

New Hampshire Title V 2010 Needs Assessment

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Maternal and Child Health Section
Bureau of Community Health Services
Division of Public Health Services
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New Hampshire's Title V 2010 Needs Assessment Summary

Process

New Hampshire's 2010 needs assessment process was based on MCHB guidance and best practices. Criteria used to choose top priorities were based on public health principles and included the magnitude of the need; disproportionate effects among population subgroups; problems resulting in significant economic costs; cross-cutting problems that have life span effects; and the feasibility of NH's Title V program to impact the problem. Assessment of Title V capacity was conducted using a modified version of CAST-5.

Process changes since the 2005 needs assessment included a more extensive public input process, as well as a more formal approach for prioritizing needs.

Public Input

Utilizing an on-line and paper survey, input on priority needs was obtained from nearly 1,000 individuals, families, advocates and health care providers. The survey was also available in Spanish and Portuguese and was completed by clients in the state-funded health care agencies and DHHS district offices, enabling the acquisition of input from an often difficult to reach population.

Priority needs

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. The importance of cultural competence in local and state Maternal and Child Health (MCH) programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as a focus for NH's Title V program. Similarly, recognition of the social determinants of health -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

From extensive research of current state data and an internal and external capacity review, combined with public input, ten priorities emerged that adequately described the needs of the Title V population subgroups of women, infants, families and children with and without special healthcare needs.

1. To improve access to children's mental health services

Public input and data suggest significant mental health needs in children and adolescents and a lack of mental health services and skilled professionals in the State. Suicide is the second leading cause of injury-related death among NH adolescents, and NH's teen suicide rate exceeds the U.S. average. Mental health safety net systems are overtaxed, with long waiting lists.

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2.To decrease pediatric overweight and obesity

Obesity is an increasing problem in NH. Available data reveal that over 29% of New Hampshire's 10-17 year olds were overweight or obese in 2007 (34% of CSHCN), and the numbers are increasing. Disproportionate obesity rates are observed in those with low socioeconomic status.

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

New Hampshire's rates of tobacco, alcohol and other substance use and abuse among youth and women are higher than the US rates. Substance abuse treatment capacity continues to be a problem in NH. Smoking during pregnancy can result in low-birth weight infants, pre-term deliveries and infant deaths. Smoking rates are higher among young pregnant women and among those on Medicaid.

4.To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

The percent of uninsured NH adults in 2009 was the highest in the Northeast and is increasing. Adults who live in rural areas, are young, low income, or members of racial and ethnic minority groups suffer disproportionately. Rising unemployment and reductions to state programs create the potential for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

5.To improve access to standardized developmental screening for young children

Nationally, less than 50% of children with a developmental delay are identified before starting school, impacting readiness to learn. NH has a fragmented system for screening that is ripe for improvement.

6.To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents

Unintentional injuries rank as the leading cause of death for children and adolescents in NH and nationally, killing more in this age group than all diseases combined. Many of these deaths are preventable.

7.To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

Asthma is the most prevalent chronic condition among children and a leading cause of ED visits for children. Young children are also vulnerable to the effects of lead poisoning.

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Children with lower socioeconomic status have poorer outcomes for asthma and are at increased risk for lead poisoning.

8. To improve oral health and access to dental care

Dental care access is a problem in NH, specifically for the poor, under and uninsured. Approximately 44% of NH 3rd grade students experienced tooth decay. Tooth decay was higher and the prevalence of dental sealants was significantly lower in several rural NH counties.

9. To increase family support and access to trained respite and childcare providers

The National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including the need for workforce development. A statewide effort is needed to provide support for workforce development to serve CSHCN.

10. To decrease the incidence of preterm birth

Younger mothers and those with Medicaid as a payer source have increased rates of smoking while pregnant and are at increased risk of premature birth. These findings point to potential intervention areas, such as anti-smoking efforts.

Changes in need and capacity since 2005:

Since 2005, New Hampshire's capacity to gather and analyze data has increased greatly, enabling us to discontinue this priority in 2010. The increased infrastructure enhanced our ability to identify the most pressing needs in the State. Significant needs continue in the areas of health care for the uninsured, substance abuse and mental health; this was evident from the data and from the public input. At the same time, New Hampshire is experiencing a severe budget shortfall that has resulted in drastic cuts to essential health and social services, further weakening the safety net for residents in need. Increasing population and racial and ethnic diversity in the younger age cohorts have the potential to increase the number of births and the need for services. Trend data indicates that enrollment in Special Medical Services continues to grow.

The data indicate that since 2005, childhood obesity rates have also continued to rise. Higher percentages of women are overweight and/or obese when they become pregnant, increasing the obesity risk for their children. New Hampshire's capacity to address this priority is enhanced since the 2005 needs assessment, with the addition of an obesity prevention program in DPHS. Asthma rates also continue to increase, and this issue will be addressed through a "Healthy Homes" priority area. The percent of 3rd grade students experiencing tooth decay improved since 2004. While recent advances have improved NH's oral health capacity, continued effort is needed to sustain this fledgling system. Since 2005, New Hampshire's capacity in injury prevention, prenatal care and childhood lead poisoning prevention have decreased, due to state budget cuts and reductions in MCH staff. New Hampshire's Maternal and Child Health Section will continue to address these priority needs over the next five years.

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Section 1: Process for Conducting the Needs Assessment
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1. Process for Conducting the Needs Assessment

1.A. New Hampshire's Approach:

New Hampshire recognizes that the needs assessment process is continuous. Data and public input about our programs, populations and maternal and child health issues must be systematically reviewed annually. A Five –Year Needs Assessment, however, allows an opportunity to apply additional rigor, analysis, and strategic thinking to resource allocation.

New Hampshire's vision for the 2010 Title V Needs Assessment was a complete analysis of available data on the state's population of pregnant women, mothers, infants, children and children with special health care needs (CSHCN) that would identify health disparities, needs and strengths among these populations. Combined with capacity assessment and input from the public and other stakeholders, a list of priority needs would emerge that would direct programming over the next five years.

A goal of New Hampshire's Title V Needs Assessment was to build on the 2005 assessment, utilizing the state's increased capacity to gather and analyze data to present a more complete picture of the strengths and needs of the Title V population in the state. New Hampshire's approach to the 2010 Needs Assessment purposefully incorporated an integration of the MCH and CSHCN populations. This integration began with the planning process and has been carried through to the reporting process. References to the Title V population highlight this integration and represent joint evaluations and activities. Planned efforts also demonstrate attention to unique populations and data sets as appropriate, for example a comprehensive Title V Capacity Assessment was undertaken along with specialized assessments for CSHCN services and for Early Childhood Services. The 2010 assessment increased both the breadth and depth of analysis for maternal indicators in order to identify the most striking disparities and to provide an indication of where interventions could be made. This more complete assessment enabled the State to develop action plans to address the identified needs. Resource allocation followed identification of strengths and needs.

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Another important goal of New Hampshire's 2010 needs assessment process was the identification of health disparities in the State. Studies over the past several decades have found that the United States ranks low among developed nations in life expectancy and that socioeconomic inequalities in health have been increasing during this period.¹ Therefore, socioeconomic as well as health indicators were reviewed, in an effort to consider a broader scope of the factors that impact the health of New Hampshire residents.

1.B. Life Course

National attention is increasingly being directed to social and economic determinants of health and to developing interventions from a life course perspective, with an understanding of the critical life stages in which to intervene to improve health outcomes. That is to say, health is a developmental process occurring throughout the lifespan. This framework often causes a shift in focus to the early part of the life span, when long-term health programming can be more intense and early childhood development, intuitively allows for interventions that may exact greater returns on resources invested. Sometimes, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions.² This fits well with the history and culture of Title V that has embraced the need to support a full range of infrastructure, enabling and supportive services in addition to clinical services. For many of these reasons, heightened consideration was given to identifying health problems in the prenatal and early childhood populations, and issues of maternal substance abuse, mental health, developmental screening and preventing preterm births emerged as priorities, following a review of the data and consultation with stakeholders during the Needs Assessment process.

It is important to recognize that incorporating a life course perspective to the Needs Assessment process may be particularly critical for CSHCN. The population of CSHCN is clearly impacted by the components generated through efforts to positively impact early

¹ Berkman Lisa F. *Social Epidemiology: Social Determinants of health in the United States: Are We Losing Ground?*. Ann. Ev. Public Health 2009. 30:27-41.

² Halfon N, Hochstein M. "Life course health development: an integrated framework for developing health, policy, and research." *Milbank Quarterly*. 2002;80(3):433-79, iii.

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childhood development. More than 90% of children/youth with chronic or disabling condition will survive into adulthood.³ These children and youth need to be considered when identifying life course approaches, as they will be impacted by social determinants along with “typical” children. Indeed, Blum, White & Gallaay state that “ethnic minorities sustain more disability with more limitations than white youth, and poor families with less-educated parents or single parents are more likely to have children with disabling conditions”⁴ indicating a strong correlate to social determinants for long term implications on functionality. Finally, for some MCH issues, such as the issue of childhood obesity, that are being addressed utilizing a Life Course perspective the potential benefits for CSHCN may have a strong impact. In particular, the population of CSHCN with mobility limitations are poised to reap significant lifelong benefits in regard to care giving and independence when incorporated into these life course action plans.

1.C. Disparities and Health Equity

The American population, as a whole, is rapidly changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations. State government, community based organizations and systems of care must implement systemic change in order to meet the health needs of a population growing in its diversity. Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States.⁵ Although New Hampshire may not be experiencing these demographic changes as dramatically as the rest of the country, our state is still changing in significant ways, especially in the southern and urban areas of our state. Language and differences in cultural practices and beliefs may present potential barriers to care as well as challenges for health care providers. More significantly in New Hampshire, health disparities abound based upon social inequalities such as poverty, socioeconomic status, insurance and employment status.

³ Blum, R., White, P., & Gallaay, L. Moving into Adulthood for Youth with Disabilities and Serious Health Concerns. Network on Transitions to Adulthood: Policy Brief. University of Pennsylvania, July 2005, Issue 26.

⁴ Blum, R., White, P., & Gallaay, L, Ibid

⁵ <http://nccc.georgetown.edu/index.html>, May 3, 2010.

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Throughout this Needs Assessment process, there was a deliberate effort to examine New Hampshire's data among socio-economic, racially, ethnically, culturally and linguistically diverse populations in order to examine disparities in health care access and health outcomes. Guided by a belief that health equity will only exist when all residents have the opportunity to attain their full health potential, free from limitations by social or economic position or circumstance, participants in the needs assessment paid increased attention to prevention-oriented approaches as they developed problem maps, action plans and sought input from practitioners so that they could incorporate strategies that, as with the life course approach, would improve health status and equity.

1.D. Framework

New Hampshire's Title V 2010 Needs Assessment process was guided by the framework provided by HRSA MCHB in the Block Grant and Needs Assessment guidance (April 2009), information gleaned from MCHB training sessions, and recommendations contained in *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study* (USDHHS, 2004). Patricia Tilley, Title V Administrator, Elizabeth Collins, Special Medical Services (CSHCN) Administrator, Marie Kiely, State Systems Development Initiative (SSDI) Manager and Maggie Bernard, SMS Program Specialist attended the MCHB training sessions in 2007 and 2008 (held in conjunction with AMCHP and MCH Epidemiology conferences). The process followed is described further in the methodology section below.

The 5-year Needs Assessment process has allowed New Hampshire Title V to purposefully and strategically evaluate issues and barriers related to the health and well being of the populations served. It has also afforded the opportunity to evaluate the effectiveness and outcomes of past service planning. This has resulted in New Hampshire Title V being in an ideal position to develop future services that will be well targeted and financially responsible.

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1.E. Allocation of Resources

In challenging fiscal times, allocating resources strategically based on data, evidence-informed practice, and potential impact is critically important. The Needs Assessment process and this document has informed current budget discussions and will guide State Fiscal Year 2012 and 2013 Title V Budget Preparations. New Hampshire Title V anticipates that in the next five years funds will continue to be directed towards the priorities developed through our collaborative process. For example, a significant amount of the State General Funds associated with Maternal and Child Health (MCH) support New Hampshire's thirteen community health centers. MCH has developed a funding strategy that employs a tiered approach that rewards health centers that further integrate both mental health care and oral health care into their primary care practices, thus promoting Title V priorities.

New Hampshire anticipates additional opportunities such as the possible creation of a Medicaid Waiver for In-Home Supports for Children with Chronic Illness and Children with Mental Health Issues. The state currently has a similar waiver for Children with Developmental Disabilities and Autism. Results from the Title V Needs Assessment echo recognition that New Hampshire children with mental health issues need access to services & supports⁶ and, that families of children with chronic health conditions bear tremendous hardship related to care and costs not covered by traditional insurance plans⁷. The CSHCN Director recently participated in submitting a report to the legislative oversight committee on the needs and implications of such a waiver. The Department of Health and Human Services is currently evaluating the possibility of requesting one or both of these waivers from the Centers for Medicaid and Medicare Services.

⁶ Children's Mental Health Services in New Hampshire: Where we are now, where we need to go, how to move forward. Endowment for Health. November 2009.

⁷ Witt W; Gottlieb C; Hampton J; Litzelman K. The impact of childhood activity limitations on parental health, mental health and workdays lost in the United States. *Academic Pediatrics*, 2009 Jul-Aug; 9 (4): 263-9

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1.F. Leadership

As part of the Needs Assessment process in 2005, there was strong and clear consensus that the New Hampshire Title V program needed to strengthen its capacity to gather and analyze data about the MCH and CSHCN populations within the state. Since that time, resources and staff, limited as they are, have been allocated to data linkage, needs assessment, and program improvement. With that emphasis on continuous needs assessment, leadership for the 2010 Needs Assessment was driven by program experts from within Title V and informed and validated throughout the process by colleagues, partners and community members and families from every corner of the state.

The 2010 Title V Needs Assessment Team consists of Program Managers from the Maternal and Child Health (MCH) Section and the Special Medical Services (SMS) Section (CSHCN). Patricia Tilley, Title V Administrator, and Elizabeth Collins, CSHCN Director, had overall responsibility for the process and design of the needs assessment. Marie Kiely, State Systems Development Initiative (SSDI) Manager, coordinated the Team, the process and the report development and writing, and with David Laflamme, the MCH Epidemiologist, developed the analysis plan, analyzed and assembled data for the needs assessment.

A Core Needs Assessment Leadership Team, consisting of Patricia Tilley, Title V Administrator, Elizabeth Collins CSHCN Director, Marie Kiely, SSDI Manager, and David Laflamme, MCH Epidemiologist met regularly to plan the process, the public input surveys, the external stakeholders meeting and other components of the needs assessment.

The Needs Assessment Team met monthly beginning in 2007 and continued through January 2010. After January 2010, work was accomplished outside of meetings and through smaller meetings among staff. Beginning in 2007, Team members were responsible initially for providing input on data needed and for identifying a list of preliminary priority issues based on available data. Once the list was developed, Team members formed work groups for each of the priorities and were responsible for reviewing the literature and data, preparing data summaries, problem maps and presentation slides, and developing action plans and

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objectives for their priority areas. Marie Kiely, SSDI Program Manager oversaw and facilitated this process.

1.G. Methodology

1.G.1 Overall Needs Assessment Methodology

As described above, New Hampshire's Title V 2010 Needs Assessment process was guided by the framework provided by HRSA MCHB in the Block Grant guidance, information gleaned from training sessions, and recommendations contained in *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study*. A diagrammatic representation of the process was developed for the 2010 needs assessment (See Figure 1.1). Core Leadership Team staff also reviewed other states' 2005 needs assessment reports to identify processes and tools that could be utilized in New Hampshire.

The five core components outlined in *Promising Practices* are listed below:

- o Assessment of Population MCH Needs
- o Analysis of the Capacity of Systems to Meet These MCH Population Needs
- o Matching Needs to Capacity
- o Setting Priorities
- o Using the Needs Assessment

Several of the components of the needs assessment process occurred concurrently. At monthly Needs Assessment Team meetings, staff reviewed preliminary data, identified an initial list of potential priority areas for review by external stakeholders, reviewed and selected processes and tools to be used in the capacity assessment and prioritization process, developed a plan and tools for obtaining public input to the needs assessment and planned and conducted a one day meeting of external stakeholders. Between meetings, staff prepared data summaries, problem maps and action plans for their priority areas.

To begin the Needs Assessment process, MCH Core Leadership Team staff first reviewed existing reports and available data in order to identify potential priority issues and any data

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gaps. The MCH Epidemiologist and SSDI Coordinator then developed an analysis plan to obtain additional data. This process began in 2008 and continued through 2009, as additional data became available. Staff reviewed analyses of birth and death records, hospital discharge data, Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS) data, the National Survey of Children with Special Healthcare Needs 2005/2006, performance measure, outcome measure, health status and health status capacity indicator data, and US Census Bureau data on poverty, health insurance status and demographic characteristics of the population. Quantitative and qualitative methods used to assess the Title V populations are described below.

A preliminary list of needs was identified in 2009, based on review of the state and local data, internal discussions with Title V program managers, input on specific issues (racial disparities, mental health) from key informants, and research by program experts and key stakeholders. At this point, New Hampshire Title V staff (working in informal work groups with other DPHS staff and with external partners) divided up the needs assessment work by topic area in which they had expertise. Staff gathered and reviewed data for their areas, and prepared data summaries that they presented to the larger group. See Table 1.1 below for list of preliminary priority areas and staff assigned to each. The Core Needs Assessment Leadership Team monitored, guided and supported this process.

Public Input:

The goal of our public input process was to hear directly from the people throughout our state what they thought the most important issues and priorities were affecting children and families in New Hampshire. By far, this was the most exciting and validating part of the Needs Assessment.

A plan for public input was developed, to include the following:

- o an on-line survey to be disseminated widely to advisory groups, committees and the general public
- o paper surveys to be distributed to the twenty-two DPHS-funded health centers and the ten DHHS district offices (TANF, Medicaid, Food Stamp clients)

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- o Focus groups (to be conducted through a contract) of two identified high risk populations:
 - o pregnant women in northern New Hampshire
 - o minority populations in Manchester (the State's largest city)
 - o the focus groups were ultimately not conducted due to lack of internal capacity related to the current economic climate
- o Public stakeholder meeting

The process of gathering public input is described below (Section 1.G.5. Stakeholder Involvement) and in *Section 5, Selection of State Priority Needs*.

Selection of State Priority Needs:

The public meeting of external stakeholders consisted of health care providers, advocates and staff from professional and non-profit organizations serving the Title V population. At this meeting, attendees ranked their top five priorities and provided input on emerging issues. This process and the tools utilized are described further in Section E. Stakeholder Involvement below and in *Section 5: Selection of State Priority Needs*. See *Section 5* also for results of the stakeholder input.

Prioritization of Needs:

To begin the prioritization process, the Team used a priority-rating tool developed by the University of California San Francisco, which was utilized by the California Title V Program in their 2005 needs assessment. The Team agreed upon criteria and weights. The ranking criteria were as follows:

- o a large number of individuals are affected
- o there are disproportionate effects among population subgroups
- o the problem results in significant economic costs
- o the problem is cross-cutting to multiple issues and has life span effects
- o feasibility of New Hampshire's Title V program to impact the problem

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Problem maps were developed to assist in ranking preliminary priorities (problem maps are available upon request).

- o Teams in each priority area were assigned problem mapping
- o Purpose: in depth analysis of a particular health problem
- o Problem maps were completed:
 - o After prioritization of problem areas
 - o Before developing action plan
- o Problem maps are tools for developing the action plans for the priority area

Priority ranking process consisted of the following:

- o Each person on the Needs Assessment Team *individually* rated need areas
- o Individual weighted scores were summed
- o Mean, minimum and maximum (of all scores) was calculated for each need area
- o Final ranking reflected means of the scores (higher mean score=higher priority ranking)

The prioritization process is further described and the results of the priority ranking are presented in *Section 5: Selection of State Priority Needs*, of this document.

Following the final prioritization of needs that took place at the external stakeholder's meeting, the Title V Needs Assessment Team reconvened, reviewed all of the information collected, and identified the final ten priority areas for the 2010 needs assessment and developed priority statements and performance measures for each area. These are listed in *Section 3: Strengths and Needs of the MCH Population* and in *Section 5: Selection of State Priority Needs*, as well as on Form 16 in the 2010 Title V Block Grant application.

1.G.2. Ongoing Nature of the Process

New Hampshire Title V ensures that the needs assessment process is ongoing through a number of methods. The MCH Data Team meets bi-weekly to plan and improve MCH data systems and to review MCH data. The MCH epidemiologist routinely analyzes vital records

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and hospital data to identify issues of concern. Results of these analyses and activities are brought to the MCH Management Team at its biweekly meetings, as needed, for discussion and decisions. The MCH Program Managers utilize the data from the needs assessment as well as the interim analyses to monitor and adjust programming as needed. Activities, programs and interventions are designed and evaluated to meet State and National Performance Measures, many of which, in turn, are directly related to the Ten Priorities

In addition, the MCH Data Team recently developed a “MCH Needs Assessment Monitoring” data display, which is centrally located in the MCH Section. A schedule is being developed for updating the board with state and national data as they are released, e.g. NCHS birth report, New Hampshire Vital Records data. Additionally, analyses of New Hampshire vital records, Medicaid, MCHS-funded clinic and other data will be posted. These data will be utilized for programming and evaluation and included in the 5-year needs assessment reports. A photograph of the board is attached in Appendix A.

Concurrently, SMS routinely reviews national and state data sets relevant to the needs of CSHCN and their families. Of particular note are the reports and tools made available from the National Centers funded by MCHB/HRSA (Family Voices, The Catalyst Center, Champions for Inclusive Communities, Healthy & Ready to Work, and the Center for Cultural Competence). SMS also creates annual reports on all Information & Referral activities and on Service Utilization. These reports highlight emerging issues/concerns as well as actual use of resources and services. These data sets are utilized yearly for resource allocation and Block Grant Planning and cumulatively for the 5-year Needs Assessment.

1.G.3. Interface Between Needs Assessment Results and Block Grant Application

The continuous nature of the needs assessment is built into the culture of quality improvement and performance measurement and management of Title V. The priorities identified in this document came as a result of a rigorous analysis of current data, system capacity and public input. Activities were developed to meet those needs with logical measures incorporated as National and State Performance Measures, Health Status Indicators and Health Systems Capacity Indicators. Much like a Plan –Do-Study-Act Model, those

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activities will be continuously evaluated and annually reported as part of the Title V Block grant process and success shall be gauged through performance measures and the narrative description of strengths, challenges and systemic change.

1.G.4. Cycling Between Phases of the Needs Assessment

Further emphasizing the cyclical process, undoubtedly, new needs and data shall emerge through this process. As external forces impact the MCH population and as Title V implements new activities and strategies the capacities of systems will change and the needs of women, children and families shall change. It is imperative that Title V continue to respond to shifts in data and public input.

1.G.5. Stakeholder Involvement

Title V stakeholders had early and continuous involvement in the needs assessment process. In 2008, the Needs Assessment Team invited New Hampshire Endowment for Health (EFH) topic experts in mental health and health disparities to present to the Team. The EFH staff provided data on these topics and made recommendations for addressing these issues as we moved forward in the needs assessment process. As a statewide health foundation, these experts are well-informed regarding efforts throughout the state. (Add info from meeting notes).

Zero to Three, the National Center for Infants, Toddlers, and Families, created a self-assessment checklist based on research about effective policies and best practices in states. In 2009, the Maternal and Child Health Section used this tool, as both an electronic survey and a facilitated discussion, to collect important data to supplement the information gathering and stakeholder involvement process. The information collected was used to help Title V identify priorities in each of the following areas: good health, strong families, positive early learning experiences, and collaboration and system building.

In mid-2009, the Core Needs Assessment Leadership Team developed and administered an on-line and paper survey to collect public input on the health needs of New Hampshire families, as mentioned above. A link to the on-line version was distributed electronically to

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all statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. The paper survey (English, Spanish and Portuguese versions) was distributed to Title V-funded health care agencies and to the ten DHHS District Offices statewide that provide TANF, Medicaid, food stamps and other services to low-income clients. A total of 689 people returned the paper surveys and 299 people responded to the on-line version. A more detailed description and results of the surveys are presented in Section 5: Selection of State Priority Needs, of this report. Copies of the surveys are attached in Appendix B.

Finally, in November 2009, Title V convened a public meeting of external stakeholders consisting of health care providers, advocates and staff from professional and non-profit organizations serving the Title V population. Staff invited 162 people, and 69 people attended. Attendees were presented with the data on the preliminary list of priorities (from the internal prioritization process and the results of the public input surveys). They were then asked to prioritize their top five issues, as well as to provide their input on emerging issues that they were observing in their practices and communities. This process and the tools utilized are described more fully in Section 5: *Selection of State Priority Needs*.

1.G.6. Methods for Assessing the Three MCH Populations

As part of the continuous nature of the needs assessment process staff reviewed local, state and national reports describing the health status of the three Title V population subgroups, in order to obtain available data to identify areas of strengths, needs and gaps of knowledge. Team members compiled data for their program areas and presented it to the larger group. Following the initial presentations, the group invited New Hampshire Endowment for Health staff with expertise in two areas: health disparities and access to mental health services, to discuss needs in these areas.

The MCH Epidemiologist and the SSDI Manager then developed an analysis plan. To assess the health status of the three population subgroups, the plan involved using a combination of available state and local data, with in-depth analysis of vital records data (birth, death and fetal death), hospital discharge data from the New Hampshire Department of Health and

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Human Services (DHHS) Health Statistics and Data Management Section, and survey data from the Behavioral Risk Factor Surveillance Survey (BRFSS) data. BRFSS data is housed in the Division of Public Health Services; YRBS data is collected and housed in the New Hampshire Department of Education. BRFSS prevalence, birth rates (per 1000 population), mortality and hospital discharge rates (per 100,000 population) were calculated and compared to national and, where possible, regional rates. Data were stratified by appropriate factors such as age, payor source, race/ethnicity, and geography, where possible, in order to identify disparities. New Hampshire's small population often limits calculation of accurate rates in many areas of the state and for sub-populations (e.g. race) where the numbers of events are low. Distributions and trends were examined to identify patterns of interest. Both quantitative and qualitative data were included.

US Census Bureau data were compiled into tables and graphs to describe and compare the demographic characteristics of the State, including racial and ethnic populations, poverty, education and health insurance status. Population estimates for 2008 were used where available. American Community Survey data 2006-2008 were used where that was the only source of the information needed, e.g. racial and ethnic characteristics of the populations of New Hampshire's small cities. Data sources are cited throughout the document.

In addition to the well-known ongoing limitations of administrative datasets (vital records and hospital discharges), we also continue to experience issues related to the irregular state-by-state implementation of the 2003 revised vital certificate worksheets. Approximately 10% of New Hampshire resident births (and a similar proportion of deaths) occur out-of-state. While some variables can be mapped across versions, others are not comparable. Perhaps the most notable area with this problem is in the timing of prenatal care. We cannot produce accurate statistics related to timing of prenatal care at the population level for a period of several years (ongoing). While we can compute system-level statistics (all events that occur in New Hampshire), we know from previous data that the group of New Hampshire residents getting care outside of the state differs in significant ways from the group getting care within the state system. Many women with high-risk pregnancies seek care in specialty hospitals just over the New Hampshire border in Massachusetts.

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Little is known about the quality of census data on the prevalence of initiation of early postpartum breastfeeding among New Hampshire residents that is available from the Newborn Screening Form (NSF) and the Facility Worksheet for Certificate of Live Birth (FWS). Preliminary analyses were completed on a sample of 17,338 infants with early postpartum breastfeeding status data on both the NSF and the FWS who were born in New Hampshire during the period September 1, 2006 through September 29, 2009. To further investigate the range in percent agreement by data source between birth facilities in New Hampshire, we conducted a qualitative investigation among nurse managers or others identified as responsible for personally recording breastfeeding status on the Newborn Screening Form and the Facility Worksheet for Certificate of Live Birth. A list of facility contacts was obtained from the acting New Hampshire Registrar of Vital Statistics and the Newborn Screening Coordinator that included name, telephone numbers and email addresses of individuals (staff) at each of the 21 maternity hospitals and 3 birthing centers. Over the period of November 1, 2009 through January 25, 2010, these individuals were contacted by project staff via telephone and email introducing them to the study details and requesting their assistance with identifying the appropriate individuals at their facility. Institutional Review Board approval was obtained from the University of New Hampshire and the Harvard School of Public Health in addition to the appropriate clearance from New Hampshire DHHS. The results of the analyses are presented in Section 3, below.

Focus groups were initially planned to obtain additional information on the needs of pregnant women in northern New Hampshire and of minority populations in the city of Manchester. The focus groups could not be conducted due to lack of internal capacity. Data from both electronic and paper surveys were collected to obtain public input on priority needs of New Hampshire families (described in detail in Section 5: Selection of State Priority Needs).

In order to identify needs in specific geographic areas, while obtaining input from a wide range of stakeholders, local needs assessments, as well as fifteen community benefit reports on file in 2008 in the New Hampshire Office of the Attorney General's Division of Charitable Trusts were reviewed and summarized. The reports represent rural and urban,

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economically advantaged and disadvantaged communities. New Hampshire law requires non-profit organizations to conduct a needs assessment every five years, develop a community benefits plan that identifies priority needs and strategies, and report the prior year results to the community annually. Documents considered included:

- City of Manchester needs assessment⁸
- 2008 Lakes Region Community Needs Assessment Report
- Cottage Hospital-Woodsville (northern New Hampshire)
- Littleton Hospital Association (northern New Hampshire)
- Speare Memorial Hospital-Plymouth (northern New Hampshire)
- Catholic Medical Center-Manchester
- Concord Hospital
- Concord Regional Visiting Nurse Association
- Huggins Hospital-Wolfboro (Lakes Region)
- Cheshire Medical Center-Keene
- The Elliot Hospital-Manchester
- St. Joseph Hospital-Nashua
- Wentworth-Douglass Hospital-Dover
- New London Hospital
- VNA at Health Care, Home Care Hospice Community Services (HCS, Inc.)-Keene
- Dartmouth-Hitchcock Clinic and Mary Hitchcock Memorial Hospital-Hanover
- Alice Peck Day Memorial Hospital-Lebanon

The data described above are presented in detail Section 3: *Strengths and Needs of the MCH Population*, below to describe the strengths, needs and disparities among the three Title V population subgroups: pregnant women, mothers and infants; children; and children with special health care needs.

⁸ Manchester Health Department, NH Department of Health and Human Services, Community Health Institute of Bow, NH. *Believe in a Healthy Community: Greater Manchester Community Needs Assessment 2009*

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1.G.7. Methods for Assessing State Capacity

Staff examined capacity in each of the following areas: direct and enabling services, population-based services, infrastructure-building capacity within the New Hampshire MCH Section (using a scaled back version of the Capacity Assessment for State Title V (CAST-V) tool).

Capacity Assessment for State Title V (CAST-5)

In 2005, New Hampshire Title V embarked on a comprehensive assessment of its internal capacity using the CAST-5 process. Capacity Assessment for State Title V (CAST-5) is a set of assessment and planning tools that uses core public health functions as the foundation from which state Title V programs can examine their organizational capacity to carry out core maternal and child health (MCH) functions. At that time, New Hampshire's Title V program had never undergone a structured capacity assessment, and with a recent reorganization within DHHS it created an opportunity to come together across programs to review capacities and develop strategies to maintain and strengthen essential services. Through federal MCHB technical assistance, a health policy consultant assisted New Hampshire in this process.

Over the past five years, the Title V program has used the results of that assessment to allocate resources and guide programming. As part of the 2010 Needs Assessment process, it was determined that it was time to challenge both the MCH and SMS programs to revisit the CAST-5 process to see what has changed in New Hampshire's Title V capacity in the past five years. Two days in Fall 2009 were set aside to review the CAST-5 of 2005 and to identify current program needs, rate the performance of core public health functions, and identify opportunities for capacity development. Capacity needs and strengths were identified at all levels of the MCH pyramid, from infrastructure building through direct services and informed the action plans associated with the Ten Priorities presented in this Needs Assessment. Discussion of the CAST-5 process and action plans that resulted from this process can be found in Section 4. Also in Section 4 are summaries of the two additional Capacity Assessment tools utilized to assess the specific systems of services for CSHCN and Early Childhood services.

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1.G.8. Data Sources

As described above, the following data sources were used, which are also outlined in Table 1.2. Vital records data were used to calculate birth rates, infant mortality, adequacy of prenatal care, and mortality rates for the leading causes of death for women, infants, children and adolescents. Vital records data is maintained by the Division of Vital Records Administration (DVRA) in the New Hampshire Secretary of State's Office. By statute, the DVRA is required to provide data to the Division of Public Health. A Memorandum of Agreement is in place to specify the data and schedules.

Through the New Hampshire Vital Records Information Network (NHVRIN), Title V staff have access to data for most births that occur in New Hampshire within a short time (days) of the event. For New Hampshire resident births occurring out-of-state, there is a delay in obtaining and entering the records into the New Hampshire database. The length of the delay has been decreasing. It appears that the file for 2009 resident births is nearly complete in May 2010. Additionally, there are plans for New Hampshire to participate in the State and Territorial Exchange of Vital Events (STEVE) system to continue to improve this process of obtaining out-of-state vital events for New Hampshire residents in a timely manner.

Injury data was analyzed by the Division of Public Health Services (DPHS) Health Statistics and Data Management Section (HSDM) and accessed on-line through CDC WISQARS. HSDM also provided the Behavioral Risk Factor Surveillance Survey (BRFSS) data, which was used to describe the prevalence of selected risk factors in the adolescent and adult populations.

The New Hampshire births and infant deaths are regularly linked by DVRA and analyzed by the MCH Epidemiologist to monitor and investigate the determinants and distribution of infant mortality in New Hampshire. Fetal death records (maintained by DVRA) are also monitored by the MCH Epidemiologist.

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The Prenatal Client Data Form (PCDF), a system developed by the MCH Section through a contract with Welligent, Inc. is a web-based system for collection and linkage of data from the MCHS-funded prenatal clinics and birth data. Demographic data as well as risk factor and outcome data are collected through this system. The data is available from July 1, 2007 to the present. Limitations of the data are that it contains data only on pregnant women served by the MCHS-funded clinics. The clinics serve approximately 14% of pregnant women in the State. Another limitation is that, due to the recent implementation of the PCDF, data are not yet complete and problems are still being resolved with the system and with the individual clinics that report.

Table 1.1 Data Sources

Data	Most Recent Year	Source	Use in report	Notes
NH Birth file	2009+	DVRA	Birth rates Adequacy of PN care Preterm birth Performance indicators	Some fields are not comparable across certificate versions and state of birth (e.g. date of first prenatal visit)
NH Death file	2007+	DVRA and EDW	Infant mortality	2008 appears to be complete but 1.6% of records do not yet have a coded cause of death.
BRFSS	varies	DHHS HSDM	adult risk factors	Not all questions asked every year
Hospital discharge	2007	EDW	leading causes of injury	
Comprehensive Health Information System (CHIS)	2008	EDW	Percent uninsured	
Injury mortality		CDC WISQARS	Injury death rates Performance indicators	
PCDF	mid-2007-2010	NH MCH Section	Prenatal care capacity	working to improve linkage rate (with birth data)

DVRA=Division of Vital Records Administration, NH Secretary of State's Office
HSDM=Health Statistics and Data Management Section, Division of Public Health, NHDHHS
EDW=Enterprise Data Warehouse, NHDHHS.
CHIS=Comprehensive Health Information System (all-payer health claims), NH DHHS
PCDF=Prenatal Client Data Form, NH MCH Section, DPHS, DHHS

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1.H. Dissemination

An executive summary of the 2010 needs assessment has been prepared and has been disseminated to all advisory group members, committees, staff in other state agencies, non-profit organizations, community health centers, external stakeholder meeting invitees, legislators and other individuals and organizations that Title V partners with. The executive summary and the full needs assessment report will also be posted on the DHHS website.

The Title V Director has already begun to take the results of the Needs Assessment on speaking engagements to local Rotary groups, Pediatric Society Meetings, Perinatal Nurse Managers meetings, etc., to help share both the process and results of the assessment. Feedback from both public health professions and non-public health professionals has been extremely positive. With the entire citizenry focused on the state's economy, conversations about the needs of the MCH population and the fraying of the state's capacity to meet those needs is compelling.

Results of the public input survey and a brief summary of the needs assessment will be compiled into a one-page document and posted in the DHHS district offices and community health centers where the survey data was collected, for the public to view.

1.I. Strengths & Weaknesses

Input on the strengths and weaknesses of the process was obtained throughout the process from the Needs Assessment Team and from all MCH Section staff at a staff meeting in February 2010.

Strengths:

Title V staff are knowledgeable, dedicated professionals who worked tirelessly to gather and present data in their topic area, thoughtfully considered all of the information presented and ensured that the final priorities reflected the greatest needs of the State. In addition, New Hampshire's capacity to analyze and utilize MCH-related data has increased significantly in recent years, providing a basis for a strong needs assessment. Recent organizational and procedural changes in the Division of Vital Records Administration have resulted in the availability of more timely and accurate data since the 2005 needs assessment. New and

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expanded datasets, such as the MCH Perinatal Client Data Form (PCDF) and the Comprehensive Health Information System (CHIS) have added important information to the current needs assessment.

Weaknesses/Opportunities for Improvement:

While California's priority rating tool was useful in scoring and ranking conditions such as preterm birth, asthma and others, it had some limitations rating issues with life changing but not life threatening implications and it was not useful for rating the workforce issues.

One improvement to the public input survey that will be made is to add a question about whether respondents work in the health care or social services field.

1.J. MCH Section Staff Feedback on the Process

Patricia Tilley, Title V Administrator presented a summary of the process to staff in February 2010, including the results of the prioritization, external stakeholders meeting and public input surveys, and a list of the final priorities. MCH staff were asked the following questions:

- How well did we engage the community and the public?
- Do we have the capacity to meet these priorities?
- Do you feel you have a place within these priorities?
- After seeing these priorities, do you see opportunities for new partnerships within MCH or with other partners?
- Strengths/weaknesses of process

Staff reported that they valued the opportunity to provide input to the process of determining how Title V Block Grant funds are allocated, and that this process does not occur with other grants that fund DPHS programs. Staff appreciated the opportunity to provide supporting data and to advocate for their program area. Staff felt that the priorities met the criteria for selection and that the State's most pressing needs were reflected in the ten priorities chosen.

**Section 1: Process for Conducting the Needs Assessment
Title V 2010 Needs Assessment**

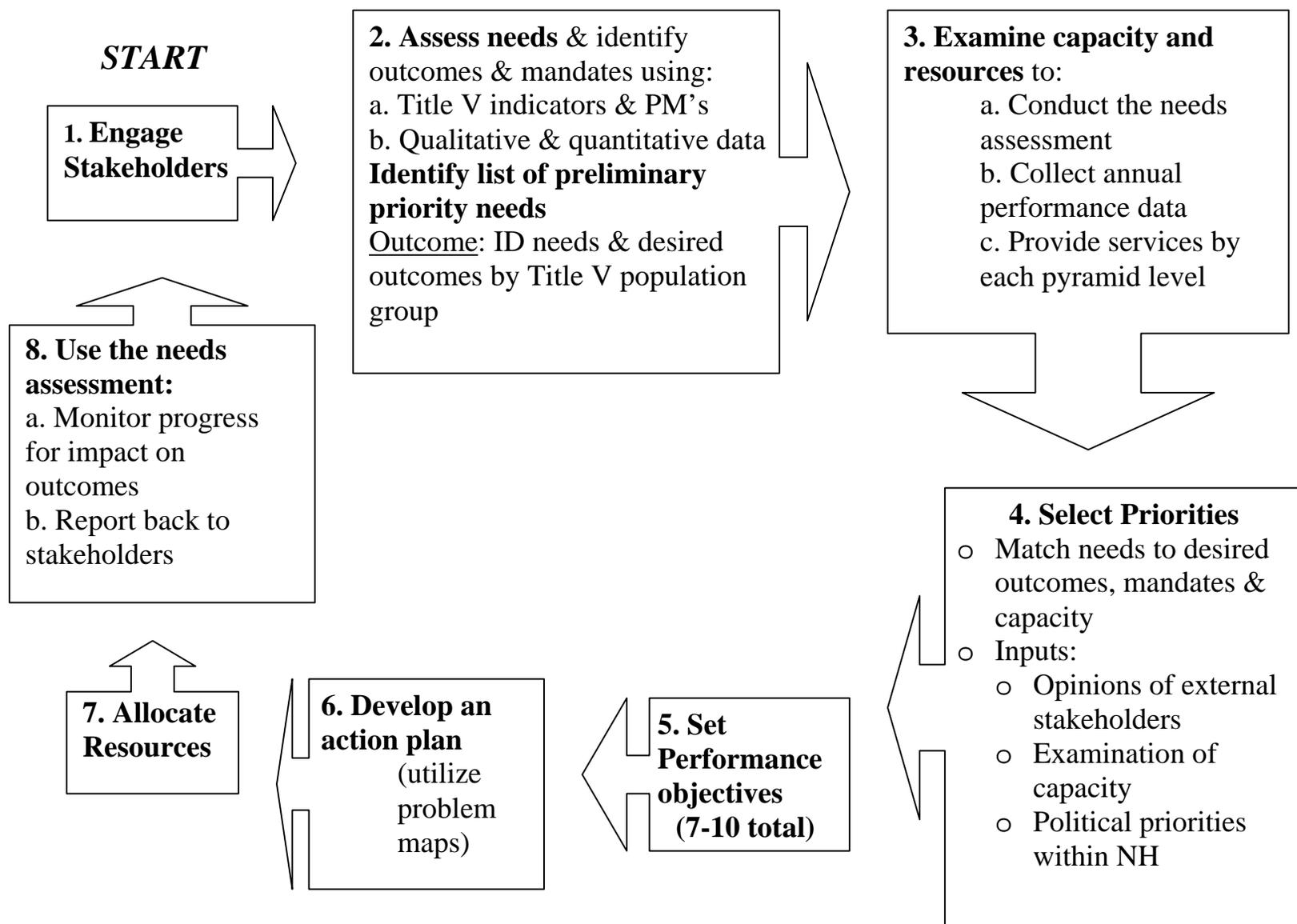
Table 1.2 List of Preliminary Priority Areas and Names and Position Titles of Title V Staff Responsible for Each Area

Preliminary priority areas	MCH population group	Responsible staff/Position title
Preterm birth	Pregnant women, mothers & infants	Initially: Kim Flynn, Prenatal Program Manager. After position became vacant, other MCH staff assigned to PT birth: Michelle Ricco, Family Planning Program Manager David Laflamme, MCH Epidemiologist
Autism	CSHCN	Liz Collins, CSHCN Director and staff
Screening and support (by 3 yrs)	Children	Liz Collins, CSHCN Director and staff Deirdre Dunn, Early Childhood Special Projects Coordinator
Maternal smoking	Pregnant women, mothers & infants	Kim Flynn, Prenatal Program Manager After position became vacant, other MCH staff assigned: Michelle Ricco, Family Planning Program Alicia L'Esperance, SMS staff
Alcohol/substance abuse	All	Michelle Ricco, Family Planning Program Alicia L'Esperance, SMS staff
Pediatric obesity	Children	Audrey Knight, Child Health Nurse Consultant Kathy Cahill, SMS
Mental health	All	Patricia Tilley, Title V Administrator Liz Collins, CSHCN Director Marie Kiely, SSDI Manager
MCH workforce: PC	All	Beverly McGuire, QA Clinical Consultant
MCH workforce: child care	Children	Deirdre Dunn, Early Childhood Special Projects
Childhood lead poisoning	Children	Laura Vincent Ford, Childhood Lead Prevention Program Manager Megan Tehan, Childhood Lead Prevention Program Epidemiologist
Asthma	Children	Lindsay Dearborn, DPHS Asthma Program Manager Liz Traore, DPHS Asthma Program Epidemiologist Marie Kiely, SSDI Coordinator
Oral health	All	Beverly McGuire, QA Clinical Consultant Nancy Martin, Oral Health Program Manager
Unintentional injury	Children & adolescents	Rhonda Siegel, Injury Prevention Program Manager
Suicide	Children	Rhonda Siegel, Injury Prevention Program Manager
Children without health insurance	Children	Audrey Knight, Child Health Nurse Consultant Kathy Cahill, SMS
Disparities	All	Incorporated into all priority areas
Respite care	CSHCN	Liz Collins, CSHCN Director and staff

SMS=Special Medical Services (Children with Special Health Care Needs)

**Section 1: Process for Conducting the Needs Assessment
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Figure 1.1. Diagram of New Hampshire's 2010 Needs Assessment Process
(Based on HRSA MCHB Guidance)



Section 2: Partnership Building and Collaboration Efforts

Title V 2010 Needs Assessment

2. Partnership Building and Collaboration Efforts

2.A. Introduction

New Hampshire's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. By establishing common goals and objectives in a multitude of collaborative relationships, Title V has greatly expanded its reach throughout the state and within communities. Because of our limited capacity, Title V utilizes its many partners to help us accomplish our priorities.

This section will highlight the status of many of the formal and informal collaborative activities and partnerships with the public and private sector and throughout New Hampshire.

Coordination of program activities takes place through joint efforts by Title V and others on topics of mutual interest and concern. Community and national health issues and available data drive the investigation, analysis and development of strategies to respond to these concerns. As described in the Methodology Sections of this Needs Assessment in Sections 1 and 5, these partners all provided valuable input to the Needs Assessment process as program experts and family advocates through participation in public input surveys, stakeholder meetings, and through the informal information gathering process. They were critical informants and decision makers throughout the process to select priorities.

2.B. Partnerships Impacting and Impacted by the Political Environment

Because of Title V's broad reach and population health approach, Title V staff have been appointed and been invited to participate in numerous executive and legislative-level committees and workgroups including the:

Brain and Spinal Cord Injury Advisory Council;	Mental Health Planning and Advisory
Children's Trust Fund;	Council;
Coordinated School Health Council,	NH Autism Council;
Council for Children and Adolescents with	NH Birth Conditions Advisory;
Chronic Health Conditions;	NH Child Care Advisory Council;

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NH Child Fatality Review Committee;	NH Teen Driving Committee;
NH Childhood Obesity Expert Panel;	Suicide Prevention Council;
NH Children’s Advocacy Network;	Vital Records Improvement Fund Advisory
NH Early Childhood Advisory Council;	Committee;
NH Early Hearing Detection and Intervention	Youth Suicide Prevention Assembly.
Advisory;	
NH Newborn Screening Advisory;	
NH Non-Public School Advisory Committee;	

The role of Title V staff, either as leaders of these groups or active participants, is to provide expertise on the needs of women, children and families and through these partnerships identify and implement cross-cutting activities to help meet priority needs.

During the 2009-2010 legislative session, the New Hampshire General Court established the Committee on Committees as a response to the large number of legislatively created Non-Regulatory Boards, Commissions, Councils, Advisories and Task Forces across state government. The charge of the Committee on Committees was to engage in a thorough decision making process to determine which of the committees should remain in effect, be consolidated, or be sunsetted immediately or within one or two years. The rationale for this review and ultimate reduction of committees is part of an overall strategy of the legislature to reduce costs and conserve state agency staff resources.

At the time of publication, it is understood that the New Hampshire Early Hearing Detection and Intervention Advisory will be terminated and it is unclear whether the New Hampshire Newborn Screening Advisory Council will be consolidated with another Advisory Council or maintained as is. It is also unclear which other important legislatively mandated committees will ultimately be affected by these changes. This speaks to the political challenges with which all executive and legislatively appointed committees, regardless of content area, are occasionally presented.

A positive example of collaboration related to the political environment has been the group effort by an extensive list of stakeholders that led to the subsequent creation of legislatively mandated Autism Council in New Hampshire. This effort began in 2001 when the New Hampshire Task

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Force on Autism was created by interested individuals (state & local agencies, private providers and families). They created a report on recommendations for Assessment & Interventions that was widely distributed. This stakeholder group continued to exert political pressure on the need for a more formal response to the considerable impact that Autism Spectrum Disorders (ASD) were having on families, service providers and state agencies. In 2007, the state passed legislation creating a Commission on Autism Spectrum Disorders. Many of the original Task Force participants became a part of this Commission. The New Hampshire Commission on Autism Spectrum Disorders submitted its report on Findings and Recommendations to the legislature in 2008. The legislature and governor reviewed this report and in 2008 created the New Hampshire Council on Autism Spectrum Disorders - to coordinate supports and services for individuals and their families. Title V is well represented in the Autism Council activities as workgroup members and Coordinating Committee chairs.

2.C. Partnerships to Support Families and Improve Socio-Economic Environment

Title V has many collaborative relationships that improve supports for families. The collaborative relationships result in changes in policies, priorities, systems and resource allocation.

In New Hampshire, the Division of Family Assistance (DFA) administers programs and services for eligible residents providing financial, medical and food and nutritional assistance, help with child care costs, and emergency help to obtain and keep safe housing. Child Care Assistance assists parents engaged in work, training or educational activities leading to employment to afford quality care for their children. DFA determines eligibility based on rules and policies administered by the Child Development Bureau.

TANF & Family Planning Program (FPP):

This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. TANF funds are allocated to the Title X Family Planning program within MCH to focus on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy.

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Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs.

TANF, Medicaid & Home Visiting New Hampshire (HVNH):

This project supports 19 home visiting programs statewide, including one program with a focus on the state's largest minority and non-English speaking population, with TANF, Medicaid and Title V funds. With MCH as the program administrator, and leveraging \$450,000 of TANF funds for base funding and Medicaid support for fee for service reimbursement, HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes. This partnership between state agencies is an excellent example of a coordinated response to meeting mutual priorities and community need.

New Hampshire is looking forward to the opportunities that may be available through the **Patient Protection and Affordable Care Act** to better understand the additional home visitation needs throughout the state and then leverage additional federal resources to enhance the current core HVNH program.

Child Care Scholarship and Redesign:

The MCH Early Childhood Comprehensive Systems (ECCS) program was a collaborative partner in the process to redesign the New Hampshire DHHS Child Care Scholarship Program ultimately benefiting families by establishing a more consistent payment to providers, reducing some out-of-pocket cost for families, supporting the inclusion of children with special needs, and encouraging increased quality from providers by creating a tiered Quality Rating System. Enacted in July 2009, this program was suspended in 2010 due to state budget constraints. Even with reductions in payments, a wait list has been developed for child care scholarships that is anticipated to reach more than 3,000 children by July 1, 2010.

Division of Children, Youth and Families (DCYF):

The Division for Children, Youth and Families (*DCYF*) manages protective programs on behalf of New Hampshire's children, youth and their families. DCYF staff provide a wide range of family-centered services with the goal of meeting a parent's and a child's needs and strengthening

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the family system. Coordination with DCYF occurs through several Title V programs and mutual committees. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the New Hampshire Child Fatality Review Committee, described later in this section, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board Members of the New Hampshire Children's Trust Fund. The Family Planning Program Manager is an active member with the Foster Care Health Program Advisory Committee, representing MCH, as are the CSHCN Director and Senior Physician, representing SMS. MCH and SMS are active members of the "Watch Me Grow" Steering Committee, a group initiated by the Title V Early Childhood Comprehensive Systems planning process, now working under the mandate of DYCF, under CAPTA and Early Supports and Services, under IDEA, for families to have universal access to developmental screening for young children. Additionally, the SMS senior state physician is now available for monthly consultation to DCYF.

Developmental Disabilities:

SMS is aligned organizationally as a part of the Bureau of Developmental Services (BDS). This affiliation has facilitated a great deal of informal collaboration between Title V and BDS. There have been some joint service efforts as well as overall system cooperation. The CSHCN Director is a member of the BDS Management Team and an SMS representative continues to be an appointee representing Title V on the Interagency Coordinating Committee for Part C. Other joint efforts include participation by SMS on the Council for Children and Adolescents for Chronic Health Conditions and the recent administrative transfer of oversight for the Partners in Health Program. In addition, HVNH has partnered with the Bureau of Developmental Services (BDS) by developing trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. Currently efforts between Title V and the BDS are focused on the statewide initiative, Watch Me Grow, that is planning for statewide implementation of common developmental screening tools and guidelines to be used in a variety of settings.

Lifespan Respite:

Through a grant received by the Administration on Aging, Special Medical Services has initiated the creation of a Lifespan Respite Coalition and workgroups with representatives from the Bureau of Elderly & Adult Services, the Bureau of Behavioral Health, the Bureau of

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Developmental Services; the Division of Children, Youth & Families, New Hampshire Family Voices, NAMI-NH and Granite State Federation for Families. This initiative is working to create a state registry of respite providers (for all age groups), implementing a competency-based curriculum and completing a pilot program on the impact of the competency-based training.

New Hampshire Family Voices:

Title V in New Hampshire has a very strong and longstanding collaboration with New Hampshire Family Voices (NHFV), which is also New Hampshire's Family-to-Family Health Information Center. SMS has funded parent consultation, through NHFV, for almost 20 years. In addition to the initial activities of helping families to access services, this role has evolved to incorporate leadership and policy development activities. SMS always seeks input from NHFV when making any kind of Administrative Rule or policy change. NHFV has also participated in discussions with MCH, Medicaid and Child Protective Services regarding rules, services and family needs. NHFV was an active participant in the Needs Assessment Planning Group along with related activities including the CAST-V process and the CSHCN Capacity Assessment.

2.D. Partnerships to Improve Health

Child Fatality Review Committee:

The Child Fatality Review Committee (CFRC), created by Executive Order in 1991, is charged with reducing preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy. The MCH Child Health Nurse Consultant and Injury Prevention Program Manager have played key roles in the CFRC working closely with representatives from the Medical Examiner's Office, DCYF, the state police, and the Attorney General's Office. Title V staff revised the process by which committee recommendations are developed and tracked. Recommendations from the case reviews are often implemented in training provided by the Child Health Nurse Consultant to health, social service, and child care personnel, to reduce the risks of SIDS, promote safer sleeping environments for infants and toddlers, and promote referrals to parenting resources for high-risk families.

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State Suicide Prevention Plan Committee:

The Injury Prevention Program and the Adolescent Health Programs collaborate with the DHHS Commissioner's Office, DCYF, and Behavioral Health and other statewide partners on the Suicide Prevention Council Legislated in 2008, the Suicide Prevention Council's mission is to implement the newly revised State Suicide Prevention Plan. The Injury Prevention Program facilitates the Communications Subcommittee. This committee works on both the communication of suicide prevention issues to the public and educating media on appropriate guidelines for reporting suicide.

The Disparate Populations Group:

Facilitated by the Division of Public Health Services, Bureau of Prevention Services Asthma Program Manager, this collaborative focuses on those sub-populations in the state with distinct health needs. This includes, but is not limited to, those who are incarcerated, the elderly, refugees and immigrants, and minority populations. This collaboration has strengthened the relationship between the Office of Minority Health and MCH. Within the past year, MCH has spearheaded interactive learning sessions with state prison and county jail medical professionals.

Medicaid & Title V:

Title V strengthens the power and reach of Medicaid indirectly through the services Title V directly supports at the local level in community health centers, specialty clinics, family resource centers and through home visits. New Hampshire uses Title V and state general funds for community based agencies to provide outreach, coordination, and referral services. Home Visiting New Hampshire, a statewide home visiting network leverages TANF funds for base funding for family support, and uses Medicaid fee for service to support health education and as a strategy for EPSDT outreach and informing.

Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy to develop and implement local Medicaid codes that pay for Title V-related services, such as child and family support, nutrition and feeding services, and expanded prenatal services. Title V staff have worked in partnership with Medicaid to revise Medicaid Rules due to

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expire in Fall 2010 and provide training in their appropriate use. Title V and Medicaid have been meeting to readopt a Memorandum of Understanding (MOU), that process has been productive but is currently on hiatus due to constraints related to internal capacity issues.

EPSDT:

The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. The SMS Senior physician's position supports SMS activities as well as offering significant support to Medicaid including consultation on EPSDT issues, with a particular focus on issues of medical necessity.

Dental:

Since 2003 New Hampshire Medicaid's initiative to increase access to dental care has resulted in most reimbursement rates being raised, a strong partnership with the New Hampshire Dental Society reduced administrative burden of claims processing, ongoing parent and PCP education programs, and improved coordination of oral health programs across the DHHS. The Medicaid initiative focuses on improving access to dental care for underserved populations, such as CSHCN who continue to have limited access to dental care, through provider outreach and education efforts.

CSHCN:

Through a joint venture between Medicaid and SMS, there is a Nurse Care Coordinator position within SMS that is directly responsible for services to CSHCN who are newly enrolled in Medicaid. This coordinator offers outreach and support to all new enrollees in Medicaid through New Hampshire's Home Care for Children with Severe Disabilities (HC-CSD). The HC-CSD coordinator represents an ongoing link between Medicaid and TitleV. This position has been integral to new rule development for Medicaid related to utilization of services for children qualified under HC-CSD criterion. This individual will continue to offer care coordination and will interface with Medicaid in an ongoing process of identifying children, who are at risk of becoming disqualified for Medicaid under this new rule, and working with their families to develop a modified service utilization plan.

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SCHIP:

MCH collaborates with New Hampshire SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. SMS' care coordinators, providing services statewide, inform uninsured families about the New Hampshire Healthy Kids (Medicaid) programs and send applications. A designated care coordinator provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to New Hampshire Family Voices as well as to SMS. The MCH Child Health Nurse Consultant was a member of the SCHIP quality assurance workgroup (QCHIP) and the workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects. MCH staff participated in the proposal review for the SCHIP contract with the Healthy Kids Corporation.

Title X Family Planning Program (FPP):

The New Hampshire Title X program is a major unit within MCH and is administered by the MCH Director, ensuring a seamless coordination between MCH and reproductive health services. MCH staff meetings, the yearly retreat and other planning activities include both MCH and FPP staff. The FPP Manager participates in the MCH Management Team. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens. As part of this work, the FPP Manager has spearheaded efforts to develop a plan for Preconception Care for New Hampshire. The FPP coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual Chlamydia screening and treatment for female FPP clients between ages 15-24. Federal monies for this screening project are for women in the targeted category who would not otherwise be able to afford this screening. Funds are provided to the PHL for testing and to STD/ HIV for treatment.

Adolescent Sexual Health Advisory Board:

Re-organized in 2009, the FPP has taken the leadership of the newly named Adolescent Sexual Health Advisory Board. This workgroup of partners representing Title V, Title X, community

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partners from across the reproductive health care and adolescent health spectrum have committed to engaging in a strategic planning process to ensure that all adolescents (10-19) and young adults (20-25) have access to quality health care services, as well as, skills, information and supports that promote healthy life choices. This group is strategically positioned to work with Title V in several of its priorities identified in the Needs Assessment, as well as in new initiative as anticipated to occur as a result of the **Patient Protection and Affordable Care Act**.

Healthy Homes:

The Childhood Lead Poisoning Prevention Program (CLPPP) has resided within MCH from 2006-2010 and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children. As the CLPPP continues to work toward the goal of eliminating childhood lead poisoning, a program shift is under way to move from this single focus to address multiple environmental, health and safety risk factors affecting families in New Hampshire. To help us achieve this more holistic approach, a Healthy Homes Taskforce that includes other programs within Division of Public Health, Department of Environmental Services, Bureau of Agriculture, Office of Energy and Planning, Community Action Programs, and Department of Safety, Fire Safety Program was developed to create and implement a statewide strategic plan. This collaborative process was critical to the development of the environmental health priority within the Needs Assessment.

Early Childhood Comprehensive Systems (ECCS):

This MCHB-funded initiative is brought together partners from a wide variety of disciplines to develop a statewide plan for early childhood systems. The ECCS partners completed the Comprehensive Plan for Early Childhood Health and Development for New Hampshire that is implemented throughout partner agencies and serving in part, as the foundation for the development of the New Hampshire Early Childhood Advisory Council, recently mandated by the Head Start Reauthorization Act. At the cornerstone of ECCS, is Healthy Child Care New Hampshire (HCCNH), a partnership of state agencies and programs that provide health and safety education and support to child care providers. The HCCNH leads the Health and Safety Committee of the Child Care Advisory Council. The HCCNH continues to liaison with DES and

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child care as they collaborate on innovative initiatives such as plans for integrated pest management in child care facilities

Rural Health and Primary Care Section (RHPCS):

RHPCS includes the Primary Care Office, the State Office of Rural Health, the Oral Health program and Workforce Development. Access to doctors, dentists, and other healthcare providers is a challenge for residents of some communities in New Hampshire. The mission of these programs is to improve access to healthcare services throughout New Hampshire particularly for those residents without commercial insurance. MCH and the RHPCS work as partners to administer contracts for 13 community health centers that provide primary care, including perinatal care, for low-income families. Funding amounts are based upon an innovative funding formula that calculates a minimum base funding, need (based upon the proportion of children in poverty in the county), the level to which each community health center integrates behavioral and oral health into its primary care services and the level to which the community health center accredited.

WIC:

Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion, injury prevention and lead screening strategies are shared across programs in both state office and in communities. Lacking an MCH nutritionist, consultation from WIC nutrition staff on key nutrition issues impacting women and children is critical. For example, MCH staff collaborated with WIC and the New Hampshire March of Dimes to develop a folic acid public education campaign in 2000 that continues today through an alliance with the New Hampshire Birth Conditions Program of Dartmouth Medical School. This program is an excellent example of using strategic partnerships to advance education to women of childbearing age about folic acid and its role in the prevention of neural tube birth defects. WIC staff present on nutrition-focused topics at MCH meetings and the Child Health Nurse Consultant provides updates on MCH programs at WIC meetings. Title V and WIC staff also jointly participate on the New Hampshire Breast Feeding Task Force which not only meets the mutual goals of improving

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breastfeeding rates, but serves as an excellent platform for sharing information on a variety of perinatal topics such as co-sleeping, SUIDS risk reduction and newborn screening.

Communicable Disease Control & Surveillance (CDCS):

The mission of Communicable Disease Control & Surveillance (CDCS) is to monitor communicable diseases in New Hampshire. The Surveillance unit maintains the mandatory reportable disease system and is responsible for collecting, analyzing, interpreting and reporting New Hampshire infectious disease data. The Disease Control unit is responsible for infectious disease control activities, case follow-up, patient and provider education and disease outbreak investigation. MCH staff has worked with the Disease Control Program assisting in the state's H1N1 response by participating in clinical advisory groups, disseminating information in a timely manner to key stakeholders, including the local community health centers, and providing nurse staffing to cover routine disease outbreak. Title V continues to participate on workgroups for emergency planning for local response ambulatory care centers.

Behavioral Health:

The Bureau of Behavioral Health (BBH) seeks to promote respect, recovery, and full community inclusion for adults who experience a mental illness and children with an emotional disturbance. Special Medical Services is organizationally located within the same division (the Division of Community Based Care Services – DCBCS). This affiliation allows for frequent collaboration on service development as well as on need resolution for individuals that are served by more than one agency in DCBCS. The CSHCN director is also a voting member of the New Hampshire Mental Health Planning & Advisory Committee (MHPAC). The MHPAC is the federally required advisory for the state's Mental Health Services Block Grant.

The *Perinatal Depression Workgroup* has been meeting for close to a year. Its purpose is to highlight the importance of both depression screening in the perinatal period, as well as the delivery of appropriate interventions for those in need. MCH represents the state's role as well as the needs of its prenatal contract providers

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Data Infrastructure:

Critical to leveraging the infrastructure and capacity of MCH, the *DPHS' Health Statistics Section (HSS)* is a close partner and ally in developing reports, analyzing data and acting as a technical resource. Although New Hampshire does not receive a CDC core injury surveillance grant, MCH works closely with the Injury Surveillance Program in HSS through activities with the MCH Data Team and DPHS Data Users Group to analyze injury related data. The programs worked in collaboration on a traumatic brain injury report released under the auspices of the Brain Injury Association of New Hampshire and prepared the data section of the Child Fatality Review Committee's 2009 Annual Report.

The programs have also looked for innovative ways to expand and improve their capacity, given their limited resources. In June 2008, the Injury Prevention Program within MCH and the Injury Surveillance Program within the Health Statistics Section together invited a state technical assistance team to evaluate the New Hampshire's programs. This process brought a team of injury prevention professionals to New Hampshire to assess the status of the injury and violence prevention program focusing on five core components including: 1) Infrastructure; 2) Data Collection, Analysis, and Dissemination; 3) Intervention: Design, Implementation and Evaluation; 4) Technical Support and Training; and 5) Public Policy. The results of that assessment were used to inform the Capacity Sections of the Needs Assessment.

In 2009, New Hampshire was granted funding, through ARRA HITECH monies, to create a Health Information Exchange (HIE). The project began in November 2011 and Title V has a representative on the project stakeholder team. This collaboration will be beneficial to advance the inclusion of Title V needs/interests in the state HIE plan

DHHS Health Data Users' Workgroup:

The Health Data Users' Workgroup was formed to maximize the quality and efficiency of data related activities that support the functions of DHHS and promote the health of New Hampshire citizens. The group meets regularly and provides members with cross-training, collaborative problem solving, guidance, and access to appropriate resources related to: dataset information; analysis methods and interpretation; confidentiality and privacy; dataset and survey development

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and infrastructure; and future dataset contents and quality. The MCH Epidemiologist and SSDI Coordinator participate in this group.

Vital Records:

The Health Statistics Section and MCH Epidemiologist have worked with DPHS legal counsel in negotiating an MOU with the New Hampshire Secretary of State Division of Vital Records Administration (DVRA). An updated MOU was recently signed and access to vital records for public health purposes continues to be protected. The MCH Epidemiologist represents the New Hampshire DHHS Commissioner on the Vital Records Improvement Fund Advisory Committee. Committee members include town clerks, data users, vital records staff, etc. The changeover to the 2003 revision of the birth certificate in July 2004 has resulted in many data quality issues requiring significant attention. Increased collaboration between the current DVRA administrator and the MCH Epidemiologist and other DHHS Health Statistics staff has resulted in greatly improved quality and timeliness of vital records data over the past year.

The MCH Epidemiologist has collaborated with staff in the (HSS) to standardize data cleaning and formatting of the DPHS birth data file. Many of the methods developed by the MCH Epidemiologist over the last several years have been institutionalized in this manner. This process continues using a prioritized list of data fields. This endeavor has led to quicker and better quality filling of public birth data requests by the Health Statistics Section staff.

2. E. Partnerships to Improve Education:

Department of Education:

Coordination with the New Hampshire Department of Education (DOE) occurs through several Title V programs. Under a cooperative agreement with the Centers for Disease Control and Prevention, the New Hampshire DOE HIV/STI/Teen Pregnancy/Health Program has focused its efforts on strengthening school health education programs and the analysis and use of the Youth Risk Behavior Survey (YRBS).

The Adolescent Health Program (AHP) collaborates with the DOE manager of the YRBS to select questions for inclusion and to assure a representative sample. MCH staff participate in a

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DHHS/DOE initiative to develop a Coordinated School Health Plan and other activities to improve the health of school age children. Although not funded with State General Funds, the Coordinated School Health Council now has a formal designation.

The New Hampshire DOE School Health Services program assists school districts in meeting the health care needs of school-aged children. DOE consults with local school districts on policy and practice related issues around school health services. This partnership between DOE and DPHS during the state's H1N1 response was critically important to ensuring that schools had accurate information and Health Alerts. The School Nurse Consultant maintains a list serve for school nurses and MCH staff post items and conduct surveys through this venue. For example, school nurses have provided valuable input to several MCH Block Grant Applications and the Needs Assessment process through electronic surveys.

MCH also works with the DOE on motor vehicle restraint and suicide prevention activities. The FPP collaborates with the HIV Prevention Coordinator on teen pregnancy and STD prevention training and education programs for teachers. The Injury Prevention Program works with the Safe and Drug Free Schools Program. This has enabled the DOE to offer funding through Safe and Drug Free Schools to school administrative units to facilitate suicide prevention and sexual violence prevention work. The Title V Director is also appointed to the DOE Non-Public School Advisory Council representing Public Health and helps coordinate information and activities with the independent school community.

Child Development Bureau -I Am Moving, I Am Learning:

The New Hampshire Child Development Bureau through technical assistance offered by the federal Headstart Program has initiated a train the trainer program called "I Am Moving, I Am Learning" (IMIL). IMIL is an initiative that offers strategies to enhance the existing curriculums in child care programs, which reflect the power of engaging children and families to make healthier choices and move more to promote health and well being. This collaboration incorporates trainers from the Child Development Bureau, MCH, SMS and the Childhood Obesity Project. These individuals offer the trainings together. They have started training childcare providers (directors and staff) from 6 different state regions. This process includes the

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training, an assessment tool (to be completed by the childcare providers) and then mentoring through local Headstart sites. It is an innovative way to integrate obesity prevention strategies across disciplines.

Child Care Consultants:

A variety of New Hampshire DHHS representatives participated in a regional training offered by the federal Child Care Bureau (Administration for Children and Families) to support consultants working with early childcare providers focusing on infants and toddlers. MCH and SMS consultants in this train the trainer framework represented Title V. Ongoing collaboration currently includes resource mapping, training additional state consultants, and will be incorporated into Higher Education curricula for child care majors in New Hampshire Community Colleges.

Zero to Three:

In 2007, Title V representatives (MCH & SMS), New Hampshire Family Voices and other DHHS and public agency staff were trained by Zero to Three, the National Center for Infants, Toddlers and Families. The ongoing activity by this trained group has included spread of the curriculum. The curriculum's focus was for childcare providers and parents to understand social emotional development and the importance of relationships in avoiding abuse and neglect. The SMS trainer and New Hampshire Family Voices trainer have team taught this curriculum approximately twice a year in different venues.

New Hampshire Transition Community of Practice (Transition COP):

In 2004, New Hampshire joined the National Transition Community of Practice led by the IDEA Partnership. Special Medical Services joined the group in 2006. This Community of Practice promotes a way of working that fosters cooperation and collaboration among all partners involved in transition to life after high school and in making a difference in the lives of New Hampshire's youth, particularly those with disabilities. The Coordinating Group is currently made up of more than 30 individuals from across state, local and community levels throughout New Hampshire who represent a wide array of experience and expertise. Goals of the group include promoting best practices in the area of transition to life after high school (including

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healthcare transition), while seeking new ideas through various avenues and partnerships, facilitating the development of regional COP's and sponsoring an annual Transition Summit.

Educational Programs & Universities:

In addition to the traditional K-12, sphere of the Department of Education, Title V frequently coordinates with educational programs and universities.

MCH contracts with the University of New Hampshire (UNH) Institute of Health Policy and Practice to fund an MCH epidemiologist. The Epidemiologist continues to play an essential role in MCH, contributing to the completion of the first comprehensive MCH statewide needs assessment in 2005 and to the current one. MCH AHP staff participated in the creation of the UNH Center on Adolescence, a clearinghouse of best practices and information for researchers and communities on adolescent concerns.

There have been efforts to increase collaboration with the Dartmouth Medical Center/UNH Leadership Education in Neurodevelopmental Disabilities (LEND) program. Collaborative clinical and educational activities have occurred as a result of joint planning. The Child Development Program at Child Health Services (Manchester), and the Seacoast Child Development Program at UNH, under SMS contracts, are working on strategies to share professional expertise and coordinate data collection. SMS staff have participated in regional LEND conferences, provided training on Healthcare Transition for LEND trainees and presented on DHHS services to state providers participating in the LEND expansion grant for Autism services.

Additionally, MCH supports the Injury Prevention Center at Dartmouth College to provide statewide population-based injury services and works with them on many injury initiatives. MCH and SMS collaborate with Dartmouth's Birth Conditions Program, New Hampshire's birth defect surveillance system, to assure access to hospital records for case finding and provide referrals for care coordination for children with these conditions.

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3. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

3.A. Introduction

Section 3 is organized into 4 major sections: an overview of the State, including geography, population demographics, and socioeconomic data, followed by sections for each of the three MCH population subgroups: pregnant women, mothers and infants; children and adolescents; and children with special health care needs. The information in each of these four sections is then organized into subsections: an overview section, followed by strengths, needs and a summary of the disparities that were identified in the assessment.

As mentioned earlier in Section 1 of this report, New Hampshire's 2010 needs assessment consisted of a review of socioeconomic as well as health indicators, in an effort to consider all of the factors that impact the health of New Hampshire residents. Identifying health disparities was an important goal of the 2010 needs assessment process. Studies over the past several decades have found that the United States ranks low among developed nations in life expectancy and that socioeconomic inequalities in health have been increasing during this period.¹ Attention is increasingly being directed to social determinants of health. For this reason, Section 3 provides detailed information on social and economic conditions and disparities among New Hampshire's residents by MCH population subgroup.

3.B. Overview of the State

3.B.1. General Information

3.B.1.a. Geography

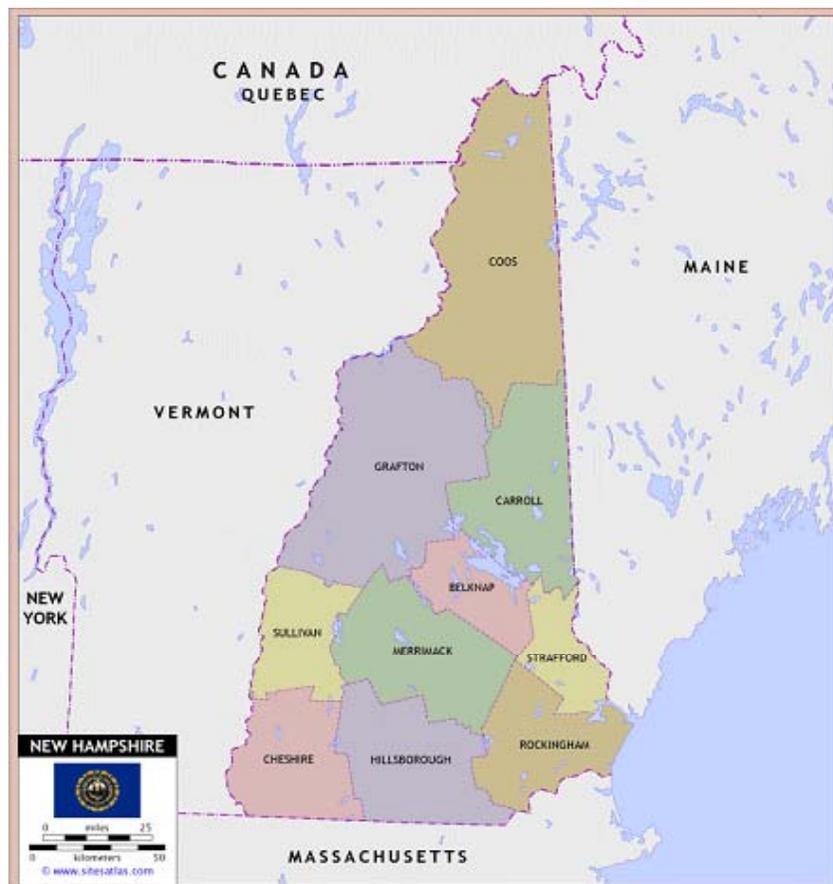
New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. New Hampshire is one of the three

¹ Berkman Lisa F. Social Epidemiology: Social Determinants of health in the United States: Are We Losing Ground?. Annu. Ev. Public Health 2009. 30:27-41.

