



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

**State Narrative for
Nebraska**

**Application for 2013
Annual Report for 2011**



Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	8
C. Needs Assessment Summary	8
III. State Overview	9
A. Overview.....	9
B. Agency Capacity.....	19
C. Organizational Structure.....	25
D. Other MCH Capacity	26
E. State Agency Coordination.....	29
F. Health Systems Capacity Indicators	35
IV. Priorities, Performance and Program Activities	37
A. Background and Overview	37
B. State Priorities	37
C. National Performance Measures.....	41
Performance Measure 01:.....	41
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	44
Performance Measure 02:.....	45
Performance Measure 03:.....	48
Performance Measure 04:.....	50
Performance Measure 05:.....	53
Performance Measure 06:.....	56
Performance Measure 07:.....	58
Performance Measure 08:.....	60
Performance Measure 09:.....	62
Performance Measure 10:.....	65
Performance Measure 11:.....	66
Performance Measure 12:.....	69
Performance Measure 13:.....	71
Performance Measure 14:.....	73
Performance Measure 15:.....	75
Performance Measure 16:.....	76
Performance Measure 17:.....	78
Performance Measure 18:.....	80
D. State Performance Measures.....	81
State Performance Measure 1:	81
State Performance Measure 2:	83
State Performance Measure 3:	84
State Performance Measure 4:	85
State Performance Measure 5:	86
State Performance Measure 6:	88
State Performance Measure 7:	90
E. Health Status Indicators	91
F. Other Program Activities.....	92
G. Technical Assistance	94
V. Budget Narrative	96
Form 3, State MCH Funding Profile	96

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	96
Form 5, State Title V Program Budget and Expenditures by Types of Services (II).....	97
A. Expenditures.....	97
B. Budget	98
VI. Reporting Forms-General Information	101
VII. Performance and Outcome Measure Detail Sheets	101
VIII. Glossary	101
IX. Technical Note	101
X. Appendices and State Supporting documents.....	101
A. Needs Assessment.....	101
B. All Reporting Forms.....	101
C. Organizational Charts and All Other State Supporting Documents	101
D. Annual Report Data.....	101

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications, signed by the CEO, Nebraska Department of Health and Human Services (DHHS), are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in DHHS, Division of Public Health, Lifespan Health Services, Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Department of Health and Human Services, Division of Public Health, Lifespan Health Services, Planning & Support, P.O. Box 95026, Lincoln, Nebraska 68509-5026. //2012/ The standard OMB Assurances - Non-construction Program (SF 424B, prescribed by OMB A-102) and Certifications 1) debarment and suspension, 2) drug free work place, 3) lobbying, 4) program fraud, and 5) tobacco smoke. (PHS-5161-1) are signed by Joann Schaefer, M.D., Chief Medical Officer, and Director, Division of Public Health, DHHS. These Assurances and Certifications are in addition to the Assurance of Compliance (Form HHS-690) signed by CEO Kerry Winterer certifying compliance with four other federal requirements, including the Civil Rights Acts of 1964 and others, which are intended to cover any application, award or contract signed by an authorized representative of DHHS. All documents are maintained on file and available for inspection, as indicated. //2012//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input for the new priorities and the 2011 application was sought using a new process that took a more personalized approach to elicit input. An email bulletin was sent to 6,015 people who subscribe to the Nebraska Department of Health and Human Services (DHHS) website. The quantity and quality of the responses provided good evaluation that this method was an improvement from previous years, and worked quite well.

Electronic subscriptions are available on many of the DHHS program sites. Subscribers automatically receive a notice whenever a webpage has been updated and the link to the webpage. The distribution list created for the public input request targeted the persons who have requested subscriptions to web pages containing content relevant to the MCH/CSHCN priorities.

The bulletin was sent to the following groups of people:

Subscribers of Community-Based Services (Developmental Disabilities), Advocacy, Alcohol and Substance Abuse, Child Abuse, Children's Health System, Developmental Disabilities, Health

Services, Lifespan Health, Tobacco/Chew/Secondhand Smoke, Access Newsletter (Office of Rural Health), Adolescent Health, Advisory Committee on Developmental Disabilities, Building Bridges - For You, For Now, For Life, COMPASS - Protection & Safety Statistics for Children, Child Abuse General Information, Child Care, Children with Disabilities, Communicable Diseases, Connections Employee Newsletter, Conversations for a Healthy Life (Office of Women's Health), Dental Health, Diabetes Prevention and Control Program, Diet, Nutrition and Eating Right, Division of Children & Family Services - Comprehensive Quality Improvement, Domestic Violence, Every Woman Matters, Every Woman Matters - Case Managers, Every Woman Matters - Outreach Workers, Every Woman Matters - Providers, Every Woman Matters.

The email addresses of subscribers to the preceding web pages provided the DHHS webmaster with a large, yet targeted group to personally invite public input. While the distribution list was very large, it was not impersonal. The email bulletin did not display to recipients the entire list of the 6,015 email addresses.

DHHS Communications assisted Lifespan Health staff to develop a clear, concise message. The reference line in the email was directive, yet inviting: "Help improve the health of Nebraska's mothers and children. Please share your thoughts". The text of the email read: "You are subscribed to Nebraska Department of Health and Human Services Website. Take a moment and share your thoughts on new priorities for mother and child health program activities. We want to hear from you! Please follow the link below.
<http://www.dhhs.ne.gov/LifespanHealth/planning/MCHGrantPublicInput2010.htm>"

The responses began arriving within a few hours after the email bulletin was sent. A steady stream of public input followed for the next three weeks. There were 962 hits to the public input webpage during a four-week period. A total of 34 persons responded. Most of the responses were sent by email, with one fax and two phone calls. Some responses were quite detailed and specific to one or several priorities, including some suggestions about how to address a priority. Three responders voiced their general support for the priorities identified by the stakeholder group. Three persons added their own suggestions on other issues of importance to MCH and CSHCN that the stakeholder group and workgroup process had not elevated to the top ten priorities, such as mental health and depression, tobacco use and exposure, and eating disorders. Two responses included the importance of education and utilizing available resources towards prevention, three persons expressed concern with issues related to large systems and change in systems or staff contacts within the system. Of the responders that focused on specific priorities, support for breastfeeding exclusively through six months garnered the largest number at 15 responses, with the next largest of four responses to increase access to oral health.

The responses that related were incorporated into the national and state performance measures of this application (breastfeeding and oral health). All comments will continue to be reviewed and incorporated into detailed planning for the ensuing five years of the 2010 needs assessment.

/2012/ The process for seeking input on the 2012 application was the same as that implemented first in 2011. The encouragement to provide input on the 2012 application was sent by an Email bulletin to 4,159 recipients who are subscribers to DHHS webpages with content relevant to MCH. The link to the 2012 webpage provides details about Nebraska's MCH priorities, then invites and instructs how persons can provide input on the development of Nebraska's 2012 MCH plans to address Nebraska's MCH priorities. (The 2012 webpage is available <http://www.dhhs.ne.gov/hew/lifespanhealth/planning/mchgrantpublicinput2012.htm>.) Four responses were received, reviewed, and incorporated into the 2012 application as relevant.

We interpret the requirement for public input to be specific to the grant application. More generally, public engagement and the critical importance to public health is recognized and valued. Often the same community representatives, and typically primarily health and human services professionals, participate in multiple, overlapping processes of gaining stakeholder input. This can lead to burn-out, limited participation in future endeavors, and may not fully

represent the public.

We wanted to implement an evidence-based approach to fully engage the public in public health of Nebraskans. We have invested Block Grant funds in a demonstration project currently underway in one of Nebraska's local public health departments, Public Health Solutions (PHS), to better involve the public in making choices and taking action on MCH issues. PHS serves the counties of Gage, Fillmore, Jefferson, Saline, and Thayer located in southeastern Nebraska. It is one of the local health departments organized within the past decade, and as such, is still building its organizational capacity in MCH collaborative leadership. Its five-county district is mostly a rural farming region. While the district has relatively close proximity to the city of Lincoln, access to sometimes limited services in local communities presents a challenge. The Crete community in Saline County is racially/ethnically diverse due to immigrants that come to work in the area food processing plants. Beatrice in Gage County, compared to Crete, is more populated, less diverse, and geographically further from the population center in Lincoln. The region presents an opportunity to assess and address public health needs within communities while through a district-wide approach.

The model selected for the demonstration is a method researched and developed by the Kettering Foundation based in Dayton, Ohio. Kettering's National Issues Forum (NIF) model actively engages the public in deliberative dialogue around issues that have been 'named and framed', i.e. describing a problem by selecting terms agreed-upon by community representatives, and then identifying what participants believe should be done to address the problem. The discussion guides developed by Kettering are issues that have already been 'named and framed' for public deliberation in forums, but for many different issues of general interest nationally, not strictly on health. Nebraska wanted to learn how to customize deliberative dialogue for public health issues in Nebraska communities. PHS was identified to be the learning laboratory for the demonstration project. With guidance from the Kettering Foundation and partners, PHS has received training on how to 'name and frame' an issue with a community-level group and then to host public forums to deliberate the benefits and drawbacks of three options to address the issue. The first 'naming and framing' occurred in Crete; the public forums will soon follow. PHS will also conduct the same processes to engage the public in Beatrice and other communities within the five-county district. Each forum will lead to next steps within communities, and not necessarily a uniform, single plan for the district. Communities will more likely be willing to identify and commit resources for action that is publically determined. An additional benefit is when the public identifies it had a hand in decision-making, the same persons will again be involved, and likely encourage others to join them to be engaged in public input and supporting implementation of plans resulting from it.

We believe the completion of training and development of techniques can be applied to a variety of community public health issues. The demonstration of this method will assess the feasibility of this model for replication with other local health departments to enhance capacity for collaborative leadership to actively engage the public in deliberative dialogue around specific MCH issues of concern to a community.

As a result of contacting the Kettering Foundation for this public health demonstration project, Kettering invited the local health department to participate in research it had been planning focused on public health. Kettering hopes to gain a keen understanding of the role of public in public health, i.e. to identify the relationship between communities and the health of people that live in them. Nebraska's Public Health Solutions local health department is midway through an 18-month research process with the Kettering Foundation and other public health entities selected across the nation. General information about the Kettering Foundation and its work is available at <http://www.kettering.org/home>. For more specific information about its research, deliberative dialogue and National issues Forums, visit http://www.kettering.org/about_the_foundation/what_we_do. //2012//

//2013/ As an update to the demonstration project described in 2012, Public Health

Solutions has completed NIF training and development of techniques, and presently is conducting forums in communities in its district. DHHS will include a summary report in our 2014 application about what was learned in this demonstration. In April 2012, DHHS sought to identify how community needs and interventions align with needs identified as state priorities. Input of particular relevance to a Nebraska priority or a National Performance Measure has been noted in the applicable sections of the application narrative. During 2013, the input will be further reviewed and utilized to update Nebraska's Needs Assessment. Such updates will be reported in the 2014 application. The Report of Public Input attached to Section I. E. of the FY 2013 application further describes the method and process evaluation of public input on the FY 2013 application. //2013// An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

//2013/

There have been no significant changes in the State's population or priorities since the last Block Grant application. Nebraska continues to monitor and assess the priorities through the National and State Performance and Outcome Measures as well as the Health Status and Health System Capacity Indicators. More information on the Nebraska's Priorities can be found within this application.

Over 2012 the Statewide Needs Assessment as mandated by the Affordable Care Act (ACA) on behalf of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was updated and no significant changes in the State's population or priorities were identified.

In 2012 Nebraska has taken steps to maintain and increase capacity around the 10 priorities. Of note are efforts to continue the WIC surveillance systems ((Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Nutrition Surveillance System (PNSS)), work on a capstone project that investigates the availability and utilization of family planning in Nebraska, increased surveillance in oral health, data linkage projects with Nebraska PRAMS (Pregnancy Risk Assessment and Monitoring System), developing metrics in adolescent health to help develop systems work, and a successful application to AMCHP's Life Course Metrics Project.

In 2012, Nebraska formed an internal workgroup on gestational diabetes and a Medical home workgroup that is assessing access to and utilization of EPSDT. Staff continue to play key roles in the following planning groups: Nutrition and Physical Activity State Plan (includes Breastfeeding), and the Oral Health Advisory Group/State Plan.

//2013//

III. State Overview

A. Overview

1. Principal characteristics of Nebraska that are important to understanding the health needs of the entire state's population.

a. Large geographic area

Nebraska is located in the east-central area of the Great Plains midway between New York and San Francisco. Nebraska is generally rectangular in shape with a protruding area in the northwest corner called the Panhandle. The Missouri River bounds the eastern border between Nebraska and Iowa. Missouri, Kansas, Colorado, Wyoming and South Dakota surround Nebraska on the other borders. The State measures 387 miles across, including the western panhandle. The diagonal from northwest to southeast measures 459 miles, and the southwest-northeast diagonal is 285 miles. The state's area is 77,227 square miles, almost 20% larger than all of New England.

Nebraska's large land expanse creates unique health service delivery issues. In Nebraska, 13.5% of the population is 65 and over, however in 46 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services.

Nebraska's population centers are Omaha, Lincoln and several smaller cities scattered along the Platte River and Interstate 80 (which together bisect the state from east to west). Only Omaha and Lincoln (60 miles apart) represent Metropolitan Statistical Areas (MSAs) with populations larger than 50,000.

b. Urban and rural

The total population of NE is projected to grow 7.4% by 2025. ***/2013/ The total population of NE is projected to grow 11.1% by 2025./2013/***

Although Nebraska's total population has grown during the 2000s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 28 out of 93 counties ***/2013/ 34 out of 93//2013/***as frontier counties (6 or fewer persons per square mile). In contrast, approximately 52.6% ***/2013/ 44%//2013/***of the state's citizens reside in the population centers of Lincoln and Omaha in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 13% between 2000 and 2009.***/2013/15% between 2000 and 2010./2013/***

c. Increasing diversity

Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, from 2000 to 2009 the state's minority population grew and now constitutes 15.4% of the total population while the white population increased by .148%. Most of this increase in minorities is Hispanic, whose numbers increased 59%, 54% of the state's overall population increase.

/2013/ According to the US Census, from 2000 to 2010 the state's minority population grew 50.7% (from 216,769 to 326,558) and now constitutes 15.4% of the total population while

the white population increased by 0.85%. Most of this increase in minorities is Hispanic, whose numbers increased 77.3%, (66% of the state's overall population increase)//2013//

In general, the minority population tends to be younger, have lower incomes, higher poverty, and less insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available, language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Nebraska's vision of healthy individuals, families and communities can only occur if racial and ethnic minority populations have equal opportunities for good health. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and the white population, it is essential to address the high risk factor prevalence, the major barriers that limit access to high quality health care services, and the need to develop effective local public health services across the state.

(1) Immigration

(a) Hispanic origin

The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase nearly quadrupling from 37,200 in 1990 to 147,984 in 2009 (a 298% increase) ***/2013/167,405 in 2010 (a 350% increase) //2013//*** according to the U.S. Census estimates. Hispanic Americans now comprise 8.3% ***/2013/9.2%/2013//*** of the state's population.

The Hispanic American population in Nebraska was projected to reach 111,000 by 2025, but has already exceeded the projection by 34% in 2009 ***/2013/50.8% in 2010//2013//***. This is largely due to the availability of employment in the central and western part of Nebraska. Hispanic Americans make up less than 10% of the population in most non-metropolitan counties, the exceptions being found in those counties with larger population centers and a sizable manufacturing base. In those places where the manufacturing base includes food processing, the population commonly exceeds 30% of the county population, and form a majority within several communities.

(b) Asian and Pacific Islander

Nebraska's Asian and Pacific Islander (API) population in 1990 was 12,629 and grew to 30,509 in 2009 ***/2013/ 32,885 in 2010 //2013//***, according to the U.S. Census Bureau estimates.

(2) Native American

The Native American population in Nebraska grew by 62%, from 12,874 in 1990 to 19,999 in 2009, ***/2013/ 14,797 in 2010 //2013//*** according to the U.S. Census estimates. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Over half of the county's population is Native American (53%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 25%.

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln account for more than 31.1% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

(3) African American

African Americans make up 4.6% of the Nebraska population. This population grew from 58,047 in 1990 to 83,400 in 2009, **/2013/ 80,959 in 2010 //2013//** a 44% increase. Almost 90% of Nebraska's African American population is located in the most populous counties (Douglas, Sarpy and Lancaster).

The African American population is expected to increase considerably by 2025, with growth projected at 30.7% (to 109,000 people). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of the largest Sudanese communities in the country.

(4) Minority Health Professionals

Cultural differences can and do present major barriers to effective health care intervention. This is especially true when health practitioners overlook, misinterpret, stereotype, or otherwise mishandle their encounters with those who might be viewed as different from them as they do their assessment, intervention, and evaluation. Health care professionals' lack of knowledge about health beliefs and practices of culturally diverse groups and problems in intercultural communication has led to significant challenges in the provision of health care services to multicultural population groups. The cultural diversity of the health care workforce itself can present problems that can disrupt the provision of services because of competing cultural values, beliefs, norms, and health practices in conflict with the traditional Western medical model.

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 2004, only about 1% of Nebraska primary care physicians were African American, although this group makes up 4.6% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. In 2009, 0.4% (5/244) graduated from the University of Nebraska Medical School compared to 6.5% nationally. There were only 54 Native American primary care physicians practicing in Nebraska (0.3% of all physicians) yet they represent 1.1% of the states population. Hispanic Americans comprise 8.4% of the state's population and are the fastest growing population group, but account for only 1.1% of Nebraska primary care physicians. Asian Americans make up only 1.6% of the population of the state, but accounts for .7% of primary care physicians.

(5) Racial and ethnic health disparities

As in other states, Nebraska's minority population has many health disparities. For example, according to the US Census Bureau, projecting life expectancy for a Nebraska woman who is white is 6.6 years longer than for a Nebraska woman who is African American and nearly ten years (9.4) longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are five times more likely to die of diabetes-related causes than white persons. The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

d. Aging population

Another significant trend is the aging of the state's population. In 2009, the percentage of the population aged 65 and older was 13.4%, compared to the national average of 12.8%. The total number of Nebraskans over age 65 increased by 3.6%, or by 8,435 individuals, from 1990 to 2000. **/2013/ In 2010, the percentage of the population aged 65 and older was 13.6%, compared to the national average of 13.3%. The total number of Nebraskans over age 65 increased by 3.85%, or by 14,482 individuals, from 2000 to 2010. //2013/**Nebraska ranks 18th in the nation for percentage of population 65 years and over. The population over 65 is projected to grow 56% by 2020. In 2009, 2.2% of Nebraskan population was 85+. This is a slight increase from 2000 (16.5%). The total number of people aged 85 and over increased by 5.59 individuals, or by 1.9%.

The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000 and 35.8 in 2009

/2013/ 36.2 in 2010//2013//.This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are available to meet the needs of the population. These inadequate services are further compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for older adults can become increasingly fragmented and challenging.

e. Special populations

(1) Incarcerated

According to Nebraska Department of Corrections there were 352 incarcerated women in 2009. 7.9% of all persons incarcerated in Nebraska were women, which is higher than the national rate of 6.8%.

/2013/According to Nebraska Department of Corrections there were 405 incarcerated women in 2010. 9.8% of all persons incarcerated in Nebraska were women, which is higher than the national rate of 7.3%./2013//

According to the US Department of Justice, 61.7% of incarcerated women have at least one child under age 18. Nationally, 2.3% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991.

(2) Homeless

The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 18,169 people were homeless in Nebraska during the grant year July 2008 to June 2009 and 43,029 people were near homeless during this same time period. Unaccompanied women accounted for 19.94% of the homeless and 7.8% of the near homeless. Unaccompanied youth accounted for 4.6% of the homeless in Nebraska and 3% of the near homeless. Single parent families accounted for 36.8% of the homeless and 49.5% of the near homeless. During the grant year, Hispanic or Latino persons represented 33.6 % of persons who were homeless and 31.8% of those who were near homeless.

f. Rural poverty

Throughout Nebraska, poverty rates remain relatively close to the state average in each city/county. Nebraska's more rural counties demonstrated a pattern common throughout non-metropolitan Nebraska, losing population while the number of residents in poverty increased. Between 2000-2007 small trade center counties (having a population center of 2,500 to 9,999) lost 12,700 residents while their poverty population grew by 1,581. Small town counties (having no population center of 2,500) saw their total population decline by about 10,500, while their poverty population grew by 632. Only Nebraska's very rural frontier counties (having no population center of 2,500 and fewer than 6 residents per square mile) saw an actual decrease in poverty numbers, with a decline of 295. However, those counties saw an actual population decline of over 6,000 during the same period. There are two counties in Nebraska which are experiencing critical poverty rates (at least 50% above the state average) Dawes (15.8%) and Thurston (20.5%).

2. Agency's current priorities and initiatives with Title V programs' roles and responsibilities.

A description of the Agency's priorities and initiatives first requires an understanding of changing organizational structure. During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill reorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family

Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health, Lifespan Health Services Unit. Title V/CSHCN functions are within the Division of Medicaid and Long Term Care and its Long Term Care Programs Section.

The Division of Public Health established five priority areas: wellness, eliminating disparities, data capacity, effective public education and use of the media, and budget transparency. Overlaying these established agency priorities are a number of issues that emerged in FFY 2004 and continue to be of importance to DHHS, including the Lifespan Health Services Unit and the Long Term Care Programs Section.

Child Protection Reform was initiated with the passage of LB 1089 in April 2004. This funding bill allocated \$5.5 million for 120 new protection and safety workers, and another \$350,000 for case coordinators. Additional funds were also made available for enhancements of the Criminal Justice Information System and other related activities. Then, during the 2005 legislative session, LB 264 was passed, which adds secondary prevention as a social service that may be provided on behalf of recipients under the Social Security Act. In addition, \$200,000 per year was appropriated in 2005 specifically for home visitation services. Funding for home visitation as secondary prevention of child abuse and neglect is currently at \$600,000 per year. ***/2013/ During the 2012 Legislative Session, the appropriations of State General Funds for this home visitation program was increased to \$850,000 for SFY 2013. In June of 2012, an agreement was reached between the Directors of the Children and Family Services (C&FS) Division and the Division of Public Health to transfer administration of the State General Fund supported home visitation services from C&FS to Public Health. This transfer was effective July 1, 2012.//2013//***

The Lifespan Health Services Unit is actively partnering with NE HHS Children and Family Services staff in addressing issues of child abuse prevention. A Child Abuse Prevention Plan was released in August 2006, and Lifespan Health Services continues to work with NDHHS Children and Family Services and the Nebraska Children and Families Foundation in its implementation. Formalizing its commitment to child abuse prevention, the Division of Public Health signed on in 2010 as a member of the Child Abuse Prevention Partnership.

Also enacted in 2004 was enabling legislation for mental health reform. This law established the Behavioral Health Division within HHS and created a State Behavioral Health Council. The focus of this system reform effort has been to ensure statewide access to behavioral health services; ensure high quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders. The immediate goal of the reform initiative had been the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders.

In FFY 2005, Nebraska Health and Human Services had the opportunity to do related work specific to children's mental health. Nebraska was the recipient of a 5-year, \$750,000/year State Infrastructure Grant (SIG), awarded by SAMHSA, which is focused enhancing and building capacity for children's mental health services. The Lifespan Health Services Unit had been actively involved in activities of the SIG grant through participation in its Project Management Team.

In recent years, several developments resulted in additional focus on children's mental health. LB 542 (2007) was created to parallel an emphasis on children and adolescents that LB 1083 (2004) provided for adults. LB 542 created the Children's Behavioral Health Task Force, which was charged with preparing a children's behavioral health plan by December 4, 2007. The Children's Behavioral Health Task Force developed 16 recommendations designed to improve Nebraska's child and adolescent behavioral health system. The scope of the plan includes:

1. The development of a statewide integrated system of care to provide appropriate

educational, behavioral health, substance abuse, and support services to youth and their families serving both adjudicated and non-adjudicated youth;

2. The development of community-based inpatient and sub acute substance abuse and behavioral health services and the allocation of funding for such services;
3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Centers;
4. Development of needed capacity for the provision of community-based substance abuse and behavioral health services for youth;
5. Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services;
6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for youth;
7. Identification of necessary and appropriate statutory changes for consideration by the Legislature; and
8. Development of a plan for a data and information system for all youth receiving substance abuse and behavioral health services.

