

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

**New Hampshire**

**FY 2023 Application/  
FY 2021 Annual Report**

Created on 8/10/2022  
at 2:22 PM

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## I. General Requirements

### I.A. Letter of Transmittal



Lori A. Shibanette  
Commissioner

Patricia M. Tilley  
Director

STATE OF NEW HAMPSHIRE  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
*DIVISION OF PUBLIC HEALTH SERVICES*  
*BUREAU OF POPULATION HEALTH AND COMMUNITY SERVICES*

29 HAZEN DRIVE, CONCORD, NH 03301-3857  
603-271-4524 1-800-852-3345 Ext. 4524  
Fax: 603-271-8705 TDD Access: 1-800-735-2964  
www.dhhs.nh.gov

May 12, 2022

Grants Management Officer, MCHB  
HRSA Grants Application Center  
901 Russell Avenue  
Suite 450  
Gaithersburg, Maryland 20879

Grants Management Officer, MCHB:

I am pleased to provide you with New Hampshire's SFY 2023 Application for the Maternal and Child Health Block Grant.

This Application follows the guidance issued by your Office and accurately reflects New Hampshire's plan for serving women and children.

The Title V program plays a major role in the Department initiative to promote and develop comprehensive community based systems of primary and preventative care services for women, children, children with special health care needs and families. This application reflects that role.

Should you need further information, please do not hesitate to contact me, or the Title V Director, Rhonda Siegel, at 603-271-4516.

Sincerely,

A handwritten signature in black ink that reads "Patricia M. Tilley".

Patricia M. Tilley  
Director

PMT/sc  
Enclosures

cc: Rhonda Siegel, MS Ed, Administrator,  
Title V Director, Maternal & Child Health Section

Lissa Sirois, Acting Bureau Chief,  
Bureau of Population Health and Community Services

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

## **I.B. Face Sheet**

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

## **I.C. Assurances and Certifications**

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## **I.D. Table of Contents**

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

## **II. Logic Model**

*Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.*

### III. Components of the Application/Annual Report

#### III.A. Executive Summary

##### III.A.1. Program Overview

The New Hampshire (NH) Title V program is a partnership of the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) with the NH Department of Health and Human Services' Maternal and Child Health (MCH) section, and the Bureau for Family Centered Services (BFCS) which oversees programs for Children and Youth with Special Health Care Needs (CYSHCN). Together, these local entities support core Title V public health functions including direct, enabling, population-based, and infrastructure-building services in maternal and child health including CYSHCN.

Title V's programming focus comes from MCH and CYSHCN populations' priority needs. A comprehensive five-year needs assessment was conducted in 2019-2020. Following an extensive data review, specific input from the public and stakeholders, as well as a capacity assessment, a list of priority issues emerged to form the basis of programming through 2025. Ongoing needs assessments are carried out routinely each year (e.g. focus groups, client satisfaction surveys, stakeholder workgroup meetings) to assure that programming remains consistent with needs, and to date the list of priorities established in 2020 are unchanged:

**Priority need #1:** Improve access to needed healthcare services for all populations.

NPM#10: Percent of adolescents, ages 12-17 with a preventive medical visit in the past year.

Domain: Adolescent Health

and

NPM#12: Percent of adolescents with and without special health care needs, ages 12-17 who received services necessary to make transitions to adult health care

Domain: Children with Special Health Care Needs

**Priority need #2:** Decrease the use and abuse of alcohol, tobacco and other substances among pregnant women.

NPM#14.1: Percent of women who smoke during pregnancy

Domain: Women/Maternal Health

**Priority need #3:** Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population.

SPM#1: Percentage of MCH-contracted Community Health Centers who meet or exceed the target of their Enabling Services workplan

Domain: Cross-cutting/Systems-building

**Priority need #4:** Improve access to mental health services for children, adolescents and women in the perinatal period.

SPM#3: Percentage of enrolled pediatric primary care providers who received pediatric mental health teleconsultations from the Pediatric Mental Health Acre Access (PMHCA) Program

Domain: Cross-cutting/Systems-building

**Priority need #5:** Decrease unintentional injury in children ages 0-21.

NPM#5: Percent of infants: a) placed to sleep on their back; b) placed to sleep on a separate approved sleep surface; c) placed to sleep without soft objects or loose bedding

Domain: Perinatal/Infant Health

and

NPM#7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19

Domain: Adolescent Health

**Priority need #6**: Increase family support and access to trained respite and childcare providers.

SPM#2: Percentage of children and youth with special health care needs enrolled in BFCS services who report access to respite care

Domain: Children with Special Health Care Needs

**Priority need #7**: Improve access to standardized developmental screening, assessment and follow-up for children and adolescents.

NPM#6: Percent of children, ages 9-35 months, receiving a developmental screening using a parent-completed screening tool in the past year.

Domain: Child Health

Specific strategies aiming to improve these performance measures are delineated in each population domain, in the State Action Plan table.

NH MCH has grown substantially in the past decade. Forty-one percent (41%) of the workforce has been in their position within DHHS for less than ten years and 63% are under the age of 50. MCH has 29 positions (25 FTEs including a contracted 1.0 FTE Epidemiologist and three part-time staffers for an additional 1.8 FTEs). Positions have been developed to implement more activities related to the Title V performance measures, such as the full-time Perinatal Coordinator and the Child-Adolescent Clinical Coordinator. MCH currently has seven programmatic units: Data/Decision Support; Infant Surveillance; Injury Prevention; Home Visiting; Quality Improvement and Clinical Services; Women's Health; and Community Engagement Programs (formerly Early Childhood Systems).

BFCS has 18 positions that provide leadership for programs and services for children with special health care needs and their families. Title V services for CYSHCN are organized in accordance with the Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0. Title V funds the following BFCS positions: the CYSHCN Director/Bureau Chief, Data Analyst, Evaluation Specialist, Systems of Care Specialist, Clinical Program Manager, one Nurse Consultant, two nurse Health Care Coordinators, one Health Care Coordinator, one Eligibility Technician, and two administrative support staff.

Much of Title V funding is braided to support staff and into contracts to implement strategies consistent with the MCH Block Grant's Five Year State Action Plan. Title V funds the Quality Improvement and MCH Clinical Services unit in full or in part, which includes the Child-Adolescent Health Nurse Consultant, the Perinatal Coordinator, the Pediatric Mental Health Care/Access Program Coordinator, and the QI/QA and Clinical Services Program Manager. MCH also utilizes Title V funding for a PhD level public health epidemiologist from the University of New Hampshire (UNH).

MCH and the BFCS work with professional training pipelines in the State, such as the increasing number of NH based colleges and universities awarding degrees in public health, as well as out-of-state online programs. MCH and the BFCS work with interns from many programs, such as the HRSA funded Leadership Education in Neurodevelopmental and Related Disabilities at UNH, CDC's Public Health Associate and Fellow Programs, and summer graduate school interns set up through AMCHP and most in-state colleges and universities.

BFCS demonstrates its commitment to family engagement and partnership throughout its programs and activities. New Hampshire Family Voices (NHFV), a long-standing partner whose staff consists of parents of CYSCHN, are co-located with BFCS staff and provide leadership across the State to families and family-serving agencies. Family support activities under the Partners in Health Program include the requirement for each regional agency to have a

family council that serves as an advisory body.

BFCS continues to partner with NHFV to plan and facilitate training opportunities for CYSHCN and their families. Family Support Coordinators frequently seek assistance to recruit, retain and strengthen family support advisory council members. While this partnership model has been used primarily with Partners in Health, it has been identified as a critical program component to be carried over into the new model being developed for care coordination.

MCH program staff worked with New Hampshire Family Voices (NHFV) to increase family partnership and engagement. The recommendations developed are serving as guiding principles for family engagement, which has subsequently been written into all MCH contract deliverables for those contractors who are public serving. All of the Title V funded Community Health Centers (CHCs) have a mandate for 51% of their advisory committees to be community members and/or clients.

MCH's Quality Improvement and Clinical Services Programs is working with and financially supporting colleagues at the Northern New England Perinatal Quality Improvement Network (NNEPQIN) with the goal of establishing a representative Perinatal Community Advisory Council (PCAC). The PCAC will be a key component in MCH and NNEPQIN's strategy in fostering accessible, respectful and safe perinatal care in the State. Focus groups were held in spring and summer of 2021 and informed the PCAC recruitment. The first PCAC meeting was held on June 7, 2022 and will continue to meet monthly via Zoom. It is anticipated that the meetings will be co-chaired, will remain confidential with the members deciding what type of feedback and recommendations to share with NNEPQIN and MCH.

During the annual writing and review of MCH programs' workplans, goals and objectives, each program seeks to incorporate family engagement into its approach. MCH'S Early Hearing Detection and Intervention (EHDI) program involves several parents in their CQI process as well as the NH chapter of Hands and Voices. MCH's Home Visiting program is focusing on family engagement with contractors as part of a larger CQI effort, devoting time during the monthly Local Implementing Agency (LIA) supervisors' meeting to provide training on how to involve families. At one meeting this past year, the federally led HVCQIIN's Parent Leadership Toolkit was reviewed as was the NH Children's Trust' (NHCT) family engagement campaign and their Strengthening Families Summit, Parents Leading the Way. Family engagement in CQI is discussed in all coaching sessions.

The success of NH's Title V programs is based in part on integral partnerships, both funded and non-funded, with governmental partners as well as community based agencies. Leveraging federal, state, and local program resources contributes to the service delivery capacity of NH's Title V program. This is evident in the almost four-year-old Early Childhood Integration Team (ECIT), of which both MCH and the BFCS staff are part of the leadership. The ECIT brings together all programs serving young children, with and without special health care needs, from birth through eight years of age, and their families. Members represent Home Visiting, WIC, Housing, Child Care, and Early Supports and Services, to name a few.

Another key in-state partner for Title V is DHHS's Division of Behavioral Health Services, which houses the bureaus for Behavioral Health, Children's Behavioral Health, and Drug and Alcohol Services. MCH works collaboratively with this Division on projects including suicide prevention and perinatal substance exposure. MCH and BFCS staff are members of the Children's Behavioral Health's System of Care Advisory Council. Much like the ECIT, this group aligns members from across DHHS and beyond in the mission to promote and improve the State's children's system of care principles and values.

MCH works with on a regular basis with the NH Children's Health Foundation, a charitable entity. One of the



collaborative projects is on sexual and reproductive health care access, particularly for decreasing unintended pregnancies, with the ultimate goal of reducing and preventing childhood trauma.

The Council for Youth with Chronic Conditions (CYCC), the only statewide organization that has a legislative mandate to focus on the issues affecting children and adolescents with chronic health conditions, represents another important partnership. Members include families of CYSHCN, the CYSHCN Director, legislators, pediatric specialists, school nurses, service providers, NH Family Voices, and other program administrators in DHHS.

New Hampshire has a State Emergency Operations Plan (SEOP) found at [State Emergency Operations Plan \(nh.gov\)](#). DHHS staff all are trained annually (virtually) in emergency response protocol and systems. NH's Title V is proactive in its emergency preparedness planning and coordinates with partners at the State and local levels to develop emergency preparedness and response plans that include the needs of the MCH and CYSHCN population.

Throughout the pandemic, but particularly this past year, Title V staff from both MCH and BFCS who are registered nurses (RNs) were asked to staff the COVID-19 vaccine clinics and testing sites held across the State. Staff skilled in data entry also assisted in managing the enormous volume of information from COVID-19 testing and vaccination efforts.

MCH's Birth Conditions Program (BCP) has been working collaboratively with the Bureau of Infectious Disease Control (BIDC) within DPHS (the lead on COVID-19 efforts) and the MCH Epidemiologist to identify and report COVID-19 outcomes in mothers and infants for the CDC Surveillance for Emerging Threats to Mothers and Babies (SET-NET) project. As a result of this effort, BIDC and MCH collaboratively applied for and were awarded CDC funding within the Epidemiology and Lab Capacity grant, Project W, "Infants with Congenital Exposure: Surveillance and Monitoring to Emerging Infectious Diseases and Other Health Threats."

Most recently, MCH and BFCS supported the Women, Infants and Children Nutrition Program (WIC) in disseminating information on the infant formula shortage, including best nutritional practices with infants, and solutions to current barriers. BFCS Health Care Coordinators have been working with families, Medicaid, and pharmacies to ensure CSHCN needing specialty formula are able to obtain some.

In this third year of the five-year project cycle, NH Title V will be submitting several requests for technical assistance, including the following.

MCH's Injury Prevention Program is requesting technical assistance to better integrate its work with the other Title V programs, such as Adolescent Health. Technical assistance would be requested from the [Children's Safety Network](#) to "strengthen their capacity, utilize data and implement effective strategies to make reductions in injury-related deaths, hospitalizations and emergency department visits" ([childrenssafetynetwork.org](#)).

To broaden the scope of work on NPM#5 (safe sleep), NH's Title V will request technical assistance for training on harm reduction within safe sleep efforts in public health. A comprehensive prevention strategy, harm reduction is part of the continuum of care, and harm reduction approaches have proven to prevent deaths and injuries associated with various human behaviors.

Technical assistance will be sought to facilitate a six part webinar series entitled "Telehealth in NH 101." The objective will be to promote a better understanding of telehealth within the state system, particularly as it intersects with NPM#10 (adolescent well-visit) and NPM#12 (transition to adult health care).

In pursuit of health equity, technical assistance will be requested for guidance and training on the collection and standardization of race, ethnicity, language, and disability data (REALD), as well data on sexual orientation and gender identity (SOGI) within the data systems that are stewarded by DHHS and/or Title V funded contractors.

BFCS will request technical assistance (1) from the [MCH Evidence Center](#) to work through strategies for preparing to implement the redesigned program for health care coordination and family support beginning July 2023; and (2) from the [Catalyst Center](#) to help NH identify strategies for improving reimbursement for services and financing services not generally covered by private insurance or Medicaid. The MCH Evidence Center will also be approached for assistance with exploring ways to measure the actual impact of the implementation of the Help Me Grow Framework with a focus on meaningful family connection, and to increase the leadership capacity for NH's CYSHCN workforce.

### **III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts**

The Maintenance of Effort required match helps to assure a basic state funding level of a little over six million dollars for Title V programming as a whole (MCH and BFCS). Unfortunately, this amount has gone down, being chipped away in each successive biennium budget despite the protestations of Title V leadership and stakeholder support and advocacy. NH is in the first year of the 22/23 (which ends 06/30/23) biennium budget and will start preparations for the 24/25 budget the spring of 2022. Therefore, the federal support of nearly two million dollars that is received is crucial in sustaining and preserving a comprehensive Title V program. Funds are both the “glue” and the “backbone” that enables staff and contracted sub-recipients flexibility in addressing the mission of improving the health and well-being of the maternal and child health population, including CYSHCN.

Title V funding is almost always leveraged with other funds, particularly state general funds. Nowhere is this more evident than in its core support for program capacity and public health infrastructure. Because of Title V funds, MCH and the BFCS are able to have full time positions such as the Perinatal Nurse Coordinator, the Public Health Nurse Consultant/Child and Adolescent Health, the Birth Conditions Program Coordinator, the Systems of Care Specialist, the Pediatric Mental Health Care Access Program Coordinator, a CYSHCN data specialist, an Infant Surveillance Coordinator and Program Managers in Injury Prevention, Newborn Screening, Data and Decision Support and Quality Improvement and Clinical Services. These positions enable a great array of programming and services such as facilitation and leadership of statewide maternal, child and infant fatality reviews, quality improvement activities in perinatal health access & care and health care coordination for CYSHCN, training for primary care practitioners in behavioral health and a coordinated injury surveillance and prevention program addressing the leading causes of death and morbidity for the state’s Title V population. The BFCS Clinical Program Manager and three registered nurses provide consultation to community-based programs serving CYSHCN and Managed Care Organizations (MCOs), back up to Medicaid prior authorization process, and outreach to families with children applying for Home Care for Children with Severe Disabilities (aka Katie Beckett).

Title V funding also enables surveillance and evaluation capacity in the form of a doctoral level Epidemiologist, specific to MCH concerns.

Once again, leveraging funding, Title V enables community health centers and community-based agencies in the state to assure the delivery and entry to core MCH and CYSHCN services, providing the ability to fill in the gaps that are not otherwise reimbursed by insurance. Services such as enabling a health care provider to spend two hours on improving the quality of pediatric care by conferencing with colleagues, maintaining child health workers visiting homes to zone in on safe sleep and barriers, enabling services such as patient navigation, transportation and translation, center based quality review teams focusing on increasing utilization of the adolescent well visit and getting input from groups of pregnant mothers with Substance Use Disorders on completing “doable” plans of safe care during prenatal visits. Title V also supports CYSHCN families through community-based contracts that include nutrition, feeding and swallowing clinic and consultation networks, a complex care network, child development clinics and consultation, health care coordination & family support that includes transition activities for CYSHCN, their families and the professionals working with them and a Family to Family Health Information Center.

### III.A.3. MCH Success Story

New Hampshire's Child Fatality Review Committee (CFRC) was re-established under RSA 132:41 in 2019 administered out of MCH. Two Title V funded positions, the MCH Administrative Secretary and the newly filled Child/Adolescent Clinical Coordinator share the responsibility of making this group "run" along with the MCH Administrator who is a legislated member. The Committee membership, incorporating a Chair and Co-Chair along with an Executive Committee, is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities. The CFRC newly wrote and revised its procedures and policies in accordance with those suggested by the HRSA funded National Center for Fatality Review and Prevention. The CFRC's objectives are the following: Identification and investigation of the prevalence of risk and protective factors among the cases; Descriptions of trends and patterns of child deaths in the State, including sudden unexpected infant deaths (SUID) and sudden death in the young (SDY); Evaluation of the service and system responses for children and families and written recommendations for improvement of these services and Improvement of the quality and comprehensiveness of child fatality data by enhancing and integration information from such sources as autopsies, death scene investigations and medical records.

The CFRC's location under the auspices of NH's Title V program in MCH enables it to focus and help prevent the leading causes of child fatality within the State, including intentional ones like suicide and unintentional injuries (motor vehicle crashes, drug overdoses and drowning) which link to National Performance Measure #7 (injury hospitalizations) and. Recommendations are now written in the form of a SMARTIE objective (specific, measurable, achievable, realistic, time-bound, inclusion and equity) and are distributed statewide through an annual report, legislative/professional presentations and are reviewed on a regular basis through a subcommittee dedicated to their implementation.

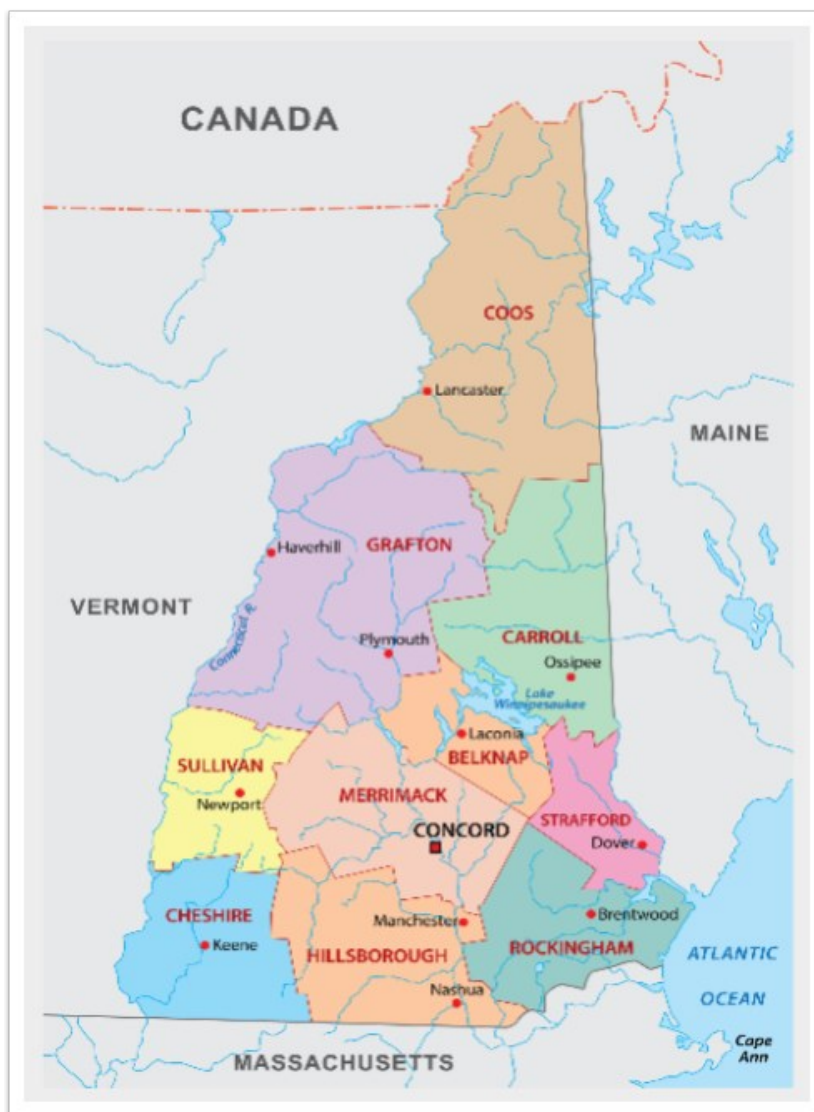
From BFCS, the following is an example of how CYSHCN was assisted by a Title V-funded nurse health care coordinator through transition to adult services. This young woman had participated in several Title V-funded programs throughout her 21 years of eligibility including Neuromotor; Nutrition, Feeding & Swallowing; and Complex Care. However, it was health care coordination that provided consistency throughout her experiences with Jacobsen syndrome; femoral and tibial torsion; developmental delays; gastroesophageal reflux post gastrostomy tube placement; congenital heart disease; and recurrent pneumonias. Gap-filling services included home visits to build supportive relationships with the family; assistance with scheduling and accompanying the family to medical appointments; communicating with nursing agencies in search of respite and home-care providers; financial assistance during hospitalizations and with some durable medical equipment not covered by insurance; and obtaining approvals from insurance for specialty items. In preparation for transition to adult health services, the nurse health care coordinator reviewed equipment needs and arranged for a safety and equipment evaluation. When she aged out of the program at 21, this family had successfully transitioned their daughter to an adult health care provider; had Area Agency for adult long-term supports and services, guardianship, SSI and Adult Medicaid in place; and all equipment needs met by the combination of private insurance and Medicaid. Comments from the family to the nurse health care coordinator include "School put on an amazing graduation ceremony for our daughter. We will definitely miss them! I think things are moving along. Thanks again for all of your help. I don't think I would have got through it without you!"

### III.B. Overview of the State

#### Demographics, Geography, Economy, Urbanization and Government:

New Hampshire (NH) is one of the oldest states in the country; it was originally a land grant in 1623 and became a state in 1775. NH's population of 1.38 million live in 9,351 mostly forested (81%<sup>[1]</sup>) square miles bordered by Canada on the north and by Massachusetts on the south. On the east is the Atlantic Ocean and Maine and on the west is Vermont. With its 1,300 lakes and ponds, 40,000 miles of river and 18 miles of seashore, NH is the 45<sup>th</sup> largest state at 190 miles long and 70 miles wide. The state's landscape lends itself to many different types of outdoor recreation. However, that same topography lends itself to difficult driving and long distances between places, particularly in the winter months, as well as disparities in broadband access with 10% of households not having an internet service subscription.

With its 10 counties, approximately 37% of the population and 84% of the landmass in NH is considered rural; most of the land area lies north and west of the capital Concord. The three most urban or metro areas are Manchester, Nashua and Concord, all located in the state's southern tier where the majority of the population lives.



NH's Title V Program consists of the Maternal and Child Health Section (MCH) located in the Bureau of Population Health and Community Services in the Division of Public Health Services (DPHS), and the Bureau for Family Centered Services (BFCS), located in the Division of Long Term Supports and Services (DLTSS). Many factors guide its efforts.

Both DPHS and DLTSS reside within the NH Department of Health and Human Services (DHHS), the State's largest agency made up of approximately 10,000 employees and the bulk of the State's budget (with Medicaid being the most costly line item). A Commissioner oversees the NH DHHS, appointed by the Governor for what typically is a four-year term. Both MCH and BFCS are physically located in the capital city of Concord. However, much of the Title V work takes place in funded agencies across the State in the form of community health centers, specialty health clinics and human services agencies that provide home visiting and the like.

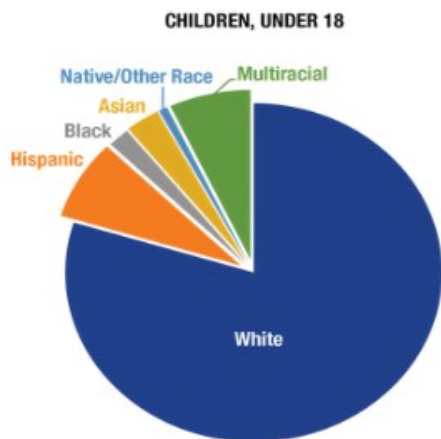
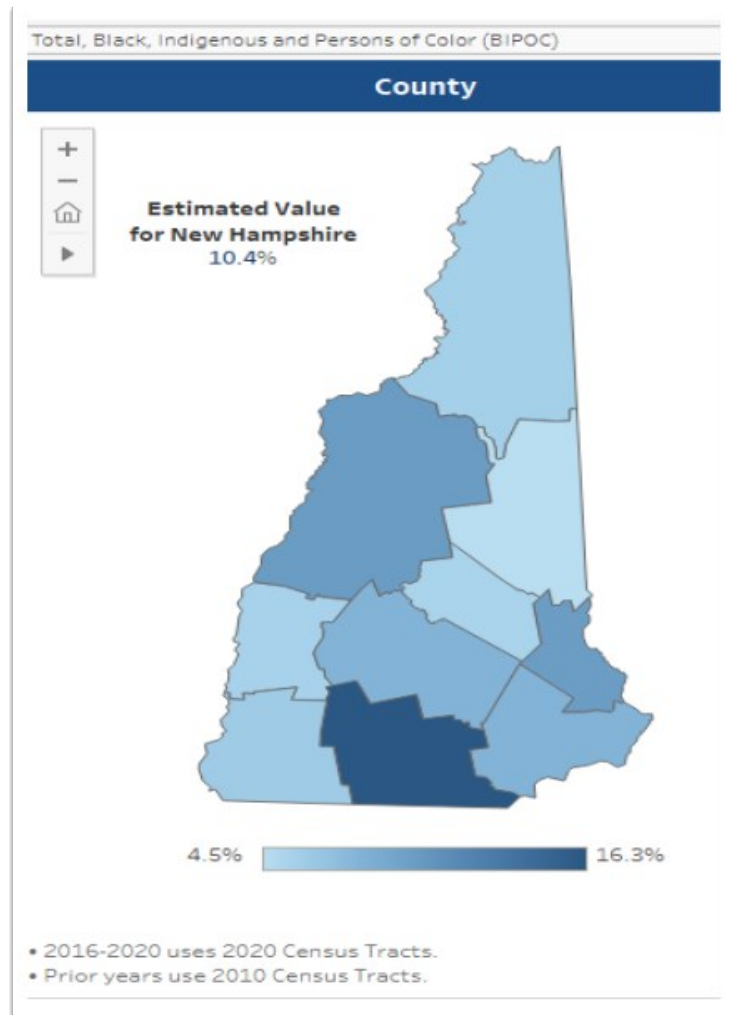
NH has the largest bicameral legislature in the English-speaking world, with 24 Senators and 400 Representatives, and operates under a unique Governor and Council (G&C) system. Five Executive Councilors, each representing 1/5 of the population are elected separately from the Governor, though for the same two-year term. All state departments and agencies must seek approval for both receipt and expenditure of state and federal funds, budgetary transfers within the department and all contracts with a value of \$10,000 or more. There is also a Joint Legislative Fiscal Committee. This group of both Senators and Representatives has to accept and give the approval to expend any new or additional funding in between the preparation and approval of the two year biennium budget.

Christopher T. Sununu, Republican, is the 82nd Governor of the State and is currently serving his third term, running for election for a fourth this November of 2022. All of the positions in the Legislature and the Executive Council are also up for election this fall. Title V policy and funding is heavily influenced by both the Legislature (particularly the Joint Legislative Fiscal Committee) and G&C.

Last year's legislative session and G&C meetings were busy for Title V staff who between MCH and BFCS have a substantial amount of contracts. This is in addition to the substantial amount of House and Senate bills that span a wide range of issues affecting the MCH population from immunization through family planning. Title V staff are asked to provide input through a bill's fiscal detail sheet and through written and in-person testimony. The upcoming year will be spent in the preparation and deliberation of the State Fiscal Years 24/25 biennium budget. The work begins the summer of 2022 with Title V staff developing budgets for every separate accounting unit and preparing justification for any state, general funds.

Over the decade from 2010 to 2020, the population of NH increased by approximately 4.6%. The 2021 population was estimated at 1,388,992 residents, an increase of 11,107 from the previous year. This was the largest one-year increase in New Hampshire's population since 2002.<sup>[2]</sup> As part of that, there was a 7% increase in the number of births those same years, 2020 to 2021 (from 11,837 to 12,674). This was the largest percentage increase in annual births in the country.<sup>[3]</sup> Most population growth since 2010 has been the result of positive net migration. Different hypotheses abound, but the general consensus is that during the COVID pandemic, people in general looked to the State as a safer place to live with its lower population density. Realtors noted that prior to the pandemic, approximately 10% of buyers were from out of state but jumped to 35% during 2020.<sup>[4]</sup> Other reports (vital records data, etc.)<sup>[5]</sup> remark that more highly educated couples in their thirties chose to use the opportunities afforded by remote work to start a family. It will be interesting to see if both the migration trend and the birth uptick continue in future years.

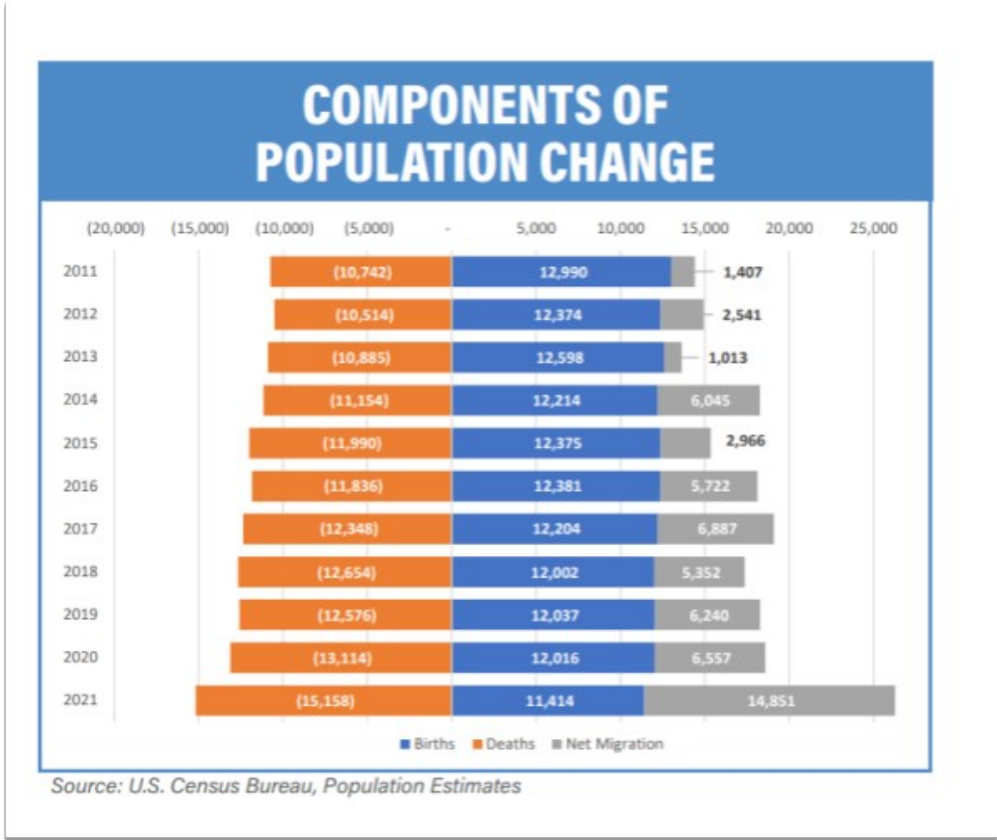
The actual population of the State of New Hampshire is primarily non-Hispanic white (89% and fourth highest in the US), but its residents of color (Asian, 3%; Black, 2%; Hispanic, 4%; Two or more races, 2% and Other at less than 1%) are increasing.<sup>[6]</sup> Diversity is geographically uneven in NH. Many square miles of the State are uniformly white, while the more urban part in southern NH is more diverse as is the Hanover/Lebanon area in the Upper Valley and a few areas of the Seacoast.<sup>[7]</sup>



Looking at it by age, children under 18 make up the greatest diversity in the State with approximately 20% in that age group identifying as Non-White in 2020.<sup>[9]</sup>

[8]

For the last five years, there were more deaths in NH than births. The COVID-19 pandemic's mortality was particularly felt in the older adult population.



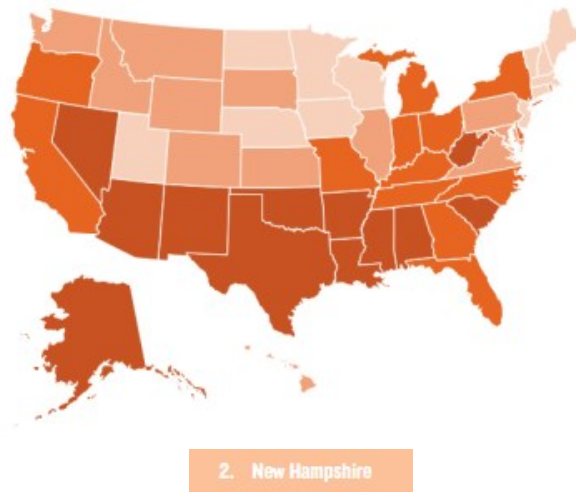
[10]

In the last decade, the number of children in NH under 18 declined close to 11%. This same decline was seen in the U.S. but at a much smaller percent. Even with the high percentage increase in number of births in 2021, NH has the lowest number of children per household in the country at 1.73 children.<sup>[11]</sup> In comparison, adults over the age of 65 increased by more than 40%.<sup>[12]</sup> The State routinely is among the top five for the highest percentage of its population enrolled in Medicare.<sup>[13]</sup> As a result, the State's older population will more than double over the next 20 years. As with its diversity numbers, older populations are not represented evenly within the State: the percentage of the population of older adults is greatest in the North Country, while the biggest number of older adults live in the Southern part, which is the most populated.

Prior to and even during the pandemic, NH has often been ranked in the top tier of overall well-being and in many of the social determinants of health.<sup>[14],[15],[16]</sup> Scores are based on a composite index of metrics that give a snapshot of the health of a population or its health care, such as Title V measures such as a low adolescent birth rate (5.44% in 2021 in NH compared to 15.4% in the US)<sup>[17]</sup> or in the or high pediatric immunization rate in the school aged population (93% children fully up to date in grades K-12).<sup>[18]</sup> The State also scores high because some of its key social determinants of health such as economic stability, quality of education and public safety in general are good.



A 2022 STATE-TO-STATE COMPARISON OF  
**OVERALL CHILD WELL-BEING**

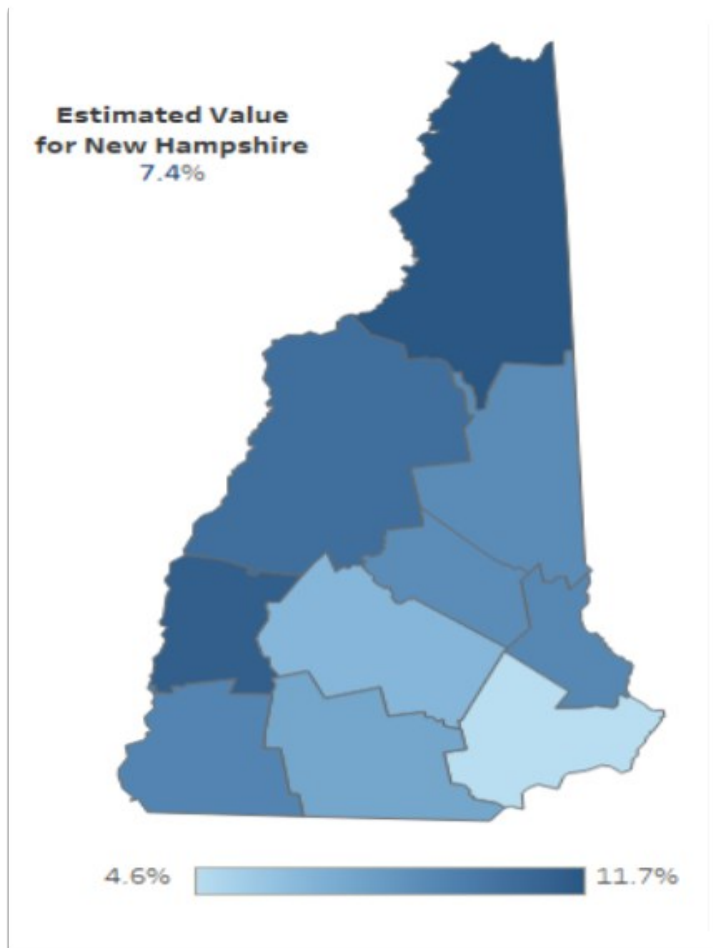


[19]

NH is a low-revenue, low-expenditure state. Its revenue structure is distinctive in that the State lacks a broad-based personal income or sales tax, and its biggest single source of revenue is local property taxes. The funding of NH's school districts is largely at the local level through property taxes, which has led to disparities across the State in property poor districts. The largest tax revenue for the State level are those on business, tobacco, rooms and meals, real estate transactions and from the State enterprises selling liquor and lottery tickets.

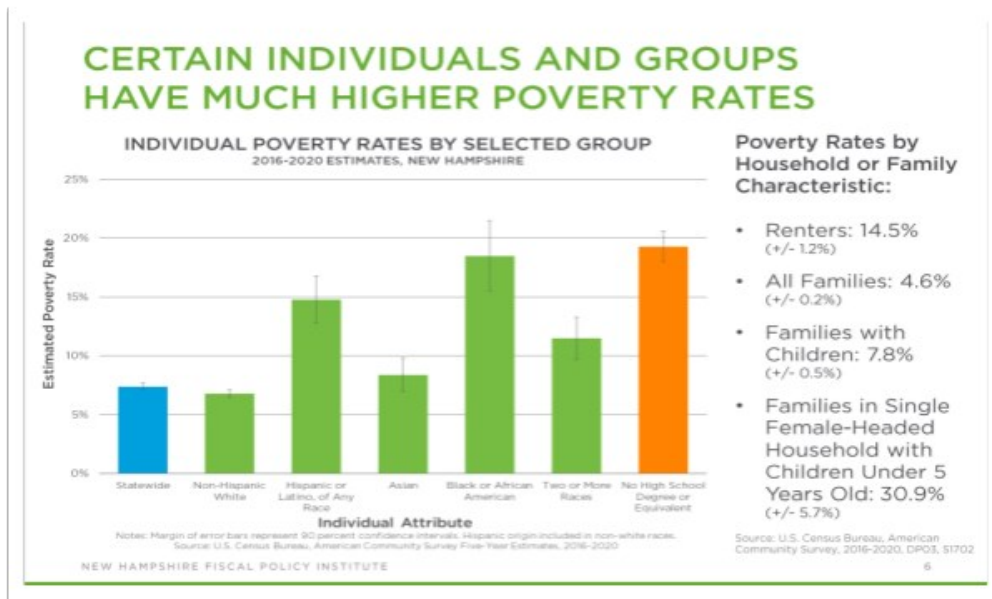
NH has a diverse mix of industries which usually makes its economy more resilient than that of states that are dependent on fewer. The State's jobs are most heavily concentrated in retail, health care, government, and manufacturing with the lowest minimum wage in New England at \$7.25 an hour. NH's unemployment rate, pre-pandemic, was usually well below that of the U.S. as a whole (hovering around 2 to 2.5 % for over a decade). Part of that is due to consistently having a more educated workforce. However, with the advent of the COVID-19 pandemic, NH, like the rest the country, experienced a significant increase in its incidence of new and sustained unemployment claims. However, also like the rest of the country, NH's current unemployment rate has bounced back to even lower than before the pandemic at 1.8% as of May 2022. <sup>[20]</sup>

NH typically has one of the lowest poverty rates in the country, most recently at 8.1% in 2021, an increase from 7.4% in 2020.<sup>[21]</sup> This varies across counties, with Coos and Sullivan having higher rates as the following map shows:



[22]

The COVID-19 pandemic has accentuated these differences, creating and accentuating the State’s vulnerable populations. There are clearly racial, family and living situation disparities in poverty level as well as median income within the State. Single female-headed families face higher levels of poverty and a lower median income (\$41,605 compared to \$80,175) regardless of their identified race, ethnicity, number of children, education level, work status, or home ownership status compared to all families.



[23]

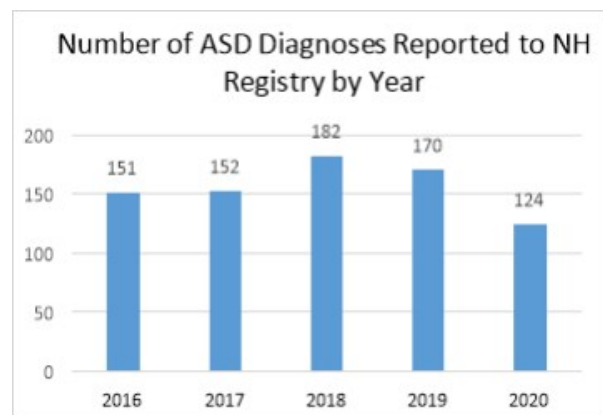
Many of the changes that have happened within the past several years have particularly affected the Title V population, as with the higher poverty rates in female headed households with young children. During the height of the pandemic, one out of three families with children received food assistance, receiving some form of public food assistance or benefits including picking up meals from schools, participating in free and reduced-price school breakfast and lunch programs or receiving benefits through the pandemic EBT program.<sup>[24]</sup> And the situation in the State does not seem to be getting any easier. A greater number than usual of families with childcare demands have risen just as capacity and costs have increased; rental costs have risen faster than overall consumer inflation. Close to half of low income families (less than \$35,000 per year) have rental costs of over half their income. This has put conflicting pressures on families to make difficult decisions about the financial viability of participating or not in the workforce. In the last week of April, first week of May 2022, approximately 33% of NH adults surveyed felt it “was somewhat or very difficult to pay for usual household expenses in the past seven days” and this has only been increasing.<sup>[25]</sup>

**Components of the state’s systems of care and Title V populations:** NH’s Title V population includes a slightly increasing number of CYSHCN. According to the National Survey of Children’s Health (NSCH) from 2016 to 2020, the percentage of children whose parent identifies them as having special health care needs based on the CYSHCN Screener has increased from 20.5% in 2016-2017 to 24.2% in 2019-2020<sup>[26]</sup>.

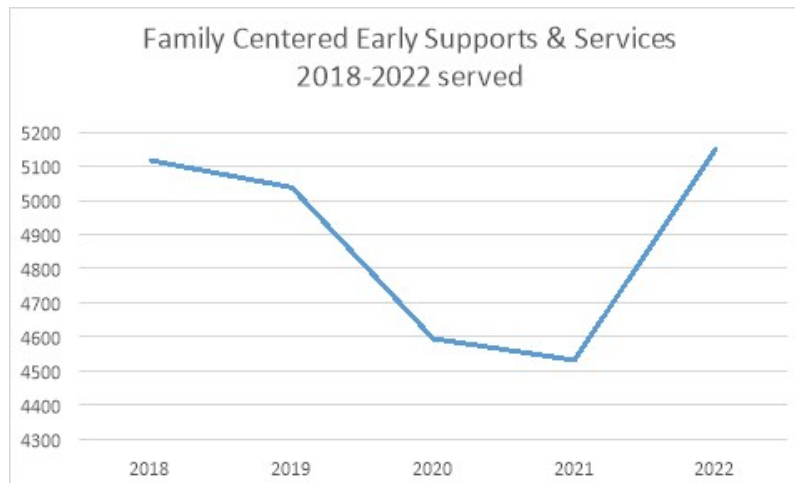


As the number of Autism Spectrum Disorder (ASD) diagnoses reported to the NH ASD Registry increased through 2018, they began to decrease with the onset of the COVID-19 Emergency.

The number of child development clinics available to assess, evaluation, and diagnose children with suspected developmental delay continues to decrease since the availability of developmental pediatricians in NH remains very limited. According to the Title V-funded Child Development Clinic Network’s *2021 Annual Report*. “Highly qualified psychologists, particularly those familiar with developmental differences in very young children have limited availability. Applied Behavioral Analysis (ABA) services are limited and constantly changing. Wait lists are long and availability varies greatly by region.”<sup>[27]</sup> Few service providers offer ABA in the home setting, making it difficult for children to learn daily living skills in their home and for parents to learn strategies to interact and teach their children. There is evidence that training parents to support developmental skill-building is helpful. Few providers offer interpreters for families, making it nearly impossible for families to have equal access to services for young children with autism. “Child psychiatry, particularly for children having Medicaid, is also limited. Securing experienced behavioral health providers for children and parent counseling for challenging behavior is also difficult for families, complicated by waitlists at the community mental health centers.”<sup>[28]</sup>

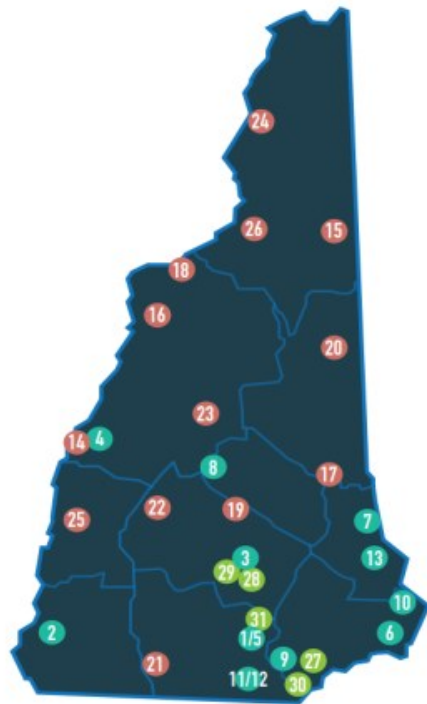


NH’s Part C services for infants and toddlers under the age of three years with a development delay, known as Family Centered Early Supports and Services (FCESS), sits within BFCS organizationally. The Part C office indicated significant changes to the numbers of children receiving early intervention services throughout the COVID pandemic. After three consecutive years of decreasing enrollment, FY2022 reached beyond the 2018 enrollment numbers as new families learned about the benefits associated with early supports and services.



While the workforce shortage has affected most, if not all, professions, the lack of nurses and Direct Service Providers (DSPs) continues to be of great concern for families with CSHCN who rely on these individuals to keep their medically complex children at home and in the community.

NH's Title V population is served by its 26 acute care hospitals. Thirteen of the 26 are designated as critical access hospitals, which have 25 beds or less and are the smaller, rural systems. Five specialty hospitals provide psychiatric and rehabilitative care with 576 beds. Dartmouth Health (DH), which recently changed its name from Dartmouth Hitchcock Medical Center, is the largest medical system in the State with its flagship hospital in Lebanon having the only Level 1 designated trauma classification. It also offers the State's only comprehensive, full-service children's hospital, a Level II designated pediatric trauma center, the Children's Hospital at DH. Three hospitals in Boston are the closest Level I designated pediatric trauma centers to almost all locations in the State. A few pediatric subspecialties are also sometimes only found in Boston, which is particularly critical for Title V programs such as newborn screening and follow up.



Prospective Payment Systems Hospitals (PPS)	
13 hospitals	with 2,715 beds
1.	Catholic Medical Center
2.	Cheshire Medical Center
3.	Concord Hospital
4.	Dartmouth-Hitchcock Medical Center
5.	Elliot Hospital
6.	Exeter Hospital
7.	Frisbie Memorial Hospital
8.	LRGHealthcare, Lakes Region General Hospital
9.	Parkland Medical Center
10.	Portsmouth Regional Hospital
11.	Southern New Hampshire Medical Center
12.	St. Joseph Hospital
13.	Wentworth-Douglass Hospital
Critical Access Hospitals (CAH)	
13 hospitals	with 336 beds
14.	Alice Peck Day Memorial Hospital
15.	Androscoggin Valley Hospital
16.	Cottage Hospital
17.	Huggins Hospital
18.	Littleton Regional Healthcare
19.	LRGHealthcare, Franklin Regional Hospital
20.	Memorial Hospital
21.	Monadnock Community Hospital
22.	New London Hospital
23.	Speare Memorial Hospital
24.	Upper Connecticut Valley Hospital
25.	Valley Regional Healthcare
26.	Weeks Medical Center
Specialty Hospitals	
5 hospitals	with 576 beds
27.	Hampstead Hospital
28.	Encompass Health Rehabilitation Hospital
29.	New Hampshire Hospital
30.	Northeast Rehabilitation Hospital
31.	Veteran's Affairs Medical Center

[29]

NH has a highly concentrated health care delivery system. Acute care hospital systems are more than just inpatient and emergency room services. Many of NH's hospitals have evolved to include the majority of the medical and primary care practices in the State as well as ownership of ambulatory surgery centers, health centers including rural health clinics, assisted or skilled nursing care facilities and home care and hospice. As payment models shift from volume to value, hospitals are working to advance population health efforts within their institutions and improve the health of the communities they serve.<sup>[30]</sup> In the past three years, most of the hospitals in the State have also merged and affiliated with one another and across stateliness, joining hospital and health care systems in Maine, Vermont and Massachusetts and even on a national level. Only three of the 26 acute care hospitals have not been the subject of recent merger activity (Cottage, Speare and Valley Regional). Thus narrowing the healthcare delivery system to a handful of players. This past May of 2022, the Attorney General's Charitable Trust Unit came out in opposition of the latest merger proposal between DH and GraniteOne Health, two of four of the State's largest Health Systems, primarily because of the lack of competition and protection for the consumer.<sup>[31]</sup> This puts any future mergers into question.

There are 10 Federally Qualified Health Centers (FQHCs), one FQHC look-alike and 15 Rural Health Clinics (RHCs), all but two them critical access hospital-affiliated. They provide services at 63 sites. During the past year, one FQHC in the northernmost town of Colebrook closed, Indian River Health Center. However, one RHC took its place and it is thought that both an existing FQHC and a RHC in nearby towns will establish satellite sites, all three in the one town. Through MCH, Title V helps to support the efforts of the majority of the FQHCs, the FQHC look-alike and one RHC.

NH DHHS also supports mental health services regionally through a network of ten designated Community Mental Health Centers. There are also designated receiving facilities that provide 24/7 care, five for adults and one for children. In the past year, NH DHHS bought Hampstead Hospital, a 116-bed acute care facility for children with the intention of turning it into a residential and treatment hospital for children and young adults, increasing pediatric psychiatric beds, in the upcoming years. This past year also saw the implementation of DHHS' Rapid Response,

which provided mental health crisis services via phone, text and chat for children, youth and adults in NH who may be experiencing a mental health or substance misuse crisis. It is available 24/7 and can also newly deploy mobile crisis teams around the State.

With the COVID 19 pandemic, all health systems have had many systemic changes, with a significant difference in the way of managing their care and a tremendous roller coaster in financial resources. There are still many federal grant opportunities specific to recovering from the COVID-19 pandemic for the State's healthcare system, particularly for FQHCs.

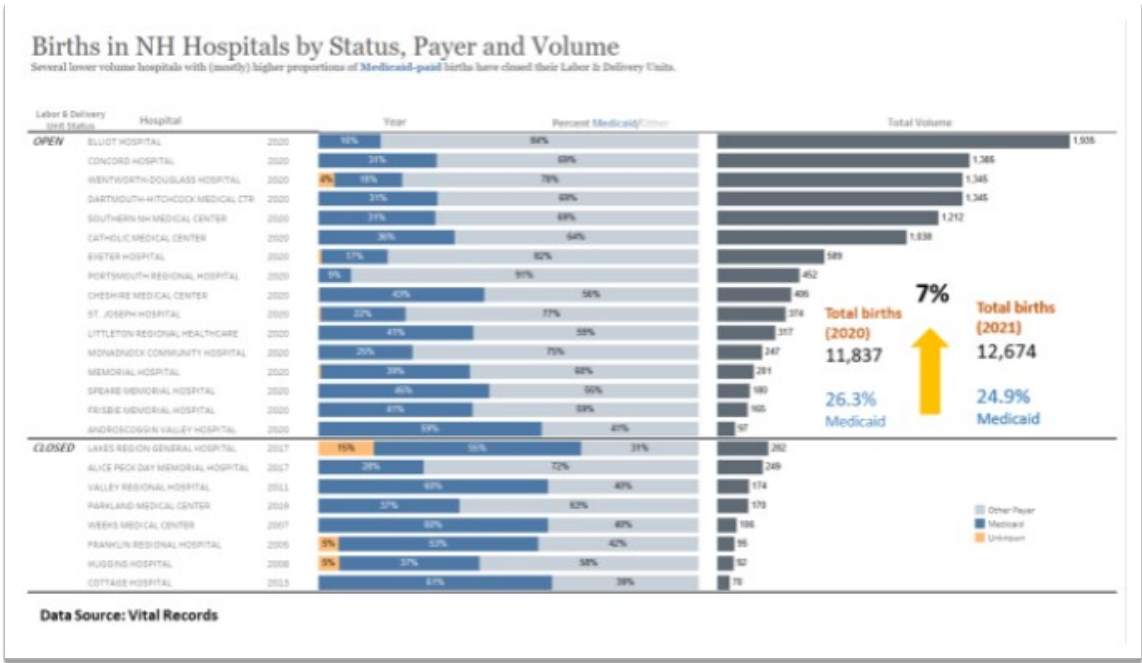
NH also has a network of 13 regional Public Health Networks (established in 2013 through emergency planning and drug and alcohol prevention funds) which seek to integrate multiple public health initiatives and services into a common network of community stakeholders for communities with comparable public health issues and priorities in order to improve health outcomes specific to these regions. These Public Health Networks took the lead along with DPHS in the State's response to the COVID-19 pandemic.

A State Health Assessment (SHA) and State Health Improvement Plan (SHIP) Advisory Council was initially established in July 2020 in New Hampshire with the expectation that a SHA would reach completion in fall 2021 and a SHIP would be produced by August 2022. Due to the COVID-19 pandemic, progress on the SHA-SHIP process was delayed with the existing council representation of the State of New Hampshire involved in the major public health emergency and unable to provide guidance to the council. New legislation was enacted on May 17, 2021 which amended previous language to read that the SHA would describe the status of health and well-being in New Hampshire, access to critical healthcare services including maternity care, the cost of healthcare and insurance coverage, and the fiscal stability and sustainability of critical services to ensure sufficient and equitable access throughout the state; utilize input from state and local level stakeholders obtained through public forums; identify disparities in social determinants that may impact health, health outcomes, and access to care; map health care service delivery, utilization, inter-entity collaboration, and identification of gaps or redundancies' describe the role of state agencies in supporting the public health system in New Hampshire; utilize existing data and plan for future data to support statewide and local planning; identify priorities for the state health improvement plan.

SHIP language was also revised with the legislation and now reads: The state health improvement plan shall guide the department in assessing, planning, implementing, and monitoring improvement in the health and well-being of New Hampshire's population; the state health improvement plan shall focus on strategies to: improve health outcomes and reduce inequities; and strengthen public health and human service delivery systems; the state health improvement plan shall identify priorities and evidence-based practices, integrate services, and leverage resources across the state. The new legislation gave the SHA a deadline of May 2022, with a deadline of May 2023 for the SHIP.

Additional delays have been experienced since this legislation was enacted, such that the SHA is anticipated for August 2022 and the SHIP for May 2023. A website is under construction to display the SHA and will also host the SHIP when it is complete.

A particular concern to the MCH population is the closure of ten labor and delivery hospital units ten over the past two decades leaving 16 birth hospitals and four birthing centers. Only six of the critical access hospitals now offer obstetrical services presenting a distance issue. Obstetrical services have high fixed costs and low reimbursement rates. Weekly for the past several years. Title V staff confer with their Alliance on Innovation in Maternal Health (AIM) partners, the Northern New England Perinatal Quality Improvement Network (NNEPQIN) on these such issues. Small volume hospitals typically have a higher percentage of patients that give birth paid for by Medicaid (up to 59% as shown in the figure below), which typically pays for a quarter of NH's births in a year.



[32]

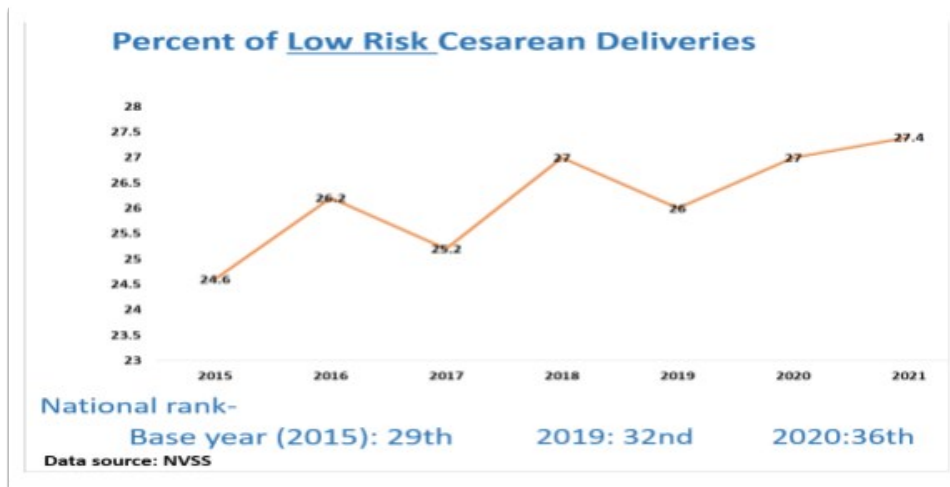
A legislative response saw the passing of an omnibus House Bill (HB) 1661<sup>[33]</sup> increase the Medicaid reimbursement rate for facility based birth services provided at hospitals by 25%, in the aggregate, based on the rate in effect as of June 30, 2022. The DHHS Commissioner has the discretion to implement the reimbursement increase to adjust for access risk geographically; provided that no critical or non-critical access hospital receives less than a 20% increase. In conjunction, Senate Bill (SB) 408<sup>[34]</sup> increased the Medicaid facility fee reimbursement schedule for freestanding birthing centers. A legislative effort to extend Medicaid coverage through at least one year postpartum failed.

Other initiatives going on in the State to address birthing unit closures include Dartmouth Health’s (NNEPQIN’s parent organization) two-year long HRSA Rural Northern Border Regional Planning grant creating the North Country Maternity Network (NCMN), which is a collaboration of agencies in rural Northern NH and adjacent border communities that “strive to better understand the needs, gaps, and opportunities in maternity care, including prenatal, labor and delivery, and postnatal care to help shape strategies to better serve the needs of pregnant and parenting people of the North Country, while also improving financial sustainability of these services”.<sup>[35]</sup> Title V staff are on the NCMN’s Executive Steering Committee.

A project focusing on increasing education to both emergency medical services and non-labor and delivery hospitals on unplanned births is taking place with NNEPQIN and the State’s Department of Safety, Bureau of Emergency Medical Services. MCH is monitoring unplanned births which occur if the birthing person gave birth at home unintentionally, gave birth during transport to a hospital with a labor and delivery unit or gave birth in a hospital without a labor and delivery unit. This group is also looking to correlate these unplanned location births with weather patterns, outcomes, characteristics of the mom (parity, gestational age, etc.), and driving distance to a birth hospital from residence.

The data associated with labor and delivery closures such as an increase in low risk cesareans or a decrease in the amount of prenatal visits suggest that this is occurring.



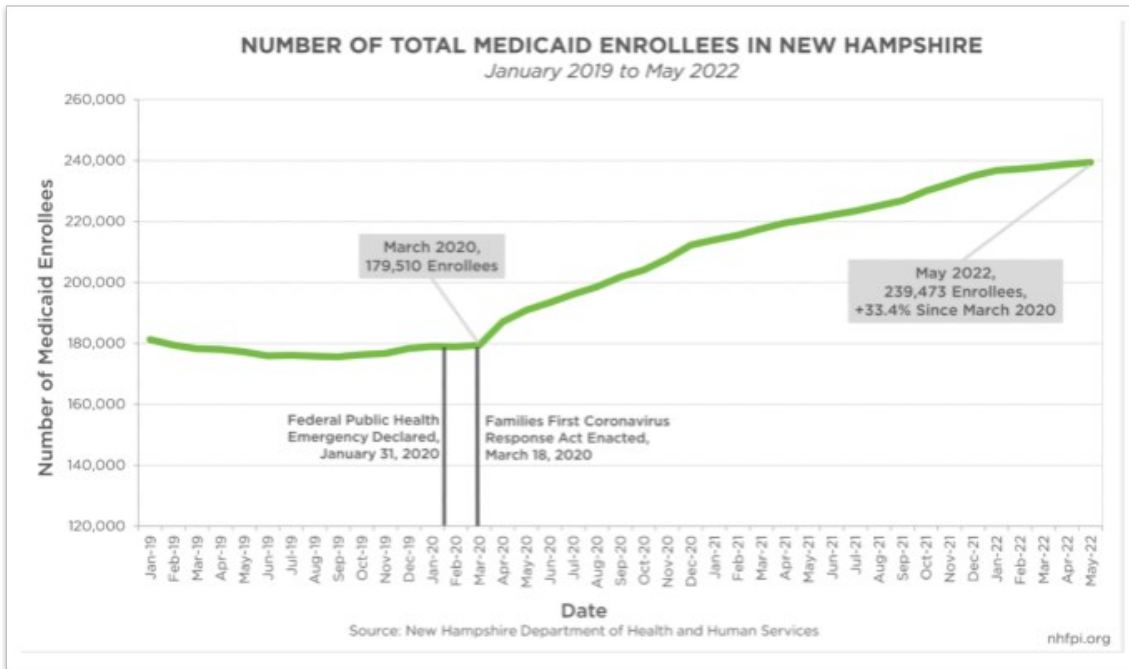


[36]

There is a significant difference in low risk cesareans between 2015 and 2020. There was also a significant difference between 2019 and 2020 when looking at birth certificate data with respect to entry into care during the first trimester from 86.6% to 85.8%.<sup>[37]</sup> Both of these are issues Title V staff and their partners are delving into.

NH Title V staff are also involved with addressing the statewide shortage of health care professionals, exacerbated by the pandemic and a rapidly increasing aging of the population. Title V is working with colleagues at DHHS's Office of Rural Health and Primary Care with participation in activities such as the Legislative Commission on Primary Care Workforce Issues and the NH Health Professions Data Center. Several of the Title V funded community health centers are also involved as placements for family practice, psychiatry and pediatric residencies with one even implementing a full residency program in Family Practice that opened with pandemic federal funds. In March of 2022, *Giving Care: A Strategic Plan to Expand and Support New Hampshire's Health Care Workforce*<sup>[38]</sup> came out under the auspices of the NH Endowment for Health. This plan outlines a detailed, long-term outline towards increasing and retaining the healthcare workforce in NH.

**Financing of services for the MCH population:** NH Medicaid utilizes a managed care model for medical services with three insurance plans, NH Healthy Families, Well Sense and AmeriHealth Caritas. Medicaid participation increased significantly during the pandemic,



[39]

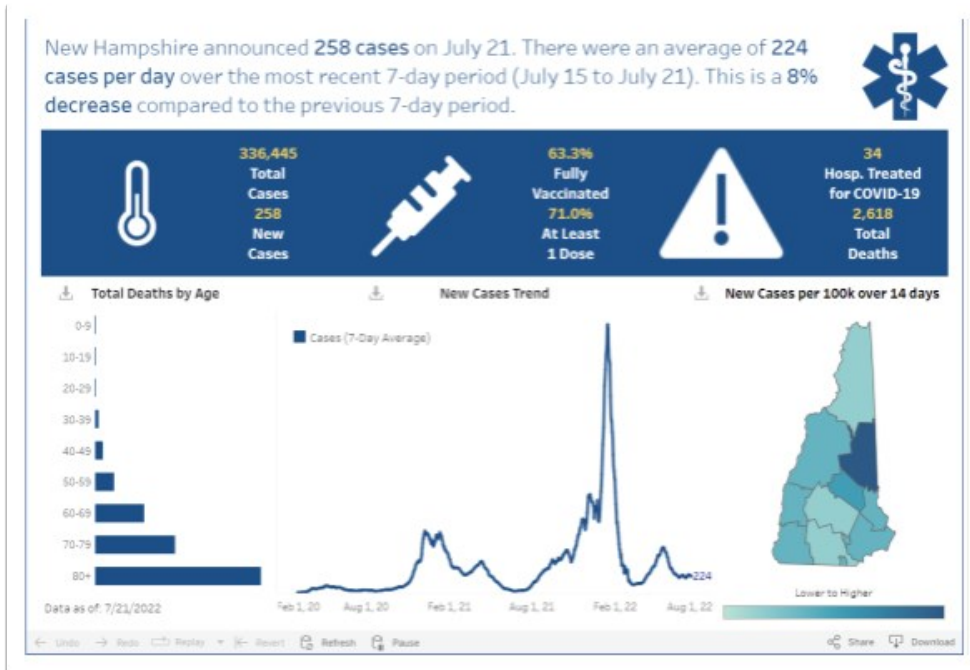
with 41% of the enrollees at the end of May 2022 being children and with one percent being pregnant women with low incomes.<sup>[40]</sup> Approximately 17% of NH's population is currently on Medicaid. In SFY22 and SFY23, Medicaid provided an across the board 3.1% increase in reimbursement fees, an approximate \$60 million in total. This was the first Medicaid rate increase in NH in decades. In addition, an adult Medicaid dental benefit was just passed into law in June 2022, the first time in NH's history.<sup>[41]</sup>

The State also operates a partnership health insurance exchange with the federal government (<https://www.nh.gov/insurance/consumers/documents/2021-plan-comparison-tool.pdf>), with the Department of Insurance having control over plan management and consumer assistance functions on the federal Marketplace. The total percent (all ages) uninsured in NH was approximately 6.3% for all ages in 2021 with it increasing to 7.5% under the age of 65.<sup>[42]</sup>

Currently of most concern is that thousands of Medicaid enrollees face potential disenrollment when the federal public health emergency declaration associated with the COVID-19 pandemic ends. Since then, those on Medicaid have not had to renew every year. It is thought that the public health emergency will likely be extended through at least October 2022, if not longer. However, NH Medicaid in collaboration with UNH's Institute on Health Policy and Practice, have initiated a "pink letter" campaign, which was both a mass mailing and a social media campaign to help enrollees maintain their coverage or find alternative health insurance options.<sup>[43]</sup> Many of the Title V funded CHCs support patient navigators specifically for the purpose of helping patients sign up for health insurance and connect with many other community resources. BFCS Health Care and Family Support Coordinators work closely with Medicaid and with families with CSHCN to assure Medicaid applications do not lapse. Throughout the pandemic, coordinators encouraged and assisted families with updating eligibility paperwork, regardless of the requirement, in an effort to avoid the cliff effect once the public health emergency ends.

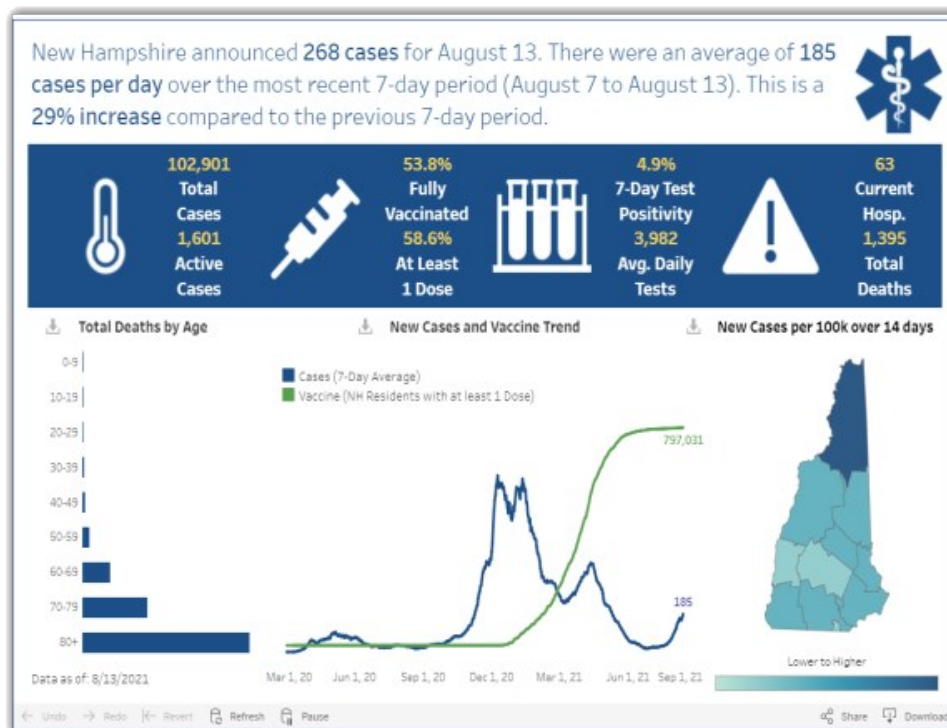
**Challenges that impact the health status:** The deferral of preventive care; the increase of substance misuse, and food insecurity all increased in the State because of the COVID-19 pandemic. However, numbers have been returning slowly over the past year to pre-pandemic times. Almost all of the Title V funded agencies now are back to facilitating in-person visits. Interestingly, a comparison of pandemic statistics from one year ago to present day,

## July 2022



[44]

## August 2021



[45]

reveals not necessarily a decrease in cases (although at the present time, cases may be undercounted with the number of home tests available), but a decline in the severity of the cases which require hospitalizations and an increase in the percentage of NH's population that are fully vaccinated as well as having only one dose. Another

difference within the last 12 months is that vaccinations for children and adolescents have become FDA-approved and available with vaccines for children six months to five years old recently becoming accessible in June of 2022.

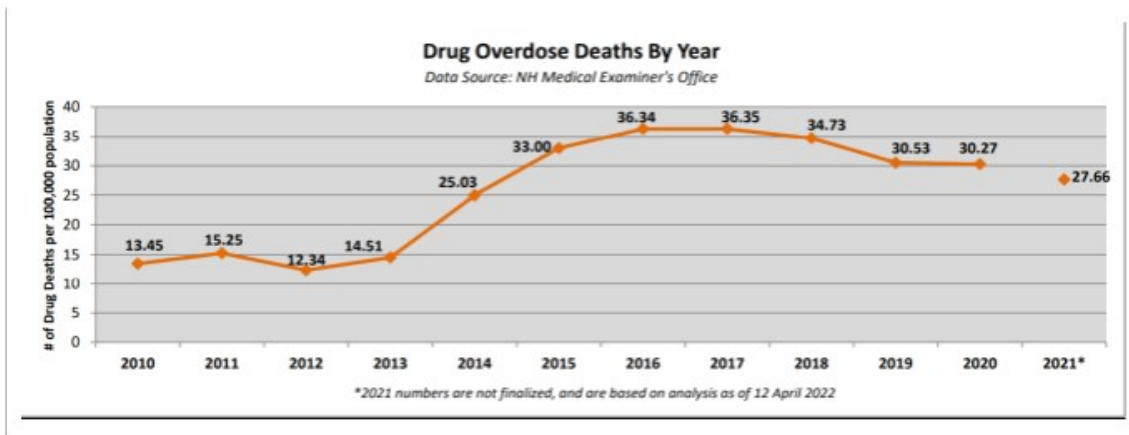
Title V staff have all been involved in the COVID-19 pandemic response, helping to keep an ear to the ground on the needs of contractors as well as surveilling pregnant woman who are COVID positive and their delivered infants. Current pandemic work primarily has been on helping immunization efforts, including messaging, in the MCH and CYSHCN populations. As of July 1, 2021, all NH state-managed fixed vaccination/National Guard-run sites closed, and Title V funded community health centers are vaccinating patients in regular office visits to offer the COVID-19 vaccine in a similar way to how patients access other common vaccines. Families have been encouraged to see their children's primary health care provider for vaccinations. This is especially true for those with CYSHCN.

The Title V population's health care and social service providers in the State have had to alter their methods of providing care. Specialized outreach will continue to make sure families did not forego routine care (i.e. child immunizations, treatment of chronic diseases, dental care, early supports and services and well-child visits). This has been accommodated through the expansion of hours, the ramp-up of telehealth visits, mobile health vans, increased transportation vouchers and on-call 24/7 health care by phone support. Community health centers and home visiting agencies mitigate the impact of food insecurity on the State's children and families by maintaining food pantries, delivering food to individuals experiencing homelessness and children usually supported by the free and reduced school lunch and breakfast programs. Health care and family support coordinators worked in collaboration with stakeholders, suppliers and Medicaid to assure families with CSHCN were able to obtain necessary supplies, medication and formula.

Telehealth has had a rapid expansion in NH aided by Medicaid and other insurers' reductions of limitations. Telehealth has advanced health equity through its reduction of geographical barriers to care, particularly in behavioral health. Several community health centers have documented that for the very first time they are seeing a 0% no-show rate for behavioral health.<sup>[46]</sup> Patients have also shared that telehealth means they do not miss as much time from work.<sup>[47]</sup> For these reasons and many more, health care providers including the health centers are making changes in their offices to accommodate for telehealth as the way of the future. MCH is also a member of the NH Telehealth Alliance along with DPHS's Primary Care and Rural Health Section; its sole mission is to support better access and more cost effective benefits of telehealth.

Although 99% of the population has access to broadband internet service, speed is the issue that creates a digital divide. Millions of dollars have come into NH in the past two years specifically for broadband. NH is beginning the regulatory process to set standards and rules to create an infrastructure of fiber optic cable that can provide higher speeds, particularly in rural regions.

NH's opioid overdoses and deaths have been plaguing the State for more than a decade and severely strains the health care system as a whole. Although the rate has been going down, provisionally 27.66 per 100,000 in 2021, this epidemic is particularly tragic for the MCH population.



[48]

One of the leading causes of maternal mortality in the State is accidental drug overdose.<sup>[49]</sup> Poisoning, mostly due to opioids, has overtaken car crashes, as the leading cause of death due to unintentional injuries particularly in the adolescent and young adult population (unintentional injuries, primarily poisoning due to opioids, continue to be the leading cause of death for all NH residents ages one through 44).<sup>[50]. [51]</sup>

MCH is the lead on the CDC’s Overdose to Action grant, which funds several opioid overdose surveillance and prevention strategies including the collection of real-time emergency department overdoses; the collection and dissemination of data related to overdose deaths; the development of overdose surveillance systems such as the Opioid Overdose Dashboard; the enhancement of the State’s Prescription Drug Monitoring Program; the provision of care navigators to help families connect to services when children are separated from their parents due to parental substance use disorder; the provision of education about syringe services to reduce harm, and the education of health care providers and support health care systems related to best practices around prescribing opioid medications.

MCH also facilitates both NH’s Maternal Mortality Review Committee and its Child Fatality Review Committee. Many case reviews in both committees (the majority in maternal mortality which reviews all deaths, unlike child fatality which picks representative cases) result in recommendations specifically related to overdose prevention such as the provision of naloxone if warranted. For the last five years, MCH has been collecting drug exposure data on its situational surveillance fields on the birth certificate. Now, the questions are permanent parts on the birth certificate work sheets, are aggregated, de-identified and submitted to DHHS’s Division of Children, Youth and Families (DCYF; the State’s Child Protection Agency) for its federal CARA/CAPTA notification requirements. The fact that an infant is born with prenatal exposure to drugs and/or alcohol does not itself require a mandatory report.

Title V staff also work in coordination with statewide colleagues on the Perinatal Substance Exposure Task Force as well as NNEPQIN on encouraging the completion of the Plan of Safe Care, developed by a pregnant person and health care and social service providers when substance misuse is present (this has been a recommendation of both maternal mortality and child fatality review committees).<sup>[52]</sup> MCH and NNEPQIN in their co-sponsorship of NH as an AIM State, have been spearheading efforts within perinatal care of both SUD screening and treatment if necessary, and the dispensation of naloxone as part of implementing the AIM patient safety bundle, “Care for Pregnant and Postpartum People with Substance Use Disorder.”<sup>[53]</sup>

Other issues Title V staff have their eye on are the increasing population of children who are obese in the State. There were significant differences between baseline years and the last survey for both WIC and the National Survey of Children’s Health (2014/2018 and 2016/2020 respectively).<sup>[54]</sup> Early indications also show that pregnant people



Retrieved on 07/24/2022 from [surveyresults-2022.pdf \(nh.gov\)](#).

[19] <https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf>

[20] NH Employment Security (2022). *Local Area Unemployment Statistics, May 2022 (updated 06/23/22)*. Retrieved on 07/20/2022 from [laus-current.pdf \(nh.gov\)](#).

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### **III.C. Needs Assessment**

#### **FY 2023 Application/FY 2021 Annual Report Update**

##### **Ongoing needs assessment activities and findings, including family engagement**

Needs assessment is an ongoing activity, implemented in many different ways. It includes the typical review and compilation of data and information from various reports produced by stakeholder groups, such as, but not limited to, the 2020-21 NH Child Advocate Annual Report, the 2021 Kids Count New Hampshire Profile, the 2021 NH Breastfeeding Report, the NH Baseline Needs Assessment (identifying current and future substance use disorder treatment needs and barriers, and COVID-19 impacts), NH DHHS' Closing the Cliff Effect progress report, monthly DPMS NH Medicaid Care Management Summary Reports, the Kaiser Family Foundations' State Profiles for Women's Health, and the NH Women's Foundation's 2021 report: The Status of Girls in NH.

Online resources for national and state-specific data include CDC's NHANES, YRBS or BRFSS survey query tools, SAMHSA's Behavioral Health Barometer, or the National Survey of Children's Health's data portal (the Data Resource Center). HRSA MCHB's Federally Available Data (FAD) document and accompanying data tables are also a rich source of information on the status of performance and outcome measures, with the presentation of stratified data over many years, allowing for the discernment of trends in the State and comparisons with other states or the national averages or trends.

Regular meetings held by multiple stakeholder working groups discussed the needs of the population especially in response to the COVID pandemic and resulting modifications of normal services, hours of operation, or availability of appointments. The MCH-funded Community Health Centers' annual family surveys continue to provide an important snapshot of real-time health needs and concerns of local families.

Within the NH DHHS MCH section, the Family Planning (FP) Program collects family planning encounter data and annual client satisfaction surveys to assess and record the performance of all sub-recipient agencies. The FP program's Advisory Committee, composed of individuals matching the demographics of the clientele, including some actual clients is involved with all assessments of performance and the addressing of barriers experienced by clients in accessing high quality family planning services.

In the Home Visiting (HV) program, family satisfaction surveys are collected on a yearly basis. There has been an emphasis on supporting family engagement in continuous quality improvement (CQI) efforts, and goals have been developed to increase engagement of participants and stakeholders in improving specific performance measures on maternal depression screening/referral and safe sleep, while continuing to allow agencies to select other CQI projects that are particularly salient for their community.

In the most recent MIECHV Needs Assessment update a key finding was the need to support families with substance exposed infants (SEI). A pilot project was developed to support families in connecting with programs through partnership with providers of these programs, as well as child protection, and prenatal and birthing hospital staff. A toolkit was developed to support spreading the lessons learned from this pilot. Existing contracts with agencies are being amended to include additional funds to support agencies to implement strategies from the toolkit.

The NH Mental Health Care Access in Pediatrics (NH MCAP) program utilizes data collection, program evaluation, provider satisfaction surveys, and its advisory board to solicit feedback regarding programmatic needs and effectiveness. NH MCAP's advisory committee, composed of commercial and Medicaid insurers, American



Academy of Pediatrics (AAP) NH chapter, Children's Hospital at Dartmouth, NH Department of Education, UNH Institute of Health Policy and Practice, UNH School of Nursing, and NH Family Voices, recommends topics and the didactic curriculum.

The high school based Teen Driver Safety peer groups, facilitated by the Injury Prevention Center (IPC) at Dartmouth Health Children's, engage other teens to be leaders in cultural change regarding motor vehicle safety at their schools and in their communities.

The Birth Conditions Program (BCP) engages a program advisory committee, which includes a parent of children with birth defects.

In preparing the performance measures for the Title V funded MCH in the Primary Care Setting RFP, the Clinical Services Program Manager consulted with other NH DHHS sections, such as the Tobacco Prevention and Cessation Program, Chronic Disease Prevention and Screening, the Lead Poisoning Prevention Program, as well as with committees such as Watch Me Grow, the Pediatric Improvement Partnership, and the Perinatal Substance Exposure Task Force. These efforts helped ensure that the performance measures for the upcoming contract would reflect some of the state priorities for the MCH population, such as developmental screenings, lead screening for both one and two year olds, as well as SUD screenings focused on the adolescent and prenatal population.

The Child & Adolescent Nurse Coordinator utilizes data from CDC's Youth Risk Behavioral Survey to assess emerging concerns among NH children and youth. These include increased depression and suicide as well as the higher rates among NH youth (compared to the US) of vaping/smoking and marijuana use, and bullying. The use of a Youth Advisory Council has been an integral part of the Youth Homeless demonstration program.

In 2021, NH was awarded the CDC COVID-19 Health Disparities Grant. As part of this work, DPHS/MCH has engaged in two new contracting activities: (1) adding funds and scope to the BFCS contract with NH Family Voices and an (2) Request for Application (RFA) for Early Childhood Comprehensive Systems, to implement additional activities in the scope for family services that will engage family voices and increase family participation in Title V through additional focus group work on barriers to care due to COVID or other reasons. The RFA will enhance training with health care providers on the Plan of Safe Care, which is one of our ESMs. The selected vendor will engage in needs and gap analysis for the P-3 population and substance exposure, as well as make policy and funding recommendations. The vendor is asked to leverage existing needs assessments and gap analysis to avoid duplicating efforts. Families, family support programs and other partners will be engaged in the process.

The CSHCN Director represents DHHS on the Council for Youth with Chronic Conditions (CYCC), which was established by NH law ([RSA 126-J](#)) to promote the organized assessment of the needs of youth with chronic conditions and their families. In 2022, the CYCC entered into a contract with the JSI Research and Training Institute, Inc. (JSI) to complete a statewide, qualitative needs assessment to identify the unmet needs of CSHCN. Strategies will include development of an advisory group and methods for stakeholder engagement. A Caregiver Survey has been widely distributed, including in non-English languages, to assist with the robust dissemination plan. Key informant interviews and caregiver focus groups will support and give context to the data collected from the survey. The results will inform the next CSHCN Survey/Needs Assessment, planned for FY2024 for the Title V Block Grant application in 2025.

NHFV routinely uses a number of methods to capture feedback, as well as advisory input. As a primary partner for BFCS' family engagement work, NHFV convenes issue-specific efforts (e.g. developmental screening access, private duty nursing) utilizing focus groups and key informant interviews to gather information.

Family and caregivers of CYSHCN are involved in the needs assessment process in different ways. Sub-recipients are required to conduct a yearly family satisfaction survey of those served during the previous year. The survey asks participants to identify needs and comment on whether or not they were met. Results are reported to BFCS as part of each agency's annual report.

### **Efforts to operationalize needs assessment**

To make needs assessment an ongoing process, the FP program utilizes quarterly data reports, semi-annual reports for data and program updates, outreach reports, and data trend tables. The HV program has utilized a parent/caregiver survey, a [PhotoVoice](#) Project, and a Home Visitor survey. The Maternal Mortality (MM) program relies on informant interviews to gather suggestions for changes that could be made in maternal mental health, obstetrical, and hospital care; these in turn help the MM Review Committee formulate recommendations. NH MCAP (implemented in NH SPM3) conducts yearly needs assessments of each Project ECHO cohort as well as pre and post cohort surveys on knowledge and confidence in treating children with mental health concerns to measure program impact.

The SUID/SDY Program and the NH Safe Sleep workgroup (part of NH's NPM5) will be using the data and feedback from the virtual events hosted for families to develop safe sleep materials targeted to new and expecting families. Both the NBS and EHDI program use the data that is collected to improve outcomes for infants who need further testing.

Historically, BFCS conducts a bi-annual Satisfaction Survey/Needs Assessment (SSNA) of individuals and families enrolled in its programs/services. The last SSNA was done in 2018, due to the COVID-19 Public Health Emergency and subsequent hiring freeze in 2019-2020. Leadership acknowledge lack of capacity to conduct the next survey. To address this need, the BFCS Data Analyst will participate in the 2022 Training Course in MCH Epidemiology; she will focus on needs assessment and gap analysis.

Additionally, annual needs assessment activities include satisfaction surveys, which are requested from all BFCS program participants. Results are compiled and submitted to BFCS as part of annual reporting each July. BFCS training needs assessments are conducted frequently, by program managers and partners, to identify annual training plans such as those for use of the ASQ for development screening.

### **Noted changes in health status and needs**

The needs of the MCH population in NH, as everywhere, have been impacted by the COVID pandemic and the measures taken for its mitigation or containment. Those measures are being scaled back, but their impact is still being felt. Service sites were closed or operated with reduced hours, at reduced capacity. Telework was improvised and televisits were instituted with no prior opportunity to coach users on how it all worked. Face-to-face visits became the exception, often used only in situations of high-need or urgency, thus pre-empting much routine, preventive care. The population is re-adapting to a new normal with fewer restrictions, but creating new routines is a work in progress, and in-person events often have reduced attendance, perhaps due to ongoing site-specific recommendations of social distancing and mask wearing, compared to pre-pandemic times.

COVID aside, MCH population needs have not changed greatly, as reflected in the list of priority needs retained for this project cycle from the previous project cycle. There remains an emphasis on access to services, which is addressed by the selection of NPM 6 (access to developmental screening), NPM 10 (preventive medical visit for adolescents), NPM 12 (adolescents' transition to adult health care), ESM 14.1.1 (the Plan of Safe Care for birthing

women), SPM 1 (enabling services to reduce SDoH barriers), SPM 2 (access to respite services for families of CYSHCN), and SPM 3 (access to pediatric mental health teleconsults). Primary health care providers are noting that many children are behind on routine physicals, routine screenings (such as developmental screenings) as well as vaccinations. In addition, children and adolescents are struggling with behavioral health issues at higher rates than pre-pandemic.

Children's mental health continues to be considerably affected by COVID-19. In December 2021, a Surgeon General's Advisory was issued to highlight the urgent need to address the nation's youth mental health crisis. This advisory provided recommendations that individuals, families, community organizations, governments, and others can take to improve the mental health of children, adolescents and young adults. One of those was to "Support integration of screening and treatment into primary care. For example, continue expanding Pediatric Mental Health Care Access programs, which give primary care providers teleconsultations, training, technical assistance, and care coordination to support diagnosis, treatment, and referral for children with mental health and substance use needs. NH's Mental Health Care Access in Pediatrics (NH MCAP) Program aims to integrate behavioral health services into pediatric primary care through utilizing the Project ECHO model to provide training and teleconsultation to pediatric primary care providers on how best to treat youth with mental health concerns within the primary care setting.

Based on a preliminary analysis of MIECHV Outcome Measure reporting for 10/1/20-9/30/21, it appears that among the program beneficiaries there was an increase in preterm births, a reduction in breastfeeding, depression screening, well child visits, and postpartum care visits, and an increase in tobacco cessation referrals from the previous year. There also appeared to be a decline in the use of safe sleep practices and an increase in investigated cases of child maltreatment, although this could be due to increased referrals of families with child welfare investigated cases to the HFA program,. Increases in parent-child interaction screenings and developmental screenings were observed, along with increased intimate partner violence (IPV) screening. Decreases in primary caregiver education, continuity of insurance coverage, and referrals for maternal depression measures also occurred.

For CYSHCN, the pandemic interfered with outpatient therapies, home care, availability of medical appointments and respite. As the number of NAS infants continues to climb, BFCS' Nutrition, Feeding & Swallowing consultants report increasing complexity and struggle to reach all those in need. Medically complex children are finding fewer options for care and providers are less available. BFCS providers also note that families are seeking financial support with transportation, utilities and rent.

### **Noted changes in program capacity or systems of care**

The entire healthcare system in the State is struggling with staffing related shortages and vacancies. This is impacting health centers and their ability to provide full, comprehensive services to patients. Many agencies have not been able to expand hours or appointment availability since the pandemic due to short staffing. In addition, many healthcare agencies have been hesitant to take on new or expanded initiatives due to staffing shortages.

Workforce shortages continue to impact access for some services for CYSHCN and their families. The nursing shortage continues and BFCS has found it nearly impossible to fill vacant positions. Pediatric providers are scarcer and which often means that families have to travel greater distances for services. There is also a shortage of pediatric mental health providers and wait lists are very long. Recently Tufts Children's Hospital announced the closing of its pediatric hospital, July 1, 2022. The impact on service delivery for NH residents is yet unknown.

The FP program is trying to expand to telehealth services among the network of FP agencies. Telehealth services

were available in 2020 but many of the agencies have moved back to the model of in-person visits with very little telehealth. Telehealth services have the ability to decrease barriers to care (e.g., transportation, child care) and may help address staffing capacity at clinic locations by making appointments more flexible, at non-traditional times. By increasing telehealth services, the FP program hopes to augment the number of clients served and further expand services statewide.

There has been significant turnover of HV staff at the local agency level. There was an opportunity to increase funds for service delivery through MIECHV American Rescue Plan (ARP) funding; however, due to staff shortages, it was not possible to increase access to families in a significant way.

NH is experiencing a shortage of mental health/substance use disorder (SUD) providers. The majority of maternal deaths occur in the postpartum period, and the majority of those deaths are related to SUD overdose. NH needs adequate mental health/SUD providers available to provide care and have more care coordinators to provide closed-loop referrals and follow-up.

In March 2022, the NBS program hired a part time position for long-term follow up. This position will be responsible for monitoring infants who need further testing to determine if a genetic disorder is present, and for providing resources to connect families and providers with the Bureau of Family Centered Services.

MCH is working to address the shortage of mental/behavioral health professionals and consequent reduction of adolescent well visits and immunizations by designing an RFA to increase access to care by providing mental/behavioral health services in the school setting.

BFCS is aware of the growing need for developmental pediatricians, pediatric neurologists, psychiatrists and other qualified professionals to evaluate children for autism spectrum disorder in NH. The Title V supported Child Development Clinic (CDC) reported a wait list that became increasingly difficult to manage, as there were simply not enough clinicians available. CDC implemented a triage process to identify those children in most need and collaborated with Complex Care Network for appropriate referrals. Children with developmental concerns who are suspected of having autism need accurate diagnoses. Ruling out autism is just as important as making an autism diagnosis, as appropriate treatment and remediation often begins at diagnosis. The BFCS is investigating what and where the gaps exist, who are other critical partners and how can workflow be changed to build a better system for service delivery.

Program staff turnover continues to be high and positions are harder to fill. Salary levels for those working in direct care and family support are often insufficient to find affordable housing options in the state.

### **Partnerships and collaborations with other entities that serve the MCH population**

New Hampshire has an extensive history and experience with partnerships and collaborations, in part because NH is a small state with limited financial, programmatic and human resources, which creates a need to get buy-in and assistance from external groups and agencies throughout the State. In addition, in a small state there is considerable overlap of membership on various stakeholder groups, which promotes collaboration and networking. A sample of partnership groups that include participants from NH Title V staff include the following:

- Alliance for Innovation on Maternal Health (AIM) and the Northern New England Quality Improvement Network (NNEPQIN), to provide educational webinars and implement AIM Safety Bundles at maternity hospitals.
- Building Futures Together Leadership Team, to support the Building Futures Together program which

prepares paraprofessionals in healthcare and school settings to provide specialized enhanced care coordination to children, youth and their caregivers whose parents are impacted by opioid use disorders (OUD) and other substance use disorders (SUD).

- Council for Youth with Chronic Conditions (CYCC), to promote assessment of the needs of children with chronic conditions and their families. The CYCC also advises and collaborates with DHHS, DOE and the insurance department for policy and program development and to enhance community-based family supports that meet the unique needs of the populations.
- Early Childhood Integration Team (ECIT), to support data driven policy and program coordination, integration, and development, while increasing performance and resource accountability across the ECCE system. Members coordinate locally with child care, schools, Public Health Networks, and community based agencies like FRCs.
- Governor's Perinatal Substance Abuse Task Force, especially around the work of the Plan of Safe Care (POSC).
- LEND Advisory Committee, which reviews programming and planning for NH-ME LEND to prepare leaders to work in the field of MCH and improve the lives of children with neurodevelopmental disabilities and their families.
- Massachusetts College of Pharmacy and Health Sciences (MCPHS) places nursing students/interns with BFCS to learn about the types of services available for CYSHCN.
- Medicaid partnership, which is critical to MCH/BFCS. Together individuals provide ideas and feedback for MCO performance measures for Medicaid's 11 priority measures for this year; including increasing BMI and nutrition referrals to combat childhood obesity, and increasing adolescent immunizations including HPV. BFCS provides training and technical assistance to MCOs relative to caring for CYSHCN, consultation to providers, and policy review.
- NH Children's Health Foundation collaborates with the FP program on a contraceptive access initiative to address adverse childhood experiences.
- NH Department of Education and the Bureau for Children's Behavioral Health's System of Care Advisory Council, which promotes, aligns, and continuously improves System of Care Principles and values into every relevant initiative, support system, service of child welfare, juvenile justice, behavioral health, education, primary care, first responders, public health, and community providers at the family, organization, community, regional, and state levels.
- NH Pediatric Improvement Partnership (PIP) Steering Committee, to work on promoting awareness of and interest in pediatric care quality measurement, projects, and resources, and is made up of a diverse group of stakeholders from around the state.
- NH Transition Community of Practice, which shares resources and problem-solves barriers and issues related to transition to the adult service system.
- Office of the Chief Medical Examiner (OCME), to identify all resident SUID and SDY cases using Centers for Disease Control and Prevention (CDC) guidance

- State Family Support Council, to exchange, share and distribute information to each regional council; provide an avenue for arbitration and mediation conflict resolution between Area Agencies and regional councils; and provide information and feedback on issues and concerns for regional councils to DHHS/BFCS and the Bureau of Developmental Services (BDS)
- University of NH Institute on Disability (UNH IOD) partners with DHHS in areas including [Charting the Life Course](#) (CtLC) Community of Practice, to promote family-centered approaches to working with families, and NH Acts Early project using LTSAE funding to support developmental screening activities.
- Watch Me Grow Steering Committee is comprised of partners that make up the developmental screening system in NH.
- Youth Homeless Demonstration Program (designed to reduce the number of youth experiencing homelessness) works to assure that assistance with Health Navigation for youths experiencing homelessness is a priority.

### **Changes in organization structure and leadership**

Within NH DHHS, the Director of the Division of Public Health Services (which houses MCH) retired and a new Director was promoted with within. More recently, the Chief of the Bureau of Population Health and Community Services (overseeing MCH) has taken another position out of state, and the position is currently vacant. In addition, the MCH Epidemiologist, after over a decade with MCH, resigned his position; a new Ph.D. level epidemiologist has been hired and began on boarding in May 2022.

Multiple changes for the FP program included the departure of the MCH nurse consultant and the MCH epidemiologist. There were also leadership changes in two of the FP program's sub-recipient agencies, and in facilitator staff.

Likewise, the HV program saw several key changes. The HRSA project officer supporting the MIECHV program changed. In-house, a new full-time HV CQI Specialist position was created and filled. There was also significant turnover among Supervisors, Program Managers, Nurses, Family Resource Specialists, and Family Support Specialists within several local implementing agencies (LIAs).

The NH MCAP program welcomed a new supervisor in June 2021, in the Clinical Services Program Manager, but that person resigned in March 2022. Also, there was a change of a key collaborator from the UNH Institute for Health Policy and Practice.

Within MCH, a new Child and Adolescent Nurse Coordinator was hired in September 2021; this is a new position in MCH. A new PRAMS Coordinator began working in November 2021 (after a 15-month vacancy) and a new Newborn Screening Program Specialist was hired in March 2022.

The Division of Long Term Supports and Services Director retired in June 2021 and a former, semi-retired Associate Commissioner returned to provide interim leadership for nearly a year; a new Director was hired in early 2022.

One of the founders and co-Directors of NH Family Voices, retired and new staff are onboarding to redistribute the workload and implement new projects.

Since December 2021, BFCS has seen four staff retirements and recruitment is underway to fill.