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northern New England states, which along with Maine and Vermont, are more rural than the southern tier: Massachusetts, Connecticut and Rhode Island. According to the State definition of rural, approximately 37 percent of the population and 84 percent of the landmass in New Hampshire is considered rural. The majority of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the State's southern third. The White Mountain National Forest separates the south from the northernmost rural section of the state, which consists of Coos County. New Hampshire citizens in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals². (See Figures 3.1 and 3.2 below).

Figure 3.1 Map of New Hampshire with Counties



² NH Department of Health and Human Services (DHHS) Rural Health and Primary Care section. A.G. Druzba (Personal communication April 12, 2010)

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Figure 3.2 Map of New Hampshire with major cities



3.B.1.b. Demographic Information

New Hampshire's population is aging. Over 25 percent of the population is 55 years of age or older. An analysis of the percentage change in population by age group concluded that the 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. New Hampshire tied with Florida with the fourth highest median age in the nation and the third highest in the New England region at 40.2 years.³ An increase in the overall aging of the population is a trend that influences needs in our communities.

New Hampshire residents under age 18 represent 22.3 percent of the population; those ages 18-24 years old represent 9.1 percent and women ages 15 to 44 years old represent 38.9 percent of the female population and 19.7 percent of the total population.⁴ Children with special health

³ NH Employment Security (NHES) Economic & Labor Market Information Bureau. (March 2010) *Vital Signs 2010 Economic & Social Indicators for New Hampshire, 2005-2008*. Retrieved April 9, 2010 from <http://www.nh.gov/nhes/elmi/pdfzip/econanalys/vitalsigns/vs2010/Vs2010population.pdf>.

⁴ Table 2: Annual Estimates of the Resident Population by Sex and Age for New Hampshire: April 1, 2000 to July 1, 2008 (SC-EST2008-02-33). Source: Population Division, U.S. Census Bureau. Release date 5/14/09. Retrieved 5/15/10 from <http://www.census.gov/popest/states/asrh/SC-EST2008-02.html>

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care needs represent 16.6 percent of the population of children 0-17 years of age and 3.8 percent of the total population of the State of New Hampshire.^{5,6}

New Hampshire has a growing population, estimated at 1,324,575 in 2009, representing a 7 percent increase since the 2000 census.⁷ The population growth rate has slowed over the past two years.⁸ While the state's population is still 93.1 percent white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9 percent of the population, followed by Black/African American at 1.2 percent. Hispanics (of all races) make up 2.6 percent of the population (table below).⁹ Most of New Hampshire's minority populations live in the southern tier communities of the state.

Table 3-1. Race and Ethnicity, Comparison of NH and US Population

Race/Ethnicity	NH		US	
	Population	Percent	Population	Percent
White, not Hispanic	1,225,368	93.1%	199,491,458	65.6%
*Black/African American	16,015	1.2%	39,058,834	12.8%
*American Indian/Alaskan Native	3,642	0.3%	3,083,434	1.0%
*Asian	25,147	1.9%	13,549,064	4.5%
*Native Hawaiian/Other Pacific Islander	549	0.0%	562,121	0.2%
*Two or more races	14,027	1.1%	5,167,029	1.7%
White Hispanic	31,061	2.4%	43,147,784	14.2%
Total population (all races)	1,315,809	100%	304,059,724	100%
Hispanic (all races)	34,676	2.6%	46,943,613	15.4%
**Non-white	59,380	4.5%	61,420,482	20.2%

*Includes Hispanic and not Hispanic

**Includes Hispanic and not Hispanic and people reporting two or more races

Data source: U.S. Census Bureau Population Division, 2009. Population estimate 7/1/08.

⁵ Child and Adolescent Health Measurement Initiative. *2005/06 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

⁶ Table 2: Annual Estimates of the Resident Population by Sex and Age for New Hampshire: April 1, 2000 to July 1, 2008 (SC-EST2008-02-33). Source: Population Division, U.S. Census Bureau. Release Date: May 14, 2009, <http://www.census.gov/popest/states/asrh/SC-EST2008-02.html>, accessed 5/15/10.

⁷ Table 1: Annual Estimates of the Resident Population for Counties of New Hampshire: April 1, 2000 to July 1, 2009 (CO-EST2009-01-33) Source: U.S. Census Bureau, Population Division, Release Date: March 2010. Retrieved 4/22/10 from <http://www.census.gov/popest/counties/tables/CO-EST2009-01-33.xls>

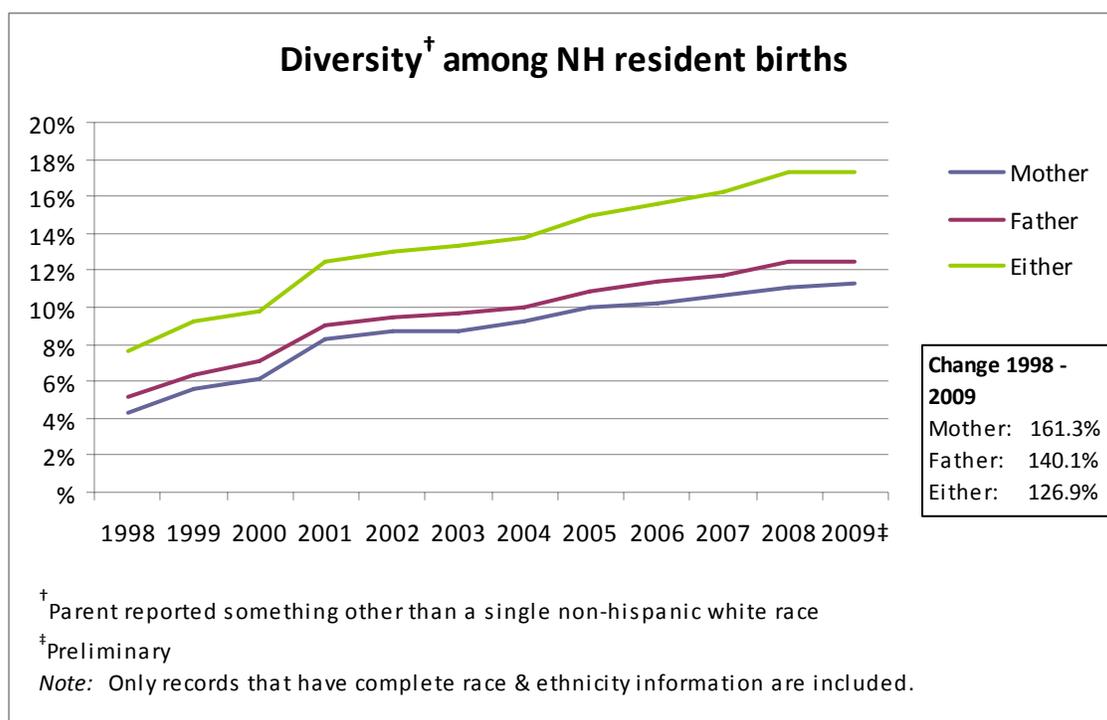
⁸ NH Employment Security (NHES) Economic & Labor Market Information Bureau. (March 2010) *Vital Signs 2010 Economic & Social Indicators for New Hampshire, 2005-2008*. Retrieved April 9, 2010 from <http://www.nh.gov/nhes/elmi/pdfzip/econanalys/vitalsigns/vs2010/Vs2010population.pdf>,

⁹ Table 4: Estimates of the Resident Population by Race and Hispanic Origin for the United States and States: July 1, 2008 (SC-EST2008-04); Population Division, U.S. Census Bureau, Release Date: May 14, 2009. Retrieved 2/19/10 from <http://www.census.gov/popest/states/asrh/SC-EST2008-04.html>

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As might be expected based on the differing racial and ethnic proportions in younger age groups, births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17 percent of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6 percent of births in 1998.¹⁰ This increase is illustrated below.

Figure 3.3



Source: NH DVRA birth file

New Hampshire has resettled over 6000 refugees since the early 1980's, over 4,800 between 1997 and 2008. The majority of refugees have come from countries in Europe (74% from Bosnia) and Africa (58% from Somalia and Sudan), with smaller populations from Asia and the Middle East (see Table 3.2 below). Of the nearly 3000 refugees resettled between fiscal years 2002 and 2009, 61 percent settled in Manchester, 26 percent in Concord, 8 percent in Laconia, with smaller populations in other cities and towns.¹¹ Case management, outreach and

¹⁰ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

¹¹ NH Office of Energy and Planning, Office of Refugee Resettlement. Retrieved April 29, 2010 from <http://www.nh.gov/oep/programs/refugee/facts.htm>.

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interpretation services are all in high demand for this population. These new residents can experience a range of health and mental health issues including poor nutrition, communicable diseases and lead poisoning, with maternal and child health issues predominating. However, a person in refugee status is granted only 8 months of federally funded health insurance coverage through Medicaid after resettlement in the U.S. Following that period, there are significant barriers to obtaining health care; a refugee must be in the U.S. for 5 years before applying again for Medicaid. Community health centers must limit the numbers of uninsured they accept due to the costs of the chronic health needs of refugee populations and the need for interpreters. The city of Manchester alone has 73 different languages spoken, and the Manchester Community Health Center spends hundreds of thousands of dollars on language needs.¹² The data presented above suggests a need to continue efforts to assure culturally and linguistically appropriate services in New Hampshire.

**Table 3.2 Refugee Arrivals to New Hampshire by Country of Origin:
1997 – 2008**

	1997-1999	2000-2007	2008	Total
Totals	1,442	2,889	520	4,851
Europe	1,068	1,167	2	2,237
Bosnia	868	788		1,656
Croatia	67	101		168
Kosovo	49	0		49
Latvia	0	2		2
Russia	28	40	2	70
Serbia	0	4		4
Ukraine	56	45		101
Meskhetian Turks	0	187		187
Africa	218	1,516	140	1,874
Algeria	3	6		9
Burundi	0	132	52	184
Cameroon	0	6		6
Congo	0	54	23	77
Egypt	0	6		6
Eritrea	0	4		4
Ethiopia	1	19		20
Liberia	27	216		243
Nigeria	52	7	8	67
Rwanda	21	50		71
Sierra Leone	3	51	2	56
Somalia	19	131	43	193
Somalia (Bantu)	0	373		373
Sudan	92	434	6	532
Togo	0	21	6	27
Zimbabwe	0	5		5
Ivory Coast	0	1		1
Asia	126	18	277	421
Vietnam	126	18		144
Bhutan			277	277
Middle East	30	186	101	317

¹² NH Department of Health and Human Services (DHHS) DPHS Maternal and Child Health Section. B. McGuire (Personal communication May 27, 2010)

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Afghanistan	0	99	3	102
Armenia	0	1		1
Azerbaijan	0	9		9
Iran	3	18		21
Iraq	27	59	98	184
Cuba	0	2		2

Source: NH OEP Office of Refugee Resettlement, 2010

The cities of Manchester and Nashua are the State’s most racially and ethnically diverse cities, and diversity is increasing. Both cities are located in Hillsborough County, in southern New Hampshire, bordering Massachusetts. See maps in Figures 3.1 and 3.2 above. Manchester is New Hampshire’s and Northern New England’s most populous community, with 108,586 residents, comprising 8.3 percent of the state’s population.¹³ Five percent of the city’s residents are Hispanic or Latino, 10.1 percent are non-white, 5.4 percent are not U.S. citizens.^{14,15} Manchester is a refugee resettlement site, receiving over 1800 of the nearly 3000 refugees resettled in the state between FY02 and FY09. The city has twice the percent of residents born outside of the U.S. (9.4%) as the State (4.4%).¹⁶ Approximately 17 percent of Manchester residents speak a language other than English at home.¹⁷ The city of Nashua’s population was estimated at 86,576 residents in 2008.¹⁸ Ten percent of its residents are Hispanic or Latino, 8.9 percent are not U.S. citizens, and 14.2 percent report a race other than white. Of the Hispanic/Latino populations ages 5 years and older in Manchester and Nashua, a significant proportion (31.9% in Manchester and 40.6% in Nashua) speak English less than” very well”, potentially limiting their ability to access health information and services.¹⁹

¹³ US Census Bureau, Population Estimates Program, 2008 population estimates, Retrieved 2/19/10 from http://factfinder.census.gov/servlet/DTSUBJECTSHOWTABLES?_lang=en&_ts=291026856878

¹⁴ U.S. Census Bureau, 2006-2008 American Community Survey 3-year estimates. Retrieved 2/19/10 from http://factfinder.census.gov/servlet/DTSUBJECTSHOWTABLES?_lang=en&_ts=291028224648

¹⁵ U.S. Census Bureau, 2008 American Community Survey. Retrieved 2/19/10 from http://factfinder.census.gov/servlet/DTSUBJECTSHOWTABLES?_lang=en&_ts=291026424829

¹⁶ Source U.S. Census Bureau: State and County QuickFacts. Retrieved April 30, 2010 from <http://quickfacts.census.gov/qfd/states/33/3345140.html>

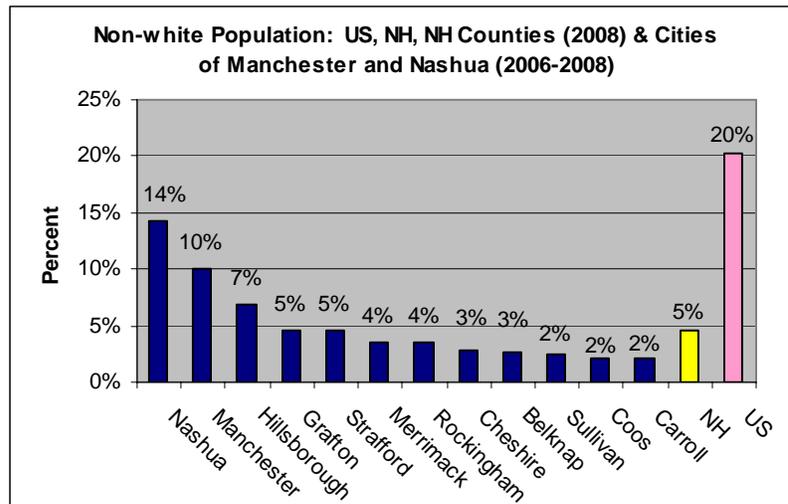
¹⁷ Manchester NH Health Department (2009) *Believe in a Healthy Community, Greater Manchester Community Needs Assessment 2009*. Retrieved March 19, 2010 from <http://www.manchesternh.gov/website/LinkClick.aspx?fileticket=omDcfigsVQ4k%3D&tabid=700>

¹⁸ US Census Bureau, Population Estimates Program, 2008 population estimates. Retrieved February 19, 2010 from http://factfinder.census.gov/servlet/DTSUBJECTSHOWTABLES?_lang=en&_ts=291026856878

¹⁹ U.S. Census Bureau, 2008 American Community Survey, Retrieved 2/19/10 from http://factfinder.census.gov/servlet/DTSUBJECTSHOWTABLES?_lang=en&_ts=291026424829

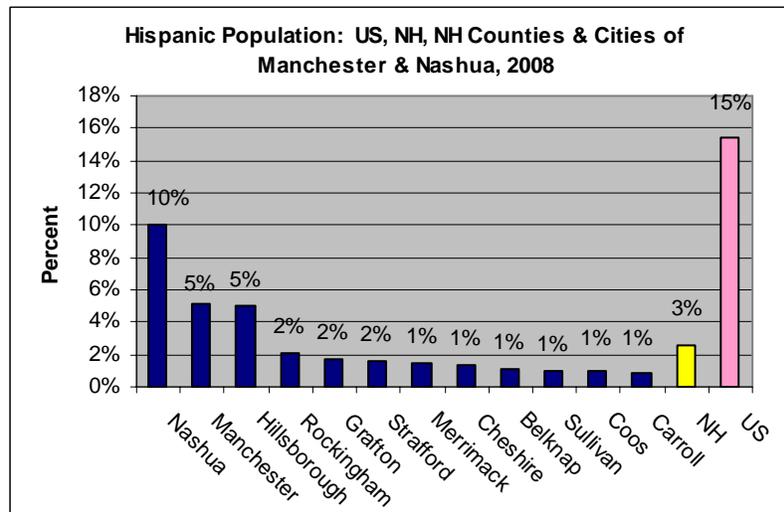
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Figure 3.4



Non-white population includes Hispanic and non-Hispanic ethnicity.
 The cities of Manchester and Nashua are located in Hillsborough County.
 Source: NH, US and county data: US Census Bureau, Population Estimates Program, 2008 1-year estimates;
 Manchester & Nashua non-white data source=U.S. Census Bureau, 2006-2008 American Community Survey

Figure 3.5



Hispanic population includes all races.
 Source: US Census Bureau, Population Estimates Program; Manchester & Nashua data source=American Community Survey, 2008

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3.B.2. Strengths

As New Hampshire's Governor proudly mentioned in his State of the State speech on January 21, 2010, New Hampshire is one of the healthiest states in the nation.²⁰ New Hampshire compares favorably to other states on many indicators of health, ranking among the top four healthiest states between 1995 and 2004.^{21,22} Rankings are based on a combination of indicators, including health outcomes (e.g. infant mortality, cancer rates), community factors, environment and health policies.

Some of New Hampshire's strengths include the lowest teen birth rate in the nation, the lowest percentage of children under age 18 in poverty, the highest percentage of children ages 19-35 months who are fully immunized, and a low infant mortality rate.

New Hampshire recently met the 2010 national health objective of reducing the prevalence of current cigarette use among high school students to less than or equal to 16 percent. A recent New Hampshire DPHS study found that smoking prevalence in this population declined significantly, from 25.3 percent in 2001, to 16 percent in 2009.²³

New Hampshire's high rankings on some health indicators may, in part, be related to the State's higher than average income and education levels when compared to other states, all of which are associated with better health outcomes.

New Hampshire has an overall median household income significantly above the national average: \$68,175 compared to \$51,233 nationally. (U.S. Census Bureau, 2007-2008 two-year average).²⁴ By this estimate, New Hampshire's median household income was the highest in the

²⁰ Text of NH Gov. John Lynch's 2010 State Of The State Address. (January 21, 2010) WMUR TV. Retrieved January 21, 2010 from <http://www.wmur.com/politics/22304068/detail.html>

²¹ United Health Foundation. *America's Health Rankings 2009*. Retrieved May 6, 2010 from <http://www.americashealthrankings.org/Measure/All%20Years/NH/Overall.aspx>

²² Annie E. Casey Foundation (2009) *2009 Kids Count Data Book: State Profiles of Child Well-Being*. Retrieved May 6, 2010 from www.aecf.org

²³ 2007 - 2009 NH Youth Tobacco Survey. NH DHHS DPHS Tobacco Prevention and Control Program. Retrieved May 6, 2010 from <http://www.dhhs.nh.gov/NR/rdonlyres/et66h3t5nbyptedostxxwyekknurfcllcam5bbzi6lsjybb7wmvd6qca4obftd5zoi6htztzjzlhed7q1b7ytkzyud/yts0709.pdf>

²⁴ US Census Bureau. Retrieved 5/18/10 from www.census.gov/hhes/www/income/statemedfaminc.html

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nation during this period. New Hampshire's 2008 per capita personal income was \$3,400 above the national average of \$40,208 and ranked eleventh highest among the states and District of Columbia. It was third highest among the New England states, but was more than \$12,000 behind top ranked Connecticut and almost \$8,000 behind second-ranked Massachusetts. In 2007 (latest county data available), per capita income varied widely by New Hampshire county, from a low of \$31,179 in northernmost Coos County to a high of \$47,196 in Rockingham County, bordering Massachusetts.²⁵

3.B.3. Needs

New Hampshire's health ranking has fallen overall and on several important measures since 2004; in 2009, the State was ranked 5th best among all states by the United Health Foundation.²⁶ Several significant changes of concern are the increase in obesity prevalence (from 15.6% to 24.8% over the past 10 years), the increase in child poverty (from 5.5% in 2006 to 8.6% in 2009), the percent of the population without health insurance (increasing since 2000), the decrease in immunization coverage (from 93.2% in 2008 to 85% in 2009) and the increase in the infant mortality rate (from 4.4 to 5.7 deaths per 1000 live births) over the past 5 years.²⁷ The National Healthcare Quality Report (2008) from the Agency for Health Care Quality Research rated New Hampshire worse than average for suicide deaths per 100,000 population.²⁸ The statistical variation inherent in small numbers often results in ranking changes that are not statistically significant, so changes in rankings not yet supported by longer-term trends should be interpreted with caution.

The United Health Foundation's America's Health Rankings for 2009 listed as a weakness, New Hampshire's low funding for public health (\$59 per person compared to \$220 for the number 1 ranked state). New Hampshire was ranked 35th in the nation on this measure, down from 34th

²⁵ NHES Economic & Labor Market Information Bureau. (March 2010) Vital Signs 2010: Economic & Social Indicators for New Hampshire, 2005-2008. Retrieved April 9, 2010 from

<http://www.nh.gov/nhes/elmi/pdfzip/econanalys/vitalsigns/vs2010/VS2010income.pdf>

²⁶ United Health Foundation. *America's Health Rankings 2009*. Retrieved May 6, 2010 from

<http://www.americashealthrankings.org/yearcompare/2009/2009/NH.aspx>

²⁷ United Health Foundation. *America's Health Rankings 2009*. Retrieved May 6, 2010 from

<http://www.americashealthrankings.org/yearcompare/2009/2009/NH.aspx>

²⁸ U.S. Department of Health and Human Services, Agency for Health Care Research and Quality. (March 2009) 2008 National Healthcare Quality Report. Rockville, MD. AHRQ Pub. No. 09-0001. Available from

<http://www.ahrq.gov/qual/qrd08.htm>

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place in 2008.²⁹ New Hampshire, like other states, is experiencing a severe budget shortfall that has resulted in drastic cuts to essential health and social services, further weakening the safety net for residents in need. Disparities in poverty and uninsurance rates are further described below.

The effects of the recession can be seen in the State: demand for utility and food assistance has increased. Enrollment in Healthy Kids, the State's Medicaid program, has also increased, partly due to increased awareness as well as decreased income of families. The 2-1-1 New Hampshire program is a collaborative effort between the State, United Way of New Hampshire and other key stakeholders to consolidate essential information on community supports and outreach programs. In 2008 (the program's first year) 2-1-1 New Hampshire received over twenty-two thousand calls. The most requested services were housing and utility assistance (28%), temporary financial aid (22%), and health care including mental health and substance abuse services (14.5%).³⁰

Access to health care is a critical need for New Hampshire residents. While the percentage of uninsured children in New Hampshire is one of the lowest in the nation, the percentage of uninsured adults, at 14.3 percent (January to June 2009), was the highest in the Northeast See Figure 3.6 below.³¹ This percentage increased by 3.4 percentage points from 2008 when it was 10.9 percent. This was the fourth greatest increase during this period among all states. Age and other health insurance disparities are described further in the disparities section below.

²⁹ United Health Foundation. *America's Health Rankings 2009*. Retrieved May 6, 2010 from <http://www.americashealthrankings.org/yearcompare/2009/2009/NH.aspx>

³⁰ NHES Economic & Labor Market Information Bureau. (March 2010) , Vital Signs 2010: Economic & Social Indicators for New Hampshire, 2005-2008.

³¹ Gallup-Healthways Well-Being Index survey. *State of the States: Midyear 2009*. (August 19, 2009) Retrieved June 11, 2010 from <http://www.gallup.com/poll/122387/uninsured-highest-percentage-texas-lowest-mass.aspx>

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The structure of New Hampshire's economy has changed in recent years from one in which a variety of well paying jobs were available, to a "boutique economy" currently, in which good paying jobs are available only to those with high educational levels and skills. The wage disparity has increased between the lowest wage earners and the highest, and the lowest wages have remained stagnant or fallen while the highest have increased, even in a weak economy. Jobs that pay a livable wage are declining, making it more difficult for some New Hampshire families to meet basic needs.³³

New Hampshire is experiencing growing racial and ethnic diversity, as described in detail above, with varying capacity to serve these new populations.

This statewide needs assessment of the MCH population pointed to a number of significant areas of need that will be detailed in the sections below. Among these are increasing childhood obesity rates, need for child and adolescent mental health and substance abuse services, oral health and others.

3.B.4. Disparities

Statewide averages mask differences among subpopulations in the State. Closer analysis of New Hampshire data reveals statistically significant differences in health behaviors and outcomes, poverty, access to health care and other health and socioeconomic indicators by race, age group and region. For example, analysis of New Hampshire birth data revealed differences in tobacco use among pregnant women, and incidence of low birth weight infants among certain populations, including young women and women on Medicaid. Educational attainment, key to improving economic opportunities and health, varied widely across New Hampshire's major cities in the 2000 census (latest data available for cities)³⁴

3.B.4.a. Geographic Disparities

As mentioned above, New Hampshire is mostly rural, with the majority of the population concentrated in the southeastern parts of the State (Hillsborough and Rockingham counties). See

³³ Children's Alliance of New Hampshire. (2008) *Kids Count New Hampshire Data Book 2008: Our Most Vulnerable Communities*. Retrieved May 6, 2010 from www.childrennh.org

³⁴ US Census Bureau, State and County QuickFacts. Available from <http://quickfacts.census.gov/qfd/states/>

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map of New Hampshire counties and major cities above (Figures [3.1](#) and [3.2](#)). Although there are some statistics that show health benefits for rural residents, the majority of the differences identified show adverse health related measures in New Hampshire's rural areas. Some of the most notable differences are in the demographic characteristics of the rural residents, which impact health status and access. Rural residents of the state are significantly older, poorer and less educated than non-rural residents. These factors have all been shown to impact health status and access to healthcare. For example, the 2000 Census found the median household income was \$51,000 in the city of Nashua (on the Massachusetts border, within commuting distance to Boston) compared to \$37,000 in Laconia, 55 miles to the north.³⁵ The percent of residents with a bachelor's degree or higher ranged from a low of 6.7 percent in Berlin and 12.8 percent in Claremont (rural areas) to a high of 41.9 in Portsmouth (seacoast, near Massachusetts) and 31.5 percent in Nashua.³⁶ Furthermore, the population age cohort shift of the elderly portion of the population over the past 10 years was particularly evident in rural areas; in Berlin (rural Coos county) 23 percent of the population was age 65 or older in 2000 compared to only 5 percent in Londonderry (southern New Hampshire).³⁷

Poverty and uninsurance rates are higher in rural counties than in the State as a whole, and in some cases, exceed the U.S. rate. While New Hampshire has the lowest percentage of people living at 100 percent of the federal poverty level among all states, the rates in several New Hampshire counties far exceed the State average, and rural Strafford County's rate is statistically significantly higher than the U.S. rate (see Figure [3.7](#) below).³⁸ The counties with the lowest poverty rates are located in the southern part of the state, bordering Massachusetts, while those with the highest rates are the more northern and/or rural counties (See map in Figures [3.1](#) and [3.2](#) above). In Berlin (in rural Coos County bordering Canada), 12.4 percent of individuals live below the poverty level compared to 6.8 percent in Nashua (southern New Hampshire)³⁹ Child poverty rates are also significantly higher in rural counties (see Section 3.D. *Children and Adolescents* below), and in two New Hampshire counties (rural Carroll and Coos counties)

³⁵ US Census Bureau, State and County QuickFacts. Available from <http://quickfacts.census.gov/qfd/states/>

³⁶ US Census Bureau, State and County QuickFacts. Available from <http://quickfacts.census.gov/qfd/states/>

³⁷ US Census Bureau, State and County QuickFacts. Available from <http://quickfacts.census.gov/qfd/states/>

³⁸ US census bureau, 2006-2008 American Community Survey. Available from http://factfinder.census.gov/home/saff/main.html?_lang=en

³⁹ US census bureau, 2006-2008 American Community Survey. Available from http://factfinder.census.gov/home/saff/main.html?_lang=en

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exceed the U.S. average.⁴⁰ The percentage of adult residents who lack health insurance is higher in rural areas (see Figure 3.8 below)⁴¹, as is the percentage of rural residents who lack dental insurance⁴². In Coos County, a significantly lower percentage of residents reported having any health care coverage (82.4%) in 2008, compared to the state average (89.9%).⁴³

Rural residents are also far more likely to be unemployed or out of the labor force, and rural workers are more likely to be self-employed or to work in industries where health insurance benefits are less available. Rural residents are significantly less likely to be insured for health services, but more likely to be on Medicaid when they are insured. These insurance patterns were reflected in the inpatient payor mix, and even more prominently in the payor mix for visits to hospital Emergency Departments. The majority of the uninsured were in employed families, however rural residents are less likely to have an employer sponsored health insurance option.⁴⁴

Birth records show that rural pregnant women report higher maternal tobacco use, maternal alcohol use, and are more likely to be under the age of twenty, unmarried and to have a birth paid for by Medicaid. Resident death records show that rural residents are more likely to die from an injury or from suicide than other New Hampshire residents. In addition rural residents are more likely to be hospitalized for injuries than other New Hampshire residents.⁴⁵

⁴⁰ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. Retrieved 2/18/10 from www.countyhealthrankings.org

⁴¹ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. Retrieved 2/18/10 from www.countyhealthrankings.org

⁴² NH Department of Health and Human Services (DHHS) Rural Health and Primary Care section. A.G. Druzba (Personal communication April 12, 2010)

⁴³ Data source: 2008 NHBRS. NH HealthWRQS Retrieved from <http://nhhealthwrqs.org/>

⁴⁴ NH Department of Health and Human Services (DHHS) Rural Health and Primary Care section. A.G. Druzba (Personal communication April 12, 2010)

⁴⁵ NH Department of Health and Human Services (DHHS) Rural Health and Primary Care section. A.G. Druzba (Personal communication April 12, 2010)

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Rural residence affects poverty and uninsurance rates. Poverty rates in several New Hampshire counties are higher than the U.S. rate

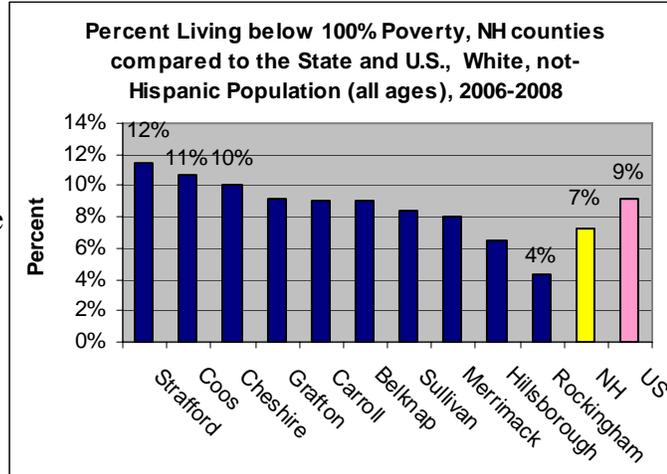


Figure 3.7

Source: US census bureau, 2006-2008 American Community Survey. Values are shown for NH and US rates and for counties whose rates are statistically significantly higher than the State average. Strafford and Rockingham County rates are statistically significantly different than the U.S. rate

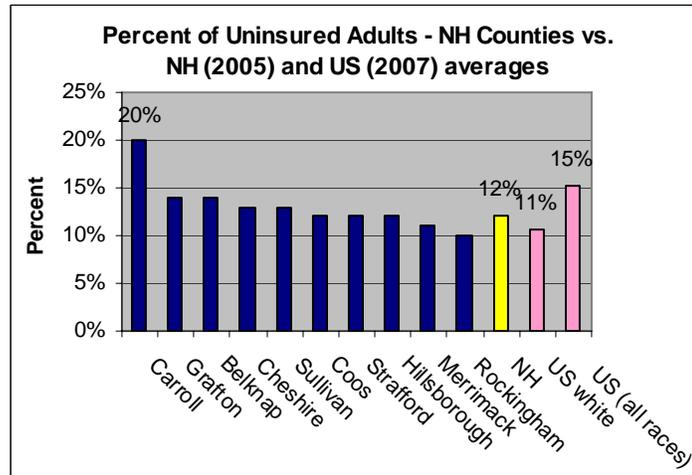


Figure 3.8

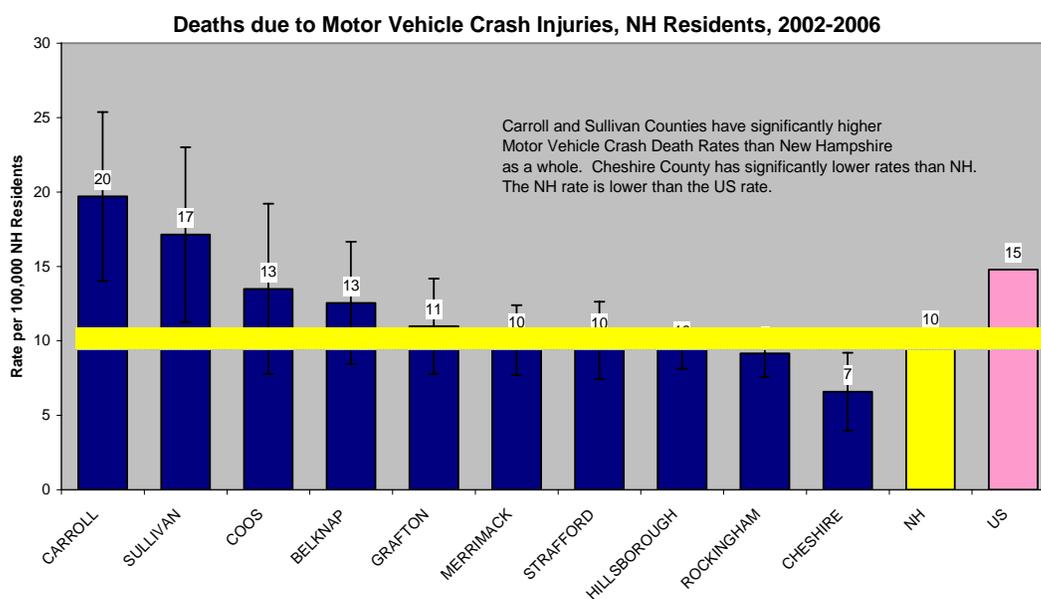
Values are shown for counties whose rates are statistically significantly higher than the State average. Source: RWJ Foundation and University of Wisconsin Population Health Institute. County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. www.countyhealthrankings.org, accessed 2/18/10. Data source: Small Area Health Insurance Estimates, U.S. Census Bureau 2005; US: 2007 CPS 2000-2009 Annual Social and Economic Supplements (ASES)

In addition to socioeconomic indicators, the health status of New Hampshire residents also varied geographically. For example, in rural Carroll County, the percentage of residents reporting “any days in the past 30 days during which mental health was not good” was

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significantly higher (65%) than the state average (35.5%).⁴⁶ In Belknap County, a significantly higher percentage of residents report current smoking (25.3%) than the State average (17.1%)⁴⁷ Teen birth rates were significantly higher in several counties (Sullivan, Coos, Belknap and Hillsborough)⁴⁸ and in several cities, than the State average (See Figure 3.31 in Section 3.C). *Pregnant Women, Mothers and Infants* below). Death rates from motor vehicle crashes in several rural New Hampshire counties (Carroll and Sullivan) are statistically significantly higher than the State average (see Figure 3.9 below).

Figure 3.9



Source (county and state data): NH death data, provided by NH DHHS DPHS HSDM 5/24/10; US: CDC WISQARS

3.B.4.b Economic Disparities

Certain demographic and geographic subpopulations in the state experience much higher poverty rates and these disparities have increased over the past decade. As described above, rural residents disproportionately experience poverty. Gender also is associated with economic inequality. Nearly 22 percent of New Hampshire families headed by a woman with no husband present had incomes below the poverty level compared to 5.6 percent of family households

⁴⁶ University of New Hampshire and NH Department of Health and Human Services, HealthWRQS Library of Indicator Reports. Data source: 2008 NHBFRS Available from <http://nhhealthwrqs.org/>

⁴⁷ University of New Hampshire and NH Department of Health and Human Services, HealthWRQS Library of Indicator Reports. Data source: 2008 NHBFRS Available from <http://nhhealthwrqs.org/>

⁴⁸ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. Retrieved 2/18/10 from www.countyhealthrankings.org

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overall.⁴⁹ This percentage has increased since 2000, when 17.6 percent of female householder families lived below the poverty level⁵⁰. In 2003, an estimated 19.4 percent of New Hampshire family households were headed by a woman with no husband present. A higher percentage of women overall (8.4%) live below 100 percent of poverty compared to men (6.8%).

Children and adolescents are disproportionately affected by poverty, with 9.3 percent of New Hampshire residents under age 18 living below 100 percent of the federal poverty level in the previous 12 months, compared to 7.0 percent of individuals aged 18 to 64 years old and 7.7 percent of residents aged 65 and older.⁵¹ Poverty and uninsurance among those in late adolescence (18-24 years) are also significantly higher than among other age groups: 16 percent of youth ages 18-24 live in poverty⁵² and 30 percent of adolescents ages 18-24 lack health insurance⁵³. (See Figure 3.10 below). See Section 3.D. *Children and Adolescents*, below, for a detailed description of the issues affecting New Hampshire's children and adolescents.

Racial and ethnic minorities are more likely to live in poverty than New Hampshire's white non-Hispanic population, as can be seen in Figures 3.10⁵⁴. The differences between the percentage of white, non-Hispanic residents living below 100 percent of poverty (7.3%) and Black/African American (21.9%), "some other race" (14.5%) and Hispanic (of any race) (13.6%) residents are statistically significant. The percentage of foreign-born New Hampshire residents with incomes below 100 percent of poverty is 9.0 percent versus 7.0 percent of native New Hampshire residents.⁵⁵

⁴⁹ U.S. Census Bureau, 2006-2008 American Community Survey 3 year estimates. Available from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_lang=en&_ts=293705362030&_ds_name=ACS_2008_3YR_G00_&_program=

⁵⁰ U.S. Census Bureau, Census 2000 Summary File 3-Sample Data. Available from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_ds_name=DEC_2000_SF3_U&_program=DEC&_lang=en

⁵¹ U.S. Census Bureau, 2006-2008 American Community Survey 3 year estimates. Available from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_lang=en&_ts=293705362030&_ds_name=ACS_2008_3YR_G00_&_program=

⁵² Data provided by national Kids Count Program, Annie E. Casey Foundation. Retrieved May 7, 2010 from www.kidscount.org

⁵³ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. Retrieved 2/18/10 from www.countyhealthrankings.org

⁵⁴ U.S. Census Bureau, 2006-2008 American Community Survey 3 year estimates. Available from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_lang=en&_ts=293705362030&_ds_name=ACS_2008_3YR_G00_&_program=

⁵⁵ U.S. Census Bureau, 2006-2008 American Community Survey 3 year estimates. Available from http://factfinder.census.gov/servlet/DatasetMainPageServlet?_lang=en&_ts=293705362030&_ds_name=ACS_2008_3YR_G00_&_program=

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Racial and ethnic minorities are also more likely to be without health insurance for some portion of the year (see Figure 3.11 below).⁵⁶

Level of educational attainment is associated with poverty. Among New Hampshire residents ages 25 and older, 16.7 percent of those with less than a high school education have incomes below 100 percent of poverty versus 7.0 percent of those with a high school education.

Racial and ethnic disparities are evident in poverty rates, as can be seen in this graph.

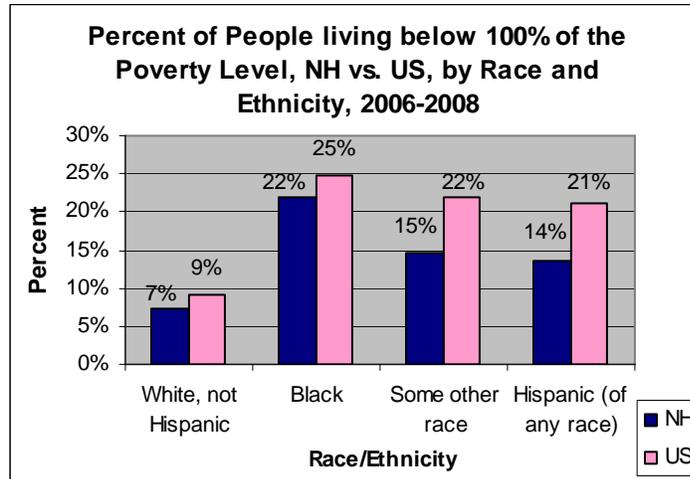


Figure 3.10

Source: US census bureau, 2006-2008 American Community Survey
White =white, not Hispanic
Values for NH Black/African American, Some other race and Hispanic are statistically significantly higher than the NH State average.

An increasing percentage of New Hampshire births (31% in 2009) are paid by Medicaid,⁵⁷ placing a strain on an already weakened system (See Figure 3.11 below). This compares to 13.4 percent of the adult population (18-64 year olds) in New Hampshire who were enrolled in Medicaid in FY 2006.⁵⁸

⁵⁶ Families USA. (March 2009) *The Uninsured: A Closer Look, New Hampshire without Health Insurance*. Retrieved January 29, 2010 from <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>

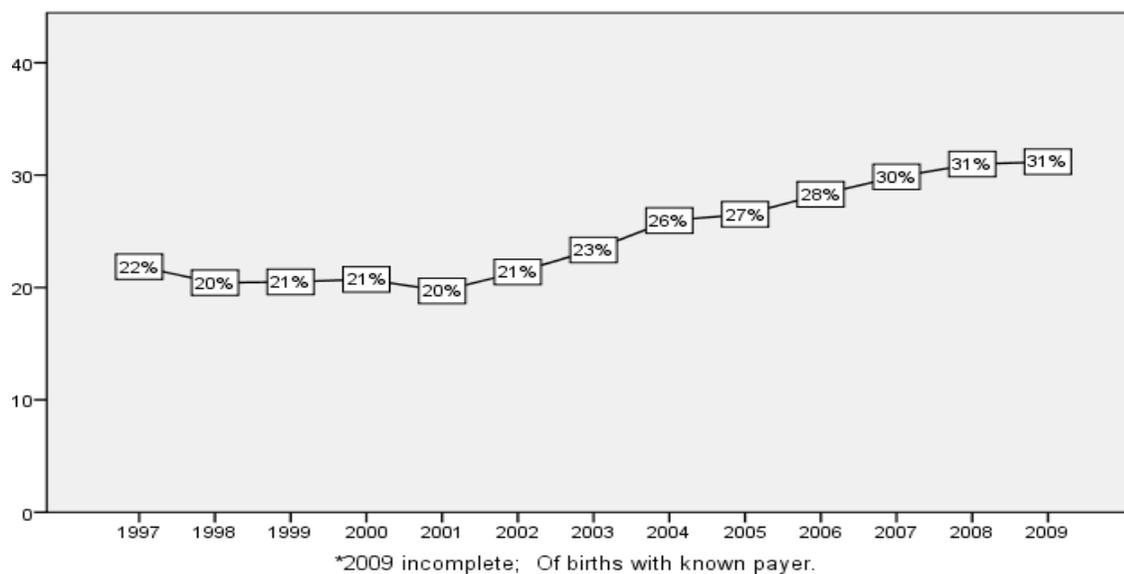
⁵⁷ NH DHHS DPHS Maternal and Child Health Section (2010) Data source: NH birth data

⁵⁸ The Kaiser Family Foundation, StateHealthFacts.org. Retrieved March 19, 2010 from <http://www.statehealthfacts.org/comparebar.jsp?ind=200&cat=4>

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Figure 3.11

Percentage of all NH resident births* paid by Medicaid



Source: NH MCHS
Percent of NH births billed to Medicaid includes births to women of all ages; does not include NH CHIP.

3.B.4.c. Disparities in Health Insurance Access

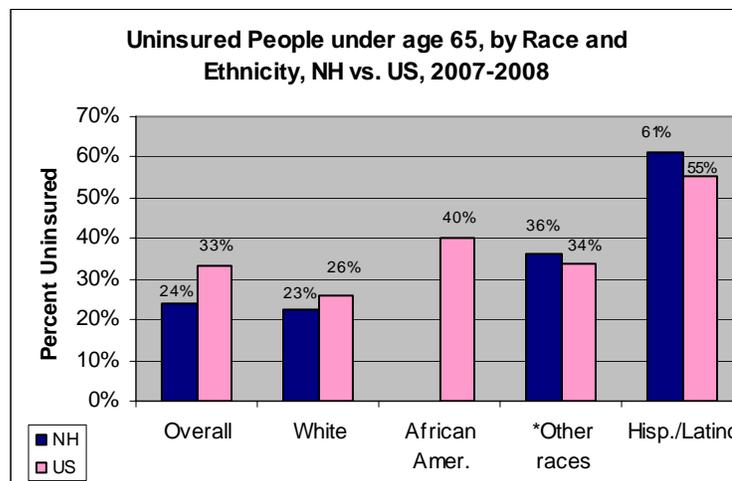
Marked disparities are evident in the percent of New Hampshire's population that is uninsured. Health insurance status varies by age, income and race, with young adults, the lowest income adults and racial and ethnic minority groups most likely to be uninsured. See Figures 3.12 and 3.13 below. There are also marked disparities in dental access by socioeconomic status. For example, 47.1 percent of New Hampshire residents with incomes below \$15,000 per year reported visiting a dentist in the past year, compared to 86.8 percent of those with incomes above \$50,000 per year (2004 BRFSS data)⁵⁹ Geographic disparities in health insurance coverage are covered above.

⁵⁹ NH DHHS DPHS, Bureau of Community Health Services, Oral Health Program. (December 2007) *NH Oral Health Data 2006*. Retrieved April 16, 2010 from <http://www.dhhs.nh.gov/NR/rdonlyres/ekhpsxlytpbdf7ydiblkrfms6u7ng2j74e372gbn5mneux7bfg3ukv42xubsl2cdzwrjpf4c7mq2i3nfbmjb27kwa/oralhealthdata.pdf>

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A recent study went beyond the U.S. Census Bureau’s poverty statistics, which describe people who were without health insurance for the entire previous year, to instead consider the many people who are uninsured for a portion of a year, but not for a whole calendar year⁶⁰. This method identifies many more uninsured and found that 279,000 New Hampshire residents under age 65 (24.1%) were without health insurance for some period of time in the 2-year period 2007 to 2008. The majority (72.4%) were without health insurance for 6 months or more. Residents who are Hispanic (of any race) and of other than white race were more likely to be uninsured and more likely to have been without health insurance for six months or longer.

Figure 3.12



Race categories are mutually exclusive. White=white, not-Hispanic

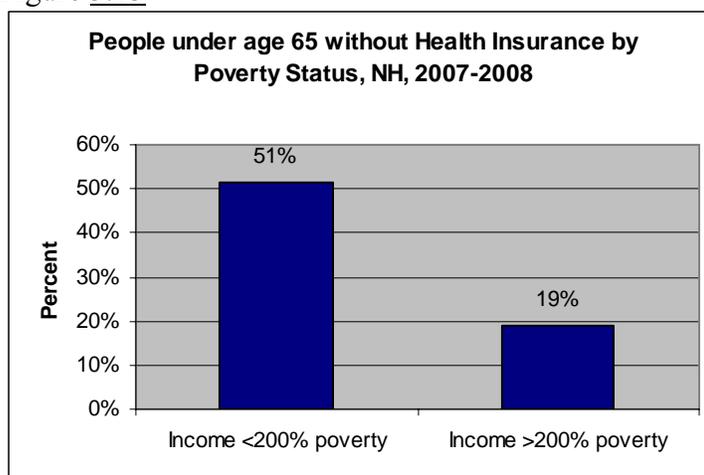
NH data not reportable for African Americans due to small sample size

Source: Families USA 2009. Data sources: Survey of Income and Program Participation (SIPP), the Current Population Survey (CPS), and the Medical Expenditure Panel Survey (MEPS), 2007-2008

⁶⁰ Families USA. (March 2009) *The Uninsured: A Closer Look, New Hampshire residents without Health Insurance*. Retrieved January 29, 2010 from <http://www.familiesusa.org/assets/pdfs/americans-at-risk.pdf>

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Figure 3.13



Source: Families USA 2009. Data sources: Survey of Income and Program Participation (SIPP), the Current Population Survey (CPS), and the Medical Expenditure Panel Survey (MEPS), 2007-2008

While public health insurance has become more available for low-income children, it remains limited and varies by state for parents and low-income adults. A minority of states provide full Medicaid benefits to working parents with incomes above the federal poverty level, and only six states nationally provide coverage to low-income, non-disabled, non-pregnant childless adults. New Hampshire is one of the seventeen states with the lowest eligibility limits for parents (<50% of FPL), and the only state in the Northeast with this low limit.⁶¹

Even with availability of coverage, national studies have found that many of the uninsured are eligible for public health insurance programs, but face barriers to enrollment or to sustaining enrollment. Barriers include lack of knowledge about program eligibility, time to complete the application and renewal process, cost of premiums for incomes above the federal poverty level, language and other barriers. It is estimated that two out of every three uninsured children in the U.S. were eligible for public coverage in 2007, but were not enrolled.⁶² Information on eligible New Hampshire children without health insurance is presented in *D. Children and Adolescents*, below.

⁶¹ Ross DC, Jarlenski M. et al. A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009. Kaiser Commission on Medicaid and the Uninsured. December 2009. Retrieved April 29, 2010 from <http://www.kff.org/medicaid/8028.cfm>

⁶² Kenney, Genevieve, PhD. (November 2009) *Uninsured and Eligible for Public Coverage: Underlying Causes and Policy Solutions*. In Expert Voices. National Institute for Health Care Management (NIHCM) Foundation. Retrieved May 7, 2010 from http://nihcm.org/pdf/EV-Kenney_FINAL.pdf

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3.B.4.d. Disparities Identified by Local Communities

The information below on local community needs was compiled from the Community Benefit Reports from each non-profit hospital in the State. New Hampshire law requires health care charitable trusts to conduct a needs assessment every five years, develop a community benefits plan that identifies priority needs and strategies, and report the prior year results to the community annually. Rapidly changing medical knowledge about all aspects of human health, new technologies to diagnose and treat diseases and expanded use of pharmaceutical products are just a few of the factors changing how health care is organized and delivered in local communities.

The graph below illustrates the top five needs from a review of the community hospital reports on file in 2008 and listed under methodology in Section 1, Process, of this report. A health care charitable trust may address a community need with on-going annual activities such as subsidizing primary care practices to maintain a community infrastructure for primary care, contribute to substance abuse efforts, etc. to prevent them from emerging as community needs.

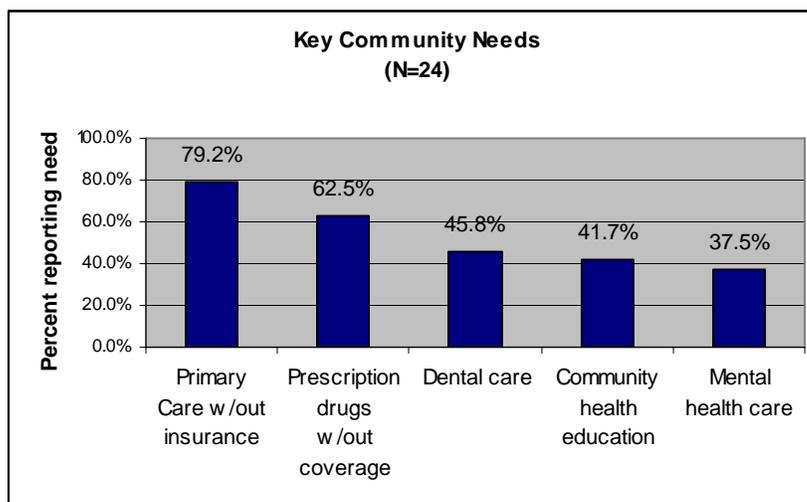
The New Hampshire Attorney General's Division of Charitable Trusts initiated a new data collection system for health care charitable trusts in 2009. It is designed to standardize and simplify data reporting and to make use of new computer software that will assist in analyzing the reports that are filed. In addition, there are new IRS reporting guidelines for all tax-exempt organizations with new reporting schedules for reporting community benefits to the federal government. General reporting categories:

- Community Health Services
- Health Professions Education (unsubsidized costs of clinical training settings)
- Subsidized Health Services: (health services operated on an on-going financial loss but continue to meet an essential need; charity care and shortfalls from government insurance programs are not included here)
- Medical Research (internal subsidies to support clinical research where the findings are made external to the organization)
- Financial Contributions (cash, grants, in-kind and resource development)

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- Community Building Activities (financial support for projects that support the quality of life)
- Charity Care: (free or discounted health care for those unable to pay)
- Government –Sponsored Health care (shortfall between government program and the actual cost)

Figure 3.14



Source: Community Needs Community Benefits, NH Hospital Association, Foundation for Healthy Communities, March 2009

Disparities for each MCH population subgroup and for each area of need are described in detail in the sections that follow.

3.C. Pregnant Women, Mothers, and Infants

3.C.1. 2010 Priorities Related to Pregnant Women, Mothers and Infants

- To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
- To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.
- To decrease the incidence of preterm births.

3.C.2. Overview

In this overview section, data are presented that describe the population of pregnant women, mothers, and infants. Highlights include a decrease in the number of New Hampshire resident births that is likely temporary, a relatively stable fertility rate, a decrease in the proportion of

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New Hampshire resident births that occur out-of-state, high and increasing uninsurance rates and the economic disparity between women and men.

Women represent half of the population of the State, with women of childbearing age making up nearly 39 percent of the total female population and nearly 20 percent of the total New Hampshire population (See Table 3.3 below)⁶³. The decrease in the number and proportion of women currently in the 25 to 34 year age group at least partially explains the decrease in the number of births we have seen over the last few years. The number of females in the youngest childbearing age subgroup (15 to 19 year old cohort) suggests that the current decrease may be temporary if the fertility rate continues to be stable.

Table 3.3

	Population	Percent of female population	Percent of total population
15 to 19 years	45,541	6.8%	
20 to 24 years	40,585	6.1%	
25 to 29 years	38,524	5.8%	
30 to 34 years	36,231	5.4%	
35 to 39 years	46,291	6.9%	
40 to 44 years	52,088	7.8%	
Total ages 15 to 44 years	259,269	38.9%	19.7%
Total female population	666,722		50.7%

Source: Population Division, U.S. Census Bureau

As mentioned in the State overview section above, women in New Hampshire, as in the U.S., are at an economic disadvantage compared to men, potentially compromising their ability to achieve and maintain good health for themselves and their families. The median earnings in the past 12 months (year-round full-time workers, in 2008 inflation adjusted dollars) for New Hampshire women was \$36,869 compared to \$52,538 for men. The disparity is greatest between women and men (25 years and older) who are not high school graduates.⁶⁴ The US Census Bureau report on

⁶³ Table 2: Annual Estimates of the Resident Population by Sex and Age for New Hampshire: April 1, 2000 to July 1, 2008 (SC-EST2008-02-33). Source: Population Division, U.S. Census Bureau. Release Date: May 14, 2009, Retrieved May 15, 2010 from <http://www.census.gov/popest/states/asrh/SC-EST2008-02.html>

⁶⁴ U.S. Census Bureau. 2006-2008 American Community Survey 3-Year Estimates Retrieved June 9, 2010 from http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=04000US33&-qr_name=ACS_2008_3YR_G00_S2001&-ds_name=ACS_2008_3YR_G00_&-redoLog=false

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income, poverty and health insurance in the U.S. 2008 showed a statistically significant decline in the female-to-male earnings ratio nationally, from .78 in 2007 to .77 in 2008.^{65,66}

The percentage of New Hampshire women with incomes below the poverty level is 8.6, compared to 6.8 percent of men.⁶⁷ Nearly 22 percent of the estimated 19.4 percent (in 2003) of New Hampshire families headed by a woman with no husband present had incomes below the poverty level compared to 5.6 percent of family households overall.⁶⁸ This percentage has increased since 2000, when 17.6 percent of female householder families lived below the poverty level⁶⁹.

Higher percentages of adult women (ages 18 to 64 years old) in New Hampshire were uninsured in 2006 (12.9%), compared to children and adolescents under age 19 (7.5% uninsured).⁷⁰ Fifteen percent of men in this age group in New Hampshire are uninsured. As described in the State overview above, New Hampshire has the highest percentage of adults without health insurance in the Northeast, and this percentage is increasing. See Figure 3.6 above.^{71,72}

The remainder of this section reviews a number of health outcomes that impact women, including issues that impact women in their roles as mothers (smoking during pregnancy, method of delivery, depression, substance abuse, etc.). In addition, broader issues in women's health and well-being are addressed by considering leading causes of death among women in the childbearing years. Finally, attention is focused on disparities with regard to teen births, maternal smoking during pregnancy and other factors.

⁶⁵ DeNavas-Walt C, Proctor BD, and Smith JC, U.S. Census Bureau, Current Population Reports, P60-236, *Income, Poverty, and Health Insurance Coverage in the United States: 2008*, U.S. Government Printing Office, Washington, DC, 2009. Retrieved June 9, 2010 from <http://www.census.gov/prod/2009pubs/p60-236.pdf>

⁶⁶ U.S. Census Bureau. Retrieved June 9, 2010 from <http://www.census.gov/hhes/www/poverty/poverty08.html>

⁶⁷ U.S. Census Bureau. 2006-2008 American Community Survey 3-Year Estimates Retrieved June 9, 2010 from http://factfinder.census.gov/servlet/STTable?_bm=y&-geo_id=04000US33&-qr_name=ACS_2008_3YR_G00_S1701&-ds_name=ACS_2008_3YR_G00

⁶⁸ U.S. Census Bureau, 2006-2008 American Community Survey 3 year estimates

⁶⁹ U.S. Census Bureau, Census 2000 Summary File 3-Sample Data

⁷⁰ US Census Bureau. Data Source: SAHIE//State and County by Demographic and Income Characteristics/2006. Available from <http://www.census.gov/did/www/sahie/data/2006/tables.html>

⁷¹ Gallup-Healthways Well-Being Index survey. *State of the States: Midyear 2009*. (August 19, 2009) Retrieved June 11, 2010 from <http://www.gallup.com/poll/122387/uninsured-highest-percentage-texas-lowest-mass.aspx>

⁷² NH Employment Security Economic and Labor Market Information Bureau. Vital Signs 2010. Available from <http://www.nh.gov/nhes/elmi/pdfzip/econanalis/vitalsigns/vs2010/VS2010health.pdf>

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This section also presents data on issues impacting infants, such as infant mortality rates, breastfeeding and preterm birth.

During the years 2004 to 2006, the leading cause of death among women ages 15 to 44 years was unintentional injuries (145 deaths), mostly due to unintentional poisoning (69 deaths) and motor vehicle crashes (63 deaths).⁷³ Three of the five leading causes of death during this period were due to intentional (suicide and homicide) and unintentional injuries. Complications of pregnancy were the cause of seven deaths during this period. Other leading causes of death are listed in Table 3.4 below.

Table 3.4
Leading Causes of Death, New Hampshire Women ages 15 to 44, 2004 – 2006

Rank	Cause of death	Number of deaths
1	Unintentional Injury	145
2	Malignant neoplasms	142
3	Suicide	48
4	Heart disease	37
5	Homicide	12
6	Cerebrovascular disease	11
7	Diabetes Mellitus	10
8	Congenital Anomalies	9
9	HIV	9
10	Complicated Pregnancy	7

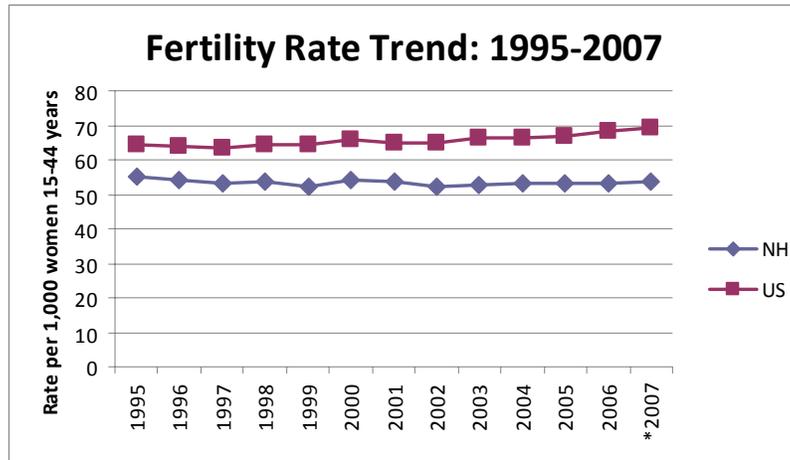
Source: CDC, NCIPC. WISQARS

⁷³ CDC National Center for Injury Prevention and Control. WISQARS. Available from <http://www.cdc.gov/injury/wisqars/fatal.html>

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Figure 3.15

The fertility rate in New Hampshire has remained steady even as the national rate has been increasing in the last few years.

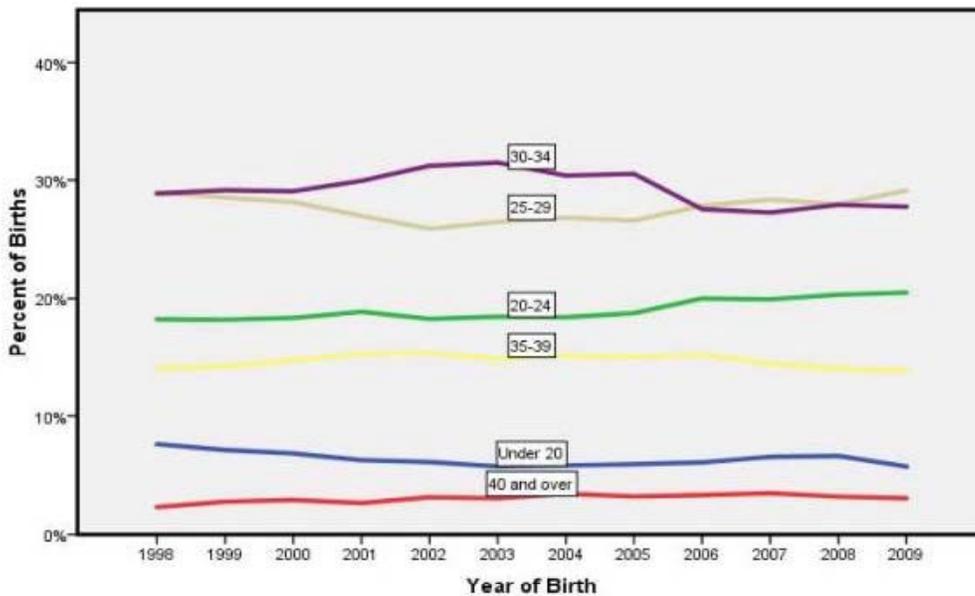


Source: National Center for Health Statistics, final natality data, retrieved May 31, 2008, from www.marchofdimes.com/peristats 2007 figure is preliminary and is from the NH data file.

While the proportional contribution of each age group to the total births in New Hampshire shows small changes, there are no striking changes to note.⁷⁴

Figure 3.16

**Age Distribution of Resident Births
Trends 1998 to 2009**



Source: NH birth data

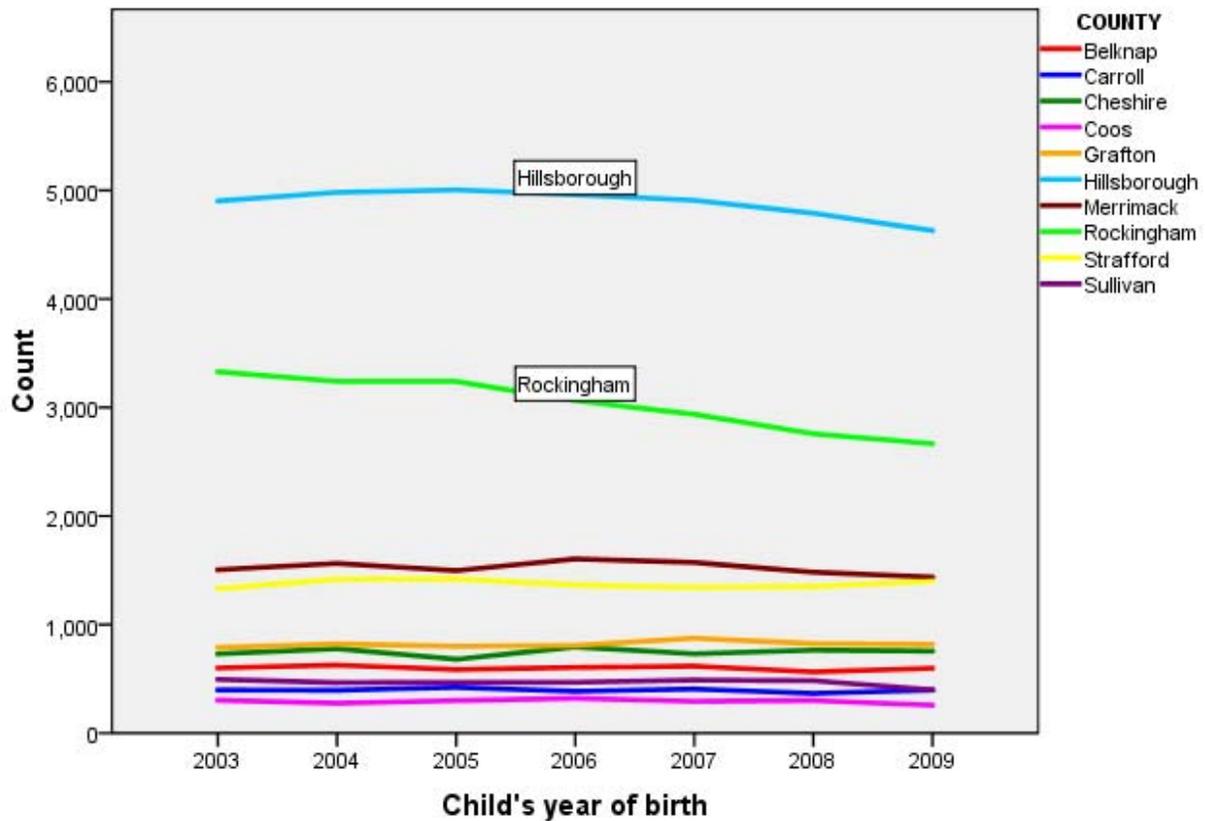
⁷⁴ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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The most populous counties (Hillsborough and Rockingham) show the largest decreases in the number of births in recent years.⁷⁵

Figure 3.17

**Number of resident births by County
(2009 preliminary)**



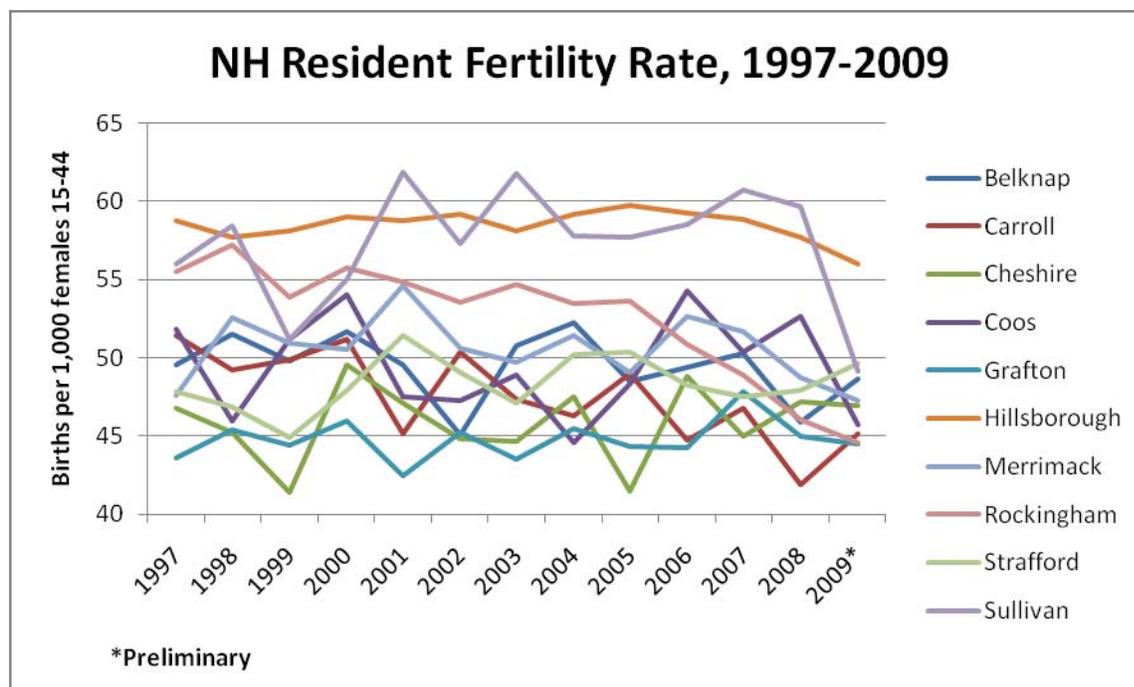
Source: NH Birth data. Includes OOS births (2009 may not be complete yet)

⁷⁵ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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The graph below indicates that Sullivan and Hillsborough counties tend to have the highest fertility rates in the state. The fertility rate is the number of births per 1,000 females age 15 to 44 years. The preliminary 2009 figures indicate that there may be a decrease in the fertility rate in many counties.⁷⁶

Figure 3.18



Source: NH birth data

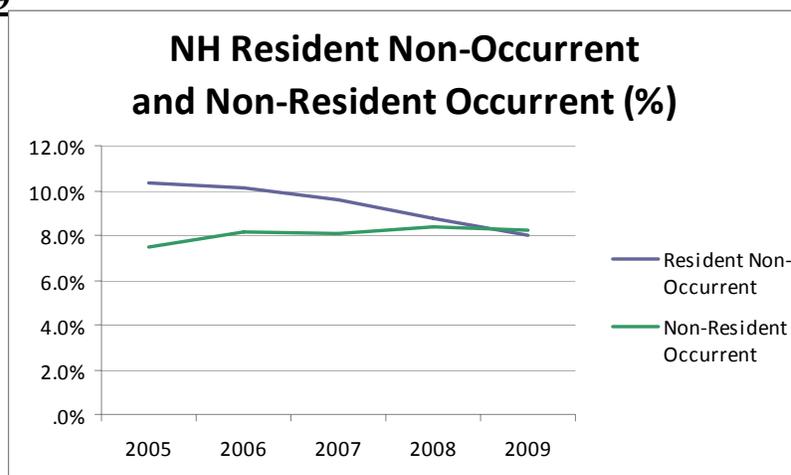
The percentage of New Hampshire resident births occurring out-of-state has been decreasing in recent years, perhaps due to the advanced perinatal services that have been added by some hospitals in southern New Hampshire. Non-resident births occurring in New Hampshire have remained stable.⁷⁷

⁷⁶ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

⁷⁷ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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Figure 3.19



Source: NH birth file

NOTES:

2009 Data Not Complete (2-23-10)

Occurrent births occurred in NH.

Non-Occurrent births did not occur in NH (but are NH resident births)

Percent is of all births in data file (both residents and non-residents, occurrent and non-occurent)

3.C.3. Strengths

As mentioned earlier, New Hampshire ranks high on many indicators of health. Between 1990 and 2007, New Hampshire ranked in the top two states for the percent of women receiving adequate PN care (Kessner index)⁷⁸. New Hampshire also continues to have the lowest teen birth rate in the nation. While still high, the cesarean birth rate does not appear to be continuing the upward trend seen in previous years.⁷⁹ In 2010, legislation passed that will create a maternal mortality review committee to address systems issues related to maternal deaths.

New Hampshire’s infant mortality rate continues to be among the lowest in the nation. The low birth weight and preterm birth rates are also among the lowest in the nation.

The Northern New England Perinatal Quality Indicators group is an active asset and partner in New Hampshire continuously working collaboratively to improve the health of infants.

⁷⁸ United Health Foundation’s America’s Health Rankings, 2009

⁷⁹ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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The New Hampshire DPHS MCH Section Perinatal Client Data Form (PCDF) data system is now online and beginning to provide previously unavailable information for Title V funded prenatal agencies in New Hampshire. New Hampshire is also fortunate to have one of the most mature all-payer health claims databases in the country. Historical data have accumulated in the system to a point where trends can now be examined. Improvements in the capture of healthcare encounter information for the uninsured have been made in the legislature that will provide a new source of information on the most vulnerable populations in the next few years.

3.C.4. Needs

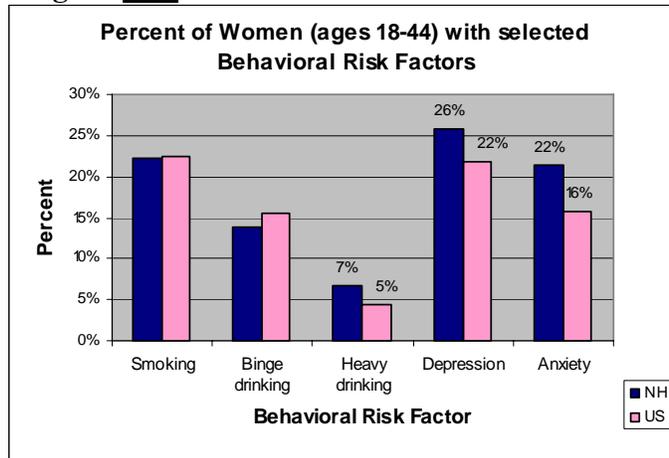
3.C.4.a. Summary

In this population group of pregnant women, mothers and infants, the priority needs are in the areas of substance use and abuse, preterm birth and access to healthcare. In addition, this section also highlights needs in the areas of prenatal care data, elective cesarean sections, teen births, perinatal and parental depression, pre-pregnancy Body Mass Index, gestational weight gain, sexual and physical assault, breastfeeding data quality, and infant mortality.

Behavioral Risk Factors Among Women of Childbearing Age

According to the BRFSS, New Hampshire women of childbearing age (18 to 44 years) report heavy drinking (7% in 2005) and experiencing depression (26% in 2006) and anxiety (22% in 2006) at rates statistically significantly higher than the U.S. average. Twenty two percent of women in this age group reported smoking, and 14 percent reported binge drinking, similar to national rates. Tobacco and alcohol abuse, as well as mental health issues impact the health of women and that of their children. These issues are described in detail below in this section.

Figure 3.20



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Values are displayed for factors where differences are statistically significantly different from the U.S

Data Source: Health Statistics and Data Management Section (HSDM), New Hampshire Behavioral Risk Factor Surveillance System (BRFSS) 2006. Binge and heavy drinking=2005 data

3.C.4.b. Substance Abuse

Directly Related Needs Assessment Priority: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

Substance use among pregnant and postpartum women is a serious public health problem in New Hampshire and in the U.S. National data consistently show that pregnant women report using tobacco, alcohol and other substances in the previous month. Early exposure to substance abuse impacts children's life use, dependence, abuse, as well as development, mental health, violence, injury, pregnancy, and infection rates.

- o Every year, an estimated 703 New Hampshire infants (4.6 percent of all) are exposed to marijuana and 2,903 (19.0 percent) are exposed to alcohol during the first trimester of pregnancy⁸⁰
- o 37,727 (11.9 percent) of New Hampshire children have parents who are abusing substances⁸¹

Substance abuse treatment capacity continues to be a problem in New Hampshire:⁸²

- o Current substance abuse treatment capacity exists to treat <10 percent of the need
- o A scarcity of Licensed Alcohol and Drug Abuse Counselors (LADC's) exists in the State
- o New Hampshire spends >\$10 million to directly treat drug/alcohol problems (half consists of federal funds)

3.C.4.c. Maternal Smoking During Pregnancy

Directly Related Needs Assessment Priority: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

⁸⁰ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (May 21, 2009). *The NSDUH Report: Substance Use among Women During Pregnancy and Following Childbirth*. Rockville, MD

⁸¹ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (May 21, 2009). *The NSDUH Report: Substance Use among Women During Pregnancy and Following Childbirth*. Rockville, MD

⁸² NH DHHS, 2007. NH Plan for overcoming the impact of alcohol & other drug problems

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Smoking during pregnancy accounts for 20 to 30 percent of low-birth weight babies, up to 14 percent of pre-term deliveries and about 10 percent of all infant deaths.⁸³ In New Hampshire from 2005-2007, 16 percent of women reported smoking during pregnancy.⁸⁴ In 2007, 21.7 percent of New Hampshire women of childbearing age (18-44 years) reported smoking, compared to 21.2 percent of women overall in the U.S.⁸⁵ These women are at risk for smoking during pregnancy.