LB 542 also required that, "The department shall provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the committee by January 4, 2008." That response was prepared, and the Division of Behavioral Health continues to work on the plan through a newly created Children's Behavioral Health Unit.

Then, Legislative Bill 157 was introduced in the 2008 Legislative Session. Forty-eight senators voted for the final version of LB 157. It was signed by Governor Heineman on February 13, 2008. This Safe Haven law did not provide an age limit for which a person would drop off a child at a hospital and not be prosecuted. The full text of LB 157 reads: "No person shall be prosecuted for any crime based solely upon the act of leaving a child in the custody of an employee on duty at a hospital licensed by the State of Nebraska. The hospital shall promptly contact appropriate authorities to take custody of the child."

The law went into effect on July 18, 2008. In September, families began leaving children at Nebraska hospitals, all of these children were over age 1 and several were older than age 10. A special session of the Legislature was called in November 2008, and LB 1 was introduced, passed and signed into law effective November 21, 2008. LB 1 limited the age of a child under the Safe Haven provisions to be 30 days old or younger. During the less than 6 months that LB 157 was in effect, 36 children were dropped off at Nebraska hospitals, many with complex behavioral health needs, bringing significant public attention to the mental health needs of children and youth and the systems that were to meet those needs.

During the 2009 session, the Legislature considered many options for addressing unmet children's behavioral health needs. On May 22, Gov. Dave Heineman signed LB 603 into law. The bill provides additional services, support and professional resources to help Nebraska families dealing with children's behavioral health issues. The bill helps address the gap in services for children with behavioral health issues by providing services and expertise to support children and their families. The bill included:

- 1) A statewide hotline for families facing a behavioral health crisis available 24/7 and staffed by professionals trained in mental health assessment;
- 2) A family navigator program to provide follow-up assistance and one-on-one support to families contacting the crisis hotline. Family navigators will have the experience and training to help a family access mental health services, and offer assistance to parents and guardians who may not be familiar with providers in Nebraska's behavioral health network; and
- 3) New services for families that adopt or serve as guardians of a child with behavioral health challenges. Case management and post-adoption services will be available on a voluntary basis. Roughly half the of the children and teens involved in 2008 safe haven cases in Nebraska had been adopted or placed in a guardianship with a relative. Studies show continuing services is

effective in helping families through the transition and ensure a child's placement is a permanent.

LB 603 also took a step toward expanding services and helping more families access help by increasing the eligibility level for the State Children's Health Insurance Program (SCHIP) from 185 to 200 percent of the federal poverty level. It also adds secure residential treatment to the list of Medicaid-eligible services in Nebraska. It also provided an additional \$1.5 million for the current biennium to Nebraska's six behavioral health regions to expand an existing mentoring program and support other services for children. Finally, the bill sought to encourage greater professional support in Nebraska communities. It established the Behavioral Health Workforce Education Center at the University of Nebraska Medical Center (UNMC). The center is recruiting and training more psychiatry residents and developing six behavioral health training sites across the state.

Then, in the spring of 2009, the H1N1 outbreak brought to light a number of issues, needs and challenges related to preparedness. Lifespan Health Services staff and the Title V/MCH Director participated in the emergency response. Experiences during this outbreak have led to more specific planning regarding the role of various professionals across the Division, how we prepare for the needs of specific populations, including MCH and CSHCHN population, and how operations are managed during an event such as an outbreak.

Medicaid reform is the priority for NDHHS Division of Medicaid and Long Term Care. Nebraska initiated Medicaid reform efforts in order to assess the current program and plan for the future. Legislation was passed in 2005 (LB 709) that established the requirements for a Medicaid reform plan. This law required that a plan be developed by December 1, 2005. As required by the law, the Governor and the chairperson of the Health and Human Services Committee have each designated a person to be responsible for the development of the plan. The Governor's designee was the Director of Health and Human Services Finance and Support (an agency within the former Nebraska Health and Human Services System); the Legislature's designee was the General Counsel of the Nebraska Legislature's Health and Human Services Committee. A Governor-appointed 10-person council advised the process, and the Health and Human Services System provided the staffing.

As required by LB 790, the Nebraska Medicaid Reform Plan was presented to the Governor and the Legislature on December 1, 2005. This plan included a wide range of findings, recommendations and strategies. The plan made it clear that no major changes in eligibility or benefits were being recommended at this time. The recommendations of most significance to the MCH and CSHCN populations were: establishing a separate SCHIP program (currently a Medicaid expansion); requiring a contribution from parents with incomes in excess of 150% of poverty for children participating in the Katie Beckett program, Aged and Disabled Waiver program, Children's Developmental Disability Waiver, the Early Intervention Waiver, and the State Ward Program; and including as a covered services, a nurse home visitation program for high-risk pregnant teens. Other recommendations, such as those related to prescription drugs, had potential impacts as well.

The initiatives of Medicaid reform have since been revisited with plans to implement various components. The priorities of the current administration are the standardization of services statewide, transparency and accountability of our programs, and long term the sustainability of Medicaid. The Medicaid Reform Plan proposed twenty-six initiatives intended to focus the program on its core mission to provide medical assistance for truly needy Nebraskans in a manner that promotes access to appropriate services, fosters the development and utilization of less intensive care, encourages consumer responsibility and Medicaid alternatives, and expends limited resources prudently. Several of the initiatives targeted management of prescribed drugs, as the fastest growing expenditure category, and long-term care services, as the largest expenditure category. Other initiatives emphasize the involvement of the consumer in appropriate health care utilization, the development of alternatives to Medicaid-financed care, and the alignment of program growth with available resources. Service limitations resulting from Medicaid

Reform are generally being applied to Medicaid-eligible adults and should not directly impact the CSHCN population.

/2012/The Nebraska Medicaid Patient-Centered Medical Home Pilot began February 1, 2011. The medical home envisioned for this pilot is a health care delivery model in which a patient establishes an ongoing relationship with a physician in a physician-directed team that provides coordinated, comprehensive, accessible, and continuous evidence-based primary and preventive care. The purpose of this two year pilot is to improve patient health outcomes and contain Medicaid costs. Two primary care practices are participating as medical homes with 28 providers and about /2013/ 7500 //2013// Medicaid clients in the middle part of the State. ***/2013/Both practices have met Tier 1 of the Nebraska Medicaid Patient-Centered Medical Home Pilot Standards and one practice has met Tier 2 of the set pilot standards.***//2013// These practices are located in a rural area of the state and are receiving technical assistance for two years to transform their practices into a recognized medical home by meeting specific standards. While change is not easy, already both practices have made good strides in making their practice more accessible, strengthening their care coordination infrastructure, establishing quality improvement protocols, and managing health data through technology.//2012// ***/2013/The pilot concludes January 31, 2013.***//2013//

3. Process used to determine the importance, magnitude, value, and priority of competing factors upon the environment of health services in the State.

Beginning with the needs assessment completed in 2005, the Lifespan Health Services Unit has utilized the Family Health Outcomes Project's (FHOP's) "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs." Adapted for state level planning processes, this model has been a very useful tool for not only determining priorities, but also for determining strategic directions for addressing the priorities.

In 2006, Lifespan Health Services completed an environmental scan to determine which of the then current 10 priorities were candidates for targeted strategy development. Criteria for targeting included whether a priority was being adequately addressed through existing programs or partnerships. Based on this scan, work groups were formed to conduct a formal problem analysis and to identify effective interventions for 4 of the priorities: preterm birth/low birth weight, healthy weight among women and children; transition for CSHCN, and infant mortality disparity. The first 3 listed work groups completed their work in 2008, and the infant mortality disparity work group was formed in 2009. The work groups continued to use adaptations of the FHOP model.

Largely through the findings of the preterm birth/low birth weight and healthy weight work groups, the Lifespan Health Services Unit adopted a new emphasis on a life course health development model and social determinants of health framework. Funding guidelines for community based projects, released in 2008, incorporated the model and framework, and the infant mortality disparity work group's findings have reinforced our emphasis going forward.

In addition to these processes, the Lifespan Health Services Unit has negotiated the demands of competing environmental factors by maintaining a focus on building its capacity to carry out the 10 essential public health services, both at the state level and at the community level. With flat or diminishing financial resources, it is clear that the Unit and Title V cannot be all things for all people, nor can it pay for an extensive array of services. Rather, it is in our best interest to build public health capacity, and be aggressive in developing and maintaining a wide range of public health partnerships.

In this vein, the Lifespan Health Services Unit completed an abbreviated version of the CAST-5 assessment in FFY 2005. During June 2005, the Unit also participated in the application of the State Public Health Performance Standards. This latter activity contributed to a state public health strategic plan that provides the blue print for building capacity over the next few years.

The Nebraska Public Health Improvement Plan was finalized, approved, and published in SFY 2009. The purpose of this strategic plan is to identify a new vision for public health in Nebraska and the resources that are necessary to achieve the vision. Seven major strategic directions are identified. The seven major strategies in this plan were developed by the Turning Point Public Health Stakeholders Group. This plan is intended as a guide for public health leaders, as well as state and local policymakers as they continue to strengthen and shape the public health system.

At the turn of the 21st century, when the first public health improvement plan was developed, stakeholders saw the public health system in Nebraska to be weak, fragmented, and severely underfunded. Public health services and programs were available in less than one-quarter of the counties in the state. By 2006, a major transformation had occurred. Local public health departments now cover every county and provide all of the core public health functions. The new public health infrastructure has strong leaders, exciting new partnerships, and improved funding.

Despite this success, many challenges still need to be addressed. For example, the public health workforce still needs training and education in many of the core competencies. Also, new resources and leadership are needed to build integrated data systems that are more accessible to researchers and public health practitioners. There are also many complex problems that can only be resolved through effective collaborative partnerships. Some of these problems include access to health care services, disparities in health status between the white population and racial and ethnic minority populations, the inadequate supply of health professionals in rural areas, the dramatic increase in the number of people that are overweight and obese, the emergence of new diseases such as SARS and West Nile Virus, and the threat of pandemic flu. To meet these challenges, the public health infrastructure will need to be strengthened and become more efficient. There is also a need to demonstrate accountability to both policymakers and the general public through the use of a more business-like model to determine the feasibility of service expansion. Finally, public health leaders must continue to build collaborative partnerships with the medical community, businesses, schools, and many others. Through these diverse partnerships, appropriate strategies can be developed and sufficient resources can be found to achieve the vision of healthy and productive individuals, families, and communities across Nebraska.

This planning document, found at <http://www.dhhs.ne.gov/puh/oph/> will be an important guide and influence on Title V/MCH and CSHCN planning as we move through this decade.

Currently underway is work to develop Nebraska's 2020 Health Objectives. It is important to note that a life course health development model is informing this work, and Lifespan Health Services staff have contributed their experience in applying that model to the planning process.

/2012/ Nebraska applied for and received an ACA Public Health Infrastructure Grant, both Component I and the competitive Component II. Included in Component I is a plan for the Nebraska DHHS Division of Public Health to create a performance management system and prepare for public health accreditation. To address performance improvement, a Nebraska Performance Improvement Advisory Council was formed, and the Title V/MCH Director and the MCH Epidemiology Surveillance Coordinator (SSDI Project Manager) are members. Other activities within Component I are continued support of the Great Plains Public Health Leadership Institute and the development of a grant monitoring system for the Division of Public Health. Component II includes the addition of an epidemiologist to provide assistance to local health departments, the establishment of a joint data center with the UNMC College of Public Health, the creation of a Policy Training Academy, a project to conduct Return on Investment studies, the creation of a cardiovascular disease syndromic surveillance system, and assistance to local health departments for accreditation and establishing performance management systems.

In addition, the Nebraska DHHS Division of Public Health submitted an application for the Prevention and Public Health Fund Community Transformation Grants to Reduce Chronic Disease and an application for that fund's Coordinated Chronic Disease Prevention and Health

Promotion Program. Both of these grant programs would provide a planning opportunity to address life course health strategies and the role of maternal and child health programs in the prevention of chronic disease.//2012//

/2013/ Nebraska DHHS's application for a Community Transformation Grant was not funded, but that for the Coordinated Chronic Disease Prevention and Health Promotion Program was. The Title V/MCH Director was the interim Principle Investigator for the latter, and continues to contribute to the project on an as needed basis.//2013//

4. Characteristics presenting a challenge to delivery of Title V services

Details are provided earlier in this section regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. These issues are ongoing challenges to the delivery of health and human services to Nebraska's MCH and CSHCN populations. The Department of Health and Human Services has been experiencing an increase monthly in Medicaid eligibility. Even with the increase in Medicaid eligibles, those remaining continue to stress the Block Grant funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid.

Practices for determining the eligibility of pregnant women were assessed and changed during FY 2010. Social services workers were counting the unborn baby in the household or even in some cases, individually, to obtain eligibility for many programs, including Medicaid. This is not a valid way to determine eligibility and the Department was advised by CMS that this practice could not continue.

/2013/ During the 2012 Legislative session, LB 599 was passed and enacted. This law requires the creation of a separate Title XXI State Children's Health Insurance Program solely for the purpose of providing services to the unborn. The NE DHHS is to submit a plan amendment to CMS within 30 days of the law's effective date.//2013//

Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Twenty-nine of 93 counties are considered all or partially included in a Health Professional Shortage Area. State-designated shortage areas include most of Nebraska's rural counties for a number of primary care provider types. The number of Federally Qualified Health Centers (FQHCs) is only 6, and these centers do not begin to address the vast distances some families have to travel to receive care.

Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation has become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With changes in income eligibility, both increasing for children but excluding certain women, the impact on local match will be complex in the short term. The impacts of federal health care reform are yet to be fully analyzed.

An issue receiving attention in Nebraska and elsewhere is the aging of the public health work force. Success in carrying out the 10 essential public health services is dependent on an adequately trained work force. As many state and community level public health professionals retire in the next few years, the recruitment and retention of new public health workers is a concern. The relatively new University of Nebraska Medical Center's College of Public Health, is addressing this need, in part. Non-competitive compensation and limited job advancement opportunities will continue to be a deterrent to recruiting new public health professionals, especially within state government and in very rural communities.

LB 403 was a bill passed and signed into law in April 2009 and which went into effect October 1, 2009. LB 403 requires the verification of lawful presence in the United States for the receipt of public benefits. It clearly exempts emergency health care, testing and treatment of communicable diseases, immunizations, and certain short term disaster or public safety services from these verification requirements. The agency examined the implementation issues related to its programs and determined that the requirements of LB 403 applied to these programs administered by the Lifespan Health Services Unit: the Commodity Supplemental Food Program (CSFP), the Breast and Cervical Cancer Screening Program and the Colon Cancer Screening Program. All federal and state funded programs administered within the Division of Medicaid and Long-Term Care have been affected and were included under the requirements of LB403.

In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; an aging public health workforce; and changing policies on eligibility for public benefits.

B. Agency Capacity

With Title V/MCH Block Grant funding remaining flat and inflation increasing costs of doing business, maintenance of agency capacity to promote the health of all mothers and children, including CSHCN, has become increasingly challenging. As indicated in the previous section, investments in infrastructure and collaborative partnerships continue to be emphasized as the most efficient means for investing the Block Grant as a means of sustaining capacity.

Community level agencies have traditionally provided a number of services that encompass all levels of the public health pyramid, but with steadily decreasing emphasis on direct services.

As noted in an earlier section, Lifespan Health Services Unit shifted its focus to a life course health development model and social determinants of health framework. A Request of Applications (RFA) issued in May 2008 incorporated this model and framework, and then focused Title V/MCH Block Grant funding at the community-level on a selected set of priority needs to concentrate efforts and maximize outcomes. Applicants were to address one and preferably no more than three of the following public health goals and one and preferably no more than three outcomes associated with each selected goal:

PERINATAL RELATED GOALS- Reduce rates of preterm and low birth weight births; reduce rates of infant mortality; and eliminate disparities among racial/ethnic minorities for preterm and low birth weight, SIDS and other sudden unexpected infant deaths, and/or infant mortality.

ASSOCIATED PERINATAL OUTCOMES- Increased access to preventive health care for women of reproductive age; health care systems provide culturally competent preconception health care; woman at risk for or with history of poor birth outcomes receive targeted pre and interconception care; women have access to supportive networks within communities (i.e. family, faith, business/workplace, education, peer networks) to decrease stress and isolation; women of reproductive age have improved access to mental health services; women demonstrate a reduction in adverse health behaviors and an increase in healthy behaviors; Women/couples have a reproductive life plan; more women/couples have pre-pregnancy health visits; women/couples have improved health literacy as measured by their ability to understand and act on information and navigate the health system; health and human service providers deliver consistent, accurate messages on safe sleep practices for infants; and parents and other caregivers routinely provide safe sleeping environments for infants.

HEALTHY WEIGHT RELATED GOALS - Women of reproductive age are at a healthy weight, including prior to and between pregnancies; and children enter kindergarten at a healthy weight.

HEALTHY WEIGHT ASSOCIATED OUTCOMES - Health care providers use evidence-based guidelines and best/promising practices in helping women achieve and maintain a healthy weight; communities and health care systems have increased capacity to provide services to promote healthy weight among women and children; more workplaces and schools will have effective wellness policies that address nutrition and physical activity, breastfeeding support, and environmental supports for wellness; more women in school and/or workplace settings engage in healthy behaviors; and communities, through governing bodies and community leadership, adopt plans and policies to increase access to healthy foods and physical activity.

Applicants were to consider and incorporate as appropriate the following themes: 1. An emphasis on population-based, primary prevention and wellness models; 2. Social ecological model, including social determinants of health and health equity; 3. A life course approach to improving health outcomes, including the importance of preconception and inter-conception health; and 4. Importance of community-wide and system level change.

Through this competitive process, the following community-level projects were approved for the 3-year funding cycle that ends September 30, 2011:

Four Corners Health Department (Butler, Polk, Seward & York counties) - Partners with communities to promote healthy weight among children. Implements Animal Trackers curriculum in daycares/preschools. Animal Trackers increases structured physical activity time during the preschool day. Hosts Family Fun Nights to support families in physical activity and healthy eating. Enhance current activities, e.g. Concordia University's Early Childhood Education Conference, and Seward Family Fun Night. Contracts with Registered Dietitian to reach families through farmers' markets and immunization clinic.

Northeast NE Family Services (Fremont) -- Reduces the incidence of low birth weight and preterm births through enhanced family planning visits to include preconception risk assessment and reproductive health plan. Increases access to early prenatal care via Three Rivers District Health Department's Call Care Line and referral to physicians.

Goldenrod Hills Community Action, Inc. (Burt, Cuming, Dodge, Madison, Pierce & Stanton counties) - Enhances pre-existing Operation Great Start, which is non-intensive case management and home visitation service provided to low and medium risk clients for infants up to 12 weeks of age with a focus on first-time mothers. Program provides an array of supports for parents to be successful. Referral sources are Faith Regional Health Services and St. Francis Memorial Hospital and clinics, and Goldenrod Hills WIC and immunization programs. Provides teen parent education to pregnant and postpartum teens in Norfolk Public Schools. Preconception and interconception care offered to females receiving HPV immunizations.

Panhandle Public Health District (the 11 counties of the Panhandle region) - Campaigns for and supports workplace policy change and environmental supports for breastfeeding, physical activity and nutrition. Partners with clinics to assess reproductive-age women for preconception / interconception plan followed by a brief intervention at regular clinic visits.

South Heartland District Health Department (Adams, Clay, Nuckolls & Webster counties) - Assesses, trains, and supports workplaces to develop teams to implement worksite wellness policies and supports in 20 small businesses. Assists workplaces and schools to have effective wellness policies that address nutrition and physical activity, breastfeeding support, and environmental supports for wellness. The local health department partners with Mary Lanning Memorial Hospital, Well Workforce Nebraska, and Educational Service Unit #9.

Lincoln Lancaster County Health Department (Lincoln) - Implements "A Family Approach to Prevention of Childhood Obesity" in three census tracts of Lincoln with a 34% minority population, > 25% of population is < 18 years of age, and with a high rate of poverty. Convenes community

partners and resources to pilot "54321 GO" project (participants focus on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day) and evaluates effectiveness of this approach.

Central Health Center (Grand Island, Kearney, and Lexington) - Reduces the incidence of low birth weight and preterm births by integrating preconception and interconception care into family planning clinic visits, developing reproductive life plans, and using information technology (My Space) to promote its program.

University of Nebraska Medical Center, Maternal Care Program (Omaha) - Expands scope of pre-existing Maternal Care Program that provides prenatal care to include pre- and inter-conception care. Adds training and continuing education for medical students, residents, and practicing physicians on life course concept to improve birth outcomes. Actively engages local providers in Omaha who provide health care to at-risk women, e.g. Charles Drew Health Center, One World Community Health Center, and the Fred LeRoy Health and Wellness Center.

Northeast Nebraska Public Health Department (Cedar, Dixon, Thurston, Wayne counties) - Creates Northeast Nebraska Child-Fetal Infant Mortality Review Project with a Case Review Team and Community Action Team to perform death case reviews with participation from Omaha and Winnebago Tribes. Evaluates home visitation services in the district. Forms Health Literacy Council.

A separate Tribal set aside of \$200,000 has been established for the four federally recognized Tribes headquartered in Nebraska. These funds may be used for either services or for infrastructure building.

/2012/ The community-level projects funded in response to the May 2008 competitive RFA were scheduled to expire in September 2011, with a new competitive RFA to have been issued in early 2011. Due to the prolonged uncertainty of Block Grant funding for the current year, and the continued uncertainty regarding funding levels for FY 2012, the NE DHHS Division of Public Health chose not to issue a competitive RFA in 2011. Instead, it intends to extend the current community-level projects for another year, at reduced funding levels. We will continue to monitor federal funding to determine next steps in planning for community-level services.//2012//

/2013/ On May 31, 2012, the Lifespan Health Services Unit, Division of Public Health, NE DHHS issued a competitive Request for Applications for community-based Title V/Maternal and Child Health Block Grant supported projects. With continued uncertainty of future funding levels, the projected total funding level for projects is estimated to be \$800,000 with individual projects to be funded at levels at or below \$150,000. Project periods are to be two-years only, with a requirement that proposals are to focus on activities that will not require extensive start-up time, effort, or resources. Applicants are to address one or more of Nebraska's ten MCH/CSHCN priorities, with an emphasis on children as an MCH population. Proposals are due July 18, 2012.//2013//

Then, to assure continued investment in community-level MCH infrastructure, time-limited contracts are executed with local health departments for specific purposes. Currently, a contract with a local health district is for the purposes of piloting a public discourse model as a means for identifying and addressing community level MCH/CSHCN issues. A second contract with an urban health department focuses on addressing the quality of prenatal care and promoting preconception health through a life course health development model./2012/ Work under the second contract has been completed.//2012//

Based on the recently completed needs assessment, additional contracts with a range of Nebraska organizations will be considered to address short-term capacity issues./2012/ A contract was awarded to the University of Nebraska Medical Center to conduct a pilot project

titled "Connections." This project seeks to address poor birth outcomes that disproportionately impact African American families in Douglas County (Omaha). The project has 3 major components: a peer support program conducted through a WIC clinic; community-based lectures/discussions focusing on community based strategies to foster healthy pregnancy; and the development of community leaders committed to advancing healthy birth outcomes in Omaha's African American community.//2012//

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include: Perinatal, Child, and Adolescent Health including school health, MCH Epidemiology (which includes the Child Death Review Team and PRAMS); Newborn Screening and Genetics; Office of Health Disparities and Health Equity; Office of Women's Health; Dental Health; and Reproductive Health. In addition, the Block Grant provides partial support to the Birth Defects Registry.

Additional sources of revenue are continually being pursued to supplement state level MCH activities. Awards in recent years included a perinatal depression grant and a two newborn hearing screening grants. Though the perinatal depression grant has expired, its work products continue to be supported and promoted in collaboration with partners.

For the past 5 years, the Lifespan Health Services Unit has administered an allocation of TANF funds that provides enabling services for women who are pregnant or believe they may be pregnant. These services are provided through a contract that is competitively awarded every two years.

Late in FFY 2008, Nebraska was awarded a First Time Motherhood/New Parents Initiative grant. Nebraska's project was initially titled "Building Bridges - For You, For Now, For Life," with a project period of September 1, 2008 through September 30, 2010. Its goals are to: Increase awareness among women, ages 16-25, of the benefits of a life-course approach to pre- and inter-conception health; and increase awareness among community-based providers of the benefits of a life-course approach to pre- and inter-conception health and how to incorporate in various settings. The target audience is Nebraska women 16 -- 25 years (Millennials) who are low income and at risk of being uninsured or underinsured. Messages are being tailored for urban/rural, African American, Hispanic, and Native American women, and husbands/partners. Key activities include:

YEAR ONE -- A contractor was selected through a competitive process. The contractor used a social marketing model to develop and test a range of messages related to a life-course perspective and pre and inter-conception health based on CDC's model. The subject matter and modes of delivery were determined through focus groups and other methods. The effectiveness of the Healthy Mothers, Healthy Babies Helpline was also tested with the Millennials.

