

A. Background and Need

New Hampshire has a strong history of working directly with communities to improve the public's health. This includes an emphasis on community-level work by the New Hampshire Department of Health and Human Services (NH DHHS) and New Hampshire Institute for Health Policy and Practice (NHIHPP) at the University of New Hampshire (UNH), which are the lead agencies applying for the "Community Transformation Grant" (CTG) cooperative agreement. NH is applying for Category B-Implementation as a "state, local government, or nonprofit organization." NHIHPP is the applicant agency, serving as a Bona Fide agent of the state (a Memorandum of Understanding is in Appendix 1). NHIHPP currently serves as the Bona Fide agent of the State of NH for other federally-funded grants, including projects funded by CDC and the Administration on Aging (AoA). This relationship for the implementation and management of federal projects is a familiar one for NHIHPP and NH DHHS.

History and Infrastructure: NH CTG is an opportunity for NH to advance its work to improve the public's health by building upon (1) efforts to improve public health capacity, (2) a history of strong partnership and collaboration, and (3) an emphasis on cross-sectional approaches, by integrating efforts in a centrally-coordinated way, with community-level intervention strategies. Successful examples of community-level work that can be expanded—both to broader geographic regions as well as in different populations—will be leveraged to realize measureable improvements to health.

NH DHHS has dedicated significant resources to strengthening the public health infrastructure at the community level. In 2004, the Bureau of Policy and Performance Management (BPPM) was created to continually assess and improve the statewide public health infrastructure and the performance of public health programs and services. In 2005, DPHS

utilized the National Public Health Performance Standards (NPHPS) to assess local and state public health system capacity. Following the NPHPS assessment, BPPM led the Public Health Improvement Action Plan (PHIAP) initiative, with many public health stakeholders working on six strategic priorities to develop a Public Health Improvement Action Plan (published in 2008). PHIAP accomplished several significant actions, including establishing a Public Health Improvement Services Council (PHISC) in legislation to provide oversight of the PHIAP process. Under PHISC's direction, the PHIAP work groups in each strategy area have achieved many goals, including a statewide media campaign to convey the importance and value of public health, the creation of a website to provide access to health promotion best practices, and securing external funding to assist in sustaining PHIAP. Appendix 2 includes the PHIAP Annual Report of progress. PHISC will serve as the basis for the Leadership Team for NH CTG.

NH currently lacks a strong, regionalized public health infrastructure. There are no county health departments; only 5 of 234 municipalities have health departments that provide services beyond enforcement of sanitation and environment-focused laws and regulations. A key recommendation of the PHIAP planning process was to develop local level public health capacity to protect and promote the public's health. DPHS has been working on a Public Health Regionalization Initiative to "Develop a performance-based public health delivery system, which provides all 10 essential services throughout New Hampshire." As part of this initiative, 15 Public Health Regions (PHR) have been defined, which are the areas to which funding is provided by DHHS for the purpose of public health emergency preparedness and response. Similarly, these regions will be the basis of community-focused work for NH CTG, if funded.

The effectiveness of cross-sectional approaches that are coordinated centrally, but executed through local projects, have been proven by several other initiatives in NH. In 2005, Governor

John Lynch convened the NH Citizen's Health Initiative (NHCHI) as a long-term, collaborative effort to improve the health of NH citizens. NHIHPP provides leadership and staff for the NHCHI. The current pillar projects of NHCHI are Health Payment Reform, Medical Home, and Health Promotion and Disease Prevention (HPDP). The Health Payment Reform pillar is currently coordinating an Accountable Care Organization (ACO) pilot, in which five health care systems across the state are working with commercial and public payers to become ACO's. This includes identifying legal, clinical, financial, reporting, and process flow changes required for transformation to an ACO. The Medical Home pillar is providing facilitation and logistical support for a pilot of nine medical practice sites in NH that have converted to the Medical Home model, based on National Committee on Quality Assurance definitions. NHCHI facilitated the process by which major commercial insurers in the state provide an additional monthly payment to these practices to support medical home processes, including a care coordinator role. Both ACO and Medical Home include participation by progressive health care delivery systems and medical practices that are dedicated to improving the health of their patients with infrastructure changes that emphasize disease prevention and adherence to best practices. The goal of overall population health are key to both of these efforts, and both have identified the integration of clinical care and community health as integral to their success, in line with the NH CTG goals.

In addition to medical system transformation, NHCHI has focused its efforts in promoting public health through its HPDP Pillar. In 2007, the NHCHI HPDP Team published a report, *A Pound of Prevention*, outlining the major actual causes of illness and death in the state. This report identified these root causes as tobacco use, physical inactivity and poor nutrition, and unhealthy alcohol use. Since 2009, HPDP has focused its work largely on the integration of the public health and medical care systems, addressing the Institute of Medicine's recognition of the

need to integrate these systems.ⁱ The HPDP work in this area has included identifying several case studies of community examples of the integration of public health and the medical system (such as supporting pediatric care clinicians in integrating statewide health promotion resources into their practice environment/techniques) and publishing a “Strategic Plan for Integrating the Work of NH’s Public Health and Medical Care Systems” (included in Appendix 3). The HPDP Pillar Group will serve as an advisory coalition for Strategic Direction 3, “Increased Use of High Impact Quality Clinical Preventive Services” for the NH CTG project.

In 2006, recognizing the need for a comprehensive state plan for obesity, four foundations, a regional health promotion organization, the governor’s health initiative, and six state agencies initiated a comprehensive obesity planning initiative in NH, “Healthy Eating Active Living (HEAL).” In the planning phase, a steering committee was established with representation from a broad pool of stakeholders from transportation, parks and recreation, agriculture, education, health, and municipalities; and a diversity of age, economic status, and non-majority populations. As a result of this statewide partnership, six workgroups reviewed an extensive list of recommended interventions and identified policy, practice, and communication interventions for six sectors. A short list of recommended interventions was selected for recommendations based on feasibility and appropriateness for NH. The Convening Partners held a NH HEAL forum to solicit input and approval of priority objectives and recommended interventions for inclusion in the *HEAL Action Plan for New Hampshire*, which was published in 2008 (Appendix 4). The HEAL framework and logic model defines recommendations for interventions for each sector, specifying policy, communication, and practice interventions. Following a shift to a policy and environmental change approach, a 3-year strategic plan was developed and recently approved by

the HEAL Leadership Council (Appendix 4). The strategic plan also includes a more equity-focused approach toward accomplishing HEAL's vision.

Upon completion of the HEAL plan, five foundations collaborated to provide funding and support to carry out HEAL's implementation strategy framework, including (1) A state-level coordinating entity (Home) for the HEAL Campaign; (2) A Community Grant Program (CGP) to support implementation of HEAL interventions across sectors at the local and regional level; and (3) A communication strategy to generate statewide awareness and engage partners and stakeholders as collaborators in the HEAL Campaign. The coordinating entity for the "HEAL Home" is the Foundation for Healthy Communities (FHC), a not-for-profit statewide partnership to assist health providers and the public in maintaining health and preventing illness or chronic diseases. HEAL's statewide infrastructure consists of a sustainable guiding body called the HEAL Leadership Council, comprised of expert multi-sector partners, which provide oversight to the HEAL Campaign. In addition, HEAL committees (e.g., Evaluation, Sustainability, and others established upon need) support the implementation of HEAL strategies, dissemination of best practices and lessons learned across the HEAL network, and monitoring of outcomes. Because of its success fostering multi-field and multi-sector collaborations to support equitable policy and environmental change, the national *Convergence Partnership* has integrated HEAL NH into its nationwide network of regional convergence partners. HEAL will serve as an advisory coalition for Strategic Direction 2, "Active Living and Healthy Eating" and Strategic Direction 5, "Healthy and Safe Physical Environment" for the NH CTG project

HEAL efforts have resulted in several examples of successful work towards environmental, policy, and infrastructure change to improve nutrition and physical patterns in NH. In 2008, NH passed legislation that established a Commission on the Prevention of Childhood Obesity (The

Commission). The Commission included legislators, NH DHHS, community organizations, local foundations, and non-profit agencies working on childhood health issues, and solicited testimony from the Departments of Education, Transportation, Health and Human Services, Agriculture, and organizations targeting childhood obesity. Two public hearings were also conducted. The Commission published the *Report of the New Hampshire Commission on Prevention of Childhood Obesity* in 2009 (Appendix 5). An example of a recommendation is that “the N.H. Board of Education use its school approval rulemaking Authority by October 2010 to support the sale and distribution of single serving size, nutrient dense foods in all schools during the school day (‘bell to bell’).” The school rulemaking process is underway, with a NH Board of Education public hearing to occur in August 2011.

Through the HEAL CGP and an additional grant provided through the national HEAL Innovation Fund, HEAL provides over \$600,000 of funding and TA to coalitions that are currently implementing multi-sector projects in 47 cities and towns throughout NH. An additional two unfunded coalitions have been integrated into the HEAL learning collaborative network. Coalition projects include such interventions as: 1) implementation of nutrition and physical activity policies in schools and child care settings; 2) adoption of BMI screening and motivational interviewing procedures in clinical practices; 3) increasing access to trails, parks and outdoor recreation facilities in municipal settings; and 4) conducting assessments and surveys to inform changes to the food and built environments. Ongoing TA is provided to these coalitions by the HEAL Home in partnership with the NH DHHS Obesity Prevention Program (OPP). Coalition best practices and lessons learned have been shared and training sessions delivered through quarterly learning collaborative networking meetings and disseminated

through the HEAL website and communication activities. NH CTG is an opportunity to expand on the reach of HEAL.

The Tobacco-Free Living direction of the CTG is also built on a solid infrastructure and history for impacting policy change in NH. In 2007, as part of HPDP, a tobacco workgroup met to develop legislative priorities for 2008 and 2009. The group also identified long-term projects, which are outlined in the Tobacco Plan of Action (Appendix 6). In the fall of 2008, TPCP, along with HPDP, secured a TA grant from CDC that focused on sustaining tobacco programming. CDC facilitated a planning process for NH in 2008 to identify potential partners and strategies for sustaining tobacco programming, which have been reflected in subsequent work.

There are important examples of impacting tobacco use via policy changes in NH. This includes the transferring of retail tobacco licenses to the Division of Liquor Enforcement (DLE). This is policy change allows DLE to conduct active enforcement of alcohol and tobacco laws. If violations are determined, each license held is in jeopardy of revocation. Also, NH DHHS Tobacco Prevention and Control Program (TPCP) staff, with support from DHHS attorneys, developed strong Administrative Rules in support of the amendment to the NH Indoor Smoking Act. The new rules took effect January 1, 2009, providing TPCP staff with enforcement authority, including investigations driven by secondhand smoke complaints, authority to warn, hold hearings, and fine those found not in compliance. Recently, The Food and Drug Administration/Center for Tobacco Products selected NH to receive funding provided by the “2009 Family Smoking Prevention and Tobacco Control Act” to DLE to support tobacco compliance inspections. For this project, DLE will arrange tobacco compliance check inspections of entities that sell or advertise cigarettes and/or smokeless tobacco products to determine whether those entities are complying with the Tobacco Control Act and appropriately

implementing the regulations. The DLE will conduct two types of tobacco compliance check inspection assignments: (1) undercover buy, to determine a retailer's compliance with age and photo identification requirements; and (2) advertising and labeling to cover other provisions of the Tobacco Control Act.

Tobacco use is a major focus area of the NH Comprehensive Cancer Collaboration (NH CCC). NH CCC is a dedicated partnership of individuals and organizations committed to eliminating cancer in the state. FHC is the DPHS-funded contracted management agent for the NH CCC. NH CCC developed a five-year New Hampshire Comprehensive Cancer Control Plan for 2004-2009, and a subsequent 2010-2014 Plan (Appendix 7) to address the following priorities: preventing cancer by creating environments that support a healthy lifestyle, increasing early detection of cancer through screening, improving the treatment of cancer and quality of life for those living with cancer, and reporting on the latest cancer research. NH CCC includes a Tobacco sub-group, which has developed four SMART objectives and strategies in the 2010-2014 Comprehensive Cancer Control Plan that aim to reduce and eliminate the use of and exposure to tobacco. The strategies address changing policy to prevent initiation; providing evidence-based prevention programs; and promoting policies to support smoke-free worksites, homes, and vehicles. Recently, the workgroup met with the CDC TPCP Project Officer, who facilitated a discussion about the CDC's Office on Smoking and Health's recommendations for NH, to advance their tobacco work. The NH CCC Tobacco sub-group will serve as an advisory coalition for the Strategic Direction 1 "Tobacco-Free Living" for NH CTG.

Across all these multi-sector initiatives is a common challenge is the need to balance different, but related, needs in a cohesive structure. Many partners can be working on similar projects simultaneously that would be complementary if coordinated more closely together. The

challenge in that can be balancing the individual needs, interests, and requirements to ensure that a coordinated effort can, indeed, be respectful of the individual stakeholder needs while maximizing the ability to work together. Finding ways to link projects together by including shared membership across efforts, including related efforts in conferences (such as the inclusion of HEAL community work in the NHCHI Fall conference and the inclusion of HEAL in Regional Planning conference) to promote better understanding of goals and objectives, and creating communication channels to provide information broadly to stakeholders are important. These lessons will be incorporated into the program infrastructure of NH CTG through strong communication and collaborative learning systems to further coordinate efforts to maximize the potential of efforts to improve health outcomes.

Resources and Capacities: The CTG project will benefit greatly from the content experience built by the NH DHHS, DPHS. TPCP serves as a resource on a variety of committees to guide intervention implementation, policy initiatives, and environmental change strategies. This includes coordination and fielding of Youth Tobacco Survey (YTS) and Youth Risk Behavior Survey (YRBS) by TPCP staff. As part of its current state-level Communities Putting Prevention to Work (CPPW) funding, NH TPCP is focusing tobacco- and smoke-efforts in voluntary policy changes in licensed child care settings, including assessing the feasibility of implementing and making recommendations for strengthening state regulatory rules to mirror 24/7 tobacco-free public schools policy. To support this, NH is currently surveying NH-licensed child care practices to determine a baseline score for licensed child care programs in their implementation of nationally recognized tobacco policies. Policy trainings about reducing exposure to second hand smoke in child care programs will be also held.

NH communities are able to leverage the resources available in the NH Try to STOP TOBACCO Resource Center (TTSRC). There are four components of the TTSRC. **Component 1:** The Resource Center, a clearinghouse, offers low-cost tobacco education materials (pamphlets, posters, etc.) to physicians and clinicians, and to organizations across the State. **Component 2:** The New Hampshire Tobacco Helpline (1-800-QuitNow), the gateway to tobacco cessation services offered to New Hampshire residents, offering toll-free, telephone-based counseling, free print materials, and referrals to local tobacco treatment programs in English and Spanish, with translation for other languages. **Component 3:** Supporting the population-based Helpline is the Try-To-STOP TOBACCO Website (www.TryToStopNH.org), which provides information about local tobacco treatment resources, fact sheets and state-of-the-art, user-friendly tools for tobacco users who want to quit on their own, including a self-referral form for those who want a tobacco treatment specialist to call them back for counseling. **Component 4:** QuitWorks-NH (www.QuitWorksNH.org), is a provider-centric program that offers health care providers tools to refer their patients to evidence-based telephonic counseling, and offers a full range of the State's tobacco treatment services. QuitWorks-NH is a collaborative effort, which originated as the QuitWorks program developed by the Massachusetts Department of Public Health and is recognized by CDC as a Best Practice.