The total smoking-attributable neonatal costs in New Hampshire are estimated at \$1,682,192 (1996 dollars).⁸⁶ This amounts to \$2,276,898 in 2009 dollars.

It is estimated that every \$1 spent on tobacco intervention saves \$3 in future health care costs.⁸⁷

In New Hampshire:

- 6.3 percent of infants born in 2007 were low birth weight (<2500 grams)
- 43.2 percent of women using MCH-funded pre-natal clinics smoked 3 months prior to becoming pregnant (7/1/07-6/4/09)⁸⁸
- 100,857 children (32.5 percent) of New Hampshire children ages 0 – 17 live in a household where someone smokes (2003)⁸⁹

⁸³ U.S Department of Health and Human Services. Women and Smoking: A Report of the Surgeon General, 2001.

⁸⁴ NH DHHS DPHS Maternal and Child Health Section. (2008) Data source: NH birth data.

⁸⁵ March of Dimes.org (data source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention.)

⁸⁶ MMWR 10/8/04 53(39);915-917. State estimates of neonatal health care costs associated with maternal smoking-US 1996. (SAMMEC)

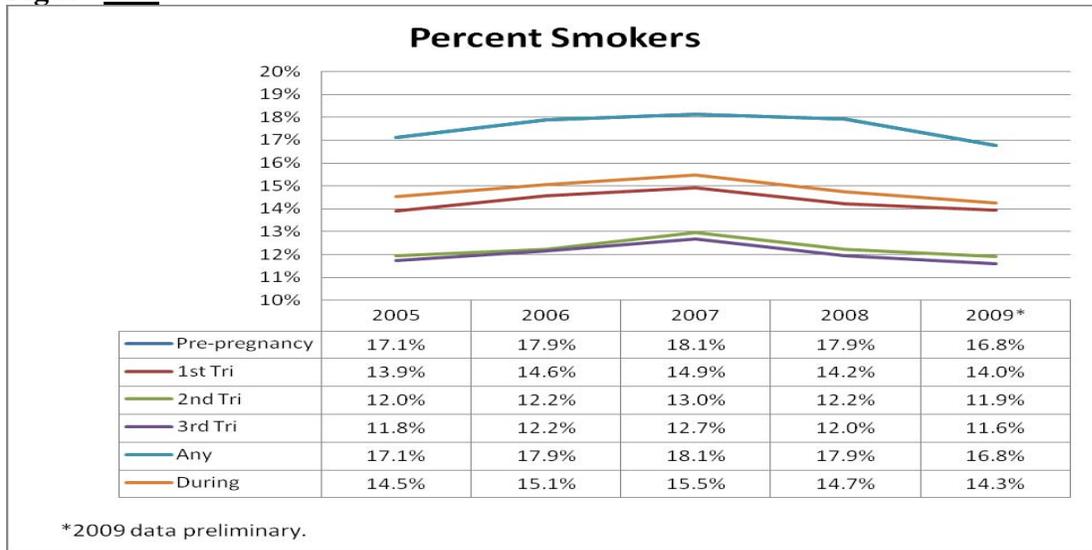
⁸⁷ Ayadi, MF et al. *Costs of smoking cessation counseling Intervention for pregnant women: Comparison of three settings*. Public Health Reports; Vol 121; 120-126; Mar-Apr 2006

⁸⁸ NH DHHS DPHS Maternal and Child Health Section. (2008) Data source: NH birth data

⁸⁹ NH Tobacco Data 2000-2007, NHDHHS DPHS Tobacco Prevention and Control Program (data source: BRFSS)

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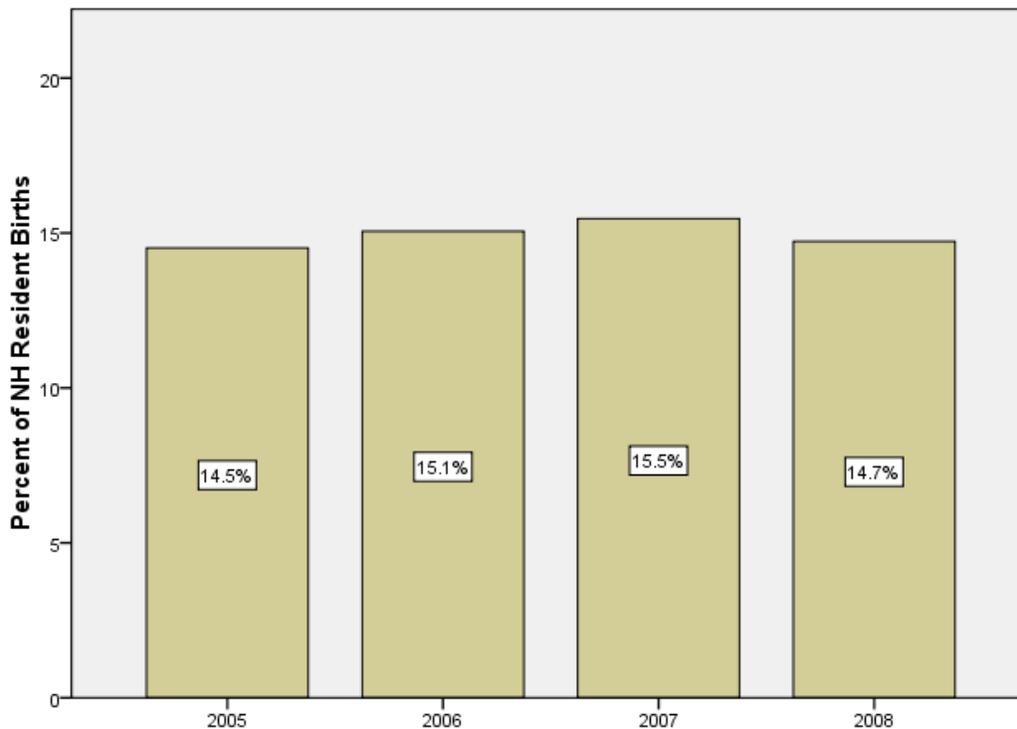
Figure 3.21



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Figure 3.22

**Maternal Smoking DURING pregnancy
2005-2008**

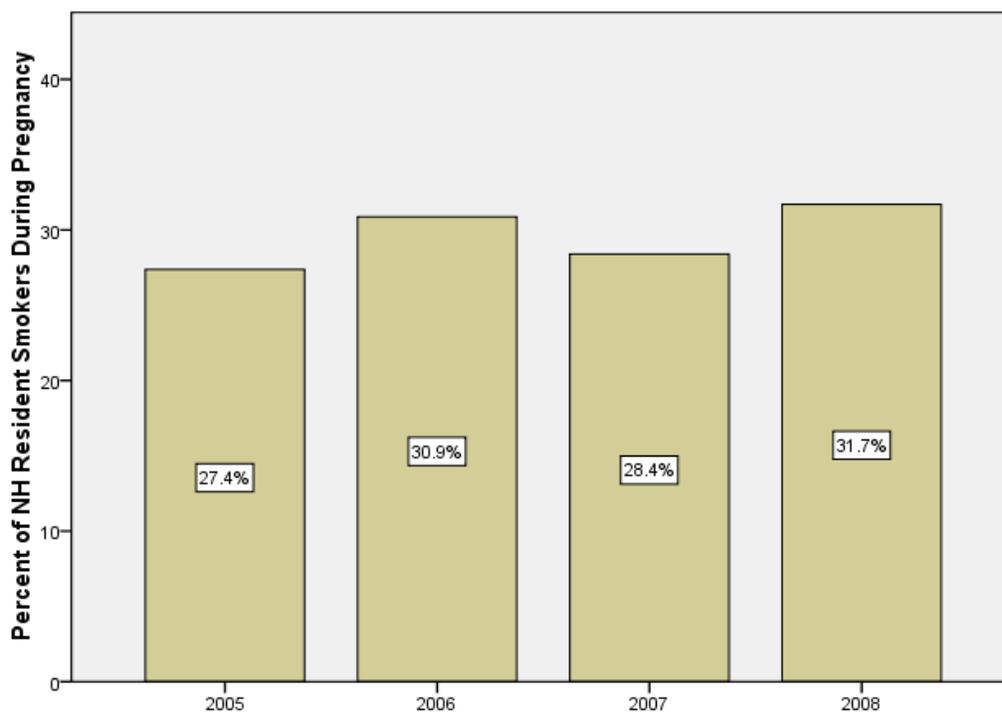


Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)
Smoking During Pregnancy-Assumes no smoking even if one or more (but not all 3) smoking fields are missing
 AND no positive responses are recorded AND at least one negative response is recorded.

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Figure 3.23

Quit by 3rd Trimester 2005-2008



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Quit by Third Trimester - Categorizes person as “quit” where at least one of the first three time points indicates smoking and the final time point (3rd tri) indicates no smoking.

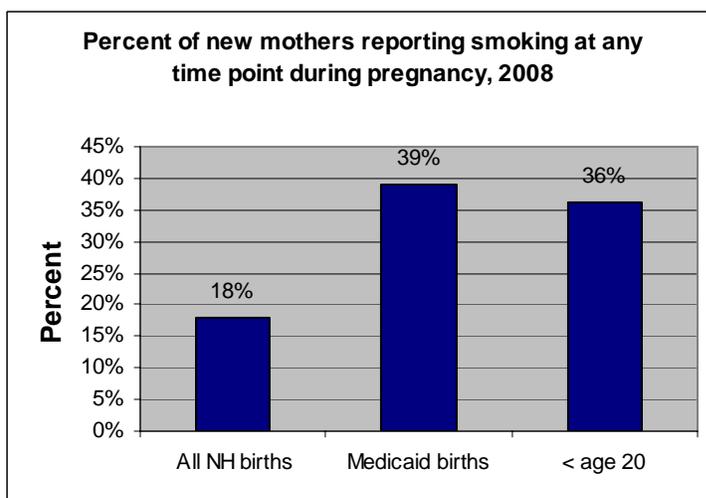
Disparities in Smoking Rates

There are disproportionate effects among certain subpopulations. Analysis of New Hampshire birth data for the years 2005 to 2009 revealed that mothers with Medicaid as the payer for their infant’s birth were more likely to report smoking pre-pregnancy and during each trimester of pregnancy and were less likely to quit by the third trimester than women for whom the payer was not Medicaid (Figure 3.24 below). Since 1990, teens and young adults have had the highest rates of maternal smoking during pregnancy. Mothers who were under 25 years old were more likely to report smoking; however, they were just as likely as mothers over 25 to quit by the third trimester. In 2008, 39 percent of New Hampshire women on Medicaid smoked during pregnancy.⁹⁰ Figure 3.25 below. A downward trend was noted in smoking rates among women on Medicaid that was not observed among the non-Medicaid women. Figure 3.27 below.

⁹⁰ DHHS DPHS Maternal and Child Health Section (2010) NH birth data.

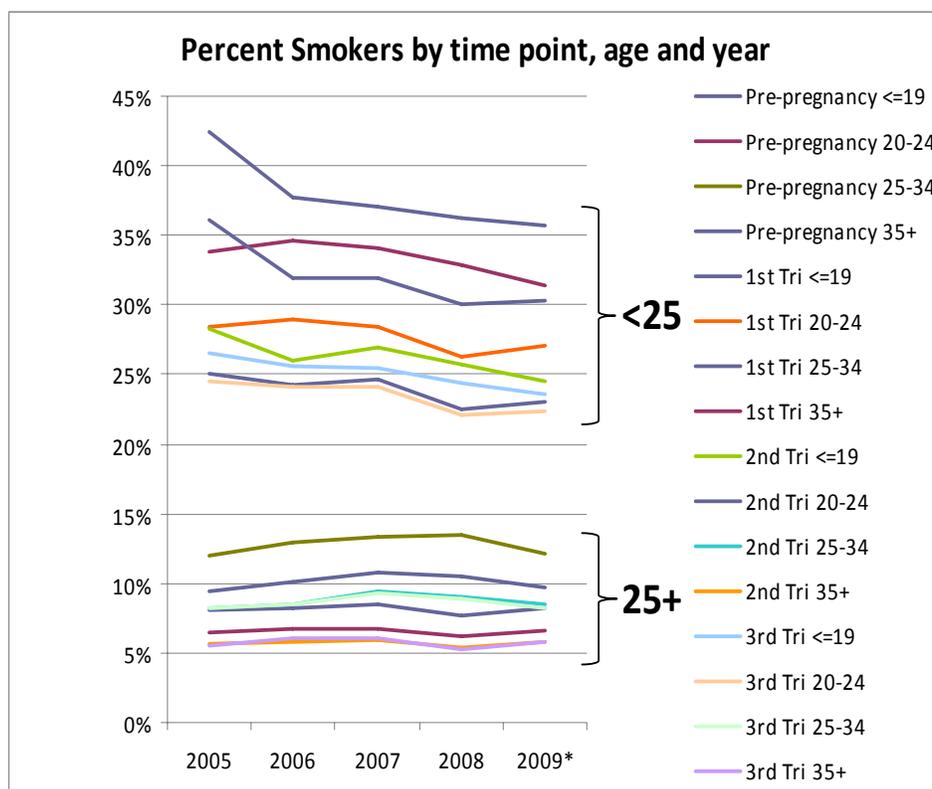
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Figure 3.24



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

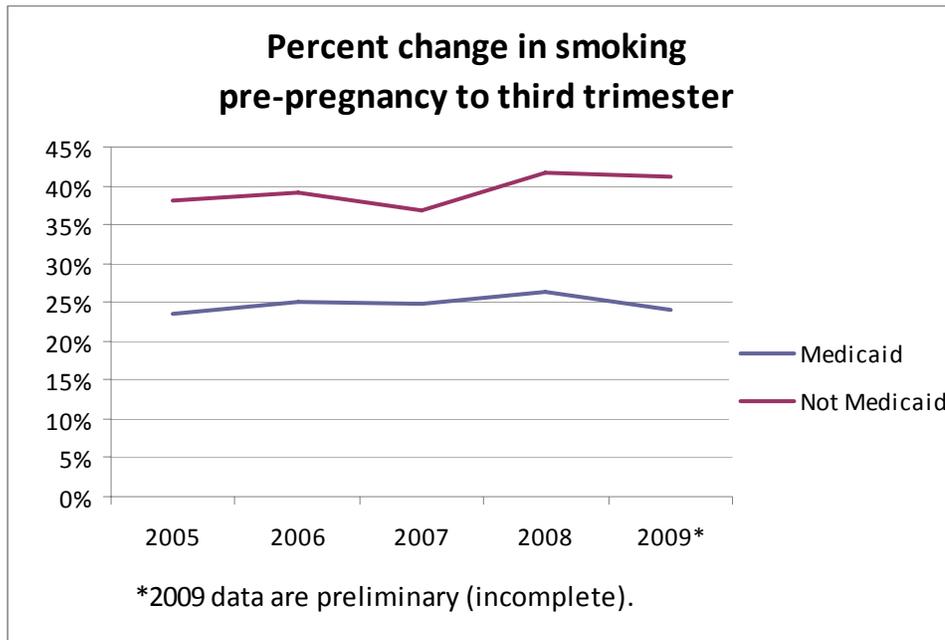
Figure 3.25



Source: NH birth data

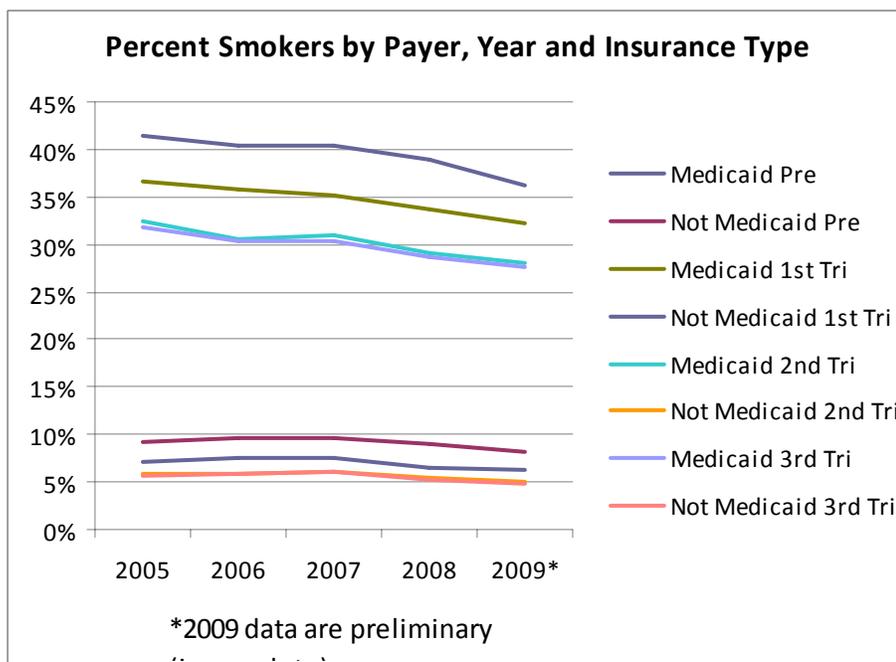
**Section 3: Strengths/Needs of the MCH Population Groups and Desired Outcomes
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Figure 3.26



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Figure 3.27



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

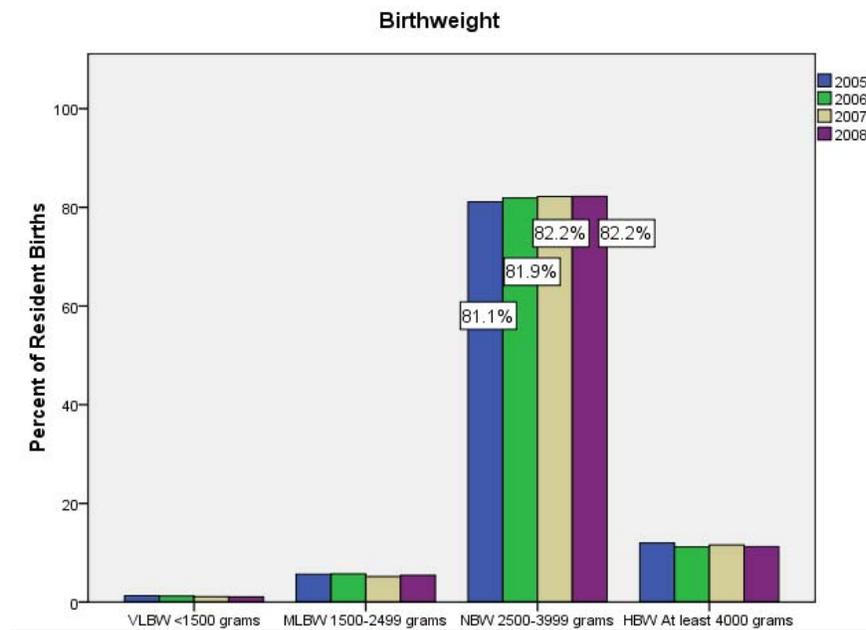
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3.C.4.d. Preterm Birth

Directly Related Needs Assessment Priority: To decrease the incidence of preterm birth.

Preterm birth has enormous health, social and economic costs. It increases the risk of infant mortality and of serious health consequences such as cerebral palsy, blindness and developmental difficulties, and can impact a person throughout their life span depending on severity of their health condition. Smoking increases the risk of preterm delivery (before 37 weeks of gestation)⁹¹ One study found that an interval of less than 18 months between birth and the beginning of the next pregnancy increased the risk of preterm labor, though the greatest risk was with intervals shorter than 6 months⁹² Interventions such as reducing maternal smoking have the potential to reduce the preterm birth rate and improve the health of infants and children and are within the scope of Title V responsibilities in expanding preconception care. Rates of preterm birth have been increasing in New Hampshire and nationally, though there is evidence of a possibly decreasing trend beginning in 2007. Disparities are evident among racial, ethnic and socioeconomic groups.⁹³

Figure 3.28



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

⁹¹ Centers for Disease Control and Prevention (CDC). What Do We Know About Tobacco Use and Pregnancy? June 11, 2007.

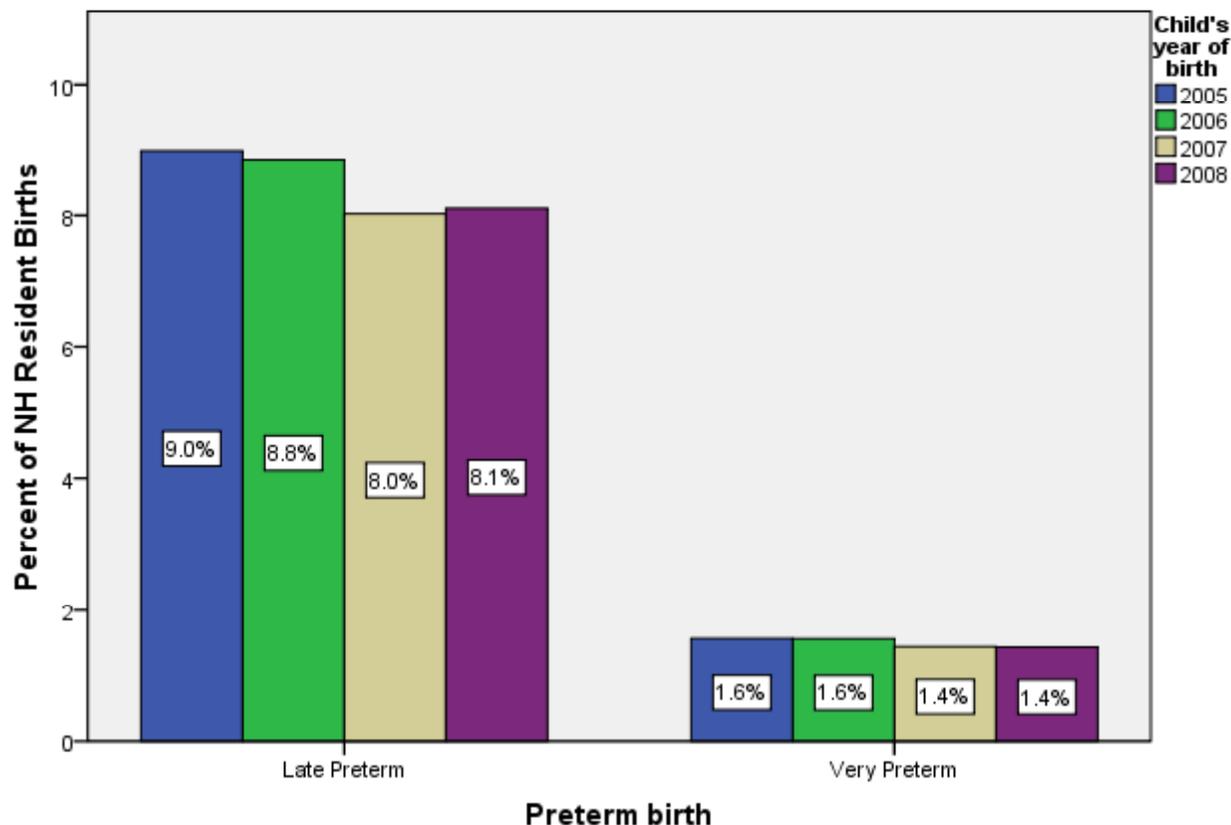
⁹² Conde-Agudelo, A., et al. Birth Spacing and Risk of Adverse Perinatal Outcomes. *Journal of the American Medical Association*, volume 295, number 15, April 19, 2006, pages 1809-1823

⁹³ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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Figure 3.29

Very (<32 wks) and Late (32-36 wks) Preterm Births by Year



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Note: the NCHS gestational age imputation algorithm was applied for comparability to national statistics.

3.C.4.e. Mental Health - Perinatal and Parental Depression

Depression among pregnant women and parents can have serious health consequences for the women and their families, and the impact can last well past childhood. The adult children of depressed parents had three times the rate of major depression, anxiety disorders, and substance abuse compared with children of non-depressed parents.⁹⁴ In addition, children of depressed

⁹⁴ Weissman, M.M., Wickramaratne, P., Noomura, Y., Warner, V., Pilowsky, D., & Verdelli, H. (2006) Offspring of depressed parents: 20 years later. *American Journal of Psychiatry*, 163, 1001-1008.

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parents had higher rates of medical problems and mortality.⁹⁵ In an American sample of 5,000 mother-infant pairs, researchers found that children of depressed mothers had more behavior problems and lower vocabulary scores at age 5.⁹⁶

- o 10 to 20 percent of women who deliver develop clinically significant mood disorders⁹⁷
- o 4.9 percent of mothers screened positive for at risk for major depression in six pediatric practices in New Hampshire and 5.4 percent fathers screened positive at risk for major depression⁹⁸
- o The lifetime prevalence of major depression is 20 to 26 percent for women and 8 to 12 percent for men⁹⁹
- o 10 percent of post-partum women who responded to a mail survey at 3 months post-partum scored in the depressed range.¹⁰⁰

The New Hampshire Behavioral Risk Factor Surveillance System (BRFSS) showed that 3.2 percent of residents reported serious psychological distress (SPD) (an indicator of serious mental illness) in 2007.¹⁰¹ The prevalence did not vary by region, but did vary by sex, age group, income, employment status and other factors. Women were more likely to report SPD than men (63.6 percent of adults with SPD were women). SPD rates were also higher among residents with lower income: 31 percent of those with SPD reported incomes less than \$30,000 per year.

Women experience depression at twice the rate of men. This two to one ratio exists regardless of racial or ethnic background or economic status. The lifetime prevalence of major depression is

⁹⁵ Weissman, M.M., Wickramaratne, P., Noomura, Y., Warner, V., Pilowsky, D., & Verdelli, H. (2006) Offspring of depressed parents: 20 years later. *American Journal of Psychiatry*, 163, 1001-1008.

⁹⁶ Brennan, P.A. Hammen, C., Anderson, M.J., Bor, W., Najam, J.M., & Williams, G.M. (2000). Chronicity, severity and timing of maternal depressive symptoms: relationships with Child outcomes at age 5. *Developmental psychology*, 36, 759-766.

⁹⁷ www.treatment4addiction.com accessed 7/1/09

⁹⁸ Olsen, A Department of Pediatrics, Dartmouth Medical School, February 27, 2009

⁹⁹ http://www.dbsalliance.org/site/PageServer?pagename=about_statistics_depression

¹⁰⁰ from a 2005-2006 survey of pregnant and postpartum women from 4 OB offices that delivered at Concord Hospital.

¹⁰¹ Data source: NH DHHS DPHS BHSDM Behavioral Risk Factor Surveillance Survey 2007.

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20 to 26 percent for women and 8 to 12 percent for men.¹⁰² Low SES women are at a higher risk because of lack of resources available¹⁰³

Treatment capacity continues to be a problem in New Hampshire:

- State and federal support to New Hampshire's community mental health centers was reduced between 1997-2007¹⁰⁴
- New Hampshire primary care providers provide mental health services to over 100,000 people per year with mental health disorders¹⁰⁵
- Low Medicaid & private insurance reimbursement rates exist for mental health disorders¹⁰⁶
- Parity in insurance coverage has not been achieved¹⁰⁷
- Northern New Hampshire is a designated Mental Health Professional Shortage Area (MHPSA)¹⁰⁸

3.C.4.f. Adequacy of Prenatal Care

As noted in the Methods section of this report, we continue to experience data limitations related to the irregular state-by-state implementation of the (national) 2003 revised vital certificate worksheets. Approximately 10 percent of New Hampshire resident births (and a similar proportion of deaths) occur out-of-state.¹⁰⁹ Our border states have been slower in adopting the latest vital records certificate versions. While some variables can be mapped across versions, others are not comparable. Perhaps the most notable area with this problem is in the timing of prenatal care. We cannot produce accurate statistics related to timing of prenatal care at the population level for a period of several years (ongoing). While we can compute system-level statistics (all events that occur in New Hampshire), we know from previous data that the group of New Hampshire residents getting care outside of the state differs in significant ways from the

¹⁰² http://www.dbsalliance.org/site/PageServer?pagename=about_statistics_depression

¹⁰³ www.nhbreastfeedingtaskforce.org accessed 7/1/09

¹⁰⁴ NH Ctr for Public Policy Studies report, August 2007

¹⁰⁵ NH Ctr for Public Policy Studies report, August 2007

¹⁰⁶ NH Commission to Develop a Comprehensive State Mental Health Plan, 2007. Fulfilling the Promise: Transforming NH's mental health system. Report of the Mental Health Commission.

¹⁰⁷ NH Commission to Develop a Comprehensive State Mental Health Plan, 2007. Fulfilling the Promise: Transforming NH's mental health system. Report of the Mental Health Commission.

¹⁰⁸ NH Department of Health and Human Services (DHHS) Rural Health and Primary Care section. A.G. Druzba (Personal communication April 12, 2010)

¹⁰⁹ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

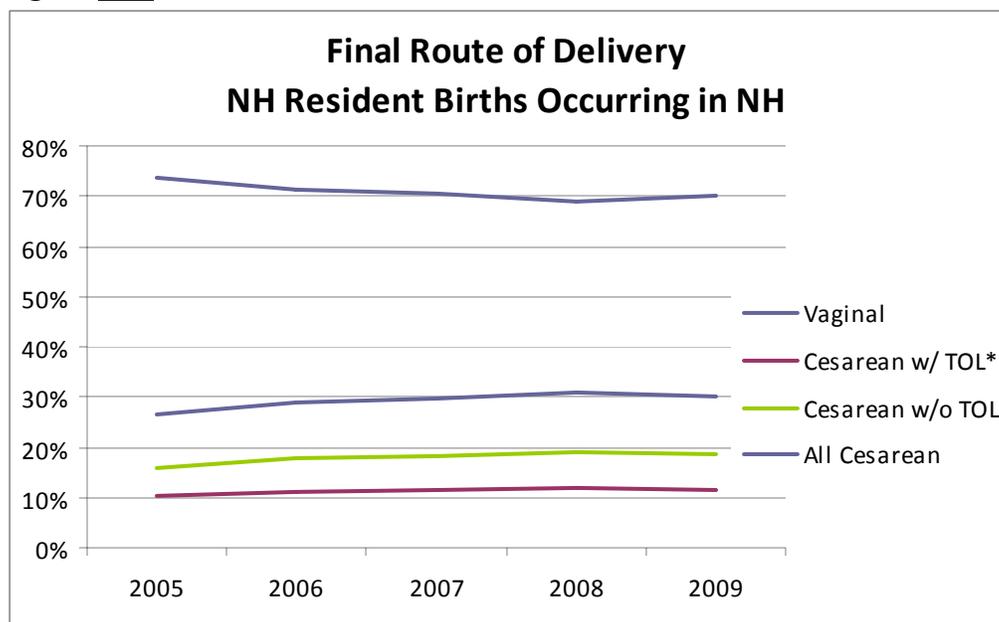
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group getting care within the state system. Many women with high risk pregnancies seek care in specialty hospitals just over the New Hampshire border in Massachusetts.

3.C.4.g. Cesarean Section Deliveries

Cesarean births, especially those without a trial of labor, have increased and then leveled off over the last few years in New Hampshire.

Figure 3.30



TOL=trial of labor

Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Several prominent organizations (e.g. ACOG & AAP) have issued guidelines discouraging elective (medically unnecessary) cesarean sections before 39 completed weeks of gestation in the absence of clear medical indication. Evidence is mounting regarding the effects of early cesarean sections on outcomes such as perinatal complications and decreased math and reading scores.

Our analysis examined a subset of the births occurring in New Hampshire from 2005 through 2008 comprised of low risk women as identified by exclusionary criteria documented on the birth certificate. By isolating this group of women in each hospital, the need for a “case mix” adjustment (i.e. accounting for differences in the types of patients each hospital sees) is negated.

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The analysis examined the proportion of low risk women who gave birth prior to 39 weeks by cesarean section (i.e. potentially elective), stratified by whether or not there was a trial of labor. Large variation across hospitals and providers was identified.¹¹⁰

We have worked with the Northern New England Perinatal Quality Indicators Group, based at Dartmouth Medical School, to share these findings with clinical professionals at birth hospitals throughout New Hampshire. Future analyses are planned using a linked birth and hospital discharge data file to improve identification of the low risk group.

3.C.4.h. Teen Births

New Hampshire is often ranked the first or second best in the nation for the teen birth rate (births per 1,000 females 15 to 19 years old).¹¹¹ The most recent NCHS state-level estimate is from 2006. New Hampshire data files suggest that the rate continues to be stable through 2008. Preliminary data for 2009 suggest the rate may have declined to an all-time low.

The 2007-2009 New Hampshire rates may differ from other estimates based on alternate data sources. The choice of population denominators often accounts for slight differences between the New Hampshire DPHS and National Center for Health Statistics (NCHS) estimates. The New Hampshire Health Statistics and Data Management Section supplies proprietary population estimates developed in-house. This allows New Hampshire DPHS staff to produce estimates more quickly than NCHS public releases. As an example of the differences sometimes seen, the 2006 NCHS estimate for the teen birth rate was 18.7 while the New Hampshire estimate was 18.1. In 2005, the NCHS estimate was 17.9 and the New Hampshire estimate was 18.1. As of the writing of this report, the last available year from an NCHS final birth report is 2006.

The 2008 New Hampshire teen birth rate was 18.4. The 2009 rate appears to be substantially lower, but it is still too early to tell (data are still coming in from out-of-state New Hampshire resident births).¹¹²

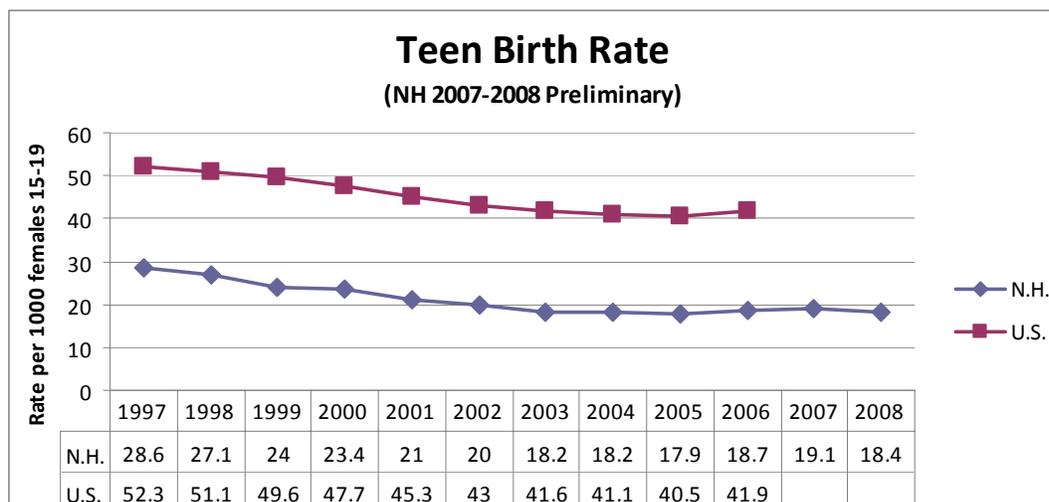
¹¹⁰ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

¹¹¹ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹¹² NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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Figure 3.31



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

Teen mothers and their children face poorer educational, health, developmental and economic outcomes than their peers who delay childbearing. Repeat teen births compound these problems. The percentage of teen births that are repeat teen births generally mirrors a state’s percentage of teen births. Factors associated with repeat births include Hispanic ethnicity and non-Hispanic Black race.¹¹³ New Hampshire’s low proportion of minority populations may account for the low rates of teen births and repeat teen births.

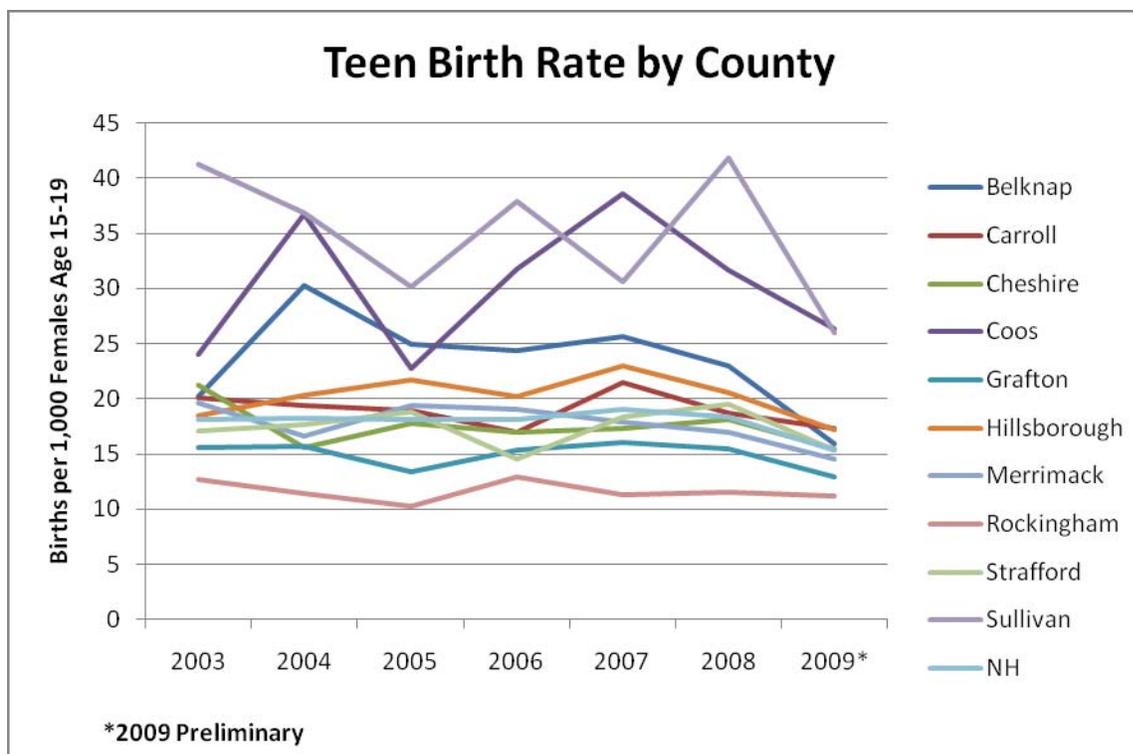
Disparities in Teen Births

Sullivan, Coos, and Belknap counties have historically had higher teen birth rates than other larger and less rural counties. Belknap County appears to be making the most progress in closing the gap in teen birth rate with the rest of the state. The overall state decline appears to be occurring in all counties when examining 2009 preliminary data.

¹¹³ Schelar E, Franzetta K and Manlove J PhD. Child Trends Research Brief October 2007 publication number 2007-23. *Repeat Teen Childbearing: Differences across States and by Race and Ethnicity*. www.childtrends.org, accessed 5/6/10.

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Figure 3.32



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

3.C.4.i. Prepregnancy Body Mass Index and Gestational Weight Gain

Several studies have linked gestational weight gain to postpartum weight retention (i.e. contributor to obesity). The Institute of Medicine (IOM) released new guidelines for weight gain in pregnancy in mid 2009.¹¹⁴ The new guidelines are based on WHO BMI (Body Mass Index) cutoffs instead of Met Life tables and include a specific, relatively narrow range, for obese women (these are the main differences from the 1990 guidelines). Additionally, there are no longer separate recommendations for adolescents. Table 3.5 below presents the new guidelines based on starting (pre-pregnancy) BMI.

¹¹⁴ Institute of Medicine (May 2009) Weight Gain During Pregnancy: Reexamining the Guidelines. Report Brief. Retrieved June 8, 2010 from <http://www.iom.edu/~media/Files/Report%20Files/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines/Report%20Brief%20-%20Weight%20Gain%20During%20Pregnancy.ashx>

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Table 3.5¹¹⁵

TABLE 1 NEW RECOMMENDATIONS FOR TOTAL AND RATE OF WEIGHT GAIN DURING PREGNANCY, BY PREPREGNANCY BMI

Prepregnancy BMI	BMI+ (kg/m ²) (WHO)	Total Weight Gain Range (lbs)	Rates of Weight Gain* 2nd and 3rd Trimester (Mean Range in lbs/wk)
Underweight	<18.5	28–40	1 (1–1.3)
Normal weight	18.5-24.9	25–35	1 (0.8–1)
Overweight	25.0-29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

+ To calculate BMI go to www.nhlbisupport.com/bmi/

* Calculations assume a 0.5–2 kg (1.1–4.4 lbs) weight gain in the first trimester (based on Siega-Riz et al., 1994; Abrams et al., 1995; Carmichael et al., 1997)

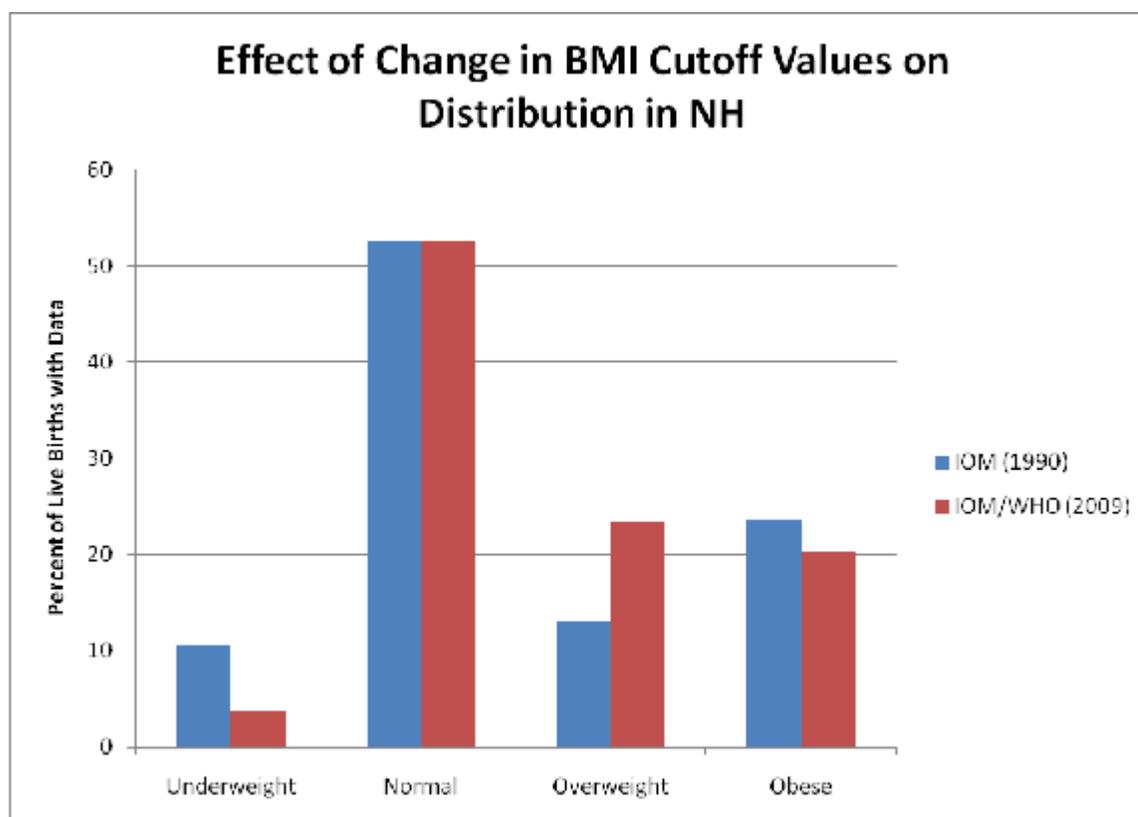
Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

¹¹⁵ Institute of Medicine (May 2009) Weight Gain During Pregnancy: Reexamining the Guidelines. Report Brief. Retrieved June 8, 2010 from <http://www.iom.edu/~media/Files/Report%20Files/2009/Weight-Gain-During-Pregnancy-Reexamining-the-Guidelines/Report%20Brief%20-%20Weight%20Gain%20During%20Pregnancy.ashx>

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When the effect of the guideline change is examined for women giving birth in New Hampshire from 2005 to 2009, it can be seen in the graph below that the distribution shifted to the right. That is, there are now fewer women categorized as underweight and more women categorized as overweight by pre-pregnancy BMI.¹¹⁶

Figure 3.33



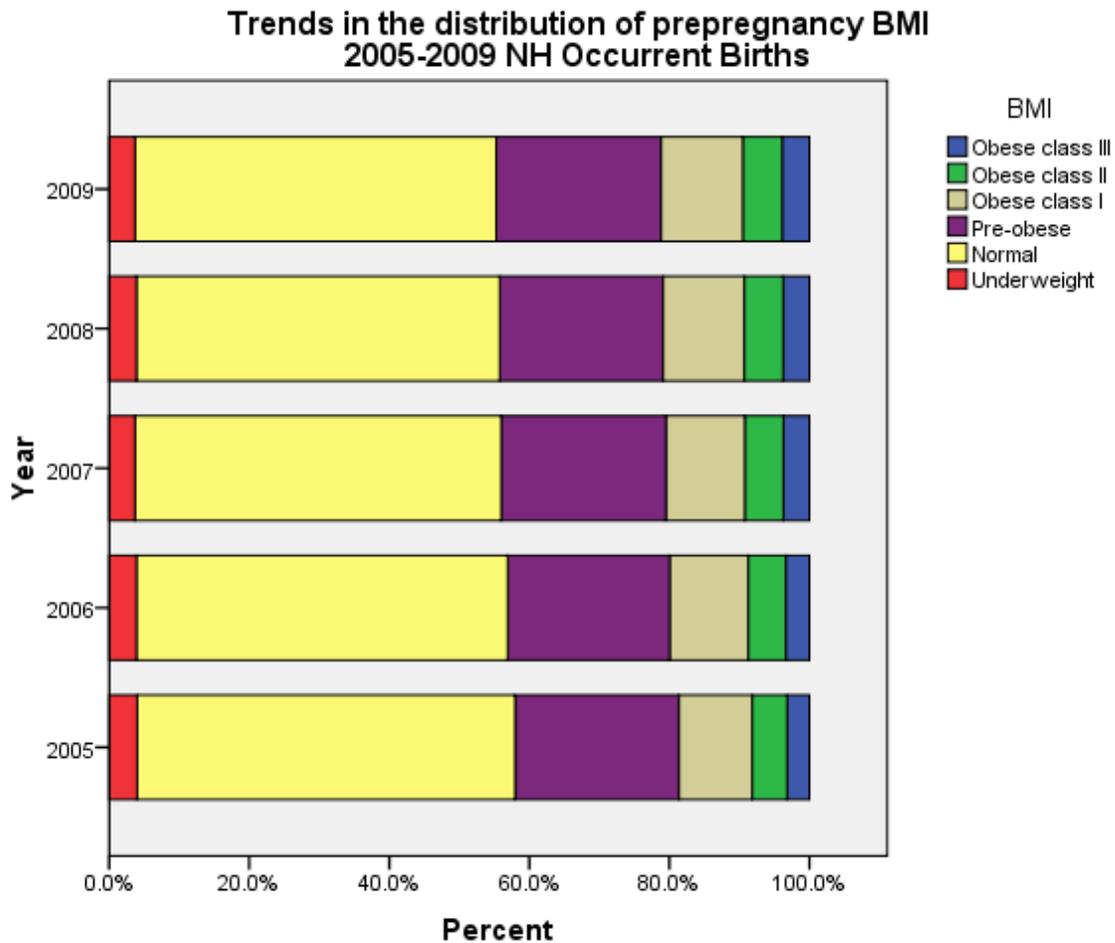
Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

¹¹⁶ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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The graph below illustrates the growing proportion of women categorized with an above normal BMI (increasing size of area to the right of the yellow Normal category bar section) at pre-pregnancy over a 5-year period.

Figure 3.34



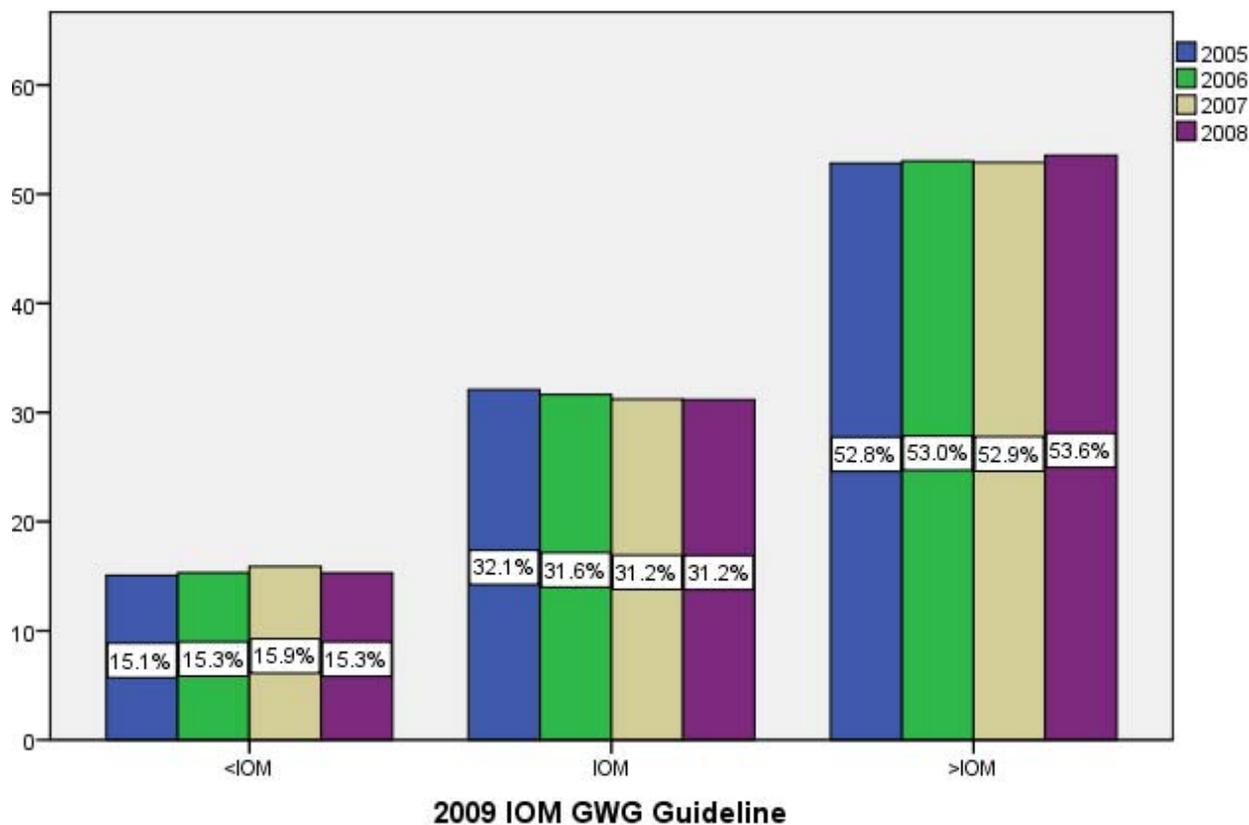
Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

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The graph below shows that more than half of New Hampshire women gain more than the recommended amount of weight during pregnancy. Less than a third of women giving birth in New Hampshire fall within the recommended guidelines for gestational weight gain.¹¹⁷

Figure 3.35

**Percent meeting 2009 IOM guidelines
2005-2008 resident births occurring in NH**



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

When examining the proportion of women who meet the IOM guidelines by their starting (pre-pregnancy) BMI, the graph below shows that a large proportion of women in each group gains

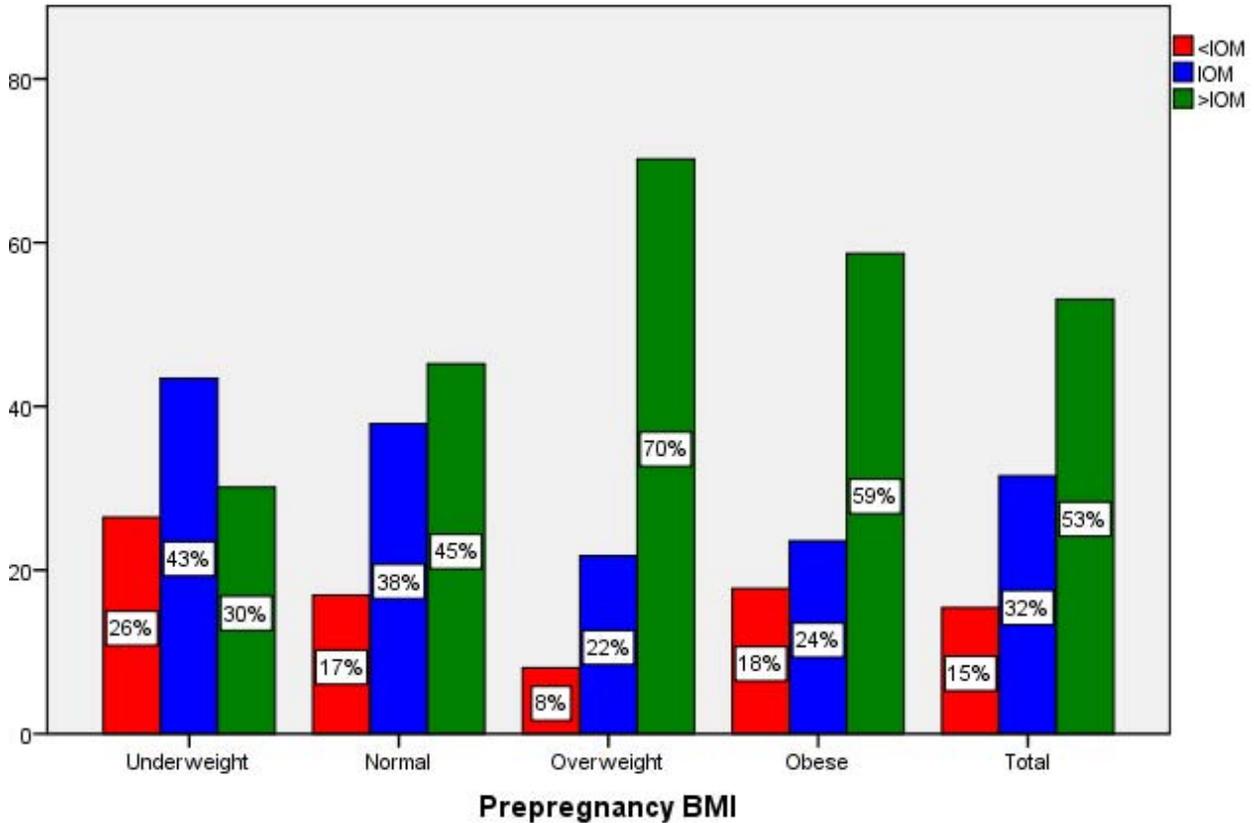
¹¹⁷ Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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more than recommended. A majority of women who begin pregnancy with a BMI categorized as overweight or obese gain more than the recommended amount. Notably, 70 percent of women who begin pregnancy with an overweight BMI gain more than recommended. This proportion drops to 59 percent in the obese group.¹¹⁸

Figure 3.36

**Percent within BMI category by 2009 IOM Guideline (GWG)
2005-2008 resident births occurring in NH**



Source: NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section

3.C.4.j. Physical and Sexual Assault: Women

The New Hampshire Violence Against Women Survey was conducted in 2006 in conjunction with partners at the University of New Hampshire and the New Hampshire Coalition Against Domestic and Sexual Violence.¹¹⁹ A similar survey of men was conducted in 2007. Survey

¹¹⁸ NH DHHS Division of Public Health Services (DPHS) Maternal and Child Health Section (MCHS)

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items from the 1996 Violence Against Women Survey were replicated to ensure comparability. Highlights of the findings from the women's survey noted below call attention to the magnitude and characteristics of the problem in New Hampshire.

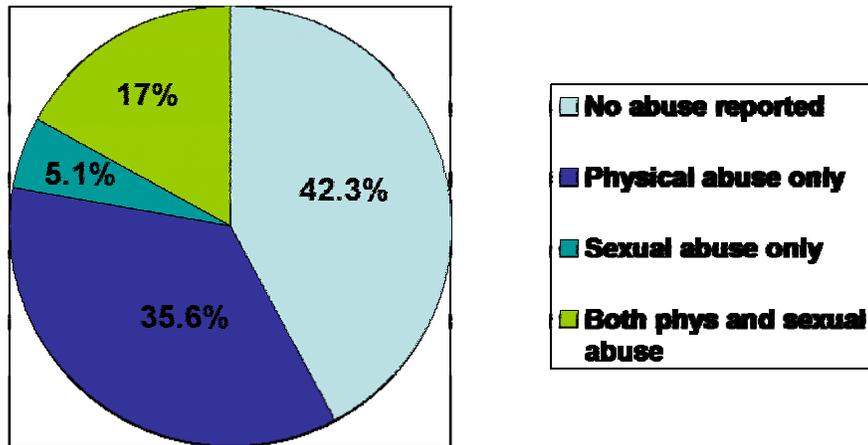
- o Half of New Hampshire women report having been physically or sexually assaulted in their lifetime
- o 113,000 or nearly 1 in four New Hampshire women have been the victim of a completed sexual assault, including penetration at some point in their life.
- o Over 166,000 women in New Hampshire have experienced physical assault by an intimate partner.
- o 41 percent of the most recent sexual assaults reported occurred before the victim's 18th birthday
 - o 83 percent occurred before the victim's 25th birthday.
- o 87.7 percent of women who were sexually assaulted were assaulted by someone in their circle of friends and families.
- o One in seven women reported being the victim of multiple abuse types (see chart below).

¹¹⁹ Potter SJ, Laflamme D, Mattern G, Baynard VL, Moynihan MM, Stapleton JG, Bujno L. New Hampshire Violence Against Women Survey. 2007.

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Figure 3.37 Lifetime Prevalence of Physical and Sexual Assault

Intersecting Abuse Types



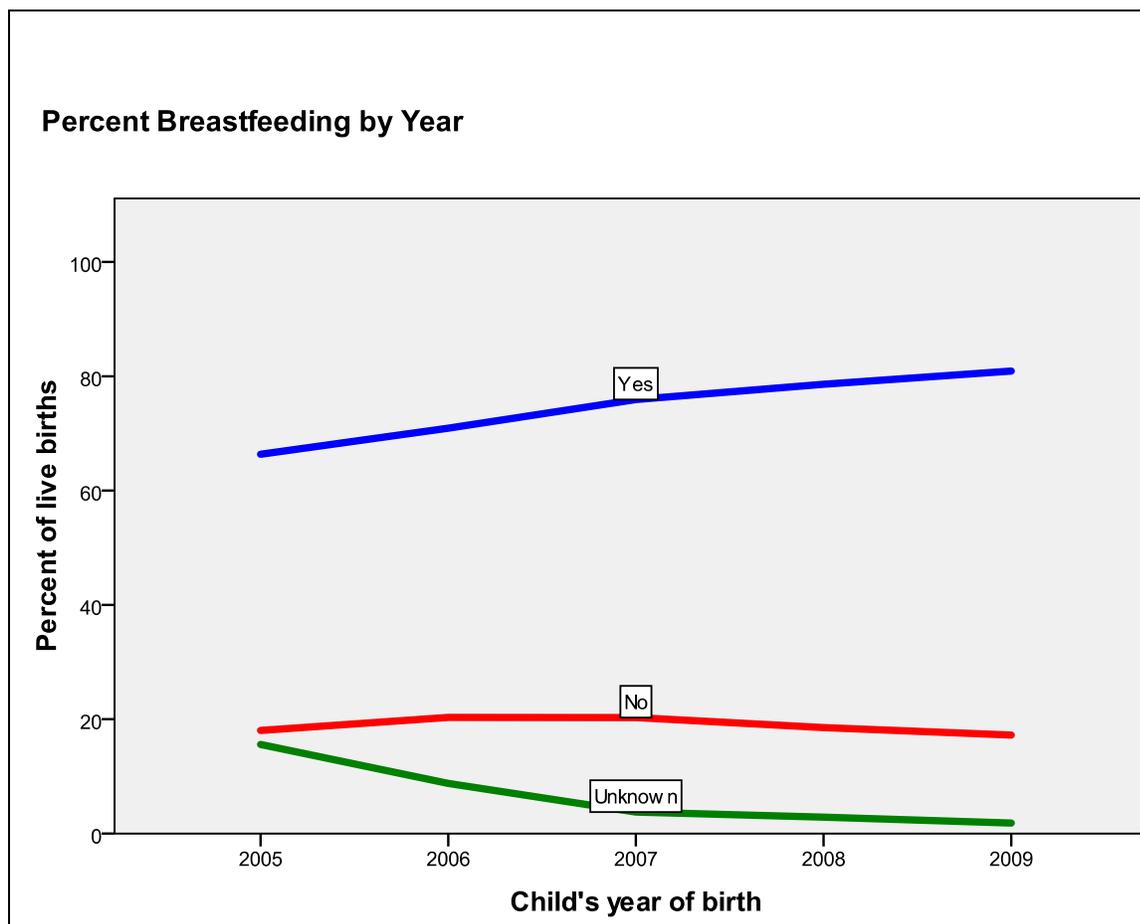
Source: Potter SJ, Laflamme D, Mattern G, Baynard VL, Moynihan MM, Stapleton JG, Bujno L. New Hampshire Violence Against Women Survey. 2007

3.C.4.k. Breastfeeding

The graph below suggests that early postpartum breastfeeding for births occurring in New Hampshire hospitals is increasing and that data completeness has improved.

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Figure 3.38



Source: NH DPHS Maternal and Child Health Section

Census data on the prevalence of initiation of early postpartum breastfeeding among New Hampshire residents is available from the Newborn Screening Form (NSF) and the Facility Worksheet for Certificate of Live Birth (FWS). However, little is known about the quality of these data. While the National Center for Health Statistics has recommended several preferred information sources for ascertaining this information, actual practices within facilities are unknown.

Preliminary analyses were completed on a sample of 17,338 infants with early postpartum breastfeeding status data on both the NSF and the FWS who were born in New Hampshire during the period September 1, 2006 through September 29, 2009. We found concordance on 82.5 percent of the records, but results from the McNemar's test indicated that proportions of

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each type of discordant pair were significantly different (χ^2 410.60, $p < 0.0001$). Overall 79.5 percent of the infants in our sample were recorded as breastfed in both data sources during the early postpartum period. An additional 2.3 percent were recorded as breastfed by the newborn screening form but not the birth certificate, and 6.9 percent by the birth certificate but not by the newborn screening form.¹²⁰

When stratified by birth facility, percent agreement between the two data sources ranged from 76.7 percent to 100.0 percent. This range may suggest different recording practices by data source across facilities in New Hampshire, and has important implications for the validity of both data sources. To further investigate this range in percent agreement by data source between birth facilities in New Hampshire, we conducted a qualitative investigation among nurse managers or others identified as responsible for personally recording breastfeeding status on the Newborn Screening Form and the Facility Worksheet for Certificate of Live Birth. The methods are further described above in Section 1. The National Center for Health Statistics provided funding to support a public health doctoral student to assist with the study.

The analysis has been completed and a report is being prepared. Findings indicate several factors that may contribute to the discordance in breastfeeding status between the two data sources. These factors include timing of item completion, understanding of the intent of the breastfeeding item on each document, and a lack of standardized training. We have presented early results to the New Hampshire Breastfeeding Task Force and intend to work with the various stakeholders to improve data quality and assessment of early postpartum breastfeeding status.

3.C.4.1. Infant Mortality

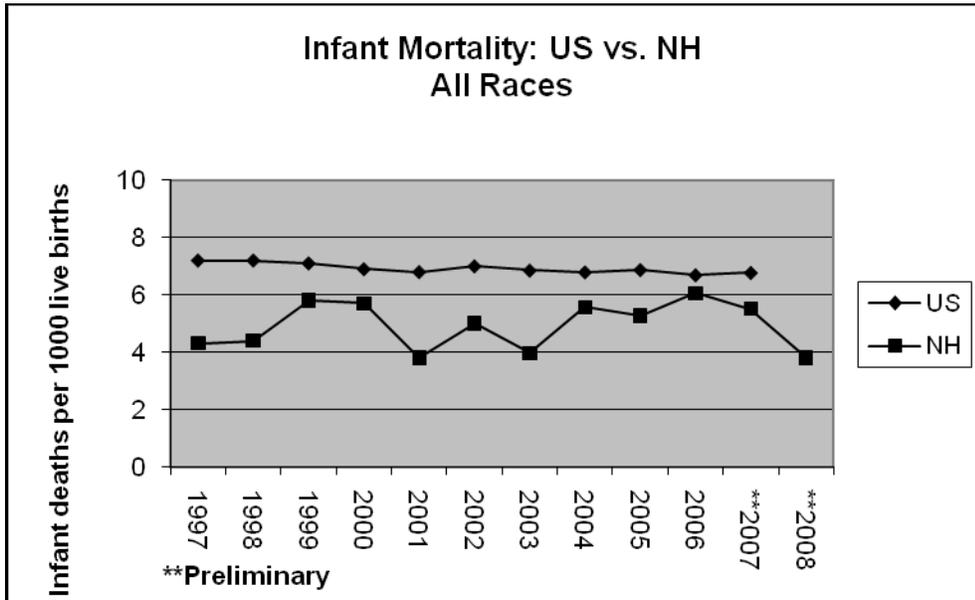
The New Hampshire infant mortality rate has remained relatively stable over the past several years (though there is some variation primarily due to the small numbers). The graphs below show the infant mortality rate for all races in New Hampshire and the US, as well as for just white infant deaths for the same two geographic stratifiers. Since New Hampshire is not as diverse as the US as a whole, the white-only graph may be a fairer comparison. The number of minority infant deaths in New Hampshire is too small to produce reliable single year statistics.

¹²⁰ NH DPHS Maternal and Child Health Section

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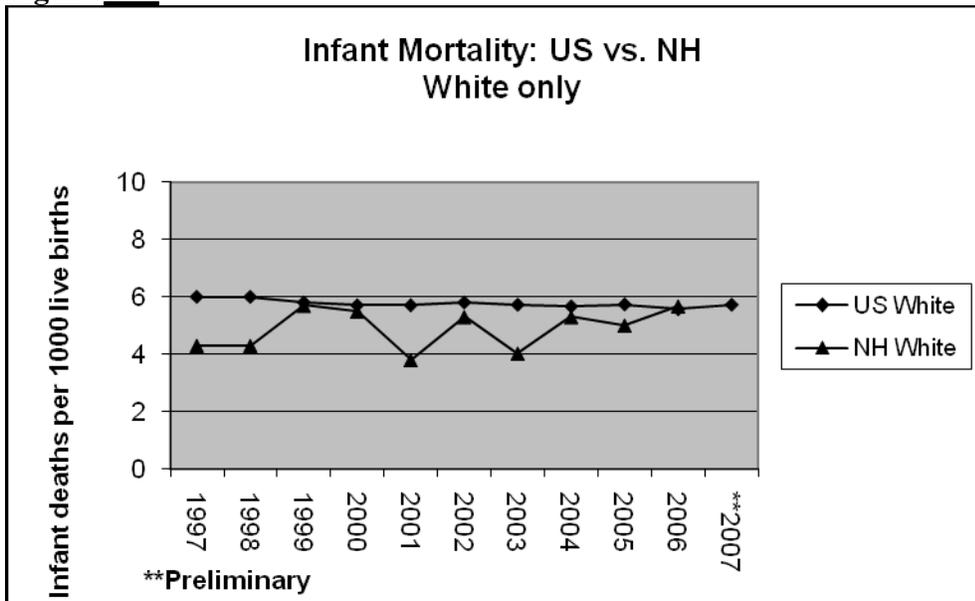
The number of years of aggregation required to show the rate would make it difficult to accurately assess temporal trends. In both graphs, the New Hampshire rate tends to trend lower than the national rate.¹²¹

Figure 3.39



Source: NH DPHS Maternal and Child Health Section

Figure 3.40



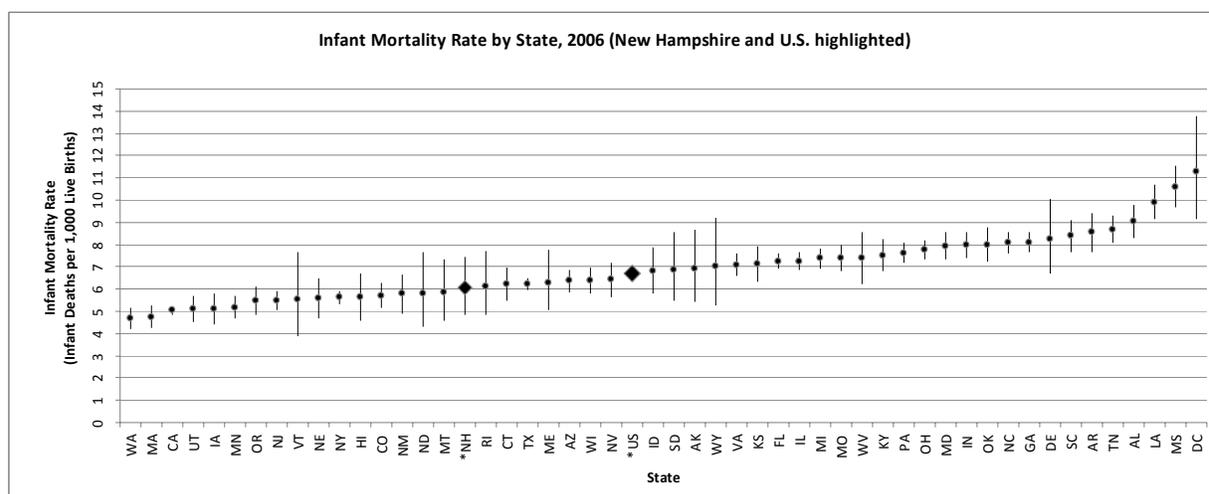
Source: NH DPHS Maternal and Child Health Section

¹²¹ NH DPHS Maternal and Child Health Section

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New Hampshire is often among the states with the best infant mortality rates as shown in the 2006 example below.

Figure 3.41



Source: NH DPHS Maternal and Child Health Section. Data Source: NCHS

3.C.5. Summary of Disparities

The analysis in this population group section for pregnant women, mothers and infants, exposes variations within the overall positive picture of health for women in New Hampshire and finds that women in the adolescent and young adult years, as well as those dependant on Medicaid as a payer for their health care, experience disproportionate smoking rates, levels of inadequate prenatal care and less favorable birth outcomes than women in other age groups. For example, analysis of New Hampshire birth data for the years 2005 to 2009 revealed that mothers with Medicaid-paid births were more likely to report smoking and less likely to quit by the third trimester. Mothers who were under 25 years old were more likely to report smoking; however, they were just as likely as mothers over 25 to quit by the third trimester. In general, younger mothers (regardless of payer) and mothers with a birth paid by Medicaid (regardless of age) reported more risk factors and had poorer outcomes. Other key findings were the large income gap between women and men and the higher poverty rates among women, as well as the percentage of adult women who are uninsured compared to children under age 18.

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3.D. Children and Adolescents

3.D.1. 2010 Priorities related to children and adolescents

- o To improve access to children’s mental health services
- o To decrease pediatric overweight and obesity.
- o To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
- o To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services
- o To improve access to standardized developmental screening for young children.
- o To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents
- o To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments
- o To improve oral health and access to dental care.
- o To increase family support and access to trained respite and childcare providers

3.D.2. Overview

Children and adolescents (ages 0 to 24 years) represent over 30 percent of New Hampshire’s total population, as can be seen in the table below.¹²²

Table 3.6 Population of NH Children and Adolescents by Age Group, 2008

	Population	Percent
Both sexes	412,472	31.3
Under 5 years	75,297	5.7
5 – 9 years	77,028	5.9
10 – 14 years	84,899	6.5
15 –19 years	92,596	7.0
20 – 24 years	82,652	6.3
Total population	1,315,809	100%

Source: Population Division, U.S. Census Bureau

¹²² Table 2: Annual Estimates of the Resident Population by Sex and Age for New Hampshire: April 1, 2000 to July 1, 2008 (SC-EST2008-02-33). Source: Population Division, U.S. Census Bureau. Release Date: May 14, 2009, Retrieved May 15, 2010 from <http://www.census.gov/popest/states/asrh/SC-EST2008-02.html>

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The population of New Hampshire children is declining; New Hampshire Office of Energy and Planning population projections suggest that the cohort of children ages 5-19 will continue to decline over the next 15 years.

While New Hampshire has the lowest overall child poverty rate in the nation, there is wide geographic variation across the State, and child poverty rates in two New Hampshire counties (rural Carroll and Coos counties) exceed the U.S. rate (See Figure 3.42 below).¹²³ New Hampshire's overall child poverty rate (10 percent) equals the rate for the U.S. white only population.¹²⁴ New Hampshire adolescents, ages 18 to 24, are more likely to live in poverty than younger children.¹²⁵

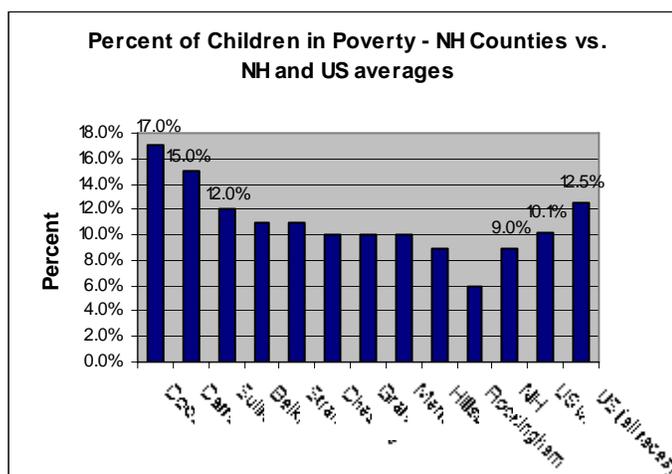


Figure 3.42

Values are shown for NH and the US, and for counties whose rates are statistically significantly higher than the State average
 U.S. white rate = white, not Hispanic
 Source: RWJ Foundation and University of Wisconsin Population Health Institute. Data source (NH and counties): Small area income and poverty estimates, US census 2007. Data source (U.S. data) US Census Bureau, Income, Poverty and Health Insurance Coverage in the US 2008.

In 2007, the five leading causes of inpatient hospital discharges for New Hampshire children ages 5 to 14 were diseases of the digestive system, injury and poisoning, respiratory system diseases, endocrine nutritional and metabolic diseases and mental disorders. Approximately 30% of inpatient discharges in this age group were billed to Medicaid. For ages 15 to 24 years, the

¹²³ RWJ Foundation and University of Wisconsin Population Health Institute. County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. www.countyhealthrankings.org, accessed 2/18/10.

¹²⁴ Annie E. Casey Foundation. Kids Count Data Center. (2010) Available from www.aecf.org

¹²⁵ Data provided by national Kids Count Program, Annie E. Casey Foundation. Available from www.kidscount.org

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three leading causes were pregnancy and childbirth, injury and poisoning and mental disorders. Over 38 percent of hospitalizations in this age group were billed to Medicaid.

