounter data from CMHCs, NHH, and Glencliff. Updated information derived from this data is included where applicable in the service-specific sections of the report. Consistent with the CMHA, a goal of DHHS is to provide data regularly and in formats that are useful for analysis.

DHHS has been working to produce the requested data, and there have been improvements in the reliability and timeliness of some of the data provided to the ER and the parties. However, some data has still not been supplied at regular intervals, in standardized formats with standardized date ranges. In addition, DHHS is still developing its capacity to match participant-level information across several data bases, including Medicaid claims data, Phoenix 2, and the Avatar system for NHH. Early testing of this data-matching capability has been promising, and when fully developed, will be beneficial to the overall effort to assure performance and quality for the priority target population of the CMHA.

In the course of identifying and testing existing data sources for analyses related to the CMHA, several gaps in current information have been identified. For example, there is no current data on the degree to which participants in Supported Employment (SE) are engaged in competitive employment in integrated community settings consistent with their individual treatment plans as opposed to other SE activities. Competitive employment in integrated community settings consistent with individual treatment plans is a key indicator of the fidelity and success of SE services, and thus another data source will need to be identified to obtain this information. Another gap in data is related to people receiving Supportive Housing (SH) under the Bridge subsidy program. These participants are not clearly identified in the Phoenix 2 system, and thus it is difficult to document the degree to which these individuals are: (a) connected to local CMHA services and supports; or (b) actually receiving services and supports to meet their individualized needs on a regular basis in the community. DHHS has identified a strategy to link data from the Bridge program to the Phoenix 2 system, so a solution to this data gap issue may be forthcoming. A third example is related to the Mobile Crisis program soon to be implemented in the Concord Region. Some data related to Mobile Crisis access and utilization will be captured and reported in the Phoenix 2 system. Other important data elements, such as encounter location, response time and disposition may have to be tabulated and reported separately pursuant to contractual and/or agreements with the prospective Mobile Crisis provider network.

The sporadic and inconsistent reporting of data from various entities has been a source of significant frustration for DHHS, the plaintiffs, and the ER over the past two reporting periods.

Thus, a major priority of the ER for the next two months will be to work with DHHS and the plaintiffs to:

- Define regular reports to be prepared and circulated to the ER and the parties on a routine and predictable basis. Report parameters will specify: the data and data sources; the time frame covered by the data in the report; the date the report is generated; the key contact person/author of the report; and the formulas or related methods used to compile and analyze the reported data;
- Identify methods, time frames and formats for the collection and reporting of some data not currently available in standard data bases and systems; and
- Develop the capacity to collect, cross walk and effectively integrate qualitative data and information collection through the QM and QSR process with service access and utilization data.

Given the importance of this process, and given the need for all parties to continue to have regular input into the data reporting design and development activities, the ER will continue to circulate memoranda and draft reports among the parties for review and comment. It is recognized that data reporting and analysis can always be improved, and that the act of using, questioning, and interpreting data is the best way to assure that it is constantly improved. Nonetheless, this initial data definition process is expected to be completed by October 1, 2015, and regular quarterly reports to be available shortly thereafter.

III. CMHA Services

The following sections of the report address specific service areas and related activities and standards contained in the CMHA.

Mobile Crisis Services

The CMHA calls for the establishment of mobile crisis capacity and crisis apartments in the Concord region by June 30, 2015 (Section V.C.3 (a)). DHHS conducted a procurement process for this program, and a contract is reported to be ready to be awarded on June 24, 2015. The selected vendor and terms of the contract will not be public until the contract has been formally approved by the State.

Given the timing of the contract award, it is unlikely that the Concord mobile crisis program (mobile team and apartments) will be operational by June 30, 2015 as required by the CMHA. At this point, the timetable for implementation is not available for review, so it is difficult to predict what the programmatic impact of this delay will be, and when mobile crisis services will be available to target population members in the Concord region.

The ER will review the contract as soon as it is awarded and becomes public. Key elements of the contract are expected to include parameters set forth in the RFP, as well as: (a) a timetable and action steps for implementation of both the mobile team and the crisis apartments; (b) specification of inter- and intra-agency agreements and protocols to be put into place; and (c) identification of the data elements and reporting timeframes to be provided by the selected vendor to DHHS on a regular basis.

The Concord region mobile crisis program is an essential component of the CMHA for at least two reasons. The first is that it is expected to provide effective mobile crisis services to target population members in the Concord region, with the intended results of reduced hospitalization, reduced Emergency Department (ED) presentations, and increased housing stability and community tenure.

The second reason is that it will be the first of three mobile crisis programs implemented in New Hampshire under the terms of the CMHA, and therefore a model upon which to construct the larger crisis system. It is critical that all parties are in close communication about the roll-out of the Concord Mobile Crisis Program and that there is agreement on key elements of that service including its design, staff training and implementation plans.

For these reasons the ER intends to develop a specific implementation monitoring plan for the Concord mobile crisis program. A draft of this monitoring plan will be circulated to all parties as soon as possible after the contract is made available and after the ER has had one initial visit with the vendor and DHHS officials to discuss the implementation process and expectations. It is expected that the implementation monitoring plan will be circulated by the end of July 2015. It is further expected that full implementation of the mobile crisis program will proceed as quickly as possible, and that mobile crisis services will be available in the Concord region no later than September 30, 2015.

Assertive Community Treatment (ACT)

ACT is a key element of the CMHA, which specifies, in part:

1. By October 1, 2014, the State will ensure that all of its 11 existing adult ACT teams operate in accordance with the standards set forth in Section V.D.2;
2. By June 30, 2014, the State will ensure that each mental health region has at least one adult ACT team; and
3. By June 30, 2015, the State will provide ACT team services consistent with the standards set forth above in Section V.D.2 with the capacity to serve at least 1,300 individuals in the Target Population at any given time.

Taken together with the other ACT provisions, the CMHA requires a robust and competent system of ACT services throughout the State as of June 30, 2015.

Table I below summarizes data provided by DHHS as of May 15, 2015.

Table I

ACT Self-Reported Staff Capacity and Active Caseload: May 2015

DHHS Region/ CMHC	FTE ACT Staff May 2015	Staff Capacity	Current Active Caseload – May, 2015	Variance
1. Northern	14.8	148	60	-88
2. West Central	3.0	30	16	-14
3. Genesis	7.1	71	22	-49
4. Riverbend	7.0	70	79	+9
5. Monadnock	8.2	82	47	-35
6. Greater Nashua	8.7	87	63	-24
7. Manchester	24.9	249	254	+5
8. Seacoast	12.8	128	73	-55
9. Community Partners	8.2	82	16	-66
10. Center for Life Management	7.8	78	39	-39
Total	102.5	1,025	669	-356

As can be seen in the table, as of May 15, 2015, there was a statewide total of 102.5 ACT staff. Using the 1:10 staff ratio defined in the ACT standards, the reported staffing results in an overall capacity of 1,025 active ACT participants. This current staff capacity is 275 lower than the 1,300 capacity specified for June 30, 2015 in the CMHA.

The reported statewide active monthly ACT caseload of 669 is 356 people below the current actual staff capacity of 1,025, and 631 people below the number of priority target population members that could be served at the capacity standard of 1,300. The State notes that the CMHA does not specify utilization as opposed to capacity. Strictly speaking, the 275 person gap between actual and required capacity is considered by the State to be the operative concern related to the June 30, 2015 CMHA requirements. However, the ER points out that unused capacity for ACT or any other CMHA service could result in difficulty meeting the overall goals and outcomes for priority target population members identified in the CMHA. It also may indicate that target population members are missing opportunities to enjoy improved and more successful lives in integrated community settings as opposed to encountering crises, potential loss of housing, increased hospitalizations, and potentially longer lengths of stay at hospital or institutional levels of care. This issue will require additional discussions with all Parties.

As can be seen from Table I, there is considerable variation in both capacity and active monthly caseload among the 10 regional CMHCs in New Hampshire. For example, Manchester is

reported to have 24.9 FTE staff, and to have an active monthly caseload of 254, slightly higher than the staff capacity would support. West Central has only three FTE ACT staff, and is also serving 14 fewer people than this capacity would support. Only two of the 11 ACT teams in New Hampshire currently have active monthly caseloads at or slightly above their reported staff capacity.

There also are inconsistencies among ACT teams with regard to their satisfaction of ACT team standards set out in the CMHA. For instance, the CMHA specifies a 1:10 staffing ratio for ACT, and requires certain types of staff competencies to be represented on each ACT team. Additionally, the CMHA requires that each ACT Team have at least one peer member on the team. Based on information provided by the CMHCs to DHHS, five of the 10 regions do not yet have a peer supports/peer counselor member on the teams and two other regions have peer capacity listed as less than one FTE. In addition, there are variations in the amount of staff provided within the competencies specified for each team. For example, some teams have more than one FTE of nursing, while other teams provide only 0.2 or 0.3 FTE of nursing. These numbers reflect important differences in service capacity and expertise among the ACT teams that may compromise the teams' ability to deliver effective ACT services, and warrants further analyses and possible corrective actions by DHHS.

All of the staffing data reported by DHHS for ACT services discussed above had been reported by the CMHCs and has not yet been independently verified by DHHS or the ER. In addition, neither DHHS nor the ER has, to date, reviewed compliance on the part of all ACT teams with the performance and quality standards specified in CMHA Section V.D.2. To help address this issue, the ER expects that the new QM/QSR capacity being developed by DHHS will conduct on-site quality reviews of ACT services and report their findings within the up-coming 12 month period. These reviews are expected to prompt, whenever necessary, implementation of needed remedies to address any compliance concerns.

The ER has visited six CMHCs to receive an overview of seven of the ACT teams in place in the state. These visits were not fidelity or compliance reviews, and did not include any record reviews or separate interviews with team staff or ACT participants. The ER will conduct such reviews in upcoming months. Impressions gleaned from these on-site visits include:

1. As supported by the data summarized above, there appears to be substantial variation among the ACT teams. Some of this variation can be explained by the longevity of ACT service delivery in different areas, and some variation can be explained by differing geographic and socio-demographic conditions in various service areas. For example, several ACT teams had been operating for some years before the CMHA was initiated, while other ACT teams are still in the formation stages. Also, some teams operate in relatively dense urban areas, while others (particularly Northern Human Services) operate in sparse rural areas with large distances to travel. It is expected that DHHS, through its

QM/QSR capacity, will address the high degree of variation among the ACT teams to assure that ACT services meeting the CMHA standards are delivered statewide.

2. There seemed to be a high degree of understanding among ACT supervisors and team members with regard to ACT principles and practices.
3. Most of the teams visited by the ER expressed commitment to the model and enthusiasm for the results that can be obtained for ACT participants. Most teams believe that they are directly facilitating increased community tenure and quality of life for target population members participating in ACT in their regions. Team members for the most part reported commitment to the high intensity service model and team structure that are key to ACT services. However, some variation in the degree of enthusiasm with which these practices were being implemented was observed during the site visits. It will be important that the State implement measures to ensure consistently high performance among all ACT teams statewide.
4. The few ACT teams that employ a peer team member report the importance and positive contribution of the peer staff to the success of the overall team.
5. Many ACT team members reported being trained in and actively utilizing other evidence based service modalities, including Illness Management and Recovery (IMR); Motivational Interviewing (MI); Stages of Change; and Cognitive Behavioral Treatment (CBT) as part of their ACT team service delivery. Use of these evidence based practices in the context of ACT services is considered to be good, pending additional research.
6. All the ACT teams visited had qualified SE staff members assigned to the team, although it appears that most of them also provided SE services to non-ACT participants. The degree to which ACT enrollees participate successfully in SE is an important topic for consideration through the QM/QSR process.
7. Most teams reported having good and cooperative relationships with local primary health care providers, local police/law enforcement, local hospital EDs, local public housing agencies or other sources of affordable housing, and other local resources of importance to ACT participants.
8. Most of the ACT teams visited by the ER reported populating their caseloads with target population members who were already active clients of their CMHC. Teams also reported active outreach to people known to the CMHC who were homeless or otherwise not engaged in services; and also reported receiving referrals from NHH consistent with the NHH transition planning process. An important area for future focus will be to expand the reach of ACT services to target population members currently not connected to NHH or a CMHC, but still utilizing substantial hospital, ED, homeless service, and possible criminal justice resources.

In the coming months, it is expected that DHHS will: 1) develop one set of eligibility and discharge criteria for the provision of ACT services; 2) analyze the high degree of variation among existing ACT teams; 3) take any steps necessary to assure that ACT services are

consistently meeting the CMHA standards statewide, and; 4) expand the capacity of ACT to meet the requirements of the CMHA.

Supported Employment (SE)

Pursuant to the CMHA's SE requirements, the State must accomplish three things: 1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for supported employment (V.F.1); and 3) meet penetration rate mandates set out in the CMHA. For example, the CMHA states: "By June 30, 2015, the state will increase its penetration rate of individuals with SMI receiving supported employment …to 16.1 percent of eligible individuals with SMI." (Section V.F.2(c)).

The baseline SE penetration rate at the beginning of the CMHA was 12.1% (2012). The State reports a current SE penetration rate of 11.3%; this is almost a full percentage point below the 2012 baseline. Moreover, this current rate is 4.8 percentage points below the CMHA target for June 30, 2015. Based on the data provided by DHHS, six CMHCs were below the original SE penetration rate of 12.1% listed in the CMHA for 2012 (Northern (7.1%), Genesis (9.4%), Monadnock (8.0%), Nashua (6.1%), Seacoast (10.5%), and Community Partners (8.1%).

Table II below displays the self-assessed fidelity, current active SE caseload, and current SE penetration rate for each region/CMHC in New Hampshire. Seven of the CMHCs report themselves to be in the "good" fidelity range, and three of the CMHCs report themselves to be in the "fair" fidelity range[2]. Neither DHHS nor the ER has yet independently verified the CMHC fidelity self-assessments. It is expected that QM/QSR validation of CMHC fidelity self assessments will be a priority for the up-coming 12 month period.

As with the ACT services discussed above, there is considerable variation among the CMHCs in the implementation and operations of SE services. Only one CMHC reports a penetration rate that exceeds the June 30, 2015 penetration rate target, while all the others report currently being below the target. Two of the CMHCs with self-reported fidelity scores in the "fair" range also have low penetration rates.

[2] Note: these ranges are defined in the Dartmouth IPS Supported Employment evidence based practice fidelity scoring worksheets.

Table II

SE Participants and Penetration Rates

DHHS Region/CMHC	Self-Reported Fidelity Score	Unique SE Participants (through March 31, 1015)	Penetration Rate (through March 31, 2015)
1. Northern	113	85	7.1%
2. West Central	110	91	13.5
3. Genesis	106	108	9.4
4. Riverbend	98	186	14.9
5. Monadnock	101	57	8.0
6. Greater Nashua	93	78	6.1
7. Manchester	106	445	14.6
8. Seacoast	109	112	10.5
9. Community Partners	92	52	8.1
10. Center for Life Management	109	107	16.3
Statewide Average		1,321	11.3%

The number of active SE participants counted towards the penetration rate calculation currently includes people who have had only one encounter of SE. It is not known whether the "one-encounter" participants become full participants in SE. It will be important for the State to engage in further analyses regarding the "one-encounter" participants as it does not appear that one encounter will satisfy Dartmouth fidelity requirements or lead to actual employment as envisioned in the outcome criteria of the CMHA.

Information supplied by DHHS indicates that all CMHCs have corrective action plans in place to improve the penetration and fidelity of SE. The ER has not yet been able to see these plans or to verify that they are being implemented.

Five SE programs were briefly visited by the ER as adjuncts to the ACT team visits. These were introductory meetings, and did not include record reviews or participant interviews. The ER will conduct more in-depth SE reviews in upcoming months. From the site visits, it would appear that the SE staff of the visited programs are familiar with the Dartmouth Individual Placement and Support (IPS) SE best practices, and with the fidelity requirements. All reported good relationships with the local Vocational Rehabilitation (VR) offices, and several reported good relationships with large local employers.

Information provided by DHHS indicates that job development is a key element of SE for which fidelity has been difficult to attain and maintain. The SE programs visited by the ER reported that they did not believe that the current reimbursement rate for SE adequately covered the costs of job development, and thus, this element received lower priority. This may be a contributing factor to what anecdotally seems to be a smaller than expected number of SE participants participating in competitive employment for wages.

DHHS does not currently receive data from the CMHCs on the number of SE participants who are in competitive employment in integrated community settings consistent with their individual treatment plans, the number of hours they are working, or what they are being paid. DHHS is aware of these gaps in information, and will be working with the CMHCs to develop improved reporting mechanisms related to these factors.

The ER has three concerns about SE that will be a priority for monitoring in the upcoming months. These are:

1. The SE penetration rates have, on a statewide basis, gone down as opposed to up. The current statewide SE penetration rate is substantially below the June 30, 2015 target of 16.1%. Thus, the first priority for DHHS and the CMHCs will be to increase the SE participation rates to specified levels. Penetration rates should include only those who are actively engaged in efforts to gain employment and comply with CMHA outcome criteria, and should not include those who have had only cursory, one-time exposure to SE activities.
2. Most of the CMHCs report doing well on their own fidelity self-assessment. However, a few have reported having difficulty reaching the "good" level of fidelity. The ER recommends that DHHS validate the fidelity self-assessments, and then develop some targeted technical assistance efforts to assist CMHCs to address their specific fidelity issues.
3. SE providers acknowledge limitations in their ability to conduct the kind of job development necessary for the identification and cultivation of competitive, community-based work. DHHS should investigate provider concerns in this area and take steps to offer additional technical assistance or other programmatic resources.
4. Overall, there appears to be a need for greater emphasis on competitive employment for SE participants. DHHS will need to collect competitive employment data as a first step in addressing this issue; this should include the number of people who are working in competitive employment, the number of hours they are working, and what they earn. Clearly, concrete data is necessary to address anecdotal impressions and to develop specific action plans for increasing competitive employment as indicated by the data.

Supportive Housing (SH)

The CMHA requires the State to achieve a target capacity of 340 supportive housing units funded through the Bridge subsidy program by June 30, 2015. At the time of the previous ER report in December of 2014, the State reported that there were 270 individuals under lease in Bridge subsidy funded apartments. As of May of 2015, the State reported an overall net increase in the program of seven people – resulting in a total of 277 participants. However, the actual number of new Bridge subsidy participants living in supportive housing cannot be determined without additional data specific to the dynamics of mental health bridge subsidy programs.

In order to determine the total number of new people added between December and May, the State must also collect data on the following:

1. The number of Bridge subsidy participants who relinquished their Bridge subsidy during that time period because they received a Housing Choice Voucher or other affordable housing subsidy;
2. The number of people who left the Bridge subsidy program during that time period, if any, without receiving a permanent housing subsidy;[3]
3. The number of new people who leased Bridge subsidy apartments during that time period after being given a "turnover" Bridge subsidy made available through (1) or (2) above;
4. The number of new people who leased Bridge subsidy apartments during that time period after being given a new Bridge subsidy.

DHHS reports that an additional 63 individuals have been approved for Bridge subsidies, and are currently in the housing search phase.[4] The 277 current leases, plus the 63 approved but not leased, equals the CMHA target capacity of 340 supportive housing units to be available as of June 30, 2015. The housing search and lease-up process is different for each person, so it is not possible to predict when all 63 people with approved Bridge subsidies will be housed. .

DHHS also reports that an additional 110 Bridge subsidies will be funded in the upcoming year, which would result in the State meeting the CMHA total of 450 SH units by June 30, 2016.

The Bridge program appears to be successful in assisting people in the target population to obtain independent supportive housing in the community. Current concerns about the program at this point are related to: (a) criteria for approval of a Bridge subsidy; (b) transparency of the application and access process for Bridge rental assistance; (c) timely and accurate reporting of data about the Bridge program, including the information noted above; and (d) the amount and sufficiency of services and supports associated with the housing.

[3] All rental subsidy programs experience some normal attrition due to changes in circumstances, such as a move out of state, certain changes in family composition, death, etc.
[4] This information was provided verbally during the All Parties meeting on June 10, 2015. The ER will seek additional information and documentation to support this number.

DHHS reports that currently there is no wait list for Bridge subsidies. This may be due to the DHHS published Bridge program eligibility criteria being narrower than the target population criteria included in the CMHA. There also appears to be a lack of consistent knowledge in the field about the process and criteria for accessing the Bridge program. In combination, these factors seem to create unnecessary barriers for people in the target population to access the program. DHHS has acknowledged that it needs a more transparent set of policies and procedures to govern the program, and will be working with the ER and the parties to establish such policies in the near future. DHHS will also review the criteria for approval for Bridge subsidies and may modify them to be broader and better in conformance with the CMHA target population definition. The State will also establish written notice of acceptance/denial and appeals procedures. The ER will discuss with the parties a time frame for completing these activities. It is expected that drafts of these policies and procedures will begin circulating for review no later than September 1, 2015.

People receiving a Bridge subsidy, whether approved or fully leased, are not automatically entered into the Phoenix 2 system. Many of these individuals are likely clients of the CMHC system, and thus included in Phoenix 2, but whether or not they have a Bridge subsidy is not recorded in Phoenix. Thus, the current Phoenix 2 system is not capable of reporting: (a) the number of unique individuals receiving the Bridge subsidy at any given time; (b) whether the individual receiving the Bridge subsidy is connected to the local CMHC or other service provider in the area; or (c) the numbers and types of services and supports provided by the CMHC to facilitate successful tenancy and community tenure. DHHS has been testing a method for linking the Bridge subsidy participants with the Phoenix 2 system, and it seems to be feasible to accomplish this objective. If that methodology is implemented, then it will be possible to generate more reliable and timely reports on SH access and utilization.

However, even with successful linkage to the Phoenix 2 system, there will be some continuing gaps in information. For example, the number of people leaving the Bridge program, and the reason for departure, will not be available except as special reports for the SH vendor. There also does not at this time seem to be a method for identifying whether any SH tenants are sharing living arrangements with other people in the target population; this information is necessary to help determine whether the State's SH comports with CMHA parameters. DHHS will have to work with the vendor to design and implement revised reporting that will complement the Phoenix 2 reports. The ER expects that the data reporting issues will be addressed and proposed solutions shared with the ER and the parties over the next three months. The ER also expects in upcoming months to conduct more in-depth reviews of SH and associated services and supports to see if they are meeting the needs of individuals, helping them to achieve positive outcomes per CMHA parameters.

Transition Planning

During the past six months the ER has visited both Glencliff and NHH to meet with staff engaged in transition planning under the new policies and procedures adopted by both facilities late last year. Transition planning activities related to specific current patients in both facilities were observed. In addition, discussions were held with both line staff and senior clinicians/administrators regarding potential barriers to effective discharge to the most appropriate community settings for patients at both facilities. The following is a brief summary of information related to transition planning and effective community discharges for each facility.

1. Glencliff

In the three years from June 2012 through May 2015, Glencliff effectuated only 10 discharges from the facility; two of these were discharged between December 2014 and May 2015. About half of the 10 were placed in institutional settings: four were discharged to other nursing facilities and one was returned to prison. The average length of stay at Glencliff of this discharge cohort was 1,437 days – or almost four years. Only one of the individuals discharged during this time frame stayed for less than a year (167 days); two individuals had lived at Glencliff for more than nine years. As of May 13, 2015, the State reports that there have been no readmissions to Glencliff among this 10-person discharge cohort.

At the same time, Glencliff has had 46 admissions, nine of these since December 2014. Glencliff reports that there are approximately 15 individuals on the wait list for admission as of May 22, 2015.

DHHS is endeavoring to access the Enhanced Family Care service modality included in New Hampshire's Home and Community-Based Services waiver for people who are aged or have disabilities. Currently, there are five individuals at Glencliff for whom this option is being developed. Although this option could be an effective and appropriate alternative to the creation of new intensive group home beds, some barriers to implementation have been encountered. Specifically, respondents have noted that the Enhanced Family Care rates may be too low to attract families to provide this level of care. This factor may be contributing to the overall dearth of providers of this service reported by some participants in the process. Glencliff and DHHS officials are reported to be working towards solutions to these issues. As of May 15, 2015, no individuals have yet been successfully discharged from Glencliff using Enhanced Family Care.

The initial review of transition planning processes at Glencliff did not include a full quality review, review of records, or interviews with patients for whom transition planning was being conducted. These activities will be included in subsequent reviews, after which it will be possible to comment more confidently on the quality and effectiveness of transition planning per CMHA parameters.

It should be noted that staff at Glencliff appear to be taking transition planning very seriously and appear to be committed to effectuating community discharges. Transition planning appears

to be done conscientiously, but also appears to be quite cautious. This could be an indicator that, early in the process, transition planning staff need more exposure to the success of community living alternatives. Absent such experience, there is a temptation be overly concerned about replicating the assumed safety and comprehensiveness of care of the facility before transition plans are effectuated. Based on reports from both Glencliff and several CMHCs, it appears that CMHCs are increasing their efforts to communicate and coordinate with Glencliff, and to take greater responsibility for working towards discharge for residents of Glencliff previously living in their catchment areas. Increased inreach on the part of CMHCs should assist Glencliff transition planners to increase their knowledge of and comfort with community living arrangements available to effectuate discharges. The ER will document inreach activities more clearly within the next six months.

In addition to enhancing transition planning and discharges to the community of existing residents of Glencliff, it is important to also focus on the 15 or so people typically waiting for admission to Glencliff at any given time. It is frequently more feasible and desirable to divert individuals who have not yet been admitted, and have not yet had long lengths of stay away from their home communities.

It is recommended that the State's Central Team, when appointed, make it a priority to address the issues noted above related to the Enhanced Family Care program. The resources set aside under the CMHA for these community settings offer a way to supplement existing waiver rates/state plan services for more complex clients, if that proves to be a barrier to effectively using this program. Over time, the Central Team should also assist DHHS to address the need to enhance and facilitate transition planning and community discharges from Glencliff through increased knowledge and trust of community alternatives in concert with more aggressive inreach from the CMHCs (and potentially the Peer Support Agencies).

PASSR

DHHS has selected the University of Massachusetts Medical School to perform PASSR functions in New Hampshire. Based on information supplied by DHHS, it is believed that PASSR reviews applicable to Glencliff applicants and residents will begin in July 2015. The ER will begin monitoring implementation of PASSR vis-à-vis Glencliff applicants and residents in the next few months.

New Hampshire Hospital

From January 2014 through mid-May 2015, the State reports that NHH effected a total of 2,093 discharges. Of these, 1,580 (75%) were discharged to home, of whom 621 were living alone and 959 were living at home with others. Eight individuals (0.04%) were discharged to Glencliff; 39 (1.9%) were transferred to an inpatient rehabilitation facility or nursing home; 79 (3.8%) were discharged to a shelter or motel; 71 (3.4%) were discharged to a group home, DDS supported living, or peer support housing; and 32 (1.5%) went to a jail or correctional facility. The

discharge destination was recorded as unknown for 264 (12.6%) of the discharges during this time frame.

The State reports that the median length of stay for 2015 (through March 2015) has been 10 days, and the mean has been 32 days. The large difference between the mean and median lengths of stay is explained by the relatively small portion of the inpatient cohort that has stays for long periods of time prior to discharge. A point-in-time snapshot of the NHH census on May 21, 2015, showed that 60% of the patients had been in the hospital for 90 days or less, whereas 40% had been inpatients for 91 days or more. Anecdotal information provided by NHH indicates that about 40 of the longer stay patients are in active transition/discharge planning at any given time.

The discharge data suggest a bifurcated inpatient cohort. The vast majority of discharges are of people who have been admitted and discharged after a median length of stay of 10 days. Transition planning for this short stay group begins on the day of admission, and is almost always focused on restoring functioning so that a person can return to her/his previous living arrangement with ongoing services from the local CMHC.

The second group, patients staying longer than 90 days, typically presents greater challenges to discharge than the shorter-stay cohort of patients. First, people who stay longer are more likely to have some combination of complex psychiatric and medical conditions, and/or criminal justice issues, which make planning for transition to the community somewhat more difficult. In addition, after staying 90 days or more, it is more likely that a person's housing and community support system is no longer in place, thereby increasing the difficulty of arranging for an appropriate living arrangement with needed and chosen supports to effectuate timely discharges. These factors were reinforced as the ER observed transition planning activities and discussed transition planning with staff of the hospital.

The ER identified several specific issues and discussed them with State representatives while reviewing the transition planning process at NHH. One issue is the need to obtain intake assessments before establishing discharge plans for people who are not already connected to the CMHC system. Both NHH and several of the CMHCs verified that there is no current source of reimbursement for CMHCs when CMHC staff travel to NHH to conduct such assessments as part of the transition planning process. This results in a potential delay in accessing and initiating follow-along services and supports following discharge for some individuals, and has been reported to be a factor slowing down the discharge process.

Another barrier is the amount of time needed to effectuate discharges for people for whom Department of Corrections approval is necessary prior to discharge from NHH. It has been reported that several months can elapse between the time a person is clinically ready for discharge and the approval is given by DoC. At the time of one site visit by the ER, it was

reported that there were currently four such individuals awaiting DoC clearance before they could be discharged.

As with the Glencliff review summarized above, the initial review of transition planning processes at NHH did not include a full quality review, review of records, or interviews with patients for whom transition planning was being conducted. These activities will be included in subsequent reviews, after which it will be possible to comment more confidently on the quality and effectiveness of transition planning per CMHA parameters.

NHH and DRF Admissions and Waiting Lists

The Transition Planning requirements of the CMHA are focused on assisting people to move from inpatient and institutional settings into integrated community settings, and thereby to have successful lives in communities of their choice. Thus, the discharge data presented above are a key part of assessing progress and performance related to transition planning.

Admissions, readmission and hospital wait list information and trends are also relevant to transition planning, and more generally speaks to the adequacy of community capacity in the State's mental health system. Any hospital contact or inpatient admission involves a certain degree of disruption to a person's community living arrangements and supports, and the longer a person stays in the hospital or nursing facility the more likely it becomes that these arrangements and supports will have to be re-built to effectuate discharge. Each admission creates a new set of issues and dynamics that both the admitting facility and the CMHC/community supports system must resolve.

In addition, readmissions within 30, 90, and 180 days are considered to be an important indicator of the degree to which transition planning and community follow-through related to facility discharges is being carried out effectively. Moreover, contacts with, and prolonged waits at, hospital emergency departments (ED) reflect a lack of capacity in the community to address mental health crises. For these reasons the ER will be tracking and periodically reporting on NHH and DRF admission and readmission data, and also hospital ED wait list data, as indicators of how the overall system is functioning relative to reduced use of inpatient and nursing facilities and increased use of community alternatives.

According to data supplied by DHHS, in the first 10 months of FY 2015 NHH has had 1,246 admissions. The average daily census during these 10 months has been 129.9, a 97% occupancy rate. Of these 1,246 admissions, a total of 223 were re-admissions within 180 days of discharge (17.9% of admissions for the 10-month period). Of these 223 readmissions total, 128 (57.4%) were readmitted within 30 days of discharge; and an additional 76 (34.1%) were readmitted within 90 days of discharge. Thus, over 90% of the readmission cohort in FY 2015 we readmitted within 90 days of discharge.

The State reports that the two Designated Receiving Facilities (DRFs) at local hospitals (Elliot and Franklin) together have had 606 admissions to date in FY 2015; this projects to 808 admissions for the entire fiscal year. Admissions to DRFs have been steadily increasing in recent years – up 58% since 2013. This warrants close monitoring going forward. In addition, the Cypress Center, which is an Acute Psychiatric Residential Treatment Program (APRTP), had 590 admissions so far in FY 2015; this projects to over 780 admissions for the fiscal year. Current data on the average length of stay in Franklin and Elliot are not available. The average length of stay at Cypress Center has been 4.6 days during SFY 2015.[5]

The State reports that 75 percent of the admissions to the Franklin DRF during FY 2015 have been Involuntary Emergency Admissions (IEAs). At Elliot DRF, 20% of the FY 2015 admissions have been IEAs. At Cypress Center 15% of the admissions in FY have been IEAs. All three facilities have increased the proportion of IEA admissions compared to previous years. This too warrants close monitoring going forward.

Because NHH operates at full occupancy, a wait list has been established throughout New Hampshire of people awaiting admission to the facility, typically at a hospital ED. In FY 2015, the monthly average number of people waiting each day for a bed at NHH has been 22.3. The monthly average of people waiting has fluctuated between a high of 33 people in September 2014 to a low of 10 people in April 2015. Wait list data from January 2013 through the present seem to indicate that the spring months tend to have fewer people waiting on a daily basis, while the late summer and fall months experience spikes in the number of people waiting on a daily basis.

The Central Team

The CMHA requires establishment of a ***"…Central Team to assist in addressing and overcoming any of the barriers to discharge identified during transition planning and/or set forth in the transition plans." (VI.A.6)*** This team is currently in formation, but has not yet been appointed or begun meeting. Implementation of this essential component was to have been substantially completed by June 30, 2014. As will be noted below, the ER believes implementation of this team should be among the highest priorities for the State in the next few months. Several of the issues related to transition planning identified above could be addressed by the Central Team as soon as it is formed. These include, but are not limited to:

- Work towards solutions for accessing Enhanced Family Care services under the aged and disability waiver to facilitate discharges to the community form Glencliff;
- Working with the CMHCs and perhaps the Peer Support Agencies to develop and implement enhanced inreach activities related to the transition planning process; and

[5] One data point for future review is whether, or how many, people are discharged from DRFs to NHH.

Peer and Family Supports

Per the CMHA, the State has maintained its contract with NAMI New Hampshire for family support services.

New Hampshire reports that it has a total of 16 peer support agency program sites, with at least one program site in each of the ten regions. The State reports that these sites have a cumulative total of 2,924 members, and there is an active daily participation rate of 169 people statewide. For a variety of geographic and historical reasons, the membership and daily participation numbers vary considerably among the 16 program sites. All peer support centers report being open eight hours per day, five and one half days per week.

The CMHA does not have specific membership or active daily participation targets. Other than the use of trained peer supports staff to provide services to help individuals in managing and coping with the symptoms of their illness, self advocacy, and identifying and using natural supports, there are no specific requirements as to the functions and activities of the peer supports programs.

Nonetheless, the peer supports programs appear to be a valuable resource for the overall New Hampshire community mental health system. Peer respite services are one good example of this. Utilization of peers as members of ACT teams and in the new mobile crisis services is already included in the CMHA, but peers can also be useful in hospital inreach related to transition planning, and with regard to employment-related activities and objectives.

IV. Quality

The CMHA has specific quality and participant-focused outcomes defined for the interventions and community services. In addition, the CMHA includes a set of overall quality standards applicable to the entirety of the CMHA and its priority target population. The CMHA states:

> The goal of the State's system will be to ensure that ***all mental health and other services/supports*** funded by the State are of good quality and are sufficient to provide ***reasonable opportunities***[6] ***to help individuals achieve increased independence, gain greater integration into the community, obtain and maintain stable housing, avoid harms, and decrease the incidence of hospital contacts and institutionalization***. [***ER emphasis added***] (Section VII.A)

The QM/QSR System

DHHS has hired a team of QM/QSR staff, and has begun working on a QM/QSR system design and process. This work is in the very early development stages and will require a significant

[6] It should be noted that in this context the term "reasonable opportunities" is intended to reflect that not all members of the target population will choose CMHA services and not all will equally benefit from such services,

investment of time and effort over the next six months in order to adequately measure the range of service fidelity, participant outcome and quality assurance issues identified above. The ER will be working with the QM/QSR Team over the next several months to assist in the development of this system, including the use of data as described throughout this report, and including the proposed design, methodology and implementation of a client review process. Early in the design process, there will be opportunities for all parties, particularly the plaintiffs, to participate in this early design phase, and to review and comment on QM/QSR materials as these are drafted.

The ER has been working with all parties to identify certain consumer focused outcome measures, for the most part available from existing data sources, which could be used as indicators of results for people in the target population consistent with the quality parameters included above and in other sections of the CMHA. The State reports some questions and concerns about some of the suggested consumer focused outcome and quality indicators, and thus the ER will continue working over the next three months with all parties to address these concerns and to reach consensus on a set of key indicators that can be employed in concert with qualitative and process related information derived through the QM/QSR process.

V. Summary of Expert Reviewer Observations

The ER has now been in place for 12 months. Much of the first year of activity for the ER has focused on:

1. Developing a comprehensive understanding of the New Hampshire Mental Health system as a foundation for tracking progress and performance related to the CMHA as well as for recommending feasible implementation strategies;
2. Working with state officials to identify data elements and sources to be used to track and document progress and performance related to the CMHA;
3. Beginning to work with state officials on the implementation of QM/QSR activities related to the CMHA; and
4. Working with all parties to the CMHA to develop mutual understandings of how the data tracking and quality/QSR activities will be used to provide the most accurate and timely information to all parties with regard to attainment of the performance targets and quality requirements of the CMHA.

Considerable work will be necessary to complete the development of the data tracking and QM/QSR elements of CMHA implementation. However, there is sufficient information available and experience derived from the first year of ER activity to identify specific priorities for attention and action in the up-coming months. Specifically, there are five major areas of concern that need to be addressed to assure that CMHA implementation and quality objectives can be met over the next six months:

1. The State needs to continue working to implement improvements in data collection, analysis and reporting consistent with the CMHA.
2. The State needs to continue expansion of capacity of ACT services for priority target population members under the CMHA. As of the most recent ACT report, there is functional capacity for 1,025 ACT participants, and the CMHA standard for ACT is capacity for 1,300 as of June 30, 2015. Renewed efforts will be required to meet the CMHA ACT capacity requirements scheduled for June 30, 2015. As noted in the body of the report, the current active ACT census is 669.lightly less than 2/3 of the reported capacity of 1,025. Active census, or ACT utilization, is not a specific compliance measure in the CMHA. However, the ER notes that this unused capacity presents an excellent opportunity for DHHS to expand needed services to the target population. Consistency of operations and attainment of CMHA staffing requirements also remain to be addressed within the ACT program statewide.
3. The State needs to immediately implement the Central Team, an essential component of NHH and Glencliff transition planning under the CMHA. DHHS is still developing a plan for the Central Team; implementation of this essential component was to have been substantially completed by June 30, 2014, yet the membership and processes associated with Central Team activities have not yet been executed.
4. The State needs to continue efforts to increase penetration of evidence-based SE services for members of the priority target population so as to achieve desired outcomes per CMHA criteria. The June 30, 2015 CMHA standard for SE penetration is 16.1%. The most recent statewide penetration rate reported by DHHS is 11.3%. Additional efforts to attain fidelity standards for SE in certain CMHCs will also be required.
5. The State needs to continue the rapid development the DHHS QM/QSR process, with an initial emphasis on assuring the quality and consumer-focused effectiveness of ACT, SE, SH, and facility transition planning. The QM/QSR capacity is essential to DHHS' on-going efforts to use data on outcomes and performance to hold CMHCs and related contractors accountable under the terms of their contracts and the CMHA.

As of this writing, it is assumed that the contract for mobile crisis services in the Concord region will be in place, effective June 30, 2015. It is not known at what point effective capacity of the mobile team will be in place to actually respond to mental health crises in the community. Monitoring of this implementation effort will be one key priority of the ER over the next three months.

Nothing in the above list of concerns should be interpreted to disregard the level of commitment of New Hampshire officials, state agencies, CMHCs and other contractors to faithful implementation of the CMHA. To date, the ER has seen no evidence of diminished commitment or reduced willingness to collaborate on the part of the State. Nonetheless, an increased level of management attention and staff capacity will be required to prevent further slippage in meeting

CMHA standards. As with the previous ER report, DHHS may have to develop statewide strategies to address technical assistance and workforce development strategies to assist CMHCs to meet the CMHA standards. DHHS assistance with finding appropriate reimbursements/financing for certain elements of CMHA services and facility transition services is also likely to be necessary.

Central oversight of the implementation of the CMHA continues to be a critical element of overall CMHA implementation and performance objectives. Clear accountabilities for CMHA implementation and high quality management of services for the CMHA target population need to be reinforced at the state and contractor levels. Equally important, the State will need to increase its efforts to develop and use both quantitative and qualitative data to assure that accountability is maintained and that corrective actions are taken when necessary.

He-M 401.06 Eligibility Criteria for Adults with Severe Mental Illness.

(a) An adult shall be eligible for community mental health services if he or she has a severe mental illness (SMI) pursuant to (b) below.

(b) An adult shall be determined by a CMHP to have a severe mental illness (SMI) if he or she meets each of the following criteria:

(1) The adult has one of the following:

a. A diagnosis of mental illness; or

b. A provisional diagnosis of mental illness, if the person has not previously applied for community mental health services;

(2) The adult has a severe functional impairment as a result of his or her mental illness as determined through assessment of the person's abilities in the following functional domains:

a. Activities of daily living;

b. Interpersonal functioning;

c. Adaptation to change; and

d. Concentration and task performance or pace; or

e. Equivalent domains as defined in an outcome measurement tool approved by the commissioner;

(3) For adults age 18-59, the assessment of functional impairment required by (2) above demonstrates:

a. Moderate impairment causing chronic or durable problems in each of the four functional domains such that the person requires regular support and a variety of services;

b. Marked impairment causing ongoing symptoms in two or more of the functional domains such that the person requires intensive and frequent supportive interventions;

c. Extreme impairment causing risk of death in at least one functional domain such that the person requires a constant level of services; or

d. Equivalent impairment ratings based on an outcome measurement tool approved by the commissioner; and

(4) The assessment of functional impairment of adults age 60 and older demonstrates, without regard to the older adult's score on the General Assessment of Functioning (GAF) scale:

a. Moderate impairment causing chronic or durable problems in three or more of the functional domains; or

b. Marked impairment causing ongoing symptoms that require intensive and frequent supportive interventions in one or more of the functional domains; and

(5) The adult has had the severe functional impairment for less than one year.

(c) Redetermination of eligibility in this category shall occur every 2 years.

He-M 401.07 Eligibility Criteria for Adults with Severe or Severe and Persistent Mental Illness with Low Service Utilization.

(a) An adult shall be eligible for community mental health services if he or she has SMI or SPMI with low service utilization pursuant to He-M 401.07 (b) below.

(b) A CMHP shall determine that an adult has SMI or SPMI with low service utilization if he or she:

(1) Has a mental illness but no longer meets all the criteria for SPMI or SMI and receives services that are designed to prevent relapse;

(2) Has functional impairments that are due to a developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities or New Hampshire hospital; or

(3) Meets criteria for SPMI or SMI but has refused recommended services and for whom the CMHP is providing outreach.

(c) Attempts by the CMHP to engage the adult with SMI or SPMI with low service utilization in further services shall be made in accordance with his or her clinical needs and be documented in the person's record.

(d) Redetermination of eligibility in this category shall occur every 2 years.

He-M 401.08 Eligibility Criteria for Children with Serious Emotional Disturbance.

(a) To be eligible for community mental health services as a result of having a serious emotional disturbance, a child shall:

(1) Have a serious emotional disturbance;

(2) Have a serious psychosocial impairment as determined through an assessment of the following domains:

a. The child's:

1. School or work role performance;
2. Home role performance;
3. Community role performance;
4. Behavior towards others;
5. Mood and emotions;
6. Behavior towards self;
7. Substance use; and
8. Thinking; and

b. The child's caregiver's ability to provide physical and emotional support to the extent necessary to promote the child's emotional health; and

(3) Have the assessment of psychosocial impairment required by (2) above demonstrate:

a. At least mild impairment in three or more of the child centered domains causing periodic difficulty or distress;

b. At least moderate impairment in one or more child centered domains causing chronic or durable problems; or

c. At least mild impairment in the caregiver's ability to provide physical and emotional support to the extent necessary to promote the child's emotional health.

(b) Redetermination of eligibility in this category shall occur annually.

(c) Redetermination of eligibility in this category shall occur every 2 years.

He-M 401.09 Eligibility Criteria for Children with Serious Emotional Disturbance and Having Current Interagency Involvement.

(a) To be eligible for community mental health services as a result of having a serious emotional disturbance and interagency involvement, a child shall:

(1) Have a diagnosed serious emotional disturbance;

(2) Have a serious psychosocial impairment as determined through an assessment of the following domains:

a. The child's:
1. School or work role performance;
2. Home role performance;
3. Community role performance;
4. Behavior towards others;
5. Moods or emotions;
6. Behavior towards self;
7. Substance use; and
8. Thinking; and

b. The child's caregiver's ability to provide physical and emotional support to the extent necessary to promote the child's emotional health;

(3) Have the assessment of psychosocial impairment required by (2) above demonstrate:

a. At least mild impairment in three or more of the child centered domains causing periodic difficulty or distress;

b. At least moderate impairment in one or more child centered domains causing chronic or durable problems; or

c. At least mild impairment in the caregiver's ability to provide physical and emotional support to the extent necessary to promote the child's emotional health; and

(4) Have current interagency involvement.

(b) Redetermination of eligibility in this category shall occur annually.

New Hampshire's System for Substance Abuse Prevention Efforts and Services

"Alcohol flows through my courtroom like a river."

– District Court Judge

"By not asking questions about alcohol and other drug use, we had become part of the problem."

– Community Health Center Staff

The prevention of alcohol and other drug misuse is a high priority in New Hampshire, with many partners, stakeholders, and investors supporting community-based efforts to prevent substance misuse. The New Hampshire Bureau of Drug and Alcohol Services is the state's leader in many of these efforts and manages funding from the federal Substance Abuse and Mental Health Block Grant to support prevention, early intervention, treatment and recovery support services.

NH GOVERNOR'S COMMISSION ON ALCOHOL AND DRUG ABUSE PREVENTION, INTERVENTION AND TREATMENT

In New Hampshire, a Governor's Commission on Alcohol and Drug Abuse was established by legislation in 2000. The Commission oversees the distribution of funds from a set-aside of state funds generated by the state's sale of alcohol; advises the Governor on policy and resources to improve prevention, intervention, treatment and recovery support efforts; and develops and oversees a state-wide strategy to prevent substance misuse and promote recovery. The Commission meets bi-monthly, and its membership includes representation from the Bureau of Drug and Alcohol Services, eight other state agencies and divisions, the Attorney General's office, the Adjutant General, the Liquor Commission, the Legislature and Senate, and representatives from primary care, business, prevention, treatment and the general public.

PRIORITIES AND POPULATIONS

The Governor's Commission's most recent state strategy, **Collective Action – Collective Impact**[1] was formally endorsed and disseminated in March of 2013. The following problem areas and populations are the current priorities of the Commission and of state efforts to prevent substance misuse.

PRIORITY PROBLEM AREAS

ALCOHOL MISUSE

MARIJUANA USE

PRESCRIPTION DRUG MISUSE

PRIORITY POPULATIONS

YOUTH

YOUNG ADULTS

PREGNANT AND PARENTING WOMEN

MILITARY PERSONNEL AND THEIR FAMILIES

JUSTICE-INVOLVED YOUTH AND ADULTS

INDIVIDUALS NEEDING BUT NOT RECEIVING TREATMENT

INDIVIDUALS WITH CO-OCCURRING DISORDERS

GOALS AND OBJECTIVES

The current state system goals are to reduce the percentage of residents misusing of alcohol or other drugs and to increase the number of residents with substance use disorders receiving treatment and recovery support.

These goals are being met through a collective effort across multiple state agencies and community sectors to increase leadership; financial resourcing; public education; training and professional development; data utilization; and effective policies, practices and programs in multiple sectors.

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1 http://www.dhhs.state.nh.us/dcbcs/bdas/documents/collectiveaction.PDF

THE SIX SECTORS

The Bureau of Drug and Alcohol Services developed a six-sector model for state and community application that serves as the foundation for building readiness, promoting best practices, and leveraging resources in a comprehensive and collective manner.

NEW HAMPSHIRE REGIONAL PUBLIC HEALTH NETWORK

THE REGIONAL NETWORK SYSTEM

The state's substance misuse prevention strategies rely on the Regional Public Health Network System as its primary prevention delivery system. This system aligns the Bureau's regional network system for substance misuse prevention with the state's Division of Public Health Services' regional public health emergency preparedness system. The two functions of the system (substance misuse prevention and emergency preparedness) are linked through shared contracts with the state and shared public health advisory council in each of the system's 13 geographies. Regional Public Health Advisory Councils represent the communities, cultures and sectors of a defined region, including key organizations involved in public health activities that assess needs, guide decision-making, and encourage shared resources and investments in positive health outcomes.

For alcohol and other drug prevention efforts, the regional networks each have a full-time substance misuse prevention coordinator and content expert panel at the community level that carries out a regional strategic plan developed using the evidence-based federal Strategic Prevention Framework for assessment, capacity building, planning, implementation and evaluation. Regional strategic plans align with the state-wide strategy and are designed to leverage resources and promote best practices with partners and stakeholders from the six sectors.

For regional information and coordinator contact information, visit http://www.dhhs.nh.gov/dcbcs/bdas/documents/rphncontactlist.pdf

SUPPORTING THE PREVENTION SYSTEM

There are many core pillars that provide the infrastructure to support the regional network system for substance misuse prevention.

New Hampshire Charitable Foundation – The foundation oversees a sizable substance abuse portfolio that is currently funding several state-wide prevention initiatives. In addition to investments in New Futures and the New Hampshire Center for Excellence (see below), the Foundation also supports several best practices in prevention in the state, including Life of an Athlete, Screening Brief Intervention and Referral to Treatment, and Partnership for a Drug Free New Hampshire. www.nhcf.org

New Hampshire Prevention Certification Board – Regional prevention coordinators must be Certified Prevention Specialists as articulated by the IC & RC credentialing organization. The required credentialing ensures a common knowledge and skill base within the regional system. www.nhpreventcert.org

New Futures – This alcohol and drug policy organization provides critical advocacy training, leadership opportunities, and legislative efforts that drive public policy priorities and that empower community leaders to influence state level policy. www.new-futures.org

New Hampshire Center for Excellence – The Center is the main hub for the technical assistance needs of substance misuse prevention efforts. In addition to regular meetings and learning collaboratives with those in the network system, the Center responds to a wide range of technical assistance needs from the field, including implementation science, assessment, strategic planning, evaluation, fidelity support, reporting, communications and other prevention activities. The Center also serves as the evaluator for the regional networks and specific best practices. www.nhcenterforexcellence.org

New Hampshire Training Institute on Addictive Disorders – the Training Institute offers low cost training to support prevention specialist programming and other training and professional development for priority programs and practices. www.nhadaca.org/NHTIAD.html

Drug Free Community Coalitions – Several federally funded coalitions exist across the state that provide more local support for substance misuse prevention. These coalitions receive federal funding directly from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to carry out locally developed, data-driven action plans. www.dhhs.nh.gov/dcbcs/bdas/documents/dfc.pdf

Partnership for a Drug Free NH – This non-profit organization works with prevention professionals and media partners to develop and disseminate effective media messages in support of state plan and regional network goals. www.drugfreenh.org

Prevention Task Force of the Governor's Commission on Alcohol and Drug Abuse – This task force meets bi-monthly, serving as an intermediary between the Commission and state and local prevention initiatives. The task force takes direction from the Commission and informs the Commission of prevention needs in the state. Their efforts have led to school alcohol and drug policy assessments and recommendations and assessments of training capacity to support prevention professionals. www.dhhs.nh.gov/dcbcs/bdas/commission.htm

New Hampshire Alcohol and Other Drug Service Providers Association – The state's association of service providers, including prevention providers, advocates, facilitates and enhances communication with funders, policy makers and the public to support the efforts of members to provide high quality substance abuse prevention,treatment, intervention, and recovery support services for the citizens of New Hampshire. http://www.nhproviders.org/

New Hampshire National Guard Counter Drug Task Force – The New Hampshire National Guard Counterdrug Task Force works to reduce the supply and demand for illegal drugs through partnerships with local, state, and federal law enforcement as well as to provide technical support to community-based organizations in an effort to prevent substance abuse statewide. The Task Force also provides direct support to their own National Guard members to prevent, identify, and treat substance abuse through its Joint Substance Abuse program.
https://www.nh.ngb.army.mil/community/counterdrug

Service to Science Process and Expert Panel – Facilitated by the NH Center for Excellence, the NH Service to Science process allows locally developed programs and practices to be reviewed by an expert panel for endorsement as evidence-based. Typically, NH Service to Science applicants receive technical assistance in evaluation design and implementation fidelity for a year or more before expert panel endorsement. www.nhcenterforexcellence.org/prevention/nh-service-to-science

State Epidemiological Outcome Workgroup – This work group is comprised of state level data analysts from a cross-section of state agencies who collect or manage large data sets, including arrest data, hospital data, risk behavior surveillance systems, service delivery, and other data. The work group provided the data analyses for the state-wide strategic plan and for the substance abuse module for the state's new data portal, WISDOM. www.dhhs.state.nh.us/dcbcs/bdas/documents/seowcharter.pdf

Effective Policies, Programs and Practices – There are several effective policies, practices or programs that are promoted by the Governor's Commission, the Bureau and Drug and Alcohol Services, and the Regional Public Health Network. They include but are not limited to:

BEST PRACTICE PREVENTION PROGRAMS IN NEW HAMPSHIRE

SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)	ADOLESCENTS AND ADULTS
LIFE OF AN ATHLETE	MIDDLE AND HIGH SCHOOLS
PROJECT SUCCESS	MIDDLE AND HIGH SCHOOLS
3 – IN – 1	HIGHER EDUCATION
REAP	OLDER ADULTS
DRUG AND MENTAL HEALTH COURTS	ADOLESCENTS AND ADULTS
PRESCRIPTION DRUG MONITORING	ALL POPULATIONS

Federal, State, Local and Private Resources – Substance Misuse Prevention in New Hampshire is supported by several sources, including the Governor's Commission Alcohol Fund, SAMHSA's Substance Abuse and Mental Health Block Grant, the New Hampshire Charitable Foundation, SAMHSA's Partnership For Success II grant program, local United Ways, and other local contributions.

PREVENTION OUTCOMES

New Hampshire and its many partners in prevention, including local communities, work together day in and day out to have a collective impact on substance misuse prevention in the state. The public-private partnerships inherent in the design of the prevention system leverage resources and promote best practices across the broadest of landscapes. These collective contributions are producing measurable changes in substance misuse indicators that will lead to increased safety and well being for our residents, children, families, and communities.

NEW HAMPSHIRE BUREAU OF DRUG AND ALCOHOL SERVICES

Valerie Morgan, Prevention Administrator • Valerie.Morgan@dhhs.state.nh.us
105 Pleasant Street • Concord NH 03301 • 603-271-6819 • http://www.dhhs.nh.gov/dcbcs/bdas/

New Hampshire
State Epidemiological Outcomes Workgroup (SEOW)
Purpose and Objectives
September 2014

PURPOSE: The NH SEOW is a multidisciplinary advisory group that works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance use and behavioral health issues in order to inform prevention and treatment policy, programs and services in the state.

The **OBJECTIVES** for the NH SEOW are to:

Objective 1: Facilitate assembly, analysis and interpretation of data and reports to determine the scope and extent of substance use and behavioral health risk and related problems at the state and regional level.

Objective 2: Facilitate assembly, analysis, and interpretation of data and reports to characterize protective factors for mental, emotional, and behavioral health, and assets vital to the delivery of prevention, treatment, and recovery services.

Objective 3: Guide the development and sustainability of a web-accessible database of substance use and substance use-related mental health indicators to enable analysis of prevalence, trends and impacts at the state and regional levels.

Objective 4: Guide the development and dissemination of data products to targeted audiences in the education, health, government, business and safety sectors to address questions of policy, increase awareness, and foster a sense of shared responsibility.

Objective 5: Provide technical assistance and recommendations for improving data sharing and use across state level systems to assess prevalence rates and financial impacts of alcohol and drug misuse, as well as outcomes of strategies being implemented to address alcohol or other drug misuse among populations served by state systems including evaluation results of the Partnership for Success Initiative.

Objective 6: Provide technical assistance and recommendations for developing a sustainable approach to data monitoring and reporting to assess progress on the 2013 State Strategic Plan to reduce substance misuse prepared by the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

NEW HAMPSHIRE

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

Ages 18+

Purpose (Choose One from Below): **Assessment Date:** _____

☐ **Eligibility Determination** **Eligibility Effective Date:** **Eligibility End Date:**

☐ **ISP Review (Period not to exceed 90 days)** **Period Starting:** _____ **Period Ending:** _____

☐ **Combined Eligibility determination/Annual ISP Review**

PLEASE USE EXTENSION MODULES TO FURTHER ASSESS ***BOLDFACE ITALICIZED*** ITEMS.

MENTAL HEALTH NEEDS

ITEM RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating:	Comments:
Psychosis	N/A		
Cognition[1]	N/A		
Impulse Control	N/A		
Depression	N/A		
Mania	N/A		
Anxiety	N/A		
Personality Disorder	N/A		
Antisocial Behavior	N/A		
Adjustment to Trauma[2s]	N/A		
Anger Control	N/A		
Substance Use[3]	N/A		
Eating Disturbance	N/A		
Autism Spectrum	N/A		

LIFE FUNCTIONING

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating:	Comments:
Physical/Medical	N/A		
Intellectual Functioning	N/A		
Communication	N/A		
Family	A		
Employment[4]	B		
Cultural[5]	N/A		
Social Functioning	A		
Caregiving Role	A		
Intimate Relationships	A		
Sexuality	B		
Living Skills	A		
Residential Stability	A		
Legal	A		
Sleep	B		
ADLs/Self Care	A		
Decision-making	A		
Medication Adherence	A		
Transportation	N/A		
Financial Resources	N/A		
Isolation	A		

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

Ages 18+

RISK BEHAVIORS

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Agitation	A		
Self-Injurious Behavior	A		
Other Self Harm	A		
Wandering	A		
Gambling	N/A		
Exploitation	A		
Criminal Behavior	B		
Suicide[6]	A		
Danger to Others[7]	A		
Sexual Aggression[8]	A		

STRENGTHS

0=Centerpiece **1=Useful** **2=Identified** **3=Not yet identified**

Item	Level	Rating	Comments:
Family	N/A		
Social Connectedness	N/A		
Optimism	N/A		
Involvement in Recovery	N/A		
Educational	N/A		
Job History	N/A		
Talents/Interests	N/A		
Leisure Activities	N/A		
Meaningfulness	N/A		
Spiritual/Religious	N/A		
Community Strengths	N/A		
Volunteering	N/A		
Natural Supports	N/A		
Resiliency	N/A		
Resourcefulness	N/A		

CAREGIVER(S) STRENGTHS & NEEDS

0=No Evidence **1= Watch/Prevent** **2= Act** **3= Act Immediately/Intensively**

Physical/Behavioral	N/A		
Involvement	N/A		
Knowledge	N/A		
Social Resources	N/A		
Family Stress	N/A		
Adult Protection	N/A		
Paid Caregiver	N/A		

EXTENSION MODULES

Extension modules are required for any italicized items with ratings >0.

MODULE 1: COGNITION

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Memory	N/A		
Planning	N/A		
Visual-Spatial Abilities	N/A		
Motor Skills	N/A		

MODULE 2: TRAUMA

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Sexual Abuse*	N/A		
Physical Abuse	N/A		
Emotional Abuse	N/A		
Medical Trauma	N/A		
Natural Disaster	N/A		
Witness to Family Violence	N/A		
Witness to Community Violence	N/A		
Witness/Victim – Criminal Acts	N/A		
***If sexual abuse >0, complete the following**			
Emotional Closeness to Perpetrator	N/A		
Frequency of Abuse	N/A		
Duration	N/A		
Force	N/A		
Reaction to Disclosure	N/A		
Adjustment			
Complete the following for all Trauma			
Affect Regulation	N/A		
Intrusions	N/A		
Attachment	N/A		
Dissociation	N/A		
Hyperarousal	N/A		

MODULE 3: SUBSTANCE USE

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Severity of Use	N/A		
Duration of Use	N/A		
Stage of Recovery	N/A		
Peer Influences	N/A		
Environmental Influences	N/A		

Please specify the drug(s) of choice:

MODULE 4: EMPLOYMENT

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Job Performance	N/A		
Job Attendance	N/A		
Job Relations	N/A		
Career Aspirations	N/A		
Job Skills	N/A		

MODULE 5: CULTURE

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Language	N/A		
Identity	N/A		
Ritual	N/A		
Cultural Stress	N/A		

MODULE 6: SUICIDE

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Suicide Risk*	N/A		
*If suicide risk >0, complete the following			
Ideation	N/A		
Intent	N/A		
Planning	N/A		
History	N/A		

MODULE 7: DANGER TO OTHERS

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:
Frustration Management	N/A		
Hostility	N/A		
Paranoid Thinking	N/A		
Secondary Gains from Anger	N/A		
Violent Thinking	N/A		
Aware of Potential for Violence	N/A		
Response to Consequences	N/A		
Commitment to Self-Control	N/A		
Treatment Involvement	N/A		

MODULE 8: SEXUAL AGGRESSION

RATINGS: **0=No Evidence** **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

Item	Level	Rating	Comments:

Relationship	N/A		
Physical Force/Threat	N/A		
Planning	N/A		
Age Differential	N/A		
Type of Sex Act	N/A		
Response to Accusation	N/A		
Temporal Consistency	N/A		
History of Sexual Behavior	N/A		
Severity of Sexual Abuse	N/A		

ADULT ELIGIBILITY DETERMINATION

Diagnosis:		**Diagnostic Code:**	
Eligibility Effective Date:		**Eligibility End Date:**	

Eligibility Categories:	☐ Severe Mental Illness (**SMI**) < 1 year	☐ Severe & Persistent Mental Illness (**SPMI**) > 1 year	☐ Low Utilizer (**LU**)	☐ Not Eligible	☐ Waiver Requested Date Approved: __/__/__

Category SMI/SPMI: An adult shall be determined by a CMHP to have a severe mental illness (SMI) or severe and persistent mental illness (SPMI) if he or she meets **EACH** of the following criteria, as per He-M 401.05 - .06:

☐ **Criterion I *(required)*:** An eligible **diagnosis** (e.g., schizophrenia and other psychotic disorders, mood disorders, borderline personality disorder, post-traumatic stress disorder, obsessive compulsive disorder, eating disorders, panic disorder, or dementia, where the psychiatric symptoms cause functional impairments and one or more of the followings co-morbid symptoms exist: anxiety, depression, delusions, hallucinations, or paranoia) *(He-M 401.02).*

☐ **Criterion II *(required - check one)*:** An assessment of **functional impairment** demonstrating at least 1 of the following:

- ☐ A rating of "3" in any 2 Level A items; or
- ☐ A rating of "2"or more for any four Level A items or combination of Level A and B items.

☐ **Criterion III *(required- check one):***

- ☐ The reported impairments are due to the diagnosis satisfying Criterion I

OR the following **Exception to Criteria II and III** applies:

☐ Although Criterion I is met, the individual does not currently meet Criteria II and III as a result of the use of clozaril or clozapine, or as a result of close supervision such as that provided in a community residence as defined in He-M 1002.02.

Low Utilizer (LU): An adult shall be determined by a CMHP to have a severe mental illness, or severe and persistent mental illness with low service utilization, if he or she meets **ONE** of the following criteria, as per He-M 401.07:

The adult

☐ Has a diagnosed mental illness but no longer meets all the criteria for SPMI or SMI and receives services that are designed to prevent relapse; OR

☐ Has functional impairments that are due to developmental disability or receives services primarily through another agency such as a provider for persons with developmental disabilities or New Hampshire Hospital; OR

☐ Meets criteria for SPMI or SMI but has refused recommended services. The CMHP provides outreach and periodically attempts to engage them in further services.

Staff Dated Signature: **Certification ID:**

NEW HAMPSHIRE

ADULT NEEDS & STRENGTHS ASSESSMENT (ANSA)

Ages 18+

PERIODIC REVIEW OF THE INDIVIDUAL SERVICE PLAN

This assessment has been used to review the client's level of treatment, progress, and needs.

As a result of this review:

The Individual Service Plan ☐ **has** **been changed.**
☐ **has not** **List services received during this reporting period**

Detail comments regarding the recipient's progress towards the treatment Goals and Objectives, that all needed services are being provided, the appropriateness of the services being furnished and the need for continued participation in the program:`

Detail reasons Goals and Objectives were not met:

ADMISSIONS TO ANY PSYCHIATRIC INPATIENT UNIT, INCLUDING ADULT PSYCHIATRIC RESIDENTIAL TREATMENT PROGRAMS, DURING THIS PERIOD: **# OF DAYS**

_____ _____

Periodic Review Date **Individual Service Plan Date:**

Verified by Evaluation Team:

Clinician Signature, Credential, Title: _____ **Date:** _____

Clinician Printed Name, Credential, Title:

Physician Signature, Credential: _____ **Date:** _____

Physician Printed Name, Credential, Title:

☐ **I have participated in this review**

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

NEW HAMPSHIRE

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Age 0 to Transition Age

Purpose (Choose One): **Assessment Date:** _____

☐ **Eligibility Determination** **Eligibility Effective Date:** **Eligibility End Date:**

☐ **ISP Review (Period not to exceed 90 days)** **Period Starting:** _____ **Period Ending:** _____

☐ **Combined Eligibility determination/Annual ISP Review**

PLEASE USE EXTENSION MODULES TO FURTHER ASSESS ***BOLDFACE ITALICIZED*** ITEMS.

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Psychosis	N/A		
Attention/Impulse	N/A		
Depression	N/A		
Anxiety	N/A		
Oppositional Behavior	N/A		
Conduct Behavior	N/A		
Adjustment to Trauma [1]	N/A		
Substance Use [2]	N/A		
Autism Spectrum	N/A		
Anger Control	N/A		
Eating Disorder	N/A		
Attachment	N/A		
Regulatory Behaviors	N/A		

CHILD LIFE FUNCTIONING

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Family	A		
Living Situation	A		
Peer Relations	A		
Adult Relations	A		
Legal [3]	A		
ADLs/Self Care	A		
Sleep	A		
Sexual Development	A		
School Achievement	A		
School Behavior	A		
School Attendance	A		
Medical/Physical	N/A		
Intellectual	N/A		
Communication	N/A		
Culture [4]	N/A		

CHILD RISK BEHAVIORS

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Age 0 to Transition Age

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Self Injurious Behavior	A		
Other Self Harm	A		
Danger to Self [5]	A		
Danger to Others [6]	A		
Sexual Aggression [7]	A		
Exploited	A		
Bullying	A		
Elopement/Runaway	A		
Crime/Delinquency	A		
Firesetting	A		
Animal Cruelty	A		
Intentional Misbehavior	A		
Aggression	A		

CHILD STRENGTHS

0=Centerpiece **1=Useful Strength** **2=Potential Strength** **3=None Identified**

	Level	Rating	Comments:
Family	N/A		
Peer Supports	N/A		
Adult Relationships	N/A		
Educational	N/A		
Vocational	N/A		
Talents/Interests	N/A		
Spiritual/Religious	N/A		
Community Life/Recreational	N/A		
Relationship Permanence	N/A		
Optimism	N/A		
Coping & Savoring	N/A		
Resiliency	N/A		
Resourcefulness	N/A		
Youth Knowledge	N/A		

CAREGIVER(S) STRENGTHS &NEEDS

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Supervision	B		
Involvement	B		
Knowledge	B		
Organization	B		
Social Resources	B		
Residential Stability	B		
Physical/Behavioral	B		
Access to Child Care	B		
Military Transitions	B		
Child Safety	B		
Family Stress	B		

EXTENSION MODULES

Extension modules are required for any italicized items with ratings >0.

TRANSITION MODULE (COMPLETE FOR AGE 16+)

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Caregiving Role	A		
Living Skills	A		
Medication Adherence	A		
Education Attainment	A		
Personality Disorder/Traits	N/A		
Job Functioning	A		

MODULE 1: TRAUMA

0=No Evidence **1=Watch/Prevent** **2=Act** **3=Act Immediately/Intensively**

	Level	Rating	Comments:
Sexual Abuse*	N/A		
Physical Abuse	N/A		
Emotional Abuse	N/A		
Medical Trauma	N/A		
Natural Disaster	N/A		
Witness to Family Violence	N/A		
Witness to Community Violence	N/A		
Witness/Victim – Criminal Acts	N/A		
War Affected	N/A		
Terrorism Affected	N/A		
***If sexual abuse >0, complete the following**			
Emotional Closeness to Perpetrator	N/A		
Frequency of Abuse	N/A		
Duration	N/A		
Force	N/A		
Reaction to Disclosure	N/A		
Adjustment (complete for all trauma)			
Affect Regulation	N/A		
Intrusions	N/A		
Attachment	N/A		
Dissociation	N/A		
Hyperarousal	N/A		

MODULE 2: SUBSTANCE USE

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Severity of Use	N/A		
Duration of Use	N/A		
Stage of Recovery	N/A		
Peer Influences	N/A		
Parental Influences	N/A		
Environmental Influences	N/A		
Please specify the drug(s) of choice:			

MODULE 3: LEGAL

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Seriousness	N/A		
History	N/A		
Arrests	N/A		
Planning	N/A		
Community Safety	N/A		
Legal Compliance	N/A		
Peer Influences	N/A		
Parental Influences	N/A		
Environmental Influences	N/A		
	Age of 1st Arrest:		

MODULE 4: CULTURE

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Language	N/A		
Identity	N/A		
Ritual	N/A		
Cultural Stress	N/A		

MODULE 5: DANGER TO SELF

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Suicide Risk*	N/A		
*If Suicide Risk >0, complete the following			
Ideation	N/A		
Intent	N/A		
Planning	N/A		
History	N/A		

MODULE 6: DANGER TO OTHERS

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Frustration Management	N/A		
Hostility	N/A		
Paranoid Thinking	N/A		
Secondary Gains from Anger	N/A		
Violent Thinking	N/A		
Aware of Potential for Violence	N/A		
Response to Consequences	N/A		
Commitment to Self-Control	N/A		
Treatment Involvement	N/A		

MODULE 7: SEXUAL AGGRESSION

0=No Evidence 1=Watch/Prevent 2=Act 3=Act Immediately/Intensively

	Level	Rating	Comments:
Relationship	N/A		
Physical Force/Threat	N/A		
Planning	N/A		
Age Differential	N/A		
Type of Sex Act	N/A		
Response to Accusation	N/A		
Temporal Consistency	N/A		
History of Sexual Behavior	N/A		
Severity of Sexual Abuse	N/A		

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Age 0 to Transition Age

Primary Diagnosis: *(Must be a diagnosis listed in He-M 401.02)*		**Diagnostic Code:**	
Eligibility Effective Date:		**Eligibility End Date:**	
Eligibility Determination:	☐ Serious Emotional Disturbance (SED)	☐ Serious Emotional Disturbance & Having Current Interagency Involvement (SED-IA)	☐ Not Eligible ☐ Waiver Requested Date Approved: __ __/__ __/ __ __

<u>SED/SED-IA</u>: An child or adolescent shall be determined by a CMHP to have a Serious Emotional Disturbance (SED) or Serious Emotional Disturbance - Inter-Agency (SED-IA)* if he or she meets the following criteria, as per He-M 401.08 - .09:

☐ **Criterion I *(required):*** Have a **<u>diagnosis</u>** of a qualifying Axis I disorder (with the exception of substance abuse disorders) as described in He-M 401.02.

☐ **Criterion II *(check one)*** The assessment of **<u>functional impairment</u>** demonstrating at least 1 of the following:

- ☐ 3 ratings of '1' or more in any A item; or
- ☐ 1 rating of '2' or mote in any A item; or
- ☐ 1 rating of '1' or more in any B domain.

☐ **Criterion III *(required):***

- ☐ The reported impairments are due to the diagnosis satisfying Criterion I

<u>Serious Emotional Disturbance - Inter-Agency (SED-IA):</u>
A child shall be determined SED-IA if he/she meets one of the following criteria, as per He-M 401.09:

☐ A legal relationship exists between the child and the school.
Please indicate the type of relationship (mark all that apply):
☐ Emotionally Handicapped ☐ Learning Disabled ☐ Intellectual Disability ☐ Speech/Language Problem
☐ Other Health Impaired ☐ 504 Plan ☐ Unknown ☐ Other , specify

<u>OR</u>

☐ DCYF is legally involved with this child (does not include investigation only).
What type of involvement is it? (mark all that apply):
☐ Abuse/Neglect ☐ Other, specify ☐ Unknown

<u>OR</u>

☐ DJJS is legally involved with this child? (does not include investigation only)
What type of involvement is it? (mark all that apply):
☐ CHINS ☐ Delinquent/Delinquency ☐ Diversion ☐ Other, specify ☐ Unknown

Staff Printed Name, Credential, Title: _____ **CANS Certification ID#:** _____

Staff Signature, Credential, Title: _____ **Date:** _____

PERIODIC REVIEW OF THE CHILD AND ADOLESCENT INDIVIDUAL SERVICE PLAN

This assessment has been used to review the client's level of treatment, progress, and needs.

As a result of this review:
The Individual Service Plan ☐ **has** ☐ **has not** **been changed.**
List services received during this reporting period.

Detail comments regarding the recipient's progress towards the treatment Goals and Objectives, that all needed services are being provided, the appropriateness of the services being furnished and the need for continued participation in the program:`

Detail reasons Goals and Objectives were not met:

ADMISSIONS TO ANY PSYCHIATRIC UNIT, INCLUDING ADULT PSYCHIATRIC RESIDENTIAL TREATMENT PROGRAMS, WITHIN THE PERIOD:		# OF DAYS	

Periodic Review Date _____ **Individual Service Plan Date:** _____

Verified by Evaluation Team:

Clinician Signature, Credential, Title: _____ **Date:** _____

Clinician Printed Name, Credential, Title:

Physician Signature, Credential: _____ **Date:** _____

Physician Printed Name, Credential, Title:

Client Signature:
☐ **I have participated in this review** _____ **Date:** _____

Parent/Guardian Signature:
☐ **I have participated in this review** _____ **Date:** _____

III: B. Planning Step 2:
Identify the unmet service needs and critical gaps within the current system.

Current Forces Directing SMHA Priorities

Community Mental Health Settlement Agreement

The State of New Hampshire's needs assessment "A Strategy for Restoration" (also known as the Ten Year Plan) was appended to the FY1 MHBG application. Since the plan was crafted in 2008, claims of over-utilization of institutions and prolonged wait times resulted in a class action suit, *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM*, filed in 2013 (attached), alleging "New Hampshire's administration of its mental health system violates the rights of individuals with SMI".

Twice a year, or more often if deemed appropriate by the Expert Reviewer (ER) specified in the Agreement, the ER will submit to the parties a public report of the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

The second semi-annual report of the Expert Reviewer (ER), required under the Settlement Agreement in the case of *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM* (attached), was released June 30, 2015. While the report cited progress, it also makes clear that much more needs to be done to bring the state into compliance with the agreement.

The settlement agreement, hereafter referred to as the Community Mental Health Agreement (CMHA) (attached), finalized in February 2014, mandates the State develop and implement certain services, including an expanded crisis system, expanded Assertive Community Treatment (ACT) and Supported Housing and Supported Employment programs. The services may be provided directly by the State or through contracts with CMHPs.

Priority populations named in the CMHA are adults who reside at New Hampshire Hospital (NHH) or Glencliff Home for the Elderly (GHE) who may have been "unnecessarily institutionalized".

A key priority for the ER during this second six-month period has been working with DHHS to further identify and access data that can be used to routinely track progress related to each element of the CMHA.

Although the CMHA makes these service improvements mandatory, they are, of course, reliant on funding. In a serious of difficult budget decisions, the NH legislature has struggled to find available funds to assist the Community Mental Health programs implement the elements of the CBHA.

Medicaid Expansion

Concurrently, Medicaid expansion, which hasn't been authorized to continue beyond SFY16, and the Affordable Care Act (ACA) has rendered more individuals eligible for Medicaid, and eligible for treatment of Substance Use Disorders (SUD). NH is reeling from increased drug-related deaths. The total number of confirmed deaths from drug overdoses in 2014 rose to at least 300, with the heaviest toll

shifting from middle-aged victims to young adults aged 21 to 30. This is an increase of 107 over 2013 – more than 1/3. Substance abuse prevention and treatment has become a legislative funding priority. The high level of attention and increased funds to help individuals suffering from SUD is a positive development; the slim budgeting methods of the NH Legislature could find funding for SED and SMI individuals to be at risk for cost-cutting or cost-shifting.

Medicaid Managed Care

During SFYs 2014 and 2015, New Hampshire has been in the process of implementing "Medicaid Care Management" (MCM), in an effort to help NH Medicaid recipients to coordinate their health care. The implementation has not been without setbacks, which have absorbed DHHS resources. These resources have been dwindling as the legislative budgeting process has mandated large cuts to the DHHS budget.

The Community Mental Health Centers (CMHCs) have devoted much of their operational resources to the shifting landscape of Managed Care. Most recently, CMHC contract renewals with the Managed Care Organizations have resulted in rate restructuring negotiations and an interim return to fee-for-service billing. It is difficult to incent the CMHCs to adopt new initiatives while they're struggling with their billing structures and the associated changes to the Electronic Medical Records (EMRs).

Children's Services

The Community Mental Health Centers maintain a Children's Directors network, and the BBH Children's Director (position currently vacant) serves as their liaison to statewide initiatives. In addition, the Children's Directors work closely with the University of New Hampshire (UNH) Institute on Disability on various evidence-based practices and initiatives, such as Project RENEW. More information on the RENEW IV Project may be found in Environmental Factors/18. Children's Services.

The NH Behavioral Health Advisory Council (NH-BHAC), along with their partners, the many child advocacy groups in the state, recognize the importance of early intervention in the incidence of mental illness symptoms in children and youth. Along with setting the foundation for First-Episode Psychosis, through provision of a training and supervision model, the use of the CANS as an objective instrument measuring improvement (or lack thereof) of functional impairments of CMHC-served youth and adolescents, and other initiatives, the NH-BHAC actively supports improving youth treatment practices.

CANS and ANSA

In 2013, the BBH contracted with a vendor to design and implement an online eligibility determination process that would ensure the State's ability to store and report on outcomes for the consumers it serves in the CMHCs. The eligibility determination process was based on a weighted rating system utilizing the Child and Adolescent Needs and Strengths assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) (attached).

CANS: Child and Youth Eligibility

The BBH performed extensive testing to devise algorithms that enable the CANS to be used to identify children and youth who are Severely Emotionally Disabled (SED) or Severely Emotionally Disabled with current interagency involvement (SED-IA), according to the abovementioned criteria. Children and youth thus identified are eligible for community-based rehabilitative services.

ANSA: Adult Eligibility

The BBH performed extensive testing to devise algorithms that enable the ANSA to be used to identify adults with Severe Mental Illness (SMI) or Severe and Persistent Mental Illness (SPMI), according to the abovementioned criteria. Adults thus identified are eligible for community-based rehabilitative services.

The ultimate goals of this project included creating a database capable of generating client level, regional and statewide outcome reports with capacity for graphical presentations of data.

The statewide adoption of the CANS/ANSA has been delayed due to the Community Mental Health Centers' absorption in MCM contracting. Currently only eight of the ten Community Mental Health Centers are using the CANS/ANSA. Only two have integrated the CANS/ANSA into their treatment planning system in the way it was intended, and the data collection process has been slow in achieving its goal of a statewide SED/SMI database.

NH System Transformation

The process of instituting an assessment that ultimately will be used state- and system-wide: the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths assessment (CANS) has absorbed the BBH's resources over the past 2 – 5 years. Once the Community Mental Health system has implemented the CANS/ANSA completely, our mid-range goal, to create the ability to "generate client level, regional and statewide outcome reports with capacity for graphical presentations of data" at the state and CMHC level will have been achieved.

At that time, the Department of Children, Youth, and Families (DCYF) will begin its implementation of the CANS, as a deliverable for its F.A.S.T. Forward SAMHSA Systems of Care grant for youth with SED, in conjunction with the Community Mental Health Centers.

The NH Department of Education (DOE), with its an $8.6 million grant from the Substance Abuse and Mental Health Administration (SAMHSA) to implement a four-year Safe Schools and Healthy Students State Planning Project, had included the CANS in its grant proposal and project plan. The three CMHCs involved in the project include the two who have not yet adopted the CANS. Consequently, CANS-assisted system transformation will most likely stop with the DCYF, as the DOE is considering dropping the requirement for use of the CANS.

Peer Support Agencies

As majority beneficiaries of the NH MHBG, the Peer Support Agencies have many successes to report, as well as plans for service enhancements.

INTENTIONAL PEER SPECIALIST

One of the most exciting developments in peer supports in NH has been the effort to establish Intentional Peer Specialists at community mental health centers. Peer Support Specialists are called for in the Community Mental Health Agreement as key members of the Assertive Community Treatment Teams. However, when the Community Mental Health Agreement was issued such positions did not exist, were not defined, and had no mechanisms for billing.

As such, the Bureau of Behavioral Health established a workgroup to develop a job description, training requirements, a code of ethics, and begin the process of making these positions Medicaid billable. This workgroup included representatives from the Bureau of Behavioral Health, the Office of Consumer and Family Affairs, Community Mental Health Centers, Peer Support Agencies, the Consumer Council, and individuals serving in peer specialist roles.

This wide variety of stakeholders created some dynamic tension which, in the end, led to a well-thought-out work product. A job description and training requirements have been developed, and soon a code of ethics will be finalized. At the same time we are prepared to begin work with Department Medicaid staff on recognizing these positions in such a way that their activities can be submitted to CMS for Medicaid billing. Thirty plus other states have followed this route so we do have guidance to follow.

Five of the ten Community Mental Health Centers currently have some sort of arrangement for Peer Specialists. Some have hired Peer Specialists outright; others are contracting with local Peer Support Agencies for those services.

It has been determined that the training and functions of the Peer Specialists will be based on standard evidence-based practices such as Intentional Peer Support (IPS), Wellness Recovery Action Plans (WRAP), and Whole Health Action Management (WHAM). Peer Specialists will serve as equal team members on ACT Teams.

The SMHA has received confirmation of the acceptance of a SAMHSA Technical Assistance (TA) request to begin the process.

PSA Hours Of Operation

In response to the CMHA, all PSA sites increased their hours to at least 44 hours per week.

PSA Conference

The first statewide peer support agency conference in several years was held in 2014 with over 100 participants. Presenters included Mathew Federici from the Copeland Center, the NH Attorney Generals Charitable Trust Office, a panel of PSA representatives, and others. Annual conferences are anticipated.

PSA Utilization Data

Considerable effort went into the refinement of the PSA statistical tool used to collect utilization data from the PSAs. These efforts included revisions to the tool and the instructions distributed to all PSAs. Revisions included recognition of PSA efforts in the areas of transitional housing, permanent housing and transportation. In addition there were two consecutive training sessions offered at the statewide conference mentioned above.

CURRENT PSA INTERNAL TRAINING CAPACITY

The NH PSA system increased its internal capacity for training and provided the first IPS training facilitated by approved NH providers. This eight week training was held in the fall of 2014 and is

anticipated to be offered annually. In addition the first WRAP training, co-facilitated by an approved NH advanced WRAP facilitator, was held in the spring of 2015.

PSA Directors participated in a facilitated retreat in the summer of 2015 intended to develop a training plan focused on the immediate future.

PEER SUPPORT AT NH HOSPITAL

In 2014 a peer specialist role was created at the single state run psychiatric hospital in NH. This position, the first of its kind in NH was filled by a former PSA Director. The position will serve to inform patients regarding peer support philosophy and services and to act as a liaison to community based peer support services.

Future PSA Internal Training Capacity

The peer support system in NH is heavily reliant on training including IPS, WRAP, warmline and others. It is essential that the NH PSA system continue to develop its internal training capacity. NH hopes to increase both its IPS and WRAP trainers to three within the next year. Three trainers would ideal, as two trainers are required to co-facilitate each training. NH will continue to explore possibilities in expanding internal warmline capacity.

Continued Expansion Of Programming

The NH PSA system will continue to explore the expansion of programming such as enhanced whole health integration and mindfulness, utilizing the application of the theories of mindfulness cultivation as antidote to aspects of mental illness.

FUTURE GOALS

NEED FOR IMPROVEMENT 1: (PRIORITY 1) Improve COMMUNITY-CENTERED CARE

For most people, a lack of belongingness in life is a temporary, unpleasant experience that is overcome by reappraising relationships, mending friendships, seeking new social bonds, and participating in social activities. These people never feel fully disconnected from society as a whole and are able to make appropriate interpersonal changes in their lives to reestablish a sense of belonging.

For a smaller segment of the population, exemplified by consumers utilizing the NH Peer Support Agencies (PSAs), a lack of belongingness – social connectedness - can be a persistent and pervasive experience that is psychologically distressing and potentially debilitating. These individuals may have some friendships but nevertheless tend to feel like loners or outsiders. They may have difficulty maintaining relationships, avoid social activities because of fear of rejection or exclusion, and may feel themselves to be interpersonally ill-equipped to overcome their circumstances

The NH Behavioral Health Advisory Council (NH-BHAC) has identified the need for improved outcomes in the realm of social connectedness across the system, but especially for those served by the Peer Support Agencies (PSAs). The URS tables cite the number of consumers reporting improved social connectedness in FFY 2014 was 57%, compared to a US average of 72.8%. This data does not include PSA survey data, because PSA survey data is not aggregated in such a way as to effectively measure social connectedness, but may be used for comparative purposes. Preliminary research of instruments attempting to measure social connectedness has already commenced.

The NH-BHAC feels the needs of consumers for improved functioning in the community as a priority target area, and so has indicated it as the first goal for this period. Using existing PSA survey questions, the SMHA will contract with a recognized university statistical expert to draft an algorithm that will accurately measure social connectedness for PSA consumers.

The first-year survey results, as expressed by the algorithmic measure, will provide baseline data. The BHAC and SMHA will work with the PSAs to determine methods of improving the sense of social connectedness reported by PSA consumers, as evidenced by the survey data.

- URS tables cite the number of consumers reporting improved social connectedness in FFY 2014 was 57%, compared to a US average of 72.8%.

NEED 2: (PRIORITY 2) CRISIS RESPITE

In times of crisis, people feel alone with their anxiety, panic, anger, frustrations and depression. One of the goals of peer-run crisis respite is to provide connections and relationships that can lessen the intensity of these feelings. These non-medical alternative programs offer a comfortable, non-judgmental environment in which one might be able to process stresses as well

as explore new options. The hope is that these interactions will result in fresh, short-term solutions and a wider array of options for handling future crises.

As people have an opportunity to stay connected to peers while moving through challenging thoughts, feelings and impulses, the need for external intervention is diminished. This alternative approach to handling crisis teaches people healthier attitudes about themselves and others. With increased skills, individuals can reduce or even eliminate their susceptibilities to the pressures that cause overwhelming emotional distress.

It must also be noted that Sheri Mead developed NH's first peer-run crisis respite program while Director of Stepping Stone Peer Support in Claremont, NH. This model has received national and international attention.

Established in 1995, Stepping Stone is an active peer center open 7 hours a day Monday through Saturday with a variety of activities for clients and with two bedrooms for those who choose to stay as respite guests. People who choose to say as guests stay overnight from one to seven days and are welcome to bring their pets. This is an alternative to psychiatric hospitalization, serving individuals with overwhelming feelings including those who feel so badly that they do not want to continue living. Guests are free to come and go. Some continue to go to work and stay overnight at Stepping Stone. Guests bring and cook their own food and can have 24-hour peer support available to them.

Stepping Stone Crisis Respite Program creates an opportunity for people to learn from, and be supported in making the transition from crisis to wellness. Within the context of a mutually responsible relationship, and with the help of consumer staff's experiential knowledge and training, those who sincerely wish to overcome their difficulties can greatly reduce the use of more restrictive hospital settings, including involuntary admissions. All services are free to New Hampshire residents.

NH has successfully replicated the model in one additional region and is ready to open two more programs once delays in the state budget are overcome.

In 2014 the second crisis respite program in NH came online in Nashua, NH. This 2 bed program is managed by the H.E.A.R.T.S. , the most recent peer support agency inn NH and the first in this region of the state.

Implementation of two additional peer run crisis respite programs has been delayed due to state budget hurdles. Once a state budget is adopted, these two new programs will be implemented bringing the number of statewide respite beds to seven.

- In SFY 13, there were 22 persons were reported served. In SFY14, 32 were reported served.

NEED 3: (PRIORITY 3) CERTIFIED INTENTIONAL PEER SPECIALIST

One of the most exciting developments in peer supports in NH has been the effort to establish Intentional Peer Specialists at community mental health centers. Peer Support Specialists are called for in the Community Mental Health Agreement as key members of the Assertive Community Treatment Teams. However, when the Community Mental Health Agreement was issued such positions did not exist, were not defined, and had no mechanisms for billing.

As such, the Bureau of Behavioral Health established a workgroup to develop a job description, training requirements, a code of ethics, and begin the process of making these positions Medicaid billable. This workgroup included representatives from the Bureau of Behavioral Health, the Office of Consumer and Family Affairs, Community Mental Health Centers, Peer Support Agencies, the Consumer Council, and individuals serving in peer specialist roles.

This wide variety of stakeholders created some dynamic tension which, in the end, led to a well-thought-out work product. A job description and training requirements have been developed, and soon a code of ethics will be finalized. At the same time we are prepared to begin work with Department Medicaid staff on recognizing these positions in such a way that their activities can be submitted to CMS for Medicaid billing. Thirty plus other states have followed this route so we do have guidance to follow.

Five of the ten Community Mental Health Centers currently have some sort of arrangement for Peer Specialists. Some have hired Peer Specialists outright; others are contracting with local Peer Support Agencies for those services.

It has been determined that the training and functions of the Peer Specialists will be based on standard evidence-based practices such as Intentional Peer Support (IPS), Wellness Recovery Action Plans (WRAP), and Whole Health Action Management (WHAM). Peer Specialists will serve as equal team members on ACT Teams.

The SMHA has received confirmation of the acceptance of a SAMHSA Technical Assistance (TA) request to begin the process.

- Five of the ten Community Mental Health Centers currently have Peer Specialists on ACT teams.

NEED 4: (PRIORITY 4) CHILDREN AND YOUTH

It is no secret that, although the child-serving system in NH is vital and powerful, there is a lack of whole-child vision. Use of the CANS across the child-serving system is a step towards ameliorating that situation. At the other end of the spectrum, providers of child and youth mental community mental health services decry the cookie-cutter approach to treatment. A workgroup composed of a selection of Children's Directors from the CMHCs has selected an evidence-based treatment modality they felt was best suited to improving treatment through an individualized approach.

These efforts to find a scientifically-proven means to improve functioning and reduce out-of-home placements in the state's SED population occurred under the sponsorship of the SMHA and the MHBG. Shortly, the NH SMHA will negotiate a contract for an expert Trainer to introduce the MATCH (Modular Approach to Therapy for Children-Anxiety, Depression, Trauma, and Conduct Problems) evidence-based model to the NH CMHC system.

Multisystemic therapy (MST) is an intensive family- and community-based treatment for adolescent youth who engage in severe willful misconduct that places them at risk for out-of-home placement. Based on the findings from eight published outcomes studies, MST has demonstrated considerable promise in the treatment of youths with criminal behavior, substance abuse, and emotional disturbance. Several follow-up studies have found that MST can prevent psychiatric inpatient hospitalization and is related to increased family cohesion, decreased youth aggression in peer relations, and fewer re-arrests at four-year follow-up as compared with individual therapy.

- There is currently one MST-trained practitioner in the CMHP system

NEED 5: (PRIORITY 5) PERFORMANCE MEASUREMENT

Client-Level Data (CLD)

Data make a difference. Much more than just numbers, data provide a means to improve service delivery. From identifying populations that fall out of care to charting a client's response to a new treatment regimen, data paint a picture of what providers are doing well and what they can do better.

Data also help the Substance Abuse and Mental Health Services Administration (SAMHSA) ensure the most effective use of its funds in increasing access to treatment and care and addressing health disparities. With grantee data reports, which track client demographics, core medical and social services provided, and client outcomes, SAMHSA can meet legislatively mandated reporting requirements and evaluate the impact and quality of services funded by the Block Grant Program. Data reports also let grantees monitor their own progress in delivering cost-effective care and show where improvements can be made in their own programs. Making changes to better serve our clients depends on having the most accurate data possible. Access to client-level data ensures this accuracy. With client-level data, grantees and SAMHSA receive comprehensive information on each client and the care he or she has received. For years, NH's URS reports have included aggregate data from providers, which led to duplicated counts when clients visited multiple providers or had multiple eligibility categories over the course of the date range. Unduplicated, client-level data, in contrast, allow grantees to track the true number of clients in care as well as the services received by each client, the quality of those services, and health outcomes, thereby giving the full scope of a client's health. With this data, grantees can better track progress on meeting performance measure guidelines, and the NH Department of Health and Human Services can ensure that it continues to reach the communities most in need of support.

- Currently our needs are served by ad hoc client count reports with duplicated counts.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Data Collection and Reporting System

The state's mental health database, Phoenix, has been successfully revised to accommodate SAMHSA-mandated client-level reporting as well as internal Bureau of Behavioral Health (BBH) needs related to the Community Mental Health Agreement (CMHA). The new file structure includes a unique client ID (identifier), which will appear de-identified to external viewers, as well as all fields required for future client-level reporting by service, program, and provider. The New Hampshire (NH) Data Infrastructure Grant (DIG) supported this important development.