BFCS sub-recipients have witnessed first-hand the phenomenon known as the “great resignation”. Several vacancies exist in community-based agencies and they have been difficult to fill.

### **Emerging issues and capacity and resources to address them**

Emerging public health issues are varied and have highly consequential impacts on the lives of NH residents. One of these is access to family planning services. The likelihood of Roe v. Wade being overturned has paved the way for states across the nation, including NH, to enact legislation to restrict access to services. New Hampshire has seen this with the dis-approval of three contracts due to agencies’ offering of services outside their Title X Family Planning project. The three agencies were among the top performers for family planning services in the FP program. MCH hands are tied in the face of legislated mandates.

Another area of concern is access to broadband internet for clients who live in rural areas. Not having access to broadband has led to a delay or halt in agencies’ ability to serve their clients through telehealth, especially during the COVID emergency. Access to telehealth could also mitigate the effects of staff shortages among providers, but the primary beneficiaries would be the population seeking services and no longer needing to drive long distances. MCH and partners are supportive of legislation and policy to expand broadband for all NH residents.

NH has among the highest rates of alcohol consumption in the country. The most current YRBS data reported that 27% of high school youth drink alcohol, with rates highest among those of color (31% for Hispanic youth). NH’s Personal Responsibility Education Program (PREP) provides evidence-based, age-appropriate education geared towards the development of social and emotional skills young people need to have healthy relationships, to make responsible decisions, and for positive youth development. PREP can address this issue by including education on alcohol consumption, and the program could be expanded to areas of the State where a higher percentage of Hispanic youth reside.

STI/STDs increased during the pandemic due to limited access to testing (and subsequent treatment). Untreated STIs/STDs can lead to infertility and adverse maternal and newborn outcomes. MCH will continue to promote the availability of free condoms and HIV self-testing kits made available by the Bureau of Infectious Disease Controls’ HIV section funding. MCH will also continue to partner with the NH Public Health Laboratories to offer free STD/HIV testing to family planning clients, who are eligible, and enrolled in the NH Title X project.

The Family Planning Program, within MCH, has also started a condom distribution project which provides free condoms within two food establishment bathrooms. The condoms include a QR code on the wrapper, which allows patrons to scan with mobile phones to find available family planning services, including STD testing and treatment. The food establishments are located near universities and populations of young people. The program anticipates expanding this project in 2022-2023.

The State of NH continues, as before the pandemic, to struggle with the issues of mental illness and substance use disorder statewide. Lack of mental health and SUD providers is impacting care globally, and lack of mental health care for children is a major component of this issue. The MCH section is currently drafting an RFA for primary care providers who are interested in creating/expanding access to school-based health services (primary care and/or behavioral health) in the school setting, for students in grades K-12.

The lack of pediatric providers, nurses and personal care staff continues to be an obstacle for families with and without CSHCN. There continues to be a shortage of in-home care providers as well, which prevents families from

accessing these services and getting respite breaks. Travel to specialty pediatric hospitals is always challenging, as there are great distances to cover. Recent increases in gas prices will further compound this challenge for families who often need to travel into other states for specialty care providers. Families report a rise in behavioral health needs in children – with insufficient capacity to address them.



**Click on the links below to view the previous years' needs assessment narrative content:**

[2022 Application/2020 Annual Report – Needs Assessment Update](#)

[2021 Application/2019 Annual Report – Needs Assessment Summary](#)

### III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$1,989,264	\$1,989,264	\$1,973,578	\$1,973,578
<b>State Funds</b>	\$5,743,753	\$4,452,151	\$5,277,519	\$3,935,578
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$966,336	\$868,333	\$1,462,030	\$1,084,666
<b>Program Funds</b>	\$0	\$0	\$0	\$0
<b>SubTotal</b>	\$8,699,353	\$7,309,748	\$8,713,127	\$6,993,822
<b>Other Federal Funds</b>	\$9,559,396	\$7,692,194	\$13,339,763	\$9,352,162
<b>Total</b>	\$18,258,749	\$15,001,942	\$22,052,890	\$16,345,984
	2021		2022	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$1,972,621	\$1,956,193	\$1,967,356	
<b>State Funds</b>	\$6,262,230	\$5,073,836	\$5,704,615	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$3,768,263	\$1,564,582	\$1,493,263	
<b>Program Funds</b>	\$0	\$0	\$0	
<b>SubTotal</b>	\$12,003,114	\$8,594,611	\$9,165,234	
<b>Other Federal Funds</b>	\$13,628,635	\$10,679,314	\$12,705,102	
<b>Total</b>	\$25,631,749	\$19,273,925	\$21,870,336	

	2023	
	Budgeted	Expended
<b>Federal Allocation</b>	\$1,981,378	
<b>State Funds</b>	\$5,883,627	
<b>Local Funds</b>	\$0	
<b>Other Funds</b>	\$1,744,554	
<b>Program Funds</b>	\$0	
<b>SubTotal</b>	\$9,609,559	
<b>Other Federal Funds</b>	\$13,509,578	
<b>Total</b>	\$23,119,137	

### III.D.1. Expenditures

The Title V budget and expenditures are managed both programmatically and fiscally during the year through regular twice monthly meetings of MCH programmatic and fiscal staff and monthly meetings between BFCS programmatic and their respective fiscal staff. There are also bi-annual meetings between BFCS and MCH programmatic/fiscal staff. MCH is the primary on the Title V Block Grant and as such its fiscal staff manages the overall budget and expenditures.

NH complied with the federal 30-30-10 requirements during FY21. Using a memorandum of understanding between MCH and BFCS, funds are appropriated through a defined methodology. The ultimate goal of using this formalized approach is to ensure that expenditures continue 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. A revision has been planned for 2025 in conjunction with the next needs assessment.

The final financial report is almost always drawn down to zero both because of the two year expenditure cycle and a continued increase in costs, while the funding has been slowly decreasing. In fact, most years, the annual amount is indeed spent in 12, not 24 months. Both MCH and BFCS have the majority of their costs on personnel/benefits and contracts, the two of them focusing on the needs, priority areas and performance measures identified in the five year needs assessment.

There were no significant variations between Forms 2 and 3. It is often a science and quite difficult to predict budgetary costs two years in advance and the pandemic made this particularly problematic. However, some of the other federal funds with the Title V programs had unspent funds, particularly because of the various staffing shortages within both MCH and the BFCS. There were also unspent funds in several grants because of contractual setbacks in G&C approval. This was due to a large amount of American Rescue Plan and COVID funding needing to be accepted into the State budget and the various contracts associated with them. All of this delayed the contractual processes for many vendors, including the new Release of Proposals for MCH in the Integrated Primary Care Setting agencies supported by Title V.

As additional focus is given on Title V expenditures related to the bottom of the MCH pyramid, public health services and systems (and less on direct and enabling services), and as the percentage of staff time and contractual work focus on this, the percentage population in all domains affected by NH's Title V work reaches one hundred percent of the total population. This is reflected in FY21's expenditures.

Title V Block Grant funding is the glue that helps state funding support efforts needed to meet priority needs and the requirements of the Title V legislation. Expenditures for FY21's piece of the five year state action plan included the following priorities and performance measures.

1. Improve access to needed healthcare services.
2. Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers.
  1. Percent of adolescents ages 12-17 with a preventive medical visit in the past year.
  2. Percent of adolescents, ages 12-17, who received services to prepare for the transition to adult health care; and
  3. Percent of the MCH-contracted Community Health Centers (CHCs) that have met or exceeded the target indicated on their Enabling Services workplans.

These two priorities complement one another. Using Title V and matching state general funds, MCH supported CHCs which serve as a safety net in their mission to provide accessible and affordable comprehensive primary care services, including perinatal care for some 112,389 individuals in 2021.<sup>[1]</sup> CHCs had to utilize funding on at least two quality improvement projects focused on the eight performance measures in the scope of services. One of the two had to be the annual adolescent preventive medical visit. The others covered a wide spectrum of clinical measures from lead screening in children, SUD screening and referral in the adolescent and pre and postnatal period as well as postpartum depression screening and appropriate referral.

New to MCH this past year was the hiring of the fully Title V funded Child/Adolescent Clinical Coordinator, a position requiring an RN, who came from a long history of providing pediatric care across a variety of different settings. This position provides clinical consultation, education and technical assistance to the CHCs, particularly on the adolescent wellness visit.

Funds also went to enabling services (ES) such as case management, transportation and interpretation. One hundred percent of the contracted CHCs had at least two ES work plans on file with MCH by the close of FY21. Often times, the plans and interventions directly addressed the social determinants of health, directly affecting accessibility into care. This past year, 43% of the CHCs reached their targets on both ES workplans.

The Clinical Services Program Administrator oversees the MCH Quality Improvement and Clinical Services Section and is paid through several funding streams including Title V. It oversees all of the CHC contracts, their required actions to meet the goals of the Title V National and State Performance Measures and has oversight over the child, adolescent and perinatal health programs. This position also works with DHHS's Rural Health and Primary Care Section whose mission is very similar to Title V in working to support innovative and effective access to quality health care services.

To support adolescents with special health care needs with preparing for the transition to adult health care, BCFS Health Care Coordinators and Nurse Consultants distribute the TRAQ (Transition Readiness Questionnaire) to all youth beginning at age 14 when they conduct annual updates and assessments of need. Following completion of the TRAQ, Coordinators meet with the youth and/or their family caregiver to discuss a goal they hope to achieve in the upcoming year. Examples include calling to schedule an appointment, contacting pharmacies to refill a prescription or identifying an adult health care provider. Title V funds also support a contract with NHFamily Voices (NHFV). This includes technical assistance and training for coordinators as well as outreach and technical assistance for providers to develop and implement transition policies in health care practices.

Health care coordination is the vehicle through which transition services are provided. This is an important gap-filling service that is particularly critical for those who might not have Medicaid or are otherwise in need of assistance that exceeds what is offered by MCO case management. This is accomplished through a contract with Amoskeag Health, a CHC that serves CYSHCN in five of the ten counties in NH. In addition, three health care coordinators who are BCFS employees provide similar services in the other five counties. The positions and the contract are supervised and monitored by the Clinical Program Manager.

Title V funds also help improve access to needed healthcare services, otherwise unavailable, through three contracts with community-based agencies:

- *Specialty Services for Children with Medical Complexities* provides coordinated, family-centered comprehensive assessments and consultation services.
- *Child Development Network* provides timely access to comprehensive pediatric interdisciplinary

developmental assessments.

- *Nutrition, feeding & swallowing consultation & network* provides comprehensive services including, but not limited to, identification, training, and oversight of staff; intake, assessment, and eligibility determination; planning for safe feeding plans, management of feeding tubes, aspiration management and consultations.

3. Decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

1. Percent of women who smoke during pregnancy.

The MCH Perinatal Nurse Coordinator position is also leveraged with Title V funds and takes an active role in substance misuse cessation activities for the pregnant population. While overall percentages of smoking have significantly decreased, there continues to be a notable disparity between the overall numbers of women smoking during pregnancy who are covered by Medicaid and those who are covered by private insurance. Title V also supported work done with the State's Perinatal Substance Exposure Task Force of the NH Governor's Commission on Alcohol and other Drugs on the Plan of Safe Care (POSC) in concordance with RSA 132:10-e, which is mandated in the case of any newborn exposed to any use of alcohol, opioids, or other non-prescription drugs *in-utero*. Increase in the development of the POSC (as gathered by a field on the birth certificate workbook papers) is NH Title V's ESM.

MCH utilized part of its Title V funding for a full time Epidemiologist from UNH who conducts analyses of state and national data sets. This includes, but is not limited to, reviewing fields on the birth certificate in a timely manner to surveil not only the uptake of POSC but smoking, other substance use and a wide variety of relevant information. The MCH Epidemiologist is crucial in keeping up to date, but also acting as a "canary in the coal mine" such as alerting about the increasing numbers and rates of first time cesarean vertex births.

4. Decrease unintentional injury in children ages 0-21.

- a. Percent of infants placed to sleep on their back; percent of infants placed to sleep on a separate approved sleep surface and percent of infants placed to sleep without soft objects or loose bedding.
- b. Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19.

Both the Injury Prevention Program (IPP) Administrator and Surveillance Coordinator positions were partially funded by Title V. The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries and oversees the contracts with the Brain Injury Association, the NH Coalition for Domestic and Sexual Violence, the Injury Prevention Center (IPC) and the Northern New England Poison Center. Part of the contractual funding is from Title V. Much of the effort of these contractors is dedicated to reducing hospitalization rates for non-fatal injuries, particularly as it relates to motorized vehicles, sports, violence and poisoning. The IPC facilitates a nationally known teen driving parent resource website, ([nhteendrivers.com](http://nhteendrivers.com)), and a distribution kit for schools on the peer-to-peer process with respect to driving safety.

The Infant Surveillance Program Coordinator, funded partially by Title V, is in charge of the facilitation of the sudden unexpected death reviews and leadership of the accompanying safe sleep efforts.

5. Improve access to standardized developmental/social emotional screening, assessment and follow-up for

children and adolescents.

1. Percent of children ages 9-35 months, receiving a developmental screening using a parent-completed screening tool.

One of the Title V-funded staff members in BFCS is the CYSHCN Systems of Care (SoC) Specialist. Her responsibilities include enhancing developmental screening statewide and leadership of the NH Watch Me Grow (WMG) activities. The CDC '*Learn the Signs. Act Early*' Ambassador for NH is an employee of NHFV who works closely with the SoC Specialist to provide facilitation to the WMG Steering Committee. Title V funds also support a BFCS contract for the statewide Child Development Clinic Network which consists of an autism clinic and four locations for interdisciplinary diagnostic evaluation services for children 0-7 years of age suspected of or at-risk for delayed developmental progress.

This position also facilitates planning for the redesign of BFCS' health care coordination services to align with the National Standards for Care Coordination for CYSHCN, beginning in FY 2024.

6. Increase family support and access to trained respite and childcare providers.

1. Percentage of families enrolled in BFCS who report access to respite.

Respite activities were delayed due to the pandemic. However, some flexible funding options were made available through coordinated funding with the Social Service Block Grant (SSBG) to support families' need for a break from daily caregiving. As BFCS moves towards a new model of service delivery that combines access to health care coordination and family support, the expectation is for seamless services and decreased potential for duplication of efforts. With this change, the SSBG-funded Program Manager will likely be reclassified to a Program Planning and Review Specialist, who will look for ways to enhance the integration of these services with additional options for family support including respite. The Data Analyst and part time Evaluation Specialist will be instrumental in the transition from the current service silos to the more functional model.

Through a contract with NHFV, Title V funds are also used to provide information and resources that support families with CYSHCN. Activities include a robust website, training and education, newsletter and a phone line answered by families who are skilled at communicating with families and knowledgeable about navigating the complex system of care for children in NH.

7. Improve access to mental health services for children, adolescents and women in the perinatal period.

MCH leveraged funds with colleagues to support the Bi-State Primary Care Association in the recruitment of behavioral health professionals. Title V also leveraged the salary and benefits of the Pediatric Mental Health Care Access Program Coordinator who works across DHHS and the State in numerous workgroups, such as the State Children's System of Care Advisory Committee. This group is often the catalyst for children's behavioral health projects aligned with the Title V priority.

Components of Title V's child development clinics, complex care network, psychiatry consultation, nutrition and feeding and swallowing consultation and financial assistance for health care support, all fall under the expenditures for direct services.

In order to assure that Title V Block Grant funds are used appropriately, both the BFCS and MCH have included language in both rules and contracts to ensure that Title V funds are the payor of last resort. The BFCS Eligibility

Specialist continued to work closely with the Clinical Program Manager and Nurse Consultants to assure this requirement was met. Examples of supports provided to families with CYSHCN include medication, specialty formula/foods, durable medical equipment, pharmacy items, family support (patient travel, meals/lodging during hospitalizations, home modification, and funeral costs), office/visit fees, and professional fees for families with household income less than 185% FPL.

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[1] NH DHHS, Maternal & Child Health Section: Uniform Data Set Table, 2021.



### III.D.2. Budget

#### **How Federal support complements the State's total Title V efforts**

Federal support is essential to the preservation of a comprehensive Title V program in NH. The Title V Maintenance of Effort, made up of state general funds for both MCH and the BFCS, along with federal funding, helps to assure the implementation of NH's State Action Plan for 2021-2025.

Title V staff continue to meet routinely to discuss fiscal matters. It is important that NH Title V's budget accurately reflects the complexity of how federal dollars are used. Most of Title V funding is leveraged with other funding, principally for staffing and contracts. Because of the necessity of tracking both domains and pyramid level, all staff underwritten by Title V monitor their time allocated by population domain and then level of the pyramid. New contractual language was embedded this past year that reflects similar verbiage. Monthly invoicing and check-in calls take place with a requirement for detailed back-up documentation.

The next biennium budget planning for SFYs 24 and 25 (07/01/23-06/30/25) has begun at the programmatic level. This means that Title V staff are now preparing budgets and their requests for state, general funds. This goes through the ranks at DHHS, the Governor and then hopefully a final budget will be voted on and signed into law by the Legislature by the end of June 2023. It is always understood, but not guaranteed, that any required federal match or maintenance of effort would remain "safe" and not be under scrutiny for potential reduction in the budget process.

#### **Amounts utilized in compliance with the 30%-30%-10% requirements**

NH will continue to comply with the federal 30%-30% 10% requirements. Services for CYSHCN are financially compensated by an MOU, last signed in 2009. This MOU will be revisited at the same time as the next five year needs assessment process.

Both the BFCS and MCH plan to utilize Title V funds in the FY23 application year to support activities and services consistent with the goal of improving the system of care for the MCH and CYSHCN populations. Funds are strategically placed to support the identified priorities and accompanying National and State Performance Measures as explained below.

Need 1. Improving access to needed healthcare services for all MCH populations.

##### Domain: Adolescent

NPM #10 Percent of adolescents, ages 12-17, with a preventive medical visit in the past year.

ESM #10.1 Percent of adolescents, ages 12-21, at the MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or and OB/GYN practitioners.

MCH intends to continue leveraging Title V funding for all four of the positions in the Quality Improvement and Clinical Services from 100% of the Child/Adolescent Clinical Nurse Consultant to 20% of the Pediatric Behavioral Health Care Access Coordinator. Staff monitor the Title V funded Community Health Centers (CHCs), all of whom focus on the adolescent well visit as both a performance measure and a quality improvement project. MCH also intends to continue its work with Medicaid Quality as the adolescent measure is one of their priorities.

MCH is going to, for the first time, leverage state general Title V funds to support the implementation of *Healthy Families America*, the evidence based home visiting program MCH's Home Visiting Program oversees. These funds will be leveraged with HRSA's Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant to support two agencies in the most rural areas. Many of MIECHV's performance measures directly measure screening and

referrals into necessary health care.

Domain: CYSHCN

NPM #12: Percent of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care

ESM #12.1: The percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program

BFCS Health Care Coordinators, who are State employees, and those working under a community agency contract along with Family Support Coordinators provide assistance to youth and families with transition activities. Coordinators provide a TRAQ survey to youth and their families beginning at age 14 and upon completing, they work together to identify a goal. A contract with NHFV provides health-care transition-focused training, consultation and technical assistance to coordinators, administrators, health providers/practices, and MCOs.

Need 2. Decreasing the use and abuse of alcohol, tobacco and other substances among pregnant women.

Domain: Women

NPM #14.1: Percent of women who smoke during pregnancy.

ESM #14.1: Percent of postpartum women whose infant was monitored for the effects of *in utero* substance exposure and had a documented Plan of Safe/Supportive Care.

The full time Perinatal Coordinator and MCH Epidemiologist, leveraged with Title V funding, will be working collaboratively on this measure with stakeholders including the Northern New England Perinatal Quality Improvement Network (NNEPQIN), the Perinatal Substance Exposure Task Force, all of the birthing hospitals/centers and CHCs among others. New this upcoming year will be leveraged funding with Title V for NNEPQIN's contract to increase the breadth of this work.

Need 3. Increase the focus of Title V on the Social Determinants of Health (SDOH) and the resolution of barriers impacting the health of the MCH population.

Domain: Cross Cutting

SPM #1 Percentage of MCH-contracted community health centers who have met or exceeded the target of their enabling services work plan.

The new Title V funded CHC contracts, beginning in June of 2022, mandate the implementation of screening for SDOH, particularly for the MCH population. MCH's Quality Improvement and Clinical Services Program staff will work directly alongside the CHCs in this effort.

Need 4. Improving access to mental health services for children, adolescents and women in the perinatal period

Domain: Cross-cutting

SPM #3: Percentage of Pediatric Mental Health teleconsultation encounters utilized by NH Pediatric Primary Care Providers

The Title V leveraged Pediatric Mental Health Coordinator continues to expand capacity in what is a consistent shortage of behavioral health care in the State.

Need 5. Decreasing unintentional injury in children ages 0-21

Domain: Adolescent

NPM #7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10-19

ESM #7.2.1: Percentage of high school students who wear a seatbelt

Unintentional injuries continue to be the leading cause of death and disability in adolescents. Prevention efforts have consistently met the objectives for both the NPM and the ESM through proven, evidence based strategies. New this upcoming year will be a restructuring of the budget to enable additional Title V funds for the Injury Prevention Center at Dartmouth Children's Hospital contract, a key collaborator with MCH's Injury Prevention Program.

Domain: Perinatal/Infant

NPM #5: A) Percent of infants placed to sleep on their back

B) Percent of infants placed to sleep on a separate approved sleep surface

C) Percent of infants placed to sleep without soft objects of loose bedding

ESM #5.1 Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding

The Safe Sleep Work group, newly reformed and led by the Title V leveraged Infant Surveillance Program Coordinator, meets routinely in the pursuit of all parts of this NPM.

Need 6. Increasing family support and access to trained respite and childcare providers

Domain: CYSHCN

SPM #2: Percentage of families enrolled in BFCS (formerly SMS) who report access to respite

BFCS provides financial support for respite to eligible families and conduct needs assessment/planning activities focused on this need.

Need 7. Improving access to standardized developmental screening, assessment and follow-up for children and adolescents

Domain: Child

NPM #6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year

ESM #6.1: The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WGM) system.

BFCS is the identified lead for the WGM system. The CYSHCN Systems of Care Specialist provides leadership and coordination for the system's activities. Child development clinics are provided through a contract with a community health center for referring CYSHCN in need of assessments following a positive screening.

**Sources of other federal MCH Dollars, state matching funds and other state funds used to support NH's Title V Program**

Sources of other federal dollars, as indicated on Form 2, include grants from HRSA's Maternal and Child Health Bureau, the Centers for Disease Control and Prevention (CDC), the Administration for Children and Families (ACF) and other federal agencies. These grants are often leveraged with Title V funds in order to support a complete FTE or a contract designed to implement an ESM. Some (but not all) of the grants whose objectives align with Title V are the following:

The State System Development Initiative grant from HRSA funds 0.8 FTE and Title V funds add on to make a complete 1.0 FTE whose responsibilities include supervision and implementation of the Title V five-year needs assessment and ongoing data needs to support the overall functioning of MCH. This position, the MCH Data Scientist/Data and Decision Making Program Administrator, is critical to Title V functioning, needs assessment preparation and implementation.

The Universal Newborn Hearing Screening and Interventions grant from HRSA and Early Hearing Detection and Intervention from the CDC are used to fund the implementation of the State's universal newborn hearing screening program including FTEs for in-house administration, database maintenance, quality assurance, a follow-up coordinator and a contracted consulting audiologist. The latter is a new audiologist, who took over from a colleague who retired after two decades of working with the program since its inception. This new audiologist practices in the northern part of the state where the needs specifically for infant and pediatric audiology, have been underserved.

The State Personal Responsibility Education Program grant through ACF is used for the implementation of an adolescent pregnancy prevention curriculum, contracted in two areas of the state with the highest adolescent birth rates. The Family Planning Program is funded with the Office of Population Affairs, state general funds and federal Temporary Assistance for Needy Families dollars.

The Pregnancy Risk Assessment Monitoring System (PRAMS) grant from the CDC is used to carry out the PRAMS survey, which collects state-specific, population-based data on maternal attitudes, behaviors and experiences before, during and after pregnancy. PRAMS is the data source for NPM5 on Safe Sleep. The funding allows for execution of the survey, including 1.6 FTEs to manage it.

The Sudden Death in Youth (SDY) and Sudden Unexpected Infant Death (SUID) grants from the CDC allow for collaboration with the Office of the Chief Medical Examiner to collect data on and review by committee all SUID and SDY deaths in the State. The Infant Surveillance Program Coordinator who oversees this grant is also in charge of the Title V safe sleep performance measure and her salary is leveraged with Title V funds.

The Opioid Data to Action grant from the CDC focuses on seven (7) multi-disciplinary strategies, from surveillance to prevention programming, all on opioid misuse, and is MCH's largest grant at just over three million dollars. MCH's Injury Prevention Program has oversight and the grant leverages all of its positions along with Title V funds.

A portion of the Preventive Health and Health Services Block grant from CDC funds part of MCH's contracts for statewide injury prevention activities with the Injury Prevention Center at Dartmouth whose focus is on Title V National Performance Measure #7.2. This contract is newly leveraged with Title V funds.

The Pediatric Mental Health Care Access Program grant from HRSA established a NH Pediatric Mental Health Team comprised of specialists in the field who are providing education, support, and consultation to pediatric primary care providers using the Project ECHO telehealth model. The Project Investigator is also the Pediatric Behavioral Health Care Access Coordinator with her salary leveraged with Title V.

The Community Collaborations to Strengthen and Preserve Families grant is from the Administration on Children, Youth and Families: Children's Bureau. The Administrator for this grant works with three communities to establish an integrated continuum of family support, with community based services such as family support groups and economic teaching (such as on the earned income tax credit) to increase protective factors in families. This grant has been leveraged with several COVID pandemic and ARPA grants from various federal agencies to establish additional early childhood initiatives. One includes a focus on training perinatal health care providers on establishing a Plan of Safe Care for birthing people with SUD earlier in the pregnancy than at the time of delivery. Another leverages funding from different sources for 1.0 FTE dedicated to increasing the utilization of community health workers in the state specifically working with the MCH population.

Social Services Block Grant (SSBG) from the Office of the Administration for Children and Families. BFCS coordinates the application and reporting for NH's SSBG grant that provides funding across four (4) DHHS Bureaus

and administers a portion of this grant for the operation of the Partners in Health Program (PIH) including 2 FTEs. PIH is a statewide community-based program that provides support to families of children, from birth to 21 years, with chronic health conditions and young adults themselves, regardless of income. PIH's role is to assist, access resources, navigate systems and build family/individual capacity to manage the chronic health condition.

Part C of IDEA from the Office of Special Education of the Department of Education. BFCS administers the Part C grant in NH referred to as Family Centered Early Supports and Services (FCESS) with 2.5 FTEs. The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive state-wide program of early intervention services for infants and toddlers with disabilities serving ages of birth through age two (2) years, and their families.

The "Other Funds" column comes from the state's designated or "revolving" fund dedicated specifically for the newborn screening program. Funds are generated by fees from the newborn screening filter paper and are paid by the State's birthing hospitals dependent upon the number of births.

### **III.E. Five-Year State Action Plan**

#### **III.E.1. Five-Year State Action Plan Table**

**State: New Hampshire**

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

### III.E.2. State Action Plan Narrative Overview

#### III.E.2.a. State Title V Program Purpose and Design

New Hampshire's Title V is located within two distinct areas of the Department of Health and Human Services (DHHS). The Maternal and Child Health Section (MCH) resides in the Bureau of Population Health and Community Health Services within the Division of Public Health Services (DPHS). The Bureau for Family Centered Services (BFCS) sits within the Division of Long Term Supports and Services (DLTSS). BFCS is made up of three units that integrate services to meet the needs of CSHCN and their families. These are Special Medical Services, Family Centered Early Supports and Services (NH's Part C program for infants and toddlers with developmental delays), and Family Support for CSHCN and individuals with developmental disabilities across the lifespan. However, despite their placements in different organizational divisions, both MCH and the BFCS share the same DHHS mission in "joining communities and families in providing opportunities for citizens to achieve health and independence. This is done by:

- Meeting the health needs of NH citizens;
- Meeting the basic human needs of NH citizens;
- Providing treatment and support services to those who have unique needs including disabilities, mental illness, special health care needs or substance abuse problems and
- Protecting and caring for NH's most vulnerable citizens."<sup>[1]</sup>

This reflects the national mission of "providing a foundation for family and community health across the State and in assuring access to the delivery of quality health care services for mother, infants and children, including CYSHCN." Building upon this, NH's Title V staff and programs have no one definitive framework, rather taking a generalized life course approach focusing on all people, acknowledging that people live within families and communities, have a trajectory of experiences which build one upon the other leading to self-determination, social capital, economic sufficiency, and community inclusion.<sup>[2]</sup> Everything is looked at with an equity lens.

The Title V Director is the Administrator of the Maternal and Child Health Section. Her colleague is the Bureau Chief of Family Centered Services. Both have worked in the maternal and child health fields for over sixty years combined. MCH and BFCS have historically worked together for decades. Their relationship is based on a signed agreement granting the BFCS 41% (out of the required 30%) of the \$1.9 million in Title V funding with MCH receiving the other 59%.

DHHS is led by a Governor appointed Commissioner who is a nurse with a long background in health facility management. DPHS's Director comes from a background well acquainted with Title V in that she previously served as the MCH Administrator for over ten years. The new DLTSS Director is an experienced Social Worker with a long history of working within the health care industry. All have a deep knowledge of and most importantly show great support for Title V and its activities within the State.

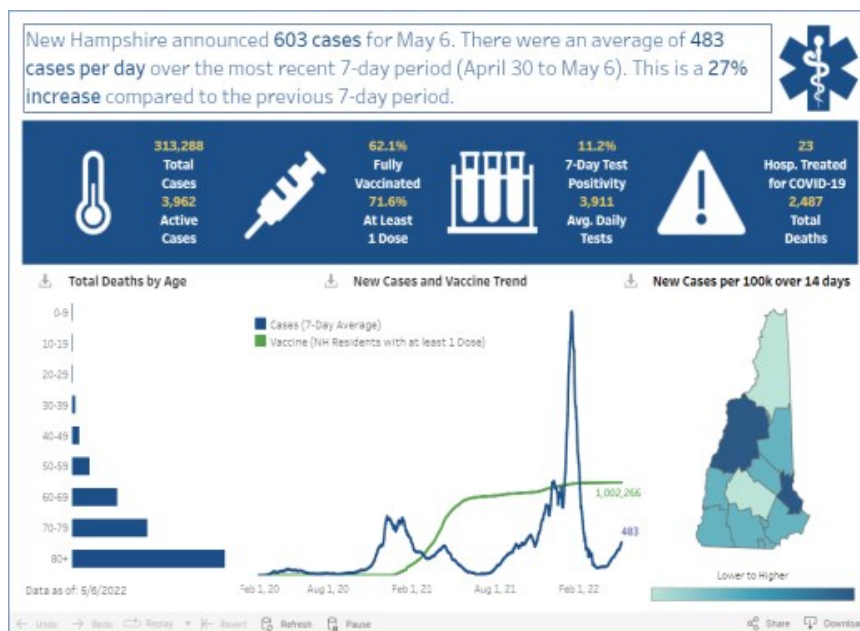
The Republican Governor Christopher Sununu is in his second year of a third two-year term with intention to run for re-election in November 2022. Rounding out the State's government is one of the world's largest bicameral, citizen-led legislatures at 424 members (400 representatives, 24 senators; currently both Republican controlled) and the Governor's Executive Council, a body of five elected Councilors (currently four Republican and one Democrat) who approve all State contracts and expenditures over the amount of ten thousand dollars. There is also a legislated Senate/House Fiscal Committee, which accepts and agrees to expend any outside (e.g. Federal) dollars within a biennium budget period and a Senate/House Health and Human Services Oversight committee, which is presented numerous Title V reports from legislated committees such as newborn screening, maternal mortality, child fatality,

and the Council for Youth with Chronic Conditions. A good portion of at least a day or two per week of any Title V staff person's day is spent writing and editing items such as a Governor and Executive Council letter explaining the contents of a contract in layman's terms, putting together a written justification of the necessity and health benefits of accepting a federal grant (including carryovers) for the Fiscal Committee or putting together a literature review of best practices and financial costs for a legislative study request (the step before a piece of legislation becomes a bill). Thus, in NH, the government and politics has an oversized role in the daily functioning of Title V.

Currently, NH is near the end of the first year of a biennium budget. Programmatically, Title V staff will be drafting State Fiscal Year 24/25 budget proposals (07/1/23-06/30/25) during the spring and summer of 2022. Division Directors then move budgets to the Department level before they are sent to the Governor for consideration. The State Legislature (all seats are up for re-election in November 2022) will begin its involvement at the start of the session in January 2023. Title V requires a general state fund match of \$2,872,257. Between MCH and the BFCS, the match is usually not a problem. However, for the last decade, these general funds have been reduced. This creates a level of fiscal insecurity during each budget session.

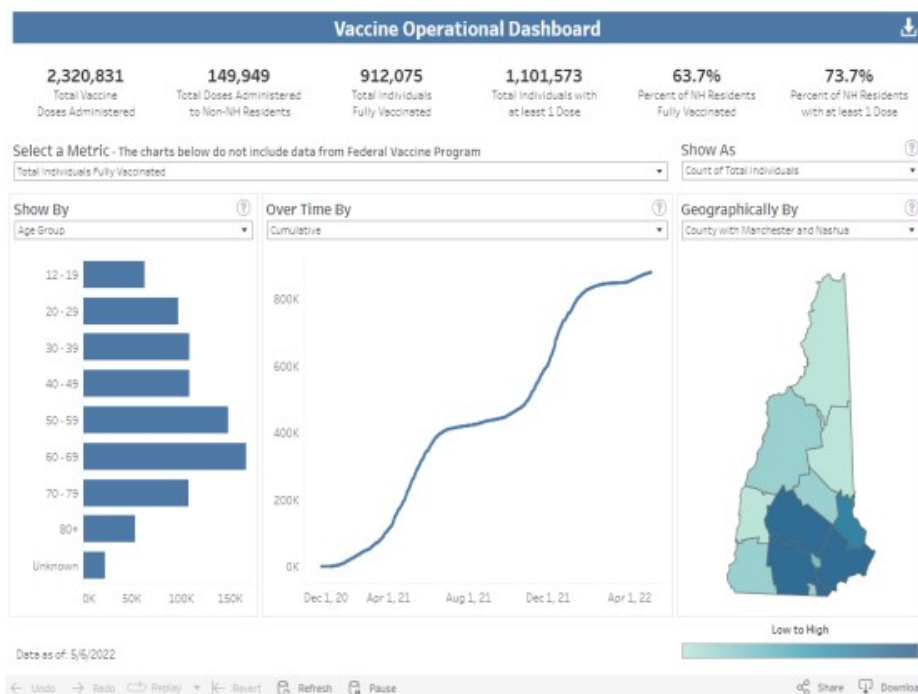
During the last year, the COVID-19 pandemic was still very much a part of NH's Title V staff's professional and personal lives. Prioritization of time and funding was and continues to be given to the response. Some staff, particularly those with clinical backgrounds, were asked to help with the large variety (large scale events; fixed sites, etc.) of COVID-19 vaccination efforts across the State, from participation in the DHHS Coordinated Response Team, working with the DPHS Bureau of Infectious Disease surveilling pregnant moms with COVID, making calls to monitor the concerns of contracted agencies and their clients, realigning contractual funds to better reflect the costs of the pandemic, assisting families with CSHCN in need of personal protective equipment and gaining expertise in telehealth issues, among many other duties, Title V staff played, and continue to play, an integral role in the COVID-19 pandemic response.

COVID statistics for NH are fairly similar to other New England states with the exception of its immunization percentage, which is lower. Like elsewhere, the number of those with severe disease, hospitalizations and deaths fortunately keeps decreasing.



[3]





[4]

The Governor opened State buildings to the public in May of 2021 and the rest of his emergency orders expired the following month. There are no current mask mandates anywhere in the State, with the exception of inside a direct contact health care facility. Although buildings are now open, nothing is as it was before the pandemic, with the majority of Title V staff continuing to work a hybrid schedule, alternating between teleworking and being in the office.

MCH has grown substantially in the past decade juxtaposed to also having retained a long term workforce. Forty-one percent of Title V's workforce has been in their position within DHHS for less than ten years and 63% are under the age of 50. MCH has 29 positions (25 FTEs including a contracted 1.0 FTE Epidemiologist and three part-time staffers for an additional 1.8 FTEs). There is also an additional unfunded, part-time position 'on the books' for future planning efforts. Positions have also developed to encompass more of the activities related to the performance measures and ESMS, such as the full-time Perinatal Coordinator and the Child-Adolescent Clinical Coordinator, broadening the availability of staff dedicated to core Title V services. MCH currently has seven programmatic units: Data/Decision Support; Infant Surveillance; Injury Prevention; Home Visiting; Quality Improvement and Clinical Services; Women's Health; and Community Engagement Programs (formerly Early Childhood Systems).

Much of Title V funding is braided to support staff and into contracts to implement strategies consistent with the MCH Block Grant's Five Year State Action Plan.

Within MCH, Title V funds two FTEs in full, three FTEs are cost allocated and 10 FTEs have leveraged support. Several grants have remained level-funded and have not kept up with personnel cost of living and salary increases, necessitating the leveraging with Title V in order to maintain full-time positions. Braiding of Federal grant and State general funding supports is crucial for an effective Title V workforce. In MCH, the Administrator, Executive Secretary and MCH Program Specialist are cost allocated across all of MCH's Federal grants and state general funds. Title V funds all of the Quality Improvement and MCH Clinical Services unit in full or in part which includes the Child-Adolescent Health Nurse Consultant (fully Title V funded), the Perinatal Coordinator, the Pediatric Mental Health Care/Access Program Coordinator, and the QI/QA and Clinical Services Program Manager. This last position, among other responsibilities, oversees the evaluation of all programming and makes specific recommendations and

required actions to meet the goals of the Title V National and State Performance Measures (NPM and SPM).

Title V also funds a portion of the Injury Prevention Program Manager and the Injury Surveillance Coordinator who seek to reduce morbidity and mortality due to intentional and unintentional injuries and oversee the contracts with the Brain Injury Association (Title V funded), the NH Coalition for Domestic and Sexual Violence, the Injury Prevention Center at Dartmouth Health (Title V funded) and the Northern New England Poison Center.

Leveraged Title V funds also support MCH's Data Scientist/SSDI Project Director, Birth Conditions Program/Early Hearing Screening Follow-Up Coordinator, Infant Surveillance Program Coordinator and Newborn Screening Program Manager.

MCH utilizes part of its Title V funding for a PhD level public health epidemiologist from the University of New Hampshire (UNH), who has worked with Title V for over two decades, conducting analyses of state and national data sets related to maternal and child health. He, in conjunction with MCH's Data Scientist/SSDI Project Director, oversee and lead MCH's Data/Decision program unit along with several data analysts in other programmatic units such as Injury Prevention, Home Visiting and QI and Clinical Services. Recently, the longtime MCH Epidemiologist left his position to work as a full-time consultant, necessitating the year long search for another Epidemiologist within the context of the UNH contract. The new MCH Epidemiologist started in May of 2022, freshly off a three year period of post-doctoral work in maternal and child health epidemiology at the University of Tsukuba in Japan. This is an exciting period for NH's MCH as the MCH Epidemiologist will be working a full FTE (as opposed to the 0.8 FTE worked by the former MCH Epidemiologist) as well as initiating what hopefully will be a long term career in the field.

MCH is looked upon as the "keeper and assessor" of all data related to maternal and child health. This is one of the core public health functions that are supported by Title V. As an example, the Injury Prevention Program completed and did its first annual data update of the "State of New Hampshire, Violence and Injury Prevention Five Year Plan (State Injury Plan)."<sup>[5]</sup> Title V supported the Injury Surveillance Coordinator in retrieving, analyzing and presenting core injury data such as hospital discharges, YRBS and vital records data such as births and deaths. This data was utilized as the foundation of the State Injury Plan as well as its evaluation and also became part of the Title V needs assessment which led to NH choosing NPM #7 Rate of Hospitalization for Non-Fatal Injury per 100,000 Adolescents Ages 10-19. The Injury Surveillance Coordinator also works with the Infant Surveillance Program Coordinator in gathering the data to look at efforts related to another of NH's chosen measures, NPM#5, around infant safe sleep. The contracted Injury Prevention Center at Dartmouth Health and the Brain Injury Association then take MCH's data analysis and utilize it to implement statewide evidence based programming and evaluation addressing unintentional injuries in adolescents.

Another example of the core assessment function is the MCH Data Scientists/SSDI Project Director's work with the PRAMS data. In the past year, she has released several data briefs including "Vaping / Smoking / Marijuana, 2016-2019."<sup>[6]</sup> This brief reports that vaping has increased the number of persons giving birth who are exposed to nicotine; before pregnancy from 14% who smoked cigarettes only, to 22% who did either or both, smoking and vaping; and during pregnancy, from 8% who smoked cigarettes only to 10% who did either or both, smoking and vaping. It also reported that vaping in the two years before pregnancy was significantly associated with low birth weight. The conclusion was that dual use of substances is widespread, even during pregnancy, when dual use ranged from nearly 6% of marijuana users who also vaped, to nearly 12% of smokers who also vaped, to 37% of smokers who also used marijuana. All of this directly impacts Title V's efforts on NPM#1, Percent of Women Who Smoke During Pregnancy.

Title V funds the birth conditions piece of the Birth Conditions Program/Early Hearing Screening Follow-Up Coordinator. NH's Birth Conditions Program, which restarted in 2018 after a six year hiatus, will be coming out with

two years of aggregated data in the upcoming months. This has been a work in progress as the staff person needed to rewrite the Administrative Rules, renegotiate chart access in all of NH's birthing hospitals and restart an abstraction process. It will be interesting to see where this data leads NH's Title V.

The former and current MCH Epidemiologists lead the State in assessing data for the Alliance in Innovation in Maternal Health (AIM). Work on this, which includes many efforts on implementing AIM's patient safety bundle, "Care for Pregnant and Postpartum People with Substance Use Disorder"<sup>[7]</sup> with colleagues at the Northern New England Perinatal Quality Improvement Network (NNEPQIN) at Dartmouth Health also addresses NPM#1.

Five of the seven MCH Block Grant State Action Plan priorities highlight access to services: needed healthcare, mental health services, family support, social determinants of health and developmental screening. Title V sees itself as the "enhancer" or "enabler" of access to quality health care services of all kinds for the MCH population, including CYSHCN. Title V funding decisions are made based on gap assessments founded on discussions of the State's health care system and the needs assessment process, which looks at health outcomes as well as process measures. This is revisited every year. For example, MCH's Quality Improvement and Clinical Services programmatic unit (consisting of the Perinatal Coordinator, Pediatric Mental Health Care/Access Program Coordinator and Child/Adolescent Health Nurse Consultant lead by the QI/QA and Clinical Services Program Manager) use the data provided by their colleagues and Title V contractors to assess the quality of the maternal and child health in the State and then lead or participate in innovative and evidence based or informed approaches to address issues. This is reflected in the work around workforce and the shortage of pediatric mental health practitioners. The Pediatric Mental Health Care/Access Program Coordinator leads a Project ECHO on pediatric psychiatric providers engaging a group of primary care providers on best practices. This MCH staff member also facilitates a Title V funded contract with the Bi-State Recruitment Center specifically geared towards increasing staffing in mental health shortage areas.

MCH's Quality Improvement and Clinical Services programmatic unit worked tirelessly this past year to write and release the Request for Proposals entitled "MCH in the Primary Care Setting" as well as closely review the 10 proposals received. Currently those 10 community health centers (CHCs) are and will be receiving Title V funds in their mission to provide accessible and affordable comprehensive primary care and perinatal services, with a focus on reproductive age women and children. Funds are the last payer of resort for the very small percentage of women and children who are not insured, and mainly go to enabling services such as case management, transportation and interpretation services, that are not reimbursed elsewhere. The successful implementation of the CHCs' enabling services workplans address SPM#1, Percentage of MCH-contracted Community Health Centers that have met or exceeded the target indicated on their NH DHHS/MCH Enabling Services workplan. Another portion of every contract is dedicated to quality improvement projects such as getting adolescents into annual care; increasing the number of pregnant women receiving tobacco cessation services; and increasing the usage of highly effective contraceptive methods. The QI projects all address the NPMs in some way. The QI/QA and Clinical Services Program Manager, the Child/Adolescent Health Nurse Consultant and the Perinatal Coordinator, all nurses with "boots on the ground" clinical experience, guide the agencies by tracking health outcome performance measures (such as the frequency of the adolescent well visit, and breastfeeding initiation and duration) and helping to design effective programs to both screen and address the social determinants of health, which are often barriers to care.

NH Title V staff and its contractors lead by calling attention to emerging issues, thinking strategically, facilitating analysis, and educating on best practices. Title V looks for gaps and tries to fill them, in alignment with priority areas. MCH continues to work in tandem with the State's Vital Records (overseen by the Secretary of State) and continued to collect birth certificate data including drug exposure, naloxone discussions and Plans of Safe Care questions. This addresses a NH Title V priority area, the need to decrease the use and abuse of alcohol, tobacco and other substances among pregnant women.

Title V also has the role of convener as well as participant in many statewide groups such as advisory committees, for example: Newborn Screening, Birth Conditions, PRAMS, and Early Hearing Screening (all led by MCH staff); mortality review groups such as Maternal Mortality, Sudden Unexpected Infant Death, Sudden Death in Youth and Child Fatality (also led by MCH staff); as well as legislatively enacted Councils such as the NH Council on Autism Spectrum Disorders (MCH and BFCS), the Perinatal Substance Exposure Task Force (a subcommittee of the Governor's Commission on Alcohol and Other Drugs), the NH Pediatric Improvement Partnership out of the University of New Hampshire (MCH and BFCS), and the Council for Youth with Chronic Conditions (BFCS). In addition, BFCS leads the Interagency Coordinating Council and participates in the Transition Community of Practice (CoP) and the Charting the Life Course CoP.

BFCS has 18 positions that provide leadership, administer, manage and implement programs and services for children with special health care needs and their families. Title V services for CSHCN are organized in accordance with the Standards for Systems of Care for Children and Youth with Special Health Care Needs Version 2.0. Title V funds the following BFCS positions: the CSHCN Director/Bureau Chief, Data Analyst, Evaluation Specialist (formerly the Program Data Specialist - part time), Systems of Care Specialist, Clinical Program Manager, one Nurse Consultant (formerly a health care coordinator), two nurse health care coordinators, one Health Care Coordinator, one Eligibility Technician, and two administrative support staff.

In addition, BFCS employs a Family Support Administrator who provides oversight for the Part C Early Supports and Services program and Family Support for individuals with developmental disabilities, and is funded with state general funds. Her staff includes the Part C Early Supports and Services Coordinator, a Program Specialist, and a Program Assistant (part time – vacant), all funded by the US Department of Education, Office of Special Education Programs (OSEP) Part C grant. The Partners in Health Program Manager and Program Assistant (vacant) are funded by the Social Services Block grant under the Service Category of Special Services for Persons with Developmental or Physical Disabilities, with the goal of preventing or reducing inappropriate institutional care by providing community-based care, home-based care, or other forms of less intensive care.

BFCS supports seven Title V-funded contracts. These contracts primarily focus on systems access, infrastructure development and improvement, and a small percentage for direct services. The support to the system of care includes statewide programming for three contracts. The first is a Child Development Clinic Network, which consists of an autism clinic and four locations for interdisciplinary diagnostic evaluation services to children 0-6 years of age suspected of or at risk for altered developmental progress. Next is a comprehensive Complex Care Network that incorporates interdisciplinary clinics and specialty consultation to providers serving CSHCN that is child specific or that addresses questions that are more general. Third is a Comprehensive Nutrition and Feeding/Swallowing (F/S) Consultation Network, which offers community-based consultation and intervention services utilizing a home visiting method of service delivery.

BFCS uses Title V funds to support training to potential providers, in addition to direct service to patients. Early in 2022, the contractor for Comprehensive Nutrition and Feeding/ Swallowing Consultation Network notified BFCS that the subcontract they held for F/S Consultation would end June 30, 2022. The community-based agency is in the process of reorganizing how these services will continue in the new fiscal year. In addition, BFCS was recently informed that the former F/S Program Coordinator will begin providing F/S services at a local hospital. This newly created position will increase NH's capacity for specialty feeding and swallowing services as a result of Title V work to identify and address gaps in access.

BFCS also funds two contracts with the New Hampshire Coalition for Citizens with Disabilities Inc. d/b/a/ Parent Information Center. Led by NH Family Voices, the first supports and enhances the State's Family-to-Family

programming to assist families with CSHCN to navigate the system of care, maintain a virtual resource center on their website, assist family advisories/councils, and provide a comprehensive lending library. Additional funding is braided into the contract from SSBG to support the Partners in Health Training services and from the Child Development and Head Start Collaboration office for coordination of the Birth through 8 Early Childhood Care and Education Advisory Team. In a recent contract amendment, two additional activities were added to the scope of services. The first is in collaboration with MCH for family engagement work with the B-8 Council and the other is in collaboration with the Bureau of Child Development and Head Start to support Watch Me Grow developmental screening system activities (NPM#6). The second contract, also led by NHFV, is specific to supporting NH's work on NPM#12, Youth Health Care Transition. In addition to the three Health Care Coordinators employed by BFCS, a community contract, Health Care Coordination, provides five additional coordinators to ensure statewide coverage.

BFCS braids funding to work on collaborative efforts including one with DHHS's Bureau of Developmental Services (BDS) for a contract that enhances access for CSHCN to Psychiatry Services, limited to one-time direct assessment, consultation, and short-term condition/ medication management. BFCS is the lead agency for Watch Me Grow (WMG) activities within DHHS addressing NPM#6.

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[1] Retrieved from <https://www.dhhs.nh.gov/about/mission.htm> on 04/27/22.

[2] Retrieved from <https://www.lifecoursetools.com/lifecourse-library/lifecourse-framework/> on 04/27/22.

[3] Retrieved from [Welcome | NH COVID-19 Response](#) on 05/09/2022.

[4] Retrieved from [Vaccination | NH COVID-19 Response](#) on 05/09/2022.

[5] Retrieved from <https://www.dhhs.nh.gov/dphs/bchs/mch/documents/nh-vip-plan-2020-2025.pdf> on 05/10/2022.

[6] Retrieved from [prams-datasummary-2020.pdf \(nh.gov\)](#) on 05/10/2022.

[7] Retrieved from [Care for Pregnant and Postpartum People with Substance Use Disorder | AIM Program \(Previously Council on Patient Safety\) \(safehealthcareforeverywoman.org\)](#) on 05/10/22.

### **III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems**

#### **III.E.2.b.i. MCH Workforce Development**

##### **Recruitment and retention of a qualified Title V program staff**

Entering into the third year of the COVID-19 pandemic, NH's Title V workforce is still adjusting to a new normal. State Office buildings were re-opened to the public in May of 2021. There are still behavioral efforts at the reduction of disease prevention such as social distancing, but masking is not mandatory and there is no daily temperature monitoring. Approximately 63% of NH residents able to receive the vaccine, are fully vaccinated as of this writing. Nonetheless, there is no mandate to be vaccinated to come to work. That being said, DHHS has a telework policy in place which supports the flexibility of a working environment dependent upon the position. Many of the Title V staff, again both MCH and BFCS, are working a hybrid schedule, meaning a mixture of home and office as their base. BFCS hybrid staff work two days remotely and three in office in accordance with policy. However, the majority of MCH staff, with the exception of newborn screening and management, spend much of their hybrid schedule at home. Thus, making for a very quiet and at times lonely environment in the office and requires the continuation of meetings on the computer. This is only interrupted by some legislatively mandated meetings (e.g. fatality reviews), which have to now meet in person because of the cancellation of the Governor's emergency declaration in mid-2021, which had enabled them to meet virtually. Other legislatively mandated meetings, including the CYCC and Council on Autism Spectrum Disorders, continue to meet virtually, allowing family members of CSHCN to participate from the safety of their homes.

This past year has continued to be difficult personally for many Title V staff, particularly those with young and school age children. Schools and day care programs are open but have strict illness policies. A cough or slight cold could send a child home. All COVID-related emergency paid sick leave and emergency paid family leave, two policies in accordance with the federal Families First Coronavirus Response Act, ended at the close of March 2021. Thus, on any given day, Title V has a reduced in-office FTE count dedicated to the implementation of its many programs.

Despite all of the above MCH has continued to grow its workforce. MCH has 29 positions (25 FTEs including a contracted 1.0 FTE Epidemiologist and three part-time staffers for an additional 1.8 FTEs). There is also an additional unfunded, part-time position 'on the books' for future planning efforts. Title V funds 12 of the positions in part and three in full (an increase from last year). Positions have also developed to encompass more of the activities related to the performance measures and ESMS, such as the full-time Perinatal Coordinator and the Child-Adolescent Clinical Coordinator, broadening the availability of staff dedicated to core Title V services. Several grants have remained level-funded and have not kept up with personnel cost of living and salary increases, necessitating the leveraging with Title V in order to maintain full-time positions. Braiding of Federal grant and State general funding supports is crucial for an effective Title V workforce. MCH currently has seven programmatic units: Data/Decision Support; Infant Surveillance; Injury Prevention; Home Visiting; Quality Improvement and Clinical Services; Women's Health; and Early Childhood Systems.

Within the past year and a half, MCH has hired four positions which require a nursing degree, two in Infant Surveillance (Newborn Screening Program Coordinator and Newborn Screening Follow-Up Coordinator) and two in Quality Improvement and Clinical Services (Perinatal Coordinator and the Child-Adolescent Clinical Coordinator). Typically, this had been difficult because all State salaries, but particularly ones requiring a direct, health care background, are compensated with salaries significantly less than what one can earn in private, clinical positions. Even more so for those in public health. However, State positions do have what are considered 'excellent' health and other benefits. During the pandemic, recruitment seems to have been aided by the fact, seen across the country and in NH, that providers were leaving clinical service due to burnout. MCH also hired a CQI Coordinator in Home Visiting as well as a similar position in Newborn Screening. It is interesting to observe that most of the new

employees commented that not only the benefits enticed them, but so did the teleworking options and the 'families first' environment that both Title V entities, MCH and the BFCS, are known for. At this current time, only the Clinical Services Program Manager within MCH is vacant.

A recent resource that MCH has utilized is the CDC's COVID-19 Public Health Workforce grant that DPHS received this past year (going through Federal Fiscal Year 2024), which has paid for position listing advertisements on LinkedIn and other similar platforms. This gave Title V the ability to set parameters (e.g., demographics, job skills) to help increase the listing's visibility. Additionally, DHHS shared the job listing on their own account in an effort to share with their current network. This allowed users who are in DHHS's network to be aware of the posting, giving them the ability to share with their own network with the goal of increasing the job listing's reach.

DPHS also just initiated a division wide workforce committee looking at additional strategies such as increasing professional development opportunities, maintaining membership in a wide variety of national and statewide professional groups (e.g. AMCHP) and tuition reimbursement.

Another recruitment and retention strategy that MCH employed during the past year is the reclassification of seven (five entirely or partially funded by Title V) of the 29 positions to a higher labor grade. Within a labor grade are nine steps that an employee, upon a satisfactory annual evaluation, can move through, albeit at a very slow pace. Reclassifying is a professional development path that enables the current workforce to grow within the context of Title V and not have to seek alternative employment elsewhere. There is currently no promotion if job duties or expertise increase. Reclassifying a position to a higher labor grade is particularly difficult with many forms needing to be filled out, having the finances necessary, and going through both DHHS's Human Resources Division, and with the final say coming from the State's Department of Administrative Services, Division of Personnel. This whole process can take up to a year and is still ongoing for six of the seven positions (one was approved).

The Bureau for Family Centered Services (BFCS) lost four long-time employees to retirement in FY 2022. The Bureau has 18 positions (16 FTE and 2 PT). Program areas including Partners in Health family support for children with chronic conditions, funded by the Social Services Block Grant; Family Centered Early Supports and Services Part C Early Intervention, funded by the Office of Special Education; Family Support for individuals with Developmental/Intellectual Disabilities, funded with state general funds; and Title V activities for CYSHCN. Currently, there are 11 FT and 1 PT positions funded by Title V.

Following several years of recruitment and retention challenges, the decision was made to seek reclassification for all three BFCS Public Health Nurse Coordinators (PHNC) to become Public Health Nurse Consultants, which is a two-labor grade increase. One PHNC position was vacant since April 2021, was the first to be approved, and was recently filled with a new hire scheduled to start mid-June. Requests for the other two positions are in the approval process. BFCS also requested and received approval to reclassify a former Data Control Clerk, vacant as of 1/1/22, to a Program Assistant II (PAII). Cheryle Conroy was hired as the new PAII, June 3. A second PAII has been hired and is scheduled to start June 17. The Bureau was also successful in hiring a new Financial Eligibility Specialist who was promoted from the Partners in Health Program Assistant II position in March 2021. Nicole Brunini is using her business and financial background to support the application, eligibility and fiscal processes for BFCS. Finally, a series of promotions in the Part C program resulted in Nicole Bushaw becoming the Part C Coordinator and Liz Sommers, the new Part C Program Specialist III.

Recruitment is underway for a full-time PIH Program Assistant, a part-time Program Assistant for Family Centered Early Supports and Services (FCESS) Part C, and a part time Evaluation Specialist. Sadly, the nurse coordinator hired in 2021 has decided to return to direct care and recently tendered her resignation, effective June 16. Once the position reclassification is approved, recruitment for the Nurse Consultant will begin.

On a statewide level, Title V staff participated with colleagues led by the Endowment for Health on the development and publication of *Giving Care: A Strategic Plan to Expand and Support New Hampshire's Health Care Workforce*.<sup>[1]</sup> Although addressing healthcare workforce issues as a whole (both clinical and programmatic), the plan's many objectives broken down into pipeline, policy, data and governance reflect on a large scale many of the initiatives that Title V has or will be implementing such as increasing internship opportunities, developing additional academic training and more timely career advancement. The support and backing of this statewide plan reinforces Title V's workforce development as a whole.

**Innovations in staffing structures, including key partnerships that enhance the capacity of Title V to meet its goals and objectives and support training of the State Title V workforce (i.e., partnerships with academic institutions, other training providers, student internships, etc.).**

Title V as whole also works with professional training pipelines in the State and their job boards, such as the increasing number of NH based colleges and universities awarding degrees in public health and the numerous schools of nursing (not to mention the plethora of out-of-state online programs). MCH and the BFCS work with interns from many programs, such as the HRSA funded Leadership Education in Neurodevelopmental and Related Disabilities (LEND; on whose advisory board both Title V Administrators sit) at UNH, CDC's Public Health Associate and Fellow Programs, and summer graduate school interns set up through AMCHP and most in-state colleges and universities. MCH this past year had two masters interns, one from LEND and another in an MPH program at Southern NH University. The latter facilitated a significant project on safe sleep, one of Title V's performance measures and detailed in the domain section. The previously mentioned and new DPHS workforce committee is investigating the possibility of paid internships, something that has never been possible.

Title V also has a seat on the Advisory Board of Boston University's (BU) School of Public Health's Center of Excellence in MCH Education, Science, and Practice. Through work with Dr. Trish Elliott, Clinical Assistant Professor of Community Health Services, NH's Title V and BU will collaboratively disseminate online MCH training modules for both students and practitioners in a new professional development co-learning initiative that fosters academic-community partnerships with the *Population Health Exchange*. This effort is just beginning.

**Assessment of training and professional development needs for new and seasoned Title V program staff and family leaders**

In both BFCS and MCH, staff are required to complete the MCH Navigator Self-Assessment to help inform professional development plans. Assessments are also being done as part of the work with BU as well as the DPHS workforce committee.

Professional training, for the most part, seemed to fall into two different topical subjects this past year. Consistent with years prior, telehealth was a subject many staff were interested in. Much of the Federal and State legislation signed during the early months of the COVID-19 pandemic enabling reimbursement for telehealth in the same way as for in-person services, as well as expanding the providers eligible for compensation are still in place. MCH is a member of the NH Telehealth Alliance, which provides monthly webinars and an annual policy conference.

Staff in all programmatic units took part in training opportunities on the second topic of general interest, quality improvement. Some employees continued in their Six Sigma LEAN training, obtaining belts in higher categories as well as training for a certification as a public supervisor and/or manager. Others participated in the DHHS Medicaid Quality Program inaugural series of programming on quality levers such as the performance based Auto-



Assignment, Withhold and Incentive and Liquidated Damages Programs. Several staff, particularly those having oversight over fatality review programs, took the CSTE Qualitative Analysis training. All staff participate in DHHS required annual trainings including Computer Use Policy Training, CPR (for nurses), and Security and Safety in the Workplace.

Staff participated in their individual annual grantee and partnership meetings virtually. Several MCH staff presented posters and sessions at AMCHP, CityMatch and others, with titles such as “Vaping/Dual Use of Substances” utilizing PRAMS data, “Changing Requirements for Specifications in Data File Uploads, Utilizing Proper Code and Table Management,” “School Based Mental Health,” “Policies on Rear Facing Car Seats as a Prevention Strategy,” and the “NH Family Planning Program.”

Other professional training opportunities Title V staff participated in this past year include, but were not limited to the following:

- Continuation of a series from the National Academy for State Health Policy on public insurance financing of home visiting (states had to apply to get into this with their Medicaid colleagues);
- Epidemiological training course offered by CityMatch (also had to apply for and be accepted);
- Participation in the National Birth Defects Prevention Network Data Standards’ Workgroup;
- National webinars on all aspects of critical congenital heart disease (which MCH is in their first year of collecting newborn screening data);
- Early Hearing Detection & Intervention Conference;
- IDEA Fiscal Forum;
- Catalyst Center’s Child Tax Credit webinar, Financing Cafes;
- Emotional Intelligence;
- Advancing Systems of Services for CYSHCN Café;
- Meeting the Care Needs of CYSHCN and Their Families: Implementation of Equitable Care Coordination;
- NH Special Education Process;
- Motivational Interviewing;
- Creating Calm and Fostering Resilience; and
- The Stress Associated With Caring for Humanity: Building Resilience and Strategies for Wellness with Donna M. White, RN, Boston.

MCH positions that have responsibility over program budgets meet twice a month with DPHS fiscal colleagues, and the BFCS Leadership Team meets monthly with their financial manager. MCH and BFCS management and fiscal staff meet quarterly to monitor Title V expenditures. The Title V budget and its 30-30-10 requirements, among others, is complicated and takes a while to gain enough competence to manage it effectively.

### **Current and anticipated training needs of key MCH partners (external to the Title V program), as relevant**

Various programs within Title V offer professional training to stakeholders, in particular those agencies that are contracted. For example, the Early Childhood Systems program, through the Community Collaborations Federal

grant, offered technical assistance to its contractors (just as the Home Visiting Program did the year prior) in a series focused on equity in family support services. MCH's Women's Health Program offered training to their contractors on using telehealth to deliver family planning and sexual health care.

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[1] Endowment for Health (March 2022). *Giving Care: A Strategic Plan to Expand and Support New Hampshire's Health Care Workforce* retrieved from [Giving-Care-A-Strategic-Plan-to-Expand-and-Support-NH-Health-Care-Workforce.pdf \(endowment-assets.nyc3.digitaloceanspaces.com\)](#) on 04/27/2022.

### III.E.2.b.ii. Family Partnership

Family partnership is defined in the MCH Block Grant as “the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level.”<sup>[1]</sup>

#### **MCH**

Two years ago, all MCH staff and respective programs worked with New Hampshire Family Voices (NHV) on a technical assistance (TA) request to increase family partnership and engagement into daily section functioning. The recommendations that were developed at the conclusion of that TA served as its cornerstone and reviewed regularly.

- Ongoing staff readiness and professional development for family engagement simultaneous to an increase of families within the work
- Goals and objectives dedicated to family engagement within every MCH program’s workplan. This is to be able to chart success and measure progress
- The inclusion of family partnership and engagement in MCH’s contracts, as feasible and appropriate
- Ongoing capitalization of opportunities for family engagement, such as the inclusion of focus groups
- Establishment of expectations for family members currently sitting on committees. Is the particular committee focused on oversight, advice giving, operations or policies? What is the role of a family member? Is it documented?

#### **Professional Development:**

Professional development, for the most part, has taken a virtual and online format since the COVID pandemic began in March of 2020. This has actually increased the number of staff able to participate, particularly in the realm of family engagement, which has recently been a popular subject matter across MCH programming. In the past year, MCH staff have attended trainings and conferences such as those entitled *Engaging Parents, Authentic Youth Engagement* and *Help Me Grow-Concordant Care*.

Staff training in family partnerships often takes the form of working with a federally funded resource center. For example, for the Home Visiting Program and specifically MIECHV, the Technical Assistance Resource Center (TARC) provides support on obtaining family voice, how best to support families, and acknowledging addressing and moving past barriers. The TARC helps MCH staff with doing this for every MIECHV performance measure, such as increasing the number of babies who receive breastmilk at six months of age, completing depression screening and referral within three months of birth, and babies being put to sleep in a safe sleep environment. The new Continuous Quality Improvement Coordinator with Home Visiting sits on the TARC’s national advisory board.

It is not only important for MCH staff, but also for the families and contractors that are partners in the work. Several programs, particularly Early Hearing and Detection (EHD), have consistently sponsored families to attend the annual EHD conference.

#### **Advisory committees and program staffing**

MCH is most likely to involve families within their programmatic advisory committees including the ones for Injury Prevention, Newborn Screening, Newborn Hearing Screening, and Birth Conditions. The Newborn Screening Advisory Committee, in particular, always has families attending to provide their experiences and expertise with a particular disorder on the screening panel. The same is true of the Birth Conditions Advisory Group.

There has been a concerted effort both to define and provide training for new members, particularly family or those with lived experience, on each of the advisory committees; what is the committee's function (oversight, advice giving, operations, policy management or all of the above); what are the roles of committee members; is there an opportunity to get compensated for this role, etc.

Family engagement in some format has been written into all of the MCH contract deliverables for those contractors that are public serving (e.g. home visiting, community health center, etc.). All of the Title V funded CHCs have a mandate for 51% of their advisory committees to be community members and/or clients. There are also best practice standards for Healthy Family America home visiting family satisfaction surveys and advisory committee family engagement requirements. Yearly, family satisfaction surveys are completed and are incorporated into continuous quality improvement.

MCH's Mental Health Care Access in Pediatrics project utilizes the Project ECHO model to increase pediatric primary care providers' knowledge and confidence in treating children with mental health conditions. These Project ECHO sessions use web-based conferencing technology to bring participants together to participate in didactic training from the established Pediatric Mental Health Team of faculty experts on set curriculum objectives and to also present a case study and receive feedback and recommendations. The Pediatric Mental Health Team includes the family engagement specialist from NHFV who also serves as a compensated member of the project's advisory committee. This specific faculty role ensures the family perspective is represented and that each Project ECHO curriculum includes training on engaging with the patient's family and treating the patient in context of their family.

EHDI provides funding to Northeast Deaf and Hard of Hearing to provide family engagement through the role model program. Northeast Deaf and Hard of Hearing recruited deaf/hard of hearing adults to participate in the SKI-HI training to become a role model. The goal of the role model program is to connect families with a deaf or hard-of-hearing adult to share their experiences, provide unbiased information regarding language modality, and to help guide and support families through their journey with a child who is deaf or hard-of-hearing. Northeast Deaf and Hard of Hearing has also updated the NH EHDI resource book, which is provided to families once they have learned their child has a hearing loss. The book has information on audiology, language modality, early intervention, hearing loss, hearing aids, etc.

One of the home visiting agencies received a contract from DHHS's DCYF to implement the "Strength to Succeed" Program. This is a voluntary program based on a trust-based model of peer-to-peer support from staff who have lived through their own adversities and have had positive outcomes. The agency reports having a culture shift as they have integrated staff with lived experience with substance use and/or involvement with DCYF (the State's child welfare system) into their existing staff. This has helped them to raise the awareness of the language that families use along with the practices implemented at the agency level to better align the agency with some of the families they serve.

MCH's Quality Improvement and Clinical Services Programs is working with and financially supporting colleagues at the Northern New England Perinatal Quality Improvement Network (NNEPQIN) with the goal of establishing a representative Perinatal Community Advisory Council (PCAC). The PCAC (formally sitting in NNEPQIN) will be a key component in MCH and NNEPQIN's strategy in fostering accessible, respectful and safe perinatal care in the State.

NNEPQIN and MCH engaged with staff at the Foundations for Healthy Communities who had expertise in developing community advisory councils, and who helped structure the workplan with the following goals:

- Develop the PCAC, including structure, guidelines, operating principles and procedures;
- Support the design, execution, and analysis of focus groups and qualitative interviews with people from historically marginalized communities to inform the work of the PCAC;
- Recruit and onboard a diverse, representative group of eight to twelve advisors;
- Provide training, education, and guidance for PCAC members as well as MCH and NNEPQIN staff to optimize engagement and collaboration;
- Recommend best practice strategies to address disparities and promote equity at the individual, organizational and systems levels.

Focus groups (described below) were held in spring and summer of 2021 and informed the PCAC recruitment which is currently happening at this time, mostly through social media. Targeted individuals are currently pregnant and/or have been pregnant within the last two years. In early May, NNEPQIN hosted a virtual “Open House” to introduce those interested and to delineate the optimal commitment and engagement timing. The first PCAC meeting was held on June 7, 2022 and will continue to meet monthly via Zoom. It is anticipated that the meetings will be co-chaired, will remain confidential with the members deciding what type of feedback and recommendations to share with NNEPQIN and MCH. In turn, NNEPQIN will report to the PCAC on how their work has informed and shaped projects going on in the State over time. The PCAC will also guide implementation of core elements of the patient safety bundles developed by the Alliance on Maternal Health (AIM) and co-facilitated by MCH and NNEPQIN.

### **Focus Groups**

MCH has increased the utilization of focus groups to inform its activities. As part of their Alliance for Innovation in Maternal Health (AIM) work in conjunction with NNEPQIN and for the development of the PCAC, focus groups were facilitated with current and former obstetrical patients across the State. One group specifically focused on pregnant and parenting people with SUD.

Given that substance use is a key driver of poor maternal health in New Hampshire and often leads to limited participation in prenatal and postnatal care, this group was important to engage. The original intent was to include members of NH communities identified as having poor perinatal outcomes, specifically those who are Medicaid insured, East African (the majority of the refugees in the State), Spanish-speaking, and/or BIPOC, but the project was delayed several times by COVID-19 pandemic surges. These focus groups have been rescheduled to the fall of 2022.

In late 2020, as described in last year’s block grant, MCH home visiting staff helped to convene a group of mothers to talk about their experience being pregnant and having a baby born exposed to substances. The purpose of this discussion was to inform the subsequent SEI (substance-exposed infant) 2020 pilot project seeking to connect families using substances during pregnancy with family support, and strengthening services during pregnancy and after. While the work itself was completed outside this reporting period, lessons learned and the final product from this convening (a one-page handout “Real Moms, Real Voices: A Note to Providers”) has been shared with various partners, with the goal of bringing in parent voice to discussions where they are not currently present. This document was shared with NH’s Perinatal Substance Exposure Taskforce, NH HFA Supervisors and Program Managers, and in the MIECHV MALL with other MIECHV awardees.

With CDC COVID-19 pandemic funding focusing on health equity, MCH was able to add to BFCS’s contract with NHFV historically for the first time ever. This additional funding will leverage NHFV’s role as the facilitator of the birth

through eight advisory group (made up of families and community advocates) to NH's Council on Thriving Children in order to facilitate family based focus groups with the intent to assess access to health care and parenting support programs. These will include level of family engagement, referral systems and barriers to service. The scope of services includes directives to

- Gather family input as it relates to closed loop referral systems, including areas of concern and recommendations relative to communication tips that can support centralized referral and intake implementation and care coordination for successful family engagement;
- Make recommendations for marketing and communication to families about access to needed services, health care access and immunization and/or vaccination, and referral follow through with identified agencies;
- Identify services, programs and/or resources that were most helpful and most utilized during the COVID-19 pandemic, as well as needs that were not met;
- Identify barriers to accessing supports including, but not limited to transportation, technology, accessing emergency supplies; and
- Identify concerns about the COVID-19 pandemic and immunization/vaccination for early childhood families including potential access barriers.

In addition, NHFV is in the process (under this funding) of developing a survey that will gather family input on adverse childhood experiences (ACEs).

MCH's Early Childhood Comprehensive Systems and Community Engagement group used the same pandemic funding to put out a Request for Applications for an agency to work with NHFV on the family focus groups as well as to conduct additional focus groups in the perinatal population, on the topic of the Plan of Safe Care (POSC).

### **Continuous Quality Improvement (CQI)**

During the annual writing and review of workplans, goals and objectives, each MCH program seeks to incorporate family engagement in its approach. MCH'S Early Hearing Detection and Intervention (EHDI) program involves several parents in their CQI process as well as the NH chapter of Hands and Voices, reviewing data for hospital and diagnostic centers in regards to performance on screening and diagnostic evaluations, documentation in the data system and referral to diagnostics and early intervention.

MIECHV is focusing on family engagement with contractors as part of a larger CQI effort, devoting time during the monthly Local Implementing Agency (LIA) supervisors' meeting to provide training on how to involve families in this particular arena. At one meeting this past year, the federally led HVCOIIN's Parent Leadership Toolkit was reviewed as was the NH Children's Trust' (NHCT) family engagement campaign and their Strengthening Families Summit, Parents Leading the Way. Family engagement in CQI is discussed in all coaching sessions including barriers to engagement. Staff turnover has impacted family retention rates and the trust necessary for families to join in this work.

There is recognition that the need and challenges faced by LIAs to authentically engage families in CQI are often similar to those that occur at the state level. As such, awardee staff have sought opportunities to elevate family voices within the broader early childhood system in NH. For example, the Home Visiting Program Supervisor attended workgroups to support family engagement within the broader early childhood system, with identified champions of family engagement from both the Department of Education (DOE) and DHHS's Early Childhood Integration Team (ECIT; co-lead by MCH). One of the workgroups, with TA from *Zero to Three*, has led thoughtful

planning to support contract development of regional leads to support streamlined communication to the field and improved infrastructure of local regions to engage the family voice. Another workgroup on family engagement had representation from DOE and DHHS ECIT members and worked to align definitions from various programs to support authentic family engagement. This work supported providing contextual information that will be provided to the Birth-8 Advisors quadrant of the NH Council for Thriving Children lead by NHFV as previously described.

## **BFCS**

BFCS continues its commitment to family engagement and partnership throughout its programs and activities. Families with CSHCN provide an important perspective that is always considered when making program decisions and planning for strategic change. New Hampshire Family Voices (NHFV), a long-standing partner whose staff consists of parents of CSHCN, are co-located with BFCS staff and provide leadership across the State to families and family-serving agencies. Program staff participate in a variety of family partnership activities described in this section.



## **Advisory Committees**

The CSHCN Director is a Department representative to the Council for Youth with Chronic Conditions (CYCC), established by [NH RSA 126.J](#), to promote the assessment of the needs of children/youth with chronic conditions and their families; serve in an advisory capacity to DHHS, the Department of Education, and the Insurance Department for policy and program development. The CYCC includes up to 13 members who are the parent or guardian of a CSHCN, appointed by the Council and another appointed by the Governor. In addition, Council membership includes a youth less than 30 years of age who has a chronic condition, state agencies, legislators, and community-based organizations serving CSHCN.

The CYCC strives to enhance community-based family supports that meet the unique needs of CSHCN and have been instrumental in providing stakeholder input through the process of redesigning the programs administered by BFCS. The Council responsible for increasing awareness in the public and private sector of the medical, social, and educational issues affecting CSHCN and their families. In 2001, the Council increased membership, stakeholder affiliations and collaboration with other organizations to identify and create a collective voice. A new website, [nhcycc.org](#), was created to be more accessible and increase social media presence. Finally, Community Health Institute/JSI (CHI/JSI) accepted a contract and began a qualitative need assessment for this population.

Family support activities under the Partners in Health Program include the requirement for each regional agency to have a family council that serves as an advisory body. Each council is comprised of members who are, or have been, CYSCHN or families of CYSCHN currently receiving services. Flexible funding and resources, supported by Social Services Block Grant (SSBG), are used to support families with CSHCN using processes developed by councils to determine utilization of funds for families' needs and council activities.

## **Strategic and Program Planning and Quality Improvement**

To help ensure that CSHCN and their unique needs are adequately represented in system design, planning and service delivery across the system of care, NHFV participates in meetings with state agencies, local service organizations and other professional organizations. Staff from NH Family Voices finalized a review of the National Standards for Care Coordination for CSHCN, in collaboration with BFCS health care coordinators. The subsequent report outlining priority recommendations was submitted (June 2021) to guide the quality improvement project that

will culminate in the redesign of the scope of their work for care coordination in the next biennium (SFY24-25).

BFCS continues to partner with NHFV to plan and facilitate training opportunities for CSHCN and their families. Family Support Coordinators frequently seek assistance to recruit, retain and strengthen family support advisory council members. While this partnership model has been used primarily with Partners in Health, it has been identified as a critical program component to be carried over into the new model being developed for care coordination. NHFV will continue to support family council members through orientation, training, and mentorship.

### **Workforce Development and Training**

BFCS also contracts with NHFV to develop and implement a training plan, in consultation with program and Bureau staff, to facilitate statewide training opportunities for individuals who work with CSHCN and their families. Topics include, but are not limited to Standards of Quality for Family Strengthening and Support Certification, Motivational Interviewing, Supporting Children's Remote Learning, Healthcare Transition, Special Education during COVID-19, Epilepsy Overview and Self-Management, Engaging Families Using the Right Question Strategy, Person-Centered Care, Charting the Life Course, and Bereavement. These opportunities reflect one way that the Bureau provides activities to strengthen and advance family partnership in the Title V program.

### **Block Grant Development and Review**

NHFV is also an active participant in the preparation of each year's Title V Block Grant application and annual report. In addition to attending regular meetings to discuss performance measures and program improvements, family members review sections of the reports and provide input to ensure the family perspective is incorporated throughout. Although mostly virtual meetings have replaced in-person meetings, BFCS leadership continues to meet with NHFV monthly and includes them in the invitation to the federal review in the fall, each year.

### **Materials**

Through NHFV's contract, educational materials are distributed through trainings, presentations, and mailings. In FY2021, 2,169 publications/resources were distributed including the educational and informative newsletter, Pass It On. The guidebook "Maneuvering through the Maze" is available in both English and Spanish providing a listing of statewide resources for families who have CSHCN. Available in hard copy, it was downloaded 2,838 times in FY2021. As a co-leader for Watch Me Grow, NH's developmental screening system, and the employer of the CDC's Act Early Ambassador, they also distribute Learn the Signs Act Early educational materials.

### **Program Outreach and Awareness**

To help assess program effectiveness and satisfaction, all BFCS contractors are required to distribute and report on an annual Family Satisfaction Survey. NHFV uses information collected from this survey to identify areas to target enhancements to outreach efforts. For example, during the COVID public health emergency, they determined the need to increase their social media presence for outreach and training. Finally, outreach to HC-CSD and SSI applications is provided by both NHFV and directly by BFCS.

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<sup>[1]</sup> HRSA, *Title V Maternal And Child Health Services Block Grant To States Program Guidance and Forms for the Title V Application/Annual Report* (2020).



### **III.E.2.b.iii. MCH Data Capacity**

#### **III.E.2.b.iii.a. MCH Epidemiology Workforce**

MCH has 5.8 FTEs whose sole responsibility is the management and analysis of different types of MCH data. However, all FTEs in MCH have a role in working with data, whether it be through its collection, a determination of what the data reveals, or its dissemination to stakeholders and the public to guide surveillance and/or prevention activities.

MCH has had a dedicated 0.8 FTE Epidemiologist under contract with the University of New Hampshire, Institute for Health Policy and Practice, Department of Health Management and Policy for almost two decades. The current MCH Epidemiologist, David Laflamme, has a PhD in public health as well as an MPH with a focus in health education and communication. Dr. Laflamme's contract is underwritten by a combination of sources primarily Title V but also including state general funding, CDC's ERASE Maternal Mortality grant, the Newborn Screening Revolving Fund (subsidized by the cost of filter papers) and the Administration on Children and Families' Personal Responsibility Education Program (PREP) grant. Aside from Title V, the funding for this position has rotated dependent upon the nature of his work that year. In some years, HRSA's Maternal, Infant and Early Childhood grant pitched in funds as well as those from CDC's Pregnancy Risk Assessment Monitoring (PRAMS) grant.

Dr. Laflamme is routinely called on to lend his expertise to discussions on a gamut of topics such as, but not confined to, rural labor and delivery unit closures, newborn screening timeliness, and the use of the situational surveillance questions on the birth certificate. Dr. Laflamme does epidemiological analysis of state and national data sets related to maternal and child health such as births, deaths, hospital discharge (emergency room and hospitalization), all payer claims including Medicaid, as well as PRAMS. Perhaps even more importantly, he has developed data linkage algorithms and established linkages to support the public health analytic goals of MCH. Dr. Laflamme is the "go-to" colleague for any analyses of pregnancy-associated and pregnancy-related maternal deaths, severe maternal morbidity, perinatal periods of risk, unintended location births, early elective deliveries, unexpected newborn complications, mortality, data quality of race and Hispanic ethnicity (comparing birth certificates vs. electronic medical records), smoking during pregnancy, birth conditions, neonatal abstinence syndrome and perinatal substance exposure to name a few. He conducts these analyses to support and direct all of Title V's programs including the five-year needs-assessment.

Just recently, however, Dr. Laflamme has taken a consulting position with the American College of Obstetrician and Gynecologist's Alliance on Maternal Innovation (AIM) project. He is still working a few hours weekly for MCH under UNH's contract. This is a significant loss for the Section. However, MCH is pleased to report that underneath the same contract Dr. Carolyn Nyamasege has been hired and will start work the summer of 2022. Dr. Nyamasege has a PhD in Clinical Sciences, majoring in Nutrition, Epidemiology and Biostatistics and an MPH. Still early in her career (as Dr. Laflamme was when he first started), Dr. Nyamasege has a background as a field researcher in maternal and child health issues, working both with the University of Tsukuba in Japan and the African Population and Health Research Center in Kenya.

Dr. Laflamme will be onboarding Dr. Nyamasege with respect to the MCH Epidemiologist's responsibilities. This also includes acting as MCH's liaison with the Division of Vital Records located at the Secretary of State's Office, who steward the Medicaid data and lead quality improvement. It also includes monthly PRAMS sampling, supports survey development and analyses of responses and ensures compliance with IRB regulations. Dr. Nyamasege will continue the collaboration of MCH with the Northern New England Perinatal Quality Improvement Network (NNEPQIN) through analysis of timely and emerging topics and serving as faculty presenting at biannual meetings.

Working with the MCH Epidemiologist on an almost daily basis is the MCH Data Scientist and Manager of the Data/Decision Support Program, Paulette Valliere. Ms. Valliere is a 1.0 FTE, funded by HRSA's SSDI grant mixed

with Title V and has an MPH with many years of experience in maternal and child health, both in NH and internationally. Ms. Valliere's job classification is that of a Senior Planner, a labor grade of 27.

Ms. Valliere coordinates the analysis, evaluation and integration of data from multiple sources for MCH programming. She is the lead on the Title V five-year needs assessment as well as being the co-writer/editor for much of the annual MCH Block grant report. As Co-Principal Investigator of PRAMS, Ms. Valliere facilitates most of the PRAMS data analyses. She also authors and presents the majority of data briefs/documents from MCH. Her latest two include an analysis on a PRAMS supplemental project with added disability questions and a safe sleep data brief based on PRAMS and SUID data.

Ms. Valliere is also consulted by all MCH staff on any analyses of survey data as well as promotes staff development in data collection, analysis, translation and dissemination. Both the MCH Epidemiologist and Ms. Valliere are frequent users of *Tableau* for data visualization and are fluent in SPSS and SAS.

Ms. Valliere oversees the 1.0 FTE PRAMS Project Coordinator, funded solely by the CDC, who holds the classification in the state system of Planning Analyst/Data Systems. Lauren Paradis was recently hired into this long vacant position. Ms. Paradis has her MPH and has worked in various administrative and clinical settings including pediatrics. As the PRAMS Project Coordinator, she is responsible for overseeing and coordinating all aspects of the CDC PRAMS grant in collaboration with internal and external partners. The position oversees data collection and management procedures of the State PRAMS survey, including ensuring the quality and timeliness of the data and preparation and dissemination of reports.

MCH also has another 2.0 FTEs in the positions of Planning Analyst/Data Systems, both in the Injury Prevention and Surveillance Program, with the titles of MCH Injury Prevention Program Surveillance Analyst and Opioid Overdose Surveillance Coordinator. This classification is a labor grade 24. However, each of the three positions' responsibilities are very different.

Xiaohui Geng who is the Opioid Overdose Surveillance Coordinator recently obtained her PhD in epidemiology. In addition to this, Dr. Geng has a nursing degree, an MS in engineering and an extensive history as a shipbuilding engineer. Dr. Geng is the Principal Investigator (PI) for the CDC's two million dollar Opioid Data to Action (OD2A) grant, which in addition to funding 100% of her salary, provides funding to both surveillance and intervention activities including the extraction of opioid morbidity and mortality information, in conjunction with a data sharing agreement with the State's Office of the Chief Medical Examiner, which enables access to many different data sources (law enforcement, autopsy, medical history, etc.). Dr. Geng is experienced in R software and has used it to develop a standardized data query which she then uses to submit monthly data reports to the CDC and to the [NH Drug Monitoring Initiative](#). She also administers contracts and memorandums of understanding with both DHHS internal and external stakeholders, ten different projects in total.

As the PI and funded solely by the OD2A grant, Dr. Geng is currently involved with getting a temporary data analyst supported by the CDC foundation, specifically to work on opioid misuse analysis. This position will last for up to two years, which will add another FTE whose sole focus is data collection and analysis.

Dr. Geng's colleague in the Injury Prevention and Surveillance Program, Kathleen Mullen, serves as the program's analyst. Ms. Mullen, whose position is financed by leveraging the Title V Block grant, OD2A and the CDC's National Violent Death Reporting System grant (NVDRS), has close to three and a half decades of experience in handling and analyzing data. She has a Masters in Health Services Administration. Ms. Mullen works with many different types of data and is responsible for many of the analyses done for both the five-years needs assessment and the annual Title V report and did all of the data analyses for the [NH Violence and Injury Prevention Plan 2020-2025](#).

Ms. Mullen also responds to outside stakeholder requests for MCH related data, and in particular injury surveillance requests. One data set that is uniquely under Ms. Mullen's purview is the FQHC UDS data which she receives, and then assists the Quality Improvement and Clinical Services Program in reviewing it for sub-recipient monitoring.

MCH has signed data sharing agreements with the CDC and the Alliance for Innovation in Maternal Health (out of the American College of Obstetrics and Gynecologists) and its agreement with the Office of the Chief Medical Examiner covers efforts under OD2A, child fatality and the efforts under the CDC's National Violent Death Reporting System grant, as well as those (grants) for maternal mortality, sudden unexpected infant death and sudden death in the young (children 18 and under).

The last MCH 1.0 FTE totally dedicated to data work is the Home Visiting Data Specialist, Gary Titus, in the classification of Systems Development Specialist III at a labor grade 23. Mr. Titus has an Associate's degree and has been working primarily in coding for over 20 years. Mr. Titus is responsible for working with HRSA's Maternal, Infant and Early Childhood Home Visiting Grant and is supported by such (MIECHV). He works with all of the local implementing home visiting agencies on the copious amount of data they collect as well as oversees the contract with Social Solutions Inc., the provider of the data system, *Evidence to Outcomes* (ETO), in the implementation of the evidence based model utilized by NH, *Healthy Families America*. Mr. Titus is also the employee who puts together all of the aggregate data for all of the outcomes MIECHV looks at including process data.

All of the other MCH staff look at data on a daily basis, but are not necessarily considered data scientists, epidemiologists or analysts. All facilitate quality improvement and assessment. For example, the Newborn Screening Program's 2.2 FTEs keep track of the filter paper results and use both the OZ data system and the one from NH's contracted laboratory. The Quality Improvement and Clinical Services program as a whole looks at the outcome and process data collected by MCH's community health center contractors, which includes prenatal, maternal and pediatric care performance measures.

DPHS also has a Bureau of Health Statistics and Data Management (BHSDM), who are the formal DPHS liaison with Vital Records as well as the stewards of survey data and surveillance systems such as the hospital discharge data (emergency room and inpatient), the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System (shared with the Department of Education). The BHSDM facilitates QA on many of the public data requests MCH receives and prepares and serves as a back-up for most of MCH's data staff. BHSDM also stewards the portal <https://wisdom.dhhs.nh.gov/wisdom/#main>, aggregating health and social services data and producing customized reports, maps and time trend analysis on hundreds of health related indicators at the town, county and state level. Data may be used to identify trends, develop program initiatives, strengthen research, aid grant writing and support policy changes. Currently the portal is in the process of being rebranded as the NH DHHS Data Portal. With this rebranding, the system of dashboards is being completely redesigned to be more accessible by the general public. By the end of 2022, additional data will be available on each dashboard, and new topics will be added.

The Bureau for Family Centered Services (BFCS), hired its first Planning Analyst/Data Systems (1 FTE, Labor Grade 23), Subha Kandasamy, in 2021. This is BFCS' only position fully dedicated to data analysis/ reporting. As such, Subha is responsible for planning, developing, initiating and directing needs assessments and program evaluations which support the development and administration of services for CYSHCN and their families. She spent her first year learning about the SMS/PIH Database and other data resources related to the CYSHCN populations. With the addition of this position, a modified Lean project was implemented to review the operational processes and develop concise recommendations to support an upcoming capital budget investment request for data system modernization project. The BFCS Data Analyst will meet with a newly-established data workgroup to review the Lean report, discuss which improvements need to be addressed first, and update the current system documentation.

BFCS recently began the process to fill a vacant Program Specialist IV (.2 FTE, LG 25) position to support and participate in the Operations Management of BFCS with a focus on evaluation and data-driven decision making. Since this is a part time position, with limited hours available, it is being pursued as a Direct Hire with a May 2022 start date.

Title V as a whole would also benefit from an improvement in epidemiology workforce recruitment and retention. As it is, NH's State employment system has position classifications in the labor grades from one to 35. An employee can fall under a position classification, but the actual job description consists only of the specific responsibilities of that position. Each labor grade has nine steps that employees can transition to, pending a successful annual evaluation and a specific (required) amount of time in the position. There can be years between steps. Once at a step nine, there is no additional place for an individual to move, unless he/she changes positions or reclassifies that particular job. Reclassification is a long process and requires a job description with additional responsibilities documented. Reclassifications must pass through DHHS's Division of Human Resources and then go to the larger Department of Administrative Services, Division of Personnel and be approved by the Governor and Executive Council. For data positions, this is even more difficult, which is why recruitment for these positions in particular is so difficult and can be very lengthy.

### III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

Launched in 1993, the purpose of SSDI is to develop, enhance, and expand state and jurisdictional Title V MCH data capacity for responding to the needs assessment activities and performance measure reporting requirements of the MCH Block Grant. Such enhanced MCH data capacity is intended to enable informed local decision-making and resource allocation that supports effective, efficient and quality programming for women, infants, children, including CYSHCN, and their families.

New Hampshire receives funding from the State Systems Development Initiative (SSDI) grant; this funding supports 0.8 FTE (the SSDI Project Director, whose job title is MCH Data Scientist), and project activities are accomplished through active collaboration with all MCH staff, and notably the MCH Epidemiologist.

The current SSDI five-year project cycle is in its fifth year, and the goals of NH SSDI now include: (1) the provision of data, research, and writing support for the Title V MCH Block Grant application/report, for the needs assessment as well as for tracking and reporting on national and state-selected performance measures; (2) the performance and updating of data linkages; and (3) support for the translation and dissemination of statewide surveillance data, notably from the Pregnancy Risk Assessment Monitoring System (PRAMS), through the analysis of yearly and multiyear data sets

**Under the NH SSDI project's goal 1**, regarding the Block Grant, the following activities were implemented in Year 5:

The SSDI Project Director (PD) led the Block Grant team in reviewing the State's federally-available data on outcome measures, as well as the data on the State's selected performance measures (National Performance Measures-NPMs, Evidence-based Strategy Measures-ESMs, and State Performance Measures-SPMs). The data review provides a snapshot of the current health status of the MCH population, including on the selected performance measures. From this review comes the determination to continue current efforts, or to change strategies in an effort to meet current targets (or modify targets if these now appear unrealistic). The start of a new five-year Block Grant project cycle typically includes such significant changes as the selection of new performance measures, based on the MCH population's changing needs as determined by the 5-year needs assessment. But in this third year of the Block Grant cycle, the ongoing needs assessment found that no such significant changes were necessary, and the data review led to only small adjustments in some target numbers—the State's selected performance measures overall continue to align well with the MCH population's needs.

As of this writing, the SSDI PD is coordinating the MCH Program Managers' writing assignments for the narratives for each performance measure in each population domain. The SSDI PD also is responsible for the data entry into the online Title V Information System (TVIS) of all performance measure data as well as the State Action Plan Table. The SSDI PD writes the Needs Assessment Update, the Program Overview, this SSDI report, and designs/updates the State's Title V brochure. The SSDI PD also collects and uploads all supporting documents including organizational charts and the Title V staff's bio-sketches.

A Title V public document is produced by the SSDI PD, namely the [Title V brochure](#). This document presents a summary of the State's current performance measures aligned with state priority needs. The current objectives are listed, as well as the current strategies to attain the objectives. National outcome measures are also included, to show the relationship between the performance measures and universally reported health indicators (outcome measures). This document is reviewed on a yearly basis, and revised as needed. It is posted online through a link on the [MCH homepage](#), where it serves to introduce Title V to the general public.

**Under the NH SSDI project's goal 2**, regarding data linkages and use of data, the following activities were implemented in Year 5:

Background: a table for linked ID pairs data was created with funding from a previous SSDI project cycle. This table was built to enhance the existing NHIMCHIS (New Hampshire Infant, Maternal and Child Health Information System), which was initially intended to assist the MCH section with the identification of infants who were not screened for specific medical conditions at birth. NHIMCHIS was then expanded to provide a comprehensive, integrated system of linked datasets.

The MCH Epidemiologist performed data linkages, including the updating of existing linkages as needed, to maintain the latest data available for program evaluation and data-driven decision making. Initially, the new table for linked ID pairs was populated with linked birth and newborn screening data. Additional ID pairs have been linked and uploaded into the secure master linkage table in NHIMCHIS, to continue institutionalizing linkages and enhance their availability for utilization.

The ongoing linkage between the NH infant births and deaths was successfully maintained throughout the year. This requires communication and collaboration with the staff of the NH Division of Vital Records Administration (DVRA), who are tasked with assuring the completeness of the State's birth and death files. This linkage is used to produce an infant mortality rate.

The linkage between NH births and Medicaid maternal delivery discharge claims has been automated as part of an ongoing data modernization effort at NH DHHS. This linkage is now available within the Enterprise Business Intelligence data source; it has been used to examine issues such as early elective deliveries, maternal mortality and severe maternal morbidity. CMS Quality Measures were successfully calculated and reported, including the measure LBW-CH, live births weighing less than 2,500 grams; and measure PC02-CH, cesarean section for nulliparous term singleton vertex (NTSV).

A linkage between death records and the maternal information on the birth records has been successfully completed on a quarterly basis. The review of all maternal deaths continues routinely. Data has been successfully migrated from the locally installed version of MMRIA (Maternal Mortality Review Information Application) to the CDC-hosted version. Data entry is up-to-date. Maternal deaths identified through the linkage were reported to the NH Maternal Mortality Review Committee (MMRC). Communicating with the MMRC ensures that any cases found will be reviewed and included in ongoing assessment of maternal mortality in NH.

Significant work to aggregate the hospital discharge data and create extracts formatted according to AIM (Alliance for Innovation on Maternal Health) standards for upload into the AIM data portal has been done. This work is contingent upon the establishment of a data use agreement (DUA) between NH DHHS and AIM, which is almost at final stage before signing. In the meantime, the significant work to aggregate the discharges has been completed, including generating the Severe Maternal Morbidity estimates to AIM specifications that will be used once the DUA is in place.