Based on this market research, TUNE was developed, and TuneMyLife.org was created. This informational campaign uses music as a means of engaging and inspiring the target audience to take control of their life and to include healthy life styles in setting their goals, including any future plans for having children. See <http://www.tunemylife.org/> for more information.

Through another competitive process, a second contract was awarded to develop and deliver outreach and training to health, human services, educational providers, and faith-based providers, then deliver this training.

YEAR TWO -- TuneMyLife.org was fully launched. The training modules and tool kits for providers are being finalized, and use at statewide training events has begun. Soon, community-based organizations will be competitively selected to develop modifications needed to incorporate new and expanded messaging within their settings, and begin creating systems supporting a life-course approach to health, including pre- and interconception health.

Plans are underway to further enhance this project, including adding additional music and messages to better reach a more diverse audience. Lifespan Health Services staff members are working with other state-level programs to incorporate messaging and social media approaches./2012/ The First Time Motherhood/New Parents Initiative is completing a one-year no-cost extension in September 2011. Underway are contracts with community-level providers to deliver life course health training to health, social service, and education professionals in their communities, using TUNE materials. Also completed during 2011 was an update to the web site with new music and messages. //2012// **/2013/ *Though the First Time Motherhood/New Parents Initiative grant has expired, the Lifespan Health Services Unit continues to maintain the TUNE website as well as a web page titled Tune Into Life Course Health for Providers. This page includes tools for classroom teachers and community and health care providers. A particularly well-received resource is the Life Course Health Plan, which is a reproductive health plan adapted for both men and women.***//2013//

/2012/ The NE DHHS Division of Public Health applied for and received funding under three Affordable Care Act programs: Abstinence Education, PREP, and Maternal, Infant, and Early Childhood Home Visiting (MIECHV). All three programs are being administered within the Lifespan Health Services Unit and are enhancing the ability of Nebraska's Title V programs to address the needs of the MCH populations. These programs are described in more detail under associated performance measures.//2012//

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN - the Medically Handicapped Children's Program (MHCP). Located in Medicaid & Long-Term Care, State and Grant Funded Programs Unit, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multidisciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the Disabled Children's Program (DCP) for those children eligible for SSI. The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI) checks, are 15 years of age or younger, and live at home with their families.

/2013/ *MHCP and DCP are housed in the Division of Medicaid & Long-Term Care which allows access to a number of other state and federal programs that provide services to children and youth with special health care needs to enhance the networking of both local and state resources. The programs include: Early Development Network, Aged and Disabled Waiver, Lifespan Respite, Disabled Person and Family Support Program, and the Ticket to Work Program.*//2013//

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

In 2003, LB 407 was signed into law which allocated \$1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005.

Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services. The biennial allocations for this program have remained steady through FY 2009 -- 2011.

/2013/ During the 2012 Legislative Session, LB 1038 was signed into law. This legislation requires that the Division of Public Health establish a lead poisoning prevention program that has the following components: (a) A coordinated plan to prevent childhood lead poisoning and to minimize exposure of the general public to lead-based paint hazards. Such plan shall: (i) Provide a standard, stated in terms of micrograms of lead per deciliter of whole blood, to be used in identifying elevated blood-lead levels; (ii) Require that a child be tested for an elevated blood-lead level in accordance with the medicaid state plan if the child is a participant in Medicaid; and (iii) Recommend that a child be tested for elevated blood-lead levels if the child resides in a zip code with a high prevalence of children with elevated blood-lead levels as demonstrated by previous testing data or if the child meets one of the criteria included in a lead poisoning prevention screening questionnaire developed by the division; and (b) An educational and community outreach plan regarding lead poisoning prevention that shall, at a minimum, include the development of appropriate educational materials targeted to health care providers, child care providers, public school personnel, owners and tenants of residential dwellings, and parents of young children. Existing reporting requirements continue under this law. The Environmental Health Unit has been assigned responsibility for implementing the law and developing the required plans and materials. The Lifespan Health Services Unit will assist in implementation through its programs serving young children.//2013//

Nebraska continues to strive to promote and support culturally competent approaches to service delivery. Data collection and analysis, whenever possible, addresses race and ethnicity, and to a lesser degree, language. For instance, Nebraska stratifies its PRAMS data by race and ethnicity, and has obtained CDC approval to include Nebraska Native American women who deliver outside of Nebraska in its sample, to assure that these women are adequately represented in data collection. Nebraska MCH/CSHCN programs benefit from the efforts of other offices in NDHHS to collect culturally relevant data, such as the Minority Behavioral Risk Factor Survey. During the comprehensive needs assessment, analysis by cultural groups was extensively done and disparities among groups was one of the criteria used in prioritizing needs.

NDHHS has a long history of offering and promoting training in cultural competency for both its staff and stakeholders. Culture and language are frequently incorporated into the wide range of training and technical assistance activities sponsored by the Lifespan Health Services Unit for its community partners. Lifespan Health Services has a strong working relationship with the Office of Health Disparities and Health Equity (OHD&HE) and has collaborated on training events tailored for specific audiences. Currently underway is an initiative to use "Unnatural Causes" in a series of public engagement meetings. This initiative is being jointly launched by the OHD&HE, the Women's Health Council, and the Minority Health Advisory Council.

The Nebraska Minority Public Health Association is a key stakeholder and partner, with its members participating in and contributing to needs assessments and major initiatives over the years.

The Lifespan Health Services Unit has had ongoing working relationships with Northern Plains Healthy Start and Aberdeen Area Tribal Health Directors' programs, and works closely with the Native American Liaison in the Office of Health Disparities & Health Equity. Individual programs work with specific communities and community leaders in developing culturally relevant initiatives.

Since FY 2003, the Lifespan Health Services Unit maintains a set-aside of Title V funds for those federally recognized Tribes headquartered in Nebraska. This set-aside recognizes the special government-to-government relationship between NDHHS and the Tribes, as well as a priority to meet the health needs of the Native American MCH populations. In allocating funds for other

community based programs, the needs of culturally diverse groups are directly addressed in the RFPs, through expectations for addressing the needs of racial and ethnic minorities and engaging representatives from culturally diverse groups in program planning and development. Further, the CLAS standards are an expectation outlined in the Title V RFP for communities and these standards are thus incorporated by reference into the awards made to community sub grantees.

C. Organizational Structure

During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill reorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health. Title V/CSHCN functions are within the Division of Medicaid and Long Term Care.

The Division of Public Health, is administered by Joanne Schaefer, MD, Chief Medical Officer and Division Director. Division functions and activities include environmental health, epidemiology, communicable disease programs, vital records, health data, facility and professional credentialing, community health planning and protection, health promotion, and public health services for various populations, including MCH.

The Lifespan Health Services Unit, Division of Public Health, provides the principle over sight for administration of the Title V/MCH Block Grant. Planning and Support staff manages the block grant and reports to the Administrator for the Unit who is also the Title V/MCH Director. Planning and Support includes the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. /2012/ Planning and Support includes the Federal Aid Administrator, for a total of 1.0 FTE.//2012// Planning and Support is responsible for organizing and leading the development of the annual plan and report, administers sub-grants to communities, monitors allocations to other NDHHS units and programs, and coordinates Title V funded activities with other public health programs within the Unit and agency.

The Lifespan Health Services Unit was formed in 2007, with the merging of the Office of Family Health with the Office of Women's Health. Other programs and activities within Lifespan Health Services include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics (including Newborn Hearing Screening); Perinatal, Child and Adolescent Health (including school health and Early Childhood Comprehensive Systems, /2012/ Abstinence Education, PREP, Maternal, Infant, and Early Childhood Home Visiting//2012//, and **/2013/State General Fund supported home visitation//2013//**); Reproductive Health; MCH Epidemiology (including PRAMS, Child Death Review, and SSDI-supported activities), Breast and Cervical Cancer Screening, Colon Cancer Screening, and women's and men's health initiatives, including logistical support for the Women's Health Advisory Council.

Special Services for Children and Adults are administered within the State and Grant Funded Programs Unit in the Division of Medicaid & Long-Term Care. The Unit houses the following programs: Medically Handicapped Children's Program (MHCP), Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, SSI Disabled Children's Program, Genetically Handicapped Persons Program, and Early Intervention, the Ticket to Work Program, Money Follow the Person and **/2013/ the Lifespan Respite Program//2013//**. This Unit coordinates with other Units within Medicaid that house the Medicaid State Plan and Home and Community Based Waiver Services for children with special health care needs. The Early Intervention Waiver ended and EI Waiver clients are now being served by the Home and

Community Based Waiver program.

Vivianne Chaumont, the Director of Medicaid & Long-Term Care, administers the following program areas: Medicaid Services, both State Plan and HCBS Waiver Services for all eligible populations; State Unit on Aging, and the State and Grant Funded Programs Unit which manages CSHCN programs listed in the above paragraph. Ms. Chaumont is the co-director for Part C of the Individuals with Disabilities Education Act and the Administrator of the Nebraska Part C/Early Intervention Program/Early Development Network. Early Intervention is co-administered with the Nebraska Department of Education.

Title V -- both MCH and CSHCN -- maintain collaborative relationships with the Medicaid program, Vital Records, and Health Statistics, all of which are located in the Department of Health and Human Services. In addition, Title V works with a number of programs throughout DHHS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, health disparities/health equity, health promotion and disease prevention, communicable diseases, dental health and rural health. Of the areas outside of Lifespan Health Services and Long Term Care Programs Section, only health disparities/health equity, data management, and dental health receive federal Title V funds. An organizational chart displaying the agencies and units is found as an attachment. Department programs funded by the Federal-State Block Grant Partnership budget are described in the previous section. See Section B Agency Capacity for details of funding for community-based and Tribal programs for the 3-year period that began October 1, 2008.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

As described earlier, Planning and Support within Lifespan Health Services has primary responsibility for the ongoing administration of the Title V/MCH Block grant. Programmatic activities are carried out by various staff within the Lifespan Health Services. The Perinatal, Child and Adolescent Health (PCAH) is responsible for school health, adolescent health, child health, Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal depression and the First Time Motherhood/New Parents Initiative grant, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff./2012/ The First Time Motherhood/New Parents Initiative will be ending in September 2012 as the one-year no cost extension expires. PCAH is now administering Abstinence Education, PREP, and Maternal, Infant and Early Childhood Home Visiting. This unit is now staffed by 7.0 FTE./2012//

MCH Epidemiology was created in FFY 2004, and includes PRAMS, Child Death Review, and SSDI activities. It is staffed by 3.5 FTE and a 0.75 contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and newborn hearing screening. It is staffed by 5.0 full-time employees and 1.5 temporary employees.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health and is staffed by 3.4 full-time employees, and a nurse practitioner consultant and a medical advisor under contract.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 45,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 10 full-time FTEs, with an

additional information technology FTE under contract.//2012/ A WIC Farmers Market Nutrition Program Grant was received by the Nebraska Department of Agriculture. This project is being implemented with the 2011 growing season, in collaboration with the WIC Program and its local agency serving a targeted neighborhood in Omaha.//2012//

The Commodity Supplemental Food Program serves 14,000 individuals each month, the majority being seniors. This program is staffed by 1 full time FTE.

Also administered within the Lifespan Health Services, the Immunization Program manages CDC 317 and Vaccine for Children funds, and oversees public immunization clinics and the registry supporting these clinics. The program is staffed by 9 full time FTEs and 2 contract employees.

The Office of Women's and Men's Health within the Lifespan Health Services Unit has 23 FTEs. Though its major programs focus on older adults, it also administers State General Funds that support cervical cancer screening for women of reproductive age. The Women's Health Council, which is supported by the Office, addresses a wide range of issues for women. Currently, the Council has an active workgroup examining access issues for women experiencing pregnancy related depression. ***//2013/ The Council has largely completed its work on perinatal depression, but during 2012 was a key partner in promoting greater awareness of employer responsibilities for accomodating breastfeeding employees in the work place.//2013//*** The Council has also partnered with other organizations to launch an initiative to address health disparities.

The Patient Protection and Affordable Care Act offers much potential for additional MCH capacity, including that home visiting, abstinence education, personal responsibility education, and the pregnancy assistance fund. The Division of Public Health is actively considering the FOA's for these funding opportunities as they are released.//2012/ The Division of Public Health applied for and received funding for Abstinence Education, PREP, and Maternal, Infant and Early Childhood Home Visiting programs. All three programs are administered in the Lifespan Health Services Unit, in close collaboration with Title V supported activities. //2012//

The Lifespan Health Services Administrator participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 1.0 Administrative Assistant and 0.2 FTE staff assistant. Paula Eurek, BS, Title V/MCH Director, has been an employee of Nebraska Health and Human Services since 1983. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for what was the Family Health Services Section and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989.

In addition to administering MHCP, the State and Grant Funded Programs Unit in the Division of Medicaid & Long- Term Care is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website hosts discussion LISTSERV (discussion groups for these populations) as well as information and Internet LISTSERV for other populations with special needs. Nebraska Resource Referral System (NRRS), which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, is accessible through this web portal. Addresses: <http://www.answers4families.org> and <http://www.answers4families.org/nrrs/>. The MHCP clinic list and addresses of local workers are available on Answers4Families. Address: <http://www.hhs.state.ne.us/hcs/programs/MHCP.htm>. Answers4Families site also includes a list of clinic staff and a short bio of background information to provide families looking at clinic services, information on the medical providers their child would receive services from.

/2013/In addition to administering MHCP, the State and Grant Funded Programs Unit in the Division of Medicaid & Long- Term Care is responsible for a number of CSHCN services and activities. It partially funds the Answers4Families website:

<http://answers4families.org>. Answers4Families includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, agencies and others concerned with children's mental health. The website hosts Email Discussion Groups (Listserv) for these populations as well as information and resources for other populations with special needs. Answers4Families offers "Ask an Expert" and "Ask Rx," two services that allow users to confidentially ask questions via email to a registered pharmacist or family specialist.

The MHCP clinic schedule and addresses of local workers are available on Answers4Families. The clinic schedule is user-friendly and easily searchable and available here: <http://www.answers4families.org/information-services/mhcp>. Answers4Families site also includes a list of clinic staff and a short bio of background information to provide families looking at clinic services and information on the medical providers their child would receive services from.

Nebraska Resource Referral System (NRRS) includes over 15,000 social services-type resources, including child care, respite coordinator information, medical/health and public health information, food pantries, and more is accessible through this website:

<http://nrrs.ne.gov>. The NRRS also provides self-assessments, designed to guide users to the resources and services that best suit their needs. Another feature of the NRRS is the Childcare Database which lists all licensed childcare within Nebraska, as well as a tool to compare childcare resources.

For FFY 2011 (October 1, 2010 -- September 30, 2011), the Answers4Families/NRRS websites reported 85,229 unique visitors. The total number of visits for this time period was 127,011 with a total number of hits to the site at 6,284,878. In reviewing the top 20 key phrases that were searched for this time period, 13 of those involved a search for information to assist a child with a special health care needs.//2013//

The Home and Community based Services for Aged and Physically Disabled is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations. Consequently, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program.

Development Tips is tracking Infant Progress statewide in Nebraska and started in 2000. The program provides specialized development follow-up for babies who have been in the Neonatal Intensive Care Unit. The Development TIPS program has two main goals: to provide a standard system of developmental follow-up for all infants who have had an NICU experience in Nebraska, and to gather information about how babies who have been in the NICU grow and develop, so we can learn how to better meet their unique needs in the future. EDN Services Coordinators are partners with 10 departments/programs to direct referrals to the appropriate service. In 2007, two additional partners were added to the list of partners (Bryan LGH and Alegant Lakeside in Omaha). Developmental TIPS also plans to begin data collection for the next three years on children that were part of the program that are now entering first grade.

/2013/The Medically Handicapped Children's Program and the Disabled Children's Program offer services throughout Nebraska providing medical and supportive services to children and youth with special health care needs and their families. MHCP has 8 full-time employees and 2 half-time staff which are located in six local offices across Nebraska: Gering, Grand Island, Lincoln, Norfolk, North Platte, and Omaha. MHCP provides medical coverage and clinic services for this population to CYSHCN ages birth through 21 years of

age. DCP offers support services such as respite, medical mileage reimbursement, lodging and meal reimbursement, home modification, vehicle modification, special equipment, sibling care, and attendant care to children and youth under 16 years of age to support family outcomes such as empowerment, care assistance, stress reduction, and access to medical supports.//2013//

Susan Buettner, JD, Title V/CSHCN Director has been an employee of the State of Nebraska since 2008. She is currently the Programs Administrator in the Medicaid & Long-Term Care Division of the Nebraska Department of Health and Human Services; areas of responsibility include Medicaid State Plan, and Home and Community -Based Services for long term and chronic care, State Unit on Aging and the State and Grant Funded Programs Unit programs, Physical Health Services, Pharmacy, Dental and Vision Programs, Mental Health and Substance Abuse. Previous work assignments have included: Special Appointed Attorney General for the State of Nebraska, Department of Health and Human Services; Deputy County Attorney for Lancaster County; and Adjunct College Instructor.

E. State Agency Coordination

Nebraska DHHS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past 27 years.

The Coordinated Family Committee continues to meet on a quarterly basis to review and discuss funding of individual cases. Statewide service and support presentations are completed by outside entities to expand the committee's knowledge of additional resources that offer funding assistance.

Child Abuse Prevention Treatment Act (CAPTA) is improving Nebraska achievement under the federal mandate. The Early Development Network (EDN) has collaborated with Juvenile Court Judges, child development experts, and Protection and Safety CPS staff to provide statewide training to all professionals and families involved in child abuse and neglect court system. EDN has provided several trainings to assist all entities to understand the law and to work together to integrate the system. Most recently, the collaboration has been expanded to include; children & family mental health providers, Family Court Judges, family and juvenile court attorneys. Since 2005, there have been trainings on the local level on CAPTA to CPS and EDN workers. These trainings are now on-going to work on issues and problems surrounding implementation of the mandate.

//2013/Helping Babies from the Bench Training is a multidisciplinary training that focused on infants and toddlers in the abuse/neglect court system and how courts and stakeholders can ensure the best possible outcomes for them. Topics in the training include Part-C early intervention services, the impact of stress, neglect and trauma on child development, focusing the Pre-Hearing Conference and Protective Custody hearing on the infant or toddler, and infant/parent relationship therapy. Leadership for Babies from the Bench includes: A Judge from a Nebraska Juvenile Court of Douglas County, a group of trainers including a child psychologist, an early development specialist, an education specialist, and infant-parent relationship therapist.//2013//

As part of the Nebraska Newborn Hearing Screening Program's Early Hearing Detection & Intervention (EHDI) State Plan one of the System Goals/Activities is: All infants with a confirmed hearing loss will begin receiving early intervention services prior to six months of age. Under

Program Objective 3.1, Health care providers and audiologists will refer all newborns and infants with suspected or confirmed hearing loss to the EDN for eligibility determination.

From this, EHDI and EDN developed Recommended Practices regarding Initial Point of Entry for Parents of Infants/toddlers identified with permanent hearing loss and was implemented in 2009. The desired outcomes includes: Families of newborns/infants identified with a permanent hearing loss will be able to access timely and appropriate early intervention services through a recognized point of entry that is knowledgeable about hearing loss, the effects on young children, and available resources (certified teachers of the deaf).

EDN Services Coordinators and Audiologists are continuously trained on these collaborative practices and processes relating to EDN referrals and early intervention services. EHDI and EDN State program managers track related referral, intervention and outcome data on infants identified with a hearing loss between these two programs/systems.

//2012/ The Early Development Network is collaborating with University of Nebraska Munroe-Meyer Institute on Project DOCC (Delivery of Chronic Care). This partnership includes Allied Health trainees and Nebraska Medical Residents in additional training on early identification and family-centered long-term care issues.//2012//

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP of children determined eligible for SSI, at which time MHCP sends a notice to the family describing possible services they may receive and how to apply. This relationship ensures that families receiving SSI for their children are notified of their potential eligibility for services. The Disability Determination Unit of Social Security provides a continual stream of referrals to the MHCP. As the result of the notification of SSI eligibility, MHCP workers have been able to provide immediate notification to families regarding the availability of services through SSI-DCP.

In regards to coordination with EPSDT, referral assistance must be provided for treatment not covered by Nebraska Medicaid, (i.e., those services not covered under 1905(a) of the Social Security Act) but found to be needed as a result of conditions disclosed during the screening exam. This includes giving the family or client the names, addresses, and the telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources. The program workers may also utilize the Nebraska Resource Referral System to attempt to provide referral assistance.

With the administration of Nebraska's Title V/MCH Block Grant located within the Lifespan Health Services Unit, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Lifespan Health Services being in the same section of the Division of Public Health with the Offices of Rural Health, Health Disparities and Health Equity, Community Health Planning and Protection, and Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application.

Within the larger Department of Health and Human Services, Lifespan Health Services has ongoing and active partnerships with Child Care Subsidy and Child Welfare within the Division of Children and Family Services, and Child Care Licensing within the Division of Public Health. It has expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMHSA SIG project, and the perinatal depression grant.
//2013/ During the past year, the Title V/MCH Director participated as a member of the Core Team and the Protocol Work Group of Nebraska's In-Depth Technical Assistance Project (IDTA). Support for the IDTA is provided by the National Center on Substance Abuse and Child Welfare, and Nebraska's project has been focused on families entering the child

welfare/juvenile services system due to problems related to parental substance use, with particular emphasis on substance exposed infants, methamphetamine dependent parents, and children in out-of-home care. Representing Public Health, the Title V/MCH Director is working with representatives of the Court system, Medicaid, child protective services, and behavioral health to achieve systems integration and coordination for the benefit of children and families.//2013//

The Nebraska Department of Education (NDE) is an active partner with Lifespan Health Services in carrying out early childhood programs and initiatives, including ECCS. The Title V/MCH Director has been reciprocally active in the NDE's Early Childhood Policy Initiative, the development of Early Learning Guidelines, and administration of the statutorily required READY Act (early learning materials for all Nebraska newborns and their families). **/2013/ During FY 2011-2012, Lifespan Health Services Unit/Division of Public Health worked extensively with the NDE in the preparation of an application for a Race to the Top early childhood grant. The application outlined a leadership role for the Division of Public Health, in coordinating efforts to establish a Quality Rating and Improvement System for Nebraska early care and education providers. Also included in the application were activities to strengthen child care health consultation and resource development. Though not funded, the application development process fostered an in-depth examination of mutual interest and commitment to early care and education, and the application remains as a blue print for future collaborative efforts as opportunities may occur.**

Also related to early childhood collaborative efforts with NDE and other entities, Nebraska submitted an application in November 2011 to the ZERO TO THREE Policy Center to participate in a 3-day meeting focused on integrating quality home visiting services in a comprehensive and coordinated early childhood system. In December, Nebraska was notified that they were selected with six other states to send a public-private sector team of four or five people to participate. Nebraska home visiting stakeholders met prior to the submission of the application to reach consensus on diverse team membership. Nebraska's team consisted of the Nebraska State Part C/Early Development Network Coordinator, Nebraska Department of Health and Human Services (DHHS), Early Childhood Comprehensive Systems (ECCS) Project Coordinator, DHHS, Director of the Department of Education and Interdisciplinary Center of Program Evaluation (ICPE) and Associate Professor at Munroe-Meyer Institute at the University of Nebraska Medical Center, Associate Vice President Early Childhood Programs-Nebraska's Birth to Three Endowment (Sixpence), Nebraska Children and Families Foundation and the Head Start Early Childhood Systems Director, Nebraska Department of Education.