The transition to Managed Care has fractured the Medicaid reporting system. Consumers covered under capitated Managed Care are tracked in one system, with accessible data, while consumers continuing to be served under a fee-for-service system are tracked in a separate database, and this data is currently unavailable to the NH DHHS.

The Bureau of Drug and Alcohol Services (BDAS) tracks their consumers in a proprietary system.

New Hampshire Hospital tracks psychiatric client-level episodes and treatment through its electronic record, the AVATAR system.

Homeless and Housing services manage individuals, including SMI consumers, in a separate system, while the Division of Children, Youth, and Families utilizes still another system.

None of these systems “speak” to one another completely. Efforts are underway to consolidate these and other Public Health systems. Obstacles abound, but consolidated system-wide data reporting has emerged as a priority, spurred by the requirements of the CMHA. Currently, the Phoenix and AVATAR systems have a limited ability to merge. This was an accomplishment achieved within the past year, and is still in its early stages.

The most recent status report on the state’s progress on the CMHA has increased the pressure on DHHS to bring data coordination into compliance with the agreement. New Hampshire’s DHHS is currently undergoing a re-design process in an effort to reduce the barriers between agencies and contribute to a shared vision of service to all consumers, including those suffering from SMI and SED.

New Hampshire is in the process of incorporating elements of the Draft Client-Level Measures one of several ways: within the Phoenix system, via consumer surveys, or through data merged from other systems.

Technical assistance in this area is desperately needed. Information technology resources in NH’s state system are extremely limited, and are in high demand from agencies with competing priorities. Contracting with private vendors seems to be the most effective way to achieve high-quality process and product improvement.

We have one planning goal that seeks to address this need.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Community-Centered Care

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To increase the social connectivity of consumers served in consumer-operated services and programs.

Objective:

The Peer Support Survey will provide data that will support a quantifiable increase rate in social connectivity for PSA consumers.

Strategies to attain the objective:

An algorithm will be drafted to indicate social connectedness for PSA consumers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Counts of persons served.

Baseline Measurement: URS tables cite the number of consumers reporting improved social connectedness in FFY 2014 was 57%, compared to a US average of 72.8%. This data does not include PSA survey data, because PSA survey data is not aggregated in such a way as to effectively measure social connectedness, but may be used for comparative purposes.

First-year target/outcome measurement: Improved social connectedness will be reported by 60% of PSA consumers.

Second-year target/outcome measurement: Improved social connectedness will be reported by 65% of PSA consumers.

Data Source:

BBH data systems and Peer Support Survey responses and report

Description of Data:

The annual PSA survey is conducted annually via an online survey service. The survey is accessed by consumers at the eight Peer Support Centers across the state. The online service aggregates the data, which is charted and analyzed by the BBH.

Data issues/caveats that affect outcome measures::

The response rate and subjectivity of consumer surveys may reduce their reliability.

Priority #: 2

Priority Area: Reduced cost of behavioral health care

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

To reduce the rate of adult psychiatric hospitalizations.

Objective:

To utilize consumer-run Crisis Respite programs as an alternative to psychiatric hospitalizations.

Strategies to attain the objective:

Crisis respite programs have been nationally proven to reduce hospitalizations. The SMHA will promote the establishment of at least two additional consumer-run Crisis Respite programs to the two existing programs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Counts of persons served in Crisis Repite.
Baseline Measurement:	In SFY 13, there were 22 persons were reported served. In SFY14, 32 were reported served.
First-year target/outcome measurement:	For SFY 16, persons served will increase by 20% over the SFY15 total unduplicated count of persons served.
Second-year target/outcome measurement:	For SFY 17, persons served will increase by 10% over the SFY16 total unduplicated count of persons served.

Data Source:

PSA Statistical Reports

Description of Data:

Monthly census, service, and training utilization data is collected from each of the eight PSAs via a standard reporting tool. Data from this tool is aggregated into a summary report for the SMHA.

Data issues/caveats that affect outcome measures::

Considerable effort has gone into the refinement of the PSA statistical tool. These efforts included revisions to the tool and the instructions distributed to all PSAs. As data definitions change, year-over-year reporting may be adversely affected.

Priority #:	3
Priority Area:	Encourage effective coordination within behavioral health care, and between behavioral health care and recovery support services.
Priority Type:	MHS
Population(s):	SMI

Goal of the priority area:

To utilize the Certified Peer Specialist model within Assertive Community Treatment (ACT) teams and Mobile Crisis teams.

Objective:

The SMHA will meet and exceed the terms of the CMHA by developing a Certified Peer Specialist (CPS) program

Strategies to attain the objective:

Technical Assistance (TA) provided by SAMHSA involving consultation with other states within Assertive Community Treatment (ACT) teams and Mobile Crisis Teams.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Counts of Peer Specialists at each CMHC.
Baseline Measurement:	Five of the ten Community Mental Health Centers currently have Peer Specialists on ACT teams.
First-year target/outcome measurement:	Seven of the ten Community Mental Health Centers will have Peer Specialists on ACT teams.
Second-year target/outcome measurement:	Each of the ten Community Mental Health Centers will have Peer Specialists on ACT teams.

Data Source:

CMHC ACT data reports submitted to the SMHA.

Description of Data:

ACT program and staffing data provider and location data submitted by the CMHCs.

Data issues/caveats that affect outcome measures::

Discussions are currently taking place formalizing the role of Peer Support within the CMHC program models.

Priority #: 4

Priority Area: Evidence-Based Practices; Person-Centered Treatment

Priority Type: MHS

Population(s): SED

Goal of the priority area:

To improve functioning and reduce out-of-home placements in the state's SED population treated using the MATCH program model.

Objective:

To assist the CMHCs in providing evidence-based alternatives, to fidelity, to current practices and thereby improve SED client outcomes.

Strategies to attain the objective:

The SMHA will announce an RFP for a Trainer to introduce the MATCH (Modular Approach to Therapy for Children-Anxiety, Depression, Trauma, and Conduct Problems) evidence-based model. A qualified vendor will provide 3, two-day training sessions and one year of supervision to practitioners at the CMHCs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: MATCH being utilized in CMHPs with fidelity.

Baseline Measurement: There is currently one MATCH practitioner in the CMHP system.

First-year target/outcome measurement: 30 CMHC child and family clinicians will be trained.

Second-year target/outcome measurement: 60 CMHC child and family clinicians will be trained.

Data Source:

Attendance sheets and the data-tracking system provided by the MATCH training vendor.

Description of Data:

The MATCH data system will provide practitioner reports, fidelity and client outcome reports.

Data issues/caveats that affect outcome measures::

Ongoing sustainability of the MATCH model will need to be assured, preferably through ongoing consultation. This may require multi-year funding.

Priority #: 5

Priority Area: Performance Measurement and Coordinated Care

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

To improve the ability of the statewide CMHP system to accurately measure SMI and SED client improvement.

Objective:

Create a means to evaluate the success of evidence-based practice programs by building a robust and accessible means for CMHPs and the SMHA to analyze accurate client data.

Strategies to attain the objective:

Adapt data structures at the state level to adhere with federal NASHMPD and SAMHSA specifications; create "dashboards" for CMHPs, the SMHA, and SAMHSA and NASHMPD contractors. These dashboards will each serve the purpose of allowing users to collect and analyze client-level data to create management-level reports. The reports will assist the users in program evaluation. Train the CMHCs to use this system with a minimum of difficulty.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Data dashboards allowing the SMHA and its partners the ability to easily access and use to targeted client-level data analysis tools.
Baseline Measurement:	Ad hoc client data reports on the ACT and Supported Employment programs are disseminated to he CMHCs to help them bring their programs into .
First-year target/outcome measurement:	All 10 CMHCs will be trained on one data dashboard created that will depict accurate NH client counts based on SMI or SED status, by geographic location.
Second-year target/outcome measurement:	All 10 CMHCs will be trained on an additional data dashboard that will depict accurate client counts by ACT and Supported Employment program participation.

Data Source:

The Phoenix database, the Medicaid MMIS, and the CANS/ANSA database, and any others that may be incorporated and any other database that may be applicable and available.

Description of Data:

Client-level service, claims, diagnosis, program-level, and demographic data.

Data issues/caveats that affect outcome measures::

The CMHA places heavy demands on data expert resources in the Department of Health and Human Services. Restructuring of the NH DHHS has created a temporary situation where data support targeting SMI and SED treatment needs, though skilled, is extremely limited at this time to the demands of the CMHA. Some of the program improvement indicators that the CMHA calls for (ACT and SE reporting) have thus been he impetus for this Block Grant goal. Previous data reporting mechanisms have been identified that created inaccurate census reports.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$2,621,516	$0	$0	$0	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$327,690	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$327,690	$0	$0	$0	$0	$0
11. Total	$0	$3,276,896	$0	$0	$0	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

This is the way we have historically filled out this table, reporting only on MHBG funds. It's worth noting that NH is not like other states: the state hospital is operated as a distinct program, independent of the SMHA as it's currently structured. We don't have ready access to data regarding other sources of state funds (Medicaid, other federal funds, local funding), or funding of programs outside the SMHA's purview

and not supported by SMHA funds. Therefore, we are unable to submit for those lines. For this table, only MHBG spending is reportable by the SMHA.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	$
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	$134,134

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	$
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	$
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	$200,000
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	$
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	$68,424
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	$2,616,822
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	$
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	$
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	$379,762
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	$
Total	$3,399,142

Footnotes:

The $200,000 planned for evidence-based outpatient practices is earmarked for Project MATCH training and implementation.

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	$5,000
MHA Planning Council Activities	$40,000
MHA Administration	$184,122
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	$229122
Comments on Data:	

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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[26] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013;91:102–123

http://www.who.int/bulletin/volumes/91/2/12-108282.pdf; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52–77

[27] Research Review of Health Promotion Programs for People with SMI, 2012, http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper; About SAMHSA's Wellness Efforts,

http://www.promoteacceptance.samhsa.gov/10by10/default.aspx; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, http://www.integration.samhsa.gov/health-wellness/samhsa-10x10 Schizophrenia as a health disparity, http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml

[28] Comorbidity: Addiction and other mental illnesses, http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; http://www.samhsa.gov/co-occurring/

[29] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); JAMA. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

[30] A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk; http://circ.ahajournals.org/

[31] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39;

http://www.cdc.gov/socialdeterminants/Index.html

[32] Depression and Diabetes, NIMH, http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5;Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780

[33] J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, Journal of Clinical Psychology Practice, 2011 (2) 33-40

[34] C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, Diabetes Care, 2010; 33(5) 1061-1064

[35] TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

[36] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011,

http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf;. Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges.* Baltimore, MD: The Hilltop Institute, UMBC.

http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf; American Psychiatric Association, http://www.psych.org/practice/professional-interests/integrated-care; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, http://nasadad.org/nasadad-reports

[37] Health Care Integration, http://samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

[38] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361; Telebehavioral Health and Technical Assistance Series, http://www.integration.samhsa.gov/operations-administration/telebehavioral-health State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8; National Telehealth Policy Resource Center, http://telehealthpolicy.us/medicaid; telemedicine, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html

[39] Health homes, http://www.integration.samhsa.gov/integrated-care-models/health-homes

[40] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[41] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html;Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS

[42] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

[43] Medicare-Medicaid Enrollee State Profiles, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html; About the Compact of Free Association, http://uscompact.org/about/cofa.php

[44] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, http://www.cbo.gov/publication/44308

[45] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[46] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[47] http://www.nrepp.samhsa.gov/

[48] Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

[49] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, http://annapoliscoalition.org/?portfolio=publications; Creating jobs by addressing primary care workforce needs, http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html

[50] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[51] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. System Integration: Section 1115 Medicaid Demonstration Waiver

The State of New Hampshire Department of Health and Human Services (DHHS) as the single state Medicaid agency is seeking Section 1115 Demonstration Waiver authority from the Centers for Medicare and Medicaid Services (CMS) to support the comprehensive reform of its Medicaid program. The initiatives proposed within this "Building Capacity for Transformation" section 1115 Demonstration Waiver will include improvements to the delivery of mental health, physical health, substance use disorder (SUD), oral health, and population health programs and services. New Hampshire requests authority to recognize costs not otherwise matchable from local and state health expenditures to implement these programs. The freed-up state and local funding would provide needed financial assistance to pursue meaningful delivery system reforms that will help improve the New Hampshire health care system.

The Waiver, titled *Building Capacity for Transformation*, proposes to address:

- The fragility of the current behavioral health delivery system;
- The challenges facing the behavioral health delivery system in meeting the needs of individuals; and
- The fragmented delivery system for individuals with complex health needs.

The Waiver addresses these needs by:

- Enhancing and expanding existing programs;
- Creating new programs that support New Hampshire's overall health care reform goals; and
- Coordinating new and existing programs in order to focus holistically on the needs of the individuals we serve.

The Waiver proposes six (6) specific Designated State Health Programs (DSHPs) that:

1. Establish a community reform pool that stabilizes the current behavioral health delivery system and supports providers' active participation in delivery system reform initiatives.
2. Implement components of its *Ten Year Mental Health Plan* and its December 2013 settlement agreement with the United States Department of Justice (U.S. DOJ) for the State's non-Medicaid population.
3. Enhance and sustain components of its System of Care/Family and Systems Together (F.A.S.T. Forward) program that supports children and youth with serious emotional disturbances (SED).
4. Administer a grant program that would fund workforce development initiatives focused on substance use disorder (SUD) and other behavioral health treatments and services.
5. Extend the current InSHAPE health promotion program to new providers and participants and include a tobacco cessation component.
6. Establish an oral health pilot program for pregnant women and mothers of young children until their child reaches his/her fifth birthday.

The 1115 waiver, in concert with the Medicaid coverage expansion and managed care initiatives, is intended to foster increased integration of physical health and behavioral health services. These integration efforts are intended to benefit many of the same people identified as priority consumers under the Agreement. Assuming the federal Centers for Medicare and Medicaid Services (CMS) approves the final waiver submission, activities under the waiver will be monitored to the extent they directly contribute to attainment of the objectives and quality standards of the Agreement.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The data system used by the State Mental Health Authority (SMHA) is named Phoenix and has capacity to report race, ethnicity, gender, and age. However, often, race and ethnicity are reported as "unknown" by the Community Mental Health Centers (CMHC) Quality of that data will depend on how completely the CMHCs report.

2. The SMHA will attempt to provide technical assistance to the CMHCs to ensure standardized responses and accuracy of information.

3. The Office of Minority Health and Refugee Affairs (OMHRA) has a strategic plan to provide culturally competent mental health screening services to refugees and minorities in the state of New Hampshire (NH). The OMHRA partners the SMHA as well as with contracted agencies to also provide a wide array of supportive services such as language interpreters, language teaching services, and case management to assist people with resettlement.

4. The CMHCs have language interpreters both onsite and available through outside agencies such as Certified Languages International and the Language Bank. All CMHCs are also contractually required to provide meaningful and effective treatment for those consumers who are deaf or hard of hearing. The Deaf Service Program ensures that CMHC staff who are fluent in American Sign Language (ASL) are available for these consumers.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III: C.3. Use of Evidence in Purchasing Decisions

New Hampshire tracks and disseminating information regarding evidence-based (EBP) required as provisions of the CMHA. Data on these practices is reported monthly by the CMHCs. Annually, the Phoenix system generates EBP penetration based on services records and reports that data using the block grant Uniform Reporting System (URS).

The CMHCs receive incentive funds to assist them in the implementation and provision of the EBPs specified in the CMHA and in their contracts.

Information involves research reports and, importantly, the assistance of our research partner, the Geisel School of Medicine at Dartmouth University, a leader in EBP development.

New Hampshire's evidence-based practices for adults in the community mental health centers system include**:**

- Assertive Community Treatment (ACT); data collected by SMHA and reported in the Mental Health Block Grant (MHBG)
- Illness Management and Recovery (IMR); data collected by SMHA and reported in the MHBG
- Supported Employment (SE); data collected by SMHA and reported in the MHBG

NH's grant-funded PSAs, statewide, provide the evidence-based practice of Wellness Recovery Action Plan (WRAP) and the emerging promising practice of Intentional Peer Support (IPS). Organized peer support in general is being looked at as an emerging promising practice, and standards and competencies for credentialing are being formulated.

The RENEW model continues to hold promise as an evidence based practice for young people in New Hampshire where RENEW was first developed and implemented.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The SMHA uses BIP and TTI funds to support the implementation the use of the CANS and the ANSA for assessment of all clients at admission to the Community Mental Health Centers, and periodically thereafter. Tracking the items assessed provides insight into the SED or SMI client's illness and impairments, and measures progress toward recovery.

What are the CANS and ANSA?

- Consistent and comprehensive information integration tools
- Facilitate communication of assessment of needs and outcomes
- Items were selected because they are relevant to service planning
- Four level rating based on past 30 day functioning in absence of service
- Web-based data repository allows outcomes tracking

Current NH DHHS CANS Implementation

- 1.Bureau of Behavioral Health
- 2.DCYF
- 3.Department of Education

Other (non-BBH) Statewide Efforts

Family Centered Early Supports and Services

New Hampshire participates in The Individuals with Disabilities Education Improvement Act Part C program, referred to in NH as Family Centered Early Supports and Services (FCESS). FCESS is program for Infants and toddlers ages birth to 3 who qualify for early intervention services under one of four categories; at-risk for developmental delay, developmental delay, established condition or atypical development.

After the referral is made, the next step is to have the child assessed. During the assessment process, a child's motor skills, communication development, learning skills, social interaction and emotional development are fully evaluated. Once completed, and the child is found eligible, an Individualized Family Support Plan is developed for the child and the family. By working Closely with parents, family centered early supports and services ensure that both services, formal and informal, and community supports are brought together to meet each child's unique needs and the needs of their families.

Family Centered Early Supports and services are provided in all communities throughout New Hampshire within the child's home or where the child spends time.

Watch Me Grow

Watch me Grow is a screening and referral system for NH families ages birth to six. It combines state and local resources to provide families with information about child development, conduct screenings using Ages and Stages Questionnaires for their children and make referrals to the appropriate state and local resources. Ages and Stages Questionnaires (ASQ), are developmental and social-emotional screenings. They are designed for children ages 1 month to 5-1/2 years of age and help identify strengths and concerns as well as educate parents about child development. For more information about Watch Me Grow, or to request an Ages and Stages Questionnaire, contact your local Watch Me Grow Site.

The New Hampshire Association for Infant Mental Health

The New Hampshire Association for Infant Mental Health (NHAIMH) works to ensure healthy social emotional development before birth and beyond. They promote evidence-based and evidence-informed practices to strengthen collaboration, services and supports for families with infants and young children.

Their goals include:

- Increase public awareness of the importance of infant and early childhood mental health, and assure that the needs of diverse populations are considered in all public awareness activities.
- Provide opportunities for increasing expertise in early childhood and family mental health (ECFMH).
- Utilize a wide array of communication technologies to increase awareness and understanding of, and access to NHAIMH and the field of Infant Mental Health (IMH).
- Increase effectiveness, efficiency and sustainability of NHAIMH.

Home Visiting New Hampshire (HVNH)

Home Visiting New Hampshire (HVNH), administered through the Division of Public Health Services, is a preventive program that provides health, education, support and linkages to other community services for Medicaid-eligible pregnant women and their families in their homes. Eighteen community-based HVNH programs across the state serve over 700 families per year. Together families and home visitors talk about concerns such as stopping smoking, depression and access to reproductive healthcare. Families get support in their roles as their child's first and best teacher and learn ways to help their child grow and learn.

The eighteen community-based agencies across New Hampshire provide HVNH services to Medicaid-eligible pregnant women and Medicaid-eligible families with children up to the age of one.

Particular emphasis is placed on:

- Adolescents who are pregnant or are new moms
- Women under age 25 who are pregnant or who are new moms
- Women pregnant with their first child
- Women at risk for having problems during their pregnancy
- Pregnant women or mothers with substance abuse problems
- Families at risk for child abuse and neglect

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The SMHA is finalizing an RFP for FEP-EBP training, to be released shortly, that will utilize the 5% MHBG set-aside funds for FFY2015. Extended vacancies in the State Planner and other positions at the BBH, combined with recent increases in the complexity and centralization of the DHHS contracting process, including RFP review, caused the FEP RFP release to have been delayed beyond September 1, 2015. Consequently, without an extension of the FFY2014 funds, they will remain unexpended. This is more than unfortunate; the SMHA as alerted SAMHSA and requested an extension of these funds.

The FFY2014 funds were to have been applied to planning, training, and/or infrastructure development, including execution of a training plan for Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (CSC). Program implementation efforts were to have been second year plan targets. This remains the plan as defined by the draft RFP for First-Episode Psychosis (FEP). FFY2015 funds will be applied to the contract award.

The RFP in process states, "Data accumulated over the past two decades supports the value of early intervention following the first episode of psychosis. Clinical research conducted world-wide supports a variety of interventions for ameliorating psychotic symptoms and promoting functional recovery in FEP."

These evidence-based components often come together in specialized early intervention programs that emphasize:

- Prompt detection of psychosis.
- Acute care during or following periods of crisis.
- Recovery-oriented services offered over a 2-3 year period following psychosis onset.

Results from the NIMH funded *Recovery After an Initial Schizophrenia Episode* (RAISE) research initiative suggest that mental health providers across multiple disciplines can learn the principles of CSC for FEP, and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a team-based, collaborative, recovery-oriented approach involving individuals experiencing first episode psychosis, treatment team members, and when appropriate, family members as active participants. CSC components emphasize outreach, low-dosage medications, cognitive and behavioral skills training, supported employment and supported education, case management, and family psychoeducation. While these individual approaches are available to some extent now, the goal of RAISE is to provide an integrated system of intervention, incorporating varied approaches in a systematic way, tailored to individuals, and achievable in the real-world environments in which people with schizophrenia obtain assistance. CSC also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with such individuals and their family members over time. Peer supports can also be an enhancement in this model. Many also braid funding from several sources to expand service capacity.

Currently, two community mental health centers (MCHC) in New Hampshire (NH) are participating in the RAISE Early Treatment Program (ETP) under the direction of Dr. John Kane of the Feinstein Institute for Medical Research in Manhasset, NY. Both of the CMHCs are in urban settings of NH with high population concentrations. One center is working as a control group and the other is a NAVIGATE site. Although for research purposes, the control group is not implementing the NAVIGATE model, the interventions offered to consumers are all evidence based and are recommended for FEP.

While RAISE is specific to schizophrenia, the evidence based components can be delivered to meet any individual's needs who are experiencing FEP or first episode of severe mental illness. CMHCs in NH

have already begun outreach to local schools and developing school based programs to increase early intervention efforts.

According to the US Census numbers for 2013, the population of NH is 1,323,459. An estimated 1-2% of the population will experience psychosis, typically between the ages of 15-25. NH has 23 undergraduate colleges and universities with out-of-state enrollment, which has a potential to inflate the numbers of youth experiencing psychosis in the state. Additionally, other populations to be included are veterans and refugees. NH has become home to over 7500 refugees in recent years and special care must be taken to provide for their behavioral health needs, including FEP.

The approved CSC practice for New Hampshire will include evaluation of early psychosis and a determination of how long an individual can have had psychotic symptoms, as well as a definition of what constitutes psychotic symptoms. In addition, covered populations will have met state SED or SMI eligibility criteria using the Child and Adolescent Needs and Strengths assessment (CANS) or the Adult Needs Assessment (ANSA). Additional inclusion or exclusion criteria (diagnostic, developmental, medical; or anticipated availability for attendance, etc.) may also need to be included when considering an individual's eligibility for First Episode Psychosis (FEP) services.

The RAISE project is designed to alter the long-term disability that can result from schizophrenia and help ensure that people with the disease can lead productive, independent lives. Preventing the disability associated with schizophrenia also has the potential to reduce the disease's impact on public systems, such as Social Security, law enforcement, state mental health services, and private organizations that serve those with mental illnesses.

Sustainability

Recent studies emphasize continuity of specialized care for up to five years post-psychosis onset in order to consolidate gains achieved through initial treatment.

Critical post-implementation issues involve sustainability of the model: ongoing training and supervision of team members, ways to measure fidelity to the team model, and how to build supervision and fidelity assessment into ongoing practice within the clinic.

Anticipated Costs FFY2015 (Carryover funds from the 2014-2015 MHBG)

Anticipated costs will include contracting with the certified EBP consultant for training staff to provide coordinated specialty care and developing training and support materials ($40,000), ongoing consultation ($10,000). The consultant will also provide access to and management of client level demographic and outcomes data generated by enrollment ($35,000). It is anticipated that the 5% set-aside will be sufficient to cover these costs.

Anticipated Costs FFY2016

Anticipated costs will include contracting with the certified EBP consultant for providing support and case consultation to program leaders who have been in turn been supervising those on their team who have been providing coordinated specialty care and developing training and support materials ($30,000), ongoing consultation and fidelity reviews and reports ($30,000). The consultant will also provide access to and management of client level demographic and outcomes data generated by enrollment ($33,000). It is anticipated that the 5% set-aside will be sufficient to cover these costs.

Anticipated Costs FFY2017

Anticipated costs will include contracting with the certified EBP consultant for training staff to provide support and case consultation to program leaders who have been in turn been supervising those on their

team who have been providing coordinated specialty care ($20,000); to assist in developing a training and fidelity support model ($10,000). The consultant will also provide assistance in the migration of client level demographic and outcomes data generated by enrollment ($35,000) to the State Mental Health Authority. The remainder of the 5% set-aside ($28,000) will be employed for technical assistance in constructing a fully integrated outcomes reporting and Medicaid billing model.

The online CANS/ANSA system will also capture client eligibility baseline and outcomes data. The SMHA will assume costs for this data management system.

II: Planning Steps

Priority #: 1

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SED, SMI

Goal of the priority area:

To determine populations experiencing first-onset psychosis.

Strategies to attain the goal:

Evaluation through use of the CANS/ANSA along with bio-psychosocial evaluations

Indicator #: 1

Indicator: Eligibility for FEP

Baseline Measurement: For 2014, CMHPs reported SMI (Severe Mental Illness for less than 12 months) clients.

First-year target/outcome measurement: Construct a means to identify SED clients experiencing first-episode psychosis.

Second-year target/outcome measurement: Reports identifying FEP client counts and assessment ratings.

Priority #: 2

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SED, SMI

Goal of the priority area:

Professional experience and expertise established and sustained in the Community Mental Health System.

Strategies to attain the goal:

A comprehensive training program in the FEP EBP.

Indicator #: 1

Indicator: Number of statewide Community Mental Health Center staff trained.

Baseline Measurement: The SMHA will assume no staff have been trained by the standard described in the draft RFP for FEP-EBP training.

First-year target/outcome measurement: Supervisory and practicing staff in each of the ten Community Mental Health Centers will be trained.

Second-year target/outcome measurement: A training sustainability plan will be in place.

Priority #: 3

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SED, SMI

Goal of the priority area:

Program Implementation.

Strategies to attain the goal:

The vendor is expected to provide a stepped plan to move from expertise to practice.

Indicator #: 1

Indicator: Number of clients enrolled in the FEP EBP.

Baseline Measurement: All SED and SMI clients.

First-year target/outcome measurement: Each Community Mental Health Center will have at least 15% of their eligible SED and SMI clients enrolled in the EBP.

Second-year target/outcome measurement: Each Community Mental Health Center will have at least 25% of their eligible SED and SMI clients enrolled in the EBP.

Priority #: 4

Priority Area: Evidence-Based Practices

Priority Type: MHS

Population(s): SED, SMI

Goal of the priority area:

Symptom reduction and functional improvement.

Strategies to attain the goal:

Implementation of the EBP with fidelity and adequate supervision and support.

Indicator #: 1

Indicator: Number of clients with demonstrated and rated symptom reduction and improved functioning.

Baseline Measurement: Initial evaluations of clients enrolled in the EBP.

First-year target/outcome measurement: Each Community Mental Health Center will have report symptom reduction and/or functional improvements for at least 15% of their eligible SED and SMI clients enrolled in the EBP.

Second-year target/outcome measurement: Each Community Mental Health Center will have report symptom reduction and/or functional improvements for at least 25% of their eligible SED and SMI clients enrolled in the EBP.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Some states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers.

The SMHA in New Hampshire has little say in innovations such voucher programs. As behavioral health transitions into a managed care environment, per-member per-month plans and the managed care organizations create the ability for consumers to choose between providers. Consumers may also choose to have their managed care company provide care management services.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III: C.7. Program Integrity

New Hampshire's (NH) Mental Health Block Grant (MHBG) funds are almost completely directed to the contracts that fund eight independent, non-profit, Peer Support Agencies (PSA), that assure statewide access to peer support for eligible adults. These services are not covered by insurance and/or Medicaid.

The Planner has primary responsibility for general oversight of the block grant expenditures and reporting (utilization management). The grant is largely directed to peer support services, and the staff who oversee the PSAs services and contracts also attend to program integrity, within the Rules and contractual requirements, and in consultation with the Planner. The Planner also oversees the maintenance of the NH Behavioral Health Advisory Council (BHAC) and the appropriate, effective, use of MHBG dollars in support of the Council's activities.

The state assists the peer support providers in adopting practices that promote compliance with program requirements, including quality and safety standards, as outlined in Administrative Rule and contract requirements, by continual and accessible oversight, direct and indirect provision of technical assistance and linkages to national resources, and periodic updates on the block grant by the State Planner. The SMHA employs a PSA contracts manager who provides oversight to the Peer Support Agencies.

The Peer Support Agencies file monthly financial reports and quarterly outcomes reports to the Financial Management department and these are reviewed and reconciled by the State Planner's office.

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

New Hampshire (NH) does not have any Federally designated Tribes.
There are no tribal governments or lands within its boundaries.

Native Americans in the public mental health system are included in efforts to address cultural, ethnic, and racial diversity. The State Behavioral Advisory Council (BHAC) has a parent and a young member of Native American heritage and the council engages in discussion of issues relative to this population. There are 77 persons served in the NH public mental health system via the Community Mental Health Centers (CMHC) who report being Native Indian or Alaskan Native (33 children and 44 adults). (FY14 URS Table 14a).

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or

an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

This element is a not function of the Bureau of Behavioral Health, the State Mental Health Authority. The Bureau of Drug and Alcohol Services (BDAS), also under the Department of Health and Human Services, has a vibrant Prevention program.

New Hampshire's prevention system is comprehensive consisting of several partners, stakeholders and investors at the state and community level. For a complete review of NH Substance Abuse Prevention Efforts and Services please review New Hampshire’s System for Substance Abuse Prevention Efforts and Services (attached).

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The past year has seen progress made in the redesign of the DHHS behavioral health oversight function. All quality improvement efforts are now managed centrally, by the Quality Management Department. This department is currently designing over-arching quality improvement plans, most notably for behavioral health, in response to the Quality Service Reviews called for by the CMHA. The scope of these reviews is well beyond that described below. These reviews must include EBP fidelity and client satisfaction interviews.

Annual Quality Improvement (QI) and Compliance reviews are conducted at all of the Community Mental Health Centers (CMHC) throughout New Hampshire (NH). A statistically valid sample of records of the Bureau of Behavioral Health (BBH) eligible population is determined and then proportionally divided among the agencies.

Reapproval reviews are conducted at all ten CMHCs in NH on a five-year review cycle. The review process is being revisited at this time to ensure the process and tools closely mirror the administrative rule addressing this process, He-M 403, Approval and Operations of Community Mental Health Programs.

Reports are written, distributed to agencies and published on the NH DHHS website. Corrective action plans are submitted to BBH, and reviewed and approved prior to redesignation being granted.

At this time, it appears that the SMHA will continue to be responsible for QI reviews of the Peer Support Agencies. QI tools are being developed based on administrative rules He-M 402 Peer Support Agencies (PSA), He-M 315 Rights of Persons Receiving Peer Support Services, as well as BBH contract compliance to begin a cycle of PSA reviews.

This cycle of reviews is expected to include site visits, individual agency reports, a statewide report, corrective action plans, and ongoing monitoring of corrective action plans. Criteria addressing programming as well as financial records will also be included in the review tool.

The SMHA continues to maintain BBH Sentinel Event Reporting Systems, Mortality Reporting Summaries (quarterly and annually), and participation in Division of Community Based Care Services (DCBCS) monthly Sentinel Event Reviews.

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The State Mental Health Authority's (SMHA) administrative rules require the community mental health centers (CMHC) to screen for and document a client's trauma history, including domestic violence, upon initial assessment and intake. The Child & Adolescent Needs and Strengths Assessment (CANS) and Adult Needs and Strengths Assessment (ANSA) each contain a module specific to trauma and this tool will be implemented throughout the CMHCs.

New Hampshire's Balancing Incentive Program (BIP) has provided $1M in funds to the CMHCs to support training in Evidence Based Practices (EBP), Trauma Informed Care for Adults, Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Motivational Interviewing and Children's Core Competencies Training. Trauma Treatment and interventions will be a significant focus for the Bureau of Behavioral Health (BBH) over the next 2 years. In addition, the implementation of the CANS and the ANSA will assist clinicians in identifying trauma- related issues and ensuring that those issues are identified on the individual service plans, which will be contributed to by the CANS and the ANSA. Contract language requires the CMHCs to utilize this comprehensive tool once it has been implemented and providers have been trained.

Formal policies directing providers on how to screen for personal history of trauma are not currently in place; however, the majority of the CMHCs use standardized trauma assessment tools.

The state does not have formal policies designed to connect individuals with trauma histories to trauma-focused therapy, at this time. According to the Trauma Survey, the majority of agencies have a therapy model for children's services, but the degree to which trauma-informed specific interventions are used in adult programs appears to be minimal. These models were listed as being in practice in one or more agencies.

- Seeking Safety
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Processing Therapy (CPT)
- Cognitive Behavioral Program for PTSD in Persons with Severe Mental Illness

Non-clinical recovery supports that include trauma-informed practices are available to participants in the block grant-funded peer support agencies, specifically Intentional Peer Support (IPS) and the EBP Wellness Recovery Action Plan (WRAP).

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Mental health treatment services available within the State correctional system are dependent upon the inmate's location in the system. At the state level the Department of Corrections (DOC) operates a full array of mental health services in what DOC terms the "outpatient" unit inside the state prison. For inmates requiring inpatient care, referral is made to the Secure Psychiatric Unit (SPU), located within the State Prison for Men in Concord, NH. The SPU is a 40-bed unit established by state statute to house and treat a mixed population of severely mentally ill persons. The residents include mentally ill prison inmates, mentally ill jail inmates, criminal and civil commitments.

The New Hampshire DHHS contracts for sex offender treatment at Transitional Housing Services for the Mentally Ill and NHH Acute Psychiatric Services. Inmates that require sub-acute residential treatment can now reside in the Residential Treatment Unit (RTU), a 20-bed unit housed next to the SPU.

At the county level each of the ten county jail facilities are independently operated and vary in the level of mental health services provided. Some, but not all, contract with the CMHCs for mental health treatment. Others contract with private practitioners.

Juvenile Justice Services (JJS), under DCYF, is responsible for providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as Children In Need of Services (CHINS). JJS provides supervision, case management, and an array of rehabilitative services through its staff of Juvenile Probation and Parole Officers (JPPOs) and a network of community-based providers who are licensed and/or certified by DHHS.
Juvenile Justice Services administers programs and services around three organizational and functional areas:

- **Institutional Services:** The Sununu Youth Services Center and the Youth Detention Services Unit provide an architecturally secure placement for committed juveniles and for NH youth involved with the NH court system prior to their adjudication.

- **Probation and Parole:** conducts investigations and provides supervision of delinquent minors and Children In Need of Services (CHINS), as well as providing supervision of committed delinquents released from the Sununu Youth Services Center on parole. JJS JPPOs are located in the 12 DHHS District Offices and 5 itinerant offices.

- **Community Programs:** all community-based services, both residential and non-residential, are administered by this unit, through JJS institutional and field staff in cooperation with the NH court system. The services are then delivered by local organizations and providers. These services include home-based therapeutic services, substances abuse assessment and counseling, mental health services and an array of residential services, (foster homes, group homes, and intensive treatment facilities).

Mental Health Courts: NH has a legislated initiative to form a commission to standardize the mental health courts. The Chief Justice of the Supreme Court also obtained a small grant and convened a task force to look at standards for mental health courts. Additionally, the Hillsborough County Department of Corrections is being studied by the Council of State Government's Justice Center, which will examine jail data on mentally ill inmates and then provide ways to improve the criminal justice system for that population.

Mental Health Courts operate at the District Court level in Nashua, Keene, Rochester, Exeter, Portsmouth, Manchester, Milford, Concord, Goffstown and Haverhill. The "sequential intercept" model is used. The review tiers, as well as the specifics of pleading, convictions, dismissal and so forth, varies among the court programs. Juvenile Probation and Parole have initiated a program with Nashua High

School, serving 16-19 year olds. There is current discussion of adding Veterans' Courts to the Mental Health courts to specifically address veteran's issues when they become involved with the judicial system.

Funding for such courts remains a challenge.

Crisis Intervention Training (CIT)

Concord, the state capital, like many other towns and cities in NH, employs a crisis intervention team strategy. The Crisis Intervention Team consists of officers specially trained in dealing with individuals experiencing a mental health crisis. The training these officers receive, combined with the exhaustive selection process of officers to the team, provides the most effective tool that the Department can offer to those in crises. Officers receive training in recognition of mental illness, de-escalation techniques, and resources available to those experiencing a mental health crisis. NH Police Departments annually respond to thousands of calls for service involving individuals who suffer from mental illness.

NAMI-NH has the ability to provide Crisis Intervention Training to statewide police departments.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Parity in New Hampshire

1. NH has Limited parity confined to HMO and group policies, covering serious mental illness, including pervasive developmental disorders, autism, anorexia, bulimia, and chronic PTSD.
2. NH has More limited coverage for other mental health and substance use disorders.

- Outpatient visits may not be less than 15 full hours per 12- month period for group plans; HMOs must provide 2 diagnostic and 3 treatment visits and may impose copays of 20 percent
- Plans may impose limits for inpatient and outpatient substance use disorders
- Yearly benefit may be limited to $3,000 and lifetime maximum of $10,00 per covered individual for major medical plans.

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III: C. 14. Medication-Assisted Treatment

New Hampshire is pursuing a number of initiatives relative to medication assisted treatment:

- Funding has been added to the current contracts to assist providers to develop integrated or coordinated MAT and it is anticipated that these funds will be available in the next round of contracts as well. Whether or not a contracted provider is funded for medication assisted treatment, they are required under current contracts to work with clients on MAT. It is anticipated that future contracts will require providers to offer integrated or coordinated MAT to all appropriate clients.

- NH is working with our technical assistance contractor and a small group of physicians and behavioral health professionals to develop a strategic plan and community of practice for medication assisted treatment. Initially, this effort will focus on physicians; however, the intent is to expand to behavioral health professionals as well.

- NH is working with our training contractor to offer training to behavioral health professionals around medication assisted treatment. The initial focus is on breaking down myths and stigma associated with medication assisted treatment and promoting skills necessary for behavioral health professionals to work in an integrated environment with primary care.

- NH has applied for SAMHSA funding to expand medication assisted treatment in community health centers.

- The NH Health Protection Program (NH's Medicaid Expansion) funds a wide range of medication assisted treatment services, including office based with prescribers and withdrawal management.

In all efforts described above, there is a heavy focus on the importance of integrating medication with behavioral health treatment to ensure the best outcomes for providers. In addition, the use of evidence based practices is required for all service delivery.

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

In the ongoing development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid in New Hampshire, and across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

The CMHA required the state to be responsible for developing a crisis system that is available 24 hours per day, seven days per week.

Crisis System Components are to include:
(a) Mobile Crisis Teams; and
(b) Community Crisis Apartments.

Currently, the array of services and supports from various providers used to address crisis response include the following:

Crisis Prevention and Early Intervention:
- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach

Post Crisis Intervention/Support:
- WRAP Post-Crisis
- Peer Support

- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

New Hampshire Disaster Behavioral Health Response Teams

The New Hampshire Department of Health and Human Services (DHHS) has developed an organized team of behavioral health providers to respond to the mental health needs of New Hampshire residents following disasters (e.g., bioterrorism, man-made or natural disasters). Five regional disaster behavioral health response teams (DBHRT) can be deployed immediately anywhere in the state. These teams would respond to disasters or critical incidents when local behavioral health resources have been depleted or are overwhelmed. The goal of the disaster behavioral health response teams is to provide an organized

response to individual victims, family members, survivors, or the community affected by critical incidents or disasters.

Team Composition

Teams include individuals with experience in human services, psychology, mental health, substance abuse, social work, psychiatry, education or spirituality. Over 800 Behavioral Health Response Team members have completed specialized training. Team members operate under the supervision of DHHS's Disaster Behavioral Health Coordinator, receive ongoing training and participate in community/statewide drills and exercises.

Interventions

The DBHRTs provide interventions in three distinct phases that may be delivered at a disaster site, in an affected community, or statewide. The phases and interventions include:

Immediate Response

- Behavioral Health Needs Assessment
- Psychological First Aid
- Crisis Incident Stress Management
- Community Outreach
- Public Information
- Behavioral Health Consultation

Transition to Recovery

- Brief Supportive Counseling
- Information Dissemination
- Screening and Referral
- Support Groups
- Public Education

Preparedness and Mitigation

- Disaster Behavioral Health Planning and Networking
- Prevention Services Designed to Strengthen Community Resiliency
- Specialized Training Initiatives for Team Members and Community Partners

Activation

The Governor or designee at the Department of Health and Human Services-Emergency Services Unit would activate these teams during federal or state emergencies. If an emergency is not declared, local municipalities or emergency response systems may request assistance in order to meet the behavioral health needs of communities in local crises by contacting the Disaster Behavioral Health Coordinator.

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BDAS has convened stakeholders from the addiction recovery and mental health peer support communities to form a team to participate in the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). The NH BRSS TACS team has established a mission and value statement for increasing the capacity to provide peer recovery support services (PRSS), across the state by:

· Educating all community sectors on what PRRS is and its value
· Increasing the involvement of peers in promoting health in all sectors of the state,
· Ensuring good communication and coordination between addiction recovery and mental health peer support systems
· Researching standards on training, certification and supervision for PRSS.
· Identifying potential public and private funding sources to pay for PRSS.
· Supporting the development of sustainable peer recovery support services.
· BDAS supports the work of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment, and its Recovery Task Force, as it seeks to increase the quality and quantity of recovery support services across the state. (as detailed in "Collective Action – Collective Impact, New Hampshire's strategy to prevent and reduce alcohol and other drug misuse and promote recovery" (http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.pdf) The Recovery Task Force is primarily comprised of people in long-term recovery so that they can be the drivers of recommendations on recovery support services development.

Individuals in recovery and family members are utilized in the planning, delivery, and evaluation of behavioral health services in several key ways: participation as state-appointed members of the NH Behavioral Health Advisory Council (BHAC), participation in consumer-related groups that provide feedback and input to the SMHA.

By far the largest efforts in supporting recovery services are the Peer Support Agencies that are subsidized by the MHBG as well as State general funds. To maintain professionalism, the PSA system in New Hampshire remains heavily reliant on ongoing training of peers. Additional trainings provided on an as needed basis have included, and will continue to include Warmline, WHAM, conflict resolution and others. These trainings offer vital opportunities for personal, professional and system-wide growth.

Intentional Peer Support (IPS) developed by Sheri Mead, and Wellness Action Recovery Plan (W.R.A.P), developed by Mary Ellen Copeland, are cornerstones of NH's peer support system.

In addition to IPS and WRAP, agencies offer an array of wellness and recovery based services including warmline, crisis respite (two current programs and two scheduled to come online), transitional housing (one program) and permanent housing (three agencies renting an apartment to consumers), Whole Health Action Management (WHAM), outreach (two agencies with specific programs) and general outreach activities at all sites, stigma busting, conflict resolution, monthly educational events, social and recreational activities.

Crisis Respite

Consumer-operated Crisis Respite programs are consumer-run efforts. Crisis Respite programs are 24-hour, short-term, non-medical interventions, designed as an alternative to psychiatric hospitalization. The two current Crisis Respite programs each have two bedrooms, located within the peer support agency. These programs are statewide resources and are available to any SMI individual in New Hampshire.

Candidates for the program must have a pre-crisis interview and develop a crisis plan with a trained staff person. Episodes of crisis respite may range from one to seven days. All supports and interventions are negotiated, by the guest and the staff, for the safety and satisfaction of the respite guest in a non-judgmental, non-critical and accepting environment. When a person leaves the program, an exit interview is conducted that helps them evaluate what they have learned and proceed with their wellness plan for the future.

Each year the state of NH conducts a Peer Support Outcomes Survey (attached). The purpose of the survey is to receive input from participants that may be used in planning activities at the local and state level. The survey includes 14 indicators measured by 41 survey items in the priority areas of Health, Purpose, Community and General Satisfaction.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The State of New Hampshire's needs assessment "A Strategy for Restoration" (also known as the Ten Year Plan) was appended to the FY1 MHBG application. Since the plan was crafted in 2008, claims of over-utilization of institutions and prolonged wait times resulted in a class action suit, *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM,* filed in 2013 (attached), alleging "New Hampshire's administration of its mental health system violates the rights of individuals with SMI".

Twice a year, or more often if deemed appropriate by the Expert Reviewer (ER) specified in the Agreement, the ER will submit to the parties a public report of the State's implementation efforts and compliance with the provisions of this Settlement Agreement, including, as appropriate, recommendations with regard to steps to be taken to facilitate or sustain compliance with the Settlement Agreement.

The latest semi-annual report of the Expert Reviewer (ER), required under the Settlement Agreement in the case of *Amanda D. v. Hassan,; United States v. New Hampshire, No. 1:12-cv-53-SM* (attached), was released June 30, 2015. While the report cited progress, it also makes clear that much more needs to be done to bring the state into compliance with the agreement.

The settlement agreement, hereafter referred to as the Community Mental Health Agreement (CMHA) (attached), finalized in February 2014, mandates the State develop and implement certain services, including an expanded crisis system, expanded Assertive Community Treatment (ACT) and Supported Housing and Supported Employment programs. The services may be provided directly by the State or through contracts with CMHPs.

Priority populations named in the CMHA are adults who reside at New Hampshire Hospital (NHH) or Glencliff Home for the Elderly (GHE) who may have been "unnecessarily institutionalized".

A key priority for the ER during this second six-month period has been working with DHHS to further identify and access data that can be used to routinely track progress related to each element of the CMHA. Although the CMHA makes these service improvements mandatory, they are, of course, reliant on funding. In a serious of difficult budget decisions, the NH legislature has struggled to find available funds to assist the Community Mental Health programs implement the elements of the CBHA.

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[94] Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010.

[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The Division of Children, Youth, and Families DCYF)
DCYF is the primary child-serving agency in the DHHS system. DCYF provides a liaison to Bureau of Behavioral Health and New Hampshire [psychiatric] Hospital
DCYF Clinical Services works closely with the Community Mental Health Centers' Children's Directors, to improve access to services and increase their capacity to treat children in our care. DCYF has linked with them by opening up all of our clinical training to CMHC staff as well as NHH clinical staff.

Foster Care Mental Health Program
Every child placed in first time foster care, relative care or in a general group home receives a Mental Health Assessment from an experienced children's clinician at the local Community Mental Health Center within 30 days of removal from home. This assists DCYF with early identification of mental health needs and facilitates timely mental health treatment interventions. This process provides the new caretaker(s) with critical information regarding the most appropriate methods to use to support this particular child in their new placement.

Project RENEW
The Balancing Incentive Program contract was awarded to the Institute on Disability for RENEW implementation across the state's 10 community mental health centers beginning October 16, 2013. The RENEW IV Project: Creating a Sustainable Infrastructure for the Delivery of RENEW to Youth with Serious Emotional Disturbance, reports that as of March 30, 2015, eight of NH's ten CMHCs are participating: Northern NH CMH, Seacoast MH, Dover, Manchester, Nashua, Concord, Derry, West-Central and Laconia. These mental health centers continue to participate in training and coaching activities during this period. RENEW is a promising practice that is under consideration for acceptance as an evidence-based practice.

The Children's Behavioral Health Collaborative
The Children's Behavioral Health Collaborative (CBHC) is a multi-disciplinary initiative fixing barriers and improving behavioral health outcomes children, youth and their families in New Hampshire. The Collaborative represents the largest ever collaboration of New Hampshire child and family organizations and agencies-more than 50-focused on mental health and substance use disorders for children, youth and families. In March 2013, the Collaborative released the NH Children's Behavioral Health Plan (attached).

The Children's Interest Group of the Behavioral Health Advisory Council is an active planning partner of the CBHC and appreciates their advocacy efforts.

NAMI-NH
NAMI NH offers a variety of supports to parents who have a child/adolescent with serious emotional disorders. In addition to those listed below, we have a large variety of printed materials on various mental illnesses. Click the links below or on the side navigation for more information on the desired topic.
Parent Support Groups ~ offered around the state for parents who have a child/adolescent with serious emotional disorders
One-on-One Support ~ our Family Support Specialist provides One-on-One support to family members seeking assistance

The Children's Interest Group of the Behavioral Health Advisory Council is an active planning partner with NAMI-NH and appreciates their service array as enhancements to CMHP services.

Transforming Children's Behavioral Health Care

A Plan for Improving the Behavioral Health of New Hampshire's Children

Executive Summary

The New Hampshire Children's Behavioral Health Collaborative – 2013

"And how are the children?"

– Traditional Masai tribal greeting

Protecting and promoting children's behavioral health is a fundamental investment in a child's future. Early behavioral health conditions have long-term implications that range from school success to future wage earnings to a sense of well-being and overall health. Behavioral health, which refers to mental health and substance use conditions, is a measure of well-being that is as complex as the human brain itself. Understanding and serving this complex inter-relationship between the body, behavior and emotion is particularly challenging with children. The patterns of experience mapped by the brain continue to influence the child's development for the rest of his or her life, impacting his or her long-term health and well-being[1].

As a society and as a state, it is our responsibility as leaders and professionals to ensure that we are supporting the healthy social and emotional development of New Hampshire's future citizens and leaders. We must meet their behavioral health needs with highly effective services and supports that provide significant long-term positive outcomes for children, youth and their families.

It is this responsibility that led to the establishment of the New Hampshire Children's Behavioral Health Collaborative (the Collaborative) in November of 2010. This unprecedented coalition of over 50 organizations came together to study the current landscape of children and families and the existing behavioral health systems, services and supports. Following the best practice approach known as System of Care, the Collaborative developed a plan to build an integrated and comprehensive service delivery structure that is family-driven, youth-guided, community-based and culturally and linguistically competent.

This publication establishes the state's first documented plan for such an integrated and comprehensive system of behavioral health care for our state's children and youth, presenting the action steps families, youth, leaders, professionals and other stakeholders will take to achieve an effective System of Care for the next generation.

The Institute of Medicine refers to the term **'behavioral health'** as including mental health and substance use conditions and recognizes that behavioral health care has several characteristics that challenge its effectiveness, such as separate care delivery systems and a less developed quality assurance infrastructure.[2]

WHERE WE ARE NOW

The first step to developing a plan for a better system of care for children's behavioral health is to understand where we are now. The Collaborative reviewed data from many sources to appreciate how children and families are being currently served and supported. This informed the Collaborative's priorities for a transformation of the service delivery system for behavioral health promotion, early intervention, treatment and supports.

OUR CHILDREN

One in five of preschoolers through teens have an emotional disorder that impacts their daily functioning at home, in school or in their community.[3] Of those children receiving mental health services, approximately 43% are diagnosed with a co-occurring alcohol or drug use disorder. Similarly, of adolescents in New Hampshire alcohol or drug treatment programs, 2/3 of males and 4/5 of females have a co-occurring mental health disorder.[4] On any given day, over 250 New Hampshire children are living and receiving care in an in-state residential placement or treatment facility outside of their home community.[5]

FAMILIES

Families also bear significant and uncounted responsibilities and expenses in supporting their children's well-being. Families report frustration with what they describe as fragmented and uncoordinated systems, often likening their experiences with current systems for children's behavioral health to being "lost in a maze." Families also describe a lack of opportunities to voice their child's strengths and needs.[6]

LOCAL SCHOOLS

Schools already play a central role in providing mental health services to New Hampshire's children, some working with community-based providers and federal aid programs to support students. Schools often see behavioral health needs at early ages and stages and reach out to families and community-based services. While New Hampshire has one of the lowest high school dropout rates in the country, New Hampshire's school suspension rates are nearly twice the national rate, and students with emotional disabilities are suspended at higher rates than other students.[7] New Hampshire's rates of regular alcohol and marijuana use among 12 to 17 year olds are also some of the highest in the country.[8]

WHERE WE ARE NOW

The assessment of state and community efforts and resources to provide behavioral health care to New Hampshire children reinforced that behavioral health care happens in many places and in many ways, but that gaps in services and in coordination of those services can compromise effective care and outcomes.

PRIMARY CARE

Primary care providers play a substantial role in treating children and youth with behavioral health disorders, with most childhood psychiatric medications prescribed by pediatricians. Although they are often stretched to capacity with monitoring and caring for the physical health of children, the frequency of well-child checkups and the relationships many families develop with their primary care professional provides an opportunity to identify behavioral health concerns earlier and coordinate services and supports.

COMMUNITY BASED PROVIDERS

Children's behavioral health needs are served by a range of community-based providers, including the state's ten community mental health centers that serve more than half of children with serious emotional health disorders. These centers and other provider agencies have been increasingly financially under-resourced in recent years, with notable gaps in services, including adolescent substance abuse and co-occurring disorder treatment. Community mental health centers now handle approximately 10,000 children with increasingly complex needs, a number that has remained constant for the past three years, despite significant budget reductions.[9]

BEHAVIORAL HEALTH EXPENDITURES

Expenditures for children's mental health services are paid for primarily by Medicaid, child protection, juvenile justice, local school districts, the state's Catastrophic Aid Program and private insurance, systems that do their best to serve the complex and long-range needs of over 50,000 children with diagnosable behavioral health needs. There is little formal coordination between the various systems receiving state and local funding to provide behavioral health services to children or between the public systems and private insurance.[10]

What is a system of care approach?

A System of Care is a behavioral health care approach that relies on a coordinated network of effective community-based services and supports with a broad array of individualized services which help children and youth to function better at home, in school, in the community, and throughout life. This evidence-based approach has been found to decrease caregiver strain, increase stability in living arrangements, increase school performance and attendance, and expand the service array.[11]

SHARING A VISION

Moving from Multiple Systems to an Integrated System of Care

Transforming New Hampshire's current behavioral health care services and supports into to one integrated, comprehensive system of care requires shared values and principles, a commitment to evidence-based and evidence-informed practice, and collaborative action from all stakeholders, establishing a common ground from which to build, with children and families actively participating in the transformation.

SHARED VALUES

The Children's Behavioral Health Care System will be

- Family driven, youth guided
- Community-based
- Culturally and linguistically competent

GUIDING PRINCIPLES

The Children's Behavioral Health Care System will involve

- Effective, evidence-informed services
- Individualized, wraparound service planning
- Least restrictive environments
- Youth and families as full partners in services and policies
- Integrated care
- Care management for service coordination
- Developmentally appropriate services
- Prevention, early identification & intervention
- Promoting advocacy and protecting rights
- Focus on accountability and quality
- Non-discrimination

The changes and improvements recommended within this plan's goals must be realized at the system level, at the service level, and at the environmental level to support transformation. For example, a policy change at the system level can lead to a wider array of services and supports available at the service level, while advocacy and media efforts can reduce stigma within a child's environment, encouraging more access to services.

These multiple levels of coordinated action are present in the goals and strategies for a transformed and improved system of care for children and their families.

BUILDING TOGETHER

Changing such a complex system of services and supports for a complex constellation of disorders and needs will not be simple, straightforward or quick. The goals for the state's transformation plan were established within five strategy areas recommended by the federal Center for Mental Health Services.[12]

"When my child is struggling mentally it seems like his entire body is breaking down."

"I honestly think it's about time that mental health issues were treated just like a cold or a broken bone [but] mental health issues still carry a stigma"

"If your mental health is suffering the rest of your life will be suffering"

Family focus group participants sharing their experiences with the current behavioral health care system[13]

TRANSFORMATION GOALS

The Collaborative's planning process focused on each System of Care strategy area and analyzed the policy, service array, financing, workforce, advocacy and other changes that would be needed to address each goal in the Plan. A more detailed matrix of sub-strategies and action items for each of the goals and five strategy areas can be found at www.NH4Youth.org .

This planning method established nine core goals that will move New Hampshire toward a System of Change approach and that underscore the effective leadership, bold policy change, adequate financing, strong workforce, mobilized advocates, and the strong voice of children and families that will be drivers of change and improvement for our next generation.

When parents of children with behavioral health conditions were asked what quality care meant to them, one shared that it was care that was **"not driven by money, but need."**[14]

Align child-serving systems toward common goals and outcomes

- Developing a state-level leadership and management body to maintain focus, commitment and action
- Conducting joint trainings, technical assistance and coaching on System of Care values and principles
- Developing agreements among agencies and organizations to braid financing in support of integrated, collaborative, and evidence-informed care

Implement family-driven, youth-guided, culturally and linguistically competent services and systems

- Increasing family and youth involvement at the policy and systems level
- Increasing family and youth involvement in the planning and delivery of their services
- Implementing peer-to-peer support services for families and youth
- Increasing the cultural and linguistic competency of children's behavioral health services, thereby reducing disparities

Improve services and outcomes for children and youth with serious and complex behavioral health needs and their families

- Creating an entity that serves as a centralized and accountability hub for managing services, costs, care, and improved outcomes, particularly those who are involved in multiple state systems
- Developing individualized care through fidelity to a wrap-around approach to service planning and care for high-need children and their families
- Broadening the array of available services and supports, such as respite care, mobile crisis units, substance use prevention, early intervention and treatment, family and youth peer supports, and other specialized services for children in key transition periods

Realign financing streams to better invest resources for behavioral health services and supports for children, youth and families

- Coordinating and redirecting financing streams to support a broader array of effective, coordinated home and community-based services and supports for high need children and their families
- Incorporating children's behavioral health provisions, structures and services into the state's Medicaid/Managed Care System

Create a sustainable infrastructure to provide on-going training in the System of Care approach, effective services, and other workforce development strategies

- Incorporating both pre-service and in-service training in evidence-based, evidence-informed and promising practices within higher education and credentialing, licensing and certification requirements
- Making available training topics relative to this plan, such as cultural and linguistic competence, co-occurring mental health and substance use disorders, and System of Care principles

Wraparound is intensive, individualized care planning that engages children and youth with complex needs and their families, considering strengths and assets in tailoring care.[15]

"It would be so helpful to make one phone call to see what services are available."[16]

–Wolfeboro area parent

"[I got] tired of hearing [my child] is too young to diagnose."[17]

– Claremont area parent

Identify emotional and behavioral health challenges and needs at earlier ages and at earlier stages

- Increasing early identification and intervention strategies
- Implementing an evidence-based multi-tiered system of supports within schools state-wide to address student behavioral health needs, improving educational outcomes

Maximize opportunities for integration of mental health and substance use prevention, intervention, and treatment with primary care

- Increasing and systematizing the use of evidence-based screening within primary care, emergency services and other child-serving systems
- Implementing an approach that supports primary care physicians, nurse practitioners and other providers in expanding their knowledge relative to prescribing psychiatric medications, such as access to specialty consultation

National Standards on Culturally and Linguistically Appropriate Services (CLAS) can serve as a standard for transformation activities.[18]

Measure outcomes of implementing improved services that are family-driven, youth-guided and culturally and linguistically competent

- Adopting a common and culturally and linguistically competent behavioral health assessment tool across multiple systems and focusing on positive outcomes and improvement and that establishes and implements clear eligibility and evaluation criteria for different social-emotional needs across multiple child-serving systems
- Developing the ability to share and track culturally and linguistically competent service data across child-serving systems
- Increasing awareness of the role of data collection and use among children, youth and families

Maximize support for implementing family-driven, youth-guided, culturally and linguistcally competent systems and services

- Use strategic marketing and a range of other communication strategies to increase knowledge, influence decision-making, and generate support for an expanding and improving a family-driven, youth-guided and culturally and linguistically competent system of care

For more information about improving children's behavioral health care in New Hampshire or to get involved, visit www.NH4Youth.org

NH Children's Behavioral Health Collaborative

ABOUT THE COLLABORATIVE

The New Hampshire Children's Behavioral Health Collaborative first convened in November of 2010 through a joint initiative of the Endowment for Health and the New Hampshire Charitable Foundation to study and respond to the strengths and challenges of meeting the behavioral health needs of New Hampshire's children and youth. The Collaborative has expanded its membership and technical expertise to ensure a robust assessment of existing systems, best practice research, assets and limitations as well as the needs and hopes of those served by the existing systems of care. The vision of the membership is to cultivate and sustain an integrated, comprehensive children's behavioral health system for the Granite State.

PARTNERS AND CONTRIBUTORS

ARCH of the Upper Valley
Autism Society of New Hampshire
Bi-State Primary Care Association
Center for Life Management
Child and Family Services
Child Health Services
Children's Alliance of New Hampshire
Community Bridges
Coos Family Support Project
Dartmouth-Hitchcock, Children's Hospital at Dartmouth
DDG Consulting
Disabilities Rights Center
Early Learning New Hampshire
Easter Seals New Hampshire
Endowment for Health
Families in Transition
Foundation for Healthy Communities
Friends of Recovery – New Hampshire
Geisel School of Medicine at Dartmouth
Granite State Children's Alliance
Granite State Federation of Families for Children's Mental Health
Greater Nashua Mental Health Center
National Alliance on Mental Illness New Hampshire
National Association of Social Workers – New Hampshire
New Futures
New Hampshire Alcohol & Drug Abuse Counselors Association
New Hampshire Alcohol & Other Drug Service Providers Association
New Hampshire Association of Infant Mental Health
New Hampshire Association of Marriage and Family Therapy
New Hampshire Association of Special Education Administrators
New Hampshire Center for Excellence
New Hampshire Charitable Foundation
New Hampshire Children's Lobby
New Hampshire Children's Trust
New Hampshire Coalition Against Domestic & Sexual Violence
New Hampshire Community Behavioral Health Association
New Hampshire Council on Autism Spectrum Disorders
New Hampshire Department of Education
New Hampshire Department of Health & Human Services
New Hampshire Family Voices
New Hampshire Legal Assistance
New Hampshire Medical Society
New Hampshire Partners in Service
New Hampshire Pediatric Society
New Hampshire Psychiatric Society
New Hampshire Psychological Association
New Hampshire Residential Provider Network
New Hampshire School Administrators Association
New Hampshire School Nurses' Association
New Hampshire Suicide Prevention Council
NFI North
Parent Information Center
Phoenix House
School Administrative Unit 39
School Administrative Unit 46
School Administrative Unit 81
School Administrative Unit 90
University of New Hampshire Institute on Disability

The Collaborative is further supported by funding and technical assistance from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), and technical expertise from the National Technical Assistance Center for Children's Mental Health (NTAC) at Georgetown University's Center for Child and Human Development.

The Collaborative wishes to recognize and thank the many youth, family members, community members, and leaders across the state who participated in focus groups and contributed their input and guidance to the development of the underlying values, concepts, and strategies of this document. The shared commitment of all who are stepping forward will help guide, build and strengthen a transformed children's behavioral health system for our state.

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[1] Raver, C. C. (2002, December). Emotions matter: Making the case for the role of young children's emotional development for early school readiness (Social Policy Report, Vo. 26, No. 3). Ann Arbor, MI: Society for Research in Child Development.

[2] *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series.* Washington, DC: The National Academies Press, 2006. Retrieved from http://www.iom.edu/Reports/2005/Improving-the-Quality-of-Health-Care-for-Mental-and-Substance-Use-Conditions-Quality-Chasm-Series.aspx#sthash.q88QHCsk.dpuf

[3] Department of Health and Human Services (US); Rockville (MD): Department of Health and Human Services. Mental health: a report of the Surgeon General. 1999

[4] *Reclaiming Our Future, A Pathway for Treating Co-Occurring Mental Health and Substance Use Disorders in New Hampshire's Adolescents and Young Adults,* National Alliance on Mental Illness -New Hampshire, 2009. http://www.naminh.org/uploads/docs/NAMIReclaimingOurFuture.pdf

[5] *Residential Placement Report*, New Hampshire Department of Health and Human Services Internal Report, January 2013

[6] *Collecting Family Voices on Children's Mental Health. NH Children's Mental Health Focus Group Project* Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[7] *Mental Health Services in New Hampshire's Schools*. NH Center for Public Policy Studies Report, April 2009

[8] U.S. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011.

[9] NH DHHS Block Grant Proposal, 2011

[10] *Mental Health Services in New Hampshire's Schools*. NH Center for Public Policy Studies Report, April 2009

[11] Stroul, B. A., & Friedman, R. M. (2011). *Issue brief: Strategies for expanding the system of care approach*. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. Retrieved from http://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf

[12] Ibid

[13] *Collecting Family Voices on Children's Mental Health*. NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[14] *Collecting Family Voices on Children's Mental Health*. NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[15] *Bruns, E. J. & Walker, J. S. (2010). The wrap-around process: An overview of implemen-tation essentials. In E. J. Bruns & J. S. Walker (Eds.), The resource guide to wraparound. Portland, OR: National Wraparound Initiative.*

[16] *Collecting Family Voices on Children's Mental Health*. NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[17] *Collecting Family Voices on Children's Mental Health*. NH Children's Mental Health Focus Group Project Final Report of Findings. National Alliance on Mental Illness NH, July 26, 2007

[18] National CLAS Standards available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

The New Hampshire Children's Behavioral Health Collaborative – 2013

RENEW
Rehabilitation for Empowerment, Natural Supports, Education, and Work

RENEW IV Project: Creating a Sustainable Infrastructure for the Delivery of RENEW to Youth with Serious Emotional Disturbance

Quarterly Report

Report Period: April 1, 2015 through June 30, 2015

The Balancing Incentive Program contract was awarded to the Institute on Disability for RENEW implementation across the state's 10 community mental health centers beginning October 16, 2013. As of March 30, 2015, eight of the centers are participating: Northern NH CMH, Seacoast MH, Dover, Manchester, Nashua, Concord, Derry, West-Central and Laconia. These mental health centers continue to participate in training and coaching activities during this period.

Progress towards Goal Attainment:

GOAL # 1. Develop the capacity for all of the state 10 community mental health centers to deliver the RENEW intervention, with fidelity, to youth who qualify for state-supported community mental health services by training and coaching no fewer than 60 staff members to be RENEW Facilitators in the children's programs over 3 years.

Reporting Period: 10/1/13-12/31/13

We have established signed agreements with the centers in Laconia and Nashua as of December 31, 2014. We anticipate signed agreements with all the other centers except for Keene, West Central and CLM in Derry. The first Facilitator training for RENEW IV grantees is scheduled for February 5 and 6, 2014. During this training, two agency RENEW coaches are finalizing their training skills in order to become RENEW trainers. These two coaches will be the first certified RENEW trainers outside of the Institute on Disability in the state of NH. IOD RENEW staff continued to attend agency RENEW implementation meetings in the center that have been implementing RENEW under the previous Endowment-funded projects, with the exception of CLM in Derry.

Reporting Period: 1/1/14-3/31/14

In addition to the previous signed agreements, we have established signed implementation agreements with Riverbend, Community Partners, Seacoast Mental Health, and Northern Human Services. The first cohorts of 12 facilitators finished their training in April,

2014 and everyone has started implementing RENEW with clients. The project staff have been spending a day each week coaching the new centers as their RENEW facilitators implement the model into their work (see project tracker below). Additionally, the project staff continue to meet with the agencies on a monthly basis to review implementation and address any challenges that arise. So far, implementation is going smoothly.

Reporting Period: 4/1/14-6/30/14

The project staff continued to meet with the agency implementation teams. Almost every agency has requested additional staff to be trained this fall. The IOD project staff continued to meet with agency coaches to support them as they mentor their facilitators. The staff also co-facilitate, model, and provide coaching to new agency facilitators.

Reporting Period: 7/1/14-9/30/14

The IOD project staff held another RENEW training beginning in September and 12 new agency staff attended. As of September 30, these facilitators have already begun to meet with youth and are being coached either by an internal coach, or by RENEW project staff. During this time period, across all of the agencies, four staff left, slightly reducing the number of facilitators. Attrition is expected and the agency implementation teams continue to plan around capacity building and maintaining that capacity. One strategy is to build financial or FTE coverage incentive for those mental health clinicians providing RENEW.

Reporting Period 10/1/2014-12/31/2014

Eight of the 10 mental health centers continued to actively participate in the project during the quarter. The project staff attempted to engage West Central Services and Monadnock Family Services in the project but those centers did not feel they had adequate staff to participate. Eight staff from the centers attended new RENEW Facilitator training which was conducted during the period.

Reporting Period: 1/1/15-3/31/15

The project staff continue to support RENEW Facilitators in 8 of the 10 community mental health centers. JoAnne Malloy, Project Director, has contacted both West-Central and Manadnock Family Services to engage them in the project. The project staff is in the process of updating the RENEW Facilitator Tracker which tracks the number of active RENEW Facilitators in the project and those who have dropped out of the project or the agency.

Reporting Period: 4/1/15-6/30/15

The project staff continue to support RENEW Facilitators in 8 of the 10 community mental health centers. JoAnne Malloy, Project Director, has met with Monadnock Family Services and

West-Central Community Services. West Central signed an MOU in July. The IOD staff has coached 72 staff at this point in the project.

Goal # 2: Ensure sustainability of RENEW implementation, with fidelity, to youth served by the 10 mental health centers by developing, delivering, and continuously assessing the effectiveness of a RENEW Coaches curriculum to maintain no fewer than 20 community mental health staff members (2 in each center) identified to be RENEW coaches in the 10 mental health centers.

Reporting Period: 10/1/13-12/31/13

RENEW Coaches have been trained and are established in the Laconia, Concord, Manchester, Seacoast, and Dover mental health centers, and the IOD staff have met with those coaches at least twice during the reporting period.

Reporting Period: 1/1/14-3/31/14

RENEW Staff continue to meet with agency coaches where they are established at least on a monthly basis. Additionally, the one new centers has identified a coach who will assume that role in the fall. The project staff have started refining RENEW coach competencies and will begin developing a training for the new coaches during this next reporting period.

Reporting Period: 4/1/14-6/30/14

The RENEW coaches training has been scheduled to take place in early December 2014. In order to develop a skill-focused training, the project staff will follow some of the strategies found in the Participatory Adult Learning Strategies (PALS). The IOD staff finalized the Coaches Competencies Checklist that will be used as the basis for coaches training and fidelity assessments. In addition, the project staff have developed a RENEW capacity building checklist which can be used by coaches to support facilitators around various skill-sets.

Reporting Period: 7/1/14-9/30/14

Of the new centers, Nashua has identified one coach and Northern Human Services has identified two. Northern's coaches attended the fall RENEW Implementation Training on October 16, 2014 to learn about necessary strategies to ensure RENEW's success in their agency. The continuing agencies still have at least one coach. Genesis had a coach leave, but has identified a skilled RENEW facilitator to replace him. The project staff are preparing for the December 10, 2014 RENEW Coach training and will have curriculum developed based on competencies by the end of November.

Reporting Period 10/1/2014-12/31/2014

A RENEW Coaches training was planned for December, but was postponed until January due to weather.

Reporting Period: 1/1/15-3/31/15

The RENEW Coaches training was held in January of 2015. Five coaches attended this training, four of which were new to this project. The staff rolled out new tools for evaluating RENEW Facilitators based on evidence-based tools from other project. The training was well-received according to the survey feedback. Two additional coaches were trained separately from this event due to weather.

Reporting Period: 4/1/15-6/30/15

The project staff have developed a draft of the RENEW Coaches Manual; complete with competencies, tools, and coaching instruction. Every currently-participating Mental Health Center maintains coaching capacity, and there are certified internal coaches in Riverbend, Manchester, Community Partners, Seacoast, and the other centers are working to obtain certification for their coaches.

Goal # 3. Continuously improve the competencies of individuals who are trained to provide RENEW services by developing online and distance training and coaching support for RENEW facilitators and trainers in the mental health centers and other entities that serve youth and young adults with emotional and behavioral challenges.

Reporting Period: 10/1/13-12/31/13

The RENEW IOD staff finalized a set of RENEW Facilitator and Coaches competencies and training curriculum during the reporting period. The project has contracted with a web knowledge management system designer, who has completed an preliminary assessment of the RENEW online training and support system, and who will design and develop our online training supports during the next 9 months. The staff have also continued to develop the online tools and social media outreach. The staff have been working very closely with the Granite State Federation of Families and Youth Move NH to develop a RENEW youth mentoring component to the RENEW training. This component will create a system for peer to peer support for RENEW youth/clients by RENEW graduates.

Reporting Period: 1/1/14-3/31/14

The RENEW IOD staff continue to work with the web knowledge system designer to improve online training, website, and social media. The project staff started to create cohesive training materials, web-based training modules, tools, and training curriculum. The staff are using a framework for which every person who seeks information and training related to RENEW will be able to meet their needs. We believe that with this new approach, we will successfully meet the needs of those seeking or delivering RENEW services, no matter who they are (youth, families, service providers, policy makers, etc.) or where they are affiliated (mental health centers, schools, state or community partners, etc.).

Reporting Period: 4/1/14-6/30/14

The knowledge management system framework has been completed. The Project staff are now using this framework to rework the RENEW Facilitators Manual, Training Protocol, and Online Training Modules. The Manual and Training will be finished by September.

Reporting Period: 7/1/14-9/30/14

The revised RENEW manual is in the final editing stage before printing. The modularized training is 50% completed. The following online learning modules are now on the IOD RENEW webpage: (1) Engaging a Youth in RENEW and, (2) Setting Meeting Ground Rules. The following videos/modules are finished and will be published soon: (3) What is Personal Futures Planning? (4) Setting Ground Rules Refresher, (5) RENEW Overview Module, (6) Using the Roles and Responsibilities Tool Refresher. The following are still under development: (7) Youth Presentations (three videos), and, (8) The Role of the RENEW Facilitator.

Reporting Period 10/1/2014-12/31/2014

Two new module went live period: 1) Youth sharing her futures plan, 2) Using the RENEW Data-base. The RENEW team started development for a video to illustrate a RENEW team meeting. This will be live in January.

Reporting Period: 1/1/15-3/31/15

The Team Development and Facilitation module went live during this reporting period. The team will review other content areas and continue to develop modules over the coming six months.

Reporting Period: 4/1/15-6/30/15

The online RENEW overview module is complete. It is anticipated this module will be live in August. RENEW trainers and coaches could use this model to give overviews to new facilitators and to orient other staff in their schools and agencies.

An additional module to illustrate how to facilitate a team meeting is now on the RENEW webpage.

Goal # 4. Improve the outcomes of youth and young adults who receive RENEW by working with the RENEW facilitators and coaches to intentionally increase the involvement of family members, schools, and vocational rehabilitation in individual youth teams, and develop and implement a process and tools for measuring team member engagement, involvement, and outcomes.

Reporting Period: 10/1/13-12/31/13

RENEW graduates are now on our payroll and co-training during the RENEW Facilitators training sessions. We continue to work closely with the Granite State Federation of Families for Children's Mental Health and YouthMove NH to design and develop our competencies and trainings.

Reporting Period: 1/1/14-3/31/14

In collaboration with Youth Move NH, and the Granite State Federation of Families, the RENEW facebook page has gone live and gained nearly 100 "likes." We hope that this social media effort will engage and educate family, professionals, and community members about RENEW and it's related projects. The RENEW Facebook page can be found at https://www.facebook.com/IOD.RENEW.

In addition to the page, there is also a closed RENEW Youth Group. This is a forum that exists on Facebook with the purpose of allowing current and past RENEW participants to support one another through the process and achieving their goals. Other than the RENEW staff administer on the account, only youth who participate in the process can access this forum, in hopes that youth will feel safe seeking help this media.

The project staff have joint monthly meetings with the Granite State Federation of Families (GSFF) and Youth Move NH in order to continue improvement in the quality of services provided to youth and families. We have found their insight and support invaluable in our development of the model, training, and coaching.

Reporting Period: 4/1/14-6/30/14

The project staff continued to work with Youth Move and GSFF to develop a peer to peer mentor training model. In order to sustain this work, we plan to apply for grant funds to pilot the model in the fall and winter.

RENEW Facilitators had a booster training which focuses on teams, family involvement, and Vocational Rehabilitation. We plan to include GSFF as well as the Minority Coalition in our fall training this year to increase facilitator competencies around this goal.

Reporting Period: 7/1/14-9/30/14

The IOD project staff, YouthMoveNH, and GSFoF have chosen to move forward with the Intentional Peer Supports Model for RENEW peer to peer supports and mentoring. We will meet with the trainers from New York and Maine, and develop a scope of work with them. The group plans to be trained in the model and start training youth in late winter/early spring.

The project staff have identified 4 youth who have been through RENEW to begin training and presenting with us starting in January. These youth are also candidates for joining

YouthMoveNH. They will inform our training curriculum, and help us develop our Intentional Peer Supports Model for Youth in RENEW.

Reporting Period 10/1/2014-12/31/2014

The project staff worked with YouthMove and GSFoF to develop a proposal to the System of Care Grant to fund Peer to Peer supports. The team also is planning on meeting with the developer of Peer to Peer supports in late January/early February.

Reporting Period: 1/1/15-3/31/15

Due to logistics and staffing issues with YouthMove National and the organization that runs Peer to Peer supports out of New York, the introductory training has been put off until June 2015. The team will continue to coordinate with YouthMove National to develop the peer to peer supports curriculum for NH.

The team also began collaborating with the mental health centers to search for youth and family leaders who have done well with the RENEW process who could eventually mentor other youth and families and help train new mental health staff.

Reporting Period: 4/1/15-6/30/15

Youth Move NH and the RENEW Staff consulted with Youth Move National to develop a set of competency areas for a peer to peer supports specialist. During this time, a peer to peer supports practice document draft has been completed and training modules have been identified. We anticipate that a peer to peer supports model will go live in November and be sustainably funded through managed care and/or Medicaid.

Goal # 5. Ensure that the providers of community behavioral health services to youth and young adults with emotional and behavioral health challenges can sustain the implementation of RENEW by addressing and making adjustments to the financial, policy, and accountability infrastructures that govern behavioral health services for children and youth.

Reporting Period: 10/1/13-12/31/13

We suspended meetings of the RENEW Leadership Team until we established the agreements and work-plans with each mental health center. We will begin to address this goal in the January-March 2014 quarter.

Reporting Period: 1/1/14-3/31/14

The RENEW Leadership Team started meeting quarterly again in March, 2014. The agenda for this meeting was primarily focused on the goals of the current project and family engagement. Notes from this meeting can be provided on request.

Reporting Period: 4/1/14-6/30/14

The Leadership Team has agreed to support the IOD to improve its data collection methods and tools. The team will approach DBH, the Fast Forward Project, and the Next Steps project to collaborate around the use of online databases held on a secure website (i.e. E-Studio).

Reporting Period: 7/1/14-9/30/14

The RENEW Leadership Team met on July 25th, and September 26th. During these meetings, the team reestablished the benchmarks for each agency for FY2015. The team started to review possibilities for collecting data on cost-benefits and outcomes. The team also has expressed interest in becoming a professional learning community, hearing success stories from the other agencies and exploring how to replicate working strategies. Riverbend's coach, Ryan Sharp presented on his coaching activities as well as how to run a RENEW Implementation Team and Seacoast Mental Health's coach Nicole Quinn presented on the intentional collaboration with Exeter High School. For future meetings, the group would like to hear other success stories from youth and other agency accomplishments.

Reporting Period 10/1/2014-12/31/2014

The Leadership Team met on 12/19/14 and discussed the NH Hospital Project. A social worker from the Hospital did a presentation with RENEW staff highlighting progress and outcome data. The team also discussed the data tracking system and how the centers are getting releases from families related to the data system.

Reporting Period: 1/1/15-3/31/15

The Leadership Team met on 3/20/15 and discussed utilization of the CANS, the online RENEW data system, Coaches competencies and certification, and an overview of the online resources found on our website.

Reporting Period: 4/1/15-6/30/15

The Leadership Team met on 6/9/15 and decided to not use the CANS for this grant. There are too many inconsistencies in its use and it would be too difficult to retroactively collect data; especially for youth who have left the mental health agencies. The Leadership Team also decided it needs a better idea on the actual cost of RENEW services. If a higher rate could be established with Managed Care, then there is more incentive to do all the parts of RENEW; especially those that don't involve face to face time with the clients.