Work continued at NH DHHS with assistance from the Director of Data Analytics and Reporting within the Bureau of Program Quality to work through the technical and policy issues required to implement a secure server for hospitals to access their data dashboards. Initially, hospitals will only have access to their own data. Eventually, de-identified comparison group data from other hospitals will be included. Further, this secure server will provide a space for other data to also be shared back with the hospitals (e.g. hospital discharge data). The incoming MCH Epidemiologist will be tasked with getting the dashboards into production on the new secure DHHS server. The re-architected data infrastructure at NH DHHS has provided an opportunity to improve how NH DHHS gets data back to stakeholders

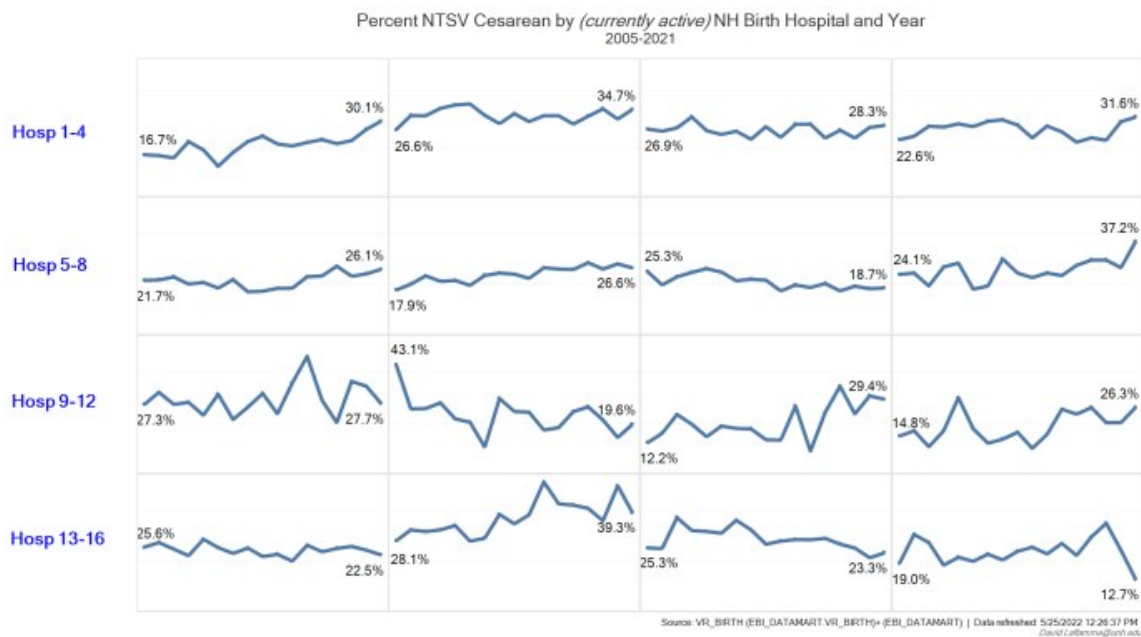
who produce that data. With the increased Quality Improvement capacity within birth hospitals developed over the last decade, working at the intersection of public health and clinical medicine in this way holds significant potential for positively impacting processes and related outcomes.

Additional accomplishments regarding the use of data include:

- A Prenatal Substance Exposure data quality guide for the NH Facility Worksheet of Live Birth was finalized and distributed to all birth hospitals. The data have been extracted for reporting purposes throughout the past year.
- In early April 2020, two COVID-related surveillance questions replaced the opioid questions in the birth situational surveillance module. One of the COVID questions was retired in January 2021 and replaced by a new question to support a naloxone initiative driven by analysis of pregnancy-associated deaths.
- A comparison of electronic medical record and birth certificate race and Hispanic origin data was completed for a large NH birth hospital. It was found that the hospital data captured 77.2% of Hispanic origin while the birth certificate captured; and the birth certificate captured nearly 50% more racial diversity than the hospital electronic medical records.

Support to replicate the race and Hispanic origin data comparison in a second NH birth hospital was provided and the comparison completed. A manuscript was developed and submitted to an academic journal (in review).

- An analysis of statewide and hospital-level Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Section rates was completed and presented at the Spring 2022 Conference of the Northern New England Perinatal Quality Improvement Network (NNEPQIN). Reducing the rate of cesarean births among low-risk women with no prior births is an objective of Healthy People 2030.



**Under the NH SSDI project's goal 3**, regarding data analysis, translation and the dissemination of surveillance data products, the SSDI PD has played a lead role in the analysis, translation and dissemination of PRAMS data. The PRAMS survey collects information on a wide variety of pregnancy-related topics, including data for the NPM#5 on safe sleep (one of NH's selected performance measures for Title V), which incorporate AAP recommendations for infants' sleep environment and sleep hygiene. The survey's smoking-related section (pertinent to NPM#14, also selected by NH for Title V) has been expanded to include questions on the use of electronic cigarettes before, during and after pregnancy.

Upon receipt of the 2020 PRAMS data set, a descriptive analysis was done, providing weighted population estimates and confidence intervals for all of the indicators in the survey, as well as some calculated indicators (e.g. summary measure of depression) and a few indicators derived from the data linkage to birth certificates, such as urban/rural residency, nativity, and maternal educational attainment. In collaboration with the PRAMS team, these findings were reported in the yearly [2020 Data Summary](#) posted online.

The SSDI PD completed an analysis of the use of electronic cigarettes, and expanded it to cover vaping, smoking, marijuana, and dual use of substances. With the collaboration of the NH's Tobacco Prevention and Cessation Program, a topic brief was written and a poster created for presentation at the CityMatCH national conference in December 2021. Key findings included: (1) vaping has increased the number of persons giving birth who are exposed to nicotine; (2) vaping in the two years before pregnancy was significantly associated with low birth weight; and (3) dual use of substances is widespread, even during pregnancy. A recommendation was made that public health messaging that targets pregnant people to quit smoking should concurrently include messages to also quit vaping and marijuana, given the prevalence of dual use. See the [Vaping/Smoking/Marijuana data brief](#) online.

The NH PRAMS teams implemented a survey supplement on the use of prescription opioids. This data was analyzed, and a data brief was prepared and posted online; see the [Prescription Opioids data brief](#). It was found that some 6% of people who recently gave birth took prescription opioids during pregnancy; nearly all of these were obtained from an ObGyn or Emergency Department, to relieve pain that began during the pregnancy. There were no significant differences in prescription opioid use by demographic characteristics, nor any significant differences in selected health indicators according to prescription opioid use.

A report entitled [Healthy People 2030 and NH PRAMS – What the Data Show](#) was completed (see the report online). PRAMS is the source of data used to establish a baseline and set a target for the HP2030 objective MICH-14: to increase the proportion of infants placed to sleep on their backs. PRAMS also collects data on several other indicators that are similar if not the same as other HP2030 objectives. This analysis examined eleven health indicators from PRAMS, and found that three of them have already met the HP2030 objectives. Three other indicators have HP2030 targets that seem attainable, if current progress continues. Three other HP2030 objectives are under development, and PRAMS may contribute to the setting of targets for these.

In 2020 NH PRAMS implemented a survey supplement on disability, focused on measuring difficulty functioning among pregnant women in six basic, universal actions. Data analysis showed that having any disability is significantly associated with reduced participation in education and employment, lower household income, and a reduction in behaviors that are indicators of health. Also, having any disability had a significant association with mental health, with affected persons more frequently reporting depression before, during and after pregnancy. The [Disability data brief](#) is available online.

The goal of the Title V MCH Safe Sleep national performance measure (NPM #5) is to increase the percent of infants placed to sleep on their backs, on a separate approved sleep surface, without soft objects or loose bedding.



Data analysis was implemented on five years of PRAMS data (2016-2020) to examine the situation in NH compared with national numbers, and to determine any trend over that time. The [Safe Sleep data brief](#) (available online) reports on these trends, as well as the practice of safe sleep behaviors stratified by maternal age, education, income and insurance status. Health care worker advice and resulting maternal behaviors was also examined: almost always, when mothers and caregivers received advice about safe sleep behaviors, they more often practiced those behaviors.

### III.E.2.b.iii.c. Other MCH Data Capacity Efforts

#### Statewide

MCH staff are very involved in the selection and analysis of questions for the statewide Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBS), both supported by the CDC and stakeholder dollars, and stewarded by DPHS's Health Statistics and Data Management Section in conjunction with the State's Department of Education for the latter. MCH has supported (through general funds) the addition of the complete ACEs module to the BRFSS on an every five-year rotating schedule, which complements the parent-reported data on the National Survey of Children's Health.

MCH's birth conditions programs works closely with the DPHS Bureau of Infectious Disease Control (BIDC) on a surveillance system to monitor pregnant people who are diagnosed with COVID-19 during pregnancy or at the time of delivery and their infants. This work falls under the CDC's Surveillance for Emerging Threats to Mothers and Babies Network project. In 2021, BIDC, in conjunction with MCH, received funding to establish a new position, a COVID-19 Maternal and Infant Program Coordinator, whose primary responsibilities include identifying and performing follow-up on all COVID-19 positive pregnant people and their infants (through six months of age), as well as infants who test positive for COVID-19 in the first 14 days. The position has the potential to expand to include surveillance of additional infectious diseases that lead to severe complications in pregnant people and infants including congenital syphilis, perinatal hepatitis C and cytomegalovirus.

Data systems play an integral part in providing quality, complete and accurate data in all of MCH's newborn screening programs. After a lengthy process, OZ Systems (OZ) was chosen as the platform for integrating all of newborn screening including birth conditions (Title V funded), newborn hearing (funded by HRSA and CDC), CCHD and blood spot (self-funded by the cost of filter papers).

OZ went live in July 2021, with a few minor glitches, but overall was successful. In September 2021, work began on interfacing OZ with vital records and on the migration of legacy data which will be complete by July 2022. Three birthing hospitals have agreed to work with OZ to set up an electronic data exchange through the pulse oximeter and hearing machines as well as the electronic medical records. The hospitals who have agreed to work on electronic data exchange are all in various phases in the onboarding process. The rest of the birthing hospitals will continue adding data manually until those three come "on-line"; at this time expected to be fall of 2022.

The CDC's Overdose to Action grant (OD2A) enables MCH's Injury Prevention Program to fund four surveillance strategies. OD2A strategy one enables work with colleagues from the BIDC on the Automated Hospital Emergency Department Data system, which collects and disseminates real-time data on suspected drug, opioid, heroin, and stimulant overdoses.

The partnership with the Office of the Chief Medical Examiner (OCME) forms surveillance strategy two and enables data analysts to enter accidental overdose death data on the State Unintentional Drug Overdose Reporting System using the National Violent Death Reporting System (NVDRS) website. The NVDRS covers all types of violent deaths including homicides, suicides, and all firearm-related deaths. The third strategy is to support the Bureau of Information Services' Enterprise Business Interface (EBI) system, which is an innovative surveillance tool that integrates multiple data sources into an interactive online data display for both public access of aggregated data, and password protected-access for data queries by NH state staff.

The fourth surveillance strategy enables DPHS' prescription drug monitoring program to enhance its system with more advanced features to monitor NH medical providers and dispensers on regulated drug prescription and distribution.

The NH DPHS had regularly participated in the Healthcare Cost and Utilization Project (HCUP), the federal hospital discharge database from 2003 to 2009. DPHS brought the discharge data “in-house” in 2010 as previously the work was contracted out. When HCUP requested data after the transition, there needed to be a change in state legislative and accompanying rules, RSA 126-25 and Administrative Rule He-C 1500, in order to share this type of data. It took almost nine years, but the law and rules were changed in July of 2019. A data sharing agreement with HCUP took even longer, but was finally signed by all parties in April of 2021. NH is now once again providing hospital discharge data to HCUP.

BFCS uses a database that is an application, maintained and supported by the Department of Information Technology (DoIT). The application, SMS/PIH Data System, can be accessed through a Citrix portal by contracted staff and via a network logon/desktop icon for state staff.

Health Care and Family Support Coordinators (both BFCS staff and contractors) use the application to collect information for each child/family being served including, but not limited to demographics, primary care provider and insurance information, programs enrollment, health information/diagnoses, financial eligibility, referrals, consultations, encounter details, care plans, authorizations, information and referral, and outreach efforts. Program staff conduct quality assurance and continuous quality improvement activities using available reporting and coaching opportunities.

BFCS’s Data Analyst and Bureau Chief continue to work closely with DLTSS and DoIT staff to address data quality and content shortfalls. With help from the Project Management Office, BFCS set out to conduct an operational review to make decisions about resources and develop contingency plans. However, due to staffing changes and time constraints, the project was scaled back to facilitate and lead a series of meetings with the primary focus on learning how to manage an older database system, cross walking of common variables, and knowledge transfer templates. In addition, information was provided to support the budget request for a capital improvement project for development of a new data system.

In addition to a more streamlined process for BFCS clients and their service delivery, this project would have a significant positive impact for external provider partners. They would have access to automated solutions and enhancements that are not available today including:

- On-line management of client information and service authorizations for provider-driven social service contract services while eliminating the need for the mailing and data entry of paper documents;
- Web submission of social service contract and fee-for-service claims to eliminate paper claims, data entry, and increase the accuracy of claims payment;
- Access to limited client information to identify clients eligible for high service priority;
- Increased speed and responsiveness of the system via the web; and
- Increased accuracy and timeliness of data for reporting.

BFCS continues to manage the state’s [Autism Registry](#) with the approval of RSA 171-A:30, 31 and He-M 501 which requires all health care and other providers who are qualified to make a diagnosis of autism spectrum disorder (ASD) to record their findings when a new case is diagnosed. The registry was intended to improve current knowledge and understanding of ASD, and to allow the conducting of thorough and complete epidemiologic surveys of the disorder. The collected data can then be analyzed in order to facilitate planning for services for ASD diagnosed children.

Contractors

MCH's MIECHV (funded by HRSA) within the home visiting program, had previously increased data quality by conducting tailored training for its' home visiting contract agencies on how to access reports and interpret the data. Training and site-specific technical assistance about using the web-based data system, *Efforts to Outcomes* (ETO), and increasing understanding of the data system was the focus of these trainings. The Data Coordinator has worked closely with contractor staff to improve functionality of several ETO reports, including videos entitled "Gary's Tips and Tricks," on the how-to's of data entry and reporting

Bi-weekly meetings continue to be held with the Social Solutions Advanced Support Consultant (data system contractor) to address ongoing and emergent issues of functionality within ETO. While NH's data within the ETO system remains a work in progress, the amount of missing data has continued to decline over the reporting period due in large part to these changes.

MIECHV's focus on improving performance in federal performance measures has provided an opportunity to dig deeper into the data to determine if areas of low performance and high missing data are issues of data capture, entry into the system, challenges with program practice, or issues with the data reports themselves. MCH staff have worked on mapping ETO touchpoints to data collection, input and report generation, in order to help identify areas that may contribute to the missing data.

This method has enabled regular monitoring of measures selected by the contractors based on higher levels of missing data and lower performance rates. The selection of targeted measures allowed for a deeper focus and understanding of how agencies approached their CQI efforts and the impact on their data as shown below.

**Percentage of Missing Data for Selected Performance Measures over Time:  
State Aggregate**

Benchmark Area	Construct	FY 2019	FY 2020	FY 2021
Benchmark Area 1	Preterm Birth	22.6%	22.6%	22.9%
	Breast Feeding	30.0%	32.0%	25.0%
	Depression Screening	0.0%	0.0%	0.0%
	Well Child Visit	0.4%	0.3%	0.0%
	Postpartum Care	3.6%	4.2%	17.7%
	Tobacco Cessation Referrals	63.6%	71.6%	15.9%
Benchmark Area 2	Safe Sleep	7.5%	6.5%	12.9%
	Child Injury	0.0%	0.0%	0.3%
	Child Maltreatment	0.6%	0.0%	0.6%
Benchmark Area 3	Parent Child Interaction	0.0%	0.0%	0.0%
	Early Language and Literacy Activities	6.5%	3.2%	2.6%
	Developmental Screening	0.0%	0.0%	0.0%
	Behavioral Concerns	0.5%	0.5%	0.4%
Benchmark Area 4	Intimate Partner Violence Screening	0.0%	49.4%	21.9%
Benchmark Area 5	Primary Caregiver Education	0.0%	0.0%	0.0%
	Continuity of Insurance Coverage	10.9%	0.0%	0.0%
Benchmark Area 6	Completed Depression Referrals	67.6%	57.6%	51.9%
	Completed Developmental Referrals	73.0%	8.1%	46.3%
	Intimate Partner Violence Referrals	78.9%	51.5%	64.2%

MCH's Family Planning Program (funded by general state funds and the Federal Office of Population Affairs-OPA' Title X grant) contracts with BOWLink Technology for the handling of data into the Family Planning Annual

Report (FPAR). In January of 2022, the OPA implemented FPAR 2.0, the next iteration of data reporting that collects additional encounter-level data such as, but not limited to, sexual orientation and gender identity, pregnancy intention, self-identified need for contraception, and reason for no birth control. The first reporting year of FPAR 2.0 will be in 2023. In order to be FPAR 2.0 compliant, the Family Planning Program worked with BOWLink Technology to move the data collection system from a regional system to a NH specific data system, enabling flexibility and one on one technical assistance. This has included working with each sub-recipients' EMR vendor to set mechanisms in place so that sub-recipients can submit electronic data files to the data base system.

The Community Collaborations to Strengthen and Preserve Families (CCSPF) grant, funded by the Children's Bureau and sitting within MCH's Early Childhood Comprehensive Systems Program, is a coordinated community response to children and families' service needs in three high risk areas of the State. Outcomes include a reduction of child maltreatment, entry into foster care, and an increase in parental protective factors. The program uses the Predict Align Prevent (PAP) method of place- and population-based data analytics for data decision-making support.

PAP, funded by Casey Family Programs, provides geospatial risk and protective factor analysis identifying high-risk places where child maltreatment may occur in the future by taking an inventory of resources that currently exist, and risk behaviors currently seen in the three CCSPF locations: the city of Manchester, Coos County and the Winnepesaukee Public Health Region. All three sites have had support through data presentations using the community needs mapping as well as technical assistance to support next steps in the utilization of the maps with each Community Implementation Team (CIT). The technical assistance topics have been focused on strategies to identify future CIT agendas, brainstorming sessions, identification of prevention strategies and areas to consider for Plan Do Study Act cycles. Each of the sites were provided with implementation resources to support next steps in sharing the community needs mapping visualizations with each CIT.

The North Country site identified care coordination across the early childhood system and expanding their partner network as critical. The North Country PDSA cycle is focused on building out a care coordination model using a closed loop referral platform and team response. An example of a specific objective the site worked on was identifying a set number of partners engaged in a closed loop referral system and care coordination model by a target date. The next step was to onboard those partners to the closed loop referral platform through readiness trainings and lastly implementing use of the centralized system.

The Lakes Region CIT coordinated a series of meetings to review the Community Needs Mapping, brainstorm strategies and then prioritize the PDSA cycles. The CIT decided to focus on lead prevention efforts across the network. The CIT coordinator has engaged additional partners such as DPHS's WIC and Healthy Home Lead Poisoning Prevention programs. DPHS's Lead Prevention Specialist has attended meetings with program staff, supervisors and the local CIT to provide education and support prevention strategy efforts.

As the lead for NH's developmental screening system, Watch Me Grow (WMG), BFCS embarked on a new initiative in collaboration with a Preschool Development Grant-funded project. The Centralized Access Point (CAP) is one of the key components of NH WMG and is essential in promoting child development and early intervention. Functioning as a streamlined system, the CAP is designed to be a central and collaborative hub that families and service providers can plug into to ensure that any child, age birth through five, is connected to the resources, services, and/or developmental support they need. Due to increased data security requirements, the launch of the CAP has been delayed since June 2021, while DoIT and the state's privacy officers review the potential implications of data sharing. A contract has been drafted and is under review by Brooke's Publishing for use of the ASQ Online Management System.

The SMS/PIH Data System described above, is used to collect, manage, and report on data related to all services provided by sub-recipients of Title V and Social Service Block Grant funds. The quality of this data is reviewed monthly by program managers and the CYSHCN Director. As needed, corrective action plans are issued to contractors not meeting their data requirements. Additional work is needed on quality assurance (QA) given the past two years of staff turnover and the lack of a formal guidance for data entry. The Program Analyst/Data System and the Clinical Program Manager, with support from DoIT, have begun planning for QA activities with the intent to bring all contracted sites up to date.

### III.E.2.b.iv. MCH Emergency Planning and Preparedness

New Hampshire has a State Emergency Operations Plan (SEOP) found at [State Emergency Operations Plan \(nh.gov\)](https://www.nh.gov). The steward of the SEOP, which is updated every five years (last published in 2019) but reviewed on an annual basis, is Homeland Security and Emergency Management, which is located within the Department of Safety. Although the Department of Safety is the lead organization, all of the State agencies' Commissioners (including DHHS) and several large charitable organizations sign off on the SEOP. The State's Incident Management Structure/Team is also led by the Department of Safety, on which both the Commissioner of DHHS and the Director of DPHS sit.

DHHS, within which lies Title V, leads the implementation of several of the emergency service functions, or ESFs. One is ESF 6, which focuses on mass care, housing and human services. Another is ESF 8, which specifically focuses on health and medical support, and is led by the Bureau of Emergency Response, Preparedness and Recovery (BERPR), which is within the Division of Public Health Services (DPHS), within DHHS, as is MCH.

BERPR works to build and strengthen the State's ability to effectively respond to a range of public health threats, including infectious disease, natural disasters and biological, chemical, nuclear and radiological events using an all hazards approach. BERPR also works to increase the ability of public health (through the public health emergency preparedness program-PHEP) and health care partners (through the hospital preparedness program-HPP) across NH to plan for and respond to large-scale emergencies and disasters.

There is no specific language relating to the Title V populations identified in the SEOP. In fact, there are no subsets of the NH population identified at all throughout the SEOP. There is language regarding people with access and functional needs as well as the term "whole community" which is to include all populations. Title V staff were not involved in the 2019 update of the SEOP, but will be in 2024, when the next updates for ESF 6 and ESF 8 will be due. That does not mean that Title V staff are not consulted in the case of a statewide emergency or help in the preparation for one. In fact, they are. It is just not documented as such within the SEOP. MCH and BFCS leadership are on the Incident Command Structure of DHHS as a whole and their respective Divisions' Continuity of Operation Plans in particular. NH's Title V programs were called upon, particularly with the COVID-19 pandemic response, but also for the recent dearth of infant formula and the systemic health care workforce shortage, to deliver critical MCH services and assist local communities in responding. NH's Title V is proactive in its emergency preparedness planning and coordinates with partners at the state and local levels to develop emergency preparedness and response plans that include the needs of the MCH and CYSHCN population.

Also in 2021, the CSHCN Director arranged for the Council for Youth with Chronic Conditions (CYCC) to meet with NH's Chief Medical Officer and Director of Division of Long Term Supports and Services, to discuss COVID-19 Vaccine distribution phases and inform DHHS of the complex challenges faced by high-risk families. The CYCC's Representative from the NH legislature contacted the Director of NH Homeland Security to identify the CYCC as a resource for future emergency preparedness planning. Following this outreach, the Director of DPHS met with the Council and encouraged them to monitor legislation related to their concerns and to share their families' stories and experiences as another way of providing important input to the processes.

DHHS staff all are trained annually (virtually) in emergency response protocol and systems. Throughout the pandemic, but particularly this past year, Title V staff from both MCH and BFCS who are registered nurses (RNs) were asked to staff the COVID-19 vaccine clinics and testing sites held across the state. RNs make up a significant part of the totality of Title V staff, thus delaying or preventing routine work responsibilities. This has eased off within the last few months, with the last public vaccination clinic being held in May of 2022. Staff skilled in data entry also helped with the enormous volume of information from COVID-19 testing and vaccination efforts.

MCH staff do work with the BERPR on developing any pertinent NH Health Alert Network (HAN) releases. The HAN is the primary method of sharing around the clock information about urgent public health incidents with healthcare partners. The HAN can also permit the exchange of information between sender and receiver. Messages are sent out via telephone, text message, fax, email and pager with recipients being a wide variety of stakeholder including health care providers of all sorts and well as hospital emergency departments and NH's network of local health officers.

MCH's Injury Prevention Program oversees the implementation of the DHHS contract with the Northern New England Poison Center (NNEPC) at Maine Medical, the State's 24/7 call center and resource for all health care providers, particularly hospital emergency departments. The NNEPC is also a steward of hotline data and can often act as the "canary in the coal mine" for public health emergencies. The BERPR contributes funding from the federal hospital preparedness grant and collaborates with MCH in work with the NNEPC.

The Newborn Screening Program within MCH has historically always had their own contingency plan of operations to ensure program continuity, largely because timeliness is of utmost importance. This is reflected best in the contract with the State's newborn screening laboratory, the New England Newborn Screening Program at the University of Massachusetts' Medical School, which outlines procedures in the event of a major disaster or emergency.

MCH's Birth Conditions Program (BCP), which Title V funds, has been working collaboratively with the Bureau of Infectious Disease Control (BIDC) within DPHS (the lead on COVID-19 efforts) and the MCH Epidemiologist to identify and report COVID-19 outcomes in mothers and infants for the CDC Surveillance for Emerging Threats to Mothers and Babies (SET-NET) project. In this collective effort, BIDC provides the confirmed COVID lab data, the MCH Epidemiologist provides the link and data from Vital Records and the BCP requests mother and infant data from hospitals. The BCP staff person then compiles the hospital and vital record data for the mother and infant and adds this to the SET-NET data entry tool for reporting. BIDC then reports this data to the CDC SET-NET team. As a result of this effort, both BIDC and MCH collaboratively applied and were awarded CDC funding within the Epidemiology and Lab Capacity grant, Project W, "Infants with Congenital Exposure: Surveillance and Monitoring to Emerging Infectious Diseases and Other Health Threats." This has added another data analyst position to BIDC (in conjunction with MCH) who devotes a full FTE in facilitating surveillance activities related to maternal/infant COVID-19 exposures and long-term infant follow-up.

MCH's Quality Improvement and Clinical Services staff have been working with the Immunization Section throughout the pandemic. MCH was recently invited to the NH VaxWell Coalition [VaxWell New Hampshire - Immunization, Vaccination \(vaxwellnh.org\)](#) a group of stakeholders interested in increasing the state's vaccination numbers, spearheaded by the NH Public Health Association. Of particular interest is an upcoming communications campaign for the summer entitled "Let's Catch Up for the Summer" which emphasizes the role of adolescent well visits for immunizations, while acknowledging that these visits went down during the pandemic. This complements Title V's work on the adolescent well visit national performance measure.

MCH's Home Visiting Program has been a consistent provider of information to colleagues about family needs and more recently about the types of information families might be looking for when the COVID vaccine for the youngest children was approved and available. This was possible due to space being provided at meetings with local implementing agency (LIA) program staff where awardee level staff could hear how the pandemic was impacting families and communities across the State. One topic that arose early on, was the technological barriers for families that not only made virtual visits difficult, but also cut these families off from virtual medical, mental health, and other supportive services. Hearing from LIAs also inspired an American Rescue Plan grant to support getting concrete support to programs and families receiving home visiting.



Recently, MCH and BFCS supported the Women, Infants and Children Nutrition Program (WIC) in getting out information on the infant formula shortage, best nutritional practices with infants, and solutions to current barriers. BFCS Health Care Coordinators have been working with families, Medicaid and pharmacies to ensure CSHCN needing specialty formula are able to obtain some. MCH routinely collaborates with WIC staff, particularly supporting its leadership in breastfeeding initiatives. WIC staff will be a key collaborator in helping Title V supported community health centers, many of whom have chosen breastfeeding efforts as both a quality improvement and enabling project.

Health Care and Family Support Coordinators continue to work with BFCS leadership to incorporate emergency planning into care planning. This became especially relevant during the COVID-19 Public Health Emergency (PHE). As the scope of services is redesigned to align with the National Care Coordination Standards for CYSHCN, FY2024, additional focus will be placed on this important aspect of each shared plan of care.

It is known that public health emergencies disproportionately affect pregnant and postpartum women, infants, and children with and without special health care needs, all of Title V's population focus. There is definitely a need for improvement for NH's Title V staff to be a part of the preparatory work for a future disaster or public health emergency. Title V staff were definitively brought into the response as described above. However, much of this work was urgent and done *ad hoc*, and refined as the pandemic went on. Title V in NH now has the commitment of DPHS's BERPR to be involved in future revisions of the State's SEOP. Such involvement will include the dedication of time and effort on the development of emergency preparedness and response training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats to the MCH population. Many lessons and best practices have been learned from the COVID-19 pandemic, which is resulting in better preparation for any upcoming public health emergencies.

### **III.E.2.b.v. Health Care Delivery System**

#### **III.E.2.b.v.a. Public and Private Partnerships**

Title V in NH does not work in a vacuum. The success of its programs has to do with integral partnerships, both funded and non-funded, with governmental partners as well as community based agencies. Leveraging federal, state, and local program resources contributes to the services delivery capacity of NH's State Title V program.

This is nowhere better reflected than in the almost four-year-old Early Childhood Integration Team (ECIT), of which both MCH and the BFCS staff are partners and part of the leadership. The ECIT brings together all programs serving young children, with and without special health care needs, from birth through eight years of age, and their families. Members represent Home Visiting, WIC, Housing, Child Care, and Early Supports and Services, to name a few.

Each month within the ECIT, a particular social determinant of health is focused upon. Several programs within the ECIT sponsored training to community agencies in learning about the kinds of economic benefits that are available to families as well as trained agency staff to become providers of NH EASY, NH's online platform gateway to apply for a variety of benefits. This increases access to health and needed services by supporting families eligible for medical coverage, food, and financial support. Another project is focusing on reducing the number of adolescents experiencing homelessness in the State.

The ECIT serves as one of the four quadrants informing the work of the Council for Thriving Children, the State's early childhood advisory council. The other quadrants are the Department of Education ECIT, B-8 Family Council (led by NHFV and comprised of regional early childhood councils and other child/family serving agencies), and Early Childhood Care and Education experts (led by the University of NH).

Title V staff are also board members of the New England Regional Genetics Group, a nonprofit organization promoting education and awareness about genetic disorders to providers and families. It is very important to partner with them for education and growth as newborn screening and birth conditions are continuously changing and evolving with new research and laboratory capabilities.

MCH also works very closely with the Office of the Chief Medical Examiner (OCME) in the NH Department of Justice. Not only do they collaborate on all fatality reviews (child, sudden unexpected infant death, sudden death in the young, and maternal), the two work through data sharing agreements and MOUs on the CDC's Secure Access Management Services database. This incorporates both the National Violent Death Registry and the State Unintentional Drug Overdose Reporting System. This effort supplies the CDC's National databases with NH death data, as gleaned from the OCME and NH Vital Records data. It increases access to health care and needed services because it provides a rich source of data on why NH drug deaths and violent deaths occur.

On a national level, MCH works very closely with the National Center for Fatality Review and Prevention (the Center). In addition to providing technical assistance on fatality review processes, the Center does QI work on the SUID and SDY case data that is entered into its child death registry. This enables MCH to facilitate analyses on the data, leading to a better understanding of how and why infants and children die in the State and catalyzes actions to prevent other deaths.

Another key in-state partner for Title V is DHHS's Division of Behavioral Health Services, including the Bureaus for Behavioral Health, Children's Behavioral Health, and Drug and Alcohol Services. MCH works collaboratively with this Division on many different projects including suicide prevention and perinatal substance exposure. MCH and BFCS

staff are participating members of the Bureau for Children's Behavioral Health's System of Care Advisory Council. Much like the ECIT, this group brings members from across DHHS and beyond, all aligned in the mission to promote and continuously improve the State's children's system of care principles and values within the behavioral health system. The NH System of Care is an integrated and comprehensive system of behavioral health supports and services working together to get the right resources to children, youth, and their families when and where they need them. New this past year is the development of the Children's System of Care Technical Assistance Center. As part of the State's ten year mental health plan, this new Center has the responsibility of implementing, monitoring and disseminating research- and evidence-based practices and interdisciplinary workforce development activities in children's behavioral health. MCH's Administrator and Pediatric Behavioral Health Coordinator sit on the Center's leadership team.

Another local organization MCH works with on a regular basis is the NH Children's Health Foundation, a charitable entity. One of the collaborative projects is on sexual and reproductive health care access, particularly in terms of decreasing unintended pregnancies with the ultimate goal of reducing and preventing childhood trauma. This included an assessment of the reproductive and sexual health needs of individuals while simultaneously assessing the skills and attitudes of sexual and reproductive health care clinical providers. Training for providers is being developed based on the analysis of both assessments.

A new collaborative within the past year is the State Partnerships for Improving Nutrition Equity. Its mission, much like that of the ECIT and the Bureau for Children's Behavioral Health's System of Care Advisory Council, is to increase collaboration and alignment of multiple food access programs across New Hampshire as well as increasing resources related to food insecurity.

BFCS continues to be part of the leadership for the Charting the Life Course (CtLC) initiative in the Division of Long Term Supports and Services (DLTSS). Through a contract with DHHS, UNH coordinates the CtLC Community of Practice.

The BFCS Family Support Administrator is the DLTSS' representative to the State's Family Support Council, which is governed by He-M 519.01 to support regional family councils and advise the Bureaus. Agenda items are formulated by members in cooperation with the Family Support Administrator and are an avenue for arbitration and mediation conflict resolution between Area Agencies (for developmental services) and regional family councils.

As a member of the National Transition Community of Practice, led by the [IDEA Partnership](#), one of BFCS' Nurse Health Care Coordinators shares responsibility for organization and facilitation of monthly meetings. Agendas are designed to bring resources together and problem-solve barriers and issues faced by youth and young adults with disabilities who are transitioning from children's services (including school and pediatric health providers) to adult services. Activities include planning of the annual summit, which often receives sponsorship from Title V through BFCS, and the NH Transition CoP free Educational Series. BFCS presents annually about health care transition from pediatric to adult providers and the role of health care coordination and family support in assisting youth and families through this important period.

Another important partnership for NH's Title V programs is with the Council for Youth with Chronic Conditions (CYCC), the only statewide organization that has a legislative mandate to focus on the issues affecting children and adolescents with chronic health conditions. In addition to the CSHCN Director, members include families of CSHCN, legislators, pediatric specialists, school nurses, service providers, NHFV, and other state administrators from DHHS. In 2022, the CYCC contracted with NH's Public Health Institute, Community Health Institute (CHI) to conduct a qualitative needs assessment to inform Title V work with CSHCN in NH. Their approach includes advisory group and stakeholder engagement, data collection, qualitative data analysis, and report development and dissemination of

findings. CHI uses a variety of data collection methods including secondary data review, [PhotoVoice](#), Caregiver Survey, Key Informant Interviews, and Caregiver Focus Groups.

Finally, the BFCS Family Support Administrator and Part C Coordinator participate in the Interagency Coordinating Council (ICC), which is federally mandated under Part C of the Individuals with Disabilities Education Improvement Act (IDEIA). It serves as an advisory group to BFCS as the state agency that oversees Family Centered Early Supports and Services for children birth to age three who have or are at risk of having developmental delays, and their families. The mission of the ICC is to promote and increase the quality of Family Centered Early Supports and Services and Preschool Special Education supports and services to eligible children, birth through five years, and their families.

### III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

In 2017, an “Intra-Agency Agreement between the NH Title V sections and the NH Office of Medicaid Services, Relative to Joint Planning, Coordination and Improvement of Health Programs under Title V and Title XIX” was signed jointly by MCH, BFCS and Medicaid.

MCH is an appointed representative on the Medicaid Medical Care Advisory Committee (MCAC), whose responsibility is to advise on policy, rules, waivers and other operational issues. Currently, the Long Term Supports & Services (DLTSS) Director attends MCAC meetings. However, due to staff turnover, BFCS has not had a representative to MCAC since late 2019. The CSHCN Director is working with Division Leadership to appoint the Clinical Program Manager. There are three Medicaid Care Management organizations (MCOs) in the State: NH Healthy Families, Well Sense and AmeriHealth Caritas.

DHHS’s Bureau of Quality Assurance and Improvement (QAI), which primarily works with NH Medicaid, has continued its partnership with MCH by routinely sharing data, such as monthly birth linkages (linked births and Medicaid delivery claims), for routine querying and matching for programs such as newborn screening and newborn hearing screening. This linkage enables more in-depth analyses than are possible with either dataset alone and has been used to examine issues such as early elective deliveries and severe maternal morbidity.

MCH staff also closely work with the Medicaid Quality Program (MQP), particularly in the last year determining the Medicaid Care Management Quality Improvement Priorities. All are HEDIS measures and seven of the eleven specifically focus on women and children and are of concern to MCH, including prenatal and postpartum care, immunizations for adolescents in combination with and without HPV, and weight assessment and follow-up counseling for children and adolescents. Each priority has a goal to be achieved by the end of December 2023 and represent the benchmark of the 75<sup>th</sup> percentile of national Medicaid health plans.

NH Medicaid Care Management Quality Improvement Priority		MEDICAID INTERNAL PARTNER	2020 RATE	CURRENT GOAL
1	<a href="#">Chlamydia Screening in Women (CHL)*</a>	DPHS	46.5%	61.7%
2	<a href="#">Comprehensive Diabetic Care Control &lt;8% (HBD)</a>	DPHS	42.8%	51.3%
3	<a href="#">Continuation of Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medications (ADD)*</a>	DPHS, DBH, DCYF	53.6%	62.4%
4	<a href="#">Controlling High Blood Pressure Total (CBP)*</a>	DPHS	52.7%	62.5%
5	<a href="#">Pharmacotherapy for Opioid Use Disorder (POD)</a>	DPHS, DBH	28%	38.9%
6	<a href="#">Timely Postpartum Care (PPC)*</a>	DPHS	73.5%	79.5%
7	<a href="#">Timely Prenatal Care (PPC)*</a>	DPHS	77.1%	83.8%
8	<a href="#">Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*</a>	DPHS, DBH, DCYF	62.8%	69.5%
9	<a href="#">Immunizations for Adolescents Combination Without HPV (IMA)*</a>	DPHS	74.3%	87.1%
10	<a href="#">Immunizations for Adolescents Combination Including HPV (IMA)*</a>	DPHS	33.4%	43.5%
11	<a href="#">Weight Assessment and Counseling in Adolescents/Children (BMI)*</a>	DPHS	63.9%	82.7%

HEDIS™ is a trademark of the National Committee for Quality Assurance (NCQA)  
 \*The Centers for Medicare and Medicaid (CMS) Core Set of Adult or Child Health Care Quality Measures

These will become the focus of MCO performance improvement projects of which MCH staff will participate as subject matter experts.

There are also eight lever measures (some the same, some different from the priority measures) and half are

focused on women and children, including the HEDIS measure on adolescent well visits. The lever programs include withholding (of a specific percentage of funds until a measure is met) and incentives (the amount that is not recouped from withholding goes to those MCOs who do meet the measures). MCOs will be required to reach specific thresholds for the measure or risk losing a percentage of their capitation payments. High performing MCOs have the potential to receive incentives. MCH staff again will be utilized as subject matter experts.

Performance Category	Performance Measure (1)	Minimum Performance Standard	Annual Goal
<b>Perinatal</b>	Prenatal and Postpartum Care (PPC) – Prenatal Care	Individual MCO 2021 Calendar Year Performance (2)	National Medicaid HMO 75 <sup>th</sup> Percentile 2021 Calendar Year Performance (3)
	Prenatal and Postpartum Care (PPC) – Postpartum Care	Individual MCO 2021 Calendar Year Performance	National Medicaid HMO 75 <sup>th</sup> Percentile 2021 Calendar Year Performance
<b>Children and Adolescents</b>	Lead Screening in Children (LSC)	Individual MCO 2021 Calendar Year Performance	National Medicaid HMO 75 <sup>th</sup> Percentile 2021 Calendar Year Performance
	Child and Adolescent Well-Care Visits (WCV) – 12-17 Years	Individual MCO 2021 Calendar Year Performance	National Medicaid HMO 75 <sup>th</sup> Percentile 2021 Calendar Year Performance

<sup>[1]</sup> Data Source: Unless otherwise noted, HEDIS.02 HEDIS Filled Workbook due on 6/30/2023

<sup>[2]</sup> Data Source: HEDIS.02 HEDIS Filled Workbook due on 6/30/2022.

<sup>[3]</sup> Data Source: NCQA Quality Compass scheduled for release September 2022

In addition, MCH is working with the MQP on its 2023 Annual Forum, which will focus on prenatal and postpartum care.

The Title V/Medicaid Agreement also reaffirms the commitment to have Title V funded contractors identify, enroll and re-enroll Medicaid eligible clients and to refer those clients to appropriate services. Seven of the funded CHCs utilize Title V for sustaining or even increasing capacity for any type of staff helping with client insurance needs. Dependent upon the CHC, approximately 1-29% of the clients coming in for the first time are uninsured.<sup>[1]</sup>

This is particularly important at this time as redeterminations are being made, post public health emergency (PHE) policies. Title V funded agencies are utilizing their insurance navigators to reach out to parents and caregivers of children receiving Medicaid coverage. Since many of these adults are on expanded Medicaid (Granite Advantage), the hope is that by talking to them about their children’s coverage, they will take action on their own coverage if necessary as well. For CSHCN who are especially vulnerable, BFCS’ health care and family support coordinators provide outreach to ensure redeterminations are completed regardless of the exemptions during the PHE. As part of the enrollment process, the Medicaid redetermination date is provided to the coordinator who works with families to complete applications on time. This has become especially important during the COVID unwinding as BFCS staff work to prevent families from being dropped. Working collaboratively with the three MCO’s or the Medicaid HIPP program, assures clients and families receive all the benefits for which they are entitled.

In addition, BFCS provides outreach to applicants for Home Care for Children with Severe Disabilities (HC-CSD aka Katie Beckett) and Social Security Disability (SSI) through a partnership with the Medicaid office.

MCH meets quarterly with Medicaid clinical and policy colleagues to discuss updates on efforts such as the unbundling of long acting reversible contraceptives after delivery, which took place almost three years ago.

MCH and BFCS staff started work almost three years ago with these same colleagues to revise the now expired Home Visiting Administrative rule [He-W-549](#), which focused payment on young, first time mothers with children under

one. A DHHS team was selected and has been working for two years in conjunction with the National Academy for State Health Policy, State Policy Institute on Public Insurance Financing of Home Visiting Services, which enable a facilitated space to learn of strategies, advantages and barriers that different states had faced in pursuing various paths to utilize public financing of home visiting. This was extremely valuable as the project to change the rule progressed and finalized.

In October 2021, HFA agencies were included in an updated rule and allowed to start billing Medicaid for home visiting, with restrictions capping the number of visits to three per year removed for prenatal families along with those with children under one. Restrictions previously limiting reimbursable visits to first time mothers under age 21 were also removed.

Medicaid and MCH's Family Planning Program also work together on a special State Plan Amendment (SPA). This particular SPA allows presumptive eligibility for Medicaid to non-pregnant individuals 19-64 years of age who are not otherwise eligible and who have an income at or below 133% of the FPL. Individuals must be enrolled by a qualified entity, including all of the MCH (Title V and Title X) contractors, who can facilitate presumptive eligibility. The SPA allows clients to receive coverage for family planning medical visits, contraceptive devices or drugs, both prescription and some non-prescription, pregnancy tests and screening and treatment for sexually transmitted infections when performed routinely as part of an initial, regular, or follow-up family planning visit, as well as sterilization. As of March 31, 2022, 630 individuals had utilized this SPA in the past year.

Sterilization is extremely difficult to get covered by Medicaid and Title V staff have heard directly from clients about the challenges in getting this service covered. Medicaid requires it to be medically necessary and not an elective, voluntary method like other contraceptive methods. No Title V funded (or Title X) offer these services, so there are few programs in the State that can help cover the costs.

The strength of the relationship between NH Medicaid and BFCS is exemplified in a recent request from the Medicaid Director. Upon his announcement that the long-time Medicaid Fee for Service Administrator, Jane Hybsch, would retire, he requested that BFCS participate in the interim plan for coverage and transition. The Clinical Program Manager and a senior nurse health care coordinator have been trained as back-up staff to provide prior authorizations. In addition, they will conduct clinical review of policies submitted by the MCOs, when Medicaid approval is required. With this retirement, the Department will lose a significant amount of institutional knowledge and BFCS is committed to supporting the transition to ensure continuity of Ms. Hybsch's long-time dedication as a champion for CSHCN and their families.

As a member of the Leadership team for DLTSS, the CSHCN Director participates in development and renewals of Medicaid Home and Community-Based Services waivers; particularly the In Home Supports Waiver for Children with Developmental Disabilities. The purpose of this 1915(c) waiver is to provide in-home residential habilitation, inclusive of personal care, and other related supports and services to promote greater independence and skill development for a child or youth who has a developmental disability and has significant medical or behavioral challenges. This is determined in accordance with state rules; allows eligible CSHCN to remain living at home with their family, and be actively engaged with their community. Health care coordinators frequently provide families with information about the Waiver and promote the benefits available to support families with CSHCN.

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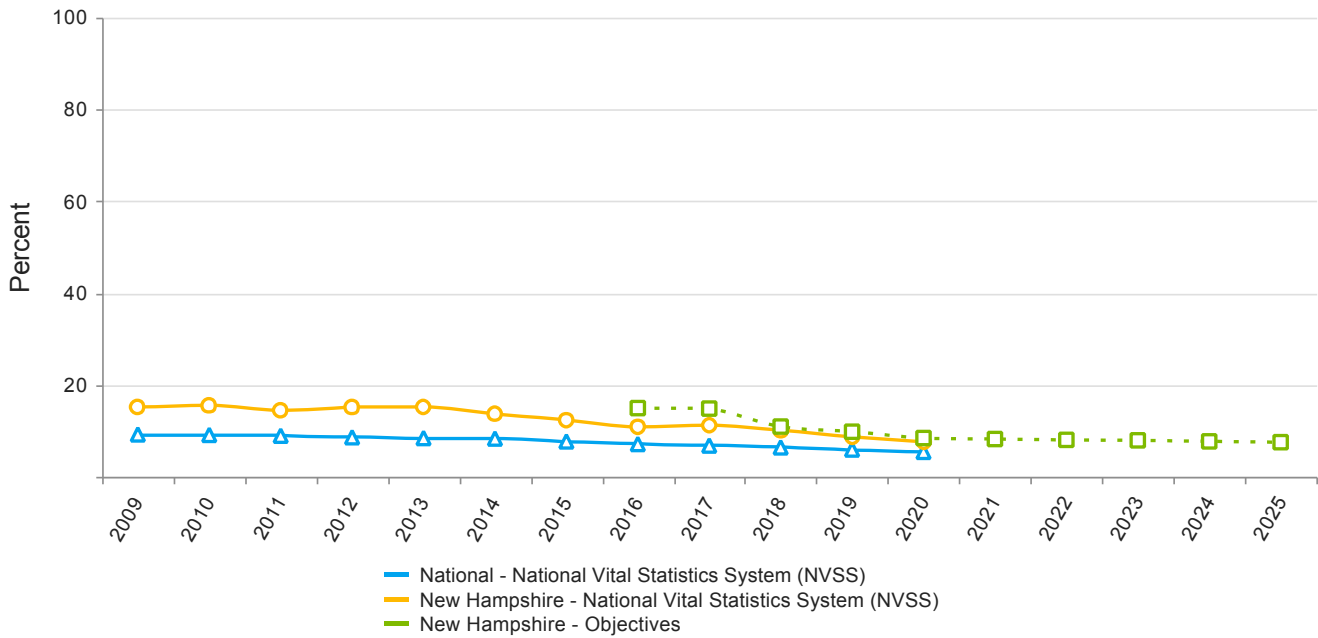
[<sup>1</sup>] UDS Tables (2020).

### III.E.2.c State Action Plan Narrative by Domain

#### Women/Maternal Health

#### National Performance Measures

**NPM 14.1 - Percent of women who smoke during pregnancy  
Indicators and Annual Objectives**



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	2018	2019	2020	2021
Annual Objective	14.9	11	9.9	8.5	8.3
Annual Indicator	11.1	11.3	10.1	8.8	7.6
Numerator	1,342	1,353	1,201	1,040	896
Denominator	12,052	12,022	11,946	11,786	11,713
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020



State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	14.9	11	9.9	8.5	8.3
Annual Indicator	11.1	10	8.8	7.5	5.9
Numerator	1,343	1,191	1,035	887	744
Denominator	12,076	11,941	11,811	11,761	12,595
Data Source	NH Division of vital records birth table	NH Division of Vital Records birth table	NH Division of Vital Records	NH Division of Vital Records	NH Div. Vital Records
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.1	8.0	7.8	7.6

**Evidence-Based or –Informed Strategy Measures**

**ESM 14.1.1 - Percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe /Supported Care (POSC)**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator		55.8	50.9
Numerator		308	419
Denominator		552	823
Data Source		EBI_Datamart.VR_Birth	EBI_Datamart.VR_Birt
Data Source Year		2020	2021
Provisional or Final ?		Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.0	80.0	90.0	95.0

## State Action Plan Table

### State Action Plan Table (New Hampshire) - Women/Maternal Health - Entry 1

#### Priority Need

Decrease the use and abuse of alcohol, tobacco, and other substances among pregnant women

#### NPM

NPM 14.1 - Percent of women who smoke during pregnancy

#### Objectives

By July 1, 2023, decrease the percentage of women with Medicaid Managed Care health plans who smoke during pregnancy from 22.6% (baseline data 2021) to 21% or less among 2022 deliveries paid by NH Medicaid

By July 1, 2023, decrease the percentage of women who smoke during pregnancy from 2.2% (baseline data 2021) to 2% or less among 2022 deliveries not paid by NH Medicaid

By July 1, 2023, the MCH-funded Primary Care practices will screen at least 90%, according to quarterly EMR audits, of prenatal patients for tobacco use

By July 1, 2023, the MCH-funded Primary Care sites will offer quit smoking assistance/resources, according to quarterly EMR audits, to 90% of pregnant women screening positive for tobacco use

By July 1, 2023, 50% of OB-GYN staff at 6 of 12 (50%) of MCH-funded Primary Care practices will complete the e-learning module evaluation, 'Supporting Pregnant and Postpartum Women to Quit Tobacco' (baseline 0)

#### Strategies

Continue to monitor the number of MCH-funded Primary Care site clinical staff that complete the e-learning module, 'Supporting Pregnant and Postpartum Women to Quit Tobacco'

Promote tobacco cessation for pregnant persons through collaborations with the Tobacco Prevention and Cessation Program (TPCP) for social marketing campaigns and print materials in provider offices

Incorporate discussion of smoking cessation into the Plan of Safe Care, which is discussed with at-risk women during pregnancy and prior to hospital discharge after delivery

#### ESMs

#### Status

ESM 14.1.1 - Percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe /Supported Care (POSC) Active

## NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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NOM 3 - Maternal mortality rate per 100,000 live births

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NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

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NOM 5 - Percent of preterm births (<37 weeks)

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NOM 6 - Percent of early term births (37, 38 weeks)

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NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

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NOM 9.1 - Infant mortality rate per 1,000 live births

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NOM 9.2 - Neonatal mortality rate per 1,000 live births

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NOM 9.3 - Post neonatal mortality rate per 1,000 live births

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NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## Women/Maternal Health - Annual Report

### National Performance Measure #14.1: Percent of women who smoke during pregnancy

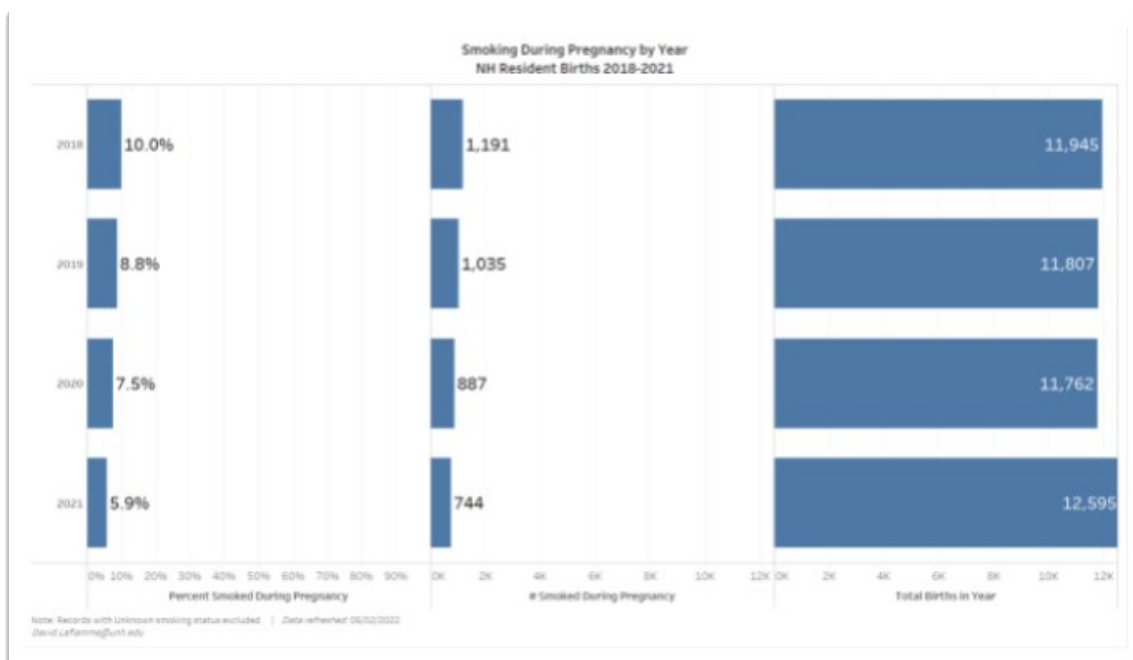
#### NPM 14.1 Objectives:

- By July 1, 2022, decrease the percentage of women who smoke during pregnancy to 25% or less among deliveries paid by NH Medicaid.
- By July 1, 2022, decrease the percentage of women who smoke during pregnancy to 2% or less among deliveries not paid by NH Medicaid.
- By July 1, 2022, the MCH-funded Primary Care sites will screen at least 90% of their prenatal patients for tobacco use and provide intervention if positive
- By July 1, 2022, clinical staff from at least 80% of MCH-funded Primary Care sites will have completed the evaluation for 'Supporting Pregnant and Postpartum Women to Quit Tobacco' e-learning module.

#### NPM 14.1 Strategies:

- Continue to provide professional education on best practices in tobacco treatment through online e-learning modules.
- Promote tobacco cessation for pregnant persons through use of public service announcements posted on DHHS social media platforms.
- Incorporate discussion of smoking cessation into the Plan of Safe Care, which is discussed with at-risk women both during their pregnancy as well as prior to hospital discharge after delivery.

The graph below shows the percentage of pregnant people who smoked during pregnancy from 2018-2021.



Demographics for year 2020  
Data Source – NH NVSS

Marital Status - 2020	Married	Unmarried
	2.7%	18.8%

Maternal Age – 2020	<20 Years	20-24 Years	25-29 Years	30-24 Years	>35 Years
	6.3%	13.3%	10.1%	5.4%	5%

Educational Attainment - 2020	< High School	High School Grad	Some College	College Graduate
	11.2%	9.4%	5.7%	0.5%

Smoking prevalence in 2019  
Data Source – NH PRAMS<sup>[1]</sup>

Perinatal Smoking	Within the Previous 2 Years	In the 3 months Before Pregnancy	In the last 3 Months of Pregnancy	At time of Survey (2 – 6 Months Postpartum)
	19.9%	18.6%	9.1%	11.3%

Screening and Counseling for Pregnant Women in the Community Health Centers (CHCs)

Smoking during pregnancy has enormous health and economic costs to the State of NH. Smoking while pregnant has a direct relationship with preterm and low birthweight infants. These infants require longer, more intensive care and a have higher incidence of long-term health deficits. Infants born to women/birthing persons who smoke are also at increased risk of sudden infant death syndrome (SIDS), birth defects, and stillbirth. Infants exposed to second hand smoke have an increased likelihood of developing asthma as children.<sup>[2]</sup>

Pregnant persons often have increased motivation to quit smoking due to concerns about their baby’s health. Providers who have contact with patients during this period around pregnancy are well positioned to address tobacco use with pregnant persons. Providers may also have more access to birthing persons for intervention and follow-up during pregnancy than at other periods of these women and birthing persons’ lives. Medical visits for prenatal care bring patients and providers together at least monthly. Due to this potential for increased motivation on the part of pregnant persons and increased access by health care providers, this is an opportune time to address smoking cessation.

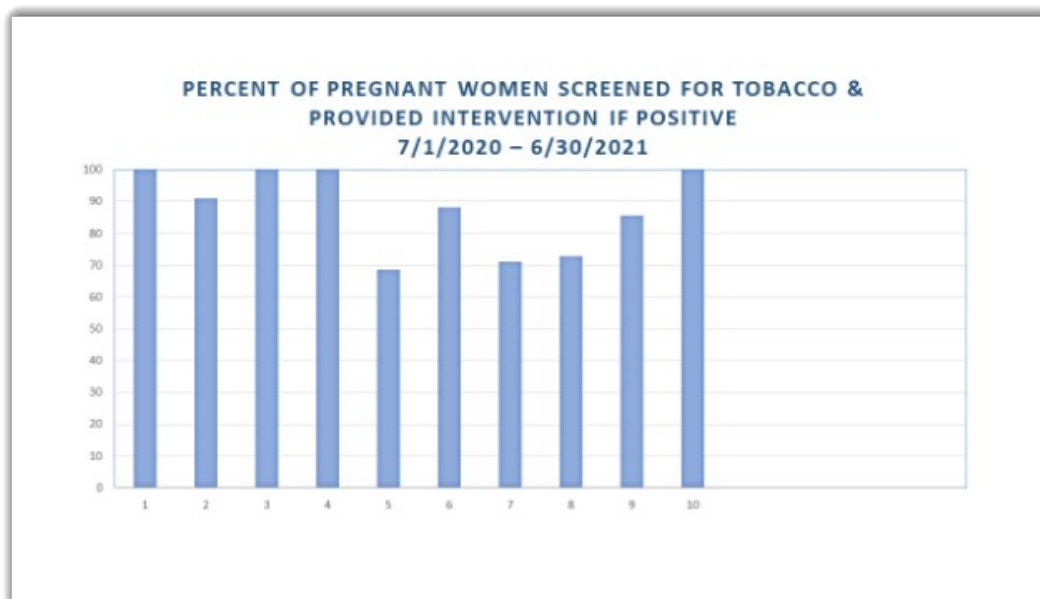
Many pregnant persons quit smoking during pregnancy, but relapse postpartum. The NH Tobacco Prevention and

Cessation Program (TPCP) began collaborating with the NH Maternal and Child Health (MCH) program in 2015 as a resource for evidence-based tobacco treatment. The collaboration supports the MCH contract requirement that smoking status and treatment interventions must be documented in the electronic medical record for all patients. TPCP contracts with the National Jewish Health (NJH) Hospital in Denver, Colorado to provide quitline services for NH's most vulnerable populations at no cost to the participant. QuitNow-NH offers multi-counseling calls and 10 weeks of nicotine replacement therapy (NRT) products for the general Medicaid, Medicare and uninsured population. QuitNow-NH's Pregnancy Postpartum Program (PPP) is staffed with specially trained; highly skilled nationally certified tobacco treatment counselors who understand the unique needs of pregnant persons. Pregnant persons may receive five counseling calls and four additional calls postpartum. NRT is supplied to these patients, upon provider approval.

There are three ways to access QuitNow-NH services:

- Call 1-800-QUIT-NOW (1-800-784-8669) for general inquires, quit-tobacco materials for self or for a loved one and/or immediately enroll in Quit Coach services
- [www.QuitNowNH.org](http://www.QuitNowNH.org) offers on-line enrollment, educational materials to download, sign up for interactive text messaging and live-chat with a Quit Coach.
- Provider Web Referral [Patient Referral Forms - QuitWorks-NHQuitWorks-NH \(quitworksnh.org\)](http://Patient Referral Forms - QuitWorks-NHQuitWorks-NH (quitworksnh.org))

The CHCs that receive funding through the MCH Title V Block Grant screen pregnant patients for smoking. Providers screen patients in each of the three trimesters of the pregnancy. The 2020 MCH target was for 90% of prenatal patients to be screened for tobacco use and to provide intervention, if positive. As noted in the graph below, of the ten (10) reporting CHCs funded through the MCH Title V Block Grant, five (5) screened 90% or higher in 2021. In 2020 six (6) of 11 CHCs funded through the MCH Title V Block Grant screened 90% or higher. Seven (7) of the reporting CHCs actually screened 100 % of their patients, but two of those fell short of offering interventions to everyone who was found to be positive.

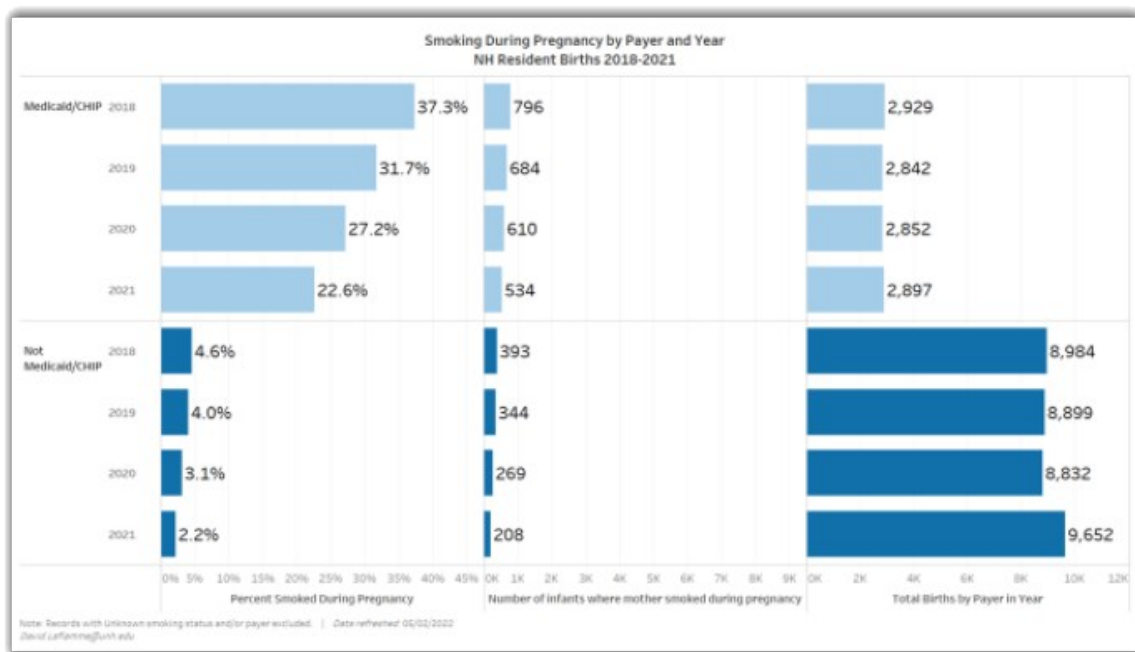


The MCH PNC will continue to collaborate with the TPCP in order to educate providers on how to screen for smoking during pregnancy and provide intervention if positive.

The data for the objective, “By July 1, 2022, clinical staff from at least 80% of MCH-funded Primary Care sites will have completed the evaluation for ‘Supporting Pregnant and Postpartum Women to Quit Tobacco’ e-learning module” is not available for State Fiscal Year (SFY) 2022 due to an 18-month-long video-update process to a new Training Platform. SFY2023 will have data on this objective.

According to the 2021 birth certificate data, smoking among pregnant persons enrolled in NH Medicaid Managed Care plans remains higher (22.6%) than among those with private health plans (2.2%). During 2023, TPCP will work with MCH to increase awareness among the contracted Primary Care practices about the PPP and all the services offered through QuitNow-NH. Further, TPCP will share with MCH the QuitNow NH data reports relative to provider utilization and six (6)-month patient outcomes for quitting (de-identified data).

The following graph shows multiple years of smoking rates among pregnant people in NH with trends by payor source: Medicaid or other than Medicaid.



The percentage of women smoking during pregnancy has been gradually decreasing over time. By assisting providers with techniques for encouraging patients to be smoke-free, the number of women offered counseling and assistance should increase, resulting in a continuation of this downward trend in smoking during pregnancy. The new video training platform will be promoted for use by providers and staff on an ongoing basis through professional newsletters and regular meetings, including the Dartmouth-Hitchcock Northern New England Perinatal Quality Improvement Network (DH-NNEPQIN), the Governor’s Task Force on Perinatal Substance Exposure, Primary Care meetings, and through collaboration with the WIC program.

**ESM 14.1:** Percentage of women postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe/Supported Care (POSC)

**ESM #14.1 Objectives:**



- By July 1, 2022, increase the percentage of postpartum women whose infant was monitored for the effects of *in utero* substance exposure who had a documented POSC to 65%.
- By July 1, 2022, increase the percent of birthing persons whose infant was monitored for the effects of *in utero* substance exposure who were offered naloxone prior to postpartum discharge from a baseline of 14% in 2021 to 20% in 2022.

### **ESM #14.1 Strategies:**

- The MCH Perinatal Nurse Coordinator (MCH PNC) will collaborate with other MCH programs such as the NH Maternal Infant Early Childhood Home Visiting (MIECHV) Program and contracted MCH Primary Care agencies in supporting efforts to promote providers in developing a POSC with all prenatal, birthing and postpartum women.
- The MCH Maternal Mortality Review (MMR) Coordinator will monitor whether or not a POSC was in place for all maternal deaths in NH related to or caused by substance misuse.
- The MCH MMR Coordinator will collaborate with other states' MMR Committees to share best practices. Through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Grant, the MCH MMR Coordinator and the MCH Epidemiologist will work with the NNEPQIN to implement the Alliance for Innovation for Maternal Health (AIM) "Obstetric Care for Women with Opioid Use Disorder" bundle in NH hospitals. This will include the Narcan distribution initiative.
- The MCH PNC will continue in advisory roles with the Governor's Task Force for Perinatal Substance Exposure and Medicaid Maternal Opioid Misuse (MOM) Grant committee

This ESM addresses a significant and many-faceted issue facing NH birthing people and their families. Substance use continues to be the leading cause of maternal death in NH. The Plan of Safe/Supportive Care (POSC) model provides consistency in the resources offered to birthing people with substance use disorders (SUD) by providers and healthcare workers statewide.

### **New Hampshire Plan of Safe/Supportive Care**

The NH POSC template offers the guidance to address this issue consistently and on an individual level for each birthing person and their family challenged by substance use. A completed POSC signifies that there has been collaboration between the patient with SUD and a provider or other designated healthcare worker. This collaboration allows a better understanding of that birthing person's view of themselves, including perceived strengths and weaknesses, as well as their vision for their future. There continues to be room for instruction on best practice for the use of the POSC in order for this document to be as effective as possible.

### **POSC Background in NH**

The Federal Comprehensive Addiction and Recovery Act of 2016 (CARA) amended the Child Abuse Prevention and Treatment Act (CAPTA) to require the development of a Plan of Safe Care (POSC) for all infants affected by prenatal drug or fetal alcohol exposure. NH law (NH Rev Stat § 132:10-e, 10-f), in compliance with federal law, requires that "when an infant is born identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, the health care provider shall develop a plan of safe care, in cooperation with the infant's parents or guardians and the department of health and human services, division of public health services, as appropriate, to ensure the safety and well-being of the infant, to

address the health and substance use treatment needs of the infant and affected family members or caregivers, and to ensure that appropriate referrals are made and services are delivered to the infant and affected family members or caregivers.”

With the goal of creating a model POSC for use in NH which meets the requirements of the federal and state laws, a stakeholder group convened to develop a framework and an effective POSC document. The Perinatal Substance Exposure Task Force of the NH Governor’s Commission on Alcohol and other Drugs led this group, which included partners from a variety of healthcare organizations and community resource providers across the State who were already actively involved in addressing SUD in pregnant and parenting women. Partners include the NH Division of Public Health Services, DH-NNEPQIN, NH DCYF, NH Bureau of Drug and Alcohol Services, and the University of NH Institute for Health Policy and Practice, among many others.

Following is the first page of the current NH POSC *This form complies with NH RSA 132:10-e and NH RSA 132:10-.*<sup>[3]</sup>

**SUPPORTIVE CARE FOR FAMILIES AND INFANTS**

**I. PLAN OF SAFE AND SUPPORTIVE CARE (POSC)**

This POSC is developed collaboratively with all birthing parents and co-parents to reinforce and coordinate supports and services. The POSC must be given to the mother upon discharge from the birthing facility and should go to the infant’s primary care provider along with the infant’s other medical records. For an electronic version of this form, visit: <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

**II. DEMOGRAPHIC INFORMATION**

Name of Birthing Parent:	Birthing Parent’s Medical Providers:
Name of Co-parent:	Infant’s Medical Providers:
Name of Infant:	Birthing Parent’s Admission Date:
Name of Other Caregiver (if relevant):	Birthing Parent’s Discharge Date:
Infant’s DOB:	Infant’s Discharge Date:
Birthing Parent’s Phone Number:	Co-Parent’s Phone Number:
Birthing Parent’s Health Insurance:	Other Caregiver’s Phone Number:
Current Address:	

**III. CURRENT SUPPORTS** [such as partner/spouse, family/friends, counselor, spiritual faith/community, recovery community, etc.]

**IV. STRENGTHS AND GOALS** [What matters to you? Breastfeeding, parenting, housing, smoking cessation, recovery?]

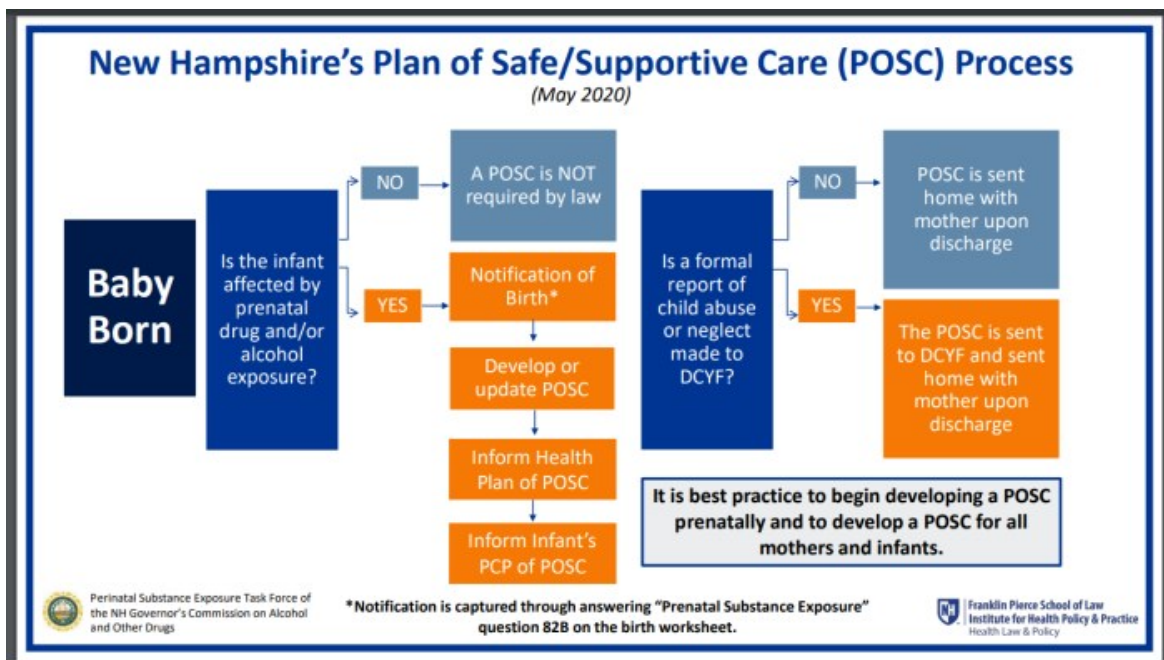
### The Governor’s Task Force for Perinatal Substance Exposure

Prior to the passing of CARA, and the subsequent development of the POSC model for NH, there had not been a reliable and consistent statewide system for identifying infants at risk due to prenatal substance exposure. Key elements in creating and maintaining successful plans for birthing people with SUD are trust, consistency, and

connections with appropriate supportive resources. This effort requires not only input from a variety of organizations across the State, but also educating all of those professionals and other support individuals involved in the care of the birthing person and infant about the laws, process, and resources for creating an effective POSC.

The Governor’s Perinatal Substance Exposure Task Force took on this challenge and brought together the necessary stakeholders to develop the plan that provided NH with the best process for the providers and women of the State. The NH Center for Excellence continues to work with the Task Force to coordinate effort with significant input from stakeholders including NH DHHS, OB-GYN providers, pediatricians, hospital staff, mental health providers, legal professionals, the NH Division of Children, Youth, and Families (DCYF), and experts in the field of SUD, among others.

The diagram below was developed by this group in order to clarify for providers when a POSC is required. This diagram also shows how the development of the plan relates to the necessity for reporting to the Division of Children, Youth, and Families (DCYF). The diagram instructs providers at the hospital level next steps with the POSC.

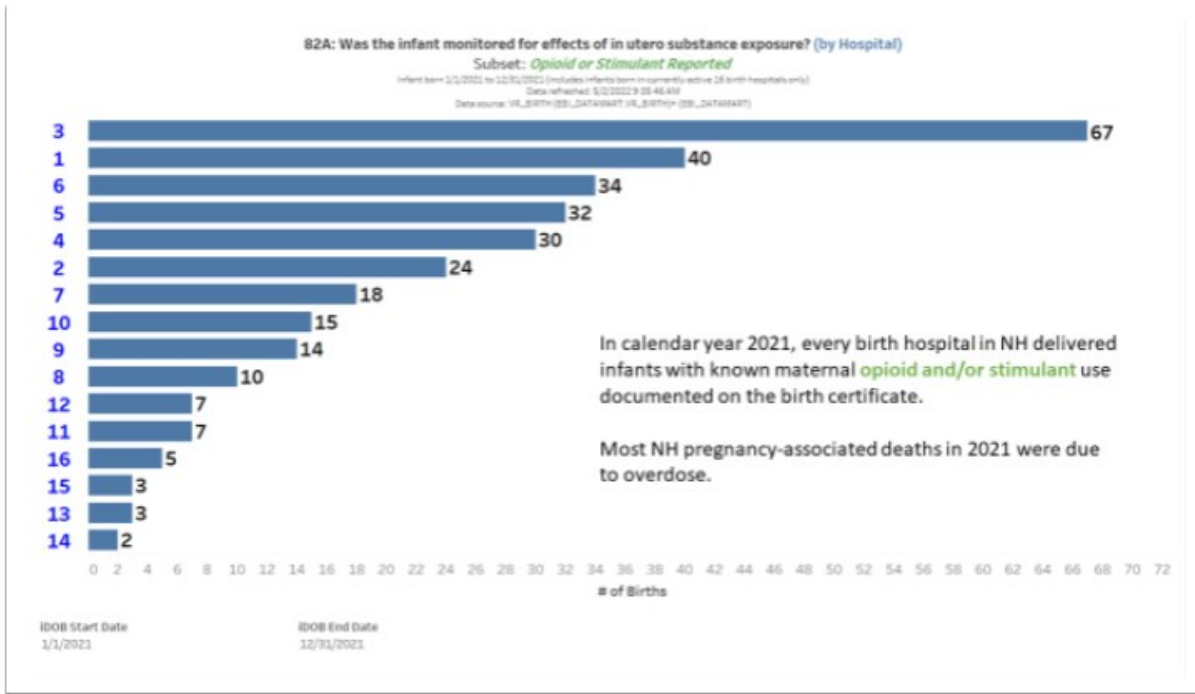


The NH birth certificate was used to capture data showing the percent of infants monitored for effects of *in utero* substance exposure and the percent of those who had a POSC created. The birth certificate worksheet questions are listed as follows:

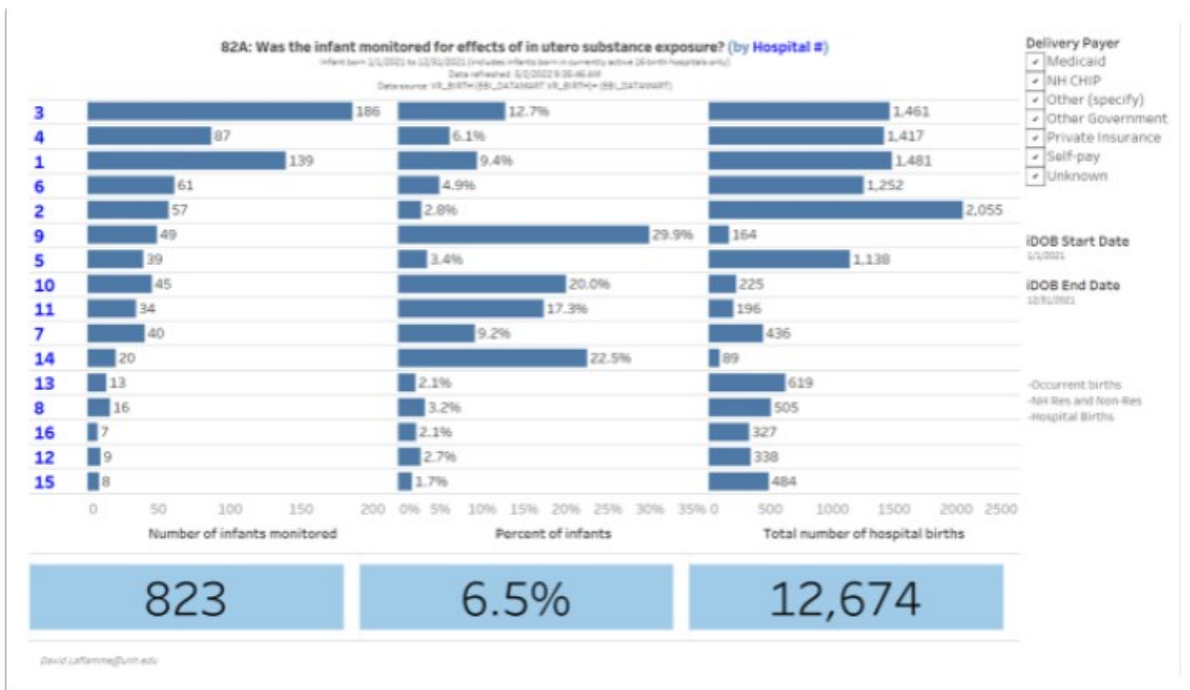
<b>Revised Perinatal Substance Exposure Questions Added to the birth certificate April 29, 2020</b>	
<p><b>Prenatal Substance Exposure</b>  <b>82A.</b> Was the infant monitored for effects of <i>in utero</i> substance exposure? Yes No</p> <p><b>If YES, Type of substance(s): (check all that apply)</b>  opioids stimulants (amphetamines, methamphetamines, other) cocaine cannabis benzodiazepines barbiturates alcohol nicotine bath salts Kratom Other (Specify)</p>	<p>To determine clinical concern relating to <i>in utero</i> substance exposure. Stakeholders with expertise in SUD recommended the list of substances. The choice of “other” was added in case of new and emerging substances of concern.</p>
<p><b>82B.</b> Was the infant identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder? Yes No</p>	<p>Uses language directly from the CAPTA legislation (with a change of “abuse” to “misuse”) in order to meet the federal reporting requirement.</p>
<p><b>83.</b> Was a Plan of Safe/Supportive Care (POSC) created? Yes No</p>	<p>Relates directly to the metric required in the new Evidence-based Strategy Measure (ESM).</p>

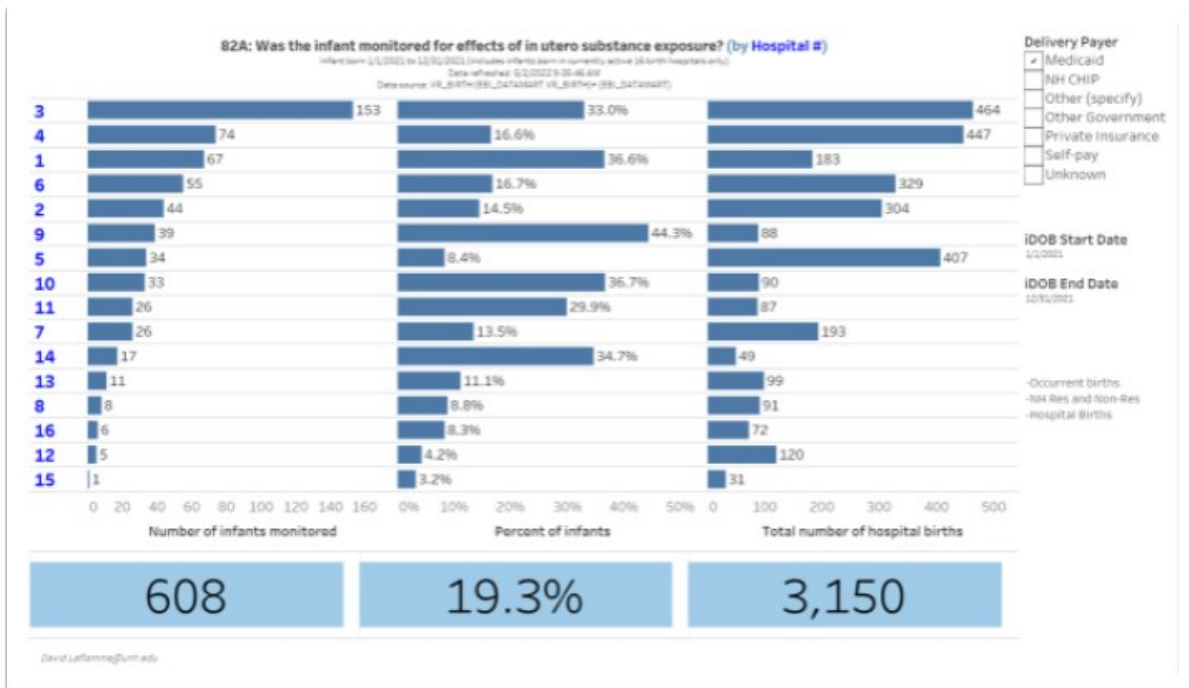
This ESM, reporting on the percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented POSC, gives important data on the number of women with SUD who were provided the opportunity to learn about and be linked with the local resources and supports available to them in the area in which they live.

Results of data collected using the birth certificate questions indicates that SUD exposure varies widely throughout the state. In the following graphic, each birthing hospital in NH is represented by a number. As demonstrated, Hospital #3, had the highest number of infants exposed to in utero substances and Hospital #14 had the least. There is a significant difference in numbers of infants exposed to in utero substances between different areas of our state.



The following two graphics demonstrate the continued disparity of infant *in utero* substance exposure based on social determinants of health. Of the 12,674 total births in NH in 2021, 6.5% were infants monitored for effects of *in utero* substance exposure; 3,150 of the 12,674 births were paid by Medicaid, and of those, 19.3% were monitored for effects of *in utero* substance exposure. This is a stark reminder that the POSC should be used as early in the pregnancy process as possible in order to help connect lower income birthing people with adequate SUD treatment.





The following graphic demonstrates that 50.9% of infants monitored for effects of *in utero* substance exposure had a POSC created. This is a decrease from 54.9% in 2020. This may be due to the staffing shortages experienced from the COVID-19 pandemic. A thoughtful completion of the POSC takes time, which for many clinicians is in short supply. This needs to be addressed with providers to find ways to help them complete these valuable documents.

**New Hampshire ESM 1\***  
 Percentage of postpartum birthing individuals whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe/Supportive Care (POSC).  
Infants born 1/1/2021 to 12/31/2021  
 Data refreshed: 5/2/2022 9:35:46 AM  
 Data source: VR\_BIRTH(SS\_DATAMART VR\_BIRTH)=(SS\_DATAMART)

		83: Was a Plan of Safe/Supportive Care (POSC) created?	
		No	Yes
82A: Was the infant monitored for effects of in utero substance exposure?	No	11,761 (99.2%)	90 (0.8%)
	Yes	404 (49.1%)	419 (50.9%) <--ESM %

\*Title V Block-Grant Evidence-based or -informed Strategic Measure  
 David LaFemme@unh.edu

This data indicates that NH needs to place even more emphasis on training providers on the POSC process, since in only half of cases where the infant was monitored for *in utero* substance exposure was a POSC created.

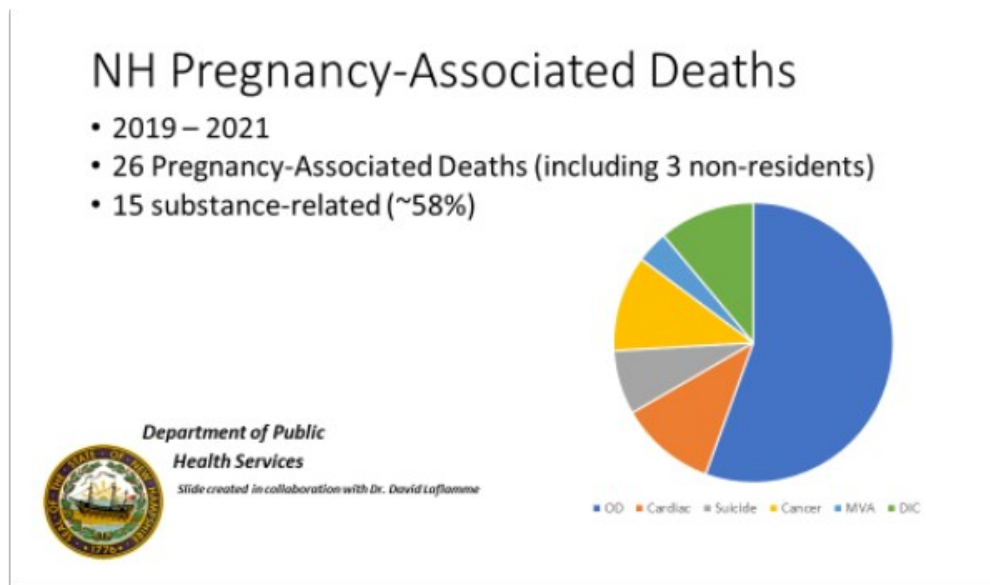
Work is continuing throughout the nation on the best ways to utilize POSCs. On February 16, 2022 the MCH PNC

attended a webinar discussing an article written about Project Nurture in Portland, Oregon. The article can be accessed here: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01574> . This webinar contained rich discussion on benefits of developing POSCs early in prenatal care or at the first engagement in prenatal care. These POSCs then result in the creation of a recovery resume binder which the birthing person takes with them to appointments and ultimately the birthing hospital. Active participation in the elements of this document by providers and the birthing person helps to build trust and reduce stigma.

The MCH PNC continues to be an active member of the NH Governor’s Task Force for Perinatal Substance Exposure. Through this collaboration, work continues on finding the most effective uses for the POSC and then educating providers in NH on what was found. Due to COVID-19 restrictions, this past year the Task Force met a few times virtually (under the state emergency COVID-19 orders).

### The Maternal Mortality Connection

As the following graphic demonstrates, the primary causes of maternal deaths in NH from 2016-2021 were substance use related. The Maternal Mortality Review Committee (MMRC) reviews all maternal deaths (deaths during pregnancy through 12 months postpartum) in NH to determine if they could have been prevented, and recommends system changes to prevent future deaths. The POSC is one aspect of a plan to help prevent these substance related maternal deaths.



The strategy to contact pediatricians to determine if there was a POSC in place was not used during the review of 2020 maternal death cases. No maternal death cases related to substance use had infants that were living after the maternal death.

### Collaborations

New Hampshire is completing the third year of a five (5)-year CDC grant titled “Enhancing Reviews and Surveillance to Eliminate Maternal Mortality” (ERASE MM). This grant continues to work with the NH Maternal Mortality Program (MMP) and DH-NNPQIN on best practices for operating the NH MMRC and for Maternal Mortality Review Information Application (MMRIA) data collection. Data that is collected is de-identified and accessed in aggregate to

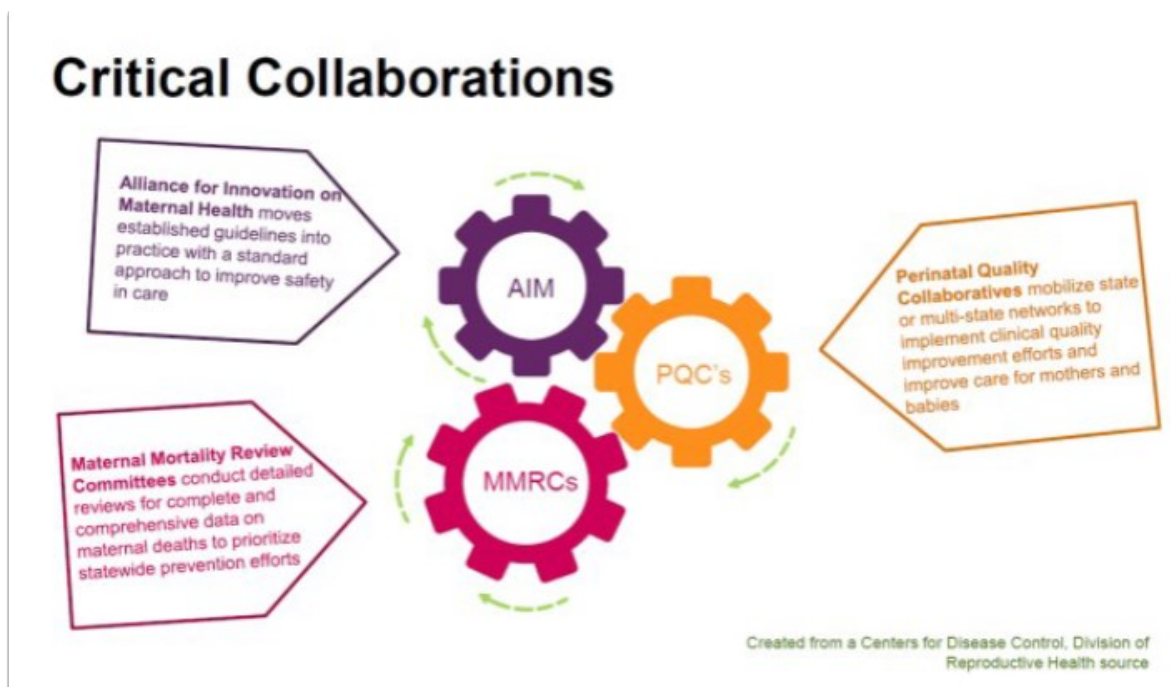
help identify reasons for maternal deaths and document recommendations made by MMRCs throughout the United States. The goal is to identify common themes and recommendations in order to help prevent future maternal deaths.

As part of the ERASE MM grant, the MCH PNC is expected to attend monthly MMRIA Office Hours. DH-NNEPQIN's co-abstractor attends many of these office hours, as well. The office hours provide the opportunity to learn best practice in the use of MMRIA and MMRC process, and also provide the opportunity to actively discuss issues that many states may be dealing with. This shared information model helps to improve the MMRC process throughout the United States and build a network of colleagues for all abstractors.

According to the Review to Action Website, which is used by all ERASE MM grant recipient states and MMRIA users to inform best practice for maternal mortality reviews, "Maternal mortality is a sentinel indicator of population health in a nation, state, territory or jurisdiction. It is a measure that signals the health and well-being of women, children, and families and the investment in and priority of that health and the systems that produce it. Each year in the United States, approximately 700 women and birthing people die because of pregnancy or a pregnancy-related complication." [4]

The reduction/elimination of preventable maternal deaths requires collaboration between state MMRCs, the CDC, perinatal quality improvement networks, the Alliance for Innovation for Maternal Health (AIM), and state legislatures.

As shown below, the NH MMP collaborates closely with DH-NNEPQIN and AIM to help educate hospital staff and providers on the causes of preventable maternal deaths. The AIM safety bundles have been developed to prevent many causes of severe maternal morbidity and preventable maternal death.



The AIM Safety Bundle "Care for Pregnant and Postpartum People with Substance Use Disorder" was chosen by the NH MMP and DH-NNEPQIN to be the first bundle implemented in NH. This choice was based on data showing that the greatest percentage of preventable NH maternal deaths were related to SUD. At least four (4) of the monthly DH-NNEPQIN webinars in the past year focused on implementation of this safety bundle. All 16 birthing hospitals in NH are members of DH-NNEPQIN and have begun implementation of the "Care for Pregnancy and Postpartum



People with Substance Use Disorder” safety bundle.<sup>[5]</sup>

One focus of the Care for Pregnancy and Postpartum People with Substance Use Disorder bundle is on distribution of naloxone (an effective, life-saving opioid antagonist which reverses opioid overdose) to birthing people prior to being discharged from the hospital after delivering their infant. Pregnancy is a time of high motivation for self-care and engagement in treatment. Conversely, postpartum is a time of vulnerability, where fatal overdose is more likely, precisely because non-prescribed opioid use and opioid tolerance typically decrease during pregnancy. If relapse occurs the risk of a deadly outcome is high. The distribution of naloxone to family and community members, so that it can be available at the time of need, is an important public health measure to decrease maternal mortality.

In order to ensure that naloxone is available to anyone who might have need for it, hospitals have been using a universal screening approach asking all pregnant patients if they know someone who might be at risk for opioid overdose and if they would like to talk with someone about naloxone. A similar screening and distribution program is taking place in the inpatient OB setting. Birth certificate surveillance questions were added and have collected data on this initiative.