One member of the team participated on a planning group that developed the agenda and in June 2012 the team traveled to Chicago to participate in the State Policy Action Team on Integrating Quality Home visiting Services in State Early Childhood Systems meeting. The meeting offered both "expert" and peer technical assistance with the state teams sharing their expertise to explore possible solutions to current challenges. The meeting design afforded the team time to discuss each presentation and engage in action planning. The diversity of Nebraska's team proved to be a great asset and the team returned to Nebraska with several key ideas related to home visiting staff in early childhood professional development systems, collecting outcome data and integrating it into early childhood data systems, linking home visiting with Part C and other health/mental health services, including home visiting in quality improvement efforts, and leveraging existing funding sources to support a strong home visiting system. The team in partnership with Nebraska MIECHV is convening a group of home visiting stakeholders in August to share ideas and engage in collaborative planning. Team members have already implemented several action steps identified at the meeting, such as creating an early childhood framework and the private partner is piloting integration around having home visitors from their early childhood program include home visits to enrolled children's child care providers. The other states participating were: Connecticut, Michigan, New Mexico, Georgia, Ohio and

Oklahoma. //2013//

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and were active participants in strategy development work groups. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active work groups. Both urban health departments had representatives participated in a Infant Mortality Disparity work group. This work group will be described in greater detail later in this report/application. In addition, the Douglas County Health Department, through a contract, is developing specific capacity to further develop and promote preconception health interventions in the Omaha area./2012/ Work has been completed through the contract with the Douglas County Health Department (DCHD). DCHD is a collaborator with the Connections Project, being carried out through a contract with the University of Nebraska Medical Center. In addition, DCHD is the WIC local agency implementing the WIC Farmers Market Nutrition Program within the targeted Omaha community./2012//

Nebraska Title V also works with local health departments in more rural areas of the state and with other community health agencies, both as a funder and a collaborator. These local health departments and community health agencies have been key stakeholders participating in a number of projects, including the needs assessment and strategy development work groups./2012/ The Panhandle Public Health District is the primary collaborator for implementation of the ACA Maternal, Infant, and Early Childhood Home Visiting Program in 3 western Nebraska counties./2012//

Nebraska's federally qualified health centers continue to be key partners in serving the MCH population. The Charles Drew Health Center, through its Healthy Start program, provides enabling services to the perinatal population of northeast Omaha. Lifespan Health Services works whenever possible to connect state level activities with Omaha Healthy Start. Staff with Omaha Health Start, Charles Drew Health Center participated in the Infant Mortality Disparity work group this past year./2012/ The WIC Farmers Market Nutrition Program being implemented through the Douglas County Health Department will be utilizing the Charles Drew Health Center for coupon distribution, with a farmers market to be established on the grounds of the clinic. This arrangement seeks to improve access to fresh fruits and vegetables in a community with few grocery stores or existing farmers markets./2012//

Local health departments, federally qualified health centers, and applicable Title V supported community projects are key partners in assuring that pregnant women access prenatal care and help identify pregnant women and children eligible for Medicaid services. In turn, Medicaid presumptive eligibility for pregnant women continues to be determined by many of these providers.

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information. The Primary Care Office was of particular assistance in providing health professional data for the comprehensive needs assessment.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses.

The UNMC College of Public Health was formed in 2007. This college, along with the Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff

development and building public health capacity. Of particular note are plans to develop a MCH emphasis at the CoPH. In addition, CityMatCH, with its administrative home in Nebraska and with partial support from UNMC, has been a valuable partner in a number of MCH initiatives.

Lifespan Health Services continues to develop and sustain a wide range of partnerships. During FY 2009, the Adolescent Health Program applied for and received a mini-grant from AMCHP to support systems planning for adolescent health. Using the ECCS framework as a model, the Adolescent Health Coordinator has assembled a wider range of partners to begin developing a framework specific for adolescent health and well being. Partners include local health departments, family representatives, community advocates, school systems, state department of education, child welfare, Medicaid managed care for mental health, and others. This collaborative project will continue into FY 2010 with the support of Title V funds.

An important partner for both Title V MCH and CSHCN is PTI Nebraska. PTI Nebraska is a statewide resource for families of children with disabilities and special health care needs. PTI Nebraska's staff are parent/professionals and are available to talk to parents and professionals about special education, other services and disability specific information. PTI Nebraska conducts relevant, no cost workshops statewide and provides printed and electronic resources. PTI Nebraska encourages and supports parents in leadership roles. Its Mission is to provide training, information and support to Nebraska parents and others who have an interest in children from birth through twenty-six and who receive or who might need special education or related services and to enable parents to have the capacity to improve educational outcomes for all children. PTI and particularly its Family to Family Program has collaborated with Nebraska Title V on activities ranging from the needs assessment, to oral health access, and to medical home initiatives.

The Medically Handicapped Children's Program (MHCP) is working in collaboration with Boys Town Research Institute for Children's Health Improvement on a medical home model which includes 10 medical practices from across Nebraska. The activities of this project support transitioning the 10 practices to medical homes providers for the children and youth with special health care needs patients they are serving. This collaboration provides different activities to improve the primary health care delivery system for CSHCN and has an emphasis on care coordination.

/2012/ The Medically Handicapped Children's Program (MHCP) continues to collaborate with Boys Town Research Institute for Children's Health Improvement on a medical home model. The initial Medical Home Grant ended in May of 2011, but was granted a no cost extension to continue funding the Parent Partners that have been established because of the pilot project through December 2011. The project is currently funding 6 Parent Partners in 6 medical practices that participated in the Medical Home Pilot Project. Additional Parent Partners were added to medical practices with funding collaboration with the Early Development Network. Additional funding is being sought to sustain all the Parent Partner positions. The data gathered from this project shall assist in expanding medical home services across Nebraska.
//2012//2013/ The partnership between MHCP and Boystown continues its collaboration to support the Partents as Partners Program that was developed from the initial Medical Home Grant.//2013//

/2012/The MHCP Program continues to work with the Answers4Families website to provide an overview of our clinic services and their staff. //2012// **/2013/MHCP provided direct administrative support for 41 medical clinics across Nebraska which provided health services to 385 children and youth with special health care needs. MHCP also has a partnership agreement with the University of Nebraska Medical Center to support the administrative functions for additional outreach clinics for diabetes, cardiology, and cystic fibrosis. The data from these clinics is not reflected in the data provided.//2013//**

/2012/The Medically Handicapped Children's Program is partnering with the University of Nebraska Medical Center's Munroe-Meyer institute on the Innovative Epilepsy Services

Expansion in Nebraska Project Access. This is a three year grant with a work plan to provide expanded service delivery for rural pediatric patients with epilepsy as well as epilepsy educational opportunities for community stakeholders and school professionals.//2012//

With two new Medicaid Managed Care Plans going into effect August 1, 2010, opportunities will be available for coordination on performance improvement projects impacting a 10 county area. This area includes the bulk of Nebraska's Medicaid eligible MCH and CSHCN population. The 2 health plans (Coventry and Share Advantage) will begin reporting on a number of HEDIS performance measures, with these of particular relevance to MCH and CSH: Comprehensive Diabetes Care; Chlamydia Screening in Women; Cervical Cancer Screening; Use of Appropriate Medications for People With Asthma; Medical Assistance With Smoking Cessation; Prenatal and Postpartum Care; Frequency of Ongoing Prenatal Care; Well Child Visits in the First 15 Months of Life; Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; Adolescent Well-Care Visits; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC); Lead Screening in Children; Childhood Immunization Status Combo 2 and Combo 3; Childhood Immunization Status Combo 3; Race/Ethnicity Diversity of Membership; and EPSDT Screening Participation Rate.

/2012/ The Department of Health and Human Services will expand the full-risk capitated physical health managed care program into the additional 83 counties not currently served by full-risk managed care effective July 1, 2012.//2012//

The managed care program for physical health is now in the following counties: Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington. Also, for case management, the clients that must be offered case management services. Each health plan must conduct a Health Risk Assessment and offer Case Management/Disease Management activities to the following groups of clients at a minimum: Clients falling under the Medicaid eligibility category of the Aged, Blind and Disabled, i.e., AABD; Special Needs clients; Children who are in Foster Care Placement; Clients with chronic and/or special health needs (i.e. diabetes, asthma, hypertension, and obesity at a minimum); Clients at risk for poor health outcomes; Children with positive results from lead testing; Clients discharging from the hospital; Clients in Lock-In status; Clients with multiple missed medical appointments; Clients with screening results indicating referral treatment without follow up; Clients requesting case management activities; and Clients whose PCP has made a referral for case management activities.

/2013/ The Department of Health and Human Services has expanded the full-risk capitated physical health managed care program into the additional 83 counties not previously served by full-risk managed care effective July 1, 2012. The managed care health plans serving the expansion 83 counties are CoventryCares and Arbor Health Plan.

The managed care program for physical health is now statewide. Also, for case management, the clients that must be offered case management services. Each health plan must conduct a Health Risk Assessment and offer Case Management/Disease Management activities to the following groups of clients at a minimum: Clients falling under the Medicaid eligibility category of the Aged, Blind and Disabled, i.e., AABD; Special Needs clients; Children who are in Foster Care Placement; Clients with chronic and/or special health needs (i.e. diabetes, asthma, hypertension, and obesity at a minimum); Clients at risk for poor health outcomes; Children with positive results from lead testing; Clients discharging from the hospital; Clients in Lock-In status; Clients with multiple missed medical appointments; Clients with screening results indicating referral treatment without follow up; Clients requesting case management activities; and Clients whose PCP has made a referral for case management activities.

DHHS will move to a full-risk capitated managed care program for the Medicaid Behavioral Health services effective July 1, 2013. This move will offer expanded case management opportunities for those with chronic mental health needs and will facilitate coordination

between the medical and behavioral health services and needs of Medicaid clients.//2013//

F. Health Systems Capacity Indicators

/2013/ The following three Health Systems Capacity Indicators are of particular relevance and utility in measuring the impact of work being carried out through Nebraska's Early Childhood Comprehensive Systems project, "Together for Kids and Families" or TFKF:

HSCI #02 -- The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

HSCI #03 -- The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year who received at least one periodic screen.

HSCI #07B -- The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

In January of 2012 Nebraska's ECCS Project Coordinator shared Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders developed by U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau with the Dental/Medical Home work group. This work group consists of early childhood stakeholders that are engaged in the implementation of the early childhood state strategic plan developed through the ECCS initiative. The two strategies of the TFKF plan that the Dental/Medical group focus efforts on are: 1) Implement and sustain the dental/medical home as a standard of care and 2) Establish the infrastructure to support a comprehensive system promoting access to oral health services including preventive oral health care.

The Dental/Medical Home work group agreed that the toolkit was useful in assisting with further development of action steps and designated a small group to review the tool in depth and make recommendations regarding its use. In May the large group met for a facilitated planning session around three sections of the document that had been recommended by the review team. The three sections chosen were; Section 2: Medicaid's EPSDT mandates financing for child health services and supports to improve access to care; Section 6: States play a central role in maximizing the impact of EPSDT comprehensive well-child screening visits and Section 8: A dental home and appropriate dental services are essential to the health of every child. Many questions and ideas were generated from this discussion and group members agreed to follow-up with colleagues to answer questions those at the table could not answer, bring this back to the group and then reach consensus on actionable items for the work plan. The next meeting of the group is scheduled for August of 2012, with work continuing into FY 2013.

In addition, HSCI #07B is utilized to measure progress in addressing Nebraska's Title V priority to increase access to oral health care for children including children with special health care needs. This indicator has shown an unfavorable trend downwards over the past three years. See narrative for National Performance Measure #9 for information on other activities related to this indicator and associated priority.

HSCI #04, the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck index has remained relatively unchanged over the past three years. To better understand factors impacting this and other pregnancy related indicators, a project is under way linking Nebraska PRAMS data with vital records. The Maternal and Child Health Epidemiology program began analysis on low birth weight and preterm outcomes, by linking PRAMS data (2000-2010) to the birth certificate, to investigate factors that are

associated with the outcomes, as well as looking for indicators that predict behavior change in mothers who have had a previous low birth weight/preterm birth. One preliminary early finding is adequate prenatal care predicts outcomes.

HSCI #04 is utilized to measure progress in addressing Nebraska's priority to increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care. This indicator may also provide a gauge to measure impact of LB 599 (2012) which will create a separate CHIP program specifically and solely for unborn children. //2013//

IV. Priorities, Performance and Program Activities

A. Background and Overview

This application for FFY 2011 marks the beginning of a new 5-year planning period. The Needs Assessment completed in 2010 establishes a new list of priorities. Though some of the priority issues had been identified in previous assessments, the new list reflects a subtle but distinct shift towards socio-ecological determinants of health and thus a greater consideration of system level strategies.

Yet at the same time, the impact of a national recession has been felt in Nebraska. Needs of children and families have increased while at the same time public resources are diminishing. The focus of the Nebraska Legislature, as it has been in many other states, has been to address revenue shortfalls. Thus there is a natural tension between the need to maintain basic services with our existing resources while at the same time attempting to move towards new models and interventions.

The Affordable Care Act (ACA) is proving to be a resource for some MCH interventions, notably home visitation, teen pregnancy prevention, and supports for pregnant and parenting teens and women. Such funds, though, are categorical and do not alleviate the need to continue to invest Title V and other funds in ongoing programs and to try to meet the increasing demands placed on them.

Title V funding provides the support for the Medically Handicapped Children's Program to continue to fill the gaps in health services and supports by providing necessary medical care and supportive services to families across Nebraska with children with complex medical needs. For FFY 11, the Medically Handicapped Children's Program supported 285 new applications that were verified and opened for services. The program continued to see an increase in pending and open applications for children with a diagnosis of diabetes. MHCP supported 804 pending, open, and deny applications for FFY 11 with 26% of the applicants not having health coverage. MHCP continues to balance between the increased need and the stagnant funding to meet the increasingly complex medical needs of CSHCN. The program continues to collaborate with community partners to identify additional local supports to assist in meeting the needs of CSHCN across Nebraska.

Title V funds continue to be a primary or significant source of support for many other components of Nebraska's public health and MCH infrastructure, such as Newborn Screening, Birth Defects Registry, Child Death Review Team, and Oral Health. In recent years, the proportion of Title V funds needed to maintain this infrastructure has steadily increased to over two thirds of the Block Grant. The ability to address new priorities and move to new public health models will require special attention to incorporating new strategies into old programs, developing new and expanded partnerships, and diligence in identifying and seeking new grant sources.

/2012/ With reductions in the federal appropriation for Title V in 2011, and additional reductions a possibility in 2012, maintenance of existing infrastructure continues to place a significant demand on the Title V Block Grant. In addition, a significant proportion of state-level MCH manpower has been focused on designing and implementing new programs funded through the Affordable Care Act, particularly Maternal, Infant and Early Childhood Home Visiting and Personal Responsibility and Education Program (PREP). Consequently, attention to priorities identified in 2010 has not received the level of attention that would have been desired. Nebraska Title V will need to continually examine its organizational and logistical capacity to address its priorities.//2012//

B. State Priorities

Nebraska completed its most recent comprehensive needs assessment in 2010. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource

capability to address each, and the relative National and State performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until planning for state-level strategies is conducted in FFY 2012.

1. Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.

This need was identified in 2005 and has been retained. Nebraska's capacity assessment committee determined the capacity to address this need as high due the large amount of resources that have been made available to address this issue, the broad based networks/collaborative(s) that are engaged, and the level of knowledge/analysis of the priority. Nebraska will retain State Performance Measure (SPM) # 1 and will use National Performance Measure (NPM) #14 to monitor progress.

SPM # 1: Percent of women (18-44) with a healthy weight.

NPM # 14: Percentage of children, age 2-5 years, receiving WIC services with a BMI at or above 85th percentile.

//2013/ Public input solicited for this applicaton included comments that schools are making greater progress in physical activity efforts, but less so in improving nutrition of foods offered.//2013//

2. Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.

This is a new priority. The priority is based on the increasing trend in STD's for youth and women as well as the persistent rate of unintended pregnancy. These data speak to the broader context and need to improve the reproductive health of youth/women. The capacity level for this priority is low due to modest funding levels and need for more dedicated resources, the lack of formal networks/coalition(s) especially state-wide, and lack of consensus among the public regarding teen pregnancy and sexual activity as a problem. Nebraska will use the following measures to track progress:

Health Status Indicator # 5A and 5B: The rate per 1,000 women age a) 15 -19 and b) 20-44 with a reported case of chlamydia.

NEW SPM : The percentage of live births that were intended at the time of Conception.

//2012/ Additional capacity to address this priority includes the newly established Personal Responsibility Education Program (PREP) and the re-established Abstinence Education program.//2012//

//2013/ Public input solicited for this application pointed to barriers to accessing reproductive health services, particularly long drives to clinics and/or limited hours.//2013//

3. Reduce the impact of poverty on infants/children including food insecurity.

This is a new priority identified by the comparison of poverty rates among Nebraska's infants and children with the national rates as well as the increasing rates of food insecurity. The capacity level assigned is moderate due to the relatively high number of programs and resources targeted at poverty, but the lack of public health participation in the networks/coalitions and the lack of expertise in addressing the issue. Nebraska will use the following measure to track progress:

NEW SPM : The percent of children living in poverty who have health insurance.

/2013/Public input solicited for this application included issues of racial/ethnic disparities and finding a balance between interventions with individuals and community-level strategies.//2013//

4. Reduce the health disparities gap in infant health status and outcomes.

This new priority incorporates two former priorities: 1) Reduce the rates of infant mortality, especially racial/ethnic disparities, and 2) Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy. The Needs Assessment Committee determined that reducing disparities in infant health would reduce rates of infant mortality, preterm and low birth weight births, as well as impact many other indicators across the remaining life course. The capacity level assigned is moderate because while there are programs dedicated to improving disparities in infant outcomes they are spotty, need more resources and are not adequately networked together. While data is available there is need for more evidence-based interventions. Nebraska will use the following measure to track progress:

Outcome Measure # 2: The ratio of the African American infant mortality rate to the Caucasian rate.

NEW SPM : The ratio of the African American premature birth rate to the Caucasian rate.

/2012/ A new initiative launched in FY2011 is the Connections Project. A one-year pilot being carried out through a contract with the University of Nebraska Medical Center, Connections is a research and outreach effort, and consists of three community-based program components in Omaha. These three programs will work synergistically to form vital connections at individual and community levels to build community capacity to support healthy African American pregnancies and families, and thus reduce disparities in birth outcomes. The 3 program components are: 1) develop a Women, Infant and Children (WIC)-based peer support program for African American women in Omaha; 2) provide community-based lectures/discussions focusing on community-based strategies to foster healthy pregnancy; and 3) develop community leaders committed to advancing healthy birth outcomes in Omaha's African American community.//2012//

/2013/ Public input solicited for this application focused on the connection between economics and disparities, such as being able to afford prenatal care, Medicaid non-coverage of a service covered by private insurance widening disparities, and cost of quality translation and interpretation.//2013//

5. Increase access to oral health care for children and CSHCN.

This is a new priority identified by the availability of more data from the National Survey on Children's Health and the low rates of access to care among Medicaid/EPSDT eligible children. The capacity level assigned is moderate because there is knowledge on how to address the problem and the amount of effort to address the problem is high, however surveillance (open mouth survey) needs to be updated and the provider shortages and barriers to accessing care particularly for Medicaid enrolled children are significant. Nebraska will use the following measure to track progress:

NPM # 9: The percent of children who have received a protective sealant on at least one permanent molar tooth

HSCI #7B: The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.

NEW SPM : The percent of young children (1-5) who have excellent/very good dental health.

/2013/ Public input solicited for this application included concerns that the new MCO agreements in rural Nebraska not including dental health as a part of case management and commenters emphasized the role of public health in addressing this need.//2013//

6. Reduce the rates of abuse and neglect of infants and CSHCN.

This need was identified in 2005 and has been retained and narrowed to the most vulnerable subpopulations, infants and CSHCN. The capacity level assigned however is low because Nebraska still lacks a comprehensive primary prevention system, and does not have adequate maltreatment surveillance. The current system requires quality improvements in data collection for CSHCN, and while the working relationships between child welfare and public health are adequate they can be enhanced. Nebraska will use the following measure to track progress:

NEW SPM: The rate per 1,000 infants of substantiated reports child abuse and neglect.

/2012/ Nebraska will be building capacity in the area of prevention of abuse and neglect through the implementation of evidence-based home visiting, through the Maternal, Infant, and Early Childhood Home Visiting Program. The model chosen, Healthy Families America, has significant potential to impact abuse and neglect within the targeted communities, and will help build state-level expertise in implementing an evidence-based model with fidelity.//2012// ***/2013/ The transfer of administrative responsibilities for the State General Fund supported home visitation program to the Division of Public Health, Lifespan Health Services Unit will allow for greater coordination and integration of effort to prevent abuse and neglect through home visiting. Public input solicited for this application raised concerns regarding reporting mechanisms for abuse and neglect and the need for more supports for parents.//2013//***

7. Reduce alcohol use and binge drinking among youth.

This need was identified in 2005 and has been retained. The capacity level for this priority is high due to years of funding for infrastructure and local collaborative(s) who are currently implementing/evaluating evidence based interventions. Nebraska will use the following measure to track progress:

SPM # 4 Percent of teens who report use of alcohol in the past 30 days.

/2013/ Nebraska's Strategic Prevention Framework State Incentive Grant Program expires September 2012. Public input solicited for this application included a recommendation that beverage server training, compliance checks, and sobriety checks should continue in some fashion, and teen alcohol prevention programs should be integrated into other adolescent health programs such as teen pregnancy prevention and Safe Kids.//2013//

8. Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care.

This is a new priority. The capacity level assigned is moderate due to the changing environment surrounding funding and other resources, as well as a lack of gap filling services. Nebraska will use the following measures to track progress:

NPM # 18: Percentage of infants born to women receiving prenatal care beginning in the first trimester.

HSCI # 4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

/2013/ Public input solicited for this application included concerns with accessing services for maternal depression, need for diabetes screening guidelines, and barriers to enrolling in Medicaid as a result in changes to the eligibility process (AccessNebraska).//2013//

9. Increase the prevalence of infants who breastfeed exclusively through six months of age.

This is a new priority identified by the availability of more data from multiple sources. The capacity level assigned is high due to the strong network of advocates in the Nebraska Breastfeeding Coalition, the knowledge of how to address the priority, and the federal legislation addressing workplace policies. Nebraska will use the following measure to track progress:

NPM # 11: The percent of mothers who breastfeed their infants at 6 months of age.

/2013/ Public input solicited for this application raised concerns with hospital practices and resources and with advice provided by medical providers.//2013//

10. Increase access to Medical Homes for CSHCN particularly for those with functional limitations.

This is a new priority identified by the availability of more data from the National Survey on Children's Health and the National Survey of Children with Special Health Care Needs. The capacity level assigned is moderate due to the strength of partners who are addressing the need and the knowledge on how to address the problem. But the efforts are fragmented and need systemic implementation. Nebraska will use the following measure to track progress:

NPM # 3: The percent of CSHCN 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

/2013/ Public input solicited for this application pointed to expansion of Medicaid managed care and the change to AccessNebraska as potentially impacting access to medical homes, and the need for navigators to help families through the health care system. Nebraska is developing an Aging and Disability Resource Center (ADRC) to support medical home outreach efforts and identify local providers utilizing this model of care.//2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	185	545	600	644	838
Denominator	185	545	600	644	838
Data Source		Program Data	Program Data	Program Data	Program Data
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

134 babies had a presumptive positive and 704 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .This number does not include the 428 hemoglobinopathy patterns that were indicative of trait/carrier status. Total infants that were tracked with presumptive positive, abnormal or inconclusive results is 1,266 for 2011 .

Notes - 2010

126 babies had a presumptive positive and 518 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .(this number does not include hemoglobinopathy patterns that were indicative of trait/carrier status)

21 out of the 518 expired and required no follow up.

Notes - 2009

123 babies had a presumptive positive and 477 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .(this number does not include hemoglobinopathy patterns that were indicative of trait/carrier status)

4 out of the 477expired and required no follow up.

a. Last Year's Accomplishments

The Nebraska Newborn Screening & Genetics Program managed mandated screening for 28 diseases (Argininosuccinic Acidemia, Beta-ketothiolase deficiency, Biotinidase Deficiency, Carnitine Uptake Defect, Citrullinemia, Congenital Adrenal Hyperplasia, Congenital Primary Hypothyroidism, Cystic Fibrosis, Galactosemia, Glutaric Acidemia type I, Hemoglobinopathies, Homocystinuria, Isovaleric Acidemia, Long Chain Hydroxyacyl-CoA Dehydrogenase Deficiency, Maple Syrup Urine Disease, Medium Chain Acyl-CoA Dehydrogenase Deficiency, Methylmalonic Acidemia, (MMA-Mutase), Methylmalonic Acidemia (Cbl A, B), Multiple Carboxylase Deficiency, Phenylketonuria, Propionic Acidemia, Tyrosinemia, Trifunctional Protein Deficiency, Very Long-Chain Acyl-CoA Dehydrogenase Deficiency, 3-Hydroxy 3-methylglutaric aciduria, and 3-Methylcrotonyl-CoA Carboxylase Deficiency during this reporting period.