During the years 2004 to 2006, the leading cause of death among children ages 1 to 14 years was unintentional injuries (22 deaths), mostly due to motor vehicle traffic (9 deaths), drowning and fire/burns (4 deaths each).¹²⁶ Three of the ten leading causes of death during this period were due to intentional (suicide and homicide) and unintentional injuries. Other leading causes of death are listed in (See Table 3.7 below).

Table 3.7 Leading Causes of Death, New Hampshire Children ages 1 to 14, 2004 - 2006

Rank	Cause of death	Number of deaths
1	Unintentional Injury	22
2	Malignant neoplasms	17
3	Congenital Anomalies	6
4	Homicide	5
5	Heart disease	4
6	Benign neoplasms	3
6	Conditions originating in the perinatal period	3
7	Pneumonitis	2
9	Suicide	2
10	Chronic lower respiratory disease	1

During the same period, the five leading causes of death for adolescents ages 15 to 24 years were unintentional injury, suicide, malignant neoplasms, heart disease and homicide.

3.D.3. Strengths

New Hampshire consistently ranks high compared to the nation on many indicators of child health and wellbeing.^{127,128} The Annie E. Casey Foundation’s 2009 Kids Count Data Book ranked New Hampshire first in the nation for trends in child well being.¹²⁹ New Hampshire has placed first on this ranking for four out of the past five years. Indicators used to calculate the

¹²⁶ CDC National Center for Injury Prevention and Control. WISQARS. Available from <http://www.cdc.gov/injury/wisqars/fatal.html>

¹²⁷ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹²⁸ United Health Foundation. *America’s Health Rankings*. Retrieved May 7, 2010 from <http://www.americashealthrankings.org/Measure/All%20Years/NH/Overall.aspx>

¹²⁹ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

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ranking include the percent of children in poverty, percent low-birthweight babies, infant mortality rate, child death rate, teen death rate, teen birth rate, percent of teens who are not attending school and not working (ages 16-19), percent of children in single parent families and the percent of children living in families where no parent has full time year round employment.

New Hampshire scored well on the following indicators:

- o Teen birth rate (19/1000 live births in 2006) (lowest in U.S.)¹³⁰
- o Percentage of repeat teen births (12 percent in 2004) (lowest in U.S., tied with Maine and Vermont)¹³¹
- o Children in poverty (8.6 percent in 2009) (lowest in U.S.)¹³²
- o Child death rate (12/100,000 in 2006) (ranked 3rd lowest in U.S.)¹³³
- o Teen death rate by injury, homicide, suicide (27/100,000 in 2006) compared to the U.S. average of 49/100,000 (range is 24-79/100,000) (ranked 2nd lowest in U.S.)¹³⁴
- o Teen death rate from all causes (38/100,000 in 2006) (ranked 3rd best in U.S.)¹³⁵
- o High immunization rates (85 percent of children 19-35 months fully immunized) in 2009 (highest in U.S.)¹³⁶

New Hampshire scores well on measures that can predict future success or risks for children and youth, when compared to other states (See Table 3.8 below).¹³⁷ When looking at these rankings, however, it's important to note that there are still large numbers of children who are at risk in the State. For example, 9 percent of New Hampshire children lived in poverty in 2008, 27 percent lived in families where no parent had full-time year-round employment in 2007 and 25 percent of children lived in single parent families in 2008.

¹³⁰ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹³¹ Schelar E, Franzetta K and Manlove J PhD. *Repeat Teen Childbearing: Differences across States and by Race and Ethnicity*. In Child Trends Research Brief (October 2007) publication number 2007-23. Available from www.childtrends.org

¹³² United Health Foundation. *America's Health Rankings*. Retrieved May 7, 2010 from

<http://www.americashealthrankings.org/Measure/All%20Years/NH/Children%20in%20Poverty.aspx>

¹³³ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹³⁴ Data provided by national Kids Count Program, Annie E. Casey Foundation. Available from www.kidscount.org

¹³⁵ Annie E. Casey Foundation 2009. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹³⁶ United Health Foundation. *America's Health Rankings*. Retrieved May 7, 2010 from

<http://www.americashealthrankings.org/Measure/All%20Years/NH/Immunization%20Coverage.aspx>

¹³⁷ Data provided by national Kids Count Program, Annie E. Casey Foundation. Available from www.kidscount.org

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Table 3.8 New Hampshire compared to the U.S. on Measures of Child Well-Being

Indicator¹³⁸	NH rate	US rate	NH rank	Range
Teens (16-19) who are not in school and not working (considered “idle teens” or “disconnected youth”) (2008)	4% in	8%	1st	4-12%
Teens (16-19) who are not in school and not high school graduates (2008)	3%	6%	1st	3-10%
Youth ages 18-24 not enrolled in school, not working and no degree beyond high school (2008)	9%	14%	3 rd (tied with 3 other states)	8-20%
Children living in families where no parent has full-time year-round employment (2008)	21%	27%	4 th (tied with 2 other states)	19-35%
Children living in single parent families (2008)	25%	32%	4 th (tied with MN)	18-45%

New Hampshire has shown progress in improving the health of children and youth in recent years. Significant decreases in youth tobacco use have occurred since the 1990’s; smoking prevalence in the high school population declined from 25.3 percent in 2001, to 16 percent in 2009.¹³⁹ New Hampshire has one of the lowest percentages of uninsured children in the U.S., and coverage has improved over the past decade.¹⁴⁰ New Hampshire’s successful New Hampshire Healthy Kids (Medicaid) public-private partnership has resulted in a steady increase in the number of kids with Medicaid coverage between 2002 and 2006, and coverage has risen in the poorest communities.¹⁴¹ Between 2000 and 2006/2007 (latest complete data), areas of child well being that improved were the child death rate, teen death rate, teen birth rate and teens that are high school dropouts.¹⁴²

¹³⁸ Data provided by national Kids Count Program, Annie E. Casey Foundation. Available from www.kidscount.org

¹³⁹ 2007 - 2009 NH Youth Tobacco Survey. NH DHHS DPHS Tobacco Prevention and Control Program. Retrieved May 6, 2010 from <http://www.dhhs.nh.gov/NR/rdonlyres/et66h3t5nbyptedostxxwyekknurfllcam5bbzi6lsjybb7wmvvd6qca4obftd5zoi6htztzjzlhed7qlb7ytkzyud/yts0709.pdf>

¹⁴⁰ Kids Count New Hampshire Data Book 2008: *Our Most Vulnerable Communities*. Children’s Alliance of New Hampshire 2008. Available from www.childrennh.org

¹⁴¹ Kids Count New Hampshire Data Book 2008: *Our Most Vulnerable Communities*. Children’s Alliance of New Hampshire 2008. Available from www.childrennh.org

¹⁴² Kids Count New Hampshire Data Book 2008: *Our Most Vulnerable Communities*. Children’s Alliance of New Hampshire 2008. Available from www.childrennh.org

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New Hampshire has broad eligibility coverage for early intervention services through the Department of Education, allowing children with less serious delays and those at risk of delay or disability to receive services.¹⁴³

New Hampshire has a primary seat belt restraint law for children and adolescents through the age of 17. Unlike other states' laws, New Hampshire's applies to every seating position, and not just the driver.¹⁴⁴ The New Hampshire Highway Safety Agency (a collaborative partner with MCH) sponsors special enforcement patrols through their "Join the New Hampshire Clique" campaign.

3.D.4. Needs

3.D.4.a. Summary

Although New Hampshire does well on many indicators of child health and well being, there are a number of significant needs among the child and adolescent population that were identified in this needs assessment. For example, 12.1 percent of children under age five¹⁴⁵ and 16 percent of youth ages 18-24 (16,000 kids) live in poverty.¹⁴⁶ and 30 percent of adolescents ages 18-24 lack health insurance¹⁴⁷. An estimated 60,000 New Hampshire children and adolescents do not have access to the resources of the State, in terms of economic, educational and health opportunities.¹⁴⁸ These disparities will be described below with each identified need, and summarized at the end of this section.

New Hampshire does not have any seat belt restraint law for those eighteen and over. Youth Risk Behavior Survey results for 2009 indicate that 20.2 percent of twelfth graders rarely or ever wore their seat belt when riding as passengers.¹⁴⁹ Although this is significantly better than the results

¹⁴³ Schneider W, Smith S, et al. *Promoting Young Children's Health: Taking Stock of State Policies*. May 2010. National Center for Children in Poverty. Available from www.nccp.org

¹⁴⁴ New Hampshire RSA 265:107-a; Child Passenger Restraints Required. Retrieved May 14, 2010 from <http://www.gencourt.state.nh.us/rsa/html/XXI/265/265-107-a.htm>

¹⁴⁵ US Census Bureau, 2008 Small Area Income and Poverty Estimates. Available from <http://www.census.gov/did/www/saipe/index.html>

¹⁴⁶ Data provided by national Kids Count Program, Annie E. Casey Foundation. Available from www.kidscount.org

¹⁴⁷ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire. Retrieved 2/18/10 from www.countyhealthrankings.org

¹⁴⁸ Children's Alliance of New Hampshire 2008. Kids Count New Hampshire Data Book 2008, Our Most Vulnerable Communities. Available from www.childrennh.org

¹⁴⁹ NH Youth Risk Behavior Survey 2009 results. Retrieved May 14, 2010 from http://www.education.nh.gov/instruction/school_health/hiv_data.htm

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from the early 1990's, the trend is leveling off, thus causing concern. Seat belts significantly decrease the risk of injury and death in a motor vehicle crash.

Children represented 17 percent of the approximately 5,000 New Hampshire residents who were sheltered in state-funded emergency shelters in State fiscal year 2009. This does not count the children sheltered in domestic violence shelters, estimated to represent an additional 10 percent. The New Hampshire Department of Education reported that 2,130 elementary, middle/junior high and high school students were homeless in the school year 2008-2009 (See Table 3.9 below)¹⁵⁰. A recently released report conservatively estimates that over 1000 New Hampshire adolescents (high school age and young adults) are homeless, and that this number is growing.¹⁵¹ This number includes 549 youth in grades 9-12 (reported by the New Hampshire DOE) that were homeless during the school year 2008-2009, representing about 1 percent of the state's high school enrollment. National studies have found that 7 to 8 percent of youth enrolled in school are homeless if the age group is expanded to include those in junior and middle schools.¹⁵² Homeless youth and young adults may have aged out (at age 18) of foster care, juvenile justice or other state systems and/or may be runaways, throwaways, living with homeless parents and/or be parents themselves. Those who stay in shelters are more likely to be female. A number of risk factors for youth homelessness have been found. These include alcohol and drug abuse, mental health issues, abuse and neglect prior to age 18 and physical, developmental or learning disabilities. Homeless youth are at risk for disease, injury, addiction, incarceration and street homelessness. They need health care services, including oral health, mental health and substance abuse treatment, in addition to services to meet their basic food and shelter needs. The system of services in New Hampshire for homeless young people is difficult to navigate, and services are unevenly distributed across the state, according to providers.¹⁵³

¹⁵⁰ Data provided by the New Hampshire Department of Education Division of Instruction.

¹⁵¹ Wauchope Barbara, Carsey Institute at the University of New Hampshire. (Spring 2010) *Homeless Teens and Young Adults in New Hampshire*.

¹⁵² Wauchope Barbara, Carsey Institute at the University of New Hampshire (Spring 2010) *Homeless Teens and Young Adults in New Hampshire*.

¹⁵³ Wauchope Barbara, Carsey Institute at the University of New Hampshire. (Spring 2010) *Homeless Teens and Young Adults in New Hampshire*.

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Table 3.9 NH Department of Education Count of Homeless Students, School Year 2008-2009

Grade	Doubled-up (i.e., living with another family)	Hotels/Motels	Shelters, Transitional housing, Awaiting Foster Care	Unsheltered (e.g. cars, parks, campgrounds, temporary trailer or other)	Totals
Pre-School	14	1	10	1	26
Kindergarten	132	8	31	2	173
Readiness			1		1
1	189	17	36	1	243
2	165	12	35	4	216
3	144	18	31	9	202
4	145	10	18	2	175
5	123	14	22	5	164
6	135	14	31	3	183
7	85	9	22	3	119
8	124	12	30	4	170
9	83	19	15	6	123
10	72	7	13	3	95
11	78	2	11	4	95
12	120	2	14	9	145
Totals	1609	145	320	56	2130

New Hampshire must also continue to monitor and address child and adolescent health issues in order to maintain its standing. For example, several significant negative changes have occurred in recent years that potentially threaten child and adolescent health and well being:

- o The child immunization rate decreased from 93.2 percent in 2008 to 85 percent in 2009¹⁵⁴
- o The percent of low birth-weight infants increased between 2000 and 2006/2007¹⁵⁵
- o The percent of children in poverty increased by 50 percent between 2000 and 2006/2007¹⁵⁶
- o The percent of children living in families where no parent has full-time, year-round employment increased between 2000 and 2006/2007¹⁵⁷
- o The infant mortality rate increased from 5.2 deaths per 1000 live births in 2008 to 5.7/1000 births in 2009¹⁵⁸

¹⁵⁴ United Health Foundation. America's Health Rankings. Retrieved May 6, 2010 from

<http://www.americashealthrankings.org/Measure/All%20Years/NH/Immunization%20Coverage.aspx>

¹⁵⁵ Annie E. Casey Foundation. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹⁵⁶ Annie E. Casey Foundation. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

¹⁵⁷ Annie E. Casey Foundation. 2009 Kids Count Data Book: State Profiles of Child Well-Being. Available from www.aecf.org

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- o Injury mortality rates among 20 to 29 year olds increased in New Hampshire and nationally during the period 1999 to 2004, mostly due to a 92.5 percent increase (nationally) in drug-related poisonings¹⁵⁹

New Hampshire data reveal a number of risks to adolescent health, and needs among this population. These are described in detail below.

3.D.4.b. Uninsured Children

Health insurance is critical for both immediate and long-term implications. With health insurance, children are more likely to have access to a medical home, well child care, immunizations, prescription medications, appropriate care for asthma, and basic dental services. They're also more likely to have fewer avoidable hospitalizations, improved asthma outcomes, and fewer missed days of school.¹⁶⁰ Uninsured children use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they're sicker and at more advanced disease stages than the insured. This contributes to higher rate of morbidity and mortality for uninsured both in general and for specific diseases.¹⁶¹

Uninsured children are not only at higher risk for negative long-term effects on health than insured children, but on economic productivity as well.¹⁶² An uninsured child accessing the health care system impacts taxpayers and society. National cost of uncompensated care was estimated \$34.6 billion in federal, state and local spending in 2004.¹⁶³

¹⁵⁸ United Health Foundation. America's Health Rankings. Retrieved May 6, 2010 from

<http://www.americashealthrankings.org/Measure/All%20Years/NH/Infant%20Mortality.aspx>

¹⁵⁹ CDC. *Increases in Age Group-Specific Injury Mortality-United States, 1999-2004*. MMWR 2007; 56: 49-1281. Retrieved May 6, 2010 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5649a1.htm>

¹⁶⁰ Institute of Medicine of the National Academies, Committee on Health Insurance Status and Its Consequences. (2009) *America's Uninsured Crisis: Consequences for Health and Health Care*. Retrieved January 13, 2010 from http://www.nap.edu/openbook.php?record_id=12511&page=19. The National Academies Press, Washington DC.

¹⁶¹ Hadley J. Urban Institute. (June 30, 2006) *Consequences of the Lack of Health Insurance on Health and Earnings*. Retrieved June 19, 2009 from <http://www.urban.org/Publications/1001001.html>

¹⁶² Johnson W, Lawthers A, et. al. *Yuma Project on Uninsured Children*. Abstr Acad Health Serv Res Health Policy Meet. 2001; 18: 85. Retrieved June 19, 2009 from <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102273318.html>

¹⁶³ *Health Insurance for Uninsured Children: Doing Health Care Right*, Heritage Lecture published by The Heritage Foundation, No. 997, March 5, 2007

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New Hampshire has one of the lowest percentages of uninsured children. Depending on data sources, the number and rate of uninsured children in the state can vary from a low of 6 percent (21,000 children) per Children's Defense Fund 2008 Fact Sheet¹⁶⁴, to a high of 9.7 percent (NSCH).¹⁶⁵ According to Kaiser State Health Facts, which looked at health insurance coverage of children 0 – 18 years in every state for 2006-2007, and compared it with the U.S. numbers and rates for 2007, New Hampshire had 7.1 percent (22,670) children uninsured compared to the national rate of 11.3 percent.¹⁶⁶ New Hampshire's rate of uninsured is comparable to that of its New England neighbors (See Table 3.10 below)¹⁶⁷

New Hampshire, along with the rest of New England, is among those with the highest health care costs in the nation, which makes it difficult for its residents to afford health care.¹⁶⁸ Employer-sponsored insurance coverage rates for children, especially low income children, have decreased substantially in recent years, with the steepest decline from 2000 to 2004 among children with family incomes lower than 200 percent of the federal poverty level¹⁶⁹. Nationally, the number of children uninsured is growing due to the recent fiscal crisis¹⁷⁰.

New Hampshire has been fortunate, in that its rate of coverage for children has improved over the last decade, partly due to the state's Healthy Kids Program¹⁷¹. Twenty-eight percent of New Hampshire children ages 0-4 and 22 percent of children ages 5-9 are enrolled in Medicaid.¹⁷² However, among the New England States, New Hampshire has the lowest percentage of children

¹⁶⁴ Children's Defense Fund. Children in New Hampshire state fact sheet, November 2008, Retrieved June 19, 2009 from <http://www.childrensdefense.org/child-research-data-publications/data/state-data-repository/children-in-the-states-factsheets.html>

¹⁶⁵ National Survey of Children's Health (2007) "Percent of children lacking consistent insurance coverage in past year", Retrieved June 19, 2009 from

<http://www.nschdata.org/StateProfiles/CustomProfile07.aspx?rid=5&geo2=Nationwide&geo=New%20Hampshire>

¹⁶⁶ Kaiser Family Foundation. State Health Facts.org. Retrieved July 14, 2008 from <http://www.statehealthfacts.org/profile>

¹⁶⁷ NH Department of Health and Human Services Office of Medicaid Business and Policy. (January 2008) *Children's Health Insurance Programs in New Hampshire, SFY2006*, page 1.

¹⁶⁸ Text of Gov. John Lynch's 2010 State Of The State Address. (January 21, 2010) Retrieved January 21, 2010 from <http://www.wmur.com/politics/22304068/detail.html>

¹⁶⁹ National Academy for State Health Policy (May 2006) "Basic Facts About Children's Coverage"

¹⁷⁰ Marian Wright Edelman. Child Watch Column: "A Public Health Insurance Plan Can Cover All of Our Children", Retrieved 4/10/09 from <http://childrensdefense.org/child-research-data-publications/data/marian-wright-edelman>

¹⁷¹ NH Children's Alliance. Kids Count NH Data Book 2008 (2008) Available from Available from <http://www.childrennh.org/web/>

¹⁷² NH Comprehensive Health Care Information System (CHIS) 2006 Available from <http://www.nhchis.org/>

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in poverty who are enrolled in Medicaid (59.5 percent) (See Table 3.11 below).¹⁷³ There are still too many children in need of health care coverage, and there is a problem with “churning”, which occurs when children are repeatedly dropped and re-enrolled on public programs due to short eligibility periods, lengthy re-enrollment processes, and complex paperwork¹⁷⁴

Disparities exist in who is uninsured in the state. With 16.6 percent of all children having special health care needs, it is known that of those, 7.0 percent were without health insurance at some point in the past year.¹⁷⁵ According to the 2007 National Survey of Children’s Health, rates of uninsured vary by age group and sex, as can be seen (See Table 3.10 below. Adolescents are far more likely to be uninsured than younger children; 30 percent of New Hampshire adolescents ages 18-24 lack health insurance¹⁷⁶ compared to 9.7 percent of children ages 0 to 18 (See Table 3.10 below). In addition, New Hampshire does not extend Medicaid coverage to children of legal immigrants with incomes above 200 percent of the federal poverty level, increasing the risk of uninsurance among this potentially needy population.¹⁷⁷ Studies show that low income, uninsured parents are mostly without access to health coverage and are much more likely to have uninsured children than those with health insurance.¹⁷⁸

**Table 3.10 Percent of children lacking consistent insurance coverage in past year 2007
(NSCH)¹⁷⁹**

Characteristic	New Hampshire	U.S.
Total children lacking insurance coverage	9.7%	15.1%
Ages 0-5	3.4%	7.9%
Ages 6-11	5.5%	9.5%
Ages 0-17, male	4.8%	9.3%

¹⁷³ Kaiser Family Foundation. *New Hampshire: Health Insurance Coverage of Children 0-18 Living in Poverty (under 100% FPL), states (2007-2008), U.S. (2008)* Retrieved April 29, 2010 from <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=31&ind=128&sub=177>

¹⁷⁴ Ukaegbu U.A. and Schwartz S. (October 2006) “*Seven Steps Toward State Success in Covering Children Continuously*” National Academy for State Health Policy Issue Brief

¹⁷⁵ Catalyst Center at Boston University (Jan. 2007) *State-at-a-Glance Chartbook on Coverage and Financing of Care for Children and Youth with Special Health Care Needs.*

¹⁷⁶ RWJ Foundation and University of Wisconsin Population Health Institute. (2010) *County Health Rankings, Mobilizing Action Toward Community Health, 2010 New Hampshire.* Retrieved 2/18/10 from www.countyhealthrankings.org

¹⁷⁷ Schneider W, Smith S, et al. (May 2010) *Promoting Young Children’s Health: Taking Stock of State Policies.* National Center for Children in Poverty. Available from www.nccp.org

¹⁷⁸ Kaiser Commission on Medicaid and the Uninsured. (June 2007) *Kaiser Low-Income Coverage and Access Survey.* Available from <http://www.kff.org/>

¹⁷⁹ National Survey of Children’s Health (2007) “*Percent of children lacking consistent insurance coverage in past year*”, Retrieved June 19, 2009 from <http://www.nschdata.org/StateProfiles/CustomProfile07.aspx?rid=5&geo2=Nationwide&geo=New%20Hampshire>

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Ages 0-17, Hispanic	7.8%	18.9%
Ages 0-17, White non-Hispanic	3.8%	6.1%
Non-CSHCN	4.7%	9.8%

Source: 2007 National Survey of Children's Health

Table 3.11 Percent of children (ages 0-18 years) below 100% FPL enrolled in Medicaid (2007-2008) (U.S. 2007) ¹⁸⁰	
State	Percent of children
Massachusetts	79.6%
Maine	78.9%
Rhode Island	69.8%
Vermont	67.2%
Connecticut	65%
New Hampshire	59.5%
United States	64.3%

Table 3.12 Health Insurance Coverage for Children by State and Coverage Type, Current Population Survey, 2006–2007¹⁸¹

	Employer	Other Public	Medicaid	Other Public	Total Insured	Uninsured
Vermont	52%	NSD	36%	NSD	92%	8%
New Hampshire	72%	4%	17%	NSD	93%	7%
Maine	57%	4%	31%	NSD	94%	6%
Massachusetts	67%	3%	24%	NSD	95%	5%
United States	55%	4%	28%	1%	89%	11%

NSD: Not sufficient data

Note: There is known underreporting in Current Population Survey of Medicaid coverage and the percent of NH children enrolled in Medicaid at any time during the year is known to be higher than shown above. The data remains unadjusted to allow for comparison of New Hampshire to the other states and the nation.

Although the cost to address the problem of uninsured children is expensive, it is critical that it be addressed, as it is even more costly to all of society to ignore it. Cost of coverage for children varies by state, type of coverage, benefit package, insurance regulation, and other factors. In 2005, the cost of employer-sponsored coverage for a family was \$10,880 annually; in 2002, the average annual cost of covering children in Medicaid was \$14,000.¹⁸² The decisions, especially in times of fiscal instability and crisis, are difficult. However, for New Hampshire to continue

¹⁸⁰ Kaiser Family Foundation. *New Hampshire: Health Insurance Coverage of Children 0-18 Living in Poverty (under 100% FPL), states (2007-2008), U.S. (2008)* Retrieved April 29, 2010 from <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=31&ind=128&sub=177>

¹⁸¹ NH Department of Health and Human Services, Office of Medicaid Business and Policy. (October, 2009) *Children's Health Insurance Programs in New Hampshire, SFY 2008*, page 1

¹⁸² National Academy for State Health Policy (May 2006) "*Basic Facts About Children's Coverage*"

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being a leader with one of the lower rates of uninsured children in the nation, there must continue to be support for both the programs providing health care coverage for the un- and under-insured and the network to assist families in accessing and utilizing available care.

3.D.4.c. Injury

Injuries are among the most serious and under-recognized public health problem. In New Hampshire and in the U.S., unintentional injuries are the leading cause of death and hospitalization to children and adolescents, killing more in this age group than all diseases combined (See Table 3.13 below).^{183, 184} Injuries are both predictable and preventable through a public health approach that combines effective policy, education and technical strategies. Injury death rates are lowest in the Northeast, compared to other parts of the U.S.¹⁸⁵

¹⁸³ Borse N PhD, Gilchrist J MD, et al. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 year olds in the United States, 2000-2006*. CDC, Atlanta GA 2008.

¹⁸⁴ NH DHHS DPHS Injury Prevention Program 2009

¹⁸⁵ Borse N PhD, Gilchrist J MD, et al. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 year olds in the United States, 2000-2006*. CDC, Atlanta GA 2008.

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Table 3.13 **5 Leading Causes of Death, New Hampshire
2005 - 2007, All Races, Both Sexes**

		Age Group					
Rank	<1	1-4	5-9	10-14	15-19	20-24	
1	Congenital Anomalies 40	Benign Neoplasms 4	Malignant Neoplasms 11	Unintentional Injury 9	Unintentional Injury 74	Unintentional Injury 123	
2	Short Gestation 36	Malignant Neoplasms 3	Unintentional Injury 9	Malignant Neoplasms 5	Malignant Neoplasms 12	Suicide 31	
3	SIDS 35	Cerebro-vascular 1	Congenital Anomalies 1	Congenital Anomalies 4	Suicide 11	Malignant Neoplasms 15	
4	Placenta Cord Membranes 13	Congenital Anomalies 1	Homicide 1	Heart Disease 3	Heart Disease 7	Homicide 8	
5	Maternal Pregnancy Comp. 11	Heart Disease 1		Suicide 3	Congenital Anomalies 3	Congenital Anomalies 5	

Source: CDC National Center for Injury Prevention and Control, Office of Statistics and Programming WISQARS

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Within the Northeast, Table 3.14 below shows that injury death rates are highest in the northern more rural states, compared to the southern, more urban states.

Table 3.14 Unintentional Injury Death Rates among Children ages 0 – 19 Years, Northeast States, 2000-2005¹⁸⁶

State	Rate per 100,000 children 0-19
Massachusetts (lowest in U.S.)	7.2
New York	8.0
New Jersey	8.2
Connecticut	8.9
Rhode Island	9.2
New Hampshire	10.9
Vermont	14.7
Maine	15.1
United States average	15.0

In the time period 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category.¹⁸⁷ The rate of unintentional injury deaths increases by approximately 300 percent between the ages of 14 and 16.¹⁸⁸ The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes.¹⁸⁹ Other leading causes of injury death are poisoning, drowning and fires and burns (See Figure 3.43 below).

¹⁸⁶ Borse N PhD, Gilchrist J MD, et al. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 year olds in the United States, 2000-2006*. CDC, Atlanta GA 2008.

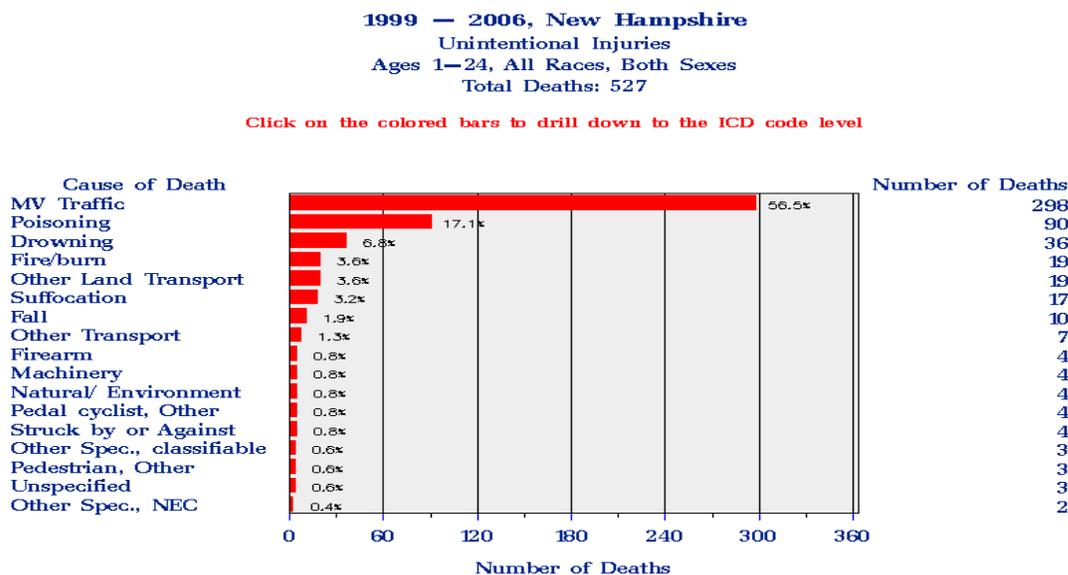
¹⁸⁷ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

¹⁸⁸ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

¹⁸⁹ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

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Figure 3.43



Source: CDC, WISQARS

The highest rate of hospitalizations for motor vehicle crashes among children and adolescents occurred among 15 to 24 year olds, and motor vehicle crashes were the most frequent cause of non-fatal injuries (inpatient hospital discharges) in this age group.^{190, 191} It is interesting to note that the emergency department visit rate for injuries due to motor vehicle crashes among 15-17 year old adolescents is decreasing, while the inpatient discharge rate for these injuries is increasing in this age group, within a five-year period (2001-2005).

Being struck by and/or against an object or person was another frequent cause of non-fatal injuries (emergency department visits) among New Hampshire 15-24 year olds, as were falls.¹⁹² Among New Hampshire children and adolescents, rates for hospitalizations due to falls (2001-2005) were highest in 15 to 17 year olds.¹⁹³

¹⁹⁰ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

¹⁹¹ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

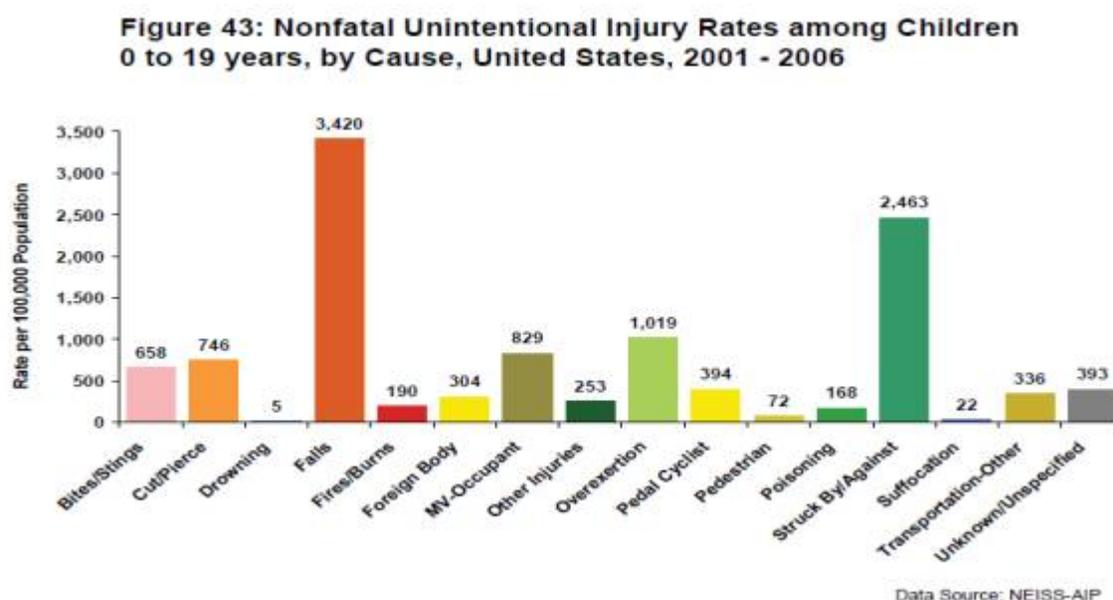
¹⁹² New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

¹⁹³ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

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In New Hampshire, falls are the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24.¹⁹⁴ The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).¹⁹⁵ Nationally also, falls are the leading cause of unintentional injuries among children 0 to 19.¹⁹⁶ Falls are responsible for approximately one-quarter of all childhood unintentional injury costs.¹⁹⁷

Figure 3.44¹⁹⁸



Data source: US Consumer Product Safety Commission. National Electronic Injury Surveillance System On-line (NEISS)

¹⁹⁴ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

¹⁹⁵ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

¹⁹⁶ Borse NN, Gilchrist J, Dellinger AM, Rudd RA, Ballesteros MF, Sleet DA. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States, 2000-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

¹⁹⁷ Safe Kids USA. (2009) Available from <http://www.safekids.org/>

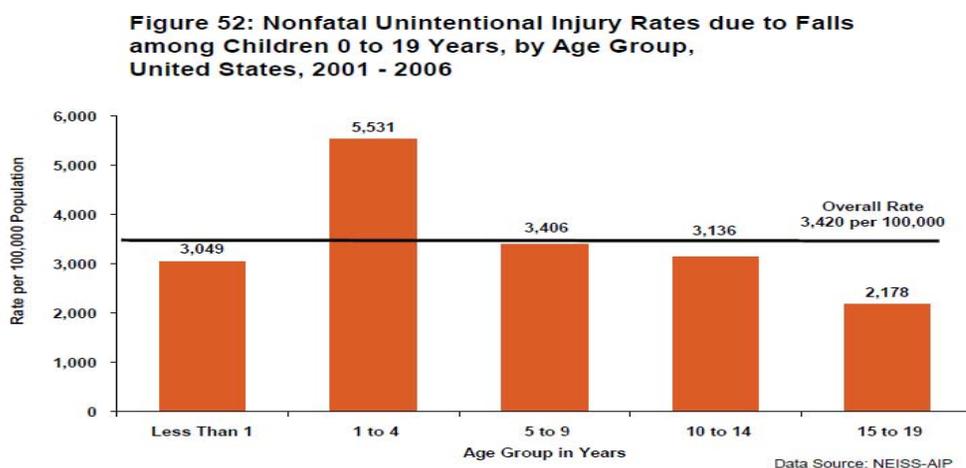
¹⁹⁸ Borse NN, Gilchrist J, Dellinger AM, Rudd RA, Ballesteros MF, Sleet DA. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States, 2000-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

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Among New Hampshire children and adolescents, rates for hospitalizations due to falls (2001-2005) were highest among 15 to 17 year olds. Rates for emergency department visits (2001-2005) were highest among the zero to four and 10 to 14 age groups.¹⁹⁹ Nonfatal fall rates nationally are highest among children ages one to four.²⁰⁰

Emergency department visits due to falls from furniture (beds and chairs were the most common) were a significant issue for children 0 to four years of age in New Hampshire; slips and trips, and falls with sports equipment were the most common after age five (2000-2006). Within the category of sports equipment, falls from playground equipment occurred the most often.²⁰¹ Fractures and contusions were the result of most fall related emergency department visits during the same time period (2000-2006).²⁰²

Figure 3.45²⁰³



Data source: US Consumer Product Safety Commission. National Electronic Injury Surveillance System On-line (NEISS)

¹⁹⁹ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

²⁰⁰ Borse NN, Gilchrist J, Dellinger AM, Rudd RA, Ballesteros MF, Sleet DA. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States, 2000-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

²⁰¹ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section. 2009.

²⁰² New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section. 2009.

²⁰³ Borse NN, Gilchrist J, Dellinger AM, Rudd RA, Ballesteros MF, Sleet DA. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 Year Olds in the United States, 2000-2006*. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

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Adolescents

Adolescents are the age group with the highest rates of motor vehicle related death and injury. Although adolescents hold only 7 percent of the driver licenses in the state of New Hampshire, their death rate is substantially higher than any other age group.²⁰⁴ New Hampshire adolescents accounted for 6.5 percent of the population and 17 percent of the total amount of motor vehicle crashes in 2007.²⁰⁵ The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, adolescent drivers ages 16 to 19 are four times more likely than older drivers to crash.²⁰⁶ In general, emergency medical responders attended to more cases of New Hampshire 16-year-olds due to motor vehicle crashes, than any other adolescent age group (2007 and 2008 data).²⁰⁷ Males were more likely to be hospitalized, while females were more likely to be treated in the emergency department and discharged (2001-2005).²⁰⁸

Most of the crashes involving adolescent drivers occurred on local roads, and speed, inexperience, and drug use were contributing factors. Adolescent drivers have several risk factors working against them, including inexperience with driving and their greater likelihood of engaging in risky driving behaviors such as speeding, driving under the influence, and following other vehicles too closely. New adolescent drivers tend to overestimate their own driving abilities and underestimate the dangers on the road.²⁰⁹ In 2001-2006, speed was the number one cause of fatal New Hampshire crashes involving 16 and 17 year olds and the majority happened between 9 p.m. and midnight.²¹⁰

The costs for unintentional, hospital admitted non-fatal injuries in New Hampshire was 1.7 billion for all ages in 2005 dollars (utilizing 2003 incidence).²¹¹ On a national scale, the medical

²⁰⁴ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section. 2009.

²⁰⁵ New Hampshire Department of Safety, Division of Motor Vehicles. Fatal Accident Reporting System (FARS)

²⁰⁶ Insurance Institute for Highway Safety, 2005. Available from <http://www.iihs.org/default.html>

²⁰⁷ Bureau of Emergency Medical Services, New Hampshire Department of Safety

²⁰⁸ New Hampshire Department of Health and Human Services, Division of Public Health Services, Health Statistics and Data Management Section 2009.

²⁰⁹ Insurance Institute for Highway Safety, 2005

²¹⁰ New Hampshire Department of Safety, Division of Motor Vehicles. Fatal Accident Reporting System (FARS)

²¹¹ Children's Safety Network, Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, in conjunction with the West Virginia University Injury Control Research Center (WVU ICRC), August 2006.

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costs alone for unintentional injuries (both fatal and non) cost \$28 billion for one year for ages zero through 24.²¹² The average cost per case of unintentional motor vehicle traffic deaths for children ages 0–14 in New Hampshire was \$1.6 million in (in 2005 dollars, utilizing aggregated 2000-2004 statistics) as compared to the national average cost per case of \$1.4 million.²¹³ Non-fatal hospital admitted injuries due to motor vehicle crashes for ages 13 to 15 in the state cost approximately 5.1 million 2005 dollars (based on 2003 incidence).²¹⁴

3.D.4.d. Pediatric Obesity

Obesity in children and adolescents in the United States of America has become a critical health problem. Across the US over the past 20 years, the prevalence of obese children has doubled and obese adolescents has tripled²¹⁵. As suggested in an article on this topic in the NE Journal of Medicine in March, 2005, life expectancy of today's youth may be less than their parents, due to obesity.²¹⁶

In New Hampshire, the problem mirrors the national picture. National surveys estimate that 29.3 percent of (approximately 41,000) New Hampshire 10 to 17 year olds were overweight or obese in 2007, compared to a US rate of 31.6 percent and the numbers are increasing; in 2003, the New Hampshire figure was 27.3 percent.²¹⁷ In a chart review of 1,453 children (in the 6-9 year old and the 10-12 year old age groups) receiving health care in 25 New Hampshire primary care practices, 32.8 percent of the children were overweight or obese²¹⁸. A current New Hampshire survey of third graders in 81 New Hampshire public schools reveals some new information about the health of children in New Hampshire. One in three students (33%) was above a healthy weight and more boys (21%) than girls (15%) were obese.²¹⁹ The Healthy People 2010 goal for

²¹² Finkelstein EA, Corso PS, et. al. *Incidence and Economic Burden of Injuries in the United States*. Oxford University Press, 2006. Oxford, England.

²¹³ Children's Safety Network National Injury and Violence Prevention Resource Center. "New Hampshire Fact Sheet" Available from <http://www.childsafetynetwork.org/stateprofiles/statepage.asp?ID=29>

²¹⁴ Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, in conjunction with the West Virginia University Injury Control Research Center (WVU ICRC), August 2006.

²¹⁵ AAP: Prevention of Pediatric Overweight and Obesity: About Obesity). Retrieved June 18, 2009 from <http://www.aap.org/obesity/about/html>

²¹⁶ Olshansky, SJ et al. *A Potential Decline in Life Expectancy in the United States in the 21st Century*. N Engl J Med 352;11 March 17, 2005

²¹⁷ National Survey of Children's Health 2007. Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health website. Retrieved [10/10/09] from www.nschdata.org

²¹⁸ New Hampshire Childhood Obesity Report, The Foundation for Healthy Communities, September 2006.

²¹⁹ The New Hampshire Department of Health and Human Services (DHHS) Healthy Smiles–Healthy Growth Survey 2009

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childhood obesity is 5 percent or below. Among New Hampshire 10-17 year olds, rates of overweight or obesity increased from 27.3 percent in 2003 to 29.3 percent in 2007.²²⁰

Disparities are evident in obesity rates. Among children with special health care needs (CSHCN), the percent of 10 to 17 year olds that are overweight or obese rises to 34 percent.²²¹ New Hampshire children on WIC have higher rates of overweight and obesity than the national average. The 2009 Pediatric NSS results identified 17.8 percent of children on WIC ages 2 to 5 years with BMI's at or above 85th percentile (overweight), compared to the national prevalence (2008) of 16.5 percent. An additional 14.4 percent of these children were at or above the 95th percentile (obese), compared to 14.8 percent nationally.²²²

Health consequences associated with overweight in children may include sleep apnea, orthopedic problems (including an association with spinal disc disease), fatty liver disease and a higher incidence of asthma and type II diabetes. Emotional health problems also exist with low self-esteem and low self confidence linked to poor academic performance, depression and negative body image.^{223,224} One social consequence is that overweight and obese children are more likely to be victims as well as perpetrators of bullying behaviors than their normal weight peers.²²⁵

Any child may become overweight or obese but there are disproportionate effects among low-income families, families of certain ethnic groups and families where there is parental obesity. Children living in poverty in less educated families as well as children of Hispanic and African American background are more likely to be overweight.²²⁶ Having one obese parent increases

²²⁰ Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health Website. Retrieved 10/10/09 from www.nschdata.org.

²²¹ National Survey of Children's Health 2007. Child and Adolescent Health Measurement Initiative. Data Resource Center for Child and Adolescent Health. Retrieved [10/10/09] from www.nschdata.org

²²² Data from Pediatric Nutrition Surveillance System (PedNSS) 2009 (Lisa Richards NH WIC Program Personal communication)

²²³ AAP: *Prevention of Pediatric Overweight and Obesity: About Obesity*. <http://www.aap.org/obesity/about/html>, 6/18/2009.

²²⁴ Whitlock, Williams, et al. *Screening and Interventions for Childhood Overweight: A Summary of Evidence for the U.S. Preventive Services Task Force*, Pediatrics 2005;116:125-144 p e 125-126

²²⁵ Janssen, I, et al. *Associations Between Overweight and Obesity with Bullying Behaviors in School-Aged Children*. Pediatrics Vol. 113 No. 5 may 2004, pp. 1187-94

²²⁶ Childhood Obesity: The Role of Health Policy – Report to the 2nd National Childhood Obesity Congress 2008, NICHG, p. 1.

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the odds of becoming overweight as a 15-17 year old and if both parents are obese the odds are increased by 3.2.²²⁷

The costs of obesity are not only the health consequences. Obesity-associated annual hospital costs for children more than tripled between 1979 and 1999.²²⁸ The Surgeon General's Call to Action states that the annual indirect cost of obesity is \$64 billion with an annual US total cost possibly as high as \$139 billion.²²⁹ The annual per capita medical cost of obesity is estimated to be \$235.²³⁰

As already seen, this epidemic will affect individuals across the life span. We have already noted that obese children are more likely to become obese adults. Issues in childhood such as overweight children being targets of bullying, having low self esteem and depression leading to poor academic performance can lead to continued poor mental health and lower earning power as adults. Even more sinister can be the pathophysiologic effects associated with overweight and obesity, such as insulin resistance, elevated blood lipid levels, metabolic syndrome, type II diabetes, hypertension, need for early joint replacements, fatty liver disease and cardiovascular disease.²³¹

There are a variety of initiatives occurring in New Hampshire in schools and communities to decrease overweight and obesity among children. One area that MCH/SMS can address is to further the education of our health care providers to identify and treat overweight early and prevent obesity among children in the state. An ounce of prevention is worth a pound of cure.

²²⁷ Pediatric Basics, Obesity edition 2005, No. 111, p. 39.

²²⁸ Wang G, Dietz, WH, Economic burden in youths aged 5 to 17 years. *Pediatrics* 2002; 109(5)

²²⁹ US Surgeon General. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2007.

²³⁰ Economos C. PhD, Goldberg J.PhD, RD. (June 2008) Tipping The Scales In Favor Of Our Children. Study sponsored by Harvard Pilgrim Health Care Foundation Growing Up Healthy Initiative

²³¹ Whitlock, Williams, et al. Screening and Interventions for Childhood Overweight: A Summary of Evidence for the U.S. Preventive Services Task Force, *Pediatrics* 2005; 116; 125-144, p. e125-126.

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Table 3.15 – Statewide prevalence* of overweight and obesity, 2008-2009²³²

Variable	Number of Children	Percent of Children	95% Confidence Interval
Obese	556	18.0	16.1-19.9
Overweight	481	15.4	14.1-16.7
Normal weight	1,994	64.9	62.9-66.8
Underweight	51	1.7	1.0-2.4

Only children 0-10 years (3,082) included.

Source: New Hampshire 2008-2009 Third Grade *Healthy Smiles – Healthy Growth*

“Researchers estimate that the direct healthcare cost of obesity for the state of New Hampshire is \$325 million. If current obesity levels are maintained, in 10 years New Hampshire could save \$1,096 million off a projected \$7,381 million healthcare bill. That’s \$958 for every adult in the state.”²³³

3.D.4.e. Mental Health

Access to mental health services continues to be an identified need in New Hampshire, and New Hampshire data overwhelmingly demonstrated that the need for these services is great.

According to a recent report, an estimated 20 percent (55,756) of New Hampshire children aged 5-19 have a diagnosed mental disorder, 3-5 percent of children are estimated to have attention disorder and 0.7 percent were diagnosed with an autism spectrum disorder.²³⁴ Depression was reported by twenty-five percent of New Hampshire high school students in 2009.²³⁵ New Hampshire ranks lowest in northern New England for child mental health providers; the current state of the mental health workforce is not sufficient to meet children’s’ needs²³⁶ “Access to

²³² NH DHHS DPHS Bureau of Prevention Services Oral Health Program 2010. Oral Health and Body Mass Index Assessment of New Hampshire Third Grade Students.

²³³ United Health Foundation. *America’s Health Rankings 2009*. Available from <http://www.americashealthrankings.org>

²³⁴ *Children’s Mental Health in New Hampshire*, New Hampshire Center for Public Policy, September 2007

²³⁵ NH Department of Education. NH Youth Risk Behavior Survey (YRBS) 2009. Available from http://www.education.nh.gov/instruction/school_health/hiv_data.htm

²³⁶ Tappin R, Norton S. (September 2007) *Children’s Mental Health in New Hampshire*. New Hampshire Center for Public Policy

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mental health services” was listed as a top priority in our public input (See section 5, *Selection of State Priority Needs*).

Access is critical: half of all child psychiatrists – potentially the providers best qualified to serve the broadest set of children’s mental health needs, including the provision of prescriptions – are located in the two southeastern counties of the state. Conversely, the two northeastern counties – Carroll and Coos - do not have a child psychiatrist in practice. Although New Hampshire parents report that they first turn to their child’s health care provider for guidance, less than 1 in 5 physicians report having expertise in early childhood mental health issues.²³⁷

Mental health disorders have far reaching implications for the children affected with them. Mental health issues can impact a child’s emotional, intellectual, and behavioral development. It can hinder proper family and social relationships. If left untreated, mental disorders can persist through development and into adulthood. Half of all lifetime mental illnesses start by 14 years old; three-quarters of them start by age 24. Children with mental health problems are less likely to succeed in school, are absent more days from school, and have suspension and expulsion rates that are three times as high as their peers. As many as 44 percent of high school youth with mental illness eventually drop out of school.²³⁸

Nationally, an estimated 10-20 percent of preschool children have significant challenging behaviors. This would translate to a conservative estimate of greater than 7,500 preschool children needing mental health services in New Hampshire.²³⁹ New Hampshire childcare providers surveyed responded that 53 percent had enrolled a child in the past 15 months that had been expelled for challenging behaviors at another facility or had expelled a child from their own program. Nationally, expulsion rates for preschoolers are three times the rate of K-12^{240, 241}

²³⁷ New Hampshire Association for Infant Mental Health. (Spring 2009) *Mental Health Services for New Hampshire’s Young Children and Their Families: Planning to Improve Access and Outcomes*. Retrieved June 8, 2010 from http://www.endowmentforhealth.org/uploads/documents/resource-center/NHAIMH_ECMH_REPORT_2009.pdf

²³⁸ Tappin R, Norton S. (September 2007) *Children’s Mental Health in New Hampshire*. New Hampshire Center for Public Policy

²³⁹ NH Association for Infant Mental Health. (Spring 2009) *Mental Health Services for New Hampshire’s Young Children and Their Families: Planning to Improve Access and Outcomes*. Concord NH.

²⁴⁰ Tappin R, Norton S. (September 2007) *Children’s Mental Health in New Hampshire*. New Hampshire Center for Public Policy

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Disproportionate effects among sub-populations

- o Children and youth from low-income families are at an increased risk for mental health disorders.
- o Nationally, 21 percent of low-income children ages 6 – 17 have mental health problems²⁴²
- o In New Hampshire, the Medicaid population presents with twice the service use prevalence for mental health services compared to privately insured children.²⁴³
- o In rural areas, the prevalence of children with mental disorders is similar to that in urban areas, but there are increased barriers to care. Treatment of children in rural areas often may be delayed until more serious and disabling.²⁴⁴
- o Because of New Hampshire's small ethnic and racial minority population, further analysis of the relationship between ethnicity and race and mental illness in the child Medicaid population is warranted.

Mental health issues have an enormous economic impact, often exceeding other health care costs. The average medical cost per case (all ages) is estimated at \$2,904.²⁴⁵ The average work-loss cost per case is estimated at \$1,441,428.²⁴⁶ Many of these costs are borne by already limited public programs. Twenty five percent (17,680) of New Hampshire children enrolled in Medicaid received services for a mental illness in 2005 through the Medicaid program, and schools were among the primary providers of those services. The Manchester and Nashua School districts alone billed the state's Medicaid program for almost \$1 million each for mental health services in 2005. In 2005, the cost to New Hampshire Medicaid to treat children's mental health issues was \$81,413,310, greater than non- mental health costs of \$66,266,345. The average costs for

²⁴¹ NH Association for Infant Mental Health. (Spring 2009) *Mental Health Services for New Hampshire's Young Children and Their Families: Planning to Improve Access and Outcomes*. Concord NH.

²⁴² Tappin R, Norton S. (September 2007) *Children's Mental Health in New Hampshire*. New Hampshire Center for Public Policy

²⁴³ Tappin R, Norton S. (September 2007) *Children's Mental Health in New Hampshire*. New Hampshire Center for Public Policy

²⁴⁴ Tappin R, Norton S. (September 2007) *Children's Mental Health in New Hampshire*. New Hampshire Center for Public Policy

²⁴⁵ Suicide Prevention Resource Center, "New Hampshire Suicide Prevention Fact Sheet"

²⁴⁶ Suicide Prevention Resource Center, "New Hampshire Suicide Prevention Fact Sheet"

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mental health care to children with permanent disabilities or to children in the foster care system are higher than other Medicaid eligible children.²⁴⁷

Concerns about cost are a considerable barrier for families seeking care, regardless of insurance status. Nearly twenty five percent of young families believed mental health services were too expensive, 16 percent believed that their insurance did not cover these services and 14.9 percent believed that cost prevented their family from getting the care they needed.^{248,249}

Depression's annual toll on U.S. businesses amounts to about \$70 billion in medical expenditures, lost productivity and other costs. Depression accounts for close to \$12 billion in lost workdays each year. Individuals with depression and limited access to treatment incurred an average of nearly three times the annual out-of-pocket costs for medication, psychotherapy and other treatment costs than individuals with less restricted access (\$4,312 versus \$1,496) (2006).²⁵⁰

3.D.4.f. Adolescent Suicide

Access to mental health services is an important component of adolescent suicide prevention.

Suicide was the second leading cause of death for New Hampshire residents ages 10 through 24 for the years 2005-2007.²⁵¹ During the years 1999-2006, the adolescent suicide rate was 11.22 deaths per 100,000; there were 149 deaths over the 8 years, 48.3 percent were due to firearms, 35.6 percent were due to suffocation. The U.S. rate was 10.01 deaths per 100,000 for that period.

²⁵²

According to inpatient admissions/discharges and ED/ambulatory use data, there are approximately 18 self-inflicted injuries requiring hospitalization and/or emergency department

²⁴⁷ Tappin R, Norton S. (September 2007) *Children's Mental Health in New Hampshire*. New Hampshire Center for Public Policy

²⁴⁸ *Children's Mental Health in New Hampshire*, New Hampshire Center for Public Policy, September 2007

²⁴⁹ NH Association for Infant Mental Health. (Spring 2009) *Mental Health Services for New Hampshire's Young Children and Their Families: Planning to Improve Access and Outcomes*. Concord NH.

²⁵⁰ National Alliance on Mental Illness (NAMI) (July 11, 2006) National Survey Finds Depression Costs Nearly Tripled for Individuals With Limited Access to Care. Retrieved January 4, 2010 from http://www.nami.org/Template.cfm?Section=Press_July_2006&Template=/ContentManagement/ContentDisplay.cfm&ContentID=36184

²⁵¹ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

²⁵² CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

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visits for every completed suicide. For females 15-19 in years 2001-2005, there were approximately 140 hospitalizations/100,000 and 500 emergency department visits/100,000 for self-inflicted injuries.²⁵³

In the 2007 Youth Risk Behavior Survey, 13.7 percent of the students seriously considered attempting suicide during the past 12 months and 5.5 percent of the students actually attempted suicide one or more times during the past 12 months.²⁵⁴

Males have a higher rate than females (18.52 deaths per 100,000 versus 3.99 deaths per 100,000 in years 1999-2006, age adjusted).²⁵⁵ Females have self-inflicted injuries requiring hospitalizations and emergency department visits at two times the rate of males in the same age category.²⁵⁶

Overall, the number of suicides appears to be trending downward. However, because of the small numbers, the rate differences are not statistically significant between years.

For each suicide death, there are approximately six survivors of suicide (family and close friends of the victim). In New Hampshire, there are approximately 66 survivors of adolescent (15-24) suicides every year. Suicide survivors are at a higher risk of depression and suicide themselves.

3.D.4.g. Alcohol and Substance Abuse

Substance use among children and adolescents is a serious public health problem in New Hampshire and in the U.S. Substance abuse in a family puts children at risk for future substance abuse, as well as neglect; in New Hampshire, an estimated 37,727 (11.9 percent) of children ages 0-17 have parents who are dependent on or abusing substances.²⁵⁷ Substance abuse impacts

²⁵³ Youth Suicide Prevention Assembly, “2007 Annual Report, Suicide Across the Lifespan, Accomplishments and Data Update”. Produced in conjunction with the State Suicide Prevention Council and NAMI NH. Concord NH.

²⁵⁴ New Hampshire Department of Education, “2007 Youth Risk Behavior Survey Results”. Available from http://www.education.nh.gov/instruction/school_health/hiv_data.htm

²⁵⁵ CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) Available from <http://www.cdc.gov/injury/wisqars/>

²⁵⁶ Youth Suicide Prevention Assembly, “2007 Annual Report, Suicide Across the Lifespan, Accomplishments and Data Update”. Produced in conjunction with the State Suicide Prevention Council and NAMI NH. Concord NH.

²⁵⁷ Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. (May 21, 2009). *The NSDUH Report: Substance Use among Women During Pregnancy and Following Childbirth*. Rockville, MD

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adolescent development, mental health, violence, injury, pregnancy, and infection rates and has effects across the lifespan^{258,259,260} Nationally, one in three suicide deaths were alcohol-related.²⁶¹

New Hampshire is among the top 10 states for the percent of teens abusing alcohol. Fifty percent of New Hampshire high school students report current alcohol use and 28 percent report binge drinking (2007). Twenty three percent of students used marijuana in the past 30 days (2007).²⁶² Significant changes in recent years include a decrease in high school youth alcohol use and an overall increase in cocaine use.²⁶³ Drinking and driving among high school youth also experienced a decrease; however the rate among 12th graders remained the same (18.8 percent)²⁶⁴ New Hampshire did not see the decrease in youth (12-17) illicit drug use that was seen in U.S. and in other New England states.²⁶⁵

New Hampshire 18-25 year olds experienced higher rates of substance abuse (27.1 percent vs. 20.0 percent) and more unmet need for treatment than the US.²⁶⁶ Higher rates were seen mostly in the percent of 18-25 year olds reporting use of marijuana in the past month (25.0 percent vs. 16.4 percent US, 20.0 percent New England states average) and past year cocaine use (9.9 percent vs. 6.9 percent). Fifty-one percent (68,859) of youth report binge drinking.²⁶⁷

Cocaine was identified as the highest drug threat to New Hampshire²⁶⁸ In New Hampshire, HIV transmission by intravenous drugs use (IDU) was higher than high risk heterosexual contact,

²⁵⁸ SAMHSA 2007 Treatment Episode Date Set (TEDS)

²⁵⁹ NH DHHS DPHS. Sexually Transmitted Diseases & HIV (STD & HIV) Prevention Programs. 2007 STD/HIV Annual report

²⁶⁰ Hingson, RW ScD, MPH, et al. (June 2009) *Age of Drinking Onset, Alcohol Use Disorders, Frequent Heavy Drinking, and Unintentionally Injuring Oneself and Others After Drinking* Pediatrics. 123;6: 1477.

²⁶¹ CDC. June 2009 MMWR Vol 58 (23) analysis of National Violent Death Reporting System (NVDRS)

²⁶² Substance abuse: NH Plan for overcoming the impact of alcohol & other drug problems, DHHS 2007. (Data source: NH BRFSS 2007).

²⁶³ NH Department of Education. NH Youth Risk Behavior Survey (YRBS) trends. Available from http://www.education.nh.gov/instruction/school_health/hiv_data.htm

²⁶⁴ NH Department of Education. NH Youth Risk Behavior Survey (YRBS) trends. Available from http://www.education.nh.gov/instruction/school_health/hiv_data.htm

²⁶⁵ SAMHSA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁶⁶ SAMHSA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁶⁷ SAMSHA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁶⁸ US Department of Justice, National Drug Intelligence Center (NDIC). 2009 National Methamphetamine Drug Assessment

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which is the reverse of the U.S.^{269,270} and 47 percent of Hepatitis C virus (HCV) transmission in 2007 was by IDU.²⁷¹

Of note, while 18-25 year olds are disproportionately affected by substance abuse nationally, the disparity is even more pronounced in New Hampshire:

Table 3.16

Age group reporting substance abuse²⁷²	NH	US
12-17 year olds	8.9%	9.8%
18-25 year olds	27.1%	20.0%
Ages 26 and older	5.7%	5.9%

- o Nationally, unemployed adults report nearly double the rate of substance use as employed adults (18.3% vs. 8.4%).²⁷³

Geographic disparities are evident in the State’s youth substance abuse problem:

- o Alcohol use among Coos County youth was greater than that reported by New Hampshire 11th graders in the 2007 New Hampshire YRBS²⁷⁴
- o Coos County youth who were not involved in out-of-school activities were significantly more likely to use cigarettes, tobacco, alcohol and marijuana than their more involved peers²⁷⁵

²⁶⁹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2007*. Vol. 19. Atlanta GA. Available from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/>

²⁷⁰ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. *2008 NCHHSTP State Health Profiles*. Atlanta GA. Available from <http://www.cdc.gov/nchhstp/stateprofiles/usmap.htm>

²⁷¹ CDC. Surveillance for Acute Viral Hepatitis --- United States, 2007. *MMWR* 2009;58(SS03):1-27. Retrieved June 8, 2010 from <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5803a1.htm>

²⁷² Substance Abuse and Mental Health Services Administration (SAMHSA). 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁷³ SAMHSA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁷⁴ Sharp, EH. *Too Much Free Time: Coos County Youth Who Are Least Involved in Out-of-School Activities Are Most Likely to Use Drugs and Alcohol*. Carsey Institute. Tracking Changes in the North Country. Issue Brief number 18, Spring 2010.

²⁷⁵ Sharp, EH. *Too Much Free Time: Coos County Youth Who Are Least Involved in Out-of-School Activities Are Most Likely to Use Drugs and Alcohol*. Carsey Institute. Tracking Changes in the North Country. Issue Brief number 18, Spring 2010.

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The costs of substance use and abuse nationally and in New Hampshire are enormous and include medical costs, as well as increased incarceration, and lower incomes. Nationally, over 5 percent of all hospital discharge visits due to injury describe the cause of the visit as alcohol & drug use.²⁷⁶

Substance abuse treatment capacity continues to be a problem in New Hampshire:

Medicare and Medicaid offer Screening, Brief Intervention, and Referral to Treatment (SBIRT) coding (\$24-48/person)²⁷⁷, but there is a 50 percent state match that New Hampshire has been unable to absorb. SBIRT is part of the Title V primary care (PC) contracts, but implementation is sparse based on site visits and a practice survey to the health centers. Costs to increase the implementation of SBIRT at PC sites in New Hampshire include the costs of technical assistance and support to the health centers; total costs to implement in all PC sites is estimated at \$165,000.²⁷⁸

- o Current substance abuse treatment capacity exists to treat <10 percent of the need
- o New Hampshire's substance abuse treatment rates for 18-25 year olds are 5th lowest in the nation. Only 9.2 percent of 18-25 year olds receive treatment for illicit drug use, and only 20.5 percent for alcohol abuse.²⁷⁹
- o A scarcity of Licensed Alcohol and Drug Abuse Counselors (LADC's) exists in the State²⁸⁰
- o New Hampshire spends >\$10 million to directly treat drug/alcohol problems (half consists of federal funds)²⁸¹

²⁷⁶ CDC NCHS. 2008 National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary

²⁷⁷ SAMHSA. *Coding for SBI Reimbursement*. (February 2008) Retrieved June 2009 from

<http://sbirt.samhsa.gov/coding.htm>,

²⁷⁸ NH DHHS DPHS. Maternal and Child Health Section and Dartmouth Center for Addiction Recovery and Education (DCARE) grant proposal. (2008) *Training and Practice Change Strategies for Adoption of Routine SBIRT for Drugs into Community Health Settings in New Hampshire*

²⁷⁹ SAMSHA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

²⁸⁰ Task force convened by the New Hampshire DHHS; the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment; Dartmouth Medical School; and the New Hampshire Alcohol and Drug Services Providers' Association (April 2007) *Overcoming the impact of alcohol & other drug problems: A Plan for New Hampshire*. Concord NH.

²⁸¹ NH DHHS, 2007. NH Plan for overcoming the impact of alcohol & other drug problems

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3.D.4.h. Oral Health

Tooth decay is the most common chronic childhood disease, and is largely preventable through a combination of community, professional and individual strategies. Enough is known about dental disease prevention that any child can grow into adulthood with good oral health.

Like the adult population, many of New Hampshire's children from low-income, uninsured families do not have access to regular oral health care and education. Even for those covered under the New Hampshire Healthy Kids Gold (Medicaid) program, families have difficulty accessing dental care for their children. Many dentists do not accept Medicaid client nor do they have a sliding fee scale.

A cost effective intervention that prevents dental disease, community water fluoridation, is underutilized in New Hampshire. Only 43 percent of residents served by a community water system benefit from fluoridated public water supplies even though the average per capita cost of water fluoridation is very low. Naturally occurring fluoride varies in wells through out the state. To help low-income families assess their need for age-appropriate supplemental fluoride, the Maternal and Child Health Section pays for well water testing for fluoride at the State Laboratory for those children in the state-funded community health centers. With this effort, appropriate fluoride supplement can be prescribed if needed.

New Hampshire has an established oral health surveillance system that includes oral health data collected on 3rd grade students in public schools.²⁸² Previously conducted in 2001 and 1004, the New Hampshire *Third Grade Healthy Smiles-Healthy Growth Survey* was conducted between September 2008 and June 2009. The goal was to collect uniform information on the oral health and weight status of third grade students, to document the burden of disease, and to use this information for public health surveillance, intervention planning, and evaluation. Altogether, 81 randomly selected New Hampshire public schools and 3,151 students participated in the survey.

One dentist and six dental hygienists were trained to provide dental screenings using the Association of State and Territorial Dental Directors Basic Screening Survey tool. Participating

²⁸² NH DHHS, DPHS Bureau of Prevention Services. (Dec 2009) *New Hampshire 2008-09 Third Grade Healthy Smiles-Healthy Growth Survey*. Concord NH.

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students underwent a brief visual examination to determine the presence of untreated decay, previous decay experience, need for dental care (any care vs. urgent care) and dental sealants.

The statewide sample consisted of 81 schools and 4,725 students. Participating schools were representative of the state in terms of eligibility for free and reduced lunch. Some used passive parental consent while others used active parental consent.

Approximately 44 percent of New Hampshire 3rd grade students experienced tooth decay and 12 percent of students had untreated decay at the time of the survey. An estimated 60 percent of the students had dental sealants. Since the last third grade survey was conducted in 2004, there has been a marked improvement in the proportion of students with dental sealants and untreated decay.²⁸³ Several oral health initiatives over the past five years may have contributed to the improvement. The survey found differences between schools with higher and lower proportions of children participating the free and reduced-price meals program. Students in schools with a higher proportion of children participating in the free ad reduced-price meals program had more tooth decay and were less likely to have protective dental sealants.

Coos County had the highest prevalence of decay experience and untreated decay and the lowest prevalence of dental sealants. This prevalence was statistically higher when compared to all other regions. Third grade students in the Carroll/Grafton region had statistically significantly fewer sealants than students in some other regions.

Table 3.17 Statewide prevalence of tooth decay experience, dental sealants and treatment urgency, 2008-2009²⁸⁴

Variable	# of Children	Percent of Children	95% Confidence Interval
Decay experience	1427	43.6	39.7-47.4
Untreated decay	443	12.0	9.6-14.4
Dental sealants	1644	60.4	56.8-64.1
Need treatment (early & urgent)	448	12.0	9.7-14.4
Need urgent treatment	39	1.0	0.5-1.5

²⁸³ NH DHHS, DPHS Bureau of Prevention Services. (Dec 2009) *New Hampshire 2008-09 Third Grade Healthy Smiles-Healthy Growth Survey*. Concord NH.

²⁸⁴ NH DHHS, DPHS Bureau of Prevention Services. (Dec 2009) *New Hampshire 2008-09 Third Grade Healthy Smiles-Healthy Growth Survey*. Concord NH.

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Table 3.18 Statewide prevalence of tooth decay experience, dental sealants stratified by Free and Reduced-Price Lunch (FRL)²⁸⁵ Status of School, 2009-2009²⁸⁶

Variable	<25% FRL 95% CI (n=1615)	25-49% FRL 95% CI (n=1099)	≥50% FRL 95% CI (n=301)
Decay experience	38.5 (34.8-42.2)	51.4 (44.6-58.2)	68.4 (63.5-73.4)
Untreated decay	9.7 (7.0-12.4)	15.6 (12.4-18.8)	22.3 (13.1-31.5)
Dental sealants	62.9 (58.1-67.7)	55.5 (51.5-59.60)	52.5 (50.8-54.1)
Need treatment (early & urgent)	9.8 (7.2-12.5)	15.5 (12.3-18.8)	22.5 (13.3-31.7)
Need urgent treatment	1.0 (0.3-1.7)	0.6 (0.2-1.1)	2.6 (0.8-4.9)

Regional disparities in oral health were detected (see Table 3.19 below). Students in Coos County were more likely to have experienced decay, have untreated decay, and to be in need of treatment. They were also less likely to have dental sealants. Statewide, children attending schools with a higher proportion (≥50% of students participating in the free and reduced lunch program) were more likely to have experienced decay, have untreated decay, and to be in need of treatment; they were less likely to have dental sealants than students in schools with <25 percent of participation in the program.

Table 3.19 Region specific prevalence estimates and 95% CI of tooth decay experience, dental sealants and treatment urgency, 2008-2009²⁸⁷

Variable	Belknap Merrimack (n=376)	Carroll Grafton (n=393)	Cheshire Sullivan (n=300)	Coos ²⁸⁸ (n=217)	Hillsborough (n=1021)	Rockingham (n=376)	Strafford (n=332)
Decay experience	50.2 (39.7-60.7)	47.7 (36.7-56.7)	51.6 (44.5-58.7)	64.0	43.9 (34.7-53.1)	38.9 (32.0-44.9)	44.2 (32.3-56.1)
Untreated decay	14.9 (7.2-22.5)	17.0 (9.2-24.7)	13.3 (8.4-18.3)	30.7	10.6 (6.8-14.4)	10.8 (5.9-15.8)	13.7 (6.0-21.3)
Dental sealants	59.8 (52.0-67.5)	39.8 (27.9-51.7)	61.7 (56.4-67.0)	23.7	60.3 (53.9-66.7)	63.8 (55.6-71.9)	56.3 (48.9-63.8)

²⁸⁵ New Hampshire Department of Education. Percent of children in the school that participate in the free/reduced price lunch program, 2007-2008.

²⁸⁶ NH DHHS, DPHS Bureau of Prevention Services. (Dec 2009) *New Hampshire 2008-09 Third Grade Healthy Smiles-Healthy Growth Survey*. Concord NH.

²⁸⁷ NH DHHS, DPHS Bureau of Prevention Services. (Dec 2009) *New Hampshire 2008-09 Third Grade Healthy Smiles-Healthy Growth Survey*. Concord NH.

²⁸⁸ Coos county estimates based on a census

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Need treatment (early & urgent)	14.9 (7.2-22.5)	16.7 (9.2-24.2)	13.7 (8.6-18.8)	31.1	10.7 (7.0-14.4)	10.8 (5.9-15.8)	14.6 (6.8-22.4)
Need urgent treatment	1.4 (0.0-3.1)	2.5 (0.9-4.2)	0.7 (0.0-1.7)	0.8	0.4 (0.0-0.9)	1.2 (0.0-2.5)	2.0 (0.2-3.7)

Schools are an excellent place to prevent dental disease in children. In New Hampshire, 168 schools (53% of all public elementary schools) provide dental services and dental health education for students.

3.D.4.i. Childhood Lead Poisoning

According to 2000 Census data, approximately 30 percent of New Hampshire housing stock was built prior to 1950 when lead paint was commonly used. Children living in older houses with deteriorated lead paint or lead contaminated dust are at increased risk for lead poisoning.

Children, especially those under age 6, are more likely to suffer persistent developmental delays, learning disabilities and behavioral problems as a result of their exposure to lead.

In 2007, 10,530 5-17 year olds had had confirmed elevated blood lead levels (EBLL) \geq 10 micrograms per deciliter of blood (mcg/dL) at some point in time. This estimate represents 5.5 percent of the children attending school during the 2006-2007 school year.²⁸⁹

In 2009, 118 New Hampshire children under the age of 6 were newly identified with EBLLs of 10 mcg/dL (See Table 3.20 below), out of 15,051 children tested for lead poisoning.²⁹⁰ The majority of these children (90 percent) lived in pre-1950 homes and approximately one-third lived in or regularly visited homes built prior to 1978 that had recently undergone renovation. Lead exposure hazards from lead-based paint and dust are identified in more than 90 percent of New Hampshire lead poisoning cases.²⁹¹

New Hampshire has comparatively high rates for housing built before 1950 when lead paint was commonly used: 39.2 percent of renter-occupied units were built before 1950 compared to 24.4

²⁸⁹ Estimated Economic Impact of Childhood Lead Poisoning in New Hampshire, Prepared by Heidi Kroll and Dr. Lisa Shapiro, Gallagher, Callahan & Gartrell, P.C., October 3, 2008

²⁹⁰ NH DHHS DPHS Maternal & Child Health Section. Childhood Lead Poisoning Prevention Program (CLPPP) 2010

²⁹¹ NH DHHS DPHS Maternal & Child Health Section. Childhood Lead Poisoning Prevention Program (CLPPP) 2008

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percent nationally (New Hampshire is the seventh highest-ranking state in this category); among Heads of Household aged 15-34 (those most likely to have young children), 38.4 percent of renter-occupied units were built before 1950 compared to 21.3 percent nationally.²⁹²

Older housing that is renter-occupied, as opposed to owner-occupied, is of high risk because it is less likely to have sufficient up-keep. In New Hampshire, rental occupants are more likely to face barriers such as lower socioeconomic status, lower education levels and cultural or language differences. Children and youth from low-income families are also at an increased risk for lead poisoning.