**NH Birth Data**

**Q1: Is there documentation that access to naloxone (e.g. Narcan) was discussed with the patient?**

Yes  
 No  
 Unknown

*Aim: Determine frequency of practice.*

*The NH Birth Situational Surveillance Narcan/Naloxone discussion question was activated at the end of January 2021.*

*The prenatal substance exposure section was added to the NH Facility Worksheet in late April 2020.*

**Prenatal Substance Exposure**

**82A.** Was the infant monitored for effects of in utero substance exposure?  
 Yes  No  
If YES, Type of substance(s):  
(check all that apply)  
 opioids  
 stimulants (amphetamines, methamphetamines, other)  
 cocaine  
 cannabis  
 benzodiazepines  
 barbiturates  
 alcohol  
 nicotine  
 bath salts  
 Kratom  
 Other (Specify) \_\_\_\_\_

**B.** Was the infant identified as being affected by substance misuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder?  
 Yes  No

**Plan of Safe/Supportive Care**

**83.** Was a Plan of Safe/Supportive Care (POSC) created?  
 Yes  No

The following graphic shows the data collected for 2021:

**Naloxone/Narcan by Prenatal Substance Exposure (82A)**  
 Infants born January 01, 2021 to December 31, 2021  
 Data refreshed: 5/2/2022 9:30:37 AM  
 Data source: VR\_BIRTH (EBI\_DATAMART.VR\_BIRTH)+ (EBI\_DATAMART)

		Prenatal Substance Exposure?		
		No	Yes	
Narcan Discussion Documented?	NO	10,421	635	11,056
	YES	258	117	375
		10,679	752	11,431

David.Leflamme@unh.edu

**117** birthing people with prenatal substance exposure indicated had a discussion documented. (16% of exposed)

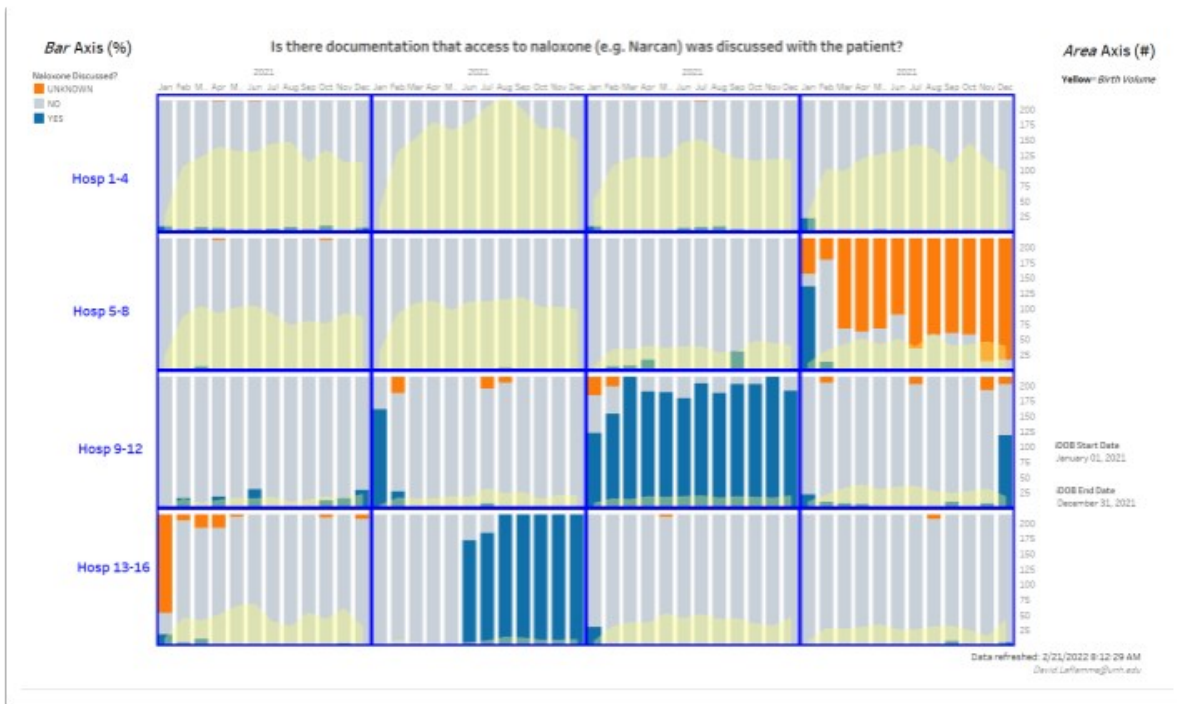
**635** birthing people with prenatal substance exposure indicated did not have a discussion documented. (84% of exposed)

**258** birthing people with no indication of prenatal substance exposure had a discussion documented. (2.4% of not exposed)

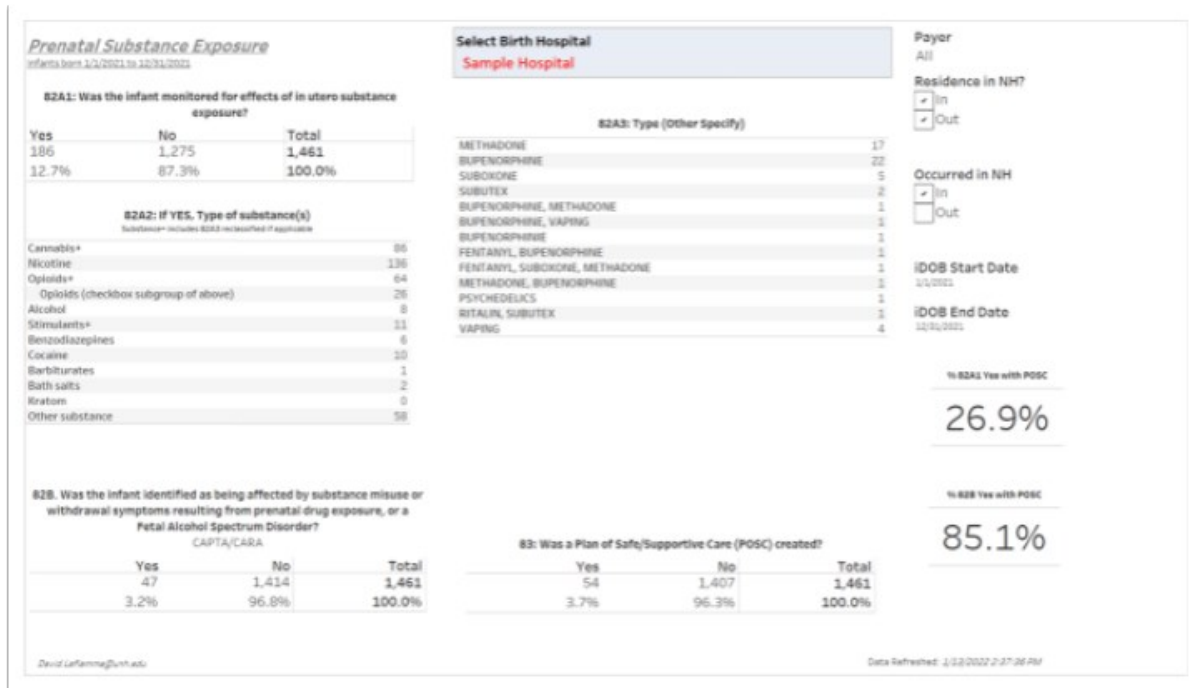
Situational Surveillance data from NH birth records (Narcan/Naloxone discussion question activated ~2/1/2021)

The MCH Epidemiologist completed the hospital-level dashboards that use real-time birth certificate data. In collaboration with DH-NNEPQIN all 16 birthing hospitals met individually via Zoom to review the dashboard and learn how their hospital can access real-time data. DH-NNEPQIN, in collaboration with the MCH Epidemiologist, also presented a webinar on proper data entry practices associated with the AIM bundle.

The following data was presented at a DH-NNEPQIN webinar from information collected through the new dashboards. The dark blue bars indicate the number of cases where there was documentation that access to naloxone was discussed with the patient. The gray lines indicate there was no discussion, and the orange lines indicate that it is unknown if a naloxone conversation took place or not. Hospital names are not shared to protect privacy; each birthing hospital knows its identifying number. DH-NNEPQIN and the MCH Epidemiologist will continue working on this project in the coming year.



Following is an example of dashboard information at the hospital level. Information is able to be sorted by demographics, subjects, etc. This particular example shows the hospital's individual data on *in utero* substance exposure.



The MCH PNC has an advisory role on the Maternal Opioid Misuse (MOM) grant workgroup. The MOM grant is currently being implemented in the southern part of NH, specifically through the Elliot Hospital. Perinatal and

postpartum people with Opioid Use Disorder (OUD) who have Medicaid coverage and who see providers in the Manchester, NH area can apply for care coordination through the MOM grant. This work helps to provide closed loop referrals and follow-up in order to keep birthing people with OUD safe and healthy. The work consists of weekly meetings to discuss progress and monthly meetings with national MOM grant recipients to strategize and share innovative ideas, including use of the POSC.

The MCH PNC and MCH Epidemiologist collaborate with DH-NNEPQIN and AIM to provide educational webinars; some based on recommendations coming from the MMRC. Webinars are held monthly. Nine (9) monthly ERASE MM/AIM webinars were held this past year along with three (3) virtual DH-NNEPQIN conferences. These webinars are attended by an average of 50 individuals each month. Subjects covered this past year were:

- Social Determinants of Health in Pregnancy Outcomes
- Operationalizing Social Determinants of Health
- Moving to a New Era of Real-Time Data Access
- Naloxone Distribution Updates
- Introducing the Revised AIM Patient Safety Bundle for the Care of Pregnant and Postpartum People with Substance Use Disorders
- Maternal Mortality Surveillance & Harm Reduction (see graphic below)
- Implementation of the AIM SUD Bundle in New Hampshire
- Preventing Maternal Mortality and Severe Maternal Morbidity in NH: Goals and Opportunities for 2022
- Time to Get it Right – Importing the Accuracy of Demographic Data in Maternal Health Records to Identify and Address Maternal Health Disparities



## Social Media

The use of social media provides a readily available tool to share information with the public. The MCH PNC posted monthly on the State of NH webpages on Facebook, Twitter, and Instagram with information on the dangers of smoking while pregnant, COVID-19, Suicide Prevention, Maternal Death Prevention, and Mental Health.

## Data Management and Visualization

The NH birth certificate continued to capture data showing the percent of infants monitored for effects of *in utero* substance exposure, the type of substances, whether the infant was identified as being affected by substance exposure, and the percent of those whose mother had a POSC created. These data will help to inform further interventions. This birth certificate data provides an estimate of the number of women with SUD who were provided the opportunity to learn about and be linked with the local resources and supports available to them in the area in which they live. Data continued to be collected via the NH birth certificate on naloxone distribution using the situational surveillance system, and the data was analyzed to determine what further actions need to take place in order to assure that naloxone is available to all who need it. A draft of an ERASE MM reporting dashboard has been constructed by the MCH Epidemiologist and will continue to be built out as needed over time. This will also be shared with the workgroup for potential use by other states.

The MCH Epidemiologist continued work on building a standardized birth extract for automatic import into the MMRIA system. This work was about 85% complete, but was stalled due to legal/technical issues. The MCH Epidemiologist made the vital statistics information needed by MMRIA available to the MCH Perinatal Nurse Coordinator who inputs this data into MMRIA.

The MCH Epidemiologist continued working on projects related to data quality, data sharing, and data presentation/visualization that are useful to Title V staff and/or stakeholders.

#### *Race and Hispanic origin data comparison*

Additional work continues with other birth hospitals and NH discharge data linked to the birth certificate. Data collected showed disparity between hospital documentation on Race/Ethnicity and the birth certificate. This information was presented to all NH hospitals during an AIM/ERASE monthly webinar.

#### *Tableau interface to expose data for MMRIA data entry*

The MCH Epidemiologist completed the Tableau dashboard. Meetings were then held individually with each NH birthing hospital. Use of the dashboard was demonstrated and hospitals are now able to request data from the MCH Epidemiologist until NH DHHS can setup secure access to the dashboards that will allow them to access the real-time dashboards on demand.

#### *Continued work on Data User Agreements (DUA)*

The AIM DUA has been worked on throughout the reporting period. Finishing touches are being done, and the DUA should be completed soon; hopefully, within the next two months.

#### *Hospital-level dashboards with webinar and individual hospital meetings*

Work continued at NH DHHS with assistance from the Director of Data Analytics and Reporting within the Bureau of Program Quality to work through the technical and policy issues required to implement a secure server for hospitals to access the dashboards. To begin, hospitals will only have access to their own data. Eventually, de-identified comparison group data from other hospitals is likely to be included. Further, this secure server will provide a space for other data to also be shared back with the hospitals (e.g. hospital discharge data). The re-architected data infrastructure at NH DHHS has provided an opportunity to improve how NH DHHS gets data back to stakeholders who produce that data. With the increased Quality Improvement capacity within birth hospitals developed over the last decade, working at the intersection of public health and clinical medicine in this way holds significant potential for positively impacting processes and related outcomes.

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[1] NH PRAMS 2019 Data Summary. Retrieved June 7, 2021 from <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-12/prams-datasummary-2019.pdf>

[2] Smoking during Pregnancy. Retrieved May 10, 2022, from <https://www.marchofdimes.org/pregnancy/smoking-duringpregnancy.aspx#:~:text=Smoking%20during%20pregnancy%20can%20cause,tell%20your%20health%20care%20provider.>

[3] Plans of Safe Care (POSC). Retrieved June 7, 2021 from <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>

[4] Review to Action: The Basics. Retrieved May 10, 2022 from <https://reviewtoaction.org/learn/basics>

[5] [AIM Patient Safety Bundles](https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/). Retrieved May 10, 2022 from <https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/>

## Women/Maternal Health - Application Year

### **National Performance Measure #14.1:** Percent of women who smoke during pregnancy

#### **NPM #14.1 Objectives:**

- By July 1, 2023, decrease the percentage of women with Medicaid Managed Care health plans who smoke during pregnancy from 22.6% (baseline data 2021) to 21% or less among 2022 deliveries paid by NH Medicaid.
- By July 1, 2023, decrease the percentage of women who smoke during pregnancy from 2.2% (baseline data 2021) to 2% or less among 2022 deliveries not paid by NH Medicaid.
- By July 1, 2023, the MCH-funded Primary Care practices will screen at least 90%, according to quarterly EMR audits, of prenatal patients for tobacco use.
- By July 1, 2023, the MCH-funded Primary Care sites will offer quit smoking assistance/resources, according to quarterly EMR audits, to 90% of pregnant women screening positive for tobacco use.
- By July 1, 2023 50% of OB-GYN staff at 6 of 12 (50%) MCH-funded Primary Care practices will complete the e-learning module evaluation, 'Supporting Pregnant and Postpartum Women to Quit Tobacco.' (Baseline 0)

#### **NPM #14.1 Strategies:**

- Continue to monitor the number of MCH-funded Primary Care site clinical staff that complete the e-learning module, 'Supporting Pregnant and Postpartum Women to Quit Tobacco.'
- Promote tobacco cessation for pregnant persons through collaborations with the Tobacco Prevention and Cessation Program (TPCP) for social marketing campaigns and print materials in provider offices.
- Incorporate discussion of smoking cessation into the Plan of Safe Care (POSC), which is discussed with at-risk women both during their pregnancy as well as prior to hospital discharge after delivery

### **Screening and Counseling for Pregnant Women in the Community Health Centers (CHCs)**

The collaboration between MCH and the NH Tobacco Prevention and Cessation Program (TPCP) will continue through the coming year. The majority of the prenatal clinics associated with the MCH contracted Community Health Centers (CHCs) are successfully screening for smoking among pregnant women during each of the three trimesters and referring as appropriate. Those who are not achieving targets for this measure are required to research the barriers to achieving success and determine what changes may lead to improvement. As part of the effort to assist in overcoming barriers, the MCH PNC will continue to encourage collaborations between the TPCP and CHCs.

In addition to continuing to monitor quality measures regarding prenatal smoking cessation, the MCH PNC will collaborate with the contracted CHCs to increase the number of POSCs that are initiated during the prenatal period for birthing people being seen at the CHCs for prenatal care.

**ESM #14.1** The percentage of postpartum women whose infant was monitored for the effects of *in utero* substance exposure who had a documented Plan of Safe/Supported Care (POSC).

#### **ESM #14.1 Objectives:**

- By July 1, 2023, increase the percentage of postpartum women whose infant was monitored for the effects of *in*

*utero* substance exposure who had a documented POSC to 65%.

- By July 1, 2023, increase the percent of birthing persons whose infant was monitored for the effects of *in utero* substance exposure who were offered naloxone prior to postpartum discharge from a baseline of 14% in 2021 to 18% in 2023.

#### **ESM #14.1 Strategies:**

- The MCH PNC will collaborate with other MCH programs such as the NH Maternal Infant Early Childhood Home Visiting (MIECHV) Program and contracted MCH Primary Care agencies in supporting efforts to promote providers in developing a POSC with all prenatal, birthing and postpartum people.
- The MCH PNC will monitor whether or not a POSC was in place for all maternal deaths in NH related to or caused by substance misuse.
- The MCH PNC will collaborate with other states' MMR Committees to share best practices.
- Through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Grant, the MCH PNC and the MCH Epidemiologist will continue to work with the Dartmouth-Hitchcock Northern New England Perinatal Quality Improvement Network (DH-NNEPQIN) on implementation of the Alliance for Innovation for Maternal Health (AIM) "Care for Pregnant and Postpartum People with Substance Use Disorder (SUD)" bundle in NH hospitals.
- The MCH PNC will collaborate with DH-NNEPQIN to review maternal mortality and severe maternal morbidity data in order to select the next AIM Patient Safety Bundle to introduce to hospitals once the "Care for Pregnant and Postpartum People with SUD" is fully implemented.
- The MCH PNC will continue in advisory roles with the Governor's Task Force for Perinatal Substance Exposure and Medicaid Maternal Opioid Misuse (MOM) Grant committee

#### **New Hampshire Plan of Safe/Supportive Care**

The Federal Comprehensive Addiction and Recovery Act of 2016 (CARA) amended the Child Abuse Prevention and Treatment Act (CAPTA) to require the development of a Plan of Safe Care (POSC) for all infants affected by prenatal drug or fetal alcohol exposure. NH law (132:10-e, 10-f), in compliance with federal law, requires that "when an infant is born identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, the health care provider shall develop a plan of safe care, in cooperation with the infant's parents or guardians and the department of health and human services, division of public health services, as appropriate, to ensure the safety and well-being of the infant, to address the health and substance use treatment needs of the infant and affected family members or caregivers, and to ensure that appropriate referrals are made and services are delivered to the infant and affected family members or caregivers."

A completed POSC signifies that there has been collaboration between the patient with SUD and a provider or other designated healthcare worker. This collaboration allows a better understanding of that birthing person's view of themselves, including perceived strengths and weaknesses, as well as their vision for their future. There continues to be room for instruction on best practice for the use of the POSC in order for this document to be as effective as possible.

As noted in the 2021 report, NH went from 54.9% of infants monitored for effects of *in utero* substance exposure having a POSC created in 2020, to only 50.9% in 2021. The MCH PNC will collaborate with the MCH funded



Primary Care agencies who are providing prenatal care to women throughout the State and will collaborate with DH-NNEPQIN in order to provide education to these agencies and hospitals regarding the importance of creating a POSC during the prenatal period.

The NH Maternal Infant Early Childhood Visiting (MIECHV) program has trained family support specialists and nurses who visit families in their homes or wherever they are most comfortable, to offer a nationally recognized, evidence-based service. The MCH PNC will continue to work with MIECHV in the coming year to promote educational opportunities for these family support specialists and nurses regarding the POSC and how to help birthing persons start this process.

No maternal death cases related to substance use had infants that were living after the maternal death. Therefore, no pediatricians were contacted about a POSC. The MCH PNC will reach out to pediatricians, as appropriate, in the coming year to determine if POSCs had been created for infants who were exposed to *in utero* substance use.

### **Advisory Contributions**

The Governor's Task Force for Perinatal Substance Exposure will continue to meet throughout the coming year in order to promote and help implement POSC. Continued opportunities for education of providers and stakeholders will be a part of this work. The MCH PNC has an advisory role on this task force and shares information from the task force in collaboration with DH-NNEPQIN, Maternal Opioid Misuse (MOM) grant group, and the Maternal Mortality Review Panel (MMR), when appropriate.

The MOM model is the next step in the Center for Medicare and Medicaid Innovation's multi-pronged strategy to combat the nation's opioid crisis. The model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants.

The MCH PNC sits on the NH MOM grant committee in an advisory role and shares information from the committee in collaboration with NNEPQIN, the Governor's Task Force for Perinatal Substance Exposure, and the Maternal Mortality Review Panel (MMR), when appropriate. The NH MOM grant is currently being implemented out of the Elliott Hospital in Manchester, NH. Women receiving Medicaid who have SUD identified may be enrolled in the project through several different options: during a prenatal visit, during a well-child check, or during a hospital stay, among others. Enrollees must be covered by Medicaid. Birthing persons are eligible from the start of prenatal care through two years postpartum.

New Hampshire is one of the 10 states receiving this five (5)-year grant. The premise of the NH grant is that resources are available for helping birthing persons with SUD, but some providers are not aware of other providers or programs working with the birthing person or their family. The NH MOM grant is developing a software program to help link all providers associated with a particular birthing person in order to assist with continued SUD treatment and help prevent relapse or overdose. Outreach is provided by MOM grant personnel to those referred to the program.

### **The MMR Connection**

The NH Maternal Mortality Review (MMR) meeting is held quarterly. The MCH PNC is also the MMR Panel

Coordinator and collaborates with DH-NNEPQIN as a co-abstractor for maternal deaths. The majority of maternal deaths in NH are related to drug overdose or suicide. The MCH PNC will request infant records as part of the review of all maternal deaths that were associated with substance use. The intent of the request will be to assess the infant's chart for a POSC. The infant charts of those mothers who have developed a POSC with their provider should contain a copy of the plan. By including pediatric providers, more professionals caring for the mother-child dyad will be aware of the resources that the mother has named as relevant to her and requested by her.

The Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) CDC grant continues to aid in collaborative work with NH's perinatal quality collaborative, DH-NNEPQIN. The work plan includes several strategies to improve educational opportunities for birthing people and providers.

The MCH PNC will continue to collaborate with other MMR abstractors, MMR coordinators, and MMR epidemiologists throughout the country (through the ERASE MM grant) to learn best practices for abstracting data and coordinating MMRs. This type of collaboration will continue to improve NH's MMRC meetings.

### **Collaborations**

DH-NNEPQIN collaborates with the MCH epidemiologist, the MCH PNC, and the Alliance for Innovation for Maternal Health (AIM) to provide educational webinars based on recommendations coming from the MMR Panel. Webinars will continue to be held monthly. DH-NNEPQIN, in collaboration with the ERASE MM Grant, AIM, and MCH is working to implement the evidence-based AIM bundles. The first bundle implemented was "Care for Pregnant and Postpartum people with Substance Use Disorder." DH-NNEPQIN will continue to work on the implementation of this AIM bundle in the coming year. Once the role-out of this bundle has been completed, DH-NNEPQIN will gather data on maternal mortality and severe maternal morbidity in order to choose the most appropriate AIM bundle to introduce next. The MCH PNC will continue to be a collaborative partner in bundle implementation.

### **Social Media**

Social media provides a readily available tool to share information with the public. The MCH PNC will continue to work with the NH DPHS social media staff to create posts for Facebook, Twitter, and Instagram that focus on different aspects of perinatal health and well-being, including resources for smoking cessation, SUD, warning signs of postpartum complications, and education regarding the POSC, among other topics. The MCH PNC will revise and update the MCH perinatal webpage to include information on resources and supports available in NH.

### **Data Management and Visualization**

The NH birth certificate will continue to capture data showing the percent of infants monitored for effects of *in utero* substance exposure and the percent of those whose mother had a POSC created using the surveillance questions on the birth certificate. This data will help to drive further interventions based on data outcomes. This birth certificate data provides an estimate of the number of women with SUD who were provided the opportunity to learn about and be linked with the local resources and supports available to them in the area in which they live. In addition, over the coming year, data will continue to be collected via the NH birth certificate on naloxone distribution, and this data will be analyzed to determine what further actions need to take place in order to assure that naloxone is available to all who need it.

### **Other data-related activities to be performed**

The MCH Epidemiologist will continue working on projects related to data quality, data sharing, and data presentation/visualization that are useful to Title V staff and/or stakeholders. These are described in a previous section of this report, and the future plans for these projects are as follows:

*Race and Hispanic origin data comparison*

Work will continue with birth hospitals and the NH discharge data linked to the birth certificate. Identifying and addressing racial and ethnic health inequities depend in part on quality data.

*Tableau interface to expose data for MMRIA data entry*

As needed, the Tableau dashboard to expose record-level data fields will be updated in the coming year to meet evolving programmatic needs of the various MCH programs using the interface. The interface includes a connection to vital records.

*Hospital-level dashboards with webinar and individual hospital meetings*

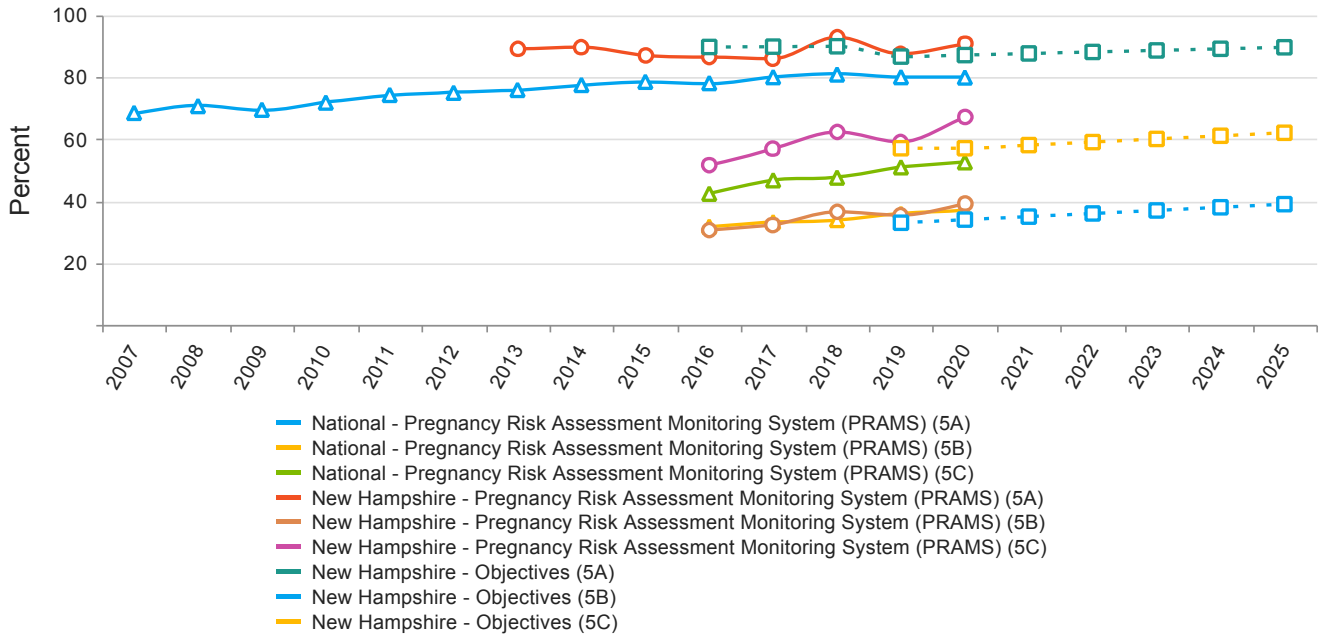
Work will continue under the new MCH Epidemiologist to eventually de-identify comparison group data from other hospitals and include on the dashboards. Further, this secure server will provide a space for other data to also be shared back with the hospitals (e.g. hospital discharge data). The re-architected data infrastructure at NH DHHS will provide opportunities to improve how NH DHHS gets data back to stakeholders who produce that data. With the increased Quality Improvement capacity within birth hospitals developed over the last decade, working at the intersection of public health and clinical medicine in this way holds significant potential for positively impacting processes and related outcomes.

Additional data points and factors will be added to the dashboards along with the ability to look at trends over time. Statistical process control charts will likely be one of the options available to users exploring the data.

**Perinatal/Infant Health**

**National Performance Measures**

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**  
**Indicators and Annual Objectives**



**NPM 5A - Percent of infants placed to sleep on their backs**

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	2018	2019	2020	2021
Annual Objective	89.7	89.8	86.5	87	87.5
Annual Indicator	87.0	86.1	86.1	87.3	90.8
Numerator	10,258	10,138	10,138	9,959	10,345
Denominator	11,798	11,782	11,782	11,403	11,387
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	89.7	89.8	86.5	87	87.5
Annual Indicator	86.3	86	87.3	90.8	
Numerator	10,315	10,138	9,959	10,345	
Denominator	11,954	11,782	11,403	11,387	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2019	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.0	88.5	89.0	89.5

**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	2019	2020	2021
Annual Objective		33	34	35
Annual Indicator	32.5	32.5	35.6	39.0
Numerator	3,550	3,550	3,847	4,267
Denominator	10,913	10,913	10,807	10,955
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			33	34	35
Annual Indicator	29.7	31.6	34.7	37.8	
Numerator	3,541	3,550	3,847	4,267	
Denominator	11,921	11,225	11,084	11,282	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2019	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	36.0	37.0	38.0	39.0

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	2019	2020	2021
Annual Objective		57	57	58
Annual Indicator	56.7	56.7	58.8	67.0
Numerator	6,129	6,129	6,307	7,335
Denominator	10,817	10,817	10,730	10,944
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			57	57	58
Annual Indicator	51.3	55.1	58.3	66	
Numerator	5,992	6,129	6,307	7,335	
Denominator	11,676	11,128	10,812	11,112	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2018	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	59.0	60.0	61.0	62.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.1 - Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator		45.3	47.1
Numerator		111	113
Denominator		245	240
Data Source		ETO - Home Visiting data system	ETO - Home Visiting data system
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.0	52.0	53.0	54.0



## State Action Plan Table

### State Action Plan Table (New Hampshire) - Perinatal/Infant Health - Entry 1

#### Priority Need

Decrease unintentional injury in children ages 0-21

#### NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

#### Objectives

By January 2023, 50% of infants enrolled in MIECHV HFA home visiting will always be placed to sleep on their back, without bed-sharing or soft bedding.

#### Strategies

Collaborate with the MIECHV HFA home visiting program on their materials and education for families on always placing their infant to sleep on their back in a separate approved sleep surface without soft objects or loose bedding.

Develop a training tool for HFA home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices

Utilize home visiting and PRAMS data to inform key stakeholders about safe sleep and education needed

Promote public education on safe sleep

Utilize the SUID committee recommendations regarding risk factors and identify possible points of intervention

Utilize the Safe Sleep Workgroup to identify methods for carrying out the recommendations identified during the SUID case reviews

#### ESMs

#### Status

ESM 5.1 - Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding      Active

#### NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## Perinatal/Infant Health - Annual Report

### **National Performance Measure #5**

1. Percent of infants placed to sleep on their backs
2. Percent of infants placed to sleep on a separate approved sleep surface
3. Percent of infants placed to sleep without soft objects or loose bedding

**Evidence Based or Informed Strategy Measure:** Percent of infants enrolled in Healthy Families America (HFA) home visiting who are always placed to sleep on their backs, without bed-sharing or soft bedding.

**Objective:** By January 2023, 50% of infants enrolled in home visiting will be placed to sleep on their backs, without bed-sharing or soft bedding.

### **Strategies:**

1. Collaborate with the HFA home visiting program on their materials and education for families on placing their infant to sleep on their backs in a separate approved sleep surface without soft objects or loose bedding.
2. Train home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices.
3. Promote public education on safe sleep.
4. Utilize home visiting and PRAMS data to inform key stakeholders about safe sleep and education needed.
5. Utilize the SUID committee recommendations for risk factors and identify possible points of intervention.
6. Utilize the Safe Sleep Workgroup to identify possible avenues to gain insight into why infants are not being placed to sleep on their backs, without bed-sharing or soft bedding.
7. Collaborate with NH American Academy for Pediatrics Champion on messaging for providers.

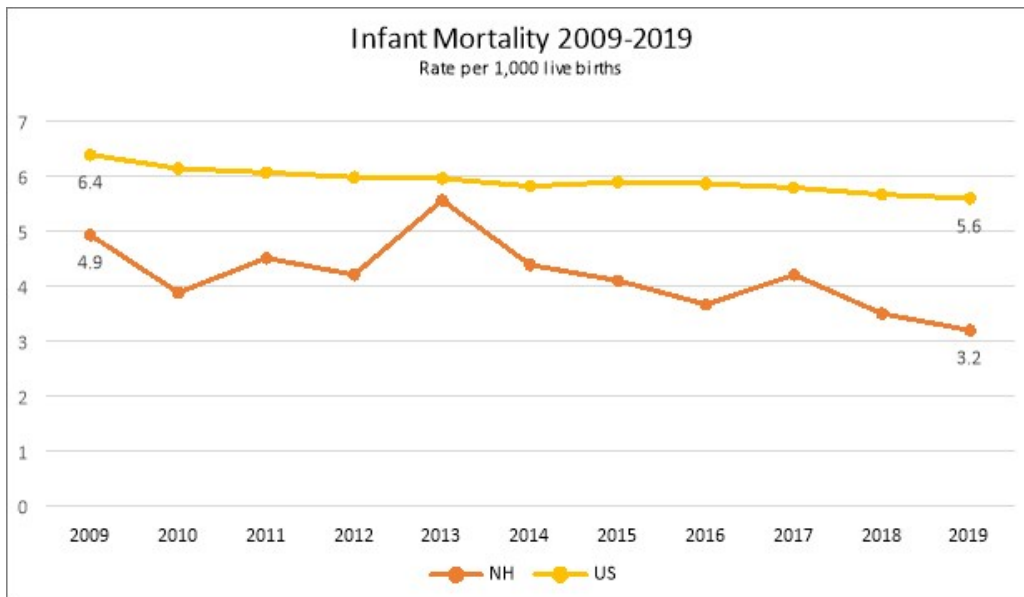
### **Reporting on National Performance Measure #5:**

National Outcome Measure 9.1 – Infant mortality rate per 1,000 live births

National Outcome Measure 9.3 – Post-neonatal mortality rate per 1,000 live births

National Outcome Measure 9.5 – Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

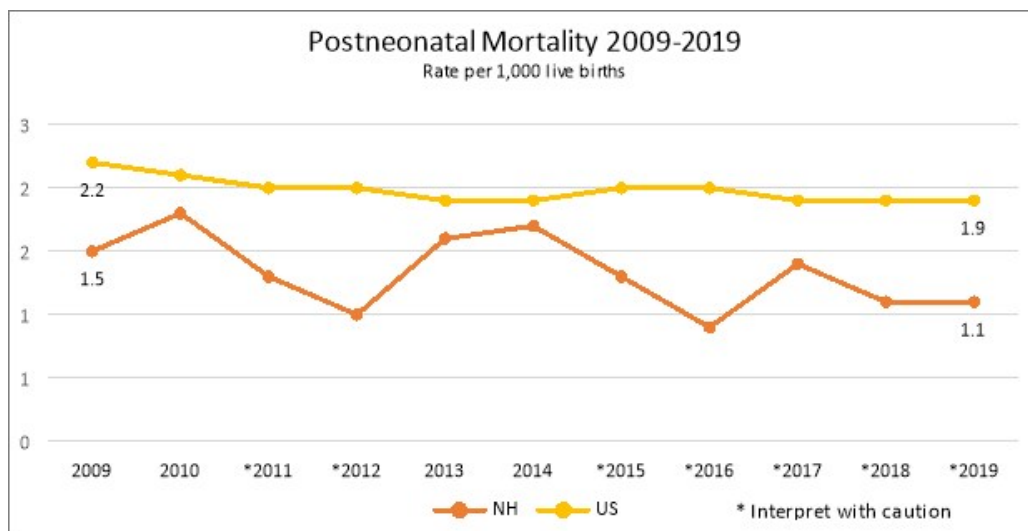
NOM data for NH from the National Vital Statistics System (NVSS) indicate that the state is seeing small changes (not attaining a statistically significant difference) in its infant mortality. Infant mortality went from 4.2 per 1,000 live births in 2017 to 3.2 in 2019 (one of the lowest in the U.S.) and post-neonatal mortality went from 1.4 per 1,000 live births in 2017 to 1.1 per 1,000 live births in 2019. Data from NVSS for NH show that the rate for SUID deaths for 2019 is not reportable due to the small number of cases (5).



Infant mortality: infant deaths under one year of age per 1,000 live births.

Source: Maternal and Child Health Bureau. Federally Available Data (FAD) Resource Document. May 17, 2022; Rockville, MD: Health Resources and Services Administration.

Available at: <https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures>



Post neonatal mortality: deaths of infants aged 28 days through 11 months per 1,000 live births

Source: Maternal and Child Health Bureau. Federally Available Data (FAD) Resource Document. May 17, 2022; Rockville, MD: Health Resources Services Administration.

Available at: <https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures>

According to the CDC, in 2019 there were about 3,390 SUID deaths in the United States.<sup>[1]</sup> Data from NVSS for NH show that the rate of SUID deaths from 2019 is not reportable due to a small number of cases (5 cases).

SUID deaths are defined as the sudden unexpected death of an infant less than one year old who have no immediately obvious cause of death. These deaths are categorized as Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in a sleep setting. NH's SUID rate has varied over the

past few years (see below). NH's SUID rate per 1,000 live births was 0.8 in 2020 and decreased to 0.7 in 2021 as compared to the national rate 0.90 deaths per 1,000 live births in 2019.

Year	SUID	Live Births	Crude Rate	Lower 95% CI	Upper 95% CI
2012	8	12,282	0.7	0.3	1.3
2013	11	12,290	0.9	0.4	1.6
2014	11	12,239	0.9	0.4	1.6
2015	9	12,376	0.7	0.3	1.4
2016	7	12,221	0.6	0.2	1.2
2017	4	12,082	0.3	0.1	0.8
2018	5	11,916	0.4	0.1	1
2019	6	11,825	0.5	0.2	1.1
2020	9	11,834	0.8	0.3	1.4
2021	9	12,660	0.7	0.3	1.2
2013-2015	31	36,905	0.8	0.5	1.1
2016-2018	16	36,219	0.4	0.2	1.7
2019-2021	24	36,319	0.7	0.4	0.9

Nationally, in 2019 there were approximately 1,250 deaths (28.3% of SUID deaths) due to SIDS, 1,180 deaths (37% of SUID deaths) due to unknown cause and 960 deaths (34.7% of SUID deaths) due to accidental suffocation and strangulation in a sleep setting.<sup>[2]</sup> NH continues to be consistent with the national data in having SIDS as one of the leading cause of infant deaths.

SIDS is one (1) of three (3) categories of SUID. SIDS is the sudden death of an infant under one (1) year of age that cannot be explained even after a thorough investigation that includes a complete autopsy, death scene investigation, and review of the infants' clinical history. With the success of national campaigns, efforts to educate parents, childcare providers, caregivers, and families to put the infant to sleep on their back on a firm flat mattress are paying off. SIDS cases nationally have continued to drop since the early 1990's and overall SUID rate appears to leveling off.

In 2020, there has been a national shift to streamline cause of deaths in SUID cases, in order to improve data collection. The Office of the Chief Medical Examiner (OCME) is now classifying most SUID cases as:

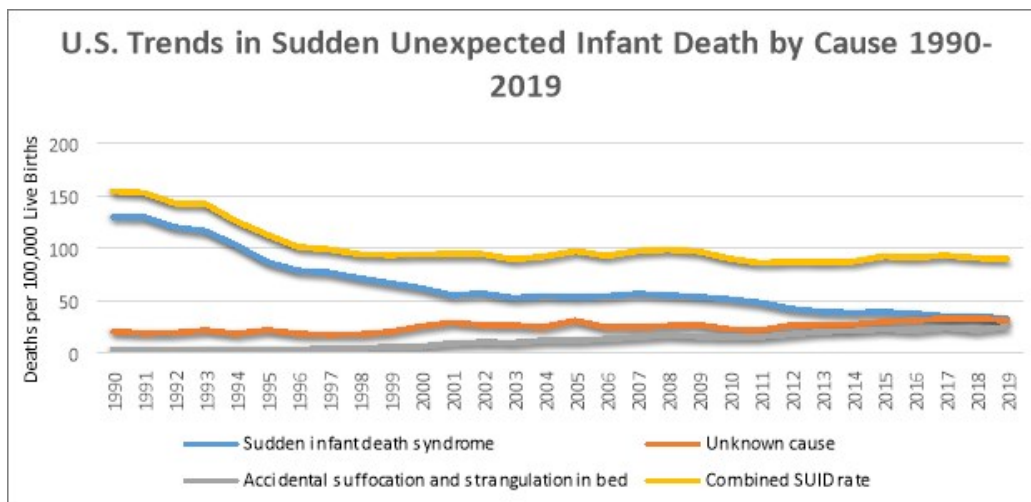
- Unexplained sudden infant death (no identified intrinsic or extrinsic factors)
- Unexplained sudden death (intrinsic factors identified)
- Unexplained sudden infant death (extrinsic factors identified)
- Unexplained sudden death (intrinsic and extrinsic factors identified)
- Undetermined (no further specified)
- Undetermined (insufficient data)

Intrinsic and Extrinsic are described by the follow:

- **“Intrinsic factors are:** natural conditions or risk factors associated with abnormal physiology or anatomy that are concerning as contributors to death but are insufficient as a cause (e.g., low birth weight, preterm birth, small for gestational age, concurrent non-lethal illness, history of febrile seizures), or natural conditions of unknown significance (e.g., cardiac channelopathy or seizure gene variants of unknown significance).” (Shapiro-Mendoza, 2021)
- **“Extrinsic factors are:** conditions in the child’s immediate environment that are a potential threat to life but cannot be deemed the cause of death with reasonable certainty (e.g., side or prone sleep if unable to roll to supine, over-bundling without documented hyperthermia, objects in immediate sleep environment, sleep environment not specifically designed for infant sleep, soft or excessive bedding, and sleep surface sharing), injuries or toxicologic findings that are either non-lethal or of unknown lethality, or circumstances/findings otherwise concerning for unnatural death” (Shapiro-Mendoza, 2021)



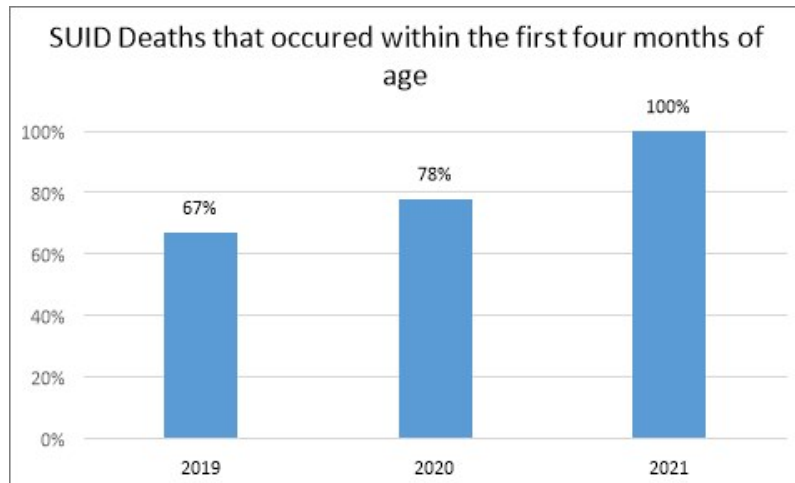
Shapiro-Mendoza, C. K., Palusci, V. J., Hoffman, B., Batra, E., Yester, M., Corey, T. S., & Sens, M. A. (2021, October 1). *Half Century since SIDS: A reappraisal of terminology*. American Academy of Pediatrics. Retrieved 5/17/2022, from <https://publications.aap.org/pediatrics/article/148/4/e2021053746/183299/Half-Century-Since-SIDS-A-Reappraisal-of>



Due to this national shift in terminology, it is expected the SUID Program will see a change in trends of cause of deaths in future reporting periods.

NH 2020 data showed that 56% (5 cases) of SUID deaths occurred within the first four months of age, and in 2021 100% of SUID deaths occurred within the first four (4) months of age. Among all causes of infant deaths in NH, deaths due to complications of pregnancy and delivery continue to be the leading cause of death with SUID being

the second leading cause of death.



Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of May 2022

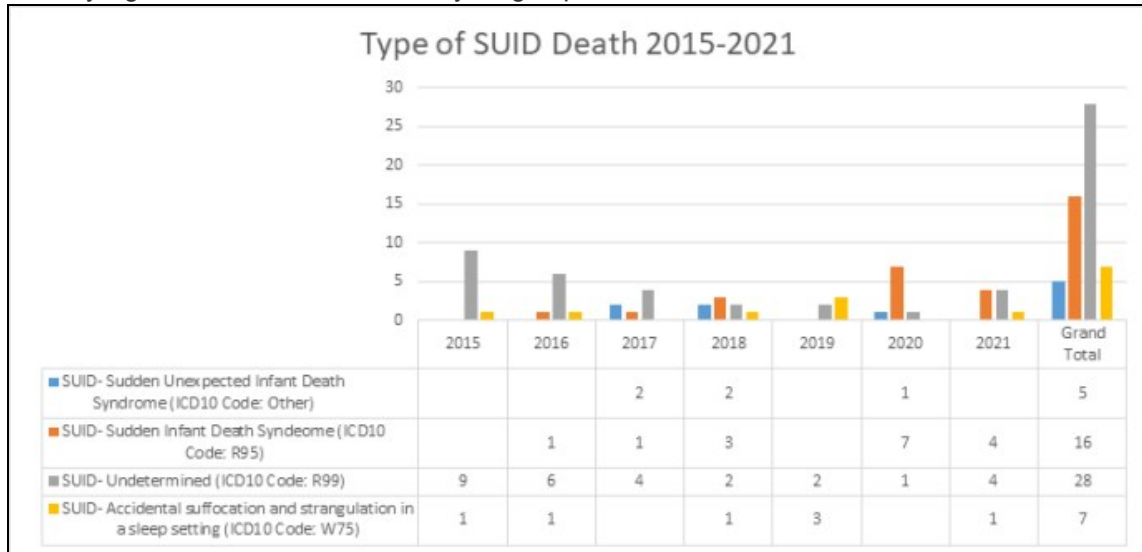
New Hampshire Residents, SUID deaths 2015-2021

CDC_infant_15_Cause	Manner	2015	2016	2017	2018	2019	2020	2021
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: R99)	Undetermined	9	5	3	2	2	1	4
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: R95)	Undetermined		1		1		6	3
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: Other)	Natural			2	2		1	
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: R95)	Natural			1	2		1	1
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: R99)	Natural		1	1				1
SUID- Sudden Unexpected Infant Death Syndrome (ICD10 Code: W75)	Accidental	1	1		1	3		1

Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of August 2021

Deaths from ICD10 codes (R95, R99, W75 and other) include SIDS, accidental suffocation and strangulation in a bed setting, and undetermined.

Broken down in the graph below, over the past six years (2015-2021), there have been a total of 56 SUID deaths, 7 (13%) are due to accidental suffocation and strangulation in a sleep setting; 16 (29%) are due to SIDS, and 28 (50%) are undetermined; 5 (9%) are due to SUID other. Other is classified as undetermined cause of death that does not have unsafe sleep factors. In NH, the SIDS rate has decreased, but due to the small number of cases, there is no statistically significant difference between year groups



### **Systems Building**

The multidisciplinary SUID Review Committee meets three (3) times a year. The Safe Sleep Workgroup, a subcommittee of the SUID Review Committee, meets every other month to work on recommendations identified during the case reviews. In 2021, the SUID program reviewed the makeup of the Review Committee and decided to invite the decedent’s medical provider to attend the case reviews. The attendance of the medical provider provides additional case information that was previously missing, direct contact with the child/family, family history, and provider notes. These additional data elements have contributed additional information to help narrow the strategies to reduce sudden unexpected infant deaths.

In 2021, the SUID program in partnered with stakeholders (hospitals, the Division of Children, Youth and Families DCYF, state childcare licensure, Office of the Child Advocate, and trauma informed specialist) to identify target audiences and next steps for promoting safe sleep. Target audiences and next steps were done using lean methods. The lean methods that were used were the five S's and swim lanes. From the lean methods it was determined that target audiences would be home visitors/community members and hospitals/providers. The method for reaching the target audience would be virtual town halls and provider lunch and learns. From this work the program has developed strategies to promote safe sleep.

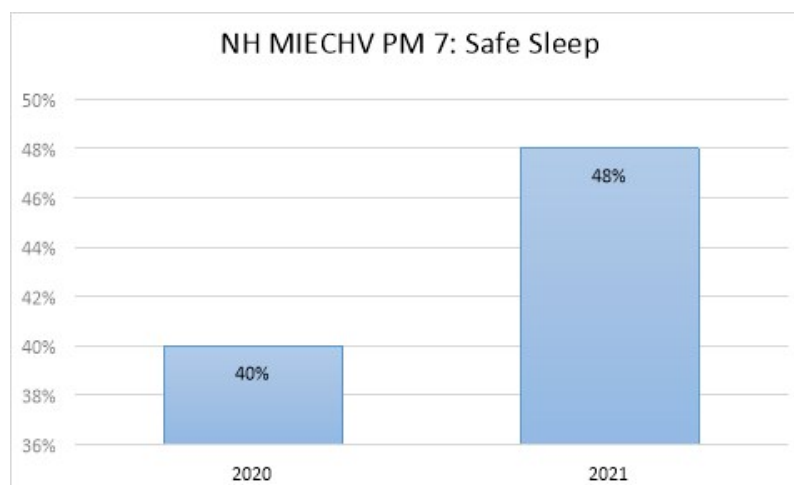


**Reporting on MCH Specific Strategies**

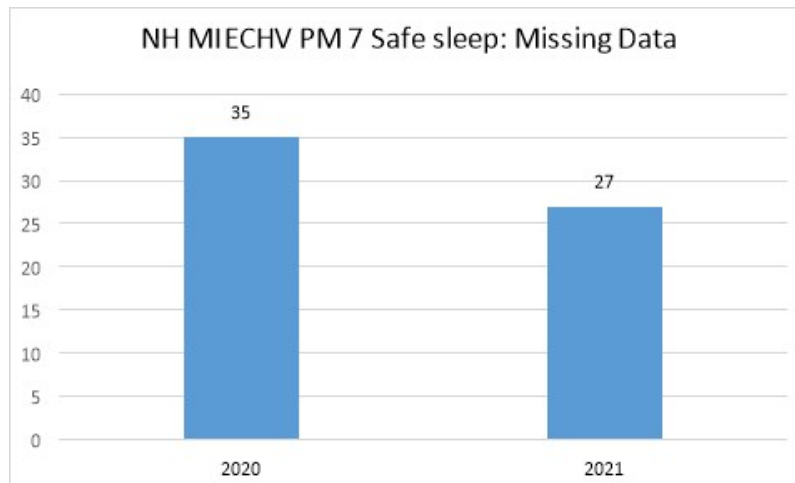
1. Collaborate with the HFA home visiting program on their materials and education for families on placing their infant to sleep on their backs in a separate approved sleep surface without soft objects or loose bedding.

The home visiting program partnered with [The Government Performance Lab](#) in a project to support and connect families who had or were expecting to have a substance-exposed infant with evidence-based home visiting services. Families that are part of this program are provided materials and education on safe sleep. Information included placing their infant to sleep on their backs in a separate approved sleep surface without soft objects or loose bedding during all sleep times (naps, night time).

In 2021, The NH Maternal, Infant, Early Childhood Home Visiting (MIECHV) team completed a prioritization matrix with the NH MIECHV Continuous Quality Improvement (CQI) team in deciding on which performance measure to focus the next in-depth PDSA cycle. Safe sleep was identified as a top priority and a Plan Do Study Act (PDSA) cycle was scheduled with a focus on safe sleep. This PDSA cycle will focus on safe sleep with a goal of increasing the number of families who currently practice safe sleep always, which is at 50%. Safe sleep is one of 19 performance measures for programs funded through MIECHV that are reported on quarterly. There has been an increase in the number of families who say they practice safe sleep over time, as defined by families stating that they always place their babies to sleep on their backs, without bed-sharing or soft bedding.







In order to increase the number of families who practice safe sleep, the MIECHV and the SUID program will collaborate to promote safe sleep in the Healthy Families America (HFA) Program.

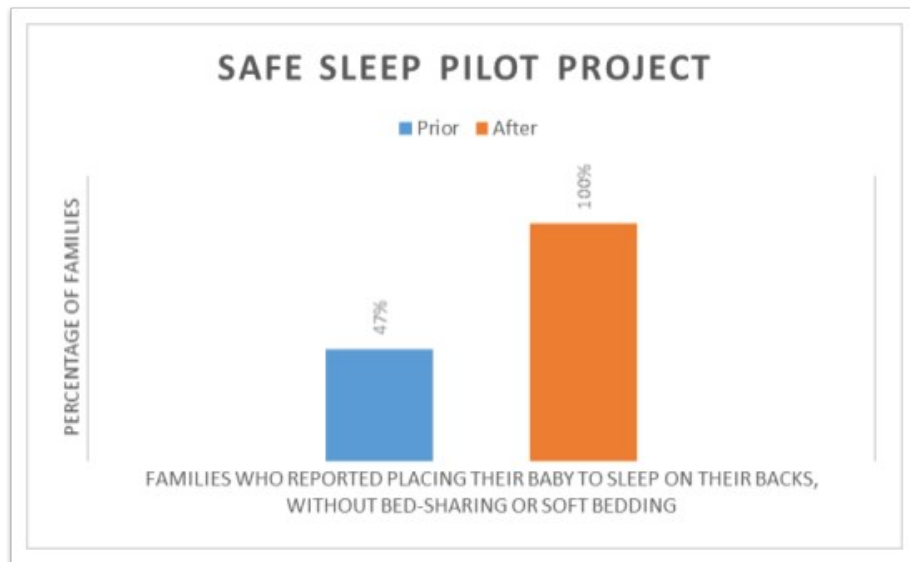
Figure 6: Prioritization Matrix used with NH MIECHV CQI Team

Identification of Focus Areas/Performance Measures to Target for Improvement:					
List of 5 Possible Focus Areas	Provide 1 reason for including this among your options	Rate each Focus Area Using Scale Provided			
		Staff Interest ● low = 1 ● medium = 2 ● high = 3	Benefit to Families &/or Staff ● low = 1 ● medium = 2 ● high = 3	Difficulty to Change ● low = 3 ● medium = 2 ● high = 1	Rating (Interest x Benefit x Difficulty)
Maternal Depression / referrals	Support bonding & attachment				18
Safe Sleep	Life saving	3	3	2	18
Developmental screens	Support connecting children to ESS				13.1
Breastfeeding	Child health	2	2	2	8
IPV screens	CQI work already happening				12.1

Which Focus Area did the group select? Resent out to agencies to select between the top two: First project: Maternal Depression Screens and Referrals. Second Project: Safe Sleep

The SUID program, the MIECHV Program, and one HFA local implementing agency (LIA) engaged in a pilot project to improve safe sleep practices in their HFA home visiting program. This pilot project included the SUID program, MIECHV HFA program, and the LIA who virtually met every other month to discuss barriers and successes with safe sleep in the home visiting program. During the meetings, the SUID program provided the LIA with updated safe sleep materials, safe sleep education for home visitors, and supported the home visitors in regards to working with families around safe sleep. The SUID program provided technical assistance to requests that arose during the pilot period. The SUID program and the MIECHV HFA program intend to compare the LIA's safe sleep data prior to the project starting and after to evaluate the successfulness of this collaboration.

During this partnership, the one (1) LIA was able to increase the number of families to 100% who reported practicing safe sleep. Insights gained from this project will be applied to the state-wide project.



2. Train home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices

MCH staff continue to be involved in the efforts by the NH Division of Children Youth and Families (DCYF) to comply with the requirements of the federal Comprehensive Addiction and Recovery Act (CARA) signed in July 2016. The Plan of Safe Care (POSC) includes education for safe sleep. Hospitals who complete a POSC, if one was not done prenatally, provide this information to DHHS through the birth certificate, regarding infants born with substance abuse or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder. MCH is a partner in the process of ensuring that all birth facilities are compliant with federal and state requirements.

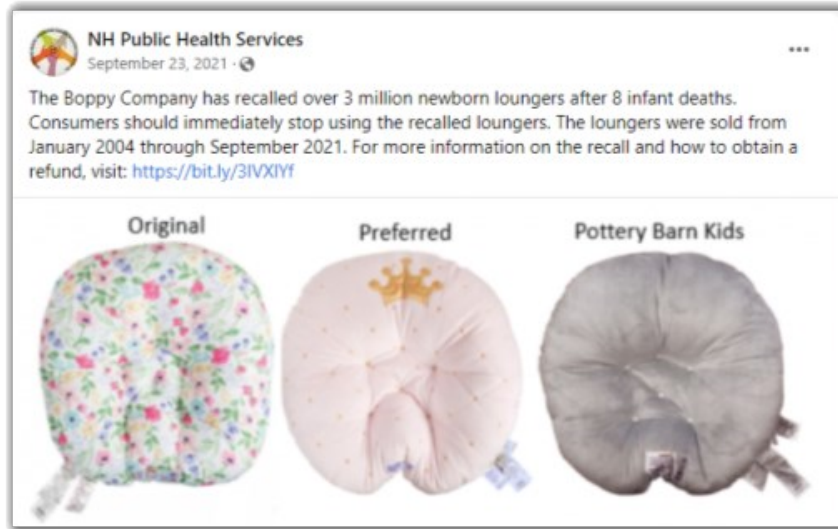
The Perinatal Substance Exposure Task Force continues to provide technical assistance on the POSC, with outreach efforts, and state monitoring and data collection. Participation in the Perinatal Substance Exposure Task Force will continue as the Task Force responds to current and emerging substance exposure threats to maternal and infant health. Visit the [Plans of Safe Care](#) webpage for more information.

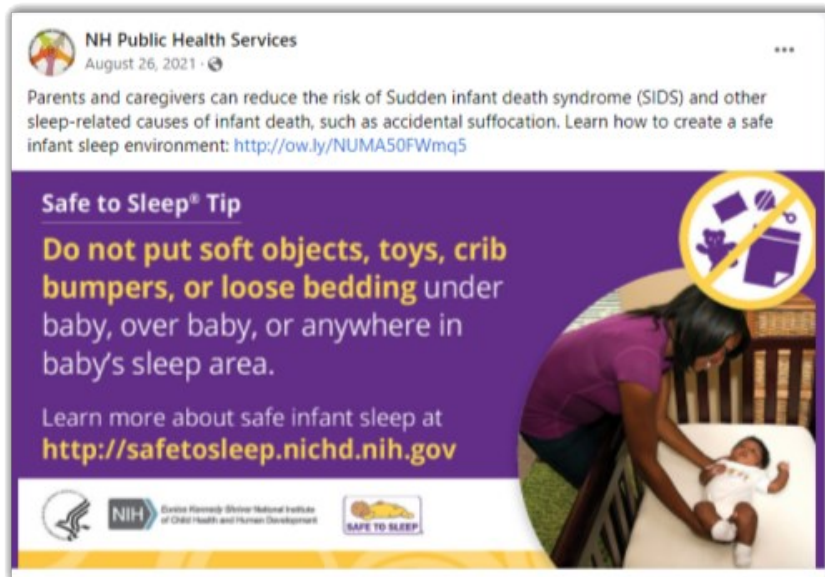
The SUID program provided safe sleep training to the New Hampshire Children's Trust Kinship Navigators, which is a community-based program that focuses on supporting caregivers who have gained guardianship over a family member's infant. During this training, the SUID program provided the Kinship Navigators with up-to-date safe sleep research, provided safe sleep materials, and allowed an open space for the Kinship Navigators to discuss their concerns or questions about safe sleep changes in the past decade.

3. Promote public education on safe sleep

To promote safe sleep in New Hampshire the SUID Program utilized social media to promote safe sleep messaging. The SUID Program posted their safe sleep messages on the Division of Public Health's social media pages, on [Facebook](#), [Instagram](#), and [Twitter](#). The SUID Program has posted several safe sleep messages

particularly during the month of October, the SIDS Awareness Month. The SUID Program utilized social media to notify the public about a popular infant product recall. This product was recalled to due multiple infant deaths reported during product use. This recall post was shared over 30 times to various community partners' social media page to enhance the SUID Program's reach.





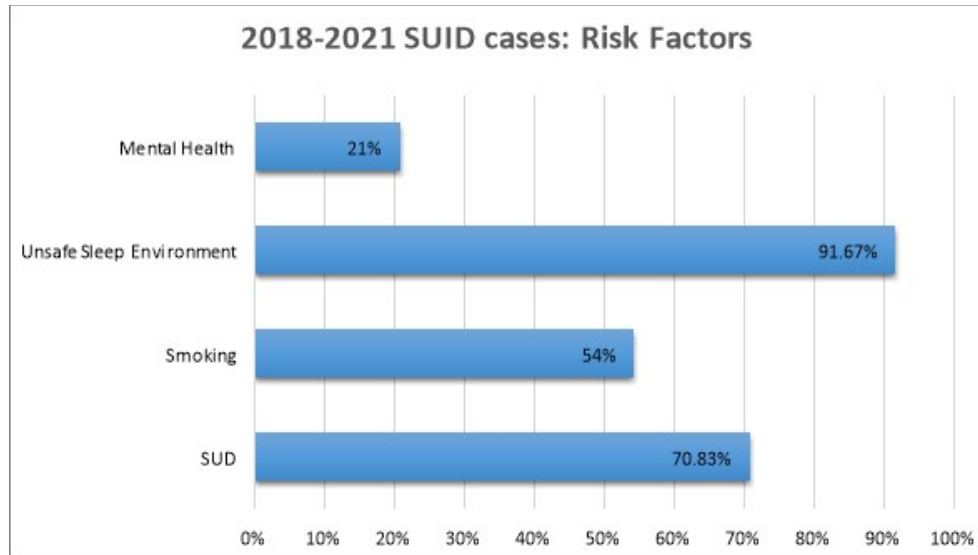
4. Utilize home visiting and PRAMS data to inform key stakeholders about safe sleep and education needed

Due to onboarding training for the new project coordinator, the SUID program was unable to update and issue the data brief in 2021. However, it is anticipated the SUID Program will issue a data brief in 2022 to include both 2020 and 2021 data. This data brief is expected to be released in late 2022. The SUID program will continue to provide technical assistance to hospitals and stakeholders and disseminate the latest PRAMS data on safe sleep behaviors and safe sleep environments annually.

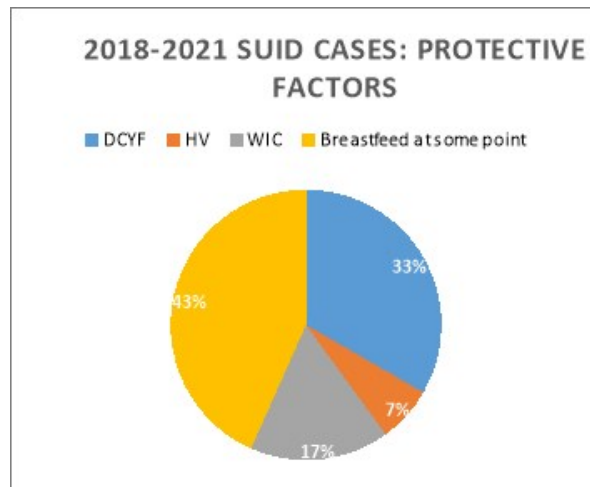
5. Utilize the SUID committee recommendations for risk factors and identify possible points of intervention.

During the case reviews the SUID program collected data on risk factors, protective factors and insurance to determine possible points of intervention. From the data collected the program identified missing data points. During each case review additional information will be collected (Plan of Safe Care, the birth hospital). By collecting this data the program will be able to identify if there are any gaps around safe sleep education.

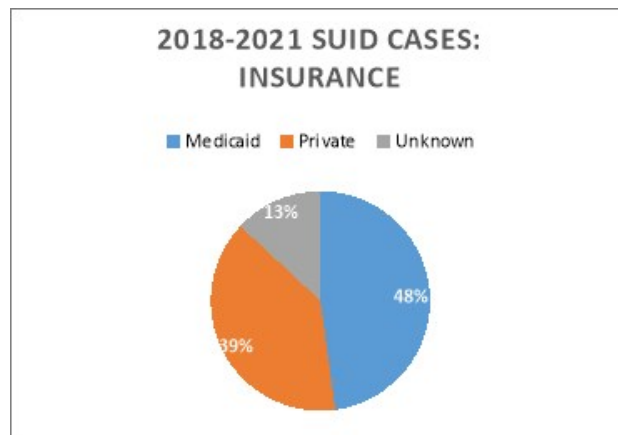
Every birthing hospital in New Hampshire has a safe sleep policy to provide safe sleep education to new parents; however data on the State's SUID cases indicate that some parents and caregivers are not necessarily following the safe sleep instructions provide by the birthing hospital.



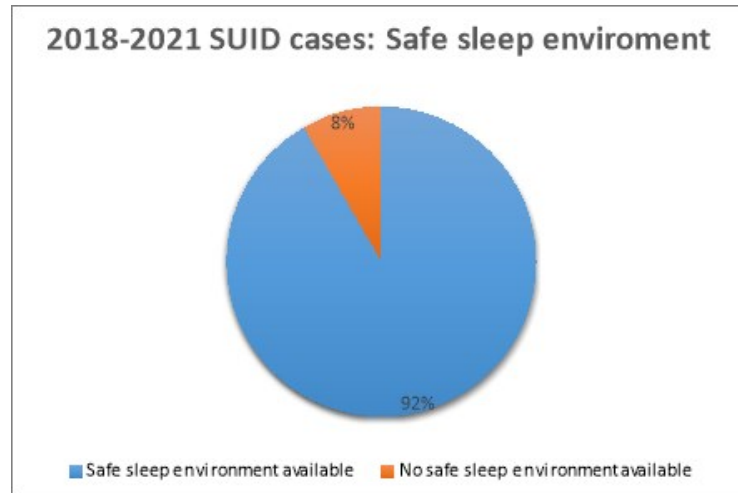
Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of May, 2022



Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of May, 2022



Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of May, 2022



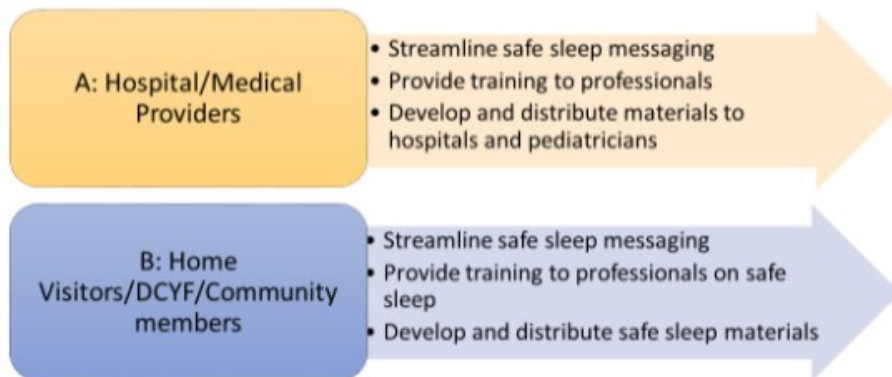
*\*The few cases where no safe sleep environment was available for an infant to sleep in, these families were either transient, homeless, or not in their usual housing situation.*

Source: NH Division of Public Health Services/Maternal and Child Health Section and NH Office of the Chief Medical Examiner, as of May, 2022

As a recommendation from a SUID case review, the SUID Program implemented a new protocol to invite primary health care providers (PHCP) to the SUID Case reviews. By having PHCPs attend these case reviews, the SUID case review committee is able to get additional patient history, family history, information that is shared with families on safe sleep, and any other pertinent case information. This project has been a huge success for the SUID program, with 100% of pediatricians participating. An unexpected project outcome is that the invited PHCPs are gaining comprehensive information on the State's OCME processes and how to request an official autopsy report for their records. By involving the PCHPs in this process, the SUID Program is strengthening community partnerships and increasing awareness of the SUID and safe sleep efforts in New Hampshire.

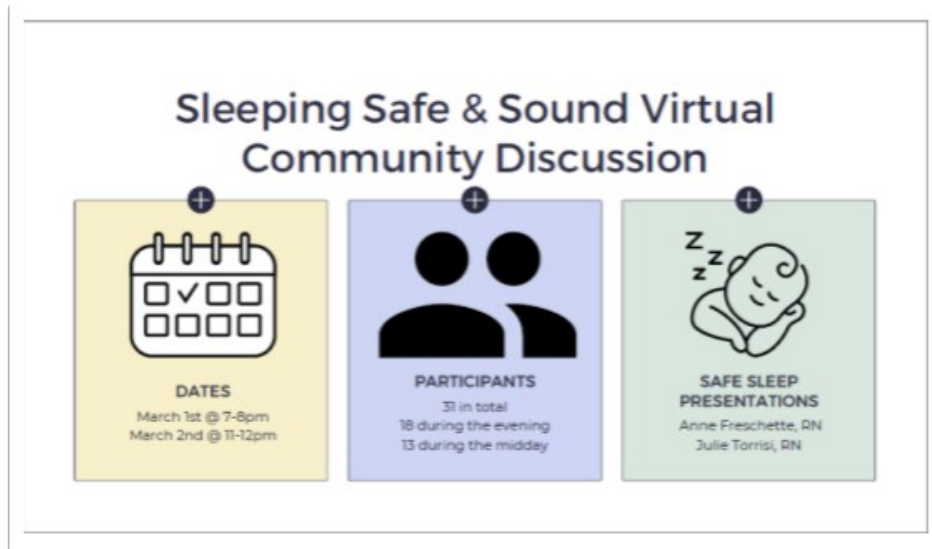
6. Utilize the Safe Sleep Workgroup to identify possible avenues to gain insight into why infants are not being placed to sleep on their backs, without bed-sharing or soft bedding.

## Safe Sleep Workgroup campaign focus: “Lane 2”



In 2021, the SUID Program was able to reconvene the NH Safe Sleep workgroup—due to the staff capacity and the ongoing pandemic efforts the Safe Sleep workgroup was not meeting regularly. The SUID Program recruited previous Safe Sleep workgroup members and new members, which include birth hospital representatives, home visiting representatives, Office of Child Advocacy representative, and other community members. The Safe Sleep workgroup met quarterly to work on recommendations from the SUID case review meetings. Based on the SUID case review recommendations the Safe Sleep workgroup focused on the best way to provide materials to the target audiences. One strategy the work group implemented is to implement town hall style meetings. The goal of the town hall meetings is to engage target audiences such as parents and caregivers, medical providers, and the public to provide educational materials and information about safe sleep and gain information on improve safe sleep education.

In early 2022, the SUID Program collaborated with a Southern New Hampshire University Masters in Public Health (MPH) intern to host two-community outreach events that were held to capture information on common barriers and themes regarding infant sleeping habits in New Hampshire. Two virtual meetings were hosted, one meeting in the evening and another at midday. The times were chosen with equity in mind to be able to offer parents and guardians the ability to choose what works best for them. Of the 31 participants, 41.9% came to the midday session and 58.1% joined the evening event. Learning of the meetings occurred through two main channels social media and safe sleep workgroup partners.



The information acquired will be used to develop recommendations to continue focusing on safe infant sleep practices and opportunities to support New Hampshire families. During these sessions, the program noticed recurring themes:

- Overwhelming post-birth educational resources
- Handling unfamiliar sleep behavior
- Educational development
- Harm reduction
- Parental mental health and support



Recommendations to address these challenges include:



- Implementing a series of focus groups with PHCPs
- Developing a safe sleep social media campaign or page,
- Re-evaluating/designing an antenatal course focused on parental concerns and questions.

Increasing resilience of the parents and guardians will support these efforts and promote confidence in utilizing safe sleep practices and overcoming the challenges. The information acquired will be used to develop recommendations to continue focusing on safe infant sleep practices and opportunities to support New Hampshire families.

Even though the Safe Sleep workgroup has shifted their focus to promoting safe sleep through town halls, NH birth hospitals continue to conduct crib audits. Some birth hospitals are part of the national organization, Cribs for Kids National Safe Sleep Hospital Certification program, which recognizes individual hospitals and hospital systems for their commitment to infant safe sleep. As a national authority on infant safe sleep, Cribs for Kids hospital certification program offers a bronze, silver, or gold designation to hospitals that model and teach infant safe sleep best practices. In NH there are 11 birthing hospitals; of these, six (6) hospitals are certified (two gold, one silver, and three bronze). Part of the program is for hospitals to conduct crib audits. Crib audits consist of spot checking inpatient cribs to see what is in the crib and how the infant is positioned. However, there are two (2) additional hospitals that conduct crib audits who are not certified; it is a standard of care for the mother and infant.

7. Collaborate with NH American Academy for Pediatrics (AAP) Champion on messaging for providers.

Due to staffing capacity the program has not connected with the NH AAP. Since the hiring of the SUID Program Coordinator in January 2021. It is expected that the SUID Program will collaborate with the NH AAP for safe sleep messaging for providers for the virtual town hall meetings in 2022.

\* \* \* \* \*

## **Birth Conditions Program**

### **Background**

The New Hampshire Birth Conditions Program (BCP) is a public health surveillance program that has been collecting statewide data since 2003, monitoring forty-five birth conditions (defects).

The mission of the BCP is to help develop birth conditions prevention strategies, support epidemiological research into the causes and public health impact of birth conditions, improve the ability of families to access intervention programs and services for infants and children with birth conditions, and to educate the community, health care providers, and service agencies regarding birth conditions.

Birth defects are common, costly, and critical, affecting one in 33 infants in the United States (US) each year.<sup>[3]</sup> A leading cause of death, birth defects account for 20% of all infant deaths nationwide.<sup>[4]</sup> Birth defects lead to \$2.6 billion per year in hospital costs alone in the U.S.<sup>[5]</sup>

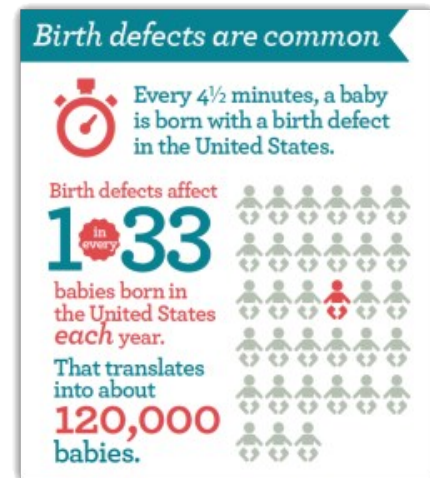
### Surveillance

The BCP utilizes an active case ascertainment model. Data is compared using vital records and open discharge records at the hospital level. Once potential cases are identified, the record abstracter reviews all records to confirm cases meet criteria for inclusion in the surveillance system and registry. The BCP utilizes case inclusion guidelines from the National Birth Defects Prevention Network (NBDPN).

The BCP has continued review of the January to December 2018 and 2019 years. For this period, 19 birth hospitals had active birthing units. All birth hospitals were solicited for record review and abstraction. Two (2) of New Hampshire's larger birth hospitals and one (1) small birth hospital that were unable to respond during the 2020 request, did respond during the 2021 request; however those responses were not timely enough to be reviewed and included in this reporting period. Of the remaining 16 birth hospitals, the BCP has completed record review and abstraction of records for five (5) hospitals, seven (7) are in process, and four (4) remain to review. The five hospitals have their records categorized as confirmed or not confirmed birth defects. A confirmed birth defect involves verifying the defect by review of specialist consultations for the birth defect after the infant is born, up to age two years. These consultations can be obtained either via the primary care physician or specialist offices. De-duplication is an essential function of the registry to prevent birth defects from being counted more than once. De-duplication occurs after all records have been reviewed abstracted and entered into the database system.

Once the birth defect is confirmed, legislation requires the BCP contact the parent(s) of the infant identified to offer information about the BCP Registry, services that the family and infant might be eligible for, and to offer the parents the option of declining participation in the registry. The BCP accomplishes this via a mailing to each family with an infant who has a confirmed and monitored defect. By law, the BCP must wait 60 days for the family to respond to the request to participate in the registry by returning the Birth Conditions Program Registry Form. Once the 60 days have passed, if the program has not heard from the parent regarding any wish to not participate, the infant becomes part of the registry.

When forms with address problems are returned to the BCP, primary care providers are contacted to confirm the address and if found to be incorrect, are re-mailed. Once re-mailed, the BCP must wait the full 60 days for the families to return forms before adding the infants to the registry. When families decide not to participate in the registry, they are added to a do-not-contact list and are not contacted again for this birth, though they may be contacted in the future regarding another birth should that infant have a birth defect that is monitored by the BCP. Additionally, the infant data is not added to the registry.



In total the BCP has reviewed approximately 1200 records for this reporting period. One hundred ten (110) Birth Conditions Program Registry Forms were mailed to families. Eleven (11) of those were returned for address issues, and seven (7) families chose not to be part of the registry leaving 91 infants as part of the registry for reporting years 2018 and 2019. These are partial totals for these years only for infants who were added to the registry for these years, as the BCP is awaiting responses from particular birth hospitals for records to review and specific primary care offices for responses on confirmation of birth defects. Outcomes for cases added to the registry are below.

For the year 2018, a total of 46 defects/conditions were detected in 37 infants. In 2019, a total of 57 birth conditions in 54 infants were detected. Birth conditions were broken down into four categories for the two years: Total birth conditions by defect/condition category, maternal age, infant sex, and race/ethnicity.

The most common birth conditions for these years were defects of the cardiovascular system.

Birth Defect Totals by Defect/Condition Category:

Birth Condition Category	2018	2019
Cardiovascular	27	36
Orofacial	1	3
Eye	1	1
CNS	2	0
GI	0	2
Genitourinary	6	11
Musculoskeletal	5	3
Chromosomal	4	1
Total	46	57

Birth condition by maternal age for 2018 show the majority of defects occurred in the age group 30-34 years, while 2019 data shows the majority occurred in the 25-29 year old age group.

Birth Conditions by Maternal Age:

Birth Condition Category	<20	20-24	25-29	30-34	35-39	40+	Unknown	Totals
<b>2018</b>								
Cardiovascular	0	2	8	8	3	1	5	27
Orofacial	0	0	0	0	1	0	0	1
Eye	0	0	0	1	0	0	0	1
CNS	0	0	0	1	0	0	1	2
GI	0	0	0	0	0	0	0	0
Genitourinary	0	0	1	3	1	1	0	6
Musculoskeletal	0	0	2	1	1	0	1	5
Chromosomal	0	0	0	2	2	0	0	4
<b>Total</b>	<b>0</b>	<b>2</b>	<b>11</b>	<b>16</b>	<b>8</b>	<b>2</b>	<b>6</b>	<b>46</b>
<b>2019</b>								
Cardiovascular	0	5	13	8	7	0	3	36
Orofacial	0	0	1	2	0	0	0	3
Eye	0	0	1	0	0	0	0	1
CNS	0	0	0	0	0	0	0	0
GI	0	0	0	2	0	0	0	2
Genitourinary	0	3	2	4	1	0	1	11
Musculoskeletal	0	0	2	0	1	0	0	3
Chromosomal	0	0	0	1	0	0	0	1
<b>Total</b>	<b>0</b>	<b>8</b>	<b>19</b>	<b>17</b>	<b>9</b>	<b>0</b>	<b>4</b>	<b>57</b>

Birth Conditions by infant sex show the majority occurred in female infants for 2018, though 2019 showed a higher total for male infants. .

Birth Conditions by Infant Sex:

Birth Conditions Category	Male	Female	UNK	Total
2018				
Cardiovascular	8	16	3	27
Orofacial	1	0	0	1
Eye	0	1	0	1
CNS	1	1	0	2
GI	0	0	0	0
Genitourinary	5	1	0	6
Musculoskeletal	4	1	0	5
Chromosomal	1	3	0	4
<b>Total</b>	<b>20</b>	<b>23</b>	<b>3</b>	<b>46</b>
2019				
Cardiovascular	17	19	0	36
Orofacial	2	1	0	3
Eye	0	1	0	1
CNS	0	0	0	0
GI	0	2	0	2
Genitourinary	11	0	0	11
Musculoskeletal	1	2	0	3
Chromosomal	1	0	0	3
<b>Total</b>	<b>32</b>	<b>25</b>	<b>0</b>	<b>57</b>

Birth conditions by maternal ethnicity show the majority of cases are born to White, Non-Hispanic mothers for both years.

Diversity: Race/Ethnicity

Birth Conditions Category	Non-Hispanic White	Non-Hispanic Black or African-American	Hispanic	Non-Hispanic Asian or Pacific Islander	Non-Hispanic American Indian or Alaska Native	Other/Unknown	Total
<b>2018</b>							
Cardiovascular	19	0	2	0	0	6	27
Orofacial	0	0	0	0	0	1	1
Eye	1	0	0	0	0	0	1
CNS	1	0	0	0	0	1	2
GI	0	0	0	0	0	0	0
Genitourinary	5	0	0	0	0	1	6
Musculoskeletal	3	0	1	0	0	1	5
Chromosomal	4	0	0	0	0	0	4
<b>Total</b>	<b>33</b>	<b>0</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>46</b>
<b>2019</b>							
Cardiovascular	30	0	2	0	0	4	36
Orofacial	2	0	0	0	0	1	3
Eye	1	0	0	0	0	0	1
CNS	0	0	0	0	0	0	0
GI	2	0	0	0	0	0	2
Genitourinary	10	0	0	0	0	1	11
Musculoskeletal	2	0	0	0	0	1	3
Chromosomal	1	0	0	0	0	0	1
<b>Total</b>	<b>48</b>	<b>0</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>7</b>	<b>57</b>

### Enhancements to Improve Capacity and Streamline Newborn Surveillance Activities

The Early Hearing Detection and Intervention (EHDI), Newborn Screening (NBS) and Birth Conditions Program (BCP) have been involved in selecting an upgraded Integrated Data Management System (IDMS) to incorporate birth data for all three programs, as well as key elements from the vital record with the purpose of creating a relatively complete picture of an infant at birth prior to discharge from the birth hospital.

In April 2021, the Maternal and Child Health (MCH) portion of the new IDMS went live which included EHDI, NBS Critical Congenital Heart Defects (CCHD) and BCP. In June a pilot of select birth hospitals began using the IDMS, and July 1<sup>st</sup>, all birth hospitals began actively entering data into the new system. Year one of IDMS birth hospital use was focused on mandatory EHDI and CCHD reporting for the NBS programs. Birth defects reporting by hospital birthing units will be revisited in year two.

There have been several challenges with legacy data mapping for the new system and configurations for the vital records feed affecting EHDI and the BCP programs. Additionally, there have been several personnel changes within our vendor, OZ Systems. Consequently, legacy data remains unavailable within the new system and the supporting near real-time vital records feed has been delayed. Availability for both are planned for late spring/early summer 2022.

Health Level Seven (HL7) data transfer into the IDMS has been made available for hospitals which are ready to pursue this function with the vendor. This option will only be available for EHDl and CCHD data as both programs use the “OZ e-Screener Plus” (OZ eSP) feature from the vendor which accesses results from screening equipment and interfaces with the data collected from the Electronic Health Record (EHR). Three (3) New Hampshire birth hospitals are currently pursuing this functionality. At this time, birth conditions reporting will not be able to utilize this function and hospitals will enter birth defect information manually into the IDMS.

The National Birth Defects Prevention Network (NBDPN) which produces the guidelines for establishing birth defects programs, birth defects data collection and reporting, established a EHR/HL7 workgroup within the Surveillance

Guidelines and Standards Committee to assist in promotion of national discussions surrounding the ability for birth defects programs to engage in use of HL7 feeds to populate some aspects of birth defects registries. The Centers for Disease Control and Prevention (CDC) Division of Birth Defects and Infant Disorders (DBDID) is collaborating with the Public Health Informatics Institute (PHII) to host a series of webinars for birth defects programs to improve knowledge and understanding of implementing and/or enhancing interoperable birth defects registries to support surveillance.

For this reporting period, the BCP added confirmed cases manually to the system related to record review and abstraction and vital records assisted with populating those cases with birth certificate data.

## Collaborations

During the ongoing COVID-19 pandemic, the BCP has continued to work collaboratively with the Bureau of Infectious Disease Control (BIDC) and the MCH Epidemiologist to identify COVID-19 outcomes in mothers and infants born in 2020 and 2021 for the CDC’s Emerging Threats to Mothers and Babies (SET-NET) project. This combined effort has BIDC supplying the confirmed lab data, the MCH Epidemiologist providing the link and data from Vital Records, and the BCP requesting and compiling mother and infant data for reporting to the CDC. An existing MOA between MCH and Vital Records allows Vital Records to support a situational enhancement to data collection using the birth record. This enhancement allows for monitoring events that effect birth outcomes and is being used in this instance for the SET-NET project. This rapid surveillance capability allows for near real time data collection surrounding these events.

## Connecting Affected Children and Families to Appropriate Social Services





The BCP offers information to families impacted by birth defects via the mailing sent to inform families about the Birth Condition Program Registry. Information about the Bureau of Family Centered Services (BFCS) and New Hampshire Family Voices, along with directions for contacting these service providers and an application for Special Medical Services, are included in the material mailed to each identified family. Parents are able to self-refer to services by contacting the Bureau of Family Centered Services and/or NH Family Voices directly.

The BCP has identified connecting families to services as a project to work collaboratively on with the Bureau of Family Centered Services. During 2021, the BCP worked with BFCS to establish a method by which families who sent in an application to Special Medical Services that was part of the packet sent to them from the BCP concerning the registry could be identified. BFCS was also able to identify if families sent an application that was not associated with the BCP registry information mailings. A total of 91 infants were identified as part of the Birth Conditions Registry for infants born in the years 2018 and 2019. Of those, 13 infants and families were enrolled in BFCS between 2018 and 2022.

The source of the majority of referrals came from the Primary Care Provider/ Medical Home followed closely by the families themselves.

#### Referral Source

Referral Source	
Family	3
From BCP Opt Out Mailing	1
Head Start	1
PCP/Medical Home	4
Early Supports Services to SMS	2
Easter Seals	1
Community Bridges	1
Totals	13

The birth condition categories for referrals were as follows:

#### Birth Condition Category for Referred Infants



Birth Condition Category	
Cardiac	3
Cardiac with Genetic Component	3
Cardiac with CNS Component	2
Genetic Alone	2
Genitourinary	3
Totals	13

The first phase of this referral project has yielded important information regarding the need to connect families to services. The next phase of this collaborative project could focus on how best to educate and utilize the medical home/primary care provider to provide information regarding BFCS and for the medical home to encourage families to enroll or refer to BFCS directly, with a future goal to refer as soon as a birth defect requiring services is determined. As we perfect the New Hampshire birth hospital use of OZ Systems to report birth defects to the BCP, a long term goal may be to work with hospitals to refer infants with a confirmed birth defect directly to BFCS before discharge.

### Educating the Public and Providers Concerning Birth Defects and Birth Defects Prevention Among Adults Desiring Pregnancy

The BCP utilizes social media to reach women of childbearing age and women who are pregnant or desire pregnancy, and their partners. Messaging encompasses preventive measures to reduce the likelihood of birth defects before and during pregnancy.

Using campaigns associated with monthly awareness activities, such as World Birth Defects Day, Folic Acid Awareness Week and National Birth Defects Awareness Month, the birth defects program offers information on select topics.



NNEPQIN (the Northern New England Perinatal Quality Improvement Network) provides up-to-date information to the perinatal provider community and holds several educational conferences throughout the year. This communication avenue serves to disseminate information to this group via presentations or written material.



The BCP has ongoing collaboration with NNEPQIN through the BCP Advisory Committee.

Development and rollout of the new database for the BCP, EHDI and NBS programs, the BCP's collaboration with BIDC for monitoring mother and baby outcomes related to COVID, along with correspondence with the medical home have increased visibility of the BCP in New Hampshire.

[1] Centers for Disease Control and Prevention, Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data and Statistics. Retrieved on 05/17/2022 from <https://www.cdc.gov/sids/data.htm>

[2] Centers for Disease Control and Prevention, Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data and Statistics. Retrieved on 5/17/2022 from <https://www.cdc.gov/sids/data.htm>

[3] Centers for Disease Control and Prevention. Update on Overall Prevalence of Major Birth Defects—Atlanta, Georgia, 1978-2005. *MMWR Morb Mortal Wkly Rep.* 2008;57 (1):1-5.

[4] T.J. Mathews, M.S.; Marian F. MacDorman, Ph.D.; and Marie E. Thoma, Ph.D., Division of Vital Statistics, "Infant Mortality Statistics From the 2013 Period Linked Birth/Infant Death Data Set", *National Vital Statistics Reports Volume 64*(August 6, 2015): Number 9.

[5] Russo CA, Elixhauser A. Hospitalizations for Birth Defects, 2004: Statistical Brief #24. In: *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2006

## Perinatal/Infant Health - Application Year

### **National Performance Measure #5**

1. Percent of infants placed to sleep on their backs
2. Percent of infants placed to sleep on a separate approved sleep surface
3. Percent of infants placed to sleep without soft objects or loose bedding

**Evidence Based or Informed Strategy Measure:** Percent of infants enrolled in Maternal, Infant, Early Childhood Home Visiting (MIECHV), New Hampshire Healthy Families America (HFA) Program who are always placed to sleep on their backs, without bed-sharing or soft bedding.

**Objective:** By January 2023, 50% of infants enrolled in MIECHV HFA home visiting program will always be placed to sleep on their backs, without bed-sharing or soft bedding.

### **Strategies:**

1. Collaborate with the MIECHV HFA home visiting program on their materials and education for families on always placing their infant to sleep on their backs in a separate approved sleep surface without soft objects or loose bedding.
2. Develop a training tool for HFA home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices
3. Utilize home visiting and PRAMS data to inform key stakeholders about safe sleep and education needed
4. Promote public education on safe sleep
5. Utilize the SUID committee recommendations regarding risk factors and identify possible points of intervention.
6. Utilize the Safe Sleep Workgroup to identify methods for carrying out the recommendations identified during the SUID case reviews

### **System Building:**

The multidisciplinary SUID Review Committee meets three (3) times a year. The Safe Sleep workgroup, a subcommittee of the SUID Review Committee, meets every other month to work on recommendations identified during the case reviews. Recommendations from cases reviews include provider trainings, educational materials, and policies regarding safe sleep practices. The Safe Sleep workgroup will continue to provide technical assistance to hospitals, midwives, home visitors, medical providers and other service providers on safe sleep policies and practices.

The SUID Program in collaboration with the MIECHV program will develop a quality improvement plan to increase the number of infants who are always placed to sleep on their backs in a safe sleep approved environment. The SUID Program and the MIECHV team will meet every other month to identify gaps to increase service provider awareness, accurate data reporting, and home visitor education on safe sleep.

### **MCH Strategy Activities:**

**Strategy 1:**

The SUID Program in collaboration with MIECHV HFA program identified a gap in that families who are enrolled in home visiting report less than 50% of the time always placing their infant to sleep on their backs, without bed-sharing or soft bedding. In order to address this gap, the SUID and MIECHV HFA program will work together to develop a training tool.

The SUID Program and MIECHV HFA program will collaborate with a local implementing agency (LIA) to discuss barriers and successes with safe sleep in the home visiting program. The SUID Program will support the LIAs by providing safe sleep materials, and support to the home visitors in regards to working with families around safe sleep. The SUID Program and MIECHV HFA program will develop a training tool that will include how to talk with families about safe sleep, how to talk to families when it is identified the families practice unsafe sleep, and provide educational materials/information to the entire MIECHV HFA program.

**Strategy 2:**

The SUID Program plans to develop a safe sleep toolkit for HFA home visitors, DCYF personnel, law enforcement, service providers (anyone who goes into the family's home) on safe sleep practices. This toolkit will include resources such as safe sleep materials, cribs, pack 'n plays, and support groups for families. Included in this toolkit will also be resources for the in-home providers on how to communicate with the family about safe sleep practices. This toolkit will be available virtually on the SUID/SDY Program's [website](#) so in-home providers will be able to access this toolkit wherever they are located.

During the SUID case reviews it has been recommended that the SUID Program partner with Emergency Medical Services (EMS) and/or Firefighters to help promote safe sleep through EMS/Firefighters. The SUID Program will collaborate with local EMS and Firefighters to develop a safe sleep protocol that will support EMS and Firefighters in talking with families about safe sleep, if an infant is present during the call. This protocol will include a toolkit with safe sleep materials, cribs, pack 'n plays, and other supports for families. In addition, a training will be developed on how EMS/Firefighters can ask families where their infant is sleeping, and how to talk to families about practicing safe sleep when it is identified that the family is not practicing safe sleep.

**Strategy 3:**

Using the home visiting data, PRAMS data, and SUID data the SUID Program will create a sleep-related infant death annual report that will be disseminated to stakeholders, and the public. This report will include demographics on the infants, infant's caregivers, and sleep environment behaviors. This report will also include guidance and recommendations from the American Academy Pediatrics (AAP) in regards to safe sleep practice. The SUID/SDY Program will post this report on the SUID Program's [website](#) to ensure all have access to the report. This annual report will be referenced in the toolkit as mentioned above.

**Strategy 4:**

The SUID Program plans to further improve infants' safe sleep promotion by working with providers to share the latest message from the American Academy of Pediatrics on safe sleep recommendations. The SUID Program will share any important safe sleep messages such as any infant product recalls by the US Consumer Product Safety Commission on social media. Dissemination of safe sleep information and promoting safe sleep will continue to be done through promoting education on safe sleep best practices through the NH DHHS Division of Public Health's social media pages ([Facebook](#), [Twitter](#), and [Instagram](#)) and by updating the SUID [website](#) to include resources as discussed above.

### Strategy 5:

The multidisciplinary SUID Review Committee meets three (3) times a year to review all SUID cases in NH. During the reviews the SUID Review Committee discusses and records all factors associated with these cases. After the review, the SUID Program will bring risk factors and possible points of intervention to the Safe Sleep workgroup to review and develop resources to address these gaps. The risk factors and recommendations from the case review meetings will be the basis of the information that provided for the trainings and toolkit.

### Strategy 6:

With data and information collected during the SUID “parent town halls”, the SUID Program will develop educational materials to provide to home visitors and include in the safe sleep toolkit. The SUID Program and the Safe Sleep Workgroup will use this information to create general public marketing materials to promote safe sleep. The SUID Program will continue to use the Safe Sleep Workgroup to focus on the risk factors and recommendations from the SUID case reviews to implement new safe sleep materials and practices.

\* \* \* \* \*

## Birth Conditions Program-Looking Toward the Future 2022-2023

### Improving Capacity and Streamlining Newborn Surveillance Activities

The Early Hearing Detection and Intervention (EHDI), Newborn Screening (NBS) and Birth Conditions Program (BCP) have begun utilizing the enhanced Integrated Data Management System (IDMS) from OZ Systems. The system was upgraded to incorporate birth data for all three programs as well as key elements from the vital record with the purpose of bringing a single point of reference for information on a New Hampshire birth.



In April 2021, the Maternal and Child Health (MCH) Newborn Screening Programs of EHDI, BCP and the Critical Congenital Heart Defects (CCHD) section of the Blood Spot (NBS) programs began utilizing the IDMS, with all birth hospitals beginning data entry into the system July 1, 2021. Year one of IDMS birth hospital use was focused on mandatory EHDI and CCHD reporting for the Newborn Screening Programs. Birth defects reporting by hospital birthing units will be revisited in the coming year (year two) with targeted trainings focused on challenges found with all NBS data entry and with instruction at stakeholder birth hospitals on

use of the birth defects reporting section specifically.

The goal for hospital birth defects real-time reporting is to capture any suspected birth defects prior to discharge to enrich the BCP data set. Any reported birth defect by the birth hospital will need to be confirmed by the BCP before being added to the final registry, though this reporting will help insure cases are not missed. The BCP will be able to run a report from the IDMS for suspected birth defects entered by all birth hospitals and use this information to add to the ICD-10 annual request for records that is sent to the Health Information Management (HIM) departments of each hospital.

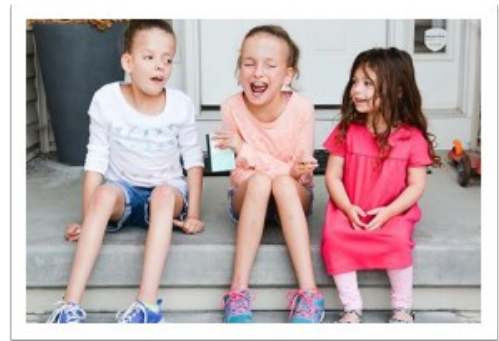
While 2021 brought challenges for IDMS use surrounding legacy data mapping configurations for the vital records feed affecting EHDI and the BCP programs, availability for both are planned for late spring/early summer 2022.

These enhancements will create more straightforward data entry for the three programs as demographics for the infants will already be in the system with the desired effect of streamlined results data entry without the additional task of demographics entry.

Health Level Seven (HL7) data transfer into the IDMS has been made available for hospitals which are ready to pursue this function with the vendor. This option will only be available for EHDI and CCHD data as both programs use the “OZ e-Screener Plus” (OZ eSP) feature from the vendor which accesses results from screening equipment and interfaces with the data collected from the Electronic Health Record (EHR). Currently there are three (3) hospitals working with the vendor to utilize this feed. Although the BCP is unable to exploit this feature thus far, the National Birth Defects Prevention Network (NBDPN) has established an EHR/HL7 workgroup within the Surveillance Guidelines and Standards Committee to assist in promotion of national discussions on the ability for birth defects programs to engage in use of HL7 feeds to populate some aspects of birth defects registries.

### Collaborations

The BCP will continue to work collaboratively with the Bureau of Infectious Disease Control (BIDC) and the MCH Epidemiologist to identify COVID-19 outcomes in mothers and infants born in 2020 and 2021 for the Center for Disease Control and Prevention Surveillance for Emerging Threats to Mothers and Babies (SET-NET) project while their funding is available. This combined effort will have a new dedicated position within BIDC for mother-infant surveillance tasks as well as infant follow-up. The MCH Epidemiologist will continue to provide linkage from Vital Records, and the BCP will assist in requesting and compiling mother and infant data for reporting to the CDC.



### Connecting Affected Children and Families to Appropriate Social Services



The BCP has identified connecting families to services as a project to work on collaboratively with the Bureau of Family Centered Services (BFCS). During 2021, the BCP worked with BFCS to establish a method by which families who sent in an application to Special Medical Services that was part of the packet sent to them from the BCP concerning the Birth Conditions Program Registry could be identified. For 2022-2023, BFCS and BCP will work together to determine the next phase of this project with possible outcomes of detailing how the infant was referred to services (from the BCP, the medical home, specialty offices or self-referral); if the families were referred, did they enroll in services and which monitored birth defects are most likely to apply for and enroll in services. With the enhanced IDMS, in the future there may be potential for documentation of the referral process to

needed services before the family leaves the hospital.

### Educating the Public and Providers Concerning Birth Defects and Birth Defects Prevention Among

## Adults Desiring Pregnancy

The BCP employs communications incorporating preventive measures to reduce the likelihood of birth defects before and during pregnancy via social media platforms and the MCH website. The social media messages are targeted to reach women of childbearing age and women who are pregnant or desire pregnancy, and their partners. Using campaigns associated with monthly awareness activities, such as World Birth Defects Day, Folic Acid Awareness Week and National Birth Defects Awareness Month, the birth defects program offers information on select topics.

The Northern New England Perinatal Quality Improvement Network (NNEPQIN) provides up-to-date information to the perinatal provider community and holds several educational conferences throughout the year. This communication avenue serves to disseminate information to this group via presentations or written material. The BCP has ongoing collaboration with NNEPQIN through the BCP Advisory Committee.