In the area of Active Living and Healthy Eating, DPHS OPP offers expertise on evidence based strategies to reduce and control obesity and TA to communities, with a focus on policy and environmental changes. OPP provides training and TA to both funded and unfunded HEAL communities with a focus on the CDC target areas for obesity prevention (increasing initiation, duration, and exclusivity of breastfeeding, increasing fruit and vegetable intake, increasing physical activity, decreasing consumption of sugar sweetened beverages, decreasing

consumption of energy dense foods, and decreasing television viewing). OPP participates on the HEAL Leadership Council, and the Sustainability and Evaluation committees. In addition to the work done to support the implementation of the HEAL plan and sustainability of the HEAL home, OPP works to integrate obesity prevention into programs within the DHHS, including the Comprehensive Cancer Collaboration, Diabetes Prevention and WIC and Maternal and Child Health. Through CDC Communities Putting Prevention to Work (CPPW) funding, two projects are underway to address improving school nutrition and child care licensing standards. This includes surveying current NH-licensed child care practices to determine a baseline score for licensed child care programs in their implementation of nationally recognized nutrition, physical activity, screen time, and tobacco policies are being conducted. A series of policy trainings on improving physical activity and nutrition environments in licensed child care programs will be held. In the school environment, wellness policies are being assessed and evaluated to create summaries for each school.

NH's CTG project will also partner with the Community Health Institute/John Snow Institute (CHI/JSI), which is NH's Public Health Institute and a member of the National Public Health Institutes. CHI/JSI was established in 1995 by JSI Research and Training Institute, Inc. in partnership with the DHHS and the Robert Wood Johnson Foundation (RWJF) to provide community-based providers with expertise and resources to strengthen NH's public health and health care systems. CHI's distinction as NH's Public Health Institute brings a wealth of experience, partnerships, and capacity to its national, state and local community work. CHI/JSI has a long history of working at the community level in NH, across many different public health issues, including facilitating the planning and stakeholder engagement process to develop the

HEAL Plan and the planning processes for the NH Diabetes Education Program (NHDEP) to identify priorities for the Statewide Diabetes Prevention and Control Improvement Plan.

CHI/JSI has been funded by RWJF through two phases of the Multistate Learning Collaborative (MLC) project (MLC II: Quality Improvement in the Context of Assessment or Accreditation Programs, and MLC III: Lead States in Public Health Quality Improvement) to conduct public health capacity assessments of regional public health systems to identify assets and gaps within public health regions, and determine those that lend themselves to regionalization. Of particular importance to CTG is the experience of CHI/JSI in establishing and implementing Action-Learning Collaboratives (ALC), which will be used for NH CTG to allow communities to share learning and assist in spreading successful change statewide. In 2008, MLC-3 convened quality improvement learning teams (QuILTs) to explore systems level solutions to identified community problems by linking public health capacity to health status outcomes. The first ALC cohort of three QuILTs was comprised of a cross-section of stakeholders representing community organizations. These QuILTs collaborated over a 15 month period to address reducing childhood obesity within their communities. Two QuILTs focused on school-based activities, and one integrated a function into the electronic medical record (EMR) that enabled routinely calculating body mass index (BMI) during well child visits to provide data to health care providers in real time, and to establish a population-level data base to guide both individual patients. Cohort 2 ALC focused on applying performance improvement techniques to public health systems engaged in supporting tobacco cessation among pregnant women in NH through the practice of smoking cessation practices based on the *Treating Tobacco Use and Dependence*ⁱⁱ. Participants received training in quality improvement principles and tools, Motivational Interviewing, and completed an online training, *Basic Skills for Working with*

*Smokers.*ⁱⁱⁱ In addition to building capacity at the local level, this work has contributed to a national initiative to improve quality improvement strategies in public health, and has been recognized by RWJF and the National Network of Public Health Institutes for its capacity for community engagement in public health efforts.

CHI/JSI works extensively with Dartmouth's CDC-supported Prevention Research Center at the Dartmouth Institute. The Prevention Research Center at Dartmouth (PRCD)'s mission is to work with community and state partners to measurably reduce disparities and improve cardiovascular health. Working initially with Manchester and Keene and an additional community in Vermont, PRCD has focused on developing ALCs to enable coalitions to determine their health priorities and identify, implement, and evaluate interventions. Working with JSI/CHI, PRCD will work to develop ALCs to support CTG. In addition, PRCD will provide advice and consultation about the evaluation of the interventions that are part of the CTG project.

NHIHPP serves on the NH Public Health Association (NHPHA) Policy Committee and will be responsible for linking the local, community level policy change priorities of NH CTG to NHPHA. Because obesity and tobacco use are NHPHA priority areas, the Policy Committee tracks all obesity legislation and provides strategic direction for prioritizing the work of the NHPHA. This includes identifying legislation about which to alert NHPHA members, provide testimony, and/or prompt action by the organization (e.g., through awareness campaigns).

NHIHPP will also link communities to other relevant expertise from UNH. This includes the Departments of Health Management and Policy (HMP), Environmental Research Group (ERG), the Institute on Disability (IOD), Recreation Management and Policy (RMP), Cooperative Extension, and Sustainability Academy. HMP includes faculty with research expertise in the

relationships between land use policies, transportation, physical activity, and obesity. ERG, located in Civil Engineering, focuses on environmental and human health through understanding of the built environment and the policy implications on engineering, building, and planning. IOD focuses on practice-based solutions to meet the needs of the disability community, with extensive reach into community-based organizations dealing with disability rights and access issues. RMP houses Northeast Passage, which focuses on delivering disability-related health promotion and adapted sports programs. Cooperative Extension works directly in communities across the state to implement strategies to improve community development, nutrition, and physical activity; this includes community gardening development, development and expansion of farmer's markets and other marketing of local fruits and vegetables, and working with schools and youth groups to improve nutrition education. UNH Sustainability Academy also houses the "Food Solutions New England (FSNE)" initiative with a mission of "promoting food systems that support sound nutrition and healthy sustainable communities." Through NH CTG, NHIHPP will work with the Leadership Team to identify needs for linking communities to this expertise, and provide opportunities to formulate links to these resources, furthering the community-academic partnerships and bringing support to local initiatives.

NH Population and Disease Burden: According to the June 2011 Census estimates, the population of NH is 1,316,470. NH's population is mix of very rural, suburban, and small city areas. Approximately 38% of the population lives in rural areas, covering 84% of NH's land area.^{iv} Of New Hampshire's 259 towns, 22 are uninhabited and only 29 have a population of 10,000 or more.^v Although primarily a rural state, NH also has pockets of densely populated urban areas, including the two largest cities in the state, Manchester (population: 109,565) and Nashua (population: 86,494).^{vi} The population density for Hillsborough County, which includes

both Manchester and Nashua, is 457.3 persons/square mile, while the average for NH as a whole is 146.8 persons/square.^{vii}

The median age of NH's population is 39.6, which is slightly higher than the national median age of 36.5.^{viii} Over the next 20 years, however, this average is expected to rapidly increase. Predictions indicate that by 2030, 21% of NH residents will be aged 65 years or older, up from 13% reported in 2000.^{ix} Given the general trend for increasing burden of chronic disease and chronic disease risk factors with increasing age, NH has an opportunity to create an environment to support healthy living now that will carry with the population as it ages. Though NH has a predominantly white population (approximately 95%), the State has pockets of diverse populations, largely in its urban settings. Manchester is the most racially and ethnically diverse area in NH, with a larger Hispanic community (7%) compared to the state as a whole (2%). Manchester has a larger foreign-born population (9%) compared to the state (4%). Nashua shows similar patterns with 6% Latino and 10% foreign-born population. In Nashua, 17% of the population speaks a language other than English at home, compared to 8% of the state population. In Manchester, 20% of the population speaks a language other than English at home; this is not only higher than the state, but also higher than the country (18%). NH is, generally, a well-educated population, with one of the highest levels of educational attainment in the country; 91% of the NH population aged 25 or older has obtained a high school diploma or equivalent. However, disparities in educational attainment at this level are seen across the state, in both the urban areas (Manchester, 86%; Nashua, 85%) and rural areas (Coos County, 84%).^{x xi}

Rural communities face unique challenges when compared to residents living in non-rural or urban areas. With a population density of 18.4 persons/square mile (compared to 146.8 persons/square mile for the entire state)^{xii}, Coos County is the least dense and, thus, most rural

area of the state. According to the County Health Rankings published by RWJF and the University of Wisconsin Population Health Institute, Coos County ranks tenth out of the ten NH counties in health outcomes and health factors. 18% of adults in Coos County report poor to fair health, compared to 11% statewide. 24% of Coos County adults report that they smoke, compared to 19% statewide and 15% nationally. Unemployment in Coos County is 8.1%, compared to 6.3% for the state and 5.3% nationally. 20% of children under the age of 18 live in poverty in Coos County, compared to 9% statewide. Lack of access to nutritious food choices (“food deserts”) can be a risk factor in rural areas; a recent report from the Carsey Institute at UNH evaluated NH food access issues and found that certain communities in the rural, northern Coos County have these access issues.^{xiii}

Manchester is the largest urban community in NH. Although Manchester lies in a relatively affluent state, it has the poverty and priority populations and complex disparities similar to those found in larger cities. The urban pockets are characterized by higher poverty; 11% of families in Manchester are under the poverty level, while only 5% of families fall below the poverty level for the state as a whole.^{xiv} The per capita income level in Manchester (\$26,406) is lower than state (\$30,640).^{xv}

State Health Profile: In early 2011, NH DHHS, DPHS published an assessment of the health of NH’s population, the *2011 New Hampshire State Health Profile*. Using a Social Determinants of Health model to guide the assessment and indicators largely adapted from County Health Rankings, the report provides a comprehensive assessment of the health of NH. The key indicators for NH include demographic information as well as measures related to health behaviors, health outcomes, access to care, and the environment. The report is included in Appendix 8. In addition to the state health report, profiles of health for each of the 15 Public

Health Regions have also been developed (included in Appendix 8). Public Health Regions will be the geographic basis for NH CTG local coordination of activities. Highlighted information from the State Health Profile and Regional Profiles with particular relevance to CTG is summarized below.

According to 2009 BRFSS estimates, 16% of NH adults report that they currently smoke cigarettes. In NH, an estimated 1,700 people die prematurely from smoking related illness, with an additional 200 dying each year from secondhand smoke exposure. The rate of smoking increases as income levels decrease. Of those who earn \$75,000 or more annually, 8% are current smokers; of those who earn \$15,000 or less annually, 40% are current smokers. Disparities in cigarette smoking also exist among Regions within the State. For example, the Upper Valley (11.2%) and Portsmouth (7.4%) public health regions—which have highly educated populations with a high average median income—have significantly lower current smoking prevalence rates compared to Franklin/Bristol (21.9%) and North Country (20.9%), two of the most rural areas of NH with worse socioeconomic profiles.

According to 2009 BRFSS estimates, 62% of New Hampshire adults are overweight or obese. Over 26% are obese, mirroring the national median of 26.7%. Obesity rates have increased from 18% in 2000 to 26% in 2009; 36% of New Hampshire adults are overweight. Obesity prevalence also increases steadily with increasing age, up to the 65 and older age group. Among public health regions, 69% of adults in the North Country public health region, the most rural region of the state, are overweight or obese; this is significantly higher than the state average. According to the NH YRBS conducted in 2009, 26% of public high school students were overweight or obese. Prevalence is higher in youth males than females.

Heart disease is the leading cause of death in NH. Men are twice more likely to have heart disease than women, with a prevalence rate among men of 5% compared to 2% in women. Prevalence of heart disease also increases with age, lower educational attainment, and lower income. According to 2009 BRFSS data, the prevalence of heart disease among those 65 years of age and older was 11%, compared to less than 5% in the 45-54 age group. The prevalence of heart disease among those with less than a high school education or GED was 9%, compared to 2.8% among college graduates. Heart disease is approximately four times as prevalent among those earning less than \$15,000 (1.8%), compared to \$75,000 or more (6.8%). The most recent BRFSS data suggests that the prevalence of heart disease is similar across all public health regions in NH.

In 2009, 83% of New Hampshire adults had their cholesterol checked with approximately 40% of those tested reporting elevated levels of cholesterol. At 45%, the North Country (the most rural public health region in the state), had a significantly higher prevalence of adults reporting elevated cholesterol levels than the state average. In addition, preliminary analysis of data from the NH Comprehensive Health Care Information System (CHIS), the state's all-payer claims database (APCD), has shown that cholesterol testing among residents with cardiovascular disease is lower in rural areas, potentially highlighting an opportunity for targeted secondary and tertiary care approaches. According to 2009 BRFSS results, 29% of NH adults reported ever being told they had high blood pressure, which is significantly higher than the reported than in 2001 (23%). Men are more likely to have high blood pressure than women. The rate of high blood pressure also increases with age and with lower income level.

In 2009, 7.1% of NH's adult population had diabetes, which is lower than the national rate of 8.4%. Among the most notable differences in diabetes rates in the state is associated with income

level and education. The rate of diabetes among those with less than a high school level education is twice as high as for college graduates; similarly, the prevalence of diabetes is three times as high among those earning less than \$15,000 compared to \$75,000 or more. Among NH adults 65 years and older, 17% report having diabetes.

With an incidence of 10% in adults and 8% in children, asthma rates in New Hampshire are among the highest in the nation. Hospital discharge data for New Hampshire indicate that the highest rates of ED visits for asthma are found in six of the seven northernmost public health regions of the State and in the cities of Manchester and Nashua.

B. Program Infrastructure

Guiding the project at NHIHPP will be the principal investigator, program manager, evaluation coordinator, research assistant, and business manager. NH DHHS will maintain a leadership role in the NH CTG project. Major decisions about the grant progress will be shared by NHIHPP and DHHS. Appendix 9 includes an organizational chart, the resumes/curriculum vitae for these individuals, as well as a job description for 1 new position. Josephine Porter, MPH (20%; Program Director/Principal Investigator) will provide overall leadership to the project. She has responsibility for maintaining the project's work plan and ensuring the goals are being met. The CTG Program Manager (100% FTE) will report directly to her; the Research Associate (30% FTE) and Business Manager (20% FTE) currently report to her. The Evaluation Coordinator (100% FTE), Ashley Peters, is currently a research associate II for NHIHPP. If this grant is funded, Ms. Peters will focus her time on the CTG evaluation, and report to the CTG Program Manager.

The CTG Project Manager will work directly with the PI, NH DHHS, Leadership Team, existing coalitions (HEAL, HPDP, NH CCC Tobacco Workgroup), and regional coordinators to

manage the CTG project. This position will be responsible for preparing for the Leadership Team meetings (setting agenda and identifying necessary background material), managing the overall work plan and schedule for events, and managing deadlines for the reporting for federal grant requirements. In addition to the time spent meeting with the Leadership Team, the CTG Program Manager will meet directly with the leads of HEAL, HPDP, and NH CCC on a regular basis to create and maintain work plans for each strategic direction. This position will be responsible for linking regional coordinators to the necessary TA, subject matter experts, trainings, and consultants necessary to support local implementation of the strategies defined in the Community Transformation Implementation Plan (CTIP). Initial project work plans will be developed within the first four months of the grant.

As the Evaluation Coordinator, Ms. Peters will identify the analytical needs of the project, and identify data needed to support evaluation and reporting. This will include the use of existing data sets and data tools as well as new data collection to support reporting to local, state, and federal partners. Ms. Peters has been actively involved in the N H Assessment Initiative (AI) project, funded by CDC, which is building web-based data dissemination tools for public health. She is familiar with BRFSS, YRBS, hospital discharge, program-specific performance measures, CHIS, and other administrative data sets. Ms. Peters will manage the development of new reporting tools for data collected for this project (such as EMR data reports, child care facility training data, etc.). Ms. Peters will be responsible for working with the PI, CTG Project Manager, and Leadership Team to develop and maintain evaluation plans for each strategy, as well as for the CTG project overall. The Research Associate, Stacey Gabriel, will support the planning, meeting support, material development, and reporting development for the program.

The Business Manager, Suzanne Shumway, will carry out activities outlined in the fiscal management section of this grant application.

PHRs will be the geographic basis for NH CTG local coordination of activities and distribution of funds. Funds will be provided to support a CTG regional coordinator in each public health region (approximately 0.5 FTE). A request for proposal process will be executed to identify the contracting regional entity in each of the public health regions to retain a regional coordinator to support local implementation of CTG activities. The regional coordinators have the responsibility of working with the Program Manager to link the strategies and activities of the CTG to community level coalitions and stakeholders. This position will work with the local health promotion coalition(s) to link the available TA and resources of CTG to further the local initiatives. This will include working locally to: identify and recruit local property owners, identify and recruit day care centers, identify local media outlets, and identify and recruit institutions to participate in the farm-to-institution purchasing, referral points for CDSM, and identify local coalitions and master plan stakeholders.

Because of their work on NH CHI and its HPDP Pillar Project, Ned Helms, NHIHPP Director, and Holly Tutko will be involved in the CTG project. Ms. Tutko is the project manager for the NHCHI HPDP Pillar group. She will serve as an HPDP representative on the Leadership Team, with responsibility for linking the HPDP workgroup to the strategies developed for Strategic Direction 3 of the CTG. Mr. Helms serves as staff director for the NHCHI. He is also on President Obama's Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. To support the CTG, Mr. Helms will attend Leadership Team meetings and link NH CTG to the broader NH CHI project, including the health care system transformation efforts in Medical Home and ACO development.

The Leadership Team will attend the Action Institute. The team will identify the 10-12 members who are best suited to represent the project's overall goals and objectives. To date, travel restrictions have not prevented any members to travel to other project-required conferences, so that is not anticipated to be a barrier for CTG in NH. The Program Manager, PI, and Research Associate will also attend the kick-off meeting. The Program Manager will be available for subsequent CDC-sponsored events related to CTG, as will the PI as needed.

To promote communication across all partners, a webpage dedicated to the CTG project will be created. This will provide a site for all interested stakeholders—including the communities, HEAL partners, the NHCHI HPDP membership, NHPHA, local foundations, NH DHHS programs, JSI/CHI, and the PCRD—to learn of upcoming events, post previous meeting history, provide resources for others, and raise awareness of the project. This site can also evolve into a web portal if needed, allowing the multiple parties to post and see resources of common interest in a single location. NHIHPP also has subscriptions to WebEx web conferencing and teleconferencing services. This will be leveraged to maximize project partner's time by hosting online meetings and eliminating travel time as much as possible.

NH CTG will also use ALCs to allow for shared learning across communities. The ALCs will provide a means for coordinated and systematic implementation of strategies related to each of the strategic directions across populations, sectors, coalitions, and geography. The ALC provides a forum for TA that is action-oriented, and geared toward systems improvement. Community-based learning teams across the state will support each other in progressing toward improvement based on the performance measures identified in each of the strategies outlined in the following sections. As an iterative process, the ALC can tap expertise from local coalitions to integrate TA

into learning sessions as well as intervening action periods, and foster tracking and incremental improvement in each of the performance areas.

C. Fiscal Management

Budget summary: As described in the budget and budget justification of the application, \$3,650,000 (55% of the total award) will be directed to sub-recipients in each PHR. Eight PHR's are rural areas (North Country, Carroll County, Upper Valley, Greater Plymouth, Franklin/Bristol, Laconia/Meredith, Greater Sullivan County, Greater Monadnock), as identified in the State Health Report in Appendix 8; thus, at least \$2,080,000 (32% of the total award) will be directed to rural areas. In addition to implementation funds, local community coalitions that have advanced work in certain strategies will be funded to provide TA to other communities. Also, \$1,045,000 is budgeted for contractors and consultants to deliver services (such as the development of EMR technology for CHCs and deliver tobacco cessation training to property owners) at the community level.

Management Plans: NH CTG project will take advantage of the fiscal and reporting capacities of UNH's Sponsored Projects Administration (SPA) and the Business Services Center (BSC) units. UNH's SPA currently manages over \$120 million in externally funded grants and contracts, with almost 60% of those awards from federal sources. As such, UNH has systems that allow grant funds to be closely tracked and reported on. When a grant is awarded, a unique fund number is created for the project. Within each fund, activity codes can be created such that individual components of the project can be charged to the unique activity code. The Project Manager and PI identify how charges are allocated to individual activity codes in the system for tracking purposes. For the CTG, each community-based sub recipient will be tracked under the specific activity code to ensure that financial tracking occurs at the community level. This will

allow funds that are distributed to community to be tracked separate from state-level funds. The business manager for the NH CTG project at NHIHPP has an account to access reports for the financial tracking system, allowing for regular review of expenditures.

Other Resources and Sustainability: All three strategic direction areas are led by existing coalitions that have been in effect, and funded, from other sources. NHCHI receives funding from several local foundations (NH Charitable Foundation, Endowment for Health, Harvard Pilgrim Health Care Foundation, and the Wellpoint Foundation), as well as partner organizations (Local Governance Center, Mary Hitchcock Hospital). HEAL receives funding from HNH*foundation*, Anthem Blue Cross and Blue Shield Foundation, Endowment for Health, Harvard Pilgrim Health Care Foundation, NH Charitable Foundation, and NH DHHS. NH CCC is funded through a contract with DPHS. While portions of the CTG funds are directed to agencies for the providing TA, CTG funds are leveraging the statewide planning that has been funded otherwise by providing ways to implement community level intervention strategies in a centrally-coordinated way.

CTG partners will continue to seek other funding opportunities and will support local community coalitions to seek their own funding. This may include providing TA to local coalitions as they develop their own funding applications to external organizations. Importantly, many of the strategies being chosen are designed to be self-sustaining in that they create policy change that, once developed and implemented, do not require ongoing costs for systems change.

D. Leadership Team and Coalitions

NH CTG project will build on NH's successful history of multi-sector partnerships, which were described in more detail in the "Background and Need" section. Existing multi-sector coalitions will support and advise each of the targeted strategic direction areas that are foci of

NH's application: Tobacco Free Living, Active Living Healthy Eating, Increased Use of High Impact Quality Clinical Preventive Services, and Healthy and Safe Physical Environments, as well as to support overall leadership of the project. For each of these coalitions (PHISC, HEAL, HPDP, NH CCC Tobacco Workgroup), the membership will be reviewed and a plan for additional member recruitment will be developed within the first 60 days of the grant award.

PHISC, described previously, will serve as the basis of the NH CTG Leadership Team. Although the statute requiring PHISC expired in November 2010, it now functions as a subcommittee of the legislative Health and Human Service Oversight Committee. The group continues to meet with the goal to provide strategic direction to improve the public's health across a broad set of issues. This group includes membership from a wide range of stakeholders, including: State officials, State Department of Education, Philanthropic Leaders, Federally Qualified Health Centers (FQHCs), hospital and health systems directors, health officer, public health advocates, local health department leadership, local health coalitions, rural area representative, and NHIHPP (the lead entity for CTG). PHISC will serve as the Leadership Team, because it has experience in integrating work across multiple focus areas (PHIAP work groups for each essential service) into a cohesive whole, with a shared overall goal of improving the public health infrastructure. A membership list of PHISC is provided in Appendix 10. Letters of support from organizations on the Leadership Team are included in Appendix 1. To support the CTG work, PHISC will add membership to ensure that the group can effectively guide the CTG Strategic Directions. This will include ensuring that the CTG Program Manager is on the Leadership Team (in addition to the CTG PI, who is a current member of the PHISC). Other additions to the Leadership Team will include a representative from the State's Office of Minority Health and Bureau of Rural Health and Primary Care. In addition, HEAL, HPDP, and

NH CCC Tobacco Workgroup will also have a seat on the Leadership Team. It should be noted that the lead agencies (FHC and NHIHPP) for each of these coalitions currently have seats on PHISC; the seats to be added are for HEAL, HPDP, and NH CCC Tobacco Workgroup.

For Strategic Direction 1: Tobacco-Free Living, the NH CCC Tobacco work-group will serve in the advisory and support role. A NH CCC Tobacco Workgroup representative will serve on the Leadership Team for NH CTG. Membership includes a variety of organizations, including: local hospital systems, insurance companies, NH DHHS, local health collaborations, and local representation from National Advocacy organizations (e.g., American Lung Association). The current membership list is included in Appendix 10, and a letter of support from the NH CCC leadership is included in Appendix 1.

For Strategic Directions 2 and 5, NH CTG will take advantage of the substantial infrastructure put into place by HEAL. The HEAL director will serve on the Leadership Team for NH CTG. The HEAL Leadership Council will serve in an advisory and support role for NH CTG. The HEAL Leadership Council is comprised of HEAL committee chairs and multi-sector leaders allied with HEAL's statewide policy and environmental change priorities, including representation from private foundations, Dartmouth Medical School, NH PHA, NH Hospital Association, Southern NH Planning Commission, NH Department of Education, Workplace Benefits Solutions, and Bike-Walk Alliance of NH. The membership list for HEAL is included in Appendix 10; a letter of support is included in Appendix 1.

For Strategic Direction 3, the NH CHI HPDP pillar will serve in an advisory and support role. HPDP includes representation across the socio-ecological model, including major public and private employers, health care providers, health plans, non-profit advocacy groups, local foundations and funders, NH DHHS, community-based groups, and academic institutions. A

membership list for HPDP is included in Appendix 10. HPDP is staffed by a project manager from NHHPP, who will serve on the Leadership Team.

Strong, multi-sector local coalitions that will be leveraged to carry out the activities of the CTG grant exist across NH. While not every local coalition in NH is described below, examples of some of those local coalitions are included.

In the Northernmost and most rural area of the state, the North Country Health Consortium (NCHC) is a regional, rural health network of 12 health and human service organizations. The NCHC member organizations are community health centers, home health agencies, critical access hospitals, a network of community mental health centers, and a community action agency. The Consortium partners represent the “safety net” providers in the North Country, health care providers, statewide health planning groups, public health professionals, public safety professionals, education institutions, municipal officials, community and business leaders, and community members within its service area. NCHC has extensive experience in developing coalitions and linking community partners around initiatives to promote health and well-being, including the management of the North Country Prevention Network. The North Country Prevention Network has created a youth leadership development framework, with the core organizing group comprised of Youth Prevention Councils in eight North Country schools. NCHC is also a Public Health Training Center for the region.

In the Western part of the state, the Council for a Healthier Community (CHC) is a diverse representation of the community convened by the Cheshire Medical Center/Dartmouth-Hitchcock Keene. Its purpose is to assess the health needs of the community, to form action plans to meet identified needs and to bring new thinking and community engagement for improved health to Cheshire County. CHC was formed in 1995 and includes representation from

public schools, churches, the United Way, the YMCA, Keene State College, the local mental health agency, visiting nurses, hospice, physicians, the chamber of commerce, local business, the NH State Legislature, and the Mayor of Keene. Since its inception, CHC has undertaken several key initiatives which were put into place in response to health needs assessments performed in 1995, 1997, and 2000.

In the state's biggest city, Manchester, there is an existing large community council known as the Healthy Manchester Leadership Council (HMLC) that leads the City's Community Health Improvement Process. HMLC currently has approximately 20 members representing several human service agencies, two hospitals and a major medical center, several philanthropic organizations, municipal government, a community health center, a mental health center, the local school system, home health, and a minority health coalition. HMLC has had many achievements in creating policy and environmental change to impact the public's health, including the adoption of comprehensive school health education in elementary schools, the passing of a referendum for community water fluoridation, and an operational plan of action to increase access to primary care for Manchester's most vulnerable residents. Manchester Health Department (MHD) is leading initiatives with a City Task Force for Safe Routes to School to improve neighborhood infrastructure to support safe walking and biking, and works with an established School Health Advisory Council that has developed a set of School Wellness policies.

E. Community Transformation Implementation Plan

Appendix 11 includes a Community Transformation Implementation Plan (CTIP) for the NH CTG project. The CTIP describes the key activities for an integrated approach to transformation that involves local coalitions (including local health departments), NH DHHS, child care centers,

the health care delivery system, academia, real estate owners, and non-traditional state partners (e.g., Dept. of Agriculture, Regional Planning Commission). If funded, NH would seek CDC and other national expert input in finalizing the CTIP, as well as getting input in the approach to the strategies and activities proposed in the CTIP (e.g., national expertise regarding media messaging about avoiding second-hand smoke exposure). The strategies are selected to develop long-lasting infrastructure, environment, and policy changes that can be implemented through the CTG project, and sustained in the long-term. This includes, as examples, implementation of smoke-free policies in multi-unit housing, development of farm-to-institution (FTI) distribution systems that address the need to price items to sustain the system, and the institutionalization of prompts in EMR technology to support clinical practice changes.

The strategies being selected are reinforcing, complementary approaches that address policy, environment, and infrastructure change where people work, where children are cared for, where people receive health care, and where they work. For example, the change in policies to improve nutrition and physical activities in child care settings are supported by FTI strategies that will facilitate changes to make attaining fruit and vegetables easier; those FTI strategies also make fruits and vegetables available to institutions such as large employers and health care facilities, increasing exposure to local fruits and vegetables to the general population; improvements in the physical environment support identified methods to improve physical activity. The health care delivery system reinforces efforts for improved nutrition through the integration local referrals to people with risk factors of high blood pressure and cholesterol. Tobacco use and treatment is addressed by restricting the ability of smoking in the home by implementing smoke-free policies in multi-unit housing, with referrals to the services to treat tobacco dependence; these referrals are reinforced in the clinical setting through implementing technology and training to facilitate

screening and referrals to treatment; addressing tobacco use as a major risk factor for lack of chronic disease control is similarly reinforced in CDSM programs.

F. Selection of Strategies and Performance Measures

The strategies selected represent a mix of strategies that are reinforcing, district-wide, and integrate similar messages. The selected strategies also build on previous successes and infrastructure that can allow model projects to be spread across the state. They were selected after substantial discussion with statewide public health stakeholders and represent their consensus.

Strategic Direction 1: Tobacco Free Living

SD1; Strategy 1: Increase smoke-free multi-unit housing

This strategy was chosen to focus second-hand smoke exposure prevention in the home, with a focus on the populations with highest rates of smoking, namely low-income and younger populations. This strategy builds on previous successful work to implement smoke-free policy in Housing and Urban Development (HUD) housing in NH. Through a partnership with TPCP and Breathe NH, HUD (and a limited number of sub-HUD housing units) units have been the focus of efforts to work with property managers to implement smoke-free policies. This includes providing a "toolkit" for property managers on how to adopt a smoke-free policy, including: (1) A Steps to a No Smoking Policy check list; (2) Breathe Better in Healthy Homes a No Smoking Policy Guide for Multi Family Dwellings; and (3) No Smoking Landlord Document Samples for Multi Family Dwellings (samples included a no smoking policy, tenant survey, notification meeting, notification letter). For the HUD work, TPCP meets with property managers, shares the tool kit with them, answers questions, and assists in adopting a policy. Once policy has been set, TPCP holds tenant meetings to share information about why there is the need for a policy

change, the dangers of secondhand smoke, details on the new policy (include smoking is and is not allowed), resources available if they wanted to quit (including the NH Tobacco Resource Helpline), and policy enforcement. TPCP can then do Air Quality Testing in units that are suspected of violating the policy, identified by property managers. Breathe NH also has also held Motivational Interview trainings for property managers to assist them in being able to approach residents around the topic of smoking and assist them if they wanted to stop getting them the assistance they needed by using resources that are out there for NH residents. With this approach in the HUD housing, 55% of the HUD units in NH have gone smoke-free; 21% sub-HUDs have gone smoke-free (baseline for both types of units was 0% prior to the start of the effort). For the NH CTG, additional sub-HUD and commercial multi-unit housing complexes, which typically rent to lower income and younger populations, will be recruited to implement smoke-free housing policy in the same way HUD housing is currently targeted.

The NH CTG will also focus on the smoke-free housing strategy by building on efforts in the largest, most urban city in NH, Manchester. MHD has completed a Healthy Homes Strategic Plan that aims to develop a coordinated and sustainable healthy homes system. This plan has been developed by the Manchester Partnership for Safe and Healthy Homes. The current plan is to first begin integrating existing healthy homes related programs, such as lead and asthma, to improve efficiency of service delivery and to ensure a Healthy Homes assessment is utilized within these existing programs. Through the NH CTG project, a smoking focus will be developed to address tobacco use and secondhand smoke exposure, with appropriate referrals for treatment, to be part of the healthy homes assessment. In addition, a healthy homes model that is proactive in nature (versus the current design in Manchester, which is based on responding to an identified issues, such as a child with either an elevated blood lead level or uncontrolled asthma)

could be considered by identifying areas of concern based on demographics and housing-related statistics, with proactive canvassing in these areas to provide healthy homes assessments.

Performance in this strategy will be measured by:

- The number of multi-unit housing landlords who receive TA for smoke-free policy implementation, tracked by the program manager for CTG.
- The number of tenants who receive information about smoke-free housing policy and tobacco cessation resources in tenant meetings as part of smoke-free policy implementation, tracked by the research associate during tenant meetings.
- The number of housing units and people covered by smoke-free policies, recorded by collecting housing unit information for each multi-unit housing owner who implements a smoke-free policy.
- The use of the Helpline, measured regionally to assess the impact of the Helpline use in areas in which multi-unit housing policies and healthy home assessments have been implemented. Helpline use rates will be collected from JSI/CHI, the contractor for the Helpline in NH. An overall increase from an average 30 calls/month to 60 calls/month is expected.
- Monitoring the quit rate from the Helpline: the percentage of people who were quit for past 30 days after 7 months, collected from the Helpline contractor's tracking system.
- An increase in the percentage of people who report having smoke-free policies in their homes and a decrease in the prevalence of current smoking, measured by BRFSS statewide and regionally. Youth smoking rates will be collected from the YRBS and YTS.

SD1; Strategy 2: Implement evidence-based strategies to protect people from second-hand smoke

A media campaign that focuses on the dangers of second-hand smoke exposures, the ways to avoid exposure, and promotion of tobacco cessation resources (NH's Tobacco Helpline) will be implemented to reinforce the smoke-free policies in housing (described above) and clinical interventions to increase treatment for tobacco dependence (described later). The media campaign will include public media channels (TV, radio, newspaper), as well as the development of informational materials that can be used in public and clinical settings. To support the use of these materials in the racial and ethnic disparate populations, special emphasis will be made to create linguistically and culturally appropriate materials.

This media campaign will build off of previous experience using media to improve tobacco cessation in NH. Since 2001, CHI/JSI has collaborated with the TPCP on a variety of health communication strategies targeted to NH health care providers and NH tobacco users who would like to quit. This included the development, production, and placement of NH-specific radio and television ads to promote the NH Smokers' Helpline, resulting in strategically placed media that aired on NH radio stations, WMUR-TV (the only commercial television station located in NH) and NH cable television with significant in-kind air time. The impact of this project is tracked through the database at the NH Smokers' Helpline, which is managed by CHI/JSI and through Google analytics. Evaluation is in progress so final numbers are not known, but an increase in Helpline use has been seen since the start of the campaign.

Performance in this strategy will be measured by:

- The use of the Helpline, measured regionally to assess the impact of the Helpline use in areas in which media emphasis is heaviest and tied to media releases. Helpline use rates will be collected from JSI/CHI, the contractor for the Helpline in NH.

- An increase in the percentage of people who report having smoke-free policies in their homes and in other areas (such as their cars) and a decrease in the rates of current smoking, measured by BRFSS statewide and regionally. Youth smoking rates will be collected from the YRBS and YTS.

SD2: Active Living and Healthy Eating

SD2, Strategy 1: Improve jurisdiction-wide nutrition, physical activity, and screen time policies and practices in early child care settings

This strategy was selected to allow NH CTG to expand current work to improve physical activity and nutrition in early child care to a broader state-wide audience. Obesity rates in children in NH have been increasing over time, and the establishment of healthy practices at early ages can impact healthy life choices as children age. In NH, obesity rates are comparable to national rates across all regions. Therefore, the early child care efforts will be statewide, although recruitment locally will include child care centers in areas with highest obesity rates. Currently, OPP and HEAL have worked with four communities in the state (those that were HEAL-funded community grants) to complete the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program, an evidenced- based intervention to improve nutrition and physical activity practices in child care programs serving children aged 2-5. NAP SACC addresses policies for the following CDC obesity prevention target areas: reducing screen time, improving daily physical activity, reducing consumption of energy dense foods, and increasing consumption of fruits and vegetables. The NAP SACC program includes “assessment of nutrition and physical activity policy, practices and environments to identify the strengths and limitations of the child care facility. Following the self-assessment, a health consultant (i.e., child care health consultant, nurse, health educator or other trained professional) works with the child

care facility staff to set goals for change and develop plans for follow-up actions to improve practice. Collaborative goal setting is followed by staff training and targeted TA to promote organizational change.”^{xvi}

In the Upper Valley of NH, the NAP SACC program has been implemented in the seven (not home-based) early child care centers in the region. The program has resulted in the implementation of policies that promote better nutrition, including: fruit/vegetable offerings at all meals/snacks; requiring skim/2% milk for children ages 2 and up; replacing white flour with whole grains; and no outside beverages for staff (i.e., no soda in front of children). Physical activity changes include requiring an increased percentage of day be spent outside or in planned moderate-vigorous physical activity, the institution of center gardens efforts, the use of Story Walks, and the use of structured music/dance.

For the NH CTG project, early child care centers statewide will be recruited to participate in the NAP SACC program to implement policy, practice, and environment changes, following the model used in the four HEAL communities. Regional coordinators will assist in identifying and recruiting centers that serve disparate populations, particularly low-income populations. In addition, the expansion of the NAP SACC assessment for use in infant and toddler groups, as well as in smaller and/or home-based childcare centers (e.g., 10-15 children) will also be evaluated, which is of importance for rural areas where home-based and small centers are common.

Performance in this strategy will be measured by:

- The number of early child care center completing the NAP SACC program, collected by the local coordinators in each region.

- The documentation of completed NAP SACC program requirements (assessment, review of results, and trainings) by early child care centers, collected by the consultant delivering the program.
- The pre and post assessment results to measure policy, environment, and practice changes, collected by NAP SACC consultant at each center.
- The measured improvement in the nutritional value of the menus at the child care facilities and time spent in physical activity, measured by TA through OPP and HEAL.

SD2, Strategy 2: Increase availability and affordability of healthful foods in institutional settings, workplaces, senior centers, and government facilities: Farm to Institution strategies

This strategy was selected to expand on the growth in NH's farming and ability to provide locally grown produce across the state. According to the 2007 Agricultural Census (USDA National Agricultural Statistics Service), NH saw a 24% increase in farms, 39% increase in farm sales from local farms, and an increase in acres used for active farming from 2002-2007. In addition, there has been a substantial increase in Farmers Markets in the state: from 12 to 80 since 2005, including the development of 20 winter farmers markets since 2008 (when there were none). Farmers markets are located in all 10 counties, and significant numbers of farms in all 10 counties report direct to consumer sales.

FTI practices allow for a broad reach to consumers by creating systems that allow institutions (hospitals, universities, large employers, etc.) to purchase farm products, which provide exposure to local agriculture to a relatively large group of individuals. The NH Dept. of Agriculture is involved in efforts to promote FTI policies, both in NH and regionally. This includes the NH Farm-to-school (NH FTS) initiative, a collaboration of the UNH's Sustainability Academy and the New Hampshire Coalition for Sustaining Agriculture. It was funded by Northeast Sustainable

Agriculture, Research and Education (SARE), a program of the USDA's Cooperative State Research, Education and Extension Service (CSREES). In its first three years, major achievements of NH FTS included: Four large apple growers developed schools as a new wholesale market and food service directors were provided a mechanism that enabled over half the schools in the state to purchase NH apples and cider.

The New England Governors Conference (NEGC) resolution 200, signed in September 2009, directed the six state chief agricultural officers (CAOs) to "Undertake a New England Farm and Food Security Initiative (NEFFSI) to Keep Farmlands in Farming that will protect the region's agricultural land base; determine the region's capacity to increase production, utilization, and consumption of New England-grown farm and food products; and identify barriers to and opportunities for expanding regional agricultural production and consumption." A July 2010 action plan drafted by CAOs with input from CLC and presented to the NEGC focused on six areas of the region's farm and food system, including FTI. Since then, the NEFFSI has leveraged federal, state, and private funding for two initial interconnected projects. A \$250,000 Farm to Institution in New England (FINE) project was funded in February 2011 through a USDA-Rural Development cooperative agreement. FINE is focused on expanding processing capacity for institutional markets and looking at the region's supply chain for commodities provided to schools through the Department of Defense Fresh Program. The FINE project has leveraged an additional \$200,000 in private funding from the John Merck Foundation.

Collaborating with the Department of Agriculture and FINE, the NH CTG will work with local communities to inform the design, development, and implementation of distribution channels to support FTI purchasing. Through the local partnerships of NH CTG, target institutions will be identified to serve as pilot sites for FTI purchasing. This will include

prioritizing target institutions in geographic areas and with reach to populations with vulnerable populations (such as identified food desert areas of rural NH). NH CTG will also emphasize the ability of people who receive local fruits and vegetables at the institutions to make purchases personally through promotion of farmers markets and direct to consumer farm sales.

Performance in this strategy will be measured by:

- The documentation of distribution channel development for purchasing of farm products by institutions, as collected by the program manager.
- An increase in total farm sales, collected from the NH Dept. of Agriculture reporting.
- The number of institutions participating in the FTI purchasing, based on a data system collected at the time of the distribution system design.
- The number of farms participating in the FTI purchasing based on a data system, collected at the time of the distribution system design.

SD3: Increased use of high impact quality clinical preventive services

SD 3, Strategy 1: Provide training and technical assistance to health care institutions, providers and provider organizations to effectively implement systems to improve delivery of clinical preventive services, consistent with USPSTF recommendations: Implement strategies to translate known interventions into usual clinical care to increase control of high blood pressure and high cholesterol

This strategy was selected to build on both NH's extensive use of EMR technology in the health care community, as well as the experience in the state using EMR to address preventative health issues. NH's rates of cardiovascular disease are highest people with lower socioeconomic status (e.g., lower income and education). Thus, strategy is directed initially in the Community Health Center (CHC) setting, which serves these disparate populations.

All of NH's CHC's have EMR systems. Several CHC's are members of the Community Health Access Network (CHAN). CHAN is a private, non-profit Health Center Controlled Network (HCCN) whose mission is to enable its member agencies to develop the programs and resources necessary to assure access to efficient, effective, quality health care for all clients in its communities. CHAN is comprised of seven Federally Qualified Health Centers (FQHC's) in southern and central NH, including three Health Care for the Homeless programs, serving the most populated and most culturally diverse areas of the state. In 2010, CHAN NH members served 61,223 patients across the state of NH; 32% of the patient population are uninsured, 26% are on Medicaid, and 19% are minority patients. For more than ten years, CHAN has methodically expanded infrastructure for technology supported health care delivery, focusing on the automation of the primary care health record as a tool to improve clinical quality and patient outcomes. CHAN's systems include a fully integrated EMR that is linked to a Practice Management System and shares a common reporting tool.

An example of this work was the implementation of a youth BMI screening tool developed and implemented in one FQHC, the Caring Community Network of the Twin Rivers (CCNTR). This EMR technology auto-calculates a youth's BMI at each visit and also prompts the provider to order recommended labs for the youth based on their BMI risk rating. In addition, the EMR function includes reviewing the elements of the statewide "5210 Healthy NH" campaign, which suggests the daily recommendations of eating 5 fruits or vegetables, cutting screen time to 2 hours or less, participating in at least one hour of physical activity, and restricting sugar-sweetened sports and fruit drinks. These screening tools uploaded into the EMR concentrates the provider's effort on reviewing these recommendations, setting self-management goals for achieving and maintaining a healthy weight, as well as recommending community resources to

be more physical active and eating healthier for the patient. Through this project, CCNTR had a goal of having 65% of youth receiving primary care preventive services with age/gender appropriate BMI documented in medical record at least once in the past year; they achieved a rate of over 70% across the four target practices.

The NH CTG will build on this experience to work with CHAN CHCs first, then other provider groups, to develop EMR technology for prompt, referral, and reminders for HBP and cholesterol. In addition to the CHCs, practices in the medical home pilot, which have a distinct care coordination function to emphasize the linking of patients to needed resources, will also be included. Referrals will be made to local resources; local coalition leaders will assist in identifying the local resources to be included in the referrals. For the chronic disease population, referrals to CDSM (described below) will be included. Reporting mechanisms to allow for reporting from the CHC's to the NH CTG will also be established.

Performance in this strategy will be measured by:

- The number of practices that have the EMR technology implemented and staff trained in the use of the tool and local resources, collected by the contractor.
- Reports of HBP measures and tests for cholesterol with measured improvement in the clinical values as reported through the EMR systems.
- The number of people with HBP and cholesterol reminders, as reported through the EMR systems.
- Overall rate of cholesterol testing in adults, collected from the NH CHIS.
- The number of referrals made to local resources, as reported through the EMR systems.
- The rate of cholesterol testing in the population, calculated from the NH CHIS.

SD3, Strategy 2: Provide training and technical assistance to health care institutions, providers, and provider organizations to effectively implement systems to increase delivery and use of treatment for tobacco use and dependence

Similar to the EMR technology to increase the control of high blood pressure and cholesterol, tobacco use and dependence was also selected to leverage NH's experience in using EMR to integrate clinical and community settings. The CHC setting was selected, because the smoking rates in the lower socioeconomic status groups (low income and education) are the highest in the state. CHAN is currently collaborating with TPCP and JSI/CHI on a Smoking Cessation Pilot project at one CHC, Families First Health and Support Center in Portsmouth, NH. Clinicians are currently able to document smoking status at each episodic visit for patients ages 12 and older and document if education and information on NH Helpline services has been provided. The pilot project is focused on patients 18+ years of age and expands on the existing model to train clinical staff to make the Ask about smoking status at EVERY clinical visit, Advise the patient on smoking and make an electronic Referral to the NH Helpline, if the patient is interested. CHAN has developed an electronic interface with the NH Helpline, which will allow information to come back from the Helpline to the providers at Families First, noting whether or not the patient has been reached and what the smoking status is at 6 months. CHAN has also developed reports offering baseline data and will offer monthly reports specific to the Ask, Advise, and Referral rates for the identified patient population. JSI/CHI and TCPC offer clinical staff training.

The NH CTG project will extend this pilot to CHCs across NH, as well as to clinical practices that not CHCs. As above, this will include medical home practices.

Performance in this strategy will be measured by:

- The number of practices that have the EMR technology implemented and staff trained in the use of the tool and local resources, collected by the contractors.
- The number smoking screenings and referrals, as reported through the EMR systems.
- The use of the Helpline, measured regionally to assess the impact of the Helpline use in areas in which practices that are trained are. Helpline use rates will be collected from JSI/CHI, the contractor for the Helpline in NH.

SD3, Strategy 3: Improve arthritis, asthma, and cardiovascular disease, and diabetes outcomes with chronic disease self-management training programs

This strategic direction was selected because it addresses the major causes of morbidity in the state, and builds off of existing infrastructure. Cardiovascular disease is the leading cause of death in NH, and its prevalence has been stable for the past 5 years. The prevalence rates of diabetes and asthma have been increasing across the state. As with other risk factors, disparities in NH are seen with socioeconomic factors; thus, a key population for referrals to CDSM will stem from CHCs.

NH DPHS held a statewide conference in 2007 to introduce the Stanford CDSM program and gauge interest among healthcare providers and community-based agencies in developing capacity to offer CDSM. In response to interest from the conference, NH trained nine Master Trainers who could act as CDSM consumer workshop Leaders and, when they finished qualifying as Master Trainers, could train Leaders. Southern NH Area Health Education Center (SNHAHEC) obtained a Stanford CDSM license, which enabled them to offer the program in NH. By 2009, nine Master Trainers were qualified to operate in NH. DPHS and SNHAHEC established the CDSM Network to support project participants. DPHS partnered with the NH DHHS, Bureau of Elderly and Adult Services to apply for AoA funding to build capacity within

the state to deliver CDSM to the 60 and older population. The two-year grant was awarded in March 2010. The project is coordinated by SNHAHEC, which retains the Stanford CDSM license and coordinates the CDSM Management Team and Network. Achievements to date include 9 active Master Trainers, 62 active Leaders (includes Master Trainers), 30 organizations with internal capacity to hold consumer workshops (have Leader(s)), 20 CDSMP mini implementation grants awarded, and 17 active consumer workshop implementation sites. Over 100 people have completed the CDSM program.

NH CTG will actively support CDSM for a broader population (i.e., not restricted to only those age 60 and over). This will include working with the EMR referrals being developed for HBP and cholesterol (described earlier) to include a referral for CDSM for people with cardiovascular disease and diabetes. NH CTG will also work with local coalitions to identify additional opportunities to refer people to the CDSM program, including through outreach efforts in wellness opportunities throughout the community.

Performance in this strategy will be measured by:

- The number of people referred to the CDSM program, as recorded by the CDSM contractor.
- The number of people completing the CDSM program, as recorded by the CDSM contractor.
- The number of Leaders trained to deliver CDSM, as recorded by the CDSM contractor.
- The improvement in measures of the impact of health on normal activities, quality of life, and patient activation measures, measured by pre and post survey results of participants six months after completion of the CDSM program completion, collected by the CDSM consultant.

SD 5: Healthy and Safe Physical Environment

SD5, Strategy 1: Increase adoption of comprehensive approaches to improve community design to enhance walking and bicycling and active transportation

This strategy was selected to address the need to create spaces that support healthy living by addressing policies and environmental changes at the community level. As described in the Recommended Community Strategies and Measurements to Prevent Obesity in the United States^{xvii}, infrastructure support for walking and biking, as well as active coalitions with broad participation are key factors in preventing obesity. Through statewide HEAL efforts and in HEAL communities, NH has established multi-sector partnerships experience to create built environment change that can be furthered by NH CTG.

As previously mentioned, HEAL's Leadership Council and committees include representation from Regional Planning Commissions, while the local HEAL coalitions benefit from partnering with the NH Department of Transportation, local police and planning departments, walk-to-school coalitions, and others. These partners have allowed HEAL and the local HEAL coalitions to benefit from state and local technical assistance as it relates to land use, infrastructure changes, and safety while building skill and knowledge about built environment strategies that support healthy places.

At the state level, HEAL was instrumental in informing the agenda for the 2011 NH Planners Association statewide conference, "Planning for Public Health," that featured the overarching themes of healthy eating, active living, and sustainability, including Health Impact Assessment training. HEAL was also a Technical Advisory Committee member on New Hampshire's HUD Sustainable Communities Initiative (SCI) grant application, which included in goals to identify and merge appropriate HEAL strategies and resources to improve public health outcomes. The plan included HEAL's community coalition network to inform the regional visioning and

planning process. While NH did not receive an SCI grant award, HUD provided notification that the application score resulted in Preferred Sustainability Status. HEAL remains a partner of the SCI consortium.

At the local level, examples of successful changes by the local HEAL communities include improvements to residential alleyways, e.g., lighting and signage to create livable spaces and development of community gardens. The Manchester HEAL Innovation Fund Project, funded by the National Convergence Partnership and the HNH*foundation*, is working to implement policy and environmental change efforts aimed at improving neighborhood walkability and livability, as well as increase access to healthy, affordable foods. The real emphasis of these efforts, beyond policy and environmental change, has been to develop multidisciplinary partnerships, e.g., planning, economic development, highway, parks, and police, and to directly engage the community residents as empowered partners in community health improvement efforts. For example, the project is working with a Neighborhood Watch Group to finalize plans to improve the built environment in three neighborhood areas (comprised of 4 census tracts) to create neighborhood-specific action plans.

The NH CTG will build on current HEAL success by expanding the number of coalitions and reach of local coalitions, support coalition training and TA from the regional planning commissions, and build community organizing skills at the local level to inform master-plan modifications or neighborhood-specific action plans that enhance walking and/or biking. NH CTG will allow NH to have a deeper impact in rural communities while continuing to strengthen its impact in the more urban communities.

Performance in this strategy will be measured by:

- The documentation of town master plan or neighborhood-specific action plans that address changes to support walking and/biking, collected by consultant TA providers.
- The documentation of changes in infrastructure as a result of planning efforts, collected by TA providers.
- The documentation of changes in the social environment as a result of cross-sector collaborations between planners and other partners (e.g., law enforcement, parks and recreation), measured through interviews, focus groups, or surveys of communities.^{xviii}
- Changes in self-reported physical activity from BRFSS, measured locally, and monitored by the evaluation coordinator.

G. Performance Monitoring and Evaluation

As previously described, since 2004, NH DHHS has maintained a commitment to performance monitoring through its Bureau of Public Health Systems, Policy and Performance. BPHSPP (formerly BPPM) will provide expertise to the NH CTG in maintaining a focus on performance management and continual improvement. In addition to the measurement described for each strategic direction above and the measures of milestone activities provided in the CTIP, a core evaluation plan for the NH CTG project is included in Appendix 12. Once finalized, the CTIP and the evaluation plan will be guiding documents throughout the NH CTG project. Measures will be updated regularly (as new data are collected with the implementation of interventions) and will be reviewed quarterly by the Leadership Team and semi-annually (at a minimum) with CDC at the time of progress report and annual report delivery. This will allow the Leadership Team to review the project overall, in addition to individual issues that are discussed during the monthly Leadership Team. The CTIP and evaluation plans will also be

reviewed quarterly by HEAL, HPDP, and NH CCC Tobacco Workgroup in their respective strategic direction areas.

NH will measure change in the following areas in the ways identified below.

1. Changes in weight: NH BRFSS will be used to measure changes in the prevalence of overweight and obesity in the adult population. YRBS collects obesity and overweight data in children. Aligning with HP2020 objectives, NH seeks a 10% improvement in the rate of obesity in adults, and in children and adolescents through these sources. In addition, data collected by the Department of Education from school nurses and in a local health department (in Manchester) will be used to measure changes in weight in children. BMI is also being collected in EMR, and the use of EMR to measure change in BMI will also be explored.
2. Changes in proper nutrition: NH BRFSS will be used to measure changes in the consumption of fruits and vegetables in the adult population (those with at least 5 servings of fruit and vegetable a day). YRBS collects information about the consumption of fruits and vegetables, as well as dairy products and sugary drinks, in children. As these are developmental targets for HP2020 (which is basing measures on calories and cups of servings) and targets are not available, a 10% improvement is targeted in these metrics (the general approach for HP2020 measures).
3. Changes in physical activity: NH BRFSS will be used to measure changes in the percentage of adults who meet recommendations for physical activity. YRBS will be used to measure physical activity in children, which is measured as being active for at least 60 minutes a day at least 5 days a week. Aligning with HP2020 objectives, NH seeks a 10% improvement in the physical activity measures.

4. Changes in tobacco use and prevalence: NH BRFSS will be used to measure changes in the percentage of adults who currently smoke cigarettes. YRBS and YTS will be used to measure tobacco use in children. Aligning to the HP2020 objectives, the NH target is 12% of adults reporting being current smokers and 21% of adolescents in grades 9-12 reporting having used cigarettes, chewing tobacco, snuff, or cigars in the past 30 days.

5. Changes in emotional well being and overall mental health: NH BRFSS will be used to measure changes in the percentage of adults who report current symptoms of depression or who report being told they had depression by a health care provider at some point in their life. YRBS will be used to measure mental health in children by measuring youth suicide ideation and attempts. In HP2020, mental health measures have a general target of a 10% improvement in the rates of suicide and depression; NH will align with these goals and set a 10% improvement as well. In addition, HP 2020 has “Health-Related Quality of Life and Well-Being” as a developmental area. In NH, BRFSS measures of activity limitations due to physical and mental health, as well as overall life satisfaction will also be evaluated, with targets of 10% improvement in those measures. There will be a particular focus in people with chronic conditions (including hypertension, cardiovascular disease, diabetes), to measure progress in groups that were targeted by the strategies in the NH CTG.

NH DPHS plans to produce state and regional health profiles (included as Appendix 8) annually, which will provide systematic analysis of data to support the measurement of metrics of interest to the NH CTG. It is important to note that NH BRFSS has been collecting BRFSS data with sample sizes sufficient for analysis at the PHR level since 2005. This commitment to BRFSS collection at levels to support local CTG effort evaluation will continue.

NH's APCD (CHIS) is a legislatively mandated collection of claims (medical and pharmacy) from all major commercial health insurers. Medicaid is also included in NH, and Medicare data are being requested. CHIS includes the claims from the inpatient, primary care, and other outpatient settings, providing information about the burden of chronic disease across all settings. Through its AI project, NH has used its APCD to develop metrics (that are being finalized) to assess the rate of preventive care, such as cholesterol testing among target populations (e.g., those with cardiovascular disease history), rates of hemoglobinA1c in people with diabetes, and emergency department visits for people with asthma, and the use of the emergency department among people with mental illness. These data will supplement the measures of effectiveness described above. More specifically, these data will support measuring changes in the long-term objectives of reducing disability due to heart disease and stroke by analyzing the rate and type of utilization and co-morbidities seen for people with heart disease and stroke.

NH CTG will share its evaluation results with CDC through its regular reporting cycles, including reporting overall program outcomes assessed in the first year and at least twice in the five year period. NH CTG will also contribute its findings to national evaluation experts (especially in conjunction with CDC activities) and to interested parties at CDC.

H. Participation in Programmatic Support Activities

NH looks forward to actively working with CDC, other states, national experts, and peer communities. Other CDC-funded programs in NH are extensively involved in the NH CTG through involvement in the coalitions and TA delivery. If funded, NH CTG will work closely with the CDC to finalize the CTIP and evaluation plans, and would seek opportunities to link to CDC's programmatic support to finalize its strategies. Using the network of other funded organizations and associated experts identified by peers and CDC to learn more about successful

implementations of interventions that are similar to what is proposed in NH will be key to continuous improvement of NH's work. NH CTG will work with CDC to identify and collaborate with other community-based programs to learn about other programs that can offer lessons for NH's intervention strategies. As mentioned previously, JSI/CHI is a member of the National Public Health Institutes, providing access to additional experts nationally.

NH will actively participate in meetings, trainings, and forums hosted by CDC, as well as opportunities identified by CDC for grantees. The NH CTG project would also look to CDC for assistance in identifying and coordinating with other Federal agencies whose projects are related to the CTG activities, such as the Dept. of Agriculture, Dept. of Transportation, and Dept. of the Interior. NH will also contribute its evaluation and measurement analysis to CDC as requested to incorporate into CDC's documentation of the overall CTG opportunity. NH will actively participate in nationally coordinated activities to (case studies, cost study, enhanced evaluation study, targeted surveillance) as requested by CDC.

NH also looks forward to finding opportunities and mechanisms to disseminate the findings from its work. This will include presentations at national conferences, publications of papers and manuscripts, and the development of technical resource materials that could be used by other states and communities. NH CTG will develop and disseminate at least four unique dissemination documents for the community, which will be posted to the NH CTG webpage. NH CTG will also develop three publications during the project period, including one manuscript based on evaluation data. Locally, through its connections with the legislature in NHCHI, PHISC, and NH PHA, NH CTG will provide quarterly updates to state representatives. In addition, NH CTG will communicate at least quarterly with the NH Senators and Representatives about the status of the NH CTG project.

Community Transformation Plan – Community Transformation Grant Date: <u>July 6, 2011</u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective (Years 1-3)	By September 30, 2014, at least 15 commercial multi-unit real estate properties will have a smoke-free housing policy			
Population Focus	General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) Target lower income populations		
Strategic Direction	Increase smoke-free multi-unit housing			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Prepare a summary of previous HUD and sub-HUD housing units that have been converted to smoke-free housing policy	Q1		Summary	Program manager, TCPC staff
Identify and document real estate owners who have inquired to NH DHHS TPCP about smoke-free housing policy support	Q1-2		Documentation of inquiries	Research associate and TPCP staff
Review existing multi-unit housing (HUD) experience with Leadership Team to develop overall strategy for expansion of that work	Q2		Meeting presentation	Program manager, TCPC staff
Plan a conference call with regional coordinators to discuss multi-unit smoking strategy for local coalitions	Q2		Conference call agenda and minutes	Program manager; research associate
Hold at least 5 local coalition meetings to explain previous HUD smoke-free housing policy work and resources and explain reinforcing messages planned in media campaign strategy	Q3-4	Ensure coalition reps from advocacy groups	Coalition meeting	Regional coordinators; project manager
Identify in each local coalition large multi-unit housing sites and owners/landlords	Q3-4	Ensure low income housing	List of housing units	Regional coordinators
Develop outreach plan for local coalitions to use to approach real estate	Q4	Ensure low income	Outreach plan	Program manager;

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owners/landlords		housing included		TPCP; Consultant
Meet with at least 15 real estate owners/landlords to explain the smoke-free housing initiative	Q4-7	Ensure low income housing included	Meeting with landlords and owners	TPCP; Consultant
Provide educational and support materials to real estate owners/landlords	Q6-8	Ensure low income housing included	Educational session held	TPCP; Consultant
Meet with tenants and landlords to discuss policy, resources for quitting smoking, and enforcement policies	Q8-12	Include low income housing	Meetings	TPCP; Consultant
Monitor implementation and enforcement of new policy	Q9-12	Include low income housing	Records on enforcement checks	Consultant
Respond to requests from landlords to test air for enforcement	Q9-12		Requests	Consultant
Develop a tobacco screening component for the Healthy Home assessment for Manchester	Q3-5	Ensure that screening is culturally and literacy appropriate	Tobacco screening component of Healthy Home assessment	Manchester HD
Implement a tobacco screening component into the existing Healthy Homes initiative in Manchester	Q6-9	Ensure that screening is culturally and literacy appropriate	Document implementation	Manchester HD
Conduct a learning session from Manchester to other communities for the Healthy Homes initiative	Q10	Include racially diverse communities	Learning session for other communities	Manchester HD
Evaluate the interest and capacity of other NH regions to implement a Healthy Homes initiative	Q11-12	Include racially diverse communities	Survey other communities re interest	Regional coordinators; project manager

Outcome Objective for Years 4 – 5: By September 30, 2016, an additional 10 commercial multi-unit real estate properties will have a smoke-free housing policy

Community Transformation Plan – Community Transformation Grant				
Date: <u> July 6, 2011 </u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective (Years 1-3)	By September 30, 2014, 85% of people will report that New Hampshire homes are smoke-free			
Population Focus	XX General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) Racial and ethnic groups will be focused on with materials that are culturally and linguistically appropriate		
Strategic Direction	Implement evidence-based strategies to protect people from second-hand smoke			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review goals of second-hand smoke media campaign with Leadership Team	Q3		Agenda and Meeting with Leadership Team	Program Manager; TPCP
Develop a defined set of priority populations, communication channels, and target approaches for media campaign; including materials appropriate use in multi-unit housing and health care practices (other targets of this project)	Q3-4		Inventory of priority populations, communication channels, target approaches and materials	Program Manager; TPCP
Plan a conference call with regional coordinators to discuss media campaigns goals and plans with local coalitions	Q4		Conference call minutes	Program manager; regional coordinators
Identify a media consultant with expertise in developing messages about second hand smoke	Q5	Ensure that consultant has experience with diverse target audience	Contract with media consultant	Program Manager
Develop draft materials for the media campaign for second-hand smoke exposure	Q6-8	Ensure that materials are culturally, linguistic, literacy appropriate	Drafts of material for media campaign	Consultant

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Assess the media materials for linguistic and cultural appropriateness	Q7-8	Assessment of cultural and lingual appropriateness		Consultant
Review media materials with local coalitions and Leadership Team	Q9		Leadership Team comment period	Consultant; Program Manager
Finalize media materials based on Leadership Team and local coalitions	Q9		Final version of media materials	Consultant
Develop a plan for distribution of media materials to state-wide and local organizations for distribution	Q9	Include communication channels with reach in racial and ethnic populations	Distribution plan	Consultant; Program Manager
Engage the media (television, radio, and print) on at least 4 occasions to communicate campaign's message	Q10-12		Strategy and schedule for engaging media	Consultant
Assess the percentage of people with smoke-free homes and vehicles	Q12	Include low income housing	BRFSS survey	Evaluation Coordinator

Outcome Objectives for Years 4-5: By September 30, 2016, an increased number of people will report smoke-free policies for other areas of their lives, such as cars in addition to smoke-free houses

Community Transformation Plan – Community Transformation Grant				
Date: <u> July 6, 2011 </u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective (Years 1-3)	By September 30, 2014, a minimum of two early child care settings in each region of the state of NH will have completed the NAP-SACC assessment tool to identify strategies to improve nutrition in the early child care setting			
Population Focus	General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) Focus on young children		
Strategic Direction	Improve jurisdiction-wide nutrition, physical activity, and screen time policies and practices in early child care settings			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review goals of the NAP-SACC effort with Leadership Team	Q3		Meeting with Leadership team	Program Manager; OPP; HEAL
Develop a plan for the expansion of NAP-SACC trainings for state-wide audience	Q4	Ensure that child care centers in low-income areas are included		Program Manager; OPP
Meet with Bureau of Child Care, Referral and Resources to identify methods to refer local child care centers to local coalitions	Q4		List of methods to refer child care centers to local coalitions	Program Manager; OPP
Plan a conference call with regional coordinators to discuss NAP-SACC process, outcomes, and goals	Q5		Conference call	Research Associate; regional coordinators
Hold local coalition meetings to discuss NAP-SACC process, outcomes, and goals	Q6-7		Coalition meetings	Program manager; regional coordinators; OPP
Develop an outreach plan for local coalitions to reach out to local early child care centers to discuss NAP-SACC implementation	Q7	Ensure that child care centers in low-income areas are included	Outreach plan	Program manager; regional coordinators; OPP

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Identify technical consultant to work with early child care centers to implement NAP-SACC assessment	Q7	Ensure that child care centers in low-income areas are included	Contract with consultant,	Program manager
Contract with technical consultant to be able to deliver consultative services to early child care centers	Q8	Ensure that child care centers in low-income areas are included	Contract with consultant, including consultation with child care centers	Program manager
Schedule NAP-SACC assessment trainings at local early child care centers	Q8-9	Ensure that child care centers in low-income areas are included	Trainings scheduled	Research associate; regional coordinators;
Deliver trainings at early child care centers to complete assessments and identify strategies to change practices to improve nutrition	Q9-10	Ensure that child care centers in low-income areas are included	Trainings held	Consultant
Monitor implementation of new policies and procedures in early child care centers resultant from NAP-SACC assessment	Q10-12	Ensure that child care centers in low-income areas are included	Survey of implementation of new policies and procedures in early child care centers	Evaluation coordinator

Outcome objectives Years 4-5: By September 30, 2016, a minimum of 15 additional early child care settings in each region of the state of NH will have completed the NAP-SACC assessment tool to identify strategies to improve nutrition in the early child care setting

Community Transformation Plan – Community Transformation Grant				
Date: <u> July 6, 2011 </u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective (Years 1-3)	By September 30, 2014, at least five institutions across the state of NH will be purchasing produce from local farmers			
Population Focus	XX General/Jurisdiction Wide	Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other)		
Strategic Direction	Increase accessibility, availability, affordability, and identification of healthful foods in institutional settings, workplaces, senior centers, and government facilities			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review goals of the Farm-to-Institution effort with Leadership Team	Q2	State-wide and inclusive	Meeting with Leadership Team	Program Manager; Dept of Agriculture; HEAL; OPP
Schedule meetings with Department of Agriculture, NH Farm to School initiative, and other stakeholders identified by the Department of Agriculture to review current Farm-to-Institution regional projects	Q3		Meetings with partners	Research Associate
Conduct an assessment of current farmer, farmers market, and growers association capacity in the state	Q4-5		Assessment report	Program Manager, Dept of Agriculture, Farm-to-School initiative
Plan a conference call with regional coordinators to discuss Farm-to-Institution goals	Q5		Conference call	Research associate; regional coordinators;

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Implement a survey to identify interested institutions in each region to assess level of interest and local needs for purchasing and analyze results	Q5-6	Evaluate interested institutions likelihood to impact disparate populations (rural and low-income) to prioritize efforts to target institutions in areas of greatest impact	Survey	Research associate; regional coordinators;
Identify potential distribution mechanisms (direct from farmer, through growers associations, via a food distributor) to allow for purchasing by large institutions	Q5-6		List of potential distribution mechanisms	Program Manager, Dept of Agriculture, Farm-to-School initiative
Develop a tool to evaluate the feasibility of each approach	Q5		Evaluation tool	Program Manager, Dept of Agriculture, Farm-to-School initiative
Conduct feasibility assessment for each approach	Q6-7		Feasibility assessment	Program Manager, Dept of Agriculture, Farm-to-School initiative
Evaluate approaches with target institutions (workplaces, senior centers) in each region	Q6-8	Ensure target institutions will include disparate populations (rural and low income)	Survey/interviews with institutions	Research associate; regional coordinators;
Develop a plan for distribution mechanism (s)	Q9		Distribution Plan	Program Manager, Dept of Agriculture, Farm-to-School initiative

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Pilot purchasing mechanism for institution in at least five pilot institutions	Q10-11		Plan for pilot test of distribution plan	Program Manager, Dept of Agriculture, regional coordinators;
Evaluate purchasing pilot, including the delivery, payment, ability to meet volume needs, and replicable	Q11		Evaluation of pilot test	Program Manager, Dept of Agriculture,
Modify distribution plans, as needed, based on pilot evaluation	Q12		Revised distribution plan	Program Manager, Dept of Agriculture,

Outcome objectives Years 4-5: By September 30, 2014, at least ten additional institutions across the state of NH will be purchasing produce from local farmers

Community Transformation Plan – Community Transformation Grant				
Date: _____ July 6, 2011 _____				
Site Name	New Hampshire State-wide CTG			
Outcome Objective	By September 30, 2014, all community health centers in the CHAN network practices in NH will have implemented EMR technology for prompts, referrals, and reminders for high blood pressure and cholesterol			
Population Focus	General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) Low SES (income) people getting care through the health centers		
Strategic Direction	Implement strategies to translate known interventions into usual clinical care to increase control of high blood pressure and high cholesterol			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review goals of the EMR-based projects (high blood pressure and cholesterol, and tobacco) with the Leadership Team	Q4		Meeting with Leadership Team	Program Manager; HPDP
Select a community health center at CHAN to serve as the pilot site for piloting the EMR templates for high blood pressure and cholesterol screening, referral, and reminder systems	Q4	Select community health center that serve low SES population	Selected health center	Program Manager; CHAN
Identify local referral resources at the community level for nutrition, physical activity, chronic disease self-management to be integrated into the EMR referral tool	Q5-6		Documentation of local referral resources, including built environment changes and opportunities identified in assessment in Strategic Direction 5 strategy	Research associate; regional coordinators;
Establish a mechanism for reporting data from the EMR for outcomes for HBP and cholesterol to NH DHHS and NHIHPP for reporting	Q5		Mechanism for reporting from EMR	Program Manager; Evaluation coordinator; CHAN
Develop the templates for HBP and	Q6-7		Templates for	CHAN

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cholesterol screening			HBP and cholesterol screening	
Develop parameters for reminders from EMR for follow-up for high blood pressure and cholesterol	Q6-7		Parameters for EMR reminders	CHAN
Develop EMR screens and tools for the HBP and cholesterol screening, referral, and reminder system	Q6-7		EMR screens and tools	CHAN
Develop training curriculum for providers for implementation of EMR technology, to include training about Motivational Interviewing and local resources that will be part of the referrals from the EMR	Q7-8		Training curriculum	CHAN; AHEC; Program Manager
Implement EMR screens and tools at one pilot health center	Q9		Documentation of EMR screens pilot	CHAN
Conduct training at pilot health center, to include clinicians and care coordinators, who can promote the referrals to community resources	Q9		Training sessions	CHAN; AHEC;
Modify EMR technology as needed based on feedback from pilot implementation	Q11		Final EMR screens	CHAN;
Modify curriculum as needed based on feedback from pilot	Q11		Revised training curriculum	CHAN; AHEC;
Implement in other CHAN community health centers	Q12		Documentation of implementation in other centers	CHAN
Monitor use of the EMR tools and referrals	Q 12		Reporting of referrals, reminders, and results from EMR	Evaluation Coordinator ; CHAN

Outcome objectives Years 4-5: By September 30, 2016, an additional 10 practices will have implemented EMR technology for prompts, referrals, and reminders for high blood pressure and cholesterol

Community Transformation Plan – Community Transformation Grant				
Date: <u>July 6, 2011</u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective	By September 30, 2014, all community health centers in the CHAN network and an additional 5 practices in NH will have implemented EMR technology for prompts and referrals for tobacco use and dependence screening and counseling			
Population Focus	General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) Low SES (income) people getting care through the health centers		
Strategic Direction	Provide training and technical assistance to health care institutions, providers, and provider organizations to effectively implement systems to increase delivery and use of treatment for tobacco use and dependence			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review findings of current EMR pilot for tobacco use screening and referral to quit resources with Leadership Team	Q2		Summary of findings Meeting with Leadership Team	Program Manager; TPCP; CHAN
Develop an outreach plan to extend tobacco screening and referral system to other community health centers and practices	Q3-4		Outreach plan	Program Manager; CHAN
Plan a conference call with regional coordinators to discuss tobacco screening and referral approach	Q4		Conference call	Research associate; regional coordinators;
Identify local medical practices to implement a tobacco use screening and quit referral tool in their EMR	Q5-6	Select community health center that serve low SES population	List of local medical practices identified for pilot	Research associate; regional coordinators;
Identify referrals to be included in local implementations of EMR tool, including local cessation resources and media materials developed for media campaign (in Strategic Direction 2)	Q5-7		Selected local referrals	Research associate; regional coordinators;

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Develop a plan to translate existing EMR tool to other EMR technology platforms, incorporating local resources	Q8-9		Plan to translate existing EMR tool to other EMR platforms	Program Manager; CHAN
Modify existing training curriculum for providers for implementation of EMR technology, to focus on unique aspects of local EMR platform and local resources	Q9		Revised training curriculum	CHAN; AHEC; Program Manager
Implement EMR screens and tools at least 10 additional practices (CHAN and private practices)	Q10-11		Documentation of implementation of EMR screens and tools in 10 practices	CHAN; AHEC; Program Manager; regional coordinators; practice sites
Conduct training in at least 10 practices, to include clinicians and care coordinators, who can promote the referrals to community resources	Q10-11		Training sessions in 10 practices	CHAN; AHEC; Program Manager; regional coordinators; practice sites
Monitor use of the EMR tools and referrals	Q12			Evaluation Coordinator; practice sites

Outcome objectives Years 4-5: By September 30, 2016, an additional 15 practices will have implemented EMR technology for prompts and referrals for tobacco use and dependence screening and counseling

Community Transformation Plan – Community Transformation Grant				
Date: <u> July 6, 2011 </u>				
Site Name	New Hampshire State-wide CTG			
Outcome Objective	By September 30, 2014, an additional 20 leaders will be trained to deliver CDSM, in addition to maintaining at least 30 of the current trainers			
Population Focus	General/Jurisdiction Wide	XX Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other) People with chronic conditions		
Strategic Direction	Improve arthritis, asthma, cardiovascular disease, and diabetes outcomes with chronic disease self-management training programs			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review a summary of current Stanford CDSM efforts in senior population with Leadership Team	Q4		Meeting with Leadership Team	Program Manager; Asthma control program; AHEC
Review state health profile with Leadership Team to review regions with populations with highest chronic disease rates	Q4	Identify areas of highest disease burden	Meeting with Leadership Team	Program Manager; evaluation coordinator
Develop an outreach strategy to expand the target populations for CDSM, including linking to the EMR referral system for high blood pressure and cholesterol	Q5	Focus on areas of highest disease burden	Outreach strategy	Program Manager; Asthma control program; AHEC;
Identify three priority focus regions as initial focus of CDSM expansion	Q5		List of priority regions	Program Manager; Asthma control program; AHEC; Leadership Team

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Meet with local coalition leaders in priority regions about CDSM expansion	Q6-7		Meeting with coalition leaders	Research associate; regional coordinators;
Develop local outreach plans to recruit CDSM trainers	Q7	Ensure recruitment plan includes disparate populations (low SES and racial and ethnic groups)	Local outreach plans for recruitment	Program manager; Research associate; regional coordinators; AHEC
Develop local outreach plans to expand referral channels for participants to local community-based organizations, including workplace wellness, nutrition counseling, and physical activity groups	Q7		Local outreach plans to expand referral channels	Program manager; Research associate; regional coordinators; AHEC
Conduct at least 4 trainer sessions for those who will deliver CDSM	Q8-9		4 trainer sessions	AHEC
Implement outreach plan for referrals, including providing at least 4 awareness presentations to referring organizations to promote the referrals to CDSM	Q9-10		Documentation of implementation of outreach plans	Program manager; Research associate; regional coordinators;
Conduct at least five CDSM participant sessions	Q10-12		5 CDSM participant sessions	AHEC
Monitor results of CDSM based on metrics defined by Stanford	Q10-12		Documentation of follow-up metrics	Evaluation coordinator; AHEC

Outcome objectives Years 4-5: By September 30, 2016, 900 adults with chronic conditions will participate in a CDSM program workshop

Community Transformation Plan – Community Transformation Grant				
Date: _____ July 6, 2011 _____				
Site Name	New Hampshire State-wide CTG			
Outcome Objective	By September 30, 2014, every planning region (8) in the state will have documented at least one town master plan or neighborhood specific action plan that include infrastructure assessment to enhance environments that supporting walking and biking			
Population Focus	General/Jurisdiction Wide	Health Disparity (age, urban or rural location, gender, race/ethnicity, education, income, sexual orientation, disability, or other)		
Strategic Direction	Increase adoption of comprehensive approaches to improve community design to enhance walking and bicycling and active transportation.			
Reportable Milestone Activities	Timeline (Initiation-Completion)	Identify the Activity (ies) related to the Health Disparity	Measure	Lead Staff and Key Partners
Review a summary of current example planning projects (from HEAL communities) with Leadership Team	Q2		Meeting with Leadership Team	Program Manager; HEAL
Develop a recruitment plan for local coalitions to enhance the built environment for towns and cities within NH's 8 regional planning commissions (RPC), including recruitment of public from CDSM programs	Q2		RPCs implement recruitment plan	Regional coordinators, RPCs, Built environment TA staff, Program Manager; HEAL
Conduct in person surveys and/or group setting assessments to determine towns/ cities readiness for master plan revisions to enhance walking or bicycling.	Q3	Identify one key indicators of health disparity in each region, e.g. poverty, rural isolation, economic, housing)	A minimum of 3 assessments per region (24 statewide)	Regional Planning Commission rep., built environment TA staff, Regional coordinators,
Identify a minimum of 3 towns/cities per region to advance master plan changes to improve the local built environment.	Q4	Ensure identified towns include areas with identified		Program Manager; Regional coordinators,

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		disparities and known barriers (rural and income)		
Conduct community forum in selected towns to educate and inform residents, local decision makers and multi-sector partners about connections between health and master plan/ built environment.	Q3-4			RPCs, Built environment TA staff, Regional coordinators,
Identify existing community develop measurement tool to elicit and prioritize concerns from residents about specific barriers to walking and bicycling by location, eg. high crime areas, high speed areas, poor lighting, lack of sidewalk or safe area for biking,	Q4			RPCs, Built environment TA staff, Regional coordinators, HEAL; OPP; program manager
Identify community resident champions to build interest and support among residents.	Q5			RPCs, Regional coordinators,
Coordinate community resident meeting to: <ul style="list-style-type: none"> a. build support and skills for master plan changes b. Engage community residents, with an emphasis on those who represent disparate populations, to participate in introductory community needs planning session(s) throughout the region. 	Q6-8	In person invitations at churches, community/neighborhood events, and posting invitations at places (multi-cultural centers, corner stores, social service agencies, Boys and Girls Clubs) frequented by disparate populations.		RPCs, Built environment TA staff, Regional coordinators,
Conduct skill building sessions for resident groups to advance a policy agenda to support master plan changes that enhance the built environment.	Q7-8			RPCs, Built environment TA staff, Regional coordinators, Program manager
Identify and select priorities for built environment/master plan changes	Q8			RPCs, Built environment

based on criteria: Evidence-informed, reduces health disparities, engages multi-sector partners, politically feasible, realistic cost, increases access to safe places to walk and bike, increased community engagement,				TA staff, Regional coordinators, HEAL
Community residents organize to advance policies and/or master plan changes to support enhanced places for walking and biking in a minimum of 15 towns.	Q6-8			Regional coordinators, HEAL
Five regions will implement master plan changes to improve the built environment	Q6-8			Regional coordinators, HEAL
Monitor master plan change and built environment changes and community interest	Q8-12			Evaluation coordinator

Outcome objectives Years 4-5: By September 30, 2016, at least 3 communities per RPC region in the state will have implemented at least one strategy identified in a town master plan or neighborhood specific action plan that include infrastructure assessment for supporting walking or biking

Logic Model for New Hampshire CTG Project

Outcomes

Inputs

- Staff**
- Program Director/PI
 - CTG Program Mgr
 - Research Associate
 - Business Mgr
 - Evaluation Coordinator

- Partners**
- NH DHHS
 - NH DOE
 - NH Dept of Ag
 - State coalitions: HEAL, HPDP, NH CCC
 - Local health departments
 - Regional coalitions
 - CHCs, CHAN, and medical care practices
 - JSI/CHI
 - UNH experts
 - Dartmouth PRC
 - AHEC
 - Regional planning commissions
 - Advocacy groups

- Resources**
- CTG funding
 - Partner Knowledge, skills, & resources
 - Local Action & Evaluation Plans
 - Sustainability plan
 - UNH Fiscal mgmt. system

Activities (Year 1)

- Form/Maintain Leadership Team and Coalition**
- Leadership Team
 - CTG Coalition
 - Representation from populations experiencing health disparities
- Program Infrastructure**
- Hire necessary staff and maintain staffing requirements
 - Engage community partners
 - Develop CTG website
 - Develop financial tracking
- Implement Community Transformation Plan (CTP)**
- Finalize CTP
 - Seek approval from CDC of final CTP
 - Implement CTP strategic directions
 - Utilize data sources to monitor impact
 - Assess rates of chronic disease risk factors
- Participate in Programmatic Support Activities**
- Attend CDC-convened meetings
- Engage in Evaluation Activities**
- Collect measures in CTP
 - Monitor progress and adjust plans in response to evaluation review
 - Participate in national evaluation efforts

Outputs (Years 1-2)

- Active and Effective Coalitions**
- Strong program infrastructure**
- Efficient program management
 - Meeting minutes
 - Progress reports
 - NH CTG website
 - Financial reports (50% of funds to local entities, 20% to rural areas)
 - Review of CITP benchmarks regularly
- Implementation of interventions, focused on populations with high disparity, in the areas of:**
- tobacco free living
 - active living & healthy eating
 - high impact quality clinical preventive services
 - healthy and safe physical environment
- Integration across objectives within the CTP**
- Skilled staff and partners to implement and evaluate interventions**
- Comprehensive evaluation of intervention activities and outcomes**

Short (Years 2-3)

- At least 15 commercial multi-unit real estate properties will have a smoke-free housing policy
- 85% of people will report that New Hampshire homes are smoke-free
- Minimum of two early child care settings in each region of NH will have completed the NAP-SACC assessment tool
- Minimum of five institutions across the state of NH will be purchasing produce or meat from local farmers
- All CHCs in the CHAN network and an additional 5 practices in NH will have implemented EMR technology for prompts, referrals, and reminders for high blood pressure and cholesterol
- All CHCs in the CHAN network and an additional 5 practices in NH will have implemented EMR technology for prompts and referrals for tobacco use and dependence screening and counseling
- 20 more leaders will be trained to deliver CDSM, in addition to maintaining at least 30 of the current trainers
- Every region in the NH will have documented at least one town master plan or neighborhood specific action plan that include infrastructure assessment for supporting walking or biking

Intermediate (Years 3-5)

- 10 additional commercial multi-unit real estate properties will have a smoke-free housing policy.
- An increased number of people will report smoke-free policies for areas outside their home (cars, balconies, etc.)
- 15 additional early child care settings in each region of NH will have completed the NAP-SACC assessment tool
- Ten additional institutions across the state of NH will be purchasing produce or meat from local farmers
- 10 more practices will have implemented EMR technology for prompts, referrals, and reminders for high blood pressure and cholesterol
- 15 more practices will have implemented EMR technology for prompts and referrals for tobacco use and dependence screening and counseling
- 900 adults with chronic conditions will participate in a CDSM workshop.
- At least 3 NH communities will have implemented at least one strategy identified in a town master plan that include infrastructure assessment for supporting walking or biking
- Improvement in BRFFS and YRBS rates of current smoking, obesity, physical activity, fruit and vegetable consumption, and emotional well-being

Long-term (Years 5+)

- Reduce death and disability due to tobacco use by 5% in NH.
- Reduce NH's obesity rate by 5%
- Reduce death and disability due to heart disease and stroke by 5% in NH.

Objective 1: Program Infrastructure.							
Project will be staffed in order to administer, manage, and evaluate the program.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Were the appropriate staff retained (hired or assigned) for the project?	Position descriptions, CVs, names and dates of hire for project staff	Administrative (hiring) records and materials	Collect from Human Resources agencies	Q1 – Q2 (Within 90 days for project leader & evaluator; within 120 days for additional staff)	Summarize the list of staff names, position descriptions, and dates of hire	Distribute list to leadership team, post names of staff to project website, submit staff names, CVs, and dates of hire in CDC progress reports	PI and Project Manager
Were the project staff levels maintained through the project?	Position vacancy information	Administrative (hiring) records	Collect from Human Resources agencies	Ongoing	Identify gaps in positions, fill as needed	Share information with the Leadership Team and CDC reports	Project Manager and PI

Objective 2: Fiscal Management. Provide funding to appropriate local entities committed to the goals of the initiative and the selected policy, environmental, programmatic, and infrastructure strategies; establish procedures to track and report expenditures; and prepare required reports on the designated schedule.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Was money provided to the local entities?	Amount of money and number and frequency of payments to local entities (50% of funds to local entities)	Financial reporting records	Business Manager will retrieve monthly reports from UNH Banner system with expense summaries using specific activity codes	Monthly; Ongoing	Review expenditures to calculate total amounts distributed to local agencies; Provide financial statements of funding to local entities to CDC at CDC-specified intervals; Business manager will review reports with Project Manager and PI monthly	Financial statements will be provided monthly to key personnel Financial reports will be sent to CDC with progress and annual reports	Project Manager and Business Manager
Were procedures put in to place to track and report the expenditures of the project?	Evidence of assignment of fund numbers and activity codes to track payments of various expenses and	Financial reporting records and communication with financial reporting administrators about reporting needs for	Business Manager will retrieve monthly reports from UNH Banner system	Q1	Business manager will review reports with Project Manager and PI to ensure fund numbers and activity codes are being set up	Financial statements will be provided to PI and Program Manager; system will be vetted with CDC project officer to ensure correct level of	Project Manager and Business Manager

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Objective 2: Fiscal Management. Provide funding to appropriate local entities committed to the goals of the initiative and the selected policy, environmental, programmatic, and infrastructure strategies; establish procedures to track and report expenditures; and prepare required reports on the designated schedule.							
	payments to local entities	tracking expenses			to capture the right level of information	reporting	
Was tracking of funds reviewed regularly?	Regular reports of expenditures	UNH Banner system	Business Manager will review monthly expense summaries using specific activity codes	Monthly; Ongoing	Business manager will review reports with Project Manager and PI	Financial statements will be provided to PI and Project Manager for monthly review	Project Manager and Business Manager
Were project reports delivered on the designated schedule?	Evidence that reports (annual reports and progress reports) were sent to CDC by their due dates	Project manager will track report delivery and confirmation	Project manager will keep record of report delivery	Semi-annually; Ongoing	None	Project Manager will communicate report delivery to PI and Leadership Team	Project Manager
Were financial reports delivered on the designated schedule?	Evidence that financial reports were sent to CDC by their due dates	Project manager will track report delivery and confirmation	Project manager will keep record of report delivery	Semi-annually; Ongoing	None	Project Manager will communicate report delivery to PI and Leadership Team	Project Manager

Objective 3: Leadership Team and Coalition.							
Strategies are integrated and coordinated across strategic directions, and are aligned and integrated with efforts by other sectors to improve the area environment. Additionally, communities will be engaged throughout the project period including the involvement of key state and community-based and public health partners comprising an alliance of partnerships, coalitions, and community members committed to participating actively in planning for implementation of CTG and in training related to policy, environmental, programmatic, and as appropriate, infrastructure changes.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Did the project team have active engagement of leadership from stakeholders?	Review of Leadership Team and coalition membership and identification of other needed partners; Attendance and participation of Leadership Team and other stakeholders	Meeting minutes, attendance & membership	Extract relevant material from meeting minute, including names of representatives and descriptions of projects	At least monthly	Summarize material from extracts of meeting minutes	Distribute by email to leadership team and CDC; post meeting minutes on the website	Project Manager; Leadership Team
Did the project team identify other projects in the state that should be aligned with CTG to improve the area environment?	Review of existing projects in NH that are related to CTG goals and objectives	Meeting minutes, attendance & membership	Extract relevant material from meeting minute, including names of representatives and descriptions of projects	At least monthly	Summarize material from extracts of meeting minutes	Distribute by email to leadership team and CDC; post meeting minutes on the website	Project Manager; Leadership Team
Are the CTG strategies aligned with efforts by other sectors to improve the area	Documentation that other efforts that are aligned	Meeting minutes, attendance &	Extract relevant material from	At least monthly	Summarize material from extracts of	Distribute by email to leadership team	Project Manager; Leadership

<p>Objective 3: Leadership Team and Coalition. Strategies are integrated and coordinated across strategic directions, and are aligned and integrated with efforts by other sectors to improve the area environment. Additionally, communities will be engaged throughout the project period including the involvement of key state and community-based and public health partners comprising an alliance of partnerships, coalitions, and community members committed to participating actively in planning for implementation of CTG and in training related to policy, environmental, programmatic, and as appropriate, infrastructure changes.</p>							
environment?	and coordinated with CTG strategies have been linked to CTG efforts; evidence that other advisory coalitions (HEAL, HPDP, NH CCC Tobacco) have included CTG in coalition meetings	membership	meeting minute, including names of representatives and descriptions of projects		meeting minutes	and CDC; post meeting minutes on the website	Team
Were strategies in CTIP integrated to the extent possible?	Documentation of cross-linked activities across CTIP strategies	Process documentation of the design and implementation of strategy activities	Process flow documents and project plans for CTIP activities	Reviewed monthly; ongoing	Synthesis of process flows and project management document to identify cross-linked activities	Discuss in Leadership Team meetings; summarize for website CTG progress summaries; incorporate into CDC reports	Project Manager; Research Associate
Did the project team engage community leaders in planning for implementation and in training?	Number of and names of attendees of the meetings, including the organization that the attendee represents. High level description of	Invitations to meetings, agendas and meeting minutes	Extract information from email invitations, meeting agendas and minutes	Annually	Summarize material from extracts of meeting minutes	Distribute by email to leadership team and CDC; post meeting minutes on the website	Project Manager, Leadership Team

Objective 3: Leadership Team and Coalition.
 Strategies are integrated and coordinated across strategic directions, and are aligned and integrated with efforts by other sectors to improve the area environment. Additionally, communities will be engaged throughout the project period including the involvement of key state and community-based and public health partners comprising an alliance of partnerships, coalitions, and community members committed to participating actively in planning for implementation of CTG and in training related to policy, environmental, programmatic, and as appropriate, infrastructure changes.

	content of meeting (e.g. implementation)						
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Objective 4: Selection of Strategies. Spend at least 50% of funds on strategies in the first three strategic directions; strategies extend area wide and toward population subgroups; strategies are integrated and informed by data; strategies together form a cohesive and effective plan that will maximize impact across the entire population and among selected population subgroups.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Were 50% of the funds directed to the first three strategic directions?	Amount of money distributed to strategies in directions 1-3	Financial reporting records	UNH Banner (financial reporting) system will produce regular reports of payments to local entities and other project expenses	Annually	Summarize the financial data – 50% to local entities	Progress report to funders and leadership team	Project Manager
Are the strategic directions extended area-wide and to population subgroups?	Description of target audience for strategic directions; Size (number of people and locations)	Data collected at implementation of activities outlined in CTIP (e.g., location of multi-unit properties implementing smoke-free policies, CHCs that implement EMR tools, location of institutions purchasing local produce, etc)	Collected in conjunction with implementation of activities	Ongoing	Populations being targeted will be analyzed based on the data from consultants, contractors, etc.	Shared with the Leadership Team; summaries posted on CTG website; reports included in reports to CDC	Project Manager; Evaluation Coordinator

<p>Objective 4: Selection of Strategies. Spend at least 50% of funds on strategies in the first three strategic directions; strategies extend area wide and toward population subgroups; strategies are integrated and informed by data; strategies together form a cohesive and effective plan that will maximize impact across the entire population and among selected population subgroups.</p>							
Are the strategic directions informed by data?	Data used to define the target audience	Data used in the grant application and ongoing updates of data from NH public health data sources	Annual NH State Health Report; data collected for CTG	At least quarterly	Summarize and present at Leadership Team and local coalition meetings	Shared with the Leadership Team; summaries posted on CTG website; reports included in reports to CDC	Project Manager Evaluation Coordinator
Do the strategies form a cohesive and effective plan that will maximize impact?	Movement in the major areas of tobacco, physical activity, and chronic disease prevention	BRFSS, YRBS, school nurse data, YTS, APCD	Run data analysis in web-based query systems; Acquisition of data files and/or analysis by data stewards for the data sets, as needed	Annually	Review current smoking rates (statewide and regionally); obesity rates; physical activity rates; fruit and vegetable consumption; social and emotional wellness	Shared with the Leadership Team; summaries posted on CTG website; reports included in reports to CDC	Project Manager Evaluation Coordinator

Objective 5: Community Transformation Implementation Plan.							
CTIP contains program objectives that are SMART and are explicitly linked to populations experiencing health disparities, that there are plans for sustainability, and that the plan is approved by CDC. Additionally, performance will be measured on a quarterly basis that the grantee is successfully meeting milestones and benchmarks as indicated in the CTIP.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Does the CTIP contain objectives that are SMART?	Evidence of SMART objectives	CTIP finalized after review with CDC	Review and documentation of SMART objectives	As part of the application process and review annually	Summarize for update to leadership team	Leadership team meeting update (email or annual retreat/meeting)	Project Manager
Are plans for sustainability being developed?	Evidence of plans or ideas sustainability	Meeting minutes; CTIP activities and milestones finalized that incorporate sustainability assessment	Review and extract from meeting minutes; incorporated into CTIP	Annually	Summarize for update to leadership team	Leadership team meeting update	Project Manager
Is the CTIP approved by CDC?	Approval by CDC	Acknowledgement from CDC that the CTIP is approved.	CDC award letter and annual notification	Submit CTIP 120 days post award for review and approval; Annually, thereafter	Summarize comments and approval from CDC for leadership team	Leadership team meeting update (email or annual retreat/meeting)	Project Manager
Are sufficient data collection efforts included in the implementation of activities outlined in the CTIP?	Data collection efforts are defined for each CTIP strategic direction, as outlined in CTIP	Documentation of data collection efforts in activity work plans	Documentation of processes and systems for data collection; evidence that data are being collected with each activity	Ongoing	Review of the data collection system and level of information being collected throughout project	Review with Leadership Team; Summarize in CDC communications and reports	Project Manager; Evaluation Coordinator; PI

<p>Objective 5: Community Transformation Implementation Plan. CTIP contains program objectives that are SMART and are explicitly linked to populations experiencing health disparities, that there are plans for sustainability, and that the plan is approved by CDC. Additionally, performance will be measured on a quarterly basis that the grantee is successfully meeting milestones and benchmarks as indicated in the CTIP.</p>							
Is progress on CTIP milestones and benchmarks measured quarterly?	Data for each of the measures listed in the CTIP	Data sources described in CTIP	Collection of measures in the CTIP, using the multiple data sources specified in CTIP (each multi-unit housing lists, lists of CHCs implementing EMR tools, etc)	Continually, with each activity implementation in CTIP; review quarterly	Synthesis of the multiple measures in the CTIP, with added tracking column to input actual measurement	Review with Leadership Team	Project Manager, Evaluation Coordinator
Is CTIP being reviewed regularly to identify issues, successes, and any needs for changes in project plans?	Evidence that Leadership Team reviewed CTIP and evaluated progress	Meeting minutes; notes and modifications to CTIP	Leadership Team meeting minutes	Quarterly	Review of the Leadership Team input into CTIP; modifications to CTIP as needed to make corrections to activities or approach	Review with Leadership Team; Summarize in CDC communications and reports	Project Manager, Evaluation Coordinator, PI

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Objective 6: Performance Monitoring and Evaluation.							
Develop an evaluation plan covering core performance monitoring, and where applicable, enhanced evaluation, in coordination with a final CTIP submission 150 days post award and attendance at CDC-required evaluation capacity building workshops and webinars.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Was the evaluation plan and CTIP completed (150 days post award)?	Confirmation of receipt of completed CTIP and evaluation plan	Documentation from CDC	Confirmation from project officer	After the submission of completed CTIP and evaluation plan	Include this update in a progress report to CDC and leadership team	Update at leadership team meeting	Project Manager
Did project team complete required evaluation capacity building workshops and webinars?	Names of attendees and dates of participation	Email confirmation and/or expense reports from attendees	Administrative records	Annually	Include this update in a progress report to CDC and leadership team	Update at leadership team meeting	Project Director
Were measures identified in evaluation plan collected on a quarterly basis?	Data for each of the measures listed in the evaluation are included in the evaluation plan summary	Data sources described in the evaluation plan	Collection of measures in the evaluation plan (meeting minutes, summaries, population reach assessments, etc.)	Quarterly	Review of each measures in evaluation plan	Review with Leadership Team	Project Manager, Evaluation Coordinator
Was evaluation plan reviewed semi-annually to ensure project evaluation was on course?	Evidence that Leadership Team reviewed evaluation plan and its collected metrics	Meeting minutes; notes about the review; modifications to evaluation plan, as needed	Leadership Team meeting minutes	Semi-annually	Review of the Leadership Team input into evaluation plan modifications to evaluation plan to address corrections to activities or approach	Review with Leadership Team; Summarize in CDC communications and reports	Project Manager, Evaluation Coordinator, PI

<p>Objective 6: Performance Monitoring and Evaluation. Develop an evaluation plan covering core performance monitoring, and where applicable, enhanced evaluation, in coordination with a final CTIP submission 150 days post award and attendance at CDC-required evaluation capacity building workshops and webinars.</p>							
Did project team meet with national experts to share evaluation findings?	Evidence that evaluation metrics were shared with CDC and national experts	Documentation of the distribution of findings from NH CTG to national experts, including CDC	Maintain records of distribution of evaluation findings being shared	Ongoing	Review the reach and impact of findings to broader community	Review with Leadership Team; Summarize in CDC communications and reports	Project Manager, Evaluation Coordinator, PI

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Objective 7: Participation in Programmatic Support.							
Collaborate with CDC, national experts, and others, related to program support and dissemination.							
Evaluation Questions	Indicators	Data Sources	Data Collection	Timeframe	Data Analysis	Communication Plan	Staff Responsible
What you want to know.	What type of data you will need.	Where you will get the data.	How you will get the data.	When you will collect the data.	What you will do with the data.	When and how you will share results.	Who will ensure this gets done.
Did NH CTG team collaborate with CDC, national experts and others related to program support and dissemination?	Number of collaboration opportunities, list of staff involved and description of collaborative effort	Meeting minutes	Count number of collaboration opportunities and staff involved	Annually	Summarize number and description of opportunities for leadership team and CDC	Review with Leadership Team; Summarize in CDC communications and reports	Project Manager; Leadership Team; PI
Were publications based on the NH CTG disseminated?	Evidence that publications were created and disseminated	Tracking of publication posting to website and in print	Publication dissemination metrics: requests for reprints, downloads from website	Annually	Assessment that at least four unique documents were disseminated	Review with Leadership Team; Summarize in CDC communications and reports; disseminate on website, with national committees, and via CDC	Project Manager; Leadership Team; PI
Were manuscripts developed and submitted based on NH CTG findings?	Evidence that manuscripts were developed and submitted	Tracking of publication review and printing	Publication editor provided comments and publication decision	Annually	Assessment of at least 1 manuscript based on evaluation data	Review with Leadership Team; Summarize in CDC communications and reports; submit to a national journal	Project Manager; Leadership Team; PI
Did NH participate in national meetings, conference calls, and CDC project status meetings to support the overall CTG effort?	Evidence of NH participation in meetings, conference	Meeting minutes	Tracking of participation in meetings, conferences, and calls	Annually	Summarize meetings, conferences, and calls participated in	Review with Leadership Team; Summarize in CDC	Project Manager; Leadership Team; PI

Objective 7: Participation in Programmatic Support. Collaborate with CDC, national experts, and others, related to program support and dissemination.							
	calls, and CDC project status meetings					communications and reports	

Budget Justification

A. Salaries and Wages

Total \$781,518

Program Director/PI – Josephine Porter, MPH

Ms. Porter will provide overall leadership to the project. She has responsibility for oversight of the program manager, research associate, and business manager. She will serve on the Leadership Team, review reports, review budgets and expenditures, and oversee CTIP and evaluation plan reviews.

Program Manager – To be hired

This position will be responsible to work directly with the PI, Leadership Team, existing coalitions (HEAL, HPDP, NH CCC Tobacco Workgroup), and community coalitions to manage the CTG project. This position will supervise the evaluation coordinator, and work with the business manager and research associate. The Program Manager will regularly review the CTIP, create agendas for Leadership Team meetings, prepare CDC reports, and oversee the reporting requirements for CTG. This position will be full-time (100%) on this project.

Evaluation Coordinator- Ashley Peters

Ms. Peters will identify the analytical needs of the project, and identify data needed to support evaluation and reporting. This will include the use of existing data sets and data tools as well as new data collection to support reporting to local, state, and federal partners. This is will also include overseeing data collection efforts for CTG activities. This position will be full-time (100%) on this project.

Research Associate – Stacey Gabriel

Ms. Gabriel will support the planning, meeting support, material development, and reporting development for the program. This position will be 30% FTE on this project.

Business Manager – Suzanne Shumway

Ms. Shumway will spend 20% on the CTG project to execute on the fiscal management obligations for the CTG project, including creating contracts, overseeing local distribution of funds, and tracking expenditures to rural communities.

B. Fringe Benefits **Total \$350,856**

45.4% of total salaries through 6/30/12; and 44.8% thereafter, based on Federal rate agreement (Appendix 15)

C. Consultant Costs **Total \$865,000**

Consultants will be hired to provide technical assistance across of a range of activities to support NH CTG. The consultants for each activity will be approved by CDC prior to funds being dispersed, should NH CTG be funded. This includes:

Working with real estate owners for policy development and tenant meetings (\$20,000/ yr; \$100,000 total)

Media campaign development (\$100,000)

NAP SACC consultant (45 centers at \$3,500/each; total \$157,500)

Expertise in the evaluation of distribution mechanisms for food purchasing (\$12,500/year for 2 years; total of \$25,000)

CDSM program license holder and trainer (\$55,000/year for 4 years; total= \$165,000)

Establishing and maintaining action learning collaboratives (\$150,000, estimated based on previous experience with MLC projects)

Regional Planning Commissions (\$20,000/year for 4 years = \$80,000)

Stakeholder facilitation and topic level expertise (\$17,500/year; total of \$87,500)

D. Equipment

No funds are requested for equipment.

E. Supplies

Total \$13,500

Justification: In Year 1, 2 laptop computers dedicated to program (laptops are required for portability to meetings, travel to partner institutions, etc), software and docking stations will be bought for new program staff (\$5,000) and \$125/month for supplies, such as binders and folders for printed materials for Leadership Team meetings.

In Years 2-5, \$125/month for supplies, such as binders and folders for printed materials for Leadership Team meetings

F. Travel

Total \$41,591

In-State Travel

(mileage rate = \$0.555/mile)

Year 1: 48 trips x1 personx75 miles x.555 per mile=\$1,998

Year 2: 48 trips x1 personx75 miles x.555 per mile=\$1,998

Year 3: 48 trips x1 personx75 miles x.555 per mile=\$1,998

Year 4: 48 trips x1 personx75 miles x.555 per mile=\$1,998

Year 5: 48trips x1 personx75 miles x.555 per mile=\$1,998

Total

\$9,990

CDC-RFA-DP11-1103PPHF11; New Hampshire Community Transformation Grant

Justification: Program staff to attend monthly meetings with the Leadership Team, HPDP, HEAL and NH CCC. Total trips for all staff: estimated to be 4 meetings statewide per month (48 per year) for 5 years.

Out-of-state Travel

A) Kick-off meeting

3 staff to travel to Atlanta* \$300 r/t airfare	\$900
5 days per diem * \$56 * 3 people	\$840
5 nights lodging * \$132 * 3 people	\$1,980
Mileage and parking at airport * 3 people	\$508
Ground transportation *3 people	\$105
<i>Total</i>	<i>\$4,333</i>

Justification: The Program Manager, Principal Investigator and Research Associate will travel to Atlanta, GA to attend the CTG kick-off meeting.

B) Action Institute meeting

12 members Leadership Team to travel to Atlanta, GA* \$300 r/t airfare	\$3,600
3 days per diem * \$56*12 people	\$2,016
3 nights lodging * \$132*12 people	\$4,752
Mileage and parking at airport *12 people	\$1,480
Ground transportation *12 people	\$420
<i>Total</i>	<i>\$12,268</i>

Justification: 10-12 Leadership Team members will travel to Atlanta, GA to attend the Action Institute meeting.

C) Annual Meeting, Years 1-5

CDC-RFA-DP11-1103PPHF11; New Hampshire Community Transformation Grant

3 staff to travel to Atlanta, GA* \$300 r/t airfare* 1 per year; 5 years	\$4,500
3 days per diem * \$56 *3 people*1 trip per year, 5 years	\$2,520
3 nights lodging * \$132* 3 people* 1 trip per year, 5 years	\$5,940
Mileage and parking at airport * 3 people* 1 trip per year, 5 years	\$1,587
Ground transportation *3 people * trip per year; 5 years	\$450
<i>Total</i>	<i>\$14,997</i>

Justification: Program staff to attend yearly CDC CTG meetings, for 5 years. Atlanta as placeholder.

5-Year Total *\$41,588*

Justification: The Program Manager, Principal Investigator and Research Associate will travel to attend annual Peer-to-Peer meetings in years two through five. Atlanta, GA is used as a place holder as location is unknown at this time.

G. Other Total \$ 183,250

Other, Web Development *Subtotal* \$3,250

Justification: The WebSolutions team at UNH will work with the CTG team to create a webpage and/or web portal for web-based dissemination of project information. Funds are included for developing, hosting, and maintaining this website.

Other, EMR technology implementation *\$180,000*

Services will be secured from Community Health Access Network for the development and deploying of EMR tools for community health centers, training about the EMR tools, establishing a reporting mechanism for measures from EMR, and developing plans for transferring technology to other practices. (\$45,000 in Year 1; \$40,000 in Year 2; \$35,000 in Year 3; \$30,000 in Year 4; \$30,000 in Year 5)

H. Contractual Costs

Total \$3,650,000

Sub-contracts will be provided to each of the 15 public health regions to pay for part of a regional coordinator to convey CTG work to local coalitions, identify local sites for implementing strategies (identifying property owners, day care centers, media outlets, and institutions to participate in the farm-to-institution purchasing, referral points for CDSM, etc.) Monies will also be provided for communities to provide technical assistance to other communities. (\$40,000 to each region in Year 1, with \$15,000 additional to 5 regions; \$55,000 to each region in years 2-5). The exact recipients for funds will be determined, and sent to CDC if NH CTG is funded.

Year 1: \$650,000
Year 2: \$750,000
Year 3: \$750,000
Year 4: \$750,000
Year 5: \$750,000
Total: \$3,650,000

I. Total Direct Costs

Total \$5,885,715

J. Indirect Costs

Total \$678,786

The rate is 26% and is computed on the following direct cost base of \$2,610,715.

K. Summary 5-Year Budget

Total Direct and Indirect

Total \$6,564,501