New Hampshire has also been the fastest growing state in the northeast in recent decades. From 1990 to 2000, New Hampshire was one of only two states to exhibit an increase in the number (and rate) of pre-1950 renter-occupied housing units. In 1990, there were 52,888 pre-1950 renter-occupied housing units in the state. In 2000, there were 56,448, representing a 6.7 percent increase. Nationally, the number of pre-1950 renter-occupied units declined by 6.9 percent.²⁹³

²⁹² U.S. Census Bureau. 2000 Census. Available from http://factfinder.census.gov/servlet/SAFFHousing?_event=&geo_id=01000US&geoContext=01000US&street=&county=&cityTown=&state=&zip=&lang=en&sse=on&ActiveGeoDiv=&useEV=&pctxt=fph&pgsl=010&submenuId=housing_1&ds_name=null&ci_nbr=null&qr_name=null®=&keyword=&industry=

²⁹³ U.S. Census Bureau. 2000 Census. Available from http://factfinder.census.gov/servlet/SAFFHousing?_event=&geo_id=01000US&geoContext=01000US&street=&county=&cityTown=&state=&zip=&lang=en&sse=on&ActiveGeoDiv=&useEV=&pctxt=fph&pgsl=010&submenuId=housing_1&ds_name=null&ci_nbr=null&qr_name=null®=&keyword=&industry=

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Table 3.20 Newly Confirmed Elevated Blood Lead Levels (≥ 10 mcg/dL) by Year, NH

Year	Age Range (months)	Lead Level (ug/dL)			Total	Confirmed Elevations/Total Children Screened (%)
		10-14	15-19	20+		
2003	0-11	11	2	3	16	0.8%
	12-23	87	34	18	139	2.1%
	24-35	49	13	13	75	2.5%
	36-71	33	4	8	45	2.1%
	Total	180	53	42	275	2.0%
2004	0-11	15	2	8	25	1.2%
	12-23	89	25	24	138	2.0%
	24-35	35	13	16	64	2.0%
	36-71	40			56	2.6%
	Total	179			283	1.9%
2005	0-11	8			15	0.8%
	12-23	77			113	1.6%
	24-35	36			57	1.7%
	36-71	19			30	1.6%
	Total	140			215	1.5%
2006	0-11	4			5	0.2%
	12-23	57	19	22	98	1.2%
	24-35	37	8	11	56	1.7%
	36-71	27	7	8	42	2.6%
	Total	125	34	42	201	1.3%
2007	0-11	7	3	4	14	0.8%
	12-23	51	25	17	93	1.2%
	24-35	28	9	4	41	1.1%
	36-71	13	6	3	22	1.0%
	Total	99	43	28	170	1.1%
2008†	0-11	5	1	1	7	0.4%
	12-23	33	23	5	61	0.8%
	24-35	30	10	6	46	1.2%
	36-71	20	3	3	26	1.1%
	Total	88	37	15	140	0.9%
2009	0-11	3	4	2	9	0.7%
	12-23	44	13	7	64	0.9%
	24-35	23	4	4	31	0.8%
	36-71	12	2	0	14	0.6%
	Total	82	23	13	118	0.8%

†Definition of confirmed elevations changed slightly
Source: NH Childhood Lead Poisoning Prevention Program, 2010

Table 3.21 Summary of Estimated Select Annual Economic Impacts of Childhood Lead Poisoning in New Hampshire, (in 2008 Dollars)

Lost Future Earnings	\$130 M - \$311 M
Lost State & Local Taxes	\$10 M - \$31 M
Special Education Costs	\$288,000 - \$973,000
Juvenile Justice System Costs	\$1.1 M - \$2.7 M
Total	\$141.1 M - \$345.7 M

3.D.4.j. Asthma

The prevalence of asthma among adults and children across the United States has increased dramatically since the mid-1980s. In New Hampshire between 2000 and 2008, there is a

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statistically significant increasing trend in the prevalence of asthma among adults; there currently aren't enough data to determine if there is a similar trend among children.²⁹⁴

Morbidity associated with asthma is high. Emergency department use, hospitalization, decreased lung function and death can characterize the experience of children with uncontrolled asthma. Parents and guardians of children in New Hampshire with asthma are less likely to rate their child's health as being excellent or very good, approximately three times more likely to report their child as being unable to do the things most children their age do, and more likely to report their child missing four or more days of school than those without asthma.²⁹⁵

Asthma is the most prevalent chronic condition among children, a leading cause of school absenteeism and, with oral health and injury, a leading cause of emergency room visits²⁹⁶. New Hampshire and other states in New England have some of the highest prevalence rates of asthma in the nation.²⁹⁷ However, there are no statistically significant differences between New Hampshire and the US for asthma prevalence among children 0-17 years old.²⁹⁸ According to the 2008 New Hampshire BRFSS, approximately 10 percent of New Hampshire adults and 8.6 percent of children ages 0-17 (24,848 children) currently have asthma.²⁹⁹

Nearly 70 percent of New Hampshire children with asthma have poorly controlled asthma.³⁰⁰ These children are particularly susceptible to environmental asthma triggers. Only 31.4 percent of New Hampshire children with asthma receive the minimum standard of asthma education.³⁰¹

²⁹⁴ NH DHHS DPHS Asthma Control Program. Data Brief Vol.1 No.1, October 2007. *Asthma in NH How does Asthma affect Communities in NH?*

²⁹⁵ National Survey of Children's Health 2003. Available from <http://www.nschdata.org/DataQuery/SurveyAreas.aspx?vid=1>

²⁹⁶ NH DHHS DPHS Asthma Control Program. Data Brief Vol.1 No.1, October 2007. *Asthma in NH How does Asthma affect Communities in NH?*

²⁹⁷ NH DHHS DPHS Asthma Control Program. Data Brief Vol.1 No.1, October 2007. *Asthma in NH How does Asthma affect Communities in NH?*

²⁹⁸ Liz Traore personal communication. NH DHHS DPHS Asthma Program

²⁹⁹ 2008 BRFSS

³⁰⁰ 2006-2007 NH BRFSS Child Asthma Call-back survey. NH Asthma Control Program Data Report Vol.3 No.1, July 2009

³⁰¹ 2006-2007 NH BRFSS Child Asthma Call-back survey. NH Asthma Control Program Data Report Vol.3 No.1, July 2009

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Health disparities for asthma occur by gender, age, educational level and household income. Those at higher risk of poor outcomes include females; pediatric, young adult and senior age groups; individuals with less than a high school level of education; and those in households with less than \$25,000 in annual income. In addition, exposure to second-hand smoke increases the risk.^{302,303,304}

Housing conditions associated with asthma and other respiratory illnesses include the presence of mold, excess moisture, allergens (i.e., dust mites, mice, pet dander and cockroaches) and tobacco smoke. Approximately 19 percent of New Hampshire adults report they currently smoke and approximately one-third of all New Hampshire children live in homes where a person smokes, making exposure to tobacco smoke a significant problem for children and adults with asthma.³⁰⁵

Inpatient hospitalizations totaled \$8.2 million in charges in 2004 for 940 hospitalizations, effectively doubling charges reported in 2000. ED visits in 2004 for all ages totaled \$3.9 million in charges. Medicaid accounted for 14.7 percent of inpatient charges and 17.5 percent of emergency department charges, with costs to the state an estimated \$12,121,742.³⁰⁶

Healthy Homes

A growing body of evidence links housing conditions to health outcomes such as asthma, lead poisoning, lung cancer, and unintentional injuries. Nationwide, nearly 5.7 million families live in substandard housing conditions placing millions of children and adults at risk

3.D.5. Summary of Disparities

The New Hampshire Children's Alliance reports that, "in our state of plenty, 60,000 children are being left behind".³⁰⁷ The Children's Alliance uses the Child Well Being Index based on the national model to categorize New Hampshire communities into five quartiles based on their

³⁰² NH DHHS DPHS Asthma Control Program. *Asthma in NH Issue Brief* (February 2007)

³⁰³ Osborne ML, Vollmer WM, Linton KLP, Buist AS. *Characteristics of patients with asthma within a large HMO: a comparison by age and gender*. Am J Respir Crit Care Med 1998;157:123-8.

³⁰⁴ Martin AJ, McLennan LA, Landau LI, Phelan PD. The natural history of childhood asthma to adult life. Br Med J 1980;280:1397-400.

³⁰⁵ National Survey of Children's Health 2003. Available from <http://www.nschdata.org/DataQuery/SurveyAreas.aspx?yid=1>

³⁰⁶ NH DHHS DPHS Asthma Control Program. *Asthma in NH Issue Brief* (February 2007) Inpatient hospital data

³⁰⁷ Children's Alliance of New Hampshire. (2008) *Kids Count New Hampshire Data Book 2008: Our Most Vulnerable Communities*. Available from www.childrennh.org

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scores on seven indicators such as food stamp participation rate, child death rate, teen birth rate, high school dropout rate and other measures of community health and economic opportunity. Their analysis shows considerable disparities in health and education between the highest scoring (Q1) and lowest scoring (Q5) quintiles. It identifies 27 towns and cities and the 60,000 children who live in those Q5 communities as not having access to the resources that support child well being. One-fifth of New Hampshire children live in these communities. Children and adolescents from communities in the lowest scoring quintile are at much greater risk than their peers in the higher scoring quintiles for poverty, infant and child death, dropping out of high school (20%) and other poor outcomes.³⁰⁸

- o More than 40 percent of elementary school children in Q5 communities receive free or reduced price lunches to meet their basic nutritional needs, compared to 5 percent of their peers in Q1 communities, and the eligibility rate has risen more than in the higher scoring quintile communities
- o 14 percent of children (ages 0 to 17) in the Q5 communities live below poverty compared to the state average of 8.6 percent
- o 20 percent of students in the Q5 communities do not finish high school.
- o A much smaller percentage of minority students in Q5 communities achieved proficiency on the math and reading portions of the New England Common Assessment Program (NECAP) test than minority students in Q1 communities.
- o Children in Q5 have higher rates of infant death and child death and are more likely to have mothers who smoked during pregnancy
- o There were 5.6 victims of child abuse or neglect per 1000 children in Q5 communities compared to 0.8 victims per 1000 children in Q1 communities.

³⁰⁸ Children's Alliance of New Hampshire. (2008) *Kids Count New Hampshire Data Book 2008, Our Most Vulnerable Communities*. Available from www.childrennh.org

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3.E. Children with Special Health Care Needs (CSHCN)

3.E.1. 2010 Priorities for Children With Special Health Care Needs

Primary Association:

- o To increase family support and access to trained respite and childcare providers
- o To improve access to standardized developmental screening for young children

Secondary Association:

- o To improve access to children's mental health services
- o To decrease pediatric overweight and obesity
- o To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services
- o To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents
- o To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments
- o To improve oral health and access to dental care
- o To increase family support and access to trained respite and childcare providers

3.E.2. Overview

In New Hampshire, one in every four households has at least one child with special health care needs.³⁰⁹ Data, utilized in the Child and Adolescent Section of this report, indicate that the general population of children and adolescents in New Hampshire are 30% of the total population (1,315,809 residents).³¹⁰ Data from the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN) indicates that New Hampshire has approximately 50,365 children with special health care needs (0-17 years of age). This is 16.6% of the population of all children 0-17 years of age and 3.8% of the total population of the State of New Hampshire. The data available, ranks New Hampshire as having the 9th highest percentile of CSHCN compared to non-CSHCN, in the nation. New Hampshire's population of CSHCN compares to the rest of the nation as follows:

³⁰⁹ Child and Adolescent Health Measurement Initiative. *2005/06 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

³¹⁰ Table 2: Annual Estimates of the Resident Population by Sex and Age for New Hampshire: April 1, 2000 to July 1, 2008 (SC-EST2008-02-33). Source: Population Division, U.S. Census Bureau. Release Date: May 14, 2009, <http://www.census.gov/popest/states/asrh/SC-EST2008-02.html>, accessed 5/15/10.

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Table 3.22

In New Hampshire:	NH %	Nation %
More CSHCN are male	19.8	16.1
There is more of a difference between # of males and # females, who are CSHCN	6.8	4.5
More CSHCN are in the 12-17 year old age group	20.3	16.8
More CSHCN have English as primary language	97.9	87.5

3.E.3. Strengths

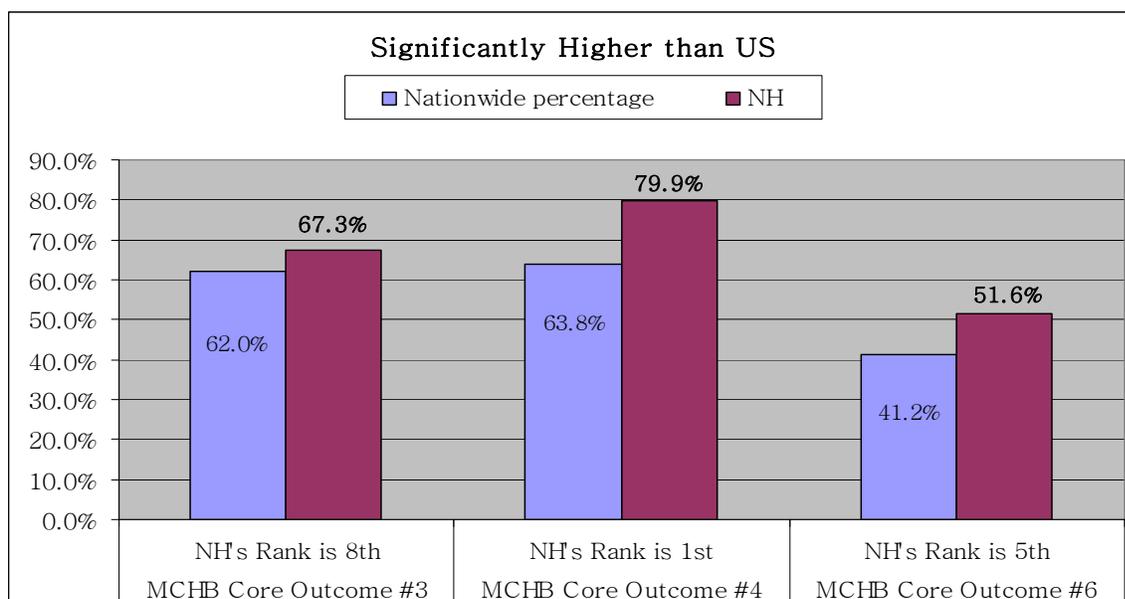
As noted in Section D. Children and Adolescents, New Hampshire fares very well in state national assessments on child health, well being and insurance status. CSHCN in New Hampshire benefit from these factors as well. In particular, New Hampshire has performed well on the MCHB Core Outcomes. A primary measure for Title V CSHCN programs in the US are the 6 federal Maternal and Child Health Bureau Core Outcomes. These are measures that are used, across state programs, to monitor progress toward the goal of a comprehensive, family-centered, community-based, coordinated system of care for CSHCN. According to the NS-CSHCN from 2005/2006, New Hampshire ranked 1st in the Nation for CSHCN ages 12-17 who met all 6 MCHB Core Outcomes and 2nd for CSHCN ages 0-11 who met all 5 MCHB Core Outcomes (the Transition Core Outcome does not apply to this age group).

When looking at the results of measurement on the MCHB Core Outcomes individually, strengths are highlighted in those measures for which New Hampshire scored higher than the US. Not only did New Hampshire score higher than the national median on these 5 Outcomes but on the two Core Outcomes that had comparable measure in 2001 (families as partners in decision-making and adequate insurance) New Hampshire's rates improved.³¹¹

³¹¹ Child and Adolescent Health Measurement Initiative. *2005/06 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

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Figure 3.46

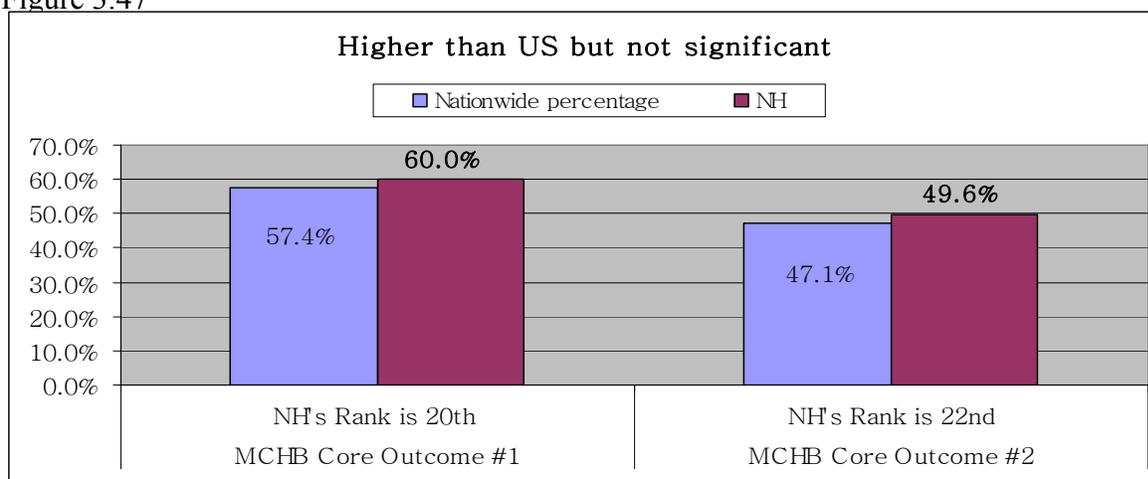


#3 -- Families have adequate public/private insurance to pay for services they need

#4 -- Children are screened early and continuously for special health care needs

#6 -- Youth with SHCN receive the services necessary to make appropriate transitions to adult health care, work and independence.

Figure 3.47



#1 -- CSHCN families are partners with decision-making and are satisfied with services.

#2 -- CSHCN have a medical home.

New Hampshire also has some significant strengths noted among the National Chartbook Indicators.³¹² On the measures below a lower rate indicates better outcomes for CSHCN

³¹² Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

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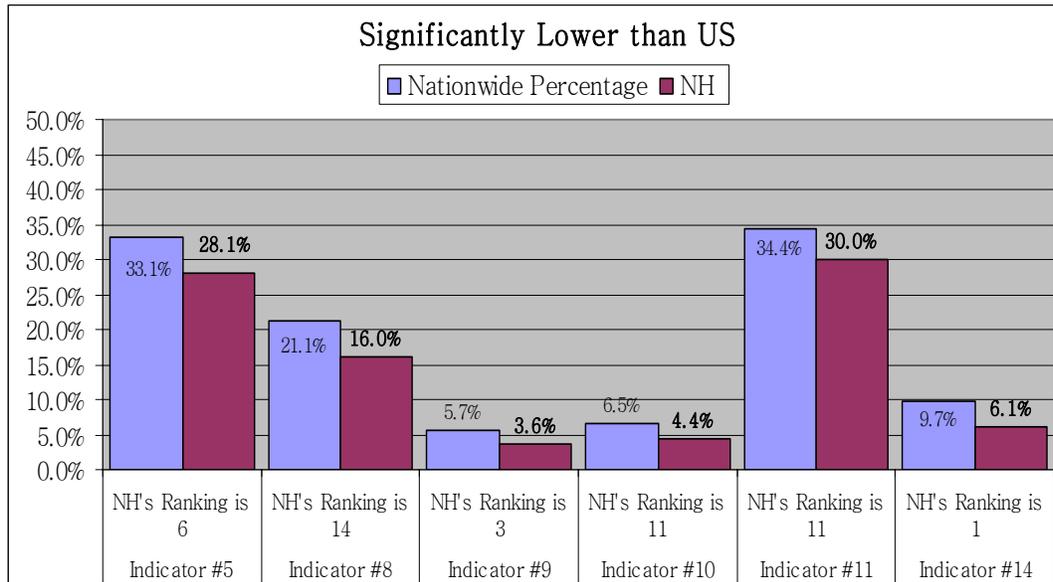


Figure 3.48

- #5 -- Currently insured CSHCN whose insurance is inadequate.
- #8 -- CSHCN needing a referral who have a difficulty getting it.
- #9 -- CSHCN without a usual source of care when sick(or who rely on the ER).
- #10--CSHCN without any personal doctor or nurse
- #11--CSHCN without family centered care.
- #14--CSHCN whose families spend ≥ 11 hours/week providing/coordinating health care.

Additional indicators for which New Hampshire is performing well:

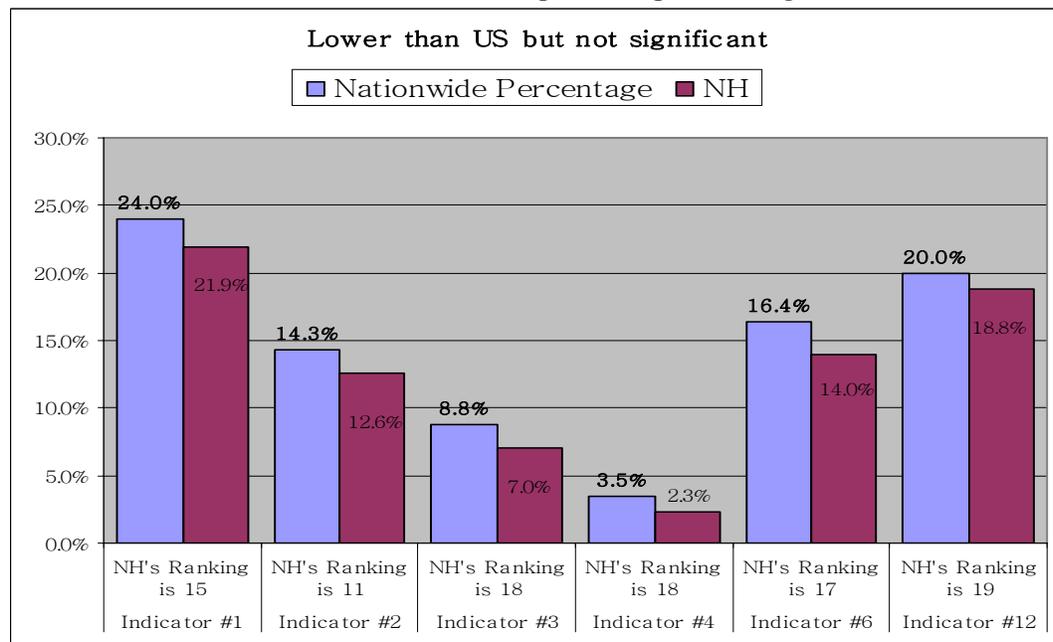


Figure 3.49

- #1 -- CSHCN whose condition affect their activities usually, always or a great deal.
- #2 -- CSHCN with 11 or more days of school absences due to illness (age s 5-17).
- #3 -- CSHCN without insurance at some point in the past year.
- #4 -- CSHCN without insurance at time of survey.

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#6 -- CHSCN with any unmet needs for specific health care services.

#12-- CSHCN whose families spend \$1,000 + out of pocket in medical expenses per year for the child.

3.E.4. Needs

3.E.4.a. Overview

Though New Hampshire, in general, (consistent with all of Region I) has high rates of insurance for CSHCN, when compared to the rest of Region I New Hampshire is ranked lowest for the percentage of CSHCN who were insured for the entire previous year.³¹³ There was one MCHB Core Outcome for which New Hampshire was rated lower than the national average. This Outcome was related to CSHCN whose services are organized in ways that families can use them easily, 85.7% of families in New Hampshire reported favorably but the national average was 89.1%. National Chartbook Indicators for New Hampshire that demonstrate some issues

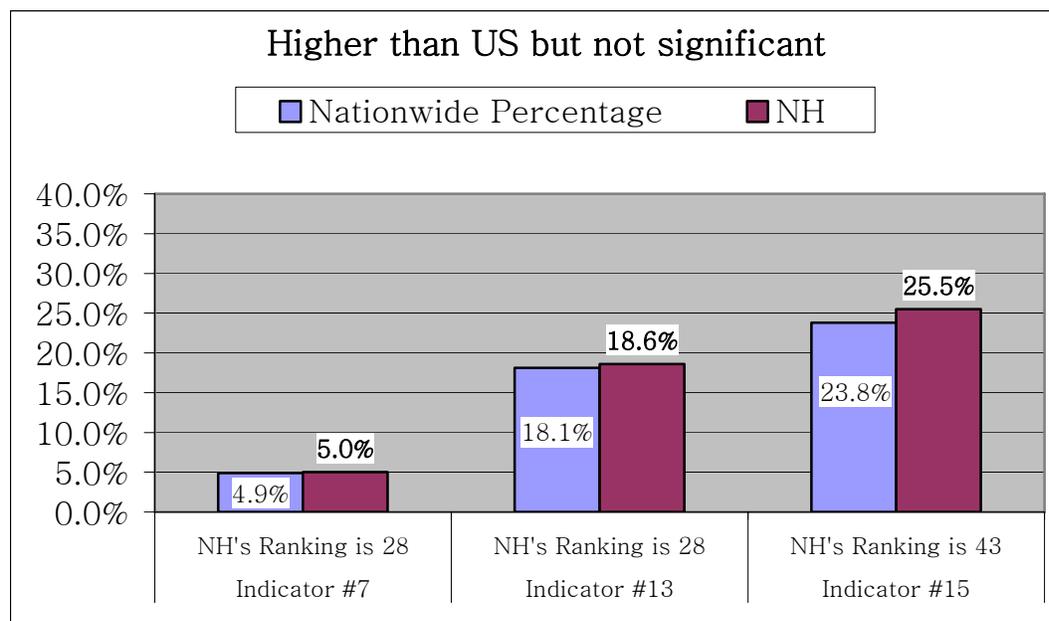


Figure 3.50

that families experience are listed below:³¹⁴

#7 -- CSHCN with any unmet need for family support services.

#13 -- CSHCN whose conditions cause financial problems for family.

#15 -- CSHCN whose conditions cause family members to cut back or stop working.

Efforts to insure that services are organized in such a way that family find the easy to utilize will be a strong focus on activity and service planning. Title V CSHCN services should design

³¹³ Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

³¹⁴ Ibid

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activities and services that facilitate families accessing services in order to decrease any burden or hardship that caregivers are experiencing. Efforts should incorporate enabling services to assist with accessing resources as well as infrastructure building activities to assure a responsive community based system of Care.

Since the criteria for a services that were easy to use was the absence of ANY difficulty using any health related services in the last 12 months it is critical to identify the needs associated with the Medical Home Core Outcomes more available and effective medical homes should conceivable limit difficulties accessing health related services. New Hampshire did rank higher than the national average for CSHCN with a medical home (49.6% compared to 47/1%) however this was the lowest ranking that New Hampshire received out of all 6 Core Outcomes.

A powerful example of the need for New Hampshire to demonstrate greater success on the Medical Home Outcome is the effect that it will have on the Ease of Use Outcome. Of CSHCN who needed specialty care when they did not have a medical home only 55.1% had no trouble getting needed referrals compared to 100% of CSHCN with a medical home. Similarly, when asked about unmet needs for 15 specific services and/or for equipment 93.6 % of respondents with a medical home reported that they had no unmet needs while only 78.9% of respondents without a medical home reported the same level of access.³¹⁵

From a statewide perspective there are several indicators of the types of services necessary for New Hampshire's CSHCN. Trend data indicates that enrollment in Special Medical Services continues to grow, as does utilization of SMS' Information and Referral services. Services with the greatest utilization are Nutrition and Feeding & Swallowing, Child Development Clinics, Community-Based Care Coordination and Neuromotor Clinics, respectively.³¹⁶

³¹⁵ Child and Adolescent Health Measurement Initiative. *2005/06 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

³¹⁶ Service Utilization Report, Special Medical Services, February 2009

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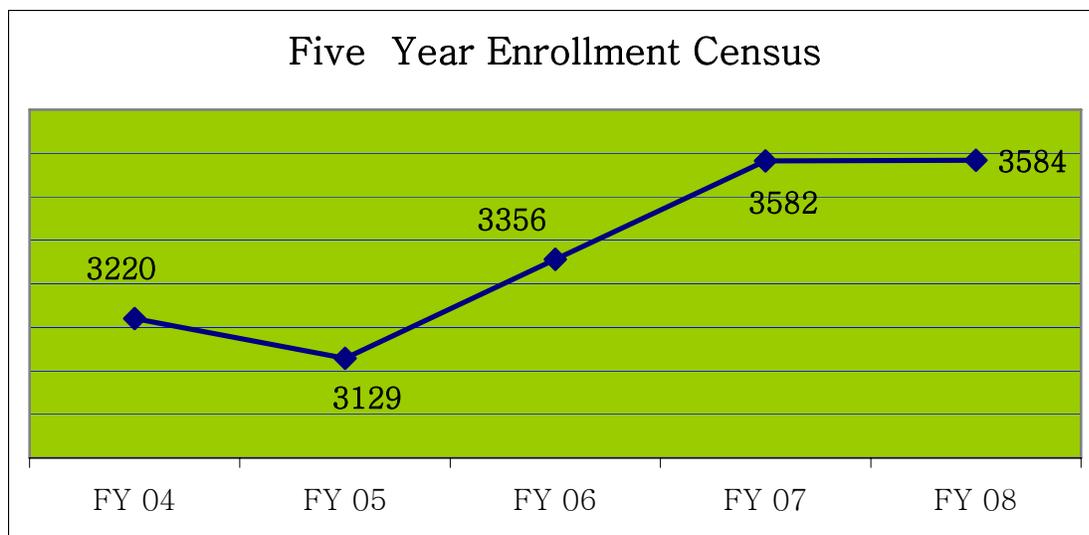


Figure 3.51

The Department of Health and Human Services is organizationally designed to have care services all within the same division, the Division of Community Based Care Services. Within this Division are the three major agencies that offer support services to CSHCN and their families: the Bureau of Developmental Services (BDS), the Bureau of Behavioral Health (BBH) and Special Medical Services (which sits within BDS). In Section D: Children and Adolescents needs were highlighted related to Screening and Autism (supported by BDS through Early Supports & Services and the Area Agencies) and Mental Health Services (supported by BBH through Community Mental Health Centers). In addition to these are the needs of children with chronic health conditions.

There are two data sets that illustrate the ongoing needs of these three populations of CSHCN. The first is related to the distribution of New Hampshire children, by diagnosis, who were newly enrolled in SSI due to their own disability and the second is the distribution of New Hampshire children, by diagnosis, who were enrolled in HC-CSD/Medicaid based on a medical diagnosis and solely their own resources (this is New Hampshire's "Katie-Beckett like" pathway to Medicaid)

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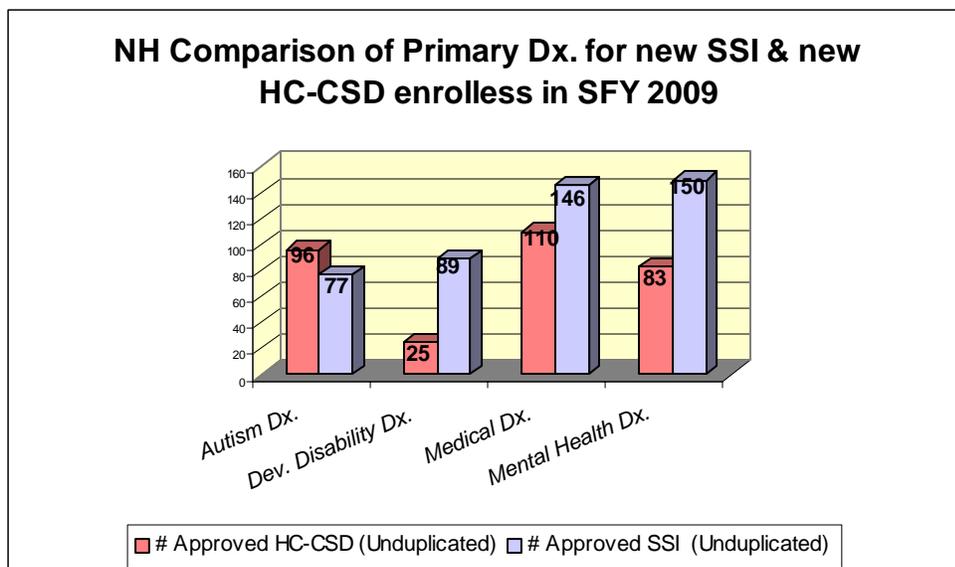


Figure 3.52

It is clear from this comparison that CSHCN in New Hampshire continue to require a wide array of services that demonstrate best practice and expertise and recognize needs within the domains of developmental, medical and behavioral services.

3.E.4.b. Respite

Care of CSHCN strains the physical, emotional, mental, financial, and social well being of caregivers. Families are the largest providers of long-term care for children with disabilities. Long-term medical care of children with complex conditions can be overwhelming and can lead to poor psychological outcomes in caregivers.³¹⁷

“Respite services can positively impact CSHCN through out their life. Respite and can afford the child opportunities for additional experience outside the family home; support the caregivers of the child; prevent family breakdown and /or rejection of the child and it can avoid the admission of the child to long term residential care or the necessity for substitute family placement”.³¹⁸

In New Hampshire, the capacity of the system to address this need has been assessed to be weak or to have gaps in certain areas (i.e., the lack of trained staff both in terms of number and skill

³¹⁷ Savithri Nageswaran, Respite Care for Children With Special Health Care Needs
Arch Pediatr Adolesc Med 163: 49-54.

³¹⁸ Lindsay, M., Kohls, M. & Collins, J. (1993) *The Patchwork Quilt: A Study of Respite Care Services in Scotland. A Report to the Social Work Services Inspectorate for Scotland*, Edinburgh: Scottish Office.

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level; limited and fragmented funding; funding that is targeted to developmentally disabled adults and medically complex only; no model for workforce development; a silo effect creating a barrier to collaborative efforts across agencies). Other input from stakeholders indicated that while child care programs in New Hampshire receive some health care consultation, the staffs of these programs are not adequately trained to provide care for behaviorally/medically fragile children and often decline to enroll them. It is clear that a statewide effort is needed to promote and provide instrumental support for workforce development to serve this population of CSHCN. a limited amount of respite providers.

There has been ongoing work, spearheaded by Special Medical Services, on the issue of respite care for medically fragile and behaviorally complex children. These efforts have identified the need for a competency based respite curriculum for families and providers of respite care. In addition, efforts will need to focus on data supporting the need for continued funding, the training of providers, and developing a registry of those providers that is available to agencies and all family caregivers of CSHCN.

A barrier in New Hampshire is the lack of a statewide Respite Coalition or a respite provider resource list. Within the Department of Health and Human Services needs have been identified by data within the Bureau of Developmental services. On the 2007 and 2008 respite care outcomes surveys the majority of regions indicated the need for more “qualified” respite providers, more available hours and a specific mention that a “list” of providers would be helpful.

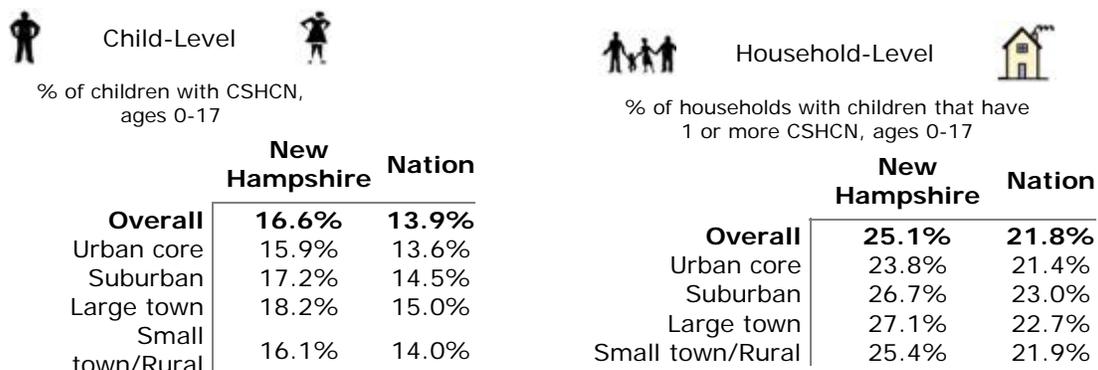
3.E.5. Disparities

The 2005/2006 NS-CSHCN has provided valuable data related to the data on geographic location of CSHCN in New Hampshire that can help to highlight related disparities. When compared, CSHCN reside in Urban, Suburban, Large town and Small town/Rural areas at the same rates as non-CSHCN. Below are the comparisons between New Hampshire and the national averages.

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Figure 3.53

Prevalence of Children with Special Health Care Needs (CSHCN)



When comparing results on the MCHB Core Outcomes and the National Indicators there are few disparities of significant note³¹⁹. There are two that are of particular interest:

1. CSHCN living in Suburban areas appear to have an advantage over CSHCN living in all three other areas as it relates to the adequacy of their insurance:

Figure 3.54

Note: Shaded estimates do not meet the National Center for Health Statistics standard for reliability or precision (RSE greater than 30%).	Overall	Urban core	Suburban	Large town	Small town/Rural
Child Health Indicator					
Currently insured CSHCN whose insurance is inadequate					
	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN
New Hampshire	28.1 (24.6 - 31.6) 13,821	29.2 (24.0 - 34.3) 6,993	19.5 (11.3 - 27.7) 1,224	31.4 (23.9 - 39.0) 3,485	27.2 (18.0 - 36.3) 2,119

It appears that this data is more indicative of the financial resources of families of CSHCN living in Suburban areas. Families living in Suburban areas reported higher out of pocket costs than the other three areas and yet they were more likely to self-report that their insurance was adequate. It can be surmised that this is a more likely a reflection that on average those families living in

³¹⁹ Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website. Retrieved 6/1/10 from www.cshcndata.org

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these areas have more financial resources and therefore their out of pocket costs are not perceived to be as much of a hardship.

2. CSHCN living in Suburban area appear to have an advantage over CSHCN living in all three other areas as it relates to having access to a Medical Home:

Figure 3.55

Overall	Urban core	Suburban	Large town	Small town/Rural	
	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	% (95% CI) Est. # CSHCN	
MCHB Core Outcomes & Performance Measures					
CSHCN who receive coordinated, ongoing, comprehensive care within a medical home					
New Hampshire	49.6 (45.6 - 53.6) 24,039	47.9 (42.2 - 53.6) 11,215	63.8 (53.6 - 74.0) 3,881	45.1 (36.9 - 53.4) 4,904	49.3 (39.4 - 59.2) 3,952

This data indicates the need for further evaluation of the geographic distribution of trained medical home providers and may highlight areas to target with future trainings, supports and learning session for providers as well as families.

Overview

In New Hampshire 16.6% of children are considered to have special needs (n= 50,365) compared to 13.9% nationally. (2005-2006 National Survey). There are 21.9% of CSHCN children whose daily activities are affected and 12.6% of CSHCN miss 11 or more days of school due to illness. Over two-thirds of families of New Hampshire SSI CSHCN surveyed reported that they provide health care for their child at home. Ninety percent of these families engaged in over 11 hours of direct care per week. In addition, half of the families of the SSI CSHCN reported having to cut work hours to care for their child even while experiencing financial distress.

Strengths

Respite services can impact the CSHCN through out their life by giving opportunities for additional experience outside the family home; support the caregivers of the child; prevent

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family breakdown and /or rejection of the child and it can avoid the admission of the child to long term residential care or the necessity for substitute family placement (Lindsay et. al, 1993)

Needs

New Hampshire has a limited amount of respite providers. There are no coordinated respite services and extremely limited funding. There is no respite funding available for behavioral health and extremely limited respite providers with training.

Addressing competency based respite curriculum among agencies and families who have CSHCN for providers of respite care, funding the training and developing a registry of those providers that is available to agencies and all family caregivers of CSHCN is an initial criteria.

Disparities

There are limited respite services available in New Hampshire, however more children have qualifying diagnoses and meet the disability criteria for these services. Respite availability is limited largely due to funding. What funding is available is not equally distributed among the 10 regions of the state. The funding issue for respite is too extensive during these economic times. Funding that is available is not equally distributed through out the state. Children with Behavioral Health have no respite care funding available. Children with Developmental Disabilities have small amounts of respite care funding, though it varies with each area agency. Qualified children with chronic medical conditions have limited short-term care through Medicaid.

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4. Capacity of the System to Meet Needs

In order to assess New Hampshire's capacity to meet the needs of the State's Title V population by level of the MCH pyramid, and before final priorities could be selected, Title V leadership and partners needed to examine both the internal capacity of the state system and the capacity and status of the current system of care. Staff used the Capacity Assessment for State Title V (CAST-V) assessment tool and further examined resources and capacity in each of the following areas: direct and enabling services, population-based services, and infrastructure-building capacity. The examination included assessing accessibility, quality, and affordability of services for MCH populations.

4.A. Internal Capacity

4.A.1. Capacity Assessment for State Title V (CAST-5)

In 2005, New Hampshire Title V embarked on a comprehensive assessment of its internal capacity using the CAST-5 process. The Capacity Assessment for State Title V (CAST-5) is a set of assessment and planning tools that uses core Public Health Essential Services as the foundation from which state Title V programs can examine their organizational capacity to carry out core maternal and child health functions. In 2005, New Hampshire's Title V program had never undergone a structured capacity assessment, and with the completion of a significant reorganization within DHHS it created an opportunity to come together across programs to develop strategies to maintain and strengthen essential services. Through federal MCHB technical assistance, a health policy consultant assisted New Hampshire in this process.

Over the past five years, the Title V program used the results of that assessment to allocate resources and guide programming. As part of the 2010 Needs Assessment process, it was determined that it was time to challenge both the MCH and SMS programs to revisit the CAST-5 process to see what has changed in New Hampshire's Title V capacity in the past five years.

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4.A.2 CAST-5 Methodology

Because a significant number of the Title V staff had participated in the CAST-5 in 2005, both MCH and SMS colleagues were comfortable with the tools and process of the assessment. There was also consensus that it would be most useful to do a somewhat more abbreviated version, focusing on just Title V staff, not external partners, and to incorporate the action planning process into other Needs Assessment activities, to avoid duplicative planning processes. All Title V staff were invited to attend two off-site retreat days, one in September 2009 and one in October 2009. A colleague from another division within the NH DHHS was selected to facilitate both sessions.

On September 22, 2009, 41 Title V staff convened to:

- o Discuss Core Questions
- o Review and Rate Process Indicators
- o Perform SWOT Analyses

To set the stage for analyzing the internal capacity of Title V programs, Core Questions were used to prompt the group to discuss the vision, mission and strategic priorities of New Hampshire Title V. This was accomplished through an interactive process by which staff shared how current priorities were translated into practice and programs over the past five years.

In preparation for reviewing the state's current and desired levels of performance, Title V staff self-selected teams prior to the meeting based upon MCH-specific Essential Services. Using CAST-5 tools, teams discussed and ultimately rated a set of detailed Process Indicators for each Essential Service. This rating determined the *adequacy* by which New Hampshire met each Essential Service.

In addition to a summary rating, each Essential Service group performed a SWOT Analysis, identifying internal and external strengths, weaknesses, opportunities, and threats that were relevant to undertaking or enhancing the specified function. Essential Service Summary Sheets are included in Appendix C.

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Prior to leaving, participants completed narrative evaluations with suggestions for improvements in process for the second day.

On October 21, 2009, 38 Title V staff reconvened for the second part of the CAST-5 process. Based upon evaluation feedback, the agenda was adjusted to allow for additional discussion time and small groups were assigned prior to the meeting. Results from the September meeting were shared and discussed prior to breaking up into four working groups each assigned to assess the extent to which resources are sufficiently present in New Hampshire or in need of enhancement, given the activities and performance goals of the Title V program. The groups focused on the following areas:

- o Structural Resources
- o Data/Information Systems
- o Organizational Relationships
- o Workforce Competencies/Skills

After rating whether resources were sufficiently present within each of these categories, or if not, what resources were needed, each team reported back how these capacity needs translate back to action plans for the priorities that were being developed for 2010 Needs Assessment. Capacity Needs Summary Sheets are attached in Appendix D. Additional Action Plans specific to capacity were not developed, so as not to become duplicative of work that was occurring in parallel Needs Assessment activities. This work, however, did inform action plans for the final Ten Priorities identified as part of the Needs Assessment.

4.A.3 CAST-5 RESULTS

New Hampshire Title V staff rated their own ability to adequately provide the following Essential Public Health Services, as follows:

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Substantially Adequate

- #5 – Provide leadership
- #4 – Mobilize community partnerships
- #6 – Promote and enforce legal requirements
- #1 – Assess and monitor MCH status
- #2 – Diagnose and Investigate health problems

Partially Adequate

- #7 – Link families to services and assure access
- #8 – Workforce capacity and competency
- #9 – Evaluate services

Minimally Adequate

- #3 – Inform and educate
- #10 – Support research

Notably, in 2005, Title V staff rated New Hampshire’s capacity to “Assess and monitor MCH status” as *Minimally Adequate*. In 2010, this rose to the level of *Substantially Adequate*. This is a direct result of additional resources, although minimal, and the strategic decision to focus on improving MCH infrastructure with data and epidemiological capacity over the past five years. Contrary, Title V staff rated “Inform and educate” as *Minimally Adequate* during this assessment, lowering it from a *Partially Adequate* in 2005. This reflected a concern that with limited resources, Title V has not shown leadership in population-based education campaigns, especially those that use new media. In general, communication themes were consistently highlighted throughout the assessment. Participants were concerned with a perceived disconnect within Title V and DHHS, as a whole, as well as with the lack of resources to have a communication plan with the general public for population-based health promotion campaigns.

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The Structural Resources Group addressed the financial, human, and material resources; policies and protocols; and other resources held by or accessible to the program that form the groundwork for the performance of core functions. While Title V has significant capacity at the present time, with adequate statutory authority in Childhood Lead Poisoning Prevention, Newborn Screening, Immunization and other programs, participants expressed that given limited funding, the ability to enforce and carry out the mission of that authority was compromised. A clear need was noted to improve routine, two-way communication channels or mechanisms with relevant constituencies across all Title V programs.

The *Data/Information Systems Group* captured the needs and capacities of Title V's technological resources, information management systems and data analysis abilities. In the past five years MCH, in particular, has made significant gains in access to timely program and population data from sources such as Vital Records, Medicaid, hospital discharge data sets, and commercial claims data. MCH has developed web based data systems for data linkage among infant screening programs and the perinatal client data form (PCDF) used by all MCH-funded community health centers, linking prenatal data with birth certificate information. Supportive environments for data sharing exist within the state with increased attention on standardized encryption and confidentiality policies. Additionally, the MCH Epidemiologist has been a leader in developing a revised Memorandum of Understanding between the Division of Public Health Services and the New Hampshire Secretary of State, Division of Vital Records.

The needs in this area, however, are clear. Beyond the limited roles of the MCH Epidemiologist and other data specialists in specific programs, many Title V staff do not feel that they have the sufficient skills or access to data that they need to provide leadership, assess and monitor health status of particular populations, and evaluate programs. Of particular frustration, the slow process of working with the State's Office of Information and Technology was noted.

4.A.4. Title V Capacity by Pyramid Levels.

The conceptual model for Title V activities has been illustrated as a pyramid with four levels of services that build upon each other and provide comprehensive coverage.

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Direct Health Care Services:

Direct Health Care Services include basic health services and health services for CSHCN, gap-filling services to Medicaid beneficiaries, and funds for services needed by uninsured children and pregnant women and for necessary services not covered by Medicaid or other sources. Title V allows states to provide, arrange, and/or administer women's health, child health, and adolescent health, CSHCN specialty services not otherwise available through health plans.

During the CAST-5 process Title V staff, rated the program as *Substantially Adequate at Linking Families to Services and Assuring Access*. Strengths were noted in New Hampshire's commitment to funding a safety net of primary care services for the uninsured through the community health center system: its ability to provide resources and technical assistance for outreach, improved enrollment procedures; service delivery methods for hard-to-reach populations, including the uninsured; and the leadership of SMS in providing resources for a system of case management and coordination of services for CSHCN. However, New Hampshire continues to only minimally address the cultural and linguistic competence of providers. This must be a priority moving forward.

Enabling Services:

Enabling Services are often the invisible glue that help hold all of the other direct health care services together for vulnerable families or families at-risk. Services may include: translation, transportation, respite care, outreach, health education, family support, or care management.

Throughout the work group discussions, it was clear that MCH often provides funds for contractors and vendors to provide Enabling Services within community, but that there is limited capacity within the state MCH program itself to provide this function. This tension was reflected in the CAST-5 rating process. As an Essential Service, Title V is responsible for *linking families to services and assuring access to comprehensive, quality systems of care*. Participants clearly articulated that, although committed to funding enabling services on the ground in communities, the state program was only *Partially Adequate* in meeting its expectations in developing tracking systems for universal, high risk, and underserved populations; publicizing and routinely updating

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a toll-free line and other resources for public access to information about health services availability; and was only *Minimally Adequate* at providing resources to strengthen the cultural and linguistic competence of providers and services.

Population Based Services:

Population Based Services are broad based efforts such as screenings (including newborn screening, lead poisoning screening, developmental screening, etc.) immunizations, oral health, nutrition and outreach, injury prevention and public education.

Of all the Essential Services, *Informing and Educating* speaks to the core of Population Based Service. Although strengths were noted for particular programs, childhood lead poisoning, SIDS, Family Voices, etc., it is in this area that many Title V staff felt that limited resources have constrained the ability of the New Hampshire Title V program to reach out to the **general population** with public health messaging and services. This service was rated as *Minimally Adequate* due to the difficulty in producing and disseminating evaluative reports on the effectiveness of health promotion and health education programs/campaigns and utilizing mechanisms for identifying existing and emerging population-based health information needs. Although Title V has many professional and community partners and collaborative relationships, neither MCH nor SMS has “branded” or marketed their role in public health. Internal communication within DHHS is not ideal and there was continued concern that programs may continue to be working in silos.

Infrastructure Building Services:

Infrastructure Building Services are the foundation of Title V pyramid. Evaluation, policy development, quality assurance, standards development, training, and information systems all combine to build effective and sustainable systems of care.

New Hampshire’s Title V program continues to grow stronger in its infrastructure development and capacity. Central to the regulatory and legal function of Title V and MCH is the Essential Service of *promoting and enforcing legal requirements*. Title V has routinely provided leadership and collaboration with professional organizations and other state agencies, as

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appropriate, as rules and standards of practices are developed and promulgated that promote excellence in quality care for women, infants, and children. Within the past year, alone, Title V staff have actively participated in Medicaid billing code revisions, child care licensing rules revisions, childhood lead poisoning rules revisions, and newborn screening rules revisions. Within the professional boundaries of state government, Title V has the capacity to review existing state MCH-related legislation to assess adequacy and any inconsistencies in legislative/regulatory mandates across programs serving MCH populations and monitor proposed legislation that may impact MCH and provide input about its effects.

As a public health entity, Title V actively *assesses and monitors maternal and child health status to identify and address problems*. MCH has established rigorous data reporting and performance measure expectations for local MCH providers and programs. Title V increasingly uses public health data sets to prepare basic and more complex analyses related to priority health issues for priority setting, strategic planning and legislative purposes. In all, participants rated this function as *Substantially Adequate*, far different than the rating of *Minimally Adequate* in 2005.

Interestingly, although participants rated themselves more highly in assessing and monitoring health status, the CAST-5 process revealed only a *Partially Adequate* rating for **Evaluating Services**. Participants in this work group believed that even though contracts with community-based programs were appropriately monitored, that due to limited staff and resources, Title V staff were less than adequate in meeting the needs of local programs in performing comparative analyses of programs and services; providing technical assistance to local programs in conducting evaluations; and providing resources for local programs to collect and analyze data on consumer satisfaction and community perceptions of health needs, access, and quality of care.

At the heart of New Hampshire Title V's *Infrastructure Building Services* capacity is its ability to *provide leadership and mobilize community partnerships*. Title V staff participate in collaborative partnerships and participate in the planning and development efforts of public and private groups to promote integrated service system initiatives. Title V staff are members of advisory bodies; provide formal review and comment on proposed requests for proposals, policies, legislation, or rules; development of interagency agreements; provide reciprocal training

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of staff; and serve as consultants to state initiatives through informal mechanisms or formal interagency agreements. Although some of this collaboration is seen as personality driven, rather than institutionally driven, participants, clearly came to the consensus that this Essential Services was *Substantially Adequate* in New Hampshire. Unlike other capacities, relationships and leadership was not as dependent upon the resources that were noted as lacking in other areas of this assessment.

4.A.5. Next Steps

One of the lessons learned from the 2005 CAST-5 is that sometimes these processes develop well-intended Action Plans that have limited follow-up if they are not incorporated into daily work or strategic priorities. Like any quality improvement process, continuous monitoring and adjustments are key to ensuring long-term commitment and success. Therefore, the observations, suggestions, and strengths/weakness noted in the 2010 CAST-5 were incorporated into the prioritization selection process, as part of the *feasibility* criteria and then also used to help begin the Action Planning process for determining activities related to each priority need.

Concurrent to CAST-5, Title V was fortunate to participate in a Division of Public Health Services Strategic Planning and Mapping process. MCH leadership was able to bring these clearly articulated needs and strengths from the CAST-5, such as the need for enhanced communication, the need to further develop population-based health messaging to inform and educate, and the need to enhance workforce capacity, to this Division-wide strategic planning process. Workgroups with Title V leadership and representation have been developed around these topics and many more and will continue through State Fiscal Year 2011. MCH will use this Division-wide planning process to maintain focus on these internal capacity concerns.

4.B. Additional Capacity Assessments

In addition to the CAST-5, Title V pursued more specific formal assessments of particular systems, including systems for early childhood services and services for children with special health care needs.

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4.B.1. Early Childhood Services Capacity Assessment

Zero to Three, the National Center for Infants, Toddlers, and Families, created a self-assessment checklist based on research about effective policies and best practices in states. In New Hampshire, the Maternal and Child Health Section used this tool to collect important data to supplement the Title V Needs Assessment. The information was used to help identify priorities for Title V in each of the following areas: early childhood health, strong families, positive early learning experiences, and collaboration and system building.

MCH used the questions developed by Zero to Three to create a survey that was distributed electronically using Survey Monkey, to the New Hampshire Early Childhood Comprehensive Systems (ECCS) listserv and on paper at the New Hampshire Child Care Advisory Council Meetings. In addition, key stakeholders were invited to participate in a face-to-face discussion at which they provided valuable information to accompany the surveys.

Through Survey Monkey, MCH collected 11 responses from high-level stakeholders who work and/or are involved with infants, toddlers and their families including state agencies, trainers of professionals who work with young children, health professionals/organizations, and providers or provider organizations. The survey asked participants to check *no/none, some, most, or yes/all* to a variety of statements under early childhood health, strong families, positive early learning experiences, and collaboration and system building. Five stakeholders representing state and community agencies attended the discussion group where they were given the opportunity to address each question and indicate their response as a group.

The electronic survey results clearly indicated that respondents believed that *some* infants are receiving services that promote good health including physical, social-emotional and developmental. Stakeholders suggested that although most pregnant women have access to prenatal health care there is disparity among populations, particularly refugees. Various health and safety initiatives were found to be increasing especially with regards to obesity prevention and environmental hazards such as lead poisoning. Respondents also referenced the New Hampshire Association for Infant Mental Health's report, "Mental Health Services for New Hampshire's Young Children and Their Families: Planning to Improve Access and Outcomes"

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as identifying the lack of access to services for assessment, diagnosis and treatment of infant mental health issues. The checklist showed that stakeholders believed that there is *some* access to developmental screening for newborns and young children, but that it was not universally available to all children.

The second section of the survey assessed services that support Strong Families. The electronic survey indicated *some* access to services; particularly financial support for families to meet basic needs provided through TANF, energy assistance programs, parent education/home visiting and child welfare. Through discussion, it was noted that family leave is not widely available as a support for strong families in New Hampshire.

Positive Early Learning Experiences are well known by these stakeholders. Both electronic survey and group discussion indicated that all infants and toddlers have access to early intervention services although there is no state supplement to Early Head Start funding. Data from the surveys indicated all children are supported by child-care however, the discussion group expressed concerns about access to quality and affordability.

Finally, the electronic survey indicated *overall lack of (no/none)* collaboration and system building efforts in New Hampshire. However, *all* noted strong collaborations exist. The negative results in this area were focused on the lack of governance and leadership, accountability and evaluation, professional development and financing. Interestingly, the discussion group indicated *some* collaboration and accountability citing state contracts that require agencies to work together. In addition, the group noted progress on the development of the New Hampshire Early Childhood Advisory Council and ECCS stakeholders' efforts.

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Although limited, the results of Zero to Three's Self-Assessment Checklist for States were useful in the development of priorities for New Hampshire's Needs Assessment work as they indicated the perception of early childhood stakeholders, particularly around areas of developmental screening and systems building. The survey and discussion helped to identify not only the areas where services are lacking, but where MCH can increase public awareness of services that support good health, strong families, positive early learning experiences and collaboration.

4.B.2. Capacity Assessment for the System of Care for CSHCN

Champions for Inclusive Communities (ChampionsInC) is a national resource center, funded by the Integrated Services Branch of the federal Maternal Child Health Bureau. ChampionsInC efforts are designed to support states and communities to successfully meet the expectations of the Title V Block Grant's National Performance Measure #5. Specifically, this Performance Measure is the percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. As part of the services they offer to states and communities, ChampionsInC created and disseminated a new tool for use in the 2010 Needs Assessment process. The ChampionsInc Community-Based Assessment Tool was "designed to assist CYSHCN leaders in the needs assessment process, with focus on the state's capacity in implementing community based service systems."¹ (See Appendix E).

The guidance for utilizing this tool was simple and straightforward. It suggested that the assessment be completed by a team of state stakeholders, in partnership with community and family leaders. The group was instructed to identify the level of development for each component in the tool and to identify priority components.

The decision was made to utilize this tool in the New Hampshire Title V Needs Assessment process and reporting. It was determined to be a valuable tool to insure that, even though the overall population size of CSHCN is small in comparison to the MCH population, an accurate

¹ Maternal and Child Health Bureau Division for Children with Special Health Care Needs. 2010. Champions for Inclusive Communities. Community-based Assessment Tool for Title V CSHCN Leaders.

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assessment of their system of care be completed. The group of New Hampshire stakeholders invited to participate in the process included:

- o New Hampshire Family Voices,
- o Child Health Services (a community based health center with CSHCN programs),
- o NH Council for Children and Adolescents with Chronic Health Conditions,
- o Medicaid,
- o Developmental Services (family services and early supports & services),
- o Department of Health and Human Services (Senior state physician),
- o Partners in Health (program providing family support for children with chronic illness),
- o Maternal Child Health staff (Title V Director, newborn screening, EHDI and children's services),
- o Special Medical Services staff.

The meeting was held on November 23, 2009 and scheduled as a ½ day session. Interest and participation by stakeholders was strong and all but 2 of the stakeholder groups invited were able to attend. There were a total of 12 participants and the Title V CSHCN Director facilitated. The group was given the tool and a brief explanation of its purpose prior to the scheduled meeting. At the meeting participants unanimously decided to complete the rating of components and priorities by consensus.

The framework of the **ChampionsInC Community-based Assessment Tool for Title V CSHCN Leaders** was designed utilizing sections matching the six MCHB National Performance Measures: NPM #1 - Early and Continuous Screening; NPM #2 - CYSHCN Whose Families Are Partners At All Levels Of Decision Making; NPM #3 - CYSHCN Receive Coordinated, Ongoing, Comprehensive Care Within The Medical Home; NPM #4 - Adequate Insurance/Financing; NPM #5 - Community-Based Services are Organized and Families are Satisfied; and NPM #6 - Transition to Adult Life. Within each of these sections there were four categories with a subset of components, which were to be used to identify the state's capacity to achieve a community-based system of care. The four categories were utilized to determine:

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1. Who are the needed stakeholders, representing families, youth, community providers, and other important players in the services system at the state level?
2. What state policies and practices should be in place to achieve outcomes?
3. What policies and practices should be in place across communities in your state?
4. What are some data sources or ways to measure achievements for children, youth and families?

The components within these categories were rated with a 4-point likert scale to identify each's level of development, additionally components, which were priorities, were identified. This format recognizes that even though National Performance Measure 5 is the one specifically related to a community-based system of care, a true system of care for CYSHCN must satisfy the expectations of the other 5 National Performance measures related to CYSHCN as well. The evaluation completed by stakeholders revealed valuable feedback about New Hampshire's system of care

Partners at the state level:

Ratings of the components relevant to this category indicate that New Hampshire's strongest partnerships are with families (NPM #2). New Hampshire was rated to have strong engagement (the highest rating) on 80% of these components and one priority was identified. The remaining NPMs had significant ratings when those components with strong and moderate engagement were combined. Partnerships related to: the organization of services (NPM #5) had an 86% rating and one priority; transition (NPM #6) had a 73% rating and one priority; screening (NPM #1) had a 70% rating and three priorities; insurance (NPM #4) had a 60% rating and two priorities: and medical home (NPM #3) had a 50% rating and four priorities. Overall, across all performance measures partnerships had strong or moderate engagement for 70% of the components, while 26% had weak engagement and twelve priorities were identified. The only components to be rated as having "no participation" (4.3%) were related to the Transition NPM and twelve priorities were identified.

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State policies and practices:

Ratings of the components relevant to this category indicated that the strongest state policies and practices are related to family involvement with 100% as being “well established/sustained” and one priority was identified. The ratings of the components of the other performance measures were greatly varied. Of those components that were related to insurance 71% were “well established/sustained” and one was identified as a priority. Components related to the organization and ease of use of the system had a combined rating of 67% for policies and practices that were “well established/sustained” or “implementation was initiated”, with two priorities among them. And 62% of the screening components also met these same two criteria, with two more priorities. The last two measures did not have any components receive the highest rating. The medical home measure had 46% of components rate as “implementation initiated”, while the transition measure had 36% of components rate comparably and each had one priority identified. Overall in this category 59% of components were well established or had been implemented, while 28% were identified to have a plan in development. There were seven components (13%) that were considered to be not yet developed, the lowest rating, and eight priorities were identified.

State support for community policies and practices:

Ratings of the components relevant to this category indicated that state support for community policies and practices was strongest related to insurance, with 100% being “well established/sustained” and one priority was identified. Four of the measures are best categorized by combining the “well established/sustained” and “implementation initiated” ratings, these apply to: 100% of the family involvement components (one priority); 57% of the organization and ease of use components (one priority); 50% of screening components (one priority); and 34% of the medical home components (one priority). The components related to transition had the lowest ratings with only 14% having “implementation implemented” (one priority). Overall, 58% of the components identified as indicating that the state supports community policies and practices were well established or implemented, while 22% were in development. There were nine components (25%) not yet developed and this category had 6 priorities identified.

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How needs and outcomes are measured for children and families:

Ratings of the components relevant to this category indicated that needs and outcomes measurement is strongest related to insurance with 75% of the components “having data available & used for state planning” (no priorities). Of the components related to transition one had “data available & shared with communities for planning” (the only component with the highest rating) and 56% had “data available & used for state planning” (one priority). The measures for screening (one priority) and for medical home (no priorities) both had 50% of their components rated as having “data available & used for state planning”. Data was “available & used for state planning” for 43% of the components related to family involvement (one priority). Of the components related to the organization and ease of use of the system 33% had “data available & used for state planning” (no priorities). Overall for components in this category only 5% had data available or shared with the community while 50% had data available but only used for internal state planning. There were twelve components (32%) for which the data was not available and this category had four priorities identified.

Considerations and limitations of assessment process:

The ChampionsInC tool was a new approach to capacity assessment for services for CYSHCN. It is important to recognize possible limitations of the tool. The assessment was new and there was minimal instruction for its utilization and interpretation. Though the New Hampshire stakeholder group opted to rate components by consensus there may have been significantly different numbers had it been done individually and anonymously. The stakeholder group also indicated a desire to have better definitions of each rating on the likert scales. As for specific components on the tool the stakeholder group did identify a couple of important issues. Several of the components related to the measurement of needs and outcomes referred to data that members of the stakeholder group knew was not yet available to the public, for example the Family to Family Health Information Center data sets.

The group design must also be considered. The tool did not identify specific stakeholders to invite. Those invited responded positively and at the meeting the group did identify additional stakeholders that it would be beneficial to invite in the future. This list included representatives from: behavioral health, child protection, childcare, preschool education and education. Also the

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group believed that it's medical home ratings might be lower than expected because it utilized as a comparison the high standards of the AAP definition of medical home, versus a usual source of care or identified primary care provider.

Summary:

Utilizing this tool confirmed that the greatest strengths of the system of care in New Hampshire are its partnerships with stakeholders. It is also clear that New Hampshire values and has a commitment to family involvement at all levels of system development. New Hampshire has room for improvement in all areas but particularly related to the components associated with medical home for CYSHCN and the area of measuring needs and outcomes. There was more variability in capacity noted in the other measures and categories.

This assessment did not identify any capacity issues that were surprising or unexpected. However, it did validate the identification of strengths, such as the level of family involvement. It also supported SMS' internal belief that there is a need for a more formal and collaborative relationship with the state AAP chapter and providers. The CSHCN program had begun to see strong indicators of this need in the last several years. The detailed components listed in each category and linked to the National Performance Measures will help Special Medical Services to easily identify action steps for improving the community-based system of care for CYSHCN.

In addition, the tool assisted in the identification of priorities. The current system of care does generally have some engagement in these components identified as priorities. The priorities will be used to guide new initiatives as well as for improvement activities related to current services. The priorities that will be easiest to address are the ones related to building and maintaining partnerships. The most difficult priorities to address will be those related to funding (medical home reimbursement and public and private insurance coverage) and to electronic records and integrated information systems. As the system moves forward those priorities associated with measuring needs and outcomes will be particularly useful to validate allocation of resources and program effectiveness.

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4.C. New Hampshire's System of Care: Title V and Beyond

4.C.1. Direct Clinical Services

Data from multiple public and private sources reveal that New Hampshire has one of the highest quality healthcare systems in the country. Its infrastructure ranks favorably compared to the best states. But New Hampshire's health care is expensive, and measures of public health and access show opportunities for improvement².

New Hampshire's health care delivery system for the MCH population consists of an array of public and private health service providers. This system, which varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens. Much of the state is designated as medically underserved or health professional shortage areas. While New Hampshire's two largest cities have public health departments, there is no statewide network of local health departments providing direct health care services. Instead, New Hampshire has built its safety net of health care on a public private partnership. In 2006, of the 88,184 members enrolled in Medicaid, 34% received care in private office-based settings; 15% in hospital-owned primary care offices; 15% in Dartmouth Hitchcock Clinics; 10% in Federally Qualified Community Health Centers or Look a-likes; 5% in Rural Health Centers; and 21% had no assignment of care.³

New Hampshire DHHS contracts with community-based, non-profit, providers such as community health centers, prenatal, family planning, and child health agencies, to ensure access to care for vulnerable populations. These agencies provide direct health care and enabling services, such as case management, nutrition, social services, home visiting, transportation, and translation to low income, uninsured and underinsured populations. Their locations assure that most services are available throughout the state. This patchwork of agencies, along with private providers and specialty clinics for those with special health care needs, comprises the State's primary health care service system.

² NH Center for Public Policy Studies, August 2009. New Hampshire's Healthcare Dashboard 2009.

³ New Hampshire Comprehensive Health Care Information System (CHIS) Users Group Meeting, April 1, 2010.

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This partnership of community health centers and other private providers has strengths and challenges. Community health agencies throughout New Hampshire have demonstrated success in meeting the health care needs of the uninsured and under-insured citizens of the state. Title V-funded providers have participated in rigorous quality improvement efforts utilizing standard performance measures that focus attention on improving health outcomes for patients. However, prior to federal health reform and stimulus incentives, community health centers in New Hampshire generally would operate with very low margins and, as a result, would not be able to generate enough funds from patient care to provide a sufficient excess to pay for working capital, and replacement or expansion of facilities.⁴ This has made the system vulnerable. In turn, State General Funds have been leveraged with Title V funds to help secure that safety net to ensure that comprehensive direct and enabling health care services are available for women, children and their families.

See maps of medically underserved areas and health professional shortage areas and MCH program service areas in Appendix G.

4.C.2. Access to Care

Preventive & Primary Care Services for Women:

Title V partners with community-based and patient-driven health centers and organizations that serve populations with limited access to health care. These populations include low-income families and individuals, the uninsured, those with limited English proficiency, those experiencing homelessness. Many, but not all, of the MCH-funded health centers have received federal designations that define their scope of care and reimbursement structure.

- **Grant-Supported Federally Qualified Health Centers** are public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(1)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

⁴ Rivenson, H. Ph.D *Community Health Centers in New Hampshire Financial Performance and Condition*. (October 20, 2008) NH Endowment for Health.

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- **Community Health Centers** serve a variety of underserved populations and areas.
- **Healthcare for the Homeless Programs** reach out to homeless individuals and families and provide primary care and substance abuse services.
- **Federally Qualified Health Center Look-Alikes** are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of “health center ” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330.

Fifteen agencies throughout the state provide perinatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and patient-specific social services. Of these, thirteen are considered primary care agencies, offering the full spectrum of health care services to all ages; the other two are ‘categorical’ agencies, offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds; six of these are primary care agencies.

Of the thirteen primary care agencies, eight have Federally Qualified Health Center (FQHC) status; one has look alike status; two are Rural Health Centers; and two are Healthcare for the Homeless Programs. These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. The two categorical prenatal agencies offer care directly or through subcontract with local physicians. By contract, social services, nutritional counseling, and referral for high-risk care must be provided.

In response to the need for care to be available to vulnerable and low-income populations throughout the state, additional State General Funds were allocated in State Fiscal Year 2008-2009 Biennium Budget and forward for the expansion of primary care services. This influx of resources allowed the expansion of a network of three additional community health centers located in the northern part of the state and funding for two Federally Qualified Health Care (FQHC) Health Care for the Homeless programs.

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In total, Title V-supported comprehensive primary care programs, including community health center and health care for the homeless programs, served 104,622 men, women and children with 477,086 encounters in 2009. Forty-five percent of those served were 185% below poverty. Twenty-four percent of the total patient population was uninsured and 47% received Medicaid, however insurance status is disproportionate among age groups. Children and pregnant women are more likely to receive public insurance and adults are more likely to be uninsured. Fifty-nine percent of those served by primary care agencies, 62,727, were women.

In 2009, the fifteen MCH-supported prenatal agencies served 1758 prenatal clients, approximately 13% of New Hampshire's pregnant women. Of pregnant women served by Maternal and Child Health Section (MCH) agencies, 68% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 14.2% were between 15 and 19 years of age, and 34.7% were between 20 and 24 years of age.⁵ Seventy-six percent of pregnant women receiving care in an MCH-supported agency started care in their first trimester, with agencies ranging in performance from 68% to 85%. Ninety-seven percent received counseling for tobacco cessation, as appropriate, and 89% received screening for substance use.⁶

Preventive & Primary Care Services for Children:

In 2009, the DHHS Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in New Hampshire Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care, despite the fact that national comparison measures are based on managed care programs and New Hampshire Medicaid is fee-for-service.^{7,8} See Tables 4.1. and 4.2.

⁵ NH DHHS, DPHS, MCH Section PCDF Data, 2010

⁶ NH DHHS, DPHS, MCH Section, Performance Measures SFY09, 2010.

⁷ NH DHHS Office of Medicaid Business and Policy. NH Comprehensive Health Care Information Systems (CHIS). *Children's Health Insurance Programs in New Hampshire: Access, Prevention, Health Status, Care Management, Utilization and Payments, State Fiscal Year 2008*. Issue Brief – October 2009

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Table 4.1 Percent of Children with Access to Primary Care Practitioner by Plan Type, SFY2008

Note: 95% confidence intervals (CI) in parentheses

New Hampshire Measurement Based on Administrative Claims Data			
Age Group	Medicaid	SCHIP	NH CHIS Commercial*
0–11 months	98.2% (97.2-99.2)	NA	95.2% (93.0-97.4)
12–24 months	97.5% (97.0-98.0)	96.1% (89.8-100.0)	94.5% (93.7-95.2)
25 months–6 years	88.9% (88.4-89.4)	93.3% (91.7-94.9)	89.4% (89.0-89.9)
7–11 years	85.9% (85.2-86.5)	91.8% (89.6-94.0)	86.9% (86.4-87.4)
12–18 years	90.9% (90.4-91.4)	95.7% (94.4-97.0)	89.8% (89.5-90.1)
National 2008 NCQA Managed Care Plan HEDIS Reporting Year			
Age Group	Medicaid	Commercial	
12–24 months	93.4%	96.9%	
25 months–6 years	84.3%	89.4%	
7–11 years	85.8%	89.5%	
12–19 years	82.6%	86.9%	

Notes: Indemnity/TPA plans were excluded from NH CHIS commercial rates. Consistent with NCQA HEDIS reporting for ages 7-11 and 12-18 the measure is a 2-year measure (primary care visit within the current or prior year). NA: SCHIP does not cover children under the age of one (in NH, infants in the federal poverty level group for SCHIP are covered under Medicaid).

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Table 4.2 Percent of Children With a Well-Child Visit to a Primary Care Practitioner by Plan Type, SFY2008

Note: 95% confidence intervals (CI) in parentheses

Measurement Based on NH CHIS Administrative Claims Data			
Age Group	Medicaid	SCHIP	NH CHIS Commercial
16–35 months	88.9% (88.1-89.8)	95.4% (92.4-98.4)	89.0% (88.1-89.8)
3–6 years	69.9% (69.1-70.7)	82.7% (80.1-85.4)	77.7% (77.0-78.4)
7–11 years	55.0% (54.2-55.8)	63.0% (60.2-65.8)	61.3% (60.7-62.0)
12–18 years	50.4% (49.7-51.2)	57.3% (55.0-59.6)	55.4% (54.9-55.8)
First 15 Months of Life, denominator (see table note)	3,588	261	Not reliable – see note
0 visits	2% (56)	0% (0)	
1 visit	1% (50)	1% (2)	
2 visits	3% (100)	1% (3)	
3 visits	5% (179)	4% (10)	
4 visits	9% (326)	8% (20)	
5 visits	15% (555)	15% (39)	
6 or more visits	65% (2,322)	72% (187)	
National 2008 NCQA Managed Care Plan HEDIS Reporting Year			
Age Group	Medicaid	Commercial	
3–6 years	65.3%	67.8%	
12–21 years	42.0%	41.8%	
First 15 Months of Life			
0 visits	5.6%	1.8%	
1 visit	3.3%	1.1%	
2 visits	3.9%	1.5%	
3 visits	6.2%	2.7%	
4 visits	10.9%	5.8%	
5 visits	17.2%	14.5%	
6 or more visits	53.0%	72.8%	

The children who do not fare as well in routinely accessing care, however, tend to be older children and teens; children in poorer households; and children in Colebrook, Franklin, Woodsville and Lancaster, which includes some of the most Northern and most remote areas of the state.⁹ This is consistent with the disparities in care and access noted throughout this assessment.

⁹ NH DHHS Office of Medicaid Business and Policy. NH Comprehensive Health Care Information Systems (CHIS). *Children's Health Insurance Programs in New Hampshire State Fiscal Year 2008 Update*. April 1, 2010.

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Title V's historical responsibility in maintaining **Direct and Enabling Services** for children has led to the continued clinical oversight and contractual relationships with a statewide network of child health agencies that provide preventive and primary care services. MCH contracts with 14 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Thirteen of these are the primary care community health centers described above; one is a 'categorical' pediatric clinic, in the state's largest urban community, which utilizes a multi-disciplinary care model. Strategically focusing efforts on access and support for low-income families, services at the child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and a spectrum of integrated behavioral and oral health services. In 2009, MCH-funded child health direct care agencies saw 17,414 children ages 12 and under, and 10,957 children ages 13-19.¹⁰

Services for CSHCN:

Title V has been committed to the continued assurance that CSHCN have access to quality and affordable care. Major components of this effort are the continued contractual relationship with community agencies to provide for comprehensive multidisciplinary specialty clinics for child development assessments and ongoing neuromotor consultation. These clinic activities assure access to all children statewide with no out of pocket costs for the services rendered.

The Child Development Clinic network has sites in 4 different locations, across the state, and serves children up to the age of 7. There are a handful of Developmental Pediatricians in the state and all of them are either contractually involved or act as consultants for these clinics. Of note, two of these providers are practicing Pediatricians who sought Developmental Certification subsequent to interest and involvement with SMS clinics. These clinics struggle to meet the demand for multidisciplinary expert assessment. The current wait time for an assessment, on average, is 6 months. The youngest children are prioritized whenever possible in recognition of the benefit of early identification and intervention. The clinics are also seeing an increase in referrals as New Hampshire providers are more routinely screening children for development delays, including autism. To insure that CSHCN have access to child psychiatry, a contract was

¹⁰ NHDHHS DPHS MCHS 2009. Data source: Uniform Data System (UDS)

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funded to have a Child Psychiatrist available for assessment, consultation and short-term medication management for any child enrolled in SMS. This has allowed for much needed services especially joint service design between this provider and the Child Development Clinic teams.

The Neuromotor Clinic (NMC) program has sites in six different locations, across the state, and serves children up to the age of 21. There are four Pediatric Orthopedists practicing in New Hampshire. These Orthopedists are all affiliated with the SMS clinics. The clinics are scheduled monthly (except the North Country clinic which is scheduled four times/year) and participants receive nurse care coordination as long as they are enrolled. The Neuromotor clinics not only protect access for children and youth with Neuromotor conditions but this framework also insures that these providers are accessible to all children in New Hampshire for emergent and follow up orthopedic care. The professionals involved in the NMC program also participate in quality improvement initiatives and long-term planning.

Long-term planning for is particularly vital as there has been no net gain in Pediatric Orthopedists in the state in the last five years. One of the providers has decreased his office time and is no longer doing surgery and is anticipating retirement in the next few years. The NMC program has struggled to identify concrete activities that can be undertaken to increase recruitment for this specialty in the state. Additionally, the NMC program continues to have waitlists for enrollment and in a parent survey completed in FY 2007 parents overwhelmingly indicated that they were satisfied with the clinic services (84%) but also that they considered the clinics to be “very necessary” (76%).

These and other contractual relationships have helped to formalize Title V’s linkages with agencies, which include community hospitals, community based clinics and the only tertiary care facility in the state. Title V has been able to cultivate these relationships, which continue to develop, and these care providers are more responsive to collaboration, service development and quality improvement initiatives. This was exemplified by the invitation and inclusion of SMS, by Dartmouth, on a quality improvement grant and initiative to improve access and care for children with epilepsy over the last 2 ½ years.

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4.C.3. Enabling Services and Family Support

Enabling Services are often the invisible glue that help hold all of the direct health care services together for vulnerable families or families at-risk. Support of these services is also what sets Title V apart from many other public health and government entities. As New Hampshire has continued to strengthen the safety net of direct care providers by supporting community health centers with State General Funds, MCH continues to assess its child health resource allocation to assure that low-income children and families have full access to these services and support in using them appropriately. *In this section, programs are highlighted that increase access and provide linkages to care across systems for vulnerable populations.*

Since 2000, MCH has had a two-fold approach to child and family health support and home visiting. The purpose of the Child and Family Health Support Services is to promote the health and well being of children ages birth through eighteen, with priority given to children birth through age ten. Focusing on low income children ages birth through 10, these services include assistance with enrollment in health care, referrals, case management and care coordination, education and counseling relative to the child and family, and are most often conducted through home visits.

The evolution of the Child and Family Health Support Services program arose with the blending of categorical "well baby clinics" into newly developed community health centers throughout the state, and the emergence of New Hampshire Healthy Kids - the state's non-profit organization providing access to low cost and free health coverage options for its uninsured children and teens. Although children now had better access to medical care, their parents still needed the education and support services that the "well baby clinic" programs had provided, and needed assistance in enrolling on Healthy Kids, and utilizing the health services.

The range of Child and Family Health Support Services are flexible and specialized to meet the needs of the family. Services are guided by individualized care plans developed following an assessment of the child/family needs by agency staff. In SFY09, 1,205 children received services through the nine contracts at eight agencies via 5,186 home visits, 732 telephone contacts and 588 office encounters, and made 2,062 referrals to a variety of health, dental, and social service

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providers. Programs are strategically placed in communities that have disparate need due to geographic access and high proportion of low-income families.

MCH also contracts with 15 community-based agencies in 19 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) provides health, education, support and linkages to other community services. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are taught strategies to enhance their child's learning and development, and are supported as the first and best teacher for their child.

HVNH served over 1000 pregnant women and their infants in SFY09.¹¹ As two thirds of the program sites are located in counties with higher than the state average poverty rates, and with one program solely dedicated to meeting the needs of minority women and those for whom English is not their primary language, the program is able to reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports that are embedded within each unique community. Each agency providing enabling services is required to demonstrate that direct care services are accessible to vulnerable families in their region and that the enabling services facilitate this connection.

Title V also assures that families of children with special health care needs receive the enabling services necessary to access care (primary and specialty) and to meet their health related needs. This is primarily accomplished through joint community and state run programs. All children meeting the definition for CSHCN have access to a community-based care coordinator. The program has both contracted and state employee coordinators who are either nurses or have a social work background and they serve any child in the state. Consistent with MCH programs, SMS care coordination focuses on home and community visits and is family centered. This

¹¹ NHDHHS DPHS MCHS 2009. Data source: Home Visiting NH (HVNH) Data

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service has no costs to the families involved and they can choose to have support from this program until their child turns 21 years of age.

Additionally, in the last year SMS has assumed oversight and administration for a statewide program of Family Support for the families of children with chronic health conditions, the Partners in Health (PIH) program. This program has 13 sites covering the entire state and offers families information and referral, identification of available resources and financial assistance. The financial assistance for this program has been particularly helpful to families. It is not needs based and it is designed be flexible enough to meet the needs of the family so that they can focus on the needs of the child. PIH is funded through the Social Services Block Grant, examples of use of this assistance include, paying for transportation to appointments, car repairs to maintain access to transportation, fuel assistance to maintain the families basic living needs, etc.

Developmental Screening:

All Title V-funded direct care child health and primary care agencies screen children for developmental delay and refer to specialty services as appropriate. Home visiting programs have performance measures that are analyzed annually that monitor timeliness in screening participants. Significant attention has been directed towards increasing awareness of timely screening with the appropriate, validated tools. Title V has partnered with experts throughout the state to provide training and support to primary care providers.

In 2009 Special Medical Services partnered with the state AAP chapter, the New Hampshire Pediatric Society (NHPS), to apply for funding from the Commonwealth Fund to offer Open Forums on the promotion of developmental screenings, to address barriers and to create a common understanding of resources for families and providers. This proposal was funded and two statewide meetings were held, one in April 2009 and the other in October 2009.

Pediatricians were part of the targeted audience though the Open Forum framework also incorporates a variety of other allies including legislatures, insurers, families, educators and other care providers. Both Open Forums were well attended (80-100 participants) by pediatricians, family physicians, nurses, early childhood providers, legislators, family members/advocates, and Medicaid representatives. The forums keynotes were on the importance of developmental

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screening, screening schedules, and the use of available screening tools. Additional panels and groups focused on referrals to specialty clinics, insurance reimbursement, family communication, and statewide resources (especially Early Supports & Services).

Recognizing that the early identification of developmental issues can help to prevent further challenges to a child's healthy development, New Hampshire has developed an inter-agency developmental screening and referral system, Watch Me Grow. The system, currently available in three communities throughout the state, assures that all families with children birth to age six have access to information on child development, screenings for their young children, and referrals to appropriate resources and supports.

The New Hampshire Department of Health and Human Services, Division for Children, Youth, and Families in coordination with projects such as the MCH Early Childhood Comprehensive Systems (ECCS) project and SMS Early Childhood efforts, administers the New Hampshire Watch Me Grow screening system. In each of the three pilot communities, the community based Family Resource Center serves as an administrative hub that trains local providers to work with families to better understand their child's development and also provide the Ages and Stages Questionnaire (ASQ) to assess their development. Infants and toddlers whose development deserves closer observation are then referred to the family's healthcare provider and the Family Centered Early Supports and Services program, New Hampshire's IDEA Part C program, for full evaluation and intervention services. The Family Resource Centers are also working to create a data system to track the screenings and assessment, as well as develop a network of screening providers in the communities.

The Watch Me Grow is supported with a variety of federal and state sources, including IDEA Part C, Head Start, the Division for Children, Youth, and Families, and ECCS funding. The pilot is expanding from three to six sites in SFY10. New Hampshire was fortunate to be able to use Federal stimulus funding from the American Recovery and Reinvestment Act to further grow the system statewide in SFY11.

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Mental Health Services:

As described throughout this Needs Assessment, a continuing gap in New Hampshire's health care infrastructure is access to mental health services. While community mental health centers are available in some regions, they are increasingly unable to meet the demand for services. All centers have waiting lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for very young children.

The New Hampshire Department of Health and Human Services hosted Listening Sessions throughout the state in 2009, gathering hours of testimony and discussion about the behavioral and mental health system. Policy makers recorded recurrent themes about the lack of resources or appropriate resources in the correct places; the need for improved communication and coordination between systems with a focus on individuals' and families' needs; and earlier intervention and access to appropriate treatment so that individuals don't end up in acute care, incarcerated, or homeless because of treatable mental health conditions. There was a call for long-term solutions.¹²

One small piece of the solution is the need for increased coordination and integration of behavioral health services. Accordingly, access to mental health supports and services for children and youth, including those with special health care needs is among the highest priorities for the New Hampshire's Title V. In a survey of Title V stakeholders and families, 97% of respondents listed this priority as "Important" (29%) or "More Important Now Than Ever" (68%). Respondents clearly articulated that they perceived the greatest challenges to be the lack of trained mental health professionals available to serve children and youth; financing; and a lack of coordination between providers. This aligns with the Needs Assessment Public Input Process as well as challenges identified nationwide by primary care providers including: reimbursement after initial mental health screening or diagnosis; limitations in reimbursement by private insurers and Medicaid for non-physician providers, such as social workers or master's prepared

¹² NH DHHS. *Addressing the Critical Mental Health Needs of NH's Citizens: A Strategy for Restoration: Report of the Listening Sessions*, April 2009.

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psychologists; and limitations on billing for mental health services and an additional medical visit on the same day.¹³

MCH-funded community health centers each have unique relationships and levels of coordination with behavioral and mental health services within each community. Recognizing this, MCH developed a funding strategy that supports primary care providers on a tiered system based upon the level to which they integrate behavioral health. As noted previously, SMS also made attempts to assure access for CSHCN for psychiatric evaluation. This service does have its limitations. There is only one provider who sees patients at a single location on set days - though currently there is no waitlist for this service.

In an ideal, fully integrated system, mental health and primary care providers would share the same sites, the same vision and the same systems in a seamless web of services. Providers and patients would have the same expectations for treatment and all would have access to the same level of care regardless of income or insurance status.¹⁴ However, few organizations have completely achieved that level of integration. Title V and State General Funds have provided funding for experts, leaders and providers within each community to develop plans that move away from fragmented separate services towards a vision of family centered care, enhanced communication, aligned systems, and meaningful interactions among providers and patients across the lifespan.

Sample outcomes of integrated services include:

- o Identification and utilization of mental health screening tools and age appropriate interview questions that are routinely used in primary care encounters.
- o Development (and enhancement of) and consistent utilization of referral mechanisms to increase timely access to services.
- o Development (and enhancement of) consultative services with behavioral health care specialists to increase timely access to services.

¹³ Association of State and Territorial Health Officials. (August 2005) Fact Sheet and Resource Guide: *Mental Health Integration into Primary Care Settings*.

¹⁴ Doherty WJ Ph.D., McDaniel SH Ph.D., Baird, MA M.D *Five Levels of Primary Care/Behavioral Healthcare Collaboration*. Behavioral Healthcare Tomorrow, October, 1996, 25-28.

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- o Development of agreements or protocols that allow patient records and billing information to be shared, as appropriate, among providers.
- o Increased utilization of co-located services.

Alcohol and Pregnant Women:

The misuse of alcohol and other drugs is a serious and growing problem in New Hampshire that has health impacts felt across all MCH populations. Alcohol and substance abuse treatment services are provided through a competitive bid contracts with community-based non-profit service providers. Treatment services include social detoxification, outpatient, intensive outpatient, short- and long-term residential treatment services, specialized services for women and children, as well as outpatient and residential services for adolescents. New Hampshire DHHS also provides outpatient methadone maintenance services. However, access to these services is limited.

New Hampshire's publicly funded treatment system has the capacity to provide treatment for approximately 6,000 people (or 10% of the people who need it) and the average wait time before an individual could receive any residential treatment was 58 days, eleven days for crisis/detoxification, fourteen days for outpatient services and three days for methadone maintenance.¹⁵ Treatment for youth or treatment in the North Country is even more limited. A survey of youth service providers in the northern-most counties found that 92% of those who have referred youth to substance abuse or mental health services say the process is "difficult" with the most significant challenges being a lack of nearby services, fragmented services, and families' limited financial resources.¹⁶

Title V and Child and Family Services, an independent child-serving non-profit entity, have collaborated for the past three years to implement an innovative screening program for Fetal Alcohol Spectrum Disorders (FASD). This collaborative project, supported by SAMHSA,

¹⁵ Task force convened by the New Hampshire Department of Health and Human Services; the New Hampshire Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention, and Treatment; Dartmouth Medical School; and the New Hampshire Alcohol and Drug Services Providers' Association. (April 2007) *Overcoming the Impact of Alcohol and Other Drug Problems: A Plan For New Hampshire*.

¹⁶ Mills, Meghan. *Help in a Haystack: Youth Substance Abuse and Mental Health Services in the North Country*. Carsey Institute, New England Issue Brief, No. 20, Spring 2010.

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incorporates the TWEAK Assessment and Brief Intervention to pregnant women who participate in the MCH-supported Home Visiting New Hampshire program in order to eliminate alcohol consumption among low-income, pregnant women. These women live in different parts of the state of New Hampshire, some of which are urban and others rural. The FASD Project helps to identify those pregnant women who are drinking during their pregnancy with the goal being that they stop drinking as a result of the Brief Intervention.

In 2009, 210 women received screening with the TWEAK assessment and 14% (30) screened positive, making them eligible for a brief intervention. Ninety percent of those women then participated in then the Brief Intervention activities and evaluation. Of the 30 women who screened positive, only five (17%) needed treatment and all were successfully referred to and placed in outpatient programs. The project supports the Title V priority of decreasing the use and abuse of alcohol, tobacco and other substances among pregnant women and families.

Oral Health Services:

Improving access to oral health services for vulnerable populations continues to be a high priority for DHHS, but barriers to realizing this goal persist. Data indicates that oral health problems such as dental caries in children and tooth loss in adults, are still common in New Hampshire. Effective preventive measures such as water fluoridation and dental sealants are under-utilized. The data also show marked disparities in oral health by socio-economic status. Individuals who have lower incomes or less education are substantially more likely to have dental problems.

Community Water Fluoridation has long been regarded as the most cost-effective method of preventing dental decay. In addition, it benefits all residents without regard to socioeconomic status. In New Hampshire, only ten communities fluoridate their water; just one municipality is located in Coos County, while Grafton and Carroll Counties have no fluoridated communities. Because the State's largest cities have water fluoridation, it is estimated, that approximately 43% of New Hampshire residents have access to community water systems with fluoridated water.

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Title V works in collaboration with the New Hampshire DHHS, DPHS New Hampshire Oral Health Program Through the Preventive Health and Health Services (PHHS) Block Grant, the DHHS funds school-based preventive programs and community dental centers, some in community health centers or mobile clinics. New Hampshire's oral health programs are located in schools, hospitals, health centers and other community agencies. In 2009 twenty-one school-based preventive dental programs served 20,262 students in 187 (59%) of New Hampshire schools. Hygienists working under public health supervision provide oral health screenings, education, prophylaxis, fluoride application, dental sealants and care coordination that links identified children to treatment and dental homes. New Hampshire's community-based oral health programs provide services using a traditional dental practice model in 14 dental centers across the state. Four New Hampshire community health centers have fully integrated dental facilities on site. Three community-based oral health programs employ public health hygienists who provide screenings, education, preventive services and care coordination that links pregnant women to treatment in local dental offices. In 2009, 17,104 residents received oral health care through publicly funded dental centers and community-based oral health programs.¹⁷

Five school-based preventive dental programs serve some of the schools in Coos, Carroll and Grafton counties, and Rochester, New Hampshire, while all public schools are served in Manchester. In the northern regions of the state, where many disparities exist, many schools still do not have sealant programs, largely due to lack of funding. Finding dentists to treat identified children needing treatment is difficult in these same regions because there are fewer dentists, a limited number that take Medicaid children, and even fewer that take uninsured children.

For the past decade, numerous improvements in the Medicaid oral health system have been realized, including increased reimbursements, streamlined claims processing, the elimination of prior authorization, improved provider relations and utilization review. In New Hampshire, children qualify for Healthy Kids Gold (Medicaid) if they are under age 19 with income no higher than 185% of the federal poverty income limits or, if the child is younger than 1 year and has no other health insurance coverage, if the income is no higher than 300% of the federal poverty income limits. Healthy Kids Gold provides a dental benefit for children. However, New

¹⁷ NH DHHS DPHS. NH Oral Health Workforce Project, May 2010.

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Hampshire does not provide Medicaid dental coverage for adults or pregnant women over 21 years of age. In 2005, approximately 50% of general and 100% of pediatric dentists practicing in New Hampshire were enrolled as Medicaid providers, based on information from the NH Board of Dental Examiners and New Hampshire Medicaid. New Hampshire SCHIP, Healthy Kids Silver, provides a dental benefit for children up to age 19 who have no other health insurance coverage and whose income is no higher than 400% of the federal poverty income limits.

To address issues of accessibility and affordability, New Hampshire's Title V-supported community health centers have unique on-site oral health programs and/or links with coordinated community-based oral health services. Recognizing this, as with behavioral health, MCH developed a funding strategy that supports primary care providers on a tiered system based upon the level to which they integrate oral health.

Support from DPHS to integrate oral health services with primary care services is intended to allow providers within each community to develop a plan and systems that moves away from fragmented separate services towards a vision of family centered care, with enhanced communication, and systems aligned to increase interaction among dental and health care providers and patients across the lifespan.

Early outcomes have included:

- o Patients across the lifespan have documented oral health screening as part of an annual primary care exam.
- o Every patient is linked to a "dental home."
- o Dental services are provided on site in the primary care practice.
- o Reliable referral system to specialists are developed with formal Memorandums of Understanding

Accessibility for Special Populations:

While New Hampshire's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6%

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of the population.¹⁸ The vast majority of the state's minority populations live in the southern tier of the state, including the two cities of Manchester and Nashua in Hillsborough County. Approximately 17% of Manchester residents speak a language other than English at home.¹⁹

Births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998.²⁰

In addition, New Hampshire has resettled over 6000 refugees since the early 1980's, over 4,800 between 1997 and 2008. The majority of refugees have come from countries in Europe (74% from Bosnia) and Africa (58% from Somalia and Sudan), with smaller populations from Asia and the Middle East. Of the nearly 3000 refugees settled between fiscal years 2002 and 2009, 61% settled in Manchester, 26% in Concord, 8% in Laconia, with smaller populations in other cities and towns.²¹ These new residents can experience a range of health and mental health issues including poor nutrition, parasitic infections, communicable diseases and lead poisoning, with maternal and child health issues predominating.

Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of minorities are smaller. Community-based health agencies are aware of the need for case management, outreach and interpretation services for this population and are working to develop capacity in this area. All SMS contracts for direct or enabling services for CSHCN have had a funded line item for Linguistic/Cultural Needs incorporated. The New Hampshire Endowment for Health reported that provider organizations varied widely in their collection, analysis and use of medical interpretation data. They identified a lack of systematic data collection within healthcare facilities. Providers in Hillsborough County, which includes the

¹⁸ US Census Bureau Population Estimates Program. Retrieved 2/19/10 from <http://www.census.gov/popest/states/asrh/SC-EST2008-04.html>

¹⁹ Manchester Health Department, 2009. *Believe in a Healthy Community, Greater Manchester Community Needs Assessment 2009*.

²⁰ NH DHHS DPHS MCH analysis; data source: NH birth data

²¹ NH Office of Energy and Planning, Office of Refugee Resettlement. 2010. Retrieved 4/29/10 from <http://www.nh.gov/oep/programs/refugee/facts.htm>

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state's most diverse communities, serve a much greater proportion of patients with Limited English Proficiency (LEP), about one in seven (14%) patients in those facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers. Facilities that responded in Nashua reported a third of their encounters (32%) were with LEP patients. The interpreter resources that facilities reported using with the greatest frequency were, in descending order, externally paid interpreters, bilingual clinical staff, bilingual non-clinical staff, and telephone services. Cost and scheduling were significant barriers to facilities in providing consistent, quality services. Providers also identified the difficulty in securing translators for languages less common, including Asian languages, Portuguese, and American Sign Language.²²

Physical Barriers to Accessibility:

New Hampshire, as a largely rural state has little infrastructure in public transportation. No municipality has a subway system, and only three municipalities have local public bus routes. AMTRAK runs through the southeastern part of the state, from Boston, MA, to Portland, ME, with only three stops in New Hampshire, in Exeter, Durham and Dover. In the northern areas of the state, there are no public transportation options. In response, several of New Hampshire CHCs have developed transportation assistance programs to aid their clientele in accessing medical care.

4.D. Affordability

As it does nationally, the cost of health care continues to rise in New Hampshire. The New Hampshire Center for Public Policy has reported that personal health care, visits to doctors, hospitalizations, medicine, etc., consumes 18 % of the State's economy. Twenty years ago, spending on personal health care was less than 10% of New Hampshire's economy. Twenty years from now, health care spending is projected to reach nearly 22% to 25 % of economic activity.²³ The personal financial implications are felt in every segment of our population, but there are disproportionate effects among those least able to pay.

²² NH Endowment for Health. (November 2004) *Assessing Language Interpretation Capacity Among New Hampshire Health Care Providers*

²³ NH Center for Public Policy. 2009. *Healthcare 101 Information on Healthcare Spending, Who Pays, and Future Trends.*

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4.D.1. Medicaid & SCHIP

Healthy Kids Gold (HKG), Medicaid, provides coverage for infants up to 300% of federal poverty level (FPL). and children 1-18, up to 185% of FPL. Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income. Effective September 14, 2009, the New Hampshire Healthy Kids program was authorized to expand coverage to young adults ages 19 to 26 years who cannot be included in their family's health insurance plan, and whose incomes are at or below 400% of FPL. Due to budget considerations, and uncertainties of federal health reform, no effective date has been set to implement this expansion.

In New Hampshire, pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. Medicaid has been growing as the payer for an increasing number of births in the state. In 2003, Medicaid was the payment source for 20.3% of all births in the state. By 2009, that number has grown to 31%. Of women obtaining prenatal care in MCH-supported community health centers, 68% received Medicaid and 12.8% were self-pay, or uninsured. These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

New Hampshire Medicaid does have a "Katie-Beckett" like eligibility pathway called Home Care for Children with Severe Disabilities (HC-CSD). This allows children up to the age of 19 to qualify for Medicaid based on their need for institutional level of care and solely considers the income and resources of the applicant. Currently there are approximately 1750 –1800 children that are covered by Medicaid through this eligibility.

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The State's Children's Health Insurance Program (CHIP) provides health coverage for uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private insurance. New Hampshire's CHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Enrollment in CHIP has decreased since 2008, while enrollment in Medicaid, or Healthy Kids Gold has increased. It is assumed that this is directly related to statewide economic indicators.

4.E. Quality

4.E.1. Performance Management & Title V Funded Agencies

Performance management is a key DHHS strategy for improving state and local capacity to deliver core public health services and increase service quality. Our vision is to promote evidence-based practice by defining and measuring quality; establishing quantitative performance expectations; and holding state and local health systems, community agencies, and other service providers accountable through performance-based contracting. Performance measures are required for contracted community agencies. Agency performance is monitored over time and used in specialized Performance Management site visits to assist agencies in improving processes and outcomes.

MCH began developing performance measures for local agencies in 2000; performance measures were selected using national and state standard measures from such sources as Healthy People 2010, Healthy New Hampshire 2010, HEDIS, and various federal funding agencies. Since then, the measures have been further defined and refined and in some cases, completely revised. Contract agencies are provided with performance measures and baseline data relative to the measure, and are asked to set targets, describe activities used to reach the targets, and outline evaluation plans. These workplans are submitted to MCH in advance of the upcoming contract year, with outcomes reported once the grant year is completed.

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Program trend data has now been collected for almost ten years in some programs and is proving useful in monitoring agency performance and highlighting areas where program support is needed.

In the past year, the MCH QA Nurse Consultant led teams of program managers on over 30 site visits to MCH-funded agencies. Site visit reports are written and returned to agency for their consideration, or remediation and action, within two weeks. MCH will continue to work with community partners over the next several years to progress from performance measurement to performance management.

4.E.2. Other Quality Initiatives

New Hampshire is one of 16 Lead States in Public Health Quality Improvement that participate in the Multistate Learning Collaborative (MLC-3). The MLC-3, funded by the Robert Wood Johnson Foundation and managed by the National Network of Public Health Institutes, aims to improve public health services and the health of communities by implementing quality improvement practices. In partnership with the Community Health Institute/JSI (CHI/JSI), the Division of Public Health Services, including MCH, is currently providing training, technical assistance, and tools to three Quality Improvement Learning Teams (QuILTs) comprised of community-level organizations focusing on improving smoking cessation rates among pregnant women and enhancing their workforce capacity. It is anticipated that MCH will then share the successes of these learning collaboratives with other prenatal providers throughout the state.

4.E.3. Community Health Center Customer Satisfaction

The Community Health Access Network (CHAN) is a regional collaboration of community health care organizations in New Hampshire, whose goal is to enable member health centers to serve vulnerable populations and maintain comprehensive range of health care services. As an integrated provider network, CHAN members collectively established common standards for the network in clinical protocols, operational policy, financial and information systems. Conditions of network participation focus on measured consistency in clinical quality, cost, patient satisfaction, and other delivery system components. Eight of the thirteen MCH-funded community health centers are CHAN members.

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In addition to a multitude of diagnosis related compliance reports, some members use the 'Opiniometer' while others use paper surveys with positive response rates to gauge patient satisfaction. Numerous questions are asked about the patient experience including: the timeliness of visit scheduling; wait times; privacy; comfort; comprehension of information provided; staff courtesy; overall satisfaction; whether clients know how to reach a provider when the practice is closed; location and parking; hours of operation, building appearance and comfort; fees and charges; the privacy of discussions about billing; and availability during off hours. Every agency asks if the client would recommend the practice to friends or relatives.

Results were very positive overall. The occasional lower than 90% result would be at one agency while not in others. Some clients are quite interested in same day appointments. Plans are made to address any result that did not meet an agency's expectation. Some plans include encouraging patients to access electronic requests for appointments, refills, referrals, etc. Also suggested was a quarterly "push" to increase the rate of survey responses and also to analyze results by individual provider.

4.F. Emerging Issues

4.F.1. Patient Protection and Affordable Health Care Act

On March 23, 2010, the President signed into law a comprehensive health reform measure, the Patient Protection and Affordable Health Care Act, PPACA (P.L. 111-148). While most Americans are aware that the law focuses on provisions to expand coverage, control health care costs, and improve the health care delivery system, it is clear that there are many other complex ramifications of the law with funding and strategic implications that may have profound implications on the way Public Health provides services, integrates with other programs, and allocates resources.

The PPACA requires most U.S. citizens and legal residents to have health insurance by 2014. It will create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals and families

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with income between 133-400% of the federal poverty level and create separate Exchanges through which small businesses can purchase coverage. It will require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. It will impose new regulations on health plans in the Exchanges and in the individual and small group markets. It will also expand Medicaid to 133% of the federal poverty level.²⁴

In addition to these broad-based insurance-related features, the law also authorized public funding for a wide array of prevention programs. Title V is particularly excited about the opportunities in the Maternal, Infant, and Early Childhood Home Visiting Program and Personal Responsibility Education, as well as in other prevention programs where Title V will partner with other Public Health entities to benefit MCH populations.

Created as an entirely new section in the Title V authorization, the Maternal, Infant, and Early Childhood Home Visiting Program provides \$1.5 billion over five years for evidence-based Maternal, Infant, and Early Childhood Home Visitation models targeted at reducing infant and maternal mortality and its related causes. The New Hampshire early childhood community is eagerly awaiting further guidance about the Home Visiting Needs assessment and process and ultimately information about how these funds may be used to support expansion of the existing statewide home visiting programs. Currently, Home Visiting New Hampshire, the MCH home visiting program that uses a unique combination of nurse home visitors and the evidence-based Parents As Teachers curriculum, has been under budget pressures from its funders. Its continuation has been uncertain, but given the expectation of maintenance of effort, as described in the PPACA, Title V is proceeding with preliminary plans to include it within the Home Visiting Needs Assessment.

The Personal Responsibility Education (PREP) provisions allot \$75 million per year through FY2014 for Personal Responsibility Education grants to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections,

²⁴ The Kaiser Family Foundation. *Focus on Health Reform: Summary of New Health Reform Law*. Available from www.kff.org

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including HIV/AIDS. As described in this Needs Assessment, New Hampshire is fortunate to compare favorably when compared to national rates of teen pregnancy, but there are pockets of disparity throughout the state. New Hampshire Title V anticipates collaborating with Title X to utilize PREP funds for comprehensive, preconception health, as well as specific teen pregnancy prevention activities. PPACA also restored funding for Abstinence-only programs. New Hampshire was the last of the New England states to continue receiving and utilizing abstinence-only funds prior to their discontinuation. At this time, a final determination has not been made if New Hampshire will continue to apply for abstinence only funding, given the current limited staffing capacity of MCH and priorities. However, since there appears to be an array of funding sources available for a full range of comprehensive adolescent sexual health, including abstinence, it is likely that Title V will work with community and state partners to maximize resources to bring as many options for appropriate health education to communities as possible.

This expansion of coverage will challenge Title V to think about its roles in providing Direct and Enabling Services. The PPACA continues to support, and in fact enhances support to community health centers, providing more than \$11 billion in funding (over five years) for the Community Health Center program, the National Health Service Corps, and construction and renovation of community health centers. This bodes well for New Hampshire, as we have built our safety net for vulnerable families on a system of community health centers. But we also must learn more about and embrace the concept of new ideas like Pediatric Accountable Care Organizations while continuing to educate the entire healthcare community about the role of Title V in Patient-Centered Medical Homes.

4.F.2. The State Budget

The biennium budget process for SFY 10/11 has brought continued fiscal challenges to both the State and DHHS, as New Hampshire strives to achieve balance the burden of providing services to an aging population in a downward spiraling economy. As in 2008 and 2009, the New Hampshire state government appropriated slightly more than \$5.1 billion. Almost two thirds of appropriations were for education (including public K-12 and the university system) and health and human services. Public policy debate about changes in the retirement system, the state's Medicaid county-based long term care services for the elderly, and state education funding

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inevitably have involved conversations about the ‘shifting financial burden of public services’ from general state taxation to the local property tax.²⁵

Budget deficits have been attributed to increasing caseloads in Medicaid, TANF and other human services and decreasing revenues in business and real estate taxes. Trends in Medicaid caseloads far exceeded budget projections and indicate a \$1.1 Million shortfall for the elderly and \$6.7 Million for non-elderly payments including hospital inpatient and outpatient services, provider payments and pharmacy. In March 2010, there was a 10.1% year over year increase in the number of Medicaid enrollees. Rates have been reduced to providers and controls have been proposed on Medicaid codes for Title V services such as home visiting and child and family health supports.

Similar trends have been seen in TANF. Caseloads have exceeded projections in the State Budget causing deficits. Year to date in SFY2010, there has been a 21% increase in TANF recipients. At this rate, the budget can expect a \$2.4 Million shortfall for cash assistance for families.

In addition to increased caseloads, state revenues have been significantly lower than expectation. Without a general sales tax or a personal income tax, New Hampshire’s tax revenues rely primarily on two forms of business taxes, the Business Profits Tax and the Business Enterprise Tax. The next highest sources of revenue are the Meals and Rooms Tax and Liquor Sales and Distribution. Currently, as in SFY09, all of these revenue sources are below budgeted expectations. The conservative estimate is that there will be a \$100 Million dollar shortfall in the budget for 2010/2011.²⁶ However, as of May 2010, the General Assembly Committee of Conference concluded that the budget deficit was closer to \$295.2 Million dollars.

The impacts of the state budget crisis are felt throughout the system. State employees were laid off in October 2009. MCH was impacted by hiring freezes for currently vacant positions and the Childhood Lead Poisoning Prevention Program (CLPPP) lost state general funding for two

²⁵ NH Center for Public Policy, December 2009. *Sharing the Common Burden: New Hampshire and Public Service*

²⁶ NH Center for Public Policy, April 2010. *2010 and Beyond: New Hampshire, the State Budget and Children’s Policy*.

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environmental lead specialists, as well as funding for its compliance project manager. This reduction of three staff members, along with two federally funded vacancies challenged the CLPPP to re-allot the resources necessary to meet goals and objectives. Adding to these difficult changes was the discontinuation of funding for blood lead testing and paint and dust sampling analyses by New Hampshire's Public Health Laboratory (PHL), also due to budget reductions in October 2009.

As previously described, Medicaid rates to providers have been reduced and additional controls for cost saving are being explored. Additionally, programs like Home Visiting New Hampshire, that have historically used innovative, collaborative approaches for funding are in jeopardy of ending due to the increased pressure from programs like Medicaid and TANF to focus on their core mission and thus, discontinue support for these joint ventures.

Looking forward, there are no easy answers to reconcile the revenue and expenditure disconnect in New Hampshire. It is clear that social services and health care will continue to be costly to the state General Fund. While perhaps moving the population towards more healthy lifestyles and preventive care in the long run, the Patient Protection and Affordable Care Act will have unknown financial impacts to the state in the next five years. Although the federal government will pay for increased Medicaid payments for fee-for-service and for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) for 2013 and 2014 the full fiscal impact of expanding Medicaid eligibility is unclear.

4.G. Population-Based Services

Population-based programs are an essential element in improving the health of MCH populations. Title V has long recognized that health status is influenced not only by human biology and clinical/direct care services, but also by social determinants of health including, income and education; socio-economic position; environment; discrimination; access to services; and chronic stress.

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The New Hampshire DHHS, Division of Public Health Services is transitioning to a more population-based model with an imperative to better align goals across the Division; link initiatives; and use scarce resources more efficiently through better integration. To do this, the Division, as a whole, will focus on the following key strategies:

- o Increase Emphasis on Approaches to Population Health
- o Expand Health Messaging with Key Audiences
- o Strengthen Public Health Infrastructure
- o Improve the Effectiveness of Resource Allocation
- o Strengthen Organizational Effectiveness and Adaptability

As part of this transition, MCH will be newly positioned within a Bureau of Population Health and Community Services (BPHCS). Programs within the new BPHCS include: WIC, MCH, Tobacco Prevention and Control, Oral Health, Comprehensive Cancer, Diabetes Education, Obesity Program and Cardiovascular Program. Together these programs will work to develop new synergies and enhance existing relationships to meet the needs of discrete populations, including women, children and their families, especially those with health disparities. The strategic direction includes:

- o Implementation of cross-program integration to increase population-health impact
- o Integration data systems to monitor population-health status
- o Positioning of DPHS as expert on approaches to population-health: policy, data, practices
- o Strategic use of partnerships to implement population-health approaches
- o Focus on chronic disease prevention, diagnosis, treatment and intervention
- o Allocation of resources externally to support strategic goals
- o Development and implementation a health messaging strategy

The priorities addressed within this needs assessment and subsequent activities and performance measures of the Title V Block Grant fit well within this model of population health. This Division-wide strategic plan will ensure that continued collaboration is the work of all public health programs and sets us on the road to achieving true cross-program integration.

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4.G.1. Accessibility & Quality

In New Hampshire, Title V staff work extensively with other state-level agencies and organizations to plan and implement population-based programming to address needs of particular groups and of the population as a whole. Most pertinent to this review are the following core MCH programs: the Newborn Screening Program; the Early Hearing Detection and Intervention Program; the Childhood Lead Poisoning Prevention Program; and the Injury Prevention Program. Title V also works extensively with other entities in cross-disciplinary, population health efforts to promote healthy behaviors and environmental and systemic change.

All of these programs strive to achieve cultural competence in serving their populations. The Early Hearing Detection and Intervention (EHDI) Program provides sign language interpreters for Advisory Committee meetings and other meetings when requested. The program utilizes EHDI materials available in Spanish through CDC, and materials developed by other states in additional languages. The Childhood Lead Poisoning Prevention Program (CLPPP) had most of their materials translated into Spanish and other languages, including African languages, as requested. The CLPPP is currently working with laborers and contractors to develop a process to provide oral examinations with translators for the certification process for lead-safe renovator classes. In Manchester and Nashua, CLPPP nurse case managers work with interpreters (and help staff find interpreters) for home visits and inspections. The Injury Prevention Program provides bilingual staff, when available, at events such as child safety seat checks and hearing aids of some events for seniors.

Newborn Screening Program (NSP):

Newborn screening in New Hampshire is required by law, unless the parent or guardian objects. The original law was passed in 1965 and since then additions have been made to the panel of conditions for which New Hampshire screens. An amendment in 2005 updated the process by which new conditions can be added to the panel, strengthened individual privacy concerns, and established a non-lapsing newborn screening fund to support the program. In 2010, the law was amended again to further clarify the purpose of the non-lapsing fund clarifying its use for not

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only the laboratory screening contract, but also for other program support including staff salary and benefits. Fees for newborn screening are incorporated into global fees for delivery. Hospitals, birthing centers and home birth attendants all have the responsibility of assuring that each infant is screened.

Table 4.3 Historical Additions to New Hampshire Newborn Screening Panel

Year	Disorder(s) Added
1965	Phenylketonuria
1976	Congenital Hypothyroidism
1983	Galactosemia, homocystinuria, and maple syrup urine disease
1988	Congenital toxoplasmosis
1990	Hemoglobinopathies, targeted
2006	Cystic Fibrosis, Congenital Adrenal Hyperplasia, Biotinidase, Medium chain Acyl CoA dehydrogenase deficiency and screening for hemoglobinopathies became universal
2007	19 additional metabolic disorders added to the panel (See Appendix F)
2010	Tyrosinemia

In 2009, 13,522 infants were screened for 32 conditions. Thirty-one disorders were detected; all received appropriate follow up. Based on calculations using 2009 Vital Records birth data and newborn screening data for that year, 99.7% of the newborns in New Hampshire (occurent births) were screened for congenital anomalies.

Table 4.4 Disorders detected through Newborn Screening, 2009

Disorder	Number Identified	
Congenital Hypothyroidism	11	
Cystic Fibrosis	10	
Hemoglobinopathies	1 Nonsickling disorder	3 Sickle Cell
Citrullinemia	1	
Partial Biotinidase	1	
Duarte Variant	3	
CAH	1	
TOTAL	31 disorders	

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Early Hearing Detection and Intervention Program (EHDI):

Although New Hampshire does not require newborn hearing screening through legislation, it is performed in all 21 hospitals with birth units and in 1 of the 3 freestanding birthing centers. Administrative Rules do require, however, that if screening does occur, that all results must be sent to the New Hampshire Title V program. Fees for this screening are included in global delivery charges and reimbursed by health insurance companies and Medicaid. In calendar year 2009, 97.3 % of infants born in the state were screened. Initial hospital pass rates ranged from 87.8% to 100% in 2009. Of infants who failed the initial screening, 92% received a second hearing screening and 1.5% were referred for diagnostic testing. To date, 152 of the 194 infants have been scheduled for diagnostic testing and 30 of the infants have a preliminary diagnostic of hearing loss in one or both ears. The average age of diagnosis for infants who were not admitted to an intensive care nursery was 1.9 months (20 infants: 18 under three months, one at four months and one at five months of age). For the eight infants admitted to an intensive care nursery, the average age at time of diagnosis was 5.75 months and ranged between five and eight months.

Population health efforts to enhance this system have included the use of a Family Advocate to work with families, guiding them through the referral and diagnostic process; hospital-based campaigns to script and standardize messages to families when infants do not pass initial screenings so as to decrease up loss to follow up.

Childhood Lead Poisoning Prevention Program (CLPPP):

As proscribed in RSA 130-A, the CLPPP provides for public education, comprehensive case management services for children with elevated lead levels, an investigation and enforcement program and the establishment of a database on lead poisoning. Screening for elevated lead levels in children in New Hampshire is accomplished largely through health care providers in the course of health maintenance visits, and accessibility is therefore dependent on the availability of preventive care for children across the state. Two exceptions are in Manchester and Nashua, where the CLPPP has contracts with local health departments to provide outreach, case management, and health education for children at risk, including minorities and children with

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Limited English Proficiency. MCH promotes adherence to the national standards of screening children at age one and age two with its contracted agencies.

Capacity for lead poisoning prevention activities has ebbed and flowed with the tide of state resources and political will. In 2007, legislation was passed that lowered the Elevated Blood Lead Level (EBLL) at which the CLPPP could investigate a rental property where a child under the age of six years old resided. The CLPPP received additional State General Funds to help support these efforts. In SFY 2010, however, the CLPPP had three positions eliminated and staff were laid off. In SFY 2011, federal funds from the CDC will be reduced further impacting the programs ability to contract with local public health agencies and services like case management may have to be reduced or eliminated.

Even with recent set backs and resource constraints, lead poisoning prevention education and screening efforts continue. Fortunately, there appears to be a downward trend in the number of children with newly confirmed elevated blood lead levels. In 2006 there were 201 confirmed elevations statewide in children birth through age six; 2007 there were 170; 2008 there were 140; and in 2009 there were 118. In 2009, preliminary data indicate that the statewide initial screening rate for 12 – 23 month old children was 50.6%, while the rate for 24-35 month olds was 26.8% (Additional data regarding lead poisoning can be found in Section 3). High-risk children with an elevated blood lead level living in rental housing receive an environmental screen for lead hazard, as per statute. For those living in their own homes, education materials are offered, but due to limited resources, home visits are no longer offered. Children with elevated blood lead levels currently receive case management services and health education, but again, due to shrinking resources, these services will not be universally offered and have to be allocated based on priority and need in the coming years.

As the CLPPP transitions to a Healthy Homes program and further ingrates with the asthma program and other environmental health programs, there will be challenges to maintain a focus on lead-specific prevention and enforcement activities while embracing a more holistic approach to promoting the availability of healthy, safe, affordable, accessible, and environmentally friendly housing.

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Injury Prevention Program (IPP):

The New Hampshire Injury Prevention Program (IPP), located within the Maternal and Child Health Section, aims to reduce morbidity and mortality due to intentional and unintentional injuries. The program focuses its efforts on those high incidence injuries that are most amenable to public health interventions. The IPP, with a with only one Full Time Equivalent (FTE) dedicated to Injury Prevention, does this through its contracts with the New Hampshire Coalition Against Domestic and Sexual Violence (NHCADSV) and the Injury Prevention Center (IPC) at Dartmouth. The IPP is also the location of the Northern New England Poison Center's (NNEPC) New Hampshire Educator. The NNEPC serves New Hampshire, Maine and Vermont, and is operated through a contract with the New Hampshire Department of Safety.

Major activities of the Injury Prevention Program include:

- o Educating the public and others about the scope and major causes of death and disability from intentional and unintentional injuries
- o Identifying and implementing effective prevention programs and strategies
- o Collaborating with private and public sector stakeholders to increase the effectiveness of Injury Prevention Program work
- o Enhancing effective public policies to reduce injuries

The overall population health program design focuses on integrating injury prevention and control activities into existing health care and other community based services. The bulk of the IPP and its partner agencies' effort is the identification of prevention strategies with demonstrated effectiveness. These then become strategies that can be recommended to local or regional initiatives.

As a program with limited resources, the IPP and its partners seek to create and lead collaborations among agencies and individuals interested in specific injury topics. Programmatic and fiscal synergy is often an outcome of these collaborations, as interested parties complement one another's resources and expertise. Currently, the IPP convenes and/or is a member of the following groups: the NH Falls Risk Reduction Task Force; Safe Kids New Hampshire; the

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Suicide Prevention Committee; the Suicide Prevention Committee's Communication's Subcommittee; the Teen Driving Committee; the Sexual Violence Prevention Planning/Implementation Committee; the Governor's Commission on Domestic and Sexual Violence's Education Subcommittee; Buckle UP New Hampshire and the Brain and Spinal Cord Injury Advisory Committee. The IPC and the NHCADSV are also working members of additional coalitions with injury prevention related missions.

The Teen Driving Committee, co-facilitated by the IPP, is working on a website specific to New Hampshire's parents of novice drivers. The website will be coordinated and supported in-kind with the help of the New Hampshire Department of Transportation and the New Hampshire Department of Safety. A marketing campaign to go along with the website will be developed, dependent upon funding. This campaign will include hard copy and electronic parent guides as well as media messages.

The Teen Driving Committee is also going to facilitate with the help of the University of North Carolina's Center for the Study of Young Drivers, Highway Safety Research Center a large-scale parent phone survey. This will determine a baseline for attitudes and knowledge with respect to graduated drivers' licensing in New Hampshire. Graduated driver licensing (GDL) systems address the high risks new drivers face by allowing them to get their initial driving experience under low-risk conditions. The survey will assess parental attitudes towards the different pieces of a model GDL system (permitting phase, restricted passengers and night driving, etc.). It will also determine parents' knowledge of the current GDL system in New Hampshire. The survey results will be collected and analyzed in a report.

The IPC facilitates Safe Kids New Hampshire through an MCH/IPP contract. Safe Kids New Hampshire provides, on an annual basis, information on low cost equipment programs and falls safety to 100% of schools and recreation departments in the state. All of this work is in complete alignment with the Title V priority reducing injury among adolescents due to teen motor vehicle crashes and falls.

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Text4Baby:

As the Title V's CAST-5 process revealed, MCH needs to be strengthened its use of social media and technology to communicate with families and individuals in order to stay relevant and provide the most culturally appropriate population based health messages. With this in mind, New Hampshire was anxious to work with the National Healthy Mothers, Healthy Babies Coalition (HMHB), to advance **Text4Baby**, a free mobile information service designed to promote maternal and child health. Participants receive three free messages a week that focus on a variety of topics critical to the health of mothers and infants, including immunization, nutrition, seasonal flu, prenatal care, emotional well being, drugs and alcohol, labor and delivery, smoking cessation, breastfeeding, mental health, birth defects prevention, oral health, car seat safety, exercise and fitness, developmental milestones, safe sleep, family violence, and more.

The New Hampshire Title V program worked closely with WIC and others throughout DPHS to develop a strategy to promote this service. Community health centers and District Offices (welfare offices) were given posters and educational materials and invited to participate on conference calls to explain the program. Title V staff have incorporated **Text4Baby** into presentations and meetings throughout the spring of 2010. As of May 2010, after the program had been launched for one month, over 280 mothers had signed up for the program. Compared to other states, New Hampshire was third in the country in penetration among its pregnant women.²⁷

New Hampshire Childhood Obesity Expert Panel:



Based on the work of a multidisciplinary panel of New Hampshire professionals, including Title V, with expertise in health care, disease prevention and community health, the Healthy New Hampshire, **New Hampshire Childhood Obesity Expert Panel** developed recommendations

²⁷ Healthy Mothers Healthy Baby Coalition. Text4Baby. Retrieved May 25, 2010 from www.text4baby.org

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and strategies to fight childhood obesity based on a review of national reports, evidence-based research, and promising practices.

The 5-2-1-0 plan addressed policy, systems, and environmental changes for families, schools, clinicians and community leaders. The name refers to the simple strategy of eating five fruits and vegetables, five times a day; cutting screen time to two hours or less a day; participating in at least one hour of moderate to vigorous physical activity every day; and restricting soda and sugar-sweetened sports and fruit drinks.

Title V has incorporated recommendations for clinicians regarding routine use of BMI into performance measures for community health centers and is participating in multiple collaborative activities to support breastfeeding promotion. New Hampshire Title V has requested and is currently planning technical assistance from the regional Knowledge to Practice resources at Boston University. This technical assistance will focus on identifying lifecourse components and best practice recommendation for addressing overweight and obesity in CSHCN, incorporating the needs of children with chronic health conditions, with developmental disabilities and with mental health issues. The challenge looking forward is to understand Title V's role in population-based efforts in promoting recommendations for healthy eating, active living directly to families.

Nutrition and Feeding & Swallowing Network:

The Nutrition and Feeding & Swallowing (NFS) Network in New Hampshire was established to meet unique assessment and consultation needs of children and youth in New Hampshire. All children being served by this program meet the broad definition of CSHCN but do not necessarily have a chronic health condition. This program provides home and community based services. It also provides consultation to schools, early intervention providers, and primary care providers. A new component of the program has been the creation of Specialty Feeding Clinics with Specialty Care providers. The NFS Network also produces and disseminates educational materials and presentation of regional meetings to the public to review information on issues such as issues related to Autism and nutrition.

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4.H Infrastructure Building

The foundation of the MCH pyramid instructs us to build infrastructure for MCH programs for state and community systems. In New Hampshire, Title V is the standard bearer for collaborative approaches to comprehensive, family centered systems for the Title V population. Coordination efforts occur with organizations that are separate from Title V programs, such as WIC, Medicaid, Early Supports and Services (Part C) but intricately involved with the populations served by Title V. **Section 2** highlights many of the partnerships and collaborative bodies that Title V participates in to help expand our reach and strengthen the State's efforts to promote infrastructure-building services that promote comprehensive systems of care. Although our capacity is somewhat limited, Title V participation, leadership and initiative is far reaching and diverse and ranges from participation on the New Hampshire Early Childhood Advisory Council to the promotion and measurement the consistent use of the 5 A's in tobacco cessation in prenatal programs to data initiatives that will complete an MCH Data Mart. Instead of providing details here in this Needs Assessment, the State's activities and progress will be presented annually in the appropriate application sections related to State Agency Coordination, State Priorities, National Performance Measures, and State Performance Measures.

As described in earlier sections, Title V provides support for a network of community health centers and categorical agencies that provide safety net preventative and primary care services for vulnerable pregnant women, children and low-income families. Infrastructure building is critical to this support. Title V and State General Funds support workforce capacity initiatives, data enhancements, and the continuous quality improvement of their work through performance measurement and monitoring.

A significant need affecting the infrastructure of both primary and specialty care in New Hampshire is workforce capacity and workforce availability. As with primary care, these needs are national in scope, and some of these needs, such as the need for early childhood mental health specialists or dentists, have disproportionate affects in rural places.

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4.H.1. Primary Care Provider Workforce

In March 2008, a report called *Strategies to Address the Issues of Access to New Hampshire's Primary Care Workforce* was released²⁸. The Workforce Committee charged to develop this report found that there are critical shortages of primary care providers in New Hampshire and that these shortages are projected to increase.

From 2000 to 2008, the number of U.S. medical school graduates entering family practice decreased by 50%; internal medicine decreased by 18%, and pediatrics by 8%. In 2006, 80% of physicians graduating from internal medicine residencies chose specialty care. "With one-third of actively-practicing physicians in the U.S. at age 55 years or older, and with the increasing demand for health care services by an aging population, a crisis in access to primary care services is looming nationally." It has been projected that the shortage of primary care providers will have its greatest impact on underserved and poorer communities and populations. There is also an increasing demand for, but decreasing supply of, registered nurses.²⁹

"New Hampshire is feeling the effects of the national trend in medical student preference for more lucrative specialty-care focused professions over primary care practice. In the highest quality and most cost-effective health care systems in the world, the ratio of primary care physicians to specialty-care physician is typically 1:1 (50% primary care; 50% specialty). At the beginning of 2008 in the U.S., 38% of physicians were primary care doctors while 62% were specialists. At the beginning of 2007 in New Hampshire, 42% of the state's physicians were registered as primary care doctors and 58% as specialists."³⁰

Primary care practices throughout the state, especially community health centers that serve low income and uninsured populations are having increasingly difficult time recruiting primary care physicians. Recruitment timelines in early 2008 averaged 18 to 24 months per vacancy. Family

²⁸ NH Citizens Health Initiative, *Strategies to Address the Issues of Access to New Hampshire's Primary Care Workforce*, A Report to Governor John Lynch, March, 2008

²⁹ NH Citizens Health Initiative, *Strategies to Address the Issues of Access to New Hampshire's Primary Care Workforce*, A Report to Governor John Lynch, March, 2008

³⁰ NH Citizens Health Initiative, *Strategies to Address the Issues of Access to New Hampshire's Primary Care Workforce*, A Report to Governor John Lynch, March, 2008

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practice vacancies known to the New Hampshire Recruitment Center increased from 25 to 45 vacancies between 2004 and 2007. In early 2008, health insurers who track primary care practices reported that about 25% were closed to new patients. While the numbers and percentage may seem relatively small, it is believed that there is a potential lack of primary care for well over 112,000 New Hampshire residents. It is also reasonable to believe that this number has grown since early 2008.³¹

Maps outlining Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs) are attached in Appendix G.

4.H.2. Dental Workforce

Results of the 2009 Third Grade Oral Health and BMI Survey and *Dental Services and Workforce in NH* from the NH Center for Public Policy Studies describe regional disparities in oral health of New Hampshire residents and point to impact of shortages of dentists and dental hygienists in the New Hampshire workforce.

Among New Hampshire's children, students in Coos County, the northern-most county in New Hampshire, had the highest prevalence of decay experience and untreated decay and the lowest prevalence of dental sealants. This prevalence was statistically significantly higher when compared to all other regions. Third grade students in the Carroll/Grafton region had statistically significantly fewer sealants than students in some other regions. Less than 40% of Medicaid enrolled children accessed dental services in Sullivan or Grafton counties.³²

Among New Hampshire's dental workforce, northern areas of the state have been designated as Dental Health Professional Shortage Areas (DHPSA). There are no pediatric dentists practicing north of Concord, in the geographic northern half of the state. While not a designated DHPSA, Sullivan County in western New Hampshire has the lowest rate of dentist providers of all counties and the lowest rate of children accessing dental services. Sullivan County also has the

³¹ NH Citizens Health Initiative, *Strategies to Address the Issues of Access to New Hampshire's Primary Care Workforce*, A Report to Governor John Lynch, March, 2008

³² DHHS DPHS. Results of the New Hampshire 2009 Third Grade Oral Health and BMI Survey. Retrieved 6/22/10 from http://www.hnhfoundation.org/documents/Report_HealthySmiles-HealthyGrowth-ThirdGradeSurvey_12-16-09.pdf

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highest number of uninsured children per provider (228) in the state indicating low numbers of providers for the Medicaid and uninsured populations. Designation of Sullivan County as a DHPSA has been denied because of its proximity to Hanover, New Hampshire.³³

Over two-thirds of New Hampshire dentists are found in three counties. The distribution of licensed, active dentists in general or pediatric private practice across the northern and western areas of the state that are experiencing shortages are as follows: Sullivan 2%; Belknap 4%; Carroll 3%; Cheshire 4%; Coos 3%.³⁴

4.H.3. Audiology Workforce

The number of audiologists in New Hampshire affects the timeliness of testing infants who do not pass their hearing screening. The national standard is to identify infants who are deaf or hard-of-hearing before three months of age. Between May 2007 and May 2009, families in New Hampshire could not schedule timely appointments due to a shortage of facilities and appointments for infant diagnostic testing. Within several months, the number of diagnostic facilities for infant testing decreased from six to two facilities. One facility restricted referrals to hospitals in the northern area of the state. This meant that only about one third of the infants born in New Hampshire could be referred to this center. The only other facility, on the State's seacoast, has limited appointments for infants because it has one audiologist who tests clients of all ages. The delay caused some parents to worry and, if allowed by their health insurance plan, to seek appointments at facilities in other states.

Recently, additional diagnostic centers were established in New Hampshire. In May 2009, the audiology department in a large southern New Hampshire hospital began testing infants. Another center opened on the seacoast in June 2009. In July 2009, the facility with the restricted service area hired an additional audiologist and resumed accepting referrals from all hospitals. The national shortage of audiologists interested in and able to perform infant diagnostic testing raises the concern that this situation may occur again.

³³ NH Center for Public Policy Studies. *Dental Services and Workforce in NH*. Available from <http://www.nhpolicy.org/>

³⁴ NH Center for Public Policy Studies. *Dental Services and Workforce in NH*. Available from <http://www.nhpolicy.org/>

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A Map of the Pediatric Audiology Diagnostic Centers (used in recent CDC reports) is attached in Appendix H.

4.H.4. Children's Mental Health Workforce

In the past five years, researchers, stakeholders and advocates have assessed and described the availability and quality of children's mental health services in New Hampshire. In 2007, the Center for Public Policy Studies published *Few and Far Between? Children's Mental Health Providers in New Hampshire* and stated that even though the data on the mental health work force is limited, a few things are quite clear. For example, half of all child psychiatrists are located in the two southeastern counties of the state. Conversely, the two northernmost counties do not have a child health psychiatrist in practice. Not surprisingly, a significant part of northern New Hampshire has been designated a mental health professional shortage area by the Health Resources Services Administration, in large part due to the absence of psychiatrists.

“Furthermore, New Hampshire has the fewest child psychiatrists per child of the four most northern New England states. In fact, when you look at all the primary providers of mental health prescriptions to children – psychiatrists, family practitioners and pediatricians – New Hampshire ranks the lowest in Northern New England.” A larger, poorly documented, pool of other mental health providers does exist, however; most commonly child psychologists, school psychologists, and clinical social workers and mental health counselors. “Based on the data available, it is clear that schools are a critical component of the mental health workforce for children. While there is less than one child psychiatrist per 10,000 children and fewer than four psychologists in the state per 10,000 residents, on average, there are more than 10 school psychologists per 10,000 students.” The report states that it is difficult to draw any definitive conclusions regarding sufficiency of workforce capacity, but it is clear that there at least insufficiencies in large areas of the state.³⁵

³⁵ Norton, S, Tappin, R, McGlashan, L, *Few and Far Between? Children's Mental Health Providers in NH*; New Hampshire Center for Public Policy Studies, September, 2007.

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Another report stated that there is also considerable variation in how rural emergency mental health care is provided. The Foundation for Healthy Communities identified seven rural hospitals that have no contract in place with their regional community mental health center.³⁶

Mental Health Services In Schools:

“As many as 55,756 children, ages 5 –19, have a diagnosable mental health disorder, and almost 14,000 have a serious emotional disturbance. According to a recent analysis of mental health service provision by the New Hampshire Center for Public Policy Studies, 25%, or 17,680 children, received services for a mental illness in 2005 through the Medicaid program; and the state’s schools were among the primary providers of those services. The Manchester and Nashua School districts billed the state’s Medicaid program for almost \$1 million each for mental health services in 2005.”³⁷

In addition to serving the special education population, most schools are providing mental health services to the general population of students. “Only 9% of schools indicated that they provided mental health services only to special education students. Slightly more than 50% of schools in New Hampshire provide school-wide screening for behavioral or emotional problems, and 73% of schools provide individual counseling services. Most schools (70-80%) did not note difficulty providing basic mental health services.” A much higher number of schools do say that they experience difficulty providing medication management and referral to specialized services, however. “Although significant resources are being devoted to mental health services, information on the types of diagnoses, the types of services being provided, and perhaps most important, the outcomes associated with this system are not well documented.” Nearly 33% of schools do not collect data on the provision of services provided for special education or mental health specific needs.³⁸

³⁶ Covert, Susan, *Children’s Mental Health Services in New Hampshire*; Endowment for Health; NH Department of Health and Human Services; NAMI-NH, November, 2009

³⁷ Norton, S, Tappin, R, *Mental Health Services in New Hampshire Schools*; New Hampshire Center for Public Policy Studies, April, 2009

³⁸ Norton, S, Tappin, R, *Mental Health Services in New Hampshire Schools*; New Hampshire Center for Public Policy Studies, April, 2009

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It is also important to highlight that the Tobey School (part of DHHS), an alternative day and residential school for students identified as educationally disabled and seriously emotionally disturbed (SED) - and entitled to services under an Individual Education Plan (IEP) – was closed and positions were eliminated during recent budget cuts. The students have been placed in other educational settings, mostly in their communities. A number of Department of Health and Human Services positions have been cut and vacancies exist, due to the monetary crisis as well. One notable position and office, responsible for Children and Adolescent Mental Health Services in the Bureau of Behavioral Health, has been abolished.³⁹ Currently children and young adolescents in need of publicly funded residential mental health treatment could be treated at the Anna Philbrook Center, a separate unit of New Hampshire Hospital (the State’s publicly funded psychiatric hospital). The Philbrook Center, however, is slated to be closed in 2010 for budgetary purposes. This will mean that children and young adolescents will be moved to section of the adult hospital.

Finally, according to the state’s Bureau of Behavioral Health, “the children’s systems’ most pressing needs are in the area of:

- o Community supports to prevent hospitalization
- o Services to special populations (such as youth with developmental disability/mental illness, sexually reactive youth, and youth dual diagnosed with mental illness and substance abuse)
- o Workforce development”⁴⁰

4.H.5. Medical Home

Title V has been a participant in the development of systems of care that support and integrate the philosophy that CSHCN, and others, should have a Medical Home. Since June 2006, Special Medical Services has had a formal contractual relationship with the Center for Medical Home Improvement (CMHI), recognized nationally as a center for expert consultation on Medical Home, to promote and facilitate the integration of Medical Homes in New Hampshire.

³⁹ NH Department of Health and Human Services Division of Behavioral Health. *Fiscal Year 2010 Mental Health Block Grant Application*, 2009

⁴⁰ NH Department of Health and Human Services Division of Behavioral Health. *Fiscal Year 2010 Mental Health Block Grant Application*, 2009

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According to the *2005/2006 National Survey of Children with Special Health care Needs*, only 49.6 percent of parents of children with special health care needs reported receiving coordinated, ongoing, comprehensive care within a medical home. In the state of New Hampshire, only slightly better than the national percentage or 47.1⁴¹ reported having a medical home. There has also been recent significant national momentum for the Medical Home model for all populations; New Hampshire is no exception to the national heightened emphasis on the medical home as a means of reemphasizing and valuing primary care. Instrumental to the spread of medical home awareness and policy development in NH are the combined efforts of CMHI and NH Title V. Efforts have included:

1. Multiple presentations to various health and community-based agencies continuing the spread of the medical home concept and philosophy;
2. The Care Plan Oversight (CPO) Pediatric pilot with Anthem and Harvard Pilgrim Health Care (HPHC). Practices working with CMHI that meet certain criteria are eligible for a \$225 prospective payment for care plan development and monitoring for children with special health care needs.
3. CMHI was awarded a theme grant from the Endowment for Health, which started in October 1, 2009. This grant has enabled CMHI to outreach to additional practices in NH, in particular community health centers.

4.H.6. Healthcare Transition

One of the 6 MCHB Core Outcomes for CSHCN identifies the significant issues that need to meet related to youth transitioning to adult life. Preparation and willingness of primary care providers (pediatric and adult providers) is critical for successful health care transition of youth with special health care needs. New Hampshire Title V has had a Transition Coalition of stakeholders for several years. The Transition Coalition has been successful in the creation of a separate Youth Advisory Council called “Youth Educating Adults about Healthcare” (YEAH). An innovative approach for data collection was a survey of adult health care providers that was completed to identify barriers/concerns related to having YSHCN transitioned to adult care (See Appendix I). The Transition Coalition collaborated with the NH Pediatric Society (AAP

⁴¹ Child and Adolescent Health Measurement Initiative. *2005/2006 National Survey of Children with Special Health Care Needs*, Data Resource Center for Child and Adolescent Health website. Retrieved 7/7/09 from www.cshcndata.org.

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chapter) to present a conference for pediatricians and family practice doctors to review the results of the survey and to provide recommendation and a toolkit of resources for facilitating successful transition.

Currently the Transition Coalition, in collaboration with SMS' Care Coordination program and the PIH Family Support program, is launching (June 2010) a multifaceted outreach campaign to pediatricians across the state. This campaign is intended to reach 300 providers and will include outreach, in-person meetings and the dissemination of "Ticket to Transition" packets. These packets include educational posters for the primary care offices, provider information, and transition guidance in the form of Parent and Youth Tickets. SMS also has a representative that actively participates in the state of NH's Community of Practice on Transition and the transition workgroup for the regional New England Genetics Collaborative.

4.H.7. Surveillance

A significant function of Title V is the ability to monitor and assess the health status of the MCH population. Title V maintains or is in partnership with several population-based MCH related surveillance and data systems, including Childhood Lead Poisoning, Newborn Screening Program, and Universal Newborn Hearing Screening (or EHDI). Additionally, in accordance with RSA 141-J Title V works in partnership with Dartmouth Medical School to manage the Birth Conditions Program Birth Defects Registry. The MCH Epidemiologist currently has the capacity to link the available Birth Certificate information, hospital discharge, death certificate, commercial claims, and Medicaid files to enhance MCH surveillance activities. These file linkage functions are supported, in part, by the SSDI grant in addition to Title V. Although New Hampshire has applied on several occasions, Title V has not been awarded funding by the CDC to implement a Pregnancy Risk Assessment Monitoring Survey (PRAMS) for the perinatal population.

Fatality Review:

As described in Section II, Title V has been an active participant in the New Hampshire Child Fatality Review. With representation from both Injury Prevention and Child Health, MCH provides leadership to this statewide review process and ensures that recommendations are

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solution-focused and grounded in systemic change. MCH works with partners such as the New Hampshire Pediatric Association, the New Hampshire Department of Safety, The New Hampshire Medical Examiner's Office, the community health centers and others to implement suggestions and recommendations.

To date, New Hampshire has not had an Infant Mortality Review or a Maternal Mortality Review process. However, in May 2010, through separate legislation, both review processes were signed into law. The Maternal Mortality Review will be a partnership of the New Hampshire Chapter of the American College of Obstetricians and Gynecologists, the Northern New England Perinatal Quality Improvement Network, the New Hampshire Chapter of the American Academy of Pediatrics, New Hampshire Hospital Association, Title V and others, including public/family participants, dedicated to comprehensive review of maternal deaths and the system changes needed to improve services for women in New Hampshire. MCH will be responsible for developing the Administrative Rules that will guide the program and protect the privacy of individuals involved.

The legislation enabling the Infant Mortality Review calls for a committee of legislators to study and report upon New Hampshire's rate of infant mortality and develop proposals for remediation.

Summary

Through this Needs Assessment, the state's capacity to provide coordinated and comprehensive services at every level of the MCH pyramid for women, families, children and especially those with special health care needs was analyzed. With the help of the CAST-5 tools, the Title V Program looked inward at its own strengths, resource allocation and opportunities for growth. Extensive data analysis, research, partnerships, and collaborative activities continue to inform Title V of policy and programmatic decisions that directly impact MCH populations. This Section, in tandem with Section 3, illustrates that the majority of MCH populations have traditionally had access to routine care and generally compare favorably to the U.S as a whole, but the system is fraying. Access to mental health services is significantly compromised, and is projected to get more challenging as state budgets tighten. Treatment for substance abuse is in

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short supply. Place matters; depending on where you live in New Hampshire, access to dentists, or maternity care is a very long drive away. Because New Hampshire is such a small state with limited funds dedicated to state infrastructure, there is a long history of maximizing resources through partnerships and collaborative activities. It is with the help of these partners, the Title V will continue to address capacity in direct services, enabling services, population-based services and infrastructure.

Section 5: Selection of State Priority Needs

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5. Selection of State Priority Needs

As described in Section I and throughout this document, one of the core tasks of this needs assessment process was to apply scientific rigor and a logical methodology to the way in which the ten Title V priorities were chosen. Title V's capacity was examined through CAST-5, and teams of Title V program experts used their data and experience to develop informed action plans complete with evaluative objectives and performance measures from which State Performance Measures could be determined.

5.A. Preliminary List

As also described previously in this document, it is important to reiterate the methodology used to select New Hampshire's State Priority Needs. The following preliminary list of needs was identified based on a review of state and local data, National and State Title V Performance Measures, internal discussions with Title V program managers, input on specific issues (racial disparities, mental health and others) from key informants, and research by program experts and key stakeholders.

- o Preterm birth
- o Screening and support (0-6 years of age)
- o Autism
- o Access to specialty care
- o Maternal smoking
- o Alcohol/substance abuse
- o Pediatric obesity
- o Access to mental health
- o Title V workforce – primary care
- o Title V workforce – child care
- o Childhood lead poisoning prevention
- o Asthma
- o Oral health
- o Unintentional injury

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- o Suicide
- o Children without health insurance
- o Reducing disparities
- o Respite care

Table 5.3 provides a list of the preliminary priority areas, comparison to the 2005 priority needs and reasons for non-selection of priority needs.

5.B. Rating Tool

Early in the Needs Assessment process, New Hampshire Title V staff (working in informal workgroups with other DPHS staff and external partners) divided up the needs assessment work by topic area in which they had expertise. Staff gathered and reviewed data for their areas, and prepared data summaries that they presented to the larger group.

To begin the prioritization process, the Needs Assessment Team utilized a priority-rating tool (with slight modifications) developed by the University of California San Francisco that the State of California Title V program had used in their 2005 needs assessment. (See tool in Appendix J) The team agreed upon criteria and weights. The ranking criteria were as follows:

- o a large number of individuals are affected
- o there are disproportionate effects among population subgroups
- o the problem results in significant economic costs
- o the problem is cross-cutting to multiple issues and has life span effects
- o feasibility of New Hampshire's Title V program to impact the problem

Internal prioritization of the preliminary list of needs occurred first. Each staff member of the Needs Assessment Team *individually* rated the need areas. Individual weighted scores were then summed and the mean, minimum and maximum (of all scores) was calculated for each need area. The final ranking reflected means of the scores (higher mean score=higher priority ranking). A preliminary rank-ordered list of priorities was produced from this internal process.

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5.C. Problem Maps

Problem maps were completed after prioritization of need areas and before developing action plans. Workgroups in each priority area were assigned problem mapping for their area. The problem maps were shared with the team for the purpose of in-depth analysis of each specific health problem and were later utilized as tools for developing the action plans for the priority areas (problem maps are available upon request).

5.D. Public Input

In mid-2009, the Needs Assessment Team developed and administered an on-line (Survey Monkey) and paper survey to collect public input on the health needs of New Hampshire families. A link to the on-line version was distributed electronically to all statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. A total of 689 people returned the paper surveys and 299 people responded to the Survey Monkey version. The paper survey was distributed to Title V-funded health care agencies and to the ten DHHS District Offices (welfare offices) statewide that provide TANF, Medicaid, food stamps and other services to low-income clients. Paper surveys, aimed at clients of services and families, were available in English, Spanish and Portuguese (Spanish and Portuguese versions were requested by one Title V health care agency) (see survey tools in Appendix B). Clients were asked to complete the surveys and office staff returned them to MCHS. The results are displayed below and suggest that we succeeded in reaching two different populations. We were pleased with the large number of responses to the paper survey, as this is a population that is often difficult to obtain input from.

The process of selecting areas of need and the results of the internal prioritization were then shared with external stakeholders at a meeting in November 2009. Participants at this meeting included staff from other state agencies, nonprofit organizations, including March of Dimes, New Hampshire Endowment for Health and others, community health centers, health care providers and others. At this meeting, Tricia Tilley, Title V Director, Liz Collins CSHCN Director, and David Laflamme, MCH Epidemiologist, also presented data on identified needs in

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the three Title V population subgroups, information from the public input surveys and problem maps. Participants were then asked to rank their top five priorities using a “Pennies for Priorities” method. Each participant received fifteen pennies and a list of the preliminary priorities and was asked to rank their top five priorities. Fifteen baskets, each labeled with a preliminary priority area, were placed in the front of the auditorium. Participants were instructed to place 5 pennies in the basket labeled with their highest priority, four in the basket of their next highest priority, three for their third, two for their fourth and one penny for their lowest priority. An extra basket collected participants’ written lists of up to three emerging issues that they were aware of in their work. The results were calculated and shared with the group at the end of the meeting and are presented below.

5.D.1. Results of Public and Stakeholder Input and Prioritization

The following tables and charts illustrate the characteristics of the populations we surveyed, as well as their reported needs and priorities. The number of responses received was surprising and far exceeded that of previous public input surveys for the Title V Block Grant application. Administering the survey by two methods, both an online and an in person method, enabled New Hampshire to reach two different populations. (See map of survey results in Appendix K.)

Table 5.1 Characteristics of Survey Population

Characteristic	<u>Paper survey</u>	<u>On-line survey</u>
Number of respondents	689	299
Average age	35 years	46 years
Gender	86% F; 14%M	88%F; 12%M
Race	90% white	96% white
Not employed	48%	7%
Have children under age 21	70%	58%

Paper: Community Health Centers and DHHS District Office clients

On-line: Providers, advocates, others

Race question allowed >1 response; percents are adjusted for this.

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Table 5.2 Primary Health Insurance of Survey Respondents

	<u>Paper survey</u>	<u>On-line survey</u>
No health insurance	25%	4%
Medicaid	15%	3%
Medicare	13%	4%
Employer based	26%	82%

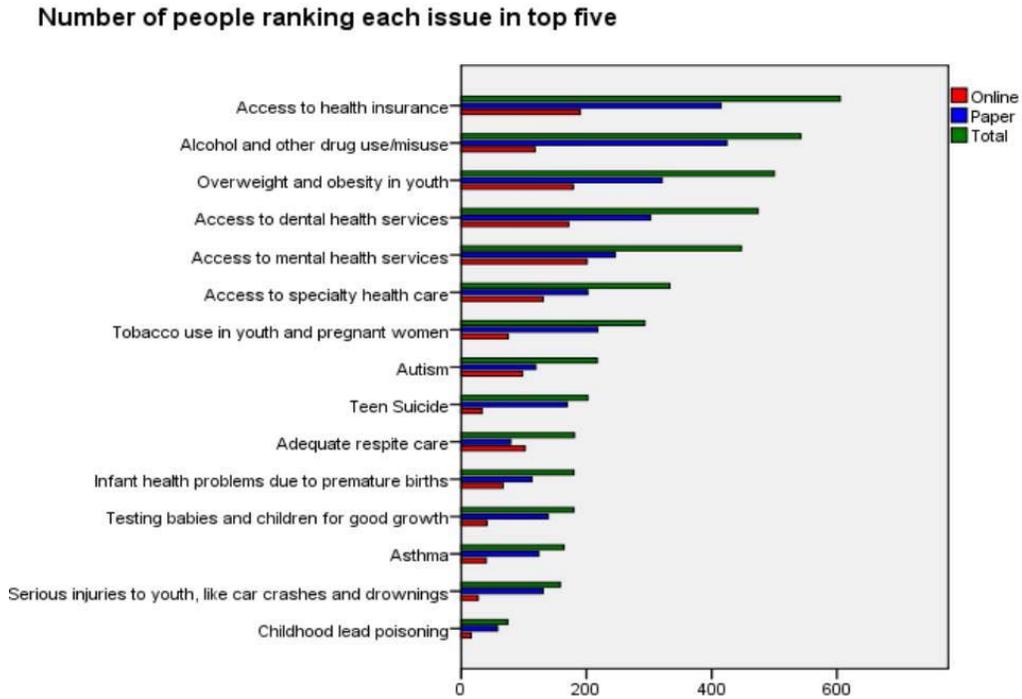
The results of the priority ranking by survey respondents is displayed below in Figure 5.1, *Number of People Ranking Each Issue in Top Five*. The sum of the scores of respondents by issue and survey type was also analyzed. No notable differences in the ordering of the priority issues was found between the two methods. Top ranked issues were:

1. Access to health insurance
2. Alcohol and other drug use/misuse
3. Overweight and obesity in youth
4. Access to dental health services
5. Access to mental health services
6. Access to specialty health care
7. Tobacco use in youth and pregnant women
8. Autism
9. Teen suicide
10. Adequate respite care/Asthma

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Inintentional injuries to children and adolescents and childhood lead poisoning were the lowest ranked issues in the survey.

Figure 5.1



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A section at the end of the survey asked respondents to provide any additional comments. The following information was obtained in response to these questions:

Question: “Think about children teens, mothers, families, as well as children with special health care needs. What are their biggest health care needs not listed above?”

- 195 Narrative responses on the Electronic Survey
- 356 Narrative responses on the Paper Survey

Question: “Is there anything else you’d like us to know about the needs of New Hampshire’s families?”

- Only available on electronic survey
- 117 Narrative responses

Responses that were repeatedly reported included:

- *“Insurance for low income moms. Dental for adults”*
- *“Loss of health care when a child turns 19. There is a huge population of uninsured 19-23 year olds.”*
- *“Teen Depression.” “Teen Pregnancy.” “Teen Suicide”*
- *“Disability services for disabled children & ADHD specialists”*
- *“More awareness of special programs for young moms”*
- *“Nutrition”*

Respondents’ specific health care needs included:

- Affordable health care for adults
- Prescription coverage
- Adequate support services: transportation, home visiting, etc. to reach needed services
- Out-of-pocket expenses: co-pays, items not covered by insurance: medical equipment, hearing aids
- Coordination of care
- Reproductive health care

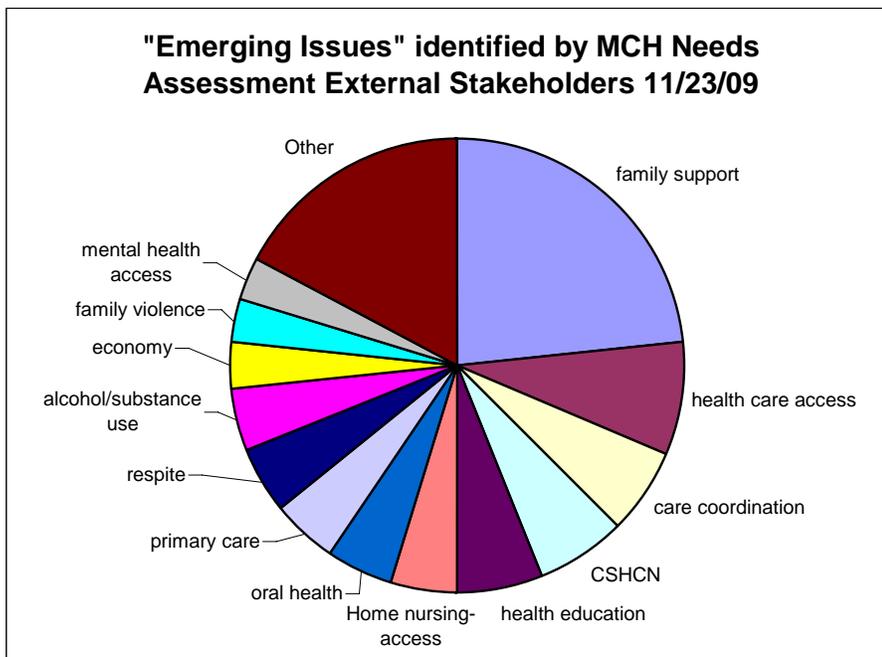
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While there was no clear cut ranking, what emerged was the fact that what still matters to advocates and families is access to:

- Health Insurance
- Mental Health Care
- Substance Abuse/Alcohol Treatment
- Dental Care for Adults and Medicaid Clients
- Respite For Those Who Need It

Participants of the Stakeholder meeting identified the “emerging issues” displayed in Figure__ below as ones that they were observing and were concerned about.

Figure 5.2 External Stakeholder Input



“other” includes 1 response each for the following issues: breastfeeding, developmental screening, promoting HS and higher education for women, medical home, new immigrant access, obesity/nutrition, CSHCN workforce-skills training needed, social issues in families, socioeconomic determinants of health, therapists (speech, PT, OT, etc), training for all areas

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Following the external stakeholders meeting, the Needs Assessment Team met again to review all of the information and make final decisions. The team paid attention to matching needs and priorities to desired outcomes, mandates and capacity, and examined potential areas for intervention and collaboration, as well as resources. Internal discussion that gave consideration to the data, capacity, opinions of external stakeholders and the political priorities within the State of New Hampshire produced a final list. This final list of priorities is also included on Form 14 in the block grant application. (See Section 3: Strengths and Needs of the MCH Population for data for a detailed narrative on all of the priority needs).

5.E Rationale For Final Selection of Priorities

From the process described above, and the extensive data and internal and external state capacity review contained throughout this Needs Assessment, ten priorities emerged that adequately addressed services for the three Title V population subgroups:

- o Preventive and primary care services for pregnant women, mothers and infants
- o Preventive and primary care services for children; and
- o Services for CSHCN

Table 5.3 illustrates each preliminary priority, whether or not it was chosen and the primary Title V population group it addresses.

To complete the prioritization process, Title V needed to consider how it would measure success in meeting each priority need and the relationships between the Priority Needs to National Performance Measures and existing State Performance Measures. Existing State Performance Measures related to each priority were reviewed, and a determination was made as to whether these measures continued to have merit in measuring progress on the associated priority. After reviewing current National Performance Measure requirements, it was determined that with new activities and partnerships and with the availability of new data sources there would be new State Performance Measures for all priorities. **Priorities, in general, are *broadly written* to capture the multi-factorial needs and populations associated with each priority. In contrast, the performance measures are often *very specific* reflecting a reliable data source that can**

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measure a strategy associated with the given priority area. Table 5.4 illustrates each priority, its new State Performance Measure and related National Measure. What follows is a *brief description* of the rationale for the 2010 New Hampshire Priorities and the new State Performance Measures.

5.F. 2010 Priorities

5.F.1. Mental Health

Access to mental health services continues to be an identified need in New Hampshire, and the need for these services is great. An estimated 20% (55,756) of New Hampshire children aged 5-19 have a diagnosed mental disorder, 3-5% of children are estimated to have attention disorder and 0.7% were diagnosed with an autism spectrum disorder.¹ Mental health disorders have far reaching implications for the children affected with them. They can impact a child's emotional, intellectual, and behavioral development and can hinder proper family and social relationships. If left untreated, mental disorders can persist through development and into adulthood. Half of all lifetime mental illnesses start by 14 years old; three-quarters of them start by age 24. Treatment capacity for mental health issues is limited in the state, and concerns about cost are a considerable barrier for families seeking care, regardless of insurance status.

Disparities are evident. Children and youth from low-income families are at an increased risk for mental health disorders; in New Hampshire, the Medicaid population presents with twice the service use prevalence for mental health services compared to privately insured children. In rural areas, the prevalence of children with mental disorders is similar to that in urban areas, but there are increased barriers to care, resulting in delayed treatment. There are considerable disparities in capacity, as well. The northernmost counties do not have the mental health workforce especially those who are trained to meet the needs of children, to treat families close to their homes. Community health centers, among other providers, are left to try, at best, innovative and integrated methods to address growing needs. Compounding these problems, it is difficult to measure even the most basic of services. Mental health screening in primary care is often *bundled* into other billing codes, so there is no simple way to easily understand how often these

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services are provided. Therefore, to measure access to service, Title V will measure the rate at which adolescents on Medicaid with a documented mental health disorder have a documented annual psychotherapy visit. This measure, also used by the New Hampshire Office of Medicaid Business and Policy, will help us better understand whether or not adolescents are receiving appropriate care. Further analysis will allow us to look for regional disparities.

These considerations led to Priority #1 and its Performance Measure:

Priority	To improve access to children’s mental health services
Performance Measure	The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder.

5.F.2. Childhood Obesity

Obesity in children and adolescents in the United States has become a critical health problem with enormous health and economic costs.² In New Hampshire the problem mirrors the national picture. More than 29% of New Hampshire school aged children are overweight or obese.³ There are disproportionate effects among low-income families, families of certain ethnic groups and families where there is parental obesity. Children living in poverty in less educated families as well as children of Hispanic and African American background are more likely to be overweight.⁴ Title V has the capacity to impact this problem through participation on statewide coalitions and through our unique relationships with the statewide network of community health centers as they implement best practices in obesity prevention and treatment strategies. The survey that Title V will use to monitor the percent of children who are overweight or obese is a unique opportunity to use uniform information on the height/weight status of school age children throughout the state, with a powerful enough denominator to see geographic trends. It allows Title V to work in collaboration with chronic disease and obesity prevention programs to further document the burden of disease, and to use this information for public health surveillance, intervention planning, and evaluation

¹ *Children’s Mental Health in New Hampshire*, New Hampshire Center for Public Policy, September 2007

² Wang G, Dietz, WH, Economic burden in youths aged 5 to 17 years. *Pediatrics* 2002; 109(5)

³ New Hampshire Childhood Obesity Report, The Foundation for Healthy Communities, September 2006.

⁴ *Childhood Obesity: The Role of Health Policy – Report to the 2nd National Childhood Obesity Congress 2008*, NICHG, p. 1.

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These considerations led to Priority #2 and its Performance Measure:

Priority	To decrease pediatric overweight and obesity.
Performance Measure	Percent of 3 rd grade children who are overweight or obese.

5.F.3. Tobacco, Alcohol and Substance Abuse

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. Neonatal health-care costs attributable to maternal smoking in the US have been estimated at \$366 million per year, or \$740 per maternal smoker. Every \$1 spent on tobacco intervention saves \$3 in future health care costs.⁵ In New Hampshire in 2007, 21.7% of women of childbearing age (18-44 years) reported smoking, compared to 21.2% of women overall in the U.S.⁶ 100,857 children (32.5% of New Hampshire children) ages 0 – 17 live in a household where someone smokes (2003)⁷

Every year, an estimated 700 New Hampshire infants (4.6 percent of all) are exposed to marijuana and 2,900 (19.0 percent) are exposed to alcohol during the first trimester of pregnancy.⁸ Over 37,000 (11.9 percent) of New Hampshire children have parents who are abusing substances.⁹ Substance abuse treatment capacity continues to be a problem in New Hampshire, with a scarcity of Licensed Alcohol and Drug Abuse Counselors (LADC’s) and current substance abuse treatment capacity to treat less than ten percent of the need¹⁰

⁵ Ayadi, MF et al. Costs of smoking cessation-counseling Intervention for pregnant women: Comparison of three settings. Public Health Reports; Vol 121; 120-126; Mar-Apr 2006

⁶ March of Dimes.org (data source: Smoking: Behavioral Risk Factor Surveillance System. Behavioral Surveillance Branch, Centers for Disease Control and Prevention.)

⁷ NH Tobacco Data 2000-2007, NHDHHS DPHS Tobacco Prevention and Control Program (data source: BRFSS)

⁸ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (May 21, 2009). *The NSDUH Report: Substance Use among Women During Pregnancy and Following Childbirth*. Rockville, MD

⁹ Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (May 21, 2009). *The NSDUH Report: Substance Use among Women During Pregnancy and Following Childbirth*. Rockville, MD

¹⁰ NH DHHS, 2007. NH Plan for overcoming the impact of alcohol & other drug problems

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Title V has the opportunity to affect change in this priority at the infrastructure, population health, enabling services and direct services levels of the pyramid. Partnerships have created learning collaboratives focused on strategies to enhance perinatal tobacco cessation and innovative community-based programs to assess pregnant women for alcohol use/abuse and fast-track access to treatment.

Because National Performance measures related to perinatal smoking rates, and other state priorities directly related to preterm birth, the Needs Assessment team chose to monitor this priority with a measure of young adult alcohol use. This population group uses alcohol differently than other groups. New Hampshire is among the top 10 states for the percent of teens abusing alcohol. Fifty percent of New Hampshire high school students report current alcohol use and 28 percent report binge drinking (2007).¹¹ New Hampshire 18-25 year olds experienced higher rates of substance abuse (27.1 percent vs. 20.0 percent) and more unmet need for treatment than the US.¹² Fifty-one percent of these youth report binge drinking.¹³

These considerations led to Priority #3 and its Performance Measure:

Priority	To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.
Performance Measure	Percent of 18-25 year olds reporting binge alcohol use in past month.

5.F.4. Access to Health Care

Uninsured children are at higher risk for negative long-term effects on health and economic productivity than insured children.⁹ The uninsured use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they tend to be sicker and at more advanced disease stages than the insured. This contributes to higher rate of

¹¹ Substance abuse: NH Plan for overcoming the impact of alcohol & other drug problems, DHHS 2007. (Data source: NH BRFSS 2007).

¹² SAMHSA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

¹³ SAMSHA. 2005-2006 National Survey of Drug Use and Health (NSDUH)

⁹ Yuma Project on Uninsured Children, NLM Gateway, U.S. National Institutes of Health, 2001 meeting abstract, <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102273318.html>, 6/19/09

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morbidity and mortality for uninsured both in general and for specific diseases.¹¹ Although New Hampshire compares favorably to the U.S. for rates of uninsured children (6%¹⁴ to 9.7%¹⁵ depending on the data source), there are age and income disparities. For example, approximately 30% of New Hampshire adolescents, ages 18-24, lack health insurance. Among the New England States, New Hampshire has the lowest percentage of children in poverty who are enrolled in Medicaid (59.5%) (the U.S. average is 64.3%).¹⁶ There are still too many children in need of health care coverage, and there is a problem with “churning”, which occurs when children are repeatedly dropped and re-enrolled on public programs due to short eligibility periods, lengthy re-enrollment processes, and complex paperwork¹⁷

This priority goes beyond the adequacy of the insurance product, public or private, that an individual may have. Critical to this need is ensuring access to a high, quality, integrated system of care for all populations. Because New Hampshire’s Title V program is charged with a contractual oversight of the state’s community health centers, it has the unique opportunity to help shape the infrastructure of this system of care for all MCH populations. Using a funding methodology that rewards agencies for increasing their level of integration, Title V will measure progress in this priority by monitoring the number of agencies that choose to provide on-site behavioral health care, thereby increasing access to care for more populations.

These considerations led to Priority #4 and its Performance Measure:

¹¹ “Consequences of the Lack of Health Insurance on Health and Earnings”, Urban Institute Publication, June 30, 2006. <http://www.urban.org/Publications/1001001.html>, 6/19/09

¹⁴ Children in New Hampshire, Children’s Defense Fund state fact sheet, November 2008, <http://www.childrensdefense.org>, accessed 6/19/09

¹⁵ 2007 National Survey of Children’s Health “percent of children lacking consistent insurance coverage in past year”, <http://nschdata.org/DataQuery/DataQueryResults.aspx>, accessed 6/16/09.

¹⁶ Kaiser Family Foundation. New Hampshire: Health Insurance Coverage of Children 0-18 Living in Poverty (under 100% FPL), states (2007-2008), U.S. (2008) <http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=31&ind=128&sub=177>, accessed 4/29/10

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Priority	To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services
Performance Measure	Percent of Community Health Centers providing on-site behavioral health services.

5.F.5. Developmental Screening

In the United States, 17% of children have a developmental or behavioral disability such as autism, intellectual disability (also known as mental retardation), or Attention-Deficit/Hyperactivity Disorder (ADHD); there are additional children with delays in language or other areas. Less than half are identified before starting school, impacting future development and readiness to learn.¹⁸ Improved standardized developmental screening identifies these delays early and enables children to receive early intervention services to be better prepared to learn when entering school. Screening and support (by 6 years of age), and Autism began as two separate priority areas, but were combined due to the benefits and strengths that this joint partnership demonstrates.

New Hampshire has expanded its capacity considerably in this area in the past several years through parent and provider education and initiatives such as Watch Me Grow and the Autism Council and its work. But, there is a significant amount of work to be done. Unfortunately, there is no easy way to determine how often developmental screens are completed with young families. Billing codes are not useful because screening is often part of a bundled code within a preventative health visit. The National Survey of Children’s Health allows us, then, to monitor the percent of parents who self-report that they completed a validated developmental screening tool for their child. Although this may not capture all of the screening, it will help us develop a baseline for future evaluation and analysis. The impact of early identification and intervention for children with Autism Spectrum Disorders has been well documented therefore though this Performance Measure is meant to benefit all children; the reporting on the measure will

¹⁷ (“Seven Steps Toward State Success in Covering Children Continuously” prepared by Uchenna A. Ukaegbu and Sonya Schwartz, National Academy for State Health Policy Issue Brief, October 2006

¹⁸ www.cdc.gov/actearly, retrieved 7/13/09.

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incorporate information regarding referral and follow-up efforts and therefore can be considered to address CSHCN.

These considerations led to Priority #5 and its Performance Measure:

Priority	To improve access to standardized developmental screening for young children
Performance Measure	The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays.

5.F.6. Unintentional Injury

Injuries are among the most serious and under-recognized public health problem. In New Hampshire and in the U.S., unintentional injuries are the leading cause of death and hospitalization to children and adolescents, killing more in this age group than all diseases combined.¹⁹ ²⁰ Injuries are predictable and preventable through a public health approach. In the time period 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category²¹. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes²². In New Hampshire, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24.²³ The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).²⁴ The medical and social costs of injuries are enormous.

Title V has been a leader in building partnerships that focus on multi-disciplinary, approaches to safe teen driving. By educating both parents and teens about safe driving practices and by promoting a graduated driver’s licensing system that allows novice drivers to get their initial driving experience under low–risk conditions, Title V is a partner in population-based education

¹⁹ Borse N PhD, Gilchrist J MD, et al. *CDC Childhood Injury Report: Patterns of Unintentional Injuries among 0-19 year olds in the United States, 2000-2006*. CDC, Atlanta GA 2008.

²⁰ NH DHHS DPHS Injury Prevention Program 2009

²¹ CDC, WISQARS

²² CDC, WISQARS

²³ Presentation by the Health Statistics and Data Management Section, Division of Public Health Services, New Hampshire Department of Health and Human Services

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and infrastructure building. Other National Performance Measures focused on motor vehicle crashes focus on different age groups or focus simply on mortality, which fortunately in New Hampshire is a very small number. By specifically measuring the rate of injuries from motor vehicle crashes in this cohort of young drivers, Title V can monitor the impact of its effort.

These considerations led to Priority #6 and its Performance Measure:

Priority	To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.
Performance Measure	The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash.

5.F.7. Healthy Homes

A growing body of evidence links housing conditions to health outcomes such as asthma, lead poisoning, lung cancer, and unintentional injuries. Children, especially those under age 6, are more likely to suffer persistent developmental delays, learning disabilities and behavioral problems as a result of their exposure to lead. Approximately 30% of New Hampshire housing stock was built prior to 1950 when lead paint was commonly used. In high-risk communities, such as Berlin in the northern corner of the state, this number rises to 68%. Among school age children, approximately 10,530 children ages 5 through 17 had an elevated blood lead level at some time. The majority of children with Elevated Blood Lead Levels (EBLL's) above 10mcg/Dl (90%) lived in pre-1950 homes, and approximately one-third lived in or regularly visited homes built prior to 1978 that had recently undergone renovation. Low income families are at increased risk due to living in rental units of older buildings with insufficient upkeep, and barriers such as lower socioeconomic status, lower education levels and cultural or language differences.

Morbidity associated with asthma is high. Emergency department use, hospitalization, decreased lung function and death can characterize the experience of both adults and children with uncontrolled asthma. Approximately 10% of New Hampshire adults and 8% of children currently have asthma and the prevalence is increasing. An estimated 71% of adults with asthma

²⁴ Health Statistics and Data Management Section, NH Department of Health and Human Services

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and 62% of children do not have their asthma under control and therefore are particularly susceptible to environmental asthma triggers. Approximately one-third of all New Hampshire children live in homes where a person smokes, making exposure to tobacco smoke a significant problem for these children. Health disparities for asthma occur by gender, age, educational level and household income.

By combining these needs together into one priority focused on addressing environmental health hazards and the promotion of healthy homes, New Hampshire is building on the national effort to integrate programmatic efforts to impact populations, such as low income children and children with special health care needs, that are disproportionately affected by health and housing issues. Childhood lead poisoning, injuries, respiratory diseases such as asthma, and quality of life issues have been linked to the more than 6 million substandard housing units nationwide.²⁵ Healthy Housing assessments are an innovative way to bring the multiple disciplines that partner with families in their homes, for lead poisoning education, home visiting, weatherization services, etc.. Paired with existing Health Status Indicators on childhood Asthma, Title V anticipates that this Performance Measure will help monitor the growth of this integrated approach to Healthy Homes.

These considerations led to Priority #7 and its Performance Measure:

Priority	To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments.
Performance Measure	The percent of households identified with environmental risks that receive healthy homes assessments.

5.F.8. Oral Health

Tooth decay is the most common chronic childhood disease, and is largely preventable through a combination of individual direct care, enabling service, population-based, and infrastructure-systems based responses. Like the adult population, many of New Hampshire's children from low-income, uninsured families do not have access to regular oral health care and education.

²⁵ <http://www.cdc.gov/healthyplaces/newhealthyhomes.htm> retrieved May 28, 2010

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Many dentists do not accept Medicaid clients, nor do they have a sliding fee scale. The New Hampshire *Third Grade Healthy Smiles-Healthy Growth Survey*, conducted between September 2008 and June 2009, found that approximately 44% of New Hampshire 3rd grade students experienced tooth decay and 12% of students had untreated decay at the time of the survey. An estimated 60% of the students had dental sealants. Regional disparities in oral health were detected. Children attending schools with a higher free and reduced lunch program participation rate, as well as all students in Coos County, were more likely to have experienced decay, have untreated decay, and be in need of treatment, and they were less likely to have dental sealants.

This priority is intentionally broad in order to capture the activities affecting all MCH populations. There are unique opportunities for action at each level of the pyramid for pregnant women, children and children with special health care needs. Understanding that, the Needs Assessment Team chose a State Performance Measure that reflected the broad population-based approach of improving overall oral health in the state. Although only a small minority of public water systems utilize Community Water Fluoridation Systems, 43% of the population has access to fluoridated water due to the large population of the cities that do fluoridate. It has been noted through partnerships with the DPHS Oral Health Program that the system to monitor and provide timely feedback to municipalities that fluoridate public water systems has been less than adequate. MCH has agreed to work with the Oral Health Program and the New Hampshire Department of Environmental Services to manage this data system and collaborate in community-focused technical assistance in order to increase the quality of this system. By doing this, Title V hopes to have a significant impact on the oral health of 43% of the New Hampshire’s residents.

These considerations led to Priority #8 and its Performance Measure:

Priority	To improve oral health and access to dental care
Performance Measure	Percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range.

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5.F.9. Respite

Over two-thirds of families of New Hampshire SSI CSHCN surveyed reported that they provide health care for their child at home; half of these families reported having to cut work hours to care for their child even while experiencing financial distress. The need for respite care for CSHCN is increasing, and availability of providers is limited. There is not a statewide Respite Coalition in New Hampshire and therefore no one entity that coordinates respite services or referrals. There is no respite funding available for children with emotional or behavioral health issues. Funding for respite is available for children with chronic illnesses and with developmental disabilities but it is extremely limited and families are expected to find their own providers. There are an extremely limited number of respite providers with training and no process for tracking them. Families of children receiving developmental services indicated, in 2008, that in 7 out of 10 regions more respite providers were a priority and that a “list” of providers would be helpful.

Though respite services can positively impact all CSHCN and their families, it is especially critical that children with mental/behavioral health issues have access to this support. Additionally, families of adoptive children/or children returning to their natural families from protective custody can find respite to be a significant support. These children generally have high rates of emotional/behavioral disturbance. Respite services, offered by providers with appropriate training, can give opportunities for additional experience outside the family home; support the caregivers of the child; prevent family breakdown and /or rejection of the child and it can avoid the admission of the child to long term residential care or the necessity for substitute family placement.

This is the primary Priority/Performance measure focusing on CSHCN though clearly others have components that interface with this population. Of particular note this Priority emerged among the top ten of all Title V options through public input, stakeholder input and the ranking tool, without any special weighting.

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These considerations led to Priority #9 and its Performance Measure:

Priority	To increase family support and access to trained respite and childcare providers.
Performance Measure	The percent of families with children/youth diagnosed with severe emotional disturbance, moving into permanency placement through DCYF, who have access to a trained respite provider for up to 50 hours during the first year of placement.

5.F.10. Preterm Birth

In New Hampshire, over six percent of infants born in 2007 were low birth weight (<2500 grams). Preterm birth has enormous health, social and economic costs. It increases the risk of infant mortality and of serious health consequences such as cerebral palsy, blindness and developmental difficulties, and can impact a person throughout their life span depending on severity of their health condition. Smoking during pregnancy accounts for 20-30% of low-birth weight babies and up to 14% of pre-term births. Of women using MCH-funded prenatal clinics (during the period 7/1/07-6/4/09), 43.2% smoked 3 months prior to becoming pregnant²⁶ Interventions such as reducing maternal smoking have the potential to reduce the preterm birth rate and improve the health of infants and children and are within the scope of Title V responsibilities in expanding preconception care. Disparities are evident among racial, ethnic and socioeconomic groups. Since 1990, teens and young adults have had the highest rates of maternal smoking during pregnancy. Thirty-seven percent of New Hampshire women on Medicaid smoked during pregnancy.²⁷

As this Needs Assessment process revealed, New Hampshire public health messengers need to strengthen its use of social media and technology to communicate with families and individuals in order to stay relevant and provide the most culturally appropriate population based health information, if we are to tackle the chronic diseases and addictions that are at the foundation of issues like preterm birth. Title V will continue to utilize strategies like **Text4Baby** while developing new partnerships to build infrastructure and strengthen enabling services. By measuring smoking cessation rates, New Hampshire will maintain focus on one area where our state does not compare as favorably when compared to other states. Data have suggested that

²⁶ NHDHHS DPHS MCHS (2008). Data source: NH birth data

²⁷ NHDHHS DPHS MCHS (2008). Data source: NH birth data

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New Hampshire’s population of poor, white childbearing- aged women tend to smoke at increased rates and anecdotal stories from clinical settings suggest that these women are often resistant to traditional methods and messages urging them to quit. Through continued multi-pronged efforts like social media messages to quality improvement efforts to increase adherence to the 5 A’s in MCH-funded prenatal clinics, Title V ultimately hopes to impact the rate of preterm birth.

These considerations led to Priority #10 and its Performance Measure:

Priority	To decrease the incidence of preterm birth
Performance Measure	The percent of preterm births to mothers who reported smoking prior to pregnancy.

The following *preliminary priority issues* were **not** selected or were incorporated into another final priority:

- o MCH workforce – primary care
Was considered to be part of the issue of access to healthcare
- o MCH workforce – child care
In part, considered to be part of the issue of access to trained respite and family support as well as limited ability of Title V to increase the numbers of traditional child care provider workforce
- o Suicide
‘Reducing suicide deaths’ was not selected as a final priority area because it is addressed under a national performance measure. Reducing adolescent suicide will be addressed as part of the mental health priority area.
- o Reducing disparities
‘Reducing disparities’ was incorporated into all of the final priority areas
- o Maternal smoking

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“Reducing maternal smoking” was included as part of two final priority areas:
“decreasing the incidence of preterm births” and “decreasing the use and abuse of
alcohol, tobacco and other substances among youth, pregnant women and families”

See also Table 5.3 below, *Preliminary list of 2010 priorities and related information*, for a comparison of the 2005 and 2010 priorities.

Summary

To select New Hampshire’s priorities, data and public input about our programs, populations and maternal and child health issues were analyzed and objectives by which to measure our progress were collaboratively developed. The selection process was rigorous, inclusive and transparent. New state performance measures were developed for each new priority. With multiple workgroups, electronic and paper surveys, and stakeholder meetings, the 2010 Needs Assessment set a new standard for New Hampshire for obtaining public input and engaging new partners. The final priorities, broad enough to allow multiple areas for intervention, but specific enough to be measurable, represent each of the four levels of the MCH pyramid and touch all MCH population groups.

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Table 5.3 Preliminary list of 2010 priorities and related information

<u>Initial list of potential priority areas (2008)</u>	<u>MCH population group</u> ²⁸	<u>Selected?</u> Yes/No	<u>Reason not selected</u> ²⁹	<u>2005 priority?</u> Yes/No	<u>Reason for change from 2005 Needs Assessment</u>
Preterm birth	Pregnant women, mothers & infants	Yes		No	2005: broader priority area selected: #2. Safe & healthy pregnancies
Autism	CSHCN	No	Autism will be addressed under the screening priority	No	2010 prioritization process led to more broadly focused priority
Screening and support (by 6 yrs)	Children, CSHCN	Yes		No	Public input supported this priority
Maternal smoking	Pregnant women, mothers & infants	No	Will be addressed under the alcohol/substance abuse priority	No	
Alcohol/substance abuse	All	Yes		No	Data, internal prioritization & public input support
Pediatric obesity	Children	Yes		Yes	
Mental health	All	Yes		Yes	

²⁸ Priorities must cover the 3 major MCH population groups: 1) preventive and primary care services for pregnant women, mothers and infants, 2) preventive and primary care services for children, and 3) services for CSHCN

²⁹ Reason not chosen as priority: 1) already being measured by a NPM, 2) falls outside the area of responsibility of the MCH or CSHCN, 3) system already in place to address the need; 4) issue is too broadly focused, 5) Other, describe

**Section 5: Selection of State Priority Needs
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<u>Initial list of potential priority areas (2008)</u>	<u>MCH population group</u> ³⁰	<u>Selected? Yes/No</u>	<u>Reason not selected</u> ³¹	<u>2005 priority? Yes/No</u>	<u>Reason for change from 2005 Needs Assessment</u>
MCH workforce: PC	All	No	Issue not ranked high in prioritization process	No	
MCH workforce: child care	Children	No	Issue not ranked high in prioritization process	No	
Childhood lead poisoning	Children	Yes	Combined with asthma in “Healthy Homes” priority	Yes	2005: safe and healthy environments for children
Asthma	Children	Yes	Combined with childhood lead poisoning in “Healthy Homes” priority	No	2005: safe and healthy environments for children
Oral Health	All	Yes		Yes	
Unintentional injury	Children & adolescents	Yes		Yes	
Adolescent suicide	Children and adolescents	No	Measured by a NPM Include under mental health SPM	No	
Children without health insurance	Children	Yes	Combined with access to health care – all ages.	No	2005: broader priority #7. Preserving safety net providers
Reducing disparities	All	No	EFH recommendation: include in all priorities	No	Included “vulnerable populations” in #2
Respite care	CSHCN	Yes	Combined with new priority: “family support”	Yes	2010 public input led to more broadly focused priority

EFH = NH Endowment for Health

³⁰ Priorities must cover the 3 major MCH population groups: 1) preventive and primary care services for pregnant women, mothers and infants, 2) preventive and primary care services for children, and 3) services for CSHCN

³¹ Reason not chosen as priority: 1) already being measured by a NPM, 2) falls outside the area of responsibility of the MCH or CSHCN, 3) system already in place to address the need; 4) issue is too broadly focused, 5) Other, describe

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Table 5.4 These priority statements relate to the MCH population: pregnant women, mothers and infants, children and CSHCN, unless more specifically defined.

	2010 priority statement	State Performance Measures	Related National Performance Measure
1	To improve access to children’s mental health services	2010 The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder	NPM #16 The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
2	To decrease pediatric overweight and obesity (Overweight is defined as a BMI => 85%ile and < 95%ile; Obesity is defined as a BMI => 95%ile for children of the same age and sex, according to the Centers for Disease Control)	2005 <i>SPM # 9 The percent of CSHCN who are at risk for/are overweight or obese.</i> 2010 Percent of 3 rd grade children who are overweight or obese	NPM # 14 Percent of children, ages 2 to 5, receiving WIC services with a Body Mass Index (BMI) at or above the 85 th percentile” NPM # 11 Percentage of mothers who breastfeed their infants at six months of age.
3	To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.	2010 Percent of 18-25 year olds reporting binge alcohol use in past month (Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007)	NPM # 15 Percent of women who smoke in the last three months of pregnancy
4	To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.	2005 <i>SPM # 6 Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year.</i> 2010 Percent of Community Health Centers providing on-site behavioral health services	NPM # 13 Percent of children without health insurance. NPM #4 The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey) NPM # 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertusis, Haemophilus Influenza, Hepatitis B. NPM # 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

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	<u>2010 priority statement</u>	<u>State Performance Measures</u>	<u>Related National Performance Measure</u>
5	To improve access to standardized developmental screening for young children.	<p><u>2005</u> <i>SPM # 7 Percent of center-based child care facilities in the MCH catchment area and serving children under 2, that are visited at least once a month by a child care health consultant</i></p> <p><u>2010</u> The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays.</p>	<p><u>NPM # 1</u> The percent of newborns who are screened and confirmed with conditions mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) and who receive appropriate follow-up and referral as defined by their State. (National Newborn Screening and Genetic Resource Center)</p> <p><u>NPM #12</u> Percentage of newborns who have been screened for hearing before hospital discharge.</p>
6	To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.	<p><u>2005</u> <i>SPM # 5 The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash.</i></p> <p><u>2010</u> The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash</p>	<p><u>NPM #10</u> The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.</p>
7	To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments.	<p><u>2005</u> <i>SPM # 3 Percent of children age two (24-35 months) on Medicaid who have been tested for lead.</i></p> <p><u>2010</u> The percent of households identified with environmental risks that receive healthy homes assessments.</p>	
8	To improve oral health and access to dental care.	<p><u>2005</u> <i>SPM # 4 Percent of third grade students with untreated decay.</i></p> <p><u>2010</u> Percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range.</p>	<p><u>NPM #9</u> Percent of third grade children who have received protective sealants on at least one permanent molar tooth.</p>

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	<u>2010 priority statement</u>	<u>State Performance Measures</u>	<u>Related National Performance Measure</u>
9	To increase family support and access to trained respite and childcare providers, especially for children with special health care needs.	<p><u>2005</u> <i>SPM # 10 The percent of respite/childcare providers serving medically and behaviorally complex children, who have participated in competence-based training.</i></p> <p><u>2010</u> The percent of families with children/youth diagnosed with severe emotional disturbance, moving into permanency placement through DCYF, who have access to a trained respite provider for up to 50 hours during the first year of placement.</p>	
10	To decrease the incidence of preterm births.	<p><u>2010</u> The percent of preterm births to mothers who reported smoking prior to pregnancy .</p>	<u>NPM # 17</u> Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Section 6: Outcome Measures

Title V 2010 Needs Assessment

6. Action Plans and Outcome Measures

This Needs Assessment is intended to be a living document that will inform stakeholders and community partners and focus the direction of program design and resource allocation. The following Action Plans and associated outcome measures detail the first steps in identifying the problems associated with each priority and the steps needed to achieve desired outcomes. It is anticipated that activities and interventions will be modified as they are continuously evaluated. The MCHB Title V Annual Report provides an opportunity for yearly review of successes and challenges. Table 5.4 in Section 5 articulates the relationship between each Priority Area and National and State Performance Measures. Detail Sheets for each new State Performance Measure are included in the Title V Block Grant.

The Action Plan template that was used in this planning process was adapted from William Sappenfield, MD, MPH, MCH Epidemiology Program Consultant, Division of Reproductive Health, CDC, AMCHP as part of the MCH Epi Pre-conference Skills Building Workshop: *Needs Assessment Training Course*, in Atlanta GA, December 2008.

New Hampshire Title V used these templates as a roadmap from which Needs Assessment Team members could frame problems and develop program hypotheses as the relative importance of each priority was weighed. The Action Plans then served the purpose of becoming the platform for structuring strategic plans and corresponding measurements of success for the following five years. Some teams broke their priorities into smaller problems and developed several plans, others focused on just one part of the overall problem. The Core Team believed that this was acceptable, as these are intended to be working documents, guiding Title V through a changing environment over the next five years. Activities will be continuously evaluated and modified, as appropriate, and reported upon within the context of the Title V Annual Report.

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6.A. Action Plans:

6.A.1.

Priority #1: To improve access to children’s mental health services

Problem statement: An estimated 20% (55,756) of New Hampshire children aged 5-19 have a diagnosed mental disorder, Suicide is the second leading cause of death for New Hampshire residents ages 10 through 24. The current state of the mental health workforce is not sufficient to meet children’s’ needs.

Table 6.1

Mental Health - Screening	
<i>Problem analysis</i>	<i>Program hypothesis</i>
Problem: Access to mental health services for the MCH population	Goal: Increase access to mental health screening services for the Title V population
Direct Precursor: Missed opportunities for screening	Policy Objective: 100% of Title V funded health care providers, including prenatal clinics, will administer an evidence-based depression screening tool by July 1, 2011
Secondary Precursor: Statewide provider workforce shortage	Program Objective: Increase skills, knowledge and awareness of mental health screening among Title V-funded primary care providers
Secondary/Tertiary Precursor: Rural residence	Operational Objective: Provide funding, information and training opportunities to (specific agency names or number of agencies) Title V-funded health care providers in the North Country (or some other identified underserved area)

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Table 6.2

Mental Health - Treatment	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: Access to mental health services for the Title V population</p>	<p>Goal: Increase access to mental health treatment services (psychotropic meds and talk therapy) for the Title V population</p>
<p>Direct Precursor: Cost</p>	<p>Policy Objective: Title V-funded health care agencies will employ staff licensed/skilled in prescribing psychotropic medications, by</p>
<p>Secondary Precursor: Decreased Medicaid support to Community Mental Health Centers</p>	<p>Program Objective: Increase skills and knowledge in psychopharmacology among Title V-funded primary care providers</p>
<p>Secondary/Tertiary Precursor: Health insurance barriers</p>	<p>Operational Objective: Provide funding, information and training opportunities in psychopharmacology to (specific agency names or number of agencies) Title V-funded health care providers in the North Country (or some other identified underserved area</p>

Performance Measure:

- o The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder

Data Source:

- o New Hampshire Medicaid claims data

Other Data Sources:

- o The percent of Community Health Centers with integrated behavioral health services
- o Rate of postpartum women enrolled in Title V funded agencies who received appropriate depression screening

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Activities:

- o Maintain Community Health Center funding that provides incentives for increased integration of behavioral health services in primary care
- o Educate MCH agency staff about use of validated screening tools for specific MCH populations including early childhood, adolescence and perinatal period
- o Partner with experts in psychopharmacology to provide training to MCH agencies
- o Continue statewide collaborative activities on perinatal depression including recommendations for statewide systems improvements in Maternal Mortality Review
- o Explore the possibility of using Title V/CSHCN funds to create psychiatrist consultation available for primary care providers for children managing psychiatric medications
- o Participate in DHHS evaluation of feasibility of an In-Home Supports Waiver for Children with Mental Health Issues

6.A.2.

Priority #2: To decrease pediatric overweight and obesity*

* Overweight is defined as a BMI \geq 85thile and \leq 95thile; Obesity is defined as a BMI $>$ 95thile for children of the same age and sex, according to the Centers for Disease Control

Problem Statement: More than 29% of NH school aged children are overweight or obese.

Table 6.3

Pediatric Obesity-BMI	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: The number of overweight or obese children</p>	<p>Goal: Increase the education and referrals by providers of children with elevated BMIs</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Quality of diet • Quantity of caloric intake • Genetic predisposition • Quality and amount of physical activities 	<p>Policy Objective: 75% of children with a reported BMI \leq 75th percentile 85% receive education and counseling</p>

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<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Parent/provider comfort in discussing obesity • Family values • Community resources • Access to health care and information 	<p>Program Objective:</p> <p>Increase provider comfort and expertise in discussing follow up and treatment of elevated BMI</p>
<p>Secondary/Tertiary Precursor:</p> <ul style="list-style-type: none"> • Providers' education on discussing weight concerns • Funding decisions on state and local level • Government policies, i.e. requirements for community health centers re: nutrition counseling services 	<p>Operational Objective:</p> <p>Provide training to staff about follow up counseling to children with an elevated BMI</p>

Possible Performance Measures:

- o Percent of children enrolled in state-funded community health centers with BMIs \geq 85th percentile with documented education and counseling follow up
- o Percent of children enrolled in state-funded specialty clinics for children with neuromotor disabilities with BMI \geq 85th percentile with documented education and counseling follow- up

Data Source:

- o Yearly MCH Child Health Performance Measure data re: percent of children enrolled in state-funded community health centers with BMIs \geq 85th percentile with documented education and counseling follow up
- o SMS chart audits from state-funded specialty clinics for children with neuromotor disabilities (this data will be available for query as a part of the electronic data set, planned for the start of State Fiscal Year 2011)

Other Data Sources:

- o SMS children enrolled in neuromotor clinics

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- o Oral health/BMI school data
- o CDC Pediatric Nutrition Surveillance System (PEDNESS) data

Activities:

- o Educate MCH agency staff about recommended protocols to follow when BMI is \geq 85 percentile
- o Reinforce CHCs to have nutritionists on staff/utilized for overweight/obese referrals
- o Educate MCH agency staff about how to talk to parents about overweight/obesity issues
- o Encourage MCH agencies to assure that all income and age- eligible children are enrolled in WIC
- o SMS coordinators will document the BMI of children with special health care needs newly enrolled in the Care Coordination program upon receipt of primary care records and identify appropriate referrals for those overweight or obese children
- o All children in the Neuromotor clinic will have their BMI assessed at clinic visits and identify appropriate referrals for those overweight or obese children
- o In the context of a lifecourse perspective, participate in and offer ongoing I Am Moving, I Am Learning trainings for childcare providers

Table 6.4

Pediatric Obesity-Breastfeeding	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: The number of overweight or obese children</p>	<p>Goals: To increase a) initiation and b) duration of breastfeeding</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Quality of diet • Quantity of diet • Breastfeeding initiation and duration 	<p>Policy Objective:</p> <p>a) 75% of women in NH will initiate breastfeeding in early postpartum period b) 75% of infants enrolled in state-funded community health centers will be exclusively breastfed for their first 3 months</p>

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<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Family practices about infant’s diet and breastfeeding • Family values • Access to information about the importance and benefits of breastfeeding • Peer attitudes/practices about breastfeeding • Community resources to support breastfeeding, such as local lactation consultants, breast pump loaners, etc. 	<p>Program Objective:</p> <p>Increase knowledge and awareness of community health center staff on the importance of breastfeeding and how to be supportive to women choosing to breastfeed</p>
<p>Secondary/Tertiary Precursor:</p> <ul style="list-style-type: none"> • Social norms about breastfeeding • Food Marketing to discourage breastfeeding • Government policies and funding decisions – grant funds supporting breast feeding activities and staff to educate/support women choosing to breastfeed • Community design – designated breastfeeding areas 	<p>Operational Objective:</p> <p>Provide education and support to pregnant and postpartum women choosing to breastfeed</p>

Performance Measure:

- o Percent of infants enrolled in state-funded community health centers who were exclusively breastfed in their first three months

Data Source:

- o Annual MCH Child Health Performance Measure data regarding percent of infants in community health centers exclusively breastfed in their first three months

Other Data Sources:

- o CDC National Immunization Survey data; Breastfeeding Report Card
- o MCH chart audit data re: percent of children breastfed exclusively for first three months

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Activities:

- o Increasing training by WIC Program staff to MCH-agency staff regarding breastfeeding by WIC staff
- o Increasing WIC enrollment by MCH contract agencies' clients
- o Increasing HVNH and Child and Family Health Support Services supports to breastfeeding moms
- o Improving collaboration/resource sharing on state/local level between WIC and MCH staff

6.A.3.

Priority # 3: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

Problem statement: Fifty percent of New Hampshire high school students report current alcohol use, 28% report binge drinking, 23% percent used marijuana in the past 30 days. Current substance abuse treatment capacity exists to treat <10% of the need.

Table 6.5

Alcohol, Tobacco and Substance Abuse	
<i>Problem analysis</i>	<i>Program hypothesis</i>
Problem: Use and abuse of alcohol and other drugs	Goal: Reduce alcohol and other drug use and abuse amongst men and woman of childbearing age (14-44 yrs).
Direct Precursor: Perception of acceptability & risk	Policy Objective: Increase the proportion of men and woman of childbearing years screened for alcohol and other drug risk factors.
Secondary Precursor: Community culture around use	Program Objective: Increase the proportion of MCH clinical sites conducting brief interventions, including a pre-contemplative component focused on community culture vs. risk.

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<p>Secondary/Tertiary Precursor: Systems/Policies in the healthcare setting</p>	<p>Operational Objective:</p> <p>1) MCH clinical site agency staff will be trained to utilize a validated alcohol and other drug screening, brief intervention, and referral (SBIRT) tool.</p> <p>2) MCH clinical site agency staff will be provided technical assistance to incorporate an alcohol and other drug screening, brief intervention, and referral (SBIRT) tool into clinical site practice.</p>
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Performance Measure:

- o Percent of 18-25 year olds reporting binge alcohol use in past month

Data Source:

- o National Survey on Drug Use and Health (2006-2007)

Activities:

- o Educate MCH agency staff about and monitor the use of validated screening tools for specific MCH populations including adolescence and perinatal period
- o Continue innovative partnerships, such as the home visiting partnership with Child and Family Services, to provide home-based TWEAK assessment for and referrals to treatment to alcohol abusing pregnant women
- o As further described in the Preterm Birth Priority, continue partnerships to address smoking cessation activities with specific MCH populations including youth, adolescents and pregnant women

6.A.4.

Priority # 4: To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.

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Problem Statement: 6% -9.7% (depending on data source) of New Hampshire children are uninsured; only 59.5% of New Hampshire children living below 100% of the federal poverty level are enrolled in Medicaid.

Table 6.6

Access to Health Insurance	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: The number of uninsured and uninsured children eligible but not enrolled in Healthy Kids Gold/Silver</p>	<p>Goal: To increase enrollment and retention of eligible children on Healthy Kids Gold/Silver</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Parent of eligible child does not apply or reapply for Healthy Kids insurance coverage 	<p>Policy Objective: 90% of eligible children served by the MCH community health centers are enrolled in Healthy Kids Gold/Silver</p>
<p>Secondary Precursors:</p> <ul style="list-style-type: none"> • Parent’s confusion/being overwhelmed or lack of knowledge/c re: how to apply or reapply for eligible services • Parent’s lack of understanding of benefits of continuous Healthy Kids coverage • PCP/Medical home’s lack of knowledge that client needs to go through re-determination process 	<p>Program Objective: Increase enrollment and retention of eligible children on Healthy Kids Gold/Silver</p>
<p>Secondary/Tertiary Precursors:</p> <ul style="list-style-type: none"> • Problematic re-determination process • Cultural/linguistic challenges for parents when applying/ re-determining • Attitude associated with state Family Assistance programs 	<p>Operational Objective: Provide education, information and support to all families eligible for Healthy Kids Gold/Silver enrolled in the MCH Community Health Centers</p>

Performance Measure:

- o Percent of eligible children enrolled in state-funded community health centers who are enrolled in Healthy Kids Gold (HKG) by the end of the fiscal year

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Data Source:

- o Annual MCH Child Health Performance Measure data regarding percent of eligible children in community health centers enrolled on HKG

Other Data Sources:

- o Yearly MCH Child Health Performance Measure data re: percent of eligible children in community health centers enrolled on HKG
- o Yearly MCH UDS data on percent of MCH community health center clients < 185% and enrolled on Medicaid
- o Yearly data from Medicaid, SCHIP, and the New Hampshire Comprehensive Health Care Information System (NH CHIS study) regarding average number of children covered by Medicaid and SCHIP
- o Yearly data from SCHIP and Medicaid re: percent of children in SCHIP and Medicaid disenrolled during the year
- o Other data from SCHIP and Medicaid

Activities:

- o Decreasing “churning”/increasing “retention”/ improving “re-determination” rates
- o Reinforce to parents the benefits of continuous health insurance coverage
- o Strategic messages
- o Community Health Center staff to be able to track/monitor when HKG coverage is about to lapse
- o Working with SCHIP and HK staff on state/local level on initiatives
- o Having Community Health Center staff as parents “Do you know when your re-determination is?”
- o Home visitors to assist parents with complex paperwork through enabling services such as, Home Visiting New Hampshire and Child and Family Health Support Programs
- o New Hampshire Family Voices and SMS staff provides assistance via phone and mail out packets regarding what to bring to the District DFA Office when applying for TANF and HKG, including HC-CSD

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- o SMS notes re-determination (required application update) dates found on New Heights at the yearly SMS application update process so that coordinators can remind families to get ready for re-de letter
- o Adding a re-determination info sheet to the current Medicaid packets mailed out by Client Services to all new enrollees

Table 6.7

Access to Health Care	
<i>Problem Analysis</i>	<i>Program Hypothesis</i>
<p>Problem: Limited success with the attempts to refer and collaboration between primary care behavioral health services in the community for the un and underinsured</p>	<p>Goal: Funded agencies will provide an integrated behavioral health/primary care service on site</p>
<p>Direct Precursor: Cost/co-pays, hours of operation, waiting lists, transportation</p>	<p>Policy Objective: Integrate behavioral health as a key component of primary care</p>
<p>Secondary Precursor: Decreased Medicaid support to CHCs; inadequate connection between local behavioral health services and primary care</p>	<p>Program Objective: Increase knowledge and skills of CHC staff to care for the BH needs of their clients</p>
<p>Secondary/Tertiary Precursor: Workforce shortage and rural residency</p>	<p>Operational Objective: Provide funding support to primary care providers to enhance behavioral health care on site</p>

Performance Measure:

- o Percent of Title V- supported Community Health Centers providing on-site behavioral health services

Data Source:

- o Title V contractual data

Activities:

- o Agencies will provide training for primary care staff about behavioral health issues

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- o Agencies will provide training for behavioral health staff on the use of the electronic medical record
- o Encourage the provision of case management time to coordinate primary care and behavioral health care for each client
- o Programs will have a variety of models to address and integrate the behavioral health needs of their practice
- o Facilitate the exchange of information from successful programs to others

6.A.5.

Priority statement #5: To improve access to standardized developmental screening for young children.

Problem statement: Children ages 0-6 are not universally screened for developmental delays.

Table 6.8

Universal Screening	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: Children ages 0-6 are not universally screened for developmental delays</p>	<p>Goal: All young children (2-months to 5 years of age) will have access to periodic universal developmental screening including screening for autism at 18- 24 and 30 months of age (as recommended by Bright Futures)</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Parents lack of knowledge of developmental milestones • Communication issues between parents and Primary Care Providers (PCPs) 	<p>Policy Objective: All families with children birth to age 6 will have access to information on child development, screenings for their young children, and referrals to appropriate resources and supports.</p>
<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Lack of formal screening 	<p>Program Objective: Providers and families will be familiar with the ASQ & ASQ/SE or other standardized screening tools</p>
<p>Tertiary Precursor:</p> <ul style="list-style-type: none"> • Inadequate connections between professional organizations and service providers 	<p>Operational Objective:</p> <ul style="list-style-type: none"> • There will be an increase in the number of trained providers who can perform standardized screening

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<ul style="list-style-type: none">• Lack of trained providers for services• Limited knowledge of referral resources	<ul style="list-style-type: none">• Referral resource lists will be created, updated and disseminated
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Performance Measure:

- o The percent of parents, who completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays¹

Data Source:

- o *National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health

Other Data Sources:

- o Data from the LEASD program on trained medical providers
- o Data from Watch Me Grow

Activities and Intervention(s):

- o Assist parents with the completion of ASQ & ASQ/SE [through HVNH & Watch Me Grow initiative]
- o Promote and support connections between professional organizations and service providers [through HVNH & Watch Me Grow initiative]
- o Creation and dissemination of updated referral lists for PCP's and others when developmental screenings are positive
- o Completion of resource list for parents and providers that identifies individuals and agencies completing assessments and capable of multidisciplinary diagnostic evaluations.
- o Continued participation in workgroups of the Autism Council and collaboration on submission for funding opportunities to create regional teams of experts on Autism

¹ Child and Adolescent Health Measurement Initiative. *2007 National Survey of Children's Health*, Data Resource Center for Child and Adolescent Health website. Retrieved [12/30/09] from www.nschdata.org

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6.A.6.

Priority #6: To decrease unintentional injuries, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

Problem statement: The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes. Falls are the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24 years.

Table 6.9

Motor Vehicle Crashes	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: Injurious or fatal motor vehicle crashes involving adolescent drivers and/or passengers</p>	<p>Goal: Decrease number and severity of automobile crashes.</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Inexperience • Number of other teen passengers • Night time • Seatbelt use • Age 	<p>Policy Objective: Familiarize parents of novice drivers and drivers to be of risk factors and protective factors related to adolescent drivers and passengers.</p>
<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Sporadic enforcement of Graduated Drivers Licenses (GDL) and seat belt law for adolescents • Parents do not know about GDL and licensing process • Lack of intense parental supervision of novice driver • No contract between parent and teen driver • Fully accessible car or own car 	<p>Program Objective: Facilitate implementation of teen driving component of Highway Strategic Safety Plan.</p>
<p>Tertiary Precursor:</p> <ul style="list-style-type: none"> • Inadequate graduated drivers' licensing, including no beginner's permit • Political climate 	<p>Operational Objectives: Support policy initiatives around new GDL license structure in the state.</p>

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Performance Measures

- o Emergency department visits due to motor vehicle crashes for those ages 15-19

Data Source:

- o New Hampshire DHHS DPHS hospital discharge and emergency department data
- o Claims data base
- o TEMSIS (EMS run) data
- o EMR forms from DPHS funded health centers

Activities:

- o Development of a website hosted by the Department of Transportation geared towards parents of novice drivers
- o Implementation of parent survey on graduated drivers licensing
- o Facilitation of New Hampshire Teen Driving Committee on a monthly basis
- o Revision of teen driving component of Strategic Highway Safety Plan
- o Policy work in collaboration with the University of North Carolina’s Highway Safety Research Center

Table 6.10

Falls	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: Injurious falls in children and adolescents</p>	<p>Goal: Decrease number and severity of falls in children and adolescents.</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Inadequate protective equipment • Inexperience • Lack of supervision 	<p>Policy Objective: Provide information on low cost equipment programs and falls safety to 100% of schools and recreation departments in the state.</p>
<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Parental awareness • Layout of family home • Lack of access to protective equipment 	<p>Program Objective: Increase professional knowledge and understanding of falls in children and adolescents and best practice interventions targeted towards parents and access to protective equipment.</p>

**Section 6: Outcome Measures
Title V 2010 Needs Assessment**

<p>Tertiary Precursor:</p> <ul style="list-style-type: none"> • Social norms 	<p>Operational Objective: Provide at least one annual statewide opportunity for parents and children where protective equipment is mandated.</p>
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Additional Performance Measure:

- o The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash

Additional Data Source:

- o New Hampshire DHHS DPHS hospital discharge and emergency department data

Additional Activities:

- o Facilitation of annual statewide event for large audience (greater than 200 people) demonstrating for and involving participants in a behavior designed to reduce injuries due to falls
- o Facilitation of Safe Kids New Hampshire on a quarterly basis
- o Professional training in falls risk reduction to members of Safe Kids New Hampshire
- o Continue information sharing on low cost equipment programs and falls safety

6.A.7.

Priority #7: To reduce exposure to lead hazards, asthma triggers and other environmental risks to assure safe and healthy home environments.

Table 6.11

Healthy Homes	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: Unhealthy and unsafe environmental factors inside and outside the home Unhealthy and unsafe indoor and outdoor home environments</p>	<p>Goal: Increase healthy homes within the state Assure safe and healthy home environments for NH families by reducing exposures to lead, asthma triggers and other environmental hazards.</p>

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<p>Direct Precursor: Exposures, inside and outside, of the home environment</p>	<p>Policy Objective: “One Touch” program to educate and offer resources, outreach and access to families, and home visits for safe and healthy homes (Piggyback on existing authority to inspect properties where children have elevations).</p>
<p>Secondary Precursor: Knowledge of exposure and ability to address</p>	<p>Program Objective: Increase knowledge and capacity among professionals, families and property owners to address health and safety hazards in homes</p>
<p>Secondary/Tertiary Precursor: SES, cultural, access, health disparities, resources, home ownership, policies, enforcement</p>	<p>Operational Objective: Implement statewide Healthy Homes strategic plan</p>

Performance Measure:

- o The percent of households identified with environmental risks that receive healthy homes assessments

Data Source:

- o CDC Healthy Homes Lead Poisoning Surveillance System (HLPSS)

Activities:

- o Increase Healthy Homes Specialists credentialed in the state
- o Establish operational checklist, protocols, and referral network
- o Increase home visits for healthy homes assessment, education, outreach

6.A.8.

Priority #8: To improve oral health and access to dental care

Problem statement: About 40% of New Hampshire residents on public water supplies receive fluoridated water, the lowest percentage in New England. Records show that some of these systems are providing less than the optimal level of fluoride.

**Section 6: Outcome Measures
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Table 6.12

Oral Health	
<i>Problem analysis</i>	<i>Program hypothesis</i>
Problem: Poor oral health in all MCH populations	Goal: Increase access to dental care
Direct Precursor: Low-income/high cost of services	Policy Objective: Seek further participation by community dental providers to share the care for those in need
Secondary Precursor: Medicaid covers children only and most frequent reason for adult ED visits is oral pain; limited number of dentists accept Medicaid and/or sliding fee scale	Program Objective: Increase access for Medicaid and sliding fee scale clients; encourage development of mid-level Registered Dental Hygenist position
Secondary/Tertiary Precursor: Lack of education/understanding about oral health	Operational Objective: Support efforts to educate the MCH population about the importance of regular dental care.

Performance Measure:

- o The percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range

Data Source:

- o CDC Water Fluoridation Reporting System (WFRS)

Actions:

- o In addition to traditional direct and enabling services to increase access to oral health care, Title V will work in partnership with the DPHS Oral Health Program and the New Hampshire Department of Environmental Services to enhance the quality of the fluoridation of municipal fluoridation systems
- o The state fluoridation administrator will be responsible for managing the fluoridation system by promoting water fluoridation

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- o Title V staff will liaison with local systems to encourage appropriate levels of added fluoride in their systems
- o Fluoridation courses will be held to train water plant operators

6.A.9.

Priority #9: To increase family support and access to trained respite and child care providers, *especially for children with special health care needs.*

Problem statement: New Hampshire has no competency-based universal curriculum for respite care providers of behaviorally and medically complex children and youth with special health care needs (CYSHCN).

Table 6.13

Respite and Family Support	
<i>Problem analysis</i>	<i>Program hypothesis</i>
<p>Problem: New Hampshire has no competency-based universal curriculum for respite care providers of behaviorally and medically complex children and youth with special health care needs (CYSHCN).</p>	<p>Goal: To increase family support for all families and trained lifespan respite providers with a focus on medically and behaviorally complex children and youth with special health care needs.</p>
<p>Direct Precursor:</p> <ul style="list-style-type: none"> • Families of CYSHCN lack social activity/difficulty daily functioning. • No/limited trained respite providers. • No/limited money to pay for respite. 	<p>Objective: 80% of identified families with adoptive/reunified children diagnosed with Severe Emotional Disturbance will have access to a trained respite provider for up to 50 hours during the first year of adoption/reunification.</p>
<p>Secondary Precursor:</p> <ul style="list-style-type: none"> • Lack of knowledge of access to respite. • Families need encouragement to use respite. • Lack of approved curriculum for respite training. • Training expense 	<p>Objective: Increase skills and knowledge of respite providers through competency based lifespan respite care (LRC) training and forming a LRC registry with family participation and marketing.</p>

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<p>Secondary/Tertiary Precursor:</p> <ul style="list-style-type: none"> • No Statewide Respite Coalition. • No National or statewide approved curriculum or respite registry. • Limits within DHHS agencies to provide for respite. 	<p>Objective:</p> <p>Funding provided through Lifespan Respite Grant to train a number of respite care providers, formulate a LRC registry, provide a foundation for a LRC Coalition in NH and initiate a pilot program to assess LRC training.</p>
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Performance Measure:

- o Number of respite providers completing the competency based training
- o Percent of families reporting access and/or satisfaction with respite resources
- o Numerator: Number of families of children/youth with SED moving into permanency placement through DCYF, who have access to trained respite providers
- o Denominator: Number of families of children/youth with SED moving into permanency placement through DCYF

Data Source:

- o Survey of Children with Special Health Care Needs
- o Lifespan Respite Program Data
- o As needed surveys of families of CSHCN

Intervention(s):

- o Increase public awareness and education about respite resources, the competency based curriculum and the Lifespan Respite Coalition
- o Collaborate with Strengthening Families initiative to support the development of skill-based curricula or life skills training for educators, families, and CSHCN
- o Create and implement statewide program for competency-based training and registry of respite providers
- o Address respite from a lifespan perspective through activities to build a New Hampshire Lifespan Respite Coalition
- o Increase availability of parent education programs
- o Sustain and improve home visitation programs

Section 6: Outcome Measures
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- o Expand protective factors provided in Strengthening Families initiative by incorporating them into respite and family support activities

6.A.10.

Priority #10: To decrease the incidence of preterm births.

Problem Statement: Premature birth is a serious health problem. Premature babies are at increased risk for newborn health complications, such as breathing problems, and even death. Any woman can give birth prematurely, but some women are at greater risk than others .In addition to certain health conditions, certain lifestyle factors and behaviors, including tobacco and substance use/addiction can increase the risk of preterm birth.

Table 6.14

Preterm Birth	
<i>Problem Analysis</i>	<i>Program Hypothesis</i>
Problem: Preterm births	Goal: Reduce preterm births by reducing smoking prevalence amongst women of childbearing age.
Direct Precursor: Initiation of tobacco use and tobacco addiction	Objective: Standardized use of a screening tool by MCH contracted agencies that is negotiated with MCH using USPHS clinical guidelines (Treating Tobacco Use and Dependence)
Secondary Precursor: Environmental exposure (tobacco smoke and media exposure)	Objective: Education of all partners/ household members and provide referral to treatment
Secondary/Tertiary Precursor: Insufficient infrastructure	Objective: MCH Agency staff training and system infrastructure development. <ul style="list-style-type: none"> • Online basic course (\$125 – 13CEUs) • EMR or paper – IT needs • Train to Model – health records

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Performance Measure:

- o The percent of preterm births to mothers who reported smoking before pregnancy

Additional Data Sources:

- o New Hampshire Vital Statistics - percent of women who reported smoking before pregnancy or 1st Trimester
- o New Hampshire Vital Statistics among preterm births, percent of mothers reported smoking before pregnancy

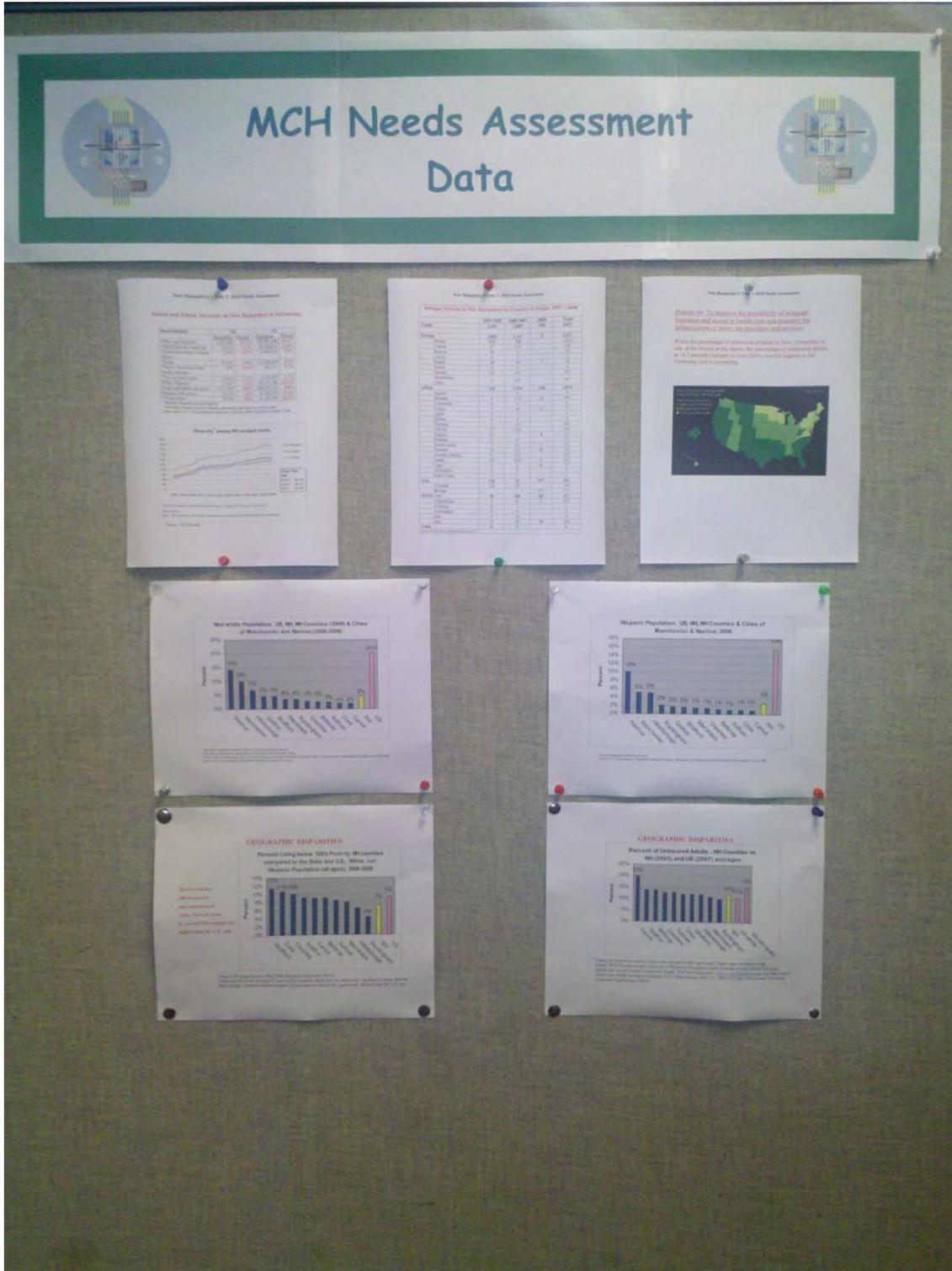
Other Data Sources:

- o BRFSS 18-44 → whole population; # of females report smoking
- o YRBS → # of females reported smoking

Activities:

- o Continue promotion of **Text4Baby** in community health centers, WIC agencies and District Offices
- o Design and participation in the two newly established Maternal Mortality Review Panel and Infant Mortality Review Panel
- o Complete a self-assessment of current smoking cessation education practice in MCH-funded agencies vs. assumptions using the Rapid cycle (Plan/Do/Study/Act)
- o Include language relative to the following as an MCH contractual requirement
 - o EMR – tobacco module and MD to MD training
- o Public Health Service Guidelines & Free NRT
 - o Plan regarding expectations within a contract
 - o Trainings to staff (field champions)
 - o Analysis of Medicaid data with those mothers that did NRT
- o Media plan (e.g. Take it Outside Campaign)

Appendix A – MCH Needs Assessment Data Board



Appendix B – Public Input – English, Spanish, Portuguese

Maternal and Child Health and Special Medical Services Public Input Survey

Each year, the New Hampshire Department of Health and Human Services receives state and federal funding to support programs that help improve the health of families. We need your help to make sure this funding helps families like yours. Your answers are confidential. This survey should take no more than **5 minutes**.

<p>1. Which issues do you think have the greatest need in New Hampshire? Rank your top 5 issues: write a 1 next to your most important, 2 next to your 2nd, etc.</p> <p> <input type="checkbox"/> Asthma <input type="checkbox"/> Autism <input type="checkbox"/> Teen suicide <input type="checkbox"/> Alcohol & other drug use/misuse <input type="checkbox"/> Access to dental health services <input type="checkbox"/> Overweight & obesity in youth <input type="checkbox"/> Childhood lead poisoning <input type="checkbox"/> Access to specialty health care <input type="checkbox"/> Adequate respite care <input type="checkbox"/> Tobacco use in youth and pregnant women <input type="checkbox"/> Access to mental health services <input type="checkbox"/> Access to health insurance <input type="checkbox"/> Infant health problems due to premature births <input type="checkbox"/> Serious injuries to youth, like car crashes & drownings <input type="checkbox"/> Testing babies & children for good growth </p>	<p>2. Think about children, teens, mothers, families, as well as youth with special health care needs. What are their biggest health needs that are not listed to the left?</p> <p>a. _____</p> <p>b. _____</p>
	<p>3. Where do you usually go for health care?</p> <p> <input type="checkbox"/> Community Health Center <input type="checkbox"/> Primary Health Care Provider <input type="checkbox"/> Emergency Room <input type="checkbox"/> Walk-In Clinics <input type="checkbox"/> Other: _____ </p>

Please answer the following confidential questions. Your answers will help us make sure we hear from people in all walks of life.

<p>4. Are you employed?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes, full-time <input type="checkbox"/> Yes, part-time <input type="checkbox"/> Retired <input type="checkbox"/> Armed Forces </p>	<p>5. Do you have kids under age 21?</p> <p> <input type="checkbox"/> No <input type="checkbox"/> Yes, how many have special health care needs? _____ </p>	<p>6. Check the type of health insurance that BEST describes the primary health insurance for you AND your child(ren):</p> <p><u>You</u> <u>Child(ren)</u></p> <p> <input type="checkbox"/>..... <input type="checkbox"/>...No health insurance coverage <input type="checkbox"/>..... Medicare <input type="checkbox"/>...NH Healthy Kids Gold <input type="checkbox"/>...NH Healthy Kids Silver <input type="checkbox"/>...Katie Beckett Medicaid <input type="checkbox"/>..... Medicaid <input type="checkbox"/>.....<input type="checkbox"/>...A plan available through an employer <input type="checkbox"/>.....<input type="checkbox"/>...A plan you purchase on your own (incl. COBRA) <input type="checkbox"/>.....<input type="checkbox"/>...VA, Champus, or other military plan <input type="checkbox"/>.....<input type="checkbox"/>...Other <input type="checkbox"/>.....<input type="checkbox"/>...Don't know/Not sure </p>
<p>7. Age: _____</p>	<p>8. Are you:</p> <p> <input type="checkbox"/> Male <input type="checkbox"/> Female </p>	
<p>9. Zip Code: _____</p>		
<p>10. Completed education:</p> <p> <input type="checkbox"/> Less than High School <input type="checkbox"/> High School or GED <input type="checkbox"/> Some college (incl. Associates degree) <input type="checkbox"/> 4-year degree or higher </p>	<p>11. What is your race/ethnicity? Check all that apply.</p> <p> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/ Native Alaskan <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____ <input type="checkbox"/> Native Hawaiian/Pacific Islander </p>	

Pesquisa sobre a saúde de mães e filhos e sobre serviços públicos especiais de saúde

Todos os anos, o Departamento de Saúde e de Recursos Humanos de New Hampshire (New Hampshire Department of Health and Human Services) recebe verbas estaduais e federais para a realização de programas para melhorar a saúde das famílias. Precisamos de sua ajuda para garantir que essa verba ajude famílias como a sua. Suas respostas são confidenciais. Esta pesquisa não levará mais do que **5 minutos**.

<p>1. Para quais problemas abaixo você acredita que existem as maiores necessidades de serviços em New Hampshire? Classifique os 5 principais problemas: escreva 1 ao lado do mais importante, 2 ao lado do segundo mais importante e assim por diante.</p> <p>___ Asma</p> <p>___ Autismo</p> <p>___ Suicídio de adolescentes</p> <p>___ Uso/abuso de álcool e outras drogas</p> <p>___ Acesso a serviços odontológicos</p> <p>___ Sobrepeso e obesidade em jovens</p> <p>___ Intoxicação por chumbo na infância</p> <p>___ Acesso a atendimento de saúde especializado</p> <p>___ Hospedagem temporária assistida adequada</p> <p>___ Tabagismo entre jovens e mulheres grávidas</p> <p>___ Acesso a serviços de saúde mental</p> <p>___ Acesso a seguro de saúde</p> <p>___ Problemas de saúde em bebês devido a partos prematuros</p> <p>___ Lesões graves em jovens, como por acidente de automóvel e afogamento</p> <p>___ Exames em bebês e crianças para um bom crescimento</p>	<p>2. Pense em crianças, adolescentes, mães, famílias e também em jovens com necessidades especiais de atendimento médico. Quais são as maiores necessidades dessas pessoas e que não foram listadas à esquerda?</p> <p>a. _____</p> <p>b. _____</p>
<p>3. Aonde você procura atendimento médico?</p> <p><input type="checkbox"/> Centros de Saúde da Comunidade</p> <p><input type="checkbox"/> Unidades Básicas de Saúde</p> <p><input type="checkbox"/> Pronto-socorro</p> <p><input type="checkbox"/> Clínicas sem hora marcada</p> <p><input type="checkbox"/> Outros: _____</p>	

Solicitamos responder as perguntas confidenciais a seguir. Suas respostas nos ajudarão a obter informações sobre pessoas com diferentes estilos de vida.

<p>4. Você está empregado?</p> <p><input type="checkbox"/> Não</p> <p><input type="checkbox"/> Sim, período integral</p> <p><input type="checkbox"/> Sim, meio período</p> <p><input type="checkbox"/> Aposentado</p> <p><input type="checkbox"/> Forças armadas</p>	<p>5. Você tem filhos menores de 21 anos?</p> <p><input type="checkbox"/> Não</p> <p><input type="checkbox"/> Sim, quantos precisam de atendimento médico especial? _____</p>	<p>6. Assinale o tipo de seguro saúde que MELHOR descreva o que você considera um seguro saúde adequado para você E seu(s) filho(s):</p> <p>Você Filho(s)</p> <p><input type="checkbox"/>.....<input type="checkbox"/>...Nenhum tipo de cobertura de seguro saúde</p> <p><input type="checkbox"/>..... Medicare</p> <p style="padding-left: 20px;"><input type="checkbox"/>....NH Healthy Kids Gold</p> <p style="padding-left: 20px;"><input type="checkbox"/>....NH Healthy Kids Silver</p> <p style="padding-left: 20px;"><input type="checkbox"/>....Katie Beckett Medicaid</p> <p><input type="checkbox"/>..... Medicaid</p> <p><input type="checkbox"/>.....<input type="checkbox"/>....Um plano disponível de empregador</p> <p><input type="checkbox"/>.....<input type="checkbox"/>....Um plano adquirido por você (incl. COBRA)</p> <p><input type="checkbox"/>.....<input type="checkbox"/>....VA, Campus, ou outro plano militar</p> <p><input type="checkbox"/>.....<input type="checkbox"/>....Outros</p> <p><input type="checkbox"/>.....<input type="checkbox"/>....Não sabe/Não tem certeza</p>
<p>7. Idade: _____</p>	<p>8. Você é:</p> <p><input type="checkbox"/> Homem</p> <p><input type="checkbox"/> Mulher</p>	
<p>9. CEP: _____</p>		
<p>10. Nível de escolaridade <u>completado</u>:</p> <p><input type="checkbox"/> Ensino médio incompleto</p> <p><input type="checkbox"/> Ensino médio completo ou equivalente (GED)</p> <p><input type="checkbox"/> Faculdade incompleta (incl. cursos universitários de 2 anos [Associates degree])</p> <p><input type="checkbox"/> Curso superior de 4 anos completo ou mais</p>		<p>11. Qual é sua raça/etnia? Assinale todas as alternativas que se aplicarem a você.</p> <p><input type="checkbox"/> Branco <input type="checkbox"/> Negro/Afro-americano</p> <p><input type="checkbox"/> Asiático <input type="checkbox"/> Índio Americano/ Nativo do Alasca</p> <p><input type="checkbox"/> Hispânico <input type="checkbox"/> Outros: _____</p> <p><input type="checkbox"/> Nativo do Havai/Ilhas do Pacífico</p>

Encuesta Pública sobre Salud Materno-Infantil y Servicios Médicos

Cada año, el Departamento de Salud y Servicios Sociales de New Hampshire recibe fondos estatales y federales para apoyar programas que ayudan a mejorar la salud de las familias. Necesitamos su ayuda para asegurarnos que esta financiación ayuda a familias como la suya. Sus respuestas son confidenciales. Esta encuesta no debería tomar más de **5 minutos** para llenarla.

<p>1. ¿Cuáles cree que son los problemas sanitarios más importantes en New Hampshire? Enumere los 5 problemas más importantes para usted: ponga un 1 al más importante, 2 al 2º más importante, etc.</p> <p>___ Asma ___ Autismo ___ Suicidio de adolescentes ___ El uso/abuso de alcohol y otras drogas ___ Acceso a servicios de salud dental ___ El sobrepeso y la obesidad en los jóvenes ___ La intoxicación infantil por plomo ___ El acceso a la atención médica especializada ___ Descanso para el cuidador de un enfermo/anciano ___ Consumo de tabaco de jóvenes y mujeres embarazadas ___ Acceso a los servicios de salud mental ___ Acceso a seguro de salud ___ Problemas de salud infantil debidos a nacimientos prematuros ___ Lesiones graves a los jóvenes, como accidentes automovilísticos o ahogamientos ___ Pruebas para bebés y niños para asegura un buen crecimiento</p>	<p>2. Piense en los niños, adolescentes, madres, familias y jóvenes que necesitan atención médica especial. ¿Qué necesidades médicas no figuran en la columna del lado izquierdo?</p> <p>a. _____</p> <p>b. _____</p>
	<p>3. ¿Dónde suele ir para recibir atención médica?</p> <p><input type="checkbox"/> Centro de Salud Comunitario <input type="checkbox"/> Proveedor Primario de Atención Médica <input type="checkbox"/> Sala de Urgencias <input type="checkbox"/> Clínicas Ambulatorias <input type="checkbox"/> Otro: _____</p>

Por favor conteste las siguientes preguntas confidenciales. Sus respuestas nos ayudarán a cerciorarnos que recibimos información de personas de todas las condiciones sociales.