Management Plan Progress:

GOALS	PERFORMANCE MEASURES		
	Year 1	Year 2	Year 3
1. Develop the capacity for all of the state 10	Goal: Train 25	Train 25 staff	Train 10 staff

community mental health centers to deliver the RENEW intervention, with fidelity, to 450 youth, ages 14-21 who qualify for state-supported community mental health services, by training and coaching 60 staff members in the children's programs over 3 years.	staff **Year End Status:** **-Newly Trained: 26 Facilitators** **-Coaching: 50 Facilitators**	**16 trained YTD** **Coaching: 72 Facilitators**	
1.a. Develop and revisit annually an individualized Memo of Understanding with each of the 10 mental health centers that specifies number of staff to be trained, youth enrollments, and mutual responsibilities of the centers and the IOD.	Goal: Within 1st 3 months of the Fiscal Year **Year End: 7 Signed MOU's**	Within 1st 3 months of the Fiscal Year **YTD: 9 Signed MOU's.**	Within 1st 3 months of the Fiscal Year
1.b. Train CMHC staff to be RENEW Facilitators-	**Year End: See 1.**	14 trained **See 1.**	10 staff trained **See 1.**
1.c. Provide "booster training for facilitators already trained	Goal: 40 facilitators **Year End: 37 facilitators in-agency training**	Goal: 40 facilitators **See attached booster training tracker.**	Goal: 40 facilitators **See attached booster training tracker.**
1.d. Enroll and serve 450 youth – (Approximately 15 per center per year)	Goal: 150 youth **Year End: 121**	Goal: 300 cumulative youth **YTD: 196 youth served**	Goal: 450 cumulative youth
1.e. Track enrollments and process	Monthly	Monthly	Monthly
2. Ensure sustainability of RENEW implementation, with fidelity, to youth served by the 10 mental health centers by developing, delivering, and continuously assessing the effectiveness of a RENEW Coaches curriculum and coaching support to 20 staff members (2 in each center) identified to be RENEW Coaches in the 10 mental health centers.	Goal: Train 8 staff as Coaches **Year End: 10 Coaches**	Goal: Train 6 staff as Coaches **YTD: 6 additional Coaches Trained** **10 Active**	Goal: Train 6 Staff as Coaches
2.a. Identify and train RENEW Coaches in the MHCs that meet readiness criteria for delivering internal coaching	Goal: 8 Staff Coaches	6 Staff Coaches	6 Staff Coaches

	Year End: 10	**11 Active Coaches**	
2.b. Provide ongoing support at coaching to agency RENEW Coaches (new and existing)	Goal: 2 New, 6 Existing Coaches **Year End: 5 existing coaches, 5 New Coaches**	Goal: 18 total Coaches **5 Existing, 6 New**	Goal: 18 total coaches
3. Expand the accessibility of RENEW to more youth and continuously improve the competencies of individuals who are trained in RENEW by developing online and distance training and coaching to train and support RENEW Facilitators and Trainers in the mental health centers and other entities that serve youth and young adults with emotional and behavioral challenges.	Goal: Expand New Hampshire Hospital Pilot with 6 youth **Year End: 21 Youth**	Expand to DCYF- 8 youth (include NHH) NHH continues to run 2 RENEW groups per week,	
3.a. Develop an information system "map" and create web-based instrumentation, website, etc.	Goal: Map developed and vetted, website developed **Year End: Map developed**	**YTD: Continuing to add content to Web**	
3.b. Train RENEW Facilitators and Coaches to use the online system	Goal:80 Facilitators and Coaches are trained **Year End: System planned to go live November, 2014**	Goal: 80 people input data using the system **Web System Online. Data has been cleaned.** **72 People inputting data.**	Goal: 80 people input data using the system
3.c. Assist Facilitators and Coaches to collect and input the data	Goal: Assist 80 Facilitators and Coaches **Year End: Data input in Project Tracker**	Goal: Assist 80 Facilitators and Coaches **Web-Based and Onsite Trainings**	Goal: Assist 80 Facilitators and Coaches

		being provided as well as coaching. **June booster training on using the data system conducted.**	
4.d. Measure youth outcomes	Goal:100 youth: CANS and additional outcome measures **Year End: Process and Outcome data collected; CANS Not Universally Used.**	200 youth: CANS and additional outcome measures **See attached data from online system.**	200 youth: CANS and additional outcome measures
4. Improve the outcomes of youth and young adults who receive RENEW by working with the RENEW facilitators and trainers to intentionally increase the involvement of family members, schools, and vocational rehabilitation in youth individualized teams, and develop and implement a process and tools for measuring team member engagement, involvement, and outcomes	Goal: Team participation and notes **Year End: # 42 Teams**	Team participation and notes **See attached data.**	Team participation and notes
4.a. Work with each CMHC to identify and include community partners	Goal: Facilitate 20 community meetings per year **Year End: 14 community meetings held**	Facilitate 20 community meetings per year **YTD: 23 Meetings**	Facilitate 20 community meetings per year
4.b. Engage the Federation of Families to conduct youth and family interviews	50 youth and family interviews	50 youth and family interviews **Not Started**	50 youth and family interviews
4.c. Facilitate the development of contracts and formal collaboration with schools, NHH, VR and other community agencies	5 agreements formed with schools; 33%	5 agreements formed with schools; 33%	5 agreements formed with schools; 33%

	VR youth Participation **Year End: 3 MOU's Completed 18% VR Participation**	VR youth Participation **YTD: 9 MOUs Signed**	VR youth Participation
5. Ensure that the providers of community behavioral health services to youth and young adults with emotional and behavioral health challenges can continue to provide RENEW to youth by addressing and making adjustments to the financial, policy, and accountability infrastructures that govern behavioral health services for children and youth.	RENEW Leadership Team notes **YTD: Leadership Team meeting in March 2014, May2014, July 2014, Sept 2014**	RENEW Leadership Team notes **YTD: Dec 2014 March 2015 June 2015**	RENEW Leadership Team notes
5.a. Continue to facilitate state RENEW Leadership Team- team reviews project data	No fewer than 6 meeting per year- meeting notes **YTD: Leadership Team meeting in March, May 2014, July 2014, Sept 2014**	No fewer than 6 meeting per year- meeting notes **YTD: Dec 2014 March 2015 June 2015**	No fewer than 6 meeting per year- meeting notes
5.b. Leadership team assesses cost-benefit of RENEW services	Annual study and review **Year End; In development**	Annual study and review	Annual study and review
5.c. Develop a fee structure for ongoing training and coaching		**YTD: Fee structure proposed.**	Trainings and fee schedules established
5.d. Obtain sustainable RENEW training infrastructure support			System in place with formal contracts/MOUS
5.e. Disseminate results- and contribute to interagency collaboration		Include DCYF	Expand RENEW implementation to other systems In

			state and in other states)
5.f. Leverage dollars and additional resources from aligned initiatives, including the System of Care project, and the Children's Behavioral Health Collaborative.	Goal: Indicated in project reports and leadership team meeting notes **Year End: Working together with the DOE Next Steps and Safe Schools projects, and the Fast Forward DHHS project**	Indicated in project reports and leadership team meeting notes **YTD: We continue to work together with the DOE Next Steps and Safe Schools projects, and the Fast Forward DHHS project**	Indicated in project reports and leadership team meeting notes

Workplan Goals and Status:

Goal	Progress	Challenges	Plans to Address
1.a. Develop and revisit annually an individualized Memo of Understanding with each of the 10 mental health centers that specifies number of staff to be trained, youth enrollments, and mutual responsibilities of the centers and the IOD.	(see attached implementation tracker) 10/1/14-12/31/14 6 new MOU's Developed 1/1/15-3/31/15 8 MOU's Developed 4/1/15-6/30/15 9 MOU's Developed Waiting on Keene for the 10th. Anticipated for next quarter.	10/1/14-12/31/14 • Manchester still in negotiations. West/Central & Keene are not participating. 4/1/2015-6/30/2015 • Meetings with west Central and Keene (W. Central agreed in July, 2015)	• Project director has met with West-Central and Keene, both have agreed to participate for year 3.
1.b. Train CMHC staff to be RENEW facilitators-	Completed for participating agencies	See attached logs	Expectations for facilitator Capacity and youth served are still being met. Will

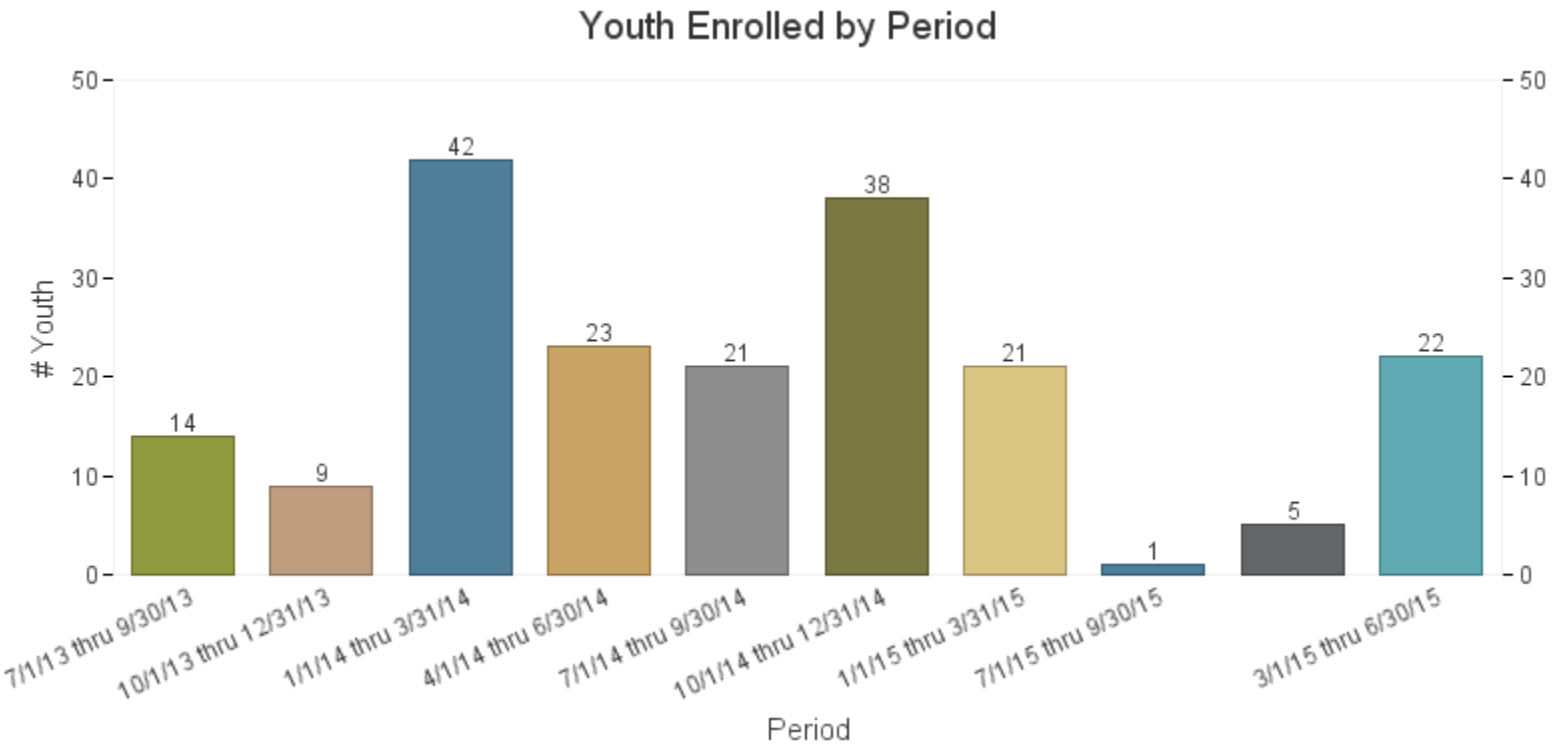
	10/1/14-12/31/14 RENEW Training for 14 staff 1/1/15-3/31/15 Training Scheduled in April		train additional facilitators in the spring. 10/1/14-12/31/14 Assisting agencies with facilitator selection criteria
1.d. Enroll and serve 450 youth – (Approximately 15 per center per year) 150 youth	(see attached student tracker)	• Main barrier is only having 8 and not 10 participating agencies until FY16. • 196 youth as of 6/30/2015	• See 1.a.
1.e. Track enrollments and process	(see attached student tracker) 10/1/14-12/31/14 Online data-base up and running 4/1/15-6/30/15 System has been cleaned. Facilitators are learning to use the system.	10/1/14-12/31/14 Agency staff learning to use system 4/1/15-6/30/15 Agency Staff report inputing data into the system for the first time is time intensive. 1/1/15-3/31/15 Online & onsite coaching provided. Additional formal trainer with developer in June. 4/1/15-6/30/15 Booster training on using the data system's features occurred in June. "Data Parties" are occurring at all agencies with the help of project staff.	10/1/14-12/31/14 Online & onsite coaching & training provided
2.b. Provide ongoing	• Project staff have		

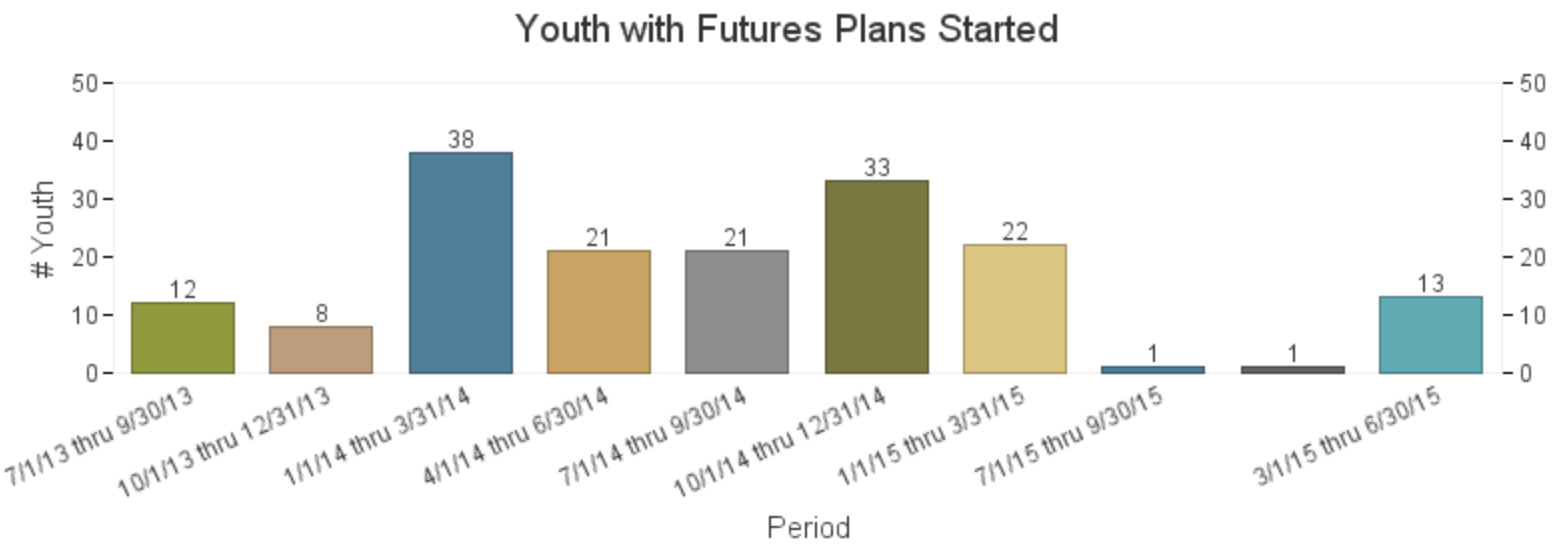
support to agency RENEW Coaches (new and existing)	continued monthly coaching of existing coaches. 10/1/14-12/31/14 • CLM has identified a coach • Genesis has identified a replacement coach 4/1/15-6/30/15 Most coaches are not certified.		
3.a. Develop an information system "map" and create web-based instrumentation, website, etc.	10/1/14-12/31/14 Using UNH website to store instruments, information, & training modules. 1/1/15-3/31/15 Continue to upload modules to the RENEW homepage as the new online system is being developed. 4/1/15-6/30/15 Continue to improve the RENEW website and upload training/coaching content.	10/1/14-12/31/14 UNH is moving to a new web-based information system	Will need training in new web-based training & information system

Respectively Submitted,

JoAnne Malloy
Jonathon Drake
IOD RENEW Project Staff

APPENDIX 1: Data (Not all data has been cleaned after the transfer from the old tracker into the online tracker. Therefore, some numbers will increase in the next report)




Youth with Futures Plans Started
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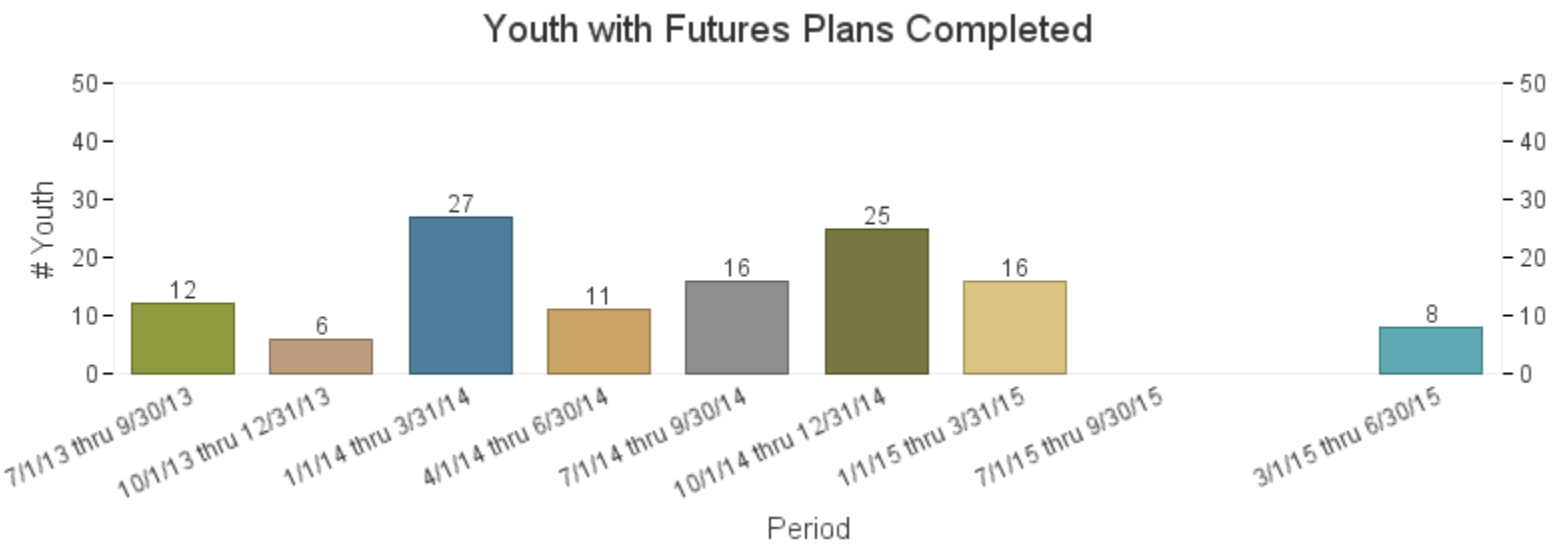
Youth with Futures Plans Completed
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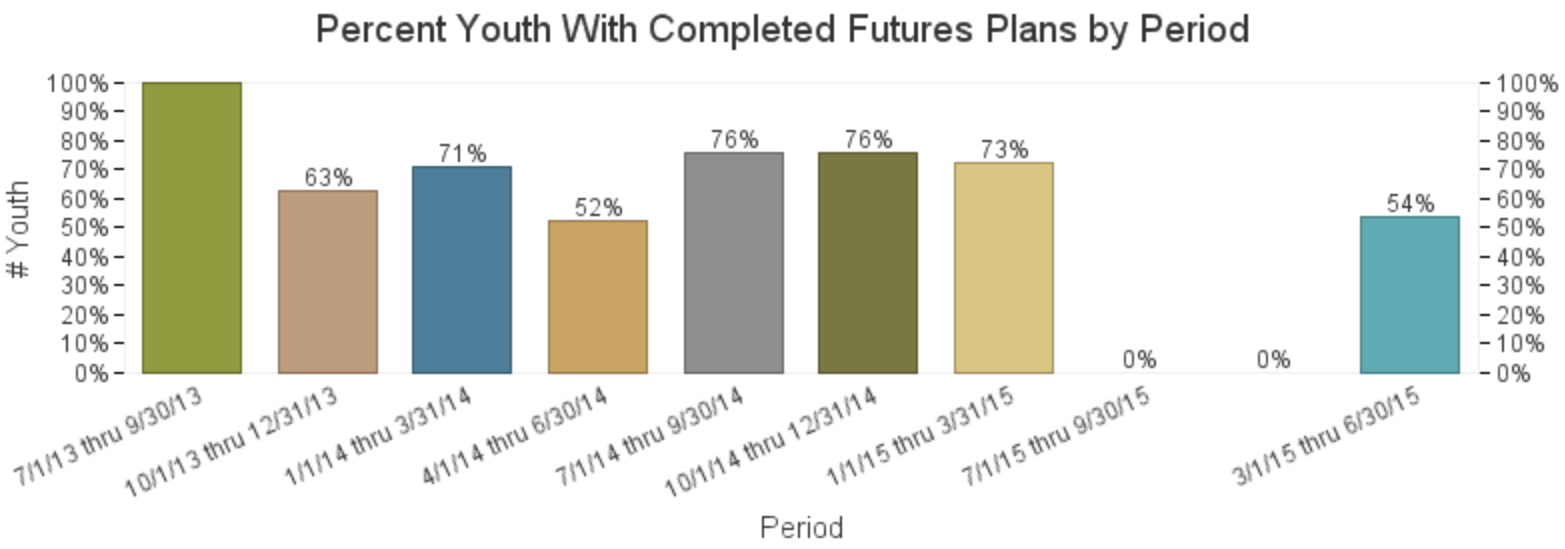
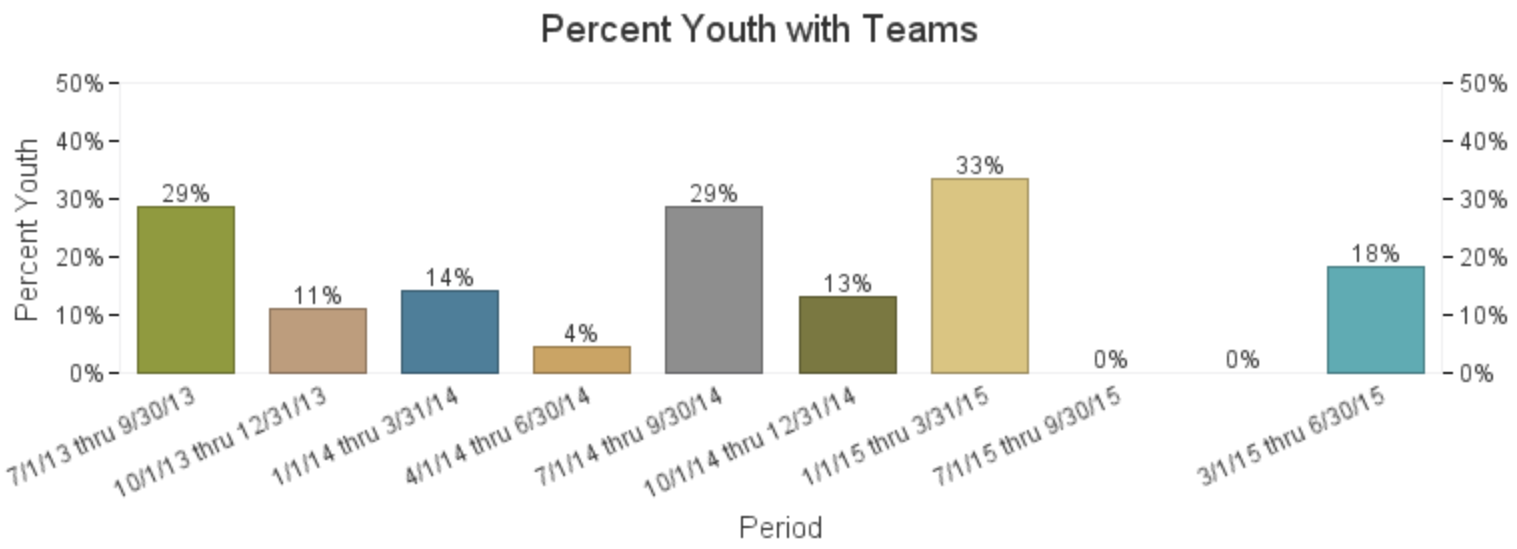
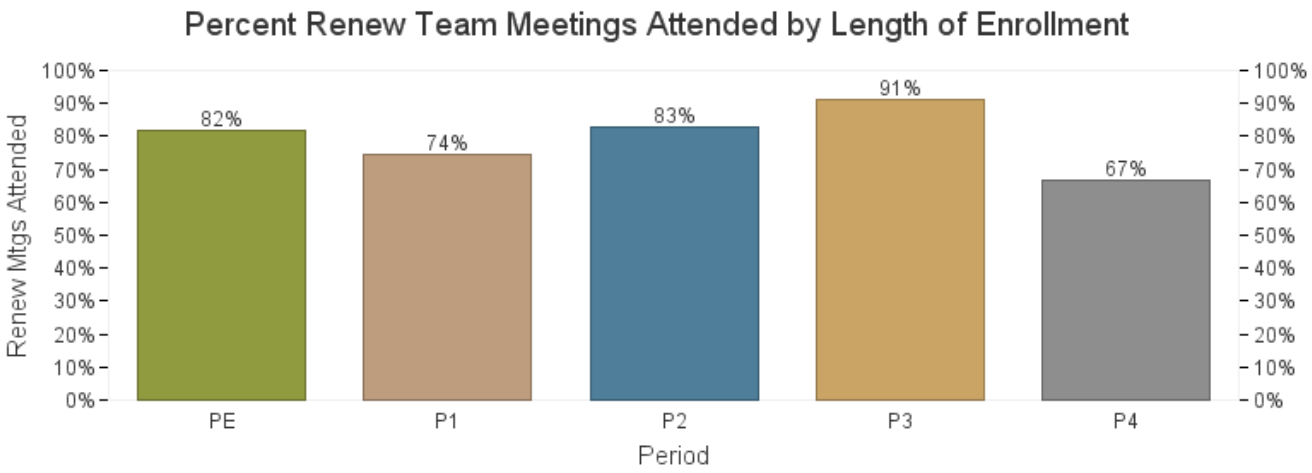
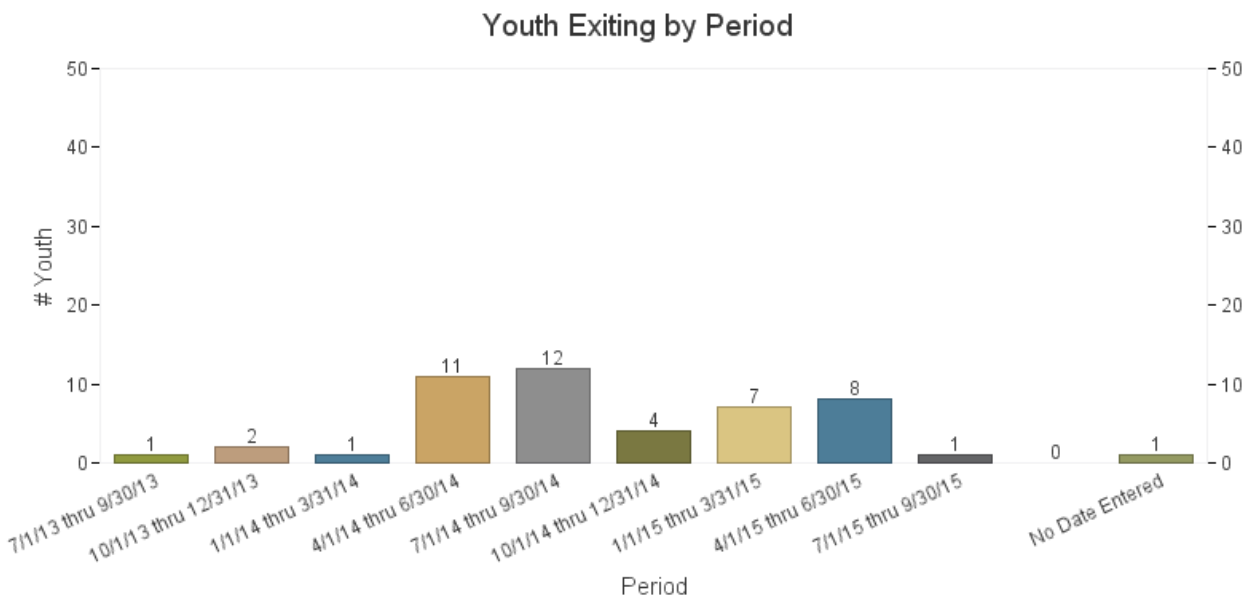
3/1/15 thru 6/30/15
Period

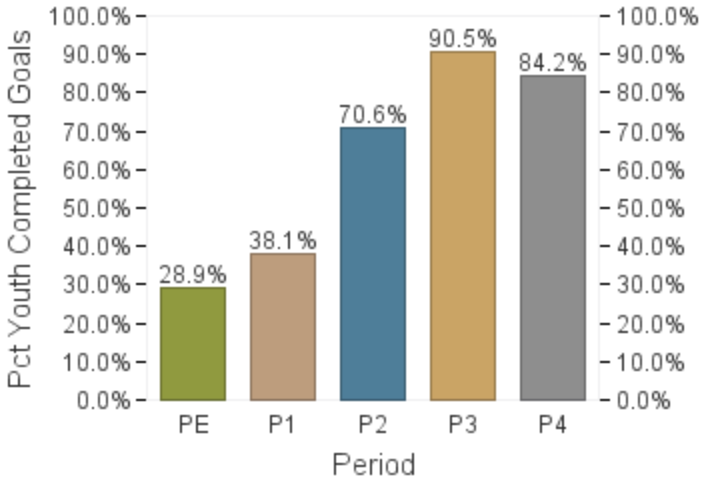

Percent Youth With Completed Futures Plans by Period
Youth
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
63%
71%
52%
76%
76%
73%
0%
0%
54%
7/1/13 thru 9/30/13
10/1/13 thru 12/31/13
1/1/14 thru 3/31/14
4/1/14 thru 6/30/14
7/1/14 thru 9/30/14
10/1/14 thru 12/31/14
1/1/15 thru 3/31/15
7/1/15 thru 9/30/15
3/1/15 thru 6/30/15
Period


Percent Youth with Teams
Percent Youth
50%
40%
30%
20%
10%
0%
29%
11%
14%
4%
29%
13%
33%
0%
0%
18%
7/1/13 thru 9/30/13
10/1/13 thru 12/31/13
1/1/14 thru 3/31/14
4/1/14 thru 6/30/14
7/1/14 thru 9/30/14
10/1/14 thru 12/31/14
1/1/15 thru 3/31/15
7/1/15 thru 9/30/15
3/1/15 thru 6/30/15
Period

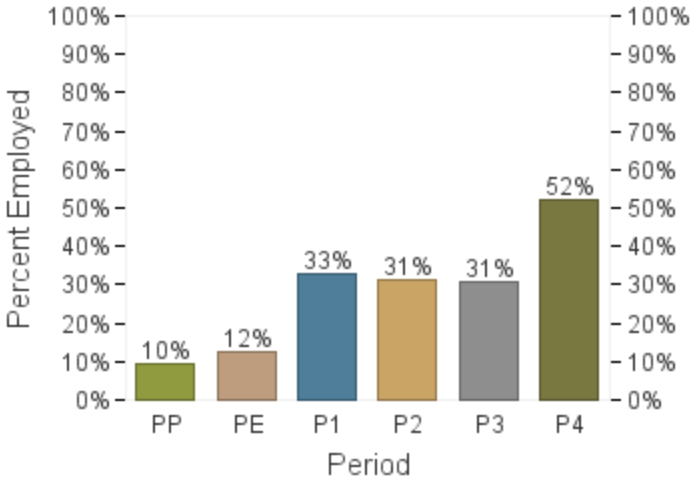

Percent Renew Team Meetings Attended by Length of Enrollment
Renew Mtgs Attended
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
82%
74%
83%
91%
67%
PE
P1
P2
P3
P4
Period


Youth Exiting by Period
Youth
50
40
30
20
10
0
1
2
1
11
12
4
7
8
1
0
1
7/1/13 thru 9/30/13
10/1/13 thru 12/31/13
1/1/14 thru 3/31/14
4/1/14 thru 6/30/14
7/1/14 thru 9/30/14
10/1/14 thru 12/31/14
1/1/15 thru 3/31/15
4/1/15 thru 6/30/15
7/1/15 thru 9/30/15
No Date Entered
Period

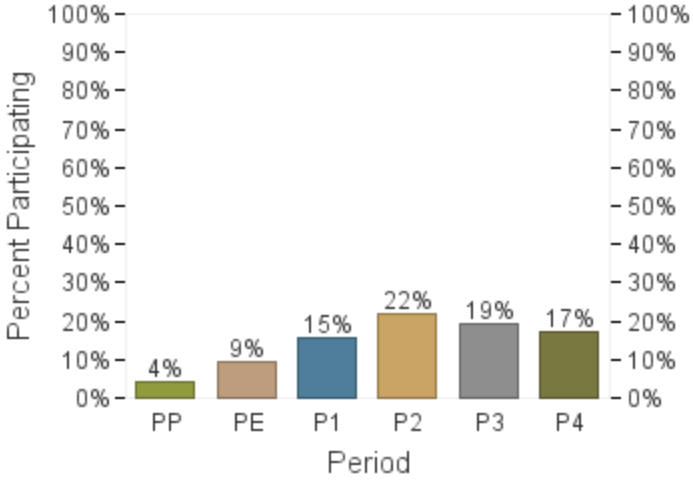
Youth with 1+ Futures Goals Met



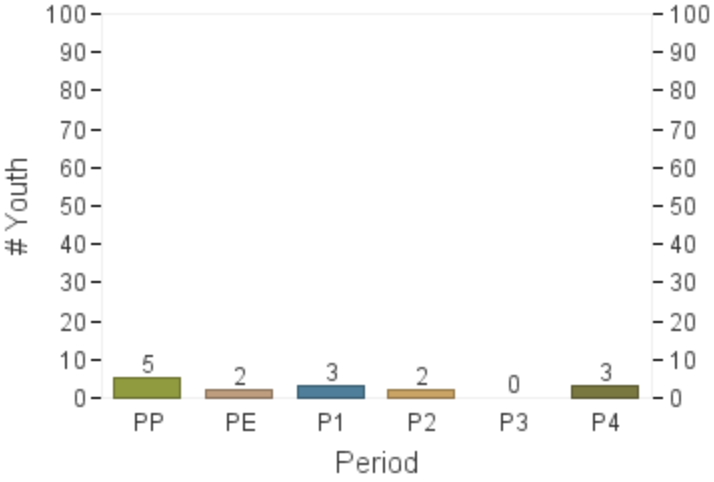
Percent Employed

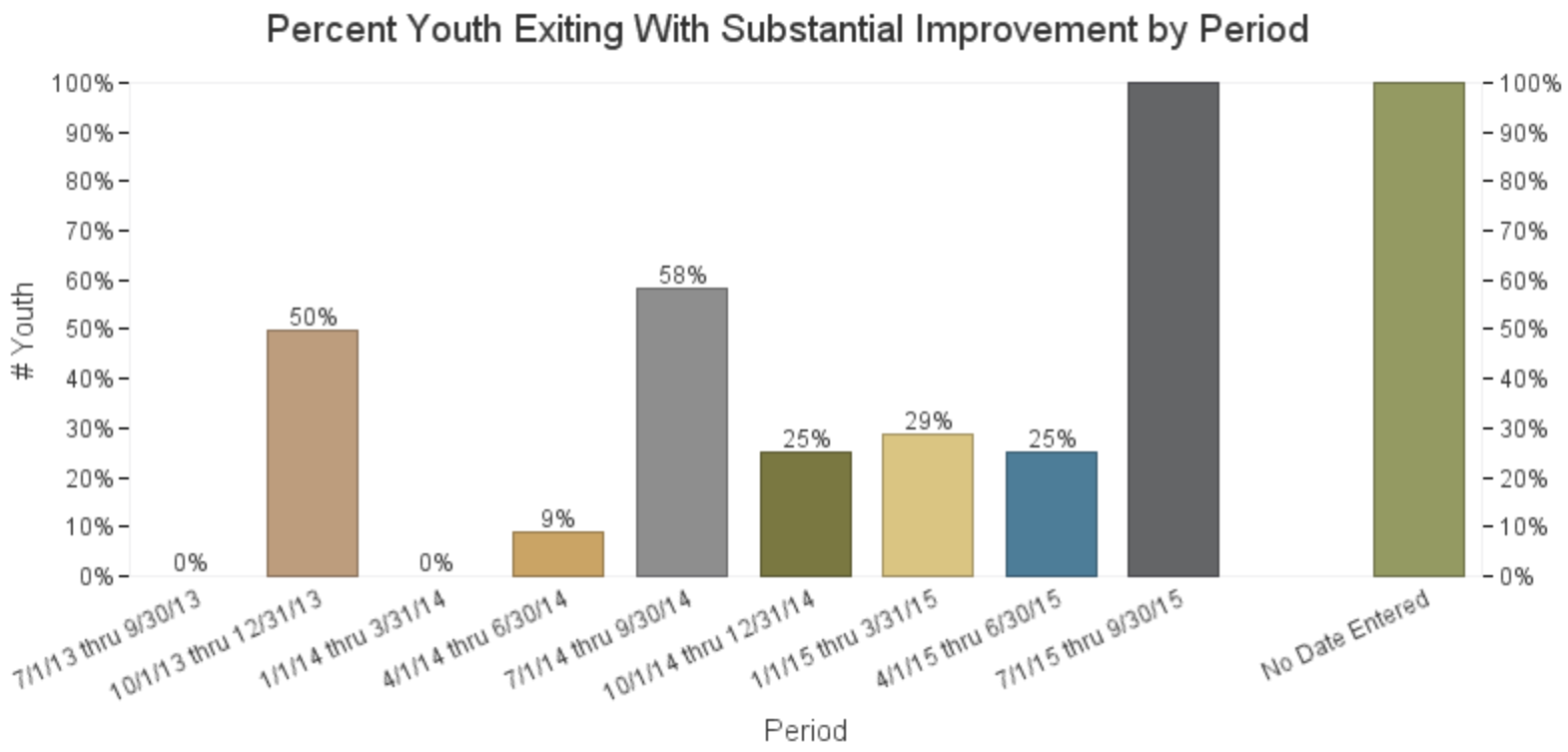


Percent Internship or Work Based Experience



Youth with Psychiatric Hospitalizations




Percent Youth Exiting With Substantial Improvement by Period
Youth
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
50%
0%
9%
58%
25%
29%
25%
100%
100%
7/1/13 thru 9/30/13
10/1/13 thru 12/31/13
1/1/14 thru 3/31/14
4/1/14 thru 6/30/14
7/1/14 thru 9/30/14
10/1/14 thru 12/31/14
1/1/15 thru 3/31/15
4/1/15 thru 6/30/15
7/1/15 thru 9/30/15
No Date Entered
Period

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The SMHA recognizes the federal requirement surrounding services to pregnant women, and requires providers to record pregnant status and prioritize services to pregnant women at the highest level (admitted within 48 hours), a step below the emergent priority level.

Currently the Phoenix CLD system does not collect pregnancy status.

DHHS Maternal and Child Health (MCH) Section

The DHHS Maternal and Child Health (MCH) Section supports a broad array of programs in order to improve the availability of and access to high quality preventive and primary health care for all children and to reproductive health care for all women and their partners regardless of their ability to pay.

It is MCH's goal that every child in New Hampshire have the opportunity to grow up healthy. Priorities are based on a yearly review of statewide need which are reported on in MCH's annual Grant Application to the federal government (attached).

Maternal and Child Health Services Title V Block Grant

State Narrative for New Hampshire

Application for 2015 Annual Report for 2013

Document Generation Date: Monday, September 22, 2014

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

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

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

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

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

In order to validate the work of the Title V professionals in the state agency and in the field, it is imperative to have family and community input into priority setting and program evaluation. Public Input for the Title V 2010 Needs Assessment and 2011 Annual Report were combined and in mid-2009, the Title V developed and administered an on-line (Survey Monkey) and paper survey to collect public input on the health needs of NH families. A link to the on-line version was placed on the DHHS website and distributed electronically to statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. A total of 689 people returned the paper surveys and 299 people responded to the Survey Monkey version.

The paper survey was distributed to Title V-funded health care agencies and to the ten DHHS District Offices (welfare offices) statewide that provide TANF, Medicaid, food stamps and other services to low-income clients. Paper surveys, aimed at clients of services and families, were available in Spanish and Portuguese. Clients were asked to complete the surveys and office staff returned them to MCH. The demographic results suggest that by providing both electronic and paper surveys, we succeeded in reaching two different populations, a population of advocates, providers and professionals and a population of clients, families and consumers of Title V services.

On the electronic survey (299 responses): the average age of the respondent was 46; 96% were white; 70% had children under 21; 48% were not employed; 4% had no insurance; 3% had Medicaid; and 82% had employment-based health insurance.

On the paper survey (689 responses): the average age of the respondent was 35; 90% were white; 58% had children under 21; 7% were not employed; 25% had no insurance; 15% had Medicaid; and 26% had employment-based health insurance.

The following were the needs and priorities identified by survey respondents. There were not overall significant differences between groups.

1. Access to health insurance
2. Alcohol and other drug use/misuse
3. Overweight and obesity in youth
4. Access to dental health services
5. Access to mental health services
6. Access to specialty health care
7. Tobacco use in youth and pregnant women
8. Autism
9. Teen suicide
10. Adequate respite care/Asthma (tie)

It is interesting to note, that although it affected a smaller number of families (those with CSHCN) access to adequate respite care was always a paramount concern for those who needed it most.

Surveys provided ample opportunity for narrative comments. Responses that were repeatedly reported included:
- "Insurance for low income moms. Dental for adults"
- "Loss of health care when a child turns 19. There is a huge population of uninsured 19-23 year olds."
- "Teen Depression." "Teen Pregnancy." "Teen Suicide"
- "Disability services for disabled children & ADHD specialists"
- "More awareness of special programs for young moms"
- "Nutrition"

In order to gather more public input, a Town Hall-style meeting was held in November 2009 to help in the prioritization process for the 2010 Needs Assessment. Participants at this meeting included staff from other state agencies, nonprofit organizations, including March of Dimes, New Hampshire Endowment for Health, NH Family Voices, community health centers, health care providers and others. At this meeting, Tricia Tilley, Title V Director, Liz Collins CSHCN Director, and David Laflamme, MCH Epidemiologist, also presented data on identified needs in the three Title V population subgroups, and information from the public input surveys. Participants were asked to rank their top five priorities using a "Pennies for Priorities" method. Each participant received fifteen pennies and a list of the preliminary priorities and was asked to rank their top five priorities. Fifteen baskets, each labeled with a priority area, were placed in the front of the auditorium. Participants were instructed to place 5 pennies in the basket labeled with their highest priority, four in the basket of their next highest priority, three for their third, two for their fourth and one penny for their lowest priority. An extra basket collected participants' written lists of up to three emerging issues that they were aware of in their work.

After the public input from professionals, advocates and families, there was no clear cut ranking across 10 priorities. But what did emerge was the fact that what still matters most to advocates and families is access to:
-Health Insurance
-Mental Health Care
-Substance Abuse/Alcohol Treatment

-Dental Care for Adults and Medicaid Clients
-Respite For Those Who Need It

In addition to public input regarding the Title V system as a whole, input was also gathered about particular systems, including early childhood services and services for children with special health care needs. In 2009, MCH modified a Zero to Three, the National Center for Infants, Toddlers, and Families survey that assessed early childhood health, strong families, positive early learning experiences, and collaboration and system building. In November 2009, SMS, utilized the Champions for Inclusive Communities survey to assess the organization and accessibility of NH's community-based service systems so that family's can easily use them. Each of these information-gathering sessions informed priority setting and directed future planning. /2012/As it relates to services for CSHCN a population specific Needs Assessment was completed for the families of children and youth with Epilepsy. This NA captured feedback on the families'/youth's access to specialty care, Medical Home experiences, and adequacy of coordination of care. This included 3 focus groups one of which targeted families whose first language was not English and translators were available. It also included a statewide survey of families. The response was strong and families responded from every county in the state. Families whose first language was not English completed the survey with the assistance of translators. //2012//

Title V plans to continue to utilize surveys and research the utility of social media of gathering public input, for specific interest areas or population groups in Title V as well as the Title V program as a whole, for future Annual Reports.

/2012/
New Hampshire places a high value on community and family participation and public comment in planning and priority setting. In an effort to increase access to New Hampshire's plans, the MCH Block Grant and Needs Assessment is available on the NH DHHS website on the MCH webpage http://www.dhhs.nh.gov/dphs/bchs/mch/ for viewers and families to review and provide feedback.

Title V has continued to reach out directly to professionals, advocates and families through an annual electronic survey to gather input on our priorities. The five-minute survey is distributed to statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, family advocacy groups, advisory groups, task forces among others and all are invited to forward the survey along to their respective partners, friends, families and contacts so that it becomes "viral". This has been a successful strategy for New Hampshire and within a matter of days, Title V receives very specific input from around the state from traditional and non-traditional partners and families.

In June 2011, Title V partners simultaneously distributed this survey and within a matter of days over 200 public input surveys from health care professionals, state agency directors, school nurses, and families, were completed. Similar to years past, respondents noted the following as the things that they most needed to keep their family healthy:

- Health insurance that doesn't cost too much
- High quality doctors and nurses
- Dentists you can afford
- Mental health doctors and counselors you can afford
- Trained care for children with special health care needs

Although statistically almost undistinguishable, the highest scoring priorities for the state and for Title V were:

- Affordable healthcare
- Ensuring children have health insurance
- Affordable mental health services

- High quality mental health services
- High quality services for children with special healthcare needs -
- Addressing the needs of overweight children

More than 60 detailed, narrative comments were also provided urging Title V to address priorities as varied as the impact of state budget reductions in safety net services, substance abuse treatment and prevention, diabetes education, Katie Beckett and in home supports for children with special health care needs, environmental health, among others.

As a whole, these suggestions and comments help confirm the direction of New Hampshire's Title V current priorites. Next year, New Hampshire intends to revise the survey instrument based on feedback on the survey itself and to better reflect current priorities. Plans are being developed to use additional forms of social media such as Twitter to further spread the tool while capturing a different audience. While New Hampshire embraces electronic and social media as a way to easily and quickly elicit and analyze diverse opinions from around the state, we acknowledge that we may be missing some of the most disenfranchised voices. In an effort towards continuous quality improvement, additional strategies will be considered such as those used for the five-year needs assessment to ensure that a wide net is cast and that the input continues to help shape future policy and priorities.

//2012//

/2013/

Due to the consistency of responses over the last 2 years, Title V did not repeat the survey instrument from last year. The plan is to revise the tool for administration in 2013. There were a variety of other Title V initiatives that reflect a statewide approach to elicit public input on services and needs. The first effort of note was the Stakeholder heavy process used for strategic planning for SMS. Stakeholders invited to participate included representatives from all MCH programs (& on the leadership group), other DHHS agencies, community services providers, families, health care providers, parent professionals. There was also a series of focus groups related to the system of care for children and youth with epilepsy targeting individuals most likely to be experiencing access issues. A focus group was held in Northern NH, in Manchester NH with families whose primary language was not english and a focus group for young adults. SMS also initiated a new comprehensive Survey of families receiving services for CSHCN. SMS received 1358 returned surveys offering input on Satisfaction (87% rated satisfaction as good/excellent), Unmet Health Care Needs, Impact to Families and Unmet Social Service Needs. These results will be used to address service design and quality improvement efforts.
//2013//

/2014/
This year, Title V took its survey instrument directly to representative community health centers and asked clients in the waiting room to complete it as they waited for appointments. Access to mental health services and access to health insurance remain the highest concerns. New to the survey was the overwhelming prioritization of alcohol & other drug use/misuse and prescription drug misuse.

Title V received additional public input as part of an Alliance for Healthy Community Coalitions Summit in May 2013. The purpose of summit was to receive feedback from local and state community partners, advocates and coalitions on the State Public Health Improvement Plan and DPHS Priorities. During the Healthy Mothers and Babies session, discussion was focused on: increasing use of preconception and prenatal care; reproductive and sexual health services and support services for pregnant and parenting women; and reducing barriers to accessing clinical and community preventive services, especially among populations at greatest risk, including children with autism and other CYSHCN. //2014//

/2015/
In preparation for the 2015 Title V Needs Assessment, MCH contracted with the Community Health Institute of Bow, NH to redesign the electronic public input survey instrument and to conduct two focus groups with NH residents aged between 18 -- 49 years in the North Country and in Manchester, NH.

The revised survey was launched in late June 2014 through social media, Facebook and Twitter, as well as through parent and professional listserves. To date, over 300 electronic responses have been received. Over 300 paper surveys were also distributed at community health centers. These responses will be used for both public input to the Annual Block Grant and the Needs assessment. Intial feedback strongly suggests that Title V must continue to focus on access to quality care.

The Block Grant and Needs assessment continue to be available for review and comment on the NH DHHS website (http://www.dhhs.nh.gov/dphs/bchs/mch/).

//2015//

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

New Hampshire's 2010 needs assessment process was based on MCHB guidance and best practices. Criteria used to choose top priorities were based on public health principles and included the magnitude of the need; disproportionate effects among population subgroups; problems resulting in significant economic costs; cross-cutting problems that have life span effects; and the feasibility of NH's Title V program to impact the problem. Assessment of Title V capacity was conducted using a modified version of CAST-5.

Public Input

Utilizing an on-line and paper survey, input on priority needs was obtained from nearly 1,000 individuals, families,
advocates and health care providers. The survey was also available in Spanish and Portuguese and was completed by clients in the state-funded health care agencies and DHHS district offices, enabling the acquisition of input from an often difficult to reach population.

Priority needs

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. The importance of cultural competence in local and state MCH programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as a focus for NH's Title V program. Similarly, recognition of the social determinants of health -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

From extensive research of current state data and an internal and external capacity review, combined with public input, ten priorities emerged that adequately described the needs of the Title V population subgroups of women, infants, families and children with and without special healthcare needs.

1.To improve access to children's mental health services

Public input and data suggest significant mental health needs in children and adolescents and a lack of mental health services and skilled professionals in the State. Suicide is the 2nd leading cause of injury-related death among NH adolescents, and NH's teen suicide rate exceeds the U.S. average. Mental health safety net systems are overtaxed, with long waiting lists.

Improving access to children's mental health services remains critically important. Families through the MCH public input process are continuing to identify this issue as one of he hisghtest needs for our state. While NH faces significant budget reductions for community mental health services and additional reductions for primary care services, it is imperative that Title V focus on building partnerships, identifying resources and understanding the data regarding access to care.

2.To decrease pediatric overweight and obesity

Obesity is an increasing problem in NH. Available data reveal that over 29% of NH 10-17 year olds were overweight or obese in 2007 (34% of CSHCN), and the numbers are increasing. Disproportionate obesity rates are observed in those with low socioeconomic status.

In the 2009 New Hampshire Healthy Smiles - Healthy Growth survey of third graders, 33% were overweight or obese. The Survey also showed regional differences in childhood obesity: 3rd grade students in the Belknap-Merrimack region (24%) and Coos County (22%) had the highest prevalence of obesity and nearly 46% of 3rd grade boys in Coos County were overweight or obese. Because of these trends, Title V is partnering with childcare professionals to work with young families to increase positive healthy behaviors and help professionals create new food and physical activity policies.

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

New Hampshire's rates of tobacco, alcohol and other substance use and abuse among youth and women are higher than the US rates. Substance abuse treatment capacity continues to be a problem in NH. Smoking during pregnancy can result in low-birth weight infants, pre-term deliveries and infant deaths. Smoking rates are higher among young pregnant women and among those on Medicaid.

Use and abuse of tobacco, alcohol and other substances is a marker for a myriad of health concerns from
prematurity to increased risk of victimization from sexual violence. Approximately one-half of the cases of sexual
violence involve alcohol consumption by the perpetrator, victim, or both. Twenty-seven percent of young adults, 18-25 report binge drinking (2010 BRFSS). MCH has piloted innovative strategies using social media to reach this
population.

4.To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

The percent of uninsured NH adults in 2009 was the highest in the Northeast and is increasing. Adults who live in rural areas, are young, low income, or members of racial and ethnic minority groups suffer disproportionately. Rising unemployment and reductions to state programs create the potential for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

Access to high quality healthcare and affordable health insurance continues to be among the highest concerns reflected in the public input to the MCH Block Grant and Needs Assessment process. The consequences of legislative changes to New Hampshire's Medicaid program for FY12 and 13 are unknown. Significant budget reductions to the state's community health centers will also impact each community. Early indicators are that CHCs are cutting services such as access to clinical and behavioral health services. MCH wil continue to monitor health indicators among women and children, including CYSHCN for trends.

5.To improve access to standardized developmental screening for young children

Nationally, less than 50% of children with a developmental delay are identified before starting school, impacting
readiness to learn. NH has a fragmented system for screening that is ripe for improvement.

Title V continued to support the expansion of Watch Me Grow, a comprehensive screening and referral system for NH families of children aged birth to six years. This work is done in tandem with the NH Council on Autism Spectrum Disorders as established by the state legislature to

improve services and supports. A new website was created to provide a single point of entry to a comprehensive body of information about NH services and the best practice guidelines www.nhcouncilonasd.org .

6.To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents

Unintentional injuries rank as the leading cause of death for children and adolescents in NH and nationally, killing more in this age group than all diseases combined. Many of these deaths are preventable.

Among NH injury deaths for those 0-44, 73% are unintentional, 25% result from violence and the remaining 2% are either undetermined or the result of legal intervention, compared to 68% unintentional, 29% from violence and 3% undetermined/legal intervention for the US. Violent deaths are far more often suicides than homicides. While nationally, there are 1.9 suicides for each homicide; in NH the ratio is 7.4.

7.To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

Asthma is the most prevalent chronic condition among children and a leading cause of ED visits for children. Young children are also vulnerable to the effects of lead poisoning. Children with lower SES have poorer outcomes for asthma and are at increased risk for lead poisoning.

8. To improve oral health and access to dental care

Dental care access is a problem in NH, specifically for the poor, under and uninsured. Approximately 44% of NH 3rd grade students experienced tooth decay. Tooth decay was higher and the prevalence of dental sealants was significantly lower in several rural NH counties.

9. To increase family support and access to trained respite and childcare providers

The National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including the need for workforce development. A statewide effort is needed to provide support for workforce development to serve CSHCN.

A survey of caregivers related to respite needs has been initiated by SMS and the Lifespan Respite Coalitions.

10. To decrease the incidence of preterm birth

Younger mothers and those with Medicaid as a payer source have increased rates of smoking while pregnant and are at increased risk of premature birth. These findings point to potential intervention areas, such as anti-smoking efforts.

NH is continuing to focus on perinatal smoking cessation among low income women as a way to impact
prematurity. In 2009, almost 33% of births with Medicaid as a payor had a mother who reported smoking while
pregnant, as compared to 6% for other payers.

/2015/
In preparation for the 2015 Title V Needs Assessment, MCH contracted with the Community Health Institute of Bow, NH to redesign the electronic public input survey instrument and to conduct two focus groups with NH residents aged between 18 -- 49 years in the North Country and in Manchester, NH. The revised survey will be rolled out in

late June 2014.

The focus groups focused on the following topics that impact the health of families in New Hampshire: Cost of Health Care & Health Insurance; Access to Health Care Providers & Services; and Self-Care, Prevention & Health Education. In the North Country, participants expressed concern over the increasing out of pocket costs for health care. If they can afford care, access is still an issue. Participants expressed a need for more PCPs and specialists recruited to the area. Pregnant women from the most northern areas are able to get obstetric care locally, but they must plan in advance to travel at least one hour to a hospital to deliver their baby. Some do not go for regular oral health care because they cannot afford to pay for the appointments.

This initial feedback suggests that Title V must continue to focus on access to quality care. //2015//

III. State Overview

A. Overview

GEOGRAPHY: New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. New Hampshire is one of the 3 northern New England states, which along with Maine and Vermont, are more rural than the southern tier: Massachusetts, Connecticut and Rhode Island. According to the State definition of rural, approximately 37% of the population and 84% of the landmass in New Hampshire is considered rural. The majority of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the State's southern tier.

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

DEMOGRAPHICS: New Hampshire has a growing population, estimated at 1,324,575 in 2009, representing a 7% increase since the 2000 census. (1) The population growth rate has slowed over the past two years. (2) While the state's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. Most minority populations live in the southern tier of the state. As might be expected based on the differing racial and ethnic proportions in younger age groups, births in NH are also becoming more ethnically and racially diverse. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998. (3) /2013/ On July 1, 2011, the U.S. Census Bureau estimated that there were 1,318,194 residents in New Hampshire. The population change from 2010 to 2011was 1,387, the third year in a row that net population gain for New Hampshire was minimal -- a sign that the state's population growth has stalled. Economists are attributing the decline to domestic out-migration- residents moving out of the state. Census data reflect that the state's five most southeastern, more urban counties are currently experiencing growth, while the more rural northern counties are experiencing decline or stagnation. //2013//

Although New Hampshire's population is slowly growing, it is also aging. Over 25% of the population is 55 years of age or older. An analysis of the percentage change in population by age group concluded that the 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. An increase in the overall aging of the population is a trend that influences needs in our communities. Women represent half of the population of the State, and women of childbearing age make up nearly 39% of the total female population and nearly 20% of the total New Hampshire population. The fertility rate in New Hampshire has remained steady, even as the national rate has increased. In 2009, there were 13,683 births in New Hampshire. But there has been a shift in the state as to where those babies are born and this has impacted community services. For a hospital, a low frequency of births makes it both ecomomically unfeasible and limits the quality of services to operate a separate unit with specialized staff and equipment. Due to declining births, two hospitals closed maternity units within the past two years (Weeks Medical Center in Lancaster in 2008, Huggins Hospital in Wolfeboro in 2009). This followed the closing of maternity units by three community hospitals that had occurred between 2002 and 2005 (New London Hospital in 2002, Upper Connecticut

Valley Hospital in Colebrook in 2003, and Franklin Regional Hospital in 2005). Currently, there is only one hospital in Coos County (the state's largest county in geographic size) with a maternity unit.

POLITICAL ENVIRONMENT: New Hampshire operates under a unique Governor & Council (G&C) form of government. Five Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. The Councilors participate in the active management of the business of the state. Together, the G&C has the authority and responsibility over the administration of the affairs of the state as defined in the New Hampshire Constitution, its' statutes and the advisory opinions of the New Hampshire Supreme Court and the Attorney General. All state departments and agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of $10,000 or more. New Hampshire also has the third largest legislative body in the English-speaking world, consisting of 24 senators and 400 representatives. The structure and size of New Hampshire's executive and legislative branches, respectively, ensure that citizens are well represented in matters of the state. NH's "citizen legislature", so called because each legislator is paid a sum of $100 annually, is historically rooted in a philosophy of limited government and protection of personal privacy.

In January 2005, democratic Governor John Lynch took office, with a platform dedicated to making progress on the issues important to NH families -- education, health care costs, the environment, and employment.

As with many states, New Hampshire is experiencing significant budget challenges as a result of the national economic recession. The DHHS Commissioner, Nicholas Toumpas and Director of DPHS, Dr. Jose Montero, are leading efforts for increased efficiencies in this resource challenged environment. The biennium budgeting process has brought continued fiscal challenges to both the State and DHHS, as New Hampshire strives to achieve balance with the burden of providing services to an aging population in a downward spiraling economy. Almost two thirds of New Hampshire appropriations were for education (including public K-12 and the university system) and health and human services. Public policy debate about changes in the state employee retirement system, the state's Medicaid county-based long term care services for the elderly, and state education funding inevitably have involved conversations about the ‘shifting financial burden of public services' from general state taxation to the local property tax. (4)

Budget deficits have been attributed to increasing caseloads in Medicaid, TANF and other human services and decreasing revenues in business and real estate taxes. Trends in Medicaid caseloads far exceeded budget projections and indicate a $1.1 million shortfall for the elderly and $6.7 million for non-elderly payments including hospital inpatient and outpatient services, provider payments and pharmacy. In March 2010, there was a 10.1% year over year increase in the number of Medicaid enrollees. Rates have been reduced to providers and controls have been proposed on Medicaid codes for Title V services such as home visiting and child and family health supports.

Similar trends have been seen in TANF. Caseloads have exceeded projections in the State Budget causing deficits. Year to date in SFY2010, there has been a 21% increase in TANF recipients. At this rate, the budget can expect a $2.4 Million shortfall for cash assistance for families.

In addition to increased caseloads, state revenues have been significantly lower than expected. Without a general sales tax or a personal income tax, New Hampshire's tax revenues rely primarily on two forms of business taxes, the Business Profits Tax and the Business Enterprise Tax. The next highest sources of revenue are the Meals and Rooms Tax and Liquor Sales and Distribution. Currently, all of these revenue sources are below budgeted expectations.

The impacts of the state budget crisis are felt throughout the system. State employees were laid

off in October 2009. MCH was impacted by hiring freezes for currently vacant positions (Adolescent Health Coordinator and Prenatal Coordinator) and the Childhood Lead Poisoning Prevention Program (CLPPP) lost state general funding for two environmental lead specialists, as well as funding for its compliance project manager. This reduction of three staff members, along with two federally funded vacancies challenged the CLPPP to re-allot the resources necessary to meet goals and objectives. Adding to these difficult changes was the discontinuation of funding for blood lead testing and paint and dust sampling analyses by New Hampshire's Public Health Laboratory (PHL), also due to budget reductions in October 2009.

As previously described, Medicaid rates to providers have been reduced and additional controls for cost savings are being explored. Additionally, programs like Home Visiting New Hampshire, that have historically used innovative, collaborative approaches for funding are in jeopardy of ending due to the increased pressure from programs like Medicaid and TANF to focus on their core mission and thus, discontinue support for these joint ventures.

Looking forward, there are no easy answers to reconcile the revenue and expenditure disconnect in New Hampshire. It is clear that social services and health care will continue to be costly to the state General Fund. While perhaps moving the population towards more healthy lifestyles and preventive care in the long run, the federal Patient Protection and Affordable Care Act will have unknown financial impacts to the state in the next five years. Although the federal government will pay for increased Medicaid payments for fee-for-service and for primary care services provided by primary care doctors for 2013 and 2014 the full fiscal impact of expanding Medicaid eligibility is unclear.

/2012/
In 2011, New Hampshire experienced political changes similar to many states in the nation. Both legislative bodies saw significant turnover in the past election and the new majority party of incoming representatives and senators is committed to a leaner, more fiscally conservative state budget with a more limited role of state government.

Concurrently, the NH Center for Public Policy, among others, have described NH as having a long-term structural budget deficit in the sense that for the scope of desired programs and current revenue system (no broad based sales or income tax), expenditures grow automatically faster than revenues. (36) The current pattern among elected officials is to reconcile the revenue and expenditure disconnect by further expenditure reductions.

Further impacting the state budget and the political environment, NH continues to feel the effect of the national recession which began in late 2007. Although it may have officially ended, enrollment in state supported systems of care has not begun to recede to pre-recession levels. Dependence on state and federal programs continues to place significant fiscal burdens on the state budget. The good news is that the growth in unduplicated individuals receiving services has slowed. In SFY10, the year over year growth rate was 11.3%; the first eight months of SFY11 has seen the growth rate moderate to 5.6%. Medicaid enrollment, specifically experienced a 8.9% growth rate in SFY10 and now has a more moderate growth rate 2.8 % for the first eight months of SFY11. In fact, caseloads slightly decreased in January and March 2011.
//2012//

/2014/ In January 2013, Democrat Margaret Hassan took office as Governor of New Hampshire. She began her career in public service in 1999 under Governor Jeanne Shaheen serving on the Advisory Committee to the Adequacy in Education and Finance Commission. She has experience as a business attorney, along with her role as the parent of two children, one of whom experiences severe disabilities. In 2004, Governor Hassan was first elected to the New Hampshire Senate, serving numerous Seacoast towns. During her six years in office, she served as both President Pro Tempore and Majority Leader of the State Senate. She has also previously served on the Council for Children and Adolescents with Chronic Health Conditions.

Governor Hassan has led efforts to develop a balanced State budget, without a sales or income tax. She has prioritized higher education, mental health funding, and economic development. She has been supportive of the concept of using federal funds for Medicaid expansion. Differences in budget projections between the Governor, NH House and Senate are focused on sources of revenue: the state's twin business taxes, the business profits and business enterprise taxes; the meals & rooms tax; and the real estate transfer tax. Governor Hassan had proposed introducing casino gambling into the State as an additional source of revenue, but both legislative Chambers rejected that proposal. Revenue estimates are critical to determining the level to which Health and Human Services funding will be impacted in the 2014-2015 budget.

//2014//

SOCIO-ECONOMIC ENVIRONMENT: New Hampshire has an overall median household income significantly above the national average: $68,175 compared to $51,233 nationally. (U.S. Census Bureau, 2007-2008 two-year average). (5) By this estimate, New Hampshire's median household income was the highest in the nation during this period. New Hampshire's 2008 per capita personal income was $3,400 above the national average of $40,208 and ranked eleventh highest among the states. In 2007, per capita income varied widely by county, from a low of $31,179 in northernmost Coos County to a high of $47,196 in Rockingham County, bordering Massachusetts. (6)

Although, New Hampshire is fortunate to boast a high median income, it belies the fact that many families are struggling. Statewide averages often mask differences among subpopulations in the state. The structure of New Hampshire's economy has changed in recent years, from one in which a variety of well paying jobs were available, to a "boutique economy" in which good paying jobs are available only to those with high educational levels and skills. The wage disparity has increased between the lowest wage earners and the highest, and the lowest wages have remained stagnant or fallen while the highest have increased, even in a weak economy. Jobs that pay a livable wage are declining, making it more difficult for some families to meet basic needs. (7)

Many occupations and industries have experienced declines in employment during the economic downturn that began in December 2007.New Hampshire's seasonally adjusted unemployment rate eventually hit 7.2 % in September 2009.(8)

The current recession period continues to have a negative impact on the housing market. Housing values have continued to decline. New residential building permits are at historically low levels and the number of foreclosures is at a historically high level. (9) The median gross rent rose for all unit types including utilities from $946 in 2007 to $969 per month in 2008. While rents continued to rise, so did vacancies. New Hampshire's vacancies increased from 4% in 2008 to 5.3 % in 2009. The state's vacancy rate had not exceeded 5% since 1993, during the last recession in New Hampshire. Often an increase in vacancy rates can be attributed to renters moving towards home ownership. Instead, current economic conditions are likely contributing to the recent rise in vacancy rates and increase in insecure housing arrangements for many New Hampshire families. (10)

/2013/ While New Hampshire's poverty rate is markedly lower than that for the entire country, it is still substantially higher than it was several ago, reflecting ongoing difficulties in bouncing back from the recession. But when applying an even longer lens, new Census data reveals that New Hampshire's socio-economic landscape has remained fairly consistent over the past three decades, at least in terms of our oldest and youngest residents. No county in the 1980 or 2010 Census registered poverty rates among the young or old over 20 percent. The good news is that poverty among seniors has significantly decreased, however poverty among children continues to rise. //2013//

Homelessness greatly impacts the health and well being of children and youth. Compared to

children with homes, homeless children are more likely to have health problems, developmental delays, mental health problems such as anxiety and depression, behavioral problems and lower academic achievement. As much as 12% of the homeless population is estimated to consist of youth between the ages of 16 and 24 years old who are not living in families. Homelessness creates enormous negative health and social costs for young people. These youth have high poverty rates and are often runaways or throwaways who have experienced physical and/or sexual abuse, childhood homelessness, parental substance abuse, foster care and/or juvenile detention. It is estimated that 25% of foster children have experienced homelessness within 2 to 4 years of leaving foster care. Homeless youth have an increased risk of physical and sexual abuse on the streets and in adult homeless shelters, with sexual assault rates of homeless youth estimated at 15 to 20 percent and physical assault at 50%. Obtaining accurate data on homelessness is challenging; these data often undercount the true population. A one-day count of the homeless in New Hampshire in 2009 found 3,328 single adults; 788 adults in 670 families; and 840 children living in shelters. (11) Other homeless families in New Hampshire often live in seasonal rentals, moving several times per year between campgrounds in the summer and motels and apartments in the winter. Children in these settings are often forced to leave school in the spring when they must leave a winter rental before the school year ends, disrupting their education and social networks.

Certain demographic and geographic subpopulations in the state experience much higher poverty rates and these disparities have increased over the past decade. Rural residents in New Hampshire experience poverty disproportionately. Gender also is associated with economic inequality. Nearly 22% of New Hampshire families headed by a woman with no husband present had incomes below the poverty level compared to 5.6% of family households overall. (12) This percentage has increased since 2000, when 17.6% of female householder families lived below the poverty level. (13) In 2003, an estimated 19.4% of New Hampshire family households were headed by a woman with no husband present. A higher percentage of women overall (8.4%) live below 100% of poverty compared to men (6.8%).

Children and adolescents are disproportionately affected by poverty, with 9.3% of New Hampshire residents under age 18 living below 100% of the federal poverty level in the previous 12 months, compared to 7.0% of individuals aged 18 to 64 years old and 7.7% of residents aged 65 and older. (14) Poverty and uninsurance among those in late adolescence (18-24 years) is also significantly higher than among other age groups: 16% of youth ages 18-24 (16,000 youth) live in poverty (15) and 30% of adolescents ages 18-24 lack health insurance. (16)

HEALTH CARE ENROLLMENT: New Hampshire is often considered one of the healthiest states in the nation and has one of the highest percentages of residents with health insurance. (17) New Hampshire compares favorably to other states on many indicators of health, ranking among the top five healthiest states between 1995 and 2004. (18,19) Rankings are based on a combination of indicators, including health outcomes, community, environment and health policies.

New Hampshire's strengths include consistently comparing favorably among other states regarding teen birth rates, rates of children under age 18 in poverty, rates of children ages 19-35 months who are fully immunized, infant mortality rates, among others. But statewide averages mask differences among subpopulations in the state. Closer analysis of New Hampshire data reveals statistically significant differences in health behaviors and outcomes, poverty, access to health care and other health and socioeconomic indicators by race, age group and region.

To achieve many of the positive health outcomes, and perhaps also the cause of many of the challenges, an intense amount of private resources and a significant amount of public funds has been invested in health care. Increases in health care costs have been far larger than increases in wages over the last decade. There has also been an increase in the number of uninsured persons, putting an extra burden on the current health care system resulting from uncompensated care. (20) The financial burden is important to consider as health status among

all populations.

Medicaid & SCHIP: Healthy Kids Gold (HKG), Medicaid, provides coverage for infants up to 300% of federal poverty level (FPL) and children age 1-18, up to 185% of FPL. Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income. Effective September 2009, the New Hampshire Healthy Kids program was authorized to expand coverage to young adults ages 19 to 26 years who cannot be included in their family's health insurance plan, and whose incomes are at or below 400% of FPL. Due to budget considerations, and uncertainties of federal health reform, no effective date has been set to implement this expansion.

Pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. Medicaid has been growing as the payer for an increasing number of births in the state. In 2003, Medicaid was the payment source for 20.3% of all births in the state. By 2009, that number has grown to 31%. Of women obtaining prenatal care in MCH-supported community health centers, 68% received Medicaid and 12.8% were self-pay, or uninsured, in 2009. These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

New Hampshire Medicaid has a "Katie-Beckett"-like eligibility pathway called Home Care for Children with Severe Disabilities (HC-CSD). This allows children up to the age of 19 to qualify for Medicaid based on their need for institutional level of care and solely considers the income and resources of the applicant. Currently there are approximately 1750 --1800 children that are covered by Medicaid through this eligibility.

The State's Children's Health Insurance Program (SCHIP) provides health coverage for uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private insurance. New Hampshire's SCHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Enrollment in SCHIP has decreased since 2008, while enrollment in Medicaid, or Healthy Kids Gold has increased. It is assumed that this is directly related to statewide economic indicators.

/2012/
New Hampshire's total budget for SFY10 was $5.47 Billion (state, federal, and other funds combined). Of this amount, $1.42 Billion, or 25.9% of all state expenditures, was accounted for by Medicaid (second only to Education at 26.9% of state spending). As rising unemployment, falling income, and decreased availability of job-based insurance left more people uninsured, increasing numbers of people have turned to Medicaid for health care coverage. However, even with a significant drop in the unemployment rate in SFY10, Medicaid enrollment has continued to increase at the rate of 4.6% during the year. In SFY10, Medicaid provided health care for 132,476 members on average, per month serving 165,609 unduplicated persons over the course of the year. Low income children represent 58% of the members, but only 22% of the program's expenditures.(38)

New Hampshire Healthy Kids (NHHK) administers the state's Children's Health Insurance Program, also known as Healthy Kids Silver. Healthy Kids Silver provides subsidized health insurance to approximately 8,600 children with family incomes between 185 and 300 percent of the federal poverty level (FPL). Enrollees are provided care by Harvard Pilgrim Health Care HMO. NHHK also administers a health insurance buy-in program for approximately 875 children with family incomes between 300 and 400 percent of FPL by providing them with non-subsidized, lower-priced insurance premiums. Buy-in program enrollees pay full premiums and have the same network and benefits as Healthy Kids Silver enrollees.

Current budget proposals by the legislature and Governor all require administrative and policy

changes for NHHK. The Governor originally proposed to convert Healthy Kids Silver enrollees into Medicaid members and transition the entire program into the existing Medicaid fee-for-service system as of July 1, 2011. Under the House and Senate budgets, Healthy Kids Silver enrollees will still be converted into Medicaid members, but will be transitioned into a new Medicaid Managed Care program, with a target implementation date of July 1, 2012. Children with incomes between 185 and 300 percent of FPL would continue to receive health insurance coverage and continue paying the same monthly premiums, but their care will be managed by a managed care vendor yet to be selected. The buy-in program for children with incomes 300-400 percent of FPL will be discontinued. Additionally, coverage will be discontinued for children who participate in NHHK through the buy-in program because they are legal residents but do not yet meet the 5 year residency requirement for Medicaid. Lisa Bujno, Bureau Chief of the Bureau of Population Health and Community Services, where MCH resides, will represent the Division of Public Health Services in the workgroup crafting these strategies. //2012//

/2013/
TRANSITIONING TO MEDICAID MANAGED CARE: Nearly every state in the United States currently uses Managed Care Payment Plans in Medicaid Programs except for Wyoming, Alaska and New Hampshire. New Hampshire followed suit when Senate Bill 147 passed in 2011, legislated that NH DHHS "shall employ a managed care model for administering the Medicaid program and its enrollees…for all Medicaid populations throughout New Hampshire…" by July 2012. There are several challenges to this mandate: the legislation required an aggressive timeline for implementation, including contract negotiations; few states have experience putting all populations in capitated plans; and a number of significant waivers must be obtained from CMS before roll out can begin.

Under a care management approach, New Hampshire's Medicaid program will provide services through companies that will be paid a set rate for members. Three managed care organizations, Boston Medical Center Health Net, Centene, and Meridian Health Plan, have negotiated contracts with NH DHHS to serve the entire Medicaid population of New Hampshire in all areas of the state.

In the first step of the program, anyone currently enrolled in New Hampshire's Medicaid and Children's Health Insurance Programs as well as newly qualified individuals will be enrolled in the Care Management Program for their medical services. In the second step, long term care services, including specialty services and community based care, will become part of the program. Step 2 is expected to begin one year after the first step.

NH DHHS will conduct a series of forums in the summer of 2012 to discuss care management and Step 1 implementation. The Department will encourage and seek volunteers to participate in Step 2 design. While Step 2 is focused on those with Developmental Disabilities, volunteers representing those from all populations served by Medicaid will be invited and encouraged to provide feedback.

The transition of the "Healthy Kids-Silver" program, which is also known as the Children's Health Insurance Program (CHIP), also a result of changes to the NH State law, as described above, will take effect July 1, 2012. Under the changes, "Healthy Kids Silver" and "Healthy Kids Gold" will no longer exist. Both programs will simply be called NH Medicaid. NH Medicaid will cover kids under the age of 19, up to 300 % of the federal poverty level. This means a family of 4 may be eligible for NH Medicaid coverage when the family's total monthly income is at or below $5,763. NH Medicaid coverage has no copayments for children and the state offering a temporary premium holiday/2014/ until January 1, 2014.//2014// In addition to no out of pocket expense, with the transition to Medicaid administered by DHHS, children will have coverage for additional services that were not available on "Healthy Kids Silver" coverage.

/2014/ Public listening sessions were held throughout 2012 to provide an opportunity for the Medicaid clients, families and advocates to hear and provide feedback on when the new Care

Management program will start, what people will have to do when enrolling in the program, how to choose a Care Management health plan and how the new program will work. The sessions were held in Berlin, Claremont, Concord, Conway, Derry, Dover, Keene, Laconia, Littleton, Manchester, Nashua and Portsmouth. Approximately 1,152 people attended the 12 sessions. Of those in attendance, half were Medicaid consumers and family caregivers.

To date, the Medicaid Care Managment program has not "gone live". None of the three Managed Care Organizations (MCOs) have established network adequacy among the State's hospitals due, in part, to ongoing litigation between the hospitals and the DHHS regarding Medicaid rates. DHHS has been analyzing and reviewing rate calculations and is confident that new rates will provide greater flexibility to the MCOs and will allow them to attact more providers to their network.

As of May 2013, one hospital had negotiated an agreement with one of the MCOs, and may be close establishing relationships with the other MCOs. Pharmacy adequacy has been attained and verified.

Title V has worked closely with NH Medicaid to ensure effective and timely communication to providers and the public. //2014//

/2015/
MEDICAID CARE MANAGEMENT (MCM)
On December 1, 2013, New Hampshire transitioned from fee-for-service to a managed care model of Medicaid. DHHS contracted with three managed care organizations (MCOs) to offer three Health Plans to Medicaid recipients. Most Medicaid participants, including low income children and pregnant women, were mandated to participate in this transition to MCM . Children in Foster Care, children with special health care needs, children with Supplemental Security Income, and dual Medicare and Medicaid eligible were encouraged to participate on a voluntary basis, and will be mandated to participate in Step 2, which will be rolled out at a date that is still to be determined.

As of April 1, 2014, 48,028 clients were enrolled in Well Sense Health Plan; 38,857 clients were enrolled in NH Healthy Families Health Plan; and 29,258 clients were enrolled in Meridian Health Plan. By April 2014, 95.3% of low income children enrolled in Medicaid had enrolled in a care management health plan; 41.6% of children with severe disabilities had enrolled in managed care; and 75.8% of children in foster care had enrolled in managed care.

By June 2014, Meridian Health Plan indicated that it would withdraw from the State of New Hampshire effective June 30, 2014. Meridian, based in Detroit, Michigan, requested withdrawal from the Medicaid Care Management Program in order to focus on the growth of its core businesses in the Midwest. With the addition of the New Hampshire Health Protection Program coming later this year, Meridian and DHHS agreed that a summer withdrawal would provide the best opportunity to minimize any disruption to the Program and its members. DHHS and Meriden are working together to ensure a smooth transition for Meridian's members and the providers who serve them. Meridian will continue to provide services until July 31, 2014. //2015//

AFFORDABLE CARE ACT: Should the individual mandate of the Affordable Care Act remain intact after the Supreme Court decision in June 2012, New Hampshire policymakers have chosen to enter into the federally run health insurance exchange, in accordance with the federal legislation.

New Hampshire passed and Governor Lynch has signed HB 1297 prohibiting the state from planning, creating, or participating in a state-run health care exchange. The bill also establishes

guidelines for interaction with a federally facilitated exchange created for New Hampshire. New Hampshire is one of only three states to pass such legislation.

/2014/
MEDICAID EXPANSION: New Hampshire, like all states, has an opportunity to reduce the number of people without health insurance by accepting federal funds to expand its Medicaid program. While the state would face some up-front costs, policy makers anticipate long term savings in Health and Corrections. With private funding, The Lewin Group evaluated the impact of such an expansion. If policy makers opt to provide NO expansion, Lewin estimated savings between $65.8 and $113.7 million between 2014 and 2020 due to effects of the ACA. If Medicaid expansion was proposed, Lewin estimates an $85.5 million cost to the state and a $2.5 billion cost to the federal government from 2014 to 2020. Offsets to the Budget would occur through the Department of Insurance due to a Premium Assessment tax and increased Federal funding. Other entities such as the Department of Corrections would see revenue increase as inmates in New Hampshire's prisons are currently not eligible for Medicaid, but underan expansion the Department of Corrections could potentially collect federal reimbursement for inmates that receive medical treatment outside the prison.

Taking into account all other provisions of the ACA, Lewin estimates that if the state expands Medicaid, the number of uninsured would be reduced by 99,100 compared to pre-ACA uninsurance rates to a total of 71,000 uninsured adults. Without an expansion, the number of uninsured could be reduced by 76,800 based upon ACA provisions alone, bringing the number of uninsured in New Hampshire to 93,200.

The reduction in number of uninsured would vary by geographic area with a Medicaid expansion. Hillsborough and Rockingham Counties could see the largest number of reductions in the uninsured. This would impact health care providers and public health systems in these Counties, as well as statewide. Newly insured citizens would have less personal financial strain and would not need to draw on private and charitable funds that support uncompenstated care.

The NH legislature agreed to a budget compromise for SFY14. The Democratic-controlled House agreed to drop its proposal to expand the Medicaid program through the state budget. A commission to study the expansion will be formed with a report and recommendations due on October 15, 2013.
//2014//

/2015/
NEW HAMPSHIRE HEALTH PROTECTION PROGRAM: MEDICAID EXPANSION
On March 27, 2014, Governor Maggie Hassan signed into law SB 413, which created the New Hampshire Health Protection Program. This legislation promotes health insurance coverage to over 50,000 adults in NH, between the ages of 19 and 65, who are not currently eligible for Medicaid and whose incomes are up to 138% of the Federal Poverty Level (FPL) : $15,800 a year for a single person and $32,500 for a family of four. However, the New Hampshire Health Protection Program takes three unique approaches to expand this coverage. . Coverage for an estimated 50,000 low-income recipients is anticipated to begin start August 15, 2014 with an enrollment period beginning July 1, 2014.

Upon Federal approval, the Health Insurance Premium Program will provide assistance with employer sponsored insurance for those adults with incomes up to 138% of the FPL and the Bridge to Premium Assistance Program will provide Medicaid Care Management for those without access to employer sponsored insurance until June 30, 2015.

Beginning, January 1, 2016, the Premium Assistance Program will then be available for those without access to employer-sponsored insurance to purchase coverage via Marketplace.

The New Hampshire Health Protection Program also states that if Federal funding falls below levels specified in the Affordable Care Act (ACA) between July 1, 2014 and December 31, 2016, the programs terminate immediately.

1115 WAIVER:
In order to fully implement expanded coverage through the New Hampshire Health Protection Program, the New Hampshire Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver from the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The application addresses critical mental health, substance use disorder (SUD), and population health priorities. The primary purpose of New Hampshire's Building Capacity for Transformation Section 1115 Demonstration Waiver is to request authority to recognize costs not otherwise matchable in order to establish Designated State Health Programs. The Building Capacity for Transformation Section 1115 Demonstration Waiver is anticipated to promote the improvement of overall health, and aligns with New Hampshire's recently launched MCM program. It proposes to:

-Establish a community reform pool focused on mental health and physical health delivery system issues that rewards hospitals, health systems, and/or community providers for their active participation in system reform initiatives and their overall commitment to reform.

-Implement components of the NH Ten Year Mental Health Plan

-Establish a grant program that would fund training education and workforce development programs focused on Substance Use Disorder treatments and services.

-Extend the current InShape program by establishing a funding pool to award grant applications from hospitals, health systems, and/or community providers to implement an InShape program that (1) includes as participants children with serious mental illness (SMI), (2) includes as participants those enrolled in New Hampshire's 1915(c) Home and Community Based Services Waiver for Developmentally Disabled (HCBS-DD "Katie Beckett"), and (3) includes a smoking cessation component for all InShape participants who smoke.

-Establish a pilot program to demonstrate the impact on children's oral health and improved birth outcomes by providing oral health education, tobacco cessation, and Medicaid coverage for dental services to women during pregnancy and up to the child's fifth birthday.

It is clear that these transformational changes within Medicaid closely align with Title V priorities and goals. The Division of Public Health Services and MCH have been active participants in planning substance use disorder benefits and training, oral health and tobacco related activities, and the promotion of the integration of primary care and behavioral health services among all populations. Special Medical Services has been providing leadership, most specifically, around children with serious mental illness and how this population integrates within the new MCM.
//2015//

Strengthening the Safety Net: In response to the need for care to be available to vulnerable and low-income populations throughout the state, Title V partners with community-based and patient-driven health centers and organizations to serve populations with limited access to health care. These populations include low-income families and individuals, the uninsured, those with limited English proficiency and those experiencing homelessness. Many, but not all, of the MCH-funded health centers have received federal health center designations that define their scope of care and reimbursement structure. Fifteen agencies throughout the state provide perinatal care and

enabling services such as case management, nutrition counseling, tobacco cessation interventions, and patient-specific social services. Of these, thirteen are considered primary care agencies, offering the full spectrum of health care services to all ages; the other two are 'categorical' agencies, offering access to reproductive health, prenatal care, and enabling services through various models that meet
their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds; six of these are primary care agencies.

In total, Title V-supported comprehensive primary care programs, including community health center and health care for the homeless programs, served 104,622 men, women and children with 477,086 encounters in 2009. Forty-five percent of those served were 185% below poverty. Twenty-four percent of the total patient population was uninsured and 47% received Medicaid, however insurance status is disproportionate among age groups. Children and pregnant women are more likely to receive public insurance and other adults are more likely to be uninsured.

In 2009, the 15 MCH-supported prenatal agencies served 1758 prenatal clients, approximately 13% of NH's pregnant women. Of pregnant women served by MCH agencies, 68% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 14.2% were between 15 and 19 years of age, and 34.7% were between 20 and 24 years of age. (21) Seventy-six percent of pregnant women receiving care in an MCH-supported agency started care in their first trimester, with agencies ranging in performance from 68% to 85%. Ninety-seven percent received counseling for tobacco cessation, as appropriate, and 89% received screening for substance use. (22)

HEALTH STATUS:
Preconception and Perinatal Health: Title V and Title X, together, are examining the way services are delivered and designed to better incorporate preconception care in order to improve the health of women and couples, before conception of a first or subsequent pregnancy. In doing so, MCH aims to improve health outcomes that include improving birth outcomes and subsequently decreasing unintended pregnancies. New Hampshire has begun work towards the development of a model designed around the ten CDC recommendations aimed at achieving the following four goals: 1) improve the knowledge and attitudes and behaviors of men and women related to preconception health; 2) assure that all women of childbearing age receive preconception care services (i.e., evidence-based risk screening, health promotion, and interventions) that will enable them to enter pregnancy in optimal health; 3) reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children; and 4) reduce the disparities in adverse pregnancy outcomes. The work to date has included the research of best practices, interviews with key programmatic partners (e.g. family planning, home visiting, prenatal, WIC); and initial drafting of a logic model.

This integrated approach is of greater importance as an increasing percentage of New Hampshire births (31% in 2009) are paid by Medicaid, (23) placing a strain on an already weakened system. This compares to 13.4% of the general population of 18-64 year olds in New Hampshire who have Medicaid as their health insurance. (24) With a greater reliance on public insurance on publicly funded health care delivery systems, it is important that programs are well coordinated and integrated to promote optimal health outcomes.

Substance use among pregnant and postpartum women is a serious public health problem in New Hampshire. National survey data consistently show that pregnant women report using tobacco, alcohol and other substances. Early exposure to substance abuse impacts children's life use, dependence, abuse, as well as development, mental health, violence, injury, pregnancy, and infection rates. Screening efforts indicate that 29% of NH prenatal clients report drinking prior to pregnancy. (25) This could result in 8-31 babies born with FAS and 23-92 with FASD annually. (26) Every year, an estimated 703 New Hampshire infants (4.6% of all) are exposed to marijuana and 2,903 (19.0%) are exposed to alcohol during the first trimester of pregnancy.(27)

/2014/Maternal drug use has increased significantly in the past decade leading to an exponential rise in the number of newborns diagnosed with Neonatal Abstinence Syndrome (NAS). NAS affects all races, ethnic groups, and socioeconomic levels. However, Medicaid enrolled patients in NH are disproportionately affected, representing over three quarters of the infants diagnosed with NAS. In response, MCH is forming the New Hampshire Statewide Partnership to Address Opioid Use Among Pregnant Women to examine and analyze data regarding prescription drug and other opioid use during pregnancy and the incidence and impact on their babies. The goal of the Partnership will be to evaluate effective prevention and treatment strategies for mothers, their babies, and their families, and to submit findings and proposals to the New Hampshire Department of Health and Human Services. //2014//

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. (28) In New Hampshire from 2005-2007, 16% of women smoked during pregnancy. (29) In 2007, 21.7% of New Hampshire women of childbearing age reported smoking, compared to 21.2% of women overall in the U.S. (30) These women are at risk for smoking during pregnancy. Title V works in partnership with the New Hampshire Tobacco Prevention and Control Program to promote evidence based prevention and cessation services for all of those affected by tobacco, especially pregnant women.

Infant Mortality: Nationally and in New Hampshire, the causes of infant mortality, in order of occurrence, are: congenital malformations; disorders related to preterm birth and low birthweight; SIDS/SUIDS; effects from maternal complications from pregnancy; complications of the placenta; cord and membranes; unintentional injuries; respiratory distress; bacterial sepsis; neonatal hemorrhage; and other causes. New Hampshire follows the nation with SIDS being the leading cause of death of infants one month to one year of age. New Hampshire routinely ranks favorably when compared to other states. Although in 2006, mortality data slipped to a rate of 6.1/1000 births and New Hampshire ranked 17th, dropping from 1st in the nation the year before. While these comparisons are compelling, they sometimes fail to highlight the hidden complexity or subtlety of the numbers behind the ranking process. Particular caution should be used when looking at movement year to year in the rate due to the very small numbers of infant deaths in New Hampshire. Many states are clustered together at the top so there is minimal difference between similarly performing states. More importantly, although each death is tragic for each family, fewer than 100 infant deaths occur per 13,500-14,000 births annually in New Hampshire suggesting that it is more important that we look at trends rather than year by year outcomes alone, given New Hampshire's small numbers. Regardless, this shift prompted policymakers to legislate an Infant Mortality Review that will take effect in July 2010.

Newborn Screening: New Hampshire continues to keep pace with the nation in the fast paced world and science of newborn screening. As of July 1, 2010, screening for Tyrosinemia will be added to the New Hampshire mandated screening panel. Our state screening panel now includes 33 disorders. In addition to program changes among screening panels, programs are evolving their fundamental roles. Other New England states are actively exploring how to implement long term follow up (LTFU) programs within their newborn screening programs. LTFU is a quality assurance component within the newborn screening systems. Monitoring includes case follow-up of basic census data to determine whether individuals identified by newborn screening continue in appropriate care, as well as evaluation of selected outcome indicators in order to evaluate the efficacy of the newborn screening system. In this way, LTFU assists the program in evaluating whether or not the newborn screening system is accomplishing its intended goal of improving health outcomes. NH has not yet begun this type of long term follow-up at the state level, but is actively engaged in discussions with state and regional partners to better assess the state's capacity to provide this type of service and its potential outcomes and impact./2013/ In the evolving world of Newborn Screening, New Hampshire has moved forward with the passage of a new law requiring all birth facilities and/or providers to perform a pulse oximetry screening for Critical Congenital Heart Disease (CCHD), according to the recommendations of the American Academy of Pediatrics, on every newborn child. Title V and the NH Newborn Screening Advisory will work with community partners to help support and

coordinate a population-based approach for this screening. //2013//

CSHCN: In New Hampshire, 16.6% of children are considered to have special needs (n= 50,365) compared to 13.9% nationally. (2005-2006 National Survey) There are 21.9% of CSHCN children whose daily activities are affected; 12.6% CSHCN miss 11 or more days of school due to illness. Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home. Ninety percent of these families engaged in over 11 hours of direct care per week. In addition, half of the families of the SSI CSHCN reported having to cut work hours to care for their child even while experiencing financial distress. Though New Hampshire, in general, (consistent with all of Region I) has high rates of insurance for CSHCN, when compared to the rest of Region I, New Hampshire is ranked lowest for the percentage of CSHCN who were insured for the entire previous year. /2013/ Of note, according to the 2009/2010 NS-CSHCN the population of CSHCN in NH as increased from 16.6% to 19.0% since the 2005/2006 survey.//2013//

Pediatric Obesity: The problem of pediatric obesity in New Hampshire mirrors the national picture. The number of children and adults in New Hampshire who are overweight has increased over the last several years. Of children enrolled in WIC, the percentage of children ages 2 -- 5 years with a BMI at the overweight level was slightly higher (17.8%) than national (16.5%) and the percent with a BMI indicating obesity was approximately the same (14.4% vs. 14.8%). A NH survey of third graders in 81 NH public schools revealed that one in three students (33%) was above a healthy weight and more boys (21%) than girls (15%) were obese. In a chart review of 1,453 children (in the 6-9 year old and the 10-12 year old age groups) receiving health care in 25 NH primary care practices, 32.8% of the children were overweight or obese. MCH will be working with the state's new Obesity Prevention Program, funded by CDC. The program's goal is to prevent and control obesity and other chronic diseases through healthy eating and physical activity targeting the increase of breastfeeding, physical exercise, and fruit and vegetable consumption, and the decrease of sugar sweetened beverage consumption, energy-dense food, and television viewing.

Teen Births: Teen mothers and their children face poorer educational, health, developmental and economic outcomes than their peers who delay childbearing. Repeat teen births compound these problems. The percentage of teen births that are repeat teen births generally mirrors a state's percentage of teen births. Factors associated with repeat births include Hispanic ethnicity and non-Hispanic Black race.(31) New Hampshire's low proportion of minority populations may account for the low rates of teen births and repeat teen births.

Similar to national rates, New Hampshire's teen birth rate had steadily decreased since 1990, when it was over 30 births/1000 females ages 15-19. In 2003, NH's teen birth rate had declined to 18.1, compared with the US white rate of 27.5 , however an increase to 18.7 percent in 2006 indicates an increasing trend mirroring national data. A decrease in non-marital births occurred across all age groups and was highest among adolescents less than age 20, where 88.1% of births were to single mothers. Three-quarters of New Hampshire's teen births are to 18-19 year olds. In 2005, 11.3% of teen births in New Hampshire were to young women who were already mothers and in 2006 this increased to 13%. /2013/ New Hampshire's teen birth rate continues to trend downward. Resources for Teen Pregnancy Prevention such as Abstinence Education and PREP have been coordinated and are tightly focused based on needs assessments. Funds are contracted to communities with high rates and relatively higher numbers of teen births, where resources could potentially make the most difference. These communities include the City of Manchester with a diverse, urban population and Sullivan County, a more remote county dotted with small, declining mill towns and rural areas. Evidence-based programs and vendors have been selected. Programs are now ramping up and working together, with clinical partners in each community towards a spectrum of coordinated Teen Pregnancy Prevention. //2013//

Youth Injury: Unintentional injuries are the leading cause of death for ages 1-24 in New Hampshire . In the time period of 1999 through 2006, there were 527 deaths in ages 1-24 due to

unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category . Nationally, the rate for the same time period and age range was 20.02 deaths per 100,000 so New Hampshire is significantly below that. The rate of unintentional injury deaths increases by approximately 300% between the ages of 14 and 16 . Thus, adolescents are more likely to die by unintentional injuries than are younger children (even though unintentional injuries are still the leading cause of death for children one and above).

Many of these deaths are preventable. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes.

Adolescents are the age group with the highest incidence and rate of motor vehicle related death and injury. Although adolescents hold only 7% of the driver licenses in the state of New Hampshire, their death rate due to motor vehicle crashes is substantially higher than any other age group. The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, adolescent drivers ages 16 to 19 are four times more likely than older drivers to crash. In New Hampshire, adolescents accounted for 6.5 percent of the population and 17 percent of the total amount of motor vehicle crashes.

It is interesting to note that adolescents had a higher inpatient discharge rate for injuries due to motor vehicle traffic crashes for adolescents 15 to 17, but lower a emergency department visit rate for injuries due to motor vehicle crashes for adolescents 15 to 17, within a five-year period (2001-2005). Adolescents, ages 15-24, have a higher rate of hospitalizations for motor vehicle crashes than any other age group. In general, emergency medical responders attended to more injuries to 16-year-olds due to motor vehicle crashes, than any other adolescent age group (2007 and 2008 data). Males were more likely to be hospitalized, while females were more likely to be seen in the emergency department and discharged (2001-2005).

Most of the crashes occurred on local roads, where speed, inexperience, and drug use were contributing factors. Adolescent drivers, just starting out, have several risk factors working against them. First is their inexperience behind the steering wheel. The second is their greater likelihood of engaging in risky driving behaviors such as speeding, driving under the influence, and following other vehicles too closely. New adolescent drivers tend to overestimate their own driving abilities and underestimate the dangers on the road. In 2001-2006, speed was the number one cause of fatal New Hampshire crashes involving 16 and 17 year olds and the majority happened between 9 p.m. and midnight.

Nationally, falls are the leading cause of unintentional injuries among children 0 to 19. They're also responsible for approximately one-quarter of all childhood unintentional injury costs. In New Hampshire, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24. The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).

Nonfatal fall rates nationally are highest among children ages one to four. In New Hampshire, rates for hospitalizations due to falls (2001-2005) were highest in 15 to 17 year olds among the focus age groups. Rates for emergency department visits (2001-2005) were highest in the zero to four and 10 to 14 age groups.

Emergency department visits due to falls from furniture (beds and chairs were the most common) were a significant issue for children 0 to four years of age in New Hampshire, but gave way to slips and trips and fallswith sports equipment from age five on (2000-2006). Within the category of sports equipment, falls from playground equipment occurred the most often. Fractures and contusions were the result of most fall related emergency department visits during the same time period (2000-2006).

Oral Health: Improving access to oral health services for vulnerable populations continues to be a

high priority for DHHS, but barriers to realizing this goal persist. Data indicate that oral health problems such as dental caries in children and tooth loss in adults are still common in New Hampshire. Effective preventive measures such as water fluoridation and dental sealants are under-utilized; individuals who have lower incomes or less education are substantially more likely to report having dental problems.

Data from the 2009 Healthy Smiles-Healthy Growth Third Grade Survey indicate that statewide the oral health of New Hampshire's children has improved since the first survey conducted in 2001: Caries experience has decreased from 52.0% to 43.6%; untreated decay has decreased from 21.7% to 12.0% and the presence of dental sealants has increased from 45.9% to 60.4%. The 2009 survey also provided the first regional children's oral health data that show marked disparities in oral health by socio-economic status. Children in northern Coos County have significantly higher rates of dental disease and have lower rates of preventive services as their peers in other regions.

Community water fluoridation has long been regarded as the most cost-effective method of preventing dental decay. In addition, it benefits all residents without regard to socioeconomic status. In New Hampshire, only ten communities fluoridate their water. Just one of these municipalities is located in Coos County, while Grafton and Carroll Counties have no fluoridated communities. Since the State's largest city, Manchester, fluoridated its water supply in 1999, it is estimated that approximately 43% of New Hampshire residents have access to fluoridated community water systems.

Title V works in collaboration with the New Hampshire DHHS, DPHS New Hampshire Oral Health Program. Through the Preventive Health and Health Services (PHHS) Block Grant, the DHHS funds school-based preventive programs and community dental centers, some in community health centers or mobile clinics. In 2009, 21 school-based preventive dental programs served 20,262 students in 181 (59%) of New Hampshire schools. Community-based oral health programs provide services using a traditional dental practice model in 14 dental centers across the state. In 2009, 17,104 residents received oral health care through publicly funded dental centers and community-based oral health programs.

Five school-based preventive dental programs serve some of the schools in Coos, Carroll and Grafton counties, and Rochester, New Hampshire, while all public schools are served in Manchester. In the northern regions of the state, where many disparities exist, many schools still do not have sealant programs, largely due to lack of funding. Finding dentists to treat children identified as needing treatment is difficult in these same regions because there are fewer dentists, a limited number that take Medicaid children, and even fewer that take uninsured children.

Mental Health: Access to mental health services continues to be a gap in New Hampshire's strained health care infrastructure. While community mental health centers are available, in some regions they are increasingly unable to meet the demand for services. All centers have waiting lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for children particularly young children. One small piece of the solution is the need for increased coordination and integration of behavioral health services. Recognizing this, MCH developed a funding strategy that supports community health centers on a tiered system based upon the level to which they integrate behavioral health services. In an ideal, fully integrated system, mental health and primary care providers would share the same sites, the same vision and the same systems in a seamless web of services. Providers and patients would have the same expectations for treatment and all would have access to the same level of care regardless of income or insurance status. However, few organizations have completely achieved that level of integration. Title V and State General Funds have provided funding within each community to move away from fragmented services towards a vision of family centered care, enhanced communication, and aligned systems among providers and patients across the lifespan. Additionally, for CSHCN SMS has leveraged funds to secure psychology and

psychiatry consultation for SMS enrollees.

Healthy Housing: As New Hampshire continues to work toward the goal of eliminating childhood lead poisoning as a public health problem, a program shift is under way for the CLPPP to move from a single focus to address multiple environmental, health and safety risk factors affecting families. This strategic planning process involves extensive collaboration between a large and diverse group of statewide experts from the fields of public health, public safety, housing agencies, historic preservation and resources, charitable foundations, the medical community, Community Action Programs (CAPs), Visiting Nurses Associations (VNAs), Community Health Centers, local and state non-profit agencies, as well as the US Centers for Disease Control and Prevention (CDC) and the US Environmental Protection Agency (EPA). Consistent state data is providing a baseline to help structure the Program. The CLPPP maintains an extensive blood lead surveillance system for the purpose of monitoring trends in blood lead levels (BLL) in adults and children in New Hampshire. In 2009, 118 of the 15,051 children tested for lead poisoning had elevated BLLs above or equal to 10 micrograms per deciliter of blood (mcg/dL). The majority of these children (90%) lived in pre-1950 homes and approximately one-third lived in or regularly visited homes built prior to 1978 that had recently undergone renovation. In New Hampshire, approximately 10% of adults and 8% of children currently have asthma, costing the state an estimated $46 million each year. Asthma rates in New Hampshire are higher than the national averages, but similar to those of other New England states. Asthma triggers and lead are present in homes where other health hazards exist, such as radon, tobacco, mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches), carbon monoxide and other safety hazards.

EDUCATION: On average, New Hampshire is a relatively wealthy, well-educated, small state with pockets of growing diversity. New Hampshire is fortunate to be known for high achieving students; youth generally perform well on standardized tests and compare favorably to other students in other states. Since 2003, eighth graders in NH schools have averaged eight points higher on math and ten points higher on reading than the national average for the National Assessment of Education Programs (NAEP), commonly referred to as the Nation's Report Card. Between 2000 and 2009, college-bound seniors scored consistently higher than the national average on both the reading and math tests. As national scores have declined, New Hampshire scores have risen, widening the gap between NH and the rest of the country. (33)

However, as described throughout this Overview, averages can mask the disparities in vulnerable populations. When children are not served well by our education system, they too often grow to be disconnected young adults who leave school, sometimes too early, without the skills necessary to succeed in the current and emerging array of careers available in the state. In New Hampshire, 9% of 18-24 year olds may be considered disconnected due to their education, incarceration, employment status, poverty and/or familial status. Although New Hampshire was fortunate to have the lowest rate of "out of school unemployed" in 2006 among 16-19 year olds, it is unclear what impact the current economic recession has had on this population of adolescents and young adults. (34)

One important and early indicator of achievement is the educational level of parents. A child born to a mother who has not completed high school faces increased challenges to school readiness, is at higher risk to drop out of high school, and is more likely to be living in poverty. The good news is that the data for this indicator has improved for the state as a whole. Year after year smaller proportions of children are born to mothers without a high school diploma or GED. On average, 78% of high school freshmen graduate with a high school diploma, 5% more than the national average. Yet, in the 20% of poorest communities, 12.2% of the births are to mothers without a high school diploma, compared to the 80% of the rest of the state, where the rate is 5.7%. (35)

ACCESS TO CHILD CARE- TANF REDUCTIONS: Learning opportunities that begin in early childhood prepare children for success in school and throughout their lives. A quality early care

and education environment can be a foundation for success, but that opportunity is not available to all NH children. Preliminary estimates of the number of families served by the Child Care Development Fund scholarship program were expected to increase from 4900 in 2005 to 5300 in 2009 and the number of children served was expected to increase from 7100 to 7700. However, under the biennium budget restrictions of 2009 and 2010 and due to an increase in the number of families seeking child care assistance through the Child Care Development Fund, DHHS instituted a Child Care Scholarship Wait List in the fall of 2009. In June 2010, there were 2,137 children on a wait list for child care scholarship opportunities.

In addition, the number of child care providers who received scholarship payment for children in their care dropped from 3387 in 2005 to only 2539 providers in 2008. This, combined with the wait list, indicates a reduction in the availability of affordable care for low-income families, which may indicate lower quality care options for young children. In 2009, it was estimated that 30% of eligible children were in unlicensed care.