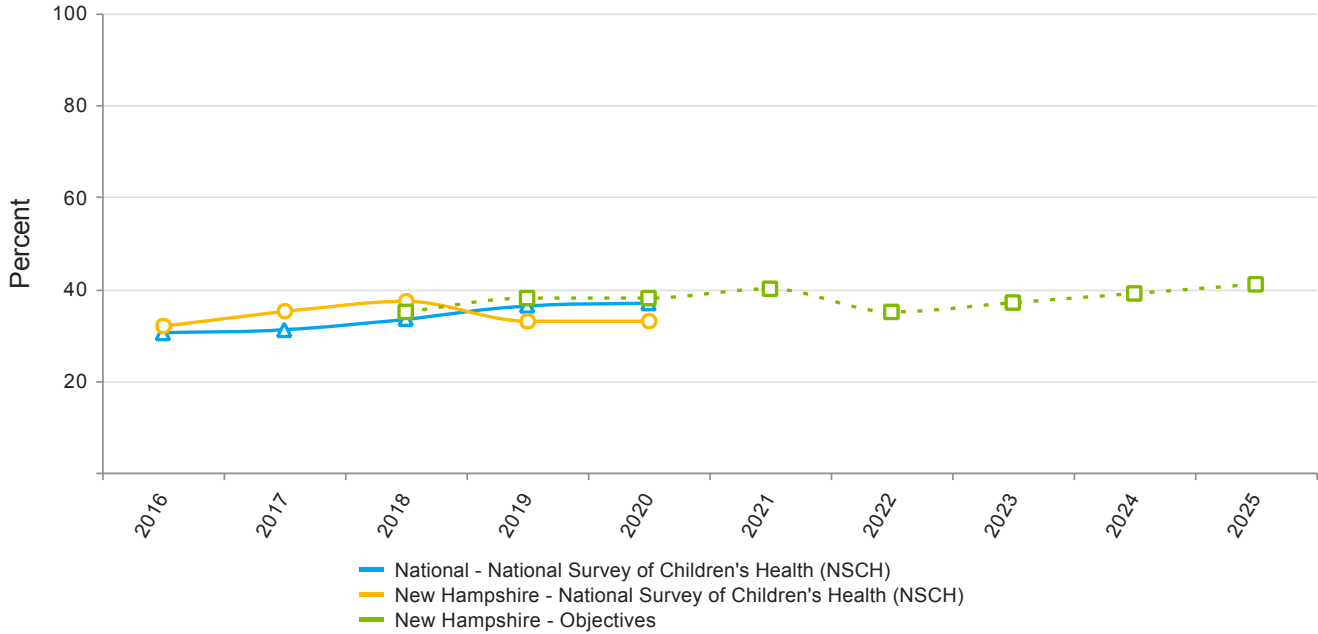
Development and rollout of the new database for the BCP, EHDl and NBS programs, the BCP's collaboration with BIDC for monitoring mother and baby outcomes related to COVID, and correspondence directly with the birth hospital nurse managers, obstetricians and pediatricians in the medical will continue to aid in increasing exposure and awareness of the BCP in New Hampshire.



**Child Health**

**National Performance Measures**

**NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**  
**Indicators and Annual Objectives**



**Federally Available Data**

**Data Source: National Survey of Children's Health (NSCH)**

	2017	2018	2019	2020	2021
Annual Objective		35	38	38	40
Annual Indicator	32.0	35.1	37.3	32.8	33.0
Numerator	8,656	8,593	8,951	8,955	10,313
Denominator	27,043	24,468	23,970	27,283	31,209
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

**Annual Objectives**

	2022	2023	2024	2025
Annual Objective	35.0	37.0	39.0	41.0



**Evidence-Based or –Informed Strategy Measures**

**ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	90	70	68	50	50
Annual Indicator	69	64	45	48	41
Numerator					
Denominator					
Data Source	WMG Welligent Data	WMG Welligent Data	WMG Welligent report (July 18 - March 19)	WMG Welligent Data System	WMG Welligent report
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	55.0	60.0	65.0

## State Action Plan Table

### State Action Plan Table (New Hampshire) - Child Health - Entry 1

#### Priority Need

Improve access to standardized developmental screening, assessment, and follow-up for children and adolescents

#### NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

#### Objectives

To increase from 36% to 46% the percentage of children, ages 9-35 months, who receive a developmental screening using a parent-completed screening tool, by 2025.

#### Strategies

Training care providers

Effective referrals

Empowering families

#### ESMs

#### Status

ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System. Active

#### NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

## Child Health - Annual Report

**National Performance Measure#6:** Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool.

**Evidence Based or Informed Strategy Measure:** The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WGM) System.

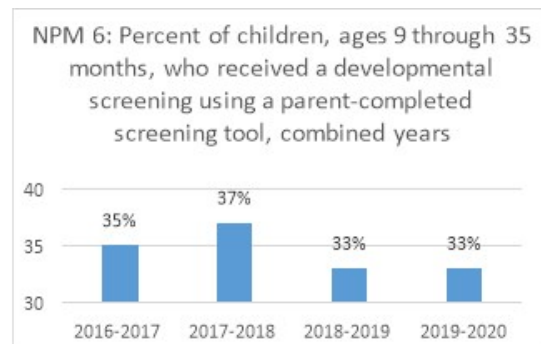
**Objectives:** To increase from 36%<sup>[1]</sup> to 46%, the percentage of children, ages 9 months to 35 months, who receive a developmental screening using a parent-completed screening tool by 2025.

### Strategies:

- Trainings to improve screening rates and capacity
- Efforts to increase awareness and education
- Intensive technical assistance/quality improvement
- Developmental screening resources

### Data Analysis

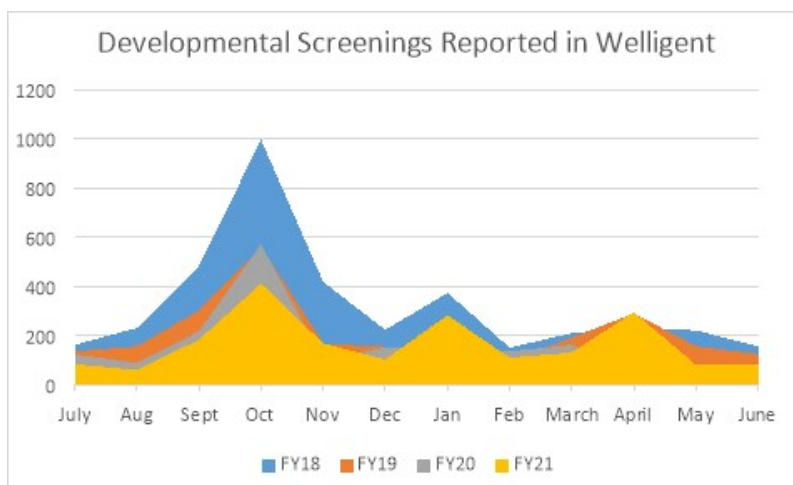
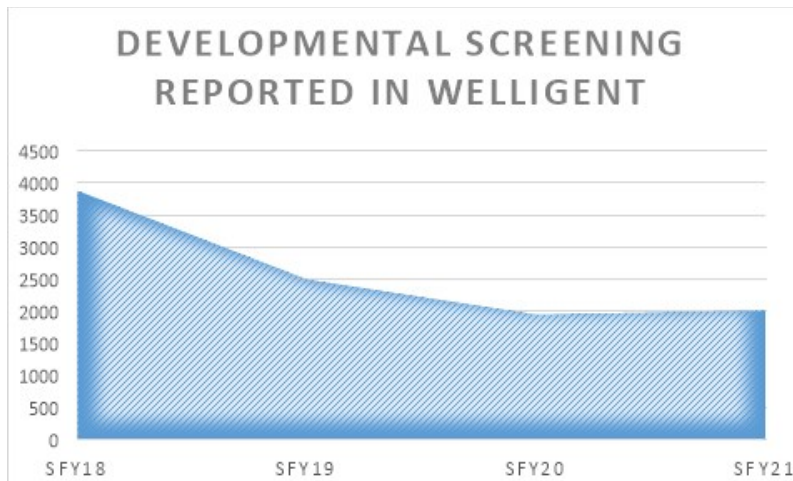
According to the National Survey of Children's Health, 33% of NH children ages 9 months through 35 months received a parent completed developmental screening in years 2019 and 2020 combined. This is almost the same (up 0.2%) as the combined previous years of 2018-2019, which dropped from 37% in the previous two-year period. The COVID-19 stay at home order resulted in less opportunity for new parents to observe their young children interacting with other children, fewer children attending early childhood programs, and reduced well-child visits. These are all factors that could have easily affected the number of parent-completed screens during the past three years.



National Survey of Children's Health

Watch Me Grow, NH's Developmental Screening System, promotes the use of the ASQ-3 and the ASQ:SE2. State-contracted Family Resource Centers are obliged to enter their screening data into Welligent, an electronic health record.

A review of the data in Welligent for SFY21 shows developmental screenings reported in the electronic record were close to the same level as the previous year, with just a small increase of 65 more screens. Anecdotally, Watch Me Grow has learned that providers are completing screens with families; however, they are not reporting screenings with fidelity as it is an awkward system that is difficult to use, does not allow for corrections and is inefficient. Watch Me Grow leadership continues to work to resolve these issues by implementing the ASQ Online System by Brookes Publishing.



## Systems Building

As the State’s identified lead for the Developmental Screening System since 2018, the Bureau for Family Centered Services (BFCS) continued to guide the efforts to enhance and expand Watch Me Grow (WMG) to a developmental screening system in NH which includes developmental monitoring, education, evaluation, diagnosis, treatment and services. SFY21 saw tremendous growth toward this goal. In the fall of 2020, the Steering Committee voted to implement Help Me Grow, a system model that utilizes and builds on existing resources to develop and enhance a comprehensive approach to early childhood system-building. Successful implementation of the Help Me Grow model requires communities to identify existing resources, and to think creatively about how to make the most of existing opportunities. Help Me Grow emphasizes the building of a coalition to work collaboratively toward a shared agenda.

Prior to SFY21, WMG viewed itself as a program, engaging partners in a top down model; if an organization partnered with WMG, a set of requirements was expected to be met. The WMG Steering committee, which includes leadership from Title V, MCH and BFCS, did a deep dive review of its mission, vision and charge. Out of this came the realization that WMG is not a program, but rather is the partnerships of organizations committed to ensuring that every child has access to developmental screening and meaningful family connection to services.

The focus of WMG shifted to be more collaborative; to meet organizations where they are at and to work to provide them the tools, trainings, and technical support they need to do the all-important work of developmental screening, supporting families in understanding the process and connecting them to services. The WMG Steering Committee

listened to partners who reported their need for access to training, and described the burden of entering data in an outdated database. The Steering Committee looked to Help Me Grow to find a path forward.

The Help Me Grow (HMG) Framework consists of the following four components that work together to build the system:

1. A Centralized Access Point to provide resources, information on child development and screening, and connect families to services;
2. Family and Community Outreach to promote the work of the Centralized Access Point, provide trainings and technical assistance to community based services;
3. Child Health Provider Outreach to provide support and information on developmental screenings to medical providers, and promote the Centralized Access Point as a referral location for providers to connect families to local resources;
4. Data Collection and Analysis to ensure continuous improvement.

When the WMG Steering Committee was looking for an organization to take on the role of a Centralized Access Point, NH Family Voices (NHFV) was an obvious choice due to their established presence as a families-serving-families organization serving the entire State. HMG describes the access point as being like a power grid: wherever a family is, they can get connected to the resources they need so that all children can thrive. When NHFV submitted their proposal to the Preschool Development Grant (PDG B-5), the WMG Steering Committee fully supported their efforts.

The proposal was approved by PDG B-5 early in SFY21. The Centralized Access Point at NHFV will be a hub for information on child development, developmental screening and resources to get families connected. It will provide training, technical assistance, and access to Brookes Publishing ASQ Online Management System to organizations in the State that wish to partner with WMG. Screenings can be completed online by families, thus eliminating the need to re-enter screening information for data reporting, and providers will benefit from the many tools and materials available through the online system.

The first enrollees will be the ten regional Family Resource Centers (FRCs) who offer developmental screening in their regions and provide families with information to contact their local Family Centered Early Supports and Services (FCESS) program (NH's Part C program). The Centralized Access Point will then open up to others in the State who have already collaborated with WMG, and expand from there.

The strength of WMG comes from its partnerships. In FY21, the Institute on Disability at the University of New Hampshire received a small grant from the Association of University Centers on Disabilities (AUCD) and the Centers for Disease Control and Prevention (CDC) to support COVID-19 recovery and strengthen resilience skills, behaviors, and resources for children, families and communities. It included an Act Early Ambassador co-led team and other key public health and early childhood partners. The WMG Steering Committee, which included nearly all required partners, embraced this work.

With the grant's support, NH was able to provide training for three partners of WMG to become Brookes certified trainers of the ASQ-3 and ASQ:SE to support the work of the Centralized Access Point, and provided training for 29 others on how to use the ASQ Online System. It also supported the creation of a communication plan to align messaging of Watch Me Grow, Learn the Signs Act Early (LTSAE) and the Centralized Access Point. This plan, created by John Snow, Inc. (JSI), New Hampshire Office, Community Health Institute, provides a road map for a

social media campaign to share broadly news and information on developmental monitoring, screening and family resources.

In SFY21, WMG, in collaboration with NH's MIECHV and the State's Bureau of Child Development and Head Start Collaboration, agreed to oversee and fund a small project to explore online platforms to offer virtual training. With these funds, JSI worked with the Watch Me Grow Steering Committee to develop a training plan and identify best platforms for digital screenings. Informally, it was discovered that the greatest need was technical assistance and ongoing support for partner organizations due to ongoing staff turnover. This became part of the role of the Centralized Access Point: to provide ongoing support and technical assistance around child development and developmental screening.

It was also discovered that a digital library for ASQ training, and use of the ASQ Online tool already exists in the ASQ Online website and is free to anyone with an account. Organizations who partner with the Centralized Access Point would receive an online account and would be given access, and have additional support from a developmental screening coordinator at NHFV.

Due to unforeseen delays in the State contract with Brookes, enrollment with the Centralized Access Point was delayed; however, Centralized Access Point staff completed Brookes Publishing's "Training of the Trainer." Plans were made, with support from the CDCs COVID-19 Recovery grant, to conduct a formalized survey in SFY22 to gain a clearer picture of training needs throughout the State, and to identify who in the State was certified by Brookes Publishing to train others on using the ASQ tools.

Another strong partnership of WMG is the long lasting relationship with the Learn the Signs Act Early (LTSAE) State Ambassador. SFY21 saw a transition when the LTSAE Ambassador, who had been supported by the BFCS, left her position. Luckily, a strong autism and parent advocate at NHFV stepped up and applied. The application was accepted and the new ambassador stepped into the role without missing a beat. NHFV disseminated 731 LTSAE publications throughout the year and continued to be a key part of the developmental screening system in NH.

The WIC partnership with LTSAE, despite some set back due to COVID-19, continues to grow. A pilot project, started in SFY20, offered free developmental monitoring to families. WIC offered the LTSAE Milestones Checklist during their annual certification visit and 6-month follow-up. WIC staff encouraged the family to complete the checklist and reviewed it with the family, linking the discussion about development to nutrition and growth. If concerns were identified, the family was encouraged to contact their primary care provider to share their concerns and the checklist. Many families chose to access the CDC Milestone Tracker App on their phone through the WIC Shopper app. When accessed this way, WIC can count how many families click on the link. For SFY21, NH families in the pilot area clicked this link 9630 times.

WMG continued to be a referral source that helped the Family Centered Early Supports and Services (FCESS), NH's Part C program, meet Child Find goals. Although the Part C State office remained committed to collaboration to build a robust developmental screening system, there was limited capacity to participate in the WMG Steering Committee in FY21, due to the COVID-19 Public Health Emergency, hiring freeze and vacant positions.

#### **Title V Specific Activities:**

BFCS' continued to contract with NHFV to support Family-to-Family Health Information Center services (F2F). Activities under this contract were designed to support families as caregivers and enhance the lives of CSHCN by improving the system of care and its ease of use by families. The F2F assisted families using a variety of means as they sought to meet their children's health care needs and navigate the public and private health care and social service systems, including Watch Me Grow for developmental screening. In addition, NHFV served as a liaison

between BFCS and CSHCN and their families to ensure that NH's Title V programs and efforts for CSHCN are family-centered.

Although BFCS was unable to add a full time a Watch Me Grow Coordinator, a significant amount of the Systems of Care Specialist's time involved leading WMG and HMG activities during the reporting period.

Lastly, BFCS continued to support the Child Development Clinic Network (CDCN), through a contract with Amoskeag Health (a.k.a. Manchester Community Health Center). The purpose of this contract was (and continues to be) to assure timely access to comprehensive pediatric interdisciplinary developmental assessments for children, from birth to age seven years for whom developmental concerns were identified. Children with a concerning developmental screening from a FRC or other WMG partner, often received a referral to the CDCN. The target population for this contract has been children without timely access to diagnostic services from other sources, without health insurance, having conditions requiring a comprehensive team approach for adequate evaluation, or being medically fragile or having complex medical needs. Although this is a step beyond developmental screening, in NH, it is a critical component of the system.

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<sup>[1]</sup> Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [3/28/22] from [www.childhealthdata.org].

## Child Health - Application Year

**National Performance Measure #6:** Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool.

**Evidence Based or Informed Strategy Measure:** To increase the number of provider sites including, but not limited to, child care centers, health care providers and other community-based organizations completing and reporting ASQ/ASQ-SE results to Watch Me Grow (WMG).

**Objectives:** To increase from 36%<sup>[1]</sup> to 46%, the percentage of children, ages 9 months to 35 months, who receive a developmental screening using a parent-completed screening tool by 2025.

### Strategies:

- Training care providers
- Effective referrals
- Empowering families

### Systems Building/ Title V Specific Activities:

In the 2020 Title V Needs Assessment, NH identified an ongoing priority need as improving access to standardized developmental/social emotional screening, assessment and follow-up for children and adolescents. This continues to be a priority according to partners including, but not limited to, those leading the Preschool Development Grant project. Activities described in this section have been identified to align with this priority using the strategies listed above.

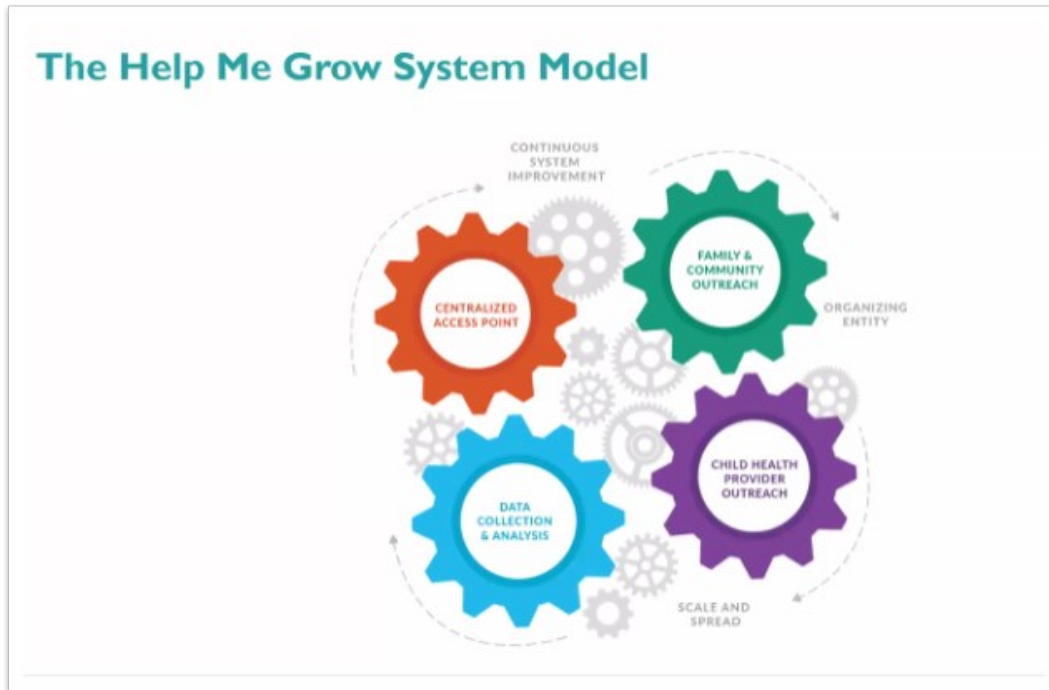
In 2022, the WMG Steering Committee, in collaboration with the UNH IOD and with a grant from the Association of University Centers on Disability, in cooperation with the Centers for Disease Control and Prevention Act Early Network (AUCD/CDC Act Early), finalized plans for the launch of the Centralized Access Point at NH Family Voices (NHFV). Based on one of the four components of Help Me Grow, in FY23 the Centralized Access Point will operate as a central and collaborative hub that families and service providers can plug into to ensure that any child, age birth through five, is connected to the resources, services, and/or developmental support they need.

The priorities of the Centralized Access Point will be to provide access to developmental monitoring and screening tools for families and service/care providers, offer free trainings, workshops, and screening events, and support families in finding the resources that best meet their needs and maneuvering the system of care. A Developmental Screening Care Coordinator will follow up when referrals are made by Watch Me Grow partners to ensure a family's meaningful connection to services. Ensuring a closed loop referral means that families are connected to what they need and assisted if they are unable to identify what is needed. The data collected in this process will support systems development and change as necessary.

It is believed that through the activities of the Centralized Access Point, access to and completion of developmental screening will increase statewide, and with the use of the ASQ Online System, data collection will be more streamlined and more accurate than the previous system using Welligent.



Parallel to the Centralized Access Point, in FY23, WMG will implement two other components of the Help Me Grow Framework: Child Health Provider Outreach and Family & Community Outreach. In 2019, the WMG Steering Committee voted to expand the scope of WMG to include developmental monitoring, referrals, education, evaluation, diagnosis, treatment and services with the awareness that a developmental screening system is much more than just completing developmental screenings. All of these pieces of the screening system fit within the Help Me Grow model.



By design, the Help Me Grow components work together and influence each other. The main purpose of Child Health Provider Outreach and Family & Community Outreach is to raise awareness about the Centralized Access Point. Increasing provider and community understanding that the system can support the many different types of organizations completing screenings in the State, and help connect the families they work with to the broader network of resources and community services.

Two activities have been planned to help build the two components: an outreach effort to child health providers on the use of Learn the Signs Act Early materials in practices throughout NH, and the development of a Developmental Screening Event project plan based on the Help Me Grow "Books, Blocks and Balls" parent engagement events. Projects will be completed through Leadership Placements from the NH-ME LEND 22 23 cohort. The WMG Steering Committee believes that by building the other components of Help Me Grow, it will make a robust system with trained providers, strong referrals and meaningful family connection.

The Bureau for Family Centered Services (BFCS) will continue its commitment as the State's identified lead for WMG and developmental screening efforts. In addition, NH Family Voices (NHFV) will continue to partner with BFCS through a collaborative contract with the Bureau of Child Development and Head Start Collaboration. In this role, they will support the Centralized Access Point, the WMG Committee, provide meeting logistics and family representation on the committee, and host a WMG web page on their website.

BFCS will also continue to monitor and report on the State's Autism Registry, which was established in 2006

(Title XII Public Safety and Welfare, chapter 171-A Services for the Developmentally Disabled, Autism Registry, Section 171-A:30). The Registry requires physicians, psychologists and any other licensed or certified health care provider who is trained and qualified to make a diagnosis, to report all new cases of this diagnosis to the department.

In FY22, NHFV was asked by some local NH providers to pull together a group to discuss network adequacy issues for diagnosing autism spectrum disorders. The group's first meetings were about managing the waitlists, which currently in NH are quite long-with most places reporting six to eight months. This continues to be an area of concern for many agencies, including WMG and Family Centered Early Supports and Services. In FY23, BFCS, represented by the Systems of Care Specialist, will continue to explore the availability of child development assessment and diagnosticians in collaboration with stakeholders.

NH continues to prioritize developmental screening while listening to families and providers about their needs related to CSHCN. The Bureau will continue to explore ways to address the increasing need for child development evaluations in a system that lacks the capacity to meet the demand for such services. In FY23, the opportunity to identify a new ESM (evidence-based strategy measure) to reflect this issue will be considered through work with child development experts from Amoskeag Health, NHFV, Dartmouth Hitchcock Medical Center, and the NH Pediatric Improvement Partnership. This work will be reflected in the FY23 Annual Report in 2024.

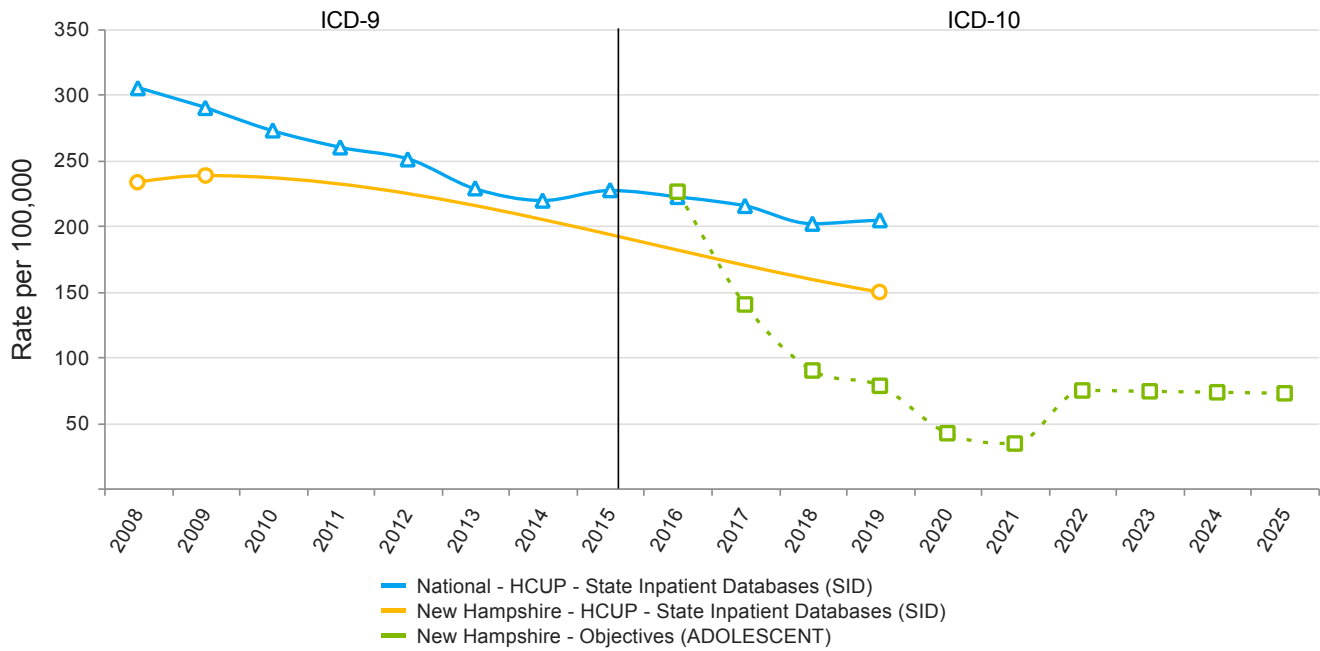
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<sup>[1]</sup> Child and Adolescent Health Measurement Initiative. 2018 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [07/28/20] from [www.childhealthdata.org].

**Adolescent Health**

**National Performance Measures**

**NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19  
Indicators and Annual Objectives**



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	2018	2019	2020	2021
Annual Objective	140	89.9	78.2	42.2	34.3
Annual Indicator	238.7	238.7	238.7	238.7	149.4
Numerator	433	433	433	433	237
Denominator	181,369	181,369	181,369	181,369	158,679
Data Source	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT
Data Source Year	2009	2009	2009	2009	2019

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	140	89.9	78.2	42.2	34.3
Annual Indicator	125.7	91	86.7	91.5	54.9
Numerator	204	147	138	144	140
Denominator	162,301	161,472	159,248	157,303	254,953
Data Source	NH Inpatient Hospital Discharge data	NH Inpatient Hospital discharge data	NH Inpatient Hospital Data	NH Inpatient Hospital Data	estimate
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	74.7	74.0	73.3	72.5

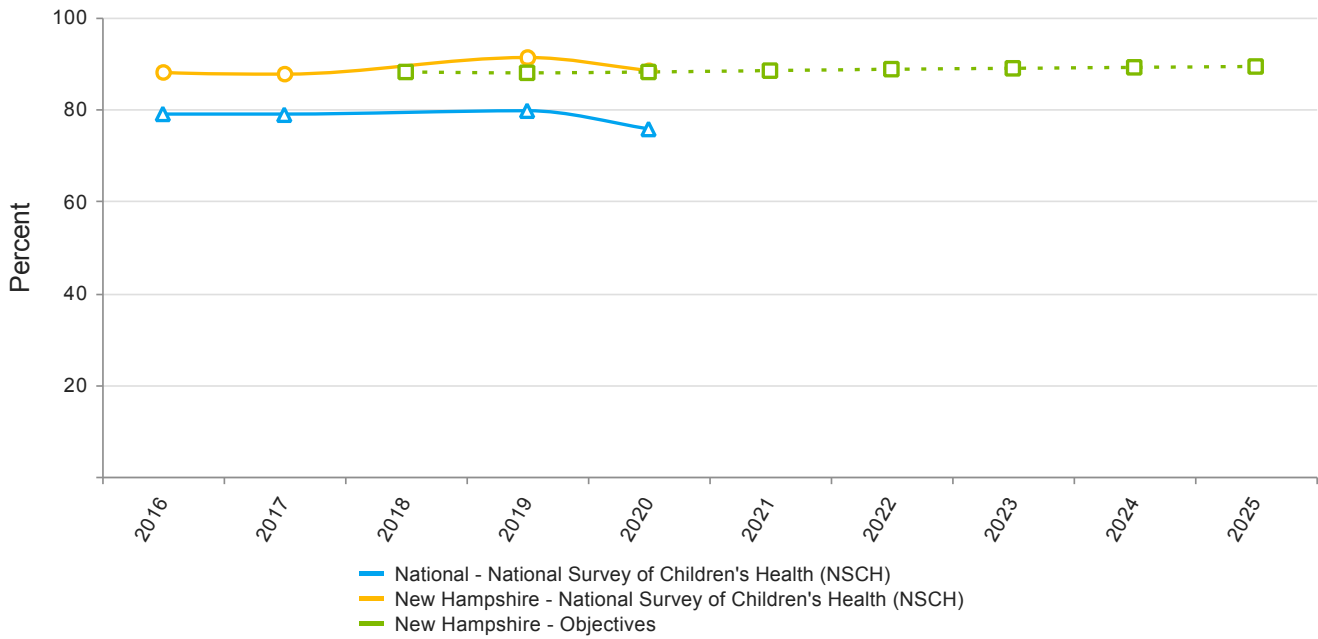
**Evidence-Based or –Informed Strategy Measures**

**ESM 7.2.1 - Percentage of high school students who wear a seatbelt**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	93.4	94	94	94.8	96.5
Annual Indicator	93.1	94.4	94.4	95.5	96.5
Numerator	10,594	11,375	12,297	11,605	12,415
Denominator	11,379	12,050	13,026	12,152	12,865
Data Source	YRBS	YRBS	YRBS	YRBS	Estimate
Data Source Year	2017	2017	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	96.5	98.2	98.2	99.1

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.  
Indicators and Annual Objectives**



**Federally Available Data**

**Data Source: National Survey of Children's Health (NSCH)**

	2017	2018	2019	2020	2021
Annual Objective		88	87.8	88	88.3
Annual Indicator	87.8	87.5	87.5	91.0	88.3
Numerator	82,975	78,283	78,283	83,204	81,481
Denominator	94,526	89,457	89,457	91,423	92,240
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

**Annual Objectives**

	2022	2023	2024	2025
Annual Objective	88.6	88.8	89.0	89.2

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year**

Measure Status:		Active				
State Provided Data						
	2017	2018	2019	2020	2021	
Annual Objective	64	60	62	58	52	
Annual Indicator	57.9	58.1	52.6	49.2	59	
Numerator	6,178	6,402	6,181	5,056	6,408	
Denominator	10,671	11,011	11,751	10,272	10,859	
Data Source	NH DHHS, MCHS	NH DHHS, MCHS	NH DHHS, MCH	NH DHHS, MCHS	NH DHHS, MCHS	
Data Source Year	2017	2018	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	Final	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	56.0	60.0	62.0	64.0

## State Action Plan Table

### State Action Plan Table (New Hampshire) - Adolescent Health - Entry 1

#### Priority Need

Decrease unintentional injury in children ages 0-21

#### NPM

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

#### Objectives

By 2022, reduce the rate of hospitalizations for non-fatal injury from 61.3 to 27.4 per 100,000 adolescents ages 10-19 years

#### Strategies

Use of statewide partners to promote the program and increase participation of high schools previously working with program and new schools wanting to work with the program

Use of peer groups within schools to increase seatbelt usage and overall teen driving safety culture

Continue to explore virtual platforms to get messaging out to teen drivers

Increase utilization of teen driver website

Increase parental participation and understanding of teen driving issues

Provide "Pool Safely" information to parents and children during at least one public event/year

Raise public and professional awareness of suicide prevention

Address the mental health and substance abuse needs of all residents

Facilitate an annual Suicide Prevention Conference and extend invitations to high school staff

Support the suicide prevention goals of the NH Suicide Prevention Council

Work with the Brain Injury Association of NH to collect data from all NH high schools regarding Return to Play and Return to Learn policies

#### ESMs

#### Status

ESM 7.2.1 - Percentage of high school students who wear a seatbelt

Active



## NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

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NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (New Hampshire) - Adolescent Health - Entry 2

Priority Need

Improve access to needed healthcare services for all MCH populations

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the percentage of adolescents aged 12-21 who have had a preventive medical visit at the MCH-funded community health centers (CHCs) from a baseline of 53% in SFY19 to 64% by the end of 2025.

Strategies

Building partnerships by: (1) networking with other State Adolescent Health Coordinators; (2) collaborating with public and private partners through the NH Pediatric Improvement Partnership; (3) statewide contracting with CHCs and provision of oversight on Primary Care services; (4) establishing mechanisms to inform the public about adolescent preventive services via social media.

Enhancing capacity of CHCs to improve access and quality of adolescent services by: (1) establishing performance measures that align with national guidelines and promote Bright Futures recommendations; (2) ensuring contracted CHCs utilize Quality Improvement (QI) processes to increase the percentage of adolescents who have a preventive medical visit; (3) collecting and analyzing Performance Measure outcome data from contracted CHCs; (4) providing feedback to CHCs on agency performance; (5) providing education, resources, QI support and technical assistance.

Increasing the number of MCH section staff who include adolescent health in their job responsibilities by establishing a new position (Child/Adolescent Health Coordinator) to support programmatic initiatives to improve child and adolescent well-being.

ESMs

Status

ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

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NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

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NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

---

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

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NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

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NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

## Adolescent Health - Annual Report

**National Performance Measure #7.2:** Rate of hospitalization for non-fatal injury per 100,000 adolescents aged 10-19

### **Objectives:**

- By 2022, reduce the rate of hospitalizations for non-fatal injury from 61.3 to 27.4 per 100,000 adolescents ages 10-19 years
  - By 2023, increase the percentage of students reporting in the YRBS that they use seatbelts from 94.4 in 2017 to 98.2. This survey is only conducted in odd numbered years.
  - Reduce the rate of emergency department visits due to drowning from 16.7 per 100,000 children ages 10-19 years in 2017 to 15.4 by 2022.
  - By 2022, schools in the state will have implemented the NH Concussion Law and/or will have written policies with at least 95% having a return to play policy and at least 75% having a “return to learn” policy
  - By 2023, reduce the percent of students who seriously consider suicide as noted in the YRBS survey from 18.4 in 2019, to 16.6 in 2023. This survey is only conducted in odd numbered years.

### **Strategies:**

The [NH State Violence and Injury Prevention 5-year Plan, 2020-2025<sup>11</sup>](#), was released in April 2020.

This plan focuses on addressing common risk and protective factors across all leading causes of injury in the state. Injury prevention topic areas in the state plan that are pertinent to the MCH Title V Block Grant currently include:

- Drowning prevention for ages 0-19 by promoting the Consumer Product Safety Commission “Pool Safely” program.
- Promoting teen driver safety in high school students ages 15-19 by facilitating the peer-to-peer Teen Driver Safety Program.
- Preventing suicide in in ages 10-19 by working with NAMI-NH and the NH Suicide Prevention Council and providing an Annual Suicide Prevention Conference.
- Concussion prevention and response for those involved in physical activity up, to age 19 by working with the Brain Injury Association of NH (BIANH) to implement “Return to Learn” and “Return to Play” policies in NH schools.

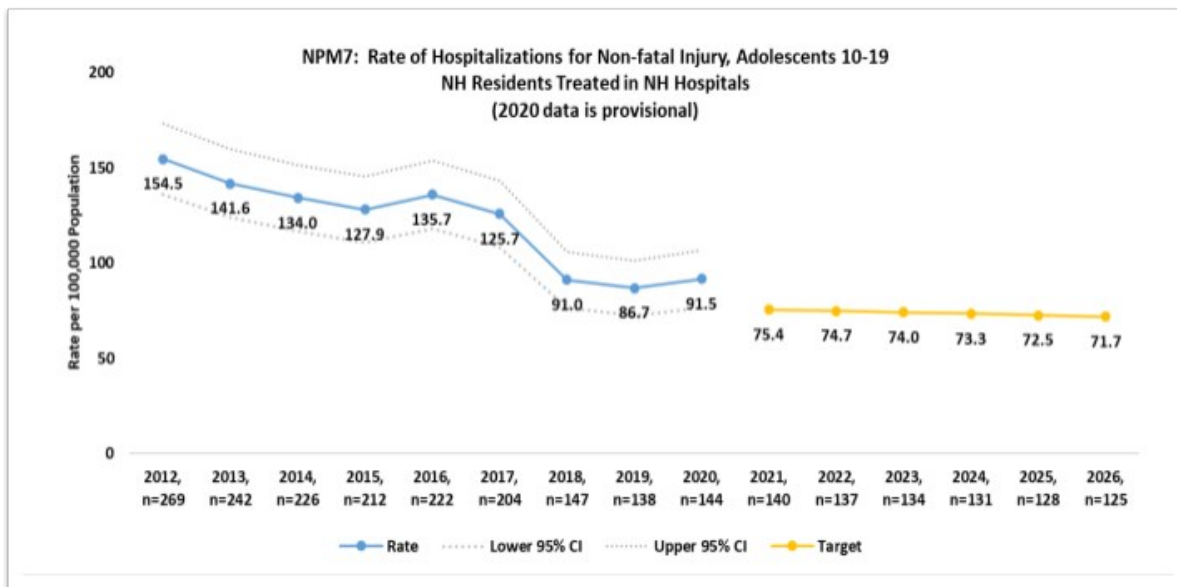
Non-fatal injuries present a significant burden to the health care system, particularly to urgent care facilities and emergency departments (ED). Unintentional injuries accounted for the majority of all injury-related visits, which are often seen among both children and young adults. One of the age groups with the highest hospitalization rate is the 10-14 age group.

Note: The data in the charts and graphs below will be different than in previous years because this year’s queries only included cases of NH residents who were treated in, or died in NH. Counts and rates will be lower than in previous reports because of this. This change was made so the most current year of data could be included, which is not yet complete for NH residents who were treated, or died, out-of-state. Data back to 2012 is included to help

visualize data trends.

Hospital data between 2012 and the first three quarters of 2015 used ICD9 codes. For the last quarter of 2015 and forward, ICD10 codes are used. Not all conditions transfer seamlessly between ICD9 and ICD10 coding. Year 2016 hospital data is the new baseline for inpatient and emergency department data because it uses only ICD10 coding. The death certificate data for 2021 and Hospital Data for 2020 is provisional, as it may be incomplete at this time.

The rate of non-fatal injury inpatient (IP) hospital discharges in NH residents aged 10-19 years has shown a decreasing trend. The data provided in the graph below is from an updated dataset for IP discharges between 2012 and 2020. If the current data trend continues, projections show a potential 54% decrease<sup>[2]</sup> in the rate of non-fatal injury in the 10-19-year-old age group by 2026.



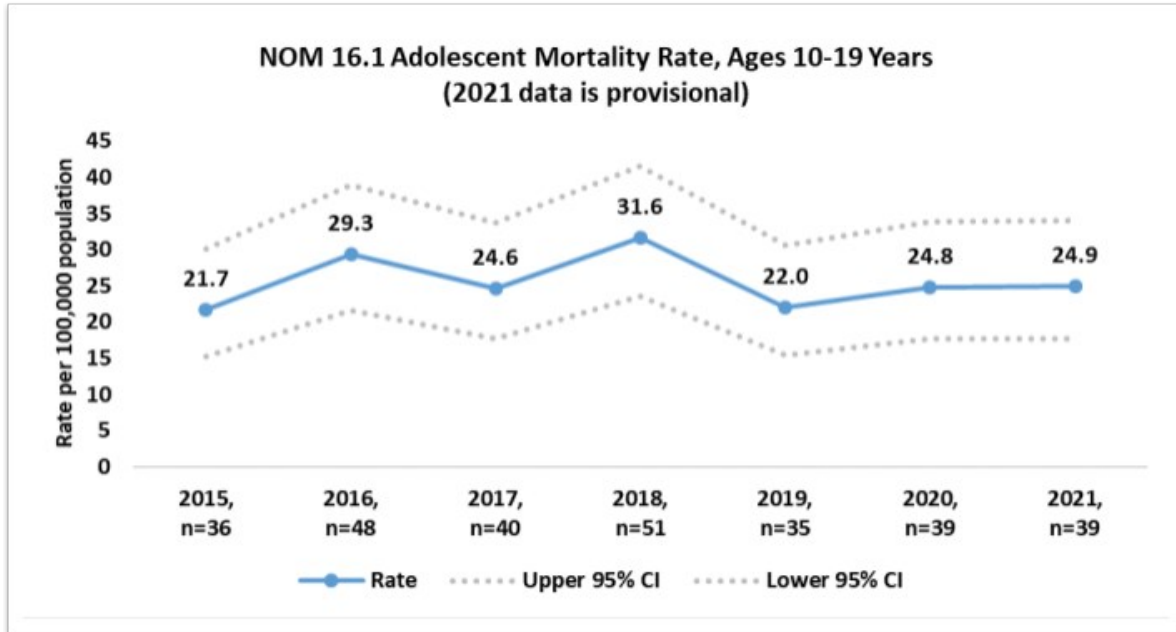
Data Source: NH Hospital Discharge Data, NH DHHS, Health Statistics and Data Management Section (HSDM), June 2022.

The focus areas selected to decrease hospitalizations for non-fatal injury in NH’s adolescent population (ages 10-19) included motor vehicle safety, concussion prevention and response, and suicide prevention. The primary focus was adolescent driver safety, which intersected with the second focus area, concussion prevention and response. The third focus area is teen suicide prevention.

The following graphics and analysis address National Outcome Measures (NOM) #15, #16.1, #16.2, and #16.3 and how they intersect with National Performance Measure (NPM) #7.

### NOM#16.1 Adolescent Mortality

Adolescent mortality has not shown a statistically significant change between 2015 and 2021. Annual counts of adolescent deaths range from 35 to 51 per year. According to the CDC WISQARS, the 10-19-year-old age group’s leading overall cause of death is unintentional injuries, with motor vehicle traffic being the number one injury-related cause. MCH selected adolescent driver safety as a primary focus area for programmatic activities. The second leading cause of adolescent death is suicide, so this issue was also addressed.



Data Source: NH Vital Records, NH DHHS, HSDM, June 2022

**Five Leading Causes of Death, NH Residents, Ages 10-19 Years, 2011-2020**

Rank	All Causes of Death	All Injury Deaths	All Unintentional Injury Deaths
1	Unintentional injury 137	Unintentional MV Traffic 79	Unintentional MV Traffic 79
2	Suicide 107	Suicide, Suffocation 52	Unintentional Poisoning 31
3	Malignant Neoplasms 44	Suicide, Firearm 40	Unintentional Drowning 10
4	Heart Disease 12	Unintentional Poisoning 31	Unintentional Fall --
5	Homicide --	Unintentional Drowning 10	Unintentional Suffocation --

Data Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System, accessed 5/23/2022.

Note: For leading cause categories in this State-level chart, counts of less than 10 deaths have been suppressed (--).

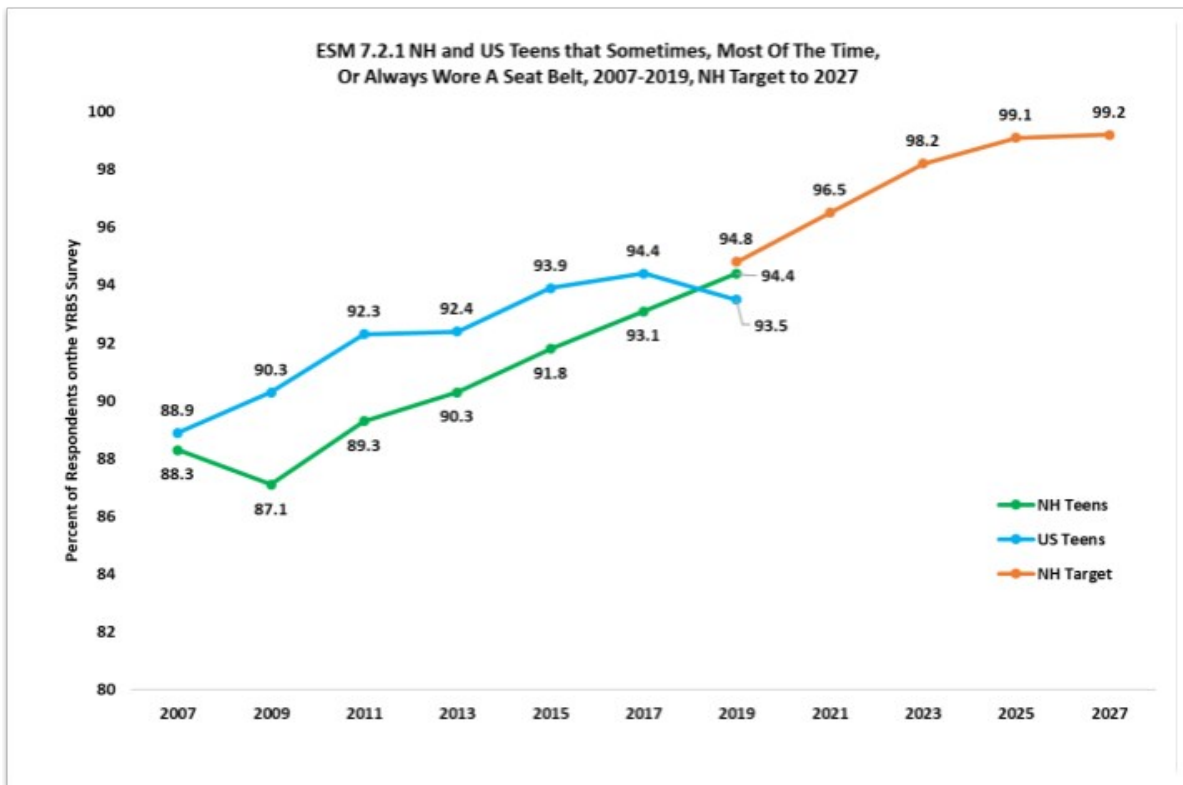
**NOM#16.2 Adolescent motor vehicle death**

**Evidence-Based or Informed Strategy Measure:** Percent of high school students who wear seatbelts.

Motor vehicle (MV) crashes continue to be the number one cause of death for adolescents and new drivers. According to [New Hampshire Driving Towards Zero](#), speed and inexperience of novice drivers are the major causes of fatal crashes among teens as reported by the NH Division of Motor Vehicle's Division of Motor Vehicle Fatal Accident Reporting System.<sup>[3]</sup> Adolescent motor vehicle death rates for NH residents 15-19 years old have not changed significantly between 2015 and 2021. Counting the deaths in individual years shows very few events and will not generate stable or statistically significant rates. The graph below includes all motor vehicle crash deaths: occupants, including drivers and passengers, who were injured in MV crashes. These data exclude motorcyclists, pedestrians, pedal cyclists, and ATV crashes. This exclusion was made because NH's prevention efforts focus on teen drivers and passengers. On average between 2015 and 2021, approximately two adolescents aged 15-19 died per year in MV crashes who were occupants of a motor vehicle.

**ESM#7.2.1 Seatbelt Use: Percent of high school students who wear seatbelts (as a driver or passenger)**

The 2019 NH Youth Risk Behavior Survey (YRBS) indicates that 94.4% of respondents “Sometimes, most of the time, or always wore a seat belt (when riding in a car driven by someone else).” This percent has increased from 72.4% when it was first assessed in 1993. The percentage of students who rarely or never wear a seat belt when driving (among students who drive a car) has decreased from 8.3% in 2013, to 7.7% in 2015, 6.3% in 2017 and down to 4.8% in 2019. The percent of students reporting that they are texting while driving has decreased from 48% when the question was first asked in 2013, to 42% in 2017, but increased to 44% in 2019. A "[Hands-Free" law](#) was passed in 2015 that forbids the use of hand-held devices by drivers except in the case of an emergency<sup>[4]</sup>.



Source: US and NH YRBS, <https://www.cdc.gov/healthyyouth/data/yrbs/results.htm>, accessed on 5/23/2022

## Adolescent Driver Safety Programmatic Activities

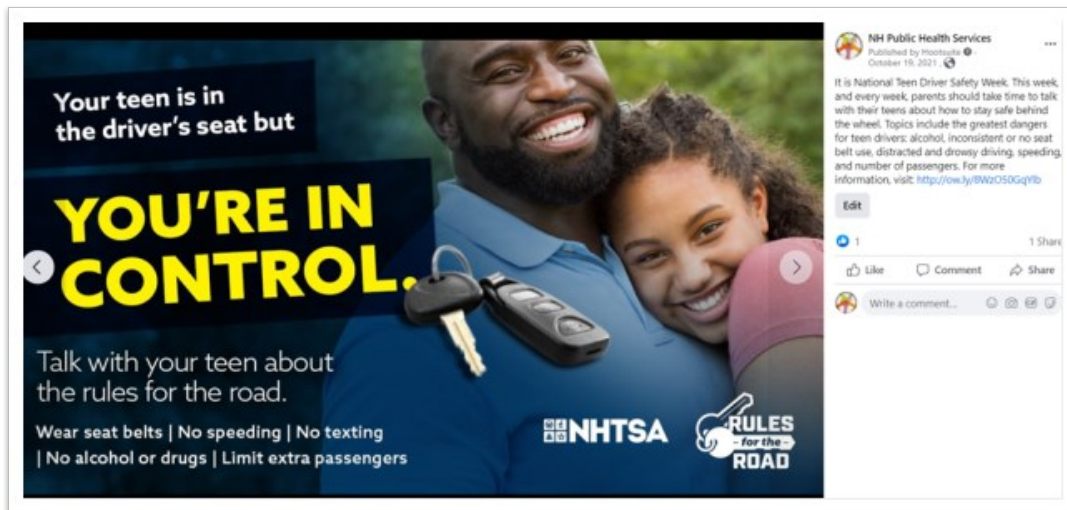
### Objective:

- By June of 2027, increase seatbelt usage reported in the NH-YRBS data from 83.3% in 2007 to 99.2%.

The seatbelt observational study was last conducted in the spring of 2019, which showed that 87.7% of teen drivers and 77.9% of teen passengers were wearing seatbelts. When driver and passenger calculations were averaged, this produced an overall 82.8% seatbelt usage. Unfortunately, observational assessments have not been conducted since 2019. This is largely due to the COVID-19 pandemic halting in-person activities for most schools but was also due to transitioning staff in the Youth Operator Program Coordinator position, and the challenges of engaging schools in such a study. During the period directly prior to the pandemic, many schools were highly focused on completing mandates from the Department of Education related to suicide prevention, vaping prevention, and opioid use prevention. Additionally, many schools are reluctant to complete assessments. Concerns about school district data privacy and the non-academic survey mandate as well as logistics were all issues that created barriers to data collection. Approval must be given by the administration for observations to be conducted and information regarding the date and time must be kept from students so the data is accurate for an average day. The recommendation going forward is to use the YRBS, which is already approved by school administrators. The YRBS is used for ongoing performance monitoring of prevention activities per school fully engaged with the Teen Driver Program.

### Strategies:

- Utilize peer groups within schools to increase seatbelt usage and overall teen driving safety culture
- Increase parental participation and understanding of teen driving issues



## Systems Building

The MCH staff continued to support efforts regarding novice adolescent driving safety. The Youth Operator Program Coordinator, with support from the Injury Prevention Center at Dartmouth (IPC) Program Manager, facilitates the Buckle Up NH and Teen Driver Program committee. Part of this work includes the [NH Teen Driving Program](#) (NHTDP).



The NHTDP's primary goals include assisting adolescents in understanding the true risks associated with their driving experience and educating parents and community members in understanding these risks. The program also attempts to change the "driving culture" for NH's adolescents by using a peer-to-peer evidence-based<sup>[5]</sup> strategy, which deems driving distracted, impaired driving, speeding and nonuse of seat belts socially unacceptable. During the 2021-2022 academic year, the Teen Driver Program interacted with 15 schools throughout the State to provide resources as needed. Statewide YRBS data is collected and reviewed every other year as a program outcome measure.

During the 2021-2022 school year, there was a transition in the Youth Operator Program Coordinator position leading to a delay in engaging schools in the fall, resulting in decreased programming during the first half of the year. Once the new program coordinator was hired in November of 2021, she began engaging schools and building community relationships. After legislation was put into place disallowing nonacademic surveys in schools,<sup>[6]</sup> the observations were changed to assessments to comply with the new law. Although the Teen Driver Program continues to put high value on observational assessments, the pandemic created many challenges to implement these assessments, which included the need for schools to lessen external programming, and there were inconsistencies in implementation of the assessments creating a concern for data collection validity.

Due to the several quarters with low school engagement and the inability to implement these assessments, the Teen Driver Program in collaboration with the NH Office of Highway Safety (OHS) and NH DHHS support are reviewing other data collection options to demonstrate program performance.

During the time of on-boarding the new Youth Operator Program Coordinator several key stakeholder interviews were conducted. Learning about stakeholders and how their work coordinates with the Youth Operator program was important towards building relationships and understanding partnerships. The key stakeholders that the Youth Operator Program Coordinator met with included the following organizations: Matrix Entertainment, AT&T, AAA, Derry Coalition, South Central Public Health Network, and the Office of Highway Safety. These meetings help to build trust with the stakeholders. Research of key stakeholder websites were conducted and provided educational tools and data for engaging teens in learning about distracted driving and impaired driving. Some of the website researched included: The Matrix Entertainment website, The AT&T "it can wait," AAA, Office of Highway Safety, CDC, DHHS, and YRBS. These sites all provided information regarding distracted driving and impaired driving which helped to create content for the NH Teen Driver Website. The Youth Operator Program Coordinator provided support, recommendations, and educational material for teens to learn about distracted driving, seat belt use, and impaired driving to several schools that were hosting school events.

The Youth Operator Program Coordinator collaborated with a representative from Matrix Entertainment to provide 10 New Hampshire high schools with the "Save a Life" tour. The "Save a Life" tour is a comprehensive high impact safe driving awareness program that informs, educates, and demonstrates the potentially deadly consequences resulting from poor choices and decisions made by the operator of a motor vehicle. The program specifically places emphasis on the following driving situations: driver experience, improper driving behavior, safety restraints, impaired driving, and distracted driving. There are two simulators-one for distracted driving (holding a cell phone and driving), the other is for impaired driving (using an oculus over the driver's eyes to simulate impaired driving; during the drive time the steering wheel will increase its impaired level by placing a delay on the steering wheel). Both simulators have a screen behind them that shows what is happening so all other students watching are able to interact as well. This link provides visualizations of the simulator videos: <https://www.youtube.com/watch?v=tRWqJ1fjI5E>. The following high schools will be participating in April 2022: Keene, Sunapee, Concord, Franklin, Salem, Epping, Milford, Windham, Goffstown, and Belmont. The Youth Operator Program Coordinator also reached out and invited local police departments and regional substance misuse and prevention representatives.

During January-March 2022, the Youth Operator Program Coordinator drafted the program introduction, listening group intentions, and with nine specific questions to have a discussion with the Pinkerton High School youth. The meeting attendees included 11 students, selected by the school's counselors. This listening group allows the youth to have a voice in the information that is provided for educational material and tools for the NH Teen driver website.

A new [Teen Drivers website](#) was developed; website content, theme, and colors were defined. A web designer created web pages, designated categories, and designed themes. The Youth Operator Program Coordinator continues to provide web designer content as information gets updated. The new website was launched in February 2022.

### **MCH Specific Activities**

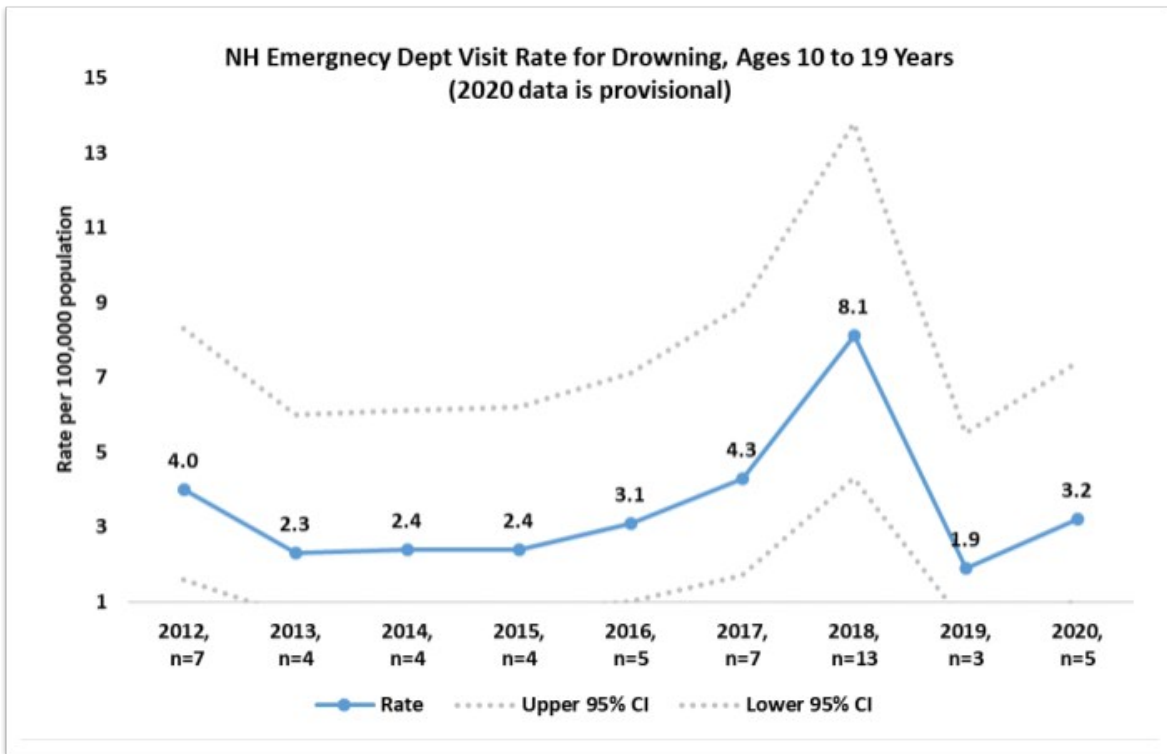
The MCH's Injury Prevention Program (IPP) continues working with the Buckle Up / NH Teen Driver Committee, comprised of multiple state agencies and organizations; this Committee is now working towards the implementation of the [New Hampshire Violence and Injury Prevention Plan 2020-2025](#), which has a component on traffic safety and adolescent drivers. The Committee is working towards educating more adolescent drivers across the State through collaboration and prevention efforts. In addition, the MCH IPP Manager and the Youth Operator Program Coordinator both sit on the Governor's Traffic Safety Commission, which meets to address traffic safety concerns in NH; the IPP Manager sits on this commission as the DHHS Commissioner's designee.

### **Drowning Prevention**

**Evidence-Based or Informed Strategy Measure:** the rate of emergency visits for drowning per 100,000 children age 0-19

**Objective:**

Reduce the rate of emergency department visits due to drowning from 16.7 per 100,000 children ages 10-19 years to 16.2 by 2021, 15.4 by 2022, 14.6 by 2023, and 13.8 by 2024.



Data Source: NH Hospital Discharge Data, NH DHHS, HSDM, June 2022

Place	Count
Drowning in natural water	8
Drowning related to watercraft	1
Unspecified drowning and submersion	1
<b>Total</b>	<b>10</b>

Data Source: NH Death Certificate Data, NH DHHS, HSDM, June 2022

**Strategy**

In preparation for the 2020 MCH Block Grant, the IPP discovered that drowning fatality is now the leading cause of injury death in NH children ages 10-19 years.<sup>[7]</sup> Between 2020 and 2023, the IPP will provide the Consumer Product Safety Commission (CPSC) "Pool Safely"<sup>[8]</sup> information to parents and children during at least one public event per year. In NH, drowning most frequently occurs in natural water bodies. Although the "Pool Safely" program focuses on swimming pools, the messaging related to attending swimming lessons and always having an adult be actively observant when children are in or near the water, also translates to lakes, rivers, and oceans. Swimming lessons can start with infants, and can occur every year until a child is a proficient swimmer. Teens and adults should be encouraged to take first aid, CPR classes, and learn basic water rescue techniques.

**Systems Building**

## MCH Specific Activities

The MCH IPP Program Manager requested free materials from the CPSC “Pool Safely” program to distribute at family-oriented events. At the Wentworth Douglas Hospitals Bike Rally on July 11, 2021, she distributed 37 Water Watcher cards on lanyard to adults, and 70 mini beach balls to children. During the Safe Kids 301 Bike Rally at the NH Motor Speedway on August 13, 2021, she distributed 143 Water Watcher cards on lanyards to adults and over 200 mini beach balls to the children. Each encounter with the families included reviewing safe swimming recommendations for both the pool and in natural bodies of water, and how to use the lanyard. Adults who received Water Watcher lanyard stated that they would definitely use that at the pool and the beach, and that the item was an excellent idea.





NH Public Health Services  
May 23 at 7:30 PM · 🌐

May is National Water Safety Month. Drowning is the leading cause of unintentional death in children ages 1-4. Learn safety tips on how to prevent drowning: <https://bit.ly/2ZvzIAf>



NH Public Health Services  
May 19 at 9:30 AM · 🌐

Recreational activities in the water can be a wonderful way to spend time with family and friends. Follow these simple water safety tips to protect yourself and others from drowning. <https://bit.ly/3dMmizN>



## Concussion

Concussion in adolescents can be a result of a non-fatal motor vehicle crash, a sports injury, or a fall. The effects of a concussion can be long-lasting and vary in severity. Cognitive abilities are affected after a concussion, and the brain needs time to rest and heal. NH has a law regarding return to playing sports after a concussion. MCH worked with the [Brain Injury Association of NH \(BIANH\)](#) to amend this law ([RSA 200:63](#)) to include “return to learn.”<sup>[9]</sup> This bill was passed the Senate and House and was signed into law by the Governor in June 2020. The IPP Manager continues to work with the BIANH to support the analysis of concussion policies relate to Return to Learn and Return to Play in school systems and make recommendations of policy changes.

**Objective:** For the 2021-2022 school year, 95% of schools in the state will have implemented the NH Concussion Law Return to Play policies and have a written Return to Play policy. At least 75% of those will also have a Return to Learn policy.

**Strategy:** Analyze concussion policies within school systems and make recommendations for potential change. MCH will work with the Brain Injury Association of NH (BIANH) to collect data from all NH high schools regarding Return to Play and Return to Learn policies. The BIANH will continue to provide information and education to NH schools and guidance for Return to Play and Return to Learn policy development.

## Data Analysis

In NH, the annual death count for traumatic brain injury (TBI) in ages 10-19 is low. Years 2017 to 2021 were aggregated in the table below. Suicide by firearm was the top cause of TBI deaths and motor vehicle crash was the second. Over the last 10 years, there have been no deaths due to concussion in this age



group.

### NH TBI Death Counts, Age 10-19 years, 2017-2021

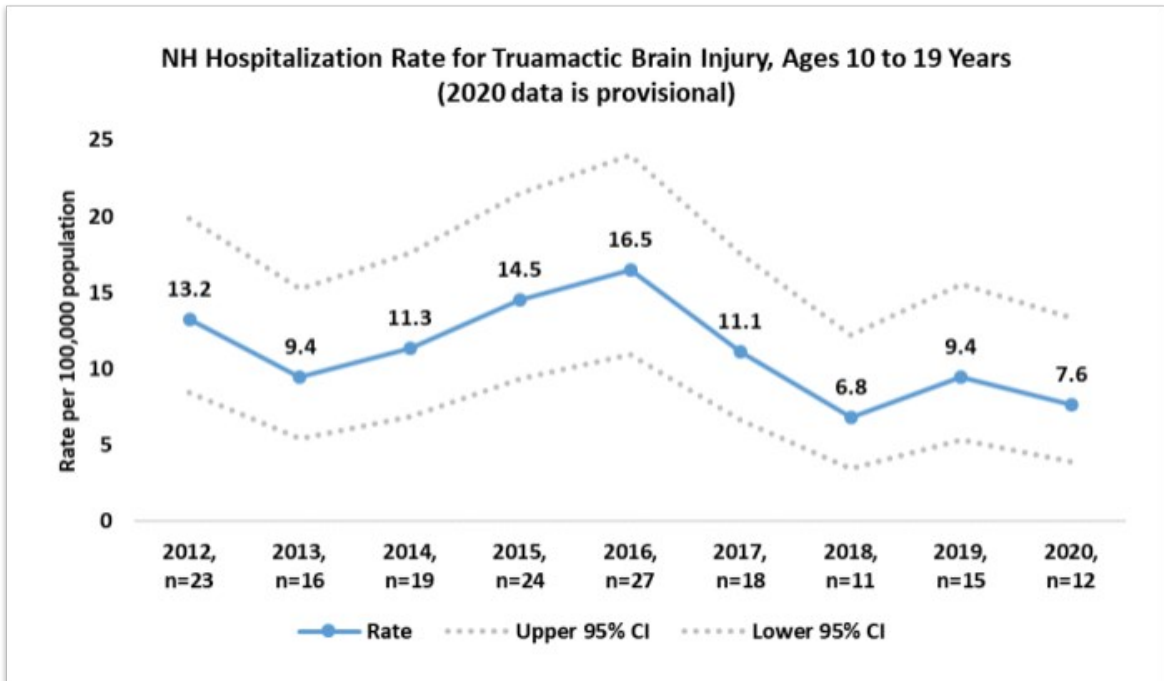
Cause of Death	Total	Percent
Suicide-Firearm	16	50%
MV Crash	11	34%
MV Crash-Motorcycle Driver	2	6%
Agricultural Vehicle Injury	1	3%
Homicide-Firearm	1	3%
Pedestrian vs MV	1	3%
<b>Grand Total</b>	<b>32</b>	<b>100%</b>

Source: NH Vital Record, NH DHHS, HSDM, June 2022

The Mayo Clinic states than the “common events causing traumatic brain injury include the following:

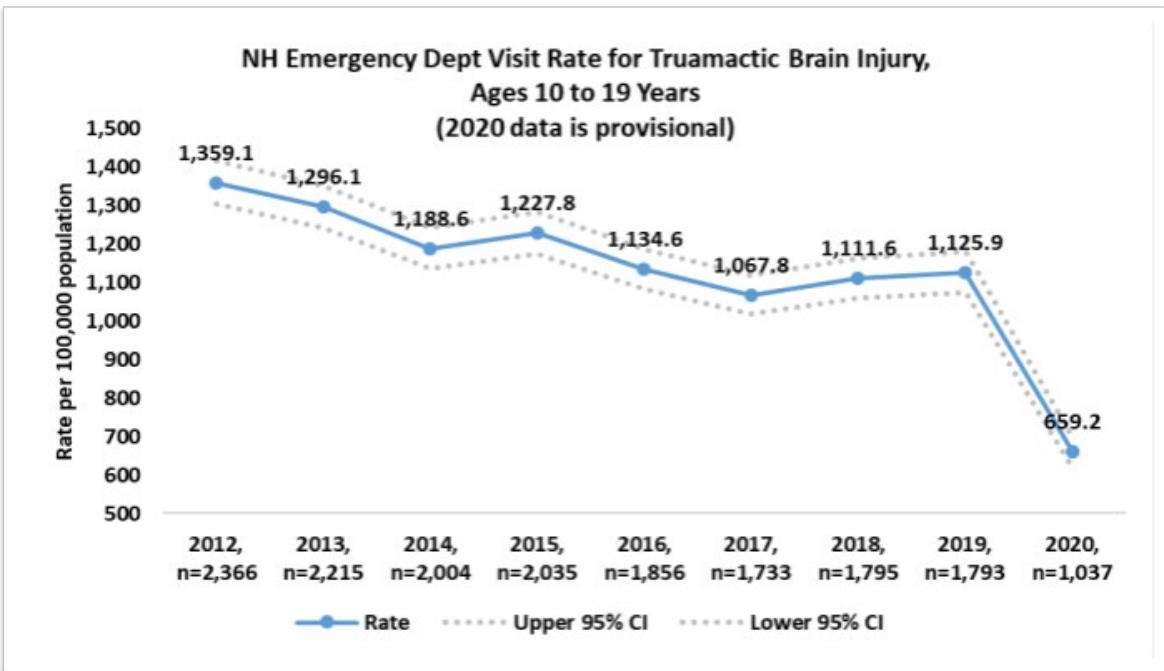
- Falls: falls from bed or a ladder, down stairs, in the bath, and other falls are the most common cause of traumatic brain injury overall, particularly in older adults and young children.;
- Vehicle-related collisions: collisions involving cars, motorcycles or bicycles — and pedestrians involved in such accidents — are a common cause of traumatic brain injury;
- Violence: gunshot wounds, domestic violence, child abuse and other assaults are common causes;
- Shaken baby syndrome is a traumatic brain injury in infants caused by violent shaking;
- Sports injuries: traumatic brain injuries may be caused by injuries from a number of sports, including soccer, boxing, football, baseball, lacrosse, skateboarding, hockey, and other high-impact or extreme sports. These are particularly common in youth.”<sup>[10]</sup>

Inpatient (IP) discharge rates for TBI for ages 10-19 showed no statistically significant changes between 2012 and 2020. There were 165 IP discharges between 2012 and 2020.



Data Source: NH Hospital Discharge Data, NH DHHS, HSDM, June 2022

Emergency Department (ED) discharge rates for this age group significantly decreased between 2012 and 2019. The 2020 data is provisional, so the sharp decrease may or may not be true in the future.



Data Source: NH Hospital Discharge Data, NH DHHS, HSDM, June 2022

The number of cases seen in the hospital as inpatients (IP) or in the Emergency Department (ED) are not a complete count of cases; some children are seen in urgent care facilities or a doctor's office, and some do not receive

medical attention at all.

On average, concussion was present in 30% of IP discharges for TBI, and 50% of ED discharges for TBI. The most common causes of non-fatal TBI in children ages 10-19 years in NH are: 1) Struck by or Against, 2) Falls, and 3) MV Crashes. Combining the non-fatal cases of TBI due to MV crash with the number of deaths due to MV crash shows the importance of adolescent driver safety programming.

In 2020, there were 500 ED discharges for NH residents age 10-19 with a concussion, with an average cost per patient of \$4,329. These numbers do not include students who may have had a concussion and sought care in a doctor's office without going to the hospital. There were fewer than five cases in 2020 that sought IP care for more serious cases of concussion, often including additional injuries or complications, with a total cost for those cases being \$65,730. In 2020, among ages 10-19, there were 1,037 children discharged from the emergency department with TBI (including concussion and other head injuries) at an average cost per patient of \$4,561. TBI IP care in 2020 for this age group had 12 discharges at an average cost per patient of \$75,032.

NH Resident Inpatient Discharges, Ages 10 to 19												
Traumatic Brain Injury (TBI)							Concussion					
Year	TBI Count	Total Cost	Average Cost per Discharge	Rate per 100,000	Lower 95% CI	Upper 95% CI	Concussion Count	Total Cost	Average Cost per Discharge	Rate per 100,000	Lower 95% CI	Upper 95% CI
2012	23	\$850,804	\$36,991	13.2	8.4	19.8	9	\$184,238	\$20,471	5.2	2.4	9.8
2013	16	\$334,755	\$20,922	9.4	5.4	15.2	*	\$47,582	*	*	*	*
2014	19	\$602,924	\$31,733	11.3	6.8	17.6	7	\$128,409	\$18,344	4.2	1.7	8.6
2015	24	\$1,290,566	\$53,774	14.5	9.3	21.5	6	\$144,755	\$24,126	3.6	1.3	7.9
2016	27	\$2,197,661	\$81,395	16.5	10.9	24.0	5	\$153,063	\$30,613	3.1	1.0	7.1
2017	18	\$711,041	\$39,502	11.1	6.6	17.5	11	\$342,035	\$31,094	6.8	3.4	12.1
2018	11	\$636,741	\$57,886	6.8	3.4	12.2	*	\$92,191	*	*	*	*
2019	15	\$915,162	\$61,011	9.4	5.3	15.5	5	\$110,306	\$22,061	3.1	1.0	7.3
2020	12	\$900,387	\$75,032	7.6	3.9	13.3	*	\$65,730	*	*	*	*

NH Resident Emergency Department Discharges, Ages 10 to 19												
Traumatic Brain Injury (TBI)							Concussion					
Year	TBI Count	Total Cost	Average Cost per Discharge	Rate per 100,000	Lower 95% CI	Upper 95% CI	Concussion Count	Total Cost	Average Cost per Discharge	Rate per 100,000	Lower 95% CI	Upper 95% CI
2012	2,366	\$5,710,688	\$2,414	1,359.1	1,304.9	1,415.0	1,189	\$3,093,805	\$2,602	683.0	644.7	722.9
2013	2,215	\$5,338,358	\$2,410	1,296.1	1,242.7	1,351.2	1,085	\$2,553,916	\$2,354	634.9	597.7	673.8
2014	2,004	\$5,184,758	\$2,587	1,188.6	1,137.1	1,241.8	1,010	\$2,834,849	\$2,807	599.0	562.7	637.1
2015	2,035	\$5,313,327	\$2,611	1,227.8	1,175.1	1,282.4	977	\$2,651,014	\$2,713	589.5	553.1	627.6
2016	1,856	\$6,038,218	\$3,253	1,134.6	1,083.6	1,187.4	981	\$3,165,070	\$3,226	599.7	562.8	638.4
2017	1,733	\$5,510,580	\$3,180	1,067.8	1,018.1	1,119.3	905	\$2,905,197	\$3,210	557.6	521.9	595.2
2018	1,795	\$5,926,217	\$3,302	1,111.6	1,060.8	1,164.3	908	\$2,722,659	\$2,999	562.3	526.3	600.1
2019	1,793	\$6,448,921	\$3,597	1,125.9	1,074.4	1,179.3	906	\$3,176,380	\$3,506	568.9	532.5	607.2
2020	1,037	\$4,729,961	\$4,561	659.2	619.7	700.6	500	\$2,164,603	\$4,329	317.9	290.6	347.0

Data Source: NH Hospital Discharge Data, NH DHHS, HSDM

There has been increased education regarding the seriousness of concussion in response to the "Return to Play" law ([RSA 200:49-52](#)). This law, enacted in 2012 and revised in 2014, calls for the immediate removal of any student-athlete from play if a concussion is suspected. The law requires medical clearance and written authorization from a health care provider trained in the evaluation and management of concussions as well as parental written permission for return to play.<sup>[11]</sup> MCH's IPP has been working with the BIANH to assess the implementation and effectiveness of NH's school return to play concussion law.

The *Morbidity and Mortality Weekly Report (MMWR) Weekly*<sup>[12]</sup> reported a decline of children ages 17 years and under seen in the emergency department (ED) for contact sports-related traumatic brain injuries, including



concussions. Between 2010 and 2016, about 45% of the 283,000 childhood traumatic TBI in the US were sports and recreation related (SRR). When reviewing data from 2012-2018, researchers found that ED visits for sport-related TBI declined 32% during this period, and “the reduction in the latter part of the study period was predominantly the result of a decline in ED visits related to football SRR-TBIs.”

“The rate of football-related TBI ED visits in children aged 5-17 years declined 39% from 118.8 in 2013 to 72.4 in 2018, after increasing approximately 200% from 2001 (38.7) to 2013 (118.8).”<sup>[13]</sup> Evidence indicates that restrictions in tackling techniques (shoulder-style tackling) and “the amount and frequency of full-contact drills during practice” might reduce the risk of concussion by 33% and TBI by 42%. Increasing public health efforts to reduce contact sports injuries could continue to lower the rate TBI ED visits.

### **Systems Building/MCH Specific Activities**

Many of the causes of TBI are predictable and preventable. Prevention includes:

- Wearing a seat belt whenever driving or riding in a motor vehicle.
- Never driving while under the influence of alcohol or drugs.
- Wearing a helmet while riding a bicycle, skateboard, motorcycle, snowmobile, or all-terrain vehicle; also wearing head protection when batting or running bases, skiing, and skating, riding a horse, or playing a contact sport.
- Installing safety features in the home, such as handrails on stairways, non-slip mats in the bathtub, grab bars in the bathroom, window guards, and safety gates on the top and bottom of stairs (especially when young children are around) to limit falls.

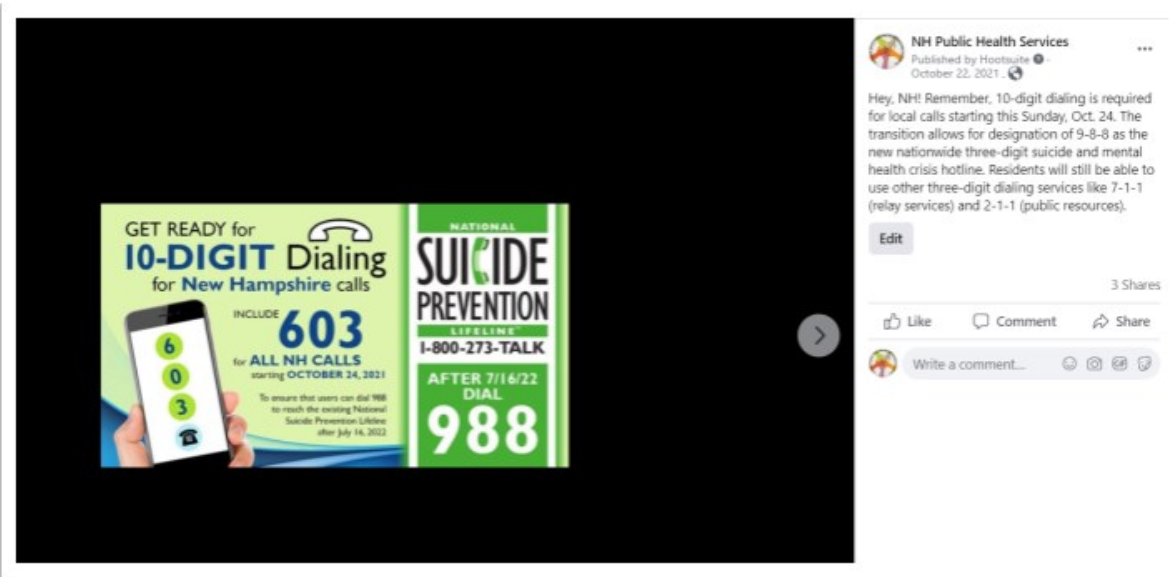
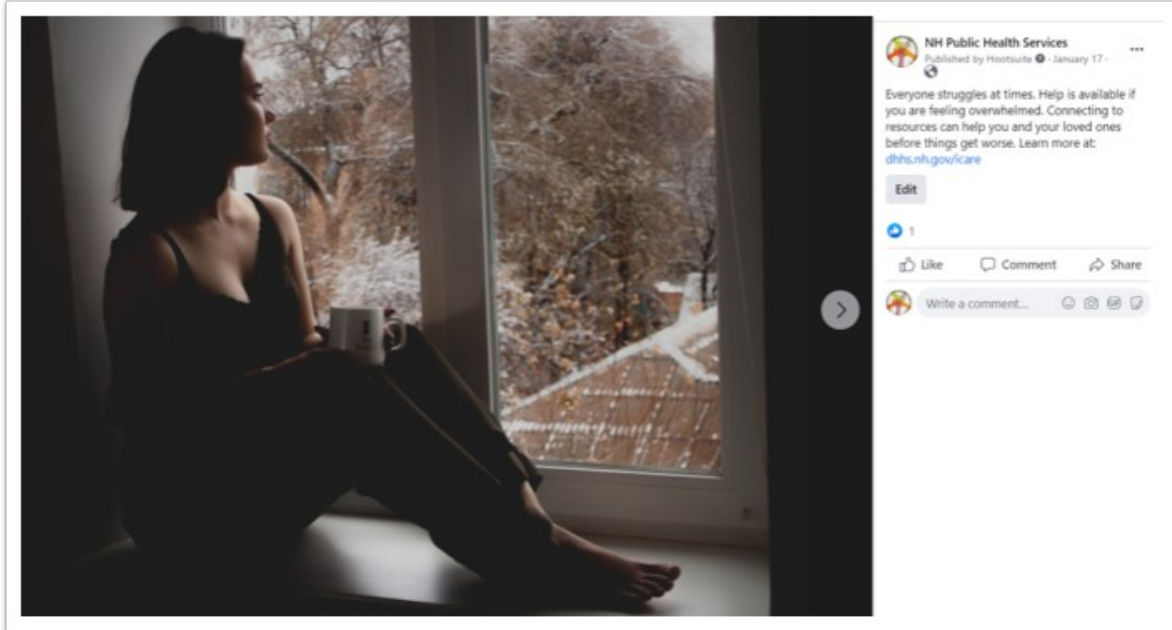
During the 2020-2021 school year, and continuing from July 2021 through March 2022, no new data was collected from school staff surveys due to the COVID-19 restrictions placing NH schools into remote learning, and sporting activities being curtailed. Conducting the school survey on the implementation of return to learn/play policies will resume during the 2023-2024 school year.

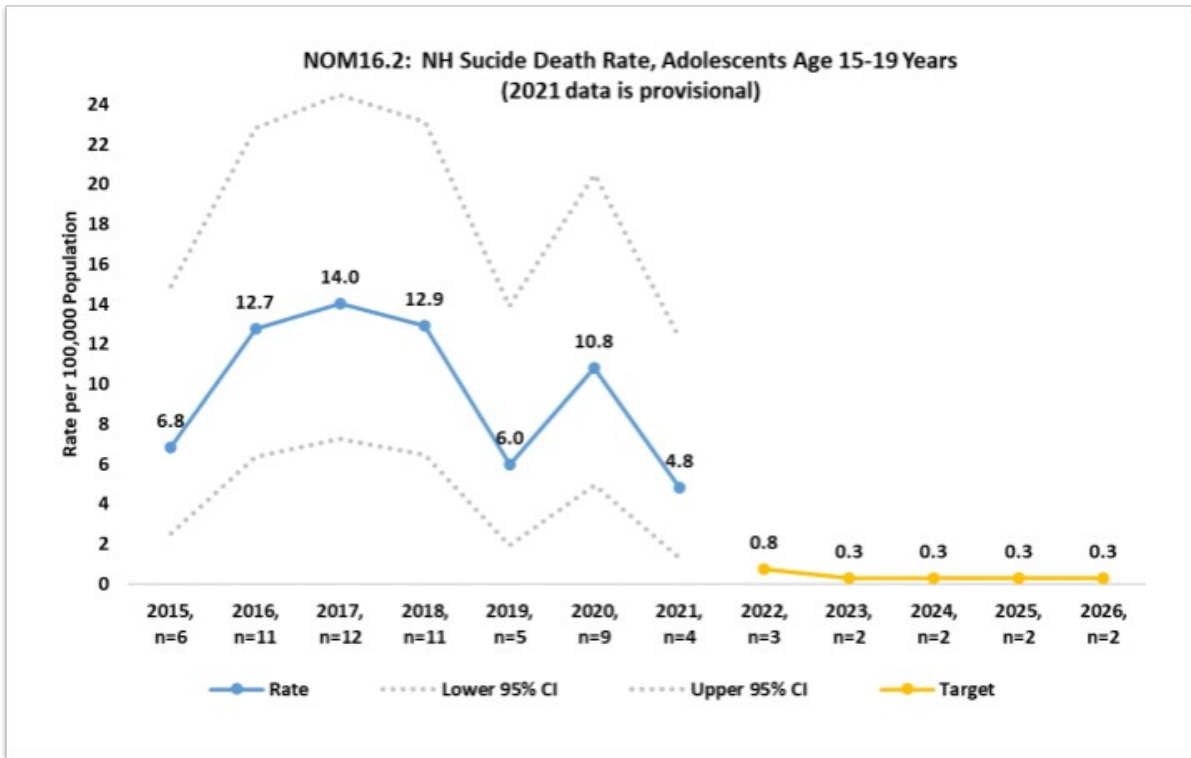
Instead, the focus has been on providing official guidance from the Department of Education to each School Administrative Unit (SAU) about the requirements of the new concussion return to learn law, along with information on best practice and online resources. Since RSA 200 was amended to include Return to Learn, work was started on drafting model return to learn policies and implementation protocols for NH schools. Concussion stakeholders statewide have a leading role in this process. A team of stakeholders met monthly between July 2021 and March 2022 to work on these policy templates. The team members included leadership from the IPP Program Manager from NH DHHS-MCH, the NH Department of Education (DOE), the School Nurses Association, classroom teachers and special education staff. This team reviewed other state models of best practices that can be adapted for use in NH. Most recently, the team reviewed information provided by the stakeholder team in Maine on the Maine DOE website, after which NH would like to model NH’s program. The draft policy template requires review by DOE supervisors before it can be shared with school staff. The finalized version will be available for download from the BIANH website.

### **NOM#16.3 Adolescent suicide**

Adolescent suicide death rates for NH residents 15-19 years old have not changed significantly between 2015 and

2021, even with the relatively sharp decline between 2018 and 2019. The suicide death rate for 2021 was 4.8 per 100,000, which is lower than expected considering the trend in previous years. While annual counts are low and may not be statistically significant, the death of any child is significant and the underlying causes need to be addressed. According to the CDC WISQARS, suicide is the second leading cause of death in the 15-19 year-old age group. The most common lethal means of suicide are suffocation, firearms, and poisoning.





Data Source: NH Vital Records, NH DHHS, HDSM

Leading Causes of Death and Violent Death, NH Residents, Ages 15-19 Years, 2011-2020				
Rank	All Causes of Death	All Injury Deaths	All Unintentional Injury Deaths	All Violent Injury Deaths
1	Unintentional injury 122	Unintentional MV Traffic 75	Unintentional MV Traffic 75	Suicide, Suffocation 38
2	Suicide 86	Suicide, Suffocation 38	Unintentional Poisoning 30	Suicide, Firearm 34
3	Malignant Neoplasms 21	Suicide, Firearm 34	Unintentional Drowning --	Suicide, Poisoning --
4	Heart Disease 10	Unintentional Poisoning 30	Unintentional Fall --	Homicide, Firearm --
5	Homicide --	Suicide, Poisoning --	Unintentional Suffocation --	Suicide, Fall --

Data Source: WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System, accessed 5/23/2022.

Note: counts of less than 10 deaths have been suppressed (--).

The NH YRBS question on “Seriously Considered Attempting Suicide (during the 12 months before the survey)” had 18.4% of respondents in 2019. Between 2011 and 2017, there was not statistically significant change in the percentage. In 2019, there was a statistically significant increase in the percent for the total, and for males. The goal by 2026 is to reduce this percentage to 16.6%. While females are more likely to consider attempting suicide, males

are more likely to die from a suicide attempt.<sup>[14]</sup>

The Trevor Project’s 2021 National Survey of LGBTQ Youth Mental Health found that 19.0% of LGBTQ youth ages 13-18 and 8.3% of LGBTQ youth ages 19-24 reported attempting suicide in the past year.<sup>[15]</sup> LGBTQ youth are at higher risk of suicide attempt than heterosexual youth.

**High School Students who, “Seriously Considered Attempting Suicide (during the 12 months before the survey)”**

Sex	2011	2013	2015	2017	2019
Total	14.3 (12.1–16.8) 1,403	14.4 (12.6–16.4) 1,624	15.3 (14.5–16.2) 14,150	16.1 (15.2–17.1) 11,310	18.4 (17.7–19.2) 12,889
Female	16.8 (13.6–20.5) 674	17.4 (15.0–20.2) 851	20.1 (18.8–21.5) 6,834	20.6 (19.2–22.1) 5,490	22.5 (21.3–23.7) 6,376
Male	12.2 (9.9–15.0) 719	11.3 (9.0–14.1) 757	10.7 (9.8–11.7) 7,092	11.5 (10.4–12.6) 5,625	14.4 (13.4–15.4) 6,357

Source: NH YRBS, <https://www.cdc.gov/healthyyouth/data/yrbs/results.htm>, accessed on 5/23/2022

**Systems Building**

The MCH IPP Manager represents the DHHS MCH section on the [Suicide Prevention Council](#) (SPC). The mission of the state SPC is to reduce the incidence of suicide in NH by accomplishing the goals of the NH Suicide Prevention Plan, which are to:

- 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.<sup>[16]</sup>

The MCH IPP, in cooperation with the Injury Prevention Center (IPC), hosted a two-day virtual Suicide Prevention Conference on November 3 and 4, 2021. The virtual conference had 110 attendees on Day 1 and 90 attendees on Day 2. Sponsorships of the conference helped offset costs. In the coming year, the conference is continuing with two days in early November with the hopes of being able to offer a hybrid option for attendance, in-person and live streaming for a virtual audience.

The SPC Communications Subcommittee coordinated a press event in September 2021 for Suicide Prevention Awareness Week. This committee also worked with the Public News Service on writing and publishing stories on prevention efforts in the State. The stories take into account the media recommendations for reporting on suicide (<http://reportingonsuicide.org/>) as well as the National Action Alliance’s Framework for Successful Messaging: <http://suicidepreventionmessaging.org/>



The MCH IPP has been awarded the [National Violent Death Reporting System](#) (NVDRS) grant from CDC

since 2014. In addition to collecting demographic data on homicides, suicides, and firearm deaths, the data abstractor also reviews police reports, medical examiner records, and toxicology reports to develop a narrative on the circumstances that lead to violent deaths. The MCH IPP collaborates with the Department of Justice, Office of Chief Medical Examiner on the grant. The first full year data set is for 2015. This data set was released by CDC in the summer of 2017. NH-NVDRS data have been included in the Annual Suicide Reports since 2017. Since 2019, the NH NVDRS data has been integrated throughout the report rather than placed in a separate section. This reduced duplication of information and improved readability. The Annual Suicide Prevention Reports from 2013 to 2020 can be viewed on [The Connect Program](#) website.<sup>[17]</sup>

\* \* \* \* \*

**National Performance Measure #10:** Percent of adolescents, aged 12-17, with a preventive medical visit in the past year

**Evidence Based or Informed Strategy Measure:** Percentage of adolescents aged 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

**Objective:** Increase the percentage of adolescents aged 12-21 who have had a preventive medical visit at the MCH-funded Community Health Centers (CHCs) from a baseline of 53% in SFY20 to 64% by the end of 2025.

**Strategies:**

**1. Build partnerships by:**

- Continuing to network with other State Adolescent Health Coordinators
- Continuing to collaborate with public and private partners through NH Pediatric Improvement Partnership
- Statewide contracting with CHCs and provision of oversight on Primary Care Services with a focus on MCH services and outcome measures
- Establishing mechanisms to inform the public about adolescent preventive services via social media and community outreach

**2. Enhance capacity of CHCs to improve access and quality of adolescent services by:**

- Establishing performance measures that align with national guidelines and promote *Bright Futures* recommendations
- Promote advancement toward HP2030 target (75.6%) for adolescent well care visit by ensuring contracted CHCs utilize Quality Improvement (QI) processes to increase the percentage of adolescents who have a preventive medical visit
- Collecting and analyzing Performance Measure outcome data from CHCs
- Providing data results and feedback to CHCs for comparison
- Providing education, resources, QI support through Newsletters, Lunch & Learns and site visits
- Providing technical assistance through group or 1:1 contact(s) via face to face meeting, remote meeting (e.g. Zoom), email and/or telephone to review, discuss and provide recommendations to address agency identified needs.

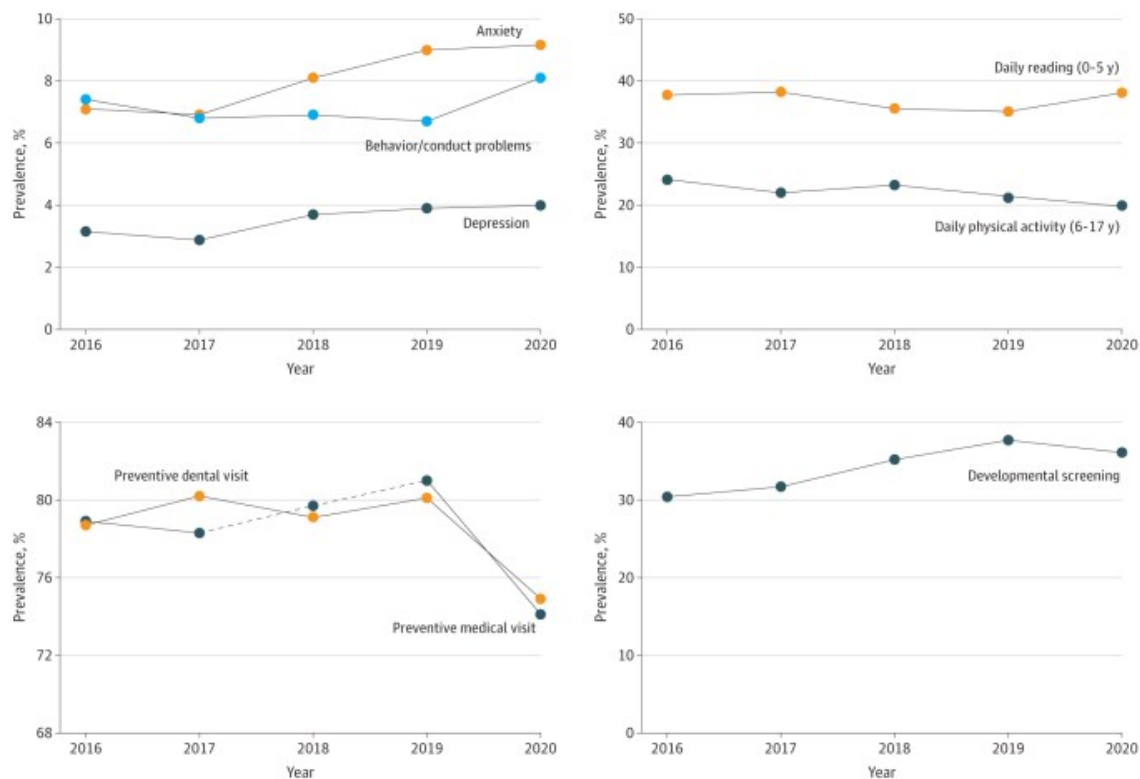
### **3. Increase MCH section staff who include adolescent health in their job responsibilities:**

- In 2021, the MCH section hired a new Child/Adolescent Health Coordinator to support programmatic initiatives to improve child and adolescent well-being.
- The Child /Adolescent Health Coordinator also serves as the Coordinator for the Child Fatality Review committee and has been collaborating with various committees and community partners to help improve overall health of NH's child and adolescent population .

### **NH Adolescent Health**

The COVID-19 pandemic has impacted both health care utilization as well as positive health behaviors. While there was an increase in positive behaviors such as daily reading, there was a decrease in other positive healthy behaviors like physical activity. There is also an increase seen in diagnosed anxiety, depression, and behavior/conduct problems .Also, both preventive health and dental visits decreased as well.

Figure 1. Trends in Selected Measures of Children's Health Conditions, Positive Health Behaviors, and Health Care Utilization, 2016-2020



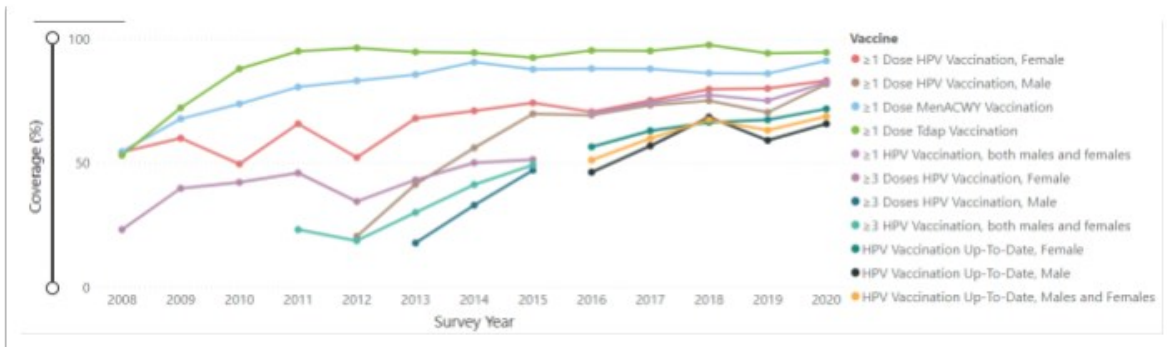
*JAMA Pediatrics*, Published online March 14, 2022. doi:10.1001/jamapediatrics.2022.0056

Annual data were examined from the National Survey of Children's Health (NSCH, 2016-2020); despite the decreases in preventive health visits, the health of NH's adolescents and young adults continues to be positively influenced by high immunization rates and low teen birth rates, but negatively influenced by tobacco, alcohol, drug use and unsafe behaviors

### **Vaccination Coverage**

For years, NH has ensured universal immunization coverage of all children 18 years of age and younger regardless of insurance status through the NH Immunization program. As a result, NH demonstrates high vaccination rates among children and adolescents. These rates will continue to be monitored closely as new data is available to identify and address gaps in routine vaccination resulting from the COVID-19 pandemic.

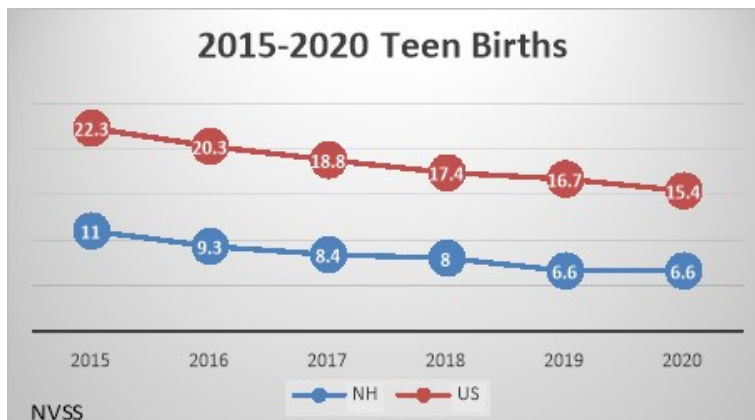
### New Hampshire Vaccination Coverage by Year among Adolescents Age 13-17 Years



Source: [TeenVaxView | Adolescent Vaccine Coverage Interactive Data | NIS | CDC](#)

### Teen Birth

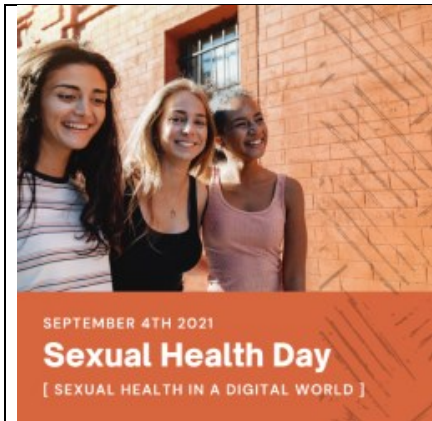
NH continues to maintain one of the lowest teen birth rates in the nation. According to the most recent data available from the CDC, NH's teen birth rate is less than seven (7) per 1000 females 15-19 years old.<sup>[18]</sup>



NH MCH contributes to this success by overseeing two adolescent pregnancy prevention projects (funded by the Administration of Children & Families) called PREP, the Personal Responsibility Education Program, which operate in areas of the State that have the highest teen birth rate, ensuring access to primary care and family planning services. In addition, Title V staff work alongside Title X staff within MCH to ensure that health care agencies funded by either or both programs are providing the highest level of comprehensive care for adolescents. Program staff also promote public awareness of adolescent sexual health by contributing to social media posts, such as the two shown below:



NH Public Health Services  
May 5 at 2:01 PM  
It is critical to give teens the sexual and reproductive health information and services they need to make informed decisions about their health. Learn more:  
<http://ow.ly/YjTn50J0hAZ>  
#HealthyYouthNAHM



NH Public Health Services  
September 4, 2021  
Part of having good sexual health is knowing how to stay safe online. For @WorldSexualHealthDay, parents & youth can check out this 6-Minute Sex Ed podcast to learn more about staying safe & kind in a virtual world. Make sure to browse the resources provided, too! <http://ow.ly/ByKG50G1MYO>

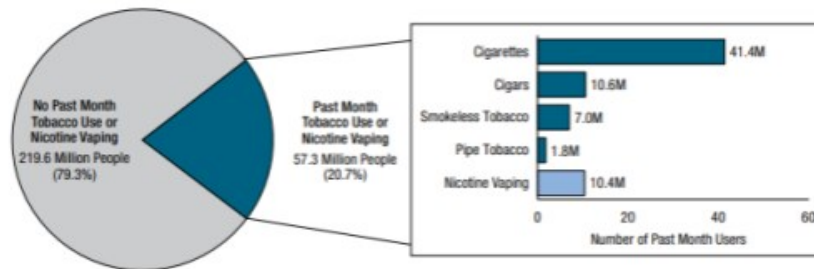
### NH Adolescent Health Risk

NH adolescents and young adults' health continues to be at risk from the use of tobacco, alcohol, and drugs as well as unsafe driving and sexual behaviors.

#### *Tobacco Use*

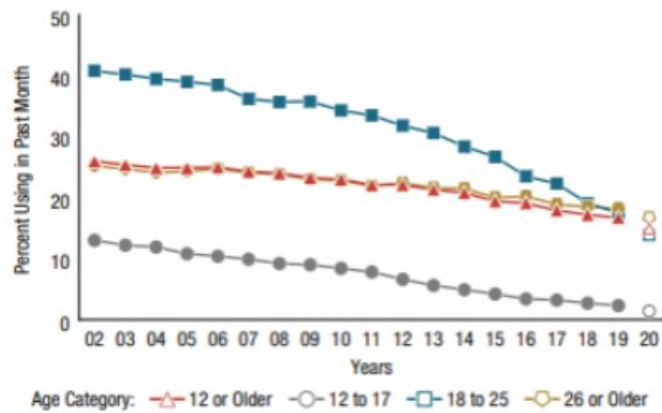


**Figure 2. Past Month Tobacco Use and Nicotine Vaping: Among People Aged 12 or Older, 2020**



Note: The estimated numbers of current users of different tobacco products or nicotine vaping are not mutually exclusive because people could have used more than one type of tobacco product or used tobacco products and vaped nicotine in the past month.

**Figure 3. Past Month Cigarette Use: Among People Aged 12 or Older, 2002-2020**



Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

According to the 2020 National Survey on Drug Use and Health (NSDUH), combined tobacco use of students 12 and older within the last 30 days use has decreased to 20.7%, compared to the most recent Youth Risk Behavioral Survey in 2109 in which 35% of high school students reported use of tobacco products in the 30 days prior to the survey. When looking at cigarettes alone in Figure 3 (above), a decrease in cigarette use in the last few years is also noted with both age groups of 12-17 year olds and 18-25 year olds which indicates prevention measures such as social media posts are working.



NH Public Health Services

August 25, 2021

Tobacco companies use flavors like mango and fruit punch to make smoking sound more attractive to children and teens.

Make sure your children's day care centers and schools are tobacco-free. A tobacco-free campus policy prohibits any tobacco use or advertising on school property by anyone at any time. This includes off-campus school events.

Find resources for schools at [www.drugfreenh.org/for-schools](http://www.drugfreenh.org/for-schools)

Adolescent Behaviors and Experiences Survey		
Tobacco Use	Percentage	Confidence Interval
Ever tried cigarette smoking (even one or two puffs)	16.1	13.7 - 19.6
First tried cigarette smoking before age 13 years (even one or two puffs)	6.0	4.5 - 7.8
Currently smoked cigarettes (on at least 1 day during the 30 days before the survey)	3.3	2.5 - 4.4
Smoked more than 10 cigarettes per day (on the days they smoked during the 30 days before the survey, among students who currently smoked cigarettes)	6.9	3.3 - 13.9
Ever used an electronic vapor product (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu])	36.1	33.0 - 39.2
Currently used an electronic vapor product (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu]), on at least 1 day during the 30 days before the survey)	15.4	13.0 - 18.1
Usually got their electronic vapor products by buying them themselves in a convenience store, supermarket, discount store, or gas station (including e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods [such as JUUL, SMOK, Suorin, Vuse, and blu]), during the 30 days before the survey, among students who currently used electronic vapor products)	8.4	6.1 - 11.4
Currently used smokeless tobacco (chewing tobacco, snuff, dip, snus, or dissolvable tobacco products [such as Copenhagen, Grizzly, Skoal, or Camel Snus], not counting any electronic vapor products, on at least 1 day during the 30 days before the survey)	1.9	1.3 - 2.8
Currently smoked cigars (cigars, cigarillos, or little cigars, on at least 1 day during the 30 days before the survey)	2.3	1.8 - 2.9
Tried to quit using all tobacco products (including cigarettes, electronic vapor products, smokeless tobacco, cigars, shisha or hookah tobacco, or pipe tobacco, during the 12 months before the survey, among students who used any tobacco products during the 12 months before the survey)	55.7	52.6 - 58.9

Source: CDC, Adolescent Behaviors and Experience Survey; EDITION YEAR: 2021

When looking at the Adolescent Behaviors and Experiences Survey (ABES) in regards to use of vapor products, although there is a fairly high number of students who have “ever used electronic vapor products”(36.1%), only about half that number (15.4%) currently use an electronic vapor product ,which has improved since the 2109 YRBS which cited 33.8% as reporting current use. Also of note is the high percentage of students that have “tried to quit“ (55.7%) which again could reflect some success with prevention measures.

*Alcohol Consumption*

Although reduced, alcohol use is still fairly prevalent across NH. According to the ABES, 19.5% of students currently drink alcohol compared to the 2019 YRBS reporting of 27 %. The YRBS also showed 11% of students had their first drink before age 13, which has not changed according to the most recent ABES. The fact that 38.4% of students get their alcohol by someone giving it to them, reflects that there is still more prevention work to do in this area. The Child Fatality review committee reviewed a case involving underage drinking recently and has made various recommendations including more consistent use of the SBIRT (screening ,brief intervention and referral to treatment), continued Substance Use/Misuse trainings for students, and reducing barriers to substance use treatment.

Adolescent Behaviors and Experiences Survey		
Alcohol and Other Drug Use	Percentage	Confidence Interval
Had their first drink of alcohol before age 13 years (other than a few sips)	11.1	9.7 - 12.6
Currently drank alcohol (at least one drink of alcohol, on at least 1 day during the 30 days before the survey)	19.5	16.8 - 22.4
Currently were binge drinking (had four or more drinks of alcohol in a row if they were female or five or more drinks of alcohol in a row if they were male, within a couple of hours, on at least 1 day during the 30 days before the survey)	7.7	5.9 - 10.1
Reported that the largest number of drinks they had in a row was 10 or more (within a couple of hours, during the 30 days before the survey)	2.2	1.6 - 3.1
Usually got the alcohol they drank by someone giving it to them (during the 30 days before the survey, among students who currently drank alcohol)	38.4	34.3 - 42.7

Source: CDC, Adolescent Behaviors and Experience Survey; EDITION YEAR: 2021

### Sexual Risk

The Adolescent Health coordinator has been and will continue to work with “Live HPV Cancer Free” to develop initiatives to increase HPV vaccines in NH. The following table shows how NH ranks 44<sup>th</sup> out of 50 states.

**Table 4B. Human Papillomavirus Vaccination Coverage (%)**, Adolescents 13-17 Years by State, 2019

	Females	Males	Overall	
	Up-to-Date*	Up-to-Date*	Up-to-Date*	Rank
<b>United States</b>	<b>57</b>	<b>52</b>	<b>55</b>	<b>Rank</b>
<i>Range</i>	32-78	29-80	31-79	(1=low)
Alabama	52	43	47	9
Alaska	58	48	53	18
Arizona	57	56	57	31
Arkansas	55	46	51	16
California	62	51	56	29
Colorado	70	57	64	45
Connecticut	56	51	54	23
Delaware	61	58	59	34
District of Columbia	73	78	76	50
Florida	56	56	56	28
Georgia	56	44	50	15
Hawaii	66	66	66	47
Idaho	48	41	44	6
Illinois	55	55	55	25
Indiana	42	41	41	2
Iowa	60	61	61	42
Kansas	47	52	50	12
Kentucky	62	48	55	25
Louisiana	58	61	60	36
Maine	57	49	53	18
Maryland	69	69	69	48
Massachusetts	74	75	74	49
Michigan	58	61	59	35
Minnesota	64	50	57	30
Mississippi	32	29	31	1
Missouri	55	54	54	24
Montana	51	42	47	8
Nebraska	62	59	61	39
Nevada	56	50	53	20
New Hampshire	67	59	63	44
New Jersey	53	50	51	17

Source: Teen Vax View, 2020; National Immunization Survey – Teen 2019

Table 4A. Vaccination Coverage (%), Youth by Sex, Race/Ethnicity, and Poverty Status, US, 2019

	Before 13th birthday				13-17 years		Hepatitis B Overall ≥ 3 doses
	HPV				HPV		
	Females		Males		Females	Males	
	Initiation	Up-to-Date*	Initiation	Up-to-Date*	Up-to-Date*	Up-to-Date*	
<b>Overall</b>	62	37	60	33	57	52	92
<b>Race/Ethnicity</b>							
White	57	34	54	30	54	49	94
Black	59	29	69	32	53	55	91
Hispanic	72	45	65	37	63	53	87
American Indian/Alaska Native	-	-	-	-	55	60	94
Asian	-	-	-	-	67	62	90
<b>Poverty Status</b>							
Below poverty level	71	43	66	35	59	57	92
At or above poverty level	57	34	60	33	56	51	92

\*According to recommendations; see sources for more information.

Source: TeenVaxView, 2020.<sup>21</sup> National Immunization Survey-Teen, 2019.

©2021, American Cancer Society, Inc., Surveillance Research

Although NH works hard at promoting the HPV vaccine, there is still work to do to promote safe sexual practices and reproductive health as it relates to condom use and youth being tested for HIV. As per the 10 year trend report for the YRBS, both statistics on use of condoms and testing for HIV are going in the “wrong direction“ (see chart below) showing a lower percentage of students using condoms and also not being tested for HIV.

NH Public Health Services  
January 26 · 🌐

Parents: Your doctors may have already talked to you about the Tdap vaccine to prevent tetanus, diphtheria, and pertussis, as well as the flu shot to prevent influenza. Did you know that the HPV vaccine is recommended to prevent cervical and HPV-associated cancers? Find out more about recommended immunizations for children here: <http://bit.ly/2TY07I>

**Did you know?**  
Children as young as ages 9-10 can receive the HPV vaccine if recommended by their provider.

#CervicalCancerAwarenessMonth

Sexual behaviors are measured with questions regarding sexual activity, numbers of sexual partners, and use of condoms and effective hormonal birth control. Not all variables were available for 10 years of trends.

THE PERCENTAGE OF HIGH SCHOOL STUDENTS WHO <sup>1</sup> :	2009 Total	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	Trend
Ever had sex	46.0	47.4	46.8	41.2	39.5	38.4	
Had four or more lifetime sexual partners	13.8	15.3	15.0	11.5	9.7	8.6	
Were currently sexually active	34.2	33.7	34.0	30.1	28.7	27.4	
Used a condom during last sexual intercourse <sup>2</sup>	61.1	60.2	59.1	56.9	53.8	54.3	
Used effective hormonal birth control <sup>3</sup>	—	—	25.3	26.8	29.4	30.9	
Used a condom and effective hormonal birth control <sup>3</sup>	—	—	8.8	8.8	8.8	9.1	
Were ever tested for HIV	12.7	12.9	12.9	10.2	9.3	9.4	
Were tested for sexually transmitted diseases during the past year <sup>4</sup>	—	—	—	—	—	8.6	—

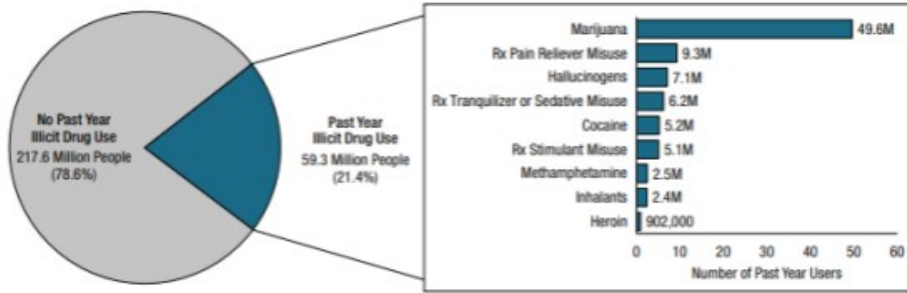
	In wrong direction
	No change
	In right direction

Source: National Youth Risk Behavior Surveys, 2009-2019  
<sup>1</sup>For the complete wording of YRBS questions, refer to Appendix.  
<sup>2</sup>Among students who were currently sexually active.  
<sup>3</sup>Variable introduced in 2019.

### Drug Use

NH youth continue to struggle with illicit drug use as well, with the majority of the illicit drug use being marijuana (49.6 million out of 53.3 million). Though any drug use is still a problem, overdose data from the CDC shows a decrease in combined overdose deaths among youths per the graph below, with the majority of the overdose deaths being among those aged 19-21.

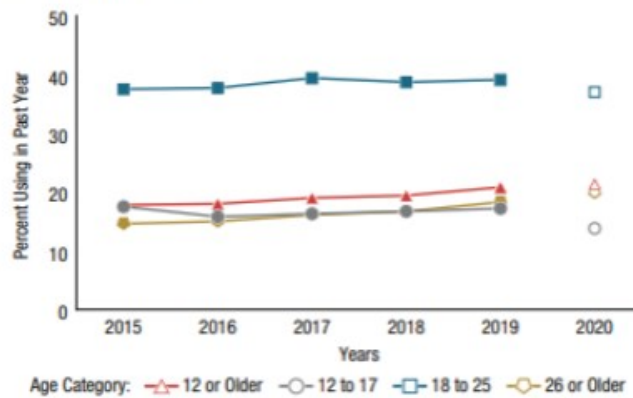
**Figure 9. Past Year Illicit Drug Use: Among People Aged 12 or Older; 2020**



Rx = prescription.

Note: The estimated numbers of past year users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past year.

**Figure 10. Past Year Illicit Drug Use: Among People Aged 12 or Older; 2015-2020**

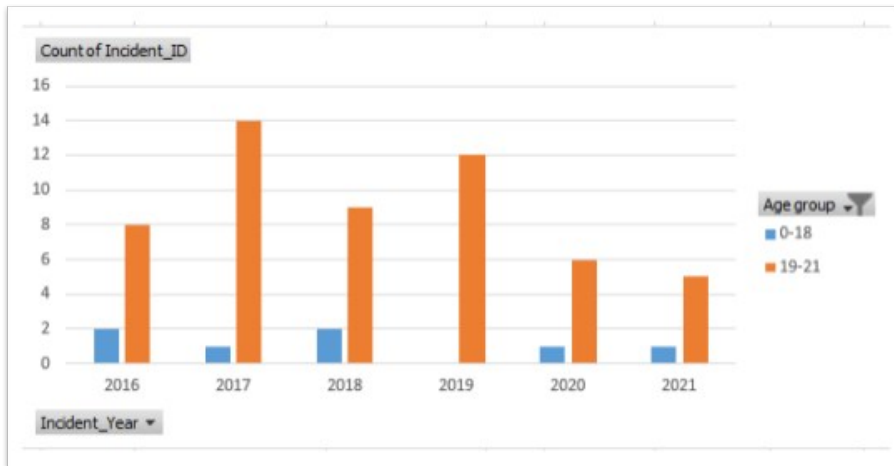


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

**Figure 10 Table. Past Year Illicit Drug Use: Among People Aged 12 or Older; 2015-2020**

Age	2015	2016	2017	2018	2019	2020
12 or Older	17.8	18.0	19.0	19.4	20.8	21.4
12 to 17	17.5	15.8	16.3	16.7	17.2	13.8
18 to 25	37.5	37.7	39.4	38.7	39.1	37.0
26 or Older	14.6	15.0	16.1	16.7	18.3	19.9

Note: The estimate in 2020 is italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.



Data Source: CDC Overdose to Action Data 2021

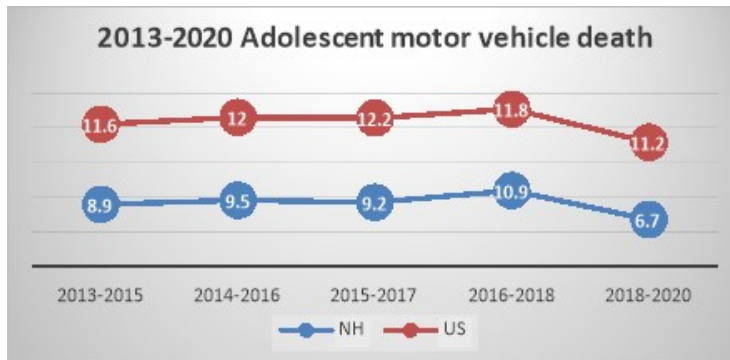
NH is addressing the drug crisis by implementing a comprehensive response that includes prevention, treatment, and recovery services in every region of the State. The strategies to combat this epidemic start with expanding resources for treatment and recovery, support for law enforcement, and enhancing prevention efforts. NH has implemented provider trainings and updated rules for prescribers, which include assessing the need for opioids, the risk for abuse, and providing education to patients. Due to the drug epidemic, all MCH-contracted CHCs are expected to screen for drug and alcohol abuse as part of primary care services. Although mechanisms are in place for CHCs to refer individuals with substance use disorder (SUD) for treatment, outpatient and residential substance abuse treatment for adolescents remains limited.

The State of NH continues to increase infrastructure to support children's behavioral health. In 2016, the Bureau of Children's Behavioral Health was established within the DHHS Division of Behavioral Health. This bureau works alongside the Bureau of Mental Health Services, the Bureau of Drug and Alcohol Services, and the State's behavioral health facilities to unify the delivery of mental health and substance use disorder services. In 2019, the MCH section established a new Pediatric Mental Health Care Access Program (PMHCAP), to increase NH pediatricians' and primary care providers' capacity to address behavioral health needs of children 0-21 years of age (refer to Cross Cutting Domain for more information on PMHCAP). The NH PMHCAP Program Coordinator has strengthened the MCH connection to the Bureau of Children's Behavioral health, to expand pediatric behavioral health services and resources for NH's children, families, and health care providers.

### *Unsafe Driving*

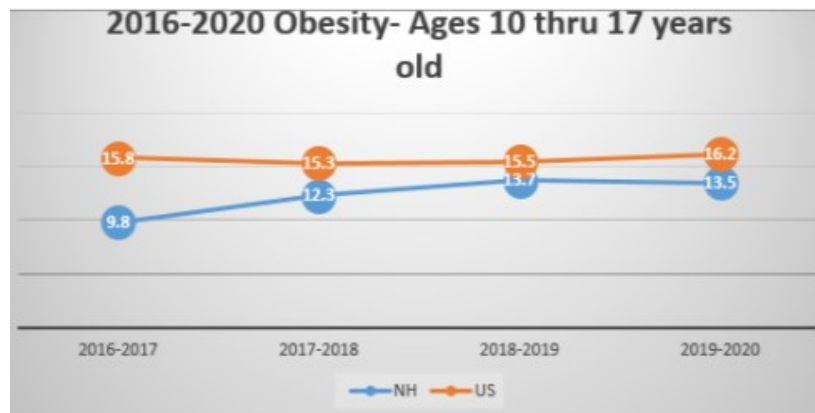
There had been an increase in adolescent motor vehicle deaths within the last few years (2016-2018-three year estimates are provided, due to small numbers in single years). But since 2018 there has been a decline possibly due to the increase in seatbelt usage as reflected in the most recent YRBS. The Child Fatality Review Committee reviewed four motor vehicle deaths this past year, and along with community partners has made a variety of recommendations related to motor vehicle safety for adolescents. Some of the recommendations include exploring some modifications to the NH drivers education program to include possible use of simulators, and an increase in focus on impaired driving, winter safety and car maintenance. The Committee also recommended developing/renewing key messaging on drinking and driving and seatbelt use.





*Obesity*

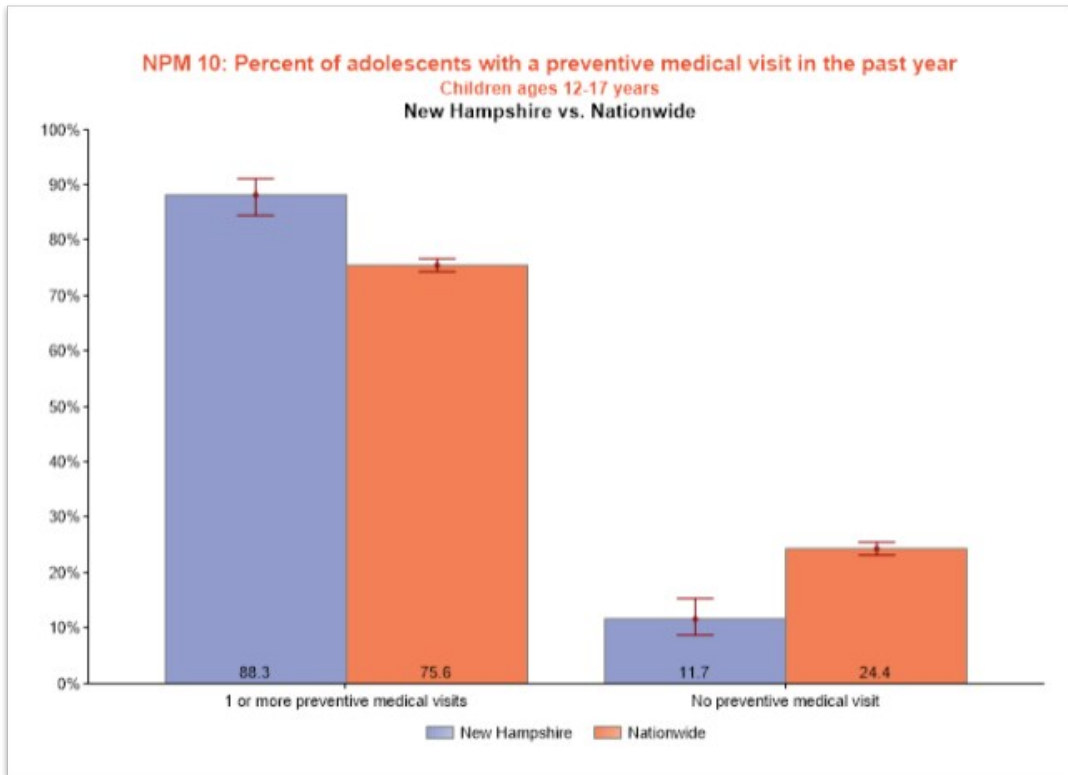
Since 2016 there has been an increase in obesity in children ages 10-17 both in NH (from 9.8% to 15.5%) and nationally (from 15.8% to 16.2%)<sup>[19]</sup> although NH does remain below the national average. Children who are overweight can go on to develop other health risk factors such as diabetes and heart disease. The Child & Adolescent Health Nurse Coordinator takes every opportunity to collaborate with community partners and participate in committee workgroups such as SPINE (State Partnership for Nutrition Equity) to help increase access to food programs and more nutritious foods for families. The Child & Adolescent Coordinator also attends community events and health fairs to share information on the importance of physical activity and healthy food choices as well as nutrition resources.



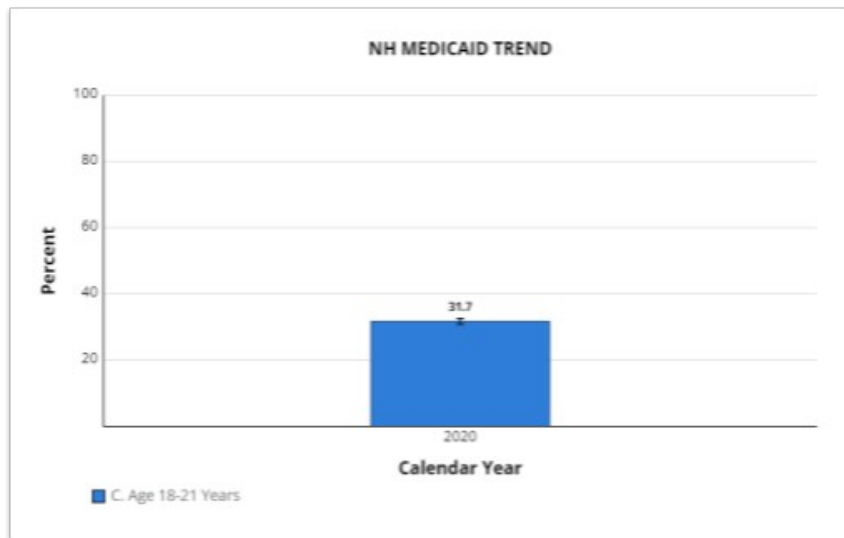
National Survey of Children’s Health (NSCH); accessed from Federally Available Data (FAD) Resource Document, April 1, 2022; Maternal and Child Health Bureau, Rockville, MD

**Adolescent Well-Visits**

The adolescent preventive medical visit is an ideal opportunity to improve adolescent biopsychosocial health by screening for adolescent health risks, addressing health concerns and providing referral and counseling to influence behaviors. According to the 2020 National Survey of Children’s Health (NSCH), the State of NH has a higher percentage of adolescents ages 12-17 who have had a preventive medical visit than the national average, at 88.3% vs 75.6%.



Child and Adolescent Health Measurement Initiative. 2020 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 05/24//22 from [www.childhealthdata.org](http://www.childhealthdata.org).



NH Department of Health and Human Services. Bureau of Program Quality. Retrieved 05/27/22 from <http://medicaidquality.nh.gov>

When reviewing 2020 data (see the two graphics, above) that includes older individuals to age 21, the percentage of preventive visits decreases significantly to 31.7% according to NH Medicaid, which is lower than the previous year, 2019 which was 62.4%. This along with anecdotal information from NH health care providers suggests that younger children/adolescents are more likely to complete annual preventive visits in comparison to young adults. Keeping this in mind, NH MCH encourages efforts to improve health literacy among young adults.

## **MCH Section Current Activities**

The Child and Adolescent Coordinator also serves as the Coordinator of the Child Fatality Review Committee (CFRC). The CFRC has decreased duplication of efforts and has had increased coordination among DHHS child and family services such as the Help Me Grow Program and preventive agencies (e.g. DHMC Injury prevention program) to streamline family supports and referrals.

The CFRC reviewed four motor vehicle deaths in the fall of 2021 and five suicides in Winter/Spring 2022. Recommendations were made and are in various stages of implementation. Examples of recommendations regarding motor vehicle accidents have been listed under “unsafe driving” in the NH Adolescent Health Risk section of this report. Some of the recommendations from the Committee regarding suicides and overdoses include continued substance use/misuse trainings, as well as increased trainings for healthcare providers and community partners on Trauma Informed Care (TIC) and Adverse Childhood Experiences (ACES). The committee would also like to see an increase in the Mental Health (MH)/SUD workforce as well as increased accessibility of MH and SUD resources and decreased stigma in utilizing these resources. Many of the recommendations above are included along with strategies in NH’s Ten year MH plan. NH has also instituted the 988 system with mobile crisis units which are able to respond to a mental health crisis in each area of the State. Also listed below are examples of some of the primary prevention measures that have been initiated through connections with Community Partners. The CFRC Coordinator’s role with each of these community partners is to collaborate and propose initiatives that support families and focus on some of the issues and concerns that have come up in case reviews, such as increasing family supports as well as assistance in dealing with the stress of issues such as housing, bullying, and transitions into adulthood that have been listed as risk factors in many of the cases that were reviewed by the CFRC this past year.

### **PRIMARY PREVENTION Activities by CFRC/ CHILD & ADOLESCENT HEALTH Coordinator:**

- **Youth Homeless Demonstration Project (YHDP)** - RFP created in workgroup to provide a tiered approach with levels of support including health navigation for youth who are homeless. (Recommendation from a case review where individual had housing concerns)
  
- **Help Me Grow(HMG)** – Systems of support with centralized access point for families that provide developmental screening/monitoring, closed loop referrals and education, based on best practices of trauma informed care (Recommendation from a case review that involved increasing community supports and more streamlined referral process)
  
- **NH PIP** – Goal of NH Pediatric Improvement Partnership is to improve healthcare quality through the use of systems and measurements–based quality improvement process (Recommendation from case review regarding mental health care, education and referrals)
  - 2022 Echo Series: Promoting Child and Family Resilience and Healing in a Pandemic
  - Trauma Informed care in Pediatric Primary Care
  - Pediatric MH Directory
  
- **NH Transitions Community Of Practice** – A Community of Practice that is family-driven and youth-focused and assists youth in succeeding at home and at school as they transition into adulthood. (Recommendation from a case review that suggested increased community protective factors)
  
- **NE Regional Child Death Review** – Addressing recommendations related to CFR process; also the

National Center for Child Death review will be doing a site visit within the next few months.

- **NH Suicide Prevention Council** – Adolescent Nurse collaborating with Council regarding recommendations for increased statewide Suicide Prevention Campaign including training for health care providers and schools
- **988/Rapid Response Workgroup** – Adolescent Nurse collaborating with team regarding increasing awareness and training on the 988 system, which provides phone support and problem solving to help resolve a behavioral health crisis; mobile crisis teams are also available if the crisis cannot be resolved over the phone (Recommendation from case review specifically suggesting 988 trainings)
- **NH Council On Autism Spectrum Disorders** - Works with Community Partners to advise stakeholders on best practices for youth with autism (have an increased likelihood of MH issues and suicide.)
  - “The new research published in the JAMA Pediatrics, found that early mortality -- which, in the meta-analysis, was usually death in childhood or by midlife -- from natural and unnatural causes was more than two times more likely for both people with Autism and those with ADHD than for the general population, said the review's lead author Ferrán Catalá-López, via email. Natural causes included cardiac events and seizures; unnatural causes included unintentional injuries, suicides and homicides.”(Kristen Rogers, CNN)
- **Medicaid Quality** – Collaborating with Medicaid Quality Department. to increase adolescent well visits for MH screening and anticipatory guidance (recommendation from a case reviewed that had no PCP connections/missed preventive appointments)

The CRFC Coordinator also takes opportunities to engage and educate Members of the Child Fatality Review Committee regarding case reviews by providing information and resources related to the topic of the specific case review either by presenting at the Case Review meeting, or providing information before or after the meeting .Two presentations were done this past year on Sodium Nitrate/Nitrite poisoning and Gun safety .The CRFC Coordinator also collaborates and consults with the National Child Death Review Program (CFRP) on a regular basis and uses the CDRP National standards as a basis for NH Policies and procedures for the NH CFRC. The National CDR team is visiting during the Fall of 2022 to assist the team in revising current procedure and policies. The CFRC Coordinator also engages in quarterly meetings with the Northeast Regional Team and attended a NE Regional Team Meeting and Conference where QI/QA and equity in CDR were discussed. Starting in April, all NH DHHS Fatality Review Committees were convened to promote collaboration between committees so that efforts with common goals and recommendations can be combined and trainings could be shared .The fatality review teams also identify gaps in common policies and procedure to help reduce loss of life in NH.

#### *Collaborative projects with key stakeholders:*

Currently, NH MCH contracts with family planning and primary care health centers to increase statewide access to well-care visits as these provide an opportunity for youth to receive recommended preventive services. MCH staff provide contract monitoring and oversight of all contracted vendors through monitoring of data, emails, calls and meetings.

MCH section staff ensure primary care agencies follow national standards of care, such as *Bright Futures*/American Academy of Pediatrics. The MCH Child and Adolescent Health Coordinator also attends the Committee meetings listed above (YHDP, HMG, NH PIP ,etc.) with other community partners to increase awareness of the issues affecting

NH youth and to work collaboratively on common health initiatives

### *MCH Contracted Community Health Centers (CHCs)*

For over 25 years, MCH has utilized Title V funding to contract agencies to support primary care. In 2021 a new focus on services specifically designed for Maternal and Child Health populations was developed with specific strategies and work plans that reflect this focus. Through this contracting, MCH has successfully engaged with CHCs across the State to ensure access and quality of primary care, including integration of behavioral health services. MCH provides agency oversight and ensures accountability by specifying reporting requirements and conducting site visits. Primary care contracted agencies are expected to provide services consistent with *Bright Futures*/National Guidelines and are required to submit performance outcome data to MCH.

### *Coordinators' Meetings*

Twice per year, the MCH QA/QI nurse coordinates and presents at the Primary Care Coordinators' meetings as an opportunity to meet face-to-face with staff from all contracted CHCs to provide them with information, resources, and technical support. Agency representatives for these meetings include agency directors/clinical managers and quality improvement staff members. During SFY21, one coordinators' meeting was held virtually (Fall 2021), and another meeting is planned for the Fall of 2022.

The November 2021 Coordinators Meeting presentations included:

- Program Updates
  - Focus on expected target population to increase access to Healthcare for MCH population with enabling services
- Changes with performance measures
- Quality Improvement:
  - Review MCH Lead Measure and DHHS Lead Screening program
  - Review of Developmental screening
  - NH MCAP presentation
  - NH Immunization Program Updates
    - New COVID-19 Vaccine for children 5-11 yrs.

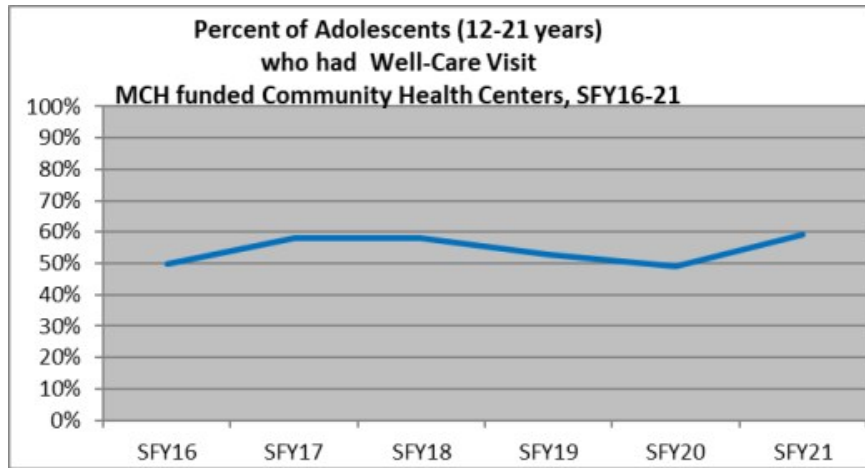
### *Quality Assurance*

MCH continues to collect CHC data on 13 primary care service performance measures. Six (6) of these measures assess preventive care for adolescents including:

- Body Mass Index (BMI) documentation and education related to nutrition and physical activity for children 3-17 years
- Body Mass Index (BMI) documentation and follow up for patients if their BMI is out of range (18 years and over)
- Depression screening (12 years and over)
- Tobacco screening and cessation for tobacco users (12 years and over)
- Screening Brief Intervention and Referral to Treatment (SBIRT) for substance misuse (18 years and over)

- Adolescent annual well-care visit (ages 12-21 years).

For the adolescent well-care visit, MCH's historical data over the past six years demonstrates rates ranging from 50-60% among CHCs.



In SFY21, the program did see an increase to 59% for the reporting period July 1, 2020 to June 30, 2021. This increase could reflect families feeling more comfortable than in the previous year in having in-person preventive visits. Also, adolescent preventive services continue to be frequently missed outside of the well-care visit, and MCH anticipates focusing efforts to support improvement of this measure outcome, including promotion of virtual telehealth visits and catch-up in-person visits.

#### *Data collection*

Aware that some agencies only reviewed their agency data when reporting was due to the State, MCH encouraged agencies to review their own data more frequently (at least quarterly). Current MCH revised Primary Care contracts require CHCs to submit MCH performance measure data to the State twice per year.

MCH staff (QI/QA nurse consultant) collects and analyzes CHC performance measure data. Following data analysis the MCH QI/QA nurse consultant reviews data results with MCH staff (Child and Adolescent Health nurse consultant and MCH program administrator) for internal discussion. The MCH QI/QA nurse consultant then disseminates all-agency data and graphs and provides recommendations for improvement activities to CHCs. MCH encourages CHCs to review all-agency data to understand how they compare to other MCH-contracted agencies and to consider incorporating MCH QI recommendations.

#### *Site Visits*

Site visits were deferred in 2020 due to COVID-19, typically each contracted CHC receives a site visit every two-year contract period to monitor adherence to contract requirements, provide an opportunity for MCH staff to better understand agency services (especially services that address social determinants of health, i.e. enabling services), and provide technical assistance on agency performance and quality improvement. Site visits continue to be affected by COVID-19 in 2021 with many practices finding it difficult to schedule on-site visits due to increased scheduling needs trying to catch-up on missed preventive appointments and immunizations

During previous site visits, chart audits were conducted for adolescents aged 11-21 to promote *Bright Futures* Guidelines. The site visits and audit findings have prompted discussions about the significance of an annual well-care visits for the AYAH (Adolescent/Young Adult Health) population and how to reduce missed opportunities for health care providers to screen, counsel and provide preventive intervention for key areas including: mental and behavioral health; tobacco and substance use; violence and injury prevention; sexual behavior; and nutritional health. Solutions and strategies related to making site visits are in progress.

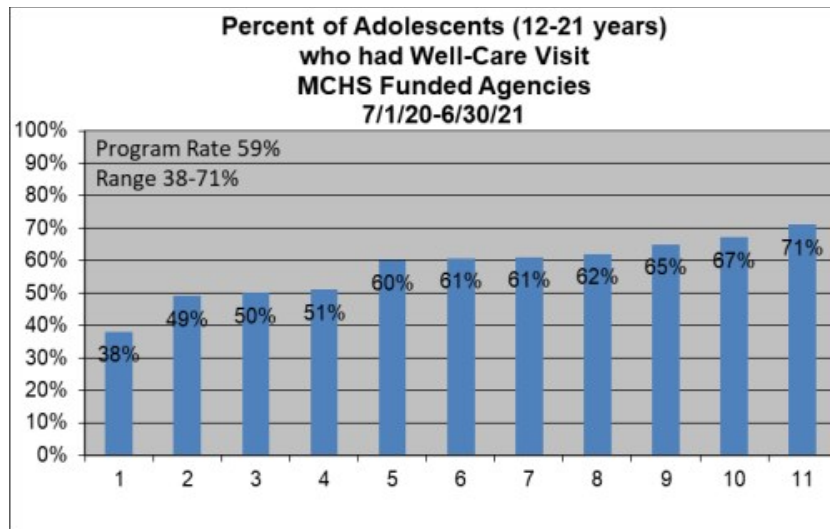
MCH currently requires MCH-contracted CHCs to submit annual Quality Improvement (QI) Work Plans to describe agency adolescent QI initiatives. Prior to instituting this requirement, MCH allowed each agency to self-select their QI project topic as long as it related to the Primary Care contract scope of services. As only two-(2) out of the 13 contracted CHCs self-selected the adolescent visit, MCH revised contract language to require an adolescent health QI workplan as a mechanism to ensure local effort for the SFY18-19 contract period. In 2020, 100% of contracted CHCs submitted two-year Adolescent Visit QI workplans. The most recent submission of these workplans occurred following the close of SFY20 to allow data and narrative information to be updated in the outcome sections to reflect the work that was done during the year (see a sample excerpt from one SYF21/22 QI Work Plan below).

<b>Agency Name: Coos County Family Health Services</b>	
<b>Name of Person Completing Workplan: Cindy Charest, RN, QA/QI Director</b>	
<b>MCH Performance Measure:</b>	
<b>Adolescent Well-Care: Percentage of Adolescents 12-21, who had at least one comprehensive well-care visit with a PCP or an OBGYN Practitioner during the measurement year.</b>	
<b>Project Objective #1:</b> 60% of adolescents 12-21 will have at least one comprehensive well-care visit during the measurement year.	
<b>INPUT/RESOURCES</b>	<b>PLANNED ACTIVITIES</b>
Nurses, Providers and Support Staff  Social Worker  Nutritionist  Care Management Nurses  Data/QI: IT Team  Crystal Reports  Commercial Insurance/Medicaid  Patient Portals	<ul style="list-style-type: none"> <li>• Clinic nurse will electronically track annual comprehensive well-care visit for adolescents.</li> <li>• Clinic nurse will send a reminder for annual well-visit to parent/legal guardian/patient via secure email, letter or phone.</li> <li>• Automated reminder system will send a text, email or phone call 3 weeks, 1 week and 24 hours prior to a scheduled appointment. Patient can confirm appointment via text and email.</li> <li>• Clinic nurse will contact parent/legal guardian/patient via secure message, letter or phone for overdue services.</li> <li>• An appointment will be made 366 days per last annual well-care visit at the time of visit.</li> <li>• A clinical summary visit for all office visits will be given to parent/patient and will include all future appointments.</li> <li>• Care management nurses will review commercial insurance and Medicaid Electronic Patient Portals for due and overdue services at least quarterly.</li> <li>• Medical teams will be notified by care management nurses of well-care services due.</li> <li>• Barriers of care will be assessed by the Medical Teams and involvement of the Medical Social Worker will be offered to ensure annual well-care services.</li> </ul>

EVALUATION ACTIVITIES	
	<ul style="list-style-type: none"> <li>• COO &amp; QA/QI Director will:               <ul style="list-style-type: none"> <li>Perform crystal report/EMR audit review to determine percentage of adolescents with an annual well-care visit.</li> <li>Share report/audit results with the staff and QI Committee.</li> <li>Recommend corrective action activities to improve compliance with goal.</li> </ul> </li>   <li>• IT will:               <ul style="list-style-type: none"> <li>Run reports to capture data for review.</li> <li>Update EMR templates as needed.</li> <li>Offer Lunch and learn trainings.</li> </ul> </li> </ul>
WORK PLAN PERFORMANCE OUTCOME (To be completed at end of each SFY)	
<p><u>SFY 20 Outcome:</u> <i>Insert your agency's data/outcome results here for July 1, 2019- June 30, 2020</i></p> <p><u>290/464=63%</u></p> <p><input checked="" type="checkbox"/> Target/Objective <b>Met</b></p> <p><b>Narrative:</b> <i>Explain what happened during the year that contributed to success i.e. PDSA cycles etc.</i></p> <p>Clinic nurses will continue to send reminders via mail, email, patient portal, phone calls for well care visits to patients/parents age 12-21. All planned activities continue. Of note: many patients age 18 and older have left the area to attend college and do not return for routine care.</p> <p><input type="checkbox"/> Target/Objective <b>Not Met</b></p> <p><b>Narrative</b> for Not Meeting Target: <i>Explain what happened during the year, why measure was not met, improvement activities, barriers, etc.</i></p> <p><b>Proposed Improvement Plan:</b> <i>Explain what your agency will do (differently) to achieve target/objective for next year.</i></p> <p><input type="checkbox"/> <b>Revised Work Plan Attached</b> (Please check if work plan has been revised)</p>	

As SFY21 performance measure outcome data for the adolescent well-care visit demonstrate, outcomes are variable among contracted CHCs (range of 38-71%) as illustrated by the graph below. MCH continues to encourage CHCs to monitor their performance measure data at least quarterly and to implement improvement activities throughout the year. In addition, MCH will continue to offer additional QI support (by phone, email and/or in person) to lower performing agencies and any agency requesting assistance.





By reviewing QI workplans, MCH staff are able to glean insight to the challenges experienced by CHCs including:

- Inability to schedule next annual visit while adolescent is in the office due to system only allowing for scheduling of appointments up to six months in advance;
- Inability to capture patients who have received an annual visit elsewhere;
- Inaccuracy of EMR data reporting.

In addition to the above described challenges included in QI workplans, MCH staff have also determined, during site visit chart audits, that CHCs are rendering appropriate clinical care, including consistent provision of recommended *Bright Futures* preventive services, may be classed as low performers for this measure as the measure specification and EMR data extraction systems will not count children who have received recommended services outside of the well-child visit.

### *COVID-19 Impact*

Since the onset of the pandemic, decreases in well-child visits have resulted in delays in appropriate screenings and referrals and delays in anticipatory guidance to assure optimal health, according to NSCH data presented at the beginning of the report. Pediatricians have adapted to provide appropriate elements of well exams through telehealth, and also implemented measures to provide in-person care as safely as possible. While outpatient visits to adult primary care physicians have almost rebounded to near pre-pandemic levels, pediatric visits have been a little slower to recover per anecdotal information from care providers. NH MCH has worked to address the need to increase access to pediatric care by partnering with Amoskeag Health to provide MCH and Primary Care in the school based setting which will begin in the 2022 school year.

<sup>[1]</sup> NH State Injury State Violence and Injury Prevention 5-year Plan, 2020-2025, <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/nh-vip-plan-2020-2025.pdf>, assessed on 6/1/2022.

<sup>[2]</sup> <https://www.percentage-change-calculator.com/calculate.php>

<sup>[3]</sup> [Krysten Godfrey Maddocks](https://www.parentingnh.com/know-the-rules-of-the-road-for-teen-drivers/), Parenting NH, "Know the rules of the road for teen drivers," July 22, 2019, <https://www.parentingnh.com/know-the-rules-of-the-road-for-teen-drivers/>, as read on 6/19/2020.

- [4] [RSA 265:79-c Use of Mobile Electronic Devices While Driving; Prohibition.](http://www.gencourt.state.nh.us/rsa/html/XXI/265/265-79-c.htm) <http://www.gencourt.state.nh.us/rsa/html/XXI/265/265-79-c.htm>, accessed on 6/28/2022.
- [5] Fischer, P. (2019, March). *Peer-to-peer teen traffic safety program guide* (Report No. DOT HS 812 631). Washington, DC: National Highway Traffic Safety Administration.
- [6] Section 186:11-IX-d Duties of State Board of Education, <http://www.gencourt.state.nh.us/rsa/html/XV/186/186-11.htm>, accessed on 7/25/2022.
- [7] WISQARS, National Center for Health Statistics (NCHS), National Vital Statistics System, accessed 5/23/2022.
- [8] Consumer Product Safety Commission, "Pool Safety", <https://www.poolsafely.gov/parents/safety-tips/>, accessed on 7/26/2022.
- [9] RSA Section 200:63 Head Injuries; Return to Learning Policy and Plan, <http://www.gencourt.state.nh.us/rsa/html/xv/200/200-63.htm>, accessed on 5/23/2022
- [10] The Mayo Clinic, "Traumatic Brain Injury," <https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557>, accessed on 6/2/2022
- [11] RSA 200:49-52, <https://www.accesssportsmed.com/news/governor-lynch-signs-nh-concussion-bill-into-law/>, viewed on 5/23/2022
- [12] Waltzman D, Womack LS, Thomas KE, Sarmiento K., "Trends in Emergency Department Visits for Contact Sports–Related Traumatic Brain Injuries Among Children - United States, 2001–2018." *MMWR Morb Mortal Wkly Rep* 2020; 69:870–874. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6927a4.htm>, viewed on 5/23/2022.
- [13] *Ibid.*
- [14] NH Annual Suicide Report, <https://theconnectprogram.org/articles/annual-reports/>, assessed on 6/5/2022.
- [15] Youth LGBTQ Suicide Risk, <https://www.thetrevorproject.org/research-briefs/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s/>, assessed on 6/5/2022.
- [16] NH NAMI, NH Suicide Prevention 2020 Annual Report <https://theconnectprogram.org/wp-content/uploads/2021/11/2020-Annual-Suicide-Report-November-24-2021.pdf>, accessed 5/23/2022
- [17] NH Annual Suicide Prevention Reports, <https://theconnectprogram.org/articles/annual-reports/>, assessed on 6/5/2022.
- [18] National Vital Statistics System (NVSS); accessed from Federally Available Data (FAD) Resource Document, April 1, 2022; Maternal and Child Health Bureau, Rockville, MD

## Adolescent Health - Application Year

**National Performance Measure #7.2:** Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19

### **Objectives:**

- Reduce the rate of hospitalizations for non-fatal injury from 135.7 (2016) to 74.0 (2023) per 100,000 adolescents ages 10-19 years
  - By 2023, increase the percentage of students reporting in the YRBS that they use seatbelts from 94.4 in 2017 to 98.2. This survey is only conducted in odd numbered years.
  - Reduce the rate of emergency department visits due to drowning from 8.1 per 100,000 children ages 10-19 in 2018 to 1.3 by 2023.
  - By 2023, reduce the percent of students who seriously consider suicide as noted in the YRBS survey from 18.4 in 2019, to 16.6 in 2023. This survey is only conducted in odd numbered years.
  - By June of 2023, schools in the State will have implemented the NH Concussion Law and/or will have written policies with at least 95% having a return to play policy and at least 75% having a “return to learn” policy.

### **Strategies:**

The [NH State Violence and Injury Prevention 5-year Plan, 2020-2025<sup>\[1\]</sup>](#), was released in April 2020. This plan focuses on addressing common risk and protective factors across all leading causes of injury in the State. Injury prevention topic areas in the State Plan that are pertinent to the MCH Title V Block Grant currently include:

- Drowning prevention for ages 0-19 by promoting the Consumer Product Safety Commission “Pool Safely” program.
- Promoting teen driver safety in high school students ages 15-19 by facilitating the peer-to-peer Teen Driver Safety Program.
- Preventing suicide in in ages 10-19 by working with NAMI-NH and the NH Suicide Prevention Council and providing an Annual Suicide Prevention Conference.
- Concussion prevention and response for those involved in physical activity up, to age 19 by working with the Brain Injury Association of NH (BIANH) to implement “Return to Learn” and “Return to Play” policies in NH schools.

The teen driver safety and suicide attempt topic areas have data to support the need to continue addressing them, and the momentum of programmatic activities that are underway. Some activities in the Title V MCH block grant also align and are leveraged with funding from the CDC’s Preventive Health and Health Services Block Grant (PHHS BG). Aligning all of these programs will help keep them on track and promote efficiency and effectiveness by reducing duplication of effort. Drowning prevention is a new activity started in 2021-2022, which has data to show the need for it to be addressed, and to track trends year-to-year to measure improvement.

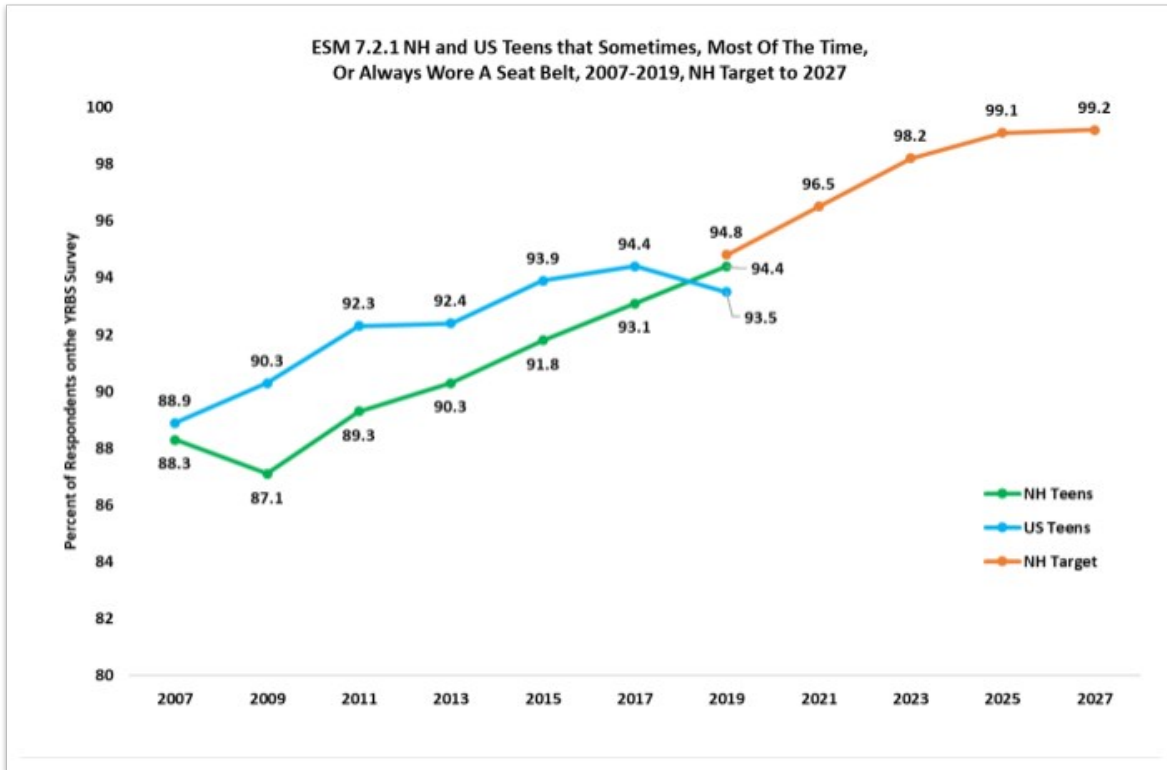
## **Adolescent Driver Safety**

**Evidence-Based or Informed Strategy Measure:** Percent of high school students who wear seatbelts (when

driving or as a passenger)

### **Objective**

By 2023, increase the percentage of students reporting in the YRBS that they use seatbelts from 94.4 in 2017 to 98.2.



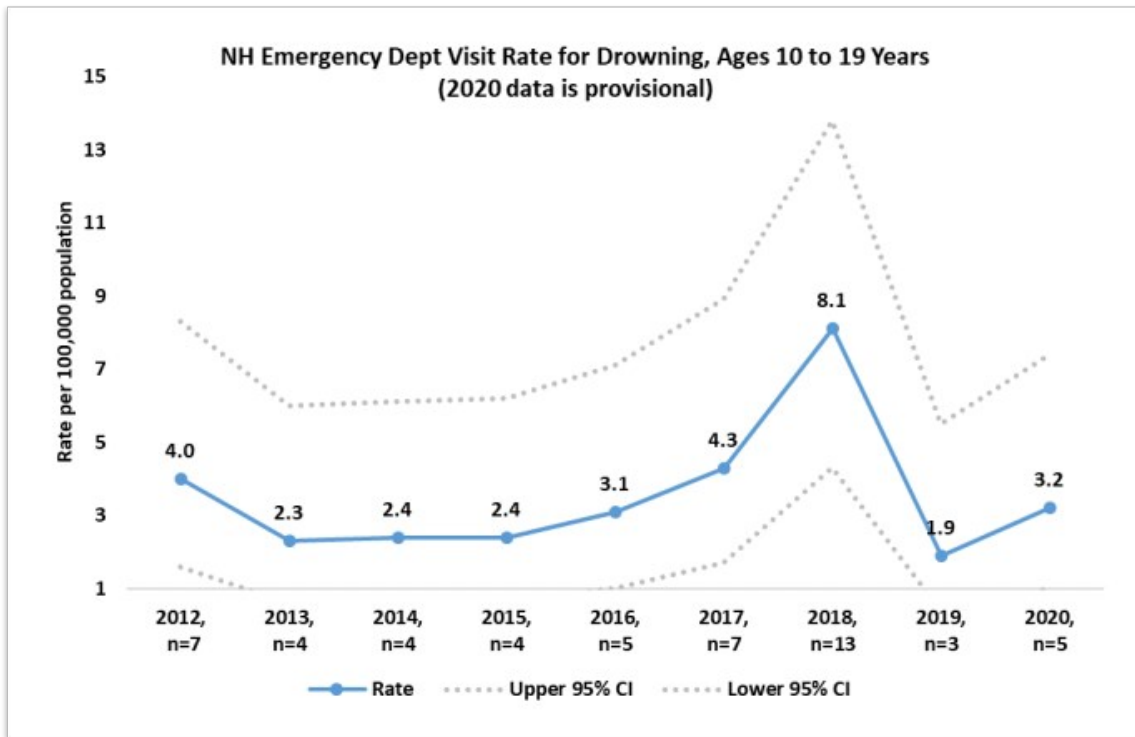
Source: US and NH YRBS, <https://www.cdc.gov/healthyouth/data/yrbs/results.htm>, accessed on 5/23/2022

### **Strategies:**

- Use of statewide partners to promote the Teen Driver Safety program and increase participation of high schools previously working with the program and new schools wanting to work with the program.
- Use of peer groups within schools to increase seatbelt usage and overall teen driving safety culture.
- Continue to explore virtual platforms to get messaging out to teen drivers.
- Increase utilization of teen driver website.
- Increase parental participation and understanding of teen driving issues.

### **Drowning Prevention**

**Evidence-Based or Informed Strategy Measure:** the rate of emergency visits for drowning per 100,000 children ages 0-19



NH Resident Drowning Deaths by Place, Ages 0-19, 2012 to 2021	
Place	Count
Drowning in a bathtub	2
Drowning in a swimming pool	4
Drowning in natural water	10
Drowning related to watercraft	1
Unspecified drowning and submersion	2
<b>Total</b>	<b>19</b>

Ed.: Number of cases among 10-19 too small to report

Data Source: NH Vital Records Death Certificate Data, NH DHHS, HSDM, June 2022

The methodology for querying drowning related emergency department visits and drowning deaths is detailed in the “State Injury Indicators Report: Instructions for Preparing 2020 Data.”<sup>[2]</sup> Cases include NH residents drownings that occurred in NH in order to be able to include the most recent year of data available in these data set, which are incomplete-missing cases of NH residents who drowned out of state.

**Objective:**

Reduce the rate of emergency department visits due to drowning from 8.1 per 100,000 children ages 10-19 in 2018 to 1.3 by 2023.

**Strategy:**

In preparation for the 2020 MCH Block Grant, the IPP discovered that drowning fatality is now the leading cause of injury death in NH children ages 10-19 years. Between 2020 and 2023, the IPP will provide the Consumer Product

Safety Commission (CPSC) "[Pool Safely](#)" information to parents and children during at least one public event per year. In NH, drowning most frequently occurs in natural bodies of water. Although the "Pool Safely" program focuses on swimming pools, the messaging related to attending swimming lessons and always having an adult be actively observant when children are in or near the water, also translates to lakes, rivers, and oceans. Swimming lessons can start with infants, and can occur every year until a child is a proficient swimmer. Teens and adults should be encouraged to take first aid and CPR classes.

## **Suicide Prevention**

**Evidence-Based or Informed Strategy Measure:** the percent of high school students who report seriously considering suicide (from the YRBS survey)

### **Objectives:**

By 2023, reduce the percent of students who seriously consider suicide as noted in the YRBS survey from 18.4 in 2019, to 16.6 in 2023. This survey is only conducted in odd numbered years.

### **Strategy:**

Over the last few decades, NH has built a robust infrastructure for suicide prevention and postvention coordinated by several key partners, including the NH branch of the National Alliance for Mental Illness (NAMI), the State's Community Mental Health Centers, the State's Disaster Behavioral Health Response Team (DBHRT), the State's Integrated Delivery Networks (IDNs), the State's Regional Public Health Networks, the State Suicide Prevention Council (SPC), the Youth Suicide Prevention Assembly, and the Office of the Chief Medical Examiner (OCME). The mission of the State Suicide Prevention Council (SPC) is to reduce the incidence of suicide in NH by accomplishing the goals of the NH Suicide Prevention Plan, which are to:

- 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.

The following strategies of the MCH-funded Injury Prevention Center will lead to better support for adolescent students who have suicidal ideation:

- Facilitate an annual Suicide Prevention Conference and extend invitations to high school staff.
- Support the suicide prevention goals of the NH Suicide Prevention Council.
- Publicize and distribute information and resources throughout NH communities, families and school districts in support of:
  - The I Care NH mental health and wellness initiative;
  - 9-8-8 national suicide prevention lifeline expansion project;
  - NH's suicide prevention council's strategic plan; and
  - NAMI NH's Connect Suicide Prevention and Postvention Programs

## **Concussion Prevention**

**Evidence-Based or Informed Strategy Measure:**

Students reporting they had a concussion from playing a sport or being physically active on the YRBS survey will be reduced from 14.4% in 2017 to 13.5% in 2023 to show a statistically significant reduction.

Had A Concussion From Playing A Sport Or Being Physically Active (one or more times during the 12 months before the survey) New Hampshire, High School Youth Risk Behavior Survey			
Find out if there is a statistical difference between two years. Select two and activate 'Compare Two'.		<b>COMPARE TWO</b> >	
		<input type="checkbox"/>	<input type="checkbox"/>
	<b>Year</b>	<b>2017</b>	<b>2019</b>
<b>Sex</b>			
Total		14.4 (13.6-15.4) 11,891†	14.7 (14.1-15.4) 13,534

**Objectives:**

By June of 2023, schools in the State will have implemented the NH Concussion Law and/or will have written policies with at least 95% having a return to play policy and at least 75% having a “return to learn” policy.

**Strategy:**

MCH will work with the Brain Injury Association of NH (BAINH) to collect data, during the 2022-2023 school year, from all NH high schools regarding Return to Play and Return to Learn policies. The BAINH will continue to provide information and education to NH schools and guidance for Return to Play and Return to Learn policy development.

The Teen Driver Safety program is related to concussion prevention in that preventing motor vehicle crashes will prevent some head injuries. The MCH program also promotes wearing a helmet to prevent head injuries while riding a bicycle, skateboard, motorcycle, snowmobile, or all-terrain vehicle; also wearing head protection when batting or running bases, skiing, and skating, riding a horse, or playing a contact sport.

\* \* \* \* \*

**National Performance Measure #10:** Percent of adolescents, aged 12-17, with a preventive medical visit in the past year

**Evidence Based or Informed Strategy Measure:** Percentage of adolescents aged 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year

**Objectives:** Increase the percentage of adolescents aged 12-21 who have had a preventive medical visit at the MCH-funded Community Health Centers (CHCs) from a baseline of 53% in SFY19 to 64% by the end of 2025.

**Strategies:**

**1. Enhance capacity of CHCs to improve access and quality of adolescent services by:**

- Overseeing the new MCH and Primary Care School-based Setting grant, for behavioral and acute medical care
- Continuing to establish performance measures that align with national guidelines and promote *Bright Futures* recommendations
- Promoting advancement toward HP2030 target (82.6%) for adolescent well care visit by ensuring contracted CHCs utilize Quality Improvement (QI) processes to increase the percentage of adolescents who have a preventive medical visit
- Collecting and analyzing performance measure outcome data from CHCs; providing data results and feedback to CHCs for comparison
- Providing education, resources, and QI support through newsletters, Lunch & Learns, and site visits
- Providing technical assistance through group or 1-on-1 contact(s) via face to face meetings, remote meetings (e.g. Zoom), email and/or telephone to review, discuss and provide recommendations to address agency's identified needs.

**2. Collaborate and Build partnerships by:**

- Continuing to network with other State Adolescent Health Coordinators including attending the National Network of State Adolescent Health Coordinator Meetings
- Continuing to work with public and private partners through the NH Pediatric Improvement Partnership
- Statewide contracting with CHCs and provision of oversight on primary care services
- Establishing and using various mechanisms to inform providers and the public about adolescent preventive services via social media, community events, newsletters, etc.
- Looking for opportunities to engage youth in program development and review

**3. Increase Educational Opportunities for the new Child & Adolescent Health Nurse Coordinator**

- In 2021, the MCH section hired a new Child/Adolescent Health Nurse Coordinator to support programmatic initiatives to improve child and adolescent well-being. This position is 100% funded by Title V.
- The Child /Adolescent Health Nurse Coordinator also serves as the Coordinator for the Child Fatality Review Committee and has been collaborating and working with various committees and community partners to participate in primary prevention activities and to help improve the overall health of NH's children.
- The Child /Adolescent Health Nurse Coordinator has expressed an interest in completing the "Train the Trainer" workshop for the ASQ (Ages & Stages Questionnaire) and plans to take the training in October, in hopes of providing training regarding the use of the ASQ to Community Health Center staff. She has also expressed an interest in attending the annual conference on Adolescent Health and will be attending this in August to bring back information to MCH and health care providers to help improve initiatives to improve the overall health and wellbeing of NH adolescents and young adults .

MCH will additionally continue to:



- Contract with CHCs for the provision of family planning and primary care services. MCH will continue to provide contract monitoring which includes performing site visits, reviewing agency data and work plans, and providing feedback to agencies to ensure access to care and improve quality of adolescent services.
- Collaborate with NH PIP, CHCs and other community partners to promote access to quality adolescent care and find ways to leverage resources to reduce missed opportunities and increase reimbursement for services.
- Promote AAP *Bright Futures* guidelines by disseminating information and resources for health professionals about adolescent health and preventive services.
- Expand capacity of the Pediatric Mental Health Care Access Program to support primary care integration of pediatric behavioral health.
- Develop social media campaigns to disseminate information and resources to the public about adolescent health and preventive services.

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<sup>[1]</sup> NH State Injury State Violence and Injury Prevention 5-year Plan, 2020-2025,

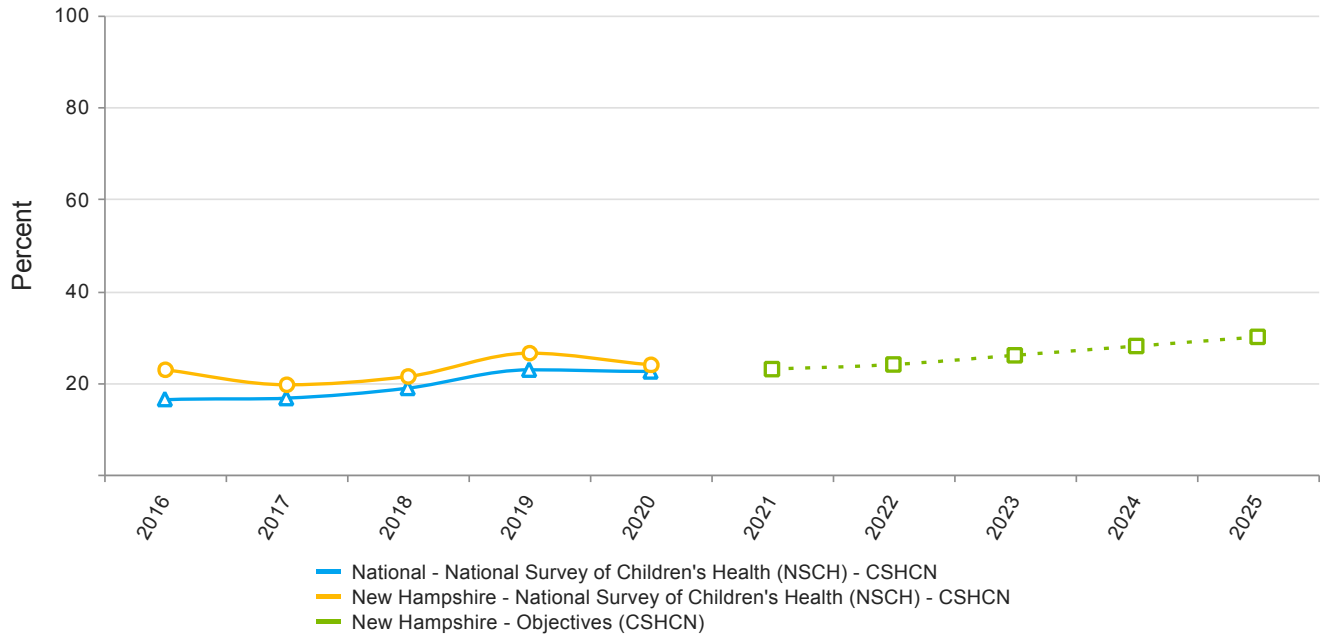
<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/nh-vip-plan-2020-2025.pdf>, assessed on 6/1/2022.

<sup>[2]</sup> CDC, "STATE INJURY INDICATORS REPORT: Instructions for Preparing 2020 Data", [State Injury Indicators Report: Instructions for Preparing 2020 Data \(cdc.gov\)](#), assessed on June 6, 2022.

## Children with Special Health Care Needs

### National Performance Measures

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care**  
**Indicators and Annual Objectives**



### NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2019	2020	2021
Annual Objective			23
Annual Indicator	21.5	26.4	23.8
Numerator	5,261	7,163	7,240
Denominator	24,422	27,179	30,446
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	26.0	28.0	30.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 12.1 - Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program**

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	
Annual Objective			70	
Annual Indicator			22.2	
Numerator			8	
Denominator			36	
Data Source			SMS database application	
Data Source Year			2021	
Provisional or Final ?			Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	30.0	35.0	40.0

**State Performance Measures**

**SPM 2 - Percentage of families enrolled in the Bureau for Family Centered Services (BFCS) who report access to respite**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	62.3	63	70	70	72
Annual Indicator	62.3	67.7	67.7	67.7	67.7
Numerator	264	126	126	126	126
Denominator	424	186	186	186	186
Data Source	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey
Data Source Year	2016	2018	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	72.0	74.0	74.0	76.0

## State Action Plan Table

### State Action Plan Table (New Hampshire) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Improve access to needed healthcare services for all MCH populations

#### NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

#### Objectives

- By July 1, 2021, increase the percentage of CSHCN enrolled in Title V programs, ages 14–20, who completed a Transition Readiness Assessment Questionnaire (TRAQ) in the past year by 5%
- By July 1, 2021, 60% of CSHCN enrolled in Title V programs, ages 14-20 and/or their family caregiver, will identify at least one transition goal in consultation with their Health Care Coordinator
- By July 1, 2022, 70% CSHCN enrolled in Title V programs, ages 14–20 and/or their family caregiver, who identified a transition goal in the previous year, will meet at least one of the previous year's goals

#### Strategies

Health Care Professional Workforce Development

Other workforce development including Title V staff, family support, MCOs, youth, families, etc.

Care coordination

Communication and social media

Measurement and assessment

#### ESMs

#### Status

ESM 12.1 - Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program      Active

#### NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (New Hampshire) - Children with Special Health Care Needs - Entry 2

Priority Need

Increase family support and access to trained respite and childcare providers

SPM

SPM 2 - Percentage of families enrolled in the Bureau for Family Centered Services (BFCS) who report access to respite

Objectives

To increase the percentage of families reporting access to respite care when needed, from 62% to 75% on the BFCS Needs Assessment and Satisfaction Survey, by 2025

Strategies

Re-determine the needs of families regarding respite

Collect and analyze data to support policy development and funding for respite

Review Relias trainings to support updated best practice standards

Re-engage the Caregiver Integration Team and assess the capacity to continue with environmental scan and strategic planning

Include respite screening and access in Quality Improvement projects

Attend the ARCH national respite conference

Assess the capacity to influence other sectors necessary to achieve goals

## Children with Special Health Care Needs - Annual Report

### National Performance Measure #12:

Percent of adolescents with and without special health care needs, ages 12–17, who received services necessary to make transitions to adult health care.

**ESM 12.1:** The percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program.

### Objectives:

- By July 1, 2021, increase the percentage of Children with Special Health Care Needs (CSHCN) enrolled in Title V programs, ages 14–20, who completed a TRAQ in the past year, by 5%.
- By July 1, 2021, 60% of CSHCN enrolled in Title V programs, ages 14–20 and/or their family caregiver, will identify at least one transition goal in consultation with their Health Care Coordinator.
- By July 1, 2022, 70% of CSHCN enrolled in Title V programs, ages 14–20 and/or their family caregiver, who identified a transition goal in the previous year, will meet at least one of the previous year's goals.

### Strategies:

- Health Care Professional Workforce Development
- Care Coordination
- Communications and Social Media
- Measurement and Assessment

### Data Analysis

BFCS has used the SMS and the Partners In Health (PIH) database to collect data related to care coordination and family support since 2015. Since then, it has become the place to store TRAQ-related information as surveys are distributed, completed, and goals are developed, measured and monitored. Notation of goals became a viable option in the care management section of the database, which allowed health care coordinators to collect data about progress in achieving goals and in transitioning youth to adult health care providers. Health care coordinators identified the need for clear instructions and training in order to better document information for reporting on transition goals.

Since 2020, the system has allowed health care coordinators to record transition encounters as “TRAQ sent” and/or “TRAQ completed.” A system update was planned for FY2021, to add options to record “Transition goal identified” and “Transition goal met.” However, due to staff turnover and loss of Department of Information Technology (DoIT) support, no new releases were possible.

Using the available data in the SMS and PIH database, on July 1, 2021, BFCS identified, 180 of the 284 (63%) Youth with Special Health Care Needs (YSHCN) enrolled in Title V programs, ages 14–20, completed a Transition Readiness Assessment Questionnaire (TRAQ) in the past year (7/1/20–6/30/21). This represents a substantial increase in TRAQ completion and recording from previous years.

NH Family Voices (NHFV), through their last year of the Medical Home Project contract (MHP), utilized Salesforce to track encounter and training activities, and captured data on two issues that relate to healthcare transition. Data reflected 235 families and 205 professionals received information or training regarding adolescent transition issues

by all NHFV staff, demonstrating benefit of the project during FY2021. In addition, the NHFV website acted as a project repository, with information regarding health care transition having 150 hits related to Health care transition page and 225 related to health care transition materials.

## **Systems Building**

In the needs assessment, BFCS identified and addressed the need for improvements to raise awareness of youth and their families that maintaining health and continuity of care are important to attaining broader adult goals. The following strategies were used to address this need in FY2021.

### ***Health Care Professional Workforce Development***

Although BFCS had planned to add language to the Supplemental Job Descriptions, (SJDs) for health care coordinators to include specific transition tasks, these updates were not realized during FY2021. However, the topic of health care transition was discussed during interviews with potential new hires, supervision, and annual evaluations. During the previous year, it became an expectation that the topic of health care transition be addressed with youth beginning at age 14 years. Additionally, each health care coordinator was required to include a TRAQ survey with each yearly application renewal, starting at or shortly after a child's fourteenth birthday. Youth and/or their parents/guardians completed and returned the TRAQ with their updated application. In FY2021, a requirement was added for coordinators to provide follow up consultation with the youth/family following the completion of a TRAQ to discuss and set a goal related to health care transition (HCT). Subsequently, goals were incorporated into individual's care plans.

Part of the FY2021 plan focused on providing support for transition to adulthood in both the pediatric and adult health care settings. This was achieved by maximizing access to care coordination in combination with improved staff training on family assessments, family centeredness, cultural competence and implicit bias. Additional training was provided to staff, in accordance with "Got Transition"™ recommendations.

In their FY2021 Annual Report, NHFV reported the shift to virtual trainings because of the pandemic, presented greater access for families, but also lower rates of participation than expected at times, with youth and families citing "Zoom fatigue" as a factor. Despite this fatigue factor, training opportunities were made available because attendees expressed satisfaction and value.

NHFV project staff provided technical assistance and training to BFCS programs and leveraged existing partnerships to infuse the topic of health care transition into broader youth transition initiatives. They also continued to support PIH family support coordinators and BFCS health care coordinators (HCC) regarding the implementation of health care transition work in their programs. Staff conducted a "Transition 101" training for PIH coordinators in October of 2020, with 13 staff in attendance.

Transition toolkits, developed as part of the contract with NHFV, were provided to new staff, each containing both hard copies and electronic versions (on a thumb drive) of all materials. The MHP Director has an active role in HCC monthly meetings, supporting staff development and quality improvement opportunities in an ongoing manner. To assure ongoing HCC satisfaction with meetings, HCC were asked to complete an anonymous meeting evaluation via Survey Monkey, with staff from the MHP compiling results and providing feedback to the Program Manager. Survey results indicated that this collaboration increased coordinator satisfaction with meetings.

The Parent Information Center (PIC), [picnh.org](http://picnh.org), offered a series of virtual trainings focused on issues related to transition. Each parent "chat" featured a different topic, with a presenter providing 15-20 minutes of content and then allowing for group discussion. The MHP staff offered a session focused on health care transition in October of 2020, with eight of 11 registered participants in attendance.



The MHP and PIC staff shared a virtual room during a transition resource fair hosted by Pinkerton Academy, presenting tools to support effective transitions in education and in healthcare. Seven family members and four professional members attended.

In addition to offering direct training, the MHP was able to support attendance at an annual conference, Baylor College of Medicine Chronic Illness and Disability Conference: Transition from Pediatric to Adult-Based Care. In October 2020, this event was held virtually due to the pandemic. The markedly decreased cost of attendance allowed the MHP to support multiple staff to participate; including the staff person overseeing PIH training; the YEAH Council Coordinator, two MHP staff and two nurses representing both HCC and PIH.



NH Medicaid's contracts with Managed Care Organizations (MCOs) included a requirement to work with BFCS to develop and offer provider training related to the needs of Children and Youth with Special Health Care Needs (CYSHCN). In FY 2021, BFCS engaged NHFV to work with the State's MCOs to develop this curriculum, in alignment with evidence based/informed practices. NH Medicaid office provided NHFV with contacts within each MCO and held an initial meeting in November of 2020, with additional meetings monthly from January–June 2021. NHFV staff worked to fulfill this request in part by drafting a brochure for MCOs to use with families of adolescents regarding health care transition. They also arranged for and obtained departmental approval for two training opportunities for MCOs to market to providers. However, marketing efforts were unclear and the level of engagement ultimately disappointing.

BFCS continued to support statewide transition readiness efforts via the MHP contract with NHFV through June 30, 2021. As the State's agency for administering the Title V Block Grant for CYSHCN, there is a long history of BFCS supporting the full implementation of the medical home concept, including the focus on patient/family engagement and health care transition.

The MHP promoted a health care transition policy for all health care practices, whether it outlines the transition of care from a pediatric practice to an adult practice, or from a pediatric model of care to an adult model of care within a family practice setting. An advisory group of diverse stakeholders including youth and family participants, as well as representation from BFCS, NHFV, and primary care practices, provided guidance to the MHP. Efforts to further enhance membership with a commercial insurance representative and an additional primary care champion were not successful due to the COVID-19 Public Health Emergency (PHE) and subsequent state restrictions on meetings, along with limited capacity of staff to participate in new activities. MCOs have not been able to meet during non-office hours and families prefer evening meetings, making it difficult to find a time when all are able to join. This will continue to be a goal in the future.

The MHP staff developed and maintained a registry of primary care practices, identifying those who have adopted transition policies. Materials from Got Transition were shared with practices and additional support was offered to increase the development and implementation of policies. The demands of the PHE shifted activities within practices, and as such, the registry data remained unchanged from 2020. A registry update and data validation will occur in 2022, in recognition that some practice locations may have been impacted during the pandemic. This data will be included in next year's annual report (FY2022).



BFCS continued to support the state's Transition of Community of Practice (CoP) by committing one Health Care Coordinator to participate and represent YSHCN in locally held meetings as well as at the annual Transition Summit. In addition, participation is a requirement of the MHP contract, which NHFV met with ease. The BFCS Health Care Coordinator also facilitated team meetings as needed and participated in the Summit Planning Committee, virtual school fairs, and conferences. The Summit is typically a statewide opportunity for training, collaboration and networking focused on post-secondary outcomes for students. The November 2020 Summit presentations were focused on topics of Collaboration, Transition for Specific Populations, Supported Employment or Skill Development Activities and Programs, and Transition Related Initiatives.

#### **Title V Specific Activities**

Throughout FY 2021, BFCS staff worked to increase knowledge and the application of evidence-based- and informed health care transition approaches through education and training to health care professionals. This was done through continued support for NHFV to provide trainings for MCOs that included transition of youth from pediatric to adult health care. The CYSHCN Director and Clinical Program Manager continued to work with Medicaid on projects related to MCO contract oversight, quality improvement and evaluation in order to assure access to and continuity of care. The PHE halted the monthly meetings that had been happening with all three NH MCO's and Medicaid. It is undetermined when these sessions, if ever, will resume. However, the process of promoting the Standards for Systems of Care for CYSHCN 2.0 specifically those that address facilitating care transitions and transition to adult care remained a focus of the Bureau.

BFCS also incorporated evidence-informed health care transition for YSHCN into care coordination. There was emphasis on educating staff on how to evaluate responses to Transition Readiness Assessment Questionnaire (TRAQ) surveys, in order to identify resources and education needed by youth and their families. In partnership with NHFV and the designated DoIT staff, BFCS planned to train all BFCS Health Care and Family Support Coordinators to support the distribution, data collection, and the expectations for consultation related to TRAQ. Because of DoIT limitations, staff turnover and a hiring freeze, training was delayed until FY2022.

BFCS developed and established program guidance for coordinators that required all CYSHCN enrolled in Title V programs, ages 14-20 and/or their family caregiver, to receive an annual TRAQ survey following a consultation that includes identification of a goal and review of progress toward meeting the previous year's goal. Ongoing training was provided in conjunction with the implementation of this requirement.

The MHP provided BFCS staff, contractors and families with training and information about the TRAQ being more than a tool for assessment of the youths' abilities and needs. As a secondary function, this document serves to become a teaching mechanism for increasing family knowledge and the catalyst for discussions around transition issues, decisions and processes. It can be the start of new conversations and the initiation of new and real choices.

The health care coordinator has had an active role in assuring that the health perspective is at the forefront of transition activities for youth with disabilities as they move into the adult service system. Through her participation, at state and local levels, the Coordinator continued to expand her ability to assist youth and their families' transition from youth to adult health care services and independence.

### **Measurement and Assessment**

In order to measure and assess the success of this new guidance, BFCS worked with DoIT to create a new data indicator and added it to the web-based application used by coordinators to collect data. The proposal included a feature in which coordinators check a box when a YSHCN identifies a goal during consultation and another when they achieve a goal during a transition planning encounter. The resulting data supplemented the information collected by BFCS relative to this transition measure.

Despite training, there were a number of challenges with data collection related to health care transition. Since the TRAQ survey was often sent out with requests for annual applications by administrative support staff, it was not always recorded as being "sent." In addition, if it was completed during an encounter, the data was often entered as "completed" assuming that "sent" was understood. BFCS and the data team will reconsider the benefit of this data point in the future. The inability for coordinators to provide home visits, due to the PHE, further complicated coordinators' ability to discuss the importance of this questionnaire and its value with families. Some coordinators reported reluctance to ask a family to complete the TRAQ on a yearly basis thinking it might seem insensitive, if it is evident that their child will never be capable of attaining specific goals. Leadership has been educating coordinators on the importance of the TRAQ not only for the youth, but also for the entire family in preparing for emergencies, transition of insurances, and seeking new adult services and health care providers at age 21.

### **Communication and Social Media**

NHFV offered communication tailored for YSHCN and their families including the Health Care Transition webpage <https://nhfv.org/projects/initiatives/health-care-transition/>. Resources were made available promoting health care transition information through a variety of social media platforms including Facebook, Pinterest, YouTube, and Twitter that are all available as links on the webpage [Resources - New Hampshire Family Voices \(nhfv.org\)](#).



In response to the PHE and subsequent restrictions on in-person activities, the Parent Information Center and NHFV established Transition Chats on Zoom in order to remain connected and available to families. Using this platform, a Transition Consultant provided a unique opportunity for families and students to learn about topics that included transition assessments, planning for post-high school, student-led IEPs and goal planning.

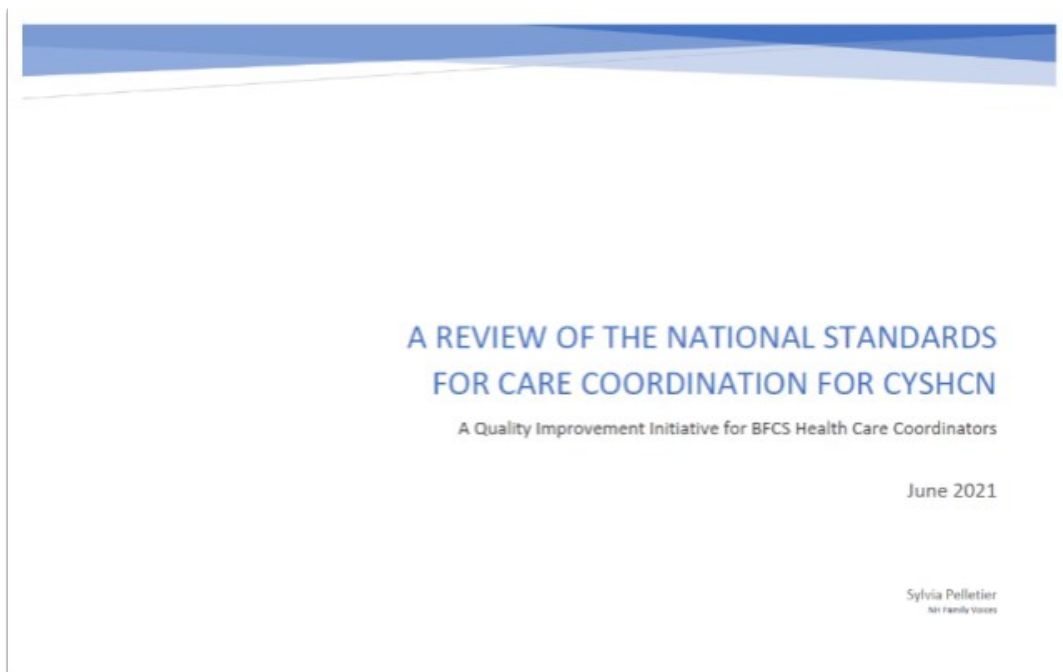
### **Materials**

During the reporting period, MHP staff drafted a brochure for use by MCOs and contributed two articles to issues of Pass It On, NHFV's popular newsletter. In addition, project staff developed tools to support health care and family support coordinators in their efforts to support youth and families with health-related skills building and health care transition, including updated flyers about health management apps, medication and provider lists. These tools will be shared in an updated toolkit once reviewed by workgroup members and adjustments made as necessary.

- Pass It On, fall 2020 issue included an article focused on the medical home concept and the patient and family experience of care, with highlights from the Medical Home Needs Assessment conducted in 2019.
- Pass It On, Spring 2021 issue featured an article dedicated to Health Care Transition, with a focus on strategies to improve medication management.
- Health care transition brochure drafted for MCO use will be adapted for use with youth and families within BFCS programs.

### Care Coordination and Quality Improvement

Continuous quality improvement in providing access to health care coordination for CYSHCN and their families is a priority for NH's Title V programs for CSHCN. In FY2021, BFCS embarked on a redesign journey. Led by the NHFV Associate Director, health care coordinators conducted a review of their work in relation to the National Standards for Care Coordination for CYSCHN (2020). The purpose of this effort was to identify where health care coordination efforts within BFCS met the Standard and where opportunity for improvement might exist. The hope was that the collected data might then inform future strategic planning initiatives. While this effort occurred during a pandemic, while the workforce was stretched, their evaluation of their coordination efforts was not specific to this point in time; and their monthly discussions validated that they were contemplating the full scope of their work.



The methodology used by NHFV staff included the use of Survey Monkey to capture feedback, after developing a survey for each domain and sending these out for review and consideration. Coordinators rated elements as not met, partially met, mostly met or fully met. They additionally provided either an example of how it was met, or a change that was needed to allow it to be met more fully. Data collection occurred from December of 2020 through the end of February 2021.

Staff from NHFV staff compiled the results, which were shared with coordinators at monthly meetings, as data collection progressed. Following the collection of all responses to all domains, coordinators were asked to engage in

priority setting at the April 2021 meeting. NHFV then compiled priorities, in light of frequency with which specific improvements were cited. Priority recommendations were developed for areas they had identified as either HIGH or HIGH-MEDIUM in nature, and presented to BFCS Leadership in June 2021.

It is important to note that none of this would have been possible without the careful, thoughtful contemplation of each health care coordinator. Coordinators provided detailed responses in SurveyMonkey and actively participated in discussion throughout this process. Their commitment to the work they do on behalf of children and families and their passion for doing it well was apparent.

Finally, in FY2021, BFCS developed an RFP to procure a new contract for FY2022 focused on providing support for Transition to Adulthood for both pediatric and adult health care settings. As the selected contractor, NHFV developed an action plan, which identified the following strategies:

- Maximize access to care coordination either via practice-based resource or in collaboration with external coordinators.
- Staff training based on staff self-assessments and regarding patient and family-centeredness, cultural competence, and implicit bias as part of ongoing staff development.
- BFCS /PIH Transition Readiness project review from 2020 and additional training and provide TA as needed
- Support quality assurance and monitoring efforts that advance transition activities and enhance access to care relative to Medicaid Managed Care contracts
- Facilitate incorporation of the evidence informed six core elements of transition into health care practices, in accordance with Got Transition™ recommendations – through practice-based technical assistance

\* \* \* \* \*

**State Performance Measure #2:**

Percentage of families enrolled in BFCS programs who report access to respite

**Objective:**

To increase the number of families reporting access to respite care when needed from 62% to 75%, on the Bureau for Family Centered Services Needs Assessment & Satisfaction Survey, by 2025.

**Strategies:**

1. Explore options to increase public awareness of, access to, and availability of respite care providers including those for families of CYSHCN with emergency respite needs
2. Collect and analyze data to support policy development and support for respite
3. Support updated competency-based training modules for respite care providers
4. Maximize the opportunity for intra-agency collaboration through the Department-wide Caregiver Integration Team (CIT).
5. Facilitate availability of respite resources for families through [NH ServiceLink](https://www.servicelink.nh.gov/), <https://www.servicelink.nh.gov/>.
6. Screen families and caregivers of CYSHCN for respite care needs and make them aware of available respite services in their community

7. Inform and assist families to access available respite services, which may be provided, in a variety of settings, on a temporary basis, including the family home, respite centers, or residential care facilities.
8. Explore transportation as a barrier to accessing out-of-home respite.

### **Data Analysis**

NH collected and analyzed a limited amount of data to support policy development and support for respite when the activities of the CIT and the environmental scan and/or needs assessment of the supply and demand for respite for CSHCN were paused, due to the COVID-19 public health emergency (PHE). A 41% vacancy rate and hiring freeze impeded BFCS' ability to complete a bi-annual survey and needs assessment 2021. Program data indicated that 1,150 families had at least one encounter during the reporting period, of which approximately 13% focused on respite as a need. Information and Referral (I&R) records indicate approximately four percent of calls were about respite availability. Although this information does not indicate whether respite was available for those in need, it does imply that families continue to have a need for respite.

Program Managers worked with Health Care and Family Support Coordinators to develop and implement screening protocols to assure that each family is assessed for respite needs. The Partners in Health (PIH) Program Manager provided and reviewed program policy and updated the program manual to assure that each family is assessed for respite needs. In addition, she provided training on uniform assessment protocols that include using a standardized "Family checklist" annually and more often as needed, to help determine families' need for respite and provide resources to support access to respite. Health Care Coordinators also standardized their process by reviewing families' need for respite services during intake, at annual application updates, and when reviewing care plans. Health Care and Family Support Coordinators also shared information about the availability of respite resources for families through [NH ServiceLink](#).

BFCS utilizes SMS and PIH applications, to meet the needs of program and contract staff who provide services for CSHCN and their families. Uses include annual application and reporting for the Title V Block Grant and the ACF Social Services Block Grant (SSBG), 5-Year Title V Needs Assessment, contract management, subrecipient monitoring, provider payment, and family reimbursement for non-covered medical expenses. The systems are also used to manage program application, intakes and eligibility determination, service authorization, care coordination, record-keeping & retention, and monitoring worker caseloads.

The SMS and PIH applications have been maintained by the NH DoIT Application Systems Development (ASD) and are accessed thru the secured Citrix portal for contracted staff and via a network logon/desktop icon for State staff.

The application is programmed in PowerBuilder, which is a language that will be unsupported in the near future due to DoIT staff turnover. The SMS and PIH application has exceeded its lifecycle and the software that SMS and PIH is comprised of is becoming obsolete. Newly hired staff do not have the knowledge of this system and as DHHS modernizes its systems, DoIT is not seeking to replace that knowledge with new staff.

The lack of substantive data and analysis capacity were identified as gaps in BFCS and partially addressed by hiring a Data Analyst and embarking on a Lean Project to review the best practices for program and database management. Although these successes resulted in a slightly increased capacity for data analysis, the lack of DoIT support for the current technology delayed progress into FY2022.

### **Systems Building**

BFCS attempted to maximize the opportunity for intra-agency collaboration through the Department-wide Caregiver Integration Team (CIT) however; all special projects were put on hold due to the PHE. Turnover at the Leadership level resulted in the loss of executive-level sponsorship and the position of the Director of DLTSS was not filled until February 2022.