<p>4. ¿Está trabajando?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Sí, a tiempo completo <input type="checkbox"/> Sí, a tiempo parcial <input type="checkbox"/> Jubilado <input type="checkbox"/> Ejército</p>	<p>5. ¿Tiene hijos menores de 21 años?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Sí, ¿cuántos tienen necesidades médicas especiales? _____</p>	<p>6. Marque el tipo de seguro de salud que MEJOR describe lo que considera el seguro médico de atención primaria para usted Y sus hijos: Usted Hijo(s)</p> <p><input type="checkbox"/>..... <input type="checkbox"/>...Sin cobertura de seguro médico <input type="checkbox"/>.....Medicare <input type="checkbox"/>...NH Healthy Kids de Oro <input type="checkbox"/>...NH Healthy Kids de Plata <input type="checkbox"/>...Katie Beckett Medicaid <input type="checkbox"/>..... Medicaid <input type="checkbox"/>.....<input type="checkbox"/>....Un plan disponible a través de un empleador <input type="checkbox"/>..... <input type="checkbox"/>....Un plan que compra por su cuenta (incluye COBRA) <input type="checkbox"/>.....<input type="checkbox"/>....VA, Champus, u otro plan militar <input type="checkbox"/>.....<input type="checkbox"/>....Otro <input type="checkbox"/>.....<input type="checkbox"/>.....No sabe/No está seguro(a)</p>
<p>7. Edad: _____</p>	<p>8. Es usted:</p> <p><input type="checkbox"/> Hombre <input type="checkbox"/> Mujer</p>	
<p>9. Código Postal: _____</p>		
<p>10. Educación <u>completada</u>:</p> <p><input type="checkbox"/> Menos que la Secundaria <input type="checkbox"/> Secundaria o GED <input type="checkbox"/> Algo estudios superiores (incluye un título de Asociado) <input type="checkbox"/> 4 años o más de estudios universitarios</p>	<p>11. ¿Cuál es su raza/etnia? Marque todas las necesarias</p> <p><input type="checkbox"/> Blanca <input type="checkbox"/> Negra/Afroamericana <input type="checkbox"/> Asiática <input type="checkbox"/> Indio Americana/ Nativo de Alaska <input type="checkbox"/> Hispana <input type="checkbox"/> Otro: _____ <input type="checkbox"/> Nativo de Hawai/Islands del Pacífico</p>	

Appendix C – Essential Service Summary

Summary Sheet: Essential Service #1

Assess and monitor maternal and child health status to identify and address problems.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.1 Use public health data sets to prepare basic descriptive analyses related to priority health issues (e.g., PRAMS; BRFSS; YRBS; live birth, fetal death, abortion, linked live birth/infant death data; community health surveys; census data; etc.)
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.2 Conduct analyses of public health data sets that go beyond descriptive statistics
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.3 Generate and analyze primary data to address state- and local-specific knowledge base gaps
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.DU.4 Interpret and report on primary and secondary data analysis for use in policy and program development
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	1.TA.1 Establish framework/template/standards about core data expectations for local health agencies and other MCH providers/programs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.TA.2 Provide training/expertise about the collection and use of MCH data to local health agencies or other constituents for MCH populations
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	1.TA.3 Assist local health agencies in data system development and coordination across geographic areas so that MCH data outputs can be compared

Summary Sheet: Essential Service #2

Diagnose and investigate health problems and health hazards affecting women, children, and youth.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.1 Use epidemiologic methods to respond to MCH issues and sentinel events as they arise
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate (Lead is Substantially)	2.2 Engage in collaborative investigation and monitoring of environmental hazards (e.g., physical surroundings and other issues of context) in schools, day care facilities, housing, and other domains affecting MCH populations, to identify threats to maternal and child health
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.3 Develop and enhance ongoing surveillance systems/population risk surveys and disseminate the results at the state and local levels
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.4 Serve as the state's expert resource for interpretation of data related to MCH issues
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.5 Provide leadership in reviews of fetal, infant, child, and maternal deaths and provide direction and technical assistance for state and local systems improvements based on their findings
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	2.6 Use epidemiologic methods to forecast emerging MCH threats that must be addressed in strategic planning

Summary Sheet: Essential Service #3

Inform and educate the public and families about maternal and child health issues.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.1 Utilize a routine mechanism for identifying existing and emerging health education needs and appropriate target audiences
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.2 Conduct and/or fund health education programs/services on MCH topics targeted to specific audiences to promote the health of MCH populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.IB.3 Produce and disseminate evaluative reports on the effectiveness of health promotion and health education programs/campaigns
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.1 Utilize a routine mechanism for identifying existing and emerging population-based health information needs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.2 Design and implement public awareness campaigns on specific MCH issues to promote behavior change
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.3 Develop, fund, and/or otherwise support the dissemination of MCH information and education resources
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	3.PB.4 Produce and disseminate evaluative reports on the effectiveness of public awareness campaigns and other population-based health information services

Summary Sheet: Essential Service #4

Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.1 Respond to community MCH concerns as they arise
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.2 Specify community geographic boundaries and/or stakeholders for use in targeting interventions and services
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.3 Provide trend information to targeted community audiences on state and local MCH status and needs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.4 Actively solicit and use community input about MCH needs
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.5 Provide funding and/or technical assistance for community-driven and –generated initiatives and partnerships among public and/or private community stakeholders (e.g., MCOs, hospital associations, parent groups)
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	4.6 Convene, stimulate, and/or provide resources (e.g., staffing, funding) for coalitions of agencies and/or constituent professional organizations to develop strategic plans to address health status and health systems issues

Summary Sheet: Essential Service #5

Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.DD.1 Actively promote the use of the scientific knowledge base in the development, evaluation, and allocation of resources for MCH policies, services, and programs
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	5.DD.2 Support the production and dissemination of an annual state report on MCH status, objectives, and programs, beyond the annual Block Grant submission
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.DD.3 Establish and routinely use formal mechanisms to gather stakeholders' guidance on MCH concerns
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	5.DD.4 Use diverse data and perspectives for data-driven planning and priority setting
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.1 Participate in and provide consultation to ongoing state initiatives to address MCH issues and coordination needs
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Formal IAs not viewed as important in NH	5.PD.2 Develop, review, and routinely update formal interagency agreements for collaborative roles in established public programs (e.g., WIC, family planning, Medicaid)
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.3 Serve as a consultant to, and cultivate collaborative roles in, new state initiatives, through either informal mechanisms or formal interagency agreements
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	5.PD.4 Advocate for programs and policies necessary to promote the health of MCH populations based on the scientific knowledge base/data and community input

Summary Sheet: Essential Service #6

Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.LA.1 Periodically review <i>existing</i> state MCH-related legislation to assess adequacy and any inconsistencies in legislative/regulatory mandates across programs serving MCH populations
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.LA.2 Monitor <i>proposed</i> legislation that may impact MCH and participate in discussions about its appropriateness and effects
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.LA.3 Devise and promote a strategy (specific to state constraints/protocols) for informing elected officials about legislative/regulatory needs for MCH
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate SMS more limited than MCH	6.LA.4 Initiate legislative proposals and/or lead regulatory efforts (specific to state constraints and protocols) pertaining to MCH concerns when appropriate
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	6.CS.1 Participate in processes led by professional organizations and other state agencies to provide MCH expertise in the development of licensure and certification processes
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	6.CS.2 Provide leadership to develop and promulgate harmonious and complementary standards that promote excellence in quality care for women, infants, and children, in collaboration with professional organizations and other state agencies with regulatory capacity as appropriate
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.3 Integrate standards of quality care into third party contracts for Title V-funded services, other publicly-funded services (e.g., Medicaid, SCHIP, WIC, family planning), and/or privately-financed services
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	6.CS.4 Develop, enhance, and promote protocols, instruments, and methodologies for use by health plans, insurance agencies, and other relevant state and local agencies that promote MCH quality assurance
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input checked="" type="checkbox"/> Fully Adequate	6.CS.5 Participate in or provide oversight for quality assurance efforts among regional health providers and systems and local health agencies and contribute resources for correcting identified problems

Summary Sheet: Essential Service #7

**Link women, children and youth to health and other community and family services,
and assure access to comprehensive, quality systems of care.**

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.1 Develop, publicize, and routinely update a toll-free line and other resources for public access to information about health services availability
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.2 Provide resources and technical assistance for outreach, improved enrollment procedures, and service delivery methods for hard-to-reach populations
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.3 Develop and routinely evaluate tracking systems for universal, high risk, and underserved populations
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.4 Provide or pay for direct services not otherwise available to CSHCN and other MCH populations (with Title V or other available funding)
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.5 Provide resources to strengthen the cultural and linguistic competence of providers and services to enhance their accessibility and effectiveness
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.6 Collaborate with other state agencies to identify and obtain resources to expand the capacity of the health and social services systems, and establish interagency agreements for the administration of capacity-expanding initiatives/protocols
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.AA.7 Actively participate in public insurers' oversight of health plan/provider enrollment procedures and development of plans for appropriate provision of services for new enrollees
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7CC.1 Provide leadership and resources for a system of case management and coordination of services
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	7.CC.2 Provide leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CSHCN

Summary Sheet: Essential Service #8

Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.1 Develop and enhance formal and informal relationships with schools of public health and other professional schools to enhance state and local public agency analytic capacity
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Federal HRSA doing; unnecessary to do at state level. NH obtains, reviews data.	8.CP.2 Monitor the numbers, types, and skills of the MCH labor force available to the state and localities
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.3 Monitor facility/institutional provider and program distribution throughout the state
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.4 Integrate information on workforce and facility/program availability or distribution with ongoing health status needs assessment in order to address identified gaps and areas of concern
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CP.5 Create financial and other incentives and program strategies to address identified clinical professional and/or public health workforce shortages
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CM.1 Make available and/or support continuing education for targeted professional audiences in public and private provider sectors on clinical and public health skills, emerging MCH issues, and other topics pertaining to MCH populations (e.g., cultural competence, availability of ancillary services and community resources, the community development process)
<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	8.CM.2 Play a leadership role in establishing professional competencies for Title V and other MCH programs

Summary Sheet: Essential Service #9

Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

<input type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input checked="" type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.1 Support and/or assure routine monitoring and structured evaluations of state-funded services and programs
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.2 Provide and/or assure technical assistance to local health agencies in conducting evaluations
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.3 Provide resources for and/or collaborate with local health or other appropriate agencies in collecting and analyzing data on consumer satisfaction with services/programs and community perceptions of health needs, access issues, and quality of care
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.4 Perform comparative analyses of programs and services
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.5 Disseminate information about the effectiveness, accessibility, and quality of personal health and population-based MCH services
<input type="checkbox"/> Minimally Adequate <input checked="" type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate	9.6 Utilize data for quality improvement at the state and local levels
<input checked="" type="checkbox"/> Minimally Adequate <input type="checkbox"/> Partially Adequate <input type="checkbox"/> Substantially Adequate <input type="checkbox"/> Fully Adequate Not applicable/role not supported by agency	9.7 Assume a leadership role in generating and disseminating information on private sector MCH outcomes

Summary Sheet: Essential Service #10

Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Minimally Adequate Partially Adequate Substantially Adequate Fully Adequate	10.1 Monitor the progress of state-specific and national MCH research and disseminate results of that research to providers, public health practitioners, and policy makers
<input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Minimally Adequate Partially Adequate Substantially Adequate Fully Adequate Performed by Health Statistics & NH Kids Count Lead Prog. seen as expert consultant in its field	10.2 Serve as a source for expert consultation to MCH research endeavors in the state
<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Minimally Adequate Partially Adequate Substantially Adequate Fully Adequate	10.3 Conduct and/or provide resources for state and local studies of MCH issues/priorities

Appendix D – Capacity Needs Summary

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Structural Resources			
Have: 1) Authority and funding sufficient for functioning at the desired level of performance ♦ Statutory authority – Lead, Newborn Screening, Maternal and Child Health, and Immunization ♦ Limited authority to carry it out ♦ Cumbersome mechanism to fill positions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	♦ Strengthen statutory authority – Lead and Maternal and Child Health ♦ Authority to accept money from Special Medical Services; 3 rd party needs to accept or money goes in general funds Mechanism to accept donations, grants, etc. ♦ Funding (general) to support programs (example: Lead, Maternal and Child Health and Oral Health) ♦ Oral Health ♦ Streamline and improve human resource tasks ♦ Resources and flexibility to perform functions of those vacant positions
Have: 2) Routine, two-way communication channels or mechanisms with relevant constituencies ♦ Special Medical Services – monthly meetings to share ♦ Special Medical Services family boards ♦ Advisory committees - all ♦ Communication with medical professional groups – Special Medical Services, Maternal and Child Health ♦ Good speakers with programs ♦ Provider and inspector newsletters (Lead)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	♦ Stronger letter writing/media releases Time to do this/education ♦ Articles for professional groups – Maternal and Child Health and Special Medical Services ♦ Internal mechanism to streamline ♦ More time and mechanism to do professional ♦ Presentations (ie speakers bureau) ♦ Communication plan ♦ Better utilization of Department of Health and Human Services newsletter ♦ Getting into social media ♦ Website! Department of Health and Human Services ease to post and navigate ♦ List serves
3) Access to up-to-date science, policy, and programmatic information ♦ Public health library ♦ Health Insurance Portability and Accountability Act newsletter ♦ Legal support for adverse action (legal) ♦ Legislation update sheets (Maternal and Child Health and Special Medical	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Need: ♦ Someone to consolidate and collect research for Maternal and Child Health ♦ Large legal capacity to support all programs

Capacity Needs Scoring Worksheet

<p>Services) Kate Frey & Sharon Kaiser</p> <ul style="list-style-type: none"> ◆ Professional list services (Lead) ◆ Webinars – access 			
<p>4) Partnership mechanisms (e.g., collaborative planning processes and community advisory structures)</p> <ul style="list-style-type: none"> ◆ Advisory committees: (Early Hearing Detection & Intervention, Newborn Screening Program, Lead, Immunization, Injury Prevention Transitional, P/H) ◆ Maternal and Child Health Directors Meetings ◆ Maternal and Child Health Coordinators Meetings ◆ LLACs (Lead) ◆ Home Visiting Program Coordinators (Maternal and Child Health) ◆ Family Voices (Special Medical Services) ◆ Some consumer representation on advisories 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>Need:</p> <ul style="list-style-type: none"> ◆ Resurrect family planning Information & Education committee ◆ Birth outcomes:/perinatal group ◆ Strong link w/PHNs
<p>5) Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans</p> <ul style="list-style-type: none"> ◆ Clear language in contracts Ex. As (Maternal and Child Health) ◆ Process to improve Exhibit As ◆ Data people (Maternal and Child Health and Special Medical Services) ◆ Dedicated staff 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>Need:</p> <ul style="list-style-type: none"> ◆ Staffing for each priority (Special Medical Services) ◆ Better capacity to work on priority issues ◆ Training programs in data collections and management (all) ◆ Data people (Lead) or more data people (Special Medical Services) ◆ Increased capacity of qualified staff

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Structural Resources			
<p>6) Mechanisms for accountability and quality improvement</p> <ul style="list-style-type: none"> ◆ Federal grant workplans ◆ Monitor contract competencies (Special Medical Services) ◆ Quality assurance through workplan assessments. Site visits, surveys. (Special Medical Services and Maternal and Child Health) ◆ Satisfaction surveys (Special Medical Services) ◆ Funding as incentives for program improvement (Special Medical Services) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>Need:</p> <ul style="list-style-type: none"> ◆ Mechanism and staffing to do contract competencies in a few months ◆ As a whole, Maternal and Child Health core system, we do not publicly articulate performance standards
<p>7) Formal protocols and guidance for all aspects of assessment, planning, and evaluation cycle</p> <ul style="list-style-type: none"> ◆ Bright Futures federal protocols/guidelines (Lead, Maternal and Child Health and Newborn Screening) ◆ Early Hearing Detection and Intervention guidelines ◆ Standard of core protocols (Special Medical Services) 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<p>Need:</p> <ul style="list-style-type: none"> ◆ Protocols for data integrity

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Data/Information Systems			
<p>8) Access to timely program and population data from relevant public and private sources</p> <ul style="list-style-type: none"> ◆ Vital records not timely but improving ◆ Hospital D/C data (timely?) ◆ Perinatal data system ◆ Medicaid claims data ◆ Comprehensive Comp. Health information data (inc. private) ◆ Family planning data – own data system. 1 x only surveys. ◆ Performance measures ◆ National data ◆ Maternal and Child Health data ◆ Youth Risk Behavior Survey / Behavioral Risk Factor Surveillance System /Early Hearing Detection and Intervention ◆ Uniform Data Systems 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> ◆ Access ability <u>how, who</u> to ask?? Staff ◆ Electronic medical data ◆ Pregnancy Risk Assessment Monitoring System – pregnancy ◆ Reliability ◆ System interaction
<p>Have:</p> <p>9) Supportive environment for data sharing</p> <ul style="list-style-type: none"> ◆ Health Insurance Portability and Accountability Act and Encryption clearer policy of how to and easier to use. (standardization) ◆ Memorandum of Understanding between vital records & Department of Health and Human Services – statutes that support this ◆ Opportunity with ARRA \$ for sharing ◆ Local policies vs state policies on data sharing & confidentiality (PCDF) 	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Consistency of use of data ◆ Accessibility Workforce development on how to read, interpret, use data ◆ System interaction ◆ Linking data Policy, Human Resources, licensing issues Bureaucracy of system ◆ Legal issues to process data internally ◆ Constrictions of some data sets (ie.other states)
<p>Have:</p> <p>10) Adequate data infrastructure</p> <ul style="list-style-type: none"> ◆ Emerging support from IT ◆ Being built MCH Data Mart 	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Emerging support from IT, not through out ◆ Personnel capacity is low within MCH ◆ Slow process/financial support for HW/SW ◆ Training – workforce development ◆ No systems for educating/communicating the

Very slow process

Capacity Needs Scoring Worksheet

<p>Staff △'s Slows process</p> <ul style="list-style-type: none">◆ access to internet based resources (process to apply)◆ external partners track services to clients◆ access to on line databases for literature searches & raw data			<p>data</p> <ul style="list-style-type: none">◆ Paper system - not everyone converted electronically some electronic systems need revisions or new/updated system
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Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Organizational Relationships			
11) State health department/agencies/programs ◆ Although we don't always know about it all	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
12) Other relevant state agencies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Need email signatures to include program & contact ◆ Define acronyms ◆ Directory of services by office/contact ◆ Build on existing (org charts) ◆ Accessible to all
13) Insurers and insurance oversight stakeholders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Access to information ◆ Convene meetings ◆ Challenge: HIPPA ◆ Relationships – Outreach ◆ Building – take a broader look at health care systems ◆ Advocate for client coverage – dept of insurance
14) Local providers of health and other services ◆ Challenges with school district ◆ Does the public/contract/stakeholders have this perception? ◆ Opportunities for feedback	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
15) Superstructure of local health operations and state-local linkages	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Education & outreach to promote more consistent standards

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Organizational Relationships			
16) State and national entities enhancing analytical and programmatic capacity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
17) National governmental sources of data	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Have: 18) State and local policymakers ◆ Have some, However,	<input type="checkbox"/>	<input checked="" type="checkbox"/>	◆ Need to inform & educate about our purpose & goals
19) Non-governmental advocates, funders, and resources for state and local public health activities ◆ Have some, but room for continued improvement. Especially cultural competency.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
20) Businesses	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> ◆ Leadership would drive ◆ Invite business to participate on committees ◆ Outreach/inform/educate ◆ Alignment of Public Health Principles

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Competencies			
21) Communication and data translation skills ♦	<input type="checkbox"/>	<input checked="" type="checkbox"/>	♦ Office of Minority Health to translate material, surveys to language needed by families ♦ Do we exist in a culture that tells us we “can’t communicate with Legislation ♦ DHHS Website is not current or consumer friendly
22) Ability to work effectively with public and private organizations /agencies and constituencies ♦ We have the ability but perhaps no staff or time ♦ We do this in small ways but with cuts in staff programs like the Lead Program may no longer be able to do this	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
23) Ability to influence the policymaking process	<input type="checkbox"/>	<input checked="" type="checkbox"/>	♦ We need training ♦ Children’s Advocacy Network NH (CAN) the “voice” – which may or may not be the “expert” in the area of concern
24) Experience and expertise in working with and in communities ♦ Community based programs that are multidisciplinary & collaborative with multiple communities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Capacity Needs Scoring Worksheet

Capacity Need	Have	Need	If need, for what area(s) of programmatic performance?
Competencies			
Have: 25) Management and organizational development skills ♦ Can we have & need these skills ♦ Starting to do more grant applications ♦ We may not look outside the “box grants” – translation of information	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
26) Knowledge and understanding of the state context	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
27) Data and analytic skills	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
28) Knowledge of MCH and related content areas	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Appendix E – ChampionsInC Assessment Tool



ChampionsInC Community-based Assessment Tool for Title V CSHCN Leaders:

Examining State Capacity for Achieving a Community-Based Service System for Children and Youth with Special Health Care Needs

Overview of Title V CSHCN Programs

Title V funding for children with special health care needs has evolved over the past fifty years, moving from: funding “Crippled Children’s Programs”; to addressing social, emotional, and physical needs of children via a community-based systems of services. Title V of the Social Security Act now provides guidance and funds to States and territories to:

- provide and promote ***family-centered, community-based, coordinated care*** for children and youth with special health care needs (CYSHCN)
- facilitate the development of ***community-based systems*** of services
- support ***core public health functions*** such as resource development, capacity building, public information, technical assistance to communities, and provider training
- build ***community capacity*** to deliver care coordination, and coalitions
- Fill gaps in need for direct health care services for children and families

Assessing your state’s capacity

Under the Omnibus Budget Reconciliation Act of 1989 (OBRA) and Healthy People 2010, states are instructed to achieve a community-based system of services and supports for children and youth with special health care needs and their families. The six performance measures for CYSHCN articulated in the Title V Block Grant provides structure for this assessment:

PM 1: Timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

PM 2: Families partner in decision making at all levels and are satisfied with the services they receive.

PM 3: Children receive coordinated, ongoing, comprehensive care within a medical home.

PM 4: Families have adequate private and/or public insurance to pay for the services they need.

PM 5: Families report the community-based service systems are organized so they can use them easily.

PM 6: Youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Role of this Community-Based Assessment

This ChampionsInC Community-Based Assessment Tool is designed to assist CYSHCN leaders in the needs assessment process, with focus on the ***state's capacity in implementing community-based service systems***. Specifically, the needs assessment helps with identifying:

1. Who are the needed stakeholders, representing families, youth, community providers, and other important players in the service system at the state level?
2. What state level policies and practices should be in place to achieve these outcomes?
3. What policies and practices should be in place across communities in your state?
4. What are some data sources or ways to measure achievements for children, youth, and families?

Important elements of such a system at the state and community level have been identified in this tool, though these elements are not exhaustive. Rather, they reflect basic components to get started -- additional partners and elements may be needed to reflect the characteristics of individual states and communities. Resources for obtaining training and technical assistance related to the CYSHCN performance outcomes are provided at the end of this document.

Instructions for Completing this assessment

This assessment is best completed by a team of state stakeholders, in partnership with community and family leaders. Together:

1. Put a check in the box pertaining to the level of development for each component.
2. After reviewing all components, go back to the beginning and identify your priorities.

PM 1: EARLY AND CONTINUOUS SCREENING

Who do you need as partners at a state level? Rate the level of engagement of the following key partners:

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. CSHCN and MCH administration	<input type="checkbox"/>				
b. EHDI, newborn dried bloodspot screening programs, public health laboratories	<input type="checkbox"/>				
c. Part C EI /other EC programs	<input type="checkbox"/>				
d. Mental health	<input type="checkbox"/>				
e. Family and youth leaders reflective of your state's diversity	<input type="checkbox"/>				
f. March of Dimes and other patient/family support organizations	<input type="checkbox"/>				
g. Pediatric and obstetric health professionals and their organizations	<input type="checkbox"/>				
h. Third party payers and employers, hospitals	<input type="checkbox"/>				
i. Relevant agencies such as CMS (EPSDT), Education (Head Start, daycare), Housing (lead), Agriculture (WIC, nutrition), etc.	<input type="checkbox"/>				
j. LEND programs	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Integrated information systems for surveillance, follow up, service coordination, and quality improvement. Systems should have privacy and confidentiality protection in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Coordinated referral process to facilitate diagnostic testing and patient management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Promotion of Bright Futures Guidelines and other relevant guidelines and standards and require their use in grant funding and contracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medical home training in comprehensive screening, including mental health, ASD, OAE (hearing), development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
e. Availability of screening information in languages spoken by majority of state residents and that's easily understood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Identification of best screening practices and tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Promote and support the use of health information technology, such as telemedicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Provide funding to encourage coordination of screening activities at local, regional, and state levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Increase compensation rates for screening activities in the medical homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. State external advisory committee to promote coordination and oversight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Collect and analyze data for continuous monitoring, evaluation, and planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Promote awareness of the need and benefits of early and continuous screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Participate in the MCHB funded Regional Newborn Screening and Genetic Services Collaborative activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Local interagency screening clinics/other systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Local use of integrated information systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Coordinated referral process employed by local providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use of cultural brokers in public awareness efforts to promote screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Community grants to facilitate coordination of screening activities, data collection and reporting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Provide training for various screening activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are some ways of measuring needs and outcomes for children and families?

	Data available & shared with communities for planning	Data available & used for state planning	Data available & used for reporting purposes	Data not available	Priority
a. National Survey of Children’s Health 2007 (CSHCN receiving preventive medical and dental care visits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of CSHCN 2005/2006 (CSHCN receiving both preventive medical/dental care during the past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pregnancy Risk Assessment Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. State newborn dried bloodspot screening and EHDI data bases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. National Newborn Screening Information System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. MCHB’s Discretionary Grant Information System (DGIS) performance measure 23	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PM 2: CYSHCN WHOSE FAMILIES ARE PARTNERS AT ALL LEVELS OF DECISION MAKING

Who do you need as partners at a state level?

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. Family leadership/advocacy groups (e.g., Family Voices, Parent Training and Information Centers)	<input type="checkbox"/>				
b. Family members representing their individual needs, with persons who reflect of the diverse populations in the state	<input type="checkbox"/>				
c. State CSCHN administration	<input type="checkbox"/>				
d. State CYSCHN decision-making boards/councils	<input type="checkbox"/>				
e. Medical home providers and medical home family representatives	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Family leadership training/mentoring system in place for families and financially supported	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Families are leaders in lobbying and social marketing for CYSHCN system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family leaders, representing the diversity of the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Family representative has a CSHCN staff position or are contracted employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family leaders are active members of state policy and advisory boards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Family leader positions exist in communities across state	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
b. Family leaders are members of local boards, such as local interagency councils	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
c. Families are supported financially for their involvement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
d. Family leadership training/networking are implemented in communities	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

What are some ways of assessing needs and outcomes for children, youth and families?

	Data available & shared with communities for planning	Data available & used with state planning	Data available & used for reporting purposes	Data not available	Priority?
a. Block Grant reporting rating scale---Form 13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of Children’s Health 2007 (parent feels like partner in child’s care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Family to Family Health Information Center data re: outcomes of training provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Parent Training and Information Center data re: outcomes of training provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Center for Medical Home Improvement: Family survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. National Center for Cultural Competence Self-Assessment Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. MCHB’s Discretionary Grant Information System (DGIS) performance measures 6 , 7, and 64	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PM 3: CYSHCN RECEIVE COORDINATED, ONGOING, COMPREHENSIVE CARE WITHIN THE MEDICAL HOME

Who do you need as partners?

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. Physicians: AAP chapter leaders	<input type="checkbox"/>				
b. Primary care providers (i.e., Pediatricians, Family Practice)	<input type="checkbox"/>				
c. Specialists and subspecialists	<input type="checkbox"/>				
d. CSHCN program administration	<input type="checkbox"/>				

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
e. Medical schools and residency training programs	<input type="checkbox"/>				
f. Family and youth leaders who reflect the diversity in your state	<input type="checkbox"/>				
g. Education (including Head Start), Medicaid, private insurers, employers	<input type="checkbox"/>				
h. Nursing and allied health professionals	<input type="checkbox"/>				
i. State epidemiologists and health information technology staff	<input type="checkbox"/>				
j. Community service providers and leaders	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Statewide Medical home training/TA for pediatric practices, families, and adult providers to support transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Medical home part of medical school/residency training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Increased reimbursement for Med. Home via Medicaid, other private insurers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Translation/interpretation supports for medical homes to serve culturally and linguistically diverse populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Promote and support health information technology initiatives that connect public health to clinical practices and/or promote the use of electronic health records and personal health records, telemedicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. state-wide medical home demonstration projects and pilots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Disseminate best practices and tools for medical home implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Public awareness activities are conducted throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Health literacy is promoted with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Well established/sustained	Implementation initiated	Plan in development	Not developed	Priority?
j. specific outreach to the medically underserved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Represent the medical homes in state emergency contingency/diaster planning activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Practices are involved in medical home training and/or serve as mentors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Medical homes are ID'd and included in all CSHCN service plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Medical homes are represented on local councils/coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medical homes partner with other entities to ensure coordinated care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Medical homes are included in IEPs/IFSPs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Translation/interpretation supports for medical homes to serve diverse families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Provide resources to community-based practices for care coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Assist in compiling a directory of community services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are some ways of measuring needs and outcomes for children and families?

	Data available & shared with communities for planning	Data available & used with state planning	Data available & used for reporting purposes	Data not available	Priority?
a. National Survey of CSHCN 2007 associated indicators for medical home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of Children’s Health associated indicators for medical home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Center for Medical Home Improvement: Physician and family surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. F2FHIC data regarding medical home needs/challenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. MCHB’s Discretionary Grant Information System (DGIS) performance measure #19 and 64	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PM 4: ADEQUATE INSURANCE/FINANCING

Who do you need as partners?

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. CSHCN program administrators	<input type="checkbox"/>				
b. CMS/Medicaid, SCHIP	<input type="checkbox"/>				
c. Private insurers/Managed Care providers	<input type="checkbox"/>				
d. Family and youth leaders who represent the diversity in your state	<input type="checkbox"/>				
e. Primary care and specialty physicians, mental health providers, ancillary care providers	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. There is a F2FHIC/other statewide program for assisting families, providers with information, resources about health care financing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. State CSHCN program & families are represented on insurance boards, Medicaid councils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The State has expanded eligibility for Medicaid, SCHIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. State initiatives to support universal, comprehensive coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Strong public awareness and simplified application procedures for Medicaid/SCHIP (e.g., online application process)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. State has streamlined application process for Medicaid/SCHIP applications (e.g., utahclicks.org)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Training in benefits management is provided to care coordinators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Strong public awareness initiatives to recruit eligible families for Medicaid/SCHIP, esp. diverse families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Training for providers to support families in obtaining insurance coverage- insurance “navigators”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Community-based /school based health centers to support uninsured/underinsured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Blended funding available to support uninsured/underinsured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are some ways of assessing needs and outcomes of children and families?

	Data available & shared with communities for planning	Data available and used with state planning	Data available & used for reporting purposes	Data not available	Priority?
a. National Survey of CSHCN 2005/2006, indicators re: adequate insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of Children’s Health 2007, indicators re: health insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. F2FHIC data pertaining to family requests for support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Child and Adolescent Health Program (CAHPS), child survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PM 5: COMMUNITY-BASED SERVICES ARE ORGANIZED AND FAMILIES ARE SATISFIED

Who do you need as partners at a state level?

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. CSHCN administrators	<input type="checkbox"/>				
b. Public health administrators and providers	<input type="checkbox"/>				
c. State interagency councils/advisory boards	<input type="checkbox"/>				
d. Medical home representatives	<input type="checkbox"/>				
e. Family and Youth leaders who represent the diversity of your state	<input type="checkbox"/>				
f. Faith-based organizations	<input type="checkbox"/>				
g. Nonprofits, charities (e.g., Shriners)	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. CSHCN Statewide regional/local offices/infrastructure is in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. CSHCN care coordination is available throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Streamlined/common application process for multiple services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Contracts w/community based providers vs. centralized clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. State funding available to support communities (e.g., "mini-grants")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. State agencies create a common application process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Regional/local CSHCN offices are part of statewide infrastructure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Funds are provided for regional/local level CSHCN care coordinators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Community-level councils/coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Community-based versus centralized health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Cultural brokers to ensure needs of all families are met	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Common application process to facilitate access to services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Single Interagency care plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are some ways of assessing needs and outcomes of children and families?

	Data available & shared with communities for planning	Data available & used with state planning	Data available & used for reporting purposes	Data not available	Priority?
a. National Survey of CSHCN 2005/2006, indicators re: outcome 5: Families of CYSHCN report that services are organized so they can use them easily; Families are satisfied with the services they receive (National Survey of CSHCN associated indicators); Families report that they can access all needed services in a timely manner (National Survey of CSHCN associated indicators); Families report that they have a care coordinator and reported # of hours families coordinate care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of Children’s Health 2007, indicators re: unmet needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. National Center for Cultural Competence Self Assessment Survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Child and Adolescent Health Program (CAHPS), child survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Voices data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. F2FHIC data Champions for Inclusive Communities community-level mapping and survey strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. MCHB’s Discretionary Grant Information System (DGIS) performance measure #37	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

PM 6: TRANSITION TO ADULT LIFE

Who do you need as partners?

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
a. Youth leadership organizations	<input type="checkbox"/>				
b. Family leadership organizations	<input type="checkbox"/>				
c. State Title V CSHCN administrators	<input type="checkbox"/>				
d. Public and private insurance representatives	<input type="checkbox"/>				

	Strong engagement	Moderate engagement	Weak engagement	No participation	Priority?
e. Pediatricians and adult medical providers	<input type="checkbox"/>				
f. Secondary and post-secondary educators	<input type="checkbox"/>				
g. Representatives from Office of Rehabilitation Services and other government funded economic support services	<input type="checkbox"/>				
h. Private employment representatives	<input type="checkbox"/>				
i. Assisted living/personal assistant representatives	<input type="checkbox"/>				
j. Major businesses that can offer employment	<input type="checkbox"/>				
k. Public Transportation administrators	<input type="checkbox"/>				

What state policies and practices are needed?

	Well established/sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Youth representatives are financially supported	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Youth advisory council created	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Youth leaders present on interagency councils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Medical home training to support transition to adult care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Youth leadership training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Youth website for resources, peer-to-peer interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. State legislation to support insurance coverage for adults with CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Health insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Systems and supports in place that support employment for youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Home and community based services are adequately funded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Health goals are integrated into education and transition plans –increased awareness of health impacting educational/vocational goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How can states support community policies and practices?

	Well established/ sustained	Implementation initiated	Plan in development	Not developed	Priority?
a. Pediatricians and adult providers receive training to support transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Youth reps on local councils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Youth reps in local councils/coalitions and financially supported	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Transportation options are available in communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Community-based youth groups financially supported	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Comprehensive school transition plans that include health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Supporting interagency councils targeting transition issues for youth/young adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What are some ways of assessing needs of youth and families?

	Data available & shared with communities for planning	Data available & used with state planning	Data available & used for reporting purposes	Data not available	Priority?
a. National Survey of CSHCN 2005/2006, indicators re: transition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. National Survey of Children’s Health 2007 (re: middle childhood and adolescence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Families of YSCHN report supports for transition to adulthood (National Survey of CSHCN associated indicators)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Family Voices data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. F2FHIC data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. National Health Interview Survey – Disabilities survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. BRFSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Education data regarding transition planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Office of Rehabilitative Services Data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Resources for Assisting States in their Needs Assessment and Planning Efforts

The Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs funds national centers whose mission is to serve as a resource in your efforts to achieve the six outcomes for CYSHCN and their families. The centers below can assist you in building partnerships, developing and implementing plans, as well as measuring your efforts to achieve these outcomes. These major centers are described below:

Family Voices National Center for Family Professional Partnerships (NCFPP)

The NCFPP provides leadership on implementing the core component of a system of care for children and youth with special health care needs (CYSHCN) working to increase the capacity of families to partner in decision making at all levels. The NCFPP works nationally with F2FHICs, the FV network, other family leaders and their professional partners in implementing this core component. <http://www.familyvoices.org>

National Center for Cultural Competence (NCCC)

The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy.

<http://www11.georgetown.edu/research/gucchd/nccc>

Healthy & Ready to Work National Resource Center (HRTW)

The Center works with State Title V CSHN programs and their partners to improve and enhance health care transition for CYSHCN. The Center provides resources, information and technical assistance addressing the transition to adult systems and services including strategies to maintain health insurance and increasing the involvement of youth in health care decisions and policymaking. The website includes tools and resources for providers, families and youth. www.hrtw.org

The National Center for Medical Home Initiatives for Children with Special Needs

The National Center of Medical Home Initiatives for Children with Special Needs provides support to physicians, families, and other medical and non-medical providers who care for children with special needs so that they have access to a medical home. <http://www.medicalhomeinfo.org/index.html>

The Catalyst Center

A national center dedicated to improving health care insurance and financing for children and youth with special health care needs (CYSHCN). <http://www.hdwg.org/catalyst>

Champions for Inclusive Communities (ChampionsInC)

A leadership and resource center designed to support states and communities in organizing services so families of children and youth with special health care needs (CYSHCN) can use them easily and families are satisfied. <http://www.championsinc.org>

National Center for Hearing Assessment and Management (NCHAM)

This National Resource Center (NRC) assists state agencies and other federal and non-federal partners in the development and operation of sustainable statewide Early Hearing Detection and Intervention (EHDI) systems. <http://www.infanthearing.org>

CAHMI Data Resource Center

Part of the Child & Adolescent Health Measurement Initiative. Provides leadership and resources for measuring and communicating information about the quality of healthcare for young children (0-3), teens (12-21), and children with chronic conditions. <http://cahmi.org/pages/Sections.aspx?section=14>

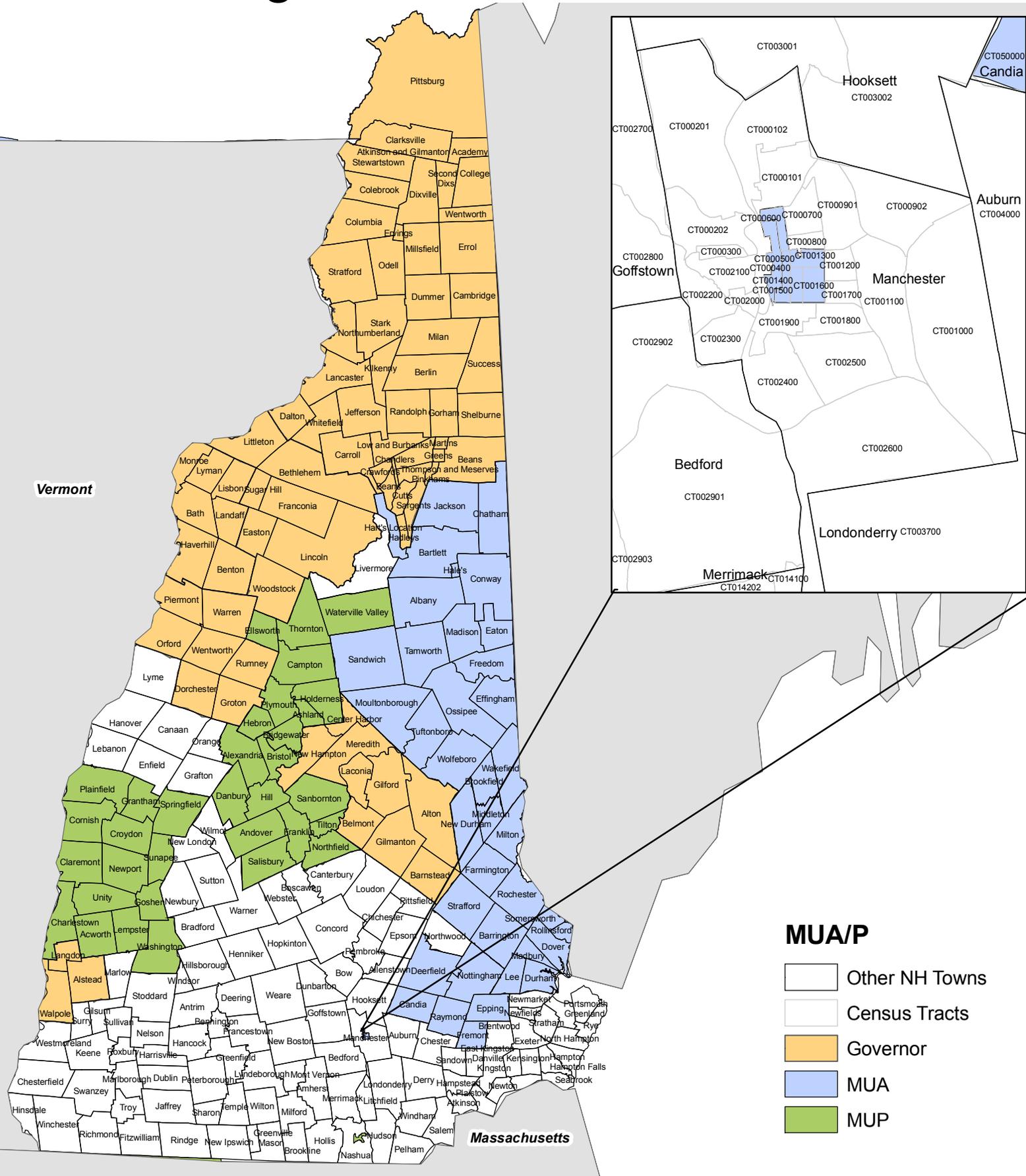
New Hampshire Newborn Screening Panel

Disorders on New Hampshire Newborn Screening Panel as of May 1, 2006	Acronym
*Galactosemia	GALT
*Congenital Toxoplasmosis	TOXO
*Congenital Hypothyroidism	CH
*Biotinidase	BIOT
*Congenital Adrenal Hyperplasia	CAH
*Hemoglobinopathies (3 types)	Hb SS + Hb S/BTh + Hb S/C
*Cystic Fibrosis	CF
*Phenylketonuria	PKU
*Maple Syrup Urine Disease	MSUD
*Homocystinuria	HCY
*Medium Chain Acyl-CoA Dehydrogenase Deficiency	MCAD
Disorders added to panel as of July 1, 2007	
Argininosuccinic Aciduria	ASA
Argininemia	ARG
Carnitine Uptake Defect	CUD
Carnitine Palmitoyltransferase II Deficiency	CPTII
Citrullinemia I (ASA Synthetase Def)	CIT
Cobalamin A,B	Cbl A,B
Glutaric Aciduria Type I	GAI
3-Hydroxy-3-Methylglutaryl-CoA Lysase Deficiency	HMG
Hyperornithinemia Hyperammoninemia, Homocitrullinemia Syndrome	HHH
Isovaleric Acidemia	IVA
Long Chain 3-hydroxyacyl-CoA Dehydrogenase Deficiency	LCHAD
3-Methylcrotonyl-CoA Carboxylase Deficiency	3MCC
Methylmalonic Acidemia	MUT
Mitochondrial Acetoacetyl-CoA Thiolase Deficiency	BKT
Multiple Acyl-CoA Dehydrogenase Deficiency	GA2
Multiple Carboxylase Deficiency	MCD
Propionic Acidemia	PROP
Trifunctional Protein Deficiency	TFP
Very Long Chain Acyl-CoA Dehydrogenase Deficiency	VLCAD

*Newborn hearing screening is also offered at all NH hospitals with birth facilities.

Appendix G – Maps (Medically Underserved Areas)
(Health Professional Shortage Area)
(Medically Underserved Populations)

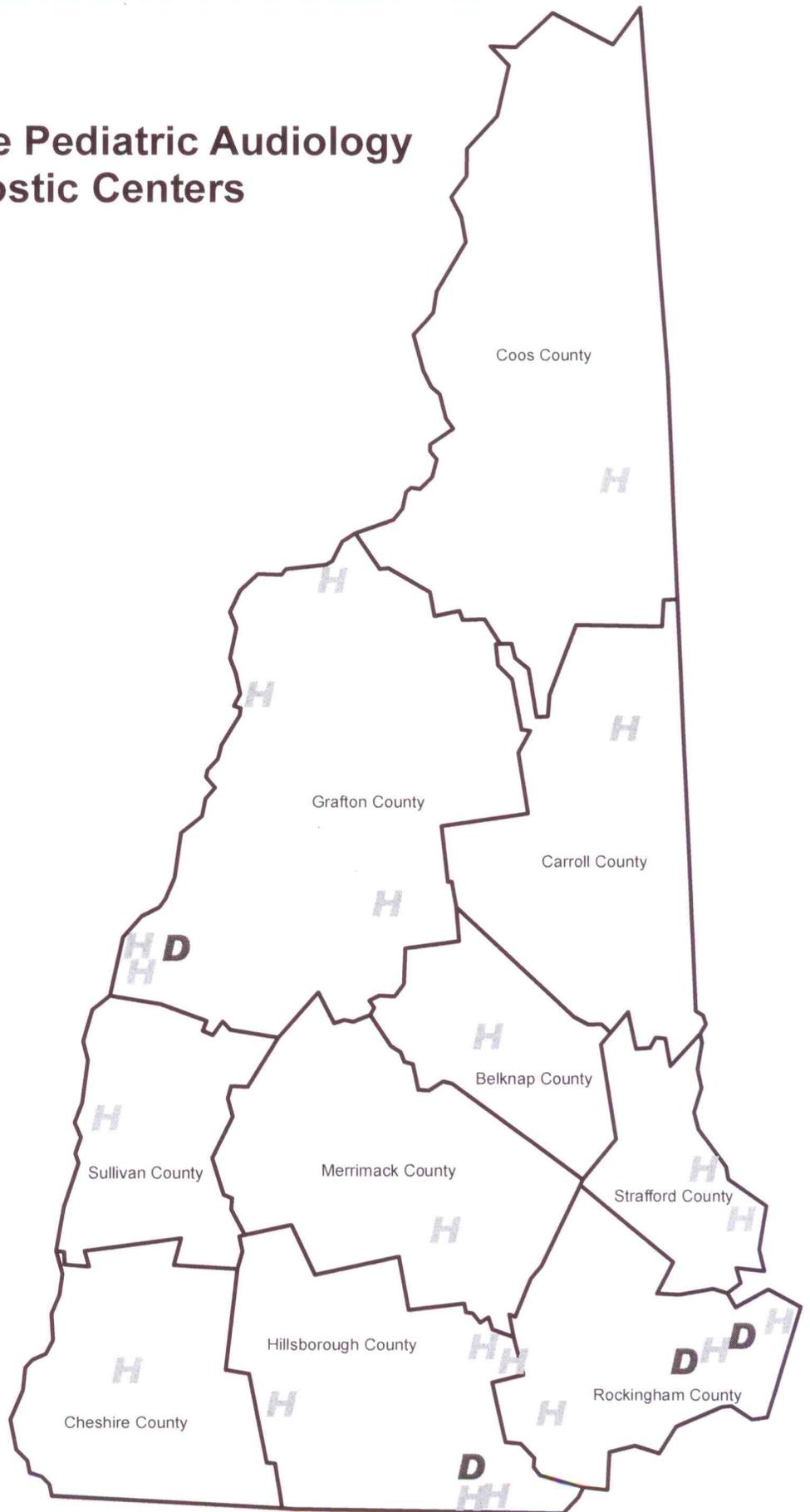
New Hampshire's Medically Underserved Area/Population Designations - March, 2009



Appendix H – Map of the Pediatric Audiology Diagnostic Centers

New Hampshire Pediatric Audiology Diagnostic Centers

- D** Diagnostic Center
- H** NH Birth Hospital



Appendix I – Survey Tool of Health Care Providers



Survey of Adult Health Care Providers about Health Care Transition for Youth with Special Health Care Needs

Special Medical Services

April 2008

Background

According to the National Survey of Children with Special Health Care Needs, 16.6 percent of New Hampshire's children and youth have special health care needs.¹ Youth with special health care needs (YSHCN) are those who "have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally"². Many of these youth will require support and services in their transition to adulthood.

Health care transition, the process of change from child- and family-centered health care to adult care requires ongoing attention and planning, especially for these youth. The goal is "to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood."³

Since 2004, Special Medical Services (SMS) of New Hampshire's Department of Health and Human Services has been educating families, youth and providers about health care transition through a variety of activities. They include direct support to pediatric practices, an on-line survey of pediatricians, parent-youth conferences, literature and an ongoing Health Care Transition Coalition.

SMS determined that the next step was to reach out to adult providers to identify unmet transition needs of youth and to identify current practices and beliefs. This was accomplished by a survey sent to several groups of adult primary care providers between October 2007 and February 2008. The survey yielded 180 responses, primarily from family physicians. (See Methods)

Results/Highlights

❖ PROVIDER COMFORT LEVEL

Respondents were most comfortable treating youth/young adults with asthma (92%), hypertension (89%), intellectual disabilities (75%), mental health conditions (57%) and diabetes (54%). They were less comfortable treating youth/young adults with conditions such as cystic fibrosis (15%), chromosomal/metabolic disorders (14%), autism (22%) and those who are technology dependent (11%). (Figure 1)

❖ COMMUNICATION AND COORDINATION

- ◆ 46% of adult providers rarely or never communicated with the previous health care provider. (Figure 2)
- ◆ 57% of adult providers rarely or never received a written transfer summary from the previous provider. (Figure 3)
- ◆ 48% of adult providers thought that youth/young adults entering their practices had experienced a gap between pediatric and adult care. (Figure 4)

❖ BARRIERS TO CARING FOR YSHCN

Lack of time, inadequate staffing, reimbursement issues and inadequate support from knowledgeable specialists were sometimes perceived as barriers. (Figure 5)

❖ WHAT WOULD HELP ADULT PROVIDERS?

- ◆ 95% would like a written transfer summary.
- ◆ 95% would like support from specialists.
- ◆ 84% wanted written information about a particular condition.
- ◆ 91% want to have conversation about the YSHCN with the prior health care provider. (Figure 6)

❖ ADDITIONAL FINDINGS

- ◆ 18-25 year olds comprise less than 10% of the patient population in 80% of the respondent's practices. Of this 10%, less than 5% were thought to have special health care needs.
- ◆ 78% of the respondents indicated that the transfer of care to adult providers should occur between 18 and 21 years.

Implications/Recommendations

The results indicate a lack of coordination and communication regarding the transition and transfer of care of youth with special health care needs. This can lead to gaps in medical care for a population that needs uninterrupted care.

To help smooth the transition, SMS promotes the use of a written medical summary that can be utilized to highlight critical medical information for the youth and can be sent to the new provider prior to the first visit. SMS also supports the use of the Transition Checklist and Timeline, or similar guide, to promote a systematic planning process for providers, families and youth/young adults.

Another important finding is that many respondents were either not comfortable or only somewhat comfortable treating certain low incidence or complex conditions. Adult providers need to have the knowledge and skills to serve these populations. SMS recommends that stakeholders, including consumers and relevant professional organizations, review these findings and develop educational programs and access to resources for physicians, medical students

¹ UD DHHS, Health Resource and Services Administration, MCH. *The National Survey of Children with Special Health Care Needs Chart-book 05-06* Rockville MD; US DHHS 07

² Maternal and Child Health Bureau; US DHHS

³ American Academy of Pediatrics, Family Physicians and ACP American Society of Internal Medicine *A Consensus Statement of Health Care Transition of Young Adults with Special Health Care Needs. Pediatrics* 2002;1110; 1304-1306

and other primary care providers to ensure that youth with special
Figure 1

health care needs receive appropriate primary and specialty care.

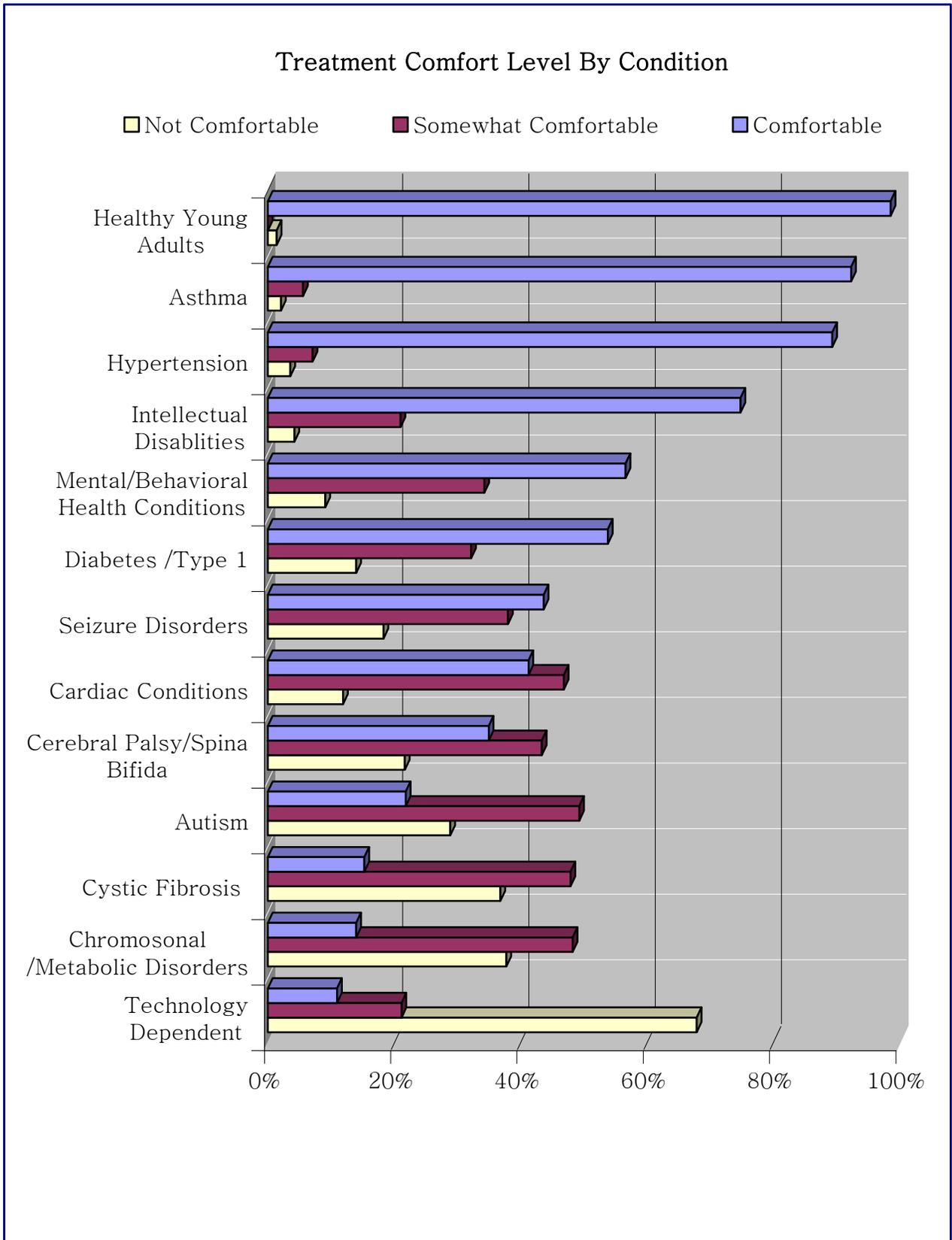


Figure 2

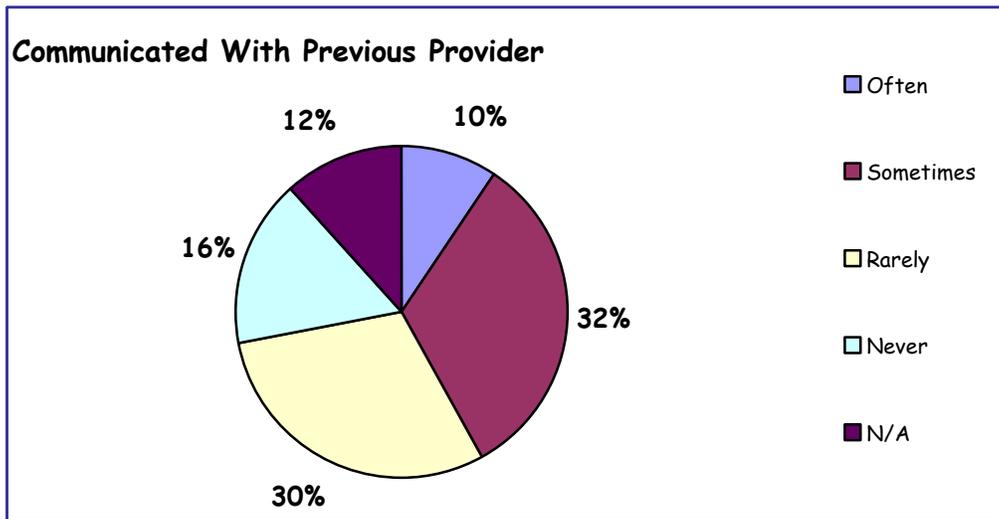


Figure 3

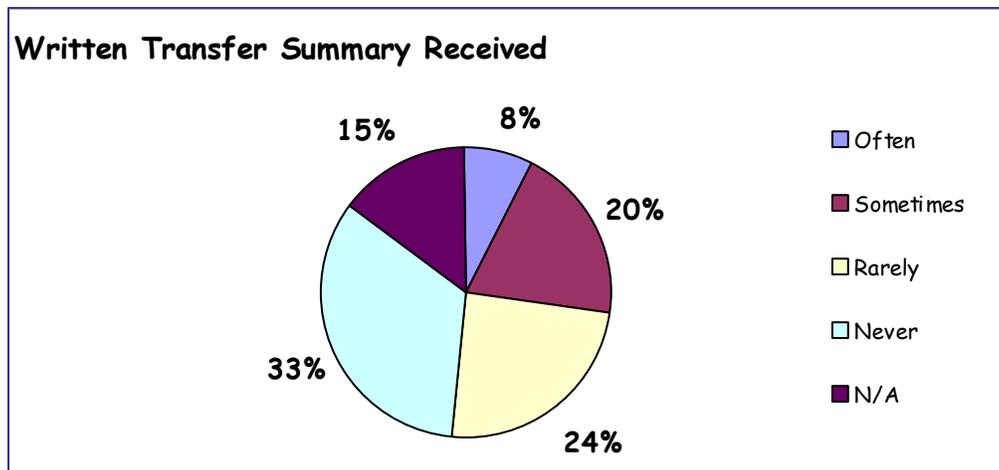


Figure 4

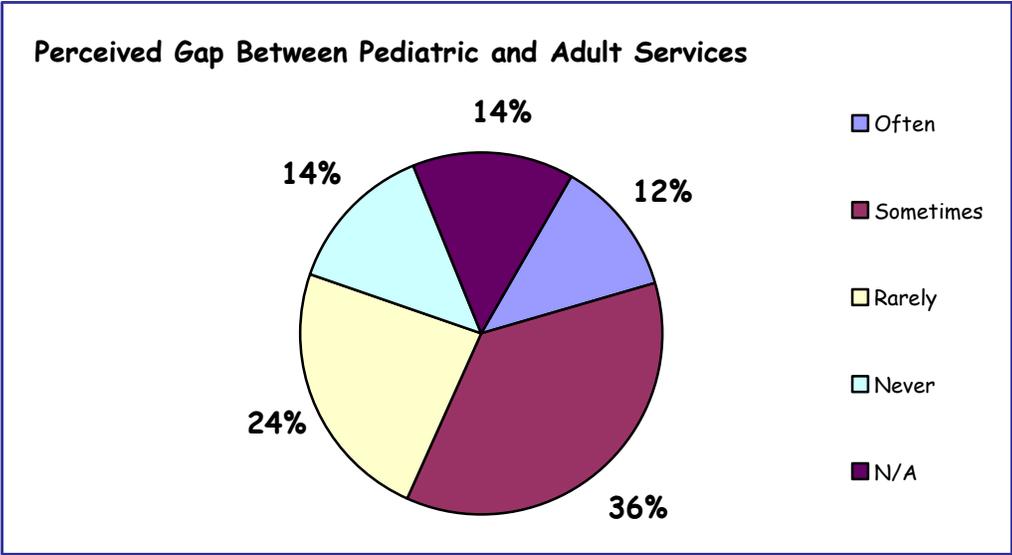


Figure 5

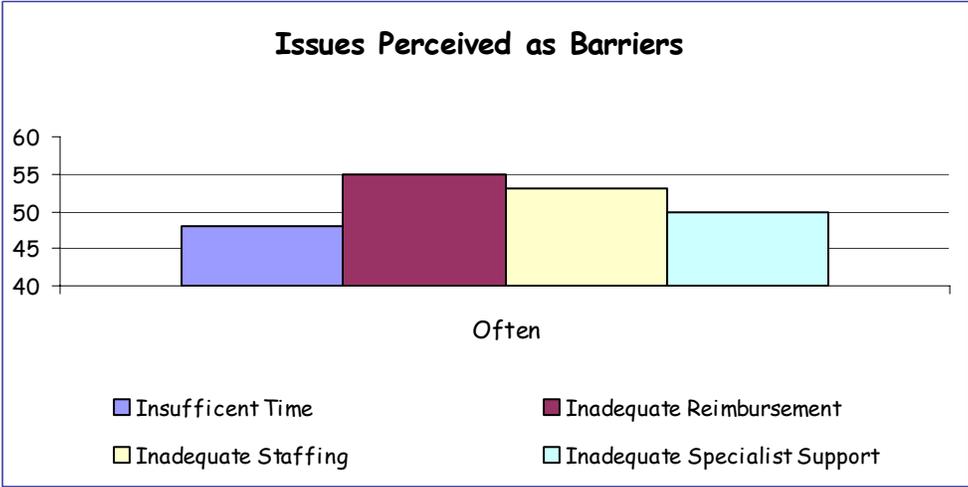
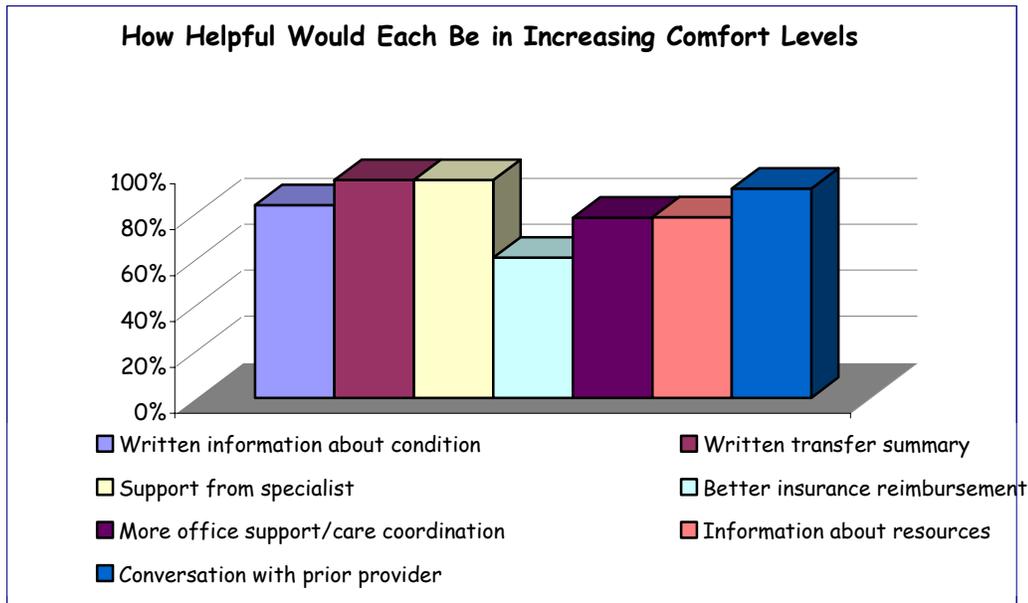


Figure 6



Methods

The survey was sent to several groups of adult health care providers between October 2007 and February 2008.

The survey questionnaire was mailed to 424 NH family physicians with 33% responding. A link to the survey was e-mailed to 320 internal medicine physicians with 12 % responding. (Several of these were med-peds physicians). A nearly identical pilot survey was distributed to a small group of providers and produced 20 responses. A link to the survey was sent to a NH nurse practitioner list serve and there were 14 responses. All of these were included in the 180 primary health care providers who constitute the survey respondents: 81% (n=147) of the responses were from family physicians, 9% internists (n=16), nurse practitioners' at 8% (n= 14) and the med/peds 2% (n=3).

The survey included questions addressing practice characteristics; timing of transfer of care, gaps in care, verbal and written communication with pediatricians, barriers, what would be helpful in caring for YSCHN and comfort level in this care. The survey design was adapted from a 2006-07 survey by Rhode Island's Office of Special Healthcare Needs.

Special Medical Services
NH Department of Health and Human Services
 129 Pleasant Street
 Concord, NH 03301
 1-603-271-4488 or in-state 1-800-852-3345 x 4488

Appendix J – MCH Priority Rating Tool

MCH Priority Rating Tool

CRITERION #1: PROBLEM/ISSUE HAS SEVERE HEALTH CONSEQUENCES	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE ISSUES/LIFE SPAN EFFECT																	
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM	CRITERION #6: FEASIBILITY																	
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION																		
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/SOCIAL COST																		
Problem/Issue	Rating Using Prioritization Criteria: C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. The agreed upon weights are shown in the line below each criterion number. Assess each indicator using each criterion. Enter your score in the box corresponding to the indicator and its criterion. To use the weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.	Total Score For Problem																
	<table border="1" style="width: 100%; border-collapse: collapse; margin: 0 auto;"> <tr> <td style="width: 10%; padding: 5px;">C1</td> <td style="width: 10%; padding: 5px;">C2</td> <td style="width: 10%; padding: 5px;">C3</td> <td style="width: 10%; padding: 5px;">C4</td> <td style="width: 10%; padding: 5px;">C5</td> <td style="width: 10%; padding: 5px;">C6</td> <td style="width: 10%; padding: 5px;"></td> <td style="width: 10%; padding: 5px;"></td> </tr> <tr> <td style="text-align: center; padding: 5px;">3</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">2</td> <td style="text-align: center; padding: 5px;">1</td> <td style="text-align: center; padding: 5px;">3</td> <td style="text-align: center; padding: 5px;">1</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> </table>	C1	C2	C3	C4	C5	C6			3	2	2	1	3	1			
	C1	C2	C3	C4	C5	C6												
3	2	2	1	3	1													
1. Preterm Birth																		
2. Autism																		
3. Screening and Support																		
4. Maternal Smoking																		
5. Alcohol/Substance Abuse																		
6. Pediatric Obesity																		
7. Mental Health																		
8a. MCH Workforce (including SMS) – Primary Care/Mid-levels																		
CRITERION #1: PROBLEM/ISSUE HAS SEVERE HEALTH	CRITERION #5: PROBLEM IS CROSS-CUTTING TO MULTIPLE																	

MCH Priority Rating Tool

CONSEQUENCES	ISSUES/LIFE SPAN EFFECT								
CRITERION #2: LARGE # OF INDIVIDUALS ARE AFFECTED BY THE PROBLEM	CRITERION #6: FEASIBILITY								
CRITERION #3: DISPROPORTIONATE EFFECTS AMONG SUBGROUPS OF THE POPULATION									
CRITERION #4: PROBLEM RESULTS IN SIGNIFICANT ECONOMIC/SOCIAL COST									
Problem/Issue	Rating Using Prioritization Criteria:								Total Score For Problem
	C1 below corresponds to Criterion #1 above, C2 to Criterion #2, etc. The agreed upon weights are shown in the line below each criterion number. Assess each indicator using each criterion. Enter your score in the box corresponding to the indicator and its criterion. To use the weighted method, multiply the score by the criterion weight and then enter the weighted score in the box.								
	C1	C2	C3	C4	C5	C6			
	3	2	2	1	3	1			
8b. MCH Workforce (including SMS) – Child Care									
9a. Childhood Lead Poisoning (Safe/healthy homes)									
9b. Asthma (Safe/healthy homes)									
10. Oral Health									
11a. Unintentional Injury									
11b. Suicide									
12. Uninsured Children									
13. Respite Care									

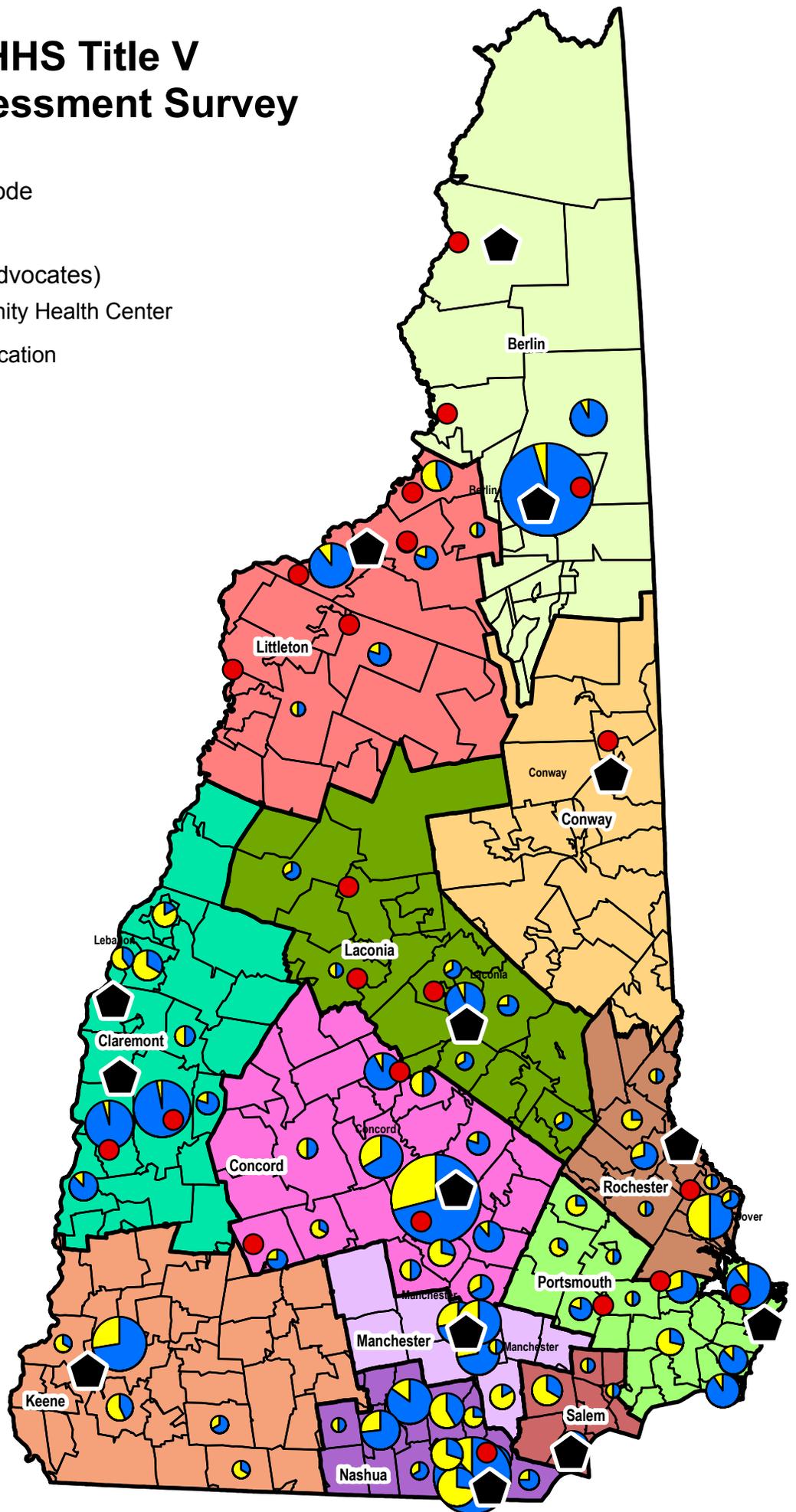
Appendix K – Public Input Map

NH DHHS Title V Needs Assessment Survey

Respondent Counts by Zipcode

-  Paper (Clients)
-  On Line (Providers, Advocates)
-  DPHS-Funded Community Health Center
-  DHHS District Office Location

Town	Total	Town	Total
Allenstown	9	Lebanon	14
Alstead	4	Lincoln	2
Amherst	20	Lisbon	8
Andover	1	Litchfield	4
Antrim	1	Littleton	19
Auburn	2	Londonderry	6
Barnstead	4	Loudon	5
Barrington	2	Madison	1
Bedford	6	Manchester	60
Belmont	3	Marlow	1
Bennington	1	Meredith	3
Berlin	85	Merrimack	12
Bethlehem	6	Milan	13
Bow	7	Milford	15
Bradford	1	Milton	2
Bristol	2	Monroe	1
Brookline	1	Mont Vernon	2
Canaan	2	Nashua	95
Candia	1	New Boston	6
Charlestown	8	New Castle	1
Chester	1	New Hampton	1
Chesterfield	2	New Ipswich	3
Chichester	1	New London	1
Claremont	23	Newbury	5
Colebrook	1	Newfields	1
Concord	97	Newmarket	10
Conway	4	Newport	32
Cornish	2	North Hampton	2
Danville	1	Northumberland	2
Deerfield	3	Northwood	4
Derry	9	Nottingham	2
Dover	20	Ossipee	1
Dunbarton	4	Pelham	4
Durham	4	Peterborough	2
East Kingston	1	Pittsfield	8
Epping	2	Plainfield	2
Epsom	3	Plymouth	2
Errol	1	Portsmouth	20
Exeter	7	Raymond	5
Farmington	4	Rindge	3
Fitzwilliam	1	Rochester	9
Franconia	5	Rollinsford	3
Franklin	13	Rumney	3
Gilford	4	Salem	10
Goffstown	1	Sanbornton	1
Gorham	7	Sandown	2
Grantham	4	Seabrook	11
Greenland	2	Somersworth	2
Greenville	2	Springfield	1
Hampstead	2	Strafford	3
Hampton	8	Stratham	3
Hampton Falls	1	Sunapee	5
Hancock	1	Swanzy	7
Hanover	6	Temple	1
Haverhill	3	Tilton	6
Henniker	3	Troy	2
Hillsborough	4	Wakefield	1
Hinsdale	4	Walpole	2
Holderness	1	Warner	4
Hollis	3	Warren	1
Hooksett	6	Washington	2
Hopkinton	4	Westmoreland	3
Hudson	11	Whitefield	5
Jaffrey	3	Wilton	2
Jefferson	2	Winchester	4
Keene	29	Windham	1
Kingston	1	Wolfeboro	1
Laconia	15	Woodstock	3
Lancaster	9	Total by zipcode	989



Note: 16 responses could not be assigned to a NH zipcode.