SUMMARY:
National attention is increasingly being directed to social and economic determinants of health and to developing interventions from a life course perspective, with an understanding of the critical life stages in which to intervene to improve health outcomes. Health is a developmental process occurring throughout the lifespan. This framework often causes a shift in focus to the early part of the life span, when long-term health programming can be more intense and early childhood development, allows for interventions that may exact greater returns on resources invested. Sometimes, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions. This fits well with the history and culture of Title V that has embraced the need to support a full range of infrastructure, enabling and supportive services in addition to clinical services.

In addition to understanding how a lifecourse perspective may frame the overview and challenges particular to our state, it is also critical to acknowledge how social, ethnic, and demographic changes may also require new priorities and new solutions. The American population, as a whole, is rapidly changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations. State government, community based organizations and systems of care must implement systemic change in order to meet the health needs of a population growing in its diversity. Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States. Although New Hampshire may not be experiencing these demographic changes as dramatically as the rest of the country, our state is still changing in significant ways, especially in the southern and urban areas. Language and differences in cultural practices and beliefs may present potential barriers to care as well as challenges for health care providers. More significantly in New Hampshire, health disparities abound based upon social inequalities such as poverty, socioeconomic status, insurance and employment status.

Each year, as part of the Annual Report, Title V will attempt to describe New Hampshire's data as a whole and among socio-economic, racially, ethnically, culturally and linguistically diverse populations in order to examine disparities in health care access and health outcomes. Guided by a belief that health equity will only exist when all residents have the opportunity to attain their full health potential, free from limitations by social or economic position or circumstance, MCH will continue to work towards its mission of improving availability of and access to preventive and primary health care for all children and reproductive health care for all women and their partners, regardless of their income. /2013/It is our goal that the Annual Report will serve as a tool to highlight how the New Hampshire Title V Program ensures access to services, ensures quality care, ensures integration across systems, and ensures appropriate measurement of outcomes.//2013//

Please see attachment for endnotes

B. Agency Capacity

Data from multiple public and private sources reveal that NH has one of the highest quality healthcare systems in the country. Its infrastructure and health outcomes rank favorably compared to the best states. But NH's health care is expensive, and measures of public health and access, by contrast, show opportunities for improvement. Like the state's public health system, in general, the Title V program is limited in scope, but fortunately rich in partnerships and collaborations that serve to promote and protect the health of women, children and families.

New Hampshire's health care delivery system for the Title V population consists of an array of public and private health service providers. This system, which varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens. Much of the state is designated as medically underserved or health professional shortage areas. While NH's two largest cities have public health departments, there is no statewide network of local health departments providing direct health care services. Instead, New Hampshire has built its safety net of health care services on a public private partnership. In 2006, of the 88,184 members enrolled in Medicaid, 34% received care in private office-based settings; 15% in hospital-owned primary care offices; 15% in Dartmouth Hitchcock Clinics; 10% in Federally Qualified Community Health Centers or Look a-likes; 5% in Rural Health Centers; and 21% had no assignment of care.

PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, MCH contracts with community agencies to provide prenatal, reproductive health care, and home visiting services for low income and underserved populations. Fifteen agencies statewide provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and individual social services. Of these, thirteen are primary care community health centers (CHC), offering the full spectrum of health care services to all ages; the others are ‘categorical', offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds, and 15 agencies provide home visiting services for pregnant women, and mothers and their infants through age one. /2012/ Unfortunately new reductions in State General Funds, federal Title X funds and potential reductions in Title V funds has weakened the strength of this safety net of primary and preventive care. As of July 2012, health centers will see funding reductions of 38 to almost 50 percent for direct health care for New Hampshire's most vulnerable populations. At this time, it is unclear what the impact of these reductions will be. //2012// /2013/ Data from the community health centers from SFY11, even prior to the budget cuts, indicate an overall downward trend in the numbers of individuals served from SFY10. The reductions are not consistent across the State. While agencies have anticipated serving fewer children in the North Country, as the population ages and decreases, other agencies in more populated areas of the State also saw reduced numbers in their pediatric primary care panels. However, other agencies find the demand for services for both Medicaid populations and the uninsured exceeds their capacity.//2013//

Of the thirteen CHCs, eight have Federally Qualified Health Center status. These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. Of the two categorical prenatal agencies, one provides direct clinical care and the other provides a rich assortment of supportive enabling services, such as home visiting, case management, etc. and direct, clinical prenatal care through subcontract with local physicians. //2012// As of July 1, 2012, due to budget constraints, one of the categorical prenatal agencies will no longer receive funding for services. This decision was made because one of the CHCs is now operating in an adjacent town with on-site, clinical prenatal services and with limited resources available, it was determined that funds should be directed at maintaining a basic infrastructure of direct care services. //2012// All MCH-funded agencies receiving funds for perinatal care must provide, social services, nutritional counseling, and referral for high-risk care. /2013/ However, because of the significant reduction

in funds available to state-contracted agencies, maternal nutritional support has been negatively affected. MCH has seen a decrease in the frequency of nutritional assessments and counseling, especially by a nutritionist, available to pregnant women. //2013//

/2013/ As of July 2011, the Family Planning Program contract with Planned Parenthood of Northern New England (PPNNE) was rejected by the Governor and Executive Council, reducing the State's Family Planning Program ability to serve, approximately 16,000 individuls, or half of the population historically served. As PPNNE did not ultimately receive State or Federal Title X funding for their 6 clinical sites through the State level project, the Federal Office of Population Affairs awarded a sole source agreement to serve these communities to PPNNE directly. //2013//

/2015/Additional State General Funds were allocated for increased access to family planning services for low income (<250% FPL) individuals. Three agencies, Planned Parenthood of Northern New England, Concord Feminist Health Center and Joan Lovering/Seacoast Feminist Health Center were selected to expand access to a broad range of acceptable and effective family planning methods and related preventative health services that include preconception health services, contraceptive methods, natural family planning methods, infertility services, and services for adolescents, including adolescent abstinence counseling and screening/treatment of STDs. //2015//

MCH also contracts with 15 community-based agencies in 18 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) is a preventive program that provides health, education, support and linkages to other community services. These comprehensive, community-integrated programs are evidence based and offer a comprehensive curriculum based on the national Parents As Teacher's early literacy program, and a public health curriculum designed to address, in part, smoking reduction and cessation, maternal depression and family planning. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are supported in their roles as their child's first and best teacher and learn ways to enhance their child's learning and development. /2013/ In SFY12, in response to changes in Medicaid rules that restricts eligibility for MCH-funded HVNH and Child and Family Health Support programs, MCH developed a plan that will merge the two programs into one "hybrid" program for SFY13. MCH re-aligned 10 service areas and issued a competitive bid that resulted in contracts in nine of the areas (one had no bidders). Two agencies are new MCH grantees. In addition to the reduction in number of agencies providing MCH-funded home visiting services, and the restriction by Medicaid in billable visits allowed, Medicaid Managed Care goes into effect January 1, 2013. It's not yet clear how the home visiting agencies will be able to be reimbursed for home visits to pregnant women and children on Medicaid. //2013//

HVNH served over 900 pregnant women and their infants in SFY09. By funding almost two thirds of program sites in counties with a higher than the state average poverty rates, the program is able reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports embedded within each unique community.

There are several sources of support for home visiting services and each source of funds is directed towards a different need in the community. Agencies use these funds to provide a comprehensive set of services to families. HVNH supports a public health and family support mission with rigorous performance measures. Comprehensive Family Support is a more flexible primary prevention support available for families. Child and Family Health Support is available to fill gaps to ensure that families' immediate health care needs can be met. Successful agencies coordinate these funding sources within their agencies and communities. DPHS and DCYF have worked together and participated on joint site visits to agencies that receive both sets of funds to ensure coordination. MCH will continue this collaboration with DCYF with new federal funding for

Home Visiting in FY2011.

/2012/ MCH was identified as lead agency for the Affordable Care Act, Maternal, Infant, and Early Childhood Home Visiting (MIEC HV) program for NH. New Hampshire's Updated State Plan for Home Visiting, supported by all required consensus partners including DCYF, identifies goals for MIEC HV that address serving at-risk communities; use of an evidence-based home visiting model; and a coordinated home visiting system. Beginning in November 2011, all five regions identified in the initial needs assessment, including Carroll County, Coos County, the city of Manchester, Strafford County and Sullivan County will begin implementation of the Healthy Families America model. Local providers in each of these regions provided input and ultimately support for selecting this model as the "best fit" for these communities. The Home Visiting Task Force includes representation from the NH Early Childhood Advisory Council and will work to ensure that this model is integrated with, and connected to, other early childhood and family support programs within these communities. Using MIEC funds, MCH hired a fulltime Home Visiting Program Coordinator whose full focus is on home visiting and the coordination of the growing state system of home visiting, that will advance the development of a comprehensive, high quality early childhood system at the state level. //2012//

/2014/ With MIECHV competitive grant funds, MCH contracted with 3 additional agencies to provide Healthy Families America home visiting programs in the remaining 5 New Hampshire counties. In order for these agencies to collect the multiple benchmark data points for federal reporting, MCH identified the need for a web-based data system. Following a competitive bid process that included the involvement DoIT and DPHS, Social Solutions was awarded the contract late in 2012. The expectation is that the Efforts to Outcomes data collection system will "go live" July 2013. The data collection serves a dual purpose that includes quality improvement planning for regional sites and for the home visiting system in New Hampshire.//2014//

Prenatal Disparities: Section IIIA of this application presents data clearly delineating disparities in prenatal care access and health outcomes for privately insured women versus those uninsured or on Medicaid. Title V -- supported community health centers saw approximately 14% of the state's pregnant women in 2009. Many of these women represent vulnerable populations, because of their low income and other psych-social risk factors including young maternal age, health risks, insecure housing, etc. Because of these factors, they are at increased risk for negative birth outcomes. Therefore, Title V prenatal programs have additional requirements for nutritional support, alcohol. substance abuse and mental health screening, and other enabling services.

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

Additional partnerships are needed to support the general population of pregnant women in the state. New legislation was passed in 2010 establishing a Maternal Mortality Review Panel. Title V will partner with the Northern New England Perinatal Quality Improvement Network and providers to to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire. The multi-disiplinary reviews will ultimately result in recommendations for systemic improvements to the perinatal systems in the state./2013/ In June 2012, a multi-disciplinary team reviewed its first maternal mortality case. They will share their findings with the larger panel in July 2012. Team participants completed a written evaluation of the process and the data is currently being reviewed and analyzed to determine if changes needed to be make before the process is finalized. //2013//

/2014/ The process was finalized in March 2013. In May 2013, two additional maternal mortality cases were investigated. Both cases are still pending. Findings will be shared with the larger panel later this year. //2014//

/2013/ The SSDI Program Planner, Marie Kiely, and the MCH Epidemiologist, David Laflamme submitted a successful application to CDC in January 2011 for the Pregnancy Risk Assessment Monitoring System (PRAMS), and New Hampshire was awarded funding in the Fall of 2011. The project is currently in the start up phase, with data collection expected to begin in Fall 2012. Sufficient data will be available for analysis one year after data collection begins.//2013//

PREVENTIVE & PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

In 2009, the DHHS Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in New Hampshire Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care. For example, among children aged 3-6 years those using Medicaid 69.9% had a well child visit in 2008; 82.7% of SCHIP; and 77.7% of commercially insured. The NCQA managed care national rate for this age group is 65.3% for Medicaid and 67.8% for Commercial. The children who do not fare as well in routinely accessing care, however, tend to be older children and teens; children in poorer households; and children in Colebrook Franklin, Woodville and Lancaster, which includes some of the most Northern and most remote areas of the state.

Title V's historical responsibility in maintaining Direct and Enabling Services for children has led to the continued clinical oversight and contractual relationships with a statewide network of child health agencies that provide preventive and primary care services. MCH contracts with 14 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Thirteen of these are the primary care community health centers described above; one is a ‘categorical' pediatric clinic, in the state's largest urban community, which utilizes a multi-disciplinary care model. Strategically focusing efforts on access and support for low-income families, services at the child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and a spectrum of integrated behavioral and oral health services. In 2009, MCH-funded child health direct care agencies saw 17,414 children ages 12 and under, and 10,957 children ages 13-19.

Enabling Services are often the invisible glue that help hold all of the direct health care services together for vulnerable families or families at-risk. Support of these services is also what sets Title V apart from many other public health and government entities. As NH has continued to strengthen the safety net of direct care providers by supporting community health centers with State General Funds, MCH continues to assess its child health resource allocation to assure that low-income children and families have full access to these services and support in using them appropriately.

Since 2000, MCH has had a two-fold approach to child and family health support and home visiting. The purpose of the Child and Family Health Support Services is to promote the health and well being of children ages birth through 18, with priority given to children birth through age ten. These services include assistance with enrollment in health care, referrals, case management and care coordination, education and counseling relative to the child and family, and are most often conducted though home visits.

The evolution of the Child and Family Health Support Services program arose with the blending of categorical "well baby clinics" into newly developed community health centers throughout the state, and the emergence of New Hampshire Healthy Kids - the state's non-profit organization providing access to low cost and free health coverage options for its uninsured children and teens. Although children now had better access to medical care, their parents still needed the education and support services that the "well baby clinic" programs had provided, and needed assistance in enrolling on Healthy Kids, and utilizing the health services.

The range of Child and Family Health Support Services are flexible and specialized to meet the

needs of the family. Services are guided by individualized care plans developed following an assessment of the child/family needs by agency staff. In SFY09, 1,205 children received services through the nine contracts at eight agencies via 5,186 home visits, 732 telephone contacts and 588 office encounters, and made 2,062 referrals to a variety of health, dental, and social service providers. /2012/ In SFY10, 1,254 children received services through the nine contracts at eight agencies via 5,336 home visits, 784 telephone contacts and 628 office encounters, and made 1.355 referrals to a variety of health, dental, and social service providers.//2012// Programs are strategically placed in communities that have disparate need due to geographic access and high proportion of low-income families.

/2014/ In SFY 2013, MCH combined Child and Family Health Support Services (CFHS) and Home Visiting NH (HVNH) programs into a single contract. The RFP was issued for each of the ten Child Care Resources and Referral service areas and contracts were awarded to agencies covering nine of the areas. The Claremont area had no bidders.

In an effort toward continuous improvement for services to families in need, MCH and the Division for Children, Youth and Families (DCYF) have worked together to further blend the HVNH and CFHS into a bundled Comprehensive Family Support Services contract that would include a strong home visiting component. A RFP is planned for a Fall 2013 release to begin the new program in SFY14.

Selected bidders will provide the new, combined Comprehensive Family Support Services to pregnant women, children, and families with children up to the age of 21 years. This program is designed to empower and strengthen pregnant women and families with infants, toddlers, young children and adolescents who are at risk for experiencing difficulty with parenting, social isolation, substance abuse and mental health issues, by intervening at critical periods of stress and/or transition. The program will assist pregnant women, children, and families who are without sufficient ability to cope with the problems of day to day living, through the development of a comprehensive, voluntary system of family support in communities throughout the state. Bidders shall demonstrate their ability to collaborate with existing Departmental programs, specifically, the Divisions of Family Assistance, DCYF and Public Health Services, Maternal and Child Health Section. //2014//

All child health agencies providing direct care and all CHCs screen children for developmental delay and refer them to specialty services as appropriate, though the screening tools used vary widely. In part to address this varied approach to developmental screening, Watch Me Grow (WMG), is a new comprehensive screening and referral system for families with children from birth to six years of age. The system is founded on the principles that families are better able to help their young children grow and learn when they have information about their child's health and development; access to screening; and referral to appropriate services.

/2012/ In 2008, 12 Family Resource Centers throughout the state applied to serve as regional pilot sites. Participating Family Resource Centers, which were already under contract to NH DHHS/DCYF to promote family strengths and prevent child abuse and neglect, received $4,000 to $5,000 each in additional funding to participate in WMG. DCYF amended its contracts with these centers to include the following requirements for WMG sites: (1) serve as regional "hubs" for the WMG system, adhering to system philosophy, guidelines, and quality assurance standards; (2) establish networks of organizations and agencies in their communities providing developmental screening to young children and their families; (3) provide and/or collect data from community partners on screenings in their areas; and (4) submit bi-annual progress reports and quarterly data reports to the WMG Steering Committee.

The evidence-based screening tools currently used in the WMG system include the Ages and Stages Questionnaires, 3rd edition (ASQ-3) for children from 1 month to 60 months of age and Ages and Stages Questionnaires: Social Emotional (ASQ: SE) for children aged 3 months to 66 months. The ASQ and ASQ: SE were designed to be completed by parents and other caregivers

During the pilot phase, WMG sites collectively received 176 hours of on-site and/or telephone training and technical assistance to support their efforts, and more than 283 individuals in eight regions were trained to use the ASQ-3 and ASQ-SE. Each site also received a set of screening tools.

At this time, NH's WMG may be characterized as a "fledgling" system, with a basic state and community infrastructure in place, dedicated community partners on board, a clear vision and guidelines to set direction, and identified components to be implemented using evidence-based practices. Collaboration on screening has begun within all WMG regions, and sites are submitting some screening data to the state (i.e., data were received on 279 children from 2010 to 2011). However, there is much work to be completed before WMG moves from a system under development to a viable, effective, fully accessible one. Future goals include (1) further development into a sustainable, quality system that includes a web-based data system (2) expansion of screening tools to include the M-CHAT (Modified Checklist for Autism in Toddlers) and the M-CHAT follow-up interview, (3) provide additional resources for families and professionals on mental health resources, and (4) assure that access to screening, early identification of behavioral and mental health concerns in young children and timely referral to appropriate supports and services for families are readily available throughout the state.//2012//

To further this more unified approach, SMS in collaboration with the NH Pediatric Society hosted two statewide Open Forums on Universal Developmental Screening in 2009 and 2010. Primary care as well as a variety of community based service providers participated in education and discussion about screening recommendations, tools, billing and community supports.

/2014/ In 2012, with support from the Endowment for Health, the Watch Me Grow (WMG) Steering Committee held a facilitated Strategic Planning Retreat to help formalize the fledgling system. Leadership and coordination responsibilities were articulated and aligned. The desired outcome for WMG remains the same: All New Hampshire children from birth to 6 years are screened early and often with standardized developmental screening tools and their families receive information and referrals to appropriate supports and services to help their children grow and learn. //2014//

With the release of the revised Bright Futures Guidelines, MCH changed its clinical pediatric and adolescent site visit tool, and is working with the Title V funded agencies to assess the impact of the recommendations, such as any subsequent training needed. The changes in developmental screening and surveillance, including universal autism screening at the 18 and 24-month visits, align with recommendations from a legislative autism commission report issued May 2008. The report of the Commission, of which MCH, representing DPHS, was a member, urges the Department of Health and Human Services to take the lead in providing technical assistance and other supports to ensure that all pediatric primary care settings screen for Autism Spectrum Disorders. Title V has multiple staff members from both MCH and SMS participating in efforts to improve screening. This has included the Autism Council's Screening and Diagonisis workgroup which is co-chaired by the Title V CYSHCN Director. This group received an AMCHP Act Early grant to facilitate the spread of the CDC Learn the Signs Act Early Campaign and hosted 2 statewide Open Forums on Universal Developmental Screening. Additionally, NH stakeholders have created a steering committee for a NH Pediatric Improvement Partnership and both MCH and SMS are participants in the planning and development.

/2015/
In further support of Preventive & Primary Care For Children, New Hampshire Project LAUNCH aims to improve coordination across early childhood-serving systems by improving identification and treatment of behavioral health issues in childcare and improve the social and emotional well-being of young children. Project LAUNCH will focus its efforts with families with children under the age of 8 whose household income is below 185 percent of the poverty line. During the course of this fi ve-year project, Project

LAUNCH will serve over 3,000 families in the Manchester area.

Title V staff have continued to engage other early childhood stakeholders on both the state and local level through Young Child Wellness Councils that support Project LAUNCH. At the state level, Spark NH, the State's early childhood advisory council, acts as the NH Young Child Wellness Council. At the local level, the Manchester Area Infant Mental Health Team has been the designated Wellness Team. However, the high level policy agenda associated with Wellness Team activities has interfered with the Team's previous and primary focus of "wraparound" type discussions for individual cases. The Project LAUNCH Leadership Team will determine how to address more effective local participation during strategic planning in June 2014. //2015//

Maps are attached to this Section.

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

REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS LESS THAN 16 YEARS OF AGE:

When the results of the 2001 National Survey of Children with Special Health Care Needs (NS CSHCN) were reviewed Special Medical Services determined that there was a need for additional data collection regarding children in NH who were receiving SSI for their own disability. The results from the NS CSHCN survey are meaningful; however, there is a subpopulation of SSI-receiving CSHCN that the national survey was not able to sufficiently capture. SMS completed a follow up survey with the known population of children receiving SSI in NH, the New Hampshire Survey of Parents of Children of Special Health Care Needs Receiving SSI for Their Own Disability, 2004. It was determined that because eligibility for SSI requires both means testing and diagnostic criteria, it was important to have an accurate picture of the needs of this population to guide strategic planning for the Title V program.

The overall results of this survey indicated that this group of children and their families experience an array of health-related difficulties, which may have a more severe impact on the family than the impact of difficulties experienced by families of NH CSHCN in general. The medical and financial eligibility requirements for SSI benefits are sufficiently restrictive to assure that the children receiving Supplemental Security Income for their own disability are, by definition, in a heightened state of need for this assistance. The cost-of-care burden is greater for these families than for the families of NH CSHCN in general. The NH survey also indicated that these children are evidencing a greater need for comprehensive, community-based, care coordination and well-organized service systems. Specific deficits are indicated in the areas of mental health services and the transition to adult services.

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

In response to this information Special Medical Services has a designated care coordinator to follow-up on all children/youth who are new recipients of SSI. The SMS coordinator provides outreach and support to all new recipients with a medical diagnosis and provides an outreach resource letter for all new recipients with a mental health or developmental diagnosis. In addition, SMS financial assistance for health related needs is available for this population.

The MICE (Multi-Sensory Intervention through Consultation and Education) program is administered by the Parent Information Center in cooperation with the Bureau of Developmental Services to serve children (0-3) for whom there is a concern relative to vision and/or hearing.

Children may be referred to the Area Agencies for intake and developmental evaluation, in conjunction with Early Supports and Services (ESS) staff. The emphasis is on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance are provided to ESS teams, and direct services to children and families.

CAPACITY TO PROVIDE FAMILY-CENTERED COMMUNITY-BASED, COORDINATED CARE:

SMS capacity regarding this element is highlighted throughout most of the SMS-specific service and system descriptions, as well as the Needs Assessment. Care Coordination is one of the programs available for children and youth with special health care needs and their families enrolled at Special Medical Services. Community Based Care Coordination for SMS means working together with families and their health care providers, community agencies and schools to help obtain access to needed health care and related services. Following assessment, comprehensive health care plans, responsive to the needs and priorities of the child/family, are developed. Central staff and contractors provide coordination of health related services with other community providers and schools, to ensure continuity of care, and family support. SMS has Care Coordinators available for all regions of the state and services are designed to incorporate home/community visits. All coordinators work with transition age youth to identify strengths and needs and develop a healthcare transition plan. SMS has had a strong focus on supporting the development of care coordination in the medical home by offering expert consultation and support.

/2012/ SMS applied for and received funding through a HRSA State Implementation Grant - Project Access/Phase III, to focus on improving the system of care for children and youth with Epilepsy/Seizure Disorders. A primary focus of this initiative, called FACETS of Epilepsy Care in NH, is to improve the coordination of care across all areas in the state. The activities will include Care Coordinator Summits to bring together SMS Coordinators as well as practice based, school and community program coordinators to faciliate increased communication and planning for families of children/youth with Epilepsy. This initiative will also focus on applying these processes to all CSHCN. //2012//

CULTURAL COMPETENCE & THE TITLE V PROGRAM:

While New Hampshire's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. The vast majority of the state's minority populations live in the southern tier of the state, including the two cities of Manchester and Nashua in Hillsborough County. Approximately 17% of Manchester residents speak a language other than English at home.

Births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998.

In addition, New Hampshire has resettled over 6000 refugees since the early 1980's, over 4,800 between 1997 and 2008. The majority of refugees have come from countries in Europe (74% from Bosnia) and Africa (58% from Somalia and Sudan), with smaller populations from Asia and the Middle East. Of the nearly 3000 refugees settled between fiscal years 2002 and 2009, 61% settled in Manchester, 26% in Concord, 8% in Laconia, with smaller populations in other cities and towns. These new residents can experience a range of health and mental health issues including poor nutrition, parasitic infections, communicable diseases and lead poisoning, with maternal and child health issues predominating.

Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of minorities are smaller. Community-based health agencies are aware of the need for

case management, outreach and interpretation services for this population and are working to develop capacity in this area. All SMS contracts for direct or enabling services for CSHCN have had a funded line item for Linguistic/Cultural Needs incorporated. The New Hampshire Endowment for Health reported that provider organizations varied widely in their collection, analysis and use of medical interpretation data. They identified a lack of systematic data collection within healthcare facilities. Providers in Hillsborough County, which includes the state's most diverse communities, serve a much greater proportion of patients with Limited English Proficiency (LEP), about one in seven (14%) patients in those facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers. Facilities that responded in Nashua reported a third of their encounters (32%) were with LEP patients. The interpreter resources that facilities reported using with the greatest frequency were, in descending order, externally paid interpreters, bilingual clinical staff, bilingual non- clinical staff, and telephone services. Cost and scheduling were significant barriers to facilities in providing consistent, quality services. Providers also identified the difficulty in securing translators for languages less common, including Asian languages, Portuguese, and American Sign Language.

Since mid 2009, a group facilitated by the Asthma Control Program has been meeting to discuss commonalities amongst vulnerable populations and the Division of Public Health's work with them. Meeting monthly, this group has fostered a closer working relationship between MCH and the Office of Minority Health.

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

In addition to race/ethnicity and language barriers impacting health care access, Title V programs are addressing other issues of cultural competence among MCH populations. These include homelessness, behavioral health, and substance abuse. One issue affecting service availability, accessibility and timely provision, is the lack of comprehensive planning, resource sharing and funding mechanisms, among the state, community-based non-profits, and the private sector. Until recently, health data specific to NH residents was minimal. The MCH and SMS Sections are assessing the new data, to improve health care service and quality, and reduce disparities. SMS has been working on improvements to its electronic data system and as of July 1, 2010 race and ethnicity information will be a formal data set.

/2013/ Special Medical Services has completed the Organizational Self-Assessment created by the National Center for Cultural Competence, with the assistance of staff from NH's Office of Minority Health and Refugee Affairs (OMHRA). Special Medical Services has also incorporated the CDC recommended questions set on Race/Ethnicity into its application and data system. //2013//

The following statutes provide Title V adequate statutory authority to promote and enforce legal requirements as well as assess and monitor MCH status.

NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO TITLE V

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

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

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders. This RSA was amended to clarify wording that allowed funds from the newborn screening filter paper purchases to be used to cover laboratory analysis and related newborn screening program costs. It also deleted the need for the newborn Screening Advisory Committee to have a public hearing before adding any recommended tests to the screening panel.

RSA 132:13 II adopts the definition for Children With Special Health Care Needs as: children who have or are at 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.

RSA 611, Medical Examiners, requires the medical examiner to file a record with MCH of any death determined to be the result of result of sudden unexplained infant death.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury, cystic fibrosis and multiple sclerosis which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by DHHS; eligibility and services to be covered are set forth in rules. /2013/ Due to funding cuts this program was suspended as of July 1, 2011. //2013//

RSA 126 contains provisions establishing a division of juvenile justice services; allowing for DHHS quality assurance activities; establishing an Advisory Council on Child Care to plan for improved child care services, report to the Legislature and Governor, and to act as a forum to receive child care related information; the development of primary preventive health services for low-income and uninsured populations; establishing an emergency shelter program, a council for children and adolescents with chronic health conditions and their families, and the Tobacco Use Prevention Funds; and restricts sale of tobacco products to minors.

RSA 126-M:1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

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

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

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

RSA 169-C mandates reporting of suspected child abuse.

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

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

RSA 265: A prohibits driving while under the influence of alcohol or drugs.

RSA 265:107 A requires the use of child passenger restraints up to age 6 or 55 inches, whichever comes first, and then seat belts in all positions up to age 18 and seat belts up to age 18.

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

RSA 141-J: establishes a statewide, population-based public health surveillance program on birth conditions

RSA 171-A30 allows a voluntary state registry which include a record of all reported cases of autism spectrum disorder (ASD) that occur in NH and other relevant information so as to conduct surveys of ASD

RSA 171-A:32 established a council on autism spectrum disorders to provide leadership in promoting comprehensive and quality education, health care, and services for individuals with autism spectrum disorders and their families.

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

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

RSA 132:30 Maternal Mortality Review Panel: establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in NH.

RSA 318-E:1: establishes a pharmaceutical drug take-back program. This bill has been passed by both the NH House and Senate and is expected to be signed by the Governor.

RSA 132:32: prohibits abortion providers from performing an abortion on unemancipated females without giving 48 hours' written notice, in person or by certified mail, to a parent or guardian unless a medical emergency exists. The bill provides a procedure for alternate notice in certain circumstances.

/2013/ SB 348 An act relative to the pulse oximetry test for newborns was passed in May 2012 and was signed by Governor Lynch. This act adds the pulse oximetry test to the medical screenings required for newborns and takes effect 60 days after its passage, August 10, 2012.

HB 1297 An act relative to federal health care reform and health care exchanges. This act prohibits New Hampshire from planning, creating, or participating in a state health care exchange. The bill also establishes guidelines for interaction with a federally-facilitated exchange created for New Hampshire. It was signed by Governor Lynch in June 2012.
//2013//

/2014/
RSA 126: A-49 designates the responsibility of a statewide poison information program and treatment center, which will be available to residents on a daily, 24 hour basis. State General Funds have been requested for the State Fiscal Year 14 budget to fund the poison center, which

will be under contract with MCH. //2014//

The full, official text of these statutes may be accessed on the State's website at: www.state.nh.us.

Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.

C. Organizational Structure

NH's Title V Program is located within the New Hampshire Department of Health and Human Services (DHHS). DHHS is headed by Commissioner Nicholas Toumpas reporting directly to Governor John Lynch. /2014/ Governor Maggie Hassan was sworn in as the 81st Governor of New Hampshire on January 3, 2013. //2014//

Administration of the Title V Block Grant is assigned jointly to the Maternal and Child Health Section (MCH) for services to women, infants and children and the Special Medical Services Section (SMS) for children with special health care needs (CSHCN). As of July 1, 2010, MCH will resides in the DPHS, Bureau of Population Health and Community Health Services (BPCHS) with population health services such as Chronic Disease and Prevention Programs, and Nutrition and Physical Activity Programs, including WIC.

This re-alignment is focused on linking initiatives and using scarce resources more efficiently through better integration. The overall strategic direction includes:
- Implementation of cross-program integration to increase population-health impact
- Integration of data systems to monitor population-health status
- Strategic use of partnerships to implement population-health approaches
- Focus on chronic disease prevention, diagnosis, treatment and intervention
- Allocation of resources externally to support strategic goals
- Development and implementation a health messaging strategy

SMS resides in the Bureau of Developmental Services, Division of Community Based Care Services. This affiliation aligns services for CSHCN in the same division as other Home and Community Based services for the elderly/disabled adults, individuals with intellectual disabilities and those with mental health issues.

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

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

While each program is distinct administratively, they coordinate frequently at the programmatic level. New Hampshire's approach to the 2010 Needs Assessment purposefully incorporated an integration of the MCH and CSHCN populations. This integration began with the planning process and was carried through to the reporting process. References to the Title V population throughout both the Needs Assessment and the annual Block Grant highlight this integration and represent joint evaluations and activities.

THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP:

MCH PROGRAMS

PRIMARY CARE PROGRAM: Using 89% State General Funds and 11% Title V funds, MCH supports thirteen community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for over 104,622 individuals/year. Many sites offer support

and enabling services such as nutrition counseling, case management, transportation and interpretation services.

/2013/PRIMARY CARE SERVICES FOR THE HOMELESS PROGRAM: Using 89% State General Funds and 11% Title V funds, MCH currently supports two agencies which provide outreach and case management services, primary medical and dental care, 24-hour emergency services, mental health, substance abuse counseling and treatment to individuals who are experiencing homelessness. People who are homeless suffer from health care problems at more than double the rate of individuals with stable housing and their healthcare needs are often not fully met in traditional office-based health care setting. Many are also burdened with additional needs including mental illness, substance abuse and chronic health conditions such as hypertension, diabetes, and/or HIV/AIDS. A third agency will be funded in FY 13 to more adequately meet the healthcare needs of New Hampshire's homeless individuals. //2013//

ORAL HEALTH PROGRAM: The Oral Health Program will now be coordinated with MCH in the Bureau of Population Health and Community Health Services. Partnering with Title V to serve all of the Title V populations through direct, enabling and infrastructure services building services, the Oral Health Program serves children and adults through contracted community based services.

PRENATAL PROGRAM: Fifteen local MCH-funded agencies provide prenatal care to over 1700 women/year. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care./2012/ As of July 2012, due to budget constraints, one of the two categorical prenatal agencies will no longer receive funding for services. With limited resources available, it was determined that funds should be directed at maintaining a basic infrastructure within the CHC system. //2012//

/2014/ PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS): MCH was awarded PRAMS funding in 2011 for this population-based survey and began data collection in March 2013. NH will sample 1,033 women annually who delivered a live infant within the previous 2 to 6 months. NH PRAMS will provide valuable data on experiences and behaviors before, during and immediately after pregnancy, on topics such as prenatal care, insurance coverage, substance abuse, safe sleep, contraception and other topics not available from other sources. //2014//

/2015/ At the end of the first year of data collection, the total PRAMS sample size of 2013 births was slightly smaller than expected (972 instead of 1033), due to a small but ongoing decline of births. The sampling fractions were recalculated for the second year of data collection. The sampling fractions are slightly larger for both normal and low birth weights (the NH sample is stratified on birth weight), and the expected total sample size for 2014 is 1006. The state birth file for 2013 is being written in NCHS format, for submission to the CDC; this will be used to weight the 2013 data. The 2013 weighted data set should be available for analysis by the end of 2014. //2015//

CHILD HEALTH PROGRAM: Twenty-two community health agencies receive funding to provide child health services. Of these, fourteen are primary care centers that offer direct care to low-income children through clinics and some home visits; eight provide health and social support services to children and their families through a Child and Family Health Support Services grant. All agencies provide case management, outreach, and SCHIP enrollment assistance. In FY09, approximately 17,500 children under age 13 years received primary care services, and over 1,200 children up to age 18, but primarily middle school and younger, received Child and Family Health Support services.

SIDS PROGRAM: The SIDS program offers information, support and resources to families and care providers of infants who died suddenly and unexpectedly. Information and training are provided upon request. Presentations are made frequently on reducing the risks of

SIDS/promoting safe sleep environments to groups such as health care professionals, childcare providers, home visitors, and early childhood education students. The SIDS Program Coordinator has taken a lead role in the state's Child Fatality Review Committee activities, participating in the Executive Committee, chairing the Recommendations Subcommittee, and helping organize and write the bi-annual report. Maternal and Child Health (MCH), in collaboration with the Bureau of Behavioral Health and the Office of the Chief Medical Examiner (OCME), developed and sends a grief packet to the families of all children autopsied through the OCME, who died from causes other than a sudden unexpected infant death or a suicide./2012/ In 2010, in collaboration with the OCME, MCH was awarded a CDC grant to pilot the Sudden Unexpected Infant Death Web-Based Registry. Case collection began January 1, 2011.//2012//

NEWBORN SCREENING PROGRAM (NSP): The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for heritable disorders ascertained through dried blood spot testing. As of July 1, 2010, RSA 132:10-a requires that infants be screened at birth for a panel of 33 disorders. The NH panel is in line with other state screening panels within New England and is similar to national recommendations. This statute includes a clause that allows parents or guardians to refuse this screening and also instructs the state to dispose of all specimens within 6 months of collection to ensure privacy /2012/ and that the remaining dried blood sample may not be used for any other purpose without the written consent of a parent or guardian. As of September 1, 2010 the filter paper fee was increased to $71 each. This fee now includes all program costs and has made the program self-sustaining with no dependence on State General Funds. //2012//

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

EARLY HEARING DETECTION & INTERVENTION (EHDI): EHDI promotes screening all newborns for hearing loss, and helps assure appropriate follow-up and intervention. In 2009, 97.3% of all infants born in NH hospitals were screened. The program has become well established with its Coordinator, along with the consulting Audiologist, as the mainstay of the tracking and quality assurance activities. The program's Family Advocate works with parents whose infant did not pass the screening to get further testing and other services as needed. Activities are planned to work with the state's lay certified midwives to increase screenings of infants delivered by these non-hospital providers.

ADOLESCENT HEALTH PROGRAM: The Adolescent Health Program promotes adolescent-friendly health care through one adolescent specific clinic, Child Health Services in Manchester and thirteen primary care sites. MCH provides technical assistance regarding adolescent health; participates in population-based activities; and coordinates forums for networking around adolescent issues.

/2012/ PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP): Title V will utilize PREP funds to target efforts in Sullivan County and the City of Manchester, as these two areas showed the highest rate and number of teen births in the State. Whereas three-quarters of the teen births in NH occur among 18-19 year olds, the targeted population will be 17-19 year olds and pregnant/parenting women up to age 21. The model will include the strengthening of partnerships between Adolescent Health, Home Visiting, Family Planning and education, both at the State and local level. //2012//

ABSTINENCE EDUCATION PROGRAM: This program seeks to reduce unintended pregnancies among children ages 10-14 years through community agreements to implement abstinence-only curricula. MCH has awarded Catholic Medical Center (CMC) the Leadership in Abstinence

Education Program. In turn, it supports community agencies statewide to provide abstinence education. This program has not been funded since the beginning of State Fiscal Year 10. However, MCH is currently awaiting the new federal funding for abstinence education, approved under health care reform, and will submit a proposal consistent with past strategies (ie, funding the Leadership in Abstinence in Education Program). /2014/ Through the Biennium Budget process, the New Hampshire legislature removed Federal Funding for Abstinence Education for SFY 14-15.It is anticipated the State will no longer apply for or receive funds to carry out these efforts.//2014//

HOME VISITING NEW HAMPSHIRE (HVNH): HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Eighteen projects currently serve in excess of 1000 families per year. Recognizing the importance of promoting healthy development and improving maternal and child health outcomes, the Affordable Care Act will soon provide funding for a needs assessment and ultimately new programming related to Maternal, Infant, and Early Childhood Home Visiting Programs in NH. New federal funds will use evidence-based home visiting strategies to help families create a nurturing environment for young children and connect to a range of services including health, early education, early intervention.

/2014/ LINKING ACTIONS FOR UNMET NEEDS IN CHILDREN'S HEALTH (LAUNCH): MCH's newest addition among its Young Families Programs is Project LAUNCH: This cooperative agreement with SAMHSA promotes behavioral health integration activities for young children and their families at the community based level and statewide systems level. //2014//

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): HCCNH focuses on improving the quality of health and safety in child care environments by increasing the number and expertise of child care health consultants and by incorporating content expertise and collaboration of other state and community programs with the child care industry in NH. /2014/ The shift of focus in ECCS has resulted in the loss of the Healthy Child Care NH Coordinator position. //2014//

INJURY PREVENTION PROGRAM (IPP): The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault and domestic violence, funds the State Injury Prevention Center, and is the liaison to the poison control educator associated with the state's Poison Control Center contractor, Northern New England Poison Center of the Maine Medical Center. /2013/ The IPP has received a Core Violence and Injury Prevention Program grant from the CDC. Increased surveillence, evaluation and interventions will be focused on four priority areas, including motor vehicle crashes; falls; poisoning; and injuries as a result of trauma "struck by or against". //2013// /2014/The CDC unexpectedly discontinued funding Core VIPP grant for the State of NH. MCH will continue to find innovative ways to integrate activities of the IPP into the work of the MIECHV program and MCH Title V. //2014//

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

TITLE X FAMILY PLANNING PROGRAM (FPP): The FPP provides confidential reproductive health care for low-income women and teens to over 30,000 individuals/year. /2013/ Because state program oversight was reduced by half due to no longer directly funding Planned Parenthood of Northern New England (PPNNE), the NH DHHS project currently covers approximately 16,000 individuals at our remaining 10 delegate sites. //2013// ***/2015/ Additional General Funds were alocated for SFY14 and 15 to expand access for Family Planning services in regions of the state that did not have a state-funded Title X FP clinic. Three agencies were awarded supplemental general funds for family planning services: Concord Feminist Health Center, Joan G Lovering Health Center and Planned Parenthood of Northern New England. It is anticipated that these agencies contracts will increase***

utilization and access of services //2015// .

CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP): As of July 1, 2010, the CLPPP will no longer reside within the MCH. The CLPPP is moving toward a more holistic approach to housing, and will become a healthy homes program in the newly formed Healthy Homes and Environments Section within the Bureau of Public Health Protection.

SMS PROGRAMS

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

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

PEDIATRIC SPECIALTY CLINICS: SMS operates Pediatric Specialty Clinics for Neuromotor Disabilities in 6 locations statewide. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children to fully participate in care planning. The clinic coordinator and consultant staff are supported by SMS. The team addresses issues of physical therapy, orthopedics, and developmental pediatrics, with access to SMS nutrition and psychology services.

NUTRITION, FEEDING AND SWALLOWING PROGRAM: The SMS Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide. Dietitians and feeding & swallowing specialists provide services utilizing a home visiting framework. SMS offers specialized training for all network providers assures a coordinated, outcome-oriented approach that is family-centered and community-based.

FAMILY EDUCATION & SUPPORT SERVICES: Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support group/organizations, and operates a comprehensive website. The staff are parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance.

PSYCHIATRY & PSYCHOLOGY CONSULTATION: SMS contracts with both a child psychologist and psychiatrist to provide access and services for CSHCN. Psychology services include statewide information and referral, educational services consultation and education/training to SMS staff as well as partner agencies. Psychiatry services include direct assessment, consultation and short-term condition/medication management while CSHCN are establishing primary care management of their mental health needs.
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

STAFFING
The Maternal and Child Health Section (MCH) is headed by an Administrator, who is the MCH Title V Director and responsible for all MCH activities. MCH employs 20 FTEs (fulltime staff equivalents); 12 positions are paid in some part through Title V funds. The five main programmatic units within MCH include: Child Health and Infant Screening (Child Health, SIDS, EHDI, NSP-- 4 FTEs); Injury Prevention and Adolescent Health (2 FTEs) Women's Health

(Family Planning, Preconception Health, 3 FTEs); Data and Decision Management (SSDI, Program Evaluation and Quality Assurance 3 FTEs); Young Families (HVNH, HCCCNH, Perinatal 4 FTEs). /2013/ Young Families (HVNH, HCCNH, ECCS, Perinatal 3.5 FTEs). The Secretary position was eliminated because of staffing realignments and funding reductions. The Perinatal position has been combined with the QI Consultant. //2013// All MCH staff are centrally located at the DPHS building in Concord, NH.

/2013/
The Injury Prevention Program received a Core Injury and Violence Prevention Program grant in August 2011. This grant has allowed for the expansion of the program internally by the hiring of an Injury Surveillance Program Coordinator, JoAnne Miles. Ms. Miles' position provides injury related epidemiological statistics, data interpretation, and recommended courses of action to the state program as well as to other colleagues in the state involved in injury prevention, federal health officials, state officials, researchers, and the general public in order to improve understanding of injury trends and issues. The funding has also enabled another contract, approved this past fiscal year, with the Injury Prevention Center at Dartmouth, to provide additional surveillance, evaluation, and coordination capabilities.

The Adolescent Health Coordinator position has not been filled due to budget reductions. However, MCH currently supports 0.5 FTE of Suzanne Allison, a public health nurse working with the Healthy Homes and Lead Poisoning Prevention Program. Within MCH, Ms. Allison focuses on special projects including facilitating the clinical chart reviews during primary care site visits for adolescents. She is also involved with reviewing work plans for the one dedicated adolescent primary care program. Ms. Allison is cross-training to provide back-up support for the early hearing and newborn screening programs. It is hoped that Ms. Allison's adolescent responsibilities will increase in the next fiscal year. //2013//

/2014/
The CDC discontinued funding for NH's Core Injury and Violence Prevention Program grant. However, activities related to that grant were performed under a 12-month cost extension through June 2013. This includes funding for the Injury Surveillance Coordinator position. Due to the need for general surveillance and analysis within MCH and DPHS as a whole, this role will be supported through a shared position between MCH and the Health Statistics and Data Management Section. Through this partnership, the Division can continue to analyze injury data, provide in-kind assistance to MCH's CDC-funded Sudden Unexpected Infant Death Registry, as well support WISDOM, the web-querying database that DPHS is publically releasing in June 2014. The public will be able access WISDOM with respect to all of DPHS's stewarded data sets including vital records (deaths and births), YRBS, BRFSS, hospitalizations, and emergency department visits.

Suzanne Allison, the 0.5FTE working on adolescent health has accepted another position in another DPHS Bureau. The position was decreased to 0.25 FTE, and was recently filled by Roberta Lawson, RN, who comes with public health experience from Maine. Ms. Lawson will assist MCH once she is thoroughly oriented into work with the NH Healthy Homes/Lead Poisoning Prevention Program. //2014////***2015//This 0.25 FTE has been discontinued.//2015//***

The MCH Data Team consists of those staff with an interest or expertise in data collection, analysis and dissemination; the SSDI Program Planner, Program Evaluation Specialist, Quality Assurance Nurse Consultant and contractual MCH Epidemiologist all participate in this team. MCH also employs administrative support staff (6.5 FTEs). / 2013/ The MCH Data Team is in transition. In 2011, the SSDI Program Planner, the Program Evaluation Specialist, and contracted MCH Epidemiologist maintained the core functions of this group. In late 2011 the newly hired, Quality Assurance Nurse Consultant/ Perinatal Coordinator joined MCH and began participating. With the addition of PRAMS and the CORE Violence and Injury Prevention Program (VIPP) Grants, new data-related staff will join as them begin on-boarding to MCH.//2013// /2014/ Given the uncertainty of funding for SSDI, the Program Planner is currently funded in part (.25 FTE) by

the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant. //2014//

MCH manages three contracts and one MOU to provide specific consulting capacity to MCH. These include: an MOU for OB-GYN medical consultation with Dr Maureen McCanty; contractual relationships for a consulting audiologist, a pediatric metabolic consultation and an MCH epidemiologist. The audiologist, Mary Jane Sullivan, MA, CCC-A, consults to the EHDI program, bringing experience in pediatric audiology and hospital-based newborn hearing screening programs. MCH epidemiologic support is provided by David LaFlamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health. He devotes three days per week to MCH issues, providing expertise in data analysis and health policy. Dr. Harvey Levy, pediatric metabolic specialist, provides support to medical providers managing clinically significant newborn screening results. /2014/ Dr Maureen McCanty has retired. MCH has twice advertised requests for OB-GYN medical consultation. At present, Title V and Title X still have a vacancy in this area. Dr. LaFlamme now provides an additional day of expertise to the MIECHV program//2014//.***/2015/ In June 2014, Dr. Heidi Rinehart will begin to provide medical consultation for the Title X family planning program and MCH; reviewing clinical standards and protocols; advising program staff of medical developments pertaining to client care; assisting in the development and/or review of federal grant applications and with review processes for community based services. Dr. Rinehart is board certified in Obstetrics and Gynecology. She has 26 years' experience in reproductive health .//2015//***

The EHDI Program also has a contractual relationship with the M.I.C.E. (Multisensory Intervention through Consultation and Education) Program of the Parent Information Center to provide parent support, education and advocacy to families of infants who were referred for diagnostic testing or confirmed with a hearing loss.

In addition, MCH houses Jocelyn Vilotti, New Hampshire's health education liaison from the New England Poison Control Center. /2012/ Ms. Viliotti was replaced by Laurie Warnock, who works 0.6FTE.//2012//

The Special Medical Services (SMS) Section is headed by an Administrator, who is the Title V CYSHCN Director and responsible for all CYSHCN activities. SMS has 18 FTE positions and 16 /2014/ SMS has lost some positions as employees have retired/resigned. Currently there are 16 FTE positions and 14 //2014// of them are funded in whole or in part by Title V funds. Some SMS staff due provide Enabling services in addition to the work that contributes to infrastructure building. SMS Care Coordinators have direct caseloads and/or run specialty clinics; 5 coordinators, 1 financial coordinator and 4 support staff work to meet these responsibilities. There is also a senior state physician who provides direct service to underserved populations and contributes to infrastructure building. There are 4 management level staff (reviewed below) and 1 contract manager. In addition, SMS administers the Partners in Health program, which is funded by the Social Services Block Grant, and the staff for this program include a Program Manager and a Program Assistant. /2012/ SMS had 3 vacant positions (a Public Health Nurse Coordinator, a Program Specialist/Contract Manager, and a Medical Secretary) that were eliminated as part of the budget process. This has resulted in fewer positions funded by Title V funds, currently 13 positions are funded in whole or in part by Title V funds. //2012//

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: MCH
Patricia M. Tilley, MS Ed, Administrator Ms. Tilley holds a Master of Science in Education from the University of Pennsylvania. She has over 10 years experience in public health in New Hampshire and 15 years experience in education and social services. Previous to becoming Administrator of MCH and Title V Director, she was the Early Childhood Special Projects Director in MCH managing home visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Prior to state service, she was the Director of a family resource center in Pennsylvania./2014/ In November 2012, Ms. Tilley was appointed to the role of Chief, Bureau of Population Health and Community Services. In May 2013 , she formally

accepted this position. She remains acting as Title V Director until that position can be filled. //2014//

/2015/ Ms. Rhonda Siegel, former MCH Injury Prevention Program Manager, accepted the position of MCH Administrator as of May 2, 2014. She has close to 30 years experience in Public Health, the last 16 in the field of Injury Prevention, with eight as Manager.//2015//

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

Rhonda Siegel, MS Ed, manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs. She has close to twenty-five years' experience in the public health field. With both her undergraduate and graduate degrees from the University of Pennsylvania, Ms. Siegel has worked in the state system for the last
ten years and prior to that was the health educator community outreach coordinator/clinic coordinator for a primary care health center and metropolitan medical center..***/2015/ Ms. Siegel accepted the position of MCH Administrator, but continues to also fulfill these duties until this role can be filled. //2015//***

Michelle Ricco, BS, Family Planning Program Manager/Title X Director
Ms. Ricco has a BS degree from the University of New Hampshire. Ms. Ricco has 10 years of experience in public health, with an emphasis on program development and management. ***/2015/ Ms. Ricco left this position as of May 2014. A waiver to hire is currently in process. Because this position is entirely Federally funded, it is anticipated that it will be waived. //2015//***

Marie Kiely, MS, SSDI Program Planner
Ms. Kiely manages the MCH Data Team and has a Master's degree in Public Health from Tufts University. Ms. Kiely has nearly 20 years of experience in public health programs, including previous management of the New Hampshire Injury Prevention Program and Cancer Registry./***2015/ Ms. Kiely retired from State service in April 2014. The position has been waived and is posted within Human Resources. //2015//***

Deirdre Dunn, MS, was hired in October 2008 as the Early Childhood Special Projects Coordinator in MCH managing Home Visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Ms. Dunn has a MS in Early Childhood Education with a focus on Leadership and Policy, from
Wheelock College and over 20 years experience in community based early childhood programs.

Beverly McGuire, MS, BSN, Quality Assurance Nurse Consultant
Ms. McGuire has a Master's degree in Health Administration and a Juris Doctorate degree. She was hired in 2004 to measure the quality assurance efforts of the funded local agencies. She has 25 years of experience in community health as the CEO of a VNA./2012/ Ms McGuire retired in October 2010 leaving this role vacant as of June 2011.//2012//

/2013/Jill Fournier, RN, BSN, Quality Assurance Nurse Consultant and Perinatal Coordinator.
Ms. Fournier has a BSN from Boston University. She has 18 years experience in public health programs in New Hampshire including previous management of the Tuberculosis Program. Ms. Fournier joined the MCH team in November 2011. Previous to her public health experience, Ms. Fournier worked for 8 years as an OB/GYN staff nurse in a local hospital. //2013//

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: SMS

Elizabeth Collins, RN-BC, MS, BSN, BA, Administrator, Title V CSHCN Director
Ms. Collins holds a Master of Science Degree in Nursing from the University of New Hampshire. She had over 20 years working with vulnerable populations in direct care and 3 years working with CSHCN through Title V prior to becoming the Title V CSHCN Director. She has completed the NH LEND program and is ANCC certified in Psychiatric Mental Health Nursing. /2012/ Ms. Collins has been accepted into the 2011-2012 cohort of the Maternal Child Health - Public Health Leadership Institute (MCH-PHLI). //2012//

Kathy Higgins Cahill, MS, Clinical Program Manager
Ms. Cahill was hired for this position in Dec. 2006. This position manages all statewide care coordination activities including oversight of state and contracted coordinators. She is also the Project Coordinator for SMS' youth transition activities. Ms. Cahill had worked as a part-time staff to SMS for many years, assisting with the formation of the Child Development Program and providing care coordination and clinic management services. Prior to accepting this position she had worked full-time as a Program Specialist.

Margaret Bernard, SMS Data Specialist
Ms. Bernard was hired for this position in 2008. She has excellent skills in database construction, knowledge of the SMS data systems, and expertise in the State Medicaid data systems. Her prior experience includes working for the State Medicaid Service Utilization Review Section and direct service provision for individuals with Behavioral Health issues./***2015/ Ms. Bernard left this position as of March 2014 and the position was then effectively eliminated when it was transferred to a non Title V program.//2015//***

Sharon Kaiser, RN, BS, Early Childhood Systems Specialist.
Ms. Kaiser was hired in Dec. 2006. She has a BS from Keene State College. She has expertise in state systems related to Early Childhood Health and CSHCN. Her previous experience includes statewide Care coordination and prior to that she dedicated herself to residential programming and quality care for children with developmental disabilities. She brings considerable partnership experience with public and private service agencies. She was the Director of a nonprofit, residential facility for CSHCN for 26 years and a MCH nurse in the community for 7 years.

PARENTS OF CHILDREN WITH SPECIAL NEEDS
New Hampshire Family Voices is supported by Title V funds. This includes funding for three staff who are parents of CSHCN. Martha-Jean Madison (the parent of eight CYSHCN) and Terry Ohlson-Martin (the parent of one CYSHCN) are Co-Directors of the project and Sylvia Pelletier (the parent of two children who are cancer survivors) is the Outreach Coordinator. /2013/ Three additional parents (Sally Weiss, Erika Downie and Kristen Costley) have joined NHFV, as part-time staff, and one young adult (Nicole Tucker) has joined NHFV as a Youth Coordinator.//2013//

STAFFING CHANGES
The most significant staffing change to MCH will take effect July 1, 2010. The entire Childhood Lead Poisoning Prevention Program will move from MCH to a newly organized Bureau of Public Health Protection where it will be re-formed as the Healthy Homes and Environment Section combining Lead Poisoning and Asthma Control. This Bureau will also house the Radiologic Health Section; Food Protection Section and Health Officer Liaison.

Budgetary issues continue to make it challenging to fill positions. Currently, MCH has several vacant positions including its Perinatal Coordinator, Adolescent Health Coordinator and support staff. As new federal funding from the Patient Protection and Affordable Care Act becomes available, it will become more clear how these positions may or may not be filled or funds be leveraged with new opportunities. Currently SMS has one FTE and one 0.5 FTE vacant positions that have been "frozen".

/2012/

The budgetary climate has remained challenging. It has become evident that it is unlikely that without new federal funds, the Adolescent Health Coordinator will not be filled. Upon the retirement of the Quality Assurance Nurse Consultant, that role was restructured to assume the responsibilities of the Perinatal Coordinator, as well. Although tentative approval has been granted to fill this position, a suitable candidate has yet to be found. The most positive staffing update has come from the ACA Maternal Infant and Early Childhood (MIEC) Home Visiting Program. Shannon Wood, MS was hired in February 2011 as the Home Visiting Program Coordinator. //2012// /2014/ MIECHV experienced transitions in 2012. Heidi Petzold, previously with the Divisions of Family Assistance and Children, Youth and Families, was hired as the new Home Visiting Coordinator in January 2013 replacing Shannon Wood. Erica Proto, RN, was hired as the MIECHV Evaluation Coordinator in August 2012. //2014//

/2013/
Having a sufficient and trained workforce continues to be one of the greatest threats to the infrastructure of Title V in New Hampshire. Budget reductions and budget policy, even when federal funds are available, make hiring an arduous process. For example, upon the retirement of the Quality Assurance Nurse Consultant, that role was restructured to assume the responsibilities of the Perinatal Coordinator, as well. The part-time perinatal position was vacant for over one year and the new combined role of Perinatal Quality Assurance Nurse Consultant took over five months to fill.

Ms. Fournier filled the Quality Assurance Nurse Consultant position in November 2011. She coordinates the primary care site visits, and writes post-assessment reports. Ms. Fournier also conducts independent site visits to agencies receiving funding to support primary care services for the homeless. In addition, Ms. Fournier participates in several MCH perinatal initiatives related to maternal mortality, smoking cessation, and the promotion of exclusive breastfeeding. She is an active member of the PRAMS Steering Committee. ***/2015/ Ms. Fournier coordinates the Maternal Mortality Review process and is an active member on the NH Statewide Partnership: Prenatal Substance Exposure/Alcohol Exposure Task Force.//2015//***

/2014/
In September 2012, Marcia Lavochkin, Newborn Screening Program Coordinator retired after twelve years. Linda Kincaid, RN, who held previous positions with DCYF and Head Start, was hired into the position and has made a smooth and successful transition.//2014//

MCH COMPETENCIES
/2013/ While there may be challenges to maintaining a sufficient workforce, NH's Title V is committed to supporting the quality of the workforce that we do have. To be a leader in Maternal and Child Health requires specific knowledge, skills, personal characteristics, and values. MCH staff were asked to evaluate themselves using the MCH Leadership Competencies Assessment developed by MCHB. To make the process easier, the Title V Director created a SurveyMonkey version of the competencies. MCH staff identified several competencies where they felt they needed more growth, such as: identifying ethical dilemmas and issues that affect MCH population groups and the ethical implications of health disparities within MCH populations. MCH staff also rated themselves as needing to more fully operationalize the "family centered care" philosophical ideals. Areas of self-rated strengths included: the ability to apply evidence based practice guidelines; the ability to identify practices and policies that are not evidence based but are of sufficient promise that they can be used in situations where actions are needed; and the ability to interact with others and solve problems in an ethical manner.

MCH will use the feedback from the survey to guide training and technical assistance requests. Information from the survey will used as part of a Coordinated Chronic Disease Plan to support workforce. MCH will also share the results of this survey with the Division of Public Health Services as it goes through its Accreditation process as additional evidence of workforce development.

//2013//

/2015/ Four of the six MCH managers participated in a 360 Leadership training. In addition, three MCH staff members became Certified LEAN Practitioners this past year.//2015//

E. State Agency Coordination

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

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

Partnerships Impacting and Impacted by the Political Environment:

Because of Title V's broad reach and population health approach, Title V staff have been appointed and been invited to participate in numerous executive and legislative-level committees and workgroups including the:

-Brain and Spinal Cord Injury Advisory Council
-Coordinated School Health Council
-Council for Children and Adolescents with Chronic Health Conditions
-Mental Health Planning and Advisory Council /2013/ Name changed to Behavioral Health Advisory Council//
-NH Autism Council
-NH Birth Conditions Advisory
-NH Child Care Advisory Council
-NH Child Fatality Review Committee-
/2013/ - NH Maternal Mortality Review Panel //2013//
-NH Childhood Obesity Expert Panel
-NH Children's Advocacy Network
-NH Early Childhood Advisory Council /2013/ now re-designated by Governor Lynch as, Spark NH //2013//
-NH Early Hearing Detection and Intervention Advisory /2014/Disbanded in 2009//2014//
-NH Newborn Screening Advisory
-NH Non-Public School Advisory Committee
-NH Teen Driving Committee
-Suicide Prevention Council
-Vital Records Improvement Fund Advisory Committee
/2013/
-NH Strategic Highway Safety Plan
-NH Sudden Unexpected Infant Death Review Group //2013//
/2014/
-NH Safe Sleep Campaign Workgroup //2014//
/2015/
-NH Leadership for Outcomes for Infants/Toddlers, and Preschoolers with Disabilities
-NH Home Visiting Coordinating Committee
-NH Association for Infant Mental Health //2015//

The role of Title V staff, either as leaders of these groups or active participants, is to provide expertise on the needs of women, children and families and through these partnerships identify and implement cross-cutting activities to help meet priority needs.

During the 2009-2010 legislative session, the NH General Court established the Committee on Committees as a response to the large number of legislatively created Non-Regulatory Boards, Commissions, Councils, Advisories and Task Forces across state government. The charge of the Committee on Committees was to engage in a thorough decision making process to determine which of the committees should remain in effect, be consolidated, or be sunsetted immediately or within one or two years. The rationale for this review and ultimate reduction of committees is part of an overall strategy of the legislature to reduce costs and conserve state agency staff resources.

At the time of publication, it is understood that the Early Hearing Detection and Intervention Advisory will be terminated and it is unclear whether the Newborn Screening Advisory Council will be consolidated with another Advisory Council or maintained as is. It is also unclear which other important legislatively mandated committees will ultimately be affected by these changes. This speaks to the political challenges with which all executive and legislatively appointed committees, regardless of content area, are occasionally presented.

A positive example of collaboration related to the political environment has been the group effort by an extensive list of stakeholders that led to the subsequent creation of legislatively mandated Autism Council in NH. This effort began in 2001 when the NH Task Force on Autism was created by interested individuals (state and local agencies, private providers and families). They created a report on recommendations for Assessment and Interventions that was widely distributed. This stakeholder group continued to exert political pressure on the need for a more formal response to the considerable impact that Autism Spectrum Disorders (ASD) were having on families, service providers and state agencies. In 2007, the state passed legislation creating a Commission on Autism Spectrum Disorders. The NH Commission on Autism Spectrum Disorders submitted its report on Findings and Recommendations to the legislature in 2008. The legislature and governor reviewed this report and in 2008 created the NH Council on Autism Spectrum Disorders - to coordinate supports and services for individuals and their families. Title V is well represented in the Autism Council activities as workgroup members and Coordinating Committee chairs.

/2012/ The Division of Public Health Services re-aligned in July 2010 in order to strengthen the Division's focus on protecting and promoting the population's health. Programs have been aligned for better integration to strengthen our capacity to address diabetes, heart disease, and other chronic conditions clearly linked to tobacco use, poor nutrition, and inadequate levels of physical activity that continue to cause long-term illness and disability. MCH is now in the same Bureau as WIC and other Chronic Diseases programs. New affinity groups, such as the Young Families Workgroup and Chronic Disease Integration Workgroup and Perinatal Smoking Workgroup, made up of partners across programs, address specific populations with innovative strategies that cut across the Division. //2012//

Partnerships to Support Families and Improve Socio-Economic Environment:

Title V has many collaborative relationships that improve supports for families. The collaborative relationships result in changes in policies, priorities, systems and resource allocation.

In New Hampshire, the Division of Family Assistance (DFA) administers programs and services for eligible residents providing financial, medical and food and nutritional assistance, help with child care costs, and emergency help to obtain and keep safe housing. Child Care Assistance assists parents engaged in work, training or educational activities leading to employment to afford quality care for their children. DFA determines eligibility based on rules and policies administered by the Child Development Bureau.

TANF & Family Planning Program (FPP):
This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. TANF funds are allocated to the Title X Family Planning program within MCH to focus on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy. Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs.

TANF, Medicaid & Home Visiting New Hampshire (HVNH):
This project supports 19 home visiting programs statewide, including one program with a focus on the state's largest minority and non-English speaking population, with TANF, Medicaid and Title V funds. With MCH as the program administrator, and leveraging TANF funds for base funding and Medicaid support for fee for service reimbursement, HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. ***/2015/ The project, combined with CFHS in 2013, supports 9 home visiting programs statewide. Enhanced partnership with DCYF resulted in further integration of home visiting services. Beginning July 2014, Comprehensive Family Support Services will include HVNH and CFHS as covered services in their contract with Community Resource Centers throughout the state. //2015//***

New Hampshire is looking forward to the opportunities that may be available through the Patient Protection and Affordable Care Act to better understand the additional home visitation needs throughout the state and then leverage additional federal resources to enhance the current core HVNH program.

Child Care Scholarship and Redesign:
The MCH ECCS program was a collaborative partner in the process to redesign the NH DHHS Child Care Scholarship Program establishing a more consistent payment to providers, reducing some out-of-pocket cost for families, supporting the inclusion of children with special needs, and encouraging increased quality from providers by creating a tiered Quality Rating System. Enacted in July 2009, this program was suspended in 2010 due to state budget constraints. Even with reductions in payments, a wait list has been developed for child care scholarships that is anticipated to reach more than 3,000 children by July1, 2010.

Division of Children, Youth and Families (DCYF):
DCYF manages protective programs on behalf of NH's children, youth and their families. DCYF staff provide a wide range of family-centered services with the goal of meeting a parent's and a child's needs and strengthening the family system. Coordination with DCYF occurs through several Title V programs and mutual committees. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the NH Child Fatality Review Committee, described later in this section, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board Members of the NH Children's Trust Fund. The Family Planning Program Manager is an active member with the Foster Care Health Program Advisory Committee, representing MCH, as are the CSHCN Director and Senior Physician, representing SMS. MCH and SMS are active members of the Watch Me Grow Steering Committee, a group initiated by the Title V Early Childhood Comprehensive Systems planning process, now working under the mandate of DYCF, under CAPTA and Early Supports and Services, under IDEA, for families to have universal access to developmental screening for young children. Additionally, the SMS senior state physician is now available for monthly consultation to DCYF.

Developmental Disabilities:
SMS is aligned organizationally as a part of the Bureau of Developmental Services (BDS). This affiliation has facilitated a great deal of informal collaboration between Title V and BDS. There have been some joint service efforts as well as overall system cooperation. The CSHCN Director is a member of the BDS Management Team and an SMS representative continues to be an appointee representing Title V on the Interagency Coordinating Committee for Part C. Other joint efforts include participation by SMS on the Council for Children and Adolescents for Chronic

Health Conditions and the recent administrative transfer of oversight for the Partners in Health Program. In addition, HVNH has partnered with the Bureau of Developmental Services (BDS) by developing trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. Currently efforts between Title V and the BDS are focused on the statewide initiative, Watch Me Grow, that is planning for statewide implementation of common developmental screening tools and guidelines to be used in a variety of settings.

Lifespan Respite:
Through a grant received by the Administration on Aging, Special Medical Services has initiated the creation of a Lifespan Respite Coalition and workgroups with representatives from the Bureau of Elderly & Adult Services, the Bureau of Behavioral Health, the Bureau of Developmental Services; the Division of Children, Youth & Families, New Hampshire Family Voices, NAMI-NH and Granite State Federation for Families. This initiative is working to create a state registry of respite providers (for all age groups), implementing a competency-based curriculum and completing a pilot program on the impact of the competency-based training.

NH Family Voices:
Title V in NH has a very strong and longstanding collaboration with New Hampshire Family Voices (NHFV), which is also New Hampshire's Family-to-Family Health Information Center. SMS has funded parent consultation, through NHFV, for almost 20 years. In addition to the initial activities of helping families to access services, this role has evolved to incorporate leadership and policy development activities. SMS always seeks input from NHFV when making any kind of Administrative Rule or policy change. NHFV has also participated in discussions with MCH, Medicaid and Child Protective Services regarding rules, services and family needs. NHFV was an active participant in the Needs Assessment Planning Group along with related activities including the CAST-V process and the CSHCN Capacity Assessment.

Partnerships to Improve Health:

Child Fatality Review Committee (CFRC):
The CFRC is charged with reducing preventable child fatalities through systematic multidisciplinary review of child fatalities in NH. The MCH Child Health Nurse Consultant and Injury Prevention Program Manager have played key roles in the CFRC working closely with representatives from the Medical Examiner's Office, DCYF, the state police, and the Attorney General's Office. Title V staff revised the process by which committee recommendations are developed and tracked. Recommendations from the case reviews are often implemented in training provided by the Child Health Nurse Consultant to health, social service, and child care personnel, to reduce the risks of SIDS, promote safer sleeping environments for infants and toddlers, and promote referrals to parenting resources for high-risk families.

Suicide Prevention Council:
The Injury Prevention Program and the Adolescent Health Programs collaborate with the DHHS Commissioner's Office, DCYF, and Behavioral Health and other statewide partners on the Suicide Prevention Council Legislated in 2008, the Suicide Prevention Council's mission is to implement the newly revised State Suicide Prevention Plan. The Injury Prevention Program facilitates the Communications Subcommittee. This committee works on both the communication of suicide prevention issues to the public and educating media on appropriate guidelines for reporting suicide. //2014// The Communications Subcommittee recently facilitated a Media Forum, designed to create dialogue between the media and suicide prevention advocates. Along with a media panel, the Injury Prevention Program described the results of a five-year analysis of media reporting on suicides in the state. From 2008 to 2012, the inclusion of resources rose from 11 to 45% while "bad" visuals decreased from 33 to 15%. However, descriptions of the method of death, which is not recommended in the guidelines, held steady over the five-years. These results will guide the activities of the Communications Subcommittee in the coming years. //2014//

/2015/

Maternal Mortality Review Panel: NH statutes established a maternal mortality review panel (MMRP) to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendation for system changes to improve services for women in the state. Administrative Rules became effective on March 16, 2013. The MMRP met in August 2013 to review three maternal deaths. Six additional maternal deaths are currently being investigated. An annual report will be provided to the NH Health and Human Services Oversight Committee. See attached 2014 Annual Report. //2015//

The Disparate Populations Group:
Facilitated by the Division of Public Health Services, Bureau of Prevention Services Asthma Program Manager, this collaborative focuses on those sub-populations in the state with distinct health needs. This includes, but is not limited to, those who are incarcerated, the elderly, refugees and immigrants, and minority populations. This collaboration has strengthened the relationship between the Office of Minority Health and MCH. Within the past year, MCH has spearheaded interactive learning sessions with state prison and county jail medical professionals./2013/ This group was put on hiatus.//2013// /2014/ MCH has coordinated efforts with the newly formed DHHS Office of Minority Health. DPHS/MCH and Office of Minority Health are collaborating to develop indicators on Health Equity and the Social Determinants of Health for WISDOM, DPHS's developing, web-based data system that will be publiclly available in October 2013. //2014//

Medicaid & Title V:
Title V strengthens the power and reach of Medicaid indirectly through the services Title V directly supports at the local level in community health centers, specialty clinics, family resource centers and through home visits. New Hampshire uses Title V and state general funds for community based agencies to provide outreach, coordination, and referral services. HVNH, a statewide home visiting network leverages TANF funds for base funding for family support, and uses Medicaid fee for service to support health education and as a strategy for EPSDT outreach and informing.

Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy to develop and implement local Medicaid codes that pay for Title V-related services, such as child and family support, nutrition and feeding services, and expanded prenatal services. Title V staff have worked in partnership with Medicaid to revise Medicaid Rules and provide training in their appropriate use. /2012/ Medicaid and Title V have been revising the "Prenatal and Child/Family Health Care Support Services" rule, instituting new eligibility restrictions and prior authorization processes in order to provide cost-savings. //2012// Title V and Medicaid have been meeting to readopt a Memorandum of Understanding (MOU), that process has been productive but is currently on hiatus due to constraints related to internal capacity issues. /2012/ SMS worked extensively with Medicaid representatives in response to sponsored legislation directing the Department of Health and Human Services to create a proposal for a Medicaid Waiver for In Home Supports for Medically Fragile Children. Unfortunately, this legislation ultimately failed due to budget constraints and the legislative commitment to not approve any new spending. //2012// /2013/ Medicaid and Title V have worked collaboratively on several objectives. A Medicaid representative was a core leadership member of SMS' Strategic Planning and the SMS Administrator was a member of the Medicaid communication workgroup related to the impending transition of CHIP services. Additionally, Medicaid is a collaborator on a new grant with the National Center on Ease of Use of Services.//2013//

/2015/
SBIRT and Substance Use Disorder (SUD) Benefit:
Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy and the Bureau of Drug and Alcohol Services to provide a new SUD and SBIRT Medicaid benefit. Training will be targeted for community health centers to enhance network capacity.//2015//

EPSDT:
The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. The SMS Senior physician's position supports SMS activities as well as offering significant support to Medicaid including consultation on EPSDT issues, with a particular focus on issues of medical necessity.

Dental:
Medicaid's initiative to increase access to dental care has resulted in most reimbursement rates being raised, a strong partnership with the New Hampshire Dental Society reduced administrative burden of claims processing, ongoing parent and PCP education programs, and improved coordination of oral health programs across the DHHS. The Medicaid initiative focuses on improving access to dental care for underserved populations, such as CSHCN who continue to have limited access to dental care, through provider outreach and education efforts.

CSHCN:
Through a joint venture between Medicaid and SMS, there is a Nurse Care Coordinator position within SMS that is directly responsible for services to CYSHCN who are newly enrolled in Medicaid. This coordinator offers outreach and support to all new enrollees in Medicaid through NH's Home Care for Children with Severe Disabilities (HC-CSD). The HC-CSD coordinator represents an ongoing link between Medicaid and Title V. This position has been integral to new rule development for Medicaid related to utilization of services for children qualified under HC-CSD criterion. This individual will continue to offer care coordination and will interface with Medicaid in an ongoing process of identifying children, who are at risk of becoming disqualified for Medicaid under this new rule, and working with their families to develop a modified service utilization plan.

SCHIP:
MCH collaborates with NH SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. SMS' care coordinators, providing services statewide, inform uninsured families about the NH Healthy Kids (Medicaid) programs and send applications. A designated care coordinator provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to NH Family Voices as well as to SMS. The MCH Child Health Nurse Consultant was a member of the SCHIP quality assurance workgroup (QCHIP) and the workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects. MCH staff participated in the proposal review for the SCHIP contract with the Healthy Kids Corporation. /2014/ As a result of changes to New Hampshire law, effective July 1, 2012, Healthy Kids Silver was folded into the New Hampshire Medicaid program, which is managed by the New Hampshire Department of Health and Human Services. Title V staff were involved in the communication group that created materials for families and providers regarding this transition. //2014//

Title X Family Planning Program (FPP):
The New Hampshire Title X program is a major unit within MCH and is administered by the MCH Director, ensuring a seamless coordination between MCH and reproductive health services. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens. As part of this work, the FPP Manager has spearheaded efforts to develop a plan for Preconception Care for NH. The FPP coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual Chlamydia screening and treatment for female FPP clients between ages 15-24. Federal monies for this screening project are for women in the

targeted category who would not otherwise be able to afford this screening. Funds are also provided to the PHL for testing and to STD/ HIV for treatment. /2013/ As described previously, NH's reproductive health care delivery system shifted in SFY12 when the NH Executive Council determined that the State could not contract with Planned Parenthood of Northern New England for family planning services. Additionally, state funds for sexually transmitted infections (STI) treatment have been significantly reduced and on-going funding from CDC for the Infertility Prevention Program is under modification. It is expected that future allocations will be focused more on training and technical assistance for STI's and no longer directed for clinical services, like screening and treatment. Title V, FPP, STD and Lab staff will continue to work collaboratively on coordinating efforts to monitor and screen for Sties. //2013//

Adolescent Sexual Health Advisory Board:
Re-organized in 2009, the FPP has taken the leadership of the newly named Adolescent Sexual Health Advisory Board. This workgroup of partners representing Title V, Title X, community partners from across the reproductive health care and adolescent health spectrum have committed to engaging in a strategic planning process to ensure that all adolescents (10-19) and young adults (20-25) have access to quality health care services, as well as, skills, information and supports that promote healthy life choices. /2012/ The Adolescent Sexual Health Advisory Board convened and provided guidance to the Personal Responsibility Education Program (PREP). NH is focusing on 17-19 year olds and pregnant or parenting females up to age 21 in the City of Manchester and Sullivan County. Both of the target areas clearly show the greatest need for reducing unintended teen pregnancy due to the high number and rates of teen births. //2012//

Healthy Homes:
The Childhood Lead Poisoning Prevention Program (CLPPP) has resided within MCH from 2006-2010 and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children. As the CLPPP continues to work toward the goal of eliminating childhood lead poisoning, a program shift is under way to move from this single focus to address multiple environmental, health and safety risk factors. /2012/In July 2010, the CLPPP broadened its reach and became the Healthy Homes and Lead Poisoning Prevention Program (HHLPPP). Although the HHLPPP is no longer housed within MCH, collaboration continues. CLPPP (now the HHLPPP) //2012// has formed a Healthy Homes Taskforce that includes other programs within DPHS, Department of Environmental Services, Bureau of Agriculture, Office of Energy and Planning, Community Action Programs, and Department of Safety, Fire Safety Program to create and implement a statewide strategic plan to better integrate services. /2012/The taskforce, with its MCH members, has worked closely with the HHLPPP to pilot healthy homes "One Touch" projects throughout the state.//2012// /2014//MCH continues to work with the Healthy Homes Program as members of its Steering Committee and as co-authors of its recently revised State Plan. //2014//***2015// MCH together with partners have developed a Healthy Homes One-Touch home visiting model that is used by 26 agencies and 90 home visitors statewide. Using the One-Touch model, home visitors are able to assess the home for environmental hazards, provide Healthy Home education to the family, and make referrals to agencies with resources to address identified environmental hazards. //2015//***

Early Childhood Comprehensive Systems (ECCS):
This MCHB-funded initiative is brought together partners from a wide variety of disciplines to develop a statewide plan for early childhood systems. The ECCS partners completed the Comprehensive Plan for Early Childhood Health and Development for NH that is implemented throughout partner agencies and serving in part, as the foundation for the development of the New Hampshire Early Childhood Advisory Council, recently mandated by the Head Start Reauthorization Act. At the cornerstone of ECCS, is Healthy Child Care New Hampshire (HCCNH), a partnership of state agencies and programs that provide health and safety education and support to child care providers. The HCCNH leads the Health and Safety Committee of the Child Care Advisory Council. The HCCNH continues to liaison with DES and child care as they collaborate on innovative initiatives such as plans for integrated pest management in child care

facilities

/2013/ MCH leveraged ECCS funds and limited Title V funds to purchase "READY! For Kindergarten" in partnership with NH Department of Education (DOE). This curriculum provides parents and primary caregivers a series of 15 parent/caregiver classes. "Ready!" was used in four low-performing school districts in support of ECCS and Title V goals in that it addresses increased parental awareness of child development and standardized, validated screenings used to identify children at risk for developmental, behavioral or social delays. The success of this small pilot allowed the NH DOE to find additional resources to bring the program to larger scale. //2013//

Rural Health and Primary Care Section (RHPCS):
RHPCS includes the Primary Care Office, the State Office of Rural Health, the Oral Health program and Workforce Development. Access to doctors, dentists, and other healthcare providers is a challenge for residents of some communities in New Hampshire. The mission of these programs is to improve access to healthcare services throughout New Hampshire particularly for those residents without commercial insurance. MCH and the RHPCS work as partners to administer contracts for 13 community health centers that provide primary care, including perinatal care, for low-income families.

WIC:
Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion, injury prevention and lead screening strategies are shared across programs in both state office and in communities. For example, Title V and WIC staff also jointly participate on the New Hampshire Breast Feeding Task Force which not only meets the mutual goals of improving breastfeeding rates, but serves as an excellent platform for sharing information on a variety of perinatal topics such as co-sleeping, SUIDS risk reduction and newborn screening. /2013/ MCH and WIC collaborated on a successful application with the ASTPHND (Association of State and Territorial Public Health Nutritionist and Dieticians) for a mini-grant which will be used to train seven staff from MCH-funded home visiting program agencies to become certified lactation counselors. The MCH SIDS Program Coordinator has also worked with State and local WIC agency staff to develop strategies on getting safe sleep information to WIC clients, especially breastfeeding moms, including developing a prenatal packet that includes safe sleep material. //2013//

/2014/WIC and MCH again collaborated on a successful application with the ASTPHND to train up to 90 nutritionists, nurses, home visitors and other health professionals, in "Moving Moms to Behavior Change: Hot Button Counseling Training". The training, also supported by the HNHFoundation, will focus on weight-related health messages for pregnant women and new mothers. //2014//

Communicable Disease Control & Surveillance (CDCS):
The mission of CDCS is to monitor communicable diseases in NH. The Surveillance unit maintains the mandatory reportable disease system and is responsible for collecting, analyzing, interpreting and reporting infectious disease data. The Disease Control unit is responsible for infectious disease control activities, case follow-up, patient and provider education and disease outbreak investigation. MCH staff has worked with the Disease Control Program assisting in the state's H1N1 response by participating in clinical advisory groups, disseminating information in a timely manner to key stakeholders, including the local community health centers, and providing nurse staffing to cover routine disease outbreak. Title V continues to participate on workgroups for emergency planning for local response ambulatory care centers.

Data Infrastructure:
Critical to leveraging the infrastructure and capacity of MCH, the DPHS' Health Statistics Section (HSS) is a close partner in developing reports, analyzing data and acting as a technical resource.

The MCH Epidemiologist has collaborated with staff in the (HSS) to standardize data. //2014// Due to the discontinuation of the Core Violence and Injury Prevention Program (Core VIPP), Title V and the DPHS Health Statisitics and Data Management Program will support the Injury Surveillance Program Coordinator, JoAnne Miles, MCH's portion of WISDOM, the new DPHS on-line surveillance query system set to go live in Summer of 2013. //2014//

/2014/
NH Pediatric Improvement Partnership
Title V staff have been working with other stakeholders as part of a Steering Committee for the creation of a Pediatric Improvement Partnership in NH to promote clinical quality improvement-collaborators include the NH Pediatric Society, UNH, Center for Medical Home Improvement, Medicaid and others. //2014//

/2015/
Million Hearts Collaborative: MCH has actively partnered with the DPHS Heart Disease and Stroke Prevention Program and with the CDC State Public Health Actions "1305" cooperative agreement to develop integrated clinical and community strategies to prevent heart disease and stroke. In 2012, MCH reviewed 608 patient records at CHCs. Ninety-nine percent (602/608) of the patient's 3 years of age or older had a documented Blood Pressure (BP) recorded during the past year with the majority having one recorded during their last visit. In 2013, MCH reviewed BP Policies and Procedures at the contracted CHCs, PC for the Homeless Programs, and FP clinics. Forty-one percent (7/17) of contracted agencies had a written BP policy and only 29% (5/17) agencies had a written BP procedure. Sample BP policies and procedures were then distributed to all contracted agencies in 2014. In addition, a comprehensive BP toolkit was developed that includes BP resources, BP posters, a competency based PowerPoint presentation, pre/post/tests, DASH Diet handout, BP registry information, and patient BP cards. These toolkits will be distributed to each of the contracted agencies prior to the rollout of a best practices webinar on taking accurate BP measurements. //2015//
An attachment is included in this section. IIIE - State Agency Coordination

F. Health Systems Capacity Indicators

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

Health Systems Capacity Indicators Forms for HSCI 01 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	19.1	19.1	15.0	15.0	15.0
Numerator	141	141	111	111	111
Denominator	73650	73650	73800	73800	73800
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data is the same as reported last year as updated information was not available. The data is provided by the NH Asthma Control Program and NH Inpatient Hospital Discharge data from 2009. The final number is inclusive of border states (ME,MA,VT) inpatient hospital data. For the Denominator, Health Statistics created a population table based on US Census and OEP

estimates. The table citation is; Health Statistics and Data Management section (HSDM), Bureau of Disease Control and Health Statistics(BDCHS), Division of Public Health Services (DPHS), NH Department of Health and Human Services (DHHS). Population data is based on US Census data to approtioned towns using NH Office of Economic Planning (OEP) estimates and projections and further apportioned to age groups and gender using Claritis Corporatio estimates and projections to town,age group and gender.

Notes - 2012
Data is the same as reported last year as updated information was not available. The data is provided by the NH Asthma Control Program and NH Inpatient Hospital Discharge data from 2009. The final number is inclusive of border states (ME,MA,VT) inpatient hospital data. For the Denominator, Health Statistics created a population table based on US Census and OEP estimates. The table citation is; Health Statistics and Data Management section (HSDM), Bureau of Disease Control and Health Statistics(BDCHS), Division of Public Health Services (DPHS), NH Department of Health and Human Services (DHHS). Population data is based on US Census data to approtioned towns using NH Office of Economic Planning (OEP) estimates and projections and further apportioned to age groups and gender using Claritis Corporatio estimates and projections to town,age group and gender.

Notes - 2011
Denominator is from DPHS Health Statistic's population table. Created based on US Census and OEP estimates.

Citation for this table: Health Statistics and Data Management Section (HSDM), Bureau of Disease Control and Health
Statistics (BDCHS), Division of Public Health Services (DPHS), New Hampshire Department of Health and Human
Services (DHHS). Population data is based on US Census data apportioned to towns using New Hampshire Office of
Economic Planning (OEP) estimates and projections, and further apportioned to age groups and gender using
Claritas Corporation estimates and projections to the town, age group, and gender levels. Data adds to US Census
data at the county level between 2008 and 2009 but does not add to OEP or Claritas data smaller geographic levels

Data are cleaned and cleared for use
Includes NH residents seen in hospitals in New Hampshire, Maine, Massachusetts and Vermont

Narrative:
Nationally, childhood lead poisoning, injuries, and respiratory diseases such as asthma have been linked to substandard housing conditions. The New Hampshire MCH Section and the Healthy Homes and Environments Section (which includes the Healthy Homes/Lead Poisoning Prevention Program (HHLPPP) and the Asthma Control Program) partner with the National Center for Healthy Housing (NCCH) and numerous NH stakeholders including MCH-funded primary care, child health, home visiting and child care funded agencies, to implement priorities from the New Hampshire Healthy Homes Statewide Strategic Action Plan.

The New Hampshire State Asthma Plan 2009-2014, states that 100% of children in New Hampshire with asthma had a routine doctor's visit in the past year, but only 74% of children with asthma had a routine checkup for their asthma in the past 12 months. Only 51% of children with asthma received a flu vaccination in the past 12 months. Almost a third of children in New Hampshire who have asthma live in a household where someone smokes, 80% have indoor pets and 57% of those allow them in their bedrooms, 65% have carpet in their bedrooms, and 31% use mattress and pillow covers.

MCH staff works closely with the Asthma Program to discuss ways to educate MCH contract agencies about how to keep children with asthma healthy and how to prevent acute episodes resulting in office, emergency room, and in-patient visits. Housing conditions associated with asthma and other respiratory illnesses include the presence of mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches) and tobacco smoke.

The Tobacco Prevention & Control Program has designed a Smoke Free Policy Toolkit and has been working with NH Property Managers on implementation of Smoke Free Policies statewide. As of May 2014, the Tobacco Prevention and Control Program have assisted, 12 of the 15 Housing and Urban Development (HUD) Authorities in NH that own Multi-Unit Housing Buildings around the state. to adopt smoke-free policies. This equals over 4061 units in NH HUD buildings that are now smoke-free which greatly improves the air quality and health of the building, tenants, staff and visitors.

Among the 86 Property Management Companies that contract with HUD and/or accept Section 8 housing vouchers, the Tobacco Prevention & Control Program worked with 4 of the largest to adopt a smoke free policy in all their units statewide. Additional property management companies are in the process to adopt similar policies in the near future.

As of FY13, Community Health Centers are required to follow the National Guidelines for the Diagnosis and Management of Asthma, 2007. MCH staff have adapted current quality assurance site visit and chart auditing tools to include adherence to asthma guidelines.

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

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	88.8	94.9	95.0	79.2	94.4
Numerator	5305	4454	4010	3158	3702
Denominator	5975	4692	4219	3987	3920
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data is from the revised FY 2013 416 report, received via email from Carolyn Richards (271-9439) in the Bureau of Health Care Analytics and Data Systems, Office of Medicaid Business and Policy. Email was dated June 30, 2014. Beginning in 2010, the 416 reports includes those who have 90 days continuous enrollment.

Notes - 2012
Data is from the FY 2012 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Business and Policy. Beginning in 2010, the 416 reports those who have 90 days continuous enrollment (however, see note below about a problem with numerators in 2010 and 2011).

This indicator decreased in FY12 for the following reason:
Previous 416 reports had the numerator based on children who were continuously and non-continuously enrolled for 90 days, while the denominator was only the continuously enrolled. This

was caused by an ambiguity in the CMS specifications for the report; which has now been resolved. Obviously, the numerator should only be based on those members continuously enrolled since that is what is in the denominator.

Notes - 2011
Data is from the FY 2011 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration. Beginning in 2010, the 416 reports those who have 90 days continuous enrollment.

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

Narrative:
Title V recognizes that New Hampshire's historical investment in its Healthy Kids Program has been critical to ensuring that all children have access to preventive health care and EPSDT. Currently, NH Medicaid provides the same level of benefits to children up to 300% FPL as the previous Healthy Kids Program ensured. As the State transitions to Medicaid Care Management, MCH and SMS have participated in numerous workgroups to provide leadership and technical assistance for policy makers and program specialists to ensure that kids have timely access to care so that the State can maintain its favorable outcomes.

MCH monitors its community health centers and community support programs through a required performance measure of Percent of Eligible Children Enrolled in Medicaid. In FY13, the community health centers had an average rate of 91%, with a range of 81% - 100%. MCH reviews charts at its funded primary care agencies for adherence to the American Academy of Pediatrics (AAP)/Bright Futures Periodicity schedule for preventive visits and key health screenings. Thirteen of the 14 community health agencies and the one pediatric primary care agency currently use an electronic medical record system, enhancing their ability to assure that children receive the necessary periodic visits on schedule. Because of the near 100% use of electronic heath record systems (EHR) that can generate postcards and reminders, automated call back systems have become more efficient. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

Developmental screening is covered as part of EPSDT. This coverage as part of the bundled service, however, does sometime present a challenge to collecting specific data on frequency of screening and what screens are used by practitioners since there are not separate billing records for them, nor are there added supports or resources for providers. All 14 MCH contracted community health centers received a site visit within the past 18 months and included a chart audit as part of the clinic assessment process.

It is important to note that 2012 report data reflects a substantively steep downward slope compared to past years. The NH Office of Medicaid Business and Policy has alerted MCH that previous year reports calculated the measure with a numerator that included children who were continuously AND non- continuously enrolled for 90 days, but the denominator included only the continuously enrolled. This calculation error was caused by an ambiguity in the CMS specifications for the report which has now been resolved. The numerator should only be based on those members continuously enrolled since that is who is in the denominator. As a result, the rate is not comparable to previous year's reports.

The 2013 report data includes those who have 90 days continuous enrollment and shows a shift back to rates similar to 2011 and previous.

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

Health Systems Capacity Indicators Forms for HSCI 04 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	86.3	87.2	86.3	86.5	85.3
Numerator	9236	8827	9428	9251	9379
Denominator	10701	10118	10930	10695	10993
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2013
Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2012
Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2011
Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Narrative:
MCH in New Hampshire contributes funding to community health agencies throughout the state to provide prenatal care for underinsured and uninsured women, as well as those covered by Medicaid. The fifteen agencies provide a safety net of accessible prenatal care throughout much

of New Hampshire, serving 16% of pregnant women in New Hampshire, with funding amounts based on a formula that accounts for need/poverty within the each community; the level to which behavioral health services and oral health services are integrated into basic care; accreditation efforts; and limited support for basic infrastructure and special provisions. This funding is critical to serving a population that is more likely to not receive adequate prenatal care, as indicated by the percent of women (15 through 44) with a live birth in the reporting year whose observed to expected prenatal visits were greater than or equal to 80 percent on the Adequacy of Prenatal Care Utilization (APNCU) Index or Kotelchuck Index.

Unfortunately, there were significant state budget cuts in SFY12 and SFY13 impacting the community health centers where many low income pregnant women receive care. In SFY 13, 1761 prenatal women received care. This number is slightly lower than in years past and may be reflective of a decreasing birthrate in New Hampshire, although the proportion of pregnant women receiving care in the community health centers is higher than in years past.

This safety net of prenatal care helps ensure that women have access to prenatal services early in their pregnancy and have the support to receive consistent care. MCH monitors the community health centers contract agencies' required workplan performance measure of prenatal entry to care. In FY13, the community health centers had an average rate of 83%, (with a range of 60% - 94%) higher than the overall statewide rate of Medicaid recipients receiving care in the first trimester. Variation among the communities is attributed to cultural differences in accessing care and variation among clinics with small numbers.

In order to further support vulnerable populations within the state and try to find perinatal women who may not be getting the care that they need, MCH will use a federally approved data collection plan to measure the percent of women enrolled in the Home Visiting NH-Healthy Families America program receiving "adequate" Prenatal care among those scoring adequate or below using the APNCU Index a.k.a. Kotelchuck Index; specifically the "Adequacy of Received Services" dimension. During the baseline period, families receiving HFA reported 57% (among formula funded programs) and 67% (among competitive funded programs) obtained an adequate number of prenatal care visits. During the fall 2014, New Hampshire will be collecting data for the comparison period to determine whether or not there has been an increase in the program's ability to support women in obtaining such services.