All newborn specimens from Nebraska newborns were sent to PerkinElmer Genetics Inc. Laboratory. As a result of a negotiated rate of \$38.50 for testing and NBS fee. The fee is billed to the specimen submitters. For each infant screened the laboratory retained \$28.50 for shipping, laboratory testing services and reporting, and \$10 per infant was returned to the state program to help support the provision of metabolic formula and food, dietitian consultation and part of an FTE for a Pediatric Metabolic Specialist to assist the program with initial follow-up communication with newborns' medical homes.

The contracts to provide metabolic foods and formula and medical/dietary services were supported via Cash funds from revenue generated by the fee, State General funds and the Title V Block grant allocation to the program. In addition, Title V funding helped support a consultant agreement with the Accredited Cystic Fibrosis Center to assist with follow-up and a consultant agreement with a pediatric hematologist.

Statistics

The numbers screened can only be reported by calendar year. Ninety nine and ¾ (99.75%) of all births in Nebraska received a screen. In 2011 Nebraska had 26,095 births reported (preliminary numbers) to the Newborn Screening Program of which 26,030 were screened. Sixty-five were not screened as they expired by 48 hours of birth. There were 113 home births, of which all were screened but three who expired.

Thirty six (36) newborns with disorders were identified and treated early to prevent mental retardation, physical disabilities and disease, and infant death. The following list identifies which conditions and the number of babies who were picked up on the screen and for whom early intervention was initiated:

- 3 babies with partial biotinidase deficiency (treated)
- 1 with congenital adrenal hyperplasia (classical)
- 6 with cystic fibrosis
- 4 with congenital primary hypothyroidism
- 3 with congenital hypothyroidism
- 1 with hypothyroidism -- prematurity
- 1 with classic galactosemia
- 2 with Duarte galactosemia
- 1 with isovaleric acidemia
- 3 with phenylketonuria (PKU)
- 2 with sickle disease
- 3 with sickle-hemoglobin C disease
- 1 with hemoglobin C disease
- 1 with hemoglobin E disease
- 4 with transient tyrosinemia - treated

The program continued to implement in collaboration with the Early Hearing Detection and Intervention (EHDI) program, the NBSAC & EHDI Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as Connexin 26 & 30, CMV, Pendred and mitochondrial causes.

The Department initiated proposed regulation revisions to add SCID (severe combined immune deficiency) to the screening panel.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened, referred, tracked & facilitated treatment for 28 required disorders as per Neb. rev. Stat. 71-519 to 525.			X	
2. Conducted quality assurance activities with hospitals, contracted laboratory, and referral networks.				X
3. Provided metabolic foods, special formula, and consultation to patients/families through contractual arrangements.		X		
4. Provided leadership both nationally and regionally in promoting high quality newborn screening.				X
5.				
6.				
7.				
8.				
9.				

10.				
-----	--	--	--	--

b. Current Activities

The program continues to screen for 28 required conditions in accordance with the ACMG core panel recommendation. Education, NBS testing, follow-up, referral and treatment and ongoing evaluation and quality assurance activities continue. The program monitors progress towards regulation revision adding SCID and developing professional education strategies/materials to prepare hospitals and clinicians for implementation . The Program is working with a sub-committee of stakeholders on newborn screening for critical congenital heart disease.

In 2011 into 2012, the Nebraska Newborn Screening Advisory Committee (NBSAC) met quarterly and advised the program on many issues resulting in program staff making procedural, policy and regulatory changes or at a minimum development of a Committee position or recommendation.

The program continued its continuous quality improvement monitoring and submission of individual hospital QA reports (providing statewide averages for comparison).

The program continued to provide all hospitals with parent education brochures, increased distribution of a new introductory one-page parent information sheet to prenatal care providers (OB/GYN & Family physicians), and developed and distributed a new brochure explaining the requirement for screening prior to discharge. The web page was updated with a new practitioner's manual developed (in 2011 & 2012) with a postcard notice provided to practitioners.

c. Plan for the Coming Year

The program and its advisory committee will continue evaluating the appropriateness of screening for Critical Congenital Heart Disease as per the endorsement of the Secretary of Health and Human Services. The evaluation includes availability of necessary resources as well as what if any role public health should have. Legislation expected to be introduced in 2013 will be monitored.

All of the activities above will continue as well.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	26095					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens		(C) No. Confirmed Cases (2)	
	No.	%	No.	No.	No.	%

Phenylketonuria (Classical)	26030	99.8	9	3	3	100.0
Congenital Hypothyroidism (Classical)	26030	99.8	70	7	7	100.0
Galactosemia (Classical)	26030	99.8	4	1	1	100.0
Sickle Cell Disease	26030	99.8	2	2	2	100.0
Congenital Adrenal Hyperplasia	26030	99.8	7	1	1	100.0
Cystic Fibrosis	26030	99.8	35	6	6	100.0
SC-Disease	26030	99.8	3	3	3	100.0
Duarte Galactosemia	26030	99.8	4	2	2	100.0
Isovaleric Acidemia	26030	99.8	1	1	1	100.0
Partial Biotinidase Deficiency	26030	99.8	8	4	4	100.0
Hemoglobin C-Disease	26030	99.8	1	1	1	100.0
Hemoglobin E-Disease	26030	99.8	1	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	69.1	67	68.4	69.7	71.1
Annual Indicator	65.7	65.7	65.7	65.7	75.6
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	77.1	78.6	80.2	81.8	83.5

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data

a. Last Year's Accomplishments

Continued parent collaborations with the Early Childhood Interagency Coordinating Council, The Regional Planning Teams, and the Early Hearing Detection Advisory Council.

Continued promotion of the comprehensive Child Find System.

Developed strategies to implement a Youth Advisory Council for the MHCP program which includes a partnership with Easter Seals of Nebraska.

Enhanced the Transportation Brokerage to provide MHCP families with improved access to authorized supportive services through one statewide entity.

Provided training to MHCP staff and families on the transition to the Transportation Brokerage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in the Family to Family Health Information Center Advisory Board which partners with parents in working to streamline communication and resources around the State for children and youth with special health care needs.				X
2. Continued to promote comprehensive Child Find System through Early Development Network.		X		
3. Continued the Early Childhood Interagency Coordinating Council which collectively brings together stakeholder, schools, parents, families, policymakers, and business and civic organizations to establish a seamless continuum of early childhood care.		X		
4. Maintained and support local Planning Region Teams to monitor and lead their area in working towards streamlined services and supports for children needing and receiving Early Intervention Services.				X

5. Facilitated supporting parent leadership/mentoring activities to enhance Early Development Network Services.				X
6. Continued to provide clinic experience surveys for the Medically Handicapped Children's Program medical clinics so that services can be enhanced and developed based on identified family need.				X
7. Maintained the Early Hearing Detection Advisory Committee which works along side parents to maintain an ongoing voice in enhancing hearing services for infants.				X
8. Participated in the development of Nebraska's Aging and Disability Resource Center (ARDC) to support streamlined access to services for all populations including CYSHCN.				X
9. Developing a transition model for the Medically Handicapped Children's Program populations to support long-term guidance and support for CYSHCN in partnership with Easter Seals of Nebraska.				X
10.				

b. Current Activities

Continue parent collaborations with the Early Childhood Interagency Coordinating Council, The Regional Planning Teams, and the Early Hearing Detection Advisory Council.

Continue promotion of the comprehensive Child Find System.

Continue to enhance the Transportation Brokerage services to provide MHCP families with easy access to authorized supportive services through one statewide entity.

Reviewing current MHCP clinic services and determine if services changes are needed.

Developing a parent test group to provide feedback on a new on-line billing system to support on-line program claim activities.

Continue participation in the Family to Family Advisory Board to encourage communication among all participant to enhance services of all types for children and youth with special health care needs.

Promote the medical home concept and assist in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

Continue participating in OSEP (U.S. Office of Special Education Programs) reporting. October 1, 2010 indicated that Nebraska served 185 infants ages birth to 1 with disabilities, which is 0.71 % of this population. The data also indicated that Nebraska served 1537 infants and toddlers, ages birth to three, which is 1.94 % of this population, which shows progress over the number served in previous years. Source: Nebraska Part C Annual Performance Report.

c. Plan for the Coming Year

Continue parent collaborations with the Early Childhood Interagency Coordinating Council, The Regional Planning Teams, and the Early Hearing Detection Advisory Council.

Continue promotion of the comprehensive Child Find System.

Finalize a transition model in partnership with Easter Seals of Nebraska. Through this process an Advisory Group shall be developed which will include MHCP participants and their families.

Finalize a new on-line billing system to support on-line program claim activities.

Continue participation in the Family to Family Advisory Board to encourage communication among all participants to enhance services of all types for children and youth with special health care needs.

Continue EDN and MHCP programs promoting the medical home concept and assisting in professional development activities related to initiatives for infants, toddlers, and young children and young adults.

Continue participating in OSEP (U.S. Office of Special Education Programs) reporting on the Part C Annual Performance Report.

Participate in the development of Nebraska's Aging and Disability Resource Center (ADRC).

Participate in the Medicaid Infrastructure Grant (MIG) to support transition and employment.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	56.1	55.2	56.4	57.5	58.6
Annual Indicator	54.2	54.2	54.2	54.2	48.2
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	49.2	50.2	51.2	52.2	53.2

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Weighted data.

a. Last Year's Accomplishments

MHCP used the information from the medical home training sessions to educate families and medical clinic providers on the medical home concept. The information will be used as a tool to assist families in screening and locating a medical home provider in their area

MHCP gathered information to work towards incorporating the medical home model into the medical clinic services that it provides to children and young adults with special health care needs.

MHCP continued to work in collaboration with Boys Town Medical Home Project to train the parent partners in pediatric medical practices to assist families with accessing local services and supports outside the scope of the child's medical.

MHCP continued to develop strategies for sharing information and resources for families on medical home on the Answer4Families Website.

Participated in the Together for Kids and Families Project to expand the medical home concept to dental providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early Development Network continued to fund Parents Partners in some of the medical practices in the Boys Town Medical Home Project to continue delivery of this service model.				X
2. MHCP continued to participate in the Nebraska Medical Home Project, per LB 396, 2009 the Nebraska Medical Home Pilot Program Act. This project will provide additional data to support expanded these services throughout Nebraska.				X
3. MHCP coordinators worked with families on establishing medical home providers.			X	
4. Continued to apply knowledge of the medical home model in the provision of CAPTA services through the Early Development Network.			X	
5. Established a partnership with Aging and Disability Resource Center (ADRC) to enhance access to medical home information and provide support direct support.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Continues to participate in the Nebraska Medical Home Project to assist in obtaining additional information for MHCP and EDN Coordinators and Medical Staff on the concept of a medical home throughout Nebraska.

The MHCP program is working towards incorporating the medical home model into the medical clinic services that it provides to children and young adults with special health care needs.

MHCP continues to collaboration with Boys Town Medical Home Project to maintain the Parent Partners in the pediatric medical practices to assist families with accessing local services and supports outside the scope of the child's medical.

MHCP is working on strategies for sharing information and resources for families on medical home on the Answer4Families Website to ensure needed information is easy to access.

Continues participation in the Together for Kids and Families Project to expand the medical home concept to dental providers.

c. Plan for the Coming Year

Continue to partner in the Nebraska Medical Home Project to support obtaining information for MHCP and EDN Coordinators and Medical Staff on the concept of a medical home throughout Nebraska.

MHCP will continue the collaboration with the Boys Town Medical Home Project to maintain the Parent Partners in the pediatric medical practices to assist families with support a medical home for patients.

Develop a transition model process for MHCP medical clinics which incorporates the medical home model into the medical clinic services that are provided to children and young adults with special health care needs.

Enhance partnership with the Aging and Disability Resource Center (ARDC) program and develop strategies for sharing information and resources for families on a medical home on the ADRC Website to ensure needed information is easy to access.

Continue participation in the Together for Kids and Families Project to expand the medical home concept to dental providers.

Continue to participate in the Family to Family Health Advisory Board to share information on this topic.

Partner with the Division of Public Health on the Chronic Disease Management Program to support promotion of the medical home concept through this program.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	66.3	67.2	68.6	69.9	71.3
Annual Indicator	65.9	65.9	65.9	65.9	59.7
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	60.9	62.1	63.4	64.6	65.9

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Weighted data.

a. Last Year's Accomplishments

MHCP gathered data from an enhancement made to the CONNECT system to review family income information to support an increase in the current 185% eligibility guideline for the MHCP program.

Worked to finalize planning for physical health managed care to be expanded to 83 counties additional that were not being served through managed care services.

The Medicaid eligibility expansion continued to provide CHIP coverage to children in families with income equal to or less than two hundred percent of the Federal Poverty Level (FPL). Additional children will receive access to Medicaid services across Nebraska. Authority is provided through Legislative Bill 603 of the 2009 Nebraska Legislative Session.

Medicaid staff continued to explore options for implementing the HCBS Waiver for autism services.

Continued collaborative efforts with the Family to Family Health Information Center and Answers4Families Website to provide health care information and resources to families across Nebraska.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked to complete expansion of the physical health managed care program into the additional 83 counties not currently served in Nebraska.				X
2. Continued expansion of Medicaid CHIP coverage to children and families with income up to 200% of the Federal Poverty Level.			X	
3. Continued planning and review to expand the financial guidelines for the Medically Handicapped Children's Program.			X	
4. Collaborated with Answers4Families to provide information and outreach for clinic services for children and youth with special health care needs.				X
5. Continued partnership with UNMC Munroe-Meyer Institute to expand health services across Nebraska for children and youth with a diagnosis of epilepsy using telehealth services.			X	
6. Established a partnership with Aging and Disability Resource Center program to support information and networking services to link CYSHCN to available coverage options and/or resources.				X
7.				
8.				
9.				
10.				

b. Current Activities

Continue collaborative efforts with the Family to Family Health Information Center to provide health care information and resources to families across Nebraska.

The Department of Health and Human Services will complete expansion of physical health managed care into the additional 83 counties not currently served by managed care.

Continue Medicaid CHIP expansion to coverage children and families with an income up to 200% of the Federal Poverty Level.

Develop a policy recommendation to increase for income guidelines for the Medically Handicapped Children's Program to expand the population served.

c. Plan for the Coming Year

Work to implement an increase in the income guidelines for the Medically Handicapped Children's Program.

Continue collaborative efforts with the Family to Family Health Information Center.

Fully implement the expansion of physical health managed care to the additional 83 counties in Nebraska not currently served by Managed Care.

Work with the Aging and Disability Resource Center program to support Information & Referral efforts, linking all consumer populations, including CSHCN, with local, state, and private resources to support locating medical coverage services and supports.

Develop a transition model for clients attending the MHCP medical clinics across the State to support options counseling, medical and educational services, resource support, and employment.

Continue the partnership with UNMC Munroe-Meyer Institute on expanding telehealth services across Nebraska for children and youth with a diagnosis of epilepsy using telehealth services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	83	93.7	95.6	97.5	99.4
Annual Indicator	91.9	91.9	91.9	91.9	70.7
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	72.1	73.5	75	76.5	78.1

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05. Weighted data.

a. Last Year's Accomplishments

Reviewed new strategies for the development of a Youth/Family Advisory Committee to involve clients and/or their family members to assist in developing a process to add transition services into our current clinics and to provide client consultation to the program. The committee would also serve as a source for information outreach on the medical home model.

Maintained the Children and Family Support Hotline as a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line and provide referrals to existing community-based resources. It would also include the establishment of a Family Navigator Program with individuals trained to respond to children's behavioral health needs.

Worked on regional collaborations on expanding telehealth services within the field of neurology for additional rural access to this specialized medical service.

Implemented a Transportation Brokerage to allow families access to authorized program services using one statewide entity for access and provided training for MHCP staff and families on the transition in authorizing supportive services to the Transportation Brokerage.

The Early Development Network (EDN) administered a satisfaction survey reporting on services coordination and delivery of service.

The MHCP program expanded the parent clinic satisfaction survey into a tool that can be utilized for all program services and recipients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued a yearly survey of families who have a child enrolled in Early Development services to assess the previous year's service delivery.				X
2. Enhanced Answers4Families website to streamline information to improve access to information for families.				X
3. Continued enhancements to the statewide Transportation Brokerage services to support access to transportation authorizations from one statewide entity.				X
4. Continued family feedback on MHCP clinic services through a family survey of services.				X
5. Established a partnership with the Aging and Disability Resource Center program (ARDC) which will support a network of local, state, and private service partners and information and referral system to support linking families resources.				X

6. Developed planning and partnerships to support development of a transition service model for clients accessing MHCP medical clinic services to support transition information and planning.				X
7.				
8.				
9.				
10.				

b. Current Activities

Continue to maintain the Children and Family Support Hotline as a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line.

Continue to collaborate with the University of Nebraska's Munroe-Meyer Institute on expanding telehealth services within the field of neurology for additional rural access to this specialized medical service.

Continue to enhance the Transportation Brokerage to allow families access to authorized program services using one statewide entity for access.

EDN will continue to administer a yearly satisfaction survey reporting on services coordination and delivery of service.

The MHCP program shall continue to use the parent clinic satisfaction survey.

Continue to enhance Medically Handicapped Children's Program/Early Development Network/Home and Community Waiver outreach services, program information, and supports processes and partnerships.

Early Development Network will continue to collaborate with the Nebraska Department of Education's Migrant recruiters/coordinators, EDN Services Coordinators and providers to increase awareness and education regarding Part C referrals for Migrant families.

c. Plan for the Coming Year

Will continue to Maintain the Children and Family Support Hotline as a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line.

Collaborate with the University of Nebraska's Munroe-Meyer Institute on expanding telehealth services within the field of neurology for additional rural access to this specialized medical service.

Continue enhancements to the Transportation Brokerage to allow streamlined access to authorized program services using one statewide entity for access for families.

EDN will administer a satisfaction survey reporting on services coordination and delivery of service.

The MHCP program will use the parent clinic satisfaction survey and explore an on-line option for completion.

Continue to enhance Medically Handicapped Children's Program/Early Development Network/Home and Community Waiver outreach services, program information, and supports.

Early Development Network will continue to collaborate with the Nebraska Department of

Education's Migrant recruiters/coordinators, EDN Services Coordinators and providers to increase awareness and education regarding Part C services.

Enhance the partnership with the Aging and Disability Resource Center program (ARDC) which will support a network of local, state, and private service partners and information and referral system to support linking families' to resources.

Finalize planning and partnerships for a transition service model for clients accessing the MHCP medical clinic services to support transition information and planning which incorporates education and medical services, benefits planning, and options counseling. This will include an Advisory Group to support program leadership and outreach efforts.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5.3	55.4	56.6	57.7	58.8
Annual Indicator	54.4	54.4	54.4	54.4	47.6
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	48.5	49.5	50.5	51.5	52.5

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Weighted data.

a. Last Year's Accomplishments

MHCP and the Waiver programs finalized a resource database system through Answer4Families which allowed those that are transitioning out of the programs, a point of access for additional resources in their area.

Partnered with the Ticket to Work Program through the Medicaid Infrastructure Grant to promote employment for workers with disabilities. Grant activities will also address the needs of youth transitioning to adulthood.

Continued to utilizing HRSA materials to assist in educating MHCP staff on transition practices in our clinics.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed planning and partnerships to support development of a transition service model for clients accessing MHCP medical clinic services to support transition information and planning.				X
2. Continued reviewing HRSA materials to assist in the development of a transition process for all youth on MHCP.				X
3. Collaborated with the Ticket to Work Program through the Medicaid Infrastructure Grant to provide supportive benefits planning and employment options to support independent living activities.				X
4. Developed a partnership with the Aging and Disability Resource Center (ADRC) to support locating and linking CYSHCN and their families to transition based services and information.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue to work on incorporating transition services into the medical clinic services that are provided through MHCP clinic services with a new partnership with Easter Seals of Nebraska.

Maintain collaboration with Nebraska's Ticket to Work Program to support youth and young adults ages 16-22 as they transition from high school into adulthood. This will provide: trained benefits planners, community employment providers and employers collaborate to provide the resources and supports youth and young adults need to achieve a transition to full participants and contributors to their community.

Continue to utilize HRSA materials to assist in educating MHCP staff on transition practices in our clinics.

Continue ongoing work with the Parent Training Center to provide trainings and information to MHCP staff and care providers on transition planning and services.

c. Plan for the Coming Year

Maintain the partnership Nebraska's Ticket to Work Program to support employment opportunities to youth and young adults ages 16-22 as they transition from high school into adulthood.

Utilize HRSA materials to assist in educating MHCP staff on transition practices.

Enhance partnership with Parent Training Center and Easter Seals of Nebraska to provide training to MHCP staff, clients and care providers on transition planning and services.

Develop useful age appropriate information tools to support preparing MHCP clients and their families for transition.

Continue the collaborative effort with the Aging and Disability Resource Center (ADRC) to support outreach, information and referral, and access to resource information to individuals and families requesting information, services, and support around transition.

Enhance outreach efforts to support transition services to CYSHCN through a partnership with the Family to Family Health Advisory Committee and the Parent Training Center.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	86.9	83.5	83.6	76.2	73.2
Annual Indicator	85.2	74.8	59.9	78.9	76.7
Numerator					
Denominator					
Data Source		CDC NIS	CDC NIS	CDC NIS	CDC NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	78.2	79.8	81.4	83	84.7

Notes - 2011

Provisional rate represents the first 6 months of 2011. The full year will be released late August/early September. This rate is 76.7% +/-6.5.

Notes - 2010

78.9+-5.9

Notes - 2009

59.9 +/- 7.2%

a. Last Year's Accomplishments

It should be noted that CDC uses a different standard for measuring immunization coverage than the one stated for this national performance measure. As the number of recommended immunizations has increased so has the CDC performance measure. The CDC considers a full schedule of age appropriate immunization to include varicella and pneumococcal vaccines. The National Immunization Survey for calendar year 2011 will not be released until late August 2012.

The Nebraska Immunization Program is located within the Lifespan Health Services Unit. Primarily funded through the CDC, this program administers the Section 317 and Vaccines for Children (VFC) funds as well as the perinatal hepatitis B prevention program. In 2011 the program supported public immunization clinics across the state, 45 public VFC providers and 232 private VFC providers.

New private providers continued to be set up in NESIIS (Nebraska's state immunization information system). Staff provided NESIIS helpdesk assistance and training opportunities throughout the state. Providers using NESIIS implemented and used more advanced program features such as reports, reminder/ recall feature, vaccine management tools and immunization coverage assessments.

Title V funds helped support the cost of NESIIS which serves all providers who immunize children. Birth data continued to be loaded into NESIIS by Nebraska's Office of Vital Statistics with weekly updates. Data exchanges with providers have increased the number of patient records, documentation of the doses administered and the number of participating organizations. Immunization documentation is now linked to the individual's eligibility status by dose.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported public immunization clinics and private VFC providers across the state.			X	
2. Fully implemented and maintained web based immunization information system, adding more private providers and linking with other data systems.			X	
3. Began preparations for change in CDC policy on use of Section 317 vaccine.				X
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Immunization Program continued to support 86 counties with public immunization clinics and private VFC providers. The Program will use the allocation of Title V funds this year as partial support for NESIIS as it continues to develop new modules and upgrades its functions, particularly the ability to download immunization data from other electronic health systems. New providers are being enrolled and trained throughout the state. Immunization records in NESIIS have increased from 1,005,232 records last year to at least 1,133,000 records so far this year. Provider organizations participating in NESIIS has grown from 714 to 974.

c. Plan for the Coming Year

There are on-going efforts to set up private providers in NESIIS. Data exchange is still a priority. The program will upgrade the Wizard component of the system and will be able to manage the immunization schedule and documentation of immunizations given at a more rapid pace. Functionality to read 2-dimensional barcodes is being developed as well as the implementation of a vaccine ordering feature that will interface with CDC's new vaccine ordering system, VtrckS.

At the policy level, CDC will be restricting use of Section 317 vaccine for insured children. Up until this time, Nebraska's public immunization clinics vaccinated any child presenting regardless of insurance status, with free will donations the only compensation sought. With the restriction of the Section 317 vaccine, a communication plan to inform providers, both public and private, and families is being developed, and methodologies for billing third party payers will be explored.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	15.9	16.6	17.4	17.1	15.2
Annual Indicator	18.1	18.2	17.4	15.3	12.1
Numerator	687	671	633	562	456
Denominator	37863	36878	36349	36734	37584
Data Source		Birth File, Census Est.	Birth File, Census Est.	Birth File, Census	Birth File, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016

Annual Performance Objective	11.8	11.6	11.4	11.2	10.9
------------------------------	------	------	------	------	------

a. Last Year's Accomplishments

The Adolescent Health Coordinator continued oversight of a contract executed to deliver services to women who are pregnant or believe they are pregnant including the revision and implementation of the contractor's new web site and enhanced marketing and outreach activities to a broader population including teens. The number of clients participating in prenatal, delivery and infant care educational classes increased during this period of the contract.

The initial delegate agency activities under the Tune My Life initiative were concluded. Materials, resources and the web site, originally developed for the initiative, continued to be promoted through the Adolescent Health Program as a tool for stakeholders to use when engaging youth. The Tune My Life Health Plan booklet was revised and distributed to grantees and others working with youth populations.

Two federal teen pregnancy prevention grant programs were formally launched. Three sub award entities began delivering programming in three sites under the Abstinence Education grant program. Staff from six sub grant entities under the Personal Responsibility Education Program (PREP) were trained and certified as facilitators of Wyman's Teen Outreach Program (TOP(r)), the state's evidence-based model selected for implementation. Youth were recruited and enrolled in eight TOP(r) "clubs" across the state.

Calendar year 2011 saw an increase in adolescent Title X Family Planning unduplicated users. Five thousand adolescents age 19 and under were provided clinical services in Nebraska Title X sites statewide. This was a 12% increase over the 2010 total of 4480 unduplicated users.

In the last two calendar years, 2010 and 2011, Nebraska's Title X Statewide Program has exceeded the one year objective established in the Program Work Plan: "Increase by 10% total number of adolescent users ages 19 and under". 2010 with a 22% increase and now 2011 with a 12% increase in unduplicated users.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided ongoing Title X Family Planning services to adolescents.	X			
2. Initiated implementation of Abstinence Education and PREP programs.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Contractor providing services to women who are pregnant or believe they are pregnant was awarded a new two year contract to continue services through 2014. An assessment

mechanism is being implemented among the Contractor's clients to collect information on the social, economic and environmental barriers faced by women who are pregnant or believe they are pregnant.

The TUNE and Tune My Life initiative is being extended to reach the adolescent population through stakeholders who work with them. The Adolescent Health Coordinator is participating in a national "Young Adult Learning Circle" with other state adolescent health coordinators with a focus on how to reach out and engage young adults through social media including developing an understanding of how young adults use social media, which mediums they use and how we can match our audience with the TUNE technology/social media strategies available.

Sub grantees of two teen pregnancy prevention grants, Abstinence Education and Personal Responsibility Education Program (PREP), received ongoing support and oversight from the Adolescent Health Coordinator through site visits and conference calls.

Title V funds support community based education offered by Title X Family Planning delegates. The education, primarily targeted to adolescents includes decision making, STDs, birth control choices including abstinence, refusal skills, life-planning, healthy relationships, and healthy pregnancy/birth planning.

c. Plan for the Coming Year

An exploratory committee is being planned to convene early fall 2012 to look at ways to continue the tunemylife.org web site as well as identify potential partners, resources and strategies for maintaining the site as well as engage stakeholders. The TUNE materials and resources will be moved to and featured on the Adolescent Health web site including a link to the Tunemylife.org web site. Suggestions and strategies provided by a workgroup to be convened early fall will inform planned updates and methodologies for a re-launch of the TUNE initiative within the Adolescent Health Program. Pre and inter-conception health and life course health for teens and young adults have been identified as two potential areas of focus for ongoing activities under the TUNE banner.

Teen pregnancy prevention activities will continue through the Abstinence Education and Personal Responsibility Education Program (PREP) grants. Abstinence Education sub grantees will continue programming in three sites and PREP sub grantees will increase programming from eight to eleven sites using the evidence-based Teen Outreach Program (TOP(r)). A focus will include training PREP sub grantees on the national performance measures and related data collection activities. The survey mechanism implemented by the state to address state-identified outcome objectives for both grants will be fine-tuned and reinitiated during this grant year. Formal site visits will be initiated and ongoing technical assistance provided.

The financial support received through the MCH block grant will continue to play an integral role in the ability of the Nebraska Title X sub-recipients to meet the expectations that the Office of Population Affairs outlines for Title X service providers. Those expectations include community education programming to enhance knowledge delivery systems available in their service areas offering evidence-based sexual and reproductive health information.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011
----------------------	------	------	------	------	------

Performance Data					
Annual Performance Objective	47.8	48.9	50	50	50
Annual Indicator	44.6	44.6	44.6	44.6	44.6
Numerator	10489	10489	10489	10489	10486
Denominator	23518	23518	23518	23518	23518
Data Source		NE Open Mouth Survey 2004	NE Open Mouth Survey	NE Open Mouth Survey	NE Open Mouth Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	50	50	50	50

a. Last Year's Accomplishments

During FY2011, a portion of Nebraska Title V Block Grant Funds were devoted to support of the contractual salary and related expenses for the Director of the Office of Oral Health and Dentistry. The second year-long contract with Kären Sorenson, DDS, ran from October 1, 2010 to September 30, 2011. The duties she assumed included the following: provide leadership for oral health in Nebraska, building the capacity and developing the vision and mission of the NDHHS Office of Oral Health and Dentistry; oversee the development and implementation of a long-range, comprehensive strategic oral health plan to improve oral health in Nebraska, particularly among low-income children - the plan addresses statewide access and workforce issues, as well as preventive and restorative oral health needs; actively work to cultivate mutually-beneficial working relationships with Nebraska's oral health stakeholders; and assure that decisions made by the NDHHS to grant financial support to oral health projects across the state are based on current guidelines for best practice or promising practice and conform to professional standards of oral health care.

In performing the above duties, Dr. Sorenson: worked to increase collaboration among Divisions, Sections, Units and Programs within the Nebraska Department of Health and Human Services; provided training to health professionals on oral public health issues; facilitated contracts with 15 local health departments and federally qualified health centers to provide preventive oral health care to young children, creating local solutions to dental access shortages; conducted a survey of dental hygienists to establish a potential alternative workforce for provision of preventive care to young children; and actively engaged an Oral Health Advisory Panel to provide guidance in development of policy and procedures of the Office of Oral Health and Dentistry.

Dr. Sorenson elected not to continue the Dental Director contract beyond September 30, 2011. The Office of Oral Health and Dentistry has been conducting interviews for the position, and intends to continue supporting the position through Title V Block Grant Funds once it has been refilled. The HRSA Grants to States to Support Oral Health Workforce Activities continues to provide financial and technical support for local prevention projects and the development of the State Oral Health Plan

Lifespan Health Services Unit continued its active engagement in oral health initiatives, largely through Together for Kids and Families (TFKF), Nebraska's Early Childhood Comprehensive Systems project. The initial strategic plan (2006) of TFKF included two strategies that focused on

access issues. As the Access Work group explored issues it became apparent that access to oral health prevention and treatment in Nebraska was concerning. The group gathered data and began to develop ideas and build relationships with oral health partners. In 2010 when the state strategic plan was updated, oral health became a primary strategy and was added to the Medical Home work group. That group continued its work during 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported oral health infrastructure and capacity building through the leadership of the Office of Oral Health and Dentistry.				X
2. Developed local capacity to provide preventive oral health services to young children through the HRSA funded oral health grant.				X
3. Through the Together for Kids and Families Program (Nebraska's ECCS project), lead coordinated assessment and planning related to oral health and EPSDT.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nebraska Title V Block Grant Funds were used to support the Dental Health Coordinator's participation in the National Oral Health Conference in Milwaukee, WI from April 29 -- May 3, 2012. She was able to attend sessions on health literacy and cultural competence, collaborative models for school-based prevention, state oral health coalitions, and partnerships with MCH programs. Nebraska Title V Block Grant Funds will also be used to support the participation of the Office of Oral Health and Dentistry in this year's Mission of Mercy, which will take place July 13-14, 2012 in Alliance, NE. Nebraska's annual Mission of Mercy serves hundreds of children and families with significant oral health needs and low access to care. The current HRSA Oral Health grant expires August 31, 2012. The Office of Oral Health and Dentistry has applied for continuation of this grant and expects to be notified by HRSA prior to the start date of September 1, 2012.

The TFKF Coordinator is engaged in the strategic planning process that the Office of Oral Health and Dentistry initiated thus enabling alignment of activities related to young children and families. She is also serving on the Oral Health Advisory Council acting as the liaison between this effort and the many early childhood oral health initiatives occurring which contributes to more coordination and less duplication of efforts.

c. Plan for the Coming Year

The new Director, when hired, will continue to lead the office as opinion leader and policy setter; will act as chair of the Oral Health Advisory Panel; will oversee the operation of the HRSA subawards; will oversee the implementation of the Oral Health State Plan; will maintain communication with a wide variety of oral health stakeholders; and will assist in identifying and applying for funding to sustain programming. The Office of Oral Health and Dentistry will continue working with key state partners, including the Head Start State Collaboration Office,

Family Voices, Creighton University Dental School and University of Nebraska Medical Center College of Dentistry, and program partners within DHHS to meet oral health access needs for Nebraska's families and children, including children with special health care needs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	3.4	3.4	3.3	3.2	2.7
Annual Indicator	4.1	1.7	3.4	3.6	1.1
Numerator	14	6	12	13	4
Denominator	341855	343908	349420	357420	359412
Data Source		Death file, Census Est.	Death file, Census Est.	Death file, Census	Death file, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	2.7	2.6	2.6	2.5	2.4

Notes - 2010

The denominator changed from a census estimate in 2009 to the decennial census 2010.

Notes - 2009

2009 death file in not complete.

a. Last Year's Accomplishments

The Safe Kids Nebraska program is responsible for carrying out unintentional injury prevention activities for children 14 and under. One of the programs provided is Safe Kids Buckle Up, which focuses on child passenger safety. Monetary support comes from the Preventative Health and Health Services Block grant, Safe Kids Worldwide, and the Nebraska Office of Highway Safety as well as local sponsors.

In 2011, child passenger safety technician certification trainings were held in Kearney, Scottsbluff, Omaha, and Lincoln. A total of 80 participants were certified. These courses have been implemented since 1999 in Nebraska. These activities have contributed to an increase in the number of children being properly restrained in car seats; the rate for 2011 was 95.1%. This is a significant increase from 1999 at which time only 56% of children were restrained. Currently, there are 345 Certified Child Passenger Safety Technicians across the state. The Safe Kids program provides technical assistance and grant opportunities to these technicians and their communities. Certification courses are sponsored by Safe Kids and the Nebraska Office of Highway through funding and staff time.

The Nebraska Office of Highway Safety and Safe Kids Nebraska co-hosted a Child Passenger Safety Technician update in Kearney, Nebraska in March, 2012 with over 160 technicians from across the state in attendance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Safe Kids Program trained child passenger safety technicians across the state.			X	X
2. Nebraska Safe Kids Program provided grants to communities to promote child passenger safety.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Office of Highway safety is supporting statewide child passenger safety efforts by funding 23 fitting stations and four child passenger safety technician certification classes. In 2012, classes have been held in Scottsbluff and Omaha with additional classes scheduled in Omaha and Lincoln. A "Safe Travel for All Children" class, which addresses child passenger safety for children with special needs, will also be held in Lincoln, Nebraska in 2012.

The Safe Kids Buckle Up program continues to support Safe Kids programs throughout the state with funding to plan and implement child passenger safety activities in their communities. Child Passenger Safety events are held routinely in these communities along with advocacy training and educational events for parents/caregivers.

c. Plan for the Coming Year

The Nebraska Child Passenger safety Advisory Committee will convene its meeting in the fall to discuss the 2013 training schedule as well as other issues affecting child passenger safety. Safe Kids Nebraska will continue to utilize safe Kids Buckle Up grants to help communities conduct child passenger safety check up events, educational programs and trainings.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	48.8	56	66.5	47	67.8
Annual Indicator	55.1	65.2	46	66.5	49.5
Numerator					
Denominator					

Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	51	52	53	54	55

Notes - 2011

80.63% of woman reported initiating breastfeeding of those 49.5% reported breastfeeding longer than 180 days. However, only 19.5% reported exclusive breastfeeding over 180 days.

Notes - 2010

72.6% of woman reported initiating breastfeeding of those 66.5% reported breastfeeding longer than 180 days. However, only 38.1% reported exclusive breastfeeding over 180 days.

Notes - 2009

80.01% of woman reported initiating breastfeeding of those 46% reported breastfeeding longer than 180 days. However, only 32.5% reported exclusive breastfeeding over 180 days.

a. Last Year's Accomplishments

All WIC local agencies completed training of all staff using the "Loving Support to Grow and Glow in WIC" breastfeeding competency training. In April 2011, approximately 200 WIC local agency staff attended the general session "Everyone Can Make Breastfeeding Easier" as part of the WIC/CSFP meeting. This session introduced the SGCTA to support breastfeeding, and highlighted local WIC success stories in implementing breastfeeding peer counseling programs. Seven WIC agencies expanded their breast pump program to make electric breast pumps available to breastfeeding mothers as part of breastfeeding support services. In November 2011 State WIC Breastfeeding Coordinator and WIC Nutrition and Health Consultant attended a regional training on the newly revised "Loving Support Through Peer Counseling" training curriculum. 18 WIC local agency staff completed the Certified Lactation Counselor training program.

The Nebraska Breastfeeding Coalition formalized the coalition structure with implementation of a coalition leadership team. The WIC Breastfeeding Coordinator serves as part of the leadership team and the coalition is currently completing strategic planning to identify activities that promote the coalition and support Nebraska's Physical Activity and Nutrition Plan - Breastfeeding Action Plan Goal to Increase Breastfeeding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted breastfeeding initiation and duration through the WIC program, including peer support activities and enhanced staff training.			X	
2. The Nebraska Breastfeeding Coalition continued its work to support educators across the state.				X
3. Women's Health Council and partners informed Nebraska employers of new labor laws relating to work place accommodations for breastfeeding employees.			X	
4. Nutrition and Physical Activity for Health Program applied for supplemental CDC funds to support community-based breastfeeding promotion efforts.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the fourth quarter of 2012, the WIC Breastfeeding Coordinator and WIC Nutrition and Health Consultant will present a "Train-the-trainer" workshop for WIC local agency peer counselor coordinators using the updated "Loving Support for Peer Counselor Curriculum, and provide an opportunity for collaboration and sharing of program challenges and successes, and receive technical assistance and training on updated peer counselor curriculum. Twelve WIC local agencies have Breastfeeding Peer Counseling programs, providing peer counselor support to WIC clients in 52 counties. Seven WIC Local agencies sent staff to attend the Certified Lactation Counselor training program in June of 2012. State WIC and MCH program staff will collaborate with the Nutrition and Activity for Health Program to implement appropriate activities as part of Nebraska's Physical Activity and Nutrition Plan - Breastfeeding Action Plan Goal to Increase Breastfeeding.

The Women's Health Council, in collaboration with the Nutrition and Physical Activity for Health Program and the Nebraska Breastfeeding Coalition, prepared materials for Nebraska employers regarding recent changes to federal labor law regarding supports for breastfeeding employees. The materials were sent with a cover letter jointly signed by the Chief Medical Officer and the Director of the Nebraska Department of Labor. The materials have been well received with many requests for additional information and technical assistance.

c. Plan for the Coming Year

Continue work on the WIC state and local agency goal to promote and support breastfeeding, providing technical assistance and administrative support for the Breastfeeding Peer Counseling Programs, collaboration with NAFH program and NEBFC activities.

Continue participation with the Nebraska Breastfeeding Coalition on collaborative promotion efforts.

The Nebraska Nutrition and Physical Activity for Health Program has submitted an application to CDC for supplemental funds to support breastfeeding promotion efforts, particularly through community based organizations. Title V and WIC staff assisted with the application, and will be involved in the implementation if funded.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99	99.9	100	100	100
Annual Indicator	99.0	99.3	98.9	99.4	99.4
Numerator	26669	26791	26804	25908	25761
Denominator	26948	26972	27103	26059	25915
Data Source		Program Data	Program Data	Program Data	Program Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Nebraska Revised Statute SS71-71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge. During calendar year 2011, 100% of the 58 birthing facilities were conducting newborn hearing screening and all but one was conducting the screenings during the birth admission. Hospitals reported screening the hearing of 98.98% of the newborns during birth admission. The average refer rate (failed inpatient screening rate) was 4.1%. Outpatient re-screenings and/or diagnostic evaluations were completed for over 87% of those needing follow-up services. Follow-up services were initiated at an average of 43.0 days of age. There have been 49 infants identified with a permanent childhood hearing loss, an incidence of 1.9 per thousand newborns. The average age of identification was 67.4 days, with a 67.3% diagnosed prior to three months of age. Of the 49 infants identified with a permanent hearing loss, 73.5% were verified for special education services through Part C and 55.1% of those were verified prior to six months of age.

A subcommittee of the Nebraska Early Hearing Detection and Intervention (NE-EHDI) Program Advisory Committee developed an Advisory Committee Charter formalizing roles, responsibilities, and scope of the Advisory Committee as well as operating procedures. It was adopted by the entire Advisory Committee. The Mission Statement of the NE-EHDI Program was also altered somewhat so that it now reads as follows: "The Nebraska Early Hearing Detection and Intervention Program develops, promotes, and supports systems to ensure all newborns in Nebraska receive hearing screenings, family-centered evaluations, and early intervention as appropriate."

During this time period, a primary focus of the NE-EHDI Program had been to strengthen family support for families with young children recently identified with hearing loss. The NE-EHDI Program once again worked with Hands and Voices in hopes of establishing the Guide by Your Side program in Nebraska. The fifth parent Roots and Wings weekend was held in Kearney, Nebraska on October 21 -- 23, 2011. Survey results were shared in a presentation to the Advisory Committee. The parent weekend targets families with children age birth to three years old through a contract with the Boys Town National Research Hospital.

A "coordinated point of entry" for families into the early intervention system continued to be implemented and the Family Support Work Group, a formal sub-committee of the NE-EHDI Advisory Committee, continued to take a guidance role in developing the family support system.

Previously, the (NE-EHDI) Program would send a packet of educational materials to home birth families with a letter discussing the importance of hearing screening. No further efforts to contact the parents were made. Implemented in 2011, the NE-EHDI Program now sends correspondence to the PCP when a home birth child is identified, as well as making follow-up phone calls to the PCP. Progress has been made in relationship building with the PCP's who care for a large portion of Nebraska home birth families, as well as information about the resources available. In addition, phone calls are made to parents to identify families that are interested in hearing screening. Making contact with the parents creates an additional opportunity to educate the families about hearing screening and the purpose of the NE-EHDI Program. When interest is expressed, but there are concerns about cost, the family is put into contact with the Educational Services Unit (ESU).

An effort to reach out to the Amish community in Nebraska was implemented as part of the new protocol for following up on out of hospital births. Through a community outreach initiative, contact was made with Amish families who were educated about the hearing screening process and the necessity to have screenings conducted on their children.

The NE-EHDI data system, an integrated module of the state's Vital Records ERS-II system, continued to be revised to provide for improved functionality for the users in birthing facilities. In addition, all correspondence is now attached to a baby's record in an electronic format.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered Newborn Hearing Screening Program as per NE Rev. Nebraska Revised, including reporting and tracking provisions.			X	
2. Promoted periodic screening of older infants and toddlers through Hearing Head Start and Hear and Now Projects.			X	
3. Held fifth parent weekend workshop, Roots and Wings, in October 2011, for parents of young children with hearing loss.			X	
4. The Nebraska Children's Hearing Aid Loaner Bank (NCHALB) completed its third year of operation but will be the Nebraska Children's Hearing Aid Bank/HearU in 2012.		X		
5. NE-EHDI data system, an integrated module of the state's Vital Records ERS-II System, continued to be revised to provide for improved functionality for the users in birthing facilities.				X
6. Procedures to retrieve the newborn dried bloodspot (DBS), prior to its destruction at 90 days, for identification of congenital cytomegalovirus (CMV), Connexin 26 and 30, mitochondrial, and Pendred syndrome continued .				X
7.				
8.				
9.				
10.				

b. Current Activities

Current program objectives are to:

Fully expand the electronic data reporting system to support the electronic reporting of audiologic results and to strengthen linkages with related early childhood data systems.

Provide quality assurance reports, including comparison on key measures and short term outcomes, to birthing facilities semi-annually and include technical assistance comments.

Continue training birthing facility staff to reduce the number of infants who are lost to follow-up and have higher "refer" rates.

Continue the decrease in the number of babies classified as "lost to follow-up/documentation" and increase the percentage of home births that get their babies hearing screened.

Continue implementation of the coordinated point of entry for parents of children recently identified with a hearing loss in partnership with the Early Development Network (EDN), Part C, and other partners.

Develop a Web site for the Nebraska Early Hearing Detection and Intervention Program.

Conduct a sixth parent weekend workshop for parents of young children recently identified.

In coordination with Parent Training and Information Nebraska (PTI), hire and supervise a .50 Community Outreach Coordinator to reach out to families with children with a hearing loss and assist in reducing lost to follow-up.

With key partners, establish a data-driven approach to early intervention that will assist in achieving the goal of maximizing the language abilities in children with a hearing loss.

c. Plan for the Coming Year

With the benchmark of 95% of newborns screened during birth admission having been consistently met, program activities for calendar year 2013 will continue on implementing the ongoing mandates of Nebraska's Infant Hearing Act: expansion, enhancement, and maintenance of the reporting and tracking system, collection of required data, application for federal funding, and providing consumer and professional education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC/NCBDDD/EHDI) will be implemented to reduce the lost to follow-up rate by furthering the development of the screening, diagnostic, and services system; expanding the reporting and tracking system, and refining the quality assurance mechanisms.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12.3	13.6	15.9	18.6	16.2
Annual Indicator	13.9	16.2	19.0	16.6	18.0
Numerator	22000	24000	30000	27000	30000
Denominator	158000	148000	158000	163000	167000
Data Source		Census	Census	Census,	Census,

				Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	17.6	17.3	16.6	16.6	16.3

a. Last Year's Accomplishments

In 2005, LB 709 became effective, providing for reform of the NE Medicaid program and a substantive recodification of statutes relating to the program, including but not limited to enactment of policies to 1) Moderate the growth of Medicaid spending, 2) Ensure future sustainability of the Medicaid program for NE residents, 3) Establish priorities and ensure flexibility in the allocation of Medicaid benefits, and 4) Provide alternative to Medicaid eligibility for NE residents.

Neb. Rev. Stat. 68-969 (added by LB 1106 of the 2010 NE Legislature) provided authority to allow for Medicaid and CHIP eligibility for pregnant women and children who are lawfully residing in the US and otherwise eligible for Medicaid, respectively.

In February, 2011, Nebraska submitted a Medicaid State Plan Amendment to the Centers for Medicare and Medicaid (CMS) for authority to implement a medical home pilot project.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded the full-risk capitated physical health managed care program into the additional 83 counties not currently served by full-risk managed care effective July 1, 2012.				X
2. LB 825 passed, to establishing DHHS local office staffing levels and requirements for community based organizations to assist public in applying for benefits, including Medicaid.				X
3. Working group of ECCS usig HRSA tool to assess EPSDT and medical care access for children in Nebraska.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

LB 825 establishes staffing requirements for DHHS to assist members of the public apply for public benefit programs, including Medicaid. It also establishes requirements for contracts with community based organizations to offer additional locations for assisting the public.

LB 821 was passed and creates a state-level Children's Commission, to evaluate and plan child welfare services. Among the tasks for the Commission is to engage an independent entity to conduct a cross-system analysis of Medicaid and other supports for children.

Physical Health Managed Care expands statewide July 1, 2012. Three Managed Care Organizations (MCO's) serve Nebraska.

Medicaid Medical Home Pilot project continues.

A working group affiliated with Early Childhood Comprehensive Systems (ECCS), the Medical-Dental Home Workgroup, is using the HRSA document, Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders to examine EPSDT and medical care access issues for children in Nebraska.

c. Plan for the Coming Year

LR 510 Early Childhood Learning and Development Reform Agenda is a study which will examine how to make the early learning and development system more effective in preparing children to succeed in school and in life, which may pull in some discussion on health care topics including insurance coverage.

Continuing education for community and school nurses on Medicaid Managed Care Organizations and EPSDT in Nebraska is planned.

In 2012, the Nebraska legislature passed LB 1048, which increased state funds to existing home visiting programs administered by Children and Family Services. Subsequently, administration of these funds and programs was moved to the Division of Public Health, in the same unit as administers federal ACA MIECHV funds. These resources provide opportunities to interact with young high risk families and promote utilization of primary and preventive health care.

Using the HRSA document, Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders, as a template, staff will map the Nebraska Child Health System and reevaluate collaborations between Title V and Title XIX.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	31.4	33.7	35.7	37.1	29.5
Annual Indicator	34.4	36.4	38.1	30.1	31.4
Numerator	5263	6204	4928	2965	2959
Denominator	15311	17034	12918	9841	9409
Data Source		NE WIC	NE WIC	NE WIC	NE WIC

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30.8	30.2	29.6	28.9	28.4

a. Last Year's Accomplishments

WIC State and Local Agencies continued work on action steps of the five-year goal to reduce the percentage of WIC children ages 2-4 at or above the 85th percentile BMI-for-age. One action step was to collaborate with Community Nutrition Partnership Council in the implementation of the "5-4-3-2-1-GO!" message throughout the lifecycle through combined campaign and materials.

The Nebraska Department of Agriculture, in cooperation with the Division of Public Health, applied for and received a WIC Farmers Market Nutrition Program grant for this growing season. Grant funds support one WIC clinic site in Omaha, with the WIC local agency (Douglas County Health Department) working with local farmers to establish a market in the local WIC clinic's parking lot. Distribution of WIC farmers market coupons began in July 2011.

The Little Voices for Healthy Choices initiative continued with child care homes. The NAP SACC Program is the centerpiece of the grant that focuses on adapting policy and environments for access to healthful foods and physical activity opportunities, influencing the facility manager's health, educating parents and enhancing the future of the children that are cared for in facilities across the state. Childcare facilities that choose to be a part of this campaign participate in a one-day education and training workshop, develop action plans, plus receive guided support for implementation of healthy outcomes, and are provided resources to prevent childhood obesity. This activity was carried out by the Nutrition and Physical Activity for Health Program with ARRA funds.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhanced skills of WIC professional staff in addressing childhood overweight, and expanded educational resources for use with families.				X
2. Little Voices for Healthy Choices initiative completed in Nebraska child care facilities with sustainability efforts underway.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WIC program is working to implement nutrition education messages and activities using the My Plate materials. Nutrition education materials targeting reducing consumption of sugar sweetened beverages, increasing fruit and vegetable consumption, and responsive child feeding practices are being identified and implemented.

The grant supporting Little Voices for Healthy Choices expired February 2012, but staff with the Nutrition and Physical Activity Program in the Health Promotion Unit are working with partners to continue this work with selected childcare providers (particularly home-based) beyond that time. In addition, in collaboration with the Department of Education, administrative policies are being developed which will provide continued support for healthy child care environments through the Child and Adult Care Food Program.

c. Plan for the Coming Year

In 2013, the WIC program will implement use of the WHO growth standards for children ages birth to 2 years old, including implantation of new nutritional risk criteria using cut-off values for overweight and obesity. WIC state and local agency staff continue to work on action steps related to goal of reducing childhood overweight. Nutrition Coordinator will remain current on recommended practices for early childhood obesity prevention and include these practices and interventions in 2013 activities.

Collaborations with other programs promoting healthy weight among young children will continue, such as that through the Nutrition and Physical Activity for Health Program. Other key partners include the University of Nebraska Extension Service and the Department of Education Early Childhood Program.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	11.7	11.3	11.5	10.3	9.8
Annual Indicator	11.6	11.8	10.6	10.0	9.2
Numerator	3122	3184	2852	2590	2358
Denominator	26935	26992	26931	25898	25677
Data Source		Birth file	Birth file	Birth file	Birth file
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9	8.8	8.6	8.5	8.3

Notes - 2011

2011 Birth file is not finalized, projected date is July 31.

a. Last Year's Accomplishments

Since 2008, tobacco cessation counseling and some drugs have been covered by Nebraska Medicaid. Eligible clients must be 18 years of age and must be enrolled and actively participating in Nebraska's free Tobacco Quitline. Pregnant women do not receive medication, but can receive up to 10 counseling sessions with the Quitline. The enhanced protocol for pregnant women includes several intervention calls in the two-week period following a quit attempt, one just prior to the due date, and two calls within two months after the baby's delivery.

In 2011 the Nebraska Tobacco Quitline had 3,312 unique callers. The Quitline provided services to 40 pregnant women, twelve women planning to become pregnant within three months, and 10 breast feeding women.

Tobacco Free Nebraska received funding via the American Recovery and Reinvestment Act (ARRA) to increase smoke-free housing policies to reduce exposure to secondhand smoke at both private and public housing facilities. Funding also expanded reach and services of the Nebraska Quitline and provided training to health care clinics in the rural parts of the state to increase tobacco cessation intervention and referral by health care professionals. 92 clinics were visited and each clinic was provided with education on the Quitline and the Medicaid Fax referral program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Quitline continued to serve pregnant women, using a pregnancy-specific protocol.			X	
2. Smoke free public housing project completed, improving environments for pregnant women and their families.				X
3. Outreach to health professionals conducted regarding their roles in making active referrals to the quitline.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ARRA funding concluded in early 2012 but efforts continue to reach out to property owners and public housing authorities regarding smoke-free housing. Also efforts continue to reach out to health care professionals regarding their role in tobacco cessation. Tobacco Free Nebraska has renewed contract with Quitline vendor so cessation services will continue to be offered statewide for all Nebraskans including pregnant women. TFN will continue to monitor and evaluate the service including the number of calls from women who are currently pregnant.

c. Plan for the Coming Year

Nebraska Title V and Tobacco Free Nebraska will continue long-standing collaborations to promote tobacco prevention and cessation and eliminate exposure to second hand smoke within the MCH population.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	13.1	12.8	12.9	12.6	5.3
Annual Indicator	11.5	13.2	4.6	6.2	6.9
Numerator	15	17	6	8	9
Denominator	130506	128885	130498	128930	130443
Data Source		Death file, Census Est.	Death file, Census Est.	Death file, Census	Death file, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.7	6.6	6.5	6.4	6.2

Notes - 2010

The denominator changed from a census estimate in 2009 to the decennial census 2010.

Notes - 2009

Three year rolling average.

a. Last Year's Accomplishments

The Nebraska Statewide Suicide Prevention Coalition (NSSPC) continued implementation of training activities and local prevention seed grants, including LOSS (Local Outreach to Suicide Survivors), QPR (Question-Persuade-Refer) Gatekeeper training, and Assessing and Managing Suicide Risk (AMSR) for Clinicians.

As of Feb. 2011, 24 QPR Gatekeeper Trainers had been trained; 2,390 persons had completed QPR Gatekeeper training, 143 clinicians completed AMSR training; and a total of 42 seed grants totaling \$195,911 had been awarded to local NE communities for suicide prevention. Nebraska is a Garret Lee Smith funding recipient, for a three year project period Oct. 1, 2009 to Sept. 30, 2012.

Within the Division of Public Health, the on-line provider training curriculum on maternal depression was revised, updated, and continuing education approval renewed for licensed nurses. In a life course development approach, successful management of maternal depression benefits the social and emotional wellbeing of children and family members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Suicide prevention coalitions established in 2 additional communities.				X
2. A Nebraska state team formed to participate in the National Children's Safety Network Youth Suicide Community of Practice.				X

3. State refugee health program is introducing suicide prevention gatekeeper training into the community of service providers and local leadership serving Nebraska's refugee population.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Statewide Suicide Prevention Coalition has worked to establish local suicide prevention coalitions in Norfolk and Hastings, in addition to Lincoln.

Nebraska has formed a state team to participate in the national Children's Safety Network Youth Suicide Community of Practice. Members of the Nebraska team represent MCH, injury prevention, behavioral health, and education. The team works for the period Jan. -- Dec. 2012, with periodic national learning sessions via webinar and state-specific team projects.

The state refugee health program is working to introduce suicide prevention gatekeeper training into the community of service providers and local leadership serving Nebraska's refugee population, both youth and adults. This work is supported by collaborative efforts between the national Refugee Health Technical Assistance Center and QPR suicide prevention model developers.

Nebraska has two initiatives relating to social and emotional health of young children, to improve mental health in adolescence. A working group affiliated with Early Childhood Comprehensive Systems (ECCS) has developed a set of competencies for providers, and tools for community-level assessment of resources to support early childhood social and emotional development. These materials have been pilot-tested, and will soon be ready for dissemination.

Maternal Infant Early Childhood Home Visiting services deliver evidence-based interventions to maximize family resilience.

c. Plan for the Coming Year

The following significant areas of activity are on the horizon: a) Home visiting expansion; b) Use of the HRSA resource, Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders, to map the Nebraska behavioral health system and related resources as pertain to child behavioral health and access to care; c) Work within the NE Statewide Suicide Prevention Coalition to plan strategically for continuation of prevention work following the close of Garret Lee Funding in fall of 2012; d) Develop resources for school health professionals on trauma-informed school health programs; and e) Refugee suicide prevention gatekeeper training.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	73.7	69.2	69.8	59	83.6
Annual Indicator	68.1	63.5	57.9	82.0	80.8

Numerator	220	207	184	259	202
Denominator	323	326	318	316	250
Data Source		Birth file	Birth file	Birth file	Birth file
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	82.4	84	85.7	87.5	89.2

Notes - 2010

Methodist Women's Hospital opened in 2010 with a Level III NICU. In addition, Alegent Health's Bergan Mercy upgraded their "self designation" to a Level III. Both Hospitals are located in Omaha, NE.

a. Last Year's Accomplishments

Level of care continues to be self-designated by Nebraska hospitals.

The Maternal Child Adolescent Health Program team has experienced new leadership and engaged in leadership development activities, setting the stage for strategic planning, particularly in the maternal infant health area.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New working relationships are being formed with March of Dimes and others related to the ASTHO/MOD pledge, with potential for impacting this and other perinatal health measures.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, Nebraska's Level III NICUs include: University of Nebraska Medical Center; Alegent Bergan Mercy; Methodist/Methodist Women's/Children's Hospital and Medical Center; and St. Elizabeth's Medical Center (Level IIIC).

Communication and collaborations around pregnancy outcomes in Nebraska have occurred: convening a perinatal health learning community re: gestational diabetes; convening networking conversations between Title V and Title XIX at the state level; and collaboration between NE DHHS, ASTHO, and March of Dimes on prematurity.

c. Plan for the Coming Year

Monitoring of trends.

Development of Nebraska data to inform partners, collaborations, and strategic planning.

Implementation of Maternal-infant health program strategic plan.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80.9	74.8	73.6	75.1	74.7
Annual Indicator	73.2	72.1	72.0	73.2	75.2
Numerator	19721	19464	19382	18979	18857
Denominator	26935	26992	26931	25916	25077
Data Source		Birth file	Birth file	Birth file	Birth file
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	76.2	77.7	79.2	80	81.6

Notes - 2011

2011 Birth file is not finalized, projected date is July 31.

a. Last Year's Accomplishments

New leadership in Maternal Infant health program area occurred, with leadership development and team building leading to enhanced strategic planning activities.

Nebraska made changes in the contractual relationship supporting a 24-hour helpline to assist women and families in locating Title XIX providers and other public benefits and resources, known as the Healthy Mothers Healthy Babies helpline.

Nebraska became a Text 4 Baby partner.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LB 599 passed into law, which will create a separate SCHIP				X

for purpose of providing coverage of unborn children.				
2. Marketing campaign underway to deliver Healthy Mothers Healthy Babies and Text4Babies information to referral sources statewide.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On April 18th, the closing day of the session, LB 599 was passed into law. The bill now law has the intent to restore prenatal care to certain low-income families not covered by Medicaid, regardless of the immigration status of the mother of the unborn child. LB 599 calls for the establishment of a separate SCHIP solely for the purposes for providing SCHIP coverage for the category of unborn children.

A marketing campaign is underway to deliver Healthy Mothers Healthy Babies visual promotions materials in English and Spanish to over 200 community level providers assisting the public with benefits and resources such as health care, social services, food assistance, homeless assistance, and substance abuse treatment services.

Text 4 Baby materials also were included in the marketing packets.

c. Plan for the Coming Year

MCH staff will undertake, with collaborative partners, a "Full term" campaign, raising awareness of a full term pregnancy for optimal development, of 39 weeks or greater.

Will continue to analyze impact of reform on Prenatal care availability and accessibility.

Continuing education for community nurses on maternal health (gestational diabetes, full term pregnancy, standards of care for prenatal and interconception health), and Medicaid Managed Care will be provided.

D. State Performance Measures

State Performance Measure 1: *Percent women (18-44) with healthy weight (BMI)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					48.5
Annual Indicator		53.5	49.4	47.6	50
Numerator					
Denominator					
Data Source		NE	NE	NE	NE

		BRFSS	BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	47.8	48.8	49.8	50.8	51.8

Notes - 2011

Comparisons of 2011 to prior data should not be made. The weighting methodology for BRFSS changed from post-stratification to raking in 2011. Raking creates the weights in different manner by iterations and it also allows for inclusion of more control variables in the weighting scheme as opposed to just age, gender, race/ethnicity and region. In addition the 2011 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.

Notes - 2010

NE BRFSS is a weighted survey. So, only weighted estimates are provided.

a. Last Year's Accomplishments

Lifespan Health Services continued to collaborate with the Health Promotion Unit in implementing the Nutrition, Physical Activity, and Obesity Prevention grant project. A new state Nutrition and Physical Activity plan was under development, with Lifespan Health Services staff actively involved. The First Time Motherhood/New Parents Initiative, now branded as TUNE, included messages for women ages 16 - 25 addressing healthy weight. Community-based contractors were selected to deliver training to health and human service providers in the use of TUNE materials, including a modified reproductive life plan tool - Life Course Health Plan - that was developed in the prior year. Four Title V community-based projects continued to provide related education to women of reproductive age. The 4 community-based Title V funded projects funded in 2008 and 2009 continued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V supported community based projects and continues to provide related education to women of reproductive age.		X	X	
2. The new state Nutrition and Physical Activity plan was finalized and released.				X
3. Lifespan Health Services staff initiated a work group addressing gestational diabetes and interconception strategies to reduce future risk, including achieving a healthy weight.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 4 Title V community-based projects continue to provide related education to women of reproductive age. The new state Nutrition and Physical Activity plan was finalized and released.

The Lifespan Health Services Unit launched a small work group to assess issues and needs regarding gestational diabetes, with a focus on interconception follow-up for those women

identified with the condition in her most recent pregnancy. Using data from Ohio as a starting point, the work group members have developed some plans for better understanding practices in Nebraska. The work group members include DHHS staff with the Diabetes Program, Minority Health and Health Equity, and the March of Dimes, as well as Lifespan Health Services staff from WIC, Reproductive Health, and Maternal, Child and Adolescent Health.

c. Plan for the Coming Year

New community based contractors will be identified, so it is unknown the mix and types of local interventions which may emerge related to this indicator and priority. The DHHS work group addressing gestational diabetes and interconception strategies will continue its work.

State Performance Measure 2: *The percentage of live births that were intended at the time of conception.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					61.3
Annual Indicator		60.2	59.1	60.1	64.2
Numerator					
Denominator					
Data Source		NE PRAMS	NE PRAMS	NE PRAMS	NE PRAMS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	65.5	66.8	68.1	69.5	70.1

Notes - 2011

NE PRAMS is a weighted survey. So, only weighted estimates are provided. There is a year lag on PRAMS data. So, 2010 will be provided in 2011, and 2011 data will be provided in 2012 etc.

Notes - 2010

NE PRAMS is a weighted survey. So, only weighted estimates are provided. There is a year lag on PRAMS data. So, 2009 will be provided in 2010, and 2010 data will be provided in 2011 etc.

a. Last Year's Accomplishments

The Abstinence Education and PREP grants were implemented, and Title X Family Planning program was ongoing. In regards to the latter, a former delegate resumed providing services, expanding options for accessing reproductive health services.

Nebraska PRAMS developed a fact sheet on unintended pregnancies in the previous year and made it available on its web site: <http://www.dhhs.ne.gov/prams/reports.htm>.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Abstinence Education and PREP community-based projects implemented.		X	X	
2. Ongoing Title X Family Planning services provided, with 2 new	X			

providers in operation.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Abstinence Education and PREP grants continue, and the Title X Family Planning program is ongoing. Through a competitive process, two new Title X Family Planning providers were selected to serve several counties in northeast Nebraska. One is a Federally Qualified Health Center and the other is a local public health department. These 2 providers are currently in the early stages of start up.

c. Plan for the Coming Year

New community-based Title V supported projects will be identified later in 2012, and it is anticipated that one or more will be addressing unintended pregnancies among adolescents. The PREP, Abstinence Education, and Title X Family Planning programs will continue to provide services in communities across the state.

State Performance Measure 3: *The percent of children living in poverty who have health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					94
Annual Indicator		72.3	77.8	93.7	89.4
Numerator		24838	43136	39297	37908
Denominator		34372	55433	41918	42387
Data Source		Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	91.2	93	94.8	96.7	98.7

a. Last Year's Accomplishments

Title V associated staff tracked trends and monitored developments associated with the Affordable Care Act and with relevant State of Nebraska legislation. This state performance measure is intended to be a barometer of the impact of poverty on infants/children. Its value in doing so was and will continue to be assessed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring trends to determine utility of this measure as an indicator of social determinants of health.				X
2. Nebraska chosen as one of seven state teams to participate in AMCHP's Life Course Metrics Project.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This indicator was an attempt to identify a "social determinant of health" indicator related to childhood poverty. It's utility is still uncertain, so continue to monitor trends and evaluate other possible indicators. Nebraska was chosen to be one of 7 state teams to participate in AMCHP's Life Course Metrics Project, which will provide a forum to explore these alternative measures.

c. Plan for the Coming Year

Lifespan Health Services staff will continue to track this indicator, and through its work with the AMCHP Life Course Metrics Project, possibly identify alternative indicator(s) relevant to childhood poverty and its impact on health status.

State Performance Measure 4: *The preterm birth disparity (ratio) between African American and Caucasian infants.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1.4
Annual Indicator				1.4	1.4
Numerator				13.5	12.1
Denominator				9.8	8.9
Data Source				Birth file	Birth file
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1.3	1.3	1.3	1.3	1.3

Notes - 2011

2011 Birth file is not finalized, projected date is July 31.

a. Last Year's Accomplishments

Among the new Title V funded activities initiated during FFY 2011 was a pilot project titled "Connections," a research and outreach effort, consisting of three community-based programs being implemented in a largely African-American community in Omaha. These three programs

were planned to work synergistically to form vital connections at individual and community levels to build community capacity to support healthy African American pregnancies and families, and thus reduce disparities in birth outcomes. The first program is a peer support program for pregnant women. The second program is a community-based lecture/discussion series that allows community members to identify and prioritize problems and potential solutions associated with poor birth outcomes in their community, develop short-term goals to implement solutions, and action plans to meet these goals. Through the lecture/discussion series model, community members formed connections with each other, local organizations, and national leaders that were brought in to provide information and strategies to advance community members' efforts at meeting their goals. The third program engaged local African American female community leaders in a community health advocacy leadership training program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Connections Project continues to provide a range of services to African American women and their infants.		X		
2. Nebraska's Chief Medical Officer signs ASTHO/March of Dimes pledge to reduce infant mortality and preterm births; strategies development initiated with MOD and other partners.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Connections Project is nearing the end of a 15 month contract period. Progress is being monitored.

In June 2012, Nebraska's Chief Medical Officer signed the ASTHO - March of Dimes pledge to reduce infant mortality. Partners, including the March of Dimes and the Nebraska Hospital Association, are in early stages of developing strategies.

c. Plan for the Coming Year

With the March of Dimes, data on preterm birth disparities and associated risk factors will be examined to determine specific strategies. Though some work has already been initiated by partners to address non-medically indicated inductions and C-sections prior to 39 weeks, the value of such strategies to impact preterm birth disparities is not clear or apparent. Staff will draw on the Perinatal Periods of Risk (PPOR) model for this work.

State Performance Measure 5: *The percent of young children (1-5) who have excellent/very good dental health.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective					82.6
Annual Indicator		81	81	81	81
Numerator					
Denominator					
Data Source		National Survey of Children's Health, 2007			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	84.3	85.9	87.7	89.4	91.1

Notes - 2011

National Survey of Children's Health, 2007

Notes - 2010

National Survey of Children's Health, 2007

a. Last Year's Accomplishments

See National Performance Measure 09 for related accomplishments. In addition, Nebraska's Head Start Dental Home Launch event was held March 30th, 2011. Through this initiative, Nebraska increased capacity to serve more Head Start children and hopefully more young children after oral health providers were trained in how to work with this population. Project activities included mentoring of dentists to serve children. Eighty dentists attended the Launch event which was held in conjunction with the NE Dental Association Meeting. Action planning conducted during this Launch event will be part of the Oral Health State Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Office of Oral Health and Dentistry and the Oral Health Advisory Council are developing a strategic plan.				X
2. Together for Kids and Families using HRSA/MCHB toolkit to assess oral health access and utilization and recommend strategies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The TFKF Coordinator is engaged in the strategic planning process that the Office of Oral Health and Dentistry initiated thus enabling alignment of activities related to young children and families.

She is also serving on the Oral Health Advisory Council acting as the liaison between this effort and the many early childhood oral health initiatives occurring which contributes to more coordination and less duplication of efforts. The oral health access issues being addressed (not an all-inclusive list) through various projects and reflected in the state plan involve educating oral health providers regarding the care of very young children to build comfort levels, educating primary care physicians on applying fluoride varnish (now reimbursable through Medicaid), increasing access through partnerships with local health departments, utilizing the telehealth system for oral health exam and treatment.

A related activity, the TFKF Project Coordinator shared Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders developed by HRSA/MCHB with the TFKF Dental/Medical Home work group. Three sections were chosen to guide their work; Section 2: Medicaid's EPSDT mandates financing for child health services and supports to improve access to care; Section 6: States play a central role in maximizing the impact of EPSDT comprehensive well-child screening visits Section 8: A dental home and appropriate dental services are essential to the health of every child.

c. Plan for the Coming Year

Lifespan Health Services staff will continue to collaborate with the Office of Oral Health and Dentistry in the development of Nebraska's oral health plan. The Together for Kids and Families (TFKF) work group will continue its system work in support of oral health of young children. See National Performance Measure 9 for more details.

State Performance Measure 6: *The rate per 1,000 infants of substantiated reports of child abuse and neglect.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					21.8
Annual Indicator			20.2	22.2	21.3
Numerator			583	579	551
Denominator			28791	26082	25907
Data Source			Child Protective Services, Census	Child Protective Services, Census	Child Protective Services, Census
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	21.4	20.9	20.6	20.2	20

Notes - 2011

a. Last Year's Accomplishments

For several years the NE DHHS has had initiatives and programming addressing SUID and shaken baby syndrome. For instance, Nebraska State Law requires that hospitals provide parents of newborns information on both safe sleep and shaken baby syndrome. NE DHHS Lifespan Health Services developed and maintains those materials.

In addition, NE DHHS's Division of Public Health, Division of Children and Family Services, and Division of Behavioral Health have participated as members in the Nebraska Child Abuse Prevention Partnership. Also including Nebraska's CB-CAP agency (Nebraska Children and Families Foundation) and the Nebraska Child Abuse Prevention Fund Board, this Prevention Partnership has had a long history of collaborative planning and programming to address the prevention of child abuse and neglect.

Healthy Families America was chosen as the evidence-based home visiting model for implementation under the ACA MIECHV Program. This model has proven effective in reducing risks for abuse and neglect and has built the capacity of the Lifespan Health Services Unit in implementing evidence-based strategies to reduce these risks.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Families America operational in 3 counties under the MIECHV program, and in one county under the state funded home visiting program.		X		
2. Nebraska Child Abuse Prevention Partnership is reviewing and updating NE Statewide Child Abuse Prevention Plan.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Healthy Families America is fully implemented in 3 counties in western Nebraska, under Nebraska's MIECHV program. Over 40 families are now enrolled. Expansion of MIECHV into another of the identified at-risk counties is being considered for later this fiscal year, also with Healthy Families America as the model.

A recent development has been the transfer of home visiting programs supported with State General Funds, from the Division of Children and Family Services to the Division of Public Health. Currently these funds support 3 programs, one of which is using Healthy Families America, and the other two using locally developed/adapted models. The appropriated funds for these home visiting services largely focused on secondary prevention of abuse and neglect. Lifespan Health Services Unit will be administering these programs, and is early in the planning stages of coordinating with MIECHV home visiting, with a focus on quality improvement and data collection.

The Nebraska Child Abuse Prevention Partnership is in the process of reviewing and updating the Nebraska Statewide Child Abuse Prevention Plan, which was completed in 2006. The Title V/MCH Director is participating in this process, and will utilize the opportunity to further address abuse and neglect experienced by CSHCN, a need identified in the Title V needs assessment completed in 2010.

c. Plan for the Coming Year

Home visiting, both MIECHV and state supported, will continue with multiple counties using Healthy Families America as the model. The MIECHV benchmark plan will provide important information to determine effectiveness of the intervention.

Nebraska will consider applying for competitive MIECHV developmental funds, to further expand the reach and quality of the program.

The Nebraska Child Abuse Prevention Partnership will continue to update its collaborative prevention plan.

Comments received through the public input process for this application included several related to the reporting of suspected abuse and neglect, particularly that made by reporters. Lifespan Health Services Unit staff will work with child welfare staff in reviewing the comments and determining follow up actions, including communications with and training for reporters.

State Performance Measure 7: *Percent of teens who report use of alcohol in last 30 days*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					30.6
Annual Indicator				31.3	27
Numerator					
Denominator					
Data Source				NE YRBS	NE YRBS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	26.5	25.9	25.4	24.9	24.4

Notes - 2011

NE YRBS is a weighted survey. So, only weighted estimates are provided.

Notes - 2010

NE YRBS is a weighted survey. So, only weighted estimates are provided.

a. Last Year's Accomplishments

Primary activities addressing alcohol use among teens have been carried out through Nebraska's Strategic Prevention Framework State Incentive Grant (SPF SIG) Program. This program is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). It aims to enhance and sustain substance abuse prevention at the State, regional, and community levels by supporting data-driven and evidence-based prevention initiatives. In August of 2008, 16 community coalitions in Nebraska were selected to address up to three of the following prevention priorities: prevent alcohol use among persons 17 and younger, reduce binge drinking among 18-25 year olds, and reduce alcohol impaired driving across all age groups. The work of the grant and the community coalitions continued through 2011. Most coalitions are working on a variety of evidence-based programs primarily aimed at kids in schools. These programs included All Stars, Project Northland, Protecting Me Protecting You, etc. They are also focused on a variety of environmental strategies such as Responsible Beverage Server Training, compliance checks, sobriety checkpoints, alcohol density, and media campaigns.

A statewide media campaign was also created to complement the individual coalition campaigns. This media campaign is aimed primarily at parents and includes traditional approaches such as posters, banners, and press releases as well as social media (e.g., facebook) messages.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community-based programs and activities supported through the SPF SIG grant continue until September 2012.			X	X
2. SPF SIG program evaluation underway.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SPF SIG project is winding down as a grant program and officially ends on September 29th. Program staff believe and are very hopeful that most of the 16 community coalitions will be able to continue some of their work. In all likelihood, the service related programs will not continue, but many of the environmental policies should be sustainable with minimal amounts of funding which could come from the Substance Abuse Prevention Block Grant.

The program is in the process of an extensive evaluation although it is far from being complete. However, both the 2010 YRBS and the Nebraska Risk and Protective Factor Student Survey indicate sharp declines for youth alcohol use, binge drinking, and alcohol-impaired driving. However, the adult rates showed minimal change and are similar to those in recent years.

c. Plan for the Coming Year

The media campaign is being viewed as one component of sustainability because program staff feel the messages will be valid for at least a year.

Through the public input process for this application, commenters recommended that coalitions continue to focus on strategies such as server training, compliance checks, and sobriety checks. Also recommended was to coordinate teen alcohol prevention activities with other related community initiatives, such as teen pregnancy prevention, Safe Kids, Safe Routes to School, and similar activities. Title V/MCH staff will be evaluating the opportunities to work with the coalitions and others on these possible strategies.

E. Health Status Indicators

/2013/ Health Status Indicators #01A -- the percent of live births weighing less than 2500 grams, #01B -- the percent of live singleton births weighing less than 2500 grams, #02A -- the percent of live births weighing less than 1500 grams, and #02B -- the percent of live singleton births weighing less than 1500 grams have all remained flat over the past 6 reporting years.

To better understand factors that may be contributing to the lack of progress, the Maternal and Child Health Epidemiology program began analysis on low birth weight and preterm

outcomes, by linking PRAMS data (2000-2010) to the birth certificate, to investigate factors that are associated with the outcomes, as well as looking for indicators that predict behavior change in mothers who have had a previous low birth weight/preterm birth.

This PRAMS-vital records project will be helpful in planning projects and initiatives under the newly enhanced partnership with the March of Dimes resulting from the ASTHO-March of Dimes pledge recently signed by the Chief Medical Officer/Director, Division of Public Health.

Strategies to reduce rates of non-medically indicated inductions and C-sections prior to 39 weeks gestation are well documented and some efforts are already underway to implement those strategies in Nebraska. These strategies may have some impact on HSIs #01A and #01B. Targeted strategies to impact #02A and #02B are less apparent, particularly as they relate to Nebraska women and health care systems. It is for these indicators that the PRAMS-vital records linked data will be most useful.

Health Status Indicators #05A -- the rate per 1000 women aged 15 through 19 years with a reported case of chlamydia and #05B -- the rate per 1000 women aged 20 through 44 years with a reported case of chlamydia, are used to measure progress in addressing Nebraska's priority to improve the reproductive health of youth and women by decreasing the rates of STDs and unintended pregnancies. Programs currently underway to impact these indicators are Title X/Family Planning, PREP, and Abstinence Education. Nebraska Title X/Family Planning has a long standing partnership with the STD program to address chlamydia through the Region VII Infertility Prevention Project, and Nebraska family planning clinics serve as STD testing sites. Nebraska PREP is using TOP as its evidence-based model, which has proven impact on risk for STDs.

Health Status Indicators #09A and #09B -- infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity will be used in developing life course metrics and better understanding disparities in social/ecological factors impacting health outcomes. Nebraska Department of Education has changed their methodology for collecting and reporting high school dropout rates to be more representative and comparable. Recent analysis of state wards (age 0-8) by the MCH Epidemiology program shows a continued decreasing liner trend (since 2005). //2013//

F. Other Program Activities

Healthy Mothers, Healthy Babies Helpline:

The Perinatal, Child and Adolescent Health (PCAH) Program, within Lifespan Health Services, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HMHB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, and folic acid supplementation. Monthly call report data are tracked and analyzed in order to guide publicity efforts. When the line first began in 1992, calls averaged 7 per month. Call frequency peaked at 880 in FY 2000 with a steady decrease to 415 for FY 2004.

Subsequently, efforts were made to promote the HMHB help line. In 2007, brochures, posters, and magnets were redesigned. Brochures were made available in English and Spanish. Sample

materials were sent to over 2,300 Nebraska physicians, nurses, health departments, and agencies to promote the helpline. Other promotion efforts included a HMHB webpage and a presentation to WIC agency directors. The HMHB helpline number is listed in the community service pages of local telephone books, and an ad was placed in the Journal-Start Baby Steps publication which reaches families in southeastern Nebraska. The helpline was also promoted through the Nebraska Perinatal Depression Project website, brochures, posters, and exhibit.

Despite these efforts, the HMHB line received only 412 calls during FFY08. As a result of the continued low usage, the marketing contractor for the First Time Motherhood/New Parents Initiative was asked to assess perceptions of young women in regards to toll-free numbers for accessing health information. Among the findings are that such numbers are no longer "toll free" for persons using cell phones with limited minute contracts. For this reason as well as greater reliance on new technologies, the Internet is becoming the more trusted source of assistance.

During 2010, the Douglas County Health Department became an outreach partner for Text4Babies. With many of the text messages including the national toll-free line and subsequent connection to Nebraska's line, we might expect an increase in usage since Douglas County includes Omaha, Nebraska's largest city. Yet initial reports from the help line contractor indicate that increases have not been significant. We will continue to monitor usage and continue research into the best ways to provide accessible information to a new generation of mothers and fathers.

/2012/ After more than 13 years, the Nebraska Methodist Hospital elected to not renew its contract for provision of the Healthy Mothers Healthy Babies helpline. The contractual relationship expired on June 30, 2011. An informal bidding process was conducted during the spring of 2011, and a new contractor selected: United Way of the Midlands - 211 System. As of this writing, the contract is being finalized, and the new contractor will begin operating the helpline on or about July 20, 2011. Interim coverage of the toll free line will be maintained by NE DHHS staff. The new helpline will no longer be staffed by nurses, and will focus on referrals to needed services. Updates to outreach materials are in process. //2012//

/2013/ The Healthy Mothers, Healthy Babies helpline contract with the United Way was executed and is in place. The HMHB helpline fielded 220 calls during the first year of that contract. In May 2012, the Maternal, Child and Adolescent Health Program in Lifespan Health Services did a mailing to 225 providers that included information on both the HMHB helpline and Text4Baby. This mailing included a letter and posters, and was sent to local health departments, community action agencies, federally qualified health centers, birthing hospitals, Head Start programs, homeless shelters, domestic violence centers, congregate feeding sites for low income persons, and other sites.//2013//

MCH and Public Health Infrastructure Development:

In many ways, Title V staff contributes to Nebraska's public health infrastructure. The Title V Grants Administrator has taken on an increasingly significant role in the Department level grants management activities, such as developing consistent subgranting tools and methodologies, arranging for agency-wide training and technical assistance, and participating in a risk management committee. The MCH Epidemiology Surveillance Coordinator (Nebraska's SSDI Director) has helped staff Nebraska's Healthy People 2020 project and participates in the agency's data committee. //2012// Both the Title V/MCH Director and the MCH Epidemiology Surveillance Coordinator are members of the advisory committee for Performance Improvement, an activity under Nebraska's Public Health Infrastructure Grant (ACA Prevention and Public Health funds). //2012//

Health Disparities:

The Office of Health Disparities and Health Equity (OHD&HE) provides leadership for a number of initiatives. The Office of Women's and Men's Health and its Women's Health Council has been working with OHD&HE to conduct a series of community viewings of "Unequal Treatment" later

this summer. This activity is seen as essential to increase awareness of health equity issues and will further efforts to move policies and programs towards a life course model that recognizes the additive effects of factors such as stress and racism. With Title V support, OHD&HE is planning additional initiatives for 2011./2012/ OHD&HE is conducting a number of "Unequal Treatment" seminars this summer, and is working with communities on a number of local initiatives.//2012//

New Opportunities:

The ACA appropriated funds for a number of MCH related activities. With thoughtful planning and coordination, these new sources of financial support can have an impact in building new systems capability. In particular, aligning the ACA Home Visiting Program with the Early Childhood Comprehensive Systems project will lead to greater capacity to impact early childhood outcomes. At the same time, should Nebraska apply for and receive funds for Supports for Pregnant and Parenting Teens and Women, even more of an interconnected system can be built. We are eagerly awaiting guidance for the Personal Responsibility Education funds, as this resource will allow us to make similar investments in building a system for adolescent health and wellbeing./2012/ Nebraska did not receive funds for Supports for Pregnant and Parenting Teens and Women, but is the recipient of both a PREP grant and an Abstinence Education grant.//2012//

/2013/ In June 2012, the Chief Medical Officer - Director of the Division of Public Health signed the ASTHO/March of Dimes Pledge to improve birth outcomes by reducing infant mortality and prematurity. The Division and its Lifespan Health Services Unit have had a long-standing working relationship with the March of Dimes, and this pledge will now provide additional focus on collaborative efforts. Initial work has begun on building capacity to address non-medically indicated inductions and C-sections prior to 39 weeks gestation, including forming working relationships with the Nebraska Hospital Association. Details of specific activities are to be developed over the next several months.//2013//

/2013/ The Lifespan Health Services Unit was recently selected to lead one of 7 state-teams to participate in AMCHP's Life Course Metrics Project. Over the next year, the state teams will propose and draft preliminary life course indicators, incorporate public and stakeholder comment, screen proposed indicators, and proposal final indicators. Nebraska's team leads are the Title V/MCH Director and its SSDI Director.//2013/

G. Technical Assistance

In many ways, Nebraska is very fortunate to have many local resources for technical assistance and training available to its Title V supported programs. These include a College of Public Health, the Great Plains Public Health Leadership Institute, CityMatCH, Munroe Meyer Institute (a LEND program), University of Nebraska Public Policy Center, and many other colleges and programs within the University system.

At the regional and national level, Nebraska has a long standing relationship with the MCH Program at the University of Chicago -- Illinois, and had 3 staff recently complete its MCH leadership coaching program. AMCHP has provided active support for our adolescent comprehensive systems development project.

Finally, through partnerships with other Nebraska organizations, such as the PTI Family to Family Program and Boys Town Center for Child Health Improvement, Nebraska Title V has gained information and expertise through participation in their technical assistance and development projects.

The needs for which Nebraska Title V would request MCHB assistance are therefore those specific to the management of the Block Grant. For FFY 2011, Nebraska specifically requests technical assistance in budgeting for and reporting activities in accordance with Block Grant statutory requirements and within the framework of the Guidance and Forms for the Title V

Application/Annual Report while at the same time moving towards a life course health model and a social determinants framework.

This model and framework, by their nature, emphasize serving populations in ways that are not rigidly tied to the categories established under Title V. In addition, an emphasis on system level activities and less on distinct services to individuals renders reporting requirements to be problematic, and earmarks difficult to interpret and measure.

In many ways, this request is less for technical assistance but a cooperative relationship to determine ways to operate within a Title V framework that dates back to the 1980's but move public health, including MCH/CSHCN, into new approaches into the next decade and beyond.

/2012/ This technical assistance request is being carried over into FFY 2012. The need to better target funds to priority issues has only increased, and Nebraska continues to have questions and concerns on the interpretation and completion of the financial forms 2, 3, 4 and 5. //2012//

/2013/ The technical assistance request originally made in 2011 and carried over into 2012, will again be carried over into 2013. Lifespan Health Services staff have conducted some independent study using information from other states available through TVIS and will seek more specific assistance as needed.//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	4024332	4145181	3989608		4036191	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	2933000	3134582	3141759		3742315	
4. Local MCH Funds <i>(Line4, Form 2)</i>	482266	470883	409300		236525	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	7439598	7750646	7540667		8015031	
8. Other Federal Funds <i>(Line10, Form 2)</i>	136673763	0	134805658		130293903	
9. Total <i>(Line11, Form 2)</i>	144113361	7750646	142346325		138308934	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	728964	877331	560350		661489	
b. Infants < 1 year old	622881	716607	983225		936093	
c. Children 1 to	1965238	1950064	1643228		2501984	

22 years old						
d. Children with Special Healthcare Needs	3067215	3028856	3274671		3136132	
e. Others	891014	1052631	964435		652149	
f. Administration	164286	125157	114758		127184	
g. SUBTOTAL	7439598	7750646	7540667		8015031	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	99954		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	218740		217136		250930	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	34195833		33541652		33535039	
h. AIDS	0		0		0	
i. CDC	8143638		7910810		7848707	
j. Education	0		0		0	
k. Home Visiting	0		0		1000000	
k. Other						
See note	0		0		87559227	
See Note	0		93036060		0	
see note	94015598		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	1931935	1769526	1402440		1780526	
II. Enabling Services	2019842	2379334	2576483		2623080	
III. Population-Based Services	1828530	1648387	1687469		1837744	
IV. Infrastructure Building Services	1659291	1953399	1874275		1773681	
V. Federal-State Title V Block Grant Partnership Total	7439598	7750646	7540667		8015031	

A. Expenditures

/2012/ This narrative replaces previous narrative.

The first two paragraphs are an introduction to Section V.

Our Financial Narrative is cross-referenced with the Technical Assistance request. Nebraska has longstanding concerns with the specific instructions and forms for an annual report for funds with a two-year period of availability. As such, we have twice responded to the Notice of Comment Request on OMB No. 0915-2286 Guidance and Forms for the Title V Application/Annual Report. Our detailed comments and recommendations most recently submitted to HRSA as part of the

clearance review are available upon request. [Reference letter to Susan G. Queen, Ph.D., HRSA Reports Clearance Officer, dated December 20, 2005.] Our financial reporting in the 2010 Report, as in prior years, conforms to the required annual report format showing funds expended in a fiscal year, rather than expenditures of an allotment.

Carry-over authority is granted to states/territories in Section 503(b) [42 U.S.C. 703], i.e. federal MCH allotment allows expenditures in the fiscal year or the succeeding one. Carry-over is defined in the Guidance as unobligated balance only. We interpret carry-over to include unliquidated obligations that become available in the succeeding year for re-obligation and expenditure within the succeeding year. Therefore, our interpretation of the specific instructions in the Guidance for Forms 2, 3, 4, and 5 produces a report which suggests expenditures exceed budget, but it is as a result of omitting carry-over in the Form 2 budget. Due to our interpretation of the Guidance instructions, Nebraska's budget in Form 2 includes only the projection of the 2012 allotment. Our internal operating budget adds the projected carry-over of the prior 2011 allotment to the new federal allotment, and is the method relied upon to obligate funds. It is available upon request.

The annual reporting requirement is stated more generally in Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706]. The audit requirement in Section 506(a)(3)(E)(b)(1) [42 U.S.C. 706] states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds. We believe the financial forms in the annual report are not designed for an audit of the two-year period in which an allotment is available for expenditure. This audit limitation is especially critical for the 30%-30% expenditure requirement established in statute. We maintain a separate expenditure accounting from the annual report to capture the 30%-30% expenditure requirements of an allotment. **//2013/ We have used the same methodology to project funds available in 2013. //2013//**

The remaining paragraphs are more specific to subsection A. Expenditures.

Nebraska has typically exercised carry-over authority with unliquidated obligations, but not due to an unobligated balance. Our annual report reports expenditures in the reporting year (12-month period) from two different federal allotments. Specifically, the 2010 report Nebraska reports expenditures in FY 2010, a combination of the 2009 and 2010 allotments. **//2013/ The 2011 report is a report of expenditures in FY 2011, a combination of the 2010 and 2011 allotments. //2013//** We use accounting codes to track payments by federal allotment and types of individuals to identify compliance with the 30% - 30% requirements and the 10% limit for administration. This is particularly important since the expenditure requirements are federal allotment only, and Forms 3, 4, and 5 combine federal with state and local expenditures.

Nebraska's considerable year-to-year expenditure variation on Forms 3, 4, and 5 is largely due to unevenness in carry-over of the federal allotment, and to a lesser extent the changeability of state and local resources. Differences are also due to a change in our interpretation of the types of services in the MCH pyramid, particularly between direct versus enabling and population-based services.

Expenditures largely correspond to the investments in our state's priorities based on the five-year needs assessment. Some of Nebraska's MCH priorities are addressed through resources other than, or in addition to, the federal Title V/MCH Block Grant. Expenditures of the federal allotment, and state funds, include support for a variety of MCH state statutory requirements, e.g. screening and follow-up of newborns for inherited and metabolic disorders, child death review, school health screening, and state-level dental health office and full-time dental director. **//2012//**

B. Budget

/2012/ This narrative replaces previous narrative.

Other federal funds to support Nebraska MCH/CSHCN include USDA WIC, CDC Immunization and Pregnancy Risk Assessment Monitoring (PRAMS), CDC and HRSA Newborn Hearing Screening, HRSA Home Visiting, Title X Family Planning, and State Early Childhood Systems, and Early Intervention Medicaid in Schools, to name a few. Form 2 and its field notes detail all other federal funds.

Federal Title V support clearly complements Nebraska's total effort to promote and improve the health of all Nebraska mothers and children. Nebraska's maintenance of effort based on FY 1989 state support (\$2,626,360) has consistently been surpassed. Exclusive state support is budgeted \$3,141,759 for FY 2012, which is a \$208,759 increase from 2011, and exceeds the minimum by over \$515,000. **/2013/ Exclusive state support is budgeted \$3,742,315 for FY 2013, which is an increase of over \$600,000 from 2012, and exceeds the minimum requirement by over \$1.1 million. //2013//**

The source of non-federal support is a combination of state funds plus local funds and in-kind support. The total value of matching resources is 89% of the projected federal allotment, which further demonstrates Nebraska's commitment by surpassing the 3:4 match requirement. The largest single source of state support (\$1,550,000) comes through the Medically Handicapped Children's Program (MHCP) to support specialty clinics and MHCP workers. Other sources of state funds that complement Title V funding include support to the following: Public Health Screening (\$653,759 for STD screening/ pap smears), the Immunization Program for vaccine purchase (\$328,000), Newborn Metabolic Screening Program which also includes a cash fund from screening fees (\$310,000), CSHCN respite services (\$300,000), and Birth Defects Prevention Fund for terratagon service at the University of Nebraska Medical Center (\$34,369). Local match (\$409,300) rounds out our matching resources to demonstrate commitment at the community-level as well. **/2013/ The total value of matching resources is 99% of the projected federal 2013 allotment, a 10% increase from the 2012 budget. The largest single source of state support (\$1,590,000) comes through the Medically Handicapped Children's Program (MHCP) to support specialty clinics and MHCP workers. Other sources of state funds that complement Title V funding include support to the following: Public Health Screening (\$653,759 for STD screening/ pap smears), the Immunization Program for vaccine purchase (\$346,556), Newborn Metabolic Screening Program which also includes a cash fund from screening fees (\$302,000), CSHCN respite services (\$100,000), and Birth Defects Prevention Fund for terratagon service at the University of Nebraska Medical Center (\$34,369). Local match (\$236,525, a projection due to a competitive subgranting process at the time of this writing) rounds out our matching resources to demonstrate commitment at the community-level as well. //2013//**

The 30%-30% requirements are tracked and monitored through separate accounting codes to identify expenditures by types of individuals of a federal allotment. Internal accounting reports are produced at least quarterly and reviewed by population coding. Similarly, the 10% limit on administration is maintained by having identified what is needed for the administration of the federal allotment, then concentrating it within a work unit, and budgeting costs for the unit to associate with administration. Due to a staffing change in 2011, we re-evaluated critical roles and essential duties associated with the administration of the Title V/MCH Block Grant and determined less staff time was needed for administration. The added value of well-established systems and procedures leads to effective administrative effort with a budget decrease of nearly \$50,000 from 4% in 2011(\$164,284) to under 3% for 2012 (\$114,758). **/2013/ Administrative costs are budgeted \$127,184 for 2013, which is 3.1% of the projected new allocation. //2013//** The increased efficiencies in administration will help to minimize the impact of potential funding reductions, thereby resulting in maximized resources for services and infrastructure.

Nebraska is knowledgeable regarding carry-over authority established in statute, and routinely exercises it for unliquidated obligations, i.e. obligations not expended that can be re-obligated in

the succeeding year. We have typically chosen to fully obligate funds as a method to maximize investments, however in the present economic uncertainty, we are initially planning to carry over an unobligated balance of 2012 funds into FY 2013. Our internal budget for FY 2012 reserves a buffer to minimize the impact of any further federal resource reductions in a final FY 2012 appropriation and beyond. The projection of the federal Title V funds is broadly summarized:

2011 funds carry-over.....\$1,329,284
 2012 funds (based on level FY 2011).....\$3,992,877
 Projection of funds available in FY 2012.....\$5,322,161

Community-based and Tribal subgrants, contracts.....\$1,197,638
 Internal allocations, state-level capacity.....\$3,274,857
 Total obligations.....\$4,472,495

2012 unobligated funds (buffer to carry-over into FY 2013)....\$ 849,666

The unliquidated obligations in 2012 will be projected by 3rd Quarter FY 2012 for re-obligation (carry-over) in FY 2013. //2012//

//2013/

2012 funds carry-over.....\$ 985785
2013 funds (projected pending final appropriation)\$4036191
Projection of funds available in FY 2013.....\$5021976

Community-based and Tribal subgrants, contracts.....\$1047002
Internal allocations, state-level capacity.....\$3334874
Total obligations.....\$4381876

2013 unobligated funds (buffer to carry-over into FY 2014).....\$ 640100

The unliquidated obligations in 2013 will be projected by 3rd Quarter, FY 2013 for re-obligation (carry-over) in FY 2014. Contingent on the final 2013 appropriation, Nebraska may obligate \$485,785 in one-year initiatives.

//2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.