## **Title V Specific Activities**

BFCS continued to provide free, confidential Family-To-Family services to families and professionals caring for children with chronic conditions and/or disabilities through a contract with NH Family Voices (NHFV). Through participation in meetings with state agencies and local and professional organizations, including the Bureau of Developmental Services (BDS) Communication Committee and the Council for Youth with Chronic Conditions, the BDS Redesign Committee ensured that the needs of CYSHCN and their families were adequately represented in system design and service delivery including for respite services.

Due to the ongoing COVID-19 emergency, families were less likely to be seeking in-home assistance such as respite, with the exception of skilled nursing care. Staff continued to promote options for respite through I&R calls, care coordination, family support, and participation in councils and committees. BFCS also explored options to increase public awareness of, access to, and availability of respite care providers for families of CYSHCN like the NH Family Caregiver Support Program which offers respite grants for grandparents and other relative caregivers who are 55 years of age and older.

Previous years' needs assessment activities indicated that the lack of a trained and well-compensated workforce was a significant problem for families seeking respite from the day-to-day requirements of caring for a child with special health care needs. In 2021, efforts to update competency-based training modules and review training materials, was pre-empted by COVID-19 PHE priorities.

BFCS continued to address the areas identified as "unmet needs" for respite through flexible funding options, designated campership/respite funds, and the exploration of family strengths and community supports.

In FY2021, BFCS engaged families and family organizations, including NHFV, in the planning process and analysis of its Information and Referral services in order to better inform and assist families to access available respite options available in a variety of settings, on a temporary basis, including the family home, respite centers, or residential care facilities.

## Children with Special Health Care Needs - Application Year

### National Performance Measure #12:

Percent of adolescents with and without special health care needs, ages 12–17, who received services necessary to make transitions to adult health care.

**ESM:** The percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program.

### Objectives:

- By May 15, 2023, increase the number of pediatric health care practices that adopt transition policies from a baseline 31 providers (out of 44 respondents to the survey) identified in May 2022.
- By June 30, 2023, 70% of CSHCN enrolled in Title V programs, ages 14–20 and/or their family caregiver, who identified a transition goal in the previous year, will meet at least one of the previous year's goals.

### Strategies:

- Communications and Social Media
- Health Care Professional Workforce Development
- Measurement and Assessment Data Improvements
- Other Workforce Development including Title V staff, family support, MCOs, youth, families, etc.
- Transition Readiness Assessment Questionnaire

### Data Analysis

Effective transitions from pediatric to adult health care promotes continuity of developmental and age-appropriate health care for youth with special health care needs (YSHCN). However, several years of national, state and community studies continue to indicate that most YSHCN and families may not receive the support they need in the transition from pediatric to adult health care. The 2019-2020 National Survey of Children's Health (NSCH) identified that 23.8% of NH's children with special health care needs received services necessary for transition. Although this is down from 27.8% in the 2017-2018 NSCH, it still slightly exceeds the nationwide rate of 22.5% for YSCHN.<sup>[1]</sup>

BFCS has been and will continue to use the SMS and PIH databases to collect data, and monitor program efforts regarding health care transition. Currently, the system allows all coordinators to record transition encounters as "TRAQ sent" and/or "TRAQ completed." It also allows goals to be entered and tracked for reporting. Although a system update is not an option given lack of DoIT support for the application, a relatively new DoIT Business Analyst will continue to work with BFCS' Data Analyst, to make modifications to data reports that will enable staff to improve reporting on transition-related data in FY2023. Users and program managers have identified the need to standardize data entry. A user's guide and corresponding training will be developed and ready for implementation by all contract and state staff effective July 1, 2023.

While several concerns have been raised about the integrity of the existing data and reporting functionality, funding will need to be identified in order to obtain a new data system. In FY 2023, DLTSS leadership will explore options for adapting existing systems, such as New Heights, the enterprise case management system for NH DHHS, to replace the SMS/PIH database.



## **Title V Specific Activities**

The Bureau for Family Centered Services (BFCS) will work to increase knowledge and the application of evidence-based and informed health care transition approaches to youth health care transition. In its second year, the Youth Health Care Transition Services Project (YHCTS) contract, NHFV will aim to ensure effective transition from pediatric to adult health care for the continuity of developmental and age-appropriate health care for CYSHCN ages 14-21, their families, caregivers, family support and health care coordinators, and health care providers and/or practices. Activities in this contract will continue to focus on providing support for transition to adulthood, within pediatric and adult health care settings, and across the system of care for CYSHCN. The action plan identifies the following activities that will be used to achieve the project's purpose:

- Maximize access to care coordination either via practice-based resource or in collaboration with external coordinators.
- Conduct staff training based on staff self-assessments and regarding patient and family-centeredness, cultural competence, and implicit bias as part of ongoing staff development.
- Support quality assurance and monitoring efforts that advance transition activities.
- Enhance access to care relative to Medicaid Managed Care contracts.
- Facilitate incorporation of the evidence informed six core elements of transition into health care practices, in accordance with Got Transition™ recommendations – through practice-based technical assistance.
- Participate on the team that reviews data base improvements and data upgrades.

BFCS will continue active participation in the state's Transition Community of Practice (CoP) in which NHFV serves as the YHCTS contractor and a BFCS Nurse Consultant (NC) represents healthcare transition for CYSHCN. This commitment assures that the health perspective is infused into all transition planning for youth with disabilities moving into the adult service system. Through participation, at state and local levels, the NC, who has a special interest and dedication to this topic, will continue to expand her ability to assist youth and their families' transition from youth to adult health care services and independence. She will continue to attend and facilitate the NH CoP state meetings as requested and participate in the Summit Planning Committee. She will represent BFCS, YSHCN and their families at the annual Transition Summit, a statewide opportunity for training, collaboration, and networking focused on post-secondary outcomes for students. The NC will participate in regional transition fairs when time allows and serve as an internal resource for DHHS staff, contractors and families, providing shared information and training opportunities.

### ***Care Coordination and Family Support***

BFCS will continue to incorporate evidence-informed health care transition processes for YSHCN into care coordination and family support services offered primarily through community-based contracts. Two full time DHHS health care coordinators will continue to provide these services through FY2023, after which they will move into new roles and all Title V care coordination will be provided through contracts with community-based agencies. In addition to utilizing the frameworks recommended by Got Transition®, BFCS will use the National Care Coordination Standards for CYSHCN to guide the redesign of the service delivery system for FY2024 that includes health care transition services. Guidance will also include the recommendations provided by NHFV's "Review of the National Standards for Care Coordination for CYSHCN: A quality improvement initiative for BFCS Health Care Coordinators" staff led BFCS health care coordinators (HCC). This report was generated following a detailed training and review of the National Care Coordination Standards for CYSHCN, and self-rating of their work in comparison to the Standards (June 2021), which included a domain on transition of care.

In the coming year, there will be an emphasis on educating BFCS staff to improve their ability to evaluate the Transition Readiness Assessment Questionnaire (TRAQ) surveys completed by youth and families, in order to identify needed resources and education. In partnership with BFCS, NHFV, the YHCTS contractor, will provide training to all coordinators and nurse consultants to support the distribution, data collection, and the expectations for consultation related to the TRAQ and health care transition.

BFCS will rely on these activities and efforts to inform the development of program guidance for coordinators to assure contract compliance and successful interactions with YSHCN and their families. Current contracts require that all YSHCN enrolled in Title V programs, ages 14-20 years and/or their family caregiver, receive an annual TRAQ survey, consultation with a coordinator to identify a goal, and review progress toward meeting the previous year's goal. The TRAQ helps serve as a guide and directs communication and conversation to the sometimes uncomfortable or awkward discussions and the creation of a workable and individualized transition care plan. Training will be provided in conjunction with this guidance, using a variety of methods including presentations at monthly coordinator meetings, in-person and virtual topical trainings and webinars, conferences and team meetings.

New Hampshire Family Voices, (NHFV), will continue to provide core materials related to the National Care Coordination Standards for CYSHCN to BFCS staff and contractors such as the Toolkit developed in FY2022. As part of the YHCTS project, they created a hard copy toolkit (with flash drive back up). In FY2023, they will create a "virtual toolkit" that contains not only tools, but serves as a compilation of tools, allowing coordinators to support youth and families in choosing tools that work for them; as it is not a one-size-fits-all process! One of the many benefits of the collaboration with NHFV is to assure the family perspective is considered when determining program guidance and instruction for implementation, in accordance with the guiding principles of the National Care Coordination Standards for CYSHCN.

### ***Measurement and Assessment***

In order to measure and assess the success of this new guidance, BFCS Evaluation Specialist, Data Analyst and program leadership will work with DoIT to review the current data collection capability of the SMS/PIH database. Following this review, the team will make recommendations for improvements and either adapting the system or reporting requirements. One early recommendation is to include a feature in which the Coordinator can check a box when a YSHCN identifies a goal during consultation and another when they achieve a goal during a transition planning encounter. The resulting data will supplement the information collected during annual satisfaction surveys, biennial needs assessment, and family focus groups.

### **Systems Building**

#### ***Health Care Professional Workforce Development***

The CYSHCN Director and Clinical Program Manager will continue to work with Medicaid on projects related to Managed Care Organization (MCO) contract oversight, quality improvement and evaluation in order to assure access to and continuity of care. This will include promoting the Standards for Systems of Care for CYSHCN 2.0 (Standards) specifically those that address facilitating care transitions and transition to adult care. MCO contracts require that they develop and make available support services for the health care professional workforce, which include, at a minimum a training curriculum, in coordination with DHHS that addresses clinical components necessary to meet the needs of CYSHCN.

As part of the YHCTS contract, NHFV will continue to work with the MCOs, the Clinical Program Manager and Nurse Consultants, to promote and provide technical assistance in support of health care transition policy development and implementation. In addition, newly created Nurse Consultant positions will begin working with providers, including Area Agencies, to provide clinical expertise to care coordinators and service coordinators relative to supporting

CYSHCN and their families.

### **Communications and Social Media**

NHFV offers communication tailored for YSHCN and families including on the Health Care Transition webpage <https://nhfv.org/projects/initiatives/health-care-transition/>. Resources will continue to be made available to promote health care transition information through a variety of social media platforms including Facebook, YouTube, and Twitter, that are all available as links on the webpage.

The YEAH Council (Youth for Education, Advocacy and Health Care) also creates and shares transition related content on their webpage <https://yeahnh.org/> and via a variety of social media platforms including Facebook, YouTube, TikTok, Instagram, and Twitter. In FY2022, they created three podcasts, which will be described more fully in next year's report. They plan for additional ones for the series "Health Care Transition Matters." They will also utilize written publications including NHFV newsletter, Pass It On, to disseminate health care transition information and the website, [Health Care Transition - New Hampshire Family Voices \(nhfv.org\)](https://nhfv.org/), will be used as a repository for information and resources.



NHFV will also continue to convene quarterly Youth Health Care Transition Advisory group meetings with diverse stakeholders including youth and family participants, BFCS, and primary health care practices. They will continue to see representation from each of the three MCOs in FY2023. In conjunction with the Advisory group, NHFV will develop methods for outreach to stakeholders and providers.

NHFV, coordinators, youth and families, the NH Chapter of the American Academy of Pediatrics, the NH Pediatric Improvement Project and other community-based partners will continue to network. Such relationships help increase potential outreach to health care providers and practices to encourage policy adoption and technical assistance. Documenting and reporting on transition policy adoption will be done using a tracking document.

While YHCTS will continue to conduct outreach and provide technical assistance to practices about the importance of policies and overall uptake of Got Transition™ six core outcomes, practices are losing their independence as they are absorbed by larger entities and face staffing challenges of their own. The reality is, it becomes more difficult to get these policies in place and more importantly, to have them utilized in a manner that truly informs transition planning. This was part of the reason NH opted to engage in systems building that infused health care into the transition planning across the continuum of care (within schools [Community of Practice]; Health Care Coordination and Family Support, and more directly engaging youth and families).

This endeavor will help raise awareness about the importance of making well-planned and informed decisions about health care as youth approach adulthood. This is significant for the client as well as the family/caretakers and helps provide assurance that important and needed services will continue despite changes in providers, Medicaid, Medicaid MCO's or private insurance. Promotion of transition policies in the upcoming year should increase the number of TRAQ forms completed and enhance consumer awareness and access to adult health care. NHFV will disseminate annual surveys that address questions and concerns and help identify families' needs and experiences on an ongoing basis.

Throughout the COVID-19 Public Health Emergency (PHE), health care and family support coordinators could not conduct in-person visits and adapted to using Zoom technology to meet with families and partner agencies when

providing consultation and setting transition goals. Fortunately, in-person visits are slowly resuming as face-to-face meetings with a youth's team builds relationships that have been lacking throughout the initial pandemic crisis.

### ***Care Coordination and Family Support***

The Bureau for Family Centered Services (BFCS) is eager to face the challenges of the next fiscal year. The biggest undertaking is the major re-design of service delivery, which includes the blending of the Health Care Coordination and the Partners in Health family support programs. This process involves the development of a new scope of services for community-based health care coordination with new guidelines and contractual obligations for vendors, revised data collection procedures and staff training. BFCS will continue to incorporate evidence-informed health care transition processes for YSHCN into care coordination and family support services offered primarily through community-based contracts.

In addition to utilizing the frameworks recommended by Got Transition®, BFCS will use the National Care Coordination Standards for CYSHCN to guide the redesign that includes health care transition services. Guidance will also include the recommendations provided by NHFV's "Review of the National Standards for Care Coordination for CYSHCN: A quality improvement initiative for BFCS Health Care Coordinators" staff led BFCS health care coordinators (HCC). This report was generated following a detailed training and review of the National Care Coordination Standards for CYSHCN, and self-rating of their work in comparison to the Standards (June 2021), which included a domain on transition of care.

Two full time nurse health care coordinators will continue to provide these services through FY2023 after which they will move into new roles and all Title V care coordination will be provided through contracts with community-based agencies. Those state employees previously providing nurse health care coordination will take on a consultant role to help strengthen the system of care for CYSHCN. The Program Specialist III Coordinator will become the advisor, trainer and technical assistance expert working in collaboration with the Program Manager and the clinical team to support the regional contract agency staff in FY2024. These regionally based programs will provide enhanced health care coordination services, aligned with the National Care Coordination Standards for CYSHCN that includes family support.

The new scope of services will eliminate the need for duplicative application, intake and goal setting and leverage other state and federal funding, along with Medicaid, for improved efficiency and quality of services. This redesign process requires new thinking, open mindedness, skill and great attention to many details, e.g., staff qualifications, family need, financial resources, and interagency collaboration etc. The RFP for the new program is anticipated for release in January 2023 with an implementation start date of July 1, 2023.

One of the most important components of this process is to be mindful of family perspective and impact as policies, procedures and services are redesigned. Health Care and Family Support Coordinators, stakeholders, providers, and parents/families have been reviewing and offering feedback related to these efforts. As a key partner, NHFV will not only participate, but will provide guidance for development of a communication plan to assure incorporation of family-friendly and sensitive information, throughout the process. Their continued role as the Youth Health Care Transition Services Project contractor will be integral to the development of guidance related to that specific part of the new scope of services.

In order to succeed with the redesign process, BFCS will continue the work in FY2023, by process-mapping the steps of care coordination and family support, including application, eligibility determination, communication, care planning, goal setting, data collection/reporting, resources/funding, transition, and evaluation. The Systems of Care for CYSHCN Specialist with BFCS will engage the MCH Workforce Development Center for technical assistance with engaging stakeholders across the system including community-based agencies and providers. The purpose of

this request will be to increase awareness of the process, provide clear understanding of the goals, and to encourage proposals for the FY2024 contract.

As the team identifies each step of the CYSHCN and/or his family's journey, there are numerous "moving parts" to consider. Title V CYSHCN in NH hopes to create a model that can be scaled up moving the focus from direct service to helping others develop similar systems with BFCS as the conduit. The procedure and this process will continue to be a group effort and an ongoing project with all staff sharing their thoughts and ideas and suggestions.

If activities are successful, NH will see an increase in the number of YSHCN who have a transition plan in place prior to their 21<sup>st</sup> birthday.

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**State Performance Measure #2:**

Percentage of families enrolled in BFCS programs who report access to respite.

**Objective:**

To increase the number of families reporting access to respite care when needed from 62% to 75%, on the Bureau for Family Centered Services Needs Assessment & Satisfaction Survey, by 2025.

**Strategies:**

1. Re-determine the needs of families regarding respite
2. Collect and analyze data to support policy development and funding for respite
3. Review Relias trainings to support updated best practice standards
4. Re-engage the Caregiver Integration Team and assess the capacity to continue with environmental scan and strategic planning.
5. Include respite screening and access in Quality Improvement projects
6. Attend the ARCH national respite conference
7. Assess the capacity to influence other sectors necessary to achieve goals

**Background**

Access to respite services has historically been identified as a priority area through several different assessment methods. In response, the Caregiver Integration Team (CIT) was formed to address access to respite and other respite quality improvement activities. The CIT developed a Charter, mapping out the goals over the next five years including a framework to guide systems change. The CIT made progress on identifying assessments, collaborating across department agencies, identifying needs and beginning to collect standardized information. In 2020, the COVID-19 Public Health Emergency (PHE) affected the CIT's ability to complete its plan in several ways including:

- Shifting of families' needs and priorities away from respite
- A reduced workforce
- Re-allocation of resources

Due to the nature of the COVID-19 virus and health guidelines recommending quarantine and isolation, families

reported shifting from requesting provider respite services to utilizing natural family supports. The DLTSS Continuity of Operations Plan, or COOP, included reallocating resources including the DHHS workforce and activities. Staff were directed to prioritize core services as well as provide assistance within call and emergency centers and with vaccination efforts.

Although the qualitative and quantitative information indicates less need for respite, BFCS is not confident that it accurately reflects the new normal and additional obstacles that families are now facing. As State Fiscal Year 2023 moves forward, NH will take this opportunity to re-assess where respite services fall within the needs of families. The following activities will help BFCS determine how to move forward with supporting the needs of families regarding respite services.

### **Re-Determine the Needs of Families Regarding Respite**

During the pandemic, many families reported not wanting respite caregivers to enter the family home and instead used natural supports to provide respite or stayed home the majority of the time, to avoid contracting the virus. As the COVID-19 virus evolves, it is important to re-assess the needs of families and its impact on respite needs. Re-determining respite needs through annual surveys, needs assessment conducted with the Council for Youth with Chronic Conditions (CYCC), and through family interactions/experiences will be planned throughout FY 2023.

### **Collect and Analyze Data to Support Policy Development and Funding For Respite**



New data and a more in-depth analysis of data is required. The Bureau for Family Centered Services successfully hired a Data Coordinator whose skills are to collect and analyze data in an organized way to better understand the unique needs of families. Although New Hampshire is a small state, the needs of families across the regions differs. NH plans to reassess, collect, and analyze data from 2020 and after to understand how the pandemic impacted family's needs. This information will help inform agencies and drive practice on the regional level to understand and respond to the needs of their community. NH intends to assess current needs, put a plan in place and implement the plan.

### **Review and Update Relias Trainings to Reflect Best Practice Standards**

New Hampshire's respite trainings are available on the Relias training platform, supported by BFCS, to provide opportunities for BFCS staff, contractors and the community providers. Although identified as a strategy in previous years, due to staff vacancies and competing priorities related to COVID-19 PHE, these trainings have not been updated. BFCS' quality improvement project will result in a reorganization of some staff positions. Individuals will be identified to review training content to ensure content provided in trainings is relevant and consistent with best practice recommendations.

### **Re-engage the Caregiver Integration Team (CIT) and Assess the Capacity to Continue**

Although the Caregiver Integration Team has been on hiatus for over two years during the COVID-19 PHE, BFCS leadership is committed to engaging and participating in lifespan respite activities in NH. A reconvening will be scheduled in the fall of 2022, to discuss the feasibility of the previous plan for environmental scan and strategic planning given the reality of limited capacity and workforce challenges. In order to continue with this work, executive level sponsorship, funding, and staff will need to be identified to facilitate the work. Increasing access to respite requires system improvements including the availability of competent and well-compensated individuals to build the respite workforce.

### **Include Respite Screening and Access in Quality Improvement (QI) Projects**

Program Managers, coordinators and leadership will incorporate respite needs assessment into quality improvement activities as an ongoing strategy to identify and respond to the needs of families with CSHCN. With a newly reclassified position, a Program Specialist will work with managers to determine how assessment of respite needs can be incorporated into a standardized screening and assessment framework for CSHCN enrolled in Health Care Coordination and Family Support programs. New Hampshire Family Voices and other community stakeholders will be included in all QI activities to ensure families remain the center of improvement activities. Information and Referral (I&R) and financial assistance will continue to be available to assist with needed respite services.

### **Attend the ARCH National Respite Conference**



The Bureau plans to send two representatives to the ARCH 2022 National Lifespan Respite Conference to learn about the most recent practices regarding respite access, care and information sharing. Ideally, a family representative from NHFV will join the travel team to provide the family perspective. Following the conference, BFCS will share best practices and success from other states and organizations with stakeholders, in an effort to consider options including re-thinking traditional respite care and possible ways to adapt to new changes.

### **Respite as a Title V Priority**

Since the reported demand for respite has declined since before the PHE, BFCS will review the results of the CYCC Needs Assessment (Fall 2022), conduct a subsequent survey (Spring 2023), and engage community stakeholders throughout the year, to determine whether respite continues to be a priority for NH families with CSHCN. Throughout the process, BFCS will continue to provide limited resources and referrals to families enrolled in Health Care Coordination and Partners in Health Family Support who identify respite needs. Finally, in FY 2023, BFCS will explore the factors influencing the availability of respite services within the Title V programs and consider new strategies to address the needs of families with CSHCN,

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<sup>[1]</sup> Child and Adolescent Health Measurement Initiative. 2019-2020 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [07/25/22] from [www.childhealthdata.org].

**Cross-Cutting/Systems Building**

**State Performance Measures**

**SPM 1 - Percentage of MCH-contracted Community Health Centers' Enabling Services workplans that have been met or exceeded the target**

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	
Annual Objective			40	
Annual Indicator	33.3	50	42.9	
Numerator	5	7	6	
Denominator	15	14	14	
Data Source	NH DHHS/MCHS SFY19, Enabling Services Workplan	NH DHHS/MCHS SFY20, Enabling Services Workplan	NH DHHS/MCHS SFY20, Enabling Services Workplan	
Data Source Year	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	65.0	75.0



**SPM 3 - Percentage of enrolled providers who received Pediatric Mental Health Teleconsultations**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			25
Annual Indicator		23	31.6
Numerator		14	12
Denominator		61	38
Data Source		NH MCAP Program data	NH MCAP Program data
Data Source Year		2020	2021
Provisional or Final ?		Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	28.0	31.0	34.0	37.0

## State Action Plan Table

### State Action Plan Table (New Hampshire) - Cross-Cutting/Systems Building - Entry 1

#### Priority Need

Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population

#### SPM

SPM 1 - Percentage of MCH-contracted Community Health Centers' Enabling Services workplans that have been met or exceeded the target

#### Objectives

Increase the percentage of MCH-contracted Community Health Centers Enabling Services (ES) workplans that have met or exceeded their target(s) to 75% by SFY25

#### Strategies

MCH requires all CHCs to submit a two-year ES work plan as a contract deliverable within 30 days the beginning of a contract period.

Review ES work plans and provide feedback/technical assistance as needed to ensure agencies have included specific, measurable, achievable, realistic and, timely (or time-bound) SMART objectives/goals and a target for each State Fiscal Year (SFY).

Monthly calls will occur between the MCH QI Clinical Staff and the CHC QI Staff to share updates, need for technical assistance, etc.

Learning communities and communities of practice on specific ES topics will be set up and implemented monthly.

Updates to the ES workplans will be formally submitted twice per year, in January and July; MCH will review ES workplan outcome sections to determine how many have reached their target. If the target has not been attained, feedback/technical assistance will be provided and the CHC will need to submit a revised ES plan.

State Action Plan Table (New Hampshire) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improve access to mental health services for children, adolescents, and women in the perinatal period

SPM

SPM 3 - Percentage of enrolled providers who received Pediatric Mental Health Teleconsultations

Objectives

Increase the percentage of enrolled providers who receive Pediatric Mental Health Care Teleconsultation in the Pediatric Mental Health Care Access (PMHCA) Program from a baseline of 23% in 2020 to 41% in 2026

Strategies

Provide NH pediatric primary care providers with additional training on the assessment and treatment of children with mental health concerns by: 1) development of a Pediatric Mental Health Project ECHO series facilitated by the NH Pediatric Mental Health Team faculty of local subject matter experts; and 2) recruitment of pediatric primary care practices across NH to participate in the Pediatric Mental Health Project ECHO, targeting those in rural/underserved areas.

Promote and provide teleconsultation opportunities as needed for primary care providers with the PMHCA pediatric mental health team faculty members.

Continuation of teleconsultation services upon completion of the HRSA grant period by: 1) increased NH pediatric primary care physician satisfaction with using teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions; and 2) development of a plan for program sustainability following the end of the PMHCA grant award period.

## Cross-Cutting/Systems Building - Annual Report

**State Performance Measure #1:** Percentage of MCH-contracted Community Health Centers who have met or exceeded the target(s) indicated on their NH DHHS, MCH Enabling Services (ES) workplan.

**Objective:** Increase the percentage of MCH contracted CHCs who have met or exceeded the target(s) indicated on their NH DHHS, MCH Enabling Services workplan from the 2020 baseline of 33% (5 of 15) to 75% in 2025.

### Strategies:

- MCH requires all CHCs to submit a two-year ES work plan as a contract deliverable within 30 days of each contract period. MCH will review ES work plans and provide feedback/technical assistance as needed to ensure agencies have included specific, measurable, achievable, realistic and, timely (or time-bound) SMART objectives/goals.
- At the end of each State Fiscal Year (SFY), MCH will review ES work plans' outcome sections to determine the percentage of CHCs attaining their target(s).
- At the end of each SFY, MCH will review and provide feedback/technical assistance as needed on the plan for improvement section(s) of CHCs not meeting their target(s).

**Background:** For more than 25 years, the NH MCH section has used Title V funding and state general funds to support a network of safety-net CHCs to provide access to health services for low-income and uninsured individuals and families. In 2021, 12% of the 112, 389 individuals served by the Title V CHCs were uninsured. While this percentage has decreased with the advent in 2014 of the Affordable Care Act (ACA) and NH's expanded Medicaid initiatives, there remains an uninsured population that is served by the health centers (range 4-22%).<sup>[1]</sup>

Historically, Title V funding was used to provide reimbursement of the cost of care for uninsured individuals. However, to better align with the Maternal and Child Health Pyramid of Health Services, MCH has encouraged its contracted CHCs to not only support the costs associated with caring for uninsured populations, but also to support infrastructure-building services (planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, systems of care, and information systems). This has been accomplished by expanding contract scope of services to include Enabling Services and Quality Improvement (QI) activities. Accountability for all MCH-contracted services has been maintained by MCH through monitoring performance via site visits and reporting requirements.

This performance measure directly addresses two priorities identified in the five year needs assessment, "Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population" and "Improving access to needed healthcare services for all MCH populations".

### **Enabling Services**

Enabling Services (ES) are non-clinical services that support the delivery of basic primary care and preventive services by addressing factors such as geographic, linguistic, cultural and socioeconomic barriers. Those ES that are not currently reimbursed by any health payor are supported by MCH funding to enhance CHCs' capacity to "do the work" needed to care for their patient population. ES positively contribute to care, improve quality of services, support health equity and reduce health care costs. The following are the types and outcomes of all of the enabling services from the Title V funded CHCs this past year.

	Agency 1	Agency 2	Agency 3	Agency 4	Agency 5	Agency 6	Agency 7	Agency 8	Agency 9	Agency 10	Agency 11	Agency 12	Agency 13	Agency 14
<b>Green: Work Plan Goals Met</b>														
<b>Yellow: Some Goals Met</b>														
<b>Red: No Goals Met</b>														
Enabling Service Initiatives														
Screen/follow up Social Determinants of Health	Yellow													
Interpreter Related Services		Green												
Transitions of Care (Hospital/ED discharge)			Red					Green		Green				
Transportation				Green										
Health insurance enrollment and health literacy					Green			Red				Green		
Case Management (Complex health issue)/Chronic Care Management						Yellow	Yellow			Green				
Care Coordination, Diabetic Care														
Care Coordinator, Lead Screening							Red							
Outreach, homeless youth											Green			
Depression & SBIRT Screening & Follow up												Green		Yellow
Increase knowledge of staff with trauma informed care												Green		
Implement ability to text homeless youth											Red			
Increase Care Coordination SUD								Green						

A total of six out of 14 CHCs met all of their enabling work plan goals for a total of 43%. Eighty six percent of the CHCs met at least one of their enabling work plan goals. However, each agency should have had at least two enabling service workplans and that did not happen. Some had only one and some had three.

The MCH section allows each CHC the flexibility to self-select the type of ES to be provided based on the unique needs of their own community. The following example from one MCH funded CHC health center illustrates the increased screening with respect to social determinants of health, particularly with respect to transportation barriers.

<b>Agency Name: Greater Seacoast Community Health</b>	
<b>Project Goal: To ensure that patients receive all available resources and assistance with transportation barriers.</b>	
<b>Project Objective #1: To ensure that primary care and prenatal patients within our service area have access to resources, coordination with transportation programs (such as CTS, Specialized transportation and COAST bus). Patients will be surveyed (minimum 100) each year for transportation needs and barriers. 60% of patients surveyed will be aware of transportation assistance and benefits by June 30, 2020 and 80% by June 30, 2021.</b>	
<b>INPUT/RESOURCES</b>	<b>PLANNED ACTIVITIES</b>
<ul style="list-style-type: none"> <li>• Social Workers</li> <li>• Community Health Workers</li> <li>• Front Office Staff</li> <li>• Call Center Staff</li> <li>• Clinical Staff</li> </ul>	<p>Extensive outreach and education on the transportation options available in their community.</p> <ul style="list-style-type: none"> <li>• Provides transportation to and from appointments when applicable to those who verbalize transportation barriers to staff.</li> <li>• Education to all new patients.</li> <li>• Bulletin boards in the health centers that showcase and educate patients on transportation options in the area and how to seek further assistance.</li> <li>• Outreach calls to patients that have missed several appointments.</li> <li>• Flyers in the exam rooms – educating patients</li> <li>• Frequent staff reminders that transportation assistance and options are available to patients in most areas.</li> <li>• Educate prenatal patients upon intake that transportation assistance is available as needed.</li> </ul>
	<b>EVALUATION ACTIVITIES</b>
	<ul style="list-style-type: none"> <li>• Compliance rate for this measure will be reviewed biannually through patient surveys by the social work department along with CQI and other stakeholders, allowing for timely adjustments to workflows to address any issues that may arise.</li> </ul>
<b>WORK PLAN PERFORMANCE OUTCOME (To be completed at end of SFY)</b>	
<b>SFY 21 Outcome: 86% awareness from patients surveyed were aware that we help with transportation services</b>	
<b>X Target/Objective Met</b>	
<p><b>Narrative:</b> Although this year proved very challenging, we were able to not only meet but exceed our targeted goal. Increased contact with many patients due to social service needs for the pandemic also brought the ability to discuss and remove additional barriers for patients and families. Education to staff played a large part in the increase in numbers as well. Social Work staff made as many outreach calls to patients as possible when noticing a trend of missed appointments. Flyers in the exam rooms through out the year also helped to educate and remind both patients and staff that transportation assistance may be available. GSCH also committed to discussing transportation updates for our clients during all staff meetings as well as clinical team meetings, keeping this as a consistent message to staff.</p> <p><b>Proposed Improvement Plan:</b> Explain what your agency will do (differently) to achieve target/objective for SFY22 For SFY22 we plan to continue this trend with the successful tasks that we have already put in place above as well as add some additional activities that were not possible in the past SFY. Our Social Work team is working on a new patient screening tool that we are hoping to roll out at our clinical sites which gives our new patients a basic social service screening of some immediate needs and resources that they may find helpful. One screening question will be taken directly from our survey and will ask if "they have difficulty finding transportation to their appointments". If this is indicated as "yes", a social work staff member will be outreaching to that patient and offering either an in office appointment or zoom call to discuss and educate about all transportation options available to them. We are hoping that this will help reduce barriers right from the beginning as well as eliminate or reduce any missed appointments. This will also give social work staff the opportunity to introduce themselves and educate on the services that we provide and options for assistance if any other needs arise ( tying into the enabling services as well).</p>	

Screening for social determinants of health and the resulting interventions was intermingled into almost all of the enabling services work plans. Another CHC has health insurance enrollment as their enabling work plan. Three of the Title V funded CHCs had an enabling service workplan on utilizing community health workers and patient navigators in helping to access insurance. A story from the CHC is as follows:

“About three months ago before Christmas time, a female patient came to the Nashua Soup Kitchen Mobile Health unit with her daughter looking to be seen for her arm pain. The daughter was very concerned because her mother also needed labs, x-rays and a possible surgery for other health issues, not related to the arm pain. The daughter said the patient hadn’t addressed these issues because she did not have insurance, due to her recent change of immigration status. The patient had only been in the United States for one year, with her Permanent Resident card, and because of this the patient did not qualify for Medicaid. The patient’s daughter expressed these concerns to a community health worker (CHW), who then asked if she had time to check the Marketplace for insurance, as it was open enrollment time. The daughter agreed and they went through the process together, and when they finished with the application, the patient was approved for an excellent insurance plan with zero copays and zero dollars for the monthly payment. The patient qualified for the Premium Tax Credit that covered the whole amount of the monthly cost- in other words for free. The patient and the daughter were so happy and grateful, and they both got so emotional. Our Title V funded CHW never thought that helping a patient acquire health insurance would mean so much. The next Wednesday the patient

and her daughter came back to the van and the daughter expressed again how grateful she was that we could help her mother with insurance. That same week the patient did all her labs, x-rays for her arm and she is seeing a specialist for her other health issues.”<sup>[2]</sup>

Title V funded CHCs have been on the forefront of utilizing Community Health Workers in the State. This past year, MCH was fortunate enough through the American Rescue Plan Act (ARPA) and pandemic workforce funds, to create a Community Engagement Specialist position whose function is to bring together all the work that is happening with CHWs together in the State, including contracts for CHW training, supporting facilitation of the NH Community Health Worker Coalition and increasing the number of CHWs utilized in all settings to benefit the MCH population.

Care coordination across different spectrums was another focus of Title V funded CHCs. CHCs often provide personal stories along with their outcome reports. One of these relates the success one particular CHC had with one particular prenatal patient.

“A patient presented to our prenatal program well into her third trimester of pregnancy, homeless and stressed out. Having relocated to the Nashua area a few weeks before, she and her 4 year old daughter were staying at an acquaintance’s apartment. However, they could only remain there for the next month, which meant that she had limited time to find another place to live before she’d deliver. She had the support of her children’s father, but he lived separately. Neither of them was employed, and they were quickly running out of their savings, so their financial situation was difficult. Food was scarce, and the patient had to walk everywhere because she did not have a car. As part of our social services program, our Title V funded Care Coordinator worked closely with the patient throughout the remainder of her pregnancy, providing ongoing emotional support and referrals to community resources. And by the time her new baby arrived, the entire family had already moved in to a transitional shelter. They were accessing local food pantries and participating in programs, such as WIC and home visiting. The patient was also able to benefit from our internal taxi voucher program for her medical appointments, as well as, her daughter’s specialty appointments out of town. The patient is definitely more relaxed and content these days. She is very grateful that she was able to find, not only the quality medical care that she and her family needed, but also the assistance in connecting with the supports and services to improve their overall lives.”<sup>[3]</sup>

## **Systems Building**

MCH staff monitored contract deliverables to ensure that services are being provided in accordance with the scope of services.

*Budget/Budget Narrative:* On an annual basis, MCH reviews and approves individual agency budgets and budget narratives, which are electronically submitted by CHCs. This activity provides MCH an opportunity to understand how CHCs anticipate they will expend their funds and is one mechanism MCH uses to ensure fiscal accountability. Agency budgets and budget justifications are submitted as part of agencies’ Request for Proposal applications and reviewed for approval with a request to revise if indicated by MCH staff. Fiscal accountability is monitored by monthly review/authorization of CHC invoices by the DHHS fiscal team and MCH staff.

*ES Work plans:* On an annual basis, MCH reviews and approves individual agency ES work plans, which are electronically submitted by CHCs. From the MCH perspective, the ES work plans are a key mechanism for CHCs to communicate with MCH about the work that is being done. The ES work plan describes each individual agency’s project goals, objectives, inputs/resources, planned activities and evaluation methods. This allows an opportunity for MCH staff to provide the CHC feedback and request revision when needed. At the end of each state fiscal year (SFY), CHCs are then required to report annual outcomes by completing the “Work Plan Performance Outcome Section.” This section prompts CHCs to: 1) revisit their work plans; 2) indicate if their agency targets/objectives were

met; 3) evaluate the effectiveness of their activities; and 4) communicate any revisions to their work plan (improvement plan, required if targets are not met) as indicated. Once completed, outcomes have been submitted to MCH's QI and Clinical Services Program for review and provide feedback as part of continuous QI.

*Data Collection and Analysis on Performance Measures:* MCH staff work in collaboration with other DHHS programs including the Chronic Disease Prevention and Screening Section, the Bureau of Drug and Alcohol Services (BDAS), Tobacco Prevention and Cessation Program for input on performance measures before each funding cycle. Care is taken to align the measures, which in general reflect health outcomes specific to the MCH population, with standard federal and state performance indicators such as those from the Healthcare Effectiveness Data and Information Set (HEDIS), the National Quality Forum (NQF), the Uniform Data System (UDS) as well as HRSA's specific to Title V. The performance measures for the CHCs for SFY 20 and 21 were the following:

1. Percent of infants who are ever breastfed (Title V NPM#4).
2. Percent of children three years of age who had two or more capillary or venous lead blood tests for lead poisoning by their third birthday (NH MCH).
3. Percent of adolescents 12 to 21 years of age, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (HEDIS).
4. Percent of patients aged 12 and older screened for clinical depression using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).
5. Percent of women who are screened for clinical depression during any visit up to 12 weeks following delivery using an appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen (NH MCH).
6. Percent of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).
7. Percent of patients aged 3-17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year (UDS).
8. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).
9. Percent of pregnant women who are screened for tobacco use during each trimester AND who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCH).
10. Percent of patients aged 18-85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHG) during the measurement year (NQF 0018).
11. Percent of patients aged 65 years and older who were screened for fall risk at least once within 12 months (NH MCH).
12. Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during an annual physical AND if positive, received a brief intervention or referral to services (NH MCH)
13. Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit AND if positive, received a brief intervention or referral to services



(NH MCH) and

14. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program AND if positive, received a brief intervention or referral to services (NH MCH)

**Key:**

HEDIS – Healthcare Effectiveness Data and Information Set

NQF – National Quality Forum

NH MCH – New Hampshire Maternal & Child Health section

Title V – Federal Maternal and Child Health Services Block Grant

UDS – Uniform Data System

At the beginning of each SFY, MCH's Quality Improvement and Clinical Services program requests that the CHCs set and submit their individual agency's target for each performance measure. Performance measure outcome data is reported to MCH twice per year (January and July) via spreadsheets known as "Data Trend Tables" (DTT). DTT forms are updated by MCH's QI and Clinical Services' program staff and forwarded to contracted agencies with instructions for completion, 30 days prior to due date. Completed DTTs are then reviewed and analyzed and compared with past data to monitor individual agency and all-agency performance outcome trends. Lower performing agencies and performance measures showing lack of improvement across all agencies are selected for QI activities. Additional individual QI support is provided by MCH staff as needed.

*Site Visits:* In the past, MCH staff have conducted site visits at each Title V funded CHC at least once per each two year contract cycle to maintain relationships with CHC staff, observe how funds are utilized, review and discuss agency-specific data, work plan(s) and QI project(s), address agency identified needs, conduct chart reviews as needed (to assess if following *Bright Futures* Guidelines) and monitor program compliance. This has been put on hold during the COVID-19 pandemic. However, staff have continued to provide technical support through individual virtual conference calls and semi-annual PC Coordinators' meetings with all of the CHC contractors.

Overall, the CHCs funded by MCH have moderately high to high QI capacity. Most agencies have embedded QI into their organization's culture and support QI activities by incorporating the following:

- Designating a QI team led by a full time Quality Assurance Manager
- Setting an expectation that all staff members will participate in one (1) to two (2) QI projects each year and allocating hours (limited) for staff members of any discipline to participate in QI projects
- Including QI participation on staff annual performance review
- Allocating IT support to automatically generate data reports, which allow the QI team to analyze data monthly/quarterly.

At this time nine (9) of 15 MCH Primary Care contracted agencies contract for clinical and administrative system infrastructure support with a Health Center Controlled Network known as the "Community Health Access Network" (CHAN). CHAN provides a computer network system, which integrates electronic medical records (EMR), practice management and accounting systems. As CHAN is responsible for writing these agencies' data queries, the MCH QI and Clinical Services Administrator has established contact with a specific CHAN staff member to discuss issues related to performance measure data collection, i.e. feasibility of collecting particular data, how to align MCH performance measures with other federally required measures, etc. Through CHAN, data reporting and analytical functions have been automated allowing CHAN-affiliated QI staff the ability to generate real time data displays.

*Transformation of the CHC scope of services and new Request for Proposals:* In the fall of 2021, revisions were made to the scope of services and the performance measures for the CHCs to even further target efforts in improving access to integrated primary care (including prenatal and behavioral health services) to the MCH target population of women, infants and children. Performance measures for a new scope of services were included in a Request for Proposals (RFP) [RFP-2022-DPHS-19-PRIMA: Maternal and Child Health Care in the Integrated Primary Care Setting | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/Portals/0/DPHS/19-PRIMA%20Maternal%20and%20Child%20Health%20Care%20in%20the%20Integrated%20Primary%20Care%20Setting.pdf) that was released at the beginning of calendar year 2022. Proposals were reviewed March of 2022 and were allocated funding utilizing a new formula, which took into account proposal scoring (proposals had to score a minimum of 70 to be funded), number of MCH clients/patients in each category and need of the MCH population served (percent uninsured, percent on Medicaid, etc.). The Governor and his Executive Council approved the contracts in the middle of June 2022.

As part of the RFP revisions, the scope of services was revised to put an increased emphasis on Social Determinants of Health (SDOH) screenings and follow-up to align with the Title V State Performance Measure. Title V funded CHCs are now required to have at least two ES workplans, with one focusing on SDOH screening and follow-up. In addition, organizations were required to select a second ES focused initiative, and were given a 'menu' of potential ES options to choose from, including, but not limited to:

- Increasing rates of developmental screenings and/or implementing visits with Child Development Specialist.
- Increasing number of postpartum women who have lactation support.
- Increasing referrals to home visiting for qualifying children.
- Initiating the Plan of Safe/Supportive Care during the prenatal period for pregnant women with Substance Use Disorder.
- Implementing the ACEs (Adverse Childhood Experiences) screening in the child/adolescent population.
- Providing targeted outreach to homeless women, children and adolescents.
- Providing an Injury Prevention Initiative for infants, children and adolescents such as safe sleep and/or suicide prevention.
- Implementing a project involving a Community Health Worker targeted to the population of women, infants, and/or children.
- Implementing a program or service aimed to increase behavioral health integration for women and children within the medical practice that may include, but is not limited to:
  - Psychiatric teleconsultation; and/or
  - Educational/training opportunities for treating women and children with mental health concerns.

Performance measures were revised to include a developmental screening measure, a Screening, Brief Intervention and Referral to Treatment (SBIRT) measure focused on the adolescent population and lead screening measures that were in line with state legislation that mandates lead testing at both one and two years of age. The following are the revised performance measures for SFY23 and 24:

- 
1. Percent of infants who are ever breastfed (Title V NPM #4).

2. Percent of children 24 months of age who had a capillary or venous blood lead test between the ages of 12-23 months (NH MCH).
3. Percent of children 36 months of age who had a capillary or venous blood lead test between the ages of 24-36 months (NH MCH).
4. Percent of adolescents, twelve (12) through twenty-one (21) years of age who had at least one (1) comprehensive well-care visit/CPE during the measurement year (HEDIS).
5. Percentage of patients ages twelve (12) and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen (NQF 0418, UDS).
6. Percentage of women who are screened for clinical depression during any visit up to 12 weeks following delivery using an appropriate standardized depression screening tool AND if positive a follow-up plan is documented on the date of the positive screen (MCH).
7. Percentage of women who are screened for clinical depression during any visit up to 12 weeks following delivery using an appropriate standardized depression
8. Percentage of patients aged 18 years and older with a calculated BMI during the measurement period AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented (NQF 0421, UDS).
9. Percent of patients aged 3 through 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year (UDS).
10. Percent of patients aged 18 years and older who were screened for tobacco use at least once during the measurement year AND who received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user (UDS).
11. Percent of women who are screened for tobacco use during each trimester in which they were enrolled AND who received tobacco cessation counseling intervention if identified as a tobacco user (NH MCH).
12. Percent of patients aged 18 years and older who were screened for substance use, using a formal valid screening tool, during any medical visit AND if positive, received a brief intervention or referral to services (NH MCH).
13. Percent of patients aged 12-17 years who were screened for substance use, using a formal valid screening tool, during any medical visit AND if positive, received a brief intervention or referral to services (NH MCH).
14. Percent of pregnant women who were screened, using a formal valid screening tool, for substance use, during every trimester they are enrolled in the prenatal program AND if positive, received a brief intervention or referral to services (NH MCH).
15. Percent of children who reached 30 months of age by the end of the reporting period, and who were screened for autism using the M-CHAT at least once between the ages of 16-30 months (NH MCH)

Funded CHCs were required to submit two QI workplans, the first being the adolescent well-visit measure to align with the Title V Performance Measure as well as one performance measure of their choice.

**State Performance Measure #3**

Percent of enrolled pediatric primary care providers that received pediatric mental health teleconsultation from the Pediatric Mental Health Care Access (PMHCA) Program.

**Objective:** Increase the percentage of enrolled providers who receive Pediatric Mental Health Care Teleconsultation in the NH Pediatric Mental Health Care Access (PMHCA) Program from a baseline of 23% in 2020 to 41% in 2026.


**Strategies:**

- Provide NH pediatric primary care providers with additional training on the assessment and treatment of children with mental health concerns by:
  - Development of a Pediatric Mental Health Project ECHO series facilitated by the NH Pediatric Mental Health Team faculty of local subject matter experts.
  - Recruitment of pediatric primary care practices across NH to participate in the Pediatric Mental Health Project ECHO, targeting those in rural/underserved areas.
  
- Provide teleconsultation opportunities as needed for primary care providers with the PMHCA pediatric mental health team faculty members by:
  - Promotion of the Teleconsultation opportunities for participating pediatric primary care practices with the NH Pediatric Mental Health Team faculty.
  
- Continuation of teleconsultation services by:
  - Increased NH pediatric primary care physician satisfaction with using teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions
  - Development of a plan for program sustainability

**Background**

*New Hampshire Children’s Mental Health*

According to the 2020 National Survey of Children’s Health (NSCH) results, New Hampshire has been ranked as having the highest rate of children ages 3-17 years-old with at least one or more reported mental, emotional, developmental, or behavioral health problem, at 30%, which is significantly higher than the national average of 23%.<sup>[4]</sup> This ranking has also worsened from NH having the second highest rate in the 2018-2019 NSCH results to now the highest rate nationally<sup>[5]</sup>.

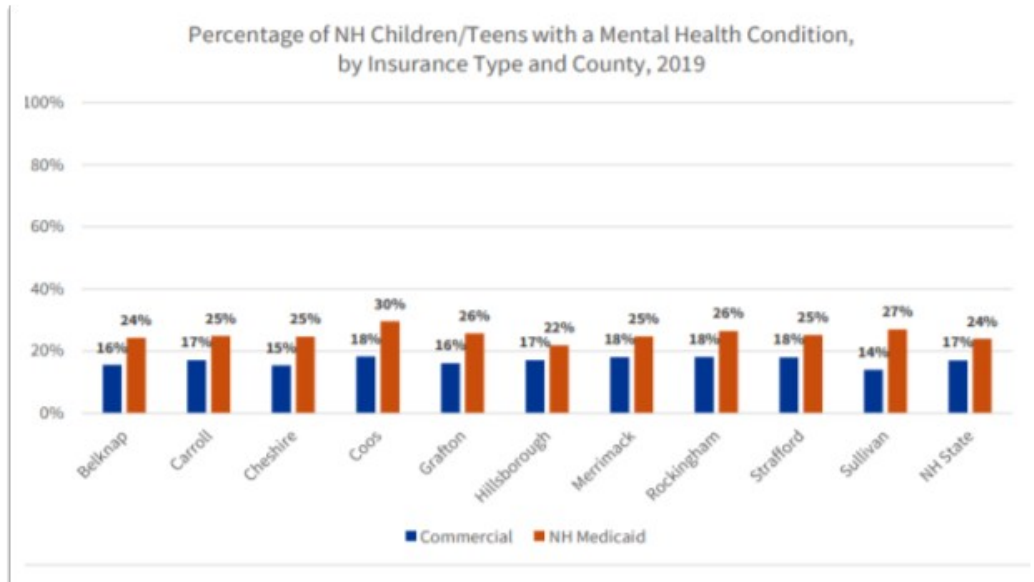
**Indicator 2.10: Does this child have a mental, emotional, developmental or behavioral (MEDB) problem, age 3-17 years?** 

Notes: Click on the Column Header to sort the results by ascending or descending order. To get a detailed explanation of the data HOVER over the text in the table.

	State	Child has 1 or more reported MEDB problems, and/or qualifies on CSHCN Screener emotional, behavioral or developmental criteria %	Child does not currently have mental, emotional, developmental, or behavioral problems %	Total %
1	New Hampshire	30.3	69.7	100.0
2	Kentucky	29.7	70.3	100.0
3	Vermont	29.6	70.4	100.0
4	Mississippi	28.5	71.5	100.0

[6]

Additionally, a recent analysis of claims data of NH children on Medicaid and commercial insurance has found that overall, 24% of children on Medicaid and 17% of children on commercial insurance have a documented mental health condition for which they had received treatment for during 2019. An analysis comparing 2019 claims to 2020 will likely be forthcoming and will shine light on the impact that the COVID-19 pandemic had on children’s mental health across the state.



[7]

Furthermore, the latest Youth Risk Behavior Survey Data Summary and Trends Report (2019), shows that youth mental health and suicidality rates are trending in the wrong direction. Of the students surveyed, 37% reported experiencing persistent feelings of sadness or hopelessness, compared to 26% surveyed in 2009. For those experiencing these depressive symptoms, 16% made a suicide plan compared to only 11% in 2009. This data was collected in 2019, pre-pandemic, so we may suppose that these numbers are actually higher now and will likely see this in the next YRBS results.

THE PERCENTAGE OF HIGH SCHOOL STUDENTS WHO:	2009 Total	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	Trend
Experienced persistent feelings of sadness or hopelessness	26.1	28.5	29.9	29.9	31.5	36.7	
Seriously considered attempting suicide	13.8	15.8	17.0	17.7	17.2	18.8	
Made a suicide plan	10.9	12.8	13.6	14.6	13.6	15.7	
Attempted suicide	6.3	7.8	8.0	8.6	7.4	8.9	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	1.9	2.4	2.7	2.8	2.4	2.5	

[8]

In order to get a more current and accurate look at youth mental health during the COVID-19 pandemic, there was a recent survey administered entitled the Adolescent Behaviors and Experiences Survey (ABES), which was conducted by the CDC from January-June 2021 which assessed student behaviors and experiences during the pandemic. Results found that 44% of adolescents surveyed reported experiencing persistent feelings of sadness or hopelessness almost every day for two weeks or more in a row to where they stopped doing some usual activities. Even more concerning is that 20%, or 1 in 5 students surveyed, reported that they had seriously considered attempting suicide within the last 12 months.<sup>[9]</sup> To address these growing concerns, in December 2021 the U.S. Surgeon General Dr. Vivek Murthy issued a Surgeon General’s Advisory for Protecting Youth Mental Health to highlight the urgent need to address the nation’s youth mental health crisis.<sup>[10]</sup>

### Mental Health

Mental Health	Total	
	Percentage	Confidence Interval*
Who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	44.2	41.6 - 46.8
Seriously considered attempting suicide (during the 12 months before the survey)	19.9	18.0 - 22.0
Made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	13.6 - 17.2
Actually attempted suicide (one or more times during the 12 months before the survey)	9.0	7.7 - 10.5
Had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	1.9	1.4 - 2.5
Reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)	31.1	28.5 - 33.7

\*95% Confidence Interval

Downloads of this table: [PDF](#) |

[11]

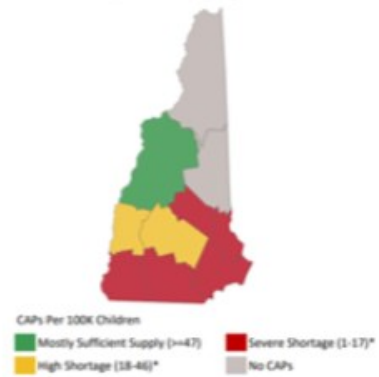
Compounding the youth mental health crisis, much of New Hampshire continues to experience a mental health professional shortage.<sup>[12]</sup> Additionally, the American Academy of Child and Adolescent Psychiatrists has found that half (five out of ten) of the NH’s counties were determined to be insufficient in their number of child and adolescent psychiatrists (CAPs) and two of NH’s counties had none at all.

New Hampshire's  
Mental Health Professional Shortage Areas  
Designations - November, 2021



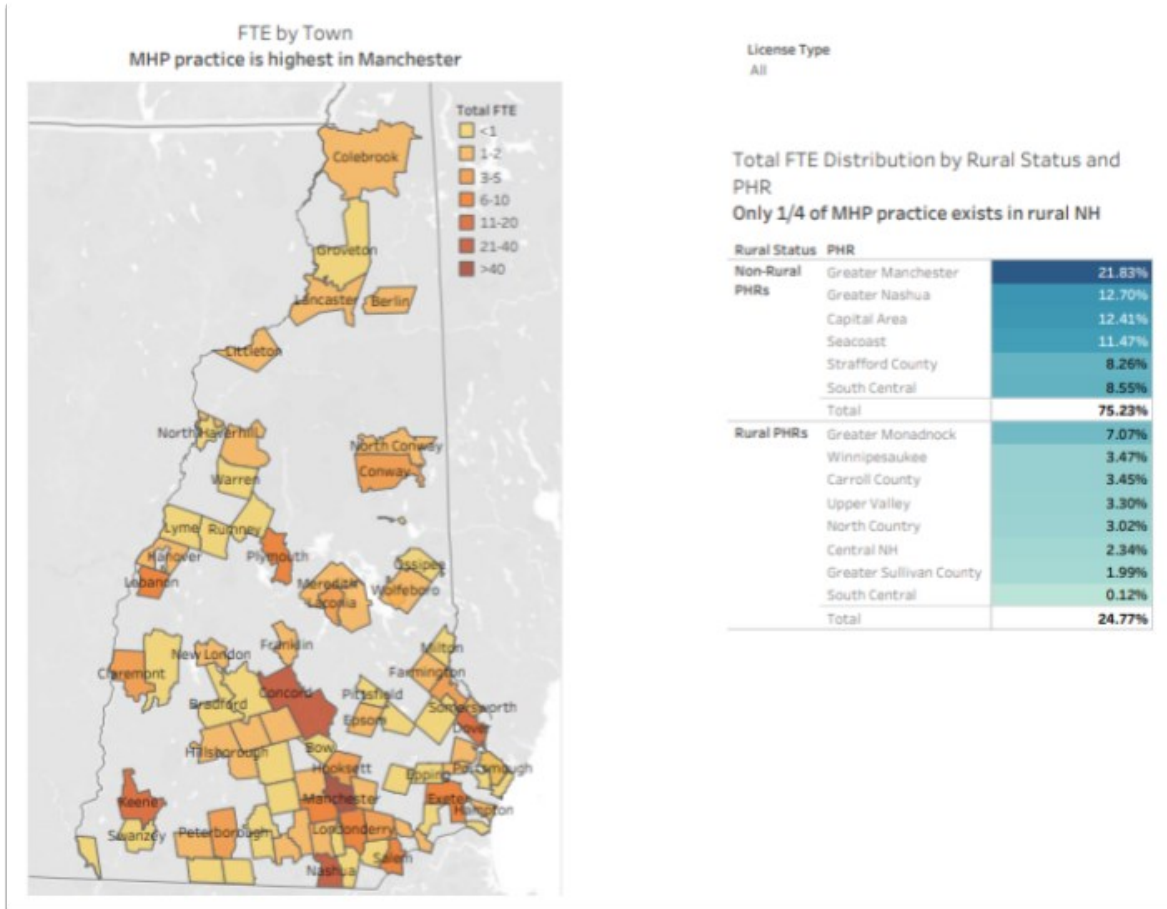
County	Total CAPs	Population, Children Under 18
Belknap	2	11,622
Carroll	0	7,977
Cheshire	1	14,137
Coos	0	5,343
Grafton	16	15,222
Hillsborough	12	87,932
Merrimack	7	29,616
Rockingham	9	62,162
Strafford	1	24,473
Sullivan	2	8,495

Practicing Child and Adolescent Psychiatrists by County 2017  
Rate per 100,000 children age 0-17



[13]

Moreover, the NH Mental Health Practitioner (MHP) Licensure Survey conducted in 2018-2019 by the NH Division of Public Health Services' Health Professions Data Center found that only 25% of mental health practices were located in rural public health regions which is where they are needed most in order to increase access for the underserved NH residents that live in the more rural areas of the state.



[14]

National Outcome Measures (NOMS) influenced by children's access to mental health treatment  
 NOM 18 - Mental health treatment or counseling, age 3-17 years: According to the 2020 National Survey of

Children’s Health, only 50% of NH children age 3-17 years old with a mental health disorder received mental health treatment or counseling in the past year (see graphic below), while the national average was 52%.<sup>[15]</sup> This is, however, an improvement from the previous 2018-2019 NSCH results that showed only 47% of NH children received mental health treatment for their condition.<sup>[16]</sup>

National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling [i](#)

		Received treatment or counseling	Did not receive treatment or counseling	Total %
New Hampshire	%	50.3	49.7	100.0
	C.I.	42.0 - 58.7	41.3 - 58.0	
	Sample Count	133	117	
	Pop. Est.	21,762	21,490	
Nationwide	%	52.3	47.7	100.0
	C.I.	50.1 - 54.6	45.4 - 49.9	
	Sample Count	5,629	4,632	
	Pop. Est.	4,478,188	4,076,197	

According to the National Alliance on Mental Illness NH (NAMI NH), as of April 15<sup>th</sup> 2022, there were a total of 19 children waiting in local Emergency Departments for inpatient psychiatric beds.<sup>[17]</sup> Comparing this to the previous year on April 1<sup>st</sup> 2021, there were 16 children waiting for a bed.<sup>[18]</sup> This number has remained relatively stable likely due in part to the continued efforts to divert people from emergency departments through increasing behavioral health integration into primary care, particularly in Community Health Centers that are being supported in part with Title V funding.

Also important to note is the roll-out of the NH Rapid Response Access Point that occurred in January 2022, which is a 24/7 service where NH residents can speak to a trained mental health professional via phone, text, or chat when in crisis. In order to alleviate the Emergency Room boarding crisis of people waiting for psychiatric evaluations, the local community mental health centers now have mobile crisis response teams that will go out to the individual in crisis to assess the need for potential hospitalization rather than the previous model of advising those in crisis to go to their local Emergency Room for assessment. Beginning in July of 2022, anyone looking to contact the Rapid Response Access Point will simply be able to dial 9-8-8 to access these crisis supports.



**The support you want in your time of need.**

**If you or someone you care about is having a mental health or substance use crisis, you can call and speak to our trained and caring staff.**

**Contact the Rapid Response Access Point at**  
**833-710-6477** or visit  **NH988.com**



**A wealth of resources at your fingertips.**



Over the phone support and problem solving to help resolve a behavioral health crisis.



Over the phone support with referrals to outpatient services, or to have a Mobile Crisis Response Team (MCRT) come to you at a place of your choice.



In-person Mobile Crisis Response Team (MCRT) if the crisis cannot be resolved over the phone.





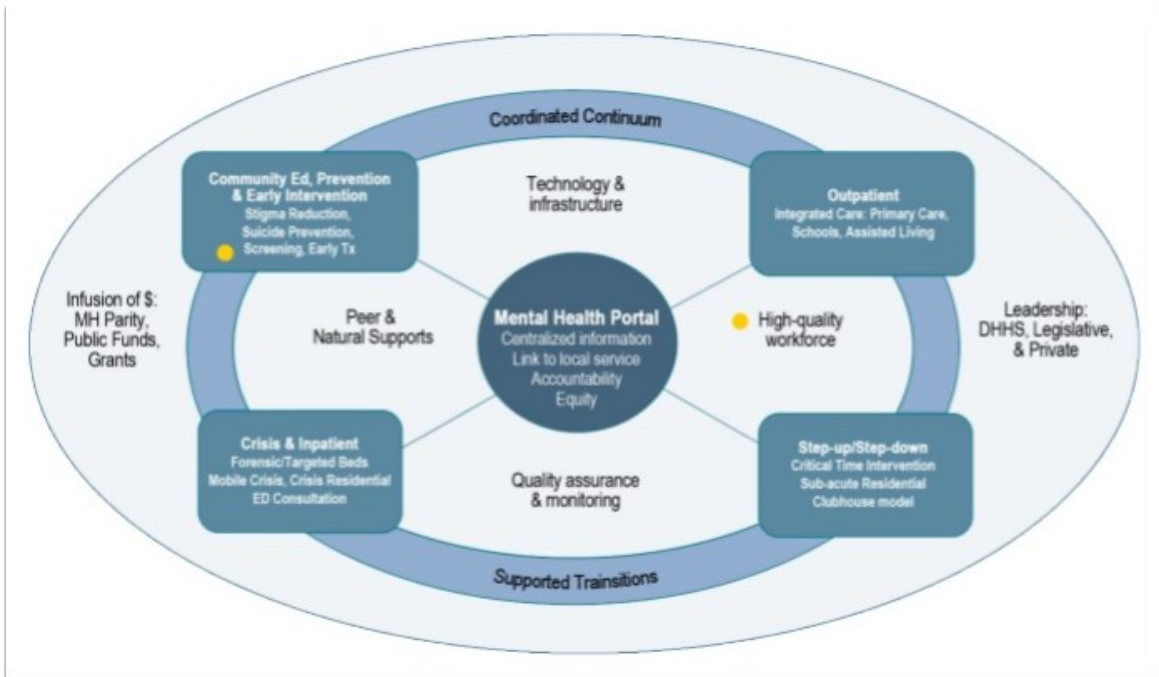

[19]

The rising rates of children with mental health disorders along with only about half of those children receiving mental health treatment continues to demonstrate the necessity of programs aimed at increasing children’s access to mental health care in New Hampshire. One of the recommendations recently provided by the newly established Surgeon General’s Advisory for Protecting Youth Mental Health (2021) is to,

“Support integration of screening and treatment into primary care. For example, continue expanding Pediatric Mental Health Care Access programs, which give primary care providers teleconsultations, training, technical assistance, and care coordination to support diagnosis, treatment, and referral for children with mental health and substance use needs. (p.36)”<sup>[20]</sup>

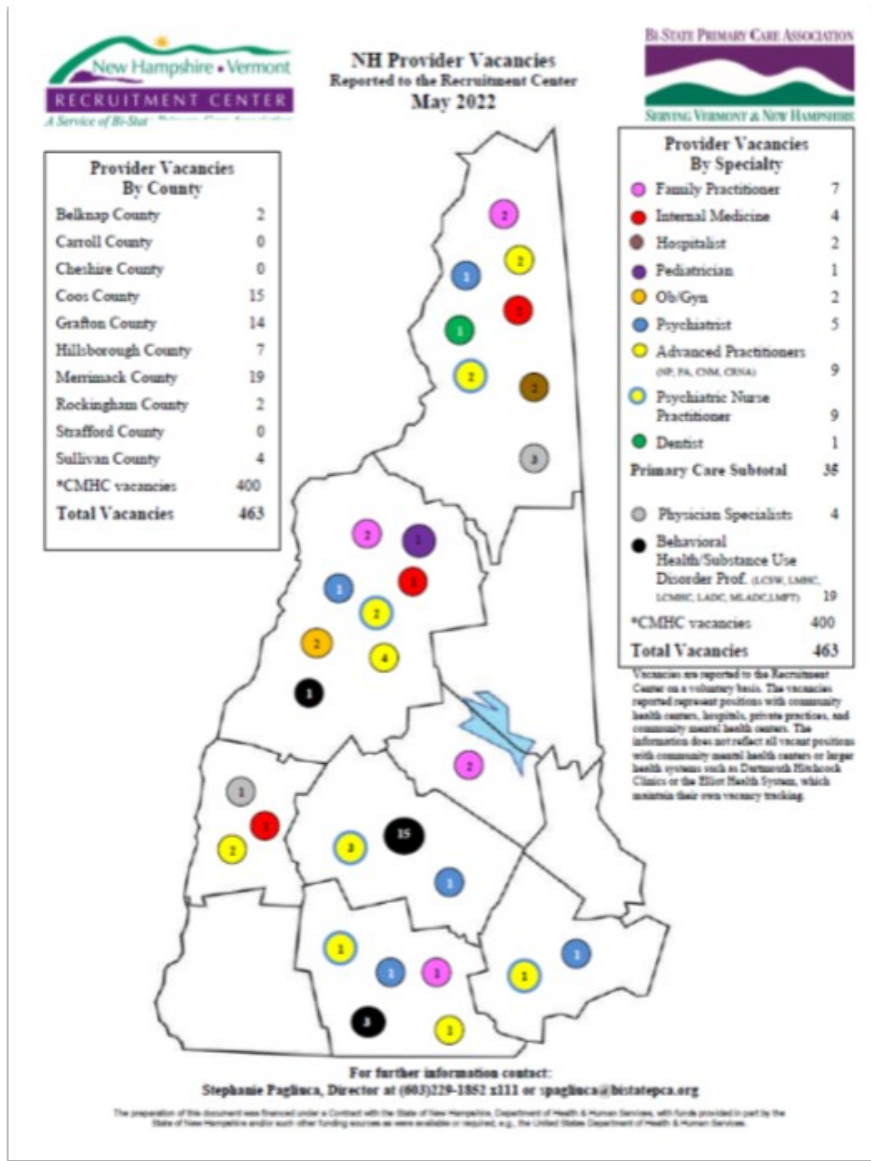
To address this, the NH Maternal and Child Health (MCH) Section’s Pediatric Mental Health Care Access (PMHCA) HRSA grant continues to fund the NH Mental Health Care Access in Pediatrics (NH MCAP) Program which is a collaboration with the University of New Hampshire Institute for Health Policy and Practice that aims to integrate behavioral health services into pediatric primary care. The NH MCAP Program utilizes a pediatric mental health team of subject matter experts that is comprised of specialists in the field who provide education, support, and consultation to primary care providers using the Project ECHO telemonitoring model. The integrated nature of the program works to enable enrolled providers to feel more confident and knowledgeable in conducting early identification and treatment of children with mental health conditions.

Through participation in NH MCAP, enrolled providers can increase their ability to screen and treat children’s mental health issues within their primary care setting which allows children to receive the mental health care where and when it is needed most. Through integrating these behavioral health services into the primary care setting, significantly fewer children will be referred out and put on long wait lists to access treatment. Behavioral health integration will also expand early intervention for mental illnesses which continues to be a major component of NH’s 10-Year Mental Health Plan.



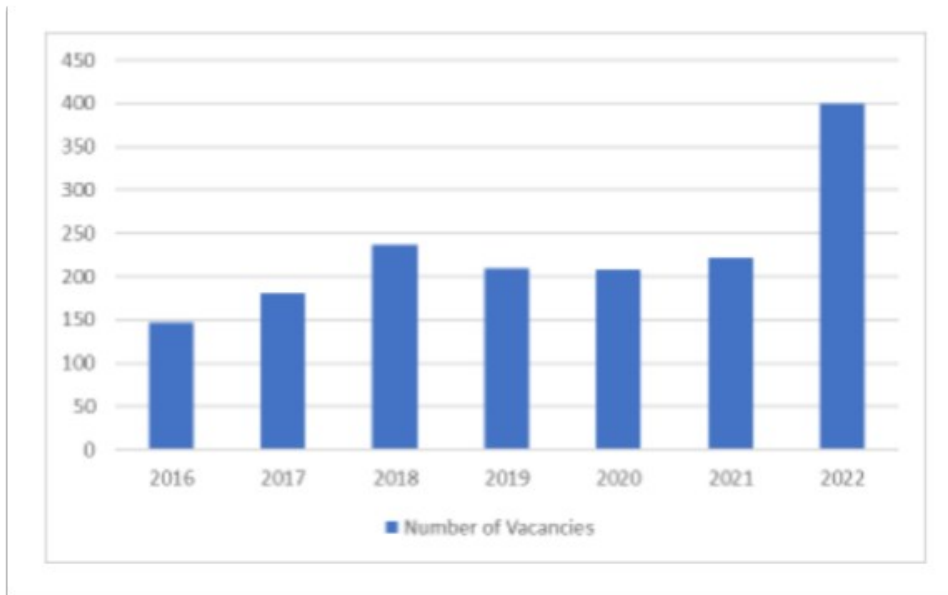
[21]

In order to address the NH 10 Year Mental Health Plan’s established goal of “improving the recruitment, retention, and quality of the mental health workforce,” MCH is continuing its Title V funded contract with the New Hampshire-Vermont Recruitment Center of Bi-State Primary Care Association (Bi-State Recruitment Center) for recruitment of behavioral health professionals (defined as psychiatrists, clinical or counseling psychologists, psychiatric nurse practitioners, masters prepared social workers, mental health counselors, family therapists, and licensed alcohol and drug counselors). Recent data from the Bi-State Recruitment Center has identified 33 vacancies (5 psychiatrists, 9 psychiatric nurse practitioners, and 19 behavioral health counselors) that they are actively recruiting for statewide as of May 2022.



[22]

In addition to the 33 behavioral health provider vacancies that the Bi-State Recruitment Center is actively recruiting for, the NH Community Behavioral Health Association (CBHA) who has been collecting data on NH's ten Community Mental Health Center (CMHC) vacancies since 2015, reported that in January 2022 that there were a total of 400 behavioral health professional vacancies among CMHC's across the state. This vacancy rate has almost doubled since the previous year.



[23]

### Systems Building

To address this need for increased access to mental health care for NH children, MCH's NH Pediatric Mental Health Care Access (PMHCA) Program continues to work to increase pediatric primary care provider knowledge and confidence in identifying, screening, and treating pediatric patients with mental health concerns. In 2019, through contract with the University of New Hampshire Institute for Health Policy and Practice (UNH IHPP) the NH Mental Health Care Access in Pediatrics (NH MCAP) Program was created to:

- Develop and facilitate three Pediatric Mental Health Project ECHO cohorts over the course of the five-year PMHCA grant period
- Offer individual provider-to-provider teleconsultations from the ECHO Pediatric Mental Health Team of subject matter experts
- Create a referral directory of NH pediatric mental health services and supports, which is to be updated and redistributed annually to enrolled participants

The NH MCAP Program is utilizing the Project ECHO (Extension for Community Health Outcomes) model which is an evidenced based all-teach all-learn method developed by the University of New Mexico and is practiced in the US and internationally. UNH is the only Project ECHO hub in NH that is focusing on children's behavioral health. The NH MCAP Project ECHO sessions connect participating practices/primary care providers via web-based conference technology to participate in a 20-minute didactic presentation from established pediatric mental health faculty experts on set curriculum objectives. After the didactic training, a participant then presents a case study and receives feedback and recommendations from both the pediatric mental health faculty members of subject matter experts and also from peers at the other participating pediatric primary care practices.

There has been a new NH MCAP Project ECHO cohort each year which has taken place from February through November. Each cohort has one ECHO session per month during that time period (10 sessions total) and each cohort has a unique curriculum based on a different children's mental health topic. The first cohort took place in 2020 and focused on Pediatric Depression and Anxiety, the second cohort occurred in 2021 and focused on Pediatric ADHD and Trauma, and the third cohort that is currently taking place in 2022 is focusing on Promoting Child and Family Resilience and Healing in a Pandemic. Curriculum topics for the didactic trainings in this cohort include:

- Pandemic impact, brief interventions, and relational health
- Building Family Relational Health
- Community supports to reduce family stressors and promote relational health
- Use of Occupational Therapy to address mental health and build relational health
- Anxiety: use of “common elements” and “common factors” to deliver a brief intervention
- Depression: use of “common elements” and “common factors” to deliver a brief intervention
- Difficult/Disruptive behaviors in young/school age children: brief interventions to support self-regulation, coping, and communication as well as linkage to supports
- Eating disorders (Part 1): Types of eating disorders, epidemiology, pandemic impact, and screening
- Eating Disorders (Part 2): Evidence-based treatments and linkage to supports for common eating disorders
- Special populations: CYSHN, BIPOC, LGBTQ, grandparent as parents, foster children, building therapeutic relationship and population-specific resources

**Promoting Child and Family Resilience and Healing in a Pandemic**

**NH MCAP**  
New Hampshire Mental Health Case Access in Pediatric

**Project ECHO**  
University of New Hampshire

Project ECHO provides virtual case based learning with experts and other pediatric/family care practices across New Hampshire.

**WHAT WILL YOU GAIN?**

- Skills to address the mental/behavioral health impact of the pandemic
- Individual provider to provider teleconsults with ECHO subject matter experts

**TOPICS INCLUDE**

- Building Family Relational Health
- Uses of Occupational Therapy
- Anxiety Related Conditions
- Difficult/Disruptive Behaviors in Children
- Eating Disorders

**WHEN**  
February 2022 - November 2022  
4th Tuesday of the Month  
12:00 - 1:30pm  
Registration Now Open  
If interested, email Corina.Chao@unh.edu

**SUBJECT MATTER EXPERTS**

- Pharmacologist
- Child Psychiatrist
- Occupational Therapist
- Pediatrician
- Social Worker
- Care Coordinator
- Patient/Family Voice
- Psychiatric Nurse Practitioner

*"I learned so much from others, I really enjoyed hearing what was happening in other clinics and I got an opportunity to reflect on ethical considerations."*  
- Participant

This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, for more information, visit [www.hrsa.gov](https://www.hrsa.gov) with 30% financial with congressional sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit [www.hrsa.gov](https://www.hrsa.gov).

**NH MCAP**  
**Enrolled Primary Care Practices**

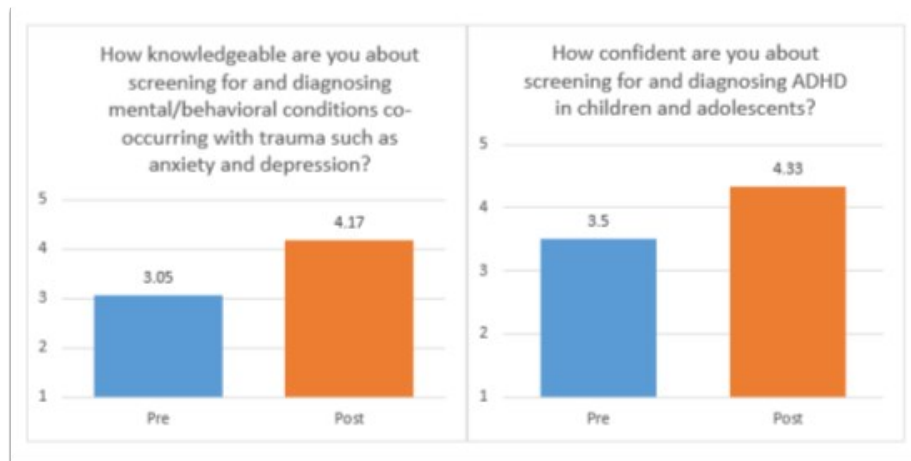
**Cohort 1 (2020) = Blue Dots**  
**Cohort 2 (2021) = Orange Dots**  
**Cohort 3 (2022) = Purple Dots**

To measure impact on enrolled providers' change in knowledge and confidence in treating children with mental health concerns as a result of participating in the NH MCAP Project ECHO cohorts, the providers are required to complete both a pre-cohort and post-cohort survey which asks them to rate their perceived knowledge and confidence in various children's mental health treatment competencies. The knowledge related questions are rated on the Likert

scale: 1 - Not knowledgeable, 2 – Slightly knowledgeable, 3- Fairly Knowledgeable, 4 –Knowledgeable, and 5 – Very Knowledgeable. The confidence related questions are rated on the Likert scale: 1 – Completely lacking confidence, 2 – Somewhat lacking confidence, 3 – Neither lacking confidence nor confident, 4 – Somewhat confident, and 5 – Completely confident.

All of the questions answered by the enrolled providers in the last cohort (cohort 2 in 2021) showed an increase in both knowledge and confidence. An example of one of the knowledge related questions is, “How knowledgeable are you about screening for and diagnosing mental/behavioral conditions co-occurring with trauma such as anxiety and depression?” The pre-cohort participant averaged rating was 3.05 (“Fairly knowledgeable”), and upon completion of the cohort the average for this question went up by 1.12 points to 4.17 (“Knowledgeable”) on the post-cohort survey.

An example of one of the confidence related questions is, “How confident are you about screening for and diagnosing ADHD in children and adolescents?” The pre-cohort survey average for this question was 3.5 (“Neither lacking confidence nor confident”) and the post-cohort survey average went up by 0.83 points to 4.33 (“Somewhat confident”).



Enrolled providers also have the opportunity to request teleconsultations as needed throughout the cohort with the pediatric mental health team faculty subject matter expert(s) of their choice to continue improving their skills in the assessment and treatment of children with mental health concerns. Over the course of the second Project ECHO cohort in 2021, the NH MCAP Program had a teleconsultation utilization rate of 31.6% with 12 teleconsults provided to unique providers among the 38 providers enrolled in the program. With the goal of increasing utilization to 41% by 2026, it is important to continue increasing the pediatric primary care providers’ satisfaction and comfort level with using teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions. Program staff have continued to utilize many strategies to improve the teleconsultation utilization rate, which have included:

- Sending reminder emails twice per month suggesting utilizing teleconsults as well as during each ECHO session
- Offering a free NH MCAP glass water bottle for a provider’s first teleconsult
- Implementing “faculty highlights” during ECHO sessions to spotlight each faculty subject matter expert and the different questions they can help participants with during teleconsults.
- Surveying participants regarding barriers in utilizing teleconsults

- Following up with each case presenter and encouraging them to utilize the faculty expertise to address any unresolved or newly developed aspects of their case.

**HOW TO USE A MCAP TELECONSULT**

Ask about...

- General medication information
- Sensitive/stigmatizing screening topics
- Treatment/referral resources
- Family support and engagement

**Your MCAP Subject Matter Experts**

*Margaret Shepard, PhD, PMHNP-BC*, Pediatric Nurse Practitioner  
*Sylvia Pelletier, BA*, Family Engagement  
*Lauren Holden, MA*, Care Coordinator  
*Devon Sherwood, PharmD, BCPP*, Pharmacist  
*Sarah Smith, DSc, OTR/L*, Occupational Therapy  
*Becky Parton, MSW, LICSW*, Trauma Expert, Social Worker  
*Charlotte Lippolis Condon, DO, MPH, FAPA*, Child Psychiatrist  
*Lisa DiBrigida, MD*, Pediatrician

**See a patient**

**Have a question !?**

**Meet with a SME for peer-to-peer support**

**Request one now!**

<http://bit.ly/MCAPTeleconsult>

**NH MCAP**  
New Hampshire's Care Access to Professionals

**nhpip**  
New Hampshire Primary Care

Although the teleconsultation process was changed during the summer of 2021 based on provider feedback from twice per month open office hours to an as needed model where the subject matter expert will respond to a teleconsult request and schedule the teleconsult within 48 hours, the increase in utilization was not as much as expected. Program staff have found that often times enrolled providers will say that they would like to utilize a teleconsult but then do not have the time to follow-through or to coordinate with the subject matter experts a scheduled time for the teleconsult that works for them both. As we know, providers are stretched thin now more than ever which causes them to be short on time and often over-scheduled. Perhaps if NH MCAP was able to utilize a hotline type teleconsult model where providers can call and speak to the subject matter expert right then when it is needed, this would be most time efficient and user friendly for the providers. However, program staff and the subject matter experts do not have the capacity to provide this type of model under the current program budget. If additional funding is received beyond the end of this grant period in September of 2023, the NH PMHCA Program will use this knowledge to create a plan to adjust to this model that has worked in other states' PMHCA programs.

In addition to the program activities listed above, NH MCAP was also able to leverage unused travel funds to develop and facilitate an additional learning opportunity/webinar titled "Improving Clinical Communication for Student Mental Health" which explored issues and on-the-ground experiences for supporting clinic-school-family communication within the regulatory frameworks of the health (HIPAA) and educational (FERPA) systems. Webinar panelists included NH pediatric primary care clinicians, school nurses/administrators, a family advocate, and legal/policy expert.

### Bi-State Primary Care Recruitment Center

Although the original state performance measure #3, "the percent of behavioral health professionals recruited," has been retired as of this year, MCH is continuing its Title V funded contract with the New Hampshire Vermont Recruitment Center of Bi-State Primary Association (Bi-State Recruitment Center) for behavioral health professional

recruitment. To address behavioral health provider vacancies, in 2021 the Recruitment Center had reached or sourced 254 candidates.

From January 1, 2021 to December 31, 2021, 41% or 104 of the 254 sourced contacts became “active” with the Recruitment Center. From an active status, an individual is then referred for matching to the recruiting agency for potential interviews, etc. Out of the 104 active contacts, 101 were referred to employers. Five professionals secured positions: one psychiatric nurse practitioner, one social worker, and three mental health counselors.<sup>[24]</sup> The following table outlines the variety of behavioral health professionals sourced, activated/matched, referred and recruited.

January 1, 2021 – December 31, 2021				
Provider Type	Sourced (expressed interest in working in NH)	Matched Candidate to Opportunity (some candidates to multiple opportunities)	Referred Candidate to Employer (mutual interest from candidate/employer)	*Recruited
Addiction Counselors	6	0	0	0
MH Counselors/Therapists	60	30	30	3
Social Workers	56	48	47	1
Marriage & Family Therapists	0	0	0	0
Psychiatric Nurse Practitioners	54	4	4	1
Physician Assistant – MAT	0	0	0	0
Psychiatrists	73	5	3	0
Psychologists	5	17	17	0
<b>Total:</b>	<b>254</b>	<b>104</b>	<b>101</b>	<b>5</b>

<b>**Annual Indicator:</b>	<b>41%</b>
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\*Recruited is defined as a candidate the RC worked with who became licensed in the state and/or secured a position in the state  
**\*\*Annual Indicator = Matches/Sourced**  
 Note: Matches and Referrals include direct referrals from Recruitment Center and 3RNet Auto-Referrals

During the past year, the Recruitment Center has used a combination of strategies in its recruitment efforts which include:

- Participating in multiple virtual career fairs with residency programs nationwide through their CareerMD Regional Access
- Presenting at the National Association of Social Workers (NASW) NH 2022 Annual Conference
- Referring candidates to client organizations through the 3RNet Auto Referral feature
- Listing on PracticeLink online job board and candidate database
- Recruiting at the NH Behavioral Health Summit 2021
- Presenting for Mental Health Counselor students at Rivier University, Nashua, NH
- Presenting for Mental Health Counselor students at Plymouth State University, Plymouth, NH
- Listing advertisements in the National Association of Social Workers quarterly newsletters for NH,



## Massachusetts and Connecticut

In addition, Bi-State continues to work to inform agencies that hire mental health treatment providers of recruitment center (RC) services and provide technical assistance to organizations and regions, inclusive of Integrated Delivery Networks (IDNs), with recruitment needs for mental health providers. For example:

- RC staff conducted a Zoom session with a community health center as they hired a new HR Director. The purpose of the meeting was to re-introduce their services and provide technical assistance regarding salary information. The RC followed up with information on salary averages for LCSWs, CMHCs, and other master's level behavioral health providers to an FQHC.
- Reached out to all Premium Promotional contacts several times to provide support and inquire about behavioral health recruiting needs. Many sites continued with their recruitment efforts during the pandemic. The RC has continued to promote their organizations and their job openings in social media, job postings and when attending virtual events.
- Reached out to all Contingency and Premium Promotional clients to keep abreast of updates relating to federal loan repayment programs.
- The RC conducted outreach to psychiatrist nurse practitioners, mental health clinicians, psychiatrists, and psychologists who expressed interest in NH opportunities through the website Indeed.com. Each clinician was provided information about opportunities located at sites that have openings listed with the RC.
- Shared information and web links with an FQHC regarding salary data for master's level clinicians and psychiatric nurse practitioners.

The recruitment center continues to update the comprehensive resource library on its website that includes key resources to help facilities stay current on the ever-evolving COVID-19 related policies and procedures, as well as available funding sources to enable them to continue to provide services. Updates are emailed to health centers in a weekly bulletin.

### **MCH Specific Activities**

In addition to the project activities within the PMHCA grant, the PMHCA Program Coordinator (leveraged to a full FTE with Title V funding) continues to collaborate and create linkages with other departments and organizations through engaging in various stakeholder and other state agency committees to further the improvement of NH children's mental health initiative. These include:

- The NH Department of Education and the Bureau for Children's Behavioral Health's System of Care Advisory Council  
Meets bimonthly with the mission to promote, align, and continuously improve System of Care Principles and values into every relevant initiative, support system, service of child welfare, juvenile justice, behavioral health, education, primary care, first responders, public health, and community providers at the family, organization, community, regional, and state levels.
- NH Children's System of Care Technical Assistance Center Leadership Advisory Team  
Meets bimonthly to support the establishment of a resource center for children's behavioral health that is available statewide and acts as a clearinghouse for information and resources on evidence-based practices for children receiving mental health services.

- The Building Futures Together Leadership Team

Meets bi-monthly to support the grant funded Building Futures together program which will prepare 98 paraprofessionals in healthcare and school settings to provide specialized enhanced care coordination to children, youth and their caregivers whose parents are impacted by substance use disorders (SUD).

- NH PIP Steering Committee

Meets quarterly to work on promoting awareness of and interest in pediatric care quality measurement, projects, and resources, and is made up of a diverse group of stakeholders from around the State.

- Watch Me Grow Steering Committee

Meets monthly to help guide the NH Watch Me Grow developmental screening system.

### Social Messaging

The PMHCA Program Coordinator continues to contribute to the DPHS/MCH social media presence by creating posts that highlight the need for increased access to mental health care for NH children that explain the presence and purpose of the NH MCAP Program, and that increase viewer knowledge on mental health statistics and resources.



<sup>[1]</sup> NH DHHS, Maternal & Child Health Section: Uniform Data Set Table, 2021

<sup>[2]</sup> MCH Staff (2022). Documented from ES Workplan Outcome.

<sup>[3]</sup> Ibid.

<sup>[4]</sup> Child and Adolescent Health Measurement Initiative. 2020 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [5/3/2022] from [www.childhealthdata.org].

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## Cross-Cutting/Systems Building - Application Year

**State Performance Measure #1:** Percentage of the MCH-contracted Community Health Centers' (CHCs) that have met or exceeded the target indicated on their Enabling Services (ES) workplans (Old). This measure is being changed for several reasons. The first being that the previous measure was not capturing CHCs that met the goals and objectives of just one of their two ES workplans. CHCs were being given credit if they met one, but did not meet the second. This was not necessarily accurate information given the wording of the original performance measure. The second reason is that all of the CHCs are in new contracts, as of June 16, 2022, after responding to a completely revised Request for Proposals.

As part of the proposal, each CHC had to submit two entirely new ES workplans, one having to focus on the social determinants of health. Thus, the **new State Performance Measure #1 is Percentage of Enabling Services workplans that have been met or exceeded on an annual basis**. The numerator is the number of CHC ES workplans that have met or exceeded their target on an annual basis. The denominator is the total number of CHC ES workplans.

**Objective:** Increase the percentage of ES workplans that have met or exceeded their target(s) to 75% in 2025.

### Strategies:

- MCH requires all CHCs to submit a two-year ES workplan as a contract deliverable within 30 days of the beginning of a contract period (in this case June 16<sup>th</sup>, 2022).
- MCH staff initially review ES workplans and provide feedback/technical assistance as needed to ensure agencies have included specific, measurable, achievable, realistic and, timely (or time-bound) SMART objectives/goals and a target for each State Fiscal Year (SFY).
- Monthly calls will occur between the MCH QI/Clinical Staff and CHC QI staff to share updates, need for technical assistance, etc.
- Learning communities and communities of practice on specific ES topics will be set up and implemented monthly.
- Updates to the ES workplans will be formally submitted twice per year, in January and July. At this point, MCH will review ES workplan outcome sections to determine how many have reached their target. If the target has not been attained, feedback/technical assistance will be provided and the CHC will need to submit a revised plan.

### **Systems Building**

NH MCH recognizes both the public health value of ES and the importance of maintaining accountability provided by contracted agencies. In the last Request for Proposals that CHCs responded to entitled "MCH in the Integrated Primary Care Setting", it was a requirement that two ES workplans be submitted. One of the two had to be focused on increasing the screening and referrals for the social determinants of health among the MCH client population. This was done to address Title V's new priority in 2020 to "**Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population.**"

In the revised deliverables, Title V contracted CHC's must submit workplan updates and outcomes every six months: in the second week of January (07/01-12/31) and the second week of July (01/01-6/30).

On a monthly basis and new to the oversight of the Title V funded CHC contracts, the MCH Quality Improvement and

Clinical Services Administrator and an assigned staff member (either the Perinatal Nurse Coordinator, the Pediatric Mental Health Care Access Coordinator or the Child-Adolescent Health Clinical Coordinator) will facilitate a monthly call with each CHC to discuss updates on all workplans and efforts. This will enable Title V staff to have an up-to-date knowledge of how the ES workplans are being implemented as well as providing any technical assistance that may be needed. Also, when monthly fiscal invoices are submitted by CHCs, the new policy is that all back-up documentation (payroll sheets, etc.) must now be supplied before any payment is made. This also gives Title V staff additional information, particularly on CHC staffing and the implementation of both the ES and Quality Improvement (QI).

Since all of the CHCs are required to implement a SDOH ES workplan, a community of practice will be set up for all to start at the beginning of 2023. MCH’s Quality Improvement and Clinical Services program will take the lead on facilitating this with occasional speakers. The topics of the ES workplans for the next year are:

<b>Agency</b>	<b>ES Topic 2</b>
Amoskeag Health	Lactation Support
Concord Hospital Family Health Center	Lactation Support
Coos County Health Center	Lactation Support
Greater Seacoast Community Health	Referrals to Home Visiting
Health First	ACES Screening
Lamprey Health Care	Enrollment into Million Hearts
Manchester Health Department	Increased outreach to homeless women and children
Mid State Health	Lactation Support
Weeks Medical Center	Behavioral Health Integration
White Mountain Community Health Center	Referrals to Home Visiting

There may also be room to have additional communities of practice, since there are several topics CHCs have in common. Home visiting referrals, ACES screening and behavioral health integration are two topics MCH has expertise in. Lactation support is an appropriate topic to bring MCH’s sister section in the Bureau of Population Health and Community Services, WIC, into the fold. WIC supports a peer-support breastfeeding program across the State and has two internationally certified breastfeeding counselors on staff. The same is true for the other sister section, Chronic Disease, with cardiac expertise. The Child-Adolescent Clinical Health Coordinator is currently working with the State’s Bureau of Housing Supports on a homelessness in adolescence state plan development project. Colleagues from that Bureau could potentially help MCH guide the particular CHC whose ES workplan focuses on that.

\* \* \* \* \*

**State Performance Measure #3**

Percent of enrolled pediatric primary care providers that received pediatric mental health teleconsultation from the Pediatric Mental Health Care Access (PMHCA) Program.

**Objective:** Increase the percentage of enrolled providers who receive Pediatric Mental Health Care Teleconsultation in the NH Pediatric Mental Health Care Access (PMHCA) Program from a baseline of 23% in 2020 to 41% in 2026.

**Strategies:**

- Provide NH pediatric primary care providers with additional training on the assessment and treatment of children with mental health concerns by:
  - Development of a Pediatric Mental Health Project ECHO series facilitated by the NH Pediatric Mental Health Team faculty of local subject matter experts.
  - Recruitment of pediatric primary care practices across NH to participate in the Pediatric Mental Health Project ECHO, targeting those in rural/underserved areas.
  
- Provide Teleconsultation opportunities as needed for primary care providers with the PMHCA pediatric mental health team faculty members by:
  - Promotion of the Teleconsultation opportunities for participating pediatric primary care practices with the NH Pediatric Mental Health Team faculty.
  
- Continuation of Teleconsultation services by:
  - Increased NH pediatric primary care physician satisfaction with using Teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions.
  - Development of a plan for program sustainability

**Systems Building**

MCH's Pediatric Mental Health Care Access (PMHCA) Program continues to fund the NH Mental Health Care Access in Pediatrics (NH MCAP) project which is a collaboration with the University of New Hampshire Institute for Health Policy and Practice that aims to integrate behavioral health services into pediatric primary care. The NH MCAP pediatric mental health team of subject matter experts is comprised of specialists in the field (child psychiatrist, clinical mental health counselor, psychiatric nurse practitioner, pharmacist, occupational therapist, care coordinator, and family engagement specialist) who provide education, support, and teleconsultation to primary care providers using the Project ECHO telemonitoring model. The integrated nature of the program works to enable enrolled providers to feel more confident and knowledgeable in conducting early identification and treatment of children with mental health conditions.

Each NH MCAP cohort lasts for a total of 10 months with one hour and a half session each month. The first part of each session consists of a didactic presentation given by one of the faculty of subject matter experts listed above on a set curriculum of topics. The second part of each session consists of an enrolled provider presenting a case study and receiving feedback and recommendations from both the pediatric mental health faculty of subject matter experts as well as their clinician peers.

In addition to the Project ECHO sessions, enrolled providers also have the opportunity to receive teleconsultations as needed throughout the cohort with the pediatric mental health team faculty subject matter expert(s) of their choice to continue improving their skills in the assessment and treatment of children with mental health concerns. In order to achieve the state performance measure objective of increasing utilization to 41% by 2026, program staff will

continue working to increase the pediatric primary care providers' satisfaction and comfort level with using teleconsultation as a way to build their knowledge and confidence in treating children with mental health conditions. Program staff plan to continue utilizing various strategies to improve the teleconsultation utilization rate, which will include but are not limited to:

- Sending reminder emails at least twice per month suggesting utilizing teleconsults as well as during each ECHO session
- Offering a free NH MCAP branded glass water bottle for a provider's first teleconsult
- Implementing "faculty highlights" during ECHO sessions to spotlight each faculty subject matter expert and the different questions they can help participants with during teleconsults
- Making the teleconsult request process easier by allowing participants to put requests for consults in the chat box during the ECHO
- Sending out bios of the subject matter experts every month
- Surveying participants regarding barriers in utilizing teleconsults
- Following up with each case presenter and encouraging them to utilize the faculty expertise to address any unresolved or newly developed aspects of their case
- Program staff are also discussing the potential to create a video showcasing a mock teleconsult to showcase what the service is and how it can be used

The most common barriers identified by providers when asked what is keeping them from utilizing the teleconsult services are that they do not need the service due to already having internal consulting resources; and the most significant barrier is the time required to request the consult, prepare for the consult, and complete the consult, as well as the inability to bill for said time. It is known that providers are stretched thin now more than ever which causes them to be short on time and often over-scheduled. Perhaps if NH MCAP were able to utilize a hotline type teleconsult model where providers can call and speak to the subject matter expert right then when it is needed, this would be most time efficient and user friendly for the providers; however, program staff and the subject matter experts do not have the capacity to provide this type of model under the current program budget. If additional funding is received beyond the end of this grant period in September of 2023, the NH PMHCA Program plans to use this knowledge to create a plan to adjust to this model that has worked in other states' PMHCA programs.

### **Bi-State Primary Care Recruitment Center**

Despite the retirement of the previous state performance measure #3, "the percent of behavioral health professionals recruited," MCH will continue its Title V funding of the Bi-State Recruitment Center for their recruitment of behavioral health providers throughout the State. Behavioral health providers are defined as psychiatrists; clinical or counseling psychologists; nurse practitioners; masters prepared social workers, mental health counselors and family therapists; licensed alcohol and drug counselors; and masters prepared licensed alcohol and drug counselors. Some of the anticipated activities of the recruitment center include, but are not limited to:

- The provision of technical assistance to organizations and agencies with recruitment needs for behavioral health providers on the techniques of recruitment and retention and the measures critical for securing candidates.
- The engagement and encouragement of agencies to post behavioral health provider/clinician vacancies through the Recruitment Center. These vacancies will be tracked as a means to identify vacancy,

recruitment and turnover trends and determine effective tactics for successful outreach, recruitment and retention. These trends will be shared with MCH and other key stakeholders as appropriate.

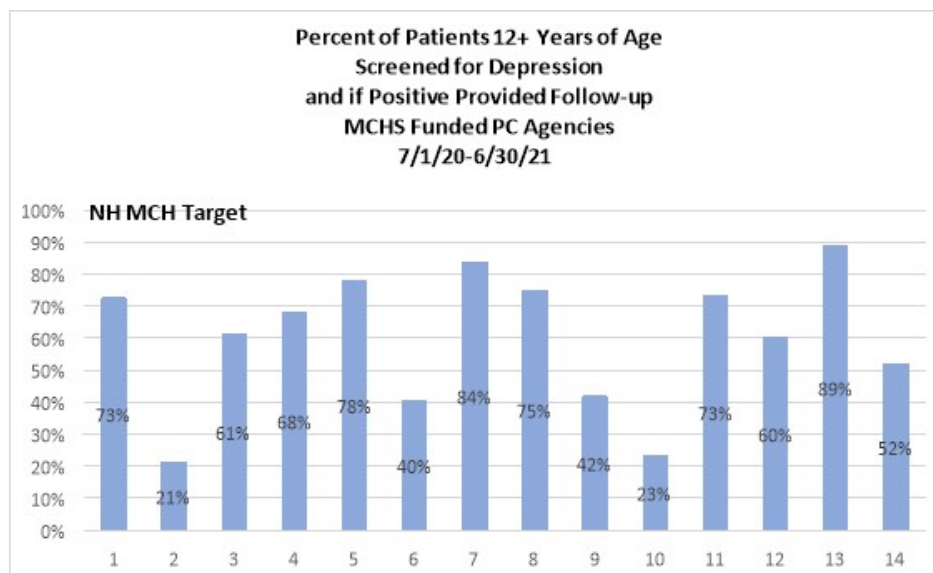
- The carrying out of efforts to fill the vacancies with the target audience of behavioral health providers using targeted marketing.

The Recruitment Center also provides MCH with quarterly statistics on the recruitment of behavioral health providers as tracked by its electronic vacancy tracking system and measured by:

- The number of contacts with behavioral health professionals broken out by provider type. This includes the number sourced, the number who have become active and the number of professionals who then match with interviews.
- The number of behavioral health professionals recruited to and who obtained employment within NH, again broken out by agency and provider type.
- The number and type of behavioral health provider who declined placement and the reason(s) for declining.

### MCH Specific Activities

Behavioral health screening for NH youth has been identified as a key performance measure for the MCH in the Integrated Primary Care Setting contracted Community Health Centers/ Federally Qualified Health Centers. Funded health centers are required to report on “The percentage of patients ages 12 and older screened for clinical depression using an age appropriate standardized depression screening tool on the date of the encounter or up to 14 days prior AND if positive, a follow-up plan us documented on the date of the positive screen.” MCH’s target rate for this measure is 75%. In SFY21, the combined average between all contracted health centers was 60% of patients ages 12 and older screened and with a follow-up plan if positive. During this next year, health centers will continue their planned activities identified on their work plans to increase this rate.



In addition to MCH in the Integrated Primary Care Setting, MCH has recently secured funding through the CDC for School-Based Health Services for which the MCH contracted health centers can apply to increase their physical and



mental health workforce in local NH schools. Activities to increase physical and mental health services as well as increase community collaboration and connection to needed external services for students will begin in the Fall of 2022.

In order to continue collaborating and creating linkages with other departments and organizations, the PMHCA Program Coordinator will continue engaging in various stakeholder and other state agency committees to further the improvement of NH children's mental health initiative. These include:

- The NH Pediatric Improvement Partnership Steering Committee
- The NH Department of Education/The Bureau for Children's Behavioral Health's System of Care Advisory Council
- The NH Watch Me Grow Developmental Screening Steering Committee
- NH Children's System of Care Technical Assistance Center Leadership Advisory Team
- The Building Futures Together Leadership Team

Through involvement in these committees and the partnerships formed, the PMHCA Program Coordinator (leveraged to a full FTE with Title V funding) will continue to work to promote awareness of and interest in the NH Mental Health Care Access in Pediatrics (NH MCAP) Program, the need for behavioral health integration in pediatrics, current children's mental health resources, as well as NH system of care initiatives and updates.

### III.F. Public Input

In non-needs assessment years such as this past year, input on the Title V MCH Block Grant is gathered routinely from stakeholders who are not members of the MCH or BFCS staff, through task force or advisory committee meetings attended or led by MCH and BFCS staff, through multidisciplinary work group meetings and through meetings with staff of Title V -funded agencies and their respective advisory groups. The Governor's Emergency Order was lifted in June of 2021, which enabled in-person meetings. However, most meetings remained virtual with the exception of any legislated committee which had to meet in-person if there was any voting to be done. In fact, most constituents and stakeholders continue to prefer virtual meetings, where attendance is often higher than pre-pandemic.

Many programmatic meetings, particularly those that are legislated, such as the Newborn Screening Advisory Committee and the non-review portions of the Child Fatality Review Committee are also open to the public, even when facilitated virtually. The DHHS website posts public notices of these meetings and the meeting minutes, if appropriate. MCH makes presentations to the Legislative Health and Human Services Oversight Committee several times each year, this year in-person, to report on the work of legislated committees such as Maternal Mortality, Newborn Screening, Birth Conditions and Child Fatality (including Sudden Unexpected Infant Death and Sudden Death in the Young). Information about the MCH Block Grant and State Action Plan is also provided regularly for potential input.

#### Stakeholder input and Advisory groups

Title V staff routinely attend meetings of various stakeholder groups and Advisory Councils where discussion of Title V related activities, ongoing or emergent needs and solicitation of feedback are always standard on the agenda. These include:

- Community Health Center Chief Executive Officers and QI Coordinators;
- Council for Autism Spectrum Disorders;
- Council for Youth with Chronic Conditions;
- Dartmouth-Hitchcock Medical Center Patient/Family Advisory Council;
- Department of Education, Bureau of Student Wellness and Nutrition;
- Division of Children, Youth and Families Annual Meeting;
- DHHS Early Childhood Integration Team;
- Early Hearing Detection and Intervention advisory board;
- Legislative Commission of Primary Care Workforce;
- Medicaid managed care organizations (MCOs);
- Newborn Screening Advisory Council;
- NH Family Support Council;
- NH Citizens Health Initiative;
- NH Pediatric Improvement Partnership;
- Partners in Health Regional Family Councils;
- Watch Me Grow Steering Committee;
- WIC Nutrition Program;
- Youth Health Care Transition Advisory Committee;
- Northern New England Perinatal Quality Improvement Network;
- NH Falls Risk Reduction Task Force;
- Legislative Study Committees (e.g. Committee to Study Requiring NH Children to be Placed in Rear Facing

Restraints);

- DPHS R User's Group;
- Overdose Data to Action quarterly contractor meeting;
- NH HIV Planning Group;
- New England Whole Families Approach to Jobs;
- NH Alliance for Innovation on Maternal Health Champions; and
- Local Implementing Agencies (home visiting) Supervisors.

Several of this year's new Requests for Proposals (RFPs) were released with Title V funding including "Maternal and Child Health Care in the Integrated Primary Care Setting," "MCH and Primary Care/School Based Setting," "Recruitment of Health Care Workforce," "Healthy Families America Home Visiting," Specialty Services for Children with Medical Complexities, Community-Based Health Care Coordination, and Child Development Services. During the early development period of each RFP, input from stakeholders is gathered.

The Title V funded Community Health Centers (CHCs) under the new "Maternal and Child Health Care in the Integrated Primary Care Setting RFP" will meet once a month with staff from MCH's Quality Improvement and Clinical Services group, including the Program Manager, the Perinatal Coordinator, the Child/Adolescent Nurse Consultant and the Pediatric Mental Health Care Access Coordinator. Historically, the CHCs have been a primary source of public input for the Title V needs assessment every five years. These monthly meetings will focus on program implementation, but will also include discussions on ways to consistently have the families they serve participate in giving feedback.

### **Web Postings**

The DHHS website went through a full re-design. As "sister programs" MCH and BFCS maintain separate webpages on the website, [Maternal & Child Health | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/health/maternal-child) and [Services for Children with Special Health Care Needs | New Hampshire Department of Health and Human Services \(nh.gov\)](https://www.nh.gov/health/services-children). In addition to using these as a way to communicate about programmatic intentions, HRSA's New Hampshire State Snapshot is posted on both pages and the Title V Block Grant Plan Overview and full plan are posted on the MCH page with contact information where individuals are encouraged to provide input or feedback to the plan and activities.

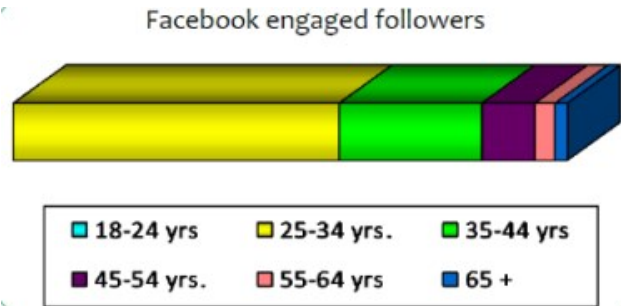
The Data and Decision Support Administrator created a document referred to as the [Title V brochure](#). This document presents a summary of the State's current performance measures aligned with state priority needs. The current objectives are listed, as well as the current strategies to attain the objectives. National outcome measures are also included, to show the relationship between the performance measures and universally reported health indicators (outcome measures). This document is reviewed on a yearly basis, and revised as needed. As additional programs within both MCH and BFCS refine their pages and links, it is planned that there will be at least a link to HRSA's State Snapshot for every program represented. There were 6,623 hits to MCH's landing site in the last 12 months.

The CSHCN Systems of Care Specialist is also the web liaison for BFCS and as such took a special interest in the website re-design process. While there are still bugs to be worked out relative to placement, the pages for [Children with Special Health Care Needs](#) was designed with Title V in mind. Highlighted are Services, Family Engagement and Systems of Care for CSHCN along with Family Centered Early Supports and Services, NH's Part C program for infants and toddlers with developmental delays. In the next year, there are plans to enhance the family engagement section of the site with new resources and links.

## Social Media

A web-based presence like social media is becoming widely used by the MCH section as it can promote programming and inform on health policies.<sup>[1],[2]</sup> BFCS provides Title V funding to NH Family Voices (NHFV) to utilize and promote social media efforts for CSHCN and their families. Using social media enables Title V as a whole to disseminate messages in real time to inform about immediate health risks, but also to share healthy lifestyle and prevention strategies. Social media allows large numbers of people to rapidly access and disseminate information.<sup>[3]</sup> Title V and its contracted agencies can use social media to disseminate time-sensitive health information, and can circulate information that encourages behavior change. Using social media can also stimulate the involvement of the public through comments and conversation. For example, during the COVID-19 emergency, NHFV provided Facebook chats and a dedicated email address on their website to obtain information about families' needs.

In an effort to maximize its communication reach, MCH has utilized the DPHS Facebook, Twitter, and Instagram social media accounts since April 2017. The DPHS Facebook page can be found at [www.facebook.com/NHPubHealth](https://www.facebook.com/NHPubHealth), and the DPHS twitter handle is @NHPubHealth. All programs within MCH are encouraged provide posts on a monthly basis at the least. The DPHS social media strategy allows programs to actively engage with the community by raising awareness of public health issues that can improve health and prevent disease. Consistent messaging helps educate the target audience about important health issues. From May 1, 2021 to April 30, 2022, MCH posted 294 social media posts to the DPHS Facebook and Twitter social media accounts. Reaching 63, 751 unique users and obtaining 777 likes. Posts include information on every MCH topic area and provide links to where women and families can access services and program information.



NHFV reports that social media statistics grew exponentially during the 'stay at home' period. Their Facebook "public" page is used for events, information, and resources. A private Facebook group was established to support parent-to-parent linkages, and information sharing. In FY2021, they reported 2,128 'likes' which was an increase from 1,923 in FY2020. Individuals who "follow" or interact with the page, are primarily NH families and professionals, 91% of whom are women and 9% are men. The majority of followers are 25 to 34 years of age followed by those 35 to 44.

The NHFV private NH Facebook group provides the opportunity to respond to questions and direct parents/family members/caregivers to viable resources quickly. At the end of FY2021, NHFV reported having 1,258 members; nearly 54% considered "active." This represents an 8% increase from the previous year.

Consistent posting of MCH and BFCS programs' information on social media platforms increases the number of individuals reached. Piloting the FPP targeting strategies for specific populations through social media advertisements has demonstrated that this marketing strategy is effective for reaching specific age individuals. By using this marketing strategy, this outreach effort can lead to increased knowledge of MCH programs and resources available, as 81% of Americans use social media. Generally, social media users have multiple accounts across many platforms (73%)<sup>[4]</sup> which is why NH DPHS and BFCS, through NHFV, have increased their efforts to use popular social media platforms.

As parents of CSHCN, NHFV employees, support Title V activities through participation in the following:

- The Federal Block Grant Review

- AMCHP Family Delegate
- BFCS Redesign Stakeholder Committee
- Watch Me Grow Steering Committee
- CDC LTSAC Ambassador
- Disability Rights Center (DRC) Supported Decision Making Committee
- NH Pediatric Society
- NH Pediatric Improvement Partnership

### **Focus Groups**

MCH has significantly increased the utilization of focus groups to inform its activities. As part of the Alliance in Maternal Innovation (AIM) work in conjunction with NNEPQIN, MCH sponsored focus groups with current and former obstetrical patients across the state. This has led to the formation of the Perinatal Community Advisory Council (PCAC). There was an initial meeting of the group, held virtually, setting the stage for respectful interaction and introducing the concept of respectful care overall. Participants shared their lived experience of that care, both helpful and not. Although unique, their experiences exposed common themes that could be the groundwork for potential future projects for the PCAC, including culturally competent care. The PCAC will be a perfect forum for introducing and getting input on the Title V strategic plan, particularly since several of the measures are tied specifically to the perinatal population.

MCH and the Safe Sleep Workgroup also hosted two focus groups of pregnant women and families exploring maternal attitudes, experiences and behaviors around the topic of safe sleep. Input focused particularly on strategies for soothing a crying baby and lack of sleep for the caregiver, both as situations increasing vulnerability for unsafe behavior. There also was a heavy focus on accessing helping resources and the role of health professionals in this area. This directly informs the ESM and strategies to address the national performance measure NH Title V has adopted around safe sleep.

### **Outreach to BFCS specific stakeholders**

BFCS continues to participate in a variety of public input activities with an emphasis on identifying barriers to care as well as unmet needs in the system of care for CYSHCN. Public input is sought from participants in all Title V-funded services using a satisfaction survey and reported in each contractor's annual report. New Hampshire Family Voices' (NHFV) participation in planning and implementation remains a critical component of the BFCS services as family involvement and engagement is central to family support for CSHCN.

In FY2022, the Medicaid Home Visiting Rules revision was finally completed. As a component of the revision process, public input sessions are held and the suggested revisions are considered by the NH Medical Care Advisory Committee (MCAC), which is a public advisory group established in accordance with [42 CFR § 431.12](#) to advise the State Medicaid Director regarding NH Medicaid policy and planning. The benefit of having the MCAC review the rules is that this group includes stakeholders who are familiar with the comprehensive healthcare needs of low-income population groups and with the resources required for their care. In FY2023, BFCS will engage in the process of reviewing and updating rules that govern programs and services for CSHCN including family support, as well as Part C services for infants and toddlers with developmental delays. All rules are distributed to contractors and stakeholders for input and public hearings are a required component.

BFCS participates in the Advisory Group meetings for CHI's Qualitative Needs Assessment, supported by the Council for Youth with Chronic Conditions. According to their proposal, the data collection methods for this work included focus groups to provide more detailed and nuanced context to specific areas of need identified in the initial survey and key informant interviews. Participants will include parents and caregivers of children with chronic

conditions.

BFCS also engaged a stakeholder group to provide important family and provider perspective for redesigning the scope of care coordination and family support to improve efficiencies, address workforce shortages and increasing costs, and improve the overall quality in alignment with the National Care Coordination Standards for CSHCN.

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[1] Fung, I., Tsz Ho Tse, Z., Fu, K. (2015). The use of social media in public health surveillance. *Western Pacific Surveillance and Response Journal*.

[2] Farsi, D. (2021). Social Media and Health Care, Part I: Literature Review of Social Media Use by Health Care Providers. *Journal of Medical Internet Research*.

[3] Dosemagen, S. & Aase, L. (January 27, 2017). How Social Media is Shaking Up Public Health and Health Care. *Huffington Post*.

[4] Smith, A., & Anderson M. (2018). Social Media Use in 2018. Pew Research Center.

### III.G. Technical Assistance

The last year has been a transitory one for NH's Title V program. The program welcomed several new staff, said good bye to a few long time colleagues all the while struggling with the burden of the pandemic. Because of the latter, not one staff member physically travelled to a grantee meeting or conference. Every staff professional development, technical assistance, every grantee meeting or conference was done online. This has actually increased the ability of Title V staff to avail themselves of the opportunity and the number of professional development sessions within Title V staff have gone up.

NH's first technical assistance request is reflective of the Title V mission. MCH and BFCS staff, both part of the state's Title V program, are physically separated in two distinct locations. The distance between the two entities is only 2.5 miles, but can sometimes feel like much more when working together routinely and on a daily basis. MCH has rebuilt the state's Birth Conditions Program in the last five years in addition to bringing the follow-up coordination for newborn hearing screening out of a contractor's purview and back with state staff. Both of these programmatic activities now require a consistent, if not daily, interaction between MCH newborn screening staff, which includes birth conditions, newborn hearing and newborn bloodspot, and BFCS staff, which includes Part C/Family Centered Early Supports and Services, Health Care Coordination, Nurse Consultation and Partners in Health. Technical assistance for a two-day workshop and ten hours of follow-up electronic consultation is requested from the DaSy Center, a national technical assistance center funded by the U.S. Department of Education that works with states to support early intervention systems. Staff from the DaSy Center could help to facilitate the data sharing agreement between MCH and BFCS from a draft one into something that is signed. DaSy staff could orient staff in the following training objectives:

- Increased understanding of the privacy requirements (e.g. under IDEA, FERPA and HIPAA) and important technical aspects needed to address data sharing.
- Increased awareness of challenges and strategies related to data sharing
- New resources on data sharing.
- Facilitated review by DaSY staff and collaborative rewrite if necessary of draft data sharing agreement.
- Discussion and agreement on follow-up coordination beyond the data sharing agreement.

Follow-up consultation would support signing and implementation of the data sharing agreement with the ability to quickly address any barriers.

The second technical assistance request is focused on MCH's Injury Prevention Program who when queried, asked for help in better integrating its work with the other Title V programs within MCH such as adolescent health. The Injury Prevention Program, which has three staff, two partially funded by Title V, has been part of MCH/Title V for many decades. Its current Title V work is aligned with National Performance Measure #7.2, Rate of hospitalizations for non-fatal injury per 100,000 adolescents ages 10-19, with activities in teen driving and concussions through contracts with community based agencies. Occasionally, programs feel that they are in silos due to the specific deliverables required by funders, even when they have been working together for years.

Technical assistance would be requested from the Children's Safety Network (CSN) at the Education Development Center, a HRSA funded center that works with state and jurisdiction Title V program to "strengthen their capacity, utilize data and implement effective strategies to make reductions in injury-related deaths, hospitalizations and emergency department visits" ([childrenssafetynetwork.org](http://childrenssafetynetwork.org)). NH's Injury Prevention Program and MCH Administrator have worked with CSN for over two decades; the Administrator is a part of the Children's Safety Now Alliance, which acts as CSN's advisory committee. CSN is uniquely poised for this type of technical assistance since they routinely

work with both Title V and Injury Prevention programs so are knowledgeable about the integration that can happen and have examples of best practices and model programs implemented at the state and local level.

Another HRSA funded center that NH's Title V would like to request technical assistance from is the National Adolescent and Young Adult Health Information Center. MCH's Adolescent/Pediatric Nurse Consultant is less than six months into her position and would benefit by a one on one discussion of National Performance Measure #10, Percent of adolescents with a past year preventive visit. A mentoring format over several months would be appropriate sharing best practices and innovative strategies.

Many strategic initiatives are described in the grant focusing on National Performance Measure #5, Percent of infants placed to sleep on their back; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding. Discussions were held with both parents and professionals serving families with infants. This has brought to light the topic of harm reduction with respect to safe sleep. Can and should it be done within the safe sleep context? Should Title V programs add harm reduction to their toolkit when working with families of infants? NH's Title V would like to, as their fourth request for technical assistance, seek additional training on harm reduction within safe sleep efforts in public health. Colleagues have suggested contacting the La Leche League International with their "Safe Sleep Seven" ([The Safe Sleep Seven - La Leche League International \(llli.org\)](#)), but are open to other suggestions from HRSA.

The fifth request is on utilization of telehealth. Many of Title V's contracted agencies utilized telehealth for home visiting and behavioral health care. Increases were seen in keeping appointments, particularly for behavioral health. However, its use for well visits and specialized services such as reproductive health care was limited. Many restrictions on telehealth were lifted during the pandemic. Currently, there is a lot of discussion and legislation in the State on keeping and expanding telehealth as there is on the Federal level. Hence, there is a need for technical assistance for both NH's Title V staff on telehealth and for funded contractors in just exactly how to perform those more complicated visits online.

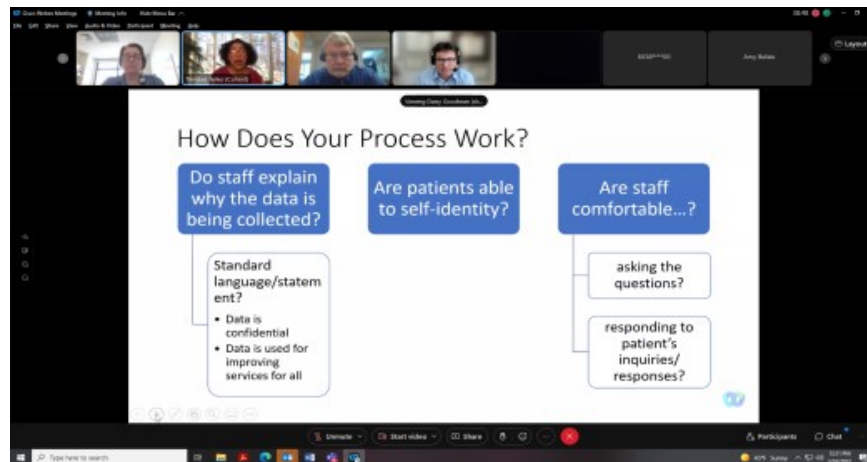
MCH is a member of the NH Telehealth Alliance (Alliance) through our colleague the Rural Health and Primary Care Section. The Alliance aims to ensure better access and cost effective benefits of healthcare through telehealth services. Technical assistance, specific to Title V state staff, will be requested through the Alliance with the objective of facilitating a six part series, one hour each, entitled "Telehealth in NH 101." The objective will be for staff to better understand telehealth within the state system and in particular to several National Performance Measures, including, but not limited to, National Performance Measure #10, Percent of adolescents with a past year preventive visit and National Performance Measure #12, Percentage of adolescents with and without special health care needs, ages 12-17, who received services necessary to make transitions to adult health care.

For Title V staff and funded contractors, particularly those who are not providing regular telehealth services, technical assistance would be requested of the Reproductive Health National Training Center (RHNTC). Recently the RHNTC presented a one session webinar on "Increasing Access to Title X through Telehealth: Lessons from the Field" which was a panel format. Although it specifically talked about Title X clinical services, it could be generalized to adolescent and well woman visits. RHNTC has facilitated technical assistance of a specified number of one-hour sessions for other states on integrating telehealth into the clinical workflow. A similar format would be requested by NH's Title V program.

Some staff within NH's Title V Program have focused some of their work these past several years on efforts to increase the collection of and standardize race, ethnicity, language and disability data as well data on sexual orientation and gender identity (REALD and SOGI data) within the data systems that are stewarded by DHHS in



general and among Title V funded contractors. However, others have not. Now that some have increased collection of this data, how can it be presented and what can be done with it to support the Title V mission? These questions can be answered by another technical assistance request from {Health} Equity Strategies, LLC a local company spearheaded by Dr. Trinidad Tellez, a family practice physician and former DHHS Office of Health Equity Director. Dr. Tellez has presented around NH in different formats, including recently within a NH Alliance for Innovation in Maternal Health (AIM) monthly webinar series as seen below where she is discussing gathering the data and later on looking at different sources of this data such as the electronic health record and birth certificate and doing a comparison.



03/10/2022-NH AIM monthly webinar

As with the technical assistance on telehealth, it may be useful to have two different audiences, Title V staff and then Title V funded contractors. The format can be determined.

In 2020, BFCS' health care coordinators and NH Family Voices conducted a self-assessment of programs using the NASHP Standards for Health Care Coordination as a framework. Health care coordinators worked with NH Family Voices staff to identify and prioritize domain areas that needed improvement. BFCS then convened an advisory group consisting of members of department staff, families, and stakeholders, to consider a program redesign that will essentially merge existing Health Care Coordination and Partners in Health Family Support programs to improve efficiency, reduce duplication, and provide families of CYSHCN with seamless services that are family-centered, supportive and sustainable. BFCS anticipated two technical assistance requests. The first, from the MCH Evidence Center to work through strategies for preparing to implement the redesigned program for health care coordination and family support beginning July 2023. Secondly, from the Catalyst Center to help NH identify strategies for improving reimbursement for services and financing services not generally covered by private insurance or Medicaid.

Throughout the process of self-assessment, coordinators, partner agencies, and BFCS staff identified the challenges and obstacles associated with using an antiquated and unsupported database. Following extensive discussions with the Department of Information Technology, BFCS drafted a capital request for a Data Modernization Project for the 24/25 biennium budget. Technical assistance will be requested to facilitate the development of measures and data requirements for the project.

Directly related to the NH's Title V-Medicaid Partnership, the Medicaid Fee for Service Administrator retired from state service, in April 2022. The recognition that BFCS has both the institutional knowledge and expertise led Medicaid to identify nurses from BFCS as a critical part of the transition plan. As Medicaid reorganizes to fill this

gap, BFCS will provide leadership to improve the system of care for CYSHCN including care coordination. To accomplish this, BFCS will request technical assistance to support these quality improvement efforts including ways in which BFCS' team of Public Health Nurse Consultants can help build the State's capacity to provide health care coordination for CYSHCN.

Finally, as Watch Me Grow moves forward implementing the Help Me Grow Framework with a focus on meaningful family connection, expectations are high that developmental screenings and children receiving services because of the screenings will increase throughout the State. Technical assistance from the MCH Evidence Center will be requested to explore ways to measure the actual impact of the implementation and to increase the leadership capacity for NH's CYSHCN workforce.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Intra-Agency Agreement - Title V and Medicaid.PDF](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [TitleV blurb ver2022\\_final.pdf](#)

Supporting Document #02 - [2022 combined biosketches MCH and BFCS.pdf](#)

Supporting Document #03 - [Glossary of Acronyms 2022.pdf](#)

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [combined\\_org\\_charts\\_2022.pdf](#)

## VII. Appendix

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**Form 2**  
**MCH Budget/Expenditure Details**

State: New Hampshire

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,981,378	
A. Preventive and Primary Care for Children	\$ 648,740	(32.7%)
B. Children with Special Health Care Needs	\$ 785,180	(39.6%)
C. Title V Administrative Costs	\$ 198,137	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,632,057	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 5,883,627	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 1,744,554	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 7,628,181	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,872,257		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 9,609,559	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 13,509,578	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 23,119,137	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 2,527,113
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	\$ 779,623
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	\$ 77,979
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 125,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	\$ 196,896
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 160,020
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	\$ 150,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 80,690
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 298,588
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	\$ 5,104
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	\$ 59,900
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 3,025,084
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	\$ 571,277
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	\$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 160,000



OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 142,338
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 918,140
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Prescription Drug Overdose: Prevention for States Program	\$ 2,973,962
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 160,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Collaboration	\$ 652,864

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,972,621 (FY 21 Federal Award: \$ 1,967,356)		\$ 1,956,193	
A. Preventive and Primary Care for Children	\$ 993,651	(50.4%)	\$ 910,855	(46.5%)
B. Children with Special Health Care Needs	\$ 781,708	(39.6%)	\$ 619,457	(31.6%)
C. Title V Administrative Costs	\$ 197,262	(10%)	\$ 122,262	(6.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,972,621		\$ 1,652,574	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 6,262,230		\$ 5,073,836	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 3,768,263		\$ 1,564,582	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 10,030,493		\$ 6,638,418	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 2,872,257				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 12,003,114		\$ 8,594,611	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 13,628,635		\$ 10,679,314	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 25,631,749		\$ 19,273,925	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 125,000	\$ 104,761
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Violent Death Registry	\$ 188,896	\$ 103,121
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 289,598	\$ 281,872
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 164,539	\$ 138,946
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Death in the Young (SDY) Registry	\$ 60,883	\$ 51,342
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 150,000	\$ 137,033
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 3,194,207	\$ 2,784,532
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	\$ 445,000	\$ 597,294
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 200,000	\$ 217,074
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 800,000	\$ 363,801
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 107,988	\$ 65,723
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	\$ 950,000	\$ 664,206

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX - Grants to States for Medical Assistance Programs	\$ 146,503	\$ 117,449
US Department of Education > Office of Special Education Programs > Grants to States for Education of Children with Disabilities (Part B of IDEA)	\$ 2,333,044	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 88,843
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)		\$ 1,937,082
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > New Hampshire Overdose Data to Action Program (OD2A)	\$ 3,672,978	\$ 2,505,090
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > NH Maternal Mortality Program	\$ 150,000	\$ 157,460
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Collaboration to Strengthen and Preserve Families in NH	\$ 549,999	\$ 363,685

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, B. Children with Special Health Care Needs:</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	2021 expenditures were less due to the COVID-19 PHE and staff vacancies that were not filled due to hiring freeze. In addition, special projects planned were not permitted due to redirection of efforts to COVID-19 activities. In addition, all planned travel costs remained unspent due to the PHE.
2.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Due to cost allocated staff vacancies, the amount for administrative costs was lower than previously expected.
3.	<b>Field Name:</b>	<b>3. STATE MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	There was a gap in contractual approvals due to the State's review process.
4.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	There were staff vacancies for an extended period of time in the newborn screening program which is what these other funds are for. Hospitals pay for each newborn screening filter paper, which then goes into a special legislatively designated revolving fund which supports the entire newborn screening program.
5.	<b>Field Name:</b>	<b>Other Federal Funds, US Department of Education &gt; Office of Special Education Programs &gt; Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)</b>
	<b>Fiscal Year:</b>	<b>2023</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>

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**Field Note:**

under the control of the CYSHCN Director

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6. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)

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**Fiscal Year:** 2023

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**Column Name:** Application Budgeted

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**Field Note:**

under the control of the CYSHCN Director

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7. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs

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**Fiscal Year:** 2023

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**Column Name:** Application Budgeted

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**Field Note:**

Under control of CYSHCN Director

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8. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)

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**Fiscal Year:** 2021

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**Column Name:** Annual Report Expended

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**Field Note:**

under control of the CYSHCN Director

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9. **Field Name:** Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs

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**Fiscal Year:** 2021

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**Column Name:** Annual Report Expended

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**Field Note:**

Under control of the CYSHCN Director.

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10. **Field Name:** Other Federal Funds, US Department of Education > Office of Special Education Programs > Grants to States for Education of Children with Disabilities (Part B of IDEA)

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**Fiscal Year:** 2021

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**Column Name:** Annual Report Expended

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**Field Note:**

This should be Part C, not Part B. Part B of IDEA is under the control of the NH Department of Education.

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11. **Field Name:** **Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)**

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**Fiscal Year:** **2021**

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**Column Name:** **Annual Report Expended**

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**Field Note:**

Part C funds are under the control of the CYSHCN director. It appears that in the prior year's budget, funds were listed under Part B in error. There were \$2,333,044 budgeted.

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: New Hampshire**

**I. TYPES OF INDIVIDUALS SERVED**

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	\$ 62,379	\$ 75,905
2. Infants < 1 year	\$ 224,564	\$ 273,257
3. Children 1 through 21 Years	\$ 523,982	\$ 637,599
4. CSHCN	\$ 785,180	\$ 619,457
5. All Others	\$ 187,136	\$ 227,713
Federal Total of Individuals Served	\$ 1,783,241	\$ 1,833,931

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	\$ 56,263	\$ 78,852
2. Infants < 1 year	\$ 544,255	\$ 762,777
3. Children 1 through 21 Years	\$ 472,609	\$ 662,366
4. CSHCN	\$ 2,527,113	\$ 1,934,238
5. All Others	\$ 3,304,835	\$ 3,200,185
Non-Federal Total of Individuals Served	\$ 6,905,075	\$ 6,638,418
Federal State MCH Block Grant Partnership Total	\$ 8,688,316	\$ 8,472,349



**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2023</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	The amount is off by a dollar to due calculations with percentages
2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1 through 21 years</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount is off by \$1 due to calculations with percentages
3.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, Federal Total of Individuals Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The amount is off by a dollar due to calculations done with percentages The amount is off by a dollar due to calculations done with percentages

**Data Alerts:**

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**

State: New Hampshire

**II. TYPES OF SERVICES**

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	\$ 428,076	\$ 422,635
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 83,044	\$ 81,988
B. Preventive and Primary Care Services for Children	\$ 154,224	\$ 152,264
C. Services for CSHCN	\$ 190,808	\$ 188,383
2. Enabling Services	\$ 832,303	\$ 821,724
3. Public Health Services and Systems	\$ 720,999	\$ 711,834
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 3,484
Physician/Office Services		\$ 100
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 196
Durable Medical Equipment and Supplies		\$ 6,947
Laboratory Services		\$ 0
Other		
Other		\$ 2,096
Nutrition and Feeding		\$ 320,392
Direct Preventive and Primary Care		\$ 89,420
Direct Services Line 4 Expended Total		\$ 422,635
<b>Federal Total</b>	<b>\$ 1,981,378</b>	<b>\$ 1,956,193</b>

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	\$ 2,419,666	\$ 1,609,425
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,225,775	\$ 815,316
B. Preventive and Primary Care Services for Children	\$ 477,997	\$ 317,936
C. Services for CSHCN	\$ 715,894	\$ 476,173
2. Enabling Services	\$ 2,813,060	\$ 1,871,089
3. Public Health Services and Systems	\$ 2,395,456	\$ 1,593,322
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 9,076
Physician/Office Services		\$ 261
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 511
Durable Medical Equipment and Supplies		\$ 18,098
Laboratory Services		\$ 0
Other		
Other		\$ 5,461
Nutrition and Feeding		\$ 834,591
Direct Preventive & Primary Care		\$ 741,427
Direct Services Line 4 Expended Total		\$ 1,609,425
<b>Non-Federal Total</b>	\$ 7,628,182	\$ 5,073,836

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**

State: New Hampshire

Total Births by Occurrence: 12,660

Data Source Year: 2021

**1. Core RUSP Conditions**

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	12,545 (99.1%)	662	35	0 (0.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, βeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
β-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

## 2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Early Hearing Detection and Intervention Program	11,406 (90.1%)	329	30	30 (100.0%)

## 3. Screening Programs for Older Children & Women

None

## 4. Long-Term Follow-Up

Notes regarding categories for “older women and children” and “long term follow up”:

We do not serve older children and women and do not perform long term follow up. Our surveillance of a diagnosed child ends when they have been connected to care. The long term follow up is the responsibility of the specialist at the PCP.

**Form Notes for Form 4:**

Notes regarding Newborn Screening:

Total Birth Records: 12,660

Total Births screened in NH: 12,545

Unscreened in NH: 115

Reason For Not being screened in NH

Refused screening by parents: 34

Died before 24 hours of age: 30

Transferred out of state: 34

Other: 17

(Unattended home birth, lost to follow up as midwife could not be reached, HOB submitted duplicate birth certificate, infant delivered by EMS, NH born infant that midwife collected NBS on out of state filter paper)

NH does not collect data regarding infants referred for treatment at this time. NH is in the process of developing long term follow up protocol.

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Notes regarding Newborn Hearing Screening Program:

Total Birth Records: 12,660

Total births documented in the NH EHDI database: 12,240

Total screened: 11,406

Total Not screened: 329

Reason for Not screened:

Died before 24 hours of age: 30

Declined: 5

Missed: 294

Unknown: 0

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Notes regarding categories for "Older Women and Children" and "Long Term Follow Up":

We do not serve older children and women and do not perform long term follow up. Our surveillance of a diagnosed child ends when they have been connected to care. The long term follow up is the responsibility of the specialist at the PCP.

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Core RUSP Conditions - Total Number Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>

**Field Note:**

NH does not collect data regarding infants referred for treatment at this time. NH is in the process of developing long term follow up protocol.

**Data Alerts: None**

**Form 5**  
**Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V**

State: New Hampshire

Annual Report Year 2021

**Form 5a – Count of Individuals Served by Title V**  
**(Direct & Enabling Services Only)**

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,977	24.0	0.0	73.0	3.0	0.0
2. Infants < 1 Year of Age	1,991	24.0	0.0	73.0	3.0	0.0
3. Children 1 through 21 Years of Age	27,444	27.0	0.0	68.0	5.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	2,152	52.7	2.7	37.9	3.4	3.3
4. Others	81,289	9.0	0.0	83.0	7.0	1.0
Total	112,701					

**Form 5b – Total Percentage of Populations Served by Title V**  
**(Direct, Enabling, and Public Health Services and Systems)**

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	11,791	Yes	11,791	100.0	11,791	1,977
2. Infants < 1 Year of Age	11,841	Yes	11,841	100.0	11,841	1,991
3. Children 1 through 21 Years of Age	313,305	Yes	313,305	100.0	313,305	27,444
3a. Children with Special Health Care Needs 0 through 21 years of age^	78,738	Yes	78,738	100.0	78,738	2,152
4. Others	1,040,912	Yes	1,040,912	40.0	416,365	81,289

^Represents a subset of all infants and children.



**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	These 1,977 pregnant women were provided direct and enabling services by home visiting agency, the Family Resource Center, with services at two sites in Coos and Grafton counties and the Maternal and Child Health in the Integrated Primary Care Setting Contractors (the Community Health Centers or CHCs) using UDS and self reported (for the two agencies not FQHCs) figures.
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	There were 1991 infants that were provided direct and enabling services by the home visiting agency, the Family Resource Center, with services at two sites in Coos and Grafton counties (count = 60), and the Maternal and Child Health in the Integrated Primary Care Setting Contractors (the Community Health Centers or CHCs) using UDS and self reported figures (for the two agencies not FQHCs) (count =1831).  This count does not include the population-based count of 12,545 infants serviced by the Newborn Screening Program, which canvasses nearly all the NH infants born, excluding only a small percent (<1) wherein the parents refused, the infant does, or the hearing test was missed for some other reason.
3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	These 27,444 children one through 21 years of age were provided direct and enabling services by the home visiting agency, the Family Resource Center, with services at two sites in Coos and Grafton counties (n= 219), and the Maternal and Child Health in the Integrated Primary Care Setting Contractors (the Community Health Centers or CHCs) using UDS and self reported (for the two agencies not FQHCs) figures (n=27,225).
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	CSHCN = 2,152 represents the number of CSHCN receiving direct and enabling services including Health Care Coordination; Complex Care and Child Development clinics/consultations; and Nutrition, Feeding & Swallowing consultations. It should also be noted that the 2019-20 NSCH estimated 61,939 CSHCN in NH. Program outreach, resources available through NHFV, and training of staff have the potential to reach all CSHCN. However, data is being reported only on those directly served, at this time.
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2021</b>

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**Field Note:**

These 81,289 non-pregnant females and males over the age of 21 were provided direct and enabling services by the home visiting agency, the Family Resource Center, with services at two sites in Coos and Grafton counties and the Maternal and Child Health in the Integrated Primary Care Setting Contractors (the Community Health Centers or CHCs) using UDS and self reported (for the two agencies not FQHCs) figures.

**Field Level Notes for Form 5b:**

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1.	<b>Field Name:</b>	<b>Pregnant Women Total % Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	This figure is the best estimate of the population served by Title V programs across all levels of the MCH pyramid; including direct services, enabling services, and public health services and systems. This includes safe sleep public health campaigns, as well as work done on quality improvement in all birthing locations.
2.	<b>Field Name:</b>	<b>Infants Less Than One Year Total % Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	This figure is the best estimate of the population served by Title V programs across all levels of the MCH pyramid; including direct services, enabling services, and public health services and systems. This includes all live births, because they are reached with newborn screening and newborn hearing screening.
3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age Total % Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	This figure is the best estimate of the population served by Title V programs across all levels of the MCH pyramid; including direct services, enabling services, and public health services and systems. This includes all injury prevention programming specific to children and adolescents, as well as quality improvement in the primary care setting done with colleagues such as the Pediatric Improvement partnership.
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs 0 through 21 Years of Age Total % Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>
	<b>Field Note:</b>	NH estimates that the percentage of all (0-21) CSHCN served, is the same rate as the percentage of children serviced (ages 1 - 21). A contributing supporting factor to NH's assumption that all children are impacted by Title V funds, is the high level of activity produced through NH Family Voices, (NHFV) website and social media. NHFV staff responded to 999 (unduplicated) families and professional requests for community resources. The website had 3,546,899 hits in FY 21 (109% increase) and the resource guide "Maneuvering Through the Maze" was downloaded from the website 2,838 times. In addition, they provide numerous training sessions to professionals who have the potential to reach all CSHCN.
5.	<b>Field Name:</b>	<b>Others Total % Served</b>
	<b>Fiscal Year:</b>	<b>2021</b>

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**Field Note:**

Due to the comprehensive nature of our public health operations, including injury prevention programs, NH estimates the total number of individuals in the category of "others" served. This figure is the best estimate of the population served by Title V programs across all levels of the MCH pyramid; including direct services, enabling services, and public health services and systems.

This includes injury prevention programming done with adults for motor vehicle safety, older adults for senior falls, and motor vehicle safety. This figure includes Family Planning agencies, Safe Sleep campaigns, social media posts, and press releases.

**Data Alerts: None**

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: New Hampshire**

**Annual Report Year 2021**

**I. Unduplicated Count by Race/Ethnicity**

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	12,670	10,944	260	818	10	332	6	144	156
Title V Served	2,520	2,103	89	153	3	66	3	41	62
Eligible for Title XIX	3,149	2,553	125	322	5	38	1	59	46
2. Total Infants in State	12,670	10,944	260	818	10	332	6	144	156
Title V Served	2,520	2,103	89	153	3	66	3	41	62
Eligible for Title XIX	3,149	2,553	125	322	5	38	1	59	46

**Form Notes for Form 6:**

Much of the population represented in the figure for "Title V Served" is included in the figure for those "Eligible for Title XIX", due to crossover. The prenatal and infant count is the UDS/PCDF total, and includes the figure from NH Child and Family Services.

The small differences between Form 4's count of "Total Births by Occurrence" and Form 6's count for "Total Deliveries in the State" is because of the official reporting of infants born in NH (Form 4) and infant births to NH residents (Form 6).

As reported in the same fashion last year, the figures in Section 1 "Total Deliveries in the State" are repeated in Section 2 "Total Infants in the State". This is because the figure in Section 2 is our best figure, taking into account the 30 infants who died during the year from all causes, and the flux of infant residency in the state.

**Field Level Notes for Form 6:**

None

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: New Hampshire**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2023 Application Year</b>	<b>2021 Annual Report Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(603) 271-4517 x4517	(603) 271-4517 x4517
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health
3. Name of Contact Person for State MCH "Hotline"	Jessica Bates	Jessica Bates
4. Contact Person's Telephone Number	(603) 271-0064 x64	(603) 271-0064 x64
5. Number of Calls Received on the State MCH "Hotline"		15

<b>B. Other Appropriate Methods</b>	<b>2023 Application Year</b>	<b>2021 Annual Report Year</b>
1. Other Toll-Free "Hotline" Names	603-271-4488 Bureau for Family Centered Services	Bureau for Family Centered Services (CYSHCN programs)
2. Number of Calls on Other Toll-Free "Hotlines"		376
3. State Title V Program Website Address	<a href="https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health">https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health</a> and <a href="https://www.dhhs.nh.gov/programs-services/disability-care/developmental-services/children-special-health-care-needs-0">https://www.dhhs.nh.gov/programs-services/disability-care/developmental-services/children-special-health-care-needs-0</a>	<a href="https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health">https://www.dhhs.nh.gov/programs-services/population-health/maternal-child-health</a> and <a href="https://www.dhhs.nh.gov/programs-services/disability-care/developmental-services/children-special-health-care-needs">https://www.dhhs.nh.gov/programs-services/disability-care/developmental-services/children-special-health-care-needs</a>
4. Number of Hits to the State Title V Program Website		6,623
5. State Title V Social Media Websites	Facebook: <a href="https://www.facebook.com/NHPubHealth">https://www.facebook.com/NHPubHealth</a> Instagram: <a href="https://www.instagram.com/nhpubhealth/">https://www.instagram.com/nhpubhealth/</a> Twitter: <a href="https://twitter.com/NHPubHealth">https://twitter.com/NHPubHealth</a>	Facebook: <a href="https://www.facebook.com/NHPubHealth">https://www.facebook.com/NHPubHealth</a> Instagram: <a href="https://www.instagram.com/nhpubhealth/">https://www.instagram.com/nhpubhealth/</a> Twitter: <a href="https://twitter.com/NHPubHealth">https://twitter.com/NHPubHealth</a>
6. Number of Hits to the State Title V Program Social Media Websites		64,528

**Form Notes for Form 7:**

MCH: Number of posts: 294

Reach: 63,751 unique users

Likes: 777

This was for Facebook & Instagram combined.

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: New Hampshire**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Rhonda Siegel
Title	MCH Director
Address 1	29 Hazen Dr.
Address 2	
City/State/Zip	Concord / NH / 03301
Telephone	(603) 271-4516
Extension	
Email	Rhonda.N.Siegel@dhhs.nh.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Deirdre Dunn Tierney
Title	Bureau Chief/CSHCN Director
Address 1	129 Pleasant Street
Address 2	Thayer Building
City/State/Zip	Concord / NH / 03301
Telephone	(603) 271-8181
Extension	
Email	deirdre.dunn@dhhs.nh.gov



### 3. State Family or Youth Leader (Optional)

Name	Jennifer Pineo
Title	NHFV Lead Trainer
Address 1	129 Pleasant St.
Address 2	Thayer Building
City/State/Zip	Concord / NH / 03301
Telephone	6032718181
Extension	
Email	jsp@nhfv.org

**Form Notes for Form 8:**

None

**Form 9**  
**List of MCH Priority Needs**

**State: New Hampshire**

**Application Year 2023**

No.	Priority Need
1.	Improve access to needed healthcare services for all MCH populations
2.	Decrease the use and abuse of alcohol, tobacco, and other substances among pregnant women
3.	Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population
4.	Improve access to mental health services for children, adolescents, and women in the perinatal period
5.	Decrease unintentional injury in children ages 0-21
6.	Increase family support and access to trained respite and childcare providers
7.	Improve access to standardized developmental screening, assessment, and follow-up for children and adolescents

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 9 State Priorities – Needs Assessment Year – Application Year 2021**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)</b>
1.	Improve access to needed healthcare services for all MCH populations	Continued
2.	Decrease the use and abuse of alcohol, tobacco, and other substances among pregnant women	Revised
3.	Increase the focus of Title V on the Social Determinants of Health and the resolution of barriers impacting the health of the MCH population	New
4.	Improve access to mental health services for children, adolescents, and women in the perinatal period	Revised
5.	Decrease unintentional injury in children ages 0-21	Continued
6.	Increase family support and access to trained respite and childcare providers	Continued
7.	Improve access to standardized developmental screening, assessment, and follow-up for children and adolescents	Continued

**Form 10  
National Outcome Measures (NOMs)**

State: New Hampshire

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

**NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	85.3 %	0.3 %	10,020	11,741
2019	86.6 %	0.3 %	10,210	11,796
2018	85.7 %	0.3 %	10,245	11,961
2017	85.7 %	0.3 %	10,345	12,071
2016	85.3 %	0.3 %	10,411	12,210
2015	85.2 %	0.3 %	10,543	12,369
2014	84.8 %	0.3 %	10,293	12,145
2013	81.1 %	0.4 %	9,830	12,116
2012	82.4 %	0.4 %	9,923	12,036
2011	82.1 %	0.3 %	10,192	12,417
2010	83.2 % ⚡	0.4 % ⚡	9,551 ⚡	11,474 ⚡
2009	83.5 % ⚡	0.3 % ⚡	9,915 ⚡	11,879 ⚡

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

**NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations**


Data Source: HCUP - State Inpatient Databases (SID)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	67.9	7.8	77	11,335
2009	49.8	6.2	64	12,854
2008	48.8	6.1	64	13,124

**Legends:**

 Indicator has a numerator  $\leq 10$  and is not reportable

 Indicator has a numerator  $< 20$  and should be interpreted with caution

**NOM 2 - Notes:**













None

**Data Alerts: None**

### NOM 3 - Maternal mortality rate per 100,000 live births


Data Source: National Vital Statistics System (NVSS)

#### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	NR 	NR 	NR 	NR 
2015_2019	NR 	NR 	NR 	NR 
2014_2018	NR 	NR 	NR 	NR 

**Legends:**

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

**NOM 3 - Notes:**

None

**Data Alerts: None**



**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**


Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.8 %	0.2 %	801	11,777
2019	6.4 %	0.2 %	756	11,830
2018	6.8 %	0.2 %	812	11,989
2017	6.9 %	0.2 %	839	12,110
2016	6.4 %	0.2 %	789	12,252
2015	6.9 %	0.2 %	852	12,382
2014	6.9 %	0.2 %	852	12,280
2013	6.8 %	0.2 %	841	12,378
2012	7.3 %	0.2 %	898	12,343
2011	7.1 %	0.2 %	911	12,835
2010	6.9 %	0.2 %	881	12,859
2009	6.9 %	0.2 %	925	13,365

**Legends:**

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

**NOM 5 - Percent of preterm births (<37 weeks)**


Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.4 %	0.3 %	991	11,779
2019	8.2 %	0.3 %	969	11,830
2018	8.3 %	0.3 %	995	11,982
2017	8.3 %	0.3 %	1,010	12,096
2016	7.8 %	0.2 %	954	12,252
2015	7.9 %	0.2 %	981	12,416
2014	8.2 %	0.3 %	1,013	12,289
2013	8.2 %	0.3 %	1,020	12,369
2012	8.6 %	0.3 %	1,057	12,315
2011	8.5 %	0.3 %	1,093	12,799
2010	8.4 %	0.3 %	1,064	12,724
2009	8.7 %	0.3 %	1,153	13,207

**Legends:**

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

**NOM 6 - Percent of early term births (37, 38 weeks)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	22.4 %	0.4 %	2,638	11,779
2019	23.2 %	0.4 %	2,740	11,830
2018	22.4 %	0.4 %	2,680	11,982
2017	21.3 %	0.4 %	2,577	12,096
2016	21.1 %	0.4 %	2,585	12,252
2015	20.6 %	0.4 %	2,559	12,416
2014	19.7 %	0.4 %	2,416	12,289
2013	19.1 %	0.4 %	2,360	12,369
2012	19.7 %	0.4 %	2,420	12,315
2011	20.9 %	0.4 %	2,681	12,799
2010	20.6 %	0.4 %	2,621	12,724
2009	21.4 %	0.4 %	2,827	13,207

**Legends:**

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 6 - Notes:**

None

**Data Alerts: None**

**NOM 7 - Percent of non-medically indicated early elective deliveries**

Data Source: CMS Hospital Compare

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	1.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	3.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	3.0 %			
2017/Q1-2017/Q4	4.0 %			
2016/Q4-2017/Q3	4.0 %			
2016/Q3-2017/Q2	4.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	2.0 %			

**Legends:**

**NOM 7 - Notes:**

None

**Data Alerts: None**

**NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.5	0.6	54	11,873
2018	4.4	0.6	53	12,022
2017	4.9	0.6	59	12,147
2016	6.2	0.7	76	12,312
2015	4.5	0.6	56	12,461
2014	4.9	0.6	60	12,336
2013	5.8	0.7	72	12,427
2012	5.4	0.7	67	12,383
2011	5.2	0.6	67	12,882
2010	3.4	0.5	44	12,900
2009	5.7	0.7	77	13,417

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 8 - Notes:**

None

**Data Alerts: None**

### NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

#### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.2	0.5	38	11,839
2018	3.5	0.5	42	11,995
2017	4.2	0.6	51	12,116
2016	3.7	0.6	45	12,267
2015	4.1	0.6	51	12,433
2014	4.4	0.6	54	12,302
2013	5.6	0.7	69	12,396
2012	4.2	0.6	52	12,352
2011	4.5	0.6	58	12,851
2010	3.9	0.6	50	12,874
2009	4.9	0.6	66	13,377

#### Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

#### NOM 9.1 - Notes:

None

Data Alerts: None



**NOM 9.2 - Neonatal mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.1	0.4	25	11,839
2018	2.4	0.5	29	11,995
2017	2.8	0.5	34	12,116
2016	2.8	0.5	34	12,267
2015	2.8	0.5	35	12,433
2014	2.7	0.5	33	12,302
2013	4.0	0.6	49	12,396
2012	3.2	0.5	40	12,352
2011	3.2	0.5	41	12,851
2010	2.1	0.4	27	12,874
2009	3.4	0.5	46	13,377

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.2 - Notes:**

None

**Data Alerts: None**

**NOM 9.3 - Post neonatal mortality rate per 1,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	1.1	0.3	13	11,839
2018	1.1	0.3	13	11,995
2017	1.4	0.3	17	12,116
2016	0.9	0.3	11	12,267
2015	1.3	0.3	16	12,433
2014	1.7	0.4	21	12,302
2013	1.6	0.4	20	12,396
2012	1.0	0.3	12	12,352
2011	1.3	0.3	17	12,851
2010	1.8	0.4	23	12,874
2009	1.5	0.3	20	13,377

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

**NOM 9.4 - Preterm-related mortality rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	126.7 ⚡	32.7 ⚡	15 ⚡	11,839 ⚡
2018	150.1 ⚡	35.4 ⚡	18 ⚡	11,995 ⚡
2017	156.8 ⚡	36.0 ⚡	19 ⚡	12,116 ⚡
2016	130.4 ⚡	32.6 ⚡	16 ⚡	12,267 ⚡
2015	112.6 ⚡	30.1 ⚡	14 ⚡	12,433 ⚡
2014	121.9 ⚡	31.5 ⚡	15 ⚡	12,302 ⚡
2013	185.5	38.7	23	12,396
2012	218.6	42.1	27	12,352
2011	171.2	36.5	22	12,851
2010	124.3 ⚡	31.1 ⚡	16 ⚡	12,874 ⚡
2009	231.7	41.7	31	13,377

**Legends:**

- 📄 Indicator has a numerator <10 and is not reportable
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.4 - Notes:**













































None

**Data Alerts: None**



**NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	NR 	NR 	NR 	NR 
2018	NR 	NR 	NR 	NR 
2017	NR 	NR 	NR 	NR 
2016	NR 	NR 	NR 	NR 
2015	80.4 	25.4 	10 	12,433 
2014	89.4 	27.0 	11 	12,302 
2013	96.8 	28.0 	12 	12,396 
2012	NR 	NR 	NR 	NR 
2011	NR 	NR 	NR 	NR 
2010	93.2 	26.9 	12 	12,874 
2009	NR 	NR 	NR 	NR 

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**


**NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy**


Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.7 %	1.4 %	1,161	11,983
2014	11.0 %	1.5 %	1,311	11,959
2013	13.0 %	1.6 %	1,562	12,032

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations**

Data Source: HCUP - State Inpatient Databases (SID)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.8	1.2	168	11,325

**Legends:**

- 🚫 Indicator has a numerator  $\leq 10$  and is not reportable
- ⚡ Indicator has a numerator  $< 20$  and should be interpreted with caution

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 13 - Notes:**

None

**Data Alerts: None**



**NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	10.0 %	1.2 %	24,276	243,118
2018_2019	10.3 %	1.3 %	25,229	244,144
2017_2018	9.6 %	1.2 %	23,206	240,788
2016_2017	9.0 %	1.0 %	21,770	242,049
2016	9.3 %	1.3 %	22,805	244,608

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.5	3.2	15	119,622
2019	14.1	3.4	17	120,307
2018	12.4	3.2	15	121,163
2017	9.9	2.9	12	120,922
2016	13.2	3.3	16	121,647
2015	12.2	3.2	15	122,586
2014	11.3	3.0	14	124,036
2013	14.3	3.4	18	126,163
2012	14.1	3.3	18	128,055
2011	9.9	2.8	13	130,716
2010	14.9	3.3	20	134,568
2009	12.5	3.0	17	135,834

**Legends:**

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

**NOM 15 - Notes:**

None

**Data Alerts: None**



**NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	24.9	4.0	39	156,737
2019	22.1	3.7	35	158,679
2018	31.6	4.4	51	161,245
2017	25.3	4.0	41	161,981
2016	30.0	4.3	49	163,287
2015	21.6	3.6	36	166,384
2014	24.9	3.8	42	168,795
2013	22.8	3.7	39	170,981
2012	22.4	3.6	39	173,906
2011	18.7	3.3	33	176,005
2010	24.1	3.7	43	178,240
2009	22.1	3.5	40	181,369

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

**NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	6.7 ⚠	1.6 ⚠	17 ⚠	252,153 ⚠
2017_2019	8.3	1.8	21	254,484
2016_2018	10.9	2.1	28	256,586
2015_2017	9.2	1.9	24	259,602
2014_2016	9.5	1.9	25	263,615
2013_2015	8.9	1.8	24	268,243
2012_2014	10.3	1.9	28	272,708
2011_2013	9.0	1.8	25	276,615
2010_2012	9.7	1.9	27	279,537
2009_2011	10.3	1.9	29	282,090
2008_2010	11.9	2.0	34	285,577
2007_2009	11.1	2.0	32	289,465

**Legends:**

- 🚫 Indicator has a numerator <10 and is not reportable
- ⚠ Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.2 - Notes:**









None

**Data Alerts: None**



**NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	10.7	2.1	27	252,153
2017_2019	11.8	2.2	30	254,484
2016_2018	14.0	2.3	36	256,586
2015_2017	11.9	2.1	31	259,602
2014_2016	10.6	2.0	28	263,615
2013_2015	8.6	1.8	23	268,243
2012_2014	8.1	1.7	22	272,708
2011_2013	6.5 	1.5 	18 	276,615 
2010_2012	7.2	1.6	20	279,537
2009_2011	8.5	1.7	24	282,090
2008_2010	8.1	1.7	23	285,577
2007_2009	6.6 	1.5 	19 	289,465 

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	24.2 %	1.5 %	61,939	256,080
2018_2019	23.7 %	1.6 %	60,875	257,126
2017_2018	21.7 %	1.5 %	56,043	258,066
2016_2017	20.5 %	1.3 %	53,426	260,794
2016	19.9 %	1.6 %	52,224	262,485

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

**NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	17.0 %	2.5 %	10,530	61,939
2018_2019	16.3 %	2.5 %	9,925	60,875
2017_2018	16.7 %	2.8 %	9,334	56,043
2016_2017	18.6 %	2.8 %	9,958	53,426
2016	21.5 %	4.0 %	11,203	52,224

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	4.3 %	0.9 %	9,171	214,507
2018_2019	3.4 %	0.8 %	7,413	219,037
2017_2018	2.5 %	0.5 %	5,556	218,922
2016_2017	2.7 %	0.6 %	6,043	220,886
2016	2.7 %	0.8 %	6,110	223,714

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.3 - Notes:**

None

**Data Alerts: None**



**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	14.3 %	1.4 %	30,526	213,425
2018_2019	12.5 %	1.4 %	27,010	216,780
2017_2018	10.0 %	1.2 %	21,802	217,653
2016_2017	10.1 %	1.1 %	22,099	219,791
2016	10.5 %	1.4 %	23,265	221,599

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	50.3 %	4.3 %	21,762	43,253
2018_2019	46.9 %	4.9 %	19,599	41,790
2017_2018	51.3 % ⚡	5.2 % ⚡	17,896 ⚡	34,919 ⚡
2016_2017	60.8 %	4.7 %	20,839	34,282
2016	63.0 % ⚡	5.7 % ⚡	22,819 ⚡	36,205 ⚡

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

**NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	93.0 %	0.9 %	237,481	255,428
2018_2019	92.2 %	1.0 %	236,763	256,800
2017_2018	93.0 %	1.0 %	239,572	257,740
2016_2017	93.0 %	0.9 %	241,971	260,158
2016	92.0 %	1.2 %	240,207	261,214

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 19 - Notes:**

None

**Data Alerts: None**

**NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)**

Data Source: WIC

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	17.2 %	0.5 %	923	5,357
2016	15.8 %	0.5 %	955	6,042
2014	15.1 %	0.5 %	838	5,551
2012	14.8 %	0.5 %	931	6,294
2010	15.0 %	0.4 %	1,086	7,263
2008	17.2 %	0.5 %	1,063	6,173

**Legends:**

🚫 Indicator has a denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.7 %	0.4 %	6,269	49,378
2017	12.8 %	0.5 %	6,370	49,756
2015	12.2 %	0.4 %	6,501	53,200
2013	11.2 %	0.8 %	6,290	55,942
2011	12.1 %	0.9 %	7,085	58,603
2009	11.9 %	1.3 %	7,436	62,334
2007	11.5 %	1.0 %	7,374	64,262
2005	11.3 %	1.1 %	6,839	60,641

**Legends:**

🚫 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	13.5 %	1.8 %	15,765	117,171
2018_2019	13.7 %	1.8 %	15,349	112,217
2017_2018	12.3 %	1.8 %	13,810	111,999
2016_2017	9.8 %	1.5 %	11,202	114,457
2016	8.5 %	1.6 %	10,029	117,963

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

**NOM 21 - Percent of children, ages 0 through 17, without health insurance**

Data Source: American Community Survey (ACS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.3 %	0.7 %	11,029	256,762
2018	1.8 %	0.4 %	4,582	257,148
2017	2.4 %	0.5 %	6,193	257,485
2016	3.1 %	0.5 %	7,967	260,834
2015	3.2 %	0.5 %	8,406	262,940
2014	5.2 %	0.7 %	13,935	268,072
2013	3.5 %	0.5 %	9,550	272,247
2012	4.2 %	0.8 %	11,423	273,099
2011	3.2 %	0.5 %	8,873	280,509
2010	4.9 %	0.8 %	13,919	285,256
2009	4.6 %	0.6 %	13,140	287,655

**Legends:**

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 21 - Notes:**

None

**Data Alerts: None**

**NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3\*:3:1:4) by age 24 months**

Data Source: National Immunization Survey (NIS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	80.9 %	3.4 %	11,000	13,000
2016	71.0 %	3.8 %	9,000	12,000
2015	79.2 %	3.4 %	10,000	13,000
2014	80.2 %	3.1 %	10,000	13,000
2013	71.3 %	3.7 %	10,000	13,000
2012	75.6 %	3.7 %	10,000	13,000
2011	75.0 %	3.5 %	10,000	14,000

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2
- ⚡ Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

**NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza**

Data Source: National Immunization Survey (NIS) – Flu

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	65.3 %	1.7 %	157,441	241,104
2019_2020	72.6 %	1.6 %	178,870	246,377
2018_2019	67.0 %	1.7 %	162,321	242,451
2017_2018	66.3 %	2.1 %	163,730	247,126
2016_2017	66.2 %	2.0 %	162,153	245,018
2015_2016	66.4 %	2.1 %	170,753	257,274
2014_2015	64.2 %	2.4 %	167,923	261,562
2013_2014	64.0 %	1.9 %	170,511	266,475
2012_2013	59.2 %	2.3 %	157,314	265,758
2011_2012	53.6 %	2.5 %	144,785	270,007
2010_2011	54.3 %	3.5 %	145,250	267,495
2009_2010	52.1 %	2.3 %	138,076	265,021

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**



**NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine**

Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	82.5 %	2.3 %	64,139	77,745
2019	75.1 %	3.1 %	59,118	78,698
2018	77.4 %	3.1 %	60,796	78,569
2017	74.2 %	2.7 %	58,832	79,287
2016	69.9 %	3.0 %	56,250	80,431
2015	71.9 %	3.0 %	59,128	82,192

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.3 - Notes:**

None

**Data Alerts: None**



**NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**

Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	94.5 %	1.3 %	73,434	77,745
2019	94.2 %	1.7 %	74,148	78,698
2018	97.5 %	0.9 %	76,602	78,569
2017	95.1 %	1.4 %	75,413	79,287
2016	95.3 %	1.4 %	76,673	80,431
2015	92.4 %	2.0 %	75,951	82,192
2014	94.5 %	1.3 %	78,391	82,999
2013	94.8 %	1.5 %	80,671	85,145
2012	96.3 %	1.1 %	83,380	86,603
2011	95.0 %	1.2 %	83,929	88,390
2010	87.9 %	2.0 %	77,104	87,681
2009	72.2 %	2.9 %	65,556	90,800

**Legends:**

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2
-  Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**


**NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine**


Data Source: National Immunization Survey (NIS) - Teen

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	91.1 %	1.5 %	70,792	77,745
2019	86.0 %	2.5 %	67,697	78,698
2018	86.2 %	2.3 %	67,748	78,569
2017	87.9 %	2.2 %	69,702	79,287
2016	88.0 %	2.2 %	70,796	80,431
2015	87.7 %	2.3 %	72,044	82,192
2014	90.6 %	1.6 %	75,216	82,999
2013	85.6 %	2.3 %	72,848	85,145
2012	83.1 %	2.9 %	71,949	86,603
2011	80.6 %	2.7 %	71,258	88,390
2010	73.8 %	2.8 %	64,714	87,681
2009	67.8 %	3.0 %	61,570	90,800

**Legends:**

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**



**NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.6	0.4	272	41,048
2019	6.6	0.4	275	41,445
2018	8.0	0.4	334	41,864
2017	8.4	0.5	353	41,865
2016	9.3	0.5	392	42,093
2015	11.0	0.5	468	42,705
2014	11.1	0.5	484	43,624
2013	12.6	0.5	560	44,434
2012	13.9	0.6	629	45,384
2011	13.6	0.5	629	46,092
2010	15.7	0.6	722	45,985
2009	16.4	0.6	765	46,557

**Legends:**

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

**NOM 23 - Notes:**

None

**Data Alerts: None**


**NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**


Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.2 %	1.6 %	1,399	11,509
2019	11.2 %	1.6 %	1,286	11,451
2018	11.9 %	1.6 %	1,384	11,643
2017	16.2 %	2.0 %	1,906	11,783
2016	13.5 %	1.7 %	1,619	11,996
2015	12.9 %	1.6 %	1,560	12,126
2014	9.3 %	1.4 %	1,114	11,995
2013	12.1 %	1.6 %	1,470	12,123

**Legends:**

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year**

Data Source: National Survey of Children's Health (NSCH)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	3.2 %	0.5 %	8,156	255,417
2018_2019	2.2 %	0.5 %	5,759	255,978
2017_2018	1.8 %	0.5 %	4,497	255,969
2016_2017	1.4 %	0.3 %	3,635	259,472
2016	1.8 %	0.4 %	4,671	261,738

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

**NOM 25 - Notes:**

None

**Data Alerts: None**

**Form 10**  
**National Performance Measures (NPMs)**  
**State: New Hampshire**

**NPM 5A - Percent of infants placed to sleep on their backs**

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	2018	2019	2020	2021
Annual Objective	89.7	89.8	86.5	87	87.5
Annual Indicator	87.0	86.1	86.1	87.3	90.8
Numerator	10,258	10,138	10,138	9,959	10,345
Denominator	11,798	11,782	11,782	11,403	11,387
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	89.7	89.8	86.5	87	87.5
Annual Indicator	86.3	86	87.3	90.8	
Numerator	10,315	10,138	9,959	10,345	
Denominator	11,954	11,782	11,403	11,387	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2019	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.0	88.5	89.0	89.5

**Field Level Notes for Form 10 NPMs:**

None



**NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface**

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	2019	2020	2021
Annual Objective		33	34	35
Annual Indicator	32.5	32.5	35.6	39.0
Numerator	3,550	3,550	3,847	4,267
Denominator	10,913	10,913	10,807	10,955
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			33	34	35
Annual Indicator	29.7	31.6	34.7	37.8	
Numerator	3,541	3,550	3,847	4,267	
Denominator	11,921	11,225	11,084	11,282	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2019	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	36.0	37.0	38.0	39.0

**Field Level Notes for Form 10 NPMs:**

None

**NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding**

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	2019	2020	2021
Annual Objective		57	57	58
Annual Indicator	56.7	56.7	58.8	67.0
Numerator	6,129	6,129	6,307	7,335
Denominator	10,817	10,817	10,730	10,944
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2017	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			57	57	58
Annual Indicator	51.3	55.1	58.3	66	
Numerator	5,992	6,129	6,307	7,335	
Denominator	11,676	11,128	10,812	11,112	
Data Source	NH PRAMS	NH PRAMS	NH PRAMS	NH PRAMS	
Data Source Year	2016	2017	2018	2020	
Provisional or Final ?	Final	Final	Final	Provisional	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	59.0	60.0	61.0	62.0

**Field Level Notes for Form 10 NPMs:**

None

**NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	2018	2019	2020	2021
Annual Objective		35	38	38	40
Annual Indicator	32.0	35.1	37.3	32.8	33.0
Numerator	8,656	8,593	8,951	8,955	10,313
Denominator	27,043	24,468	23,970	27,283	31,209
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	35.0	37.0	39.0	41.0

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH's Watch Me Grow developmental screening system collects data on the number of screens using Welligent however, at this time, there is no way to determine an unduplicated number of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.
2.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH's Watch Me Grow developmental screening system was developed to collect data on the number of screens. At this time, there is no way to determine an unduplicated number of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. NH's Contracts & Procurement office has been working with Brooke's Publishing to ensure security requirements for the ASQ Online Management system. Once complete (anticipated 2022), NH will use the ASQ Online system to measure and report screening numbers.
3.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH's Watch Me Grow developmental screening system was developed to collect data on the number of screens. At this time, there is no way to determine an unduplicated number of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. NH's Contracts & Procurement office has been working with Brooke's Publishing to ensure security requirements for the ASQ Online Management system. Once complete (anticipated 2022), NH will use the ASQ Online system to measure and report screening numbers.
4.	<b>Field Name:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH's Watch Me Grow developmental screening system was developed to collect data on the number of screens. At this time, there is no way to determine an unduplicated number of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. NH's Contracts & Procurement office has been working with Brooke's Publishing to ensure security requirements for the ASQ Online Management system. Once complete (anticipated 2022), NH will use the ASQ Online system to measure and report screening numbers.
5.	<b>Field Name:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	NH's Contracts & Procurement office has been working with Brooke's Publishing to finalize a contract that will ensure security requirements for the ASQ Online Management system. Once complete (anticipated 2022), NH will use the ASQ Online system to measure and report screening numbers.

**NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	2018	2019	2020	2021
Annual Objective	140	89.9	78.2	42.2	34.3
Annual Indicator	238.7	238.7	238.7	238.7	149.4
Numerator	433	433	433	433	237
Denominator	181,369	181,369	181,369	181,369	158,679
Data Source	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT
Data Source Year	2009	2009	2009	2009	2019

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	140	89.9	78.2	42.2	34.3
Annual Indicator	125.7	91	86.7	91.5	54.9
Numerator	204	147	138	144	140
Denominator	162,301	161,472	159,248	157,303	254,953
Data Source	NH Inpatient Hospital Discharge data	NH Inpatient Hospital discharge data	NH Inpatient Hospital Data	NH Inpatient Hospital Data	estimate
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	74.7	74.0	73.3	72.5

**Field Level Notes for Form 10 NPMs:**

None

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	2018	2019	2020	2021
Annual Objective		88	87.8	88	88.3
Annual Indicator	87.8	87.5	87.5	91.0	88.3
Numerator	82,975	78,283	78,283	83,204	81,481
Denominator	94,526	89,457	89,457	91,423	92,240
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.6	88.8	89.0	89.2

**Field Level Notes for Form 10 NPMs:**

None

**NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs**

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2019	2020	2021
Annual Objective			23
Annual Indicator	21.5	26.4	23.8
Numerator	5,261	7,163	7,240
Denominator	24,422	27,179	30,446
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	24.0	26.0	28.0	30.0

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

This is a new measure for 2021 therefore no data is available for 2019 reporting.

ESM: The percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program. This data will be collected by coordinators and reported in annual reports.

**NPM 14.1 - Percent of women who smoke during pregnancy**

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2017	2018	2019	2020	2021
Annual Objective	14.9	11	9.9	8.5	8.3
Annual Indicator	11.1	11.3	10.1	8.8	7.6
Numerator	1,342	1,353	1,201	1,040	896
Denominator	12,052	12,022	11,946	11,786	11,713
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2016	2017	2018	2019	2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	14.9	11	9.9	8.5	8.3
Annual Indicator	11.1	10	8.8	7.5	5.9
Numerator	1,343	1,191	1,035	887	744
Denominator	12,076	11,941	11,811	11,761	12,595
Data Source	NH Division of vital records birth table	NH Division of Vital Records birth table	NH Division of Vital Records	NH Division of Vital Records	NH Div. Vital Records
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	8.1	8.0	7.8	7.6

**Field Level Notes for Form 10 NPMs:**

None



**Form 10  
State Performance Measures (SPMs)**

State: New Hampshire

**SPM 1 - Percentage of MCH-contracted Community Health Centers' Enabling Services workplans that have been met or exceeded the target**

Measure Status:		Active		
State Provided Data				
	2019	2020	2021	
Annual Objective			40	
Annual Indicator	33.3	50	42.9	
Numerator	5	7	6	
Denominator	15	14	14	
Data Source	NH DHHS/MCHS SFY19, Enabling Services Workplan	NH DHHS/MCHS SFY20, Enabling Services Workplan	NH DHHS/MCHS SFY20, Enabling Services Workplan	
Data Source Year	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	45.0	50.0	65.0	75.0

**Field Level Notes for Form 10 SPMs:**

None

**SPM 2 - Percentage of families enrolled in the Bureau for Family Centered Services (BFCS) who report access to respite**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	62.3	63	70	70	72
Annual Indicator	62.3	67.7	67.7	67.7	67.7
Numerator	264	126	126	126	126
Denominator	424	186	186	186	186
Data Source	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey	SMS Biennial Survey
Data Source Year	2016	2018	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	72.0	74.0	74.0	76.0

**Field Level Notes for Form 10 SPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	The SMS biennial survey administration date was changed to January 2018 and results are not yet available. Additional questions were added to the SMS Survey in to better identify barriers that families experience related to respite care.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	In 2016, 648 responded to the survey whereas 512 responded in 2018. This may account for some of the reduction in the numbers of families indicating a need for respite. The percentage of those able to find respite care when needed has gone up minimally.
3.	<b>Field Name:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	No new data available. 2020 survey was cancelled due to COVID-19 related staff vacancies/hiring freeze.

**SPM 3 - Percentage of enrolled providers who received Pediatric Mental Health Teleconsultations**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			25
Annual Indicator		23	31.6
Numerator		14	12
Denominator		61	38
Data Source		NH MCAP Program data	NH MCAP Program data
Data Source Year		2020	2021
Provisional or Final ?		Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	28.0	31.0	34.0	37.0

**Field Level Notes for Form 10 SPMs:**

None

**Form 10  
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: New Hampshire

**ESM 5.1 - Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator		45.3	47.1
Numerator		111	113
Denominator		245	240
Data Source		ETO - Home Visiting data system	ETO - Home Visiting data system
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.0	52.0	53.0	54.0

**Field Level Notes for Form 10 ESMs:**

None

**ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	90	70	68	50	50
Annual Indicator	69	64	45	48	41
Numerator					
Denominator					
Data Source	WMG Welligent Data	WMG Welligent Data	WMG Welligent report (July 18 - March 19)	WMG Welligent Data System	WMG Welligent report
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	50.0	55.0	60.0	65.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	In SFY 2017 the Watch Me Grow program experienced several challenges including changes in the Leadership Team when NH's ECCS grant ended and planned support from a VISTA volunteer 'fell through'. These issues impacted the programs ability to focus on recruitment and training of new sites.
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH experienced a slight decrease in the number of sites reporting in the WMG data system in 2018. This is due, in part, to the closing of two Family Resource Centers and transition of leadership. With a recent approval to expand the WMG system, NH anticipates a new Data Source in 2019 that will include new sites i.e. medical practitioners.
3.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	NH experienced a decrease in the number of sites reporting in the WMG data system in 2019. This is due, in part, to transition of leadership and focus on improving access to the electronic ASQ via Brookes Publishing. With the award of the Preschool Development Grant, NH is moving toward becoming a Help Me Grow state and reassessing the current data collection tools. The Steering Committee is reconsidering this measure and is likely to review in 2021.

**ESM 7.2.1 - Percentage of high school students who wear a seatbelt**

Measure Status:				Active	
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	93.4	94	94	94.8	96.5
Annual Indicator	93.1	94.4	94.4	95.5	96.5
Numerator	10,594	11,375	12,297	11,605	12,415
Denominator	11,379	12,050	13,026	12,152	12,865
Data Source	YRBS	YRBS	YRBS	YRBS	Estimate
Data Source Year	2017	2017	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	96.5	98.2	98.2	99.1

**Field Level Notes for Form 10 ESMs:**

- Field Name:** 2018

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**Column Name:** State Provided Data

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**Field Note:**  
This data comes from YRBS, which is only done in odd-numbered years; there is no data for 2018, this is a projection based on 2017 data.
- Field Name:** 2020

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**Column Name:** State Provided Data

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**Field Note:**  
This data comes from YRBS, which is only done in odd-numbered years; there is no data for 2020, this is a projection based on 2019 data.



**ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year**

Measure Status:		Active				
State Provided Data						
	2017	2018	2019	2020	2021	
Annual Objective	64	60	62	58	52	
Annual Indicator	57.9	58.1	52.6	49.2	59	
Numerator	6,178	6,402	6,181	5,056	6,408	
Denominator	10,671	11,011	11,751	10,272	10,859	
Data Source	NH DHHS, MCHS	NH DHHS, MCHS	NH DHHS, MCH	NH DHHS, MCHS	NH DHHS, MCHS	
Data Source Year	2017	2018	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	Final	Final	

Annual Objectives					
	2022	2023	2024	2025	
Annual Objective	56.0	60.0	62.0	64.0	

**Field Level Notes for Form 10 ESMs:**

None

**ESM 12.1 - Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			70
Annual Indicator			22.2
Numerator			8
Denominator			36
Data Source			SMS database application
Data Source Year			2021
Provisional or Final ?			Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	30.0	35.0	40.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2019</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2021 will be the first year for reporting on ESM 12.1
2.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2021 will be the first year for reporting on ESM 12.1
3.	<b>Field Name:</b>	<b>2021</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Results were significantly lower than anticipated. This is in part due to the challenges of collecting and reporting on this new data element in the SMS database. DoIT staff turnover of the two individuals who developed the database, resulted in the inability to create the new measure in the system and subsequently, instructions to coordinators for collecting data was delayed. Much of the data collection related to this measure is being done by hand. A new DoIT Business Analyst and the BFCS Data Analyst are working on reports and NHFV is working with staff under the Youth Health Care Transition Project contract, to improve reporting on this measure.
4.	<b>Field Name:</b>	<b>2022</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objective was reduced given the baseline data collected in FY 2021.
5.	<b>Field Name:</b>	<b>2023</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objective was reduced given the baseline data collected in FY 2021.
6.	<b>Field Name:</b>	<b>2024</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objective was reduced given the baseline data collected in FY 2021.
7.	<b>Field Name:</b>	<b>2025</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	Objective was reduced given the baseline data collected in FY 2021.

**ESM 14.1.1 - Percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe /Supported Care (POSC)**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			60
Annual Indicator		55.8	50.9
Numerator		308	419
Denominator		552	823
Data Source		EBI_Datamart.VR_Birth	EBI_Datamart.VR_Birt
Data Source Year		2020	2021
Provisional or Final ?		Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	70.0	80.0	90.0	95.0

**Field Level Notes for Form 10 ESMs:**

None

**Form 10**  
**State Performance Measure (SPM) Detail Sheets**

**State: New Hampshire**

**SPM 1 - Percentage of MCH-contracted Community Health Centers' Enabling Services workplans that have been met or exceeded the target**

**Population Domain(s) – Cross-Cutting/Systems Building**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percentage of NH MCH-contracted Community Health Centers who demonstrate measurable outcomes in addressing Social Determinants of Health by providing enabling services such as transportation, interpretation, outreach, health education								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>number of CHC Enabling Services workplans that have met or exceeded their target; each CHC has at least two Enabling Services workplans each contract year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>total number of Enabling Services workplans; each CHC must have at least two</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	number of CHC Enabling Services workplans that have met or exceeded their target; each CHC has at least two Enabling Services workplans each contract year	<b>Denominator:</b>	total number of Enabling Services workplans; each CHC must have at least two
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	number of CHC Enabling Services workplans that have met or exceeded their target; each CHC has at least two Enabling Services workplans each contract year								
<b>Denominator:</b>	total number of Enabling Services workplans; each CHC must have at least two								
<b>Data Sources and Data Issues:</b>	NH DHHS/MCH Enabling Services workplan SFY20; Baseline data for this new measure will be established in SFY20 A new contract for CHCs started June 15, 2022 with new Enabling Services workplans. Thus the measure is being adjusted now, in 2022.								
<b>Significance:</b>	Enabling services are an essential element of health care as these services: 1) contribute to health equity for all populations 2) improve health outcomes and 3) reduce health care costs. Enabling services ensure health equity by increasing access and utilization of primary care for some of NH's most vulnerable populations, especially for racial and ethnic minorities and people living in poverty. By addressing social and economic conditions that present barriers to care, enabling services promote the use of community health centers as medical homes. As a usual source of care, medical homes not only improve health outcomes but also reduce inappropriate use of Emergency Departments which are both associated with reducing health care costs.								

**SPM 2 - Percentage of families enrolled in the Bureau for Family Centered Services (BFCS) who report access to respite**

**Population Domain(s) – Children with Special Health Care Needs**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the number of families reporting access to respite care when needed								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>number of families enrolled in SMS programs who found and received respite care</td> </tr> <tr> <td><b>Denominator:</b></td> <td>number or families enrolled in SMS who identified respite care as a need</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	number of families enrolled in SMS programs who found and received respite care	<b>Denominator:</b>	number or families enrolled in SMS who identified respite care as a need
	<b>Unit Type:</b>	Percentage							
	<b>Unit Number:</b>	100							
	<b>Numerator:</b>	number of families enrolled in SMS programs who found and received respite care							
<b>Denominator:</b>	number or families enrolled in SMS who identified respite care as a need								
<b>Healthy People 2030 Objective:</b>	Help parents and caregivers improve health and well-being for their loved ones and themselves.								
<b>Data Sources and Data Issues:</b>	Families enrolled in SMS programs are are provided with an annual satisfaction survey. Survey results are reported in each programs Annual Report. Beginning in FY 2022, programs will be required to ask questions to better assess families' ability to obtain respite care.								
<b>Significance:</b>	Respite improves child health status, and reduces high parental stress that can negatively affect physical and emotional health; improves overall family well-being and stability; improves marriages, sibling and other family relationships; and reduces hospital costs and helps avoid or delay more costly foster care, institutional or other out-of-home placements (Kagan & Kaiser, 2012).								

**SPM 3 - Percentage of enrolled providers who received Pediatric Mental Health Teleconsultations**  
**Population Domain(s) – Cross-Cutting/Systems Building**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percentage of enrolled providers who receive Pediatric Mental Health teleconsultations in the NH Pediatric Mental Health Care Access (PMHCA) program from a baseline of 23% in 2020 to 55% by 2026.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td># of unique enrolled providers who received a teleconsultation</td> </tr> <tr> <td><b>Denominator:</b></td> <td># of enrolled providers</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	# of unique enrolled providers who received a teleconsultation	<b>Denominator:</b>	# of enrolled providers
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	# of unique enrolled providers who received a teleconsultation								
<b>Denominator:</b>	# of enrolled providers								
<b>Healthy People 2030 Objective:</b>	MHMD-6: Increase the proportion of children with mental health problems who receive treatment								
<b>Data Sources and Data Issues:</b>	NH DHHS, Pediatric Mental Health Care Access Program Teleconsultation data								
<b>Significance:</b>	Access to mental health care services for NH’s pediatric population is limited, as many areas in NH are designated as Mental Health Professional Shortage areas and other areas have months long waitlists to access treatment. To increase the availability of mental health treatment for NH youth, the NH Pediatric Mental Health Care Access (PMHCA) Program was established in 2019 to provide additional training and consultation opportunities for NH pediatric primary care providers to increase their knowledge and confidence in treating youth with mental health conditions within their practice. Increasing mental health care access will help ensure health equity among NH’s most vulnerable populations, especially those of racial minorities and those living in poverty.								

**Form 10**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: New Hampshire**

No State Outcome Measures were created by the State.



**Form 10**  
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

State: New Hampshire

**ESM 5.1 - Percent of infants enrolled in home visiting who are always placed to sleep on their back, without bed-sharing or soft bedding**

**NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	By January 2022, 50% of infants enrolled I home visiting will always be places to sleep on their back, without bed-sharing or soft bedding									
<b>Definition:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of infants (less than 1 year old) enrolled in home visiting whose primary caregiver reports always placing the infant on their back, without bed-sharing or soft bedding.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of infant (less than 1 year old) enrolled in the home visiting program</td> </tr> </table>		<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of infants (less than 1 year old) enrolled in home visiting whose primary caregiver reports always placing the infant on their back, without bed-sharing or soft bedding.	<b>Denominator:</b>	Number of infant (less than 1 year old) enrolled in the home visiting program
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Numerator:</b>	Number of infants (less than 1 year old) enrolled in home visiting whose primary caregiver reports always placing the infant on their back, without bed-sharing or soft bedding.									
<b>Denominator:</b>	Number of infant (less than 1 year old) enrolled in the home visiting program									
<b>Data Sources and Data Issues:</b>	Home Visiting data (Social Solutions)									
<b>Significance:</b>	The American Academy of Pediatrics recommends that infants be put to sleep on their backs to reduce the risk of Sudden Infant Death Syndrome (SIDS); also that home visitors are trained on safe sleep using an evidence-based curriculum, prenatally through age one, to support maternal and infant health.									

**ESM 6.1 - The number of sites using ASQ/ASQ-SE screening tools and participating in the Watch Me Grow (WMG) System.**

**NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase from 43 (WMG, 2015) to 100 the number of provider sites including, but not limited to, child care centers, health care providers and other community-based organizations completing and reporting ASQ/ASQ-SE results to WMG								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of sites reporting ASQ/ASQ-SE results to WMG</td> </tr> <tr> <td><b>Denominator:</b></td> <td></td> </tr> </table>	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of sites reporting ASQ/ASQ-SE results to WMG	<b>Denominator:</b>	
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of sites reporting ASQ/ASQ-SE results to WMG								
<b>Denominator:</b>									
<b>Data Sources and Data Issues:</b>	NH's statewide developmental screening system, Watch Me Grow (WMG), maintains a database that tracks individual ASQ/ASQ-SE results, referrals and information regarding the providers administering the tool. The data is generally reported on annually. The data system is being evaluated for capacity to follow up on referrals and outcomes.								
<b>Evidence-based/informed strategy:</b>	ASQ/ASQ-SE is an Evidence-based developmental screening tool								
<b>Significance:</b>	According to the Spark NH's Framework for Action 2016, 1 in 5 New Hampshire children under the age of 5 are at risk for developmental or behavioral concerns. Yet the majority of New Hampshire's children do not receive standardized screening designed to identify these concerns in the early years (Spark NH, 2015). As a result, some children with delays do not have access to early identification and services that could change the trajectory of their learning and ability to thrive.								

**ESM 7.2.1 - Percentage of high school students who wear a seatbelt**

**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase the percent of high school students wearing seatbelts								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>number of students reporting seatbelt use</td> </tr> <tr> <td><b>Denominator:</b></td> <td>total number of students responding to this question on YRBS</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	number of students reporting seatbelt use	<b>Denominator:</b>	total number of students responding to this question on YRBS
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	number of students reporting seatbelt use								
<b>Denominator:</b>	total number of students responding to this question on YRBS								
<b>Data Sources and Data Issues:</b>	<p>NH YRBS data (<a href="https://nccd.cdc.gov/youthonline">https://nccd.cdc.gov/youthonline</a>)</p> <p>YRBS is a self-reported survey and students may respond positively to questions about wearing a seatbelt because there is a law in NH requiring people under 18 to wear seatbelts. School participation in the survey is voluntary, so data is not captured from 100% of NH students. The number of students who do respond is considered high enough to be representative of the state as a whole, but data is not reliable at a sub-state level.</p>								
<b>Significance:</b>	Unintentional injuries among children and young adults up to age 24 are a significant cause of premature deaths and serious injuries, many of which have life-altering impacts. Motor vehicle crashes are the leading cause of these injuries; many of these would be mitigated or even prevented if seatbelts were used consistently.								

**ESM 10.1 - Percentage of adolescents ages 12-21 at MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year**  
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of adolescents ages 12-21 at the MCH-contracted health centers who have at least one comprehensive well-care visit with a PCP or OB/GYN practitioner each year								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>number of adolescents 12-21 years of age at the MCH-contracted health centers who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>total number of adolescent patients ages 12-21 years of age at the MCH-contracted health centers by the end of the measurement year</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	number of adolescents 12-21 years of age at the MCH-contracted health centers who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	<b>Denominator:</b>	total number of adolescent patients ages 12-21 years of age at the MCH-contracted health centers by the end of the measurement year
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	number of adolescents 12-21 years of age at the MCH-contracted health centers who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year								
<b>Denominator:</b>	total number of adolescent patients ages 12-21 years of age at the MCH-contracted health centers by the end of the measurement year								
<b>Data Sources and Data Issues:</b>	<p>DHHS will collect adolescent well-care visit data from MCH-contracted Community Health Centers per Primary Care contracts exhibit A.</p> <p>The MCH Performance Measure was changed from 12-17 years of age to 12-21 years of age as of July 1, 2015. During the January 2016 reporting DHHS determined that this change caused some issues with data collection and reporting. DHHS has provided technical support to reduce reporting issues.</p>								
<b>Significance:</b>	Recognizing that the health of adolescents is largely impacted by behavioral patterns developed during this developmental period, NH MCH collaborates with state and local partners to increase access to health care and promotes annual well-care visits for families and adolescents. The well-care visit is a prime opportunity for health care providers to screen and counsel adolescent/family about key areas including: mental and behavioral health, tobacco and substance use, violence and injury prevention, sexual behavior and nutritional health.								

**ESM 12.1 - Percent of young adults with special health care needs, ages 18-21, who identify an adult health care provider at discharge from the Title V program**

**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percent of adolescents with special health care needs, ages 14 – 20, who received services necessary to make transitions to adult health care								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>the number of adolescents or family caregivers in the denominator who indicated their goal had been achieved, when reviewed at one year</td> </tr> <tr> <td><b>Denominator:</b></td> <td>number of adolescents with special health care needs, ages 14 – 20, who identified a goal related to transition during TRAQ consultation with their health care coordinator</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	the number of adolescents or family caregivers in the denominator who indicated their goal had been achieved, when reviewed at one year	<b>Denominator:</b>	number of adolescents with special health care needs, ages 14 – 20, who identified a goal related to transition during TRAQ consultation with their health care coordinator
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	the number of adolescents or family caregivers in the denominator who indicated their goal had been achieved, when reviewed at one year								
<b>Denominator:</b>	number of adolescents with special health care needs, ages 14 – 20, who identified a goal related to transition during TRAQ consultation with their health care coordinator								
<b>Data Sources and Data Issues:</b>	BFCS will use the SMS database to collect data. Currently, the system allows for the health care coordinator to record transition encounters as “TRAQ sent” and/or “TRAQ completed”. A system update will be required to add options to record “Transition goal identified” and “Transition goal met”. Instructions will be provided to health care coordinators to require an encounter note be included in the documentation that identifies the goal.								
<b>Significance:</b>	Effective transition from pediatric to adult health care promotes continuity of developmental and age-appropriate care for youth with special health care needs. Yet years of national, state and community studies continue to demonstrate that most youth with special health care needs (SHCN) and families do not receive the support they need in the transition from pediatric to adult health care. Improvements are needed to raise awareness of youth and their families that maintaining health and continuity of care are important to attaining broader adult goals. (Pediatrics November 2018, 142 (5) e20182587; DOI: <a href="https://doi.org/10.1542/peds.2018-2587">https://doi.org/10.1542/peds.2018-2587</a> )								

**ESM 14.1.1 - Percentage of postpartum women whose infant was monitored for the effects of in utero substance exposure who had a documented Plan of Safe /Supported Care (POSC)**  
**NPM 14.1 – Percent of women who smoke during pregnancy**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To increase the percentage of women who have a documented Plan of Safe Care (POSC) prior to delivery, to reduce the harmful effects of substance use and improve perinatal outcomes, and to provide supportive services during the perinatal period								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> <tr> <td><b>Numerator:</b></td> <td>Number of women whose infant was monitored for the effects of in utero substance exposure and who had a Plan of Safe/Supportive Care (POSC) documented</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of women who delivered during the measurement period, whose infant was monitored for the effects of in utero substance exposure</td> </tr> </table>	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100	<b>Numerator:</b>	Number of women whose infant was monitored for the effects of in utero substance exposure and who had a Plan of Safe/Supportive Care (POSC) documented	<b>Denominator:</b>	Number of women who delivered during the measurement period, whose infant was monitored for the effects of in utero substance exposure
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Numerator:</b>	Number of women whose infant was monitored for the effects of in utero substance exposure and who had a Plan of Safe/Supportive Care (POSC) documented								
<b>Denominator:</b>	Number of women who delivered during the measurement period, whose infant was monitored for the effects of in utero substance exposure								
<b>Data Sources and Data Issues:</b>	NH DHHS Vital Records As NH has newly created a mechanism for collecting this data from Birth Certificates, baseline data for this new measure will be gathered in 2020.								
<b>Significance:</b>	<p>The CDC reports that between 1999-2014 the US had seen an increase of four times the amount of infants experiencing Neonatal Abstinence Syndrome (NAS). New Hampshire (NH) saw a spike in overdose deaths in 2014 in the general population. In 2015-2017 the NH Maternal Mortality Review Committee has seen the effect of this opioid epidemic in pregnant and postpartum women. The leading cause of maternal deaths during this time was accidental drug overdose. The NH Maternal Mortality Review Program reported this in the annual report to the NH Health and Human Services Oversight Committee. The report also showed that almost all of the maternal deaths occurred in the postpartum period. In the same timeframe of these maternal deaths the Governor’s Perinatal Exposure Task Force brought a multidisciplinary group of stakeholders together to develop the work plan for NH on Plans of Safe Care (POSC).</p> <p>The Child Abuse Prevention and Treatment Act (CAPTA) was amended in 2016 to require that states create a plan that would result in all infants affected by prenatal drug or fetal alcohol exposure have a Plan of Safe Care (POSC). NH RSA 132-10e and 10f provides details for the NH plan for women and providers on the development of these POSC. NH emphasizes supports for women during the perinatal period. The POSC, through conversation with providers, engages women to connect to local resources. The NH POSC template allows providers to connect with women around the future for themselves and their families. The template includes treatment services and services that are offered in the area. Knowledge of services and discussion with providers about the available services has potential to enroll more families. The development of a POSC between provider and a woman, especially when initiated prenatally, can be a critical tool to keep mothers engaged and supported, which will contribute to the improvement of health and social well-being for women and families.</p>								

**Form 11  
Other State Data  
State: New Hampshire**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

**Form 12  
MCH Data Access and Linkages**

**State: New Hampshire**

**Annual Report Year 2021**

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	Yes	Yes	Daily	0	Yes	
4) WIC	Yes	No	More often than monthly	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Annually	24	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	9	Yes	



**Form Notes for Form 12:**

None

**Field Level Notes for Form 12:**

None