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

Health Systems Capacity Indicators Forms for HSCI 07A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	74.8	78.3	78.1	77.8	
Numerator	84384	89328	90270	95448	
Denominator	112764	114101	115616	122747	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2013

The numerator was provided by Carolyn Richards, Bureau of Health Care Analytics and Data Systems, Office of Medicaid Business & Policy. Data for the denominator is the sum of two numbers: the number of 1 to 21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number is uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the two age groups used to determine the denominator do not match exactly, this methodology results in the most accurate estimate available

Notes - 2012
The numerator was provided by Maria Pliakos (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1 to 21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number is uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the two age groups used to determine the denominator do not match exactly, this methodology results in the most accurate estimate available.

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Narrative:
New Hampshire continues to maintain a favorable rate of the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. Community health centers, home visiting programs and other child advocacy programs continue to promote access to NH Medicaid and medical homes.

Further supporting access to care, the Affordable Care Act (ACA) authorized Medicaid reimbursement for eligible primary care services at parity with Medicare for calendar years 2013 and 2014. New Hampshire Medicaid primary care providers (PCPs), including pediatricians and family practice providers, who meet requirements for this enhanced reimbursement, have received instruction on how to certify for retroactive payment to January 2013. The funding enhancement is completely funded by the federal government. The rationale for this strategy is aligned with the anticipated growth of Medicaid enrollment with the advent of important Affordable Care Act milestones starting in 2014. A shortage of primary care providers who accept Medicaid is anticipated, and increasing reimbursement rates may promote increased access to primary care for low-income residents. Providers associated with Federally Qualified Community Health Centers and other specially designated entities were not eligible for a rate increase as they already receive enhanced, cost-based reimbursement.

MCHS staff are in the midst of conducting routine site visits to the DPHS-funded community health centers and primary care for the homeless programs. Local agency staff have described challenges with newly implemented prior authorization requirements of the Managed Care Organizations for certain referral visits and prescriptions which pose obstacles in providing timely care or routine services. Agencies and direct care providers are being encouraged to share these difficulties with staff from DPHS, the New Hampshire Medicaid Program, and the involved Managed Care Organization.

Because of the significant changes within the New Hampshire's Medicaid program, data and analysis for 2013 was not available by July 2014. Title V anticipates that this information will be

ready by September 2014.

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

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	64.7	68.0	67.1	65.2	68.0
Numerator	12782	13641	13721	14625	15710
Denominator	19742	20063	20439	22418	23099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data is from FY2013 CMS 416 report, obtained from Carolyn Richards and Jackie Leone in the Bureau of Health Care Analytics and Data Systems,
Office of Medicaid Business & Policy.

Notes - 2012
Data is from FY2012 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone. 2010 was the first year in which individuals had to have 90 days continuous enrollment.

Notes - 2011
Data is from FY2011 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone. 2010 was the first year in which individuals had to have 90 days continuous enrollment.

Narrative:
In 2013, 68% of Medicaid eligible children aged 6 through 9 years received a dental service. This indicates a two year upward trend, returning to the previous high of 68% in 2010. It should be noted that the raw numerator and denominator have both increased since 2010, placing greater demands on the system.

The NH DPHS Oral Health Program has 15 Agreements with schools and community based agencies to provide increased access oral health care services for children and adults. Second and third grade children eligible for school-based dental services will receive oral health education, prophylaxis (cleanings), dental sealants, and treatment needed to repair decayed teeth. Children through age 19, and adults eligible for community-based dental services will receive oral health basic preventive, diagnostic, and restorative dental services at a community dental provider's office.

Second and third grade children eligible for school-based dental services receive oral health education, prophylaxis (cleanings), dental sealants, and treatment needed to repair decayed teeth within the school environment. Children through age 19, and adults eligible for community-based dental services receive oral health basic preventive, diagnostic, and restorative dental services at a community dental provider's office.

NH school-based oral health programs also provide preventive services to children enrolled in

Head Start and the Women, Infants and Children's (WIC) Program. External grants for Head Start and WIC dental projects have provided on-site preventive services and have raised family awareness of the importance of oral health and the need to have a child's first dental visit by age one.

One of the measures for New Hampshire's MIECHV Benchmark 6 - Coordination and Referrals, is based on the American Academy of Pediatric Dentistry recommendation that the establishment of a dental home begins no later than 12 months of age. By developing a dental home by age 1, we anticipate that children will continue to receive consistent, preventive care.

Baseline data indicates that 60% of children, in the formula funded home visiting programs, and 100% of children in the competitive funded home visiting programs are meeting this benchmark.

Through MCH quality assurance site visits, MCH audits community health center medical charts items include documentation of age-appropriate oral health risk assessment, indication of a dental home or a referral to one, the drinking water source, fluoride content if the source is well water, and if indicated, an age-appropriate fluoride supplement according to the documented well water content. MCH continues to provide free well water analysis for fluoride content for low income New Hampshire residents

Clinical chart audits of community health agencies indicate that enrolled children, most of whom are Medicaid eligible, are more successfully getting referred to a dentist or have an established dental home.

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

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	12.8	12.9	13.9	17.2	17.3
Numerator	244	264	294	381	387
Denominator	1912	2039	2111	2220	2238
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
The Denominator is the number of recipients of SSI under age 16 as reported from the SSA - table titled "Number and percentage distribution of children under age 16 receiving federally administered SSI paymentsby selected characterisitcs,December 2013. The Numerator utilized was determined by the unduplicated number of children served by SMS in CY 2013 with SSI and who were under the age of 16 as of December 31,2013.

Notes - 2012
The Denominator is the number of recipients of SSI under age 16 as reported from the SSA - table titled "Number and percentage distribution of children under age 16 receiving federally administered SSI paymentsby selected characterisitcs,December 2012. The Numerator utilized was determined by the unduplicated number of children served by SMS in CY 2012 with SSI and who were under the age of 16 as of December 31,2012. The increase in the indicator may be related to the fact that there have been continued improvements in the SMS Database to capture unduplicated and timely data as well as continued outreach activities that SMS has undertaken.

Narrative:
SMS has an outreach program that targets all families of children (with chronic health conditions) newly accepted for SSI. This process incorporates written and telephone contact from a Nurse Care Coordinator to assess the needs of families and to connect them with the appropriate resources, including ongoing Community Based Health Care Coordination through enrollment in Special Medical Services.

All new SSI enrollees with a primary medical diagnosis - whether they have Medicaid or not - receive an outreach letter indicating what services SMS might be able to offer them with contact information for the SSI Coordinator. The written outreach letter has also been translated into Spanish to better connect with those who speak Spanish as their primary language. In addition, outreach letters are sent for all new enrollees with a primary mental health or Autism diagnosis, indicating which community and state services and agencies are intended to support their needs.

The rate of children, in New Hampshire, under the age of 16 receiving SSI benefits has increased in each of the last 4 years. It is possible that the rationale for this is related to negative changes in the economy, resulting in more children meeting the financial eligibility criteria. There is also a need to consider a correlation with the significant rate of children being diagnosed with Autism Spectrum Disorders as part of this increase. The percentage of those children being served by Special Medical Services through outreach has also increased. It is possible that SMS' efforts at outreaching to community agencies to make better connections has been successful. The consistent increase in children qualifying for SSI has been matched by a consistent increase in the number of children with SSI being service by Title V, through SMS. This is undoubtedly due to the ongoing collaboration with the Social Security office for identification of these individuals and the now routine process of outreach to all new SSI enrollees.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2013	payment source from birth certificate	7.8	6	6.7

Narrative:
Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight.

Even though New Hampshire continues to compare favorably in the nation for the overall rate of low birth weight babies, it shares a similar disparity between Medicaid and non-Medicaid recipients. There is growing consensus that the complex issues surrounding LBW call for a broad, strategies, that incorporate a lifecourse perspective to address chronic health problems, such as obesity, diabetes, and heart disease, that impact pregnant women.

Centering Pregnancy is an evidenced-based model for the delivery of prenatal care that focuses

on health assessment, education, and support within a group setting. Women are empowered to choose health-promoting behaviors that can lead to better neonatal outcomes including a decrease in low birth weight and premature deliveries. Two MCH funded health agencies currently offer Centering Pregnancy as well as the traditional model for the delivery of care. This model is especially targeted for low income women who could benefit from the additional support. Because of its success, March of Dimes and Title V has provided support to the programs and several other agencies are exploring the possibility of offering this evidenced-based model in the future.

Because of its impact on health across the lifecourse, New Hampshire has also promoted Healthy Mothers and Babies in its State Health Improvement Plan, specifically the reduction of preterm birth.

Other Title V partnerships to address low birthweight include continued efforts to promote perinatal smoking cessation among women receiving care in community health centers by facilitating e-referrals to NH Quitworks and the development of the New Hampshire Statewide Partnership to Address Opioid Use Among Pregnant Women. Medicaid enrolled patients are disproportionately affected, representing over three quarters of the infants diagnosed with NAS.

The Northern New England Perinatal Quality Improvement Network (NNEPQIN) released "Guidelines for Medically Indicated Induction of Labor". NNEPQIN promoted these guidelines at several professional state and regional conferences during 2012 and 2013.

In 2012, New Hampshire signed on to the Association of State and Territorial Health Officials (ASTHO) and March of Dimes challenge to improve birth outcomes by reducing infant mortality and prematurity in the United States. Specifically, the ASTHO goal is to decrease prematurity in the United States by 8% by 2014. NCHS estimated New Hampshire's 2009 Preterm Birth rate at 9.9%, or 1,323 premature births out of a total of 13,377 live births. An 8% reduction goal for New Hampshire would be 9.1%, or a reduction of approximately 106 preterm births. MCH is pleased to report that NH reached its goal.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2012	matching data files	4.7	4	4.2

Notes - 2015
2012 infant deaths (from the death file). All linked to births. All are NH residents.

Narrative:
Although New Hampshire is fortunate in that its infant mortality rates typically compare favorably to national rates, communities and Title V professionals continue to focus on efforts to ensure that every baby has a first birthday. State averages may mask the fact that disparities that are evident in other regions of the county also exist in New Hampshire. Disparities have historically existed between those who receive Medicaid and those who have commercial insurance. The data in 2012 shows that the difference between these two rates is narrowing.

Approaches and strategies to impact infant mortality and to ensure greater equity vary. Some

address general maternal health such as efforts to reduce chronic disease and improve healthy behaviors among pregnant women and women of reproductive age. Others efforts emphasize ensuring access to a safety net of health care services including, health education, prenatal counseling, prenatal care and preconception and interconception health preventive care. New Hampshire has embraced population based strategies such as Text4baby, as a way to leverage social media health messaging literally into the hands of pregnant and parenting women who are primed to make behavior changes. Still other approaches are more specific, concentrating on reducing the incidence of Sudden Infant Death Syndrome or Sudden Unexpected Infant Death (SIDS/SUID), which is the leading cause of death for babies from one to 12 months of age.

New Hampshire is one of 9 states implementing a SUID Case Registry to analyze SUID data and inform death reviews. Data from the SUID Case Registry shows that as of May 2014, there have been 22 confirmed cases of SUID deaths to state residents. Causes of death included: 13 Undetermined; 8 SIDS; and 1 Positional Asphyxia. All deaths involved an unsafe sleep environment with soft or loose bedding and/or soft toys near the infant. Nine of the infants (41%) were found in an adult bed. Only 2 of the 22 cases shared a room without bedsharing, as is the American Academy of Pediatrics' recommendation. The NH Safe Sleep Workgroup continues to expand its activities and educational outreach to inform providers and the general population on reducing the risk of unsafe sleep environment deaths.

It is interesting to note that although the overall 2012 rate of 4.2 deaths is similar to the previous year, there was an increase in infant deaths among Non- Medicaid births and a decrease of deaths among Medicaid births.

New Hampshire is seeking CDC funding to expand its infant death review and data collection include Sudden Death in the Young, involving sudden and unexpected deaths to state residents birth to 19 for all causes except homicides, suicides, overdoses, poisonings, or as passengers in motor vehicle accidents. Additionally, New Hampshire will also work to decrease infant mortality as it joins the national Infant Mortality Collaborative Improvement and Innovation Network (CoIIN), July 2014.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2013	payment source from birth certificate	68.7	85.6	81

Narrative:
MCH monitors the community health centers contract agencies' required performance measure of prenatal entry to care. In FY 13, the community health centers had an average rate of 83%, with a range of 60-97%, higher than the overall statewide rate of Medicaid recipients receiving care in the first trimester. Variation among the communities may be attributed to cultural differences in accessing care and variation among clinics with small numbers.

SPARK NH, the state's early childhood advisory council in its draft needs assessment, states that

Sullivan County and Hillsborough County have a significantly higher rate of births to mothers receiving late or no prenatal care while Rockingham County is significantly lower. This is consistent with data from our community health centers and may be indicative of challenges associated with providing outreach to racial, ethnic and linguistic minorities in urban areas and access to care in rural areas. It is interesting to note that Sullivan County has no birthing hospital.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2013	payment source from birth certificate	77.6	88.1	85.3

Narrative:
Unfortunately, there were significant state budget cuts in SFY13 impacting the community health centers where many low income pregnant women receive care. In SFY 13, 1,761 prenatal women received care. This number is slightly lower than last year and may be reflective of a decreasing birthrate in New Hampshire, although the proportion of pregnant women receiving care in the community health centers remains higher than in years past.

As with early entry to care in their first trimester, it is disappointing to note that the Kotelchuck Index has decreased among Medicaid, non-Medicaid, and all populations in the State. This is a trend worth further examination to determine if there are geographical or other differences.

This safety net of prenatal care helps ensure that women have access to prenatal services early in their pregnancy and have the support to receive consistent care. MCH monitors the community health centers contract agencies' required workplan performance measure of prenatal entry to care. In FY 13, the community health centers had an average rate of 83%, with a range of 60-97%, higher than the overall statewide rate of Medicaid recipients receiving care in the first trimester, and slightly higher than the overall statewide rate of Medicaid recipients receiving care in the first trimester. Variation among the communities is attributed to cultural differences in accessing care and variation among clinics with small numbers.

In order to further support vulnerable populations within the state and try to find perinatal women who may not be getting the care that they need, MCH will use a federally approved data collection plan to measure the percent of women enrolled in the Home Visiting NH-Healthy Families America program receiving "adequate" Prenatal care among those scoring adequate or below using the APNCU Index a.k.a. Kotelchuck Index; specifically the "Adequacy of Received Services" dimension. MCH has revised the definition of improvement in the MIECHV Benchmark Plan to more clearly answer the question, "Is the program getting better at supporting women in obtaining the adequate number of prenatal care visits?" During the later months of implementation, the programs' policies and procedures may be refined to achieve a higher percentage of women obtaining an adequate number of prenatal care visits.

During the baseline period, families receiving Cohort I, formula funded HFA services reported 57% and families receiving Cohort II, competitive funded HFA services 67% obtained an adequate number of prenatal care visits. During the fall 2014, New Hampshire will be collecting data for the comparison period to determine whether or not there has been an increase in the program's ability to support women in obtaining such services.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2013	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2013	300

Narrative:
New Hampshire is experiencing transformational changes to its Medicaid program. In anticipation of these changes and a legislative directive to better control costs, coverage under "Healthy Kids- Silver" (SCHIP) and "Healthy Kids-Gold" (Medicaid) moved to New Hampshire Medicaid on July 1, 2012. New Hampshire Medicaid will continue to cover kids under the age of 19, up to 300% of the federal poverty level, with a premium holiday until an undetermined date in 2014. New Hampshire Medicaid has assured those families with a total monthly income between 186 to 300 percent of the federal poverty level that they will be notified well in advance when the Department resumes premium collection in 2014.

On December 1, 2013, New Hampshire transitioned from fee-for-service to a managed care model of Medicaid. DHHS contracted with three managed care organizations (MCOs) to offer three Health Plans to Medicaid recipients. Most Medicaid participants, including low income children and pregnant women, were mandated to participate in this transition to MCM . Children in Foster Care, children with special health care needs, children with Supplemental Security Income, and dual Medicare and Medicaid eligible were encouraged to participate on a voluntary basis, and will be mandated to participate in Step 2. The roll out for Step 2 will begin January 1, 2015.

By April 2014, 95.3% of low income children enrolled in Medicaid had enrolled in a care management health plan; 41.6% of children with severe disabilities had enrolled in managed care; and 75.8% of children in foster care had enrolled in managed care. As of April 1, 2014, 48,028 clients were enrolled in Well Sense Health Plan; 38,857 clients were enrolled in NH Healthy Families Health Plan; and 29,258 clients were enrolled in Meridian Health Plan.

On June 3, 2014, Meridian Health Plan indicated that it would withdraw from the State of New Hampshire effective June 30, 2014. Meridian, based in Detroit, Michigan, requested withdrawal from the Medicaid Care Management Program in order to focus on the growth of its core businesses in the Midwest. With the addition of the New Hampshire Health Protection Program coming later this year, Meridian and DHHS agreed that a summer withdrawal would provide the best opportunity to minimize any disruption to the Program and its members. DHHS and Meriden are working together to ensure a smooth transition for Meridian's members and the providers who serve them. Meridian will continue to provide services until July 31, 2014.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2013	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2013	300

Narrative:
Please refer to narrative for HSCI 6A.

In anticipation of the transition to Managed Care and a legislative directive to greater control costs, coverage under "Healthy Kids- Silver" and "Healthy Kids-Gold" moved to NH Medicaid on July 1, 2012.

On December 1, 2013, New Hampshire transitioned from fee-for-service to a managed care model of Medicaid.

New Hampshire Medicaid will continue to cover kids under the age of 19, up to 300% of the federal poverty level, with a premium holiday until an undetermined date in 2014. New Hampshire Medicaid has assured those families with a total monthly income between 186 to 300 percent of the federal poverty level that they will be notified well in advance when the Department resumes premium collection in 2014.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2013	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2015
Pregnant women are not covered under SCHIP.

Narrative:
Like all states, New Hampshire is in the midst of transformational changes to its Medicaid program. As described in HSCI 6A and elsewhere, in December 2013, New Hampshire transitioned from fee-for-service to a managed care model (MCM) of Medicaid. DHHS contracted with managed care organizations (MCOs) to offer three Health Plans to Medicaid recipients. Most Medicaid participants, including low income children and pregnant women, were mandated to participate in this transition to MCM .

Pregnant women with incomes up to 185% FPL continue to be eligible for New Hampshire Medicaid. Once eligible, pregnant women receive coverage through the 60th day post-partum regardless of income. Children born to mothers receiving medical coverage at the time of birth are automatically eligible for up to one year.

As of July 1, 2013, women and men with incomes up to 185%FPL became eligible for a new Medicaid Family Planning benefit. The Family Planning Expansion Medical Assistance program is designed to improve access to and use of family planning services among eligible individuals. The goal of this program is to improve the wellbeing of children and families by reducing unintended pregnancies. The Family Planning Expansion Medical Assistance Program is limited to services and supplies where the primary purpose is family planning and which are provided in a family planning or other medical setting. This benefit will promote continued care for postnatal women who were eligible for New Hampshire Medicaid as a result of pregnancy.

The newly legislated Health Protection Program proposes to use federal Medicaid dollars to purchase private, employer-based medical insurance and expand access to approximately 50,000 new recipients, including anyone under 65 who earns up to 138 percent of federal poverty guidelines. If income eligible adults cannot access commercial insurance through an employer, they may be eligible to sign up for a private health insurance plan through the state's Bridge Program. The Health Protection Program will also promote continued care for some low-income, postnatal women.

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

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

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

Notes - 2015

Narrative:
SSDI funding enables MCHS to access timely and accurate data for both internal and external users. Through collaborative efforts with all data stewards and users, MCHS has increased its ability to obtain vital records and Medicaid data for reporting on Title V performance measures and ongoing needs assessment, and increased the ability and skills of project staff to analyze these data routinely.

The Section continues to improve linkages between birth certificate and Newborn Hearing Screening Program and Newborn Screening Program data to assure that all newborns are screened for hearing loss and metabolic and other disorders at birth. The system to link birth and perinatal data is complete and contains 4.5 years of data. Improvements to the quality and monitoring of the Perinatal clinic data set has resulted in usable data that has been shared with community health centers.

The Data Mart, which will eventually house all linked MCH data, continues to mature as progress is made in carrying out the linkage plan. WIC data was added in 2014. These linkages will assist the Section in assessing the MCH population and evaluating MCH programs.

PRAMS survey data will be available in early 2015.

A data sharing agreement is now in place between NH MCH, WIC and DoIT that assists with follow-up by allowing limited access to confidential WIC data for the PRAMS survey and for the MCH Data Linkages.

The Maternal Infant Early Childhood Home Visiting has coordinated with other MCH Data Mart in the development of a web-based data system for Home Visiting programs. The MCH Epidemiologist, Home Visiting Evaluation Team, and Home Visiting Coordinator have developed the data-base and are now working on the data transfer project to ensure the quality of data being migrated from paper files, spreadsheets, and the Family Assessment Form (database) into the new data system hosted by an outside vendor, Social Solutions. The project is expected to be completed the summer 2014.

The most significant data challenge to date has been in accessing timely hospital discharge data. New Hampshire previously contracted with an outside agency to collect and clean hospital discharge data. A decision was made to bring this process in-house starting with the 2010 data year. However, developing and implementing a coding system at the state level has presented a number of challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. There is no estimated time when the 2010 hospital data will be ready for use. Because a new data collection process is being used, it will be recommended that the 2010 hospital data be used as a new base line as it may not be

comparable to previous year's data.

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

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

Notes - 2015

Narrative:
Preventing youth from starting to use tobacco begins with increasing their knowledge of the dangers of tobacco use, changing their attitudes toward tobacco use, and increasing public support for policies that reduce the likelihood that they will use tobacco. Evidence shows that media campaigns, when combined with other interventions, are effective in reducing tobacco use by youth and keeping them from starting smoking. NH is collaborating with the CDC to promote an extensive media campaign, Tips from Former Smokers. The campaign features real people suffering as a result of smoking and exposure to secondhand smoke. Their compelling stories send a powerful message: Quit smoking now. Or better yet -- don't start. This campaign will expand upon the first campaign and feature additional health conditions and population groups (American Indian/Alaska Native; Lesbian, Gay, Bisexual, and Transgender) that were not included in the first Tips campaign.

Trend data from YRBS from 1993-2013 overall shows a significant decrease in the current use of cigarettes by NH high school students over time. Female students, in particular, continue to demonstrate a steady decrease in current cigarette smoking over time.

In order to address smoking among youth, it is important to address environmental access. New Hampshire continues to partner with retailers as they help enforce state policy and law. Progress has resumed in improving tobacco merchant compliance with laws concerning tobacco sales to youth, tobacco sales to New Hampshire. According to the most recent compliance checks, tobacco sales to youth in NH dropped to 11.2% in 2013, down from 13.2% in 2012. New Hampshire continues to be well below the required Federal benchmark of 20%.

Research demonstrates that lower tobacco use by youth also decreases the chance that they will use drugs or alcohol.

In 2013, the Youth Risk Behavior Survey (YRBS) revealed that:

7.7% of the students smoked a whole cigarette for the first time before age 13 years; 8.9 % of males answered affirmatively as did 6.3% of females. This is a linear decrease from 2011 results, but not significant.

13.8% of the students smoked cigarettes on one or more of the past 30 days; 14.2 % of males answered affirmatively as did 13.2% of females. This is a significant linear decrease from 2011 results.

5.5% of the students smoked cigarettes on 20 or more of the past 30 days: 6.1 % of males answered affirmatively as did 4.9 % of females. This is a significant linear decrease from 2011

results.

IV. Priorities, Performance and Program Activities

A. Background and Overview

New Hampshire recognizes that the needs assessment process is continuous. Data and public input about our programs, populations and maternal and child health issues must be systematically reviewed annually. Results from the 2010 Statewide Needs Assessment, state and national performance measures, health systems and capacity indicators, public comment and community stakeholders provided an even richer, more comprehensive picture of the Title V needs and capacities in our state. Together, the priorities represent each of the four levels of the MCH pyramid and all MCH population groups.

State government, community based organizations and systems of care must implement systemic change in order to make substantive improvements for the Title V population. To affect needed change, Title V must select among many possible priorities. This is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. In the past decade, NH's Title V planning and prioritization process has become stronger, more structured and much more deliberate in order to meet the health needs of a population growing in its diversity. It is imperative to continue to methodically move towards reducing health disparities and enhance the cultural competency of local and state MCH programs. Similarly, recognition of other social determinants influencing health outcomes -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities and State Performance Measures (SPM) have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

SPM 1: The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder.
Addresses Priority 1: To improve access to children's mental health services.
.
SPM 2: Percent of 3rd grade children who are overweight or obese.
Addresses Priority 2: To decrease pediatric overweight and obesity

SPM 3: Percent of 18-25 year olds reporting binge alcohol use in past month.
Addresses Priority 3: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

SPM 4: Percent of Community Health Centers providing on-site behavioral health services.
Addresses Priority 4: To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.

SPM 5: The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays.
Addresses Priority 5: To improve access to standardized developmental screening for young children.

SPM 6: The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash
Addresses Priority 6: To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

SPM 7: The percent of households identified with environmental risks that receive healthy homes assessments.
Addresses Priority 7: To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments.

SPM 8: Percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range.
Addresses Priority 8: To improve oral health and access to dental care.

SPM 9: The percent of families with children/youth diagnosed with severe emotional disturbance, moving into permanency placement through DCYF, who have access to a trained respite provider for up to 50 hours during the first year of placement.
Addresses Priority 9: To increase family support and access to trained respite and childcare providers.

SPM 10: The percent of preterm births to mothers who reported smoking before pregnancy.
Addresses Priority 10: To decrease the incidence of preterm birth.

Once priorities are set and the appropriate metrics for evaluation are assigned, it is critical that strategies and interventions are aligned with existing Title V capacities and leveraged with collaborative partnerships.

For example, children and youth from low-income families are at an increased risk for mental health disorders and in NH, the Medicaid population presents with twice the service use prevalence for mental health services compared to privately insured children. In rural areas, the prevalence of children with mental disorders is similar to that in urban areas, but there are increased barriers to care, resulting in delayed treatment. There are additional significant geographic disparities in capacity. The northernmost counties do not have the mental health workforce, especially those who are trained to meet the needs of children. Community health centers, among other providers, are left to try, at best, innovative and integrated methods to address growing needs. Therefore, to measure access to service, Title V will measure the rate at which adolescents on Medicaid with a documented mental health disorder have a documented annual psychotherapy visit. This measure, also used by the NH Office of Medicaid Business and Policy, will help us better understand whether or not adolescents are receiving appropriate care. Further analysis will allow us to look for regional disparities.

Several of NH's priorities and performance measures lend themselves to collaborative and integrated interventions. Title V will utilize strategies like Text4Baby, a mobile phone-based health promotion program, while developing new partnerships to build infrastructure and strengthen enabling services. By measuring smoking prevalence rates, NH will maintain focus on one area where our state does not compare as favorably when compared to other states. Through continued multi-pronged efforts like social media messages to quality improvement efforts to increase adherence to the 5 A's, Title V ultimately will impact the rate of preterm birth.

Annual report accomplishments, current activities, and planned activities for each of the 18 National Performance Measures and other outcome measures and indicators are discussed in the following sections.

/2015/
In 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan
(NH SHIP), "Charting a Course to Improve the Health of New Hampshire". The NH SHIP sets priorities to improve the health status of New Hampshire's people. It highlights 10 key health areas and associated health outcome indicators that reflect the most significant health issues currently facing our population. Its aims are to assist state and community leaders in focusing their work to improve the public's health and to promote coordination and collaboration among public health partners. The strategies proposed for each priority area are based on evidence and designed to have a high impact on the health of the population.

Because of the broad lifecourse impact of MCH issues, Healthy Mothers & Babies is

highlighted as one of the 10 key health areas in the NH SHIP. Specific objectives and strategies are outlined for premature birth; autism spectrum disorders (ASD); oral health for children; and teen pregnancy. Other areas of the plan address Obesity/Diabetes, Injury Prevention, including suicide, injuries to teens from motor vehicle crashes, and the Misuse of Alcohol and Drugs are other key health topics addressed in the NH SHIP, all of which have a profound impact to the health and well being of the MCH population.

These Division priorities align with New Hampshire's Title V priorities. By using a Collective Impact framework, MCH now shares a common agenda, shared measurement, mutually reinforcing activities, and continuous communication with internal and external partners. The Division of Public Health Services and MCH act as the Backbone Organization for many of these activities, coordinating and monitoring local initiatives and accelerating change.
//2015//

B. State Priorities

STATE PRIORITIES

The New Hampshire Title V Needs Assessment is intended to be a living document that will inform stakeholders and community partners and focus the direction of program design and resource allocation. It is anticipated that the activities described below will be modified as they are continuously evaluated.

To improve access to children's mental health services

Access to mental health services continues to be an identified need in New Hampshire, and the need for these services is great. An estimated 20% of New Hampshire children aged 5-19 have a diagnosed mental disorder, 3-5% of children are estimated to have attention disorder and 0.7% were diagnosed with an autism spectrum disorder. Mental and behavioral health disorders can impact a child's emotional, intellectual, and behavioral development and can hinder proper family and social relationships. Treatment capacity for mental health issues is limited in the state, and concerns about cost are a considerable barrier for families seeking care, regardless of insurance status.

Because of these needs, activities in the following year will include: maintenance of community health center (CHC) funding that provides incentives for increased integration of behavioral health services in primary care; education of CHC staff about use of validated screening tools for specific MCH populations including early childhood, adolescence and perinatal periods; partnerships with experts in psychopharmacology to provide training to CHCs; statewide collaborative activities on perinatal depression; and recommendations for statewide systems improvements in Maternal Mortality Review

Strategies for CHYSCN include: exploration of using Title V/CSHCN funds to create psychiatrist consultation available for primary care providers for children managing psychiatric medications and participation in DHHS evaluation of feasibility of an In-Home Supports Waiver for children with diagnosed mental health disorders.

To decrease pediatric overweight and obesity.

Obesity in children and adolescents in the United States of America has become a critical health problem with enormous health and economic costs. More than 29% of NH school aged children are overweight or obese. There are disproportionate effects among low-income families, families of certain ethnic groups and families where there is parental obesity. Children living in poverty in less educated families as well as children of Hispanic and African American background are more

likely to be overweight.

Title V will take an integrated approach to address this issue that has life course and population health ramifications. Strategies will include: increased breastfeeding training for providers; education of CHCs about recommended protocols to follow when BMI is > 85 percentile; education and strategies about family engagement and how to talk to parents about overweight/obesity issues, and ensuring all eligible families are enrolled in WIC. SMS coordinators will document the BMI of children with special health care needs newly enrolled in the Care Coordination program upon receipt of primary care records and identify appropriate referrals for those overweight or obese children. All children in the Neuromotor clinic will have their BMI assessed at clinic visits and identify appropriate referrals for those overweight or obese children. Both SMS and MCH staff will continue participation in I Am Moving, I Am Learning trainings for childcare providers. Additionally, technical assistance from the Region I Knowledge to Practice resource will focus on understanding the lifecourse implications and strategies for including CSHCN into statewide overweight and obesity initiatives. This is scheduled for the Fall 2010 with expert assistance from Boston University.

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

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. In NH in 2007, 21.7% of women of childbearing age smoked, compared to 21.2% of women overall in the U.S. YRBS data reveals that 45% of NH high school students had an alcoholic drink in the past 30 days and 28% participated in binge drinking. Over 50% of NH young adults 18-25 participate in binge drinking.

Because of the cross cutting health and social needs related to tobacco, alcohol and substance abuse, the following strategies are being implemented: CHCs will use validated screening tools for specific MCH populations including adolescence and perinatal period; innovative collaborations, such as the home visiting partnership with Child and Family Services, to provide home --based TWEAK assessment and referrals for treatment to alcohol abusing pregnant women; social media messaging with high school students combining binge drinking and sexual violence messages. MCH will continue partnerships to address smoking cessation activities with specific MCH populations including youth, adolescents and pregnant women.

To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

Uninsured children are at higher risk for negative long-term effects on health and economic productivity than insured children.(9) The uninsured use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they tend to be sicker and at more advanced disease stages than the insured. This contributes to higher rates of morbidity and mortality for the uninsured both in general and for specific diseases.(11) Although NH compares favorably to the U.S. for rates of uninsured children, there are age and income disparities.

Title V staff will continue to work with Community Health Center staff as they track/monitor when children's Medicaid coverage is about to lapse in order to decrease "churning" thereby increasing retention and improving "re-determination" rates. MCH will continue to monitor performance measures of direct and enabling services, which ensure that all eligible children are continuously enrolled. NH Family Voices and SMS staff provides assistance via phone and mail out packets regarding what to bring to the District DFA Office when applying for TANF and HKG, including HC-CSD. At the state systems level, Title V staff will continue to collaborate with SCHIP and Medicaid staff on state/local level on initiatives.

Beyond simply having access to an insurance product as a means to care, Title V will specifically

work with community health centers to increase their capacity to integrate mental health services with primary care to enhance access. To accomplish this agencies will provide training for primary care staff about behavioral health issues; provide training for behavioral health staff on the use of the electronic medical record; and encourage case management to coordinate primary care and behavioral health care. MCH will fund a variety of models of care and will facilitate the exchange of information from successful programs to others.

To improve access to standardized developmental screening for young children

Nationally, 17% of children have a developmental or behavioral disability such as autism, intellectual disability (also known as mental retardation),or Attention-Deficit/ Hyperactivity Disorder (ADHD); there are additional children with delays in language or other areas. Less than half are identified before starting school, impacting future development and readiness to learn. Improved standardized developmental screening identifies these delays early and enables children to receive early intervention services to be better prepared to learn when entering school.

Title V will coordinate with partners across systems to ensure that families have access to developmental screening for their children and will assist parents with the completion of ASQ & ASQ/SE through Home Visiting New Hampshire programs and the Watch Me Grow initiative. MCH and SMS will also work with partners to: promote and support connections between professional organizations and service providers; participate in workgroups of the Autism Council and collaborate on submission for funding opportunities to create regional teams of experts on autism.

To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

Injuries are among the most serious and under-recognized public health problem. In New Hampshire and in the U.S., unintentional injuries are the leading cause of death and hospitalization to children and adolescents, killing more in this age group than all diseases combined. Injuries are predictable and preventable through a public health approach. In the time period 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes. In NH, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24.

Activities for motor vehicle injury prevention will include: development of a website hosted by the Department of Transportation geared towards parents of novice drivers; implementation of parent survey on graduated drivers licensing; facilitation of NH Teen Driving Committee on a monthly basis; revision of teen driving component of Strategic Highway Safety Plan.

To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

A growing body of evidence links housing conditions to health outcomes such as asthma, lead poisoning, lung cancer, and unintentional injuries. Children, especially those under age 6, are more likely to suffer persistent developmental delays, learning disabilities and behavioral problems as a result of their exposure to lead. Approximately 30% of New Hampshire housing stock was built prior to 1950 when lead paint was commonly used.

Morbidity associated with asthma is high. Emergency department use, hospitalization, decreased lung function and death can characterize the experience of both adults and children with uncontrolled asthma. Approximately 10% of NH adults and 8% of children currently have asthma

and the prevalence is increasing. Approximately one-third of all New Hampshire children live in homes where a person smokes, making exposure to tobacco smoke a significant problem for these children. Health disparities for asthma occur by gender, age, educational level and household income.

By taking a "Healthy Homes " approach to these issues, MCH will address the environment and systems that affect the lives of families throughout the state. MCH will work with state and local partners to increase the number of Healthy Homes Specialists credentialed in throughout the state; create an operational checklist, protocols, and referral network for healthy homes activities; and increase home visits for healthy homes assessment, education, outreach.

To improve oral health and access to dental care

Tooth decay is the most common chronic childhood disease, and is largely preventable through a combination of community, professional and individual strategies. Like the adult population, many children from low-income, uninsured families do not have access to regular oral health care and education. Many dentists do not accept Medicaid clients, nor do they have a sliding fee scale. Community water fluoridation is underutilized in New Hampshire. The NH Third Grade Healthy Smiles-Healthy Growth Survey found that approximately 44% of NH 3rd grade students experienced tooth decay and 12% of students had untreated decay at the time of the survey. Regional disparities in oral health were detected. Children attending schools with a higher free and reduced lunch program participation rate, as well as all students in Coos County, were more likely to have experienced decay, have untreated decay, and be in need of treatment, and they were less likely to have dental sealants.

In addition to traditional direct and enabling services to increase access to oral health care, Title V will work in partnership with the DPHS Oral Health Program and the NH Department of Environmental Services (DES) to enhance the quality of the fluoridation of municipal fluoridation systems. The state fluoridation administrator will be responsible for managing the fluoridation system by promoting water fluoridation while the Title V staff will liaison with local systems to encourage appropriate levels of added fluoride in their systems. To build capacity and infrastructure, MCH will help facilitate fluoridation courses with DES to train water plant operators.

To increase family support and access to trained respite and childcare providers.

Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home; half of these families reported having to cut work hours to care for their child even while experiencing financial distress. The need for respite care for CSHCN is increasing, and availability of providers is limited. There are no coordinated respite services and extremely limited funding; what is available is not equally distributed throughout the State in the area of developmental disabilities. There is no respite funding available for behavioral health and an extremely limited number of respite providers with training.

Because this need was so strongly stated by families who most need this service, SMS plans to build public awareness and education about respite resources. SMS will create a competency-based curriculum with competency-based training and registry of respite providers and coordinate a Lifespan Respite Coalition.

To decrease the incidence of preterm birth

Preterm birth has enormous health, social and economic costs. Smoking during pregnancy accounts for 20-30% of low-birth weight babies and up to 14% of pre-term births. Of women using MCH-funded prenatal clinics (during the period 7/1/07-6/4/09), 43.2% smoked 3 months prior to becoming pregnant. Disparities are evident among racial, ethnic and socioeconomic groups. Since 1990, teens and young adults have had the highest rates of maternal smoking during

pregnancy. Thirty-seven percent of NH women on Medicaid smoked during pregnancy. Interventions such as reducing maternal smoking have the potential to reduce the preterm birth rate and improve the health of infants and children and are within the scope of Title V responsibilities in expanding preconception care.

In order to address and understand the many causes and drivers of preterm birth, MCH will work with partners to develop the Maternal Mortality Review Panel; build the capacity of CHCs to better support smoking cessation to pregnant women and women of reproductive age; and develop a plan for preconception health that integrates models of chronic disease prevention and reproductive health.

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	27	14	20	26	25
Denominator	27	14	20	26	25
Data Source	screening records	screening records	screening records	screening records	screening records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

RSA 132:10-a requires that all infants born in New Hampshire be screened at birth for a panel of thirty-three (33) disorders, as determined by the State. This statute includes a clause, 132:10-c, which allows parents or guardians to refuse this screening if they so desire. NH DHHS, Division of Public Health Services, Bureau of Population Health and Community Services, Maternal and Child Health Section has responsibility for oversight of the Newborn Screening Program. This includes daily management of screening results; assuring that all infants born in New Hampshire are screened; assuring that screening is timely and complete for each infant and that any infants identified through this process receive timely referral to specialty care for confirmation of diagnosis and initiation of treatment.

The NH Newborn Screening Program managed the programs essential daily tasks: daily reporting out of results to birth hospitals; daily data linkage with vital records to assure that all newborns receive newborn screening; technical assistance to birth hospitals, midwives and providers as needed; tracking and follow-up of infants who missed screening or who need repeat screenings or further evaluation by specialists. (PB)

SYSTEMS BUILDING:

Provided Quality Assurance (QA) Reports to New Hampshire birth hospitals biannually with statistics on newborn screening performance. (IB)

Amended contract with current NBS lab to continue contract for FY14 and 15.

Continued utilizing services of the Medical Consultant via a Service Delivery Agreement. (IB)

Updated internal protocols program's Internal Operations Manual. (IB)

Worked with a MPH intern on improving follow-up for babies determined to have hemoglobinopathy traits. Results included revising provider and parent handouts. (IB)

Partnered with Dartmouth College's Children's Environmental Health and Disease Prevention Center and UMASS to facilitate use of residual dried blood spots for research. The goal of this study is to better understand health impacts of exposure to arsenic and to evaluate whether this exposure affects physical growth and neurological development. Families opt in to participate in this voluntary research. (IB, PB)

REGIONAL AND NATIONAL EFFORTS:
Participated with the New England Genetic Collaborative (NEGC) in a demonstration project for statewide screening for Critical Congenital Heart Defect (CCHD). (IB)

Participated in regional activities including New England Regional Genetic Group (NERGG), New England Metabolic Consortium Annual Meeting and NEGC.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Manage essential daily tasks of the program.			X	
2. Support work of the Newborn Screening Advisory Committee around screening for CCHD and SCID.				X
3. Provide formal feedback via QA Report to New Hampshire birth hospitals and home birth providers biannually with statistics on various aspects of the newborn screening process.				X
4. Perform Data Linkage Process daily and monitor findings (refusals and misses) of this process.				X
5. Support educational efforts regarding newborn screening through periodic presentations and dissemination of newborn screening brochures.				X
6. Utilize services of the Metabolic Medical Consultant via the Service Delivery Agreement for handling clinically significant metabolic screening results.				X
7. Participate in regional efforts including NERGG, New England Metabolic Consortium, and NEGC.				X

8. Participate in regional demonstration project around screening for CCHD, awarded to Monica McClain, University of New Hampshire.				X
9.				
10.				

b. Current Activities
The NH Newborn Screening Program continued essential daily tasks. (PB)

Monitoring numbers of both refusals and misses to better target educational efforts. (IB)

Responding to requests for educational presentations and provide educational brochures to New Hampshire birth hospitals, midwives and providers as needed. (PB) (E)

SYSTEMS BUILDING:
Support the work of the Newborn Screening Advisory Committee. Both chairmen of the committee resigned early in FY 14, a meeting has not yet taken place. It is anticipated that with a new Title V Director coming on board in Spring 2014, meetings will resume in Summer/Fall 2014. (IB)

Provided QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)

Began making site visits to birth hospitals. (IB, PB)

Utilized services of the Medical Consultant via a Service Delivery Agreement and assessed the benefits of this service for state medical providers. (IB)

Completed the Service Delivery Agreement with the Metabolic Medical Consultant for FY 15 and 16. (IB)

Continuing to develop and update internal protocols for inclusion in the program's Internal Operations Manual. (IB)

REGIONAL AND NATIONAL EFFORTS:
Continued participation in regional activities including NERGG, New England Metabolic Consortium and NEGC. National activities, APHL IDF, CCHD, National DBS Legal Issues (IB)

Executed a successful celebration of the 50th anniversary of Newborn Screening in September 2013. (PB)

c. Plan for the Coming Year
The NH Newborn Screening Program will continue essential daily tasks, including: daily reporting out of results back to birth hospitals; daily data linkage with vital records; provide technical assistance to birth hospitals and providers as needed; tracking and follow-up of infants who missed screening or need repeat screenings or further evaluation. (PB)

Continue monitoring numbers of both refusals and misses to better target educational efforts. (IB)

Respond to requests for educational presentations and provide educational brochures to New Hampshire birth hospitals, midwives and providers as needed. (PB) (E)

SYSTEMS BUILDING:
Support the work of the Newborn Screening Advisory Committee. Plans for 2014/15 include:

further review and possible recommendation for the inclusion of SCID on the New Hampshire panel; discussion about the role of Public Health in CCHD screening; quality assurance/ monitoring; and long term follow-up. (IB)

To determine what support the home and center birthing community need to comply with the statute that mandates CCHD screening using pulse oximetry

Provide QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)
Continue site visits to all 20 birth hospitals. (IB, PB)

Utilize services of the Medical Consultant via a Service Delivery Agreement and assess the benefits of this service for state medical providers. (IB)

Begin work on a Contract for Lab Services for FY 16 and 17. Explore opportunities for increased timeliness of collection, delivery, receipt, and screening of specimens. (IB)

Continue to develop and update internal protocols for inclusion in the program's Internal Operations Manual. (IB)

REGIONAL AND NATIONAL EFFORTS:
Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and NEGC. (IB)

Attend National Newborn Screening and Genetic Testing Symposium October 27-30, 2014. (IB)

Participate with NEGC in demonstration project for screening for CCHD. The goal of this project is to develop processes for CCHD screening that will set the stage for improved health outcomes for newborns with CCHD, and their families. This project aims to enhance and expand existing networks among state public health departments and birthing facilities, and to share resources in developing CCHD newborn screening protocols, educational materials and programs, and program evaluation, including the development of new data collection systems, among five New England states. (PB, IB)

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12559**					
Reporting Year:	**2013**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria	12496	99.5	31	3	3	100.0

(Classical)						
Congenital Hypothyroidism (Classical)	12496	99.5	154	6	6	100.0
Galactosemia (Classical)	12496	99.5	2	0	0	
Sickle Cell Disease	12496	99.5	0	0	0	
Biotinidase Deficiency	12496	99.5	2	0	0	
Cystic Fibrosis	12496	99.5	60	11	11	100.0
Homocystinuria	12496	99.5	102	0	0	
Maple Syrup Urine Disease	12496	99.5	56	0	0	
Tyrosinemia Type I	12496	99.5	23	1	1	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	12496	99.5	1	0	0	
Citrullinemia	12496	99.5	1	1	1	100.0
Isovaleric Acidemia	12496	99.5	0	0	0	
Propionic Acidemia	12496	99.5	11	0	0	
Carnitine Uptake Defect	12496	99.5	2	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	12496	99.5	3	0	0	
Ornithine Transcarbamylase Deficiency (OTC)	12496	99.5	3	0	0	
Methylmalonic acidemia (Cbl A,B)	12496	99.5	11	0	0	
Multiple Carboxylase Deficiency	12496	99.5	2	0	0	
Glutaric Acidemia Type I	12496	99.5	3	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	12496	99.5	55	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	12496	99.5	3	2	2	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	12496	99.5	0	0	0	
3-Hydroxy 3-	12496	99.5	2	0	0	

Methyl Glutaric Aciduria						
Methylmalonic Acidemia (Mutase Deficiency)	12496	99.5	11	0	0	
Argininemia (Arg)	12496	99.5	1	0	0	
CPT II	12496	99.5	1	0	0	

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	75	75
Annual Indicator	60	60	74.9	74.9	74.9
Numerator					
Denominator					
Data Source	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	75	79	79	79

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
Special Medical Services demonstrated ongoing commitment to supporting Family partnership and involvement through a contract with NHFV. The contract with SMS did incorporate into the NHFV contract a component to address Parent-to-Parent activities and resources. NHFV had undertaken a statewide assessment of Family-to-Family connections. The initial report was completed and they continued to coordinate stakeholder meetings into the current year in order to create recommendations for services. Through this project they have created a video tutorial on the topic. The relationship between SMS and the parent partners participating in Phase III of Project Access (Improving the System of Care for children and youth with Epilepsy) continued as part of SMS' status as grantee. SMS as the Phase III grantee created a focus on Parent/Youth involvement and coordination of care efforts statewide. This began with the Statewide Needs Assessment. NHFV staff acted as the project Coordinator for the Project Access Phase 3 initiative. This project resulted in 6 Regional Family / Provider Forums with robust attendance.

SMS is the administering agency for a Family Support and community integration program called Partners in Health (PIH). This program is run in local communities (13 different sites) statewide with a focus on Family involvement and oversight. Each PIH site has a Family Council that leads the service visioning and community activity agenda. The Family Councils also determine the parameters and oversee distribution of flexible funding that is available through the program. A PIH Stakeholder group began meeting and included providers and representatives from Family Councils. One of the long-term objectives will be for it to also act as a Family Advisory to SMS. One of the Partners in Health Family Support Coordinators participated in the training for the "Powerful Tools for Caregivers for families of CSHCN" and hosted a family group experience using this validated model (See attached description).

An attachment is included in this section. IVC_NPM02_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to contract directly with NH Family Voices for family to family health education and program consultation				X
2. Collaborate with NH Family Voices and practice based parent partners working with clinical sites for Project Access				X
3. Require annual parent satisfaction surveys from all clinical programs	X	X		X
4. Recruit and involve parents and YSHCN on all planning and advisory groups				X
5. Increased coordination with Partners in Health program and statewide family councils				X
6. Statewide Needs Assessment on system of care for children/youth with epilepsy included parent and youth focus groups and a survey with representation from parents from all NH counties			X	X
7. Ongoing support of a training module for parents of children with disabilities based on the "Powerful Tools for Caregivers" curriculum		X		X
8. Statewide Needs Assessment on system of care for children/youth with autism through family focus groups and stakeholder World Cafes.				X
9. Special Medical Services program Needs Assessment and Satisfaction Survey for all service recipients				X
10.				

b. Current Activities

Special Medical Services remains committed to supporting Family partnership and involvement through a contract with NHFV. This partnership has developed into the current model used for 2 Federal Grants that have SMS as the grantee but through contracting parents (employees of NH Family Voices) are the coordinators for this important Quality and System of Care Improvement efforts. One of these grants is an Autism Planning Grant and has incorporated 8 Family Focus groups (2 of them hosted for Spanish speaking families). The other is the Project Access grant and included a Parent Survey.

SMS administered a statewide family satisfaction survey on all service areas with a significant component of Needs Assessment related to the Core Outcomes for CYSHCN. The survey's response rate was approximately 22% and was a proportionate representation of program enrollment. Survey respondents represented a cross section of families served in each area of the state, in the catchment areas of each program, and from a diverse cross section of served family members. Family satisfaction with services was high, rated as good or excellent by 80.5% of respondents and 84.7% of respondents indicated that they were likely to refer a fried or family member for these services

c. Plan for the Coming Year

Special Medical Services has evidenced a long-term and ongoing commitment to support Family partnership and involvement. This will be demonstrated by an ongoing contract relationship (in place for 2 decades) for State fiscal year 2015. MCH and SMS remain committed to a collaborative relationship with NH Family Voices including participation of NHFV in the Title V Block Grant reporting and planning meetings. All SMS supported programs (contract and state supported) will continue to be required to conduct and submit parent satisfaction surveys focusing on quality of care indicators. Since SFY 2009 all agency contracts with SMS have had a funded

line item for cultural and linguistic supports in order to make services more accessible and responsive to families.

The work of the family-to-family stakeholder group will continue to be disseminated and incorporated into resources and recommendations. SMS will review these recommendations and begin to put in place the supports and structure needed to implement them. SMS is the grantee for a federal MCHB grant to support statewide planning for Autism and other Developmental Disabilities. The plan for the coming year will continue to see NH Family Voices as the major contractor and the project coordinator will be a staff member of NH Family Voices who is also the parent of children Autism Spectrum Disorders. This process with include additional work to insure that family's input is fully captured and that their perspectives will be fully incorporated into the State Plan that will be created. This will be achieved by hosting 6 family focus groups around the state.

The relationship between SMS and the project coordinator (NH Family Voices staff) for the Project Access activities (a Federal Grant to Improve the System of Care of children and youth with Epilepsy) will continue. SMS is responsible to maintain and spread these efforts, which relies heavily on the expertise of the project coordinator. She will insure involvement of the parent partners and youth coordinator at clinical sites. The coming year will represent activities for the second year of Phase 4 of the National Project Access project (NH's application focused on creating a consultation model and transition clinic) with baseline and updated family input.
SMS applied for and was chosen to have the assistance of a MCHB funded Graduate Student Intern. The intern is evaluating the SMS Satisfaction Survey and Needs Assessment in detail and will offer guidance on how to use the results as part of the 5 Year Needs Assessment report. The intern will also work with SMS to identify how the newly released Standards for Systems of Care for CSHCN can be braided with the survey results.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	49.6	49.6	49.4	49.4	49.4
Numerator					
Denominator					
Data Source	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	50	50	55	55	55

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
Special Medical Services has continued to support Medical Home Improvement through a funded contract. Last year the contract was with the Center for Medical Home Improvement. The ongoing focus has been to enhance existing health care systems in New Hampshire for CYSHCN, to provide explicit, proactive care including identification, care coordination, advocacy and patient / family education. Obstacles to improving primary care for CYSHCN include limited consumer involvement, inadequate provider reimbursement, poorly defined professional roles

and a lack of systematic approaches to care. Based on these issues, activities of the funded project have included, but have not be limited to, the following:
-Initiation of communication regarding The Medical Home Model with community based agencies and within the health cares system.
-Development of awareness project of The Medical Home Model to include hospital and health network leadership, parent and families.
-Facilitation of dialogue with public/private payors regarding reimbursement for care coordination activities within Medical Home
-Provision of technical assistance to interested medical practices.
-Support for improved practice based health care transition

Due to CMHI's role as the National Health Care Transition Center (NHCTC) "Got Transition" SMS was also able to improve NH Title V's linkages and engagement with CMHI at several levels and within the NHCTC promotion and dissemination of transition information as it relates to medical home.

SMS' Project Access activities had a strong focus on Parent/Youth involvement and coordination of care efforts statewide, both major components of Medical Home development. The Project hosted Care Coordination Forums to focus on role identification, incorporating family/youth perspective into planning and communication across domains. This fostered development of a system of communication that interconnects coordination of care across all domains impacting the health and well being of children and youth.

Finally there has been a great deal of work on both Care Coordination and Care Plans. The NH CYSHCN Director has been a participant of the development group working on a national project, funded by the Lucille Packard Foundation, to create Shared Care Plan Standards. Additionally, SMS has been creating a plan to develop Core Competencies of Care Coordination, which will also increase and improve the Medical Home experience for children, youth and families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SMS incorporated learning and achievements from transition of activities from Phase 2 to Phase 3 of Project Access			X	X
2. SMS Administrator participation in the Medical Home workgroup of the New England Genetics Coalition			X	X
3. Ongoing efforts to participate and advocate for state of NH efforts at incorporating Medical Home language and tenets into services				X
4. Continued contract with NH Family Voices for NH Medical Home initiatives				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The contractor for the past 5 years , the Center for Medical Home Improvement (CMHI), has decided to cease operations therefore an open Request for Proposals was issued and 2 competitive bids were received. After final review the bid submitted by NH Family Voices was

awarded the contract. NHFV has focused on increasing political and public understanding from a grassroots perspective. This is being achieved by placing an emphasis on addressing the role of family partnerships in Medical Homes in order to spread the model. National attention has been brought to forefront related to the fact that Family partnerships has been the component of Medical Homes that continues to need the most attention/support. NH's opportunity to have the Family to Family Organization lead the systems improvement efforts will inherently incorporate a focus on family partnership development. SMS' grant activities related to Epilepsy and Autism have both incorporated components to assess family perspective/need on Medical Homes along with improvements to the self report of these CSHCN as experiencing health care in Medical Homes.

c. Plan for the Coming Year

For the seventh consecutive year, Medical Home development efforts for CYSHCN are being supported with a contractual arrangement funded by SMS. NH Family Voices will also work on integration of medical home development and collaboration with State Stakeholders and assisting policy development in the State of New Hampshire to be consistent and in keeping with the principles of a patient and family-centered, effectively coordinated, medical home. NHFV will be identifying a new Primary Care champion to participate in their efforts, as the previous champion is no longer practicing in New Hampshire.

The involvement of SMS in Project Access will continue as a part of the Phase IV, for which NH's proposal will focus on offering practices support and addressing the ongoing issue of defining components of care coordination for children with epilepsy, across service sectors. With Phase IV funding NH will significantly upgrade the supports available to practices for communication and coordination of care along with the creation of a Transition Clinic with a Medical Home emphasis.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67	67	68	66.5	66.5
Annual Indicator	67.3	67.3	66.2	66.2	66.2
Numerator					
Denominator					
Data Source	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	66.5	66.5	70	70	70

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
SMS continued to participate in statewide and programmatic planning to improve the percentage of children with adequate insurance. These efforts have been related to those CYSHCN who are 0-18 years old and also included the needs of young adults 18-21 years old. SMS continued to work with identified partners in New Hampshire who were interested in improving the access to and adequacy of insurance for children, including CYSHCN. These groups included the NH Children's Advocacy Network, the Council for Children and Adolescents with Chronic Health Conditions (this Council changed its name to the Council for Youths with Chronic Conditions) and NH's Autism Council. The Autism Council is charged with the need to improve public and private insurance coverage for recommended services for those children and youth diagnosed with Autism Spectrum Disorder, SMS' Administrator (Collins) is a workgroup chair. The population that SMS saw the greatest need from were children who were legal residents but had been so for less than 5 years (and therefore were not eligible for Medicaid) and for youth ages18-21 who aged out of HC-CSD and/or their parents private health insurance (in some instances

they had the option to continue on their parent's plans but found them too expensive for this to be a feasible plan).

SMS' alignment with the Bureau of Developmental Services has allowed for collaboration with other programs that offer support to families. SMS continues to participate in planning discussions about ideal sources of support as well as when it is appropriate to collaborate and "braid" funding to meet the needs of CYSHCN. SMS sponsored/contracted services (i.e.: clinics, nutrition, feeding & swallowing) continued to explore and expand third party reimbursement. This has helped to build the infrastructure necessary to allow for increased capacity to serve those children without insurance. In addition, SMS continued to maintain its Equipment Bank, which allowed children to access DME that has been used but refurbished by a Certified Equipment Vendor.

The SMS HC-CSD Coordinator continued to provide intake services, care coordination and service utilization for children newly accepted for Medicaid by the HC-CSD eligibility pathway ("Katie-Becket like"). SMS also continued to outreach to children and youth newly enrolled in SSI. Care coordinators have continued to familiarize themselves with options for insurance and other financial resources (local, state, regional and national) for families to access, this included being aware of ACA reforms and state Medicaid changes.

SMS has continued to support the costs of some health related needs for children and youth, who met financial eligibility criteria (>185% of FPL). SMS budgeted monies to support these needs (ex: DME, medications, specialty services/providers and transportation). The need for these funds as it relates to Insurance coverage and Insurance adequacy had increased.

NH had a program that was available, through the agency that administered the CHIP program, to families whose income fell between 300-400% of the FPL. It was also available to families of CYSHCN who were legal aliens but had not been so for more than 5 years, since NH did not apply for the CHIPRA expansion that would have allowed these children to be eligible for Medicaid. As of July 1, 2012 NH opted to integrate CHIP into Children's Medicaid and the "Buy In" option was eliminated. The SMS' Administrator had been involved in the communications workgroup for CHIP coverage transitioning to Medicaid. SMS successfully wrote for a small grant from the National Center on Ease of Use of Services. The group's focus was to craft messaging and community events that would meet the needs of Latino Families of CYSHCN so that they could understand the significant changes being made to NH's Medicaid system. These changes included the planned transition to a Managed Care design which was delayed past its original initiation date, enrollment and implementation did not begin until October 2013.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Follow up on all SSI referral transmittals with information and referral and outreach		X	X	X
2. Outreach and short-term coordination for families of children enrolled in Medicaid based on their chronic health condition		X	X	
3. Exploration of strategies for insurance re-imbursement for nutrition services continue			X	X
4. Revision of SMS policy/procedure and data collection methods continue				X
5. Collaboration on statewide coalitions and groups addressing access to services in NH				X
6. Coordination of supports to families of CYSHCN related to		X		X

Managed Care services and upcoming Mandatory enrollment				
7. Development of Proposal for NH Medicaid State Plan coverage for Applied Behavioral Analysis				X
8.				
9.				
10.				

b. Current Activities
NH families have faced both the issue of ACA implementation as well as the change in NH Medicaid to a Managed Care system. Children with Special Health Care Needs were identified as voluntary enrollees and SMS worked closely with Medicaid and community partners to make sure families had accurate information about how to best insure their child's access to healthcare. (Please see the attached tool created in collaboration with NH Family Voices) SMS worked with Medicaid and the Managed Care Organizations (MCO) to insure that children enrolled in SMS were identified as voluntary and that those families who opted to enroll in an MCO continued to receive services seamlessly. The CYSHCN Director has had the opportunity for several meetings with MCO representatives to fully maximize the service array's supporting families of CYSHCN and to problem solve difficulties or barriers that families have experienced. There have been some barriers particularly related to processes for Prior Authorization for services, continuity of care with Specialty Care Providers and Medications. The CYSHCN Director has continued to work with MCO staff and with the Department of Health and Human Services Liaisons for each MCO to resolve family and vendor concerns.
An attachment is included in this section. IVC_NPM04_Current Activities

c. Plan for the Coming Year
NH has had an altered course related to consideration of Medicaid Expansion but the determination as been made to move forward. NH has created a program named the NH Health Protection Program. This program will begin enrollment in July 2014 and enrollees will begin to receive services in August 2014. The opportunities for Young Adults with Special Health Care Needs to be covered by the NH Health Protection Program are being actively evaluated and pursued. NH's plan for Managed Care includes the incorporation of all Long Term Care Services, which will be phased in over the next year. Part of this plan is to change the status of CYSHCN from Voluntary to Mandatory status. Families whose children are on Medicaid but have currently opted out of Managed Care (approximately 70% of SMS enrollees) will need additional assistance to make sure that they understand the Managed Care Organizations options that they will have to choose from. There has been an additional challenge in that one of the three Managed Care Organizations who contracted with the state of NH (Meridian) has opted to cease involvement in NH Medicaid. This change significantly decreases family choice as CYSHCN are transitioned into Managed Care. SMS Care Coordinators have already begun to collate the information needed to help families to make the best decision for their children regarding choosing a Managed Care Organization that will best meet their child's health care needs.

SMS does have a cooperative relationship with Medicaid and will continue to advocate for the needs of CYSHCN and the plan for mandatory enrollment in Care Management comes to fruition. SMS will continue to work with identified partners in New Hampshire who are interested in improving the access to and adequacy of insurance for children, including CYSHCN.

The HC-CSD Coordinator (this position was vacant for 4 months in FY 12 but the new Coordinator has completed orientation and is fully integrated into the role) will continue to work with Medicaid (Disability Determination and Prior Authorization departments) and Family Voices to provide intake services, care coordination and service utilization for children newly accepted for Medicaid by the HC-CSD eligibility pathway ("Katie-Becket like"). SMS will also continue its outreach to the children, from NH, who are newly approved for SSI.

SMS' grant from the National Center on Ease of Use of Services has officially ended but due to

the ongoing changes to the timeframe for implementation of the Medicaid Care Management Project the NH partners on this project are planning to continue to work on crafting messaging and community events that will meet the needs of Latino Families of CYSHCN so that they can understand the significant changes being made to NH's Medicaid system.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	86	67	67
Annual Indicator	85.8	85.8	67	67	67
Numerator					
Denominator					
Data Source	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	67	67	70	70	70

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

Special Medical Services (SMS) has had a longstanding collaboration with the NH Social Security office and the NH Medicaid office that allows for these entities to share with SMS the contact information for children/youth newly enrolled in their programs, when the child is qualifying based on their own health condition. SMS has continued to outreach to these newly identified CSHCN through regular referrals as well as case finding via our SSI Transmittal Outreach project and to children approved for the "Katie Beckett" waiver known as Home Care for Children with Chronic and Severe Disabilities. All newly identified children through this collaboration receive outreach. Those with primary mental health and developmental conditions receive Information and Referral packets with local and regional contacts and resources. Those with primary medical conditions receive written and phone contact with some short-term outreach, by a Nurse Coordinator, and if indicated enrollment in Care Coordination. The health care coordinators and neuromotor clinic coordinators continued using the Complexity Scale and Levels of Care tools as part of their assessment and care planning with families. These tools were reviewed and final edits were incorporated (Final versions of the Tools are attached).

As follow up of the work on Core Competencies for Care Coordination SMS used the on-line training program that is based on the article "Making Care Coordination a critical component of the pediatric health system: a multidisciplinary Framework by Antonelli, McAllister and Popp May 2009. Use of the core competencies as part of orientation for new Coordinators began and one of the competencies was highlighted at each monthly meeting.

As part of care coordination development existing Health Care Transition tools were reviewed and Guidelines for a policy about interventions for health care transition activities for youth from age 14 through to 21 years of age were developed. The SMS Psychologist provided two education system presentations and continued his consultation to families referred by the Health Care Coordinators. Collaboration with the Partners in Health Family Support Coordinators and their Program Manager continued to assure best practices with families and clearer delineation of roles. An Information and Referral process that was developed with leadership from both the health care coordinators and the PIH family support coordinators was piloted. The pilot demonstrated a positive impact and the systems for referral and updating applications between

the two programs was improved.

NH has a strong network of school nurses and SMS has assumed responsibility for a robust web-based list serve for this group. This affiliation has improved recognition amongst school nurses as to the supports Title V has to offer and has allowed SMS to have direct and consistent communication with school nurses, therefore improving the coordination of care for CSHCN. Through the Federal Grant for Improving the Access to Care for Children and Youth with Epilepsy (Project Access) SMS has built upon the platform of partners to impact greater collaboration amongst these groups. There has been a great deal of work focused on incorporating school nurses into statewide coordination trainings and efforts. This will continue and the NH School Nurse Association has expressed a willingness to have training and skills building session related to Seizure Disorders. These condition specific efforts have demonstrated a positive impact on relationship building regarding other conditions and the overall system of care for CYSHCN.

An attachment is included in this section. IVC_NPM05_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuous improvement activities for care coordination-complexity /levels of care tools				X
2. Collaboration with Partners in Health Program through joint meetings and shared data.		X		X
3. Care coordination is offered statewide		X		X
4. Grant to continue quality improvement in the system of care for children with Epilepsy (and all CSHCN)	X		X	X
5. Continued collaboration with NH Family Voices			X	X
6. Completion of SMS Satisfaction Survey for Care Coordination and Neuromotor clinic coordination.		X		X
7. Ongoing supervision and support for current coordinators and orientation for new coordinators		X		X
8.				
9.				
10.				

b. Current Activities

SMS continued to have case presentations in the Care Coordination monthly meetings to improve validity of the Complexity Scale and Levels of Care. This also provided an opportunity to discuss other aspects of the Care Coordination role. For example, the topic of palliative and hospice care of our clients was addressed through an in-service program and literature review. Some collaborative work was done between the Health Care Coordinators and the PIH Family Support Coordinators including joint meetings on Bereavement, review of the Division of Child and Family Services programs as well as attendance at a state wide Collaboration meeting among child serving agencies.

This year a great amount of effort was directed to educating our families about the three new managed care companies that have contracted with Medicaid addressing issues specific to CSHCN and how to choose or opt out of the programs (as enrollment in Managed Care for CSHCN is voluntary). NH Family Voices provided an in-service on the ACA, a session on how families deal with their child's cancer diagnosis, help with Managed Care and also were valuable in orienting new staff. Internally, SMS also improved the systems for referral and updating applications. SMS has been working with a variety of intra departmental partners such as DCYF,

Medicaid, Behavioral Health and external partners including school nurses, parent and advocacy groups and others to improve the organize and communication about services.

c. Plan for the Coming Year

Special Medical Services has a plan to follow up on the work on Core Competencies for Care Coordination that SMS has reviewed and begun to incorporate into guidance and procedures. This will include the individual assessment and care planning process done for enrolled CSHCN. SMS will also study and determine how best to utilize and adapt the Standards for Care Coordination for CYSHCN developed by AMCHP and the Lucile Packard Foundation into our services and program design. Additionally, SMS Care Coordinators will be evaluating the recently released Lucile Packard Foundation brief on Achieving a Shared Plan of Care for CYSHCN. SMS is strongly invested in this effort, as the SMS Administrator was a member of the development team. These tools will inform the way we interface with the existing system of medical primary and specialty providers as well as the other members of the health care and community teams working with the child and family at the center of care. There is a strong interest in using the Care Coordination Curriculum developed at Children's Hospital Boston to help us tailor a training program for Care Coordination in New Hampshire. This would be reviewed for applicability to SMS Coordination as well as to the possibility that SMS could take the lead in training other Coordinators in the state.

The NH Family Centered Early Supports and Services (FC-ESS) program sits within the same Bureau as Special Medical Services (the Bureau of Developmental Services) and there is an interest in developing a process for referral from FC-ESS to SMS. The emphasis would be on delineating the roles of each of our programs for infants up to age three. Inherent in the process is the need to assure that infants with chronic, complex medical conditions are referred to Health Care Coordination by age 27-30 months so that we can assist the family with the transition and help with any pre-school planning or needed care coordination.

SMS is planning to develop a self-audit tool/checklist for the health record to assure all health care transition topics have been broached and that the transfer to adult health care has been completed or planned for adolescents and youth. Meetings between SMS Health Care Coordinators and PIH Family Support Coordinators will continue to better collaborate and serve jointly enrolled families. It will be important to review communication between the two programs in this year, as there is a plan in place to make PIH data more accessible.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	52	52	52	50	50
Annual Indicator	51.6	51.6	49	49	49
Numerator					
Denominator					
Data Source	National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN	2009/2010 National Survey of CSHCN
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	50	50	55	55	55

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

SMS and NH Family Voices have collaborated on transition initiatives since 2005 when we worked with pediatric practices to develop a model for the transition process. The Health Care Transition Coalition (HCTC), formed in 2005, continued its advisory role to help us develop strategies to promote health care transition. It is co-chaired by SMS and NH Family Voices. Some projects have included development of the youth transition group Youth Educating Adults about Healthcare. (YEAH), surveying Adult Health Care Providers about transition, developing the Ticket to Adult Health Care Independence Project (meeting with 69 pediatric and family practices to share transition materials) and working with Leadership and Education in Neurodevelopmental Disabilities (LEND) trainees to evaluate this project and help prepare a poster for presentation at the AMCHP conference.

Last year the Coalition provided workshops at the annual state Transition Summit, the Community of Practice in Keene and at the School Health Educators meeting, At these meetings Coalition representatives introduced health care issues, as part of a life skills assessment tool called "Ready? Get Set. Go! ", that need to happen for all YSHCN in various agencies including the education system. The HCTC met to help plan the content of the Summit presentation by reviewing the materials and asking selected youth to complete the assessment process so we could use their responses. A Health Care Transition web page is posted on the SMS website and the NHFV website and there is a Face book page for YEAH. SMS Health Care Coordinators offered transition assessment and education to families and youth on an ongoing basis.

SMS participated in the Got Transition National Advisory Committee (both the Title V CYSHCN Director and the Transition Coordinator) and the SMS Transition Coordinator attended the Got Transition Learning Collaborative and collaborated with statewide and regional stakeholders, including active participation in the NH Community of Practice on Transition, the Autism Council Independent Living Workgroup, and the Region I NEGC Transition workgroup.

Special Medical Services had a state contract with the Center for Medical Home Improvement that included activities related to dissemination and spread within NH of important lessons and recommendations made by Got Transition. The National Center for Got Transition changed from CMHI and SMS shared with the new leadership a willingness to continue participation in any capacity that would be of assistance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and coordinate health care transition activities				X
2. Meet quarterly with the Health Care Transition Coalition to develop initiatives and materials to educate youth and families and others about health care transition.				X
3. Expand membership on the HCTC to school nurses and transition coordinators				X
4. Health Care Coordinators (HCC) include health care transition for youth and parents as part of care planning utilizing an assessment process and standards.		X	X	
5. Participate in and present at collaborative educational programs with community partners to describe health care transition.		X		X

6. Collaborate with NH Family Voices and the YEAH Council facilitator on projects, including management of an internet presence, development of the web pages in SMS and NHFV and outreach education via web and conferences.		X	X	X
7. Provide health care perspective on Transition on state committees for post secondary transition and ASD as well as participation in the NEGC transition workgroup.			X	X
8.				
9.				
10.				

b. Current Activities
The HCTC met six times this year. The HCTC oriented new members, including two school nurses and two parents. Meetings focused on getting updated on Transition activities and working on a replacement for the "Ticket" materials to produce and distribute. It was determined that educational materials would focus primarily on families with a goal to reach a wider audience of families and youth through their schools, area agencies and others, including providers. The co-chairs of the HCTC group from NHFV and SMS had the opportunity to meet with the leadership team of a new State Personnel Development Grant education project called Next Steps-College, Career and Life Readiness. The co-chairs of the HCTC and the YEAH facilitator presented at three conferences. The YEAH group changed its name to Youth for Education, Advocacy and Health Care and they are developing more materials. The group has an Internet presence and has participated in several conferences.

The SMS Transition Coordinator worked with the SMS health care coordinators to produce standards to assure that certain basic knowledge and skills are assessed, reviewed and in place prior to discharge from SMS at age 21. The SMS administrator presented at AMCHP on Strategies to Facilitate Effective Health Care Transition for CYSHCN with Albert Hergenroeder, from Texas, and Marilyn Hartzell, from Oregon. This presentation focused on a 10-year data set of transition readiness surveys from NH's Neuromotor Specialty Clinics.

c. Plan for the Coming Year
The Health Care Transition Coalition is planning to create and produce an educational brochure or card and develop a distribution plan. The group is also considering doing a Transition Timeline. The HCTC will help SMS-NHFV to develop a plan to do increased outreach to area agency transition coordinators and school nurses about inclusion of health care transition in their client/student assessments. One promising opportunity is that our HCTC co-chairs are planning to meet again with the leadership team of a new State Personnel Development Grant from the Office of Special Ed project called Next Steps-College, Career and Life Readiness. The hope is to identify or develop some health transition materials they could use with the 12-16 high schools they will work with over the next three years perhaps using the Parent Information Center materials as a model.

The Health Care Transition page on the NH Family Voices website will be expanded to include materials used during the Ticket to Adult Health Care Independence project, such as the assessment tools and the Medical Summary forms as well as providing links to other national resources such as the GotTransition website. A pamphlet called "Growing Up Health Care Transition for Teens with Chronic Conditions - Tips for parents" will be distributed to SMS families of children 12 and older who are enrolled in our health care coordination and Neuromotor clinic programs when their annual application updates are sent out. This will provide a bridge to the conversations that staff might have with a family.

The SMS Program Manager/Transition Coordinator will continue active participation in the NH Community of Practice on Transition, the Autism Council Independent Living Workgroup, and the

Region I NEGC Transition workgroup. The SMS Program Manager/Transition Coordinator will participate in the development of a transition education process for the Partners in Health program (a statewide program offering Family Support to young adults and the families of children with chronic health conditions) as one of their initiatives.
The SMS Transition Guidelines will be promoted by reviewing transition plans at care coordination meetings. Overall the work will focus on improving transition efforts with youth and families by actively discussing transition topics at every transition assessment visit and identifying what topics need a care plan. There will be an active effort to engage primary care providers in transition and discuss how to integrate SMS' work with pediatric and family practice transition plans as well as to ask at school meetings if health care transition topics can be addressed in the IEP.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	86	87	86
Annual Indicator	81.0	75.8	86.8	79.7	81.9
Numerator	11528	10788			
Denominator	14233	14233			
Data Source	CDC Survey	CDC Survey	HRSA Email sent 5/16/12	HRSA Email sent 5/2/13	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	88	89	90	91	92

Notes - 2013
Rate is for vaccination coverage for the 4:3:1:3:3 series complete; among children 19 to 35 months; from US National Immunization Survey; 2012 data reported in 2013.

Data from CDC.gov website. Rate is 81.9 + or - 5.6.

Notes - 2012
Rate is for vaccination coverage for the 4:3:1:3:3 series among children 19 to 35 months, US National Immunization Survey 2011, per recommendation of Ellen Volpe (HRSA) in email sent May 2, 2013. Unlike previous years, MCH did not adjust CDC rate according to its most recent two-year old Census Population figure. Rate of 79.7 is + or - 6.1.

Notes - 2011

Rate is for vaccination coverage for the 4:3:1:3:3 series among children 19 to 35 months, US National Immunization Survey 2010, per recommendation of Vanessa Lee (HRSA) in email sent May 16, 2012. Unlike previous years, MCH did not adjust CDC rate according to its most recent two-year old Census Population figure. Rate of 86.8 is + or - 5.9.

a. Last Year's Accomplishments

BACKGROUND:

The State of New Hampshire presently purchases all vaccines recommended under the U.S. Childhood Immunization Schedule. They are purchased for all resident children, regardless of insurance coverage or income, through 18 years of age. The State distributes the vaccines to health care providers at no cost. No one is billed directly for the vaccines. This universal purchase and funding system was originally designed in 1991 with an insurers' fund created to pay for childhood vaccines not covered by federal and state funds. To ensure more proportionate contributions among contributing funders, the New Hampshire Vaccine Association, an independent, nonprofit organization was established through legislation in 2002. The New Hampshire Vaccine Association collects assessments from private insureres and remits the funds to the State. While the assessment model based on "covered lives" has been successful for 10 years, shifts within the insurance marketplace have placed constrainsts over the long-term efficacy of the current assessment mechanism.

STRATEGIES AND PARTNERSHIPS:

MCH worked closely with the Immunization Program staff to update/share information with the MCH-funded programs through emails, presentations at the twice yearly meetings with program coordinators from the state-funded community health centers and home visiting program. (PB, IB)

MCH reinforced Immunization Program quality assurance recommendations at MCH primary care site visits. (IB)

MCH staff kept informed of the latest changes in immunization practices by receiving Immunization Program email updates, attending the annual NH Immunization Conference, participating in the Immunization monthly conference calls, and attending the twice-yearly hospital-owned practice meetings, and encouraged similar participation by the state-funded community health centers. (IB, PB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the NH Immunization Program on any state or local activities.			X	X
2. Communicate immunization policy changes and immunization updates to Title V-funded primary care & home visiting agencies via the Immunization monthly conference calls, email updates, Immunization Program workshops and its annual conference.			X	X
3. Collaborate with the NH Immunization Program in using Co-CASA results and Immunization Assessment & Vaccine Management site visits results from Title V-funded community health agencies for MCH agencies quality assurance activities.				X
4. Attend NH Immunization Program sponsored meetings, conferences, and conference calls to stay current.			X	X
5. Carry out strategies with Title V-funded community health and home visiting to improve Hepatitis B #1 compliance.			X	X
6.				

7.				
8.				
9.				
10.				

b. Current Activities
MCH collaborates with other programs, coalitions, and early childhood efforts to assure that every effort is made to get all children appropriately immunized. (IB)

MCH staff continues to learn of the latest changes in immunization practices by receiving Immunization Program email updates, attending the annual NH Immunization Conference, participating in the Immunization monthly conference calls, and attending the twice-yearly hospital-owned practice meetings, and encourages similar participation by the agencies. (IB, PB)

MCH works closely with the Immunization Program staff to encourage reinforcement at MCH site visits of any Immunization Program quality improvement recommendations. (IB)

The MCH Child Health Nurse Consultant is participating in a project at The Dartmouth Institute for Health Policy and Clinical Practice (TDI), with three other DPHS students (from WIC, Disease Control, and the Immunization Program) and three TDI MPH students, to improve the immunization rate of the first dose of Hepatitis B from its current 8% refusal to 5%. Recommended strategies for improvement will be carried out in the end of FY14, into FY15. (PB, IB)

DPHS released a new RFP and entered into a contract for a immunization information system, VaxNH. VaxNH will provide confidential, population based, records of all immunization doses administered by medical providers throughout New Hampshire. (PB,IB)

c. Plan for the Coming Year

STRATEGIES AND PARTNERSHIPS:
MCH will partner with the New Hampshire Immunization Program's new immunization information system, VaxNH to identify non-immunized populations and develop policies that will improve the health of New Hampshire residents. (IB, PB)

MCH will continue to share the latest immunization information with its MCH-funded contract agencies through emails/mailings, conference calls and by inviting Immunization Program staff to an FY15 MCH Coordinators' meeting. (IB, PB)

MCH will be reviewing immunization rates, successes and obstacles via site visits and then assessing if this method provides better information than collecting it via workplan reporting, as was previously done. (IB)

MCH will continue to collaborate with other programs, coalitions, and early childhood efforts such as SPARK NH, the State's Early Childhood Advisory Council, and "Child Care Aware" (the state's child care resource and referral network) to assure that every effort is made to get all children appropriately immunized. (IB)

MCH will continue to learn of the latest changes in immunization practices by receiving Immunization Program email updates, attending the annual NH Immunization Conference, participating in the Immunization monthly conference calls, and attending the twice-yearly hospital-owned practice meetings, and encourages similar participation by the agencies. (IB, PB)

MCH will work with the state-funded home visiting programs and community health centers to carry out strategies identified in the The Dartmouth Institute for Health Policy and Clinical Practice

project to improve the immunization rate of the Hepatitis B #1 vaccine. (IB, PB)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.2	7.5	6.7	5.9	5.8
Annual Indicator	6.8	6.0	5.6	6.3	4.6
Numerator	187	164	142	160	118
Denominator	27473	27155	25323	25323	25670
Data Source	Birth data	Vital Records Birth Data	Vital Records Birth data	Vital Records Birth Data	Vital Records Birth Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	4.5	4.4	4.3	4.2	4.1

Notes - 2011
Population updated using 2010 Census.

a. Last Year's Accomplishments
In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Even though New Hampshire is proud to once again have the lowest teen birth rate in the country, preventing teen births is a priority area within SHIP. The plan sets an objective to reduce unintended birth rate for adolescents from 15.7 (2010) to 15.0 by 2015 and to 14.0 by 2020.

It is important to note that statewide averages may mask often-significant geographic differences. Places such as Sullivan, Coos, Belknap County and the Cities of Manchester and Nashua continue to have significantly higher rates of teen birth than other communities

PARTNERSHIPS AND STRATEGIES:
MCH has maintained oversight and management of federal funds for the administration of Personal Responsibility Education Program (PREP) funds through a contract with two local providers in the targeted areas of Sullivan County and the City of Manchester, where data

suggests there are disproportionately high numbers and rates of teen births. The contracted providers began implementing the EBP -- FOCUS. (IB)

MCH facilitated several meetings with the Adolescent Sexual Health Task Force to work on a strategic planning that would incorporate the abstinence and PREP services. Small progress was made in identifying a three-year plan that involves increasing the use of NH assets to invoke a cultural/climate change to sexual health prevention.

The Family Planning Program continued to offer confidential reproductive health services to adolescents as required by Title X. Education and reproductive health services have continued through teen clinics. In June 2011, New Hampshire's Executive Council did not approve a contract with Planned Parenthood of Northern New England (PPNNE), a long-term family planning provider. As a result, the service system was cut virtually in half, threatening a serious service system disruption for family planning clients in those areas served by PPNNE. Subsequently, the US DHHS Office of Population Affairs contracted directly with PPNNE to provide services to those communities. New Hampshire continues to have a bifurcated Title X program. One administered by PPNNE and one administered by NH DHHS.

In CY 2012, Title X clinics funded through NH DPHS served 2305 adolescents, approximately 25%, of their entire Title X patient panel. (DHC)

MCH continued to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to fund and monitor PREP contracts and activities in Manchester and Sullivan County.	X	X	X	X
2. Continue to monitor and provide technical assistance to MCH funded prenatal and primary care agencies that provide prenatal care to low income, uninsured and underinsured women.	X	X	X	X
3. Continue to facilitate Adolescent Health and Wellness Task Force to foster state collaboration and further strategic planning effort.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues to administer the Personal Responsibility Education Program (PREP) funds through a contract with two local providers in the targeted areas of Sullivan County and the City of Manchester, where data suggests there are disproportionately high numbers and rates of teen births. The current contractors continue to implement the EBP -- FOCUS. The current contractors have discovered the need to address young males reproductive health needs, their role in teen pregnancy prevention and have worked to develop a male curriculum that they plan to

pilot in the summer/fall 2014.(IB)

MCH has facilitated the Adolescent Health and Wellness Task Force to finalize a strategic plan that incorporates PREP services. The Plan includes: 1. An assessment of capacity 2. Increasing awareness and 3.Increasing skills. This task force has served in an advisory capacity to the PREP services. The task force is made up of a collection of key partners from around the state to include: family planning, adolescent health, Department of Education, TANF, home visiting, family planning providers, home visiting providers, higher education, minority health office, physicians and nurses. (IB)

MCH monitors and provides technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The Family Planning Program received additional State General Funds to support expanded family planning services.

c. Plan for the Coming Year

MCH will continue oversight and management of federal funds for the administration of Personal Responsibility Education Program (PREP) funds through a contract with two local providers in the targeted areas of Sullivan County and the City of Manchester, where data suggests there are disproportionately high numbers and rates of teen births. MCH is committed to reaching even deeper into these communities where there are significant disparities; where the cycle of poverty and low educational attainment puts adolescents at heightened risk for teen pregnancy and teen birth. (IB)

The Manchester PREP Program will continue an innovative, collaboration with the Manchester School District Alternative Education Program to offer a 1/2 credit for a health required for graduation for those students who complete PREP/teen pregnancy prevention education. This creates an added incentive for students to complete the program with fidelity.

MCH will continue to facilitate the Adolescent Health and Wellness Task Force to finalize a strategic plan that will incorporate PREP services. The Plan will include: 1. An assessment of capacity; 2. Increasing awareness; and 3. Increasing skills. This task force will continue to serve in an advisory capacity to the PREP services. The task force is made up of a collection of key partners from around the state to include: family planning, adolescent health, Department of Education, TANF, home visiting, family planning providers, home visiting providers, higher education, minority health office, physicians and nurses. (IB)

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

MCH and the MCH Family Planning Program will continue to promote the new Family Planning Medical Assistance Program, a limited set of family planning benefits available to a new Medicaid eligibility group through the enactment of the Affordable Care Act. Individuals eligible under the new family planning group are adult individuals; men, and women who are not pregnant; whose income does not exceed 185% FPL. While the intended eligibility group does not include teenagers aged 15 through 17 years who are eligible for Medicaid, this benefit serves as a safety net for young adults and potential partners of older teens.

Authorized qualified entities (community outreach providers who have received training on presumptive eligibility policy) may make presumptive eligibility (PE) decisions for Family Planning medical assistance. Presumptive eligibility is a process by which a qualified entity (QE) acts on behalf of DHHS and makes an eligibility determination for Family Planning medical assistance

using verifications collected from the applicant. (DS, ES, IB)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44	54.5	54.5	54.5	54.5
Annual Indicator	54.5	54.5	54.5	54.5	54.5
Numerator	1644	1644	1644	1644	1644
Denominator	3015	3015	3015	3015	3015
Data Source	2009 3rd grade survey	2009 3rd grade survey	2009 3rd grade survey	2009 3rd grade survey	2009 third grade survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	60	61	62	63	64

Notes - 2013
Statewide oral health data for NPM #9 is collected every five years through the Oral Health Survey of Third Grade Children. The data for 2013is the same as for 2009, 2010, and 2011. Future objectives reflect the fact that new data will not be available until the summer of 2014.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

Notes - 2012
Statewide oral health data for NPM #9 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2012 is the same as for 2009, 2010, and 2011. Future objectives reflect the fact that new data will not be available until 2014.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

Notes - 2011
Statewide oral health data for NPM #9 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2011 is the same as for 2009 and 2010.

Future objectives reflect the fact that new data will not be available until 2014.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

a. Last Year's Accomplishments

In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Because tooth decay is the single most common chronic childhood disease, five times more common than asthma, oral health care for children was prioritized within the SHIP. An objective was set to reduce the percent of third grade students with dental caries experience in their primary and permanent teeth from 43.6% (2009) to 41.4% by 2015 and 39.2% by 2020.

DATA ANALYSIS:
The Oral Health Program (OHP) worked with the Chronic Disease Epidemiologist to annually collect and analyze data and provide programmatic feedback on the presence of dental sealants among NH's students. (IBS, PBS, ES.)

SYSTEMS BUILDING:
The OHP worked with the Medicaid Dental Director, the NH Dental Society, and dental public health professionals to increase the effectiveness and sustainability of school-based sealant programs that link identified children with a "dental home." (IB, PBS, ES, DS)

The OHP sponsored a Calibration Clinic to enhance clinical skills of public health hygienists working in schools on the use of the ASTDD Basic Screening Surveys for children to assess the prevalence of sealants among third grade students for the 2013-2014 Third Grade Healthy Smiles-Healthy Growth Survey (IB, PBS, ES, DS.)

As one of only five states to receive a grade of "A" by the Pew Research Foundation on the impact of school sealant programs on children's oral health, the NH OHP continued its work with the HNH Foundation to implement sustainable models to deliver early OH preventive interventions and improve access to care for at-risk WIC and Head Start children while educating parents and caregivers about sealants and the importance of children's oral health. (IB, ES, PBS, DS).

The OHP collaborated with the NH Technical Institute Allied Health Program to develop high-quality continuing education on new sealant materials and techniques as part of the Public Health Certificate curriculum. (IBS, PBS, ES.)

Patricia Tilley, Bureau Chief of the Bureau of Population Health and Community Services, where MCH resides, represented DPHS in the Steering Committee of the NH Oral Health Coalition. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OHP will collect, analyze and report on oral health data,			X	X

specifically the percent of third grade students with dental sealants on their molar teeth.				
2. The OHP will collaborate with the Chronic Disease Epidemiologist and our CDC Assignee on the publication of articles in reputable national journals that contribute to the growing body of oral health knowledge.			X	X
3. The OHP will collaborate with the NH Medicaid, WIC programs, parents, staff, and public health hygienists, to provide sustainable early oral health education, preventive services and links to dental homes.	X	X	X	X
4. The OHP and New Hampshire Technical Institute will collaborate to conduct a high-quality “Caries Stabilization” course to complete a set of core courses required for a public health certificate for hygienists working with high-risk populations.				
5. The OHP will collaborate with 4 NH rural school oral health programs and Dr. Rick Niederman (New York University) to improve the clinical and cost effectiveness of rural school caries prevention programs.	X	X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
NH focuses on strategies to improve oral health with changes in the NH Medicaid dental program for children; optimal fluoridation of 10 NH supplies; preventive services for WIC children at risk for decay; and school-based application of sealants.

DATA ANALYSIS:
The OHP, Chronic Disease Epidemiologist and the Healthy Eating and Physical Activity Section collaborate on the 2014 Third Grade Survey to assess oral health, height and weight status of students. Comparisons between 2009 and 2014 survey results will measure progress toward reducing overweight, obesity and dental disease among NH's children. (IBS, PBS, ES.)

SYSTEMS BUILDING
The Medicaid Dental Director and OHP collaborate on the CMS Oral Health Learning Collaborative to develop a sustainable WIC model for on-site delivery by public health hygienists of education, preventive services and links to dental homes for pregnant women and young children. (IB, PBS, ES, DS)

Funded by the HNH and Jessie B. Cox Foundations the OHP has launched a model to sustain WIC dental clinics in Concord, Pittsfield and Keene. (IB, ES, PBS, DS).

The OHP, the Chronic Disease Epidemiologist, the Healthy Eating and Physical Activity Section, our CDC PH Associate, and 8 public health hygienists are conducting the 2014 Third Grade Survey in 128 NH schools. (IBS)

The OHP and 4 rural school-based OH programs are evaluating preventive interventions comprehensive that the clinical and cost effectiveness of rural school-based caries prevention programs.

c. Plan for the Coming Year

The NH Division of Public Health Services will continue to focus on the State Health Improvement Plan (NH SHIP)objective to reduce the percent of third grade students with dental caries experience in their primary and permanent teeth from 43.6% (2009) to 41.4% by 2015 and 39.2% by 2020.

New Hampshire will focus on strategies to improve residents' oral health with changes in the NH Medicaid dental program through a federal waiver that could expand NH Medicaid coverage for children, pregnant women and mothers of young children; the consistent optimization of added fluoride to 10 NH water supplies; preventive oral health services for WIC pregnant women and children at risk for decay; and school-based application of sealants.

DATA ANALYSIS:
The OHP and Chronic Disease Epidemiologist will complete the 2014 Third Grade Survey to assess oral health, height and weight status of students in 128 NH schools. Survey data will be cleaned, analyzed and a final report with survey results will be disseminated to stakeholders statewide. Comparisons between 2009 and 2014 survey results will measure progress toward reducing overweight, obesity and dental disease among NH's children. (IBS, PBS, ES.)

SYSTEMS BUILDING:
The OHP will utilize the new CDC Cooperative Agreement, NH Oral Disease Prevention Program, to build program capacity by hiring a fulltime Program Coordinator, a half-time Program Evaluator and sharing one-third of the time of a Communications Specialist. (IB, PBS, ES.)

The OHP will collaborate with rural FQHC's to build three new dental facilities to improve access to oral health care for vulnerable children and adults living in rural NH. (IBS, PBS. EB, DS)

The Medicaid Dental Director and OHP will continue to collaborate on the CMS Oral Health Learning Collaborative project to develop a sustainable WIC model for on-site delivery by public health hygienists of education, preventive services and links to dental homes for pregnant women and young children. (IB, PBS, ES, DS)

With funding from the HNH Foundation and the Jessie B. Cox Foundation, the OHP will maintain and improve model WIC dental clinics in Concord, Pittsfield and Keene. (IB, ES, PBS, DS).

In collaboration with Dr. Rick Niederman, Director of Evidence-Based Dentistry New York University, the OHP and 4 rural school-based OH programs will complete Year 3 of the NIH Effectiveness and Improvement of Rural, School-Based, Caries Prevention Programs project to assess comprehensive preventive interventions and improve the clinical and cost effectiveness of rural school-based caries prevention programs. (IBS, PBS, ES, DS.)

The OHP will continue collaboration with the New Hampshire Technical Institute to imbed five core courses into the dental hygiene curriculum to assure that requirements for Public Health Certification are in place to expand the scope of practice for dental hygienists who serve vulnerable populations. (IBS, PBS, ES, DS.)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0	0	0	0.8	0.6
Annual Indicator	1	0	0	1	0

Numerator					
Denominator					
Data Source	Vital Records	Health Statistics	Health Statistics	Health Statistics	Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	0.4	0.2	0	0	0

Notes - 2013
Calendar year 2013 out of state data is unavailable.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2012
Calendar year 2012 out of state data is unavailable. 2009 is the most recent final data.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2011
Calendar year 2011out of state data is unavailable. 2008 is the most recent final data.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events

and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

a. Last Year's Accomplishments

Motor vehicle crashes kill more children in the United States than any other cause of death. Most motor vehicle-related deaths and injuries are predictable and preventable. Laws in the United States and within each State regarding use of car seats for children have significantly reduced the rate of non-fatal injuries due to motor vehicle crashes. The use of appropriately installed car seats and booster seats significantly reduces the risk for death and serious injury.

PARTNERSHIPS AND STRATEGIES:

Two four-day car seat certification-training programs took place in 2013/14. One was in the northern most region of the state, Coos County. (IB)

A train the trainer was program was developed and held to teach currently certified technicians who are also EMS providers about restraint use on emergency medical service vehicles, such as ambulances. This training provided an overview of the best use of all passenger restraints, including car seats, in emergency vehicles. (IB)

The Injury Prevention and MIEC Home Visiting Programs released a data brief specific to childhood injuries and focusing on restraint issues. The Injury Surveillance Program Coordinator followed up the release by facilitating several professional workshops across the state highlighting the brief's focal areas. (IB)

Resources and technical assistance were given to families and hospitals regarding ways to transport children with special medical needs. (IB, PB)

Four train the trainer programs were developed and implemented for Head Start professionals including child passenger, pedestrian, and bicycle safety. After the Head Start staff present to parents, a check-up event was then scheduled with certified technicians helping to install car seats. (IB, PB)

The Injury Prevention Program developed, in conjunction with the MIEC Home Visiting Program and the Children's Safety Network, an in person and online professional training in the concepts of injury prevention for infants and young children. This includes the basics of child passenger restraint. One session has been facilitated to MIEC's Home Visitors and more are scheduled for the upcoming year. (IB)

New car seat legislation was passed at the end of the 2013 legislative session resulting in RSA 265:107-a, which became effective January 1, 2014. Under the new bill, all children under age 7 or 57 inches (whichever is reached first) must use a properly fastened and secured child safety seat. This is an increase of one year in age and ten in inches from the previous law. Children under age 18 still must be properly restrained in a motor vehicle, including a car pickup truck or SUV. MCH staff participated both in the legislative process for this bill as well as in the distribution of materials on the law after its passage. (IB, PB, ES)

An analysis of the car seat observational surveys were completed and released at the Winter 2014 Injury Prevention Advisory Council meeting. Surveys were conducted by Child Passenger Safety Technicians to document current restraint use of children under age 16 and their drivers.

This survey replicated surveys conducted in 1991 and 1996. The observations were conducted at child care facilities, parks, social service agencies, stores, and fast food restaurants. Observers were asked to document seating location and if restraint was CORRECT or INCORRECT (Gross Misuse or Non-Use).

Eight out of ten counties were represented in the surveys with observations of 448 children and

313 adults.

Some of the results of the surveys included:
- 86% of children were reported to have been correctly harnessed or restrained.
- 14% were incorrectly restrained
- Number of children in the vehicle made no difference in restraint use.
- Driver restraint use (67%) is consistent with the 2012 observed state seat belt use rate (68.5%).
- Drivers were nearly twice as likely to be women.
- 60 % of both driver and child combinations were correctly restrained.
- When the driver was not buckled, the child was incorrect 34 % of the time.

There were 1, 677 documented car seat checks that took place in the last year. (PB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train and certify child passenger safety technicians and instructors.				X
2. Continue to promote and distribute booster, convertible, and infant seats.			X	
3. Facilitate car seat checks.			X	
4. Work with the Department of Transportation on its “Driving Towards Zero” campaign.			X	X
5. Implement the Home Visiting Injury Prevention Curriculum to MIEC Home Visitors.			X	X
6. Continue to facilitate implementation of EMS and Head Start “Train the Trainer” programs.				X
7. Provide information and additional training on transportation of children with special medical needs.			X	X
8. Participate in the Child Fatality Review Team.				X
9.				
10.				

b. Current Activities

PARTNERSHIPS AND STRATEGIES:

There are currently 145 Certified Passenger Safety Technicians and 32 inspection stations in New Hampshire. Inspection stations are typically located at a local law enforcement or fire station, hospital and/or child care center. Inspection times are held routinely on a monthly basis and appointments can be scheduled. (IB, PB)

Car seat inspections by certified technicians are also happening at SAFE KIDS New Hampshire community events happening several times a year, usually in the spring and summer. (PB)

Trained Head Start professionals are currently facilitating information sessions to parents on restraint use with a check-up event follow each session with certified technicians checking seats. (PB)

Trained EMS/CPS technicians have been providing professional opportunities for their peers on the use of restraint systems in emergency vehicles. (IB)

Two Child Passenger Safety Technician trainings will be held this year, both in the Southern part of the State. (IB, PB)

MCH is working with the Department of Transportation in implementing the Restraint Usage section of the "State Strategic Highway Safety Plan". This plan is being promoted on the website www.nhdtz.com. (IB, PB)

MCH's Early Childhood Programs Manager presented the Home Visiting Injury Prevention Curriculum at the Association of Maternal and Child Health Program's (AMCHP) Conference, January 2014. The Curriculum inlcudes basic training in child passenger restraint for home visitors. (IB, PB

c. Plan for the Coming Year
Partnerships and Strategies:
Additional sessions of the Home Visiting Injury Prevention curriculum will be presented to at least two more groups of MIEC Home Visitors. The curriculum will also be put on line for easier access. (ES, PB)

A two-day course for Child Passenger Safety technicians entitled "Transporting Children with Special Health Care Needs" will be facilitated with continuing education units provided. (IB)

An automotive safety patch for Cub Scouts is still in the development stage. Cub Scouts will attain a patch after finishing five sections, including one on passenger restraints. (PB)

The Injury Prevention Center at Dartmouth recently hired a new Statewide Coordinator the New Hampshire Child Passenger Safety Program, Thomas Leach. Mr. Leach has many years of law enforcement experience in additional to being a Certified Trainer and Technician in Child Passenger Safety. (IB)

MCH Staff will participate in the Child Fatality Review Team. Deaths from motor vehicle crashes are often discussed since this continues to be the number one reason that children in New Hampshire die. (IB, ES)

Car seats will be checked by Certified Passenger Safety Technicians through private appointments, regularly scheduled times through inspection stations and at SAFE KIDS New Hampshire community events. (PB)

MCH will continue its work with the Department of Transportation in implementing the Restraint Usage section of the "State Strategic Highway Safety Plan". (IB, PB)

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	49	56	52	60	62
Annual Indicator	55.1	50	58.2	60	53.6
Numerator					
Denominator					
Data Source	CDC report card	CDC report card	CDC report card	CDC report card	CDC report card
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	56	58	60	62	64

Notes - 2013
Data is from the CDC Breast Feeding Report Card, 2013 (www.cdc.gov). A numerator and denominator are not available.

2013 was the first year that cell phone data was included, so comparing against previous years needs to be done with caution. In addition, NH is a small population state where numbers have historically gone both up and down.

Notes - 2012
Data is from the CDC Breast Feeding Report Card, 2012: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

Notes - 2011
Data is from the CDC Breast Feeding Report Card, 2011: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

a. Last Year's Accomplishments
Breastfeeding is crucially important to the health of mothers and children. Breastmilk is the preferred and most appropriate source of nutrition for infants. Breastfeeding delivers health benefits to both the infant and mother.

DATA
New Hampshire has continued to have steady improvement in breastfeeding rates. The 2011 CDC Maternity Practices in Infant Nutrition and Care (mPINC) survey identified NH as the leading state in the nation for maternity care practices. All facilities (100%) in New Hampshire include breastfeeding education as a routine element of their prenatal classes.52% of facilities in New Hampshire adhere to standard clinical practice guidelines against routine supplementation with formula, glucose water, or water; 38% of facilities in New Hampshire have comprehensive breastfeeding policies including all model breastfeeding policy components recommended by the Academy of Breastfeeding Medicine. (PB)

Three of 20 birthing hospitals are "Baby Friendly" and an additional four are working on achieving the status. (PB, IB)

MCH monitored breastfeeding duration and WIC enrollment efforts at MCH-funded agencies through its workplan performance measures, sharing successful strategies among agencies. (IB)

MCH promoted breastfeeding in public and professional information activities focusing on SIDS/Safe Sleep risk reduction and spoke with WIC Directors, WIC Peer Counselors, and WIC Nutritionists to discuss their role in encouraging risk reduction especially among breastfeeding clients. (IB, PB)

The MCH-chaired CDC grant SUID Review Group and Safe Sleep Campaign workgroup continued to include a state WIC Program staff member and a lactation consultant. (IB)

Six MCH-contract community health center and home visiting agency staff attended the Fall 2012 five-day Breastfeeding Certified Lactation Counselor training on scholarship funded by an ASTPHND minigrant obtained by MCH in collaboration with WIC. (IB, PB)

MCH contract agency staff attended a 3-session free spring breastfeeding training by the WIC Breastfeeding Consultant. MCH collaborated with WIC to offer IBLC, nutrition, and nursing contact hours. (IB, PB)

MCH and WIC staff met with NH Breast Feeding Task Force representatives and local hospital representatives to discuss whether MCH could assist in documenting breast feeding initiation for Baby Friendly documentation on birth certificates or newborn screening filter papers. (IB)

MCH and WIC collaborated on developing "Breast care after your baby dies: Suggestions to relieve breast discomfort", a handout for women who experienced infant death. This is included in infant death bereavement packages sent by MCH, and is available on the DPHS website, WIC website, and was shared with hospitals and the NH Breastfeeding Task Force.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support the MCH contract agencies' efforts to promote initiation and duration of breastfeeding among clients, via workplan monitoring and reporting, and via site visits.				X
2. Share information about breastfeeding education with MCH contract agencies.				X
3. Participate in committees and workgroups targeting improving breastfeeding rates.				X
4. Promoting breastfeeding as an infant death risk reduction strategy during SIDS/Safe Sleep activities.			X	
5. Collaborate with the WIC Program on any activities that can improve the breast feeding rates of both the state and the MCH contract agencies.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH participates in the DPHS Breastfeeding Integration Committee, the NH Breastfeeding Task Force, and works with WIC to share breastfeeding information, resources, and training opportunities, and promote World Breastfeeding Week. (IB, PB)

MCH is following up on the best-practice collaboration efforts between local Title V contract agencies and local WIC agencies. Results from an April survey to Title V funded agencies on collaboration, WIC eligibility determination, and breast feeding support training needs will be discussed at the June 2 MCH Coordinators' meeting. (IB)

MCH monitors efforts by the Title V funded agencies to improve breastfeeding duration, and WIC enrollment, through workplan performance measures, year-end reports and site visits. (IB)

MCH promotes breastfeeding in public and professional information activities focused on

SIDS/safe sleep risk reduction practices and includes a state level WIC staff member and a lactation consultant on its SUID Review Group and Safe Sleep Campaign workgroup. (IB, PB)

MCH collaborated with WIC to acquire a minigrant from the Association of State and Territorial Public Health Nutritionists and Dieticians to sponsor Dr. Jane Hienig, PhD, IBCLC, Executive Director of the Human Lactation Center in California, at a day-long training May 5th on the relationship between infant behavior, feeding, and childhood obesity open to health and early childhood professionals. (IB, PB)

c. Plan for the Coming Year

New Hampshire will continue to build upon the success it has had in supporting breastfeeding. The State's strengths include; availability of prenatal breastfeeding instruction in prenatal classes and documentation of mother's feeding decision, with staff consistently asking and recording infant feeding decisions. Even though the State has consistently had favorable outcomes on the CDC mPINC survey, New Hampshire still has work to do, particularly in areas such as inclusion of model breastfeeding policy elements and use of combined mother--baby postpartum care.

PARTNERSHIPS AND STRATEGIES:

New Hampshire will continue to coordinate multiple initiatives and programs focused on supporting, protecting, and promoting breastfeeding for New Hampshire's most vulnerable families. These programs include the Women, Infants and Children (WIC) Nutrition Program, WIC's Breastfeeding Peer Counseling Program and Maternal and Child Health programs.

The NH SUID Registry Project found that 64% 2012-2013 SUID deaths were breastfed. This identified breastfeeding women and those health professionals who support women in their choice to breast feed, as a target for safe sleep outreach for the current and upcoming grant year. (IB, PB)

MCH will continue to participate in the DPHS Breastfeeding Integration Committee and the NH Breastfeeding Task Force. (IB, PB)

MCH will follow up with the discussion with Title V contract agencies at the June 2nd MCH Coordinators' meeting to assist in improving local collaboration between WIC and Title V health agencies, consistency in determining WIC eligibility, and breast feeding support training needs, as indicated. (IB)

The MCH Child Health/SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS/safe sleep risk reduction practices. (PB)

The CDC funded SUID Project will focus on analyzing its data to identify the occurrence of breastfeeding bedsharing situations among the infants who have died, and develop actionable prevention strategies which will include advocating breastfeeding as a protective risk factor yet identifying the dangers of bedsharing for breastfeeding women. (IB, PB)

MCH will continue to share breastfeeding information and resources from WIC to MCH-contract agencies. MCH will continue to monitor efforts by the MCH-funded agencies to improve breastfeeding initiation and duration, and WIC enrollment, by requiring the related workplan performance measures and assessing progress via end of the year reports and site visits. (IB)

Because of a substantial increase in Medicaid reimbursement for breast pumps, Medicaid enrolled mothers will have coverage for a single user electric breast pump. MCH prenatal programs will promote this opportunity among pregnant and newly parenting women. The WIC

Program will continue to offer manual pumps and multi-user electric breast pumps to women enrolled in WIC.

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	97.4
Annual Indicator	97.3	97.5	97.3	97.3	97.2
Numerator	12968	12702	12733	12236	12115
Denominator	13327	13027	13080	12578	12466
Data Source	screening records	screening records	screening records	screening records	screening records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	97.5	97.6	97.7	97.8	97.9

Notes - 2013
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2012
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2011
Numerator is actual number of infants screened. Denominator is number of occurrent births.

a. Last Year's Accomplishments
GOALS AND STRATEGIES:

In 2012, the NH EHDI Program had six primary goals and made significant progress on five of those goals:

- Increase the percent of newborns that complete hearing screening no later than 1 month of age.
- Improve the accuracy and reporting options for reports available in the Auris tracking system.
- Increase the reports in the Auris tracking system to facilitate additional data collection.
- Increase the percent of families at all birth facilities with hearing screening equipment that are offered newborn hearing screening.

- Increase the percent of infants who did not pass their final hearing screening who are referred to audiologists who are qualified to test young infants.
- Increase the percent of newborn hearing screening programs that achieve or exceed the acceptable level of performance.

Technical challenges with the data collection system impeded progress in meeting all six goals, but there was sufficient improvement in increasing access to screening for infants, especially for infants born in non-hospital settings.

Because at 97% newborn hearing screening within the hospital setting is almost universal, the NH EHDI program has turned its attention to infants born at home and in freestanding birthing centers. In calendar year 2012, newborn hearing screening by certified lay midwives at freestanding birth facilities increased from 25% to 50%. With support from the NH EHDI Program, the midwife at one facility volunteered to be a EHDI demonstration site. She wrote protocols, received instruction conducting newborn hearing screening and began offering newborn hearing screening. Midwives at the remaining three freestanding birth facilities wrote newborn hearing protocols, learned how to perform newborn hearing screening and report hearing screening results through the AURIS tracking system. Beginning in 2012, midwives now provide newborn hearing screening to families at three freestanding birth facilities and in the rural area served by Seacoast Midwifery.

OTHER DAILY TASKS:
EHDI staff provided technical assistance, assured that all babies were screened and received appropriate follow up. (IB, PB)

EHDI staff provided technical assistance on newborn hearing screening to midwives at freestanding non-hospital birth facilities. (P, IB)

EHDI staff monitored audiologists to ensure compliance with Joint Committee on Infant Hearing Guidelines. (IB)

SYSTEMS BUILDING:
EHDI staff worked with Auris tracking system developers to produce accurate/ timely reports. (IB)

EHDI staff provided annual performance reports to hospital program managers for quality improvement. (IB) (P)

LOSS TO FOLLOW-UP:
EHDI Program assisted parents to obtain audiologic diagnostic testing for their infants and maintained a list of approved diagnostic facilities with licensed qualified audiologists. (IB, PB)

EHDI Program added a new audiologic diagnostic testing site at Elliot Hospital, the largest hospital in New Hampshire, which is located in the most populated area of the state.

EHDI staff used performance measures to provide feedback and, if needed, recommended activities to improve the quality of hearing screening and referral procedures to the newborn hearing screening program manager. (IB)

EHDI staff obtained hearing screening results for newborns transferred or screened out of state. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The EHDI staff provides technical assistance to birth hospitals, using birth certificate data to assure that all newborns are offered hearing screenings, and receive appropriate follow-up.			X	X
2. The EHDI staff uses performance measures to assess performance of staff at all hospital newborn hearing screening programs and distribute annual performance reports to the program managers.				X
3. The EHDI staff monitors the performance of audiologists at pediatric audiology diagnostic centers to ensure that all audiologists adhere to the 2007 Joint Committee on Infant Hearing (JCIH) Guidelines for audiologic diagnostic evaluations.				X
4. The EHDI staff supports the development/ maintenance of qualified pediatric audiology diagnostic centers in NH.		X		
5. The EHDI staff work with hospitals to support activities that reduce loss to follow-up.				X
6. The EHDI staff requests assistance from primary care physicians if they are unable to contact families of infants who need diagnostic testing.				X
7. The EHDI staff requests newborn hearing screening results for infants transferred to and screened in out-of-state hospitals.				X
8. The EHDI staff requests diagnostic testing results for infants tested out of state.				X
9.				
10.				

b. Current Activities
The NH EHDI Program has focused on the Daily Tasks of the program to ensure that infants are screened for, diagnosed with, and receiving intervention services for hearing loss.

The EHDI Program has spent significant time working with the data vendor to address technical challenges with the data collection system so that NH can be confident that birth facility data accurately captures how the State is increasing access to screening for infants, especially for infants born in non-hospital settings; the type and severity of hearing loss; and demographic data on infants with hearing loss. (IB)

The program participated in a LEAN activities and created a Value Stream Map to document in high detail every step of the EHDI process. This tool has been used identify the flow of EHDI-related information and documents so as to reduce process cycle times and implement process improvements. The Value Stream Map was a useful tool for all members of the EHDI team to use to beeter understand the entire flow of EHDI information, rather
than previously focusing on discrete operations.(IB)

DAILY TASKS
EHDI staff provides technical assistance to all screeners, focusing on certified lay midwives. (IB)

EHDI staff has continued to work with midwives at the freestanding birth centers to offer newborn hearing screening to every family at their facility. (IB)

EHDI staff contacts parents by telephone and US mail to ensure that infants who do not pass their final hearing screening receive diagnostic testing.

c. Plan for the Coming Year
STRATEGIES AND PARTNERSHIPS:
The EHDI team is currently recruiting new members for a new Quality Improvement (QI)

Committee that had been briefly mobilized for the 2011 NICHQ Collaborative. This new QI committee will replace the former EHDI Advisory Committee which was officially "sunsetted" by legislative authority. The members of QI Committee will include, the EHDI team, a parent of a child with a hearing loss, a representative from the state's early intervention program, and an epidemiologist/statistician. Others that will be invited include a Co-Director of NH Family Voices, the American Academy of Pediatrics' NH Chapter Champion, and a representative from Home Visiting/Early Head Start, the MCH Title V Quality Assurance Nurse Consultant, and a selection of newborn hearing screening managers from birthing facilities.

The first meeting will focus on crafting an AIM statement, orienting the committee members to Plan Do Study Act (PDSA) cycles, and planning an evaluation project related to increasing the rate of scheduling appointments to audiologic diagnostic centers prior to discharge home. Future meetings will identify change strategies, work with birth facilities to conduct PDSA cycles, analyze results to determine if the change results in improvement, discuss challenges, and expand and test successful strategies on a larger scale, to other birth facilities.

The first evaluation project will focus on activities that worked in the high performing facilities, then plan and encourage low performing agencies to conduct small tests of change that will increase appointment rates. The second evaluation project will focus on activities to improve timely enrollment in the state's early intervention program.

OTHER DAILY TASKS
EHDI staff will provide technical assistance to all screeners, focusing on certified lay midwives. (IB)

EHDI staff will continue to work with midwives at the freestanding birth centers to offer newborn hearing screening to every family at their facility. (IB)

EHDI staff will continue to support development of qualified pediatric audiology diagnostic centers in New Hampshire (E, IB)

SYSTEM BUILDING
EHDI staff will work with the Auris tracking developers to generate new reports for grant reporting requirements. (IB)

EHDI staff will work with midwives to increase the percent of hearing screening results entered into the tracking system within two weeks. (P)

EHDI staff will review and revise resource lists, education materials and website references to ensure access to the current information. (P)

LOSS TO FOLLOW UP
EHDI staff will review protocols for the newborn hearing screening facilities and make recommendations for improvement. (IB)

EHDI staff will work to increase number of hearing screening and diagnostic testing results obtained from and reported to neighboring states. (IB, P)

EHDI staff will contact parents by telephone and US mail to ensure that infants who do not pass their final hearing screening receive diagnostic testing.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	4	4	4	4	4
Annual Indicator	4.3	4.0	5.0	7.0	6.8
Numerator	12921	11900	14000	19900	19900
Denominator	298439	297500	280000	284286	294500
Data Source	2007 Nat'l Survey	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts	Kaiser Foundation State Health Facts
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	6	5	4	3	2

Notes - 2013
Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2011-2012), US (2012)

http://www.statehealthfacts.org

Notes - 2012
Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2010-2011), US (2011)

http://www.statehealthfacts.org

Notes - 2011
Data is from the Kaiser Family Foundation State Health Facts: "New Hampshire: Health Insurance Coverage of Children 0-18, States (2009-2010), US (2010)

http://www.statehealthfacts.org

a. Last Year's Accomplishments
The Affordable Care Act (ACA) provides parents and guardians with more security that their children will receive access to quality, affordable health coverage. The ACA should expand access for children and young adults, and strengthen consumer protections for those who have coverage. It prohibits health insurers from excluding
coverage of children because of preexisting conditions. New plans should cover prevention and wellness benefits, exempting those benefits from deductibles and cost-sharing requirements. This will help ensure that all children have access to free preventive services.

New Hampshire has made significant changes to its healthcare delivery and financing system. In 2012 and 2013, the state prepared for a transition from Fee For Service Medicaid to a Medicaid Care Management model. At the same time, the NH DHHS worked with policy makers to implement provisions of the ACA including the development of a Federally-facilitated Marketplace (FFM) and an expansion of insurance benefits for low income adults.

During this time of change, MCH monitored the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on Medicaid, and activities to enhance Medicaid enrollment through review of statistics and annual workplans. During SFY13, 91% of eligible children served at the MCH-funded community health centers were enrolled in Medicaid. The range among the agencies was 81% - 100%. Each agency received detailed reports of their outcomes comparing their performance with other agencies.

MEDICAID CARE MANAGEMENT:
Step 1 of New Hampshire's Medicaid Care Management Program was officially launched on December 1, 2013. Step 1 includes the majority of Medicaid benefisciaries including most children and pregnant women. Medicaid benefits did not change. Medicaid recipients picked a Health Plan and a primary care provider from the Health Plan's list of providers.

NH DHHS conducted a series of forums during summer 2012 to discuss care management and Step 1 implementation. The Department encouraged and sought volunteers to participate in Step 2 design. The Step 2 population includes: children in Foster Care; children with special health care needs; home care for children with severe disabilities ("Katie Beckett"); children with Supplemental Security Income; and dual Medicare and Medicaid eligible. Instructions on how to sign up with a plan were sent to families in Fall 2012.

Step 2 implementation is scheduled to be launched in late 2014 or 2015.

As the Medicaid Care Management Program was ramping up, MCH-funded community health centers and home visiting agencies met with representatives from the Managed Care Organizations (MCO) to better inform the MCOs about needed services and in the hope that services currently provided on a fee for service basis, such as the support services provided at home visits, can continue and be reimbursed. (IB)

EXCHANGE
NH opted, through statute, to enter into the federally run health insurance exchange. The exchange will be called NH Health Insurance Marketplace. NH has been conditionally approved for Exchange partnership status. The Exchange website will be operational 10-1-2013.

As of October 1, 2013 the NH Health Insurance Marketplace will begin enrollment for Qualified Health Plans in the individual and small business markets. Income eligible individuals and eligible small businesses will have access to subsidies to help pay for insurance. Navigators will be available to assist individuals and businesses.

MEDICAID EXPANSION:
In January 2013, the NH Office of Medicaid and Business Policy received a report from the Lewin Group that estimated the impact of a possible Medicaid expansion. Medicaid expansion would not directly impact children, as they continue to be eligible for Medicaid services, but the parents of low-income children would have greater access to coverage. The Lewin Group estimated that if the state expands Medicaid, the number of uninsured would be reduced by 99,100 compared to pre-ACA uninsurance rates. Thus, the number of uninsured in New Hampshire would be approximately 71,000 with Medicaid expansion. Absent an expansion, the number of uninsured would be reduced by 76,800 compared to pre-ACA uninsurance rates, bringing the number of uninsured in New Hampshire to 93,200. MCH participated in policy workgroups to keep families and providers aware of changes and opportunities for health insurance coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund a safety net of primary care providers through the community health centers with a primary goal of ensuring that children maintain access to health insurance.				X
2. Monitor MCH-funded agency statistics on children uninsured, and enrolled on Medicaid, and supportive activities through reports and site visits.				X
3. Monitor appropriate documentation of client financial status at site visits to MCH funded community health centers.				X
4. In partnership with the Office of Medicaid Business and Policy, provide technical assistance to community based agencies, including community health centers, regarding possible enrollment policy changes.				X
5. Provide information, as needed, to the NH Insurance Department regarding ACA Health Reform Implementation.				X
6. Collaborate with DCYF to offer seamless services to families through a home visiting program funded by a combined funding stream which promotes efficiency and avoidance of duplication of reporting and contracting by the local agencies.				X
7.				
8.				
9.				
10.				

b. Current Activities

NH's Medicaid and CHIP program is changing and improving - NH has just authorized expanded coverage for low-income adults; NH has implemented new simpler Medicaid income eligibility rules that are generally aligned with the rules that will be used to determine eligibility within the Marketplace; and NH Medicaid has enrolled most members, including children, into a new Medicaid Care Management model.

MEDICAID CARE MANAGEMENT:
Most Medicaid-eligble children and pregnant women enrolled in a MCM Health plan in 2013. MCH staff worked with the Office of Medicaid and Business Management and the MCOs to share information with Title V agency staff on information available to families about enrollment, services, and benefits through emails and mailings.

MCH encouraged MCH contracted home visiting programs to negotiate covered services, including home visiting services for education, support, and assistance in getting enrolled on Medicaid and finding a Medical Home. (IB, PB)

MCH collaborated with DCYF to offer a newly combined FY15 MCH/DCYF-funded home visiting program through competitive bid process after numerous years of planning and discussion. MCH will share the monitoring, quality assurance, and other program oversight responsibilities, with DCYF playing the lead role. This collaborative project will provide seamless services to clients and reduce the burden of local agencies to contract with and report to multiple state agencies for similar and overlapping services.

c. Plan for the Coming Year
STRATEGIES AND PARTNERSHIPS:

MCH will continue to monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on Medicaid, and activities to enhance Medicaid enrollment through review of statistics, annual workplans, and discussions at site visits. (IB)

MEDICAID CARE MANAGEMENT:
MCH staff will continue to work with the Office of Medicaid and Business Management and the MCOs to share information with Title V agency staff on information and services available to families through emails and mailings.

Meridian Health Plan, one of three Managed Care Organizations (MCOs) providing Medicaid Care Management benefits in NH, has chosen to withdraw from the State effective June 30, 2014. Meridian, based in Detroit, Michigan, requested withdrawal from the program in order to focus on the growth of its core businesses in the Midwest. With the addition of the New Hampshire Health Protection Program ("Medicaid expansion") ramping up in late 2014, Meridian and NH DHHS agreed that a summer withdrawal would provide the best opportunity to minimize any disruption to the Program and its members.

Title V will continue to participate in DHHS workgroups to prepare for the rollout of Step 2 for MCM that will include children in Foster Care; children with special health care needs; home care for children with severe disabilities ("Katie Beckett"); children with Supplemental Security Income; and dual Medicare and Medicaid eligible.

MCH will collaborate with DCYF to offer a newly combined FY15 MCH/DCYF-funded home visiting program through competitive bid process following numerous years of planning and discussion. They will share the monitoring, quality assurance, and other program oversight responsibilities, with DCYF playing the lead role. This collaborative project will provide seamless services to clients and reduce the burden of local agencies to contract with and report to multiple state agencies for similar and overlapping services. (IB)

MEDICAID EXPANSION:
In 2014, policy makers in NH authorized the New Hampshire Health Protection Program (NHHPP) to provide health care coverage to low-income adults in New Hampshire. The NHHPP will be offered to people ages 19 to 65 whose income level is between 0 and 133% of Federal Poverty Level.

The NH Health Protection Program has two coverage options beginning in late 2014. The Health Insurance Premium Payment Program (HIPP) will help cover insurance costs for someone if they or a member of their family have access to health insurance through an employer. The Bridge Program is for those that don't have access to health insurance through an employer, or if they do not qualify for the HIPP Program.

In 2016, the Premium Assistance Program (PAP) will begin. Participants will move from the Bridge Program to the Health Insurance Marketplace. The State will subsidize the cost of qualified health insurance plans found in Marketplace for eligible adults.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

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

Annual Objective and	2009	2010	2011	2012	2013

Performance Data					
Annual Performance Objective	32	31	30	29	29
Annual Indicator	32.2	31.3	31.5	31.6	30.1
Numerator	2886	2698	2598	2453	2191
Denominator	8963	8621	8249	7763	7271
Data Source	NH WIC Program	NH WIC Program	NH WIC Program	NH WIC Program	NH WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29	28	28	27	26

Notes - 2013
Pediatric Nutrition Surveillance System, New Hampshire Department of Health and Human Services, 2013.

Notes - 2012
Pediatric Nutrition Surveillance System, New Hampshire Department of Health and Human Services, 2012.

Notes - 2011
Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

a. Last Year's Accomplishments
In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Obesity prevention is a priority area within SHIP. The plan sets an objective to reduce the proportion of children considered obese from a baseline of 18.1 % (2008) to 17.2% by 2015 and 16.2% by 2020.

Public health's role in obesity prevention is to create environments that support families and individuals in making healthy eating and active lifestyle choices. MCH will continue to participate in and support statewide initiatives that focus on planning and interventions that impact policy and environmental changes among schools, childcare, worksites and municipalities.

CDC no longer provides the state analyzed data for the Pediatric Nutrition Surveillance System. NH DPHS was unable to utilize internal resources to clean and prepare the raw data for this measure.

NH DPHS and Title V continued to participate in statewide initiatives focused on planning and interventions that impact policy and environmental changes among schools, childcare, worksites

and municipalities. (IB)

MCH and WIC together participated in statewide obesity prevention and control activities, including the Chronic Disease Integration initiative and State Health Improvement Planning. (IB, PB)

MCH collaborated with the Child Development Bureau, the Obesity Prevention Program and the Tobacco Prevention and Control Program to increase physical activity among preschoolers through training to child care providers and improving licensing rules pertaining to nutrition, physical exercise, screen time and tobacco exposure. (IB, PB)

MCH staff monitored BMI use by the community health centers through the results of its annual workplan and at site visits. Among the community health centers in SFY13, 67% of children two to nineteen years old, with a Body Mass Index (BMI) percentile greater than or equal to the 85%ile, received documented discussion that encouraged 5 servings of fruits and vegetables/day, 2 hours or less of screen time, 1 hour or more of physical activity and 0 sugared drinks. (IB)

MCH, in collaboration with WIC, received another Association of Public Health Nutrition Directors Blueprint Collaborative Project Mini- Grant to support training for MCH contract agency staff in counseling women about the impact of weight throughout the preconception and perinatal periods and on their child's health. This collaborative training was held June 18, 2013. (IB, PB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue participation in any statewide obesity prevention and control activities representing MCH, including the Chronic Disease Integration initiative, as they develop.			X	X
2. Collaborate with WIC and the Obesity Prevention Program in sharing trainings, educational material, and obesity data with the MCH contract agencies.				X
3. Continue to monitor BMI use by the community health centers through site visits, focusing on what guidelines are followed for children whose BMI indicates overweight or obesity status.				X
4. Work with other Department programs to increase physical activity among preschoolers through training to child care providers and improving licensing rules pertaining to exercise.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH is following up on the best-practice collaboration efforts between local Title V contract agencies and local WIC agencies. Results from an April survey to Title V funded agencies on collaboration, WIC eligibility determination, and breast feeding support training needs will be discussed at the June 2 MCH Coordinators' meeting. (IB)

MCH collaborated with WIC to receive a minigrant from the Association of State and Territorial Public Health Nutritionists and Dieticians to sponsor Dr. Jane Hienig, PhD, IBCLC, Executive Director of the Human Lactation Center in California, at a day-long training May 5th on the

relationship between infant behavior, feeding, and childhood obesity open to health and early childhood professionals. (IB, PB)

MCH collaborates with the Chronic Disease Integration initiative, the Child Development Bureau, WIC, and the Tobacco Prevention and Control Program on a variety of trainings and information sharing activities to increase physical activity, decrease screen time, and improve nutrition among early childhood population and the families enrolled in Title V funded health and home visiting programs. (IB, PB)

MCH continues to work with its contract agencies to encourage WIC enrollment of eligible children by monitoring WIC enrollment via site visits and workplan performance measure results and sharing successful local agency collaborative strategies at the spring 2014 MCH Coordinators' Meeting. (IB)

c. Plan for the Coming Year

MCH ACTIVITIES

MCH will continue to work with Title V contract agencies to improve local collaboration between WIC and Title V health agencies, consistency in determining WIC eligibility, and breast feeding support training needs, as indicated. In SFY 13, 76% of eligible infants and children seen at MCH-funded community health centers were also enrolled in WIC. Agencies that are below this average will be asked to develop action plans to improve coordination. (IB)

MCH will continue to collaborate with WIC and with the Obesity Prevention Program in sharing trainings, educational material, obesity data, and speakers with the MCH contract agencies. (IB)

MCH will collaborate with the Child Development Bureau, the Obesity Prevention Program and the Tobacco Prevention and Control Program to increase physical activity among preschoolers through training to child care providers and improving licensing rules pertaining to nutrition, physical exercise, screen time and tobacco exposure. (IB, PB)

MCH will continue to audit follow up of children with BMI indicating overweight or obesity status according to national guidelines at quality improvement site visits to community health centers. (IB)

MCH will work with agencies to discuss changing the BMI performance measure to one that is a more valuable indicator of assessing the agencies' response to overweight or obese children. (IB)

MCH will be requiring its community health centers to switch to use of the WHO growth charts for children under age two. (IB)

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	11.5	11	11.5	11
Annual Indicator	11.6	11.9	11.2	11.7	11.6
Numerator	1542	1529	1432	1424	1415
Denominator	13319	12797	12743	12220	12232

Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11	10.5	10	9.5	9

Notes - 2011
2010 provisional data used in FY13 application is updated to 2011 final data.

a. Last Year's Accomplishments
In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Because tobacco use and dependence remains the single most preventable cause of death and disability in New Hampshire, tobacco use among pregnant women is a priority area within SHIP. The plan sets an objective to reduce the number of women who report smoking cigarettes during pregnancy from 13.6% (2011) to 12% by 2015 and 10% by 2020.

MCH QUALITY ASSURANCE:
MCH monitored and provided technical assistance to MCH-funded prenatal and primary care agencies with particular attention to the prenatal performance on QuitWorks referrals (Prenatal PM #2). Health centers needed additional training to capture the rate of referrals to the Quitline as there was a wide variation in understanding of what "counts" as a referral. MCH Coordinators meetings are held twice a year and at least one representative from each Community Health Center is in attendance. During the fall meeting, a nurse from a local Community Health Center spoke about the successful integration of tobacco cessation counseling and referrals to the tobacco Quitline into the electronic medical record system. (DS, ES, IB)

The Perinatal Coordinator analyzed data from each community health center (data trend tables) and presented key findings from 2012 at the spring MCH Coordinator's meeting. All 17 contracted agencies that provide prenatal and/or primary care services (including primary care for the homeless) were sent an agency specific report including information on all performance measures including Quitline referrals. (IB)

In SFY13, 29% of pregnant women identified as cigarette smokers had a documented electronic referral to QuitWorks-New Hampshire. As described above, electronic referrals are made directly to QuitWorks-New Hampshire when a woman indicates that she is ready and interested in

receiving smoking cessation counseling.

COLLABORATION AND SYSTEMS BUILDING:
MCH continues to work with the Tobacco Control Program and CHCs interested in replicating the modified model of the 5 A's protocol using EMR and HL7 technology. Providers are required to refer patients directly to the State's Quitline. (DS, ES)

MCH expanded Healthy Families America home visiting model from five to eleven at-risk communities to bring the system statewide. Agencies are required to provide data that relate to improved maternal and newborn health including parental use of tobacco. (IB)

The Perinatal Coordinator monitored client-specific data for completeness and timely reporting by contracted agencies. Follow-up was done to three agencies that had not provided data in the requested timeframes. Agencies are encouraged to use the data for QI within their prospective agencies. (IB)

The PRAMS project was launched in March 2013. Several questions are related to tobacco use in the mother and in the home. (PB, IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women.	X	X		X
2. Continue to provide technical support to MCH-funded agencies that wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link.	X	X		
3. Promote Text4Baby when interacting with pregnant women, new parents/grandparents, and people who work with these groups of individuals.			X	
4. Conduct site visits in contracted agencies according to the clinic assessment schedule to monitor prenatal, primary care, and home visiting services.				X
5. Collect and monitor PCDF data on a quarterly basis and DTT information on a yearly basis. Share key findings with stakeholders. Use information for quality improvement and program planning.				X
6. Continue PRAMS project. Use available PRAMS data for program planning.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Technical support is provided to MCH-funded agencies who wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

Technical support is provided to home visitors regarding 2 As and R best practice model as requested. (DS, ES)

NH continues to actively promote Text4Baby engaging all pregnant women with social media about the importance of avoiding tobacco products and second-hand smoke exposure. Text4Baby tear off pads are distributed to prenatal programs as requested, during clinic assessment site visits, at WIC sites, and at a variety of in-state conferences. (PB)

QUALITY ASSURANCE/QUALITY IMPROVEMENT:
The Clinic Assessment process is ongoing. At least five MCH-funded Community Health Centers will be assessed. A random selection of prenatal and post-partum medical records will be checked to ensure patients are screened for tobacco use each trimester and during the post-partum period. Technical support will be provided to those agencies that require assistance completing required actions necessary for state and/or compliance. (IB)

c. Plan for the Coming Year
MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Technical support will be provided to MCH-funded agencies who wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

NH will continue to promote Text4Baby engaging all pregnant women with social media about the importance of avoiding tobacco products and second-hand smoke exposure. Text4Baby tear off pads will be distributed to prenatal programs as requested, during clinic assessment site visits, and at a variety of in-state conferences. (PB)

QUALITY ASSURANCE/QUALITY IMPROVEMENT:
The Clinic Assessment process has been an effective way to monitor contracted services. We will assess those MCH-funded Community Health Centers that were not assessed in FY 14. A random selection of prenatal and post-partum medical records will be checked to ensure patients are screened for tobacco use each trimester and during the post-partum period. (IB)

MCH contracted home visiting agencies will continue to participate in the clinic assessment process. Technical support will be provided to those agencies that require assistance completing required actions necessary for state and/or federal compliance. (IB)

MCH will continue to monitor DTT information for completeness and timeliness of reporting. This includes information related to tobacco cessation. Screening compliance and referral will be validated during site visit chart audits as part of the clinic assessment process. (IB)

The Perinatal Coordinator will provide contracted agencies that provide prenatal care, PC (including PC for the homeless), and home visiting services an updated agency specific DTT report with FY 2014 data. Key findings will be presented during a MCH Coordinator's meeting. High preforming agencies will be given encouraged to share strategies will other Community Health Centers during at least one MCH Coordinator's meeting. (IB)

MCH will continue to monitor quarterly PCDF data for completeness and timeliness of reporting. Key findings will be presented during a MCH Coordinator's meeting. (IB)

MCH will continue to participate in PRAMS. Data related to pregnant women and tobacco use and second-hand exposure will be shared with stakeholders. (PB, IB)

The Maternal, Infant, and Early Childhood Home Visiting Program will continue to collect data related to tobacco use and second-hand smoke exposure. Data will continue to be analyzed to determine if prenatal tobacco use decreases over time. (ES, IB)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0	2	7	7	8
Annual Indicator	8.9	9.6	9.6	5.4	7.6
Numerator	9	9	9	5	7
Denominator	100630	93620	93620	92612	92612
Data Source	Vital Records	Health Statistics	Health Statistics	Health Statistics	Health Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	7	6.5	6	5.5	5

Notes - 2013
2013 death data is provisional and subject to change.

Notes - 2011
Out of state data is unavailable. 2009 data is used as an estimate.

a. Last Year's Accomplishments
Suicide Prevention Council (SPC):
The mission of the State Suicide Prevention Council (SPC) is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the NH's Suicide Prevention Plan:
* Raise public and professional awareness of suicide prevention;
* Address the mental health and substance abuse needs of all residents;
* Address the needs of those affected by suicide; and
* Promote policy change.

MCH's Injury Prevention Program continued as a member of the SPC Leadership Team and serves as the full Council's Clerk. (IB)

The Injury Prevention Program Manager attended the "Suicide Prevention Research Symposium", a weeklong training seminar as the guest of the Injury Control and Research Center in Suicide at the University of Rochester. (IB)

A six year media analysis by the SPC Communications Subcommittee (n=150 articles on suicide) revealed that there has been a significant increase in the percentage of articles listing warning signs and resources for help. However, detailed description of the method of suicide and location has hovered around 50%. (IB, PB)

"A Decade of Hope", the 10th Annual New Hampshire Suicide Prevention Conference took place with 300 participants in the Fall of 2013. Six years of past conference participants were surveyed to determine what types of conference sessions would be of interest. Those surveyed consistently reported that an advanced level of training in all areas of suicide prevention would be desirable. Thus, the conference offered workshops geared towards the practitioner with at least several years in the field.

The 2013 plenary speaker discussed safe messaging. Drawing on examples from media and data reports as well as recent research, he explored the importance of safe messaging for all involved in suicide prevention efforts. A student from a local college also made a video, entitled "Decade of Hope", which interviewed over 20 people involved in suicide prevention.

Conference participants rated their knowledge of suicide prior to the conference as a mean of 3.65 (out of 5) and after as a mean of 4.33. Overall satisfaction was rated at a 4.46 (also out of 5) and expectations met were a 4.35. A workshop presenting first-hand insights into suicide prevention through the eyes of individuals who had experienced suicidal feelings and attempts rated the highest with a 4.83. Panel presenters in this workshop highlighted resources, people, treatment and strategies that helped them to stay alive, become stable and move towards recovery. (IB, PB)

"Reporting on Suicide: A Dialogue" took place on April 10, 2013 at the Nackey Loeb School of Communications in Manchester, New Hampshire. The Director of Nackey Loeb helped to bring on two additional organizations for co-sponsorship of the forum, the New Hampshire Association of Broadcasters and the New Hampshire Press Association. The intent was to have a relatively small audience of invited participants, media professionals and suicide prevention advocates, particularly the public information specialists in respective agencies. Approximately twenty-four people attended, with an equal mix of media and prevention making a ripe audience for discussion.

There was an additional facilitator, a Professor of Journalism from the University of New Hampshire and two guest speakers, the MCH's Injury Prevention Program Manager and the Executive Director of the National Alliance on Mental Illness, New Hampshire. A media panel was convened, including: a journalist at a large newspaper who has the distinction of writing the most articles on individual suicides in the state; an editor of a medium size outlet in a college community; and an on-line journalist. Panel and audience members were given several articles which were identified as being consistent or not-consistent with the recommendations. An evaluation facilitated with participants a week post forum generated positive feedback, particularly about the media panel. One editor in the audience took back materials handed out in the forum and facilitated his own learning/discussion session on the media guidelines/recommendations with his staff. A post forum evaluation revealed that a majority of the respondents still utilized the media recommendations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor MCH funded adolescent health programs and community health centers on integration of behavioral health and appropriate screening, referral and follow up.	X			X
2. Work with state partners, the SPC, and the various subcommittees to implement the newly revised Statewide			X	X

Suicide Prevention Plan.				
3. Coordinate with the Communications Subcommittee of the Suicide Prevention Council, monitor media reporting and offer guest lectures to journalism students in suicide reporting guidelines.			X	X
4. Write and submit a proposal to the Centers for Disease Control and Prevention for implementation of the National Violent Death Reporting System.				X
5. Write and release new request for proposals for adolescent health contract.	X			
6. Train first responders on the media recommendations for the reporting of suicide.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
MCH Strategies:
MCH is continuing its efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development. (PB, IB)

The adolescent and pediatric specialty sub contracts have been combined for Federal Fiscal Years 14 and 15. In previous years, the contract was implemented by the same agency with two distinct scopes of services. Both the Adolescent Health and Pediatric Primary Care Contract required specific behavioral health and depression screening for the adolescent population. (DHC)

Suicide Prevention Council (SPC):
The SPC Communications Subcommittee is working with the National Suicide Prevention Resource Center on adapting a subjective matrix for the evaluation of articles in accordance with media guidelines. A suicide coalition in California has developed a draft and through initial research has determined that consensus when using the matrix is greater than in merely having the media guidelines as a resource. (IB, PB)

The SPC Communications Subcommittee is continuing its monitoring of the reporting of suicides in the state. (IB, PB)

The Injury Prevention Program Manager presented at the 2014 American Association on Suicidology's annual conference. As part of a four person panel with colleagues from California and the Suicide Prevention Resource Center, New Hampshire's presentation focused on its media analyses and media forum. (PB)

c. Plan for the Coming Year
MCH Strategies:
MCH is partnering with the Medical Examiner's Office to respond to Centers for Disease Control and Prevention's Request for Proposals for implementation of the National Violent Death Reporting System. This is going to be done in accordance with previously organized inter-departmental plans which were written in accordance with 2012 legislation, House Bill 1436. (IB, PB)

MCH will continue to monitor funded adolescent health programs and community health centers on integration of behavioral health and appropriate screening, referral and follow up. This

includes newly funded Screening, Behavioral Intervention, and Referral to Treatment (SBIRT) programs in some of the community health centers. (DHC)

MCH will be putting out to bid the adolescent health contract for Federal Fiscal Year 16. Part of the contract includes an indicator on percentage of screening for suicide risk. (IB, DHC)

Guided by the newly revised New Hampshire Strategic Suicide Prevention Plan, MCH will continue its efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development. (PB, IB)

Suicide Prevention Council:
Journalism classes at Keene State, the University of New Hampshire and Franklin Pierce University (who offers a special degree in broadcast journalism) will be hosting representatives from the SPC in its annual teaching of the media guidelines. (PB)

The SPC Communications Subcommittee will continue its monitoring of the reporting of suicides in the state. Special emphasis will be given to training first responders, who are often the media's initial call after a suicide has happened. The media analyses showed that reports are still listing details of the method of suicide as well as the location. By training first responders on the media recommendations and their background, it is hoped that the percentage of articles that do not contain method and location are increased. (IB, PB)

The SPC Communications Subcommittee will be working with the National Alliance on Mental Illness, New Hampshire Chapter on a special visual and artistic presentation to take place during Suicide Prevention Awareness Week in September of 2014. (PB)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	89	90	83	87	76
Annual Indicator	81.3	78.2	73.6	74.2	79.8
Numerator	87	86	89	89	95
Denominator	107	110	121	120	119
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**

Annual Performance Objective	81	82	83	84	85

Notes - 2012
Final data is available for 2012.

a. Last Year's Accomplishments
In order to ensure that high-risk infants are delivered at the most appropriate facility, a comprehensive prenatal and perinatal care system must be in place. New Hampshire has 20 birthing hospitals, three of which are designated as Level III NICU and three additional are Level II NICU. Several other smaller community hospitals will care for sick neonates but only for a few days as they do not have the capacity on a longer term basis.

Because of New Hampshire's small geographic size, families and the healthcare system can take advantage of specialty facilities in Massachusetts, Maine and even Vermont, if necessary.

The CDC Maternity Practices in Infant Nutrition and Care (mPINC) survey identified NH as the leading state in the nation for maternity care practices. All facilities (100%) in New Hampshire include breastfeeding education as a routine element of their prenatal classes: 52% of facilities in New Hampshire adhere to standard clinical practice guidelines against routine supplementation with formula, glucose water, or water; 38% of facilities in New Hampshire have comprehensive breastfeeding policies including all model breastfeeding policy components recommended by the Academy of Breastfeeding Medicine. (PB)

CERTIFICATE OF NEED:
The Certificate of Need (CON) is a state regulatory program intended to determine the appropriateness of health care services and facilities developed in the State of New Hampshire. New Hampshire's CON Program was enacted in 1979 and is administered and managed by the Health Services Planning and Review Board within the Department of Health and Human Services. A CON is required to:
- Construct or modify health care facilities.
- Acquire new medical equipment (MRI, PET, radiation therapy,etc).
- Offer new inpatient care beds or services.

Hospitals that wish to provide Level III or Level II NICU Services must .....

MCH LEADERSHIP:
MCH participated in Perinatal Nurse Manager Meetings and Transport Conferences to promote communication between the hospitals. (IB)

Data from community health centers (CHCs) related to alcohol and substance use screening of pregnant women health centers (CHCs) was monitored through Data Trend Table reviews and chart audits during clinic assessments. MCH applied for SBIRT funding from SAMSHA to further support the CHCs. (DS, IB)

The PRAMS project was successfully launched in March 2013. PRAMS will provide data for MCH and other state health officials to use to not only improve the health of mothers and infants, but also ensure that there are adequate facilities in the appropriate geographic areas of the state. PRAMS provides data not available from other sources about pregnancy and the first few months after birth. (PB, IB)

The Maternal Mortality Review Panel (MMRP) reviewed a trial case in July 2013. Draft documents were revised based on feedback from the panel. MMRP Administrative Rules were officially approved and adopted. The MMRP reviewed three cases from 2012 and 2013 using the revised documents. (PB, IB)

MCH wrote a data brief on Neonatal Abstinence Syndrome (NAS), a postnatal drug withdrawal syndrome caused by maternal drug use. NH specific data was presented at the Northern New England Perinatal Quality Improvement Network conference in April. (IB)

MCH staff participated in regional and national conference calls and attended a national conference related to Critical Congenital Heart Disorder/Pulse Oximetry Screening. (PB, IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to MCH funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women.	X	X		X
2. Collect & monitor performance measures information in the Data Trend Tables. Share key findings with stakeholders. Use information obtained for quality improvement and program planning.				X
3. Conduct clinic assessments in contracted agencies according to the clinic assessment schedule.	X	X		X
4. Collect and monitor quarterly PCDF data. Use information for quality improvement and program planning.				X
5. Continue PRAMS project. Use available PRAMS data for program planning.			X	X
6. MCH will continue to participate on the Maternal Mortality Review Panel (MMRP).			X	X
7. MCH will continue to participate in regional and national conference calls related to Critical Congenital Heart Disorder/Pulse Oximetry Screening.				X
8. Continues to actively participate in the NH Statewide Partnership on Prenatal Substance Exposure and Alcohol Exposure.				X
9. Collaborate with BDAS to promote SBIRT in the CHCs.				X
10. Participate in Perinatal Nurse Manager Meetings and Transport Conferences to promote communication and coordination between providers and Public Health initiatives.				X

b. Current Activities

Representatives from MCH continue to participate in Perinatal Nurse Manager Meetings and Transport Conferences coordinated by Dartmouth Hitchcock to promote communication and coordination between providers and Public Health initiatives. (IB)

MCH continues to monitor and provide technical assistance to MCH funded prenatal and primary care community health centers that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Continue to monitor DTT information for completeness and timeliness of reporting. This includes information related to alcohol and substance use screening of pregnant women (Prenatal PM #3). The Perinatal Coordinator provided contracted agencies that provide prenatal care, PC (including PC for the homeless), and home visiting services an updated agency specific DTT report with FY 2013 data. The report was enhanced this year to include additional data that should assist agencies to reach targets. Key findings were presented during the June MCH Coordinator's meeting. Agencies are encouraged to use the data for QI and strategic planning within their prospective agencies. (IB)

MCH continues to monitor PCDF data for completeness and timeliness of reporting by contracted agencies. Data will be analyzed and used for quality improvement purposes as well as to guide public health policy in MCH. (IB)

MCH continues to participate in PRAMS. When available, PRAMS data related to very low birth rate infants and risk factors

c. Plan for the Coming Year

Continue to monitor and provide technical assistance to MCH funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Collect & monitor performance measure information in the Data Trend Tables. Share key findings with stakeholders. Use information obtained for quality improvement and program planning. (IB)

Alcohol and substance use screening of pregnant women (Prenatal PM #3) is validated during site visit chart audits as part of the clinic assessment process. (IB)

Monitor PCDF data for completeness and timeliness of reporting by contracted agencies. Utilize available data for quality improvement purposes and to guide public health policy in MCH. (IB)

Continue the PRAMS project. Use available PRAMS data for program planning. (PB, IB)

MCH will continue to participate on the Maternal Mortality Review Panel. Share finding with stakeholders. (PB, IB)

MCH will continue to participate in regional and national conference calls related to Critical Congenital Heart Disorder/Pulse Oximetry Screening. (PB, IB)

MCH will conduct clinic assessments in contracted agencies according to the clinic assessment schedule. (IB)

MCH continues to actively participate in the NH Statewide Partnership on Prenatal Substance Exposure and Alcohol Exposure and raise awareness related to Neonatal Abstinence Syndrome (NAS). (IB)

MCH will continue to collaborate with the Bureau of Drug and Alcohol services to promote SBIRT in the CHCs. (IB)

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

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	84	84	85	84	85
Annual Indicator	83.6	83.5	82.5	82.9	81.0
Numerator	8986	8504	9056	8946	8986
Denominator	10753	10183	10976	10785	11097

Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	83	84	85	86	87

a. Last Year's Accomplishments

QUALITY ASSURANCE:
MCH provided technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. Analysis and trending of the first prenatal performance measure, which looks at entry into care within the first trimester, was a priority. In SFY13, 83% of women enrolled in perinatal programs, received prenatal care beginning in the first trimester of pregnancy. Health center performance ranged from 60% - 94%. Special emphasis focused on those agencies with a low percentage of women coming into first trimester care. Each contracted agency was required to address how they were going to promote early entry into prenatal care within their practice in the workplan they submitted to MCH. (IB)

SYSTEMS DEVELOPMENT:
The data linkage project problems with birth certificates and PCDF linkage were addressed by the contractor and resolved. (IB)

PRAMS was launched with surveys to perinatal women in March 2013. (PB, IB)

MCH staff participated on the March of Dimes Program Planning Committee to ensure efforts for improving birth outcomes were linked. The "Healthy Babies are Worth the Wait" campaign aimed to reduce early elective non-medically necessary deliveries. Prenatal vitamins were supplied to one Community Health Center at no cost. (ES, PB, IB)

New Hampshire continued to actively promote Text4Baby engaging all pregnant women with social media about the importance of early and consistent prenatal care. Text4Baby tear off pads were supplied to prenatal programs during clinic assessment site visits. (PB)

Home visiting agency staff provided education and support to the pregnant women and the families they serve related to regular prenatal care including early entry into prenatal care. (DS)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and provide technical assistance to MCH-funded	X	X		X

prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women.				
2. The MIECHV Program continues to collect data related to early entry into prenatal care for families served through the home visiting agency contracts. Data will be analyzed over time to look for trends.		X		X
3. Conduct clinic assessments in all CHCs and at least three Home Visiting Programs not assessed this year.				X
4. Provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women.	X	X		X
5. Collect and monitor quarterly PCDF data. Share key findings with stakeholders. Use information for quality improvement and program planning.				X
6. Continue PRAMS project. Use available PRAMS data for program planning.			X	X
7. Continue to participate in the March of Dimes Planning Committee.			X	X
8. Promote Text4Baby when interacting with pregnant women, new parents/grandparents, and people who work with these groups of individuals.			X	
9. Promote LEAN activities within MCH.				X
10.				

b. Current Activities
MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The Maternal, Infant, and Early Childhood Home Visiting Program collects data related to early entry into prenatal care for families served through the home visiting agency contracts. (ES, IB)

MEDICAID MANAGED CARE /POSSIBLE MEDICAID EXPANSION
NH Medicaid made changes to its Medicaid program. It is moving most Medicaid recipients, including pregnant women to a Care Management program. Medicaid benefits did not change. Medicaid recipients are picking a health plan and a primary care provider from one of three contracted managed care vendors.

MCH leadership will continue to work closely with NH Medicaid in developing communication strategies for the provider community about the transition to Care Management.

Title V will continue to support community health centers to provide primary and perinatal care for all low income individuals during this transition.

c. Plan for the Coming Year
MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The Maternal, Infant, and Early Childhood Home Visiting Program will continue to collect data related to early entry into prenatal care for families served through the home visiting agency

contracts. Data will be analyzed over time to look for trends. (ES, IB)

Conduct clinic assessments in all CHCs and at least three Home Visiting Programs not assessed this year. (IB)

PCDF data will be monitored for completeness and timely reporting by contracted agencies. Agencies will be encouraged to use the data for QI within their prospective agencies. (IB)

MCH will continue to participate in PRAMS. PRAMS data related to pregnant women accessing prenatal care should be available and will be shared with stakeholders. Identified strengths and weakness will be used in program planning. (PB, IB)

The Maternal, Infant, and Early Childhood Home Visiting Program will continue to collect data related to adequacy of prenatal care using the Kotelchuck Index. Our goal is that the data will demonstrate an increase in the percent of women who receive adequate prenatal care. (ES, IB)

MCH staff will continue to participate on the March of Dimes Program Planning Committee to ensure efforts for improving birth outcomes are linked. (IB)

Continue to participate on the March of Dimes Program Planning Committee to ensure efforts for improving birth outcomes are linked. (IB)

NH will continue to actively promote Text4Baby engaging all pregnant women with social media about the importance of early and consistent prenatal care. (PBS)

D. State Performance Measures

State Performance Measure 1: *The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			48	50	85
Annual Indicator		45.7	45.7	82.8	66.8
Numerator		4086	4086	6187	5854
Denominator		8939	8939	7475	8758
Data Source		NH Medicaid Claims Data	NH Medicaid Claims Data	NH Medicaid Claims Data	NH Medicaid Claims Data
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87	89	91	93	95

Notes - 2013
Data and note from Andrew Chalsma, Office of Medicaid Business and Policy.

The lower rate for this measure is thought to be for two reasons:

NH Medicaid is using different systems to extract the data this year. In addition, most 12-18 year olds went into Care Management in December, and we do not yet have encounter data from the health plans doing managed care.

Notes - 2011
2011 data is unavailable, so 2010 data is used.

a. Last Year's Accomplishments
Integration:
With budget cuts to the DPHS-supported community health centers in SFY12 and SFY13 ranging from 38%- 50%, there were concerns that integrated services were being significantly impacted and access to care limited. MCH conducted primary care site visits to establish a new baseline of service assessment. The visits have shown that behavioral health services are being provided in a myriad of combinations, including direct care on site, integration into primary care, providing a "warm handoff" and referral to off-site services, and integration into a co-located contracted service provider. Recognizing the increased need for behavioral health services with the challenging financial times, agencies have attempted to retain such services but some have had to make adjustments, as one agency did by decreasing social worker visits with pregnant women from once each trimester to twice during the pregnancy.

In fact, using the same-tiered survey as in the past year, 84% of the agencies said that they have Tier III, which are fully integrated behavioral health services on a sliding scale fee for all patients. This is in comparison to last year's result, which was 66% of the agencies reporting a Tier III. (IB)

MCH Strategies:
The New Hampshire Children's Behavioral Health Collaborative released "Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children". The plan focuses on five areas of change including 1) policy, regulation and administration, 2) expanded services and supports, 3) adequate resources, 4) a supported workforce and 5) advocacy and outreach. (IB, PB)

MCH staff met with their counterparts from the Bureau of Behavioral Health (BBH). BBH is the part of the overall Department of Health and Human Services that contracts out Federal funds with ten local community mental health centers statewide. During MCH site visits, contracted community health centers have shared their positive and negative experiences with their local community mental health centers. Ideally, there is cooperation and collaboration between all local entities. Various questions and concerns have come up that were discussed at this initial State level meeting between MCH and BBH. (IB)

MCH worked with the New Hampshire Center on Excellence (for drug and alcohol issues) on an unsuccessful attempt to obtain funding for the evidence based approach to screening adolescents known as Screening, Brief Intervention and Referral to Treatment (SBIRT). However, the New Hampshire Charitable Foundation was successful in receiving funding from the Conrad N. Hilton Foundation to support MCH funded community health centers, amongst others, in their adoption of SBIRT. SBIRT helps to identify drug and alcohol use problems early when brief interventions are most effective and fosters appropriate referrals to treatment. (IB, DCS)

MCH worked with the Public Policy Subcommittee of the Suicide Prevention Council to petition the State's Mental Health Board for the inclusion of continuing education credits in suicide screening and prevention as a mandate for recertification. A decision by the Board will be coming out in Summer of 2014. (IB, DHC)

MCH received a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Project Launch. This program works across nine state agencies to improve coordination across early childhood systems that are focused on expectant parents, children from birth through third grade and their families. The objectives are multifold; 1) to increase access to

screening, assessment and referral to appropriate services for young children and families, 2) to increase integration of behavioral health into primary care settings, 3) to expand use of culturally relevant, evidence based prevention and wellness promotion practices in a range of settings, 4) to improve coordination and collaboration across local, state and federal agencies serving young children and families and 5) to increase the workforce's knowledge of children's social and emotional development and preparation to deliver high quality care. (IB, DHC, PB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate clinical chart reviews at community health center site visits looking for both screening and follow up on mental health diagnoses and referral.				X
2. Continue to encourage integration of behavioral health into primary care.				X
3. Work with Medicaid to further analyze the claims data related to this measure in order to explore geographic disparities in care, and better understand the mix of professionals providing care to this population.				X
4. Serve as a resource for educational opportunities and potential funding.				X
5. Share continuing education opportunities with agencies to increase their knowledge and expertise about caring for primary care patients with behavioral health issues.				X
6. Facilitate the implementation of “Project Launch”.	X	X	X	X
7. Following up with the Bureau of Behavioral Health Services on concerns on integrating behavioral health into primary care.				X
8. Work with partners on implementation of children’s behavioral health plan and SBIRT.	X	X	X	X
9.				
10.				

b. Current Activities

MCH Strategies:

The State's Medicaid program continues to monitor the rate of psychotherapy visits among this population as a key performance measure and provides data on an as needed basis. MCH is working with Medicaid and the MCH Epidemiologist to better understand the claims data related to this measure in order to explore geographic disparities in care, and better understand the mix of professionals providing care to this population. (IB)

MCH staff continues to work with the Manchester Health Department of the implementation of Project Launch. (IB, DHC, PB)

MCH continues to serve in an advisory capacity for the New Hampshire Charitable Foundation's in their implementation of SBIRT amongst some of the funded community health centers. (IB, DHC, PB)

MCH is working with the Children's Behavioral Health Collaborative on the implementation of "Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children". (IB, PB, DHC)

MCH is following up with the Bureau of Behavioral Health on action items from their meeting. (IB)

Integration:
MCH continues to visit all of its community health centers, including health care for the homeless, to assess how behavioral health services are provided within the CHCs.

WAIVER:
NH DHHS is applying for a Section 1115 Demonstration Waiver from CMS to support reform of the health care delivery system. It will focus on improving the integration of behavioral health and primary care.

c. Plan for the Coming Year

MCH Strategies:
MCH staff will work with the Children's Behavioral Health Collaborative on the implementation of "Transforming Children's Behavioral Health Care: A Plan for Improving the Behavioral Health of New Hampshire's Children". (IB, PB, DHC)

MCH staff will provide oversight to the Manchester Community Health Center on its implementation of Project Launch. (IB, DHC, PB)

Integration:
MCH staff will continue to visit all of its funded community health centers to assess how behavioral health services are provided to its clients. A new Request for Proposals for the Primary Care contracts will be released for Federal and State Fiscal Years 16, which will include behavioral health services as part of its scope of services. (IB, DHC)

MCH will also continue to share information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. This includes information from national partners including the Society for Adolescent Medicine. This also includes a potential roundtable at future MCH Directors' meetings where ideas such as the following can be discussed:

- Routinely utilizing a behavioral health staff member to go into the exam rooms during primary care sick visits and preventive visits, as needed, to do assessments and address issues.
- Leveraging private and foundation funding for additional on-site behavioral health services.
- Utilization of MDs, APRNs, LCSW, and other appropriate clinical and behavioral health professionals to create the best team for increasing access to psychotherapy, as well as medication management, for primary care patients

As a result of site visits, MCH staff has learned that this already exists at some community health centers. As such, MCH staff will invite appropriate partners to present at such a roundtable discussion. (DC, ES, IB)

MEDICAID WAIVER:
If the Section 1115 Demonstration Waiver is approved by CMS, MCH will work with NH Medicaid and other partners within the NH DHHS such as the Bureau of Drug and Alcohol Services (BDAS) to improve the integration of behavioral health services. MCH will work closely with BDAS as they administer a grant program for the community health centers that would fund workforce development initiatives focused on substance use disorder (SUD) and other behavioral health treatments and services. In addition to the main focus of the Waiver to improve access to integrated care for the Medicaid expansion population of low income adults, the training, technical assistance and support for infrastructure at the local level should also assist providers in better meeting the complex needs of adolescents. (DC, ES, IB)

State Performance Measure 2: *Percent of 3rd grade children who are overweight or obese*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			33.6	33.6	33.6
Annual Indicator	33.6	33.6	33.6	33.6	33.6
Numerator	1037	1037	1037	1037	1037
Denominator	3082	3082	3082	3082	3082
Data Source	NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey	NH 3rd Grade Healthy Smiles Healthy Growth Survey
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	30	30	30	30	30

Notes - 2012
No new data for 2012. Survey will not be repeated until 2014, as long term changes are not statistically significant in a short time frame.

Objectives are based on the NH Comprehensive Cancer Collaboration's Cancer Control Plan (2010-2011) that says "Reduce the average biennial increase in prevalence of overweight and obese youth to 0 %".

Notes - 2011
No new data for 2011. Survey will not be repeated until 2014, as long term changes are not statistically significant in a short time frame.

Objectives are based on the NH Comprehensive Cancer Collaboration's Cancer Control Plan (2010-2011) that says "Reduce the average biennial increase in prevalence of overweight and obese youth to 0 %".

a. Last Year's Accomplishments
BACKGROUND:
In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Obesity prevention is a priority area within SHIP. The plan sets an objective to reduce the proportion of children considered obese from a baseline of 18.1 % (2008) to 17.2% by 2015 and 16.2% by 2020.

Public health's role in obesity prevention is to create environments that support families and individuals in making healthy eating and active lifestyle choices. MCH will continue to participate in and support statewide initiatives that focus on planning and interventions that impact policy and environmental changes among schools, childcare, worksites and municipalities.

MCH LEADERSHIP:
MCH participates in the DPHS Chronic Disease Integration initiative which focuses on programmatic and policy changes using a life course approach to integrate obesity prevention into programs to decrease the burden of obesity, heart disease, diabetes, and reduce risk through school-based initiatives. Childhood obesity continues to be a priority. (IB)

MCH funded community health centers completed the first year of their new required Performance Measure regarding educating on the "5-2-1-0 Healthy NH Campaign" if a child is considered overweight or obese per their BMI percentile. Results ranged from no documented education on 5-2-1-0, to 99%, with an average of 75% compliance for the 14 centers. (IB, PB)

DPHS partnered with private funders to host a screening of HBO's, Weight of the Nation, for policy makers with discussion on role of government in promoting wellness. (PB)

State WIC staff presented information on World Health Organizational (WHO) growth charts for children birth to age two at the Spring 2013 MCH Coordinators' Meeting. (IB)

MCH collaborated with WIC and the Obesity Prevention Program to successfully win a $5,000 minigrant from the Association of State and Territorial Public Health Nutritionists and Dietitians which is sponsoring a June conference for MCH-funded community health center and home visiting program staff, WIC local agency staff, and Public Health Network staff on the impact of weight before, during, and after pregnancy on a woman and her child. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assess what MCH-funded community health centers are doing re: providing education and follow up to children obese or overweight as noted in quality assurance site visits and record reviews.				X
2. Continue to collaborate with other public health and childcare leaders to institutionalize healthy eating and physical activity training.				X
3. Continue to explore and provide education and training opportunities for MCH contract agency staff on topics related to obesity prevention/healthy lifestyle/nutrition.			X	X
4. Utilize county-level surveillance through the "Third Grade Healthy Smiles-Healthy Growth Survey" to develop and implement strategies for healthy growth of NH children.			X	X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
MCH continues to participate in the DPHS Chronic Disease Integration initiative which focuses on programmatic and policy changes using a life course approach to integrate obesity prevention into all of its programs. (IB)

MCH continues to provide leadership to the Young Families workgroup of early childhood content specialists from the Bureau of Population Health and Community Services which seeks to establish coordinated messaging to the early childhood community relative to the Bureau's work with and on behalf of the maternal and child health population. (IB)

MCH, in collaboration with WIC, received another Association of Public Health Nutrition Directors Blueprint Collaborative Project Mini- Grant to support training for MCH contract agency staff in counseling women about the impact of weight throughout the preconception and perinatal periods and on their child's health. This collaborative training was held June 18, 2013. (IB, PB)

The New Hampshire "Third Grade Healthy Smiles-Healthy Growth Survey" is currently being conducted. Analysis of new county-level data will be available in SFY15. (IB)

c. Plan for the Coming Year
STRATEGIC PARTNERSHIPS:

MCH will utilize the results of the Third Grade Healthy Smiles-Healthy Growth Survey to develop targeted strategies for improving the health of its children. (IB, PB)

MCH staff will revise its chart audit tool for site visits to state-funded community health centers to more closely assess the follow-up of children documented as being overweight or obese to assess if national guidelines are being adhered to. (IB)

MCH will change the requirement in its Scope of Services in the SFY15 Request for Proposals for primary care services to include use of the WHO growth charts for children birth to age two to align with CDC recommendations and the WIC clinics' state and national use. (IB)

MCH will continue to provide leadership to the Young Families workgroup of early childhood content specialists from the Bureau of Population Health and Community Services including Healthy Child Care NH; Obesity Prevention Program; Healthy Homes and Lead Poisoning Prevention Program; Immunization Program; Diabetes; Tobacco Prevention Program; Oral Health; WIC and Home Visiting. This integrated workgroup seeks to establish coordinated messaging to the early childhood community relative to the Bureau's work with and on behalf of the maternal and child health population. The Young Families workgroup will work with the NH DHHS Child Development Bureau and Child Care Licensing Unit to strengthen licensing standards for early learning centers to include nutritional requirements for foods and beverages served. (IB)

MCH will continue to participate in the DPHS Chronic Disease Integration initiative which focuses on programmatic and policy changes using a life course approach to integrate obesity prevention into all of its programs. (IB)

State Performance Measure 3: *Percent of 18-25 year olds reporting binge alcohol use in the past month*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			51	49	49
Annual Indicator	53.7	53.7	51.3	51.3	49.3
Numerator	72000	72000	72000	72000	
Denominator	134153	134153	140300	140300	
Data Source	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health	National Survey on Drug Use and Health
Is the Data Provisional or Final?				Provisional	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	47	45	43	42	41

Notes - 2013
The latest data from The National Survey on Drug Use and Health, 2010-2011 shows in Table 10 that the estimate is now 49.32% of 18-25 yr olds reporting binge alcohol use in the past month. There is no numerator and denominator available.

http://samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/ExcelTabs/NSDUHsaeTables2011.pdf

Notes - 2012
Data is the most recent from the National Survey on Drug Use and Health. This data is 2008-2009.

Notes - 2011
Data is the most recent from the National Survey on Drug Use and Health. This data is 2008-2009.

a. Last Year's Accomplishments
BACKGROUND:
As the most misused substance by youth and adults, alcohol causes the most significant safety and health burdens, including car crashes, alcohol poisoning, domestic violence, fetal alcohol exposure and other consequences. In New Hampshire, the rate of alcohol use and binge drinking (having five or more drinks within a couple of hours) among 12 to 20 year olds is significantly higher than the national average.

PROMOTING QUALITY CARE:
MCH provided training about using validated screening tools for specific populations including adolescence & perinatal period. MCH QA Nurse Consultant monitored agencies' use of a validated screening tool for adolescents that detect alcohol & other substance abuse during site visits through interviews & random chart audits.

In SFY 13, 87% of pregnant women who receive care at an MCH-funded community health center were screened, using a formal valid screening tool, for alcohol and other drug use during

every trimester the patient was enrolled. Those agencies that performed lower than this average were required to develop a corrective action plan to improve screening rates. (IB, ES)

SYSTEMS DEVELOPMENT:
MCH explored alternate sources of funding for Screening, Brief Intervention, & Referral to Treatment with Trauma Modules (SBIRT-TM) & ECCS. (EB)

MCH promoted screenings & referrals to treatment for alcohol abusing pregnant women to reduce the incidence of Fetal Alcohol Syndrome (FAS). (PB)

The Title V Director was a member of the NO-FAS NH Board of Directors, which emphasizes public awareness, primary prevention, education, appropriate treatment, & support. NOFAS- NH Annual Summit was held in the fall 2012. (PB, IB)

Substance Abuse During Pregnancy & Beyond: A Conference Focused on Home Visiting was held June 5, 2013. This full-day event featured national speakers who covered multiple topics including resources for intervention & treatment in New Hampshire. (PB)

Project LAUNCH identified a Leadership Team, hired staff, and conducted an Environmental Scan of services that promote young child wellness & prevention activities including screening & assessment in a range of child-serving settings. (IB)

NH Fetal Alcohol Syndrome Association (NOFAS) Strategic plan was used in the development of the New Hampshire Comprehensive Strategic Plan for Early Childhood in 2013. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate and provide leadership to NOFAS- NH Fetal Alcohol Spectrum Disorders and its Annual Summit.			X	
2. Support Project LAUNCH implementation.		X	X	X
3. Promote training and professional development to support the implementation of SBIRT activities in community health centers.		X	X	X
4. Support ECCS project to mitigate toxic stress across early childhood systems.			X	X
5. Promote Validated screening and referrals.			X	
6. Participate in the New Hampshire Statewide Partnership to Address Opioid Use Among Pregnant Women.			X	X
7. MIECHV funds support community level collaborative meetings to coordinate activities related to binge-drinking and other public health issues in local communities.				X
8.				
9.				
10.				

b. Current Activities
Alcohol Screening and Brief Intervention is provided to women during the perinatal period in MIECHV and other MCH programs. Women enrolled in MCH-funded prenatal programs receive screening once per trimester. Training about NH Substance Abuse Treatment Services and Resources was provided by Bureau of Drug and Alcohol Services. (ES)

Project LAUNCH coordinates validated screenings such as those for parental/family alcohol use, depression and child development and is expanding use into a range of child-serving settings.

(ES)

NO-FAS NH promotes primary prevention education about binge drinking among young adults and the relationship between it and FASD. (PB, IB)

MCH disseminates public education materials and messages, such as NH BDAS Resource Guide for Promoting Prevention and Recovery, to youth, families, and individuals served by its programs and systems. (PB)

Workforce development activities in the early childhood system increase staff knowledge about screening and appropriate referral services for alcohol and other substance abuse. (PB)

MCH facilitates a statewide partnership that examines and analyzes data about prescription drug and other opioid use during pregnancy and its impact on babies. Some objectives and strategies for this Partnership may have crossover impact for the population of young adults binge drinking, including the development of new signage at NH Liquor Stores. (PB IB)

BDAS released the following:
http://www.dhhs.nh.gov/dcbcs/bdas/documents/issue-brief3.pdf

c. Plan for the Coming Year

Young adults in NH continue to have some of the highest rates of alcohol and drug misuse when compared to young adults nationally. By collaborating with partners such as Bureau of Drug and Alcohol Services and Medicaid, MCH hopes to reverse this trend.

SYSTEMS DEVELOPMENT/ SUPPORTING STRATEGIC PARTNERSHIPS:
In alignment with the New Hampshire Health Protection Plan (Medicaid "expansion") the NH Department of Health and Human Services (DHHS) is applying for a Section 1115 Demonstration Waiver (Waiver) from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support the continuing reform of its Medicaid program and of NH's health care delivery system as a whole. The Waiver, titled Building Capacity for Transformation, proposes to address:
• The fragility of the current behavioral health delivery system;
• The challenges facing the behavioral health delivery system in meeting the needs of individuals; and
• The fragmented delivery system for individuals with complex health needs.

In preparation for this waiver, DPHS leadership has worked with the Bureau of Drug and Alcohol Services and Medicaid to develop a new substance use disorder (SUD) benefit to be available to both the current Medicaid population and new enrollees in the New Hampshire Health Protection Plan .

Specific to this benefit, Community Health Centers will receive specific training to increase the capacity to provide SBIRT activities, treatment and recovery supports. MCH will work in partnership with Bureau of Drug and Alcohol Services and Medicaid to support these efforts.

PROMOTING QUALITY CARE:
MCH will promote the FASD Center for Excellence's comprehensive web site (www.fasdcenter.samhsa.gov) which includes environmental scanning of current literature and practices related to FASD.

The PRAMS survey will continue to explore use of alcohol and tobacco before and during pregnancy.

Project LAUNCH local pilot will coordinate screening and assessment in a range of child-serving

settings. Validated screenings for parental/family alcohol use, depression and child development will continue to expand into child care centers, Early Head Start, and early supports and services as the results are being evaluated. (ES, IB)

Alcohol Screening and Brief Intervention and other SBIRT activities will be provided to women during the perinatal period in MIECHV and other MCH programs. Women enrolled in MCH-funded prenatal programs will continue to receive screening once per trimester. Additional training will be provided about best practices for adolescents and adults in primary care settings. (ES)

Through a contract with Community Health Institute (CHI), MCH will use ECCS funds to provide a Train-the-trainer program throughout the state that focuses on Trauma Informed Care. The program will increase awareness of the the impact of toxic stress on brain development and thus the potential for long term consequences for young families experiencing trauma.

State Performance Measure 4: *Percent of Community Health Centers providing on-site behavioral health services*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			100	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		15	14	14	16
Denominator		15	14	14	16
Data Source		Email survey of contracted CHCs	Email survey of contracted CHCs	Email survey of contracted CHCs	Email survey of contracted CHCs
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2012
Data obtained from March, 2014 email survey received from the 13 state-funded Community Health Centers, 1 pediatric primary care agency, and 2 primary care for the homeless programs; assessing level of on-site behavioral health services. Options were:

- Tier 1: Formal process (i.e., MOU/A) for referring health center patient population to services
- Tier 2: On site services based on health center sliding fee scale available to some, but not all, populations of patients
- Tier 3: Fully integrated services based on health center sliding fee scale available to all patients.

All but three agencies indicated they were Tier 3. The other three agencies were Tier 2.

Notes - 2011

Data obtained from May, 2011 email survey to the 13 state-funded Community Health Centers, plus 1 pediatric primary care agency, assessing level of on-site behavioral health services. Options were:

- Tier 1: Formal process (i.e., MOU/A) for referring health center patient population to services
- Tier 2: On site services based on health center sliding fee scale available to some, but not all, populations of patients
- Tier 3: Fully integrated services based on health center sliding fee scale available to all patients.

One (Pediatric Primary Care) agency falls into both Tier 1 and Tier 2. One falls into Tier 2 for 2 of its 3 sites, and Tier 3 for its third site.
The other 12 are in Tier 3.

a. Last Year's Accomplishments
SUPPORTING THE SYSTEM
The Community Behavioral Health Association of New Hampshire, a coalition of mental health groups, released a two-year $33 million plan to increase the state's capacity to treat the mentally ill in the hospital and in the community in January 2013. (IB, PB)

The new Governor asked for $28 million over two years to begin restoring community mental health services which would help to relieve the burden currently on the community health centers. (IB, PB)

New funding was proposed for Community Health Centers for SFY14 and 15 to help restore cuts made in previous bienniums. However, the NH DHHS must still make 'back of the budget" cuts which could ultimately have an impact on personnel and/or services. (IB)

MCH conducted site visits to its community health centers including health care for the homeless, to assess how behavioral health services are provided to its clients. (IB)

MCH shared information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. (IB)

MCH provided leadership for the newly awarded SAMHSA collaborative, Project LAUNCH, which partners with SPARK NH, the State's Early Childhood Advisory Council and community partners in the City of Manchester to expand and enhance of evidence-based mental health services for young children and their families. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Share continuing education opportunities with agencies to increase their knowledge and expertise about caring for primary care patients with behavioral health issues.				X
2. Conduct site visits to learn about how behavioral health services are provided to its clients.				X
3. Utilize a funding formula that incentivizes integrated approaches to primary care.				X
4. Continue to provide leadership and oversight of Project LAUNCH.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
MCH provides leadership and oversight of Project LAUNCH. The project is working to increase screening and assessment; integrate behavioral health interventions into primary care practice; increase identification and treatment of behavioral health issues in child care and Head Start; improve social and emotional well-being of young children through enhanced home visiting services; and improve families' ability to support the multidimensional needs of their children through training and education.
(IB, PB)

MCH continues to share information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. (IB)

MCH conducts site visits to its community health centers including health care for the homeless, to assess how behavioral health services are provided to its clients and assess any changes due to budget changes. (IB)

The majority of the state-contracted community health centers and primary care for the homeless programs continue to offer Tier 3, full integrated services based on a health center sliding fee scale available to all patients. (DC)

WAIVER:
NH DHHS is applying for a Section 1115 Demonstration Waiver from CMS to support reform of the health care delivery system. It will focus on improving the integration of behavioral health and primary care.

c. Plan for the Coming Year
MCH will continue to provide leadership and oversight of Project LAUNCH which works to increase screening and assessment; integrate behavioral health interventions into primary care practice; increase identification and treatment of behavioral health issues in child care and Head Start; improve social and emotional well-being of young children through enhanced home visiting services; and improve families' ability to support the multidimensional needs of their children through training and education.
(IB, PB)

MCH will continue to share information about training and education opportunities and potential funding, for staff of community health centers to increase their knowledge and expertise about caring for primary care patients with behavioral health issues. (IB)

MCH will continue to conducts site visits to its community health centers including health care for the homeless, to assess how behavioral health services are provided to its clients and assess any changes due to budget changes. (IB)

MCH has signed a Memorandum of Understanding with the Bureau of Drug and Alcohol Services to facilitate access for eligible pregnant/postpartum women and low income adults in the Title V funded agencies to recovery services through the BDAS "Access to Recovery Initiative" if BDAS receives funding from a federal grant for which it has applied. (IB, PB)

WAIVER:
If the Section 1115 Demonstration Waiver is approved by CMS, MCH will work with NH Medicaid and other partners within the NH DHHS such as the Bureau of Drug and Alcohol Services (BDAS) to improve the integration of behavioral health services. MCH will work closely with BDAS as they administer a grant program for the community health centers that would fund workforce development initiatives focused on substance use disorder (SUD) and other behavioral health treatments and services.

In addition, New Hampshire will be introducing a SUD benefit for the newly eligible childless adult population enrolled in the NH Health Protection Plan. New Hampshire has seen an alarming increase in the abuse of prescription and illegal drugs in the State such as heroin and other opioids, as has occurred across the nation.
This combination of an increasing need for screening and treatment services and the implementation of a SUD benefit will have an impact on an already overburdened provider network, including the community health centers.

Supports from the BDAS administered grant program for infrastructure and workforce development coupled with a new SUD benefit will provide the needed resources to help each of the community health centers further integrate care and provide on-site behavioral health services.
(DC, ES, IB)

State Performance Measure 5: *The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			28	30	32
Annual Indicator	26.5	26.5	30.6	30.6	
Numerator	18921	18921	19643	19643	
Denominator	71450	71450	64194	64194	
Data Source	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	National Survey of Children's Health	
Is the Data Provisional or Final?				Final	
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	34	36	38	40	

Notes - 2013
Data from NSCH 2011-2012, Indicator 4.16

Notes - 2012
Data from NSCH 2011-2012, Indicator 4.16

Notes - 2011
Data from NSCH 2011-2012, Indicator 4.16

a. Last Year's Accomplishments
In 103, the NH State Health Improvement Plan (SHIP) identified Healthy Mothers and Babies as one of its 10 Priority Areas. Among the strategies to promote a healthy start to life that may have the greatest potential to reduce health disparities across the life course is to increase screening for Autism Spectrum Disorder (ASD) and other developmental delays. (PB, IB)

The plan sets an objective to improve early diagnosis and access to care among those children with Autism Spectrum Disorders, who receive a diagnosis by 36 months of age from 33.6% in 2012 to 40% by 2015 and to 50% by 2020.

STRATEGIC PARTNERSHIPS:
The NH Registry for ASD requires physicians, licensed clinical psychologists,and other healthcare professionals who diagnose a NH resident with ASD to report the diagnosis, using an online reporting form. In SFY 13,
146 NH residents were newly diagnosed with ASD and added to the online registry for ASD. More than one third of new ASD diagnoses were made for children under the age of three (37%) and 87% were made in elementary school age children under the age of nine. This was an increase in both age groups demonstrating improvements in early diagnosis.

MCH has been an active leader in the Watch Me Grow statewide developmental screening collaborative and system since its earilist planning over 10 years ago. MCH supported the leadership for the Watch Me Grow Steering Committee and participated in the annual stakeholder meeting. In partnership with Part C and DCYF, MCH led the Steering Committee which engaged a leading consultant to help design a WMG communications and public awareness plan. (IB, PB)

Title V actively participated in the NH Autism Council and the Act Early Team . As per the NH Autism Registry, 2013, more than one third of new ASD diagnoses in NH have been made for children under the age of three, and 87% were made in elementary school age children under the age of nine. (PB, IB)

MCH administers the SAMHSA Project LAUNCH Cooperative Agreement which included the hiring of a Watch Me Grow Coordinator in the pilot community to enhance developmental screening by coordinator referrals and increasing the settings for such screenings across early childhood serving programs in Manchester.(IB, ES)

MCH provided cross-systems training and TA on developmental screening and related topics. Each home visiting contract required that home visitors assist families with young children, beginning when the child is 4 weeks of age, with the completion of the ASQ-3 developmental screening. (IB)

Data collected from HVNH agencies and the WMG system was included in the Needs Assessment for Spark NH, the state's early childhood advisory council, and the development of the State's Comprehensive Early Childhood Plan (IB)

MCH funded six agencies that provided ASQ-3 Developmental Screenings in HVNH/CFHS programs. Two additional agencies provide ASQ-3 in Healthy Families America programs that are supported by the MIECHV grant but administered through MCH in NH. (IB)

Title V Director and the ECCS Coordinator continued as members of the leadership of the State Early Childhood Advisory Council. Priority areas included ensuring that all young children and their families have access to trained professionals to screen, assess, diagnose, and treat them. Strategic Planning included family input regarding access to screening with a resulting

comprehensive plan for early childhood systems in New Hampshire that supports developmental screening and referrals. (IB)

Act Early Ambassador provided CDC materials at June MCH Coordinators' meeting. MCH coordinated efforts with WIC and ACT Early to promote developmental screening in WIC sites. (PB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Watch Me Grow Steering Committee will use information from the 2014 Stakeholder Committee to continue development of the Watch Me Grow System and implement a communications and public awareness plan.			X	X
2. All MIECHV grantees are required to screen at regularly indicated times; systems will be in place to capture data.			X	X
3. Project LAUNCH activities will be implemented in Manchester to increase the number and type of settings providing valid screening and assessment to serve more children.			X	X
4. Watch Me Grow (WMG) will be included in the collaborative Comprehensive Family Support Services contract requiring programs to use and track screening and referrals.			X	X
5. Title V will continue to provide leadership to the NH Autism Council.				X
6. MCH will coordinate with WIC and ACT Early to promote possible developmental screening in WIC sites.			X	X
7. Title V will continue to provide leadership to Spark NH, the state's early childhood advisory council.				X
8. MCH will partner with the Leadership Education in LEND program to train providers on developmental disabilities screening.			X	X
9. MCH will promote the CDC "Learn the Signs, Act Early" • public information campaign.			X	X
10. MCH will include developmental screening requirements in home visiting contracts.		X	X	X

b. Current Activities

MCH provides quality assurance oversight to community health centers to ensure comprehensive and age appropriate health care, screenings, and health education according to the AAPs' most recent periodicity schedule. (PB, IB)

MCH collaborates with DCYF to provide a wide range of family-centered services, including developmental screening, to support families and children in their own homes. (IB, PB)

The training plan for staff who provide home visiting services includes developmental screening and referrals. (IB, PB)

MIECHV HFA programs report more than 92% of children who were at least 5 months old, received at least 1 ASQ and more than 83% of children who scored below the cutoff on any ASQ, received a referral. (IB, PB)

As one of the three WMG State Administrators; MCH ensures system implementation,

accountability, sustainability and quality. Website launched 2014: watchmegrownh.com (ES) (IB)

Project LAUNCH activities include the hiring of a Watch Me Grow Coordinator to increase the number and type of settings providing valid screening and assessment to serve more children in the pilot community (EB)

Title V with the University of New Hampshire is working to implement a Child Health Improvement Partnership (CHIP) model in NH called the NH Pediatric Improvement Partnership (NH PIP). Developmental screening will be one of the child health priorities that will be addressed as its first effort for quality improvement and systems change. (IB)

c. Plan for the Coming Year

As recommended in the NH SHIP, MCH will continue to promote and support comprehensive preventive pediatric care in community health centers to ensure autism screening and development screening per American Academy of Pediatrics (AAP) guidelines. MCH will continue to monitor and provide technical assistance to MCH-funded primary care agencies to ensure that providers are using formal, validated screening tools and screening is timely and appropriate. (IB, ES)

STRATEGIC PARTNERSHIPS:

Title V will continue to support community based developmental screening systems including Watch Me Grow. WMG will continue to be coordinated by the NH Department of Health and Human Services and the WMG Steering Committee, which includes representatives from state agencies and public and private organizations. WMG locations and their partners throughout the state offer screening activities to families. (IB)

20th Annual NH Association for Infant Mental Health Conference will be held September 11 and 12, 2014, "Understanding and Promoting Neuro-Development, Prenatal through Preschool" featuring Dr. Pat Levitt, PhD. (IB)

New Hampshire Comprehensive Strategic Plan for Early Childhood, 2013-2016, brings together all statewide efforts in the state related to the critical period of child development across health, early learning and family support. Activities will enhance the coordination and alignment of the early childhood system in New Hampshire. (IB)

Title V will continue to participate in Spark NH, the state's early childhood advisory council in support of programs to engage in quality early identification screening and referral activities and the expansion of state developmental screening, early identification and referral system (WMG) as outlined in the Comprehensive Strategic Plan for Early Childhood. In addition, MCH will collaborate with public and private partners to explore ways of connecting screening of young children and their families (e.g., maternal depression screening, lead poisoning screening, etc. (IB, PB)

MCH will continue to promote and support comprehensive preventive pediatric care in community health centers to ensure autism screening and development screening per American Academy of Pediatrics (AAP) guidelines. (IB, PB, EB)

Title V will continue to partner with the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program to train providers on developmental disabilities screening. (PB, IB)

DHHS will continue to maintain an Autism Registry. (PB)

Title V will promote the CDC "Learn the Signs, Act Early" public information campaign. (IB)

State Performance Measure 6: *The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2100	2000	1775	1400	1450
Annual Indicator	1,794.2	1,482.7	1,482.7	1,482.7	1,482.7
Numerator	1762	1410	1410	1410	1410
Denominator	98207	95099	95099	95099	95099
Data Source	Vital Record	Health Statistics	Health Statistics	Health Statistics	Health Statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1400	1350	1300	1250	1200

Notes - 2013
Previously, New Hampshire contracted with an outside agency to collect and clean all hospital discharge data. Due to issues of data quality, a decision was made to manage and steward this data within the Division of Public Health Services beginning with 2010 data year. Developing and implementing a coding system at the state level has presented a number of technical challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. At this time, there is no estimated time when the 2010 hospital data will be ready for use. Also please note that since a new data collection process is being used, it is recommended that the 2010 hospital data be used as a new base line as it may not be comparable to previous year's data.

Notes - 2012
Most recent updated data is 2009. This is used as an estimate.

Notes - 2011
Most recent updated data is 2009. This is used as an estimate.

a. Last Year's Accomplishments
Teen Driving Committee (TDC):
The TDC led New Hampshire Teen Driving Program (NHTDP) continued into its second academic year with three high schools continuing to participate. The NHDTDP's objectives continue to be to an increase in seat belt use and in students' understanding of the actual risks associated with driving and, therefore, the importance of making safe choices when driving or when riding as passengers. Members of the TDC worked with the students from the three schools on content area and in designing peer led traffic safety programming. One of the high schools developed a highway safety club that coordinated monthly safety events for their peers. Students from another high school, with assistance from their community, created a video promoting teen seat belt use entitled "Somebody Loves You, Somebody Needs You" (www.youtube.com/watch?v=k1pfvGwnXHs). This video continues to be used in driver education and defensive driving courses around the state.

The usage rate after the first year went up 21 percentage points averaged amongst the three schools. However, a comparison between the first seatbelt surveys done at the beginning of the project and those done after year two resulted in an average increase of nine percentage points

(a decrease between years). Although the seatbelt usage was higher over the two years, it decreased from the end of year one to the end of year two. One potential remedy is to facilitate additional programming. The idea is to create a culture of "sustained" highway safety. In general health messaging works in changing behavior if it is sustained and people feel efficacious about changing their behavior. Students at the three schools started out the second year strong with many presentations and projects, but during second semester only did presentations around prom time.

The initial success of the NHTDP with these first three high schools resulted in the Department of Transportation providing funding (a contract was signed by Governor and Council in November of 2013) through the Brain Injury Association (a TDC member) to expand the program into 15 schools for a three year period. The TDC will continue to have oversight. Schools will be chosen by application, but schools scoring in the lowest percentile of the Youth Risk Behavior Survey seatbelt questions will be approached first. (PB)

"Saving Lives: Graduated Licensing Best Practice for New Hampshire's Teen Drivers", written by the TDC and produced by WeDu, a marketing firm contracted with the Department of Transportation, was distributed to both the Senate and House Transportation Committee members. It can be accessed at the New Hampshire Driving Towards Zero website at www.nhdtz.com. The Transportation Committees of both the House and the Senate are often the places where bills start their journey to the possibility of becoming a law. Testimony is taken within those committees that then vote on a recommendation to the full House and/or Senate. Having members understand evidence based public health reasons for policies like GDL is very important. The brochure contains data on teen crashes, particularly time of crashes and number of passengers, both important concepts in Graduated Driver Licensing or GDL. It also includes suggestions on how to protect teen drivers, particularly for parents. (PB)

MCH Strategies:
The Injury Prevention Program created a five-year plan, which includes evaluation, under the two year (one year with unexpended carry over funds for a second year) CDC Core Injury and Violence Prevention Grant. This plan focuses on six areas of injury, one of which is motor vehicle crashes, with the distal goal consistent with the MCH Block Grant. The plan was released at a special Injury Prevention Advisory Council (IPAC) meeting where colleagues from AAA and the Rhode Island Injury Prevention Program spoke about best practice with respect to motor vehicle crash prevention policy. An accompanying evaluation plan was also created with the help of the Center for Program Design and Evaluation at Dartmouth. (IB)

Several new Youth Risk Behavior Survey questions were added to the 2013 survey on teen driving behaviors, such as " During the past 30 days, on how many days did you text or e-mail while driving a car or other vehicle?" and "How often do you wear a seat belt when driving a car?" (ES, IB, PB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate monthly meetings of the Teen Driving Committee.				X
2. Work with the Teen Driving Committee and the Brain Injury Association on expanding the New Hampshire Teen Driving Project.				X
3. Work with the Teen Driving Committee and other colleagues to implement the strategies outlined in the teen driving section of DPHS's Strategic Health Improvement Plan which are consistent with those in the Strategic Highway Safety Plan.			X	X
4. Attend the Evaluation Institute and subsequently develop and				X

implement an evaluation plan specific to the New Hampshire Teen Driving Project.				
5. Monitor clinical adolescent health activities at the contracted primary care agencies through site visits.	X			
6. Work with the Teen Driving Committee on the development and implementation of the parent component of www.nhdtz.com.			X	
7. Develop Performance Management Application strategies specific to teen driving.				X
8.				
9.				
10.				

b. Current Activities
Teen Driving Committee (TDC):
The TDC has begun oversight over the expanded NHTDP, enlarging the project to 15 schools. Schools are currently being vetted for participation and once chosen, are facilitating initial observational seat belt surveys. (PB)

The TDC and the New Hampshire Drivers' Educator Association are co-facilitating a survey on the current status of parent information meetings during the course of driver education. Questions not only include if a parent meeting is taking place, but what types of information are shared. Parent information meetings are not mandated under State rules, just encouraged. However, integrating parents into their children's learning to drive is a best practice. (PB, IB)

MCH Strategies:
The adolescent and pediatric specialty subcontracts are now combined for Federal Fiscal Years 14 and 15. In previous years, the contract was implemented by the same agency with two distinct scopes of services. These guidelines were meshed together for one year until Federal Fiscal Year 15 when the primary care contracts will be put out to bid once again.

The recently published State Health Improvement Plan (SHIP) contains a section on injury prevention, which includes an emphasis on teen driving issues along with a long term objective consistent with the MCH indicator on emergency department visits. (PB, IB)

MCH staff continues to monitor all clinical activities including the provision of anticipatory guidance in clinical services. (PB, DS)

c. Plan for the Coming Year
Teen Driving Committee (TDC):
The TDC will continue to provide oversight and be an integral part of the expanded NHTDP. (PB)

Five members of the TDC were chosen from a competitive application to attend the American Public Health Association and the Safe States Alliance's "Evaluation Institute in Injury Prevention Program and Policy". New Hampshire's team is one of only eight states attending. This three day intensive training will enable the TDC members to design and begin to implement an evaluation plan specific to the NHTDP.

An additional eight hours of one on one evaluation consultation will be provided by web during regularly scheduled TDC meetings. A community of practice with other state teams will be developed and information and resources liberally shared with the TDC. The critical evaluation skills gained by the Evaluation Team will definitively enhance evaluation of other MCH injury prevention programs and policies in the future, including those dealing with motor vehicle issues. (IB)

Through a Department of Transportation grant, the TDC is working with the Brain Injury Association on the development of a parent website, specific to those with children who are novice drivers. The website will be an extension of the current www.nhdtz.com. (PB)

The TDC will also continue its work with the New Hampshire Drivers' Educator Association to determine whether or not rules changes related to parent information meetings are warranted. (IB, PB)

MCH Strategies:
MCH staff will provide oversight and be involved in direction implementation of the strategies chosen to address the teen driving objective in the DPHS's SHIP, which are consistent with those in the Department of Transportation's Strategic Highway Safety Plan. (IB, PB)

MCH staff will continue to monitor all clinical activities including the provision of anticipatory guidance (e.g. questions on seatbelt use) in clinical services. (PB, DS)

MCH will work with the NH DHHS Public Information Office to send out social media messages via Twitter and Press Releases aimed at specific populations such as teens and parents of teens regarding seat belt usage, teen driving and GDL. (PB)

MCH's Injury Prevention Program will also continue to be on the Executive Committee of the Department of Transportation's State Highway Strategic Plan. This includes both the writing and implementation of the teen driving section of the Plan. This will be done in conjunction with the TDC. (PB, IB)

MCH will be part of the committee deciding upon the questions to be included in the 2015 YRBS. It is hoped that yet another teen driving question will be added to the recently expanded injury section of the YRBS. (IB)

MCH's Injury Prevention Program will continue to develop the Performance Management Application (PMA) strategies for the teen driving section of the SHIP, which are consistent with those in the Department of Transportation's Strategic Highway Safety Plan. (IB)

State Performance Measure 7: *Percent of households identified with environmental risks that receive healthy homes assessments.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			100	100	63
Annual Indicator		74.5	62.7	61.5	37.5
Numerator		38	37	91	24
Denominator		51	59	148	64
Data Source		Staff assessments	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra	Healthy Homes & Lead Poisoning Prevention Progra
Is the Data				Final	Final

Provisional or Final?					
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	65	67	70	75	80

Notes - 2013
Data is from the Healthy Homes & Lead Poisoning Prevention Program data surveillance system. The numerator is the number of "one-touch" forms completed. The denominator is nurse case management visits.

In 2013, there were a significant number of environmentalists and nurse staff turnovers and vacancies. The former position was vacant most of the year; and the nurse position was vacant about half the year. Our nurse did not start until about halfway through the year, and the environmentalist position was vacant most of the year. For these reasons, numbers for 2013 are skewed. We believe that in 2014 there will be a significant increase in both numbers and percentage.

Notes - 2011
Re future objectives: any number would be invalid, thus 100 has been used as a "placeholder". Not entering a number was not possible to complete this measure.

a. Last Year's Accomplishments
BACKGROUND:
The New Hampshire Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) developed, in partnership with Title V and other Federal, State and community stakeholders, a healthy homes assessment questionnaire for homeowners and residents. Beginning in 2010, state HHLPPP staff conducted these healthy home assessments within local communities in conjunction with other activities, such as lead exposure inspections. In 2011-2012, HHLPPP began transitioning childhood lead poisoning case management, regional Healthy Homes needs assessments, strategic planning as well as "One-Touch" activities to seven public health regions to integrate these services into communities.

In December 2013, the NH Division of Public Health Services published the New Hampshire State Health Improvement Plan (NH SHIP) 2013-2020, Charting a Course to Improve the Health of New Hampshire". Developed with input from partners from diverse sectors, agencies and organizations that address population health across the state, it identifies 10 priority areas for heath improvement with measurable objectives and targets for health outcomes; areas for needed attention in public health capacity; and, recommendations for evidence-based interventions and actions. It includes measurable objectives, recommended strategies for improvement, and performance measures with time-framed targets for each priority.

Because New Hampshire's asthma rate is among the highest in the nation, asthma was selected as one of the 10 priorities for the State. The NH SHIP recommends the "One-Touch" home visiting approach and regional healthy homes strategic planning for target communities as important strategies to reduce the burden of asthma among children and adults. (ES, PB, IB)

SYSTEMS DEVELOPMENT:
The HHLPPP, Asthma Control Program (ACP) and its stakeholders have modified the New Hampshire Healthy Homes (HH) Statewide Strategic Action Plan to include current progress and partnerships. MCH continued to jointly fund a nurse position with HHLPPP.(IB)

The HHLPPP convened the statewide Healthy Homes (HH) Steering Committee and six workgroups monthly to implement HH priorities.(IB)

The HHLPPP hosted the 2nd annual one-day HH Conference with 175 attendees that provided an outreach and education opportunity to HH partners in October 2012.(PB,IB)

The HHLPPP continued to plan the implementation of the CDC HHLPSS, a new database.(IB)

The HHLPPP and ACP staff continued to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care.(IB)

The HHLPPP coordinated HH trainings and technical assistance for partners to build the capacity to perform HH assessments and in-home interventions.(ES, PB, IB)

The ACP implemented and evaluated Motivational Interviewing trainings with stakeholders to increase the effectiveness of healthy homes interventions.(IB)

The ACP conducted Town Meetings with housing authorities, property owners and tenants to introduce Breathe Better in HH, an initiative to make multi-unit properties smoke-free.(IB)

The HHLPPP and ACP utilized the DPHS' NH Health WISDOM database to further the goal of streamlining and organizing data.(IB)

The HHLPPP provided a monthly electronic HH Newsletter, which provides current funding opportunities to over 500 partners.(IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The HHLPPP will continue to coordinate HH trainings and TA for partners, including home visitors and MCH – funded agencies and programs to continue to build capacity to perform HH assessments and in home interventions.		X	X	X
2. The HHLPPP will continue to share educational material from literature the literature toolkit with families of children with elevated blood lead levels, facilitate referrals, and collect information using the HH questionnaire.				X
3. The HHLPPP and ACP will continue to attend MCH Coordinators' meetings to share updates with title V funded Child Health and Primary care.				X
4. The HHLPPP will continue to provide an electronic HH newsletter, which provides the most current local, regional and federal funding opportunities to over 1,500 partners.				X
5. The HHLPPP will continue to convene the statewide HH steering committee monthly to implement HH priorities statewide and within the public health regions.				X
6. The HHLPPP Nurse case managers will make referrals to MCH home-visitors were appropriate in the homes that we visit using the One-Touch Assessment form.				X
7. The HHLPPP will transition our own in-house database specifically storing data collected by the One -Touch forms used by home visitors throughout the state to FluidSurveys, an on-line database.				X
8.				
9.				
10.				

b. Current Activities

SYSTEMS DEVELOPMENT AND STRATEGIC PARTNERSHIPS:

The Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) is continuing with the implementation of the CDC HHLPSS, a new data management system including healthy homes variables. HHLPSS will be the replacement for the current CDC STELLAR surveillance system.

The HHLPPP and the Healthy Homes Steering Committee coordinated the 3rd Annual New Hampshire Healthy Homes Conference that took place in October 2013 with 275 people in attendance. (PB, IB)

The HHLPPP has continued to coordinate healthy homes trainings and technical assistance for partners throughout the state including HUD grantees, regional healthy homes committees, health and code officials, energy auditors, home visitors and MCH-funded agencies and programs to build the capacity to perform healthy homes assessments and in-home interventions. The HHLPPP continues to develop and modify its own database to specifically store data collected by the one touch forms used by home visitors throughout the state. (ES, PB, IB)

The ACP continues to conduct town meetings with housing authorities, property owners and tenants to introduce Breathe Better in Healthy Homes, an initiative to make multi unit properties smoke-free. (IB)

The HHLPPP and ACP are continuing to partner with the DPHS' NH Health WISDOM (Web-based Interactive System for Direction and Outcome of Measures) to further the goal of streamlining and organizing data for public view.

c. Plan for the Coming Year

SYSTEMS DEVELOPMENT AND STRATEGIC PARTNERSHIPS:

The Healthy Homes and Lead Poisoning Prevention Program (HHLPPP) will be implementing Phase I of the CDC HHLPSS, a new data management system including healthy homes variables. HHLPSS will be the replacement for the current CDC STELLAR surveillance system.

The HHLPPP, in conjunction with the Healthy Homes Steering Committee will be coordinating the 4th Annual New Hampshire Healthy Homes Conference for September 2014 with a target of 275 people in attendance. (PB, IB)

The HHLPPP is providing an electronic Healthy Homes Newsletter, which provides the most current local, state and federal funding opportunities to over 1,500 healthy homes partners statewide. (IB)

The HHLPPP will partner with the Environmental Public Health Tracking program to build a database system to allow MCH-home visitors to research healthy home variables (i.e. drinking water, radon, safety) by address prior to a home visit.

The HHLPPP Nurse case managers will make referrals to MCH home-visitors were appropriate in the homes that we visit using the One-Touch Assessment form. (IB)

The HHLPPP will continue to coordinate healthy homes trainings and technical assistance for partners throughout the state including HUD grantees, regional healthy homes committees, health and code officials, energy auditors, home visitors and MCH-funded agencies and programs to build the capacity to perform healthy homes assessments and in-home interventions. (ES, PB, IB)

The HHLPPP continues to convene the statewide Healthy Homes Steering Committee on a

monthly basis to coordinate and implement healthy homes priorities. (IB)

The HHLPPP will continue to share educational material from literature the literature toolkit with families of children with elevated blood lead levels, facilitate referrals, and collect information using the HH questionnaire. (IB)

The HHLPPP will transition our own in-house database specifically storing data collected by the One -Touch forms used by home visitors throughout the state to FluidSurveys, an on-line database. (IB)

The HHLPPP and ACP staff continues to attend MCH Coordinators' Meetings to improve integration of HH activities with clinicla care within the community health centers. (IB)

State Performance Measure 8: *The percent of public water systems that optimally fluoridate the water system on a monthly basis.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			4	3	50
Annual Indicator	20.0	30.0	10.0	40.0	10.0
Numerator	2	3	1	4	1
Denominator	10	10	10	10	10
Data Source	NH Dept of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs	NH Dept. of Environmental Svcs
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	60	70	80	90	100

Notes - 2013
For reporting year 2013, the numerator (number of systems that optimally fluoridate 80% of the days measured and reported each month) dropped to one system. The DPHS Oral Health Program believes there are three reasons for the decline in optimal fluoridation by 10 water systems for all 12 months in 2013: 1- US Department of Health and Human Services still had not finalized the recommended level of added fluoride required to reach a new optimal range for community water fluoridation; 2- Reporting included months before the March 5, 2013 fluoridation training, convened for water operators by DES and DPHS, to explain the pending change to CWF recommendations and introduce a new fluoridation monthly operating report (FMOR). The fluoridation training included a live link to Kip Duchon, CDC Fluoridation Engineer who answered many questions posed by NH water operators. In spite of the fact that CDC had not finalized its CWF recommendations, NH DES adopted the new lower optimal range for assessing quality water fluoridation. 3- Water operators' adoption of the new electronic FMOR

was slower than expected in 2013, but we did note a monthly increase among early adopters in the number of optimally fluoridated water systems. In 2014 widespread adoption of the new FMOR will simplify performance measurement by DPHS, improve performance management by DES, and increase the number of municipalities that optimally fluoridate their water systems all 12 months of the year.

Notes - 2012
The percent is based on an annual average of NH fluoridated water systems that optimally fluoridate their water based on monthly reporting.

In 2013 the Centers for Disease Control and Prevention released an adjusted target range (0.6-0.8 mg/l.) for fluoridated community water systems for use in achieving optimized fluoridation of water delivered to customers. Prior to release of CDC's final recommendation, New Hampshire water systems were using the two different target ranges making it difficult to track systems' performance. A March 2013 fluoridation training workshop convened by the NH Oral Health Program in collaboration with the NH Department of Environmental Services, Ground Water and Drinking Water Bureau incorporated a NH specific webinar featuring Kip Duchon, CDC's Fluoridation Engineer, presenting CDC's final recommendation on the target range to achieve optimal community water fluoridation. Enabled by a DPHS Quality Improvement project, DES and DPHS have cooperated to develop a new Monthly Fluoridation Reporting (MOR) form for 10 fluoridated NH water departments that calculates the daily addition of fluoride to the water supply to determine the average monthly value and whether or not the system has optimized fluoridation during the month. This relatively simple change to the MOR provides instant feedback to water operators indicating if the system's monthly value falls within the new lower target range. Feedback from water operators has been extremely positive. The new form and consequent buy-in from water departments will simplify performance measurement by DPHS and improve performance management by DES.

Notes - 2011
For reporting year 2011, the numerator (number of systems that optimally fluoridate 80% of the days measured and reported each month) has dropped to one. The DPHS Oral Health Program believes the decline in optimal fluoridation is because the US Department of Health and Human Services has not yet released it's final recommended level of added fluoride required to reach a new optimal range for community water fluoridation. The Oral Health Program has worked closely this year with the NH Department of Environmental Services, Drinking Water and Ground Water Bureau, to standardize community reporting and data entry in order to ease management of the Water Fluoride Reporting System (WFRS.)

With improved reporting and data entry, the Oral Health Program plans to rewrite the State Performance Measure next year to identify fluoridated communities within the range of optimal fluoride levels ten months each year.

a. Last Year's Accomplishments
BACKGROUND:
Community water fluoridation has been a safe and healthy way to effectively prevent tooth decay. This simple, and inexpensive public health intervention has contributed to a significant decline in tooth decay throughout the 20th and now 21st Century. The benefits of community water fluoridation reach nearly 74% of the U.S. population served by community water systems. Access to this intervention in NH is mixed. Although only 10 NH communities add fluoride to their public water systems, 43% of the State's population has access to fluoridated water due to the larger populations in the cities that do fluoridate.

In January 2011, the U.S. Department of Health and Human Services (HHS) and the U.S. Environmental Protection Agency (EPA) announced preliminary changes to the guidelines on fluoride in drinking water. HHS recommendations were to lower the level of fluoride in drinkingwater to the lowest end of the current optimal range to prevent tooth decay, while

continuing to provide maximum protection, especially for children. These guidelines and standards have not been finalized or required. Without a final standard, there is greater interpretation as to the "optimal level" for fluoridation in community water systems.

SYSTEMS BUILDING:
The Oral Health Program (OHP) participated in an intensive, year-long DPHS quality improvement initiative to improve monthly fluoridation reporting by ten fluoridated NH water departments. The Title V Director actively participated in the quality improvement team. (IBS, PBS, ES)

Following a fluoridation training co-sponsored with NH Department of Environmental Services (DES), municipal water department staff from ten fluoridated NH water systems adopted a revised Fluoride Monthly Operating Report to increase the quality and timeliness of fluoridation data reporting. (IBS, PBS, ES.)

The OHP monitored results reported on the new Fluoride Monthly Operating Report that calculates optimized fluoridation eighty percent of days water is served to the public and promoted continuous quality improvement by providing instant DES feedback to water department staff on reaching the optimized fluoridation range. (IBS, PBS, ES)

In collaboration with DES the OHP worked to identify, engage and sustain staff that will complete monthly fluoride data entry and maintain CDC's Water Fluoridation Reporting System (WFRS). (IBS, PBS.)

By the end of the fiscal year (June 2013), all ten (100%) NH communities that add fluoride to their public water supply had the skills and tools to optimally fluoridate the water supply within the new optimal range. (IBS, PBS)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The OHP will continue collaborating with DES to monitor effectiveness of the new Fluoride Monthly Operating Report that helps to optimize community water fluoridation and facilitates reporting results for the MCH block grant.			X	X
2. The OHP will provide technical support for the DPHS Legislative Liason who monitors the NH legislative session regarding new bills related to CWF.			X	X
3. With city-level oral health data results for the 2014 Healthy Smiles-Healthy GrowthThird Grade Survey, the OHP will reach out to the Nashua Health Department, seeking their support for a campaign to fluoridate the city's water supply.		X	X	X
4. The OHP will provide technical support to communities interested in implementing CWF to improve the oral health of their residents.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

QUALITY IMPROVEMENT
The Oral Health Program (OHP) has completed the DPHS Quality Improvement project and reported to team leaders that, as a result of the project, all ten fluoridated NH communities (100%) have implemented use of the new Fluoride Monthly Operating Report and have increased optimization of added fluoride levels within the recommended range 80% of the days each month when water is served to the public. (IBS, PBS, ES.)

The OHP was notified that, on completion of the DPHS Quality Improvement project, CDC has selected NH's Community Water Fluoridation Improvement performance measures for inclusion in their technical assistance manual. NH's CWF performance measures were described as clear, measurable, specific and representative of public health performance improvement activities.

The OHP was notified by CDC that three NH fluoridated water systems were recognized for continuous optimized fluoridation over a twelve month period. The OHP organized an award ceremony attended by Dr. Jose Montero, Director of the Division of Public Health Services, staff from the three water systems receiving CDC recognition, representatives from DPHS, DES and the media. (IBS, PBS, ES.)

The OHP continues its ongoing collaboration with the NH Department of Environmental Services (DES) and Title V to ensure that the fluoridation reporting process continues to run smoothly and that water systems continue to receive DES feedback until 100% of fluoridated water supplies are optimized.

c. Plan for the Coming Year
QUALITY IMPROVEMENT:
In collaboration with the NH DES the OHP will use the new Fluoride Monthly Operating Report provide oversight of ten fluoridated NH water systems to assure optimization of added fluoride levels within the recommended range 80% of the days each month when water is served to the public. (IBS, PBS, ES.)

The OHP will work with fluoridated municipal water systems to assure recognition by CDC, the NH public and the media of outstanding examples of optimized fluoridation by community water systems over a twelve month period. (IBS, PBS, ES.)

The OHP will continue its ongoing collaboration with the NH DES and Title V to ensure that the fluoridation reporting process continues to run smoothly and that water systems continue to receive DES and OHP feedback until 100% of fluoridated water supplies are optimized. Data will continue to be collected and any additional opportunities for quality improvement in the data collection and reporting procedure will be explored. (IBS, PBS, ES.)

The OHP will continue to submit to CDC monthly fluoridation data from ten NH water systems for CDC to upload into the Water Fluoridation Reporting System with the goal of making the fluoridation information transparent and available for the public through the website "My Water's Fluoride." (IBS, PBS, ES.)

Following completion of the 2014 Third Grade Survey in Nashua our second largest city, preliminary results indicate more untreated decay among students in schools with higher participation in the Free and Reduced Lunch program. In the coming year, the OHP will advocate for a community-based campaign to fluoridate the city's water system.
(IBS, PBS, ES.)

State Performance Measure 9: *REVISED: The number of individuals who have completed a competency based training for respite providers.*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective		36	15	20	20
Annual Indicator		9	14	19	19
Numerator					
Denominator					
Data Source		SMS Training Record & CDS	SMS Training Records	SMS Training Records	SMS Training Records
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	20	20	25	25	25

Notes - 2013
This is a manual indicator, therefore the numerator and denominator fields are blank

Notes - 2012
This is a manual indicator, therefore the numerator and denominator fields are blank

Notes - 2011
This is a manual indicator, therefore the numerator and denominator fields are blank

a. Last Year's Accomplishments
The AoA issued the first grants for Lifespan Respite projects in 2009 and New Hampshire received one of the ten grants awarded. NH was the only state whose lead agency was not an AoA agency. New Hampshire's proposal represented a strong collaboration amongst the agencies within DHHS, especially within the Division of Community-Based Care Services, with the Lead Agency identified as Special Medical Services (SMS). This was done with the assistance of the Advisory Planning Group (Title V staff, parent consultant, State Behavioral Health (BBH) staff, Parent/Director Council for Children and Adolescents with Chronic Health Conditions (CCACHC), State Bureau of Developmental Service (BDS) staff, a partner, knowledgeable in medically fragile children from the private sector, State Bureau of Elderly and Adult (BEAS), and the Division of Children and Youth (DCYF), and family members to meet the lifespan representation as well as a NH local community based agency for competency based training. The 3-year grant period ended September 29, 2012, however SMS requested and received a no-cost extension for one year ending September 2013. This extension was planned to allow for the completion of the workplan (respite locator; evaluate training; expansion of project respite to caregivers through the lifespan; identify other learning for safe LRC).

The College of Direct Support's respite training through "Direct Connect" at UNH --Institute on Disability (IOD) was started on 7/1/2012. This affiliation provided an opportunity for additional training; interested individuals trained through Direct Connect were listed on the "locator" when finalized. The IOD grant ended in February 2013. The NH LRC training curriculum was presented and well received at the "International Short Break Conference" October 2012 in Toronto, Canada. As of March 2013 the administrative access in NH for CDS, through the Moore Center, was discontinued. The NH Development Disabilities system (Area Agencies) had also used the CDS platform and they made the choice to use Essential Learning (a web-based curriculum) for their employee training. A Crosswalk of the Essential Learning competency-based curriculum and the CDS respite curriculum was completed. The NH LRC contracted with Essential Learning as its provider curriculum starting May 2013. Two NH Lifespan Respite Coalition members completed the "Train the Trainer" Respite Education Support Tool (REST) in February 2013. The

NH Core Coalition members met monthly. Strategic Planning in April-May 2013 led Stakeholders and Coalition members to take more responsibility for the NH LRC Program. They created a draft job description and a design for State infrastructure building for respite. There were also changes made to the curriculum to meet families' and provider's needs upon completion of a Family Satisfaction Survey review.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Manage activities of the "no cost extension" LRC Grant and present progress NH LRC Coalition Group representing families, state agencies and private not-for-profits.				X
2. Review the pilot pre-post surveys of families and trained respite providers for changes necessary to the curriculum.				X
3. Meet with individuals and groups in state agencies and communities regarding respite/childcare needs for medically and behaviorally complex children.				X
4. Participating in Federal, State and local activities that are associated with respite/childcare to help build collaboration and infrastructure.				X
5. Assist with coordination activities for the LRC Coalition to develop its' infrastructure for sustainability of the respite training program.				X
6. Provide marketing and recruitment with materials for the NH LRC Provider Training through variety of State and Local of settings including the adult population.				X
7. Coordinate Respite Provider Training through Essential Learning (EL) now Relias web-based program				X
8. Identify opportunities to integrate, expand, and sustain respite care in NH through grants from US Department of Administration on Aging (AoA) and private foundations.				X
9. Assist the NH LRC Coalition to develop a sustainability plan with utilizing the TA Finance Grant forms from ARCH National Respite & NH LRC Strategic Plan (SP)				X
10. Assist the NH LRC Coalition to develop a sustainability plan with utilizing the TA Finance Grant forms from ARCH National Respite & NH LRC Strategic Plan (SP)				X

b. Current Activities

Infrastructure building has continued with the NHLRC Coalition. The Coalition met with Gateways (Area Agency) re: fiscal management and collaboration activities to assist with mission and vision of LRC throughout NH. The respite training continues through Essential Learning this year with SMS as a site administrator for the application and criminal and registry checks. Interested trained respite providers will be listed on the NH Provider Link through the Rewarding Work locator platform, which was created in collaboration with Gateways and became active in May 2014 (http://www.rewardingwork.org/en/State-Resources/New-Hampshire/NH%20Respite%20services.aspx). Marketing for use of the locator to the Area Agencies, other state agencies, and organizations (private and non-profit) and individuals started in June 2014. This website is a resource for trained respite providers and for caregivers' short break needs. NH Provider Link will provide SMS and the NHLRC Coalition data (NH respite care utilization, available trained respite providers, etc.). Gateways developed marketing materials for NH regarding respite and use of the system.

SMS developed 2 short videos of participating caregivers and respite providers with a focus on

"What respite means and how it helps". These short videos will be available on the NH Lifespan Website that is under development. Volunteer training is available by two NH LRC Coalition members, utilizing Respite Education Support Tool (REST).

An attachment is included in this section. IVD_SPM9_Current Activities

c. Plan for the Coming Year

Two NH Coalition members are REST (Respite Education Support Tool) trainers for volunteers and plan to train 25 --30 individuals (currently marketing is targeted for faith based organizations) with opportunities for the newly trained volunteers to be identified on the respite portion of the NH Provider Link. NH LRC Provider Training applicants will be recruited and processed as the NH Provider Link goes Statewide and is fully marketed by Gateways. The Coalition's plan has identified a target of 36 newly trained respite providers this next year. The training needs and opportunities for Provider training are ongoing. The application for respite provider training is on the http://www.nh providerlink.org/.

The NH Lifespan Respite Coalition's completion of a Finance Plan for Sustainability with assistance of the TA Grant from the Finance Project at Chapel Hill and ARCH National Respite is planned for September 1, 2014. In conjunction with the Finance Plan, the Coalition will produce a grant proposal to meet the NH LRC Strategic Plan with a primary focus to fund the Outreach Coordinator who will work with identified groups, representing a variety of local agencies/organizations, which have identified an interest in addressing the need for respite in NH's 10 Counties. The agencies/organizations will meet regularly to identify needs of caregivers, use of NH Provider Link and share respite resources in their regions. The Outreach Coordinator will regularly meet with and provide each County's information to the NH LRC. The NH LRC anticipates seeking grants for financial resources for the above activities and to continue the training activities. A MOU/MOA will have mutual agreement from the Coalition and Gateways when a proposal(s) is submitted. It is anticipated next spring (2015) there will be an opportunity for a State Agency (BEAS) to submit a proposal to AoA for a Lifespan Respite Sustainability Grant. The State of NH DHHS, BEAS and BDS will need "human capital" to submit such a grant as agencies are currently understaffed and the requirements from A0A are stipulating the State Office (preferably BEAS) submission. The NH LRC is aware of the CYSHCN Standards regarding Respite. SMS continues to coordinate activities for the NH Respite Program but expects the NH LRC will seek the funding through grants or other measure this coming year with an Outreach Coordinator to be hired to continue the work. NH LRC will continue to find ways to connect with caregivers such as Website linkages and facebook.

State Performance Measure 10: *Of women who had a preterm birth: Percent who reported smoking before pregnancy*

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

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective			18	17	18
Annual Indicator	19.4	18.8	18.6	21.6	22.1
Numerator	223	199	204	224	221
Denominator	1148	1059	1096	1036	1001
Data Source	Vital Records	Vital Records	Vital Records	Vital Records	Vital Records
Is the Data Provisional or Final?				Provisional	Provisional

	2014	2015	2016	2017	2018
Annual Performance Objective	18	17	16	15	14

a. Last Year's Accomplishments
The New Hampshire State Health Improvement Plan (NH SHIP), "Charting a Course to Improve the Health of New Hampshire", highlights 10 key health areas and their health outcome indicators that describe the most significant health issues currently facing our population. Objectives were set for the reduction of tobacco use among pregnant women and strategies were identified that may have the greatest potential to reduce health disparities across the life course, and may reduce preterm births.

STRATEGIC PARTNERSHIPS AND SYSTEMS DEVELOPMENT:
MCH collaborated with the TPCP on evidenced-based ways to decrease tobacco use in pregnant women and in household contacts. Support was provided to those CHCs interested in replicating the modified model of the 5 A's protocol using EMR and HL7 technology. (DS, ES)

The Clinic Assessments process was ongoing. Agencies not assessed in FY 12 were assessed and provided technical support. (IB)

MCH expanded Healthy Families America home visiting model from five to eleven communities to bring the system statewide. Agencies provided data that relates to improved maternal and newborn health including parental use of tobacco. (IB)

Text4Baby was promoted when interacting with pregnant women and new parents/grandparents or people who work with these groups of individuals. (PB)

PRAMS was launched in March 2012. Information related to tobacco use in the mother and in the home was collected through several questions in the survey. (PB, IB)

MCH participated on the March of Dimes Program Planning Committee to ensure the efforts for improving birth outcomes were linked. The Centering Model for delivery of prenatal care was promoted at CHCs. (IB)

NH signed on to the Association of State and Territorial Health Officials (ASTHO) challenge to improve birth outcomes by reducing prematurity in the US by 8% by 2014. The National Center for Health Statistics (NCHS) estimated NH's 2009 Preterm Birth rate at 9.9%. An 8% reduction goal for NH is 9.1%, or a reduction of approximately 106 preterm births. (PB, IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women.	X	X		X
2. Continue to provide technical support to MCH-funded agencies that wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link.	X	X		
3. Monitor and provide technical assistance to MCH-funded home visiting agencies that provide services to pregnant women.	X	X		X
4. Conduct site visits in contracted agencies to monitor prenatal and home visiting services according to the clinic assessment				X

schedule.				
5. Continue PRAMS project. Use available PRAMS data for program planning.			X	
6. Continue to participate in the March of Dimes Planning Committee.			X	X
7. Promote Text4Baby when interacting with pregnant women, new parents/grandparents, and people who work with these groups of individuals.			X	
8. NH will continue to actively participate in the ASTHO challenge to improve birth outcomes by reducing prematurity in the US by 8% by 2014.			X	X
9.				
10.				

b. Current Activities

QUALITY ASSURANCE:

Monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Continue to provide technical support to MCH-funded agencies that wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

MCH continues to monitor and provide technical assistance to MCH-funded home visiting agencies that provide services to pregnant women. Pregnant and parenting women receive information and support around the dangers of smoking during pregnancy and exposure to environmental tobacco smoke. Smokers are advised of the health risks and provided with information about quitting, including the NH Tobacco Helpline 1-800-QUIT-NOW. (ES, PB)

The clinic assessments process is ongoing. At least seven MCH funded agencies will be assessed this year including five CHCs and two Home Visiting Programs. (IB)

MCH continues to collect tobacco use data through the PRAMS project. (PB, IB)

STRATEGIC PARTNERSHIPS AND SYSTEMS DEVELOPMENT:

MCH continues to partner with Tobacco Prevention and Control Program (TPCP) to provide MCH-funded Home Visiting Agencies additional training in evidence-based practice, data collection and motivational interviewing as needed. (ES, PB)

MCH promotes Text4Baby engaging pregnant women with social media about the importance of not smoking during pregnancy. (PB)

c. Plan for the Coming Year

MCH LEADERSHIP:

Continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provides comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Support MCH-funded agencies that wish to directly refer patients, including perinatal patients, directly to the State's Quitline via Health-E link. (DS, ES)

Monitor and provide technical assistance to MCH-funded home visiting agencies that provide services to pregnant women. Provide information and support to pregnant and parenting women around the dangers of smoking during pregnancy and exposure to environmental tobacco smoke. Promote the NH Tobacco Helpline 1-800-QUIT-NOW. (ES, PB)

Conduct clinic assessments in all CHCs and at least three Home Visiting Programs not assessed this year. (IB)

STRATEGIC PARTNERSHIPS AND SYSTEMS DEVELOPMENT:
Continue to partner with Tobacco Prevention and Control Program (TPCP) to provide MCH-funded Home Visiting Agencies and CHCs additional training in evidence-based practice, data collection and motivational interviewing as needed. (ES, PB)

Continue to collect tobacco use data through the PRAMS project. Utilize available PRAMS data for program planning. (PB, IB)

Promote Text4Baby when interacting with pregnant women, new parents/grandparents, and people who work with these groups of individuals. (PB)

New Hampshire will be awarded the March of Dimes, Prematurity Campaign Virginia Apgar Leadership Award, based on 2013 preliminary data released by the National Center for Health Statistics. New Hampshire achieved an 8% reduction in the preterm birth rate since 2009, thereby meeting the goal set by the March of Dimes and the Association of State and Territorial Health Officials. MCH will continue to participate in the March of Dimes Planning Committee to leverage resources dedicated to preventing prematurity. (PB, IB)

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	6.9	6.8	7.2	7.2	6.7
Numerator	923	874	920	891	821
Denominator	13371	12856	12828	12306	12262
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight.

New Hampshire's LBW rate has been relatively stable in recent years and remains consistently lower than national rates although it does not negate the emotional, medical, and economic costs of LBW babies. Disparities are evident in New Hampshire's relatively small racial, ethnic and socio-economic groups. Interventions such as maternal smoking cessation have the potential to reduce premature births, and thus reduce the impact of low birth weight, and are well within the

scope of Title V activities.

In 2013, 6.7% or 821 New Hampshire infants were born with low birth weight. This is a small decrease from the previous year (7.2% or 891 births). There are no significant regional differences in outcomes throughout the State so this creates a powerful incentive to address prevention efforts throughout NH communities.

Even though New Hampshire continues to compare favorably in the nation for the rate of very low birth weight babies, the growing consensus is that the complex issues surrounding LBW call for broad, new strategies, that incorporates a lifecourse perspectives to address chronic health problems, such as obesity, diabetes, and heart disease, that impact pregnant women. These strategies may include group prenatal visits like Centering Pregnancy, or targeted chronic disease self-management, or innovative technology based supports like Text4Baby.

The MCH Epidemiologist has been supporting the New Hampshire CMS Adult Medicaid Quality Care Measures project with an assessment of early elective delivery (EED) rates. After linking five years of Medicaid maternal claims with birth records, the Joint Commission PC-01 measure algorithm was applied to produce an EED rate by year and hospital. An OB/GYN then reviewed the medical records for births identified as EEDs in the year 2012. Preliminary findings suggest that a substantial number of births categorized as EEDs were misclassified primarily due to poor documentation of risk factors. An assessment of elective delivery policies is also being conducted and preliminary findings suggest there may be utility in standardizing a recommendation for the core components that each elective delivery policy should include.

In addition, New Hampshire has rallied behind reducing its prematurity rate as one of its State Health Priorities. The State Health Improvement Plan goal is to reduce preterm births in New Hampshire by 8%, from 9.9% (2009) to 9.1% in 2015 and by a total of 10% to 8.9% in 2020. New Hampshire is well on its way to meeting this challenge.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	5.0	4.9	5.3	5.3	5.2
Numerator	634	600	654	625	608
Denominator	12807	12348	12302	11786	11800
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
The percent of live singleton births weighing less than 2,500 grams has continued to stay steady. In 2013, there was a slight downward trend with a rate of 5.2%, or 608 births.

In addition to information presented in Health Status Indicator 1 A relative to Low birth weight, MCH is partnering with the State's Medicaid Program as it launches an effort to reduce the number of medically unnecessary Caesarian births.

The Department of Health and Human Services has taken substantive steps in measuring and reporting quality through the launch of the NH Medicaid Quality Indicators (www.nhmedicaidquality.org) website in July 2012. The NH Medicaid Quality Indicators currently includes many of the CMS Adult Medicaid Quality Indicators and building the website has provided valuable experience in the area of measurement production and presentation. The NH Medicaid Program received the CMS Adult Medicaid Quality Grant: Measuring and Improving the Quality of Care in Medicaid to test and evaluate methods for data collection and measure production, expand the number of adult quality indicators included on the NH Medicaid Quality Indicators website, expand and enhance the reporting capabilities of the NH Medicaid Quality Indicators website, and support the critical work of translating data into meaningful quality improvement. NH Medicaid's grant-supported quality improvement initiatives will work in partnership with UNH and NH Title V to reduce the number of early term elective deliveries =37 through <39 weeks. In support of this effort, the MCH Epidemiologist has linked five years of Medicaid maternal claims with birth records, in order to apply the Joint Commission PC-01 measure algorithm to produce an EED rate by year and hospital. An OB/GYN has reviewed the medical records for births identified as EEDs in the year 2012. Preliminary findings suggest that a substantial number of births categorized as EEDs were misclassified primarily due to poor documentation of risk factors. An assessment of elective delivery policies is also being conducted and preliminary findings suggest there may be utility in standardizing a recommendation for the core components that each elective delivery policy should include.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1.1	1.1	1.3	1.0	1.1
Numerator	148	143	169	120	137
Denominator	13371	12856	12828	12306	12262
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
Much like Low Birth Weight rate, New Hampshire's Very Low Birth Weight (VLBW) rate has been relatively stable in recent years and remains consistently lower than national rates. In 2013, 137 New Hampshire infants were born less than 1500 grams. This is 1.1 percent of births, a slight increase from the pevious year's rate of 1.0%, or 120 births. With these very small numbers, efforts such as the Northern New England Perinatal Quality Improvement Network bring together clinicians across specialties to work on issues regarding transport and special projects such as the Maternal Mortality Review, New Hampshire Statewide Partnership to Address Opioid Use Among Pregnant Women and NO FAS NH among other activities.

One of the state's three tertiary care centers has high-risk OB providers on staff 24/7. These providers have made it a priority to keep babies in utero for as long as possible, even if only by a day or two, when a woman is transferred to their center in preterm labor between 24 -- 27 weeks

gestation.

It should also be noted that it appears that fewer VLBW or complex infants are born out of state than in previous years. This data will need to be more adequately investigated in the 2015 Title V Needs assessment

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	0.8	0.7	1.0	0.7	0.8
Numerator	99	91	118	83	91
Denominator	12807	12348	12302	11786	11800
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
Much like Low Birth Weight Rate, New Hampshire's Very Low Birth Weight (VLBW) rate has been relatively stable in recent years and remains consistently lower than national rates. In 2013, 91 New Hampshire singleton infants were born less than 1500 grams. This is less than 1% of births. Similar to the overall VLBW data, there was a slight increase in VLBW singleton births in 2013 from 2012's rate of 0.7% or 83 births. Because of these small numbers, it is difficult to determine meaningful trends.

Please see additional general LBW comments for Health Status Indicator 1A, 1B and 2A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	4.2	5.2	5.2	3.6	1.8
Numerator	10	12	12	8	4
Denominator	237507	232182	232182	221978	221978
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
2013 death data from NH Dept. of Vital Records is provisional and subject to change.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2012
Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2011
Data from 2010 is used as an estimate, as valid data beyond that year is not available.

Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

An attachment is included in this section. IVE_HSI03A

Narrative:
New Hampshire is pleased that the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger continues to trend downward to a rate of 1.8 in 2013, representing 4 deaths.

Specific attention has been placed on building the Sudden Unexpected Infant Death Case Registry and SUID Review Group. The group consists of all the CFRC members with the addition of several professionals relative to the perinatal period, such as Lactation Consultant, Nurse Midwife, Neonatologist, Birthing Hospital Perinatal Nurse Manager, local Home Visiting Program nurse, WIC nutritionist, etc. This multi-disciplinary group reviews all sudden and unexpected infant deaths in the state.

In 2013, the NH SUID Project has expanded to include new partners, the DPHS Tobacco Program, the NH Children's Trust, and the New Hampshire Chapter of the United Way, to help get the safe sleep message out. New Hampshire was one of the three states to present SUID findings at the Fall 2013 American Public Health Association's annual conference. The presentation showcased how states put data to action.

At the National Association of Medical Examiner's Annual Conference in Portland, Oregon, September 2014, the Chief Forensic Investigator of the NH Office of Chief Medical Examiner, with whom MCH collaborates closely to carry out the NH SUID Project, will be presenting a podium/oral presentation on "SUID: How Multidisciplinary Collaboration Can Inform Diagnosis and Prevention". This presentation will highlight the strong partnership between the two offices in collecting, reviewing, and analyzing the case information and developing prevention strategies to improve death investigation and reduce the risks and incidence of SUID deaths.

The New Hampshire Abusive Head Trauma Coalition, of which the NH DPHS, MCHS, is a member, received an award from the National Center on Shaken Baby Syndrome at a recent statewide conference for outstanding implementation of the Period of Purple Crying Program and its dedication to Shaken Baby Syndrome and abusive head trauma prevention. Currently 17 of 20 birth hospitals implement the Period of Purple Program.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	1	1	1	1	0
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied

Notes - 2012
Out of state data is unavailable.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied

Notes - 2011
Out of state data is unavailable.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for

NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Narrative:
RSA 265:107-a passed and became effective January 1, 2014. This law states that all children under age 7 or 57 inches, whichever is reached first, must use a properly fastened and secured child safety seat. Although best practice is 4 feet 9 inches and at least 8 years of age, some parents (as known through observational surveys and car seat inspections), are not aware of or choose not follow the recommendation or the current law. A phone survey, conducted by the University of New Hampshire's Survey Center, was used to determine current knowledge of child passenger safety laws and potential support for a policy that is consistent with best practice. Fifty-one percent of those surveyed favored a law that required children to sit in a booster seat until 8 years of age. In preparation for the new policy that started in 2014, the Injury Prevention Center at Dartmouth led an educational campaign informing citizens of the State about the efficacy of booster seats and the details of the new law.

There continues to be 30 child passenger safety inspection stations in New Hampshire. At these stations, families can make appointments to get their seats checked by certified car seat technicians on a specific day and time. Most stations have checks on the same day every month. They are located in agencies such as the local police and fire department and hospitals across the state. The Injury Prevention Program Manager, a certified car seat technician, participates when possible, at the Concord Hospital inspection station.

The Maternal Infant and Early Childhood Home Visiting (MIECHV) program has a benchmark related to the incidence of child injuries requiring medical attention, measured by the reduction of auto-related injuries due to incorrectly installed car sets. Using MIECHV funds, the Injury Prevention Center at Dartmouth worked collaboratively with partners in Massachusetts to develop a train the trainer curriculum to train home visitors and other early childhood service providers about the incidence of injuries among young children and effective car seat practices.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	5.0	9.0	9.0	1.7	4.5
Numerator	10	16	16	3	8
Denominator	199273	178166	178166	178615	178615
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2013

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007

Notes - 2012
Out of state data is unavailable. 2010 provisional data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007

Notes - 2011
Out of state data is unavailable. 2010 provisional data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007

Narrative:
Because unintentional injuries are the leading cause of death for all New Hampshire residents between age 1 and 44, Injury Prevention has been prioritized within New Hampshire's State Health Improvement Plan with a priority to reduce Motor Vehicle Crashes Among Teens. A specific objective has been set to reduce the rate of emergency department discharges due to motor vehicle crashes in 15-19 year olds from 1,925.4 per 100,000 population (2009) to 1,837.0 by 2020.

As described in HSI 4C, the MCH Injury Prevention Program works in close coordination with partners such as the Department of Safety and Department of Transportation to reduce teen and young adult injury due to motor vehicle crashes. The New Hampshire Driving Toward Zero Coalition (NHDTZ), spearheaded by the State's Department of Transportation, is a collaborative effort of both public and private entities, including Title V, whose mission is to create a culture of safety on New Hampshire roadways. The vision of the Coalition is to reduce the number of fatal and severe injury crashes on New Hampshire roadways to zero through the implementation of education, enforcement, engineering, and emergency management solutions.

The Injury Prevention Program continues to support the Teen Driving Committee (TDC), a group of youth and community-based and state professionals to promote teen seatbelt and best practice, such as Graduated Driver's Licensing. A grant from the Allstate Foundation will continue support education efforts within schools that demonstrate high rates of non-seatbelt use on the YRBS.

MCH is also applying for Centers of Disease Control and Prevention funding to expand its current Sudden Unexpected Infant Death Registry to include some sudden and unexpected deaths of children birth to 19. The grant is especially focused on sudden cardiac deaths and deaths from genetic forms of epilepsy undetected in the driver of a motor vehicle death.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	129.8	131.0	131.0	131.0	131.0
Numerator	311	307	307	307	307
Denominator	239613	234439	234439	234439	234439
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2013
Previously, New Hampshire contracted with an outside agency to collect and clean all hospital discharge data. Due to issues of data quality, a decision was made to manage and steward this data within the Division of Public Health Services beginning with 2010 data year. Developing and implementing a coding system at the state level has presented a number of technical challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. At this time, there is no estimated time when the 2010 hospital data will be ready for use. Also please note that since a new data collection process is being used, it is recommended that the 2010 hospital data be used as a new base line as it may not be comparable to previous year's data.

Notes - 2012
2012 data is unavailable. Updated 2009 data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007

Notes - 2011
2011 data is unavailable. Updated 2009 data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007

Narrative:
The New Hampshire Injury Prevention Program's (IPP) mission is to reduce death and disabilities that result from intentional and unintentional injuries. Unintentional injuries are those that are considered "accidental" such as poisonings, falls, or motor vehicle crashes. Unintentional injuries are the leading cause of death in New Hampshire for those aged 1-44 years. Injuries often do not occur by chance and are thus preventable. In New Hampshire, and nationally, the age groups most likely to go to the Emergency Department due to fall injury are 0 to 14 years and 75 years

and older.

Fatal childhood injuries in New Hampshire have decreased between 2001 and 2009 from 13.2 per 100,000 to 5.6 per 100,000.

Between 2005 and 2009, 308 children age 0-5 were hospitalized for inpatient care due to injuries. The most common injuries were falls (30%) followed by poisoning (18%) and assault related injuries (17%).Over 20,000 children age 5 and under were injured in falls seriously enough to require a visit to the emergency department or inpatient care.

Unfortunately, obtaining more recent emergency department or inpatient care data has been a significant challenge. In prior years, New Hampshire contracted with an outside agency to collect and clean hospital discharge data. A decision was made to bring this process in-house starting with the 2010 data year. Developing and implementing a coding system at the state level has presented a number of challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. There is no estimated time when the 2010 hospital data will be ready for use.

Meanwhile, Safe Kids New Hampshire serves as a hub for communication and collaboration for people and organizations in the State who are interested in preventing unintentional childhood injuries, including those in the water. Safe Kids New Hampshire provides educational materials to the public as well as barriers to preventing drowning.

In follow up to case specific recommendations, the NH Child Fatality Review Committee frequently disseminates information on reducing the risks of preventable injuries and deaths due to causes such as drowning, ATV accidents, guns not being properly stored, access of hazardous situations to children with Autism Spectrum Disorder, etc. The information generated includes informational sheets from the NH Safe Kids committee member, and articles written by the pediatrician representative that are shared with the multidisciplinary group and their individual constituents, such as law enforcement members, staff of state wide mental health centers, home visiting programs, community health centers WIC agencies, lactation consultants, DCYF staff and foster parents, etc.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 04B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	5.8	4.3	4.3	4.3	4.3
Numerator	14	10	10	10	10
Denominator	241716	234944	234944	234944	234944
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2013

Previously, New Hampshire contracted with an outside agency to collect and clean all hospital discharge data. Due to issues of data quality, a decision was made to manage and steward this data within the Division of Public Health Services beginning with 2010 data year. Developing and implementing a coding system at the state level has presented a number of technical challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. At this time, there is no estimated time when the 2010 hospital data will be ready for use. Also please note that since a new data collection process is being used, it is recommended that the 2010 hospital data be used as a new base line as it may not be comparable to previous year's data.

Notes - 2012
2009 is the most recent year for which complete data is updated and available. Therefore, this has been used as an estimate for 2012 (there is no provisional data for 2012).

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2011
2009 is the most recent year for which complete data is updated and available. Therefore, this has been used as an estimate for 2011 (there is no provisional data for 2011).

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
In the wake of losing support for CDC CORE VIPP funds, New Hampshire Title V has continued to work strategically to implement injury prevention programs using a combination of Title V funds, General Funds and partnerships throughout the state.

Please note that HSI 4B is reflective of data up to 2009. Unfortunately, obtaining more recent emergency department or inpatient care data has been a significant challenge. In prior years, New Hampshire contracted with an outside agency to collect and clean hospital discharge data. A decision was made to bring this process in-house starting with the 2010 data year. Developing and implementing a coding system at the state level has presented a number of challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. There is no estimated time when the 2010 hospital data will be ready for use.

There are currently 164 certified child passenger safety (CPS) technicians in New Hampshire. Two four-day car seat certification-training programs are planned this year. One is in the northern most region of the state, Coos County.

A train the trainer was program was developed to teach currently certified technicians who are also EMS providers about restraint use on emergency medical service vehicles, such as ambulances. This training will provide an overview of the best use of all passenger restraints, including car seats, in emergency vehicles.

Resources and technical assistance continues to be given to families and hospitals regarding ways to transport children with special medical needs.

A train the trainer program was developed for Head Start professionals including child passenger, pedestrian, and bicycle safety. One session was facilitated and three scheduled. After the Head Start staff present to parents, a check-up event is scheduled with certified technicians helping to install car seats.

The Injury Prevention Program's contract with the Injury Prevention Center (IPC) at Dartmouth College includes the development of a New Hampshire specific car seat course for the MIECHV Home Visiting Program contractors. This course includes both in person and on-line training in injury prevention specifics for the MIECHV age group, young children. Partnering with Home Visiting is one way to reach a vulnerable population and secure additional resources.

The home visiting training was implemented in 2013 with one cohort of MIEC agencies and another is scheduled for the Fall of 2014. The training is a unique regional collaboration with the State of Massachusetts' Maternal and Child Health Section and the Children's Safety Network, Waltham, MA. The project itself was presented at 2014 Association of Maternal and Child Health Professionals (AMCHP) Annual Conference and at the 2014 Safe States' Annual Conference.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 04C - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	73.2	62.0	62.0	62.0	62.0
Numerator	140	111	111	111	111
Denominator	191336	179084	179084	179084	179084
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2013
Previously, New Hampshire contracted with an outside agency to collect and clean all hospital discharge data. Due to issues of data quality, a decision was made to manage and steward this data within the Division of Public Health Services beginning with 2010 data year. Developing and implementing a coding system at the state level has presented a number of technical challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. At this time, there is no estimated time when the 2010 hospital data will be ready for use. Also please note that since a new data collection process is being used, it is recommended that the 2010 hospital data be used as a new base line as it may not be comparable to previous year's data.

Notes - 2012
2009 is the most recent year for which complete data is updated and available. Therefore, this has been used as an estimate for 2011.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005

Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2011
2009 is the most recent year for which complete data is updated and available. Therefore, this has been used as an estimate for 2011.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
Because unintentional injuries are the leading cause of death for all New Hampshire residents between age 1 and 44, Injury Prevention has been prioritized within New Hampshire's State Health Improvement Plan with a priority to reduce Motor Vehicle Crashes Among Teens. A specific objective has been set to reduce the rate of emergency department discharges due to motor vehicle crashes in 15-19 year olds from 1,925.4 per 100,000 population (2009) to 1,837.0 by 2020.

Please note that HSI 4C is reflective of data up to 2009. Unfortunately, obtaining more recent emergency department or inpatient care data has been a significant challenge. In prior years, New Hampshire contracted with an outside agency to collect and clean hospital discharge data. A decision was made to bring this process in-house starting with the 2010 data year. Developing and implementing a coding system at the state level has presented a number of challenges. Once the 2010 hospital data are released for use, it is believed that subsequent years will follow more quickly. There is no estimated time when the 2010 hospital data will be ready for use.

Efforts to impact this indicator continue. The New Hampshire Driving Toward Zero Coalition (NHDTZ), spearheaded by the State's Department of Transportation, is a collaborative effort of both public and private entities, including Title V, whose mission is to create a culture of safety on New Hampshire roadways. The vision of the Coalition is to reduce the number of fatal and severe injury crashes on New Hampshire roadways to zero through the implementation of education, enforcement, engineering, and emergency management solutions.

The Injury Prevention Program will continue to support the Teen Driving Committee (TDC), a group of youth and community-based and state professionals to promote teen seatbelt and best practice, such as Graduated Driver's Licensing. A grant from the Allstate Foundation will continue support education efforts within schools that demonstrate high rates of non-seatbelt use on the YRBS.

MCH is also applying for Centers of Disease Control and Prevention funding to expand its current Sudden Unexpected Infant Death Registry to include some sudden and unexpected deaths of children birth to 19. The grant is especially focused on sudden cardiac deaths and deaths from genetic forms of epilepsy undetected in the driver of a motor vehicle death.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05A - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	10.6	13.8	12.1	11.9	10.7

Numerator	499	650	567	547	492
Denominator	46955	46955	46955	45852	45852
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data from Theresa Dawson, DPHS Infection Disease Surveillance Section.

Narrative:
Chlamydia (CT) incidence continues to have an increasing presence in NH as it has for the last several years. The NH STD Prevention Program, Title V and Title X Family Planning Program (FPP) continue to associate the increase in cases to the continuation of screening and enhanced surveillance both in the private provider settings and publicly funded sites.

In 2013, there were a total of 492 CT cases among 15-19 year olds, down to a rate of 10.7 from a rate of 11.9 per 1,000 women age 15-19 in 2012. This continues a downward trend from 2010. Adolescents remain a priority age group, as they are at increased risk. Family Planning programs (FPP) prioritize this age group and young adults up to age 24 for screening, assurance that treatment was completed, and encouragement for follow-up testing per CDC guidelines, and provide partner notification.

The Title X Family Planning Program (FPP) contracted with 10 agencies (20 clinical sites) in 2013. These contracted agencies address the following related objectives in their workplans:
1. Screening of all women <25 for CT
2. Treatment of women with a positive CT within 14-30 days of specimen collection
3. Re-screening of women diagnosed with chlamydia 3-4 months after the completion of their treatment

Documentation of Chlamydia screening is monitored during Family Planning Clinic Assessments. One family planning agency had low testing rates in 2013 because although they collected urine samples on site, patients were required to walk a short distance across the parking lot to the lab, often by-passing the lab before going home. This CHC has continued to collect urine samples in-house but now takes the responsibility to send specimens to the lab at the end of the day, in one large batch. This has resulted in a significant increase in the rate of testing. Several other CHCs use reminder prompts in the EMR to remind providers that yearly testing is due for a specific patient. Two CHCs with high chlamydia screening rates shared strategies with other CHCs during the 2014 Spring MCH Coordinator's meeting. This lead to a thoughtful discussion among participants. These quality improvement activities can result in positive changes.

These efforts are further supported through the FPP partnership with the STD program and the DPHS Lab as we oversee NH's involvement with the Infertility Prevention Project (IPP) and the NH Family Plannning Chlamyida Project (FPCP). Currently one juvenile detention center and fourteen eligible Family Planning Clinics (clinic sites with a minimum 3% positivity rate) participate in the IPP and all remaining sites participate in in FPCP. These clinic sites target:
1. All women <25 annually
2. Women >25 who are symptomatic or have had new or multiple partners since their last tested
3. Partners of women who have had a positive test; and any client who had a positive CT within the past 3-4 months and has not been re-tested.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 05B - Multi-Year Data

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Indicator	4.7	5.6	6.6	6.6	7.2
Numerator	1025	1164	1379	1368	1485
Denominator	217692	207692	207692	207692	207692
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013
Data from Theresa Dawson, DPHS Infection Disease Surveillance Section.

Notes - 2012
Numerator is from Theresa Dawson, Communicable Disease Surveillance Section.

Notes - 2011
Numerator is from Theresa Dawson, Communicable Disease Surveillance Section.

Narrative:
As described in Health Status Indicator 5A, Chlamydia (CT) incidence continues to have an increasing presence in NH. The NH STD Prevention Program, Title V and Title X Family Planning Program (FPP) continue to associate the increase in cases to the continuation of screening and enhanced surveillance both in the private provider settings and publicly funded sites.

In 2013, there were a total of 1485 CT cases among 20-44 year old women, leading a slightly higher rate of 7.2 per 1,000 women age 20-44 years than the rate of 6.6 in 2012. Women age twenty through twenty-four years old are among the priority age group for screening and intervention in New Hampshire, as they are at higher risk for chlamydia. Family Planning programs (FPP) prioritize this age group for screening, assurance that treatment was completed, and encouragement for follow-up testing per CDC guidelines, and provide partner notification. For females older than 25, screening, education, treatment and re-screening happen if they have symptoms suggestive of a bacterial STD and/or have had a new partner or multiple partners since last tested.

FPP currently contracts with 10 agencies (20 clinical sites). These contracted agencies will target the following related objectives in there workplans:
1. Screening of all women <25 for CT
2. Treatment of women with a positive CT within 14-30 days of specimen collection
3. Re-screening of women diagnosed with chlamydia 3-4 months after the completion of their treatment

These efforts are further supported through the FPP partnership with the STD program and the DPHS Lab as we oversee NH's involvement with the Infertility Prevention Project (IPP) and the

NH Family Plannning Chlamyida Project (FPCP). Currently one juvenile detention center and fourteen eligible Family Planning Clinics (clinic sites with a minimum 3% positivity rate) participate in the IPP and all remaining sites participate in in FPCP. These clinic sites target:
1. All women <25 annually
2. Women >25 who are symptomatic or have had new or multiple partners since their last tested
3. Partners of women who have had a positive test; and any client who had a positive CT within the past 3-4 months and has not been re-tested.

The NH Center for Public Policy and the NH DHHS Office of Minority Health & Refugee Affairs published, Health and Equity in New Hampshire: 2013 Report Card in January 2013. The report noted that Hispanic residents of New Hampshire are 2.5 more likely than whites to screen positive for chlamydia. Black or African American residents have case rates 3.4 times the rate found in the white non-Hispanic population.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12860	11941	276	46	344	6	247	0
Children 1 through 4	54791	50877	1174	196	1468	23	1053	0
Children 5 through 9	75976	70549	1628	271	2035	33	1460	0
Children 10 through 14	82699	76793	1772	295	2215	35	1589	0
Children 15 through 19	93305	86641	1999	333	2499	40	1793	0
Children 20 through 24	85139	79058	1824	304	2281	36	1636	0
Children 0 through 24	404770	375859	8673	1445	10842	173	7778	0

Notes - 2015

Narrative:
To more fully understand this Health Status Indicator, it is important to recognize that New Hampshire's population is aging. As reported by the NH Kids Count Cities Data Book, 2012, there has been a 10% increase in New Hampshire's adult population since 2000, yet the population of children has declined 7.2 % between 2000 and 2010. New Hampshire has the fourth oldest median age population in the country and the state's senior population citizen will almost double by 2025.

The counties in New Hampshire with the highest numbers of aging individuals continue to be Belknap, Carroll, Cheshire, Coos, Grafton, and Sullivan. These are the most rural in the State and to a large degree lack the economic and service-oriented infrastructure that exists in the State's more populated counties, where the majority of growth among children has occurred.

Racial diversity among children is spreading unevenly among states, communities and

neighborhoods. Where there is overall population growth in New Hampshire, especially in the southern tier, there is growing diversity. Each year, births in New Hampshire are becoming more ethnically and racially diverse.

In New Hampshire, persons of Asian origin are the largest single non-white race; Asian residents comprise approximately 51% of the state's non-white population. The largest portion of the Asian population is Asian Indian, followed by Chinese. Among children, 38% of the non-white population, including those of more than one race, are Asian.

The Annie E. Casey Foundation released a policy report entitled Race for Results: Building a Path to Opportunity for All Children in May 2014. The report highlights a new index based on 12 indicators that measure children's success in each stage of life in the areas of health, education, community and family. Although New Hampshire scores are higher than the national averages, they reflect similar racial and ethnic disparities seen across the country. Even though New Hampshire ranks among the top states for outcomes for African American and Latino children, their composite scores of well-being continue to lag behind White, Non-Hispanic children.

New Hampshire should continue to gather and analyze racial and ethnic data to inform all phases of health and human services programs, policies and decision making.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12370	489	0
Children 1 through 4	52709	2062	0
Children 5 through 9	73089	2887	0
Children 10 through 14	79557	3413	0
Children 15 through 19	89759	3546	0
Children 20 through 24	81904	3235	0
Children 0 through 24	389388	15632	0

Notes - 2015

Narrative:
According to the Carsey Institute of University of New Hampshire's, Spring 2014 issue brief, The Increasing Diversity of America's Youth, diversity is increasing among American youth because there are more minority children and fewer Non-Hispanic White children. In particular, Hispanics are driving rapid increases in racial diversity among across the nation. Yet this diversity is uneven. States such as New Hampshire are not experiencing this growth to the same extent as other regions of the country. Even in New Hampshire, it is important to note that the growth in diversity is contained to the southern and more urban areas of the state.

Although not all of these children are of Hispanic origin, it is illustrative to point out that the New Hampshire Children's Alliance reports that approximately 43 percent of New Hampshire public school students receiving LEP services in the 2011--2012 school year were enrolled in the

Manchester School District (although the district enrolled only 8 percent of students statewide). The Manchester School District provided LEP services to both the highest number (1,661) and percentage (nearly 11 percent) of students. In contrast, no students in the Berlin School District located in the North Country of the State received LEP services in that year.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	3	2	0	0	0	0	0	1
Women 15 through 17	118	107	2	2	0	0	2	5
Women 18 through 19	442	387	12	1	2	0	13	27
Women 20 through 34	9692	8645	161	20	313	8	105	440
Women 35 or older	2118	1878	31	0	88	2	27	92
Women of all ages	12373	11019	206	23	403	10	147	565

Notes - 2015

Narrative:
Health Status Indicators 7A and 7B allow the NH Title V Program to analyze the maternal population across racial and ethnic populations to better understand the changing demographics of our state and potential risk factors.

Diversity is increasing in New Hampshire. Although the diversity remains geographically concentrated in the southern tier, the state is becoming more racially and ethnically diverse. Young families are at the center of this demographic shift. While minorities represented 4.9 percent of New Hampshire's population in 2000, they produced 50 percent of the population gain between 2000 and 2010.

The NH Center for Public Policy and the NH DHHS Office of Minority Health & Refugee Affairs published, Health and Equity in New Hampshire: 2013 Report Card in January 2013. The report is the state's first Health and Equity Report Card specifically reflecting data to measure key health disparities among the state's racial, ethnic, and linguistic minority populations.

Black or African-American households in New Hampshire are two and a half times more likely to be headed by a single female, with no spouse present, compared to White non-Hispanic households.

Regardless of race, infants delivered to younger and older women are often at increased risk of poor birth outcomes, including prematurity, low birthweight and infant mortality.

New Hampshire is fortunate to consistently have the lowest teen birth rate in the country. In 2013, there were a total of 121 births to women age 17 and under, and among those births 109 were to white mothers; 6 were to women for whom race was not recorded or was unknown; 2 to women of more than one race; two births to Black/African American women; and zero births among Asians or Native Hawaiian/Other Pacific Islander in this age cohort.

MCH has focused teen pregnancy prevention efforts in high risk communities. MCH supports community-based agencies in Manchester and Sullivan County providing the Personal Responsibility Education Program (PREP). PREP uses evidence-based effective programs that have been shown to help reduce sexual activity, increase contraceptive use in already sexually active youth, and ultimately reduce teen pregnancy. In addition, PREP works with teens to build important life skills such as financial literacy, education and employment preparation skills, and healthy parent/child communication skills. PREP compliments other teen pregnancy-prevention initiatives already supported by DPHS and communities, such as abstinence education and access to comprehensive reproductive health care.

Although the largest population having children are women age 20-34, New Hampshire also has a significant number women of advanced maternal age. This can lead to complications such as increased risk for prematurity, low birthweight and certain birth conditions.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	2	1	0
Women 15 through 17	107	9	2
Women 18 through 19	398	41	3
Women 20 through 34	9183	408	101
Women 35 or older	2005	70	43
Women of all ages	11695	529	149

Notes - 2015

Narrative:
Throughout the country, Hispanics are driving rapid increases in racial diversity. In 2013, approximately 4% of the total births in New Hampshire were to Hispanic or Latino women.

Nine percent of the births to women 19 or younger were among Hispanic or Latino women. Hispanic households in New Hampshire are also greater than two times more likely to be headed by a single female, with no husband present, compared to White non-Hispanic households.

These disparities highlight a need for teen pregnancy prevention, family planning, prenatal programs and home visiting programs to target efforts within the Hispanic community, especially in the New Hampshire's largest urban areas.

For more information about live births to women enumerated by maternal age, please see Health Status 7A.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	59	54	3	0	0	0	0	2
Children 1 through 4	12	10	1	0	1	0	0	0
Children 5 through 9	4	4	0	0	0	0	0	0
Children 10 through 14	6	6	0	0	0	0	0	0
Children 15 through 19	24	24	0	0	0	0	0	0
Children 20 through 24	65	62	3	0	0	0	0	0
Children 0 through 24	170	160	7	0	1	0	0	2

Notes - 2015

Narrative:
Ninety-four percent of deaths of infants and children aged 0 through 24 years occurred among white children and young adults. Among infants, 0-1, 92% of deaths were among white children and 8% among Non-white children. This data is consistent with the demographics of the overall infant- young adult population of New Hampshire.

The New Hampshire Child Fatality Review reports that our State has been consistent with national data in ranking Sudden Infant Death Syndrome (SIDS), as one of the leading causes of infant deaths, making up 17% of the natural deaths. SIDS is defined as the death of an infant less than one year of age, which remains unexplained after a thorough case investigation. With the success of the national "Back to Sleep" campaign, the rate of sudden and unexpected infant deaths (SUID) has increased. This category includes deaths thought of as injury related including deaths from overlaying, suffocation, wedging, and other unsafe sleep situations.

Although SUID deaths to non English speaking families are rare, with the state's increasing population of non Caucasian, non English speaking women, MCHS is continuing to make special effort to find resources, and/or obtain safe sleep and grief support educational material to have available should it be needed.

Motor vehicle crashes was the leading cause of death. Malignant neoplasms, or cancer, are the leading natural cause of death for children and adolescents one through 18.

In the 2011-2013 time period, on average, only 40% of New Hampshire resident deaths age birth through 18 were autopsied. In this same time period, of the New Hampshire resident deaths to children birth through 18 years, there were a total of 27 deaths excluding deaths due to SUID, Suicide, or Homicide which were suspected Sudden Death in Youth (SDY) cases autopsied by the NH Office of Chief Medical Examiner; tenty-eight infants died from Sudden Unexpected Infant Death, encompassing Sudden Infant Death Syndrome (SIDS), accidental asphyxia or suffocation

in a sleep setting, or "Undetermined" occurring in a sleep setting.

MCH has submitted a proposal to the CDC to expand its current SUID Death Case Registry to include all unexplained deaths of infants, children and adolescents to age 19 to create a Sudden Death in the Young (SDY) Registry. The proposed expanded SDY Death Case Registry will be a repository for epidemiological data for use here within the State and to will contribute to a national data set, to help identify incidence rates and etiology. This will help develop data driven practices and policies to identify through screening high-risk individuals. It will help develop treatment strategies to ultimately reduce the incidence of SDY due to cardiac and neurological conditions.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	56	2	0
Children 1 through 4	12	0	0
Children 5 through 9	4	0	0
Children 10 through 14	6	0	0
Children 15 through 19	23	1	0
Children 20 through 24	64	2	0
Children 0 through 24	165	5	0

Notes - 2015

Narrative:
The numbers of deaths of infants and children aged 0 through 24 years enumerated by age and Hispanic ethnicity in New Hampshire in any one year are too small to be stable enough to make any inference or conclusions.

However, efforts have directed to ensuring that the State has information available in languages other than English. The NH SIDS/SUID Program offers safe sleep risk reduction educational material in Spanish at its conference display table and disseminates the material liberally to WIC, home visiting, and community health center agencies, as well as to the general public upon request.

In MCH's proposal to the CDC to expand its current SUID Death Case Registry to include all unexplained deaths of infants, children and adolescents to age 19 to create a Sudden Death in the Young (SDY) Registry, there will be an opportunity to aggregate data over several years, to better understand if there are trends among populations. The proposed expanded SDY Death Case Registry will be a repository for epidemiological data for use here within the State and to will contribute to a national data set, to help identify incidence rates and etiology. This will help develop data driven practices and policies to identify through screening high-risk individuals. It will help develop treatment strategies to ultimately reduce the incidence of SDY due to cardiac and neurological conditions.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	325792	305023	6342	892	6933	135	6467	0	2013
Percent in household headed by single parent	20.0	19.5	40.0	32.0	11.2	29.5	29.3	35.0	2010
Percent in TANF (Grant) families	1.5	1.3	2.8	0.7	0.2	3.7	0.0	0.0	2013
Number enrolled in Medicaid	117107	108587	3251	169	1477	98	1338	2187	2013
Number enrolled in SCHIP	20086	18399	361	29	334	10	501	452	2013
Number living in foster home care	752	647	61	6	2	0	36	0	2013
Number enrolled in food stamp program	42231	38594	1610	65	491	59	0	1412	2013
Number enrolled in WIC	14644	13096	827	179	439	103	0	0	2012
Rate (per 100,000) of juvenile crime arrests	1028.0	1028.0	1028.0	1028.0	1028.0	1028.0	1028.0	1028.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	2012

Notes - 2015
2010 U.S. Census

NH no longer has an SCHIP program. Data is from Medicaid CHIP data (Carolyn Richards).

Race breakdowns are not available. Therefore, the same rate is used for each race and ethnicity category. 2009 is the most recent year that accurate data is available.

Race breakdowns are not available. Therefore, the same percentage is used for each category.

Narrative:

Disparities are often discussed in the context of the provision of, or outcomes associated with, medical care. Health Status Indicators 9A and 9B illustrate factors that impact social determinants of health that may be more likely to have an impact to the long term well-being of populations within the State.

The minority population in New Hampshire, on whole, is much younger than the non-minority population. Income level, income below the poverty level, and need to access social services differs significantly among racial and ethnic groups in New Hampshire.

According to the New Hampshire Employment Security, Economic and Labor Market Information Bureau, in the first quarter of 2013, 95% of jobs were held by white workers. In 2013, at least seven percent of job holders in four industries were non-white, above the 4.9 % average for all industries. Those industries include: Accommodation and food services, 7.9 %; Administrative and waste management services, 7.7 %; Professional and technical services, 7.3 %; and Manufacturing, 7.0 %. Although, service industries have a larger proportion of non-White workers, in New Hampshire, 39.8% of foreign-born persons who were naturalized U.S. citizens in 2011 had a bachelor's or higher degree.

The Supplemental Nutrition Assistance Program (SNAP) reaches 9% of the total population in New Hampshire. Minority households in New Hampshire are over two times more likely to be participating in SNAP. In New Hampshire, families with gross income up to 185 % of the federal poverty level (FPL) are eligible for SNAP. Among those who benefit from SNAP, approximately 41% are children and 59% are adults.

The NH Kids Count, New Hampshire School Breakfast Program Report 2013, has called attention to the fact that nearly 15% of New Hampshire's children are from food insecure families. For every 100 students participating in the National School Lunch Program, on average, only 22 New Hampshire students eat school breakfast. Additionally, for every 100 students receiving free and reduced price lunches, an average of only 38 New Hampshire students also eat free and reduced price breakfasts.

TANF policies also provide a safety net to low income families. However, a 2014 survey indicates that 66% of the New Hampshire Employment Program caseload, with a child 13 or younger, makes a decision about caring for their children that does not take advantage of one of the most important financial supports that the NH DHHS offers--the New Hampshire Child Care Scholarship (NHCCS) program. In fact, roughly 75% of children whose families receive TANF supports are not accessing the NHCCS. The NH Division of Family Assistance will investigate how to improve the NHCCS program and access to quality care for working parents. States can invest in the future work force in several ways, but there may be no better return on investment than good early childhood care and education, especially for those most vulnerable children.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	317916	10876	0	2013
Percent in household headed by single parent	19.0	33.0	0.0	2013
Percent in TANF (Grant) families	1.5	4.1	0.0	2013
Number enrolled in Medicaid	109590	7517	0	2013

Number enrolled in SCHIP	0	0	0	2013
Number living in foster home care	673	71	0	2013
Number enrolled in food stamp program	40819	3977	1412	2013
Number enrolled in WIC	12965	1689	0	2012
Rate (per 100,000) of juvenile crime arrests	1028.0	1028.0	1028.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.3	1.3	1.3	2012

Notes - 2015
2010 U.S. Census

Ethnicity data unavailable.

Race breakdowns are not available. Therefore, the same rate is used for each race and ethnicity category. 2009 is the most recent year that accurate data is available.

Race breakdowns are not available. Therefore, the same percentage is used for each category.

Narrative:
Although relatively small in number, the portion of New Hampshire Hispanics living below the poverty line is twice that of the white population.

It is important to note, although still relatively small in number, that New Hampshire's Hispanic population has increased over 79 percent between 2000 and 2010. The Manchester School District has the highest proportion of English Language Learners in the State at 11 percent. To further illustrate the concentration of diversity in the State, two-thirds of all New Hampshire public school students receiving LEP services are enrolled in one of only three school districts in the state - Manchester, Nashua, and/or Concord School Districts. This indicates a need for services in these areas to be particularly sensitive to a growing population.

About 20% of the percent of the total population lives in single female households. These households are headed by unmarried women, with no husband present in the home. The portion of Hispanic or Latino people living in single female households is almost twice the rate for the White non-Hispanic population. Hispanic residents in New Hampshire are also more likely to be renters than home owners, compared to the White non-Hispanic population. Benefits of owning a home include tax deduction, appreciation, equity, borrowing power.

Overall, there has been a 15% decrease in the total number of WIC participants in the past 3 years. Some of the decrease has been due to a declining birth rate in New Hampshire and nationally. Fewer births not only affect WIC's infant participation, but also its enrollment among women, because they must be pregnant, breastfeeding, or postpartum to receive program benefits. There has been anecdotal evidence that mothers may be dropping out of WIC because SNAP benefits are easier to get and easier to use. Food stamps are now provided on a debit-like card, whereas states have until 2020 to provide WIC benefits that way. New Hampshire has plans to develop an Electronic Benefit Transfer (EBT) for WIC within the next 5 years. Even with these changes, WIC in New Hampshire has seen a steady participation among Hispanic/Latino women and children of 10-12% of the total population for the past three years.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	197031
Living in rural areas	128761
Living in frontier areas	0
Total - all children 0 through 19	325792

Notes - 2015

Narrative:
Where we live impacts our health, education and behaviors. New Hampshire's children are not proportionately scattered throughout the state. They are mostly located in the more urban areas in the southern and eastern areas within commuting distance to the Metropolitan Boston Area in Massachusetts. Despite a 10 percent increase in New Hampshire's adult population since 2000, the overall population of children in New Hampshire has declined 7.2 percent.

As described by the 2013 County Health Rankings, overall health outcomes and health factors/behaviors are best in the suburban, southern, seacoast area of our State. The poorest health outcomes and health factors/behaviors are found in most northern, rural areas of the state.

An un-yet published needs assessment of SPARK NH, the State's early childhood advisory council, describes that in New Hampshire, nearly three-quarters (73%) of low-income children live in households where more than 30 percent of the monthly income was spent on rent, mortgage payments, taxes, insurance, and/or related expenses. Unlike other state data, this statistic compares unfavorably to the nation (66%). (Population Reference Bureau, 2011). Six percent of children live in households with no vehicle at home. This may be less significant in urban areas, but by far, most areas of the state do not have access to convenient public transportation. Six percent of New Hampshire children also live in crowded housing. Crowded households have more than one person per room (counting all rooms in the house, not just bedrooms) as compared to 14% for the nation. This is particularly true for children of racial and ethnic minorities. (http://www.nhpolicy.org/reports/healthequity2013.pdf)

These data tell the broad brush story of three New Hampshires. There is the New Hampshire "below the Hooksett toll booth", in Southern New Hampshire, with a growing, more diverse, more densely populated, younger population of children. There is the New Hampshire of Central New Hampshire that lives on its lakes or by its mountains, and many who live in this area are relatively affluent and/or retired, or cater to this population in service or healthcare industries. And finally, there is the isolated population of the North Country, generally the oldest, least healthy and poorest of the three. Understanding the idiosyncrasies of each of these populations and its impact on children's health and access to services is the key to developing new strategies and providing the appropriate funding for support.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1323459
Percent Below: 50% of poverty	4
100% of poverty	10
200% of poverty	24

Notes - 2015

Narrative:
Often ranked among the wealthiest states, 5.3% of the population of New Hampshire was unemployed in 2013 and the median household income was $63,280. Approximately 10% of the total population had an income that placed them below the poverty line, compared to nearly 16% nationwide.

However, child poverty continues to rise, even in New Hampshire. The number of children in low income families has risen by 6% since 2007. That trend places New Hampshire toward the middle of the states.

According to the National Center for Children in Poverty, 68% of children in poor families in New Hampshire live with a single parent compared to the rate of children (21%) that do not live in poor families who live with a single parent. Consistent with national trends, a greater proportion of the youngest children live in poor families. In New Hampshire 13% of children, under age 6, live in poor families compared to 9% among children six years or older.
http://www.nccp.org/profiles/NH_profile_7.html

Employment policies and laws can promote the economic security of expecting and new parents. In 2014, the National Partnership for Women & Families, published a report, EXPECTING BETTER (THIRD EDITION). It describes how New Hampshire women in the private and public sector have greater access to pregnancy disability leave under the state antidiscrimination law than under federal law. The New Hampshire law applies to state workers and employers with six or more employees and covers all workers regardless of tenure and number of hours worked. This policy allows workers the right to a leave of absence of an unspecified length for the period of temporary physical disability due to "pregnancy, childbirth, or related medical conditions." New Hampshire state workers are also entitled to use up to five days of sick time to care for an ill or injured family member who is incapable of self-care or to accompany the family member to healthcare provider visits. In addition, because New Hampshire law recognizes same-sex marriages, same-sex married couples in the state have access to federal FMLA leave. Even though New Hampshire has some supportive policies, there are no laws that ensure paid family or medical leave to new parents who are caring for newborns, newly adopted children or newly placed foster children.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	325792
Percent Below: 50% of poverty	4
100% of poverty	10
200% of poverty	24

Notes - 2015

Narrative:

New Hampshire is fortunate that it is has consistently been favorably ranked among states among many measures of child poverty. However, New Hampshire has recently lost its coveted status of having the lowest rate of child poverty in the country.

While the national rate of 22.6% is not statistically different than the rate in 2011, New Hampshire's child poverty rate is continuing to rise. Between 2011 and 2012, child poverty increased the most in New Hampshire and Mississippi; New Hampshire's rate rose from 12% to 15.6%, while Mississippi's rate rose from 31.8% to 34.7%. Within New Hampshire, child poverty remained stable in suburban areas, but increased in rural and urban centers. http://carseyinstitute.unh.edu/sites/carseyinstitute.unh.edu/files/publications/IB-Mattingly-Carson-Same-Day-Poverty-web.pdf

According to the National Center for Children in Poverty, in 2012, 68% of children in poor families in New Hampshire live with a single parent compared to the rate of children (22%) that do not live in poor families who live with a single parent. Consistent with national trends, a greater proportion of the youngest children live in poor families. In New Hampshire 14% of children, under age 6, live in poor families compared to 10% among children six years or older. http://www.nccp.org/profiles/NH_profile_7.html

Fifty-seven percent of children in poor families have a parent that is employed. Over 55,000 children under age 6 in New Hampshire potentially need child care because both parents or a single head of household is working. Child Care Aware, recently published that the average annual fees for full-time care for an infant in center-based child care is $11,901. For married couples, this is approximately 12% of the annual average income and 41% of the average annual income for single mothers.

Child poverty carries additional burden, including the risk for food insecurity. The UNH Carsey Institute describes that there are places in New Hampshire where access to food, particularly affordable, nutritious food, may be limited by the need to travel long distances to grocery stores. Fifty-three percent of the towns in Sullivan County and 48% of the towns in Coos County may be at particular risk. This is consistent with New Hampshire trends in Supplemental Nutrition Assistance Program (SNAP). All ten New Hampshire counties between 2008 and 2011 reported increases in the use of food stamps, ranging from almost 20 percent in Rockingham County to 93 percent in Coos County.

The takeaway message is that although New Hampshire is fortunate to continue to have fewer children in poverty than many states, the data is headed in the wrong direction. New Hampshire has poor children in cities and in very rural isolated places and their numbers are growing.

F. Other Program Activities

NEW HAMPSHIRE BIRTH CONDITIONS PROGRAM: Dartmouth Medical School (DMS), SMS, MCH, WIC, and Early Intervention continue to collaborate on the implementation of a birth defect surveillance system for NH. Funded through a CDC cooperative agreement, the project is: establishing a high quality, statewide, comprehensive birth defect surveillance system; expanding NH folic acid education and birth defect prevention activities; and improving access to health care and early intervention services for infants with birth defects. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, a new advisory board structure monitors and provides oversight to the program. The MCH & SMS Directors are active members of the project's Advisory Council. MCH also provides oversight of the "opt out" process for inclusion in the program. MCH provides support as appropriate, such as development of the MOU between DHHS and Dartmouth, and a letter outlining the project to encourage hospital participation. /2013/ SMS and the Birth Conditions

program are now synchronizing data to assess what percentage of identified children actually received Title V follow up. //2013//

ELDERLY FALLS: Preventing falls, particularly among older adults, can greatly impact injury-related deaths. Falls are not an inevitable consequence of aging and proven effective strategies exist for decreasing the risk. The Injury Prevention Program within MCH facilitates the New Hampshire Falls Risk Reduction Task Force (Task Force). In 2009, the Task Force attended to the prioritized goals it set for itself during 2008's yearlong web-based process survey. A website is in development and is planned to launch on National Falls Awareness Day on September 21st, 2010.

The Task Force continues to promote routine falls screening in primary care settings, coinciding with the release of the new American Geriatrics Society guidelines in the winter of 2010. This work is happening in collaboration with the Northern New England Geriatric Education Center at Dartmouth Hitchcock Medical Center.

The Task Force also completed a survey of E-911 calls during one week each in the winters and summers of 09 and 10 , resulting not only in informative season specific data, but also confirming that falls are the number one E-911 call in the state. Results indicated approximately 30% more calls during the winter weeks. There was more of an equitable share of calls between men and women in the weeks in winter than in the summer when women were three times more likely to call. Geographic locations varied and were not consistent. /2014/The Task Force facilitated a training in the evidence based program, "Tai Chi- Moving for Better Balance" with 15 tai chi instructors in 2012. Early results show that after a 12 week class period, 73% of elderly participants reduced their time to complete the Timed Up and Go (TUG), 85% increased their Functional Reach and 64% decreased their time in completing the Five Times Sit and Stand. //2014// ***/2015/ The Task Force facilitated a second training for instructors in what is now a trademarked name "Tai Ji Chuan: Moving for Better Balance". One of the current instructors became a Master Trainer this past year, increasing New Hampshire's capacity in sustaining the program long term. //2015//***

SEXUAL VIOLENCE PREVENTION: The Injury Prevention Program with funding from the Centers from Disease Control (Sexual Violence Grant and Preventive Health and Health Services Grant) contracts with the New Hampshire Coalition Against Domestic and Sexual Violence who in turn subcontracts with 13 local crisis centers to provide primary sexual assault prevention education activities within local communities throughout the state.

The sexual violence prevention plan was completed and will guide the efforts of grant-funded activities. New Hampshire's plan places a large emphasis on infrastructure building & professional development, which is consistent with what is happening on a national level.

POISON PREVENTION:
The Poison Center is currently focusing its outreach efforts on two large projects. One focuses on seniors in rural Coos County regarding medication safety and involves distribution of revised brochure as well as performances by a senior acting troupe. The other revolves around the Community Partner Program, whereby community members take online courses in Poisoning 101, Medication Misuse, and Inhalant Abuse.

HEALTHY CHILDCARE NH (HHCNH) has continued to work with Child Care Licensing and the Child Development Bureau to support all child care providers with health and safety best practices, including mandated training in medication administration. Also, HCCNH has been the liaison with childcare in developing strategies for obesity prevention programs such as the "I am Moving, I am Learning" curriculum.

TEEN DRIVING: The teen driving group is coordinated by the Adolescent Health/Injury Prevention Program and includes region-wide professional groups. The group is pursuing a

seatbelt initiative in schools and collaborating on law revisions for extended graduated driver's licensing (GDL).

AUTISM LEGISLATIVE COMMISSION- MCH staff have been participating in a commission mandated by NH House Bill 236, to develop a report and recommendations, released spring 2008, on improving awareness, services, training, and reimbursement related to serving the needs of children and young adults with Autism Spectrum Disorders. Among the recommendations was that a council be formed to continue the work of the commission. In 2008, legislation was passed to form the NH Autism Council to continue the work of the Autism Commission. SMS & MCH staff participate in several of the workgroups including Screening and Early Diagnosis Workgroup.

NH HEALTHY HOMES -- MCH has been part of spearheading the planning process to move the Childhood Lead Poisoning Prevention Program (CLPPP) to a Healthy Homes Program, and to move statewide implementation efforts of a "One Touch" information and referral system. The CLPPP has formed a Healthy Homes Steering Committee to review the priorities of the statewide strategic plan and to be the coordinating body to overseeand assist in implementing healthy homes activities statewide.

TEXT4BABY: MCH & WIC have co-sponsored an initiative to promote this innovative mobile phone based health promotion campaign for pregnant and parenting mothers. Since the inception of the program in New Hampshire on April 2010, over 300 women have signed up for this free service. Pregnant women send a text message to receive three texts a week about maternal and child health specially geared toward their child's due date until the baby's first birthday. /2013/ A new partnership with the Department of Education increased the outreach efforts and helped NH lead the way to winning 2nd place in the National text4baby State Enrollment Contest. //2013//

/2012/ ORAL HEALTH PROGRAM: The Oral Health Program & WIC are collaborating to provide on-site oral health assessments, preventive services, and links to reparative dental treatment for WIC enrolled children and families when they come in for recertification or to pick up vouchers. //2012// /2013/ The Oral Health Program further developed a pilot project to provide oral health education, screening, cleaning and fluoride varnish application to children 0-5 years enrolled in WIC at 7 WIC sites across the state. An external partner will fund planning and implementation of a sustainable expansion of the WIC "dental clinics" in SFY13. //2013//

//2013// In 2013 the NH DPHS Oral Health Program applied for and received funding for a year-long oral health pilot project in collaboration with DPHS partners in the Women, Infants and Children's (WIC) program. Dental health hygienists working under public health supervision are providing oral health education, preventive services and referrals for treatment for women and young children enrolled in WIC and NH Medicaid. Uninsured WIC enrolled women and young children identified with urgent needs are also referred to collaborating local dental practices. Treatment is paid for from the grant for the WIC Pay for Prevention project. WIC provides a unique opportunity to reinforce oral health messaging and provide ongoing preventive care to high risk women and young children since WIC clients regularly return to be recertified for WIC eligibility every quarter. A robust evaluation is anticipated to demonstrate long term project sustainability once the initiative is completed.

In 2013 the Oral Health Program also completed the second Healthy Smiles-Healthy Growth survey to assess the oral health and BMI status of students in 126 randomly selected schools across the state. //2013

EMERGENCY SERVICES for CSHCN: Several State of NH entities have been working together to try to improve the outcomes of emergency response situations for children with complex and chronic health conditions. These groups are: Department of Safety-Division of Emergency Services, New Hampshire Family Voices, the EMSC, and SMS. Surveys responses from EMS responders and Hospital staff will guide future activity.

/2012/
ABUSIVE HEAD TRAUMA COALITION: Funded by ARRA, and in collaboration with the NH Brain Injury Association, the Abusive Head Trauma Coalition represents the evolution of the state's Shaken Baby Coalition. This new coalition has focused on initiating Period of Purple Crying (PPC) programs in several of the larger birth hospitals.//2012// /2014/ Thirteen of 20 birthing hospitals have received training in PPC, as well as several health centers and medical practices.//2014

/2012/ LIFESPAN RESPITE COALITION: SMS activity through AoA funding to create a statewide coalition. Stakeholders include caregivers, state & public representatives for the elderly, developmentaly disabled, mental health, child protection and condition specific advocates.//2012//

/2014/ PROJECT ACCESS: SMS and it's contracted partners are in year 3 of a 3 year state implementation grant to improve access to care for children and youth with Epilepsy. This grant is focusing on awareness, family/youth education, and coordination of care. //2014//

/2015/ DISABILITY & PUBLIC HEALTH : MCH is collaborating with the University of New Hampshire Institute on Disability to conduct Disability Accessibility Assessments at all contracted CHCs during the 2014 & 2015 Clinic Assessment Process to assure adequate access to care for persons with disabilities. To date, six CHCs have been assessed using the Outpatient Health Care Usability Profile (OHCUP). An agency specific report with findings and recommendations is included with each post-assessment report that is sent to each CHC. //2015//.

G. Technical Assistance

In March 2010, the New Hampshire Maternal and Child Health Section (MCH) utilized technical assistance from Mr. Russell Funk, Independent Consultant from Louisville, Kentucky and author of many books such as "Reaching Men: Strategies for Addressing Sexist Attitudes, Behaviors, and Violence" to help address the State priority of maintaining safe and healthy environments for pregnant women, families and children. Mr. Funk worked in collaboration with staff from MCH and the NH Coalition Against Domestic and Sexual Violence (Coalition) to help advance the work of NH Sexual Violence Prevention Plan.

The two-day workshop, held on March 25th and 26th 2010 was based on the following:

- Best science and practical strategies in engaging adolescent boys/men in violence prevention (particularly sexual violence prevention).
- Incorporation of above strategies into existing primary prevention activities and practices
- Gender stereotyping, specifically as it relates to violence and sexual violence prevention.

Approximately forty participants, including at least two staff from each of 13 Coalition member programs (crisis centers) attended. All participants completed ten open-ended questions at the end of day two to evaluate the success and learning opportunities of the training session.

One of the goals of the technical assistance was to increase the current and future capacity of prevention educators and other colleagues in the state in the primary prevention of sexual violence. This was in addition to utilizing this as a piece of the core competency training outlined in the new state sexual violence prevention plan. The development of the core- competency training guidelines has not been finished. The former goal was met by the answers to the questions, "How useful did you find this training?" and "How can you apply what you've learned today to your everyday work?"

"Very useful in that it provided exercises and information that I can use when speaking to men, I am trying to engage them in discussion about the work to end violence."

"Great frameworks and tools for organizing around engagement."

"Good review of many theories/philosophies that I was familiar with but hadn't applied to engaging men. I learned a lot about the complexity of addressing sexist violence with men you're trying to engage (defensiveness, the connection between sexism and violence not being obvious to men)".

"Increased awareness of opportunities to involve men. Approaching current activities from a new perspective."

"At the end of my presentations with the high schools I will dedicate some time to specifically ask questions to the students regarding why a male should care about sexual assault".

"That you engage men doesn't mean bringing them from 0-60 in one push, that even a little positive change is a win".

Most participants valued this training as a basic component of violence prevention.

"Make this discussion a regular long term component pertaining to how we work to end violence".

"Build engagement into existing work, recognize existing allies".

"Add this part to advocate and prevention training; change our agency policies about how we approach male clients, both formal and informal; change format of presentation to more dialogue".

Some of the participants listed challenges to implementation.

"This was helpful for thinking through but implementing is another thing and it's hard to think through without the rest of the organization. Sometimes it was like having homework in a class and having the class keep going before you've been able to do or process your homework and the fullness of the first lesson. So much but I'm still processing so it is tough to articulate."

"Our most limited resource is time".

"System based sexism that is hard to recognize yet is constantly present to reinforce wrong behaviors".

"At the Coalition level I think there is still resistance to engaging men in a manner that meets them where they are at on the continuum of understanding DV/SA/IPV/sexism".

At six months and one-year post workshop, there will be another evaluation to see what technical assistance participants continue to need as well as completed implementation.

ADDITIONAL REQUESTS:

Looking forward, MCH anticipates that technical assistance will be needed from federal partners as New Hampshire establishes its first Maternal Mortality Review Panel and Infant Mortality Review Panel.

The Maternal Mortality Review Panel was established in law in June 2010 to conduct comprehensive, multidisciplinary reviews of maternal deaths. The Panel, which includes the Title V Director, shall submit an annual report beginning on June 1, 2011 to the legislative oversight

describing adverse events reviewed by the panel, including statistics and causes, and outlining, in aggregate, corrective action plans, and making recommendations for system change and legislation relative to state health care operations. As per the legislation, the NH DHHS Commissioner may delegate to the Northern New England Perinatal Quality Improvement Network (NNEPQIN) the functions of collecting, analyzing, and disseminating maternal mortality information, organizing and convening meetings of the panel, and other substantive and administrative tasks as may be incident to these activities.

Because this process is new to New Hampshire, Title V hopes that federal partners from CDC, HRSA and peers from other states have standards, experience, and best practices to share as we develop Administrative Rules and protocols.

Much like the Maternal Mortality Review, the Infant Mortality Review Panel was also newly enacted in June 2010 to study New Hampshire's rate of infant mortality and develop proposals for remediation. Unlike the Maternal Mortality Review Panel, this legislation did not specify community and professional partners to be present and active on the commitee. It is unclear what role the legislature would like Title V to play in the development in this committee, but we feel it is important to have technical assistance ready for their use, if appropriate./2014/ MCH is developing an application through the Every Mother Initiative to support a maternal mortality learning collaborative.//2014//

/2012/NH participated in a Region I training, "Social Connectedness, Introduction, Overview, Literature and Data Sources" No consensus on a regional measure was gathered. New Hampshire is continuing to explore whether a new indicator is warranted based on the information gathered in this training session. //2012//

/2013/
With the support of MCHB TA funds, over 60 NH DPHS and Title V staff participated in "Storytelling: Tapping the Power of Narrative" and "Why Bad Presentations Happen to Good Causes". This one-day event was offered to staff from MCH and throughout the Division of Public Health Services. It was preceded by screenings of Unnatural Causes, the acclaimed PBS documentary that explores the root causes of our nation's socio-economic and racial inequities in health (not part of the TA request), and followed by three in-depth storytelling webinar workshops for 20 staff. The goal was to assist staff in developing storytelling and presentation skills and to improve their understanding of the links among Title V services, health inequities and the determinants of health.

Over 60 DPHS staff participated in the half day on-site training and 20 staff participated in a series of interactive webinars. Each of the 20 staff members that participated in the webinars created their own "story" with detailed feedback from the consultant to be used in communication of their specific program area. In addition to the personal growth and substantive changes made to presentations from those who attended the training, MCH is now housing those stories in a "Story Bank", aligned thematically with our DPHS strategic plan and vision so that we can better communicate the work of public health.//2013//

/2014/ During this past year, MCH Technical Assistance was used to support the Prevention Institute, to provide a professional training series for the NH Coalition Against Domestic and Sexual Violence's (the Coalition) Member Program Education staff. These trainings were the result of a needs assessments of the Statewide Sexual Violence Prevention Plan and were based on new, state-specific core competencies. Combining the training needs of the Member Programs along with that of MCH and the Coalition was the key to its success. Prevention Innovations at the University of New Hampshire facilitated the trainings on evaluation. Prevention Innovations is an interdisciplinary group of academics dedicated to studying and doing training in the field of violence against women. It also supported NH's Alliance for Healthy Community Coalitions Summit to engage community advocates and provide an opportunity for public input to State Health Priorities and the Title V Block Grant.

//2014//

/2015/

With Region I, New Hampshire will participate in the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality. Reducing New Hampshire's already comparitively low infant mortality rate will take strategic planning and implementation of cross-cutting activities. It is anticipated that technical asistance will be required for the New Hampshire team to help determine specific activities to further reduce Elective Deliveries < 39 weeks; enhance interconception care; further promote safe sleep; increase smoking cessation among pregnant women; and address social determinants of health.

Additionally, New Hampshire may request TA for the 2015 Needs Assessment as we determine the best way to assess capacity.
//2015//

TECHNICAL ASSISTANCE FOR SPECIAL MEDICAL SERVICES (CSHCN Program)

I. Strategic Planning

Special Medical Services (SMS) will be requesting technical assistance, consultation, and facilitation to conduct a formal Section-level strategic planning process to include the review of care coordination, clinic services, program design, needs assessment, cultural & linguistic competence and public awareness/marketing. This process with take into account all identified priorities for NH CSHCN and all National and State Performance Measures for CSHCN.

Assistance is needed to help guide the SMS staff in the identification of the technology, policies, and funding strategies necessary to achieve the goals of SMS. Special Medical Services offers infrastructure-building expertise to develop the NH systems of health care for CSHCN, in balance with the direct provision of community-based care coordination.

To fully actualize the principles of family-centered, community-based care, both the direct provision of service by state coordinators, and the provision of consultation to other public and private providers, is crucial. Facilitated planning will encompass the priorities and needs of NH CSHCN, their families, and the provider community. The core issue is the defining of future applications of the SMS resources and determining the nature and extent of direct services provided by SMS staff and contractors, within the overall CSHCN health care system. Defining exactly which CSHCN subpopulations, which geographic areas of the state, what family impact factors, eligibility criteria, and other such specifics, is necessary in order to target the limited resources to the identified priority needs in the most effective manner.

SMS has significantly changed the direction of its services but formal reflection and strategic planning has not taken place. SMS needs to develop a vision and mission statement and a planned approach to meet the needs of CSHCN in NH

/2013/
SMS received MCHB TA funds to support the process of Strategic planning. With the help of an expert consultant, 80 stakeholders and a leadership group of 15 the process was successfully completed. The SMS 2020 Strategic Intentions and Mission statement (see attachments) were completed and shared with the public at the SMS Reflection on 75 years of service. This celebration drew 100 participants with great success. //2013//

II. Disparities and CSHCN in NH.

SMS has seen a significant increase the number of diverse populations accessing services. A formal evaluation is needed related to incorporating cultural and linguistic appropriate components into provided services. The intent is to request technical assistance to conduct this evaluation. This will be done in concert with a formal plan on program evaluation that is being completed by an MCH funded intern Summer 2010. This will be a standardized and comprehensive framework for ongoing program evaluation for SMS for the next five years that is responsive to the needs of families of CSHCN and to federal and state reporting requirements.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1976838	1421854	1967556		1954157	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5658150	4296193	6560499		7352499	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	929675	797265	889518		931486	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	8564663	6515312	9417573		10238142	
8. Other Federal Funds *(Line10, Form 2)*	3909368	4103535	4378195		4519197	
9. Total *(Line11, Form 2)*	12474031	10618847	13795768		14757339	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	615233	478591	670561		781610	
b. Infants < 1 year old	1011046	796316	1132222		1323760	
c. Children 1 to 22 years old	2833493	2314187	3427154		4039896	
d. Children with	3372123	2396728	3384967		3113822	

Special Healthcare Needs						
e. Others	404365	333391	498746		589077	
f. Administration	328403	196099	303923		389977	
g. SUBTOTAL	8564663	6515312	9417573		10238142	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		91045		100000	
c. CISS	150000		150000		140000	
d. Abstinence Education	100149		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	681340		427946		568215	
j. Education	0		0		0	
k. Home Visiting	2461379		2461379		2461377	
k. Other						
NH Univ Newborn Hear	166500				159955	
Personal Responsibil	250000		250000		250000	
Project Launch			839650		839650	
NH Newborn Hearing S			158175			

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		**FY 2014**		**FY 2015**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	3039565	2352214	3383021		3551273	
II. Enabling Services	1761744	1522649	2138125		2439927	
III. Population-Based Services	838849	695871	847867		939810	
IV. Infrastructure Building Services	2924505	1944578	3048560		3307132	
V. Federal-State Title V Block Grant Partnership Total	8564663	6515312	9417573		10238142	

A. Expenditures

Expenditure trends:

The following factors have had, or are likely to have, an impact on MCH-related expenditures

Cost Allocation and Administrative Costs:
As noted SMS will continue to work with financial manangement to insure that budget planning for the next biennium will more clearly reflect planned spending and revenue.

Other State Budget Reductions:
It can be anticipated that the primary impact of State line item freezes or budget reductions will be the expenditure of fewer dollars than planned. Title V has focused a great deal on engineering any budget reductions so that they have least impact on services possible. However, as more reductions are anticipated in the next fiscal year this will become increasingly difficult.

Staffing Vacancies:
Title V is currently experiencing some capacity issues related to both "frozen" vacancies and some position reassignments/layoffs. Currently all vacant DHHS positions are "frozen" until such a time as a request to fill the position is granted by the Commissioner. DHHS guidance for additional budget reductions are focusing on transformation of operations to maximize efficiencies. However, this does reflect as decreased expenditures than what had been planned with the expectation was that Title V programs would be fully staffed.

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

Form 3:
The expended amount for Line 3, State Funds, was 11% less than originally budgeted. This line is reflective of the many mandatory state budget reductions in travel, supplies, equipment and hiring freezes that began in SFY09. Reductions in expenditures are also reflective of an effort of Special Medical Services (SMS) work within its new organizational alignment to better understand administrative costs to get at a "truer" budget of State General Funds.

The expended amount for Line 5, Other Funds, was 22% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to a continued declining number of births, the contract for newborn screening has been less than originally budgeted, as well as contracts for Metabolic Consultation.

Form 4:
Line Ie: The expended amount for Others was less than the budgeted amount by 14%, due mostly to the re-assignment and ultimately the elimination of the Catastrophic Illness Program from SMS. The program was reorganized to another Bureau and the funds were all State General Funds.

Line If: The expended amount for Administration was less than the budgeted amount by more than 37%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative functions within MCH. It should be noted that in the current structure between MCH and SMS, SMS does not capture "administrative" costs. This is also a significant driver in the discrepancy between the budgeted amount and the expended amount.

Form 5:
In order to move towards the MCH pyramid, funds have slowly moved "down" the pyramid of services to support increased infrastructure, population based, and enabling services. Both arms of Title V, MCH and SMS have made efforts to fund less direct services and provide more support for the foundation of the pyramid.

This budget also continues to reflect the overall downsizing of the Title V Partnership, due to the combined factors of state budget cuts and "right sizing" budgets of previous years.

Line I represents a 15% decrease in Direct Services. Fewer clinical services were provided directly by SMS staff.

Line II shows an 13% reduction in enabling services. This is due to reduced staff time in SMS devoted to providing direct enabling services for families.

The remaining lines in population based activities and infrastructure did not have significant budget variation.

/2012/
State Budget Reductions:
New Hampshire continues to feel the impact of State and Federal budget reductions. All expenses are scrutinized and austerity measures are in place. State line item freezes and continued budget reductions create expenditures less than planned.

In 2010, Title V managed to maintain most cost containment activities to infrastructure and administration within NH DHHS so that it had less impact on direct or enabling services. Future budgets will show that significant State Funds will be lost and services to families will be affected.

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

Form 3:

The expended amount for Line 5, Other Funds, was 23% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Even with an expanded panel, due to the continued decline in the number of births and other contractual savings, the contract for newborn screening has been less than originally budgeted.

The expended amount for Line 8, Other Federal Funds, was 20% less than originally budgeted. This can be accounted for primarily due to unanticipated changes in two grants. The 510 Abstinence Education grant was awarded, but not funded in FY 2010. It was subsequently funded in FY2011. The CISS/SECCS total federal funds authorized were less than anticipated. Other grants such as the CDC Sexual Violence Prevention Grant (formerly RPE) and HRSA SSDI also had downward funding adjustments during this fiscal year that contributed to reduced expenditures.

Form 4:

Line Id: The expended amount for Children with Special Health Care Needs included both encumbered (contracted) and unencumbered funds. Due to department and state budgetary constraints all unencumbered spending was critically evaluated and limited. This resulted in the 11% discrepancy noted between anticipated spending and actual spending.

Line If: The expended amount for Administration was less than the budgeted amount by more than 21%. The FFY10 budget as projected was in error. The Title V amount of $105,555 was duplicated in the total. The total projected was $452,911, however, the correct amount for admin should have read $347,356.

Form 5:

Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY10 was a mixed result of administrative constraint and changes in the demographics of the state.

Line I represents a 12% decrease in Direct Services. There appear to be two primary drivers to the variation in budget and expenditure.

1.) This line included both encumbered (contracted) and unencumbered funds from SMS. Due to department and state budgetary constraints all unencumbered spending was critically evaluated and limited. This resulted in the discrepancy noted between anticipated spending and actual spending.

2.) The Newborn Screening Program ("other funds") budget in FFY10 / Direct Care was $870,000. Actual University of Mass contract expenditure was $672,454, contributing approximately $200,000 to the overall difference.

The remaining lines did not have significant budget variation.

//2012//

/2013/
State Budget Reductions:
New Hampshire began implementation of an austere biennium budget for SFY 11 and 12. State General Funds have been reduced throughout the Department of Health and Human Services, including in Title V, specifically for the Community Health Centers. All expenses continue to be scrutinized. Specific State line items are frozen and other processes, such as hiring and contracting, are strictly monitored and managed.

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

Form 3:
The expended amount for Line 3, State Funds, was 20% less than originally budgeted. This is in large part due to a legislated $2 Million reduction in State General Funds in SFY11 and SFY12 for the State's Community Health Centers. Each of the 13 Primary and Perinatal Care and two Healthcare for the Homeless contracts managed by MCH experienced between a 42%-48% reduction in funds.

The expended amount for Line 5, Other Funds, was 16% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to the continued decline in the number of births and other contractual savings, the contract for newborn screening continues to come in less than budgeted. MCH has re-negotiated the program costs that can be paid using these funds in future years so that we can more efficiently manage these funds.

Form 4:
Because of the $2 million reduction in funds for the Community Health Centers and smaller austerity savings throughout the Title V budget, expenditures were less than originally budgeted for every population group in FFY11.

Line Ia: The expended amount for Pregnant Women was less than the budgeted amount by more than 15%.

Line Ib: The expended amount for Infants was less than the budgeted amount by more than 14%.

Line Ic: The expended amount for Pregnant Women was less than the budgeted amount by more than 14%.

Line Id: The expended amount for Children with Special Health Care Needs was less than the budgeted amount by more than 16%. Special Medical Services did not spend approximately $489,492 of their original SFY11 budgeted General Funds.

Line Ie: The expended amount for Others was less than the budgeted amount by more than 13%.

Line If: The expended amount for Administration was less than the budgeted amount by more than 35%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative support functions within MCH. The cost allocation method is highly reflective of staffing capacity and it should be noted that during much of FFY 11 there were significant vacancies.

Form 5:
Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY11 continues to be delicate balance between current state policy, prudent financial stewardship and providing mechanisms for effective delivery for care within local communities.

Title V uses our financial job coding and contracting system to track how Title V funds support each level of the pyramid. In this year of budget reductions, the impact was clearly cross-cutting. Yet, NH continues to make significant investments of State Resources specifically earmarked for safety net providers, such as the Community Health Centers. While NH's formula represents some of these dollars as "Direct Services", it should be made clear that they are contracted to community-based health centers to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement.

Line I represents a 13% decrease in Direct Services. As stated above, this is directly liked to the reductions in General Funds for Community Health Centers.

Line II represents a 16% decrease in Enabling Services. In addition to Community Health Center funding, Child and Family Health Support Home Visiting Contracts were reduced.

Line III represents a 12% decrease in Population-Based Services. Although as in other areas of the pyramid, there was a reduction in spending at this level, as well, it is clear that there was less of an impact in this area because it is supported with with other funds such as Federal Funds for Early Hearing Detection and Intervention and Newborn Screening Hospital Filter Paper Fees for newborn screening.

Line II represents a 22% decrease in Infrastructure Services. This is also reflective of the overall reduction in General Funds for Community Health Centers as well as reductions in overall MCH administrative support.
//2013//

/2014/

State Budget Reductions:
New Hampshire continued implementation of the austere SFY 11 and 12 biennium biennium. As described in previous year, State General Funds were reduced throughout the Department of Health and Human Services, including in Title V, specifically for the Community Health Centers. All expenses were scrutinized. Specific State line items were frozen and other processes, such as hiring and contracting, were strictly monitored and managed. This became evident as there was a 35% reduction in Administrative expenditures compared to what was originally budgeted.

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

Form 3:
The expended amount for Line 3, State Funds, was 20% less than originally budgeted. This is in large part due to a legislated $2 Million reduction in State General Funds in SFY11 and SFY12 for the State's Community Health Centers. Each of the 13 Primary and Perinatal Care and three

Healthcare for the Homeless contracts managed by MCH experienced between a 42%-48% reduction in funds. It should be noted that Federal Title V funds only contribute approximately 11% of the grant towards Community Health Center Funding. State General Funds provide the remaining 89 %.

The expended amount for Line 5, Other Funds, was 11% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to the continued decline in the number of births and other contractual savings, the contract for newborn screening continues to come in less than budgeted. MCH has re-negotiated the program costs that can be paid using these funds in future years so that we can more efficiently manage these funds.

Form 4:
Like in FFY11, because of the $2 million reduction in funds for the Community Health Centers and smaller austerity savings throughout the Title V budget, expenditures were less than originally budgeted for every population group in FFY12.

Line Ia: The expended amount for Pregnant Women was less than the budgeted amount by more than 15%.

Line Ib: The expended amount for Infants was less than the budgeted amount by more than 14%.

Line Ic: The expended amount for Pregnant Women was less than the budgeted amount by more than 14%.

Line Id: The expended amount for Children with Special Health Care Needs was less than the budgeted amount by more than 14%.

Line Ie: The expended amount for Others was less than the budgeted amount by more than 13%.

Line If: The expended amount for Administration was less than the budgeted amount by more than 35%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative support functions within MCH. The cost allocation method is highly reflective of staffing capacity and it should be noted that during much of FFY 12 there continued to be Title V related vacancies.

It should also be noted that other Federal Sources of Revenue fluctuated at this time including decrease in the CDC EHDI grant, a no cost extension of CORE VIPP to 07/30/13, fluctuating availability of Title V Abstinence, and the re-instatement of funds to SSDI.

Form 5:
Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY12 continues to be delicate balance between current state policy, prudent financial stewardship and providing mechanisms for effective delivery for care within local communities.

Title V uses our financial job coding and contracting system to track how Title V funds and State Match support each level of the pyramid. In this environment of continued budget reductions, the impact continues to be crosscutting. Yet, our state still values investments for safety net providers, such as the Community Health Centers. New Hampshire uses State dollars to support the infrastructure of community based health care providers. While NH's formula represents some of these dollars as "Direct Services", it should be made clear that they are contracted to community-based health centers to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement. In the future, as health care reform evolves, this formula may change as needs change, but the State has committed to ensuring that vulnerable populations have access to high quality care.

Line I represents a 5% decrease in Direct Services. As stated above, this is directly linked to the continued reductions in General Funds for Community Health Centers.

Line II represents an 11% decrease in Enabling Services. In addition to a reduction in Community Health Center funding, expenditures in Child and Family Health Support Home Visiting Contracts were reduced due to the loss of one geographic area of the state choosing not to re-bid to provide services.

Line III represents a 14% decrease in Population-Based Services. Although as in other areas of the pyramid, there was a reduction in spending at this level, as well, it is clear that there was less of an impact in this area because it is supported with other funds such as Federal Funds for Early Hearing Detection and Intervention and Newborn Screening Hospital Filter Paper Fees for newborn screening.

Line II represents a 35% decrease in Infrastructure Services. This is also reflective of the overall reduction in General Funds for Community Health Centers as well as reductions in overall MCH administrative support.

//2014//

/2015/
State Budget Reductions:
In the wake of the austere SFY 11 and 12 biennium budget, New Hampshire continued implementation of a lean SFY13 budget which resulted in discrepancies between proposed budgets and actual expenditures. There are two general explanations for this gap. The first, is a process explanation. The Budgeted amount reported was based on the entirety of Title V accounting units, including MCH and SMS, but there are activities in those budgets that are not Title V Block Grant funded and when the actual expenses were tallied they were not allocated to the Maternal Child Health Block Grant. The second is a operations explanation. Due to uncertainty regarding both federal and general funding availability , both MCH and SMS configured services to operate and utilize its budget conservatively and therefore some of the planned budgeted expenditures, including personnel costs that impact multiple layers of the MCH Pyramid and populations, were curtailed.

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

Form 3:
The expended amount for Line 3, State Funds, was 24% less than originally budgeted. This is in large part due to the continued reduction of State General Funds for the State's Community Health Centers. Each of the 13 Primary and Perinatal Care and three Healthcare for the Homeless contracts managed by MCH experienced between a 42%-48% reduction in funds. During this time, several key positions were also vacant, including the Title V director position. Those positions use a combination of State and Federal Funds. Because of Department-wide reductions, allocated costs using General Funds were also less than budgeted in SFY13 by $82,011. MCH was also instructed to provide $250,000 of General Fund savings from the State Budget for "back of the budget cuts" when State revenue was not as robust as expected.

The expended amount for Line 5, Other Funds, was 15% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to the continuing decline in the number of births and other contractual savings, the contract for newborn screening continues to come in less than budgeted. MCH has re-negotiated the program costs that can be paid using these funds in future years so that we can more

efficiently manage these funds. This reduction is apparent in the SFY14 budget.

Form 4:
As described in the narrative for Form 3, because of the significant reductions in State General Funds and austerity savings throughout the Title V budget, expenditures were less than originally budgeted for every population group in FFY13. Similarly, due to uncertainty regarding both federal and general funding availability, Title V configured services to operate its budget conservatively and therefore some activities and key hiring was postponed.

Line Ia: The expended amount for Pregnant Women was less than the budgeted amount by 22%.

Line Ib: The expended amount for Infants was less than the budgeted amount by 21%.

Line Ic: The expended amount for Children Age 1-22, was less than the budgeted amount by 18%.

Line Id: The expended amount for Children with Special Health Care Needs was less than the budgeted amount by 26%.

Line Ie: The expended amount for Others was less than the budgeted amount by 17%.

Line If: The expended amount for Administration was less than the budgeted amount by more than 40%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative support functions within MCH. The cost allocation method is highly reflective of staffing capacity and it should be noted that during much of FFY 13 there continued to be Title V related vacancies.

Form 5:
Title V has continued to try to align its funding along the MCHB pyramid structure. However, the variation in expenditure FFY13 continued to be delicate balance between interpreting Federal expectations for expenditures at each level, state policy, prudent financial stewardship and providing mechanisms for effective delivery for care within local communities.

Title V uses a financial job coding and contracting system to track how Title V funds and State Match support each level of the pyramid. In this environment of continued budget reductions, the impact was crosscutting. Yet, our state still values investments for safety net providers, such as the Community Health Centers. New Hampshire uses State dollars to support the infrastructure of community based health care providers. While NH's formula represents some of these dollars as "Direct Services", it should be made clear that they are contracted to community-based health centers to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement. Federal guidance is evolving and it appears that these funds will not all be counted as "Direct" in the future.

Line I represents a 22% decrease in Direct Services. As stated above, this is directly linked to the continued reductions in General Funds for Community Health Centers.

Line II represents an 14% decrease in Enabling Services. In addition to a reduction in Community Health Center funding, expenditures in Child and Family Health Support Home Visiting Contracts were reduced due to the loss of one geographic area of the state choosing not to re-bid to provide services.

Line III represents a 17% decrease in Population-Based Services. Although as in other areas of the pyramid, there was a reduction in spending at this level, as well, it is clear that there was less of an impact in this area because it is supported with other funds such as Federal Funds for Early Hearing Detection and Intervention and Newborn Screening Hospital Filter Paper Fees for newborn screening.

Line IV represents a 44% decrease in Infrastructure Services. This is also reflective of the overall reduction in General Funds for Community Health Centers, reduced administrative costs associated with cost allocation, and reductions in SMS and MCH administrative support.
//2015//

B. Budget

HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL EFFORTS

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

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

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

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMS; $834,088, or 41.65% of New Hampshire's Title V allocation, is appropriated to the SMS budget for FY 2011. Using a memorandum of understanding (MOU) developed between the the two sister programs in 2008, and revised in 2009, that clearly delineates the roles, responsibilities and commitments between the two programs, funds are easily appropriated through a well-defined methodology. The ultimate goal of using this formalized approach was to ensure that expenditures continued to be more closely aligned with the proportions suggested by the MCH pyramid while providing a mechanism to ensure collaboration in joint Title V goals.

Preventive and primary care services for children are provided through the MCHS; costs include direct care and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCHS children's services. The total of $795,173, the amount projected for children's services for FY 2011, is 39.54% of the Title V allocation. Administration is projected to remain at 5.041% at $108,440.

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

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

SSDI Grant: $100,000
These funds are used to address New Hampshire's capacity to improve performance on Health

Systems Capacity Indicator 09A and to develop linkages between MCH program datasets and New Hampshire birth files.

/2012/ In FY 2012, SSDI is budgeted to receive $97,260. This funding source is critically important to the infrastructure of MCH. Currently the MIEC Home Visiting Program is supporting 0.25 FTE of the SSDI Coordinator which will enable the MIEC Home Visiting Data System to be completely integrated with MCH program datasets in addition to providing more secuity and funding sustainability to the SSDI initaitives.//2012//

Universal Newborn Hearing Screening Grant: $150,000
These funds are used to establish New Hampshire's universal newborn hearing screening program, including
implementation of quality assurance standards and a data-tracking initiative.

ECCS Grant: $140,000
This grant is used to fund a strategic planning project for early childhood comprehensive systems. This planning project is in its final year, and will address strategies to strengthen the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood. The ECCS Coordinator plays a critical role in in aligning early childhood efforts throughout DHHS and is the key liaison for the Early Childhood Advisory Council and the key contact for the Affordable Care Act Home Visiting initiative.

/2012/
ACA Maternal Infant Early Childhood Home Visiting Program (MIEC HV):

Work on the ACA MIEC HV program began approximately a year ago with the release of the Funding Opportunity Announcement on June 10, 2010. Governor John Lynch designated the Maternal and Child Health Section as the lead agency to administer funds under this program that would meet the criteria identified in the ACA legislation. NH developed and submitted an application for funding that included plans for the statewide home visiting needs assessment based on the identification and inventory the data and information currently available. MCH developed work teams to address the components of the home visiting needs assessment: data analysis, coordination, survey, capacity, program model selection and benchmarking.

Next, MCH conducted a needs assessment of home visiting services in NH to identify communities in need of intensive, evidence-based services that would enhance Title V services being delivered through community agencies. Following the submission of the Needs Assessment, in September 2010, MCH was awarded $607,315 to develop a state plan for implementation within these at-risk communities. With these funds, MCH hired a full time Home Visiting Program Coordinator; the first position with 100% focus on home visiting programming. In addition, the MIEC program includes 0.25 FTE of the Program Planner from SSDI who is accountable for the data reporting requirements, including gathering, analyzing and reporting data for the needs assessment and evaluation activities. Travel expenses include MCH staff attendance at the AMCHP annual conference, the Home Visiting Summit and upcoming grantee meetings as required. In addition, funds were budgeted to set-up the workstation for new staff. MCH has contracted with the NH Children's Trust, Inc. to provide capacity building services that support implementation of Home Visiting NH activities, expand performance/quality improvement for Home Visiting NH, improve and integrate with other early childhood services, and facilitate the production of the Home Visiting State Plan, submitted in June 2011. With statewide input from a wide range of early childhood supporting agencies including home visiting, Head Start, family resource centers, community health centers, early supports and services, and the Early Childhood Advisory Council, MCH selected Healthy Families America as the evidence-based model NH will use in the MIEC programs.

Currently MCH is working with the DoIT (Department of Information Technology) to purchase (or create) a web-based data collection system, preparing a response to the Funding Opportunity

Announcement for MIECHV programs to support the development of statewide home visiting programs and anticipates implementation of HVNH-HFA in November 2011. //2012// MCH has continued to work with DoIT to develop an RFP and procure the Data Collection System for HVNH-HFA. This has been a rigorous, competitive, and detailed process. A vendor has been selected, but the contract has not yet been signed by New Hampshire's Governor and Excecutive Council. It is anticipated that the contract will begin Late Summer 2012, thus delaying expenditures. //2013//

CDC funds include support for the Rape Prevention and Education Grant (RPEG), $160,196 and Early Hearing Detection and Intervention (EHDI) program, $150,000.

/2012/
Awareness and Access to Care for Children and Youths with Epilepsy. In September 2011 SMS received funding from HRSA for improvement of the system of care for children and youth with Epilepsy under Project Access/Phase III. This is a 3 year grant and will build upon recent lessons and advances resulting from involvement as a non-funded collaborative in Project Access/Phase II. The focus of this Project Access extension initiative will be the spread to primary care providers in medically underserved and rural areas, with an emphasis on improving coordination of care efforts across all domains. This project will use the learning collaborative structure to increase the consistency and effectiveness of epilepsy care. It will also focus on the advantages and strength of parent and youth involvement in health care design. The project will utilize the expertise presented at the national Learning Sessions and emphasize continued Learning Collaborative activities within the state in conjunction with Regional Parent/Youth forums addressing leadership, the role of parent/youth partners in medical homes, and standards of epilepsy care.
//2012//

NH does not receive funding for PRAMS. /2013/ The New Hampshire Department of Health and Human Services (DHHS) Division of Public Health Services (DPHS), Maternal and Child Health Section will soon be able to survey mothers of newborns to learn why some babies are born healthy and some are not. In late Fall 2011, New Hampshire was awarded a cooperative agreement for $164,584 annually from the Centers for Disease Control and Prevention (CDC) to conduct the Pregnancy Risk Assessment Monitoring System (PRAMS), joining 39 other states in the country in a joint effort to improve the health of moms and babies. Funding will allow MCH to hire new staff and redirect exisiting infrastructure. //2013//

All State matching funds, as indicated on Form 2 and explained previously in Achievement of Required Match, are
appropriated from the New Hampshire General Fund during the State's biennium budget process.

Due to the configuration of New Hampshire's public health infrastructure and its system of contracting with local agencies to provide MCH services, there are no sources of "Local MCH" or "Other State" funds included in the MCH or SMS appropriations, as indicated on Form 2.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

For the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

FY2011 reflects significantly fewer Other Federal Funds than in FY2010. The leading contributor to this is the loss of the 510 Abstinence Grant. Although the Affordable Care Act has noted that there will be opportunities for Abstinence funding in FY 2011, it is unclear at the publication of the Annual Report what the funding will be and if NH will apply for it. Additionally, other federal

grants, especially those from CDC, such as Rape Prevention and Education (RPEG) and Early Hearing Detection and Interventuion (EHDI) have all seen smaller decreases in the past year that contribute incrementally to this decrease in federal funds.

It should be noted however that in next year's Annual Report, that New Hampshire anticipates additional Home Visiting, Teen Pregnancy (PREP) funds and perhaps other federal opportunities that will more than offset these reductions. It is just unclear at this time what those final budgeted amounts will be.

Form 4:

No budgeted amounts per population served for FY 2011 differ more than 10% from amounts for FY 2010.

Form 5:

Form 5 is reflective of the slow shift of moving Title V services down the MCH pyramid. While there is no significant difference in the amount Expended in 2009, Budgeted in FY 2010 and Budgeted in 2011, in Direct Health services, there funds continue to decrease. The significant changes occur in the below in Lines III and IV where there are increases are reflected in the amount that is budgeted for Population-based activities and Infrastructure Building Services. Contributors to this shift include fewer the final shift of the Catastrophic Illness Program out of SMS (thus out of Direct Services); increased allocation of time to injury prevention(Population-based services); increased newborn screening fees (Population-based services); and increased federal funds for Early Childhood Comprehensive Systems (Infrastructure-building).

/2012/
Like so many states, New Hampshire is facing significant budget challenges. In June 2011, the New Hampshire House and Senate compromised on a State Biennium Budget for SFY12 and 13. Governor John Lynch allowed the budget to become law without signing it. Although he stated publicly that he did not agree with many of its details, he also stated that he believed that vetoing it would most likely not lead to a better budget. Budget cuts are felt across virtually all sectors of the human service safety net. Among the many cuts include:

- Significant reductions for community mental health services and primary care services for both children and adults
- Virtual elimination of alcohol prevention programs and drastic reductions in treatment, possibly leaving more than 30,000 individuals without access to these services.
- Significant reduction in State General Funds for Family Planning Services.
- Re-creation of a child-care subsidy waitlist.
- Elimination of core funding for Family Resource Centers.
- Elimination of adoption subsidies, limiting the number of families that will be financially able to adopt children, many of whom have special needs, from foster care.

When budgeting for Title V in FY 12, New Hampshire was reminded of how essential both federal and state support is to the preservation of a comprehensive Title V program in New Hampshire. In times of fiscal constraint, the Title V Maintenance of Effort and required match continues to assure a basic funding level for state and local maternal and child health programs.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

As described above, for the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

The FY12 budget reflects significantly fewer State General Funds than in FFY2011. The largest line item reduction for MCH will be for the state's community health centers. The Governor and subsequently the House and Senate all approved a $2Million reduction for the state's safety net providers. It is important to note that even with this significant reduction, New Hampshire continues to meet its Maintenance of Effort and required match funding partnership.

Line 3. State Funds are reduced by 20% in FFY12. This is due primarily to the reduction in primary care funds for the community health centers.

Line 8. Other Federal Funds is increased in FFY12 by 40% than budgeted in FFY11. This increase is due to the ACA Maternal Infant Early Childhood Home Visiting Program (MIEC HV), Personal Responsibility Education Program (PREP), resumption of the Abstinence Education Program and Sudden Unexpected Infant Death (SUID) Grant.

Form 4:

Unlike the FY 10 and 11, almost all MCH populations experience a budgeting difference greater than 10% between FY 11 and 12. This is overwhelmingly due to the significant State Fund reduction for primary care. Pregnant women and infants were less affected by the cuts because historically New Hampshire has used a greater proportion of Federal Title V funds for these populations, so there were slightly less impacted by the cuts.

Line 1a. Pregnant Women are budgeted at an 18% reduction.

Line 1b. Infants are budgeted at an 20% reduction.

Line 1c. Children are budgeted at an 27% reduction.

Line 1e. Others are budgeted at an 27% reduction.

Form 5:

Form 5 is not only reflective of the slow shift of moving Title V services down the MCH pyramid, it is also reflective of the significant MCH budget reduction for FY12. Because these funds had previously been appropriated for community health centers, Direct and Enabling Services were most impacted. No other lines exceeded 10%.

The community health centers are currently revising their budgets and workplans for SFY12. Cuts to individual community health centers range from 39% to 50% in annual funding from MCH. It is unclear what the ultimate community impact will be of these reductions.

I Direct Services is reduced by 20% in FY12.
II Enabling Services is reduced by 25% in FY12.

//2012//

/2013/
As described last year, New Hampshire is in the middle of a complex and difficult budget biennium. While there have been significant cuts to State General Funds that have resulted in 40-50% cuts to perinatal and primary care services for community health centers, there has been continued and new support for Federal Programs like MIEC Home Visiting, PRAMS, CORE Violence and Injury Prevention Program (VIPP).

Title V will continue to refine our financial job coding and contracting system to determine how Title V funds support each level of the pyramid. It is important that New Hampshire's formula accurately reflects the complexity of how contract dollars are used within each of our

communities. As described in the Expenditures Section, historically, for example, a significant proportion of the funds directed to community health centers has been coded as "Direct Services", when in fact the funds are used in many different ways to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

As described above, for the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:
Other Federal Funds increased in FFY13 by 47% than budgeted in FFY12. This is due to significant competitive and formula grants from ACA Maternal Infant Early Childhood Home Visiting Program (MIEC HV), Personal Responsibility Education Program (PREP), PRAMS, and the CORE Violence and Injury Prevention Program.

There were no other significant variations from FFY12.

Form 4:
No budgeted amounts per population served for FFY 2013 differ more than 10% from amounts for FFY 2012.

Form 5:
Budgeted amouts per pyramid levels are remaining relatively stable. Line items for FFY 2013 do not differ more than 10% from amounts for FFY 2012.

//2013//

/2014/
The New Hampshire budget environment is constantly evolving. While State Government continues to function within very modest means with expectations for efficiency, new policy makers and leadership have developed a SFY14/15 budget that has its own unique challenges and opportunities. General Funds have been restored to perinatal, primary care, and family planning services for community health centers. However, there is an expectation that administrative and personnel costs will be strictly contained.

It is important to note that while the State Biennium Budget has legislated these funds, the NH Department of Health and Human Services must also find additional General Fund savings for SFY14. It is unclear at this time what the expenditure will be for SFY14.

Title V will continue to refine financial job coding and contracting system to further determine how Title V funds support each level of the pyramid. It is important that New Hampshire's formula accurately reflects the complexity of how contract dollars are used within each of our communities. As described in the Expenditures Section, historically, for example, a significant proportion of the funds directed to community health centers has been coded as "Direct Services", when in fact the funds are used in many different ways to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement. MCH will have the opportunity to re-define the scope of service and how community health center invoice Title V for Federal Title V dollars and State General Funds to more clearly articulate these infrastructure costs through a Request for Proposals for SFY 15.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

As described above, for the purpose of this application, "significant budget variation" is defined as

an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:
Line 3- State Funds: State Funds will increase in FFY14 by 15% with the increase of $2 Million dollars in SFY 14 and $2 Million dollars in SFY15 for the State's community health centers. This will restore funds that were reduced in the SFY 12/13 Budget.

There were no other significant variations from FFY14.

Form 4:
Line 1b. Infants are budgeted at an 11% increase due to community health center funding.

Line 1c. Children are budgeted at a 17% increase community health center funding

Line 1e. Others are budgeted at a 19% increase community health center funding.

Line 1f. Administration is budgeted at an 8% decrease due to requested budget efficiencies.

Form 5:
Budgeted amounts per pyramid levels are increased due to the inclusion of additional State General Funds for New Hampshire's community health centers. Again, it should be noted that these State investments for community health centers have been authorized within the State Budget, but there is also a concurrent legislative directive to find significant General Fund savings in SFY14/15. It is unclear if all of these funds will be expended.

I Direct Services is increased by 12% in FY14.
II Enabling Services is increased by 18% in FY14.

//2014//

/2015/
While State Government continued to function within a drastically reduced, austere budget for FFY13, the SFY14 and 15 budgets were increased by new policy makers and leadership. General Funds have been restored to perinatal, primary care, and family planning services for community health centers. It is important to note that while the State Biennium Budget has legislated these funds, DHHS was required to find additional General Fund savings for SFY14. Ultimately, a portion of the General Funds allocated for CHCs was expended.

Title V continues to refine financial job coding and contracting system to further determine how Title V funds support each level of the pyramid. As described in the Expenditures Section, historically, for example, a significant proportion of the funds directed to community health centers has been coded as "Direct Services", when in fact the funds are used in many different ways to ensure access to care; improve quality; promote integration across systems and support appropriate performance measurement. Federal guidance indicates that in the future these activities may not meet the definition for "Direct Services". MCH will have the opportunity to re-define the scope of service and how community health center invoice Title V for Federal Title V dollars and State General Funds through a Request for Proposals for SFY 15.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

As described above, for the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this

criterion:

Form 3:
Line 3- State Funds: State Funds will increase in FFY14 by 11% with the continued increase of funds for the State's community health centers. Although these dollars are allocated, it is apparent that the entirety will not be expended in FFY15.

Form 4:
Line 1b. Infants are budgeted at a 14% increase due to community health center funding.

Line 1c. Children are budgeted at a 15% increase community health center funding

Line 1e. Others are budgeted at a 15% increase community health center funding.

Line 1f. Administration is budgeted at a 28% increase due to anticipated hiring and cost allocation.

Form 5:
Budgeted amounts per pyramid levels are increased due to the inclusion of additional State General Funds for New Hampshire's community health centers. Again, it should be noted that these State investments for community health centers have been authorized within the State Budget, but they may not be expended.

II Enabling Services is increased by 15% in FY14.

//2015//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

New Hampshire

Suicide Prevention Plan

January 2013

Suicide Prevention Council

The mission of the State Suicide Prevention Council is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:

**** Raise public and professional awareness of suicide prevention;***

**** Address the mental health and substance abuse needs of all residents;***

**** Address the needs of those affected by suicide; and***

**** Promote policy change***

For more information on the State Suicide Prevention Plan, contact Jo Moncher at jamoncher@dhhs.state.nh.us

MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

July 2, 2013

I want to thank the New Hampshire Suicide Prevention Council for its work on the 2013 State Suicide Prevention Plan. Since the Plan's last revision in 2010, New Hampshire has accomplished a great deal, and the Suicide Prevention Council has been instrumental in helping to guide these efforts.

Legislatively established in 2008, this Council is responsible for the oversight of the implementation of the State Suicide Prevention Plan, and has developed a strong public and private partnership throughout the State to accomplish this goal. As citizens of New Hampshire, we can all be proud that our Connect Program is a National Best Practice Program that has trained hundreds of professionals and community members to prevent and respond effectively to suicide across the lifespan. Additionally, New Hampshire is a national model for our work recognizing the training and prevention efforts needed to support our veterans and military families. Due to the efforts of the Council, New Hampshire is now recognized as a Leadership State and was awarded one of the first Garrett Lee Smith grants through the Substance Abuse and Mental Health Services Administration.

Suicide, however, remains the second-leading cause of death for New Hampshire young people, and is a major concern for all ages. We must continue our efforts to reduce the number of suicides and suicide attempts statewide. Prevention must be a collaborative effort. The entire community must share the responsibility of identifying at-risk individuals and ensuring that these individuals receive essential, life-saving services. Broad awareness of the warning signs of suicide can only increase appropriate referrals and interventions.

This 2013 State Suicide Prevention Plan has been a true collaboration among many stakeholders, and I look forward to working together to address this issue that affects all of our citizens.

With every good wish,

Margaret Wood Hassan
Governor

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.nh.gov/ • Email: governorhassan@nh.gov
TDD Access: Relay NH 1-800-735-2964

Suicide Prevention Council
85 North State Street, Concord, NH 03301

Child and Family Services of NH

Disabilities Rights Center

Elliot Hospital

Faith Based Community

Genesis Behavioral Health

Injury Prevention Center

Lakes Region Partnership for Public Health

NAMI NH

New Futures

NH Association of Counties

NH Community Behavioral Health Association

NH Dept. of Corrections

NH Dept. of Education

NH Dept. of Health and Human Services

NH Dept. of Safety

NH General Court

NH Hospital Association

NH Medical Society

NH Mental Health Council

NH National Guard

NH State Senate

Office of the Chief Medical Examiner

Survivors of Suicide Loss

VA Medical Center

Youth Suicide Prevention Assembly

From the State Suicide Prevention Council

As the member organizations of the State Suicide Prevention Council (SPC), we are pleased to present the 2013 State Suicide Prevention Plan. Our hope is that this Plan will help to guide and focus our efforts in addressing the tragedy and burden of suicide across New Hampshire.

The Plan was developed through the wisdom, expertise and collaboration of the SPC, as well as many groups, committees and organizations who have dedicated time and resources to study the issue of suicide and to look at prevention and postvention across the lifespan.

Community collaboration is at the heart of SPC and is included throughout the Plan. The partnerships that have developed at all levels - public and private, local, state and federal, and military and civilian – continue to guide our efforts.

The planning process also included input from the 2012 National Strategy for Suicide Prevention, recognizing our nation's new approach in enlisting all individuals in the fight to prevent suicide.

The State Suicide Prevention Plan was last revised in 2010 and since that time, the SPC has accomplished much to address suicide prevention across the State. The Leadership Team spearheaded several strategic planning sessions, including a 50-person retreat at New Hampshire Hospital and a 100-person summit at the Concord Holiday Inn. Both events addressed state plan development, community collaboration and sustainability.

In 2012, the SPC partnered with the National Alliance on Mental Illness NH and the Youth Suicide Prevention Assembly on the Annual Suicide Prevention Conference. With close to 300 individuals attending, this conference continues to grow every year, reaching the largest and most diverse gathering of individuals in the nine–year history of this Conference.

The SPC will continue to build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability to reduce the risk of suicide for all New Hampshire citizens and promote healing for all those affected by suicide. Despite significant challenges with a struggling economic environment including budget cuts and reduced access to mental health and substance abuse treatment, our State will continue to make progress in suicide prevention work in many diverse and systemic ways.

Knowing that it takes all of us working together with common passion and goals, we would like to thank everyone who has been involved in suicide prevention efforts in our State.

2013 Revised

New Hampshire Suicide Prevention Plan

Presented by the
New Hampshire Suicide Prevention Council
(SPC)

INTRODUCTION

Suicide – a Major Issue in New Hampshire

Suicide is a significant public health problem in NH:

- Between 2004 and 2008 suicides outnumbered homicides by more than 8 to 1.
- Suicide is the second leading cause of death for those from age 15 to 34.
- Between 2002 and 2011, firearms were the leading method used, representing 42% of all suicide deaths.
- Three times more males than females ages 10-24 died by suicide between 2005 and 2009.
- Suicidal behaviors, which include attempts as well as completed deaths, are a significant cause of inpatient hospitalization, emergency and outpatient treatment.
- In an average year, between 2004 and 2008, 156 people died; nearly 185 were hospitalized and close to 945 were treated in emergency departments for self-inflicted injuries.
- These attempts and suicides represented an estimated $16.8 million in acute health care costs alone in 2008.
- For each suicide death, family and close friends are at higher risk for suicide themselves.
- Many others are affected in a variety of ways, including those providing emergency care to the victims and those who may feel they failed to prevent the death.

The data above is from *New Hampshire's 2011 Suicide Prevention Annual Report: Suicide Across the Lifespan.* Annual NH Suicide Data reports can be found here: http://www.theconnectprogram.org/annual-reports-suicide-prevention-data-nh

Underlying Principles for the State Suicide Prevention Plan

- **Suicide is generally preventable**. The vast majority of people who die by suicide have mental illness and/or substance use disorders which research demonstrates can be successfully treated. Early identification and access to care are essential.
- **Prevention must be a collaborative effort.** The entire community must share the responsibility of identifying and getting those at risk into needed services. Most people who die by suicide give some indication they are contemplating suicide before they die. Broad awareness of warning signs of suicide will increase appropriate referrals and interventions.
- **Risk factors** occur at the community as well as the individual level. Identifying and addressing community risk factors as well as individual risk factors is an important suicide prevention strategy. Likewise, communities that build and support protective factors will benefit not just in preventing suicide but also in improving public health and public safety.
- **Promoting healing and reducing risk following a suicide** (postvention) for both individuals and communities is an important component of suicide prevention efforts.
- **Significant investments** of time and other resources are required to prevent suicide. Focusing on recognized Best Practices will ensure that these efforts lead to positive outcomes across the lifespan, across the state and across cultures.
- **Suicide prevention must become a part of all of our ongoing work** and become embedded throughout our communities including our schools, health care systems, corrections at all levels. **The NH Suicide Prevention State Plan will be most effective when it is implemented from an ecological perspective that encourages working across individuals, families, communities, workplaces, the military, organizations and systems.**

State Suicide Prevention Plan Process

This Plan has been developed to focus and coordinate suicide prevention efforts in New Hampshire. The SPC and its partners will guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as the strengths and constraints of the current political and economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC will provide an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

COMMUNICATIONS & PUBLIC EDUCATION SUBCOMMITTEE

Goal 1: Promote Awareness that Suicide in NH is a Public Health Problem that is Generally Preventable

Objective 1.1: Promote recognition of suicide as a generally preventable public health problem and promote active involvement in prevention activities.

1. Partner with key stakeholders, including public health regions, throughout the State on planning and convening an annual conference in order to build awareness of suicide prevention, increase knowledge of best practices for prevention, intervention and response to suicide, and increase collaboration, networking and support.

Objective 1.2: Promote education that includes hopeful messaging to NH residents on risk factors, suicide-warning signs, help seeking behaviors, and resources.

1. Create audience specific messaging that encourages individuals to take steps towards preventing suicide, and coordinate with other national, state and local media efforts.
2. Maintain a central repository website updated regularly for press releases, presentations, and fact sheets that include data, risk and protective factors, warning signs, and resources.
3. Periodically repeat surveys to measure attitudes towards suicide prevention and media reporting.
4. Design and sponsor wide dissemination of public health messages and education on suicide prevention, using traditional and new/social media.
5. Encourage communities to effectively implement protocols listed in the Suicide Prevention Resource Center's Best Practice Registry.
6. Continue to educate the general public as well as health care providers and other key stakeholders (e.g. law enforcement/first responders) on risk factors and the efficacy of reducing access to lethal means for those at risk of suicide, particularly regarding firearms and medications.
7. Disseminate and promote information regarding the National Suicide Prevention Lifeline (1-800-273-8255).

Objective 1.3: Encourage new and diverse stakeholders, including policy makers, who work on preventing suicide in all communication subcommittee activities.

1. Review progress and update the State Suicide Prevention Plan.
2. Increase venues where the work of the SPC can be highlighted, e.g. newsletters, etc.

Goal 2: Reduce the Stigma Associated With Obtaining Mental Health, Substance Misuse and Suicide Prevention Services

Objective 2.1: Increase the proportion of the public that views mental disorders as real illnesses, equal and inseparable components of overall health, that respond to specific treatments and consumers of these services as persons taking responsibility for their overall health.

1. Disseminate information to legislators, policy makers, providers and the public demonstrating that there are effective treatments for mental illness and substance use disorders.
2. Educate the public and key gatekeepers that their acceptance of persons with mental illness and substance use disorders and their addressing suicide openly can reduce suicide risk and prevent suicidal behaviors.

3. Provide opportunities for the public to hear from those in recovery from mental illness, survivors of suicide loss, and survivors of suicide attempts, making use of existing speakers bureaus in NH such as *In Our Own Voice*, *Life Interrupted* and *Survivor Voices*.
4. Support initiatives which increase insurance coverage and reimbursement and access to treatment for mental illness and substance use disorders.

Goal 3: Promote Safe Messaging, Media Reporting and Portrayal of Suicidal Behavior

Objective 3.1: Increase the proportion of media professionals who have received training in appropriate reporting of suicidal events, identifying allies who will educate the media and journalism teachers on the national Reporting on Suicide: Recommendations for the Media.

1. Continue and expand efforts to participate in the education of journalism students in New Hampshire on the importance of sensitive reporting of suicide and suicide behavior.

Objective 3.2: Increase the number of sources (public health officials, school personnel, medical examiners, etc.) who have received contact from suicide prevention representatives around media recommendations and training/consultation in appropriate responses to inquiries from media professionals concerning suicide and suicidal events.

1. Incorporate orientation to the *Reporting on Suicide: Recommendations for the Media* and safe messaging in general into all suicide prevention training.

Objective 3.3: Promote news reports and portrayals in NH that observe appropriate reporting of suicidal events, present prevention messages and offer positive adaptations and non-stigmatizing views of mental illness.

1. Continue to respond to positive and negative media stories on an ongoing basis.
2. Cultivate relationships with media personnel for proactive dialogue around media reporting on suicides and encourage media contact with identified SPC spokespersons when suicide incidents occur.
3. Encourage all media reports to encourage hope and help seeking and include information on local supports and treatment resources as well as the National Suicide Prevention Lifeline (1-800-273-8255).

Goal 4: Support survivors of suicide attempts and survivors of suicide loss through the implementation of support and education programs for family, friends, and associates of people who completed or attempted suicide.

Objective 4.1: Support survivors of suicide loss (SOSL) services.

1. Continue distribution of Medical Examiner's Suicide Survivors Bereavement packet and maintain the list of resources for support.
2. Promote American Foundation for Suicide Prevention's (AFSP) annual teleconference for SOSL.
3. Support the continued development of a NH SOSL Network.
4. Encourage use of funds raised by SOSL in NH to promote SOSL resources, information and events.
5. Explore the establishment of a statewide SOSL Committee as part of the SPC to provide oversight and coordination of resources and a voice to planning at the state level.
6. Explore opportunities and strategies for engaging and offering supports and education to suicide attempt survivors and their families/loved ones.

DATA COLLECTION AND ANALYSIS SUBCOMMITTEE

Goal 1: Improve and Expand Suicide Surveillance Systems

Objective 1.1: Produce and disseminate periodic reports on suicide and suicide attempts to policy makers and stakeholders.

1. Produce annual report on suicide to include suicide deaths, attempts, hospitalizations and Emergency Department (ED) visits and ideation utilizing available data sources.
    a. On a yearly basis, review available data sources to identify other relevant information to include in the annual report.
    b. Expand and improve methods and templates for reporting on suicide data.
    c. Coordinate with the Suicide Fatality Review Committee to include recommendations resulting from their case reviews in the annual report.
    d. Include in annual document progress reports from statewide and local efforts such as suicide prevention grantees (campus and state), coalitions, and other coordinated suicide prevention efforts.
2. Provide interim reports on data related to attempts, deaths, and other related factors to the SPC as requested.
3. On an annual basis, review the guidelines for appropriate release of data (including suppression of smaller numbers) to ensure that current best practices are being followed.
4. On an annual basis, review the summary of pertinent epidemiology terms included within the annual report and update as needed.

Objective 1.2: Increase the proportion of organizations and institutions that routinely collect and analyze reports on suicide attempts, deaths, and related factors.

1. Improve data collection on suicidal behavior.
    a. On a yearly basis, review the data extraction tools used with compiling data from the Medical Examiner's Office. Refine the extraction tool as needed.
    b. Track current trends in NH and national data related to suicide deaths and make recommendations to the Medical Examiner's Office on additional and/or alternative data to collect following a suicide death.
2. Investigate data sources related to help-seeking behavior.
    a. Inventory current data sources and questions used.
    b. Recommend integration of questions on help-seeking behavior in other surveys when appropriate.
3. Increase and maintain representation by organizations and institutions that would benefit from collecting, analyzing, reporting and utilizing data related to suicide attempts and deaths.
4. Continue assessing needs around the collection and analysis of data.
5. Revisit and update the 2010 review of professional literature on best practices around suicide data collection and analysis every two years.
6. Support New Hampshire's proposal submission for the National Violent Death Reporting System.

Objective 1.3: Increase the proportion of organizations and institutions that utilize data to develop and/or evaluate interventions.

1. Collaborate with other sub-committees of the NH Suicide Prevention Council to increase the number of suicide prevention initiatives in the state that utilize relevant data in an appropriate manner.
2. Include evaluations of current initiatives.

3. Encourage the dissemination of evaluation results.

Objective 1.4: Conduct ongoing epidemiological analyses of current and historical suicide-related and substance misuse data.

1. Increase analysis capacity for all suicide-related data.
    a. Identify key data sources, tools and personnel.
        i. Explore nontraditional data sources.
        ii. Explore emerging technologies and analysis (e.g., small area analysis, GIS).
    b. Collaborate with key personnel on coordinated analysis.
    c. Explore how integrating different data sets may identify high-risk populations, regions or other trends, which would inform suicide prevention efforts.

MILITARY AND VETERANS SUBCOMMITTEE

Goal 1: Educate the Public to Improve Recognition of At Risk Behaviors and the Use of Effective Interventions.

Objective 1.1: Promote effective educational programs to the general public to increase awareness, comfort, and knowledge of resources on potentially suicidal veterans, service members and/or their families.

Goal 2: Promote training to personnel that are directly involved with veterans, service members and/or their families who exhibit high risk, concerning behaviors.

Objective 2.1: Promote effective educational programs for community providers who serve veterans, service members, and/or their families to promote collaboration with the Veterans Administration and the involved military unit (NH National Guard, Reserves).

Goal 3: Coordinate delivery of informational material to the community and treatment sites on resources on potentially suicidal veterans, service members and/or their families.

Objective 3.1: Regular delivery of informational outreach materials to local hospitals, Veteran Service Organizations (VSO), military units, law enforcement, family programs, and community resource locations.

Goal 4: Ensure that the Military and Veterans Subcommittee collaborates with all other SPC Subcommittees.

Objective 4.1: Request and share minutes/agenda of all State Suicide Prevention Council subcommittee meetings.

Objective 4.2: Subcommittee members of the SPC band together as needed to form a Task Force to work on Suicide Prevention Council projects (i.e.; revise the State Plan or create the Strategic Plan for the SPC), which will build and improve our collaboration and cohesiveness as a council.

CROSS TRAINING & PROFESSIONAL EDUCATION SUBCOMMITTEE

Goal 1: Promote Effective Clinical and Professional Practices

Objective 1.1: Promote guidelines for clinical practice and continuity of care for all health care providers who treat persons with suicide risk.

1. Promote routine screening for suicide risk and the documentation of results in the provision of health care.
2. Promote the use of concrete, specific and individualized mental health follow-up plans for patients treated for suicidal ideation or behavior.
3. Encourage post-assessment contact to reinforce plans where appropriate (e.g. Project RED).
4. Promote use of effective protocols for ensuring collaboration and effective communication among professionals.
5. Promote education on laws/RSAs, ethical obligations, and best practices regarding the sharing of information related to the treatment of individuals at risk for suicide.
6. Promote and cultivate relationships with other agencies and individuals so that collaboration and response can occur seamlessly and in a timely manner.
7. Foster sustainability and infrastructure by encouraging exchange of information/learning among providers and systems who are implementing best practices in suicide prevention.
8. Stay abreast of current trends, research and resources in suicide prevention and disseminate as appropriate.
9. Promote the use and availability of research based, age and culturally appropriate screening and assessment tools.

Goal 2: Support sustainability and infrastructure of best practices in NH by promoting training and protocols to community members, schools, organizations and providers on the prevention of suicide and related behaviors.

Objective 2.1: Encourage recertification and continued delivery of training programs through existing NH trainers in Connect, Counseling on Access to Lethal Means (CALM) Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR) and other best practices that are available in NH.

Objective 2.2: Promote culturally informed training to mental health and substance use disorder treatment and prevention providers on the recognition, assessment and management of at-risk behavior.

Objective 2.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors for all health professions including graduate and continuing education.

*Objective 2.4**:** Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.*

Objective 2.5: Promote the implementation of protocols and programs for clinicians and clinical supervisors, first responders, crisis staff and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Goal 3: Promote the integration and coordination of suicide prevention activities across multiple sectors and settings.

Objective 3.1: Promote awareness of local and regional resources for suicide assessment and intervention to Accountable Care Organizations (ACOs).

Objective 3.2: Promote training for primary care Providers, care managers and ambulatory care staff around risk assessment and referral and their relationship to untreated medical conditions (e.g. asthma).

Objective 3.3: Promote integration of suicide prevention and interventions into all relevant health care reform efforts.

Objective 3.4: Strengthen linkages between systems and build on existing infrastructure of suicide prevention efforts such as communities, organizations, systems and trainers that have implemented best practices around suicide prevention.

Objective 3.5: Consider options and resources for a central clearing house (i.e. statewide website) that can provide readily available information to NH citizens about suicide prevention and postvention resources and supports as well as upcoming events, trainings, etc.

Goal 4. Support efforts to reduce risk and promote healing after a suicide by identifying and linking existing programs and resources with needs.

Objective 4.1: Inform key stakeholders who may be in need of or involved in postvention response (i.e. faith leaders, school superintendents) about existing resources, such as Disaster Behavioral Health Response Teams (DBHRTs), National Alliance on Mental Illness NH Chapter (NAMI NH), Community Mental Health Centers (CMHCs), Survivor Network & Resources, Postvention Trainers and Coalitions.

Objective 4.2: Support coalitions in having readily available information about postvention practices and resources in their region such as Victims Inc, Samaritans, survivor of suicide loss support groups, medical examiner and related information packets.

Objective 4.3: Encourage utilization of postvention training and protocols (i.e. After a Suicide Toolkit, Media Recommendations) for first responders, law enforcement, emergency departments, schools and others who may be involved or affected by a suicide to reduce risk of contagion and promote healing.

PUBLIC POLICY SUBCOMMITTEE

Goal 1: Develop and implement public policy initiatives to ensure the sustainability of suicide prevention efforts.

Objective 1.1: Require training in suicide prevention for education, healthcare, mental health and substance misuse professional licensure and certification in New Hampshire.

1. Research licensure and certification requirements for above-mentioned professions.
2. Outreach to Professional Practice Subcommittee for input and partnership on achieving goal.
3. Develop strategic approach for working with above-mentioned licensure and certification boards to encourage training in suicide prevention as part of credentialing requirements.

Objective 1.2: *Require schools to include mental wellness/suicide prevention education as part of the health curriculum.*

1. Outreach to the State Board of Education and the NH Department of Education for support in achieving goal.
2. Create workgroup to develop strategic approach for achieving goal.

Objective 1.3: Recruit additional subcommittee members and formalize expectations of membership.

1. Review subcommittee charter annually with members of subcommittee.
2. Develop and implement member recruitment plan.

Objective 1.4: Support other subcommittees with policy needs.

1. Outreach to other subcommittees to offer support with policy issues.

Objective 1.5: Track legislation related to suicide prevention and advocate where appropriate.

1. Utilize legislative tracking document to track legislation of interest to the Suicide Prevention Council.
2. Report on legislation of interest at Suicide Prevention Council meetings.
3. With support of SPC leadership, testify on legislation of importance to Suicide Prevention Council.

III: C. 20. Suicide Prevention

The State Mental Health Authority (SMHA) collaborates with the Office of Chief Medical Examiner (OCME) and is able to access data related to suicides directly. This expedient process informs future projects and targeted community training and support. Data is also readily available to identify trends or changes. For example, in the first two reporting quarters of annual year 2013 (1/1/13-6/30/13) there were 48 deaths in NH, 13 of which were deemed to be the result of suicide. Additional readily available data includes death by region, age groups, gender, and cause of death. The Chief Medical Examiner is Public Health minded and supported the development of a liaison between the OCME and the NH Department of Social Services; this later led to the creation of a similar role between the OCME and the NH National Guard.

All 10 of the CMHC provide 24-hour emergency services that are able to address the needs of children and youth who might pose a threat to themselves. New Hampshire Hospital (NHH), the state's public psychiatric facility, has a children and youth unit that provides services to children and youth who require hospital-level care for their safety. NH is fortunate to have a community-based suicide prevention and training program that evolved from the Garret Lee Smith work. Project Connect! provides suicide prevention and postvention information and training to families, communities, providers and any other interested stakeholders. Connect! is a program of NAMI New Hampshire.

Counseling on Access to Lethal Means (CALM) is a protocol delivered in workshop format, developed by NH's Elaine Frank and Mark Ciocca, and accepted into the AFSP/SPRC Best Practice Registry Section III: Adherence to Standards. Per the informational notice, "Suicide is the second leading cause of death for young people ages 15 to 34 in New Hampshire and a significant cause of death for those of all ages. We know that many attempters are as ambivalent about suicide as they are about life. Preventing these suicides is a very complex puzzle that requires all of us to work collaboratively to complete the picture. In NH, firearms are the leading method used in suicide deaths accounting for more suicide deaths than all other methods combined."

One piece of that puzzle that has been demonstrated to be effective is to reduce access to lethal means – particularly firearms as well as medications. Elaine Frank and Mark Ciocca have developed CALM - a two hour workshop designed for mental health and primary care providers that addresses why and how to counsel clients and their families on reducing access to these suicide means. CALM includes: PowerPoint presentations regarding why CALM is important, a model videotaped counseling session, lots of time for discussion and, when time allows, role plays. The workshop is not designed to teach suicide risk assessment but rather, once a risk has been identified, it focuses on ....four specific CALM steps..." taught in the training series. The workshop is provided to participants such as the Community Mental Health Centers, consumers of behavioral health services, and peer supporters in NH's Peer Support Agencies.

The NH Suicide Prevention Plan (attached) was revised in 2013. A product of the State Suicide Prevention Council, the Plan is on a 5-year revision schedule. Recommendations from the National Strategy for Suicide Prevention (2012) are crosswalked within the plan. The plan is coordinated through the services of NAMI-NH.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III: C. 21: Support of State Partners

The Behavioral Health Advisory Council (BHAC) includes representatives from other required state agencies (RSA) Developmental Services (includes the section Special Medical Services, for children with special health care needs), Vocational Rehabilitation, the Bureau of Homeless & Housing Services (BHHS) Department of Corrections (DOC), the Department of Family Assistance DFA), and the Office of Medicaid Business and Policy(OMBP). These relationships provide the SMHA with the ability to collect information and have informed discussions regarding the future of healthcare in NH.

It is understood that letters of support or memorandum of understanding, indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, are being requested by SAMHSA and are desired to include: the Department of Education (DOE); the State Medicaid agency; the Department of Insurance; the DOC; Juvenile Justice Services (JJS); the Department of Public Health (DPHS); the Bureau of Maternal and Child Health; and the DCYF.

In New Hampshire, children's public mental health services are organizationally located within DHHS. Some school-based services are located within the authority of DOE. The DOE has representation on the NH planning council via Vocational Rehabilitation. Within DHHS, there are several Divisions where the need for children's mental health services can be found. These Divisions include: DCYF (child protection), Juvenile Justice, Community Based Care Services (mental health, substance abuse, special medical services, developmental disabilities, and New Hampshire Hospital-inpatient care). Although not state (agency) partners, all of New Hampshire's family organizations are partners in our children's mental health initiatives. Granite State Federation of Families for Children's Mental Health, Family Voices, and NAMI NH (National Alliance on Mental Illness –NH) are key partners in our system of care initiative.

The support of these partners is ongoing, but has not been formalized.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

NH requests technical assistance from the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) to provide orientation on statutory responsibilities of the Advisory Council.
NH would like to request technical assistance in providing outreach to consumers and family members of different ethnicities that live in the rural parts of the state to enhance the membership of the Behavioral Health Advisory Council.

Footnotes:

Behavioral Health Advisory Council Meeting

Minutes

June 9, 2015

I. Call to order

Candace called to order the regular meeting of the **Behavioral Health Advisory Council** at 5:30 on June 9, 2015 at McLane Center.

II. Roll call

The following persons were present:

☒ Allen Penrod	☐ Joshua Whitehead-Millar
☒ Beth Anne Nichols	☒ Ken Lewis
☒ Bill Guinther	☒ Kestrel Cole-McCrea
☒ Candace Cole-McCrea	☒ Linda Thomas
☒ Deb Green	☒ Liz Henning
☐ Doreen Boutin	☒ Matthew Huse-Gold
☒ Elizabeth Collins	☐ Molly Gray
☒ Emily Larson	☐ Nanci Collica
☐ Gail Rueggeberg	☒ Patricia Jackson
☒ Harvey Schow	☐ Thandi Tshabangu-Soko
☒ Jane Hybsch	☒ Thomas Grinley
☐ Janine Lesser	☒ Valerie Morgan-

III. Approval of minutes from last meeting

There was one correction to the minutes: the previous meeting adjourned at 7:30, not at 8:30. Motion to approve the minutes; 2 members abstained from voting; the minutes were approved.

IV. State Mental Health Authority (BBH) Update

a) Geoff Souther was present and spoke briefly of the status of the budget. The Senate voted on the budget last Thursday. Geoff suggested that members go on www.nh.gov to look at the briefing paper that goes through the entire state budget and how the senate budget differs from the house budget, and then goes to the committee of conference. The governor's budget is a high watermark.

b) Geoff gave a brief update on the Community Mental Health Agreement. The expert reviewer will issue his second report by the end of June or early July. There is a link to his first report on eStudio.

c) Geoff also gave an update on what is going on at the Bureau of Behavioral Health and the department's redesign efforts. The Commissioner attended the last Executive Director meeting and presented an update. The Commissioner is

appointing Geoff as the Chief Operating Officer at New Hampshire Hospital, so he will be transitioning soon. The senior management team is putting together an operational review including everything the Bureau of Behavioral Health (BBH) does, and what BBH needs to do. Geoff is not sure how much longer he will be attending this meeting (BHAC).

- **Action items:** Emily will upload the slides from the Commissioner's ED meeting presentation regarding the DHHS redesign to eStudio.

d) Allen asked if the legislature can change the budget after it is passed and before it takes effect. Geoff answered that since it is a biennium budget, changes will be made during those two years.

V. Guest Presentation

e) Beth Anne Nichols presented on the Block Grant application. The application for FY15/16 is on eStudio. This application seems to be much shorter than previous. While advocacy is part of the role of the BHAC, the main role is to help drive the state plan. Input from the BHAC needs to be verified on the application, and it must be real and specific. Key initiatives of the state plan are integration and prevention. Valerie said that the Bureau of Drug and Alcohol Services received a BRSS TACS grant for substance abuse and mental health. This collaboration will be helpful to mention in the plan. SAMHSA has an expectation that we will monitor some of the programs that we pay for. The Monitoring and Evaluation Committee will be doing the monitoring. The BHAC used to work on the state plan continuously so it didn't seem like so much to do in such little time, but this has changed due to things like changes in leadership. We still have not received a report from the SAMHSA Mental Health Block Grant project officer. She plans to attend a BHAC meeting in the fall.

f) Beth Anne reviewed priorities with the group. Integrated care is huge. This is a trend through the department. This was mentioned by the BHAC previously as a priority. We have mobile crisis units and crisis housing. The goal is to reduce institutionalization across the board. An RFP has been drafted for early intervention first episode psychosis.

- **Action Item:** Beth Anne distributed a handout of items she asked the group to prioritize. We will discuss this at the next BHAC meeting.

- **Action Item:** Beth Anne will see SAMHSA has designed a standard means of collecting LBGT data, as this has been indicated as a minority population to include in planning efforts.

VI. Open Issues

a) Candace and Allen have not met to talk about the BHAC meeting format. This discussion was tabled.

b) Tom discussed the annual schedule of BHAC meetings. Tom and Ken engaged in a spirited discussion re: MA vs. GA models of peer support specialists. Candace ruled that this discussion should continue on their own time.

- **Action Items:** Tom will upload the annual schedule to eStudio.

c) Liz is now the chair of the Monitoring and Evaluation Committee. Doreen is now the chair of the Development Committee. Tom is now the chair of the State Plan Committee. The position of chair for the Advocacy Committee is currently vacant. Candace directed a standard agenda item to be that each committees would get together as and brainstorm, then come back and give the group a report.

VII. Committees

g) Monitoring and Evaluation Committee: Liz wants to look at the spreadsheet of priorities and identify which items apply to data, so that the committee can decide what points to focus on. It is important to consider what data points intersect with the state plan. The committee would like to do an inventory of mental health data points especially the expert reviewers, epidemiologist, and other data points like the satisfaction survey and 2010 audit. There is also a lot of data potentially within the accounting systems in the state.

h) Advocacy Committee: As this committee currently has no chair, Matt led their discussion. The role of this committee should be to speak for the rights and needs of consumers in the BHAC's activities and to hold the groups accountable to make sure these are being implemented. Prevention is a high priority, as is keeping people out of jail. The committee wants to look at ways to make sure people with mental health issues don't have to harm the community to get treatment.

i) State Plan Committee: This committee came to the conclusion that the state needs to develop a new state plan. We are seven years into the ten year plan. There are many things left out of the ten year plan and the CMHA that need to be addressed.

j) Development Committee: This committee would like to update the list of current members of the BHAC, as it is out of date. The committee would also like to revisit the bylaws, to determine if they align with the direction of the council or if they need to be edited. This should be a routine task.

- **Action Item:** Doreen will create a flier for the BHAC.

VIII. New business

a) Josh Burkhard is the contact for the Phoenix System. If you have any data requests for him, please contact Beth Anne.

b) Valerie would like a place on the monthly agenda for BDAS Updates. The Executive Committee would like someone from BDAS to attend the monthly EC meetings, but since Valerie is unable to attend she will share it with her coworkers and see if anyone else may be able to attend. The EC will also be discussing the possibility of changing their meeting schedule to accommodate Valerie.

- **Action Item:** Add Valerie to the monthly BHAC agenda – 10 minute BDAS update.

c) Liz would like to focus on cultural competency, and would like the group to keep in mind that cultural competency does not refer only to ethnicity.

IX. Announcements and……

d) Valerie reported that BDAS just finished a SAMHSA core review for prevention services and treatment, and they are now waiting on the report for those.

X. Adjournment

Candace adjourned the meeting at 7:26 pm.

Minutes submitted by: Emily Larson

THE MENTAL HEALTH BLOCK GRANT & BEHAVIORAL HEALTH ADVISORY COUNCILS

MHBG APPLICATION FOR FFY 16/17

The block grant application includes 4 major parts:

1. Introduction,
2. Submission of application and plan timeframes,
3. Behavioral health assessment and plan, and
4. Reporting requirements.

BEHAVIORAL HEALTH ASSESSMENT AND PLAN

Evidence of the process and input of the Planning Council required by section 1914(b) of the PHS Act (42 U.S.C. 300x-4(b)) for the MHBG must be included in the application that addresses MHBG funds.

States are also encouraged to expand this Planning Council to include prevention and substance abuse.

1. INTRODUCTION

State block grant expenditures should be based on the best possible evidence.

Program quality and outcomes should be carefully tracked.

Ultimately, such data will lead to improvements as science and circumstances change.

Which committee(s) should be charged with tracking program quality and outcomes?

The FY 2016-2017 Block Grant Application continues to allow states to submit an application for both mental health and substance abuse services as well as a biennial plan.

This application also reflects the Affordable Care Act's strong emphasis on

a. coordinated and **integrated** care, along with
b. the need to improve services for persons facing behavioral health **crises**.

SAMHSA's Six Strategic Initiatives

1. *Prevention of Substance Abuse and Mental Illness*
2. *Health Care and Health Systems Integration*
3. *Trauma and Justice*
4. *Recovery Support*
5. *Health Information Technology*
6. *Workforce Development*

1. Prevention of Substance Abuse and Mental Illness

This SI will include a focus on several populations of high risk, including:

- College students and transition-age youth, especially those at risk of first episodes of mental illness or substance abuse;
- American Indian/Alaska Natives;
- Ethnic minorities experiencing health and behavioral health disparities;
- Military families;
- and lesbian, gay, bisexual, and transgender (LGBT) individuals.

BHAC PRIORITY LEVEL: _____

2. Health Care and Health Systems Integration

Focuses on health care and integration across systems including systems of particular importance for persons with behavioral health needs such as:

- Community health promotion;
- Health care delivery;
- Specialty prevention;
- Treatment and recovery; and
- Community living needs.

BHAC PRIORITY LEVEL:

3. *Trauma and Justice*

- Focuses on trauma and justice by integrating a trauma-informed approach throughout health, behavioral health, human services, and related systems.
- This SI also will support the use of innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

BHAC PRIORITY LEVEL: _____

Recovery Support

Promotes partnering with people in recovery from mental and substance use disorders and their family members to:

- Guide the behavioral health system to promote approaches that help individuals …
  - Be **well**,
  - Manage **symptoms**, and
  - Achieve and maintain **abstinence**;

- Increase **housing** to support recovery;
  - Reduce barriers to **employment**, **education**, and other life goals; and
  - Secure necessary **social supports** in their chosen community.

BHAC PRIORITY LEVEL: _____

Health Information Technology

Ensures that the behavioral health system fully participates with the general healthcare delivery system in the adoption of health information technology (Health IT).

This will help ensure high-quality integrated health care, appropriate specialty care, improved patient/consumer engagement, and effective prevention and wellness strategies.

BHAC PRIORITY LEVEL: _____

Workforce Development

The initiative will promote an **integrated**, aligned, competent workforce; and

Will continually **monitor and assess** the needs of peers, communities, and health professionals….

…Through technical assistance, training, and focused programs.

BHAC PRIORITY LEVEL: _____

SUBMISSION OF APPLICATION AND PLAN TIMEFRAMES

Application for the MHBG-only is due no later than September 1, 2015.

THE END

The New Hampshire Behavioral Health Advisory Council (BHAC) maintains the required 50:50 ratio of Consumers/Family/Other to State Employees/Providers. All required state agencies are represented. Two parents identify as the parents of children with serious emotional disturbances but one must identify as a provider. Representation of parents of children with SED remains less than optimal but recruiting efforts continue. There is more than adequate professional and advocacy representation at the table for children's issues. Greater representation in the past has dwindled as youth "age out" of children's services. Three members of the BHAC also serve on the Department of Education's State Advisory Council which addresses children with special education needs, including mental health issues.

The Council has several opportunities: 1) New officers have recently been elected and will continue the practice of meeting with the Administrator of the State Mental Health Authority once that position is filled. These meetings will continue to inform and mutually guide the ongoing development of state plans for mental health services including responses to the Community Mental Health Agreement. 2) A development day has now become standard practice for the Council at which we further articulate the role of the Council and set our schedule of presentations for the coming year. 3) The required state agencies are supported in taking a more active role in the informational and communications process between these agencies and the behavioral health system as discussed by the Council in the performance of its duties. Recently, the meeting time of the Council Executive Committee was changed to accommodate the representative of the Bureau of Drug and Alcohol Services (BDAS) to assure her attendance at those meetings. At each meeting we receive an update from both the State Mental Health Authority and the BDAS. 4) Funds available through the budget support of the Council for the Council to prepare and produce certain print materials of relevance to the stakeholders and the general public. 5) Working with the Children's Special Interest Group to look at how we want to expend MHBG funds going forward.

Some items previously addressed as challenges have been successfully resolved. The Council was able to recruit a provider from the Community Mental Health Centers community. We were also successful in recruiting minority representation and now have 13% minority representation in a state that has a population which is 94% white. Remaining challenges are to recruit more consumers and more families to both maintain our 50:50 ratio and to make sure that all voices are well represented. The Development Committee has been tasked with expanding our recruiting techniques.

The Advocacy Committee: Advocacy is continuing to prepare formal, brief, position papers for the Council to review and issue as formal guidance to the State Mental Health Authority and as public information as to the Council's priorities. This past year, position papers addressed co-occurring disorders, adequate funding of the Community Mental Health Agreement, and Medicaid expansion.

The Development Committee: Development is attending to the composition of the Council and member types, per state definitions. This includes assisting members to maintain the minimum standard for effective participation, such as a minimum attendance requirement and service on at least one standing committee. Development oversees the ad hoc Bylaws/Protocols Committee and the ad hoc Nominations/Election committee when they are activated. The committee also continues to develop the new member orientation process.

The Monitoring and Evaluation Committee: This committee is involved in attention to care management as it is implemented and, through the Children's Interest Group, the monitoring of the implementation of the Children's Behavioral Health Plan. This committee is also responsible for monitoring and evaluation of the Community

Mental Health Agreement. The committee works with the BBH data analyst to identify needed data elements for evaluation. The implementation of the Child and Adolescent Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) are also of particular interest to this committee.

The State Plan Committee: The committee continues to evolve with increasing involvement in developing the SMHS plans. The committee is focused on the changes resulting from the new unified block grant application to assist the BHAC in in developing and reviewing the state plan. Progress on the Ten Year Plan and the Community Mental Health Agreement is central to the MHBG State Plan.

The Children's Interest Group: Affiliated with the Monitoring and Evaluation Committee, this group is following current events and issues in the development of the children's system as related to public behavioral health services. Three members of the BHAC sit on the statewide Children's Special Interest Group and other members of that group are frequent guests at BHAC meetings. Through this connection is also an indirect connection to the NH Children's Behavioral Health Collaborative.

The Executive Committee: The Executive Committee, convened by the SMHA in collaboration with the BHAC, includes the State Planner or administrator's designee, a presentative of state children's MH services, the BHAC officers, a representative of the Bureau of Drug and Alcohol Services, and the chairs of the standing committees. The committee provides oversight for the coordination and implementation of council activities, facilitates the operational needs of the council, and review council materials for BBH before approval for release as public information.

BHAC Input on the MH Block Grant Application

The Council participates in the development of the state plan for the Mental Health Block Grant by providing input to the State Mental Health Authority and contributes to the writing of the MHBG application. This year, several sub-committees reviewed various reports on the quality of service delivery in the state and used those reports to identify priorities to be addressed in the new state plan. One of these reports was the report of the Expert Reviewer charged with monitoring the state Community Mental Health Agreement, an agreement reached in response to a recent Olmstead suit. Questions and concerns will also be addressed directly to the State Mental Health Authority. (sample of minutes attached)

The Behavioral Health Advisory Council (BHAC) was oriented to this year's Block Grant application at their August meeting. The Power Point presentation used by the State Planner is attached. The BHAC was asked to identify planning priorities and spent portions of that meeting and the following meeting to reflect, react, and report on consensus priorities.

Given the short time frame for its preparation this year and the long-term vacancy in the State Planner position that wasn't filled until July, the MHBG application was posted online for public comment and review Oct 1.

Corrective Action

In the future, as soon as the final Mental Health Block Grant application requirements are released by SAMHSA, they will be posted on the NH-DHHS website and circulated among State partners and other interested parties, in order to allow sufficient time for public comment.

Technical Assistance

The Behavioral Health Advisory Council has technical assistance needs that perhaps supersede any others for NH, particularly, in this case, on organizing priorities and developing action steps.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Doreen Boutin	Providers	Mental Health Center of Greater Manchester		Doreenboutin.bhac@gmail.com
Elizabeth Collins	State Employees	NH DHHS Bureau of Developmental Services		ecollins@dhhs.state.nh.us
Ken Lewis	Providers	H.E.A.R.T.S.		kenl-hearts@comcast.net
Deb Green	State Employees	NH Department of Corrections		dworster@nhdoc.state.nh.us
Bill Guinther	Others (Not State employees or providers)	NH Housing		
Patricia Jackson	State Employees	NH DHHS Bureau of Homeless & Housing		pajackson@dhhs.state.nh.us
Jane Hybsch	State Employees	NH DHHS Office of Medicaid Business and Policy		jhybsch@dhhs.state.nh.us
Valerie Morgan	State Employees	NH DHHS Bureau of Drug & Alcohol Services		valerie.morgan@dhhs.state.nh.us
Thomas Grinley	State Employees	NH DHHS BBH Office of Client & Family Services		thomas.grinley@dhhs.state.nh.us
Kestrel Cole-McCrea	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			kcdemccrea@gmail.com
Candace Cole-McCrea	Family Members of Individuals in Recovery (to include family members of adults with SMI)			snowyowl@metrocast.net
Molly Gray	Family Members of Individuals in Recovery (to include family members of adults with SMI)			gray_molly@gmail.com
Matthew Huse-Gold	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			redlaylabooks@gmail.com
Thandi Tshabangu-Soko	Others (Not State employees or providers)			stshabango@aol.com
Allen Penrod	Providers	Community Improvement Associates		allen@be-like-water.com
Beth Anne Nichols	State Employees	NH DHHS Bureau of Behavioral Health		beth.nichols@dhhs.state.nh.us
Liz Hennig	Others (Not State employees or providers)	Communities United Regional Network of Sullivan County		lhennig@sullivancountynh.org
Linda Thomas	Others (Not State employees or providers)			lthomasgsffcmh@comcast.net

Footnotes:

NH has a corrective action plan that will involve receiving technical assistance to bring us into compliance with the required representation on the BHAC. We realize that we need three of the four State agencies: Dept. of Ed; Division of Children, Youth, and Families; Division of Family Assistance; Vocational Rehabilitation.

NH will formally request Technical Assistance via the TA Tracker on protocols and best practices for recruitment from State Agencies and advocacy partners, in order to come into compliance with required membership proportions within 3 months.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	22	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	4	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	12	54.55%
State Employees	7	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	10	45.45%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Persons in recovery from or providing treatment for or advocating for substance abuse services	3	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Planning Council was involved in the development of the plan. The Council assisted in setting priorities. The Council has also scheduled a Planning and Development Day for September at which they'll establish implementation and monitoring strategies.
The agenda for the Council meeting where the application was discussed are attached. Other minutes and agendas are available. Council meetings occur monthly, and the Executive Committee of the Council meets monthly as well.

Footnotes:

Commonly Used Acronyms: New Hampshire Mental Health System and Related

ACA	Affordable Care Act (Patient Protection and Affordable Care Act)
ACT	Assertive Community Treatment
ANSA	Adult Needs and Services Assessment
APRTP	Acute Psychiatric Residential Treatment Program
BBH	Bureau of Behavioral Health
BEAS	Bureau of Elderly and Adult Services
BDAS	Bureau of Drug and Alcohol Services
BDS	Bureau of Developmental Services
BHAC	Behavioral Health Advisory Council (MH Planning Council; federal "PAC")
BHHS	Bureau of Homeless and Housing Services
BHTalk	Behavioral Health Talk
BIP	Balancing Incentive Program
BRSS TACS	Bringing Recovery Supports to Scale Technical Assistance Center Strategy
CANS	Child and Adolescent Needs and Strengths
CAP	Community Action Program
CBHA	Community Behavioral Health Association
CBHC	Children's Behavioral Health Collaborative
CBHSQ	Center for Behavioral Health Statistics and Quality
CC	Consumer Council (NH Mental Health Consumer Council)
CHC	Community Health Center (may also be a FQHC)
CMHC	Community Mental Health Center (or CMHP- program)
CMS	Centers for Medicare and Medicaid Services
CoP	Community of Practice
COSP	Consumer-Operated Services and Programs
CPS	Certified Peer Specialist
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DBHRT	Disaster Behavioral Health Response Team
DCBCS	Division of Community Based Care Services
DCYF	Division for Children, Youth & Families
DFA	Division of Family Assistance
DHHS	Department of Health and Human Services
DIG	Data Infrastructure Grant
DOC	Department of Corrections
DOE	Department of Education
DPHS	Division of Public Health Services
DRC	Disabilities Rights Center
DRF	Designated Receiving Facility
EBP	Evidence-Based Practices
EC	Executive Committee (of the NH BHAC)
ED	Emergency Department (sometimes still called "the ER" or emergency room)
EHB	Essential Health Benefit
EHR	Electronic Health Record
ES	Emergency Services
FMSS	Family Mutual Support Services
FSS	Functional Support Services
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HCBC	Home and Community Based Care
HIPAA	Health Insurance Portability and Accountability Act

HOIP	Homeless Outreach Intervention and Prevention
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources Service Administration
HUD	Housing and Urban Development
ICT	Interactive Communication Technology
IDEA	Individuals with Disabilities Education Act
IDDT	Integrated Dual Diagnosis Treatment
IEA	Involuntary Emergency Admission
IMR	Illness Management and Recovery
iNAPS	International Association of Peer Supporters
IOM	Institute of Medicine
IPS	Intentional Peer Support
IROS	Individualized Resiliency & Recovery Oriented Services
ISO	Individual Service Options
JJS	Juvenile Justice Services
LADC	Licensed Alcohol and Drug Counselor
LGBT-LCBTQ	Lesbian, Gay, Bisexual, and Transgendered (- and Questioning)
LOS	Letter of Support
LU	Low Utilizer
MCO	Managed Care Organization
MEAD	Medicaid for Employed Adults
MH	Mental Health
MHBG	Mental Health Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MHSIP	Mental Health Statistics Improvement Program
MI	Mental Illness
MI/SA or MI/SUD	Mental Illness / Substance Abuse or /Substance Use Disorder
MLADC	Master Licensed Alcohol and Drug Counselor
MMIS	Medicaid Management Information System
MOE	Maintenance of Effort
MOU	Memorandum of Understanding (or MOA, Memorandum of Agreement)
MUA/MUP	Medically Underserved Area/Medically Underserved Population (federal)
NAMHPAC	National Association of Mental Health Planning and Advisory Councils
NAMI-NH	National Alliance on Mental Illness of New Hampshire
NASMHPD	National Association of State Mental Health Program Directors
NHEP	NH Employment Program
NHH	New Hampshire Hospital
NRI	National Research Institute (of NASMHPD)
NOMS	National Outcome Measures
OCFA	Office of Consumer & Family Affairs
OCME	Office of Chief Medical Examiner
OIS	Office of Information Systems
OMBP	Office of Medicaid Business and Policy
PAIMI	Protection and Advocacy for Individuals with Mental Illness
PASARR	Preadmission Screening and Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness
PATT	Partners in Adolescent Trauma Treatment
PBIS	Positive Behavioral Interventions and Supports
PIO	Public Information Office
PSA	Peer Support Agency

QHP	Qualified Health Plan
QI	Quality Improvement
REAP	Referral Education, Assistance & Prevention
RFP	Request for Proposals
RENEW	Rehabilitation for Empowerment, Natural Supports, Education, and Work
ROSC	Recovery Oriented System of Care
RROSC	Recovery and Resiliency Oriented System of Care
RSA	Required State Agency (for State MH Planning Council)
RSA	Revises Statutes Annotated (NH statutes)
SABG	Substance Abuse Block Grant
SAMHSA	Substance Abuse & Mental Health Services Administration
SAU	School Administration Units
SBIRT	Screening, Brief Interventions, Referrals to Treatment
SCHIP	State Children's Health Insurance Program
SE	Supported Employment
SED	Serious Emotional Disturbance
SEOW	State Epidemiological Outcomes Workgroup
SFY	State Fiscal Year
SHP	Supported Housing Programs
SIM	State Innovation Model
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SMS	Special Medical Services
SNAP	Supplemental Nutrition Assistance Program
SOC	Systems of Care
SOSL	Survivors of Suicide Loss
SPC	Suicide Prevention Council
SPF	Strategic Prevention Framework
SPMI	Severe and Persistent Mental Illness
SPU	Secure Psychiatric Unit
SSA	Single State Authority
SSDI	Supplemental Security Disability Income
SSI	Supplemental Security Income
SUD	Substance Use Disorder
TCM	Targeted Case Management
TF-CBT	Trauma Focused-Cognitive Behavioral Therapy
THS	Transitional Housing Support
TTI	Technology Transfer Initiative
URS	Uniform Reporting System
VA	Veterans Administration
YGC	Youth Guided Coalition
YSPA	Youth Suicide Prevention Assembly
WHAM	Whole Health Action Management
WRAP	Wellness Recovery Action Plan