Maternal and Child Health Services Title V Block Grant

Nebraska

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

Department of Health & Human Services
DHHS
NEBRASKA

Division of Public Health

State of Nebraska
Pete Ricketts, Governor

July 15, 2015

U.S. Department of Health and Human Services
Health Resources Services Administration (HRSA)
Via the Electronic Handbook (EHB)

To Whom It May Concern:

Nebraska's Title V/Maternal and Child Health Services Block Grant FY 2016 Application and FY 2014 Report are being submitted in the Title V Information System (TVIS) via the HRSA Electronic Handbook (EHB). The electronic submission also includes this Letter of Transmittal and the SF 424, in accordance with the Guidance & Forms, OMB No. 0915-0172, expiration December 31, 2017.

Please direct any questions regarding this Application and Report to Rayma Delaney, Title V Grant Administrator, Nebraska Department of Health and Human Services at rayma.delaney@nebraska.gov, (402) 471-0197.

Sincerely,

Judy Martin

Judy Martin, M.S., Deputy Director
Division of Public Health – Community and Environmental Health Section
Department of Health and Human Services
PO Box 95026
Lincoln, NE 68509-5026

Xc: Paula Eurek, Administrator, Title V MCH Director
Division of Public Health -- Lifespan Health Services

Rayma Delaney, Federal Aid Administrator
Division of Public Health -- Lifespan Health Services

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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Title V Maternal and Child Health (MCH) Services Block Grant to the State of Nebraska is awarded to the Nebraska Department of Health and Human Services (NE DHHS), with the primary responsibility for the Block Grant's administration organizationally placed in the Division of Public Health, Lifespan Health Services Unit. The Medically Handicapped Children's Program (MHCP) is organizationally placed and administered in the Division of Children and Family Services and MHCP is the primary Title V-supported program serving CSHCN.
Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 34 out of 93 counties considered to be frontier (6 or fewer persons per square mile). In contrast, approximately 45% of the state's residents reside in the population centers of Lincoln and Omaha in the eastern part of the state.
In 2015, NE DHHS completed a statewide needs assessment as required under Section 505 of Title V. The findings of that needs assessment and the subsequently identified priorities provide the foundation for Title V supported services and activities for FFY 2016 through FFY 2020. Organized by six population domains and the priorities identified for each, this summary describes the need, associated National Performance Measures (NPMs), plans to address each need, and any emergent issues related to the priority.

WOMEN/MATERNAL HEALTH DOMAIN

Priority Need: *Access to and Adequacy of Prenatal Care*
NPM: *#1, Percent of women with a past year preventive medical visit*

In 2013, 27.4 percent of Nebraska's pregnant women did not receive prenatal care in the first trimester and 26.6 percent did not receive adequate prenatal care. According to Nebraska PRAMS, among Nebraska women with late or no prenatal care *and* who did not receive care as early as they wanted, a number of barriers have been identified: 1) the provider or health insurance plan would not start coverage sooner (21.5%); 2) could not get an appointment (31.8%); 3) couldn't afford the care (48.9%); and 4) didn't have transportation (15.6%).

Action plan objectives addressing this priority include increasing first trimester care for all women, American Indian women, and women under age 20. Access to prenatal care will also be addressed within the continuum of preventive health care for women of child bearing age. The objective set for NPM #1 for 2016 is 59.4%, as compared to the 2013 level of 58.2%.

Priority Need: *Sexually Transmitted Diseases (STD) among (youth and) women of child bearing age.*

NPM: *#1, Percent of women with a past year preventive medical visit*

Nebraska data from 2013 shows a rate of infection for chlamydia as 1,166.5 per 100,000 women ages 20-44 and for gonorrhea as 166.5 per 100,000 women ages 20-44. The chlamydia rate within Nebraska is increasing and disparities for chlamydia and gonorrhea exist by race and geography. This priority also relates to the Adolescent Health Domain, and replaces a similar priority identified in 2010.

Nebraska's Title V action plan for this priority sets forth objectives to increase use of preventive health care services for young adult women and to decrease chlamydia rates for African American and all women ages 20 to 44. The objective set for NPM #1 for 2016 is 59.4%, as compared to the 2013 level of 58.2%.

PERINATAL/INFANT HEALTH DOMAIN
Priority Need: *Infant Mortality*
NPM: *#5, Percent of infants placed on their backs.*

Nebraska infants died at a rate of 5.3 per 1,000 live births in 2013, an increase from 2012. Death resulted primarily from birth defects, prematurity, and Sudden Infant Death Syndrome/ Sudden Unexpected Infant Death. African American and American Indian infants have a significantly higher death rate than other racial/ethnic groups in Nebraska. A newly identified priority in 2015, it includes the emergent issue of increasing rates of SIDS/SUID. The number of SIDS/SUIDS cases in Nebraska's most populous county has increased over the past 2-3 years, with 4-6 deaths previously identified per year, but with a total 7 deaths in the first 6 months of 2015.

Nebraska's Title V action plan includes objectives to decrease rates of SUID overall and among African American and American Indian infants. Place-based strategies will be developed through a learning community with Nebraska stakeholders. The recently funded Nebraska Perinatal Quality Collaborative offers a framework for identifying and addressing disparities within the perinatal period. The objective set for NPM #5 for 2016 is 83.3%, as compared to the level of 81.7% reported for 2011.

Priority Need: *Infant Abuse and Neglect*
NPM*: State Performance Measure (SPM) to be established for 2017.*

The incidence of maltreatment in infancy is not improving over time and Nebraska's infants are the most likely to be abused/neglected. Considerable racial and ethnic disparities exist. A similar priority was identified in 2010.

Plans for 2016 include objectives to increase screening of infants and young children for social/emotional developmental status, to develop and implement a plan for using multiple modes for delivering evidence-based parenting education, and to reduce risks for maternal depression.

Priority Need: *Breastfeeding of Infants*
NPM: *#4-A, Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months.*

According to the CDC's 2014 Breastfeeding Report Card, Nebraska moms report ever breastfeeding their infants, with less than one half of Nebraska infants breastfeeding at six months and only one fifth exclusively breastfeeding at six months. Breastfeeding initiation, duration, and exclusivity rates vary across racial, ethnic, and socioeconomic groups. This priority was also identified in 2010.

The action plan for this priority includes objectives to increase the duration of exclusive breastfeeding, particularly

among African American and American Indian mother-infant dyads, and to expand adoption of Baby Friendly Hospital standards. The objective set for NPM #4-A for 2016 is 84%, and 20.4% for 4-B, as compared to 82.4% and 20.2%, respectively, reported in 2011.

CHILD HEALTH DOMAIN
Priority Need: *Unintentional Injury among children (and youth), including motor vehicle crashes*
NPM: *#7, Rate of hospitalization for non-fatal injury per 100,000 children 0 through 9 and adolescents 10 through 19*

Unintentional injuries are the leading cause of death for Nebraska children ages 1-9. In 2012, the Nebraska death rate due to unintentional injuries for children ages 1-9 was 7.5 per 100,000 children compared to a national rate of 5.7. This priority was newly identified through the needs assessment completed in 2015 and is also related to the Adolescent Health Domain.

Action plan objectives have been established to increase proper use of child safety restraints and seatbelt use by women (as a means to reinforce proper use for their children). The objective set for NPM # 7 for 2016 is 111.4 per 100,000 children ages 0 -9 and adolescents 10 – 19.

Priority Need: *Access to Preventive and Early Intervention Mental Health Services for Children*
NPM: *SPM to be established for 2017.*

In 2012, data from the National Survey of Children's Health (NSCH) showed that approximately one-third of Nebraska 6 to 11 year old children who needed some type of mental health care or counseling did not receive it. It is assumed that access to care and counseling is likely no better for young children, who are highly susceptible to both positive supports and "toxic" stressors in the child's environment and relationships. This priority was newly identified in the 2015 needs assessment.

The action plan for this priority includes objectives to increase: rates of age-appropriate social/emotional development screening of children ages 0 to 3; delivery of professional development to health care professionals on early childhood mental health issues; integration of behavioral health and primary care for children; and numbers of children served in a medical home.

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) DOMAIN
Priority Need: *Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (CYSHCN)*
NPM: *SPM to be established for 2017.*

Twenty-eight percent of CYSHCN ages 3-17 in Nebraska have on-going emotional, developmental and/or behavioral conditions (2009-2010). Newly identified in the 2015 assessment, this priority bridges that of early screening and intervention identified as a related priority in the Children's Health Domain, to one that better focuses on mental health needs as a CYSHCN issue.

The action plan for this priority includes objectives to increase family involvement in Medicaid Behavioral Health Managed Care, to address workforce development needs related to promoting optimal early identification of and intervention for behavioral health needs of CYSHCN, and to increase screening of CYSHCN for age-appropriate social/emotional development and receipt of needed care or counseling.

Priority Need: *Medical Home for CYSHCN, including empowerment of families to partner in decision making and access to additional family supports*
NPM: *#11, Percent of children with and without special health care needs having a medical home*

According to the 2009/10 National Survey for Children with Special Healthcare Needs, the percentage of CSHCN in Nebraska who receive coordinated, ongoing, comprehensive care within a medical home is significantly lower than the national average and that more of Nebraska families have one or more unmet needs in family support services, compared to the national average. A similar priority need was identified in 2010, but this priority established in 2015 has expanded emphasis on family supports.

The action plan for this priority includes objectives to increase: care coordination services in medical clinics; percent of CYSHCN whose families partner in decision making and are satisfied with services; percent of CYSHCN who receive care in a medical home; and the number and percent of CYSHCN covered by health insurance. The objective set for NPM #11 is 51.9 percent for 2016 for CSHCN, compared to 50.9% reported in 2011-2012

ADOLESCENT HEALTH DOMAIN
Priority Need: *Unintentional Injury among youth (and children), including motor vehicle crashes*
NPM: *#7, Rate of hospitalization for non-fatal injury per 100,000 children 0 through 9 and adolescents 10 through 19*

Motor vehicle crashes are the leading cause of death for Nebraska teens ages 10-19. In 2012, the Nebraska death rate due to motor vehicle crashes for youth ages 10-19 was 15.0 per 100,000 youth compared to 7.8 nationally. Risk factors include inexperience, brain development, exposure to driving in high risk situations such a driving at night, driving distractions, low seat belt use, speeding and alcohol. This priority also relates to the Child Health Domain and is newly identified in 2015.

The objective set for this priority in the action plan calls for decreasing youth injury due to motor vehicle crashes through increased seat belt use, decreased distracted driving, and recognition of the risks of drowsy driving, speed, and alcohol use. The objective set for NPM # 7 for 2016 is 111.4 per 100,000 children ages 0 -9 and adolescents 10 – 19.

Priority Need: *Sexually Transmitted Disease (STD) among youth (and women of child bearing age)*
NPM: *#10, Percent of adolescents, ages 12 through 17 with a preventive medical visit in the past year.*

Also associated with the Women's/Maternal Health Domain, this priority need has particular implications for adolescents. The highest reported rates of STDs are found among young people aged 15-19 and 20-24. A similar priority was identified in 2010.

One of the action plan objectives to address STDs among youth targets a reduction in chlamydia. Other objectives include increasing adolescent use of preventive health care services and incorporation of STD prevention into preconception health planning. The objective set for NPM #10 for 2016 is 85.1%, compared to 83.4% reported in 2011-2012.

CROSS-CUTTING OR LIFE COURSE DOMAIN
Priority Need: *Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity*
NPM: *#8, Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day*

According to the 2013 Behavioral Risk Factor Surveillance System (BRFSS), 30.2% of Nebraska women aged 18-44 are overweight and 28.3% are obese. The percentage of women who are highly active and active have not significantly changed in the past six years. Approximately 29% of Nebraska's children and adolescents (10-17 years) are obese (BMI ≥30.0) or overweight (BMI 25.0-29.9). There has been substantial worsening of indicators of food insecurity. The 2012 National Survey of Children's Health indicates that only 23% of Nebraska youth age 12-17 engage in vigorous physical activity every day.

This priority need was also identified in 2010, and has been placed in the Cross-Cutting or Life Course Domain because of its implications for more than two populations, the complex array of factors that contribute to overweight and obesity at the socio-ecological level, and the impact on life course outcomes.

Action plan objectives have been set to increase: BMI data collection in Nebraska schools, place-based initiatives to increase physical activity, and percent of women in active or highly active levels of recommended physical activity. The objective for NPM # 8 for 2016 has been set at 33%.

Priority Needs: *Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (CYSHCN), Access to and Adequacy of Prenatal Care, Sexually Transmitted Diseases (STD) among (youth and) women of child bearing age, Access to Preventive and Early Intervention Mental Health Services for Children, and Medical Home for CYSHCN, including empowerment of families to partner in decision making and access to additional family supports*
NPM: *#15, Percent of children ages 0 through 17 who are adequately insured.*

These five priorities were previously described in other population domains, but are again addressed in the Cross-Cutting or Life Course Domain because of the commonalities around access to and utilization of health care associated with each, including insurance coverage, type and cost of coverage (deductibles, co-pays, premiums, conditions and treatments not covered, etc.), availability of providers, education and language barriers, and geographic barriers.
The action plan for this cross-cutting issue includes an objective to facilitate and promote agency-level cross-cutting planning and policy development that includes Title V but goes beyond it in scope and impact, and an objective to utilize the plan in future Title V MCH and CSHCN programming and policy development. The objective set for NPM #15 for 2016 is 75.8%, compared to 74.4% reported in 2011-2012.

II. Components of the Application/Annual Report

II.A. Overview of the State

II. A. Overview of the State

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. 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, 14.4% of the population is 65 and over, however in 52 counties, the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services for the MCH population because an older population needs more and different services.

The annual 2014 Nebraska population is 1,881,503 people according to the U.S. Census Bureau. 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
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 34 out of 93 counties considered to be frontier (6 or fewer persons per square mile). In contrast, approximately 45% of the state's residents 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 21% between 2000 and 2014.

c. Increasing diversity
Another source of change is Nebraska's rapidly increasing diversity in a state previously perceived 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 2014 the state's minority population grew 50.7% (from 216,769 to 367,117) and now constitutes 19.5% of the total population while the white population increased by 1.15%. Most of this increase in minorities is Hispanic, whose numbers increased 69.3%, (56.9% of the state's overall population increase).

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 appropriate tools.

(1) Hispanic origin
The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase more than quadrupling from 94,425 in 2000 to 191,325 in 2014 (102.6% increase) according to the U.S. Census estimates. Hispanic Americans now comprise 9.9% 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 72.3% in 2014. This is largely due to the availability of employment in the central, western, and northeastern parts of Nebraska. Hispanic Americans make up less than 10% of the population in most nonmetropolitan 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.

(2) Asian and Pacific Islander
Nebraska's Asian and Pacific Islander (API) population grew by 84.7% from 23,521 in 2000 to 43,451 in 2014 according to the U.S. Census Bureau estimates.

(3) Native American
The Native American population in Nebraska grew by 64.3% from 15,634 in 2000 to 25,690 in 2014 according to the U.S. Census estimates. Thurston County, which includes both Omaha and Winnebago Tribal land, ranks number 26 in the U.S. for percentage Native American. Over half of the county's population is Native American (56%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. 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 number of Native Americans also reside 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.

(4) African American
African Americans make up 4.9% of the Nebraska population. This population grew from 70,043 in 2000 to 92,289 in 2014 a 31.8% 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).

(5) Racial and ethnic health disparities
As in other states, Nebraska's minority populations have many health disparities. For example, according to the Henry J. Kaiser Family Foundation, projecting life expectancy for a Nebraska person who is white is 6 years longer than for a Nebraska person who is African American. A Hispanic Nebraska person’s life expectancy is 5 years more than a White Person. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. 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 2014, the percentage of the population aged 65 and older was 14.4%, compared to the national average of 14.5%. The total number of Nebraskans over age 65 increased by 16.6%, or by 38,559 individuals, from 2000 to 2014. Nebraska ranks 21st in the nation for percentage of population 65 years and over. The population over 65 is projected to grow 56% by 2020. The median age of Nebraskans increased from 35.4 in 2000 to 36.2 in 2014.

e. Special populations

(1) Incarcerated

According to Nebraska Department of Corrections there were 345 incarcerated women in 2013. 7.1% of all persons incarcerated in Nebraska were women, which is comparable with the national rate of 7.3%.

(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, 7,845 people were homeless in Nebraska during the grant year July 2013 to June 2014 and 3,511 people were near homeless during this same time period this count excludes the Lincoln Metro area. Women accounted for 52.3% of the homeless and of the near homeless in Region 7 which includes Omaha. During the grant year, Hispanic or Latino persons represented 20.5 % of persons who were homeless and of the near homeless. Children accounted for 26.8% of those homeless and who are near homeless. Among those homeless and near homeless in Region 7 which includes Omaha 31% were under 18 and 11% were between the ages of 18 and 24.

f. Rural poverty

Between 2000 and 2013 the overall rate of poverty across the state of Nebraska increased by approximately 45% from 8.9% to 12.9%. There are two counties in Nebraska which are experiencing critical poverty rates (at least 50% above the state average) Key Paha (19.4%) and Thurston (30.5%).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 nonmetropolitan Nebraska, losing population while the number of residents in poverty increased.

Between 2000 and 2013 metro counties gained 171,310 residents while their poverty population grew by 1,581. Urban counties saw their total population increase by about 13,859, while their poverty population grew by 632. Nebraska's rural counties saw an actual increase in poverty numbers, with an increase of 201. Those counties saw an actual population decline of over 28,074 residents during the same period.

2. Agency's current priorities and initiatives with the resulting Title V program’s roles and responsibilities

2015 has been a year of significant change and many transitions for the Nebraska Department of Health and Human Services. Nebraska elected its first new governor in 10 years, and NE DHHS leadership has changed over the subsequent 6 months. A new Chief Executive Officer joined the agency in April 2015, and is serving as the interim Director of the Division of Public Health as a result of the previous director’s resignation in May 2015. The Division of Children and Families, the organizational home for Nebraska’s Title V/CHSHCN program, will have a new director starting in August 2015. Thus the following description of agency priorities and initiatives will likely be updated over the next year as the new leadership assesses needs and sets new directions.

The Division of Public Health (DPH) has applied for national public health accreditation, and has consequently devoted significant effort to complete prerequisites, achieve standards, and establish quality improvement processes. Title V/MCH staff in the Division have been actively engaged in the development and implementation of the Division's Strategic Plan and the State Health Improvement Plan.

The DPH Strategic Plan identified the following four priorities: 1) Creating a culture of wellness; 2) Becoming a trusted source of state health data; 3) Addressing health disparities; and 4) Creating a communications plan. Title V/MCH staff have been particularly engaged in or are leading activities related to improving data collection and consistency on demographic factors (e.g., race/ethnicity, gender, age, disability status, and geographic location) throughout the division and to use a data-informed quality improvement approach to address health disparities.

The Title V/MCH Director had been an active member of the committee that developed the State Health Improvement Plan and continues as a member of a committee overseeing its implementation. Staff in the Lifespan Health Services Unit are collaborative partners in carrying out activities related to the following objectives:

- By December 2016, public health partners will increase professional lactation support across Nebraska through the use of International Board Certified Lactation Consultants (IBCLCs).
- By December 2016, increase the number of schools that implement a Coordinated School Health approach to improve the health of students by focusing on healthy eating, physical activity, obesity, and tobacco prevention.
- By June 2014, complete a study of the role of the state and local public health agencies in the prevention of mental health and substance abuse problems and the coordination of these services.

Implementation of the last objective related to the role of public health in the prevention of mental health and substance abuse problems has been extended into 2015, with the University of Nebraska Public Policy Center completing the study under contract. The Title V/MCH Director serves as the co-lead overseeing the project. The development of the plan has offered an opportunity to examine MCH related activities within the larger context of public health, particularly in the area of early childhood mental health.

DPH and its Title V/MCH staff have also been collaborative partners with the Division of Behavioral Health in the development of a System of Care Strategic Plan. Completed August 2014, this strategic plan has the following priorities:

- Expanding the array of services and supports;
- Enhancing the cultural and linguistic appropriateness of services to match family needs;
- Improving access to services and supports;
- Maximizing use of all funding sources, especially federal;
- Inclusion of trauma-informed service options;
- Expanding family and youth involvement and leadership; and
- Systems to monitor quality and outcomes.

The Maternal Child Adolescent Health (MCAH) Program Manager continues to participate in a committee working to implement the strategic plan. A particular focus has been trauma-informed care, with the MCAH Program Manager a member of a steering committee overseeing a contract with the Behavioral Health Education Center of Nebraska (BHECN) to develop training and supports for trauma informed care across the Divisions of Behavioral Health, Public Health and Children & Family Services.

3. Health care reform efforts and ACA implementation impact on the health status of MCH and CSHCN populations and the delivery of Title V-supported services

Nebraska has chosen not to expand Medicaid under the ACA nor establish a health exchange. Direct impact of the ACA has thus largely been related to expanded coverage for some low to middle income women and families, and for young adults to age 26; elimination of pre-existing conditions as a requirement for health care coverage; and the

requirements for certain preventive health services to be covered in health plans. Referrals to the national exchange are made by home visiting staff and local clinics/providers. Medically Handicapped Children's Program staff refer non-insured families to the ACA resources/national exchange and to Medicaid. As noted in the Annual Report for the Child Health Domain, there has been an increase in insurance coverage for children, an assumed effect of expanded coverage for some low to middle income women and families.

Legislative bills authorizing Medicaid expansion have been introduced in three consecutive legislative sessions and have failed each year. In 2015, a bill to require a Medicaid family planning plan amendment also failed. A number of Legislative Interim Studies will explore health care reform and ACA related topics later in 2015. These include:

- LR22 to monitor medical care transformation including the health care delivery process of patient-centered medical homes.
- LR182 to investigate and make recommendations regarding what can be done to provide Nebraska consumers the necessary information to enable them to make informed decisions as to which health care plan to purchase.
- LR306 to examine ways in which Medicaid expansion could be implemented in Nebraska under the federal Patient Protection and Affordable Care Act for medical assistance for newly eligible individuals.

Title V/MCH and CSHCN staff will monitor these studies and provide information when/if requested within agency protocols.

Title V/MCH staff and others, co-led by the MCAH Program Manager and the Adolescent Health Coordinator, are currently participating in Cohort 2 of the National MCH Workforce Development Center's Advancing Health Reform Implementation project. The intended purpose of Nebraska's Young Adults in Health Transformation project is to convene a group of interested partners and stakeholders to undertake a learning and message formulation project related to access to health care in the environment of health transformation, for young adults aged 20-24 years in Nebraska. The approach to study and messaging focuses on three population subgroups: young adults with autism (YAA); young adult females with behavioral or mental health conditions (YAFBH); and young adults with foster care experiences (YAFC). This project is currently underway, with workgroups formed for each population subgroup.

The Maternal/Infant Community Health Nurse, Sr. has been participating in an oversight committee for a project in central Nebraska examining the use of texting and social media by community health workers as a means of improving birth outcomes. This project is funded by Blue Cross/Blue Shield. This project and others in the area of chronic disease are actively exploring the role of community health workers in promoting health care access and utilization as part of health care transformation.

4. Process used by the Title V administrator to determine the importance, magnitude, value and priority of competing factors

The Five-Year Comprehensive Needs Assessment and the identified priorities provides the framework for program development and planning. Other major considerations include:

- Programs and activities established in Nebraska Statute and for which Title V support is necessary, including Newborn Screening, Birth Defects Registry, and the Medically Handicapped Children's Program.
- Availability of complementary financial and manpower resources to leverage Title V funds. An example would be promotion of and training in trauma informed care.
- Governor, Agency, and/or Division priorities and directives, such as public health accreditation and performance accountability.

All planning and program development activities are reviewed and approved in accordance with Agency chain-of-command protocols, with decisions made at the applicable level of delegated authority. To the extent possible,

decisions are data-driven and consider evidence-based or evidence-informed solutions.

5. Current and emerging issues

As stated earlier, NE DHHS is currently experiencing many changes and transitions. Bringing new leadership up-to-date on MCH and CYSHCN issues will require time and attention and will be ongoing. Within this context, Title V staff are monitoring and developing responses to the following issues:

- Increased awareness of and attention to social determinants of health.
- Barriers to accessing and utilizing health care (see Needs Assessment).
- Trauma-informed care as an agency priority.
- Performance accountability and government transparency.
- Continuous quality improvement, within the context of public health accreditation.

These current and emerging issues have relevance to the identified Title V priorities for 2016-2020, and as such, consideration of each will be integrated in the planning and program development going forward.

6. Extent to which poverty, racial and ethnic disparities in health status, geography, urbanization and the private sector create unique challenges for the delivery of Title V services

These issues were described earlier in Section IIA, under 1. Principal characteristics of Nebraska that are important to understanding the health needs of the entire state's population. Some of the more significant challenges that these characteristics pose for Title V in Nebraska are compounded by certain features of the health care infrastructure.

Nebraska currently has 88 of 93 counties designated as a federal mental health professional shortage area. These areas include the vast majority of the state with only the metropolitan area around Omaha as not having such a designation. Nebraska currently has 62 of 93 counties either in whole or partially designated as a federal primary care health professional shortage area. These shortages, particularly in rural areas, have had significant impact on access to health care for both MCH and CSHCN populations.

As stated earlier, Nebraska has not expanded Medicaid under the ACA nor has it pursued a Medicaid family planning amendment, which has limited access to pre and inter-conception care for low income women who do not qualify for subsidies under the health care exchange. As a consequence, options for providing services to these women have primarily focused on Title X Family Planning clinics and Federally Qualified Health Centers.

Immigration and refugee resettlement has resulted in significant increases in families for which English is not the primary language. Many of the families have taken residence in rural areas because of the availability of livestock and food production employment. The health care system in Nebraska has and continues to struggle with identifying, training, and supporting interpreters and translators.

Disparities in health outcomes have been long standing for Nebraska's racial and ethnic minorities. Though progress has been made in some indicators, significant disparities in outcomes such as infant mortality persist. Nebraska Title V and its partners are increasingly examining social determinants of health to better understand the disparities and identify effective strategies. This work is being facilitated through the Infant Mortality Collaborative Innovation and Improvement Network (CoIIN), and its Social Determinants of Health (SDOH) Learning Network.

7. State statutes and other regulations that have relevance to Title V Program authority

In Nebraska, statutes pertaining to the broad authority to carry out maternal and child health services are found in Chapter 71, sections 2201-2208 which originated in 1935. The statute requiring the birth defects registry is found in

71-645 through 648, metabolic screening and associated responsibilities in 71-519 through 71- 524, newborn hearing screening in71-4734 to 4744, and WIC at 71-2227. The statute pertaining to the Medically Handicapped Children's Program is found in Chapter 68, sections 1401 - 1405. NE DHHS regulations implementing Title V services for the Medically Handicapped Children's Program are found in Title 467 Chapter 4.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

1. Process

(1) Goals, Framework and Methodology

The overarching goal of Nebraska's MCH/CSHCN Needs Assessment is to produce a list of well documented priorities that will guide the work of the Title V Block Grant, NDHHS, and its stakeholders over the next five years. NDHHS had two desired goals in conducting the stakeholder portion of the MCH/CSHCN needs assessment:

A) To conduct an objective process by utilizing rigorous public health methods and relying on data and evidence for decision-making whenever possible.

B) To empower stakeholders to determine and commit to a list of ten priorities.

In 2004, Nebraska began to utilize the planning methodology described by the Family Health Outcomes Project (FHOP), University of California, San Francisco in "Developing an Effective MCH Planning Process: A Guide for Local MCH Programs" (September 2003). The FHOP process is adapted from assessment methods developed by the University of North Carolina School of Public Health as outlined in HRSA/MCHB's commissioned "Assessment of Health Status Problems" (1996, revised 2001), evaluation methods from University of Chicago Illinois School of Public Health, and logic model methods developed by the University of Wisconsin Extension.

The FHOP planning methodology results in an ongoing process of assessment, strategic planning, implementing/monitoring and evaluation that has had a strong impact on Nebraska's Title V direction (short, medium and long term goals), resource/staff allocation, program development and activities, as well as performance measurement and accountability. The following figure outlines the planning cycle that is followed:

The Needs Assessment was conducted by MCH Epidemiology, Lifespan Health Services Unit (LSHU), Division of Public Health, Nebraska Department of Health and Human Services. The assessment process began in July 2014. Stakeholders were involved in the process from the October, 2014 Kick-off meeting until the May, 2015 Prioritization meeting. In between the two meetings the stakeholder committee broke into the following five subcommittees: Women of Childbearing Age, Infants, Children (1-9), Youth (10-19), and Children with Special Health Care Needs.

The following table describes the flow of the process and is followed by detailed description of each step:

	Steps in Needs Assessment Process

1.	Data collection and analysis
2.	Stakeholder process Kick-off
3.	Stakeholders develop criteria
4.	Stakeholders determine weights for each criterion
5.	Staff finalizes definitions and develops rating scales for criteria
6.	Subcommittee meeting 1: provide orientation and present data
7.	Subcommittee meeting 2: Review data, identify list of needs, determine top 3-5 needs per population group
8.	Subcommittee meeting 3: Write problem statements, draft issue briefs, and determine presenters
9.	Presentation of identified problems by subcommittees to the entire stakeholder group
10.	Use weighted criteria to score problems
11.	Sum participant's scores / rank problems
12.	Discuss and confirm results
13.	Finalize list of 10 priorities

1. Data collection and analysis

In July 2014 Nebraska employed a Needs Assessment Intern to assist with the collection and management of data. The data process began with a comprehensive review of indicators relevant to Nebraska's MCH/CSHCN populations. The complete indicator list totaled 217 indicators plus demographics for the five population groups. Once the indicator list was established data were collected and formatted in the following forms (when available):

- For years 2008-current (in most cases 2013)
- By race/ethnicity, geography, and gender
- National rates
- Healthy People 2020 objectives

A data factsheet was created for each indicator, showing (as available) time trends and significance, comparisons to national data and HP2020 goals, and disparities across sub-populations.

2. Stakeholder process Kick-off

The stakeholder process Kick-off occurred on October 23, 2014 in Lincoln, NE with 86 participants. The process began with an orientation to the Title V Block Grant, the planning process and purpose of the Needs Assessment, as well as an introduction to the priority setting process, specifically the development of criteria. The five population groups to be assessed were introduced and attendees were able to self-select and meet with their population group sub-committee prior to the end of the day.

3. Stakeholders develop criteria

The stakeholders developed criteria to prioritize health problems/needs of Nebraska's MCH/CSHCN population through a facilitated process. These criteria were developed to objectively assess the health problems/needs, such that the group could determine if a given problem was more or less important compared to other problems. The criteria are the direct means of determining the list of 10 priorities and as such the selection of criteria prior to discussion of specific health problems is an essential element to the process.

The discussion generated during the criteria development workshop was meant to stimulate critical thinking about the stakeholders' values as a community. The group was given time to thoroughly discuss the proposed criteria and assure each member had a common understanding of each criterion. At the end of the discussion the group voted and selected the following five criteria:

1. The Problem is Worse than the Benchmark or Increasing

2. Disparities Exist Related to Health Outcomes
3. Strategies Exist to Address the Problem/An Effective Intervention is Available
4. Societal Capacity to Address the Problem
5. Severity of Consequence

4. Stakeholders determine weights for each criterion

Not all of the criteria developed are of equal importance; each was weighted using a points system. For example, using a scale of 1 to 3, a criterion is given a weight of "1" if it is considered important but not as important as other criteria, "2" if more important than some criteria but not as important as other criteria and a "3" if of very great importance. The weighted score for each criterion was agreed upon and determined by voting. The following criteria and weighting was developed:

1. The Problem is Worse than the Benchmark or Increasing **(Weight = 1)**
2. Disparities Exist Related to Health Outcomes **(Weight = 1)**
3. Strategies Exist to Address the Problem/Effective Intervention is Available **(Weight = 3)**
4. Societal Capacity to Address the Problem **(Weight = 2)**
5. Severity of Consequences **(Weight = 2)**

5. Staff finalizes definitions and develops rating scales for criteria

Staff drafted expanded definitions for the five selected criteria and developed a rating scale particular to each criterion. A rating scale is a way to assure that each participant is using the same, agreed upon definitions for scoring. The rating system was used to capture the degree to which a problem met a criterion on a 5-point scale. The following is an example:

Severity of Consequences

Definition: This means that the problem identified could result in severe disability or death. Even though some health indicators may have improved due to effective interventions, these interventions must be sustained to avoid severe negative outcomes. An example of this would be the importance of sustaining an effective immunization program to avoid the reemergence of vaccine-preventable diseases.

Criterion Weight: 2

Rating Scale:

1. Problem is not life threatening or disabling to individuals or community
2. Problem is not life threatening but is sometimes disabling
3. Problem can be moderately life threatening or disabling
4. Problem can be moderately life threatening and there is also a strong likelihood of disability
5. Problem has a high likelihood of death or disability

6. Subcommittee meeting one: provide orientation, and present data

There were five stakeholders who volunteered to chair a subcommittee (women, infants, children, youth, and CYSHCN). The chairs were supported by 7 staff members who provided for meeting logistics, communication and organization. During the first meeting, the Needs Assessment Coordinator provided an orientation to the sub-committee scope of work/tasks to complete, reviewed and sought approval of the draft criteria definitions and rating scales, and presented the data factsheets and identified requests for additional data.

7. Subcommittee meeting two: Review data, identify list of needs, and determine top 3-5 needs per population group

During the second subcommittee meetings the members reviewed additional data, identified a preliminary list of issues, and utilized the criteria to narrow their list to three -five issues to propose to the larger group. There were a total of 22 issues identified across the five subcommittees.

8. Subcommittee meeting three: Write problem statements, draft issue briefs, and determine presenters

Between the second and third/final subcommittee meeting the members wrote problem statements for their chosen

indicators, and began to draft issue briefs. The issue briefs contain a problem statement and detailed information addressing each of the five criteria. Each issue brief averaged three pages in length. The subcommittees spent their third meetings reviewing/editing the issue briefs and planning the presentation of the issue to the large stakeholder group.

9. Presentation of identified problems by subcommittees to the entire stakeholder group

After the third subcommittee meeting the issue briefs were finalized and published to the NDHHS website (http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/NAIssueBriefs.aspx). A total of 22 Issue Briefs were developed. Each stakeholder attending the final meeting were asked to read the briefs prior to the meeting. At the final meeting the subcommittees presented their findings and made the case to the larger group why the particular priority should be included in the final selection of ten state priorities.

10. Use weighted criteria to score problems

Following the presentations and prior to voting, five issues (overweight/obesity in women, children, and youth; and sexually transmitted diseases among youth and women) were combined to make two issues, reducing the total number of issues from 22 to 19. Stakeholders scored each of the 19 issues individually utilizing the rating scales of weighted criteria. Staff provided a copy of the prioritization tool (scoring sheet) and instructed participants in the use of this tool illustrating with an example. Staff circulated the room answering questions and providing support to stakeholders as they worked through the process and deliberated.

11. Sum participant scores / rank problems

The results of the individual scoring of each problem were validated by staff and entered in a summary table that showed the sum total of the weighted individual scores and the rank order of each problem. The total scores were ranked from the highest, priority #1, to the lowest, #19. Results of the ranking, all stakeholder's results combined, were then presented to the large group.

12. Discuss and confirm ranked results

After review of the scores and ranking the stakeholders discussed at their tables and then documented their comments and suggestions to DHHS.

13. Finalize list of 10 priorities

Following the final meeting staff analyzed and refined the recommendations then presented to the leadership within NDHHS for final approval. Once approved the list was disseminated back to the participants through e-mail and published for public input on the NDHHS website (http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/PublicInput.aspx).

(2) Stakeholder Involvement

Stakeholders play a significant role in the assessment process, specifically in identifying and prioritizing identified problems and in providing input on the development of action strategies for prioritized issues. Nebraska's MCH/CYSHCN stakeholders are asked to fully participate in the process by attending all five meetings, sharing their knowledge, making the hard decisions, and preparing documents and messages to convey their findings. The stakeholder group must be active and engaged in order for the Needs Assessment process to work. The stakeholders are a diverse membership consisting of Families, representatives from State and local MCH/CSYHCN programs, NDHHS programs (Public Health, Medicaid, Children and Families), other State Agencies (Education, University Departments), other HRSA programs, local public health agencies, non-profit and community service organizations.

There were a total of 86 participants who participated in the Kick-off meeting, 68 participants in the subcommittees, and 75 attendees at the final meeting.

While participation in this type of needs assessment process is time intensive there are real benefits to participation. Comments from stakeholders about the Needs Assessment process include: value of meeting new contacts, networking, learning about public health processes and NE DHHS, gaining experience in methodologies of assessment, group process, facilitation and communication, expansion of knowledge of MCH issues, insight into improvements needed, access to data, and leadership opportunities.

(3) Quantitative and Qualitative methods

Nebraska's needs assessment methodology relies heavily on the interplay between quantitative qualitative methods. As previously mentioned in Step 1 of needs assessment process/ methodology staff collected data on nearly 250 indicators and demographics. For each indicator/demographic the data was collected overall and by race/ethnicity for the past five/six years. Time trends and significance tests for comparisons to national data and HP2020 goals and disparities across sub-populations were conducted. The findings were presented in both tabular and graphical formats in the form of fact sheets.

The utilization of criteria and a prioritization tool are quantitative methods that aim to incorporate community values into the process in an objective manner. The criteria themselves are standards the group chose to assess the needs of the population. More importantly criteria shape and determine the final list of priorities. Step 4 and 5 of the previous section articulatesthe quantitative nature of the criteria and Step 10 illustrates the prioritization tool (scoring sheet). Nebraska's process requires that the criteria are agreed upon and established prior to any discussion of needs. Stakeholders are informed of how the criteria impact the final priorities before they adopt them, and this is emphasized at every step in the process. Stakeholders only fully understand the direct correlation between the priorities and the criteria when the final voting/ranking is complete.

The stakeholders reviewed and discussed each fact sheet looking for emerging trends, entrenched issues, and disparities. They utilized the fact sheets along with their knowledge and expertise of their population group/community/profession to identify a short list of top issues in each of the population groups. The fact sheets start the discussions, and the criteria frame the discussions, but real life experiences and relationships are the qualitative content. Once a subcommittee determines their list of needs to propose to the larger group, they develop issue briefs. The issue briefs articulate the subcommittee consensus positions on issues and make a case for inclusion in the final list of 10 state priorities. The issue briefs are built on the data and criteria and also are infused with the qualitative opinions/positions of the subcommittees and the stakeholder members.

(4) Data Sources

The following is a list of the secondary data sources utilized for the state level data in the 2015 Needs Assessment:

A. Nebraska Behavioral Risk Factor Surveillance System (BRFSS)

B. Nebraska Cancer Registry (NCR)

C. US Census Bureau, specifically Population Estimates, and the Current Population Survey (CPS), as well as the U.S. Department of Agriculture (USDA) annual food security survey, conducted as a supplement to the nationally representative Current Population Survey (CPS).

D. Nebraska Children and Family Services come from the state's Statewide Automated Child Welfare Information System (SACWIS), also known as N-FOCUS (Nebraska Family Online Client User System)

E. Nebraska Hospital Association's Nebraska Hospital Information System (NHIS)

F. Nebraska Medicaid data derived from the annual EPSDT (Early Periodic Screening Diagnosis, and Treatment) Participation Report, Form CMS-416.

G. National Immunization Survey (NIS)

H. National Survey of Children's Health (NSCH) and the National Survey of Children with Special Healthcare Needs (NSCSHCN)

J. Nebraska's Pregnancy Risk Assessment Monitoring System (PRAMS)

K. Sexually Transmitted Disease Surveillance data from the DHHS STD Program

L. Nebraska Vital Statistics

M. Nebraska's Youth Risk Behavior Surveillance System (YRBSS)

(5) Interface between data, priority needs, and state Action Plan

Nebraska's needs assessment process is data-driven. Without data an issue/need cannot be identified. Once identified, data are essential to developing a problem statement, and a case for inclusion to the list of 10 state priorities that will guide Nebraska's MCH Title V work and investments over the next five years. The list of 10 state priorities and the strategies/activities to address them are monitored and measured in Nebraska's Action Plan by the indicators that led to their identification (when possible: in some cases, when there were no corresponding

national measures). Nebraska will write the State Performance to align with the priority data. This creates a circular process and should yield progress/improvement on the ten identified priority needs over the five years.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Women/Maternal Health Domain

i. Overview of health status - Nebraska assessed demographics and 53 morbidity/mortality and health determinant or health status indicators in the women/maternal health domain. In 2013 there were an estimated 299,168 women aged 20-44 living in Nebraska. 12.2% of these women were reported living below the Federal Poverty Level. The leading cause of death for women in Nebraska aged 15-44 is unintentional injuries. Rates of obesity, hypertension, and chlamydia have all shown statistically significant increases in recent years.

ii. Summary of population-specific strengths/needs - The stakeholder subcommittees reviewed data fact sheets on the indicator data. Based on their review, the population specific needs identified by the women's subcommittee were:

1) Access to Prenatal Care
2) Access to and of Utilization of Care
3) Binge Drinking
4) C-Section/Induction
5) Obesity
6) Sexually Transmitted Diseases

iii. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization," the following two major health issues were included in Nebraska's priority needs (Obesity will be discussed in the Cross-cutting section):

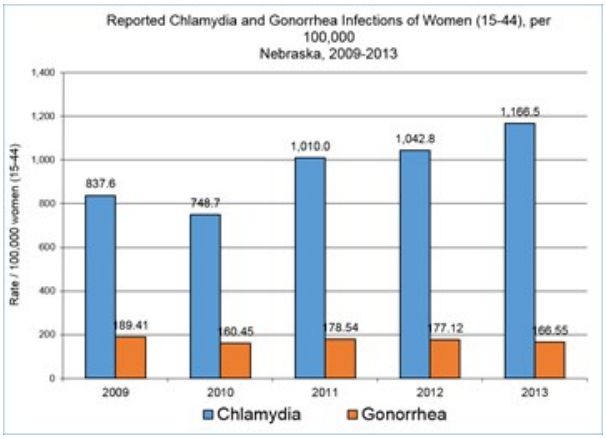
- ***Access to and Adequacy of Prenatal Care***

In 2013, 27.4 percent of Nebraska's pregnant women did not receive prenatal care in the first trimester and 26.6 percent did not receive adequate prenatal care. According to the 2013 Behavioral Risk Factor Surveillance System, 78 percent of women (aged 18-44) reported having a personal physician. Approximately 85% of Nebraska women (aged 18-44) reported having health insurance. While only 15 percent of women (18-44) are uninsured, 26% of mothers did not obtain adequate prenatal care. This indicates a potential gap in access.

According to Nebraska PRAMS, among Nebraska women with late or no prenatal care (26% of all post-partum women) *and* who did not receive care as early as they wanted (10% of all post-partum women), a number of barriers have been identified. Specifically, these women cite: 1) the provider or health insurance plan would not start coverage sooner (21.5%); 2) could not get an appointment (31.8%); 3) couldn't afford the care (48.9%); and 4) didn't have transportation (15.6%).

- ***Sexually Transmitted Diseases***

According to the Nebraska STD program surveillance, in 2013 the rate of infection for chlamydia was 1,166.5 per 100,000 women ages 20-44 and the rate of infection for gonorrhea was 166.5 per 100,000 women ages 20-44. The chlamydia rate within Nebraska is increasing while Nebraska's rate of gonorrhea is stable but high. Within Nebraska, disparities for chlamydia and gonorrhea exist by race and geography.



iv. Title V-specific programmatic approaches - Of the two identified priorities for this domain, Nebraska Title V has well established state-level infrastructure to build on through NE DHHS's Reproductive Health and STD programs. In addition, a major local initiative to address adolescent health in the highest incident metropolitan area has specific objectives to reduce incidence of STDs. In the area of prenatal care and related birth outcomes, in 2014 Nebraska MCH Title V joined the Infant Mortality Collaborative Innovation and Improvement Network (IM CoIIN). Nebraska has a newly formed and legislatively-funded Perinatal Quality Improvement Collaborative (N-PQIC), for which Nebraska Title V will serve as designated funding contract manager. Action plan initiatives in this domain include quality improvement projects with Nebraska 's Medicaid Managed Care Organizations, a cross-program strategic planning and implementation project in preconceptions health, the CoIIN, the N-PQIC, and ongoing collaborations with N-MIECHV.

Perinatal/Infant Health Domain

i. Overview of health status - Nebraska assessed demographics and 37 morbidity/mortality and health determinant or health status indicators in this domain. In 2013 there were an estimated 25,793 infants living in Nebraska. 31% were reported living below the Federal Poverty Level, which is higher than the national rate. The leading cause of death for infants in Nebraska is birth defects. Rates of low birth weight and prematurity in Nebraska are decreasing over time at a statistically significant rate.

ii. Summary of population-specific strengths/needs - The stakeholder subcommittees reviewed data fact sheets on the selected indicators. Based on their review, the subcommittee members identified the following priority issues of the population domain:

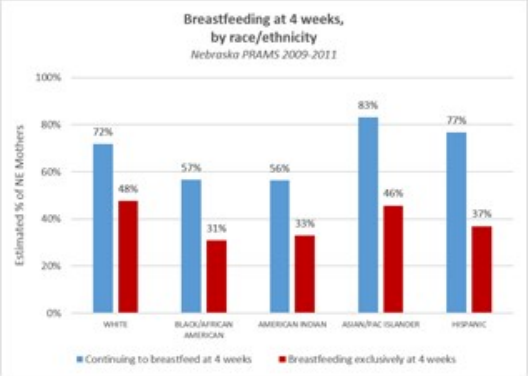
1) Abuse and Neglect
2) Breastfeeding
3) Disparities in Access to Prenatal Care
3) Health Insurance
4) Maternal Depression
5) Prematurity leading to Mortality

6) SUID and Safe Sleep

iii. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization" the following major health issues were included in Nebraska's priority needs:

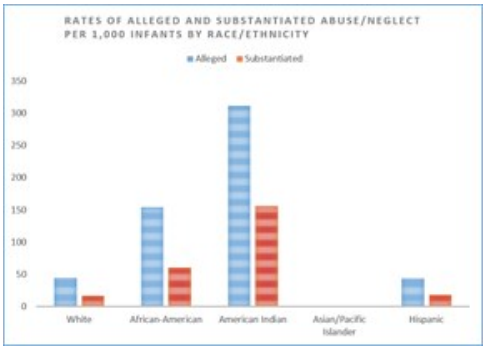
- ***Breastfeeding of Infants***

According to the CDC's 2014 Breastfeeding Report Card, 82.4 % of Nebraska moms report ever breastfeeding their infants. However, this report shows that less than one half (46.5%) of Nebraska infants are breastfeeding at six months, and only one fifth (20.2%) are exclusively breastfeeding at six months. Breastfeeding initiation, duration, and exclusivity rates vary across racial, ethnic, and socioeconomic groups.



- ***Infant Abuse and Neglect***

According to Nebraska's Division of Children and Family Services, the incidence of maltreatment (abuse and/or neglect) of infants is not improving over time. In 2009 the rate of substantiated maltreatment (evidenced child abuse/neglect after investigation) was 25.2 per 1,000 infants. In 2013 the rate was not significantly lower at 22.7 per 1,000 infants. The state of Nebraska removes children from their homes at nearly twice the national rate, according to the Kids Count report. Considerable racial and ethnic disparities exist, with American Indian infants suffering substantiated maltreatment at a rate nine times higher than White infants. Substantiated maltreatment of African American infants occurs at a rate three and a half times higher than for White children.



- ***Infant Mortality***

In 2013, 139 infants died in Nebraska. Death resulted primarily from birth defects, prematurity, and Sudden Infant Death Syndrome/ Sudden Unexpected Infant Death. Nebraska infants died at a rate of 5.3 per 1,000 live births in 2013, an increase from 2012. Although Nebraska's rate overall is lower than the US average (5.98 per 1,000 live births), African Americans and American Indian infants in Nebraska have a significantly higher death rate than other

racial/ethnic groups.

Indicator	Nebraska (year)	U.S. (year)	HP2020
Infant Mortality	5.3 (2013)	5.98 (2012)	6.0
Leading Causes per 1,000 live births			
Birth Defects	1.94 (2011)	1.27 (2011)	1.3
Prematurity	0.48 (2011)	1.03 (2011)	-
SIDS	.603 (2011)	.478 (2011)	.50
SUID	.849 (2011)	.851 (2011)	.84

iv. Title V-specific programmatic approaches – Infrastructure and system strategies exist to address these three priority needs in this domain. For breastfeeding, this includes: the Nebraska Breastfeeding Coalition, Women's Health Initiatives' workplace promotion activities, Maternal Infant Health education and outreach to rural hospitals and providers, promotion of IBCLCs as part of NE's State Health Improvement Plan, and working relationships with WIC peer supports and N-MIECHV home visitors. The Nebraska Prevention Partnership and ongoing working relationships with the CB-CAP agency, the delivery of Healthy Families America as evidence-based home visiting, and collaborations with ECCS related to toxic stress have formed a foundation for the prevention of abuse and neglect. Nebraska Title V is actively working to address infant mortality through the IM CoIIN. New initiatives led by Title V include efforts to target specific disparities, including increasing adoption of CLAS standards (culturally and linguistically appropriate services) and increasing breastfeeding rates among African American and American Indian mothers; leading collaborative approaches to develop consensus messaging on the topic of mothers co-sleeping with their infants; the Nebraska Perinatal Quality Improvement Collaborative; and emerging new approaches to address maternal mental and behavioral health before, during, and after pregnancy, looking at maternal depression and mental health as an antecedent to infant exposure to toxic stress.

Child Health Domain

i. Overview of health status - Nebraska assessed demographics and 43 morbidity/mortality and health determinant or health status indicators in this domain. In 2013 there were an estimated 245,203 children age 1-9 living in Nebraska, 32.2% were living in single-family households and 17.2 % were reported living below the Federal Poverty Level, both rates are lower the national rate. The leading cause of death for children was unintentional injury followed by cancer.

ii. Summary of population-specific strengths/needs - The stakeholder subcommittees reviewed data factsheets that communicated the analysis of the indicators. Based on the review the population-specific issues identified by the Child Health domain subcommittee were:

1) Access to Oral Health Services
2) Disparities in Abuse and Neglect
3) Health Insurance
4) Mental Health Services
5) Medical Home
6) Overweight, food insecurity, and inadequate exercise
7) Unintentional Injuries

iii. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization" the following major

health issues were included in Nebraska's priority needs (Overweight will be discussed in the Cross-cutting section) for the Child Health Domain:

- ***Access to Preventive and Early Intervention Mental Health Services for Children***

In 2012 data from the National Survey of Children's Health (NSCH) noted 65.7% of children in Nebraska age 6 to 11 years old needed and received some type of mental health care or counseling during the past 12 months. There is a lack of early childhood data on social/emotional or mental health of children under the age of 5 years. Approximately one-third of Nebraska children aged 6 to 11 years who needed some type of mental health care or counseling did not receive it.

*The Number and Percentage of children (1-11) who needed **and** received some type of mental health care or counseling during the past 12 months*			
Children	**Nebraska 2012**	**Nation 2012**	**2020 Goal**
1-5 years	---	43.4% (313,631)	---
6-11 years	65.7% (8728)	62.6% (1,571,397)	---

- ***Unintentional Injury among Children***

According to the Nebraska Vital Records, unintentional injuries are the leading cause of death for Nebraska children ages 1-9. In 2012, the Nebraska death rate due to unintentional injuries for children ages 1-9 was 7.5 per 100,000 children compared to a national rate of 5.7. For Nebraska children ages 1 to 9, the leading cause of inpatient hospitalization due to injury is falls and the second leading cause is motor vehicle crashes. Other frequent causes of emergency department visits include fire/burn, natural/environment, cut/pierce, poisoning, overexertion, drowning, and other pedal cyclist.

iv. Title V-specific programmatic approaches - Nebraska Title V has extensive experience, existing structures, and well established partnerships to address preventive and early intervention mental health services for children, including those built through ECCS and N-MIECHV. Less developed is its capacity to address unintentional injuries. Title V will strengthen its working relationships with the Injury Prevention Program and Safe Kids coalitions, and make investments in community-level programming.

CYSHCN Domain

i. Overview of health status - Nebraska assessed demographics and 31 morbidity/mortality and health determinant or health status indicators in this domain. In 2010 there were an estimated 61,071 Children and Youth with Special Health Care Needs living in Nebraska, 33.7% were living in single-family households yet 53.3% reported living in households with three or more adults, while 24 % were reported living below the Federal Poverty Level.

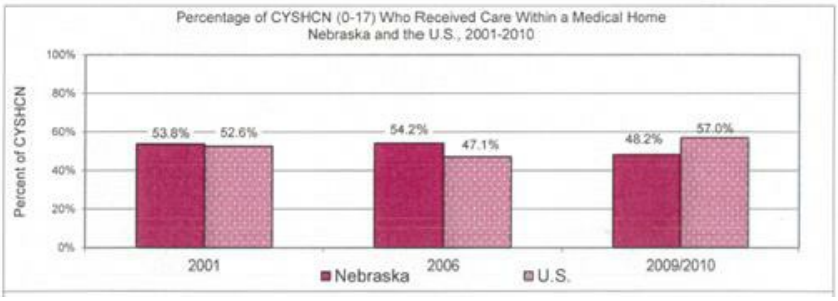
ii. Summary of population-specific strengths/needs - The stakeholder subcommittees reviewed data factsheets that communicated the analysis of the indicators. Based on their review the population specific needs identified by the CYSHCN's subcommittee were:

1) Adequate Insurance
2) Families Experiencing Financial Problems
3) Mental/Behavioral Health Services
4) Medical Home – Number of Families that Partner in Decision Making

5) Referral's for Specialty Care
6) Transition
7) Unmet Need Intentional Injuries

iii. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization" the following major health issues were included in Nebraska's priority needs:

- ***Medical Home for CYSHCN, including empowerment of families to partner in decision-making and access to additional family supports***



According to the National Survey on CYSHCN 2009/10 the percentage of CYSHCN in Nebraska who receive coordinated, ongoing, comprehensive care within a medical home is significantly lower than the national average (48.2% in Nebraska versus 57% nationally) and has remained fairly constant (53.8% in 2001 and 54.2% in 2006). The disparity between CYSHCN (ages 0-11 years) and the data for all children (ages 0-11 years) was significant. Approximately 60% (2011/2012) of children had access to Medical Homes compared to about 50% of CYSHCN (2009/2010).

There are significant disparities within the CYSHCN population for those who receive care within a medical home; disparities were noted for children by type of insurance (38.9% for children with public insurance only versus 53.8% for children with private insurance only), by race/ethnicity (Hispanic 34.7% versus White, non-Hispanic 51.7%), and poverty (children with families at or greater than 400% of FPL had access averaging 57.1% versus 36% for children below the FPL). Furthermore, CYSHCN with more reported conditions have a lower probability of having a medical home (33.5% of children with 4 or more functional difficulties vs 56.9% to 59.4 % for children with 0 to 3 functional difficulties).

Data from the National Survey on Children with Special Health Care Needs estimate that 51.4% of Nebraska families have one or more unmet needs in family support services, compared to the national average of 36.9%. The data also confirm that Nebraska's indicator is has been growing worse since 2001.

- ***Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (CYSHCN)***

Mental disorders (for example, attention-deficit/hyperactivity disorder (ADHD), Tourette syndrome, behavior disorders, mood and anxiety disorders, autism spectrum disorders, substance use disorders, etc.) are chronic health conditions that often times continue through the lifespan. Children and youth who have intellectual disabilities or developmental disorders are at higher risk of mental health issues or behavioral problems. 81.9% of CYSHCN ages 2-17 in Nebraska received all the mental health care or counseling that they needed, but almost 20% did not. Averages of 38.8% of Nebraska CYSHCN ages 6-17 are reported experiencing anxiety or depression (2009/2010).

There is no data for ages 0-5 years. Finally, 28% of (CYSHCN in Nebraska, have on-going emotional, developmental and/or behavioral conditions according to the National Survey of CSHCN compared the 31.9% nationally (2009-2010).

iv. Title V-specific programmatic approaches – Nebraska's Title V assets to address the CYSHCN priority needs include: the Medically Handicapped Children's Program, contractual and collaborative relationships with Munroe Meyer Institute, a partnership with Parent Training and Information (PTI) Nebraska, and a children's behavioral health system of care plan ready to implement. Additional focused attention is warranted to further engage families in program planning, and to strengthen working relationships with Medicaid and third party payers. In the state action plan, Nebraska Title V proposes new leadership and attention to systems approaches to engaging family and consumer voices in Medicaid Managed Care and the Behavioral Health System of Care; developing family-centered care coordination services standard competencies for medical home approaches; workforce development among Nebraska's primary care providers to increase awareness of mental and behavioral health needs of CYSHCN, including CLAS standards; and an ECCS-Medicaid project to increase early social-emotional screening in the pediatric medical home.

Adolescent Health Domain

i. Overview of health status - Nebraska assessed demographics and 53 morbidity/mortality and health determinant or health status indicators in this domain In 2013 there were an estimated 231,041 adolescents age 10-19 living in Nebraska, 9.8% were reported living below the Federal Poverty Level, which lower the National rate. The leading cause of death for adolescents was unintentional injury specifically motor vehicle crashes. Access to mental health services and suicide deaths had an increasing trend, while access to EPSDT/Medicaid services had a trend down.

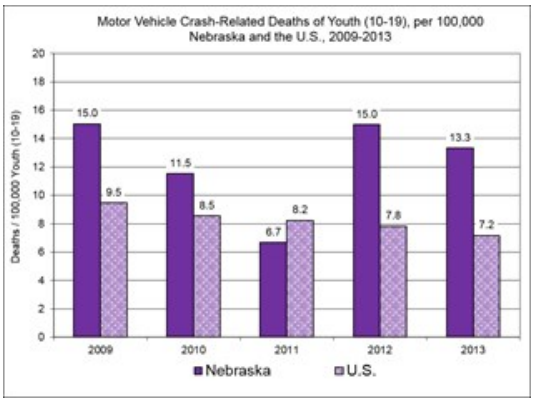
ii. Summary of population-specific strengths/needs - The stakeholder subcommittees reviewed data factsheets that communicated the analysis of the indicators. Based on their review the population specific needs identified by the adolescent's subcommittee were:

1) Motor Vehicle Deaths
2) Obesity/Overweight
3) Sexually Transmitted Diseases
4) Substance Use
5) Utilization of Care

iii. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization" the following major health issues were included in Nebraska's priority needs (Overweight/obesity will be discussing in the cross-cutting section):

- ***Motor Vehicle Crashes among Youth***

According to the Nebraska Health and Human Services Vital Records, motor vehicle crashes are the leading cause of death for Nebraska teens ages 10-19. In 2012, the Nebraska death rate due to motor vehicle crashes for youth ages 10-19 was 15.0 per 100,000 youth compared to 7.8 nationally. When comparing teens to other age groups, Nebraska's teens are dying in motor vehicle crashes at three times the rate of the average adult. According to the 2012 Nebraska Youth Risk Behavior Survey, 11.9% of youth reported that they never/rarely wore their seat belt, which is significantly higher than the United States at 7.6% and the Healthy People 2020 objective of 8.0%. Also, nearly half of students (45%) reported texting or emailing while driving in the past 30 days.



- ***Sexually Transmitted Diseases among Youth***

According to data from the DHHS Sexually Transmitted Disease Surveillance Program (2012), both chlamydia and gonorrhea rates among youth in Nebraska are lower than national rates. Nebraska's adolescent rates of gonorrhea and chlamydia have been stable among adolescents since 2008. While chlamydia rates are not increasing for youth less than the age of 19, they are increasing significantly for those over the age of 20. According to the 2013 Nebraska YRBS, 35% of Nebraska youth ages 15-19 have had sex at least once. Teen birth rates have been decreasing in the past five years. Nebraska's teen birth rate was 26.8 per 1,000 women ages 15-19 (Vital Records data, 2012). In 2012 there were 1,688 teen births in Nebraska (Vital Records data, 2012). According to Nebraska PRAMS data, in 2011, 75% of pregnancies among Nebraska adolescent mothers (<20) were unintended. Thus, only 25% of pregnancies were intended.

iv. Title V-specific programmatic approaches - Of the two identified priorities for this domain, Nebraska Title V has well established state-level infrastructure to build on to address the STD priority through NE DHHS's Reproductive Health and STD programs, as well as a major local initiative in the highest incident metropolitan area. Less developed is its capacity to address unintentional injuries. Nebraska's Adolescent Health and School Health programs deliver positive messages about safety and injury prevention. From a life course perspective, there is more to be done with maternal and preconception populations, and in the home visiting and other parenting education venues, to raise parental awareness about the impact of parent safety behaviors (seat belt use, using phone while driving) on adolescent driving behaviors.

Cross-cutting or Life Course Domain

i. Overview of health status - Nebraska incorporated the Life Course Metric Indicators into the assessment but did not have a specific process for Cross-cutting or Life Course findings.

ii. Summary of population-specific strengths/needs - There were several issues/needs identified that cross over population domains such as:

1. Mental Health
2. Overweight/Obesity
3. Sexually Transmitted Diseases
4. Unintentional Injuries

A strong theme running through numerous issues was access to and utilization of health care.

i. Successes, challenges, gaps and areas of disparity - Utilizing the "Criteria for Prioritization" the following major health issue crossed over more than two domains and was included in Nebraska's priority needs:

- ***Obesity/Overweight among Women, Youth, and Children, including Food Insecurity and Physical Inactivity***

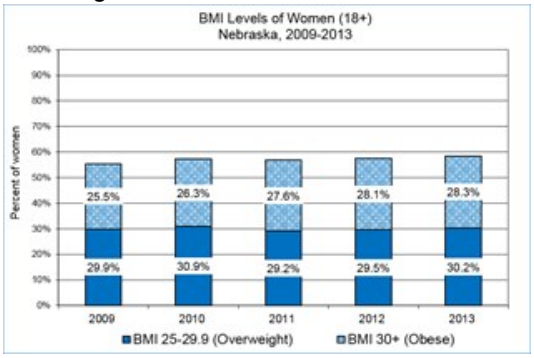
Approximately 29% of Nebraska's children and adolescents (10-17 years) are obese (BMI ≥30.0) or overweight (BMI 25.0-29.9). With 1 in 3 children at an overweight or obese health status, and nearly 90,000 children considered food insecure. While there has been no change in childhood overweight/obesity since 2007, childhood obesity has more than doubled in children and quadrupled in adolescents in the past 30 years. Nebraska ranked 31 of 50 states in childhood obesity prevalence in 2007, compared to a ranking of 10 in 2003 (1 is the best).

Critical to note is the substantial worsening of indicators of food insecurity:

- Children participating in SNAP rose from 15.9% (2009) to 20.1% (2013).
- Children eligible for free and reduced meals increased from 36% (2008/09) to 44.2% (2012/13).
- Nebraska is ranked 49th out of 50 states in school breakfast participation (a key strategy for improving food security in children). Only 39% of eligible children participate in a school breakfast program and less than 10% are taking advantage of summer meal programs.

  The US Office of Disease Prevention and Health Promotion recommends 60 minutes daily of moderate to vigorous physical activity, but data from the 2012 National Survey of Children's Health indicate that only 23% of Nebraska youth age 12-17 engage in vigorous physical activity every day.

  According to the 2013 Behavioral Risk Factor Surveillance System (BRFSS), 30.2% of Nebraska women aged 18-44 are overweight and 28.3% are obese. The percentage of the population that is overweight has not changed in the last six years and is not improving over time. The percentage of the population that is obese is increasing over time. According the NE BRFSS, in 2008-13, American Indian (74%), African American (68.4%), and Hispanic (63.7%) women were more likely than the state average to be overweight or obese. Of American Indian women, 38.8% were overweight and 35.2% were obese in 2013. Of African American women, 29.3% were overweight and 38.1% were obese in 2013. Finally, for Hispanic women, 32.2% were overweight and 31.5% were obese in 2013.



- ***Access to and utilization of health care***

This Cross-cutting/Life Course issue is not a specific priority but an issue identified within the following priorities: Access to and Adequacy of Prenatal Care, Access to Preventive and Early Intervention Mental Health Services for children, Mental and Behavioral Health needs of Children/Youth with Special Health Care Needs (CYSHCN), Medical Home for CYSHCN, and Sexually Transmitted Diseases among youth and women of child bearing age. The topic of

health insurance coverage occurs in some of the state's objectives and strategies in the State Plan, specific to a priority (such as access to prenatal care). And the topic of utilization appears where appropriate as well in state priorities, for example, in the objectives for screening of young children. However, in Nebraska one aspect of Title V leadership for MCH populations is recognition, and leading others to see, that access and utilization issues in the current health transformation climate are too complex and systemic for piecemeal program solutions, and require a coordinated, overarching approach that takes health reform and social and economic issues into account.
iv. Title V-specific programmatic approaches – Nebraska Title V has existing investments in community-based preventive services addressing childhood overweight and obesity and has built, through it School Health Program, a surveillance methodology for body mass index of school age children. Nebraska schools are strong supporters of Coordinated School Health approaches, and Nebraska's QRIS program includes NAP SACC standards (Nutrition and Physical Activity Self-Assessment for Child Care). Title V leadership will occur as described in the state plan to undertake a strategic engagement process to identify opportunities and priorities for Title V and other public health partners to be working in place-based initiatives to address social determinants of health, including those influential as risk or protective factors for obesity. New leadership in the NDHHS system suggests new opportunities for Title V, Medicaid, and systems-wide collaborative approaches to addressing access to and utilization of health care by MCH populations.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

II.B.2.b.i. Organizational Structure

(a) Description of organizational structure

The Nebraska Department of Health and Human Services (NE DHHS) is headed by a Chief Executive Officer (CEO) who is appointed by and reports to the Governor. The CEO supervises the Directors of each of the six divisions: Public Health, Children and Family Services, Behavioral Health, Medicaid and Long Term Care, Developmental Disabilities, and Veterans Homes.

Administration of the Title V Block Grant is organizationally placed in the Division of Public Health (DPH)), within the Lifespan Health Services Unit (LHSU). The LHSU Administrator serves as the Title V/MCH Director, providing broad oversight for the Block Grant. The LHSU Administrator/Title V MCH Director reports to the Deputy Director for Community & Environmental Health, who in turn reports to the DPH Director. The LHSU Administrator/Title V MCH Director supervises the Federal Aid Administrator III in Planning & Support, who is responsible for day-to-day administration of the Block Grant, including developing and monitoring the budget, overseeing sub-granting processes, assisting with planning and strategy development, and developing and implementing financial management processes. The LHSU Administrator/Title V MCH Director also is direct supervisor for the Program Managers leading Nebraska's Women's Health Initiative, and Maternal Child Adolescent Health Programs, and the MCH Epidemiology Coordinator, among others.

CYSHCN program activities are administered in the Division of Children and Family Services (CFS). The Economic Assistance (EA) Policy Chief serves as the Title V CSHCN Director. She reports to the EA Deputy Director who in turn reports to the CFS Director. The EA Policy Chief/Title V CSHCN Director supervises the Medically Handicapped Children's Program (MHCP) Coordinator. The Coordinator is responsible for the day-to-day management and supervision of the MHCP.

(b) Responsibility for administration of programs
The LHSU Administrator and the Federal Aid Administrator III have primary responsibility for assuring compliance with Title V requirements. Budgeting and subsequent allocation of funds are done in accordance with the requirements of Sec. 505. This includes ensuring that 30% of funds are budgeted and expended for preventive and primary care services for children, and 30% for services for children with special health care needs. This budgeting process includes allocation of funds internally to NE DHHS and for sub-grants to community-based providers. NE DHHS programs to be supported with Title V funds in 2016 include: Medically Handicapped Children's Program, Maternal Child Adolescent Health, Planning and Support (administration), Reproductive Health, Newborn Screening, PRAMS, Birth Defects Registry, Child and Maternal Death Review Team, Women's Health Initiative, and Title V special projects (such as IM CoIIN activities). Within the Maternal Child Adolescent Health program area are the Adolescent Health, Maternal Infant Health, and School Health Programs (all receiving Title V allocations) as well as the federally funded Early Childhood Comprehensive Systems project and Nebraska Maternal Infant Early Childhood Home Visiting program. These programs are described in Section F.1.b.i and ii. Twelve community-based projects were awarded through a competitive process for 2015 and 2016. A description of these projects is found as an attached supporting document. A non-competitive set-aside has been established for the four Nebraska-based Tribes.

(c) Organizational chart is attached as a supporting document.

II.B.2.b.ii. Agency Capacity

II.B.2.b.ii. Agency Capacity

(a) Agency capacity by the six domains
Women/Maternal Health
Nebraska Title V does not support direct services for the maternal population. It has built significant capacity to develop and support a wide range of enabling services and public health services & systems through: the Maternal and Infant Health program, particularly provider education and resources; support of community outreach and education offered through the Reproductive Health Program, and partial support of planning and policy analysis carried out through the Women's Health Initiatives.

Perinatal/Infant Health
Nebraska Title V does not provide direct services related to this domain. Title V is a significant source of support for the Newborn Screening Program, which provides high quality screening and follow up services. Title V also supports the Maternal Infant Health program (web link above) and the position of the Community Health Nurse, Sr., providing expertise in maternal and newborn health, education and quality improvement activities. Significant to enhancing capacity in this domain are Title V's involvement with and leadership of Nebraska's IM CoIIN team and learning network activities. In addition, the Nebraska Legislature appropriated funds to support Nebraska's Perinatal Quality Improvement Collaborative (N-PQIC), for which Nebraska Title V will provide contract management for an agreement with the University of Nebraska Medical Center to conduct the work of the N-PQIC.

Child Health
No direct services for this population are supported with Title V funds. Nebraska Title V supports the School Health Program, and the position of the Nebraska State School Nurse Consultant, which has provided leadership and coordination on a wide range of issues: quality care of children with medical issues at school, overweight and obesity, injury prevention, infection control, and prevention of drug use and violence. Community-based projects supported through sub-grants of Title V funds almost exclusively focused on children, as a means to assure that 30%

of block grant funds are expended for this population. A description of these projects are found as an attached supporting document.

CYSHCN

Nebraska's CYSHCN population receives sub-specialty care through the Title V funded Medically Handicapped Children's Program (MHCP). MHCP is administrated within the Department of Health and Human Services Division of Children & Family Services. MHCP provides diagnostic and evaluation clinic services, referral services, and active medical treatment financial assistance for medically and financially eligible individuals (under age 21) to meet families' needs for medical or social support for the eligible child or young adult. Currently this program provides services to 347 clients with eligible conditions. The SSI-Disabled Children's Program (DCP) is for children under age 16 who are eligible for SSI benefits and require support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). This program includes funding for respite care, medical mileage assistance, and home/vehicle accessibility modifications. It currently provides services to 663 clients. The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a letter to the family describing possible services they may receive and how to apply. The Genetically Handicapped Person's Program provides treatment for persons age 21 or older with the genetically handicapping conditions of cystic fibrosis, hemophilia, or sickle cell disease. The individual must have an open/active status with MHCP on the 21st birthday in order to transition to Genetically Handicapped Person's Program coverage. In addition to the MHCP, the Nebraska Newborn Screening Program and the Nebraska School Health programs provide significant resources and supports to organizations serving CYSHCN.

Adolescent Health

Nebraska Title V has significant capacity to support public health services and systems for Nebraska youth. Examples include the formation of the Nebraska Adolescent Health Advisory Committee and coordination with PREP and Abstinence Education. Title V also supports outreach and communication to youth through the Reproductive Health Program. One of the Title V supported community-based projects addresses adolescent health (Nebraska Children's Home Society's Teen Chat project, see attached supporting document).

Cross-cutting or Life Course

Nebraska Title V has developed its capacity to plan and implement life course strategies through its engagement in the following activities: AMCHP's Life Course Metrics Project completed in 2013 and Life Course Indicator Intensive Technical Assistance completed in 2015 (http://www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseMetricsProject.aspx). Currently, Nebraska Title V is engaged in the IM CoIIN and its Social Determinants of Health Learning Network, and will be utilizing information gained on place based strategies in addressing the cross-cutting priority of overweight/obesity among women, children and youth. Nebraska Title V is presently engaged in a project with the national MCH Workforce Development Center, which seeks to increase utilization of preventive health care services, pertinent to the overarching goal on access.

(b) Steps Taken to Ensure a Statewide System of Services

(1) Collaboration – Nebraska Title V has well established collaborations ranging from formal advisory bodies such as the Newborn Screening Advisory Council (http://dhhs.ne.gov/publichealth/Pages/nsp_contact.aspx), the Women's Health Advisory Council (http://dhhs.ne.gov/publichealth/WHI/Pages/AdvisoryCouncil.aspx), and the NE Adolescent Health Advisory Council (http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_adolescenthealth_NAHAC.aspx), to ad hoc initiative related bodies, such as the needs assessment work groups. See the full listing in B.2.c.

(2) State support for communities – Nebraska Title V issues a competitive subgrant Request for Applications (RFA) approximately every two years, with the most recent RFA issued in 2014 for the FFYs of 2015 and 2016

(http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/home.aspx). A description of the community based projects are found as an attached supporting document.

(3) and (4) Coordination with health components of community-based systems and of health services with other services– Representatives of community-based services, such as home visiting, family planning, federally qualified health centers, family support organizations, and WIC participated in the needs assessment process and many have commented on this (and previous applications). RFAs include requirements that Title V supported services reflect community needs and coordinate with existing services. Active outreach to and collaboration with communities is a standard component of strategy development across all domains.

II.B.2.b.iii. MCH Workforce Development and Capacity

The following table lists the Title V MCH and CSHCN workforce with primary responsibility for planning, administration, evaluation, and data analysis. All are located in Lincoln except where noted.

Name	Position	FTE Funded by Title V
Paula Eurek	Title V MCH Director	*
Teri Chasten	Title V CSHCN Director	*
Rayma Delaney	Federal Aid Administrator III	1.0
Staci Zuerlein	MHCP Program Coordinator	*
Jennifer Severe-Oforah	MCH Epidemiology Coordinator	*
Debora Barnes-Josiah, Ph.D.	MCH Epidemiologist (contractor)	0.8
Kathy Karsting, RN	Maternal Child Adolescent Health Program Manager II	1.0
Carol Tucker, RN BSN, NCSN	School Health Program Manager/State School Nurse Consultant	1.0
Jackie Moline, RN, BSN	Community Health Nurse Sr., Maternal Infant Health Program	1.0
Michaela Meismer	Adolescent Health Program Manager	1.0
Lori Rowley, RN	Community Health Nurse Sr., Alliance, NE	0.18

* Administrators/coordinators with multiple programmatic roles and supported with other funds.

Paula Eurek has been the Title V MCH Director since 1995 and employed with the Department since 1983. She has a BS degree in Home Economics and has had previous experience as a clinical dietitian, a WIC nutritionist, and the State WIC Director.

Teri Chasten assumed the role of Title V CSHCN Director in 2013. She has been with the Department since 2002 and is currently the Economic Assistance Policy Chief and administrator for multiple programs including SNAP, TANF, Child Care subsidy, MHCP, and DCP.

The NE DHHS augments its limited Title V data analysis capabilities with contracts with the University of Nebraska Medical Center, College of Public Health. No parent or family members are employed by NE DHHS/Title V. Parents

and youth are engaged through advisory bodies and as consultants.

Data is routinely collected and analyzed by race and ethnicity for needs assessment and program planning purposes. CLAS standards are included as expectations in sub-awards to community based providers. Title V staff collaborates with the Office of Health Disparities and Health Equity in providing training on CLAS and cultural intelligence (http://dhhs.ne.gov/publichealth/Pages/healthdisparities_index.aspx), for enhancing and maintaining working relationships with Nebraska's Tribes, and for outreach to community leaders. Nebraska Title V has established a set-aside of non-competitive Title V funds for Nebraska's four Tribes headquartered in Nebraska.

II.B.2.c. Partnerships, Collaboration, and Coordination

For the purposes of the findings of the Nebraska Five-year Needs Assessment, the following partnerships, collaborations, and coordination efforts are significant to the selected State Priorities.

Partner/Collaboration	Relevant to State Priorities
Division of Medicaid and Long Term Care	Improve prenatal care, address mental health issues of children and CYSHCN, quality improvement and data projects.
Division of Behavioral Health	Improve mental and behavioral health screening and services for children and youth. Assure children receive the care they need.
Division of Children and Family Services	Address needs of CYSCHN and families; infant abuse and neglect.
Nebraska Maternal Infant Early Childhood Home Visiting	Implement activities related to prenatal care, mental/behavioral health screening, injury prevention.
Early Childhood Comprehensive Systems	Abuse and neglect (toxic stress) among very young children, injury prevention, systems approaches to family involvement.
Personal Responsibility Education Program	Injury prevention, STD reduction, health care utilization, physical activity and preconception health.
Abstinence Education	Injury prevention, STD reduction, health care utilization, physical activity and preconception health.
Immunization Program	HPV campaign.
WIC	Breastfeeding and injury prevention; food insecurity.
Child Death Review Team	Infant mortality priority.
Reproductive Health Program	Preconception health, STDs, prenatal care.
Local Health Departments and Federally Qualified Health Centers	Community Health Improvement Plans with MCH objectives; community-based services
Injury Prevention Program	Injury prevention
University of Nebraska Medical Center College of Public Health	BMI surveillance, parenting education, and perinatal quality improvement indicators.
University of Nebraska Medical	LEND and the Autism State Team; YAHT

Center Munroe Myer Institute	project; training and workforce development on family empowerment; system of care for mental and behavioral health.
PTI Nebraska and other family organizations	Family to Family Health Education Center; Family Voices. CYSCHN, families, and medical home
Women's Health Initiative Advisory Committee	Preconception health strategic planning; YAHT project.
Nebraska Adolescent Health Advisory Council	Youth voices and youth-driven priorities; STDs; injury prevention.
Nebraska Department of Education/Early Development Network	Early identification and early intervention
Nebraska Children and Families Foundation	Programs and services for children and families at-risk; policy advocates.
Nebraska Children's Home Society	Programs and services for children and families at-risk; policy advocates.

An advantage of a small, relatively stable, state is the opportunity to develop and sustain rich, intentional, relationships across programs and sectors in service to mutual interests and concerns. As a result, there is truly a "community" of partners who are invested in stewardship of resources and policies important to children and youth with special health care needs, and a "community" of breastfeeding advocates as examples. Nebraska Title V provides visible and consistent leadership for reaching consensus and working collaboratively on shared goals to improve life course outcomes for the MCH population.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	1. Infant Mortality (III)	New	
2	2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity (XII)	Continued	
3	3. Infant Abuse and Neglect (IV)	Replaced	Nebraska will develop a SPM
4	4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (VIII)	New	
5	5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes (VI and X)	New	
6	6. Access to and Adequacy of Prenatal Care (I)	Replaced	
7	7. Breastfeeding of Infants (V)	Continued	
8	8. Sexually Transmitted Disease among Youth and Women of Child Bearing Age (II and XI)	Replaced	
9	9. Access to Preventive and Early Intervention Mental Health Services for Children (VII)	New	Nebraska will develop a SPM
10	10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports (IX)	Replaced	Nebraska will develop a SPM

The following are Nebraska's priority needs identified from the needs assessment process:

1. Infant Mortality
2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity
3. Infant Abuse and Neglect
4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs

5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes
6. Access to and Adequacy of Prenatal Care
7. Breastfeeding of Infants
8. Sexually Transmitted Disease among Youth and Women of Child Bearing Age
9. Access to Preventive and Early Intervention Mental Health Services for Children
10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports

Nebraska utilizes methods as described in the University of California at San Francisco Family Health Outcomes Project (FHOP) in "Developing an Effective MCH Planning Process" to conduct the Needs Assessment of the MCH/CSHCN populations.

	Steps in Needs Assessment Process
1.	Data collection and analysis
2.	Stakeholder process Kick-off
3.	Stakeholders develops criteria
4.	Stakeholders determine weights for each criterion
5.	Staff finalizes definitions and develops rating scales for criteria
6.	Subcommittee meeting 1: provide orientation, and present data
7.	Subcommittee meeting 2: Review data, identify list of needs, determine top 3-5 needs per population group
8.	Subcommittee meeting 3: Write problem statements, draft issue briefs, and determine presenters
9.	Presentation of identified problems by subcommittees to the entire stakeholder group
10.	Use weighted criteria to score problems
11.	Sum participant's scores / rank problems
12.	Discuss and confirm results
13.	Finalize list of 10 priorities

Nebraska's stakeholders reviewed analysis of 217 health indicators from which they identified 22 needs and prioritized 10. The method/tool used to narrow and prioritize were five weighted and ranked criterion. The stakeholders developed the criteria through a facilitated process. These criteria were developed to objectively assess the health problems/needs, such that the group could determine if a given problem was more or less important compared to other problems. The criteria are the direct means of determining the list of 10 priorities and as such the selection of criteria prior to discussion of specific health problems is an essential element to the process.

The discussion generated during the criteria development workshop is meant to stimulate critical thinking about the stakeholder's values as a community. The group takes time to thoroughly discuss the proposed criteria and assure each member has a common understanding of each criterion. At the end of the discussion the group votes and in 2014 the stakeholders selected the following five criterion:

1. The Problem is Worse than the Benchmark or Increasing
2. Disparities Exist Related to Health Outcomes
3. Strategies Exist to Address the Problem/An Effective Intervention is Available
4. Societal Capacity to Address the Problem
5. Severity of Consequences

The criterion one and two had the most effect on which indicators were identified as issues by the subcommittees, but the criterion that had the most effect on the outcome of the assessment was severity of the consequences, which put more emphasis on issues/needs associated with mortality.
There were seven issues/needs identified through the needs assessment process that were strongly considered but not included among the final 10. Of the seven not included, six had content related to the ten identified priorities, specifically access to care/care utilization. As such Nebraska' Title V will incorporate this theme into its work over the next five years. The remaining issue of alcohol use, while important, has actually shown an improving trend over the past several years. The seven issues/needs were:

- Access to Care/Care Utilization for women
- Access to Oral Health Care for children
- Access to Medical Homes for children
- Alcohol Use for adolescents
- Under Utilization of Health Care for adolescents
- Adequate Insurance for CYSCHN
- Transition for CYSCHN

1) Priorities Continued from Previous Needs Assessment
Two priorities remained essentially the same from the 2010 assessment: a) Overweight/obesity among women, youth, and children, including food insecurity and physical inactivity, and b) Breastfeeding of infants. These priorities continue primarily because data indicate they are significant issues that require continued effort for the designated population groups.
2) Priorities Replaced
A total of four priorities previously identified in 2010 were modified to be more specific a) Reduce the rates of abuse and neglect of infants and CSHCN became Infant Abuse and Neglect, b) Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, and delivery services, and post-partum care became Access to and Adequacy of Prenatal Care, c) Improve the reproduction health of youth and women by decreasing the rates of STD's and unintentional pregnancies became Sexually Transmitted Disease among Youth and Women of Child Bearing Age and, d) Increase access to Medical Homes for CSHCN particularly for those with functional limitations became Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports. The modifications represent a more proficient use of the criteria to determine the final priorities by the stakeholders.
3) Priorities Added
The remaining four priorities are new. Infant mortality, Unintentional Injury among Children and Youth, including Motor Vehicle Crashes, and the two mental health priorities, Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs and Access to Preventive and Early Intervention Mental Health Services for Children. These additions are due in large part to the severity of the consequences criterion.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	59.4	60.6	61.8	63.0	64.3

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.0	85.7	87.4	89.2	91.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.4	20.8	21.2	21.6	22.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	83.3	85.0	86.7	88.4	90.2

NPM 7-Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	114.4	112.1	109.7	107.6	105.5

Annual Objectives					
	2016	2017	2018	2019	2020

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33.0	33.6	34.3	34.9	35.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.1	86.8	88.5	90.3	92.1

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	51.9	53.0	54.0	55.1	56.2

NPM 15-Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.8	77.4	78.9	80.5	82.1

Nebraska chose the following eight National Performance Measures:

NPM 1 - Percent of women with a past year preventive medical visit

NPM 4 - a) Percent of infants who are ever breastfed and b) Percent of infants breastfeed exclusively through 6 months

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

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 and adolescents 10-19

NPM 8 - Percent of children ages 6-11 and adolescents 12-17 who are physically active at least 60 minutes per day

NPM 10 – Percent of adolescents, age 12-17, with a preventive medical visit in the past year

NPM 11 – Percent of children with and without special health care needs having a medical home

NPM 15- Percent of children 0 -17 who are adequately insured

The NPMs are linked with all but one of Nebraska's state priorities as described below:

1. Infant Mortality

NPM 5 - Percent of infants placed to sleep on their backs was chosen because SIDS/SUID is the third leading cause of infant mortality and Nebraska's SIDS/SUIDS rates are higher than the national average.

2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity
NPM 8 - Percent of children ages 6-11 and adolescents 12-17 who are physically active at least 60 minutes per day was chosen because it one of the indicators that lead this priority to be identified and placed on the final list.

3. Infant Abuse and Neglect
A State Performance Measure will be developed as there was not a NPM that is closely linked.

4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs
State Performance Measure will be developed as there was not a NPM that is closely linked. However, because this priority is focuses on access to and utilization of services, NPM 15- Percent of children 0 -17 who are adequately insured, was chosen to address the cross-cutting nature of the priority when combined with other aligned priorities (priorities 6, 8, 9 and 10).

5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 and adolescents 10-19 was chosen because it one of the indicators that lead this priority to be identified and placed on the final list particularly for children.

6. Access to and Adequacy of Prenatal Care

NPM 1 - Percent of women with a past year preventive medical visit was chosen because it best supports the priority, that is, if women routinely access preventive care they will likely access prenatal care in a timely manner.

Further because this priority focuses on access to and utilization of services, NPM 15- Percent of children 0 -17 who are adequately insured, was chosen to address the cross-cutting nature of the priority when combined with other aligned priorities (priorities 4, 8, 9 and 10).

7. Breastfeeding of Infants

NPM 4 - a) Percent of infants who are ever breastfed and b) Percent of infants breastfed exclusively through 6 months was chosen because it directly measures the priority, although Nebraska utilizes the National Immunization Survey as the annual source of data.

8. Sexually Transmitted Disease among Youth and Women of Child Bearing Age

NPM 10 – Percent of adolescents, age 12-17, with a preventive medical visit in the past year was chosen because it best supports the priority, that is, if adolescents routinely access preventive care they are more likely to prevent and/or treat STDS. NPM 15- Percent of children 0 -17 who are adequately insured, was chosen to address the cross-cutting nature of the priority when combined with other aligned priorities (priorities 4, 6, 9 and 10).

9. Access to Preventive and Early Intervention Mental Health Services for Children

State Performance Measure will be developed as there was not a NPM that is closely linked. However, because this priority is focuses on access to and utilization of services, NPM 15- Percent of children 0 -17 who are adequately insured, was chosen to address the cross-cutting nature of the priority when combined with other aligned priorities (priorities 4, 6, 8, and 10).

10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Support

NPM 11 – Percent of children with and without special health care needs having a medical home because it directly measures the priority. NPM 15- Percent of children 0 -17 who are adequately insured, was chosen to address the cross-cutting nature of the priority when combined with other aligned priorities (priorities 4, 6, 8, and 9).

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

F.1.b. State Action Plan Introduction

Nebraska's needs assessment process yielded priority needs that in some cases included populations from more than one domain. For those needs that were relevant to two population domains, the action plan is organized to show the priority need in both of the relevant domains. In the case of overweight and obesity, this priority need is inclusive of three population domains. This priority need has been placed within the Cross-Cutting or Life Course Domain. Five of the priority needs specifically pointed to a need for improved strategies to address the common contributing factors of access to and utilization of health care. Coordinated approaches to improving access to and utilization of health care that crossed five priorities was thus also included in the Cross-Cutting or Life Course Domain.

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
6. Access to and Adequacy of Prenatal Care (I)	Ia. By 2020, increase by 10% the percent of women starting prenatal care in the first trimester. Ib. By 2020, increase by 10% the percent of American Indian women starting prenatal care in the first trimester. Ic. By 2020, increase by 10% the percent of pregnant women under	Ia1. Presumptive eligibility quality improvement project with Medicaid Managed Care Organizations (MCOs).Ia2. Continue Collaborative Improvement & Innovation Network (CoIIN) Preconception/Inter-conception focus on the postpartum visit as an outcome indicator of optimal prenatal care. Ia3. Assure Healthy Mothers Healthy Babies helpline keeps current on referral resources to locate providers.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	age 20 starting prenatal care in the first trimester. Id. By 2020, Nebraska will implement a strategic plan for preconception health, with data collection, evaluation and quality improvement practices in place.	Ib1. Partner with Office of Health Disparities and Health Equity to address barriers and facilitators among American Indian women in accessing prenatal care in the first trimester. 1b2. Assess prenatal care gatekeepers (Access Medicaid) in the community for implementation of CLAS standards and knowledge of presumptive eligibility in Medicaid. Ic1. Adapt lessons learned from the Young Adults in Health Transformation (YAHT) project. 1c2. Provide resources for school nurses and college health program statewide on promoting prenatal care during the first trimester for pregnant teens. Ic3. Provide resources and training for home visitors on accessing prenatal	grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		care in the first trimester in collaboration with N-MIECHV.Ic4. Reproductive health programs assess and screen clients for future plans to become pregnant. Provide pregnancy testing at all clinics. Educate about preconception and prenatal care. Ic5. Healthy Mothers Healthy Babies Helpline, 24-hour toll-free access to assistance in locating a provider. Id1. Cross-program strategic planning for coordinated and collaborative approaches to promoting Preconception Health.1d2. Cross-program coordination of implementation strategies with measurable outcomes on selected target measures				
8. Sexually Transmitted	IIa. By 2020, increase by	IIa1. Implement tools and strategies	Rate of severe maternal	Percent of women with a		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Disease among Youth and Women of Child Bearing Age (II and XI)	10% use of preventive health care services by young adult women. IIb. By 2020, decrease by 10% rates of chlamydia among African American women ages 20 – 44 years. IIc. By 2020, decrease by 10% rates of chlamydia among Nebraska women ages 20 – 44 years.	developed through Young Adults in Health Transformation (YAHT project) to increase utilization of preventive health services. IIa2. Increase health insurance coverage of young adult women through health insurance exchange and the private insurance market.IIa3. Conduct Preconception Health strategic planning for coordinated program approaches. IIa4. Conduct cross-program collaboration to promote HPV vaccination. IIb1. Reproductive Health Program is Title V liaison with Douglas County (greater Omaha) privately-funded Adolescent Health Project, designed to reduce STD rates.	morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks)	past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		IIc1. Reproductive Health Program provides infrastructure for STD screening and follow-up services.	Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

WOMEN/MATERNAL HEALTH DOMAIN
Plan for the Application Year

-

Analysis of Effectiveness of Current Program Activities and Strengths

Nebraska Title V has seen several recent program developments which contribute to readiness for working on new state priorities in the Women/Maternal Health Domain. Collaborations between Title V and the Nebraska Behavioral Health System of Care work and Nebraska's trauma-informed care movement have extended into the Maternal-Infant program area. Nebraska Title V is leading planning for the first statewide health professionals' conference on maternal behavioral health topics for primary care providers. Nebraska's Women's Health Initiative has completed Strategic Planning, a new Nebraska Perinatal Quality Improvement Collaborative has formed, and Nebraska Title V has launched into the Infant Mortality CoIIN, (Collaborative Improvement and Innovation Network).

Early and adequate prenatal care has long been an interest area in the Maternal-Infant Health Program, as have tobacco use in pregnancy and prematurity prevention, as reflected in past National Performance Measures. Evolving Title V in Nebraska means that these topics and others, such as obesity, are now addressed as priorities of life course significance in preconception health promotion, with objectives for increasing protective factors, and addressing social determinants of health. Entry into prenatal care during the first trimester of pregnancy is one indicator of a life-long pattern of utilization of preventive health care services, to be cultivated in the adolescent and young adult preconception periods along with other health-producing and health-supporting behaviors.

Similarly, former state objectives related to intendedness of pregnancy now are viewed in the larger context of how MCH populations have coverage for health care and use it to access the services they need. Increasing the utilization of preventive health services by women of childbearing age thus becomes an effective approach to realize increases in "intendedness" of pregnancy.

Program-level interest in life course approaches to addressing disparities in birth outcomes has stimulated interest in cross-program collaborations to address preconception health; place-based initiatives and social determinants of health; and joint coordinated campaigns to promote HPV vaccination for adolescents. Focus on addressing disparities in MCH populations has brought new attention to CLAS (Culturally and Linguistically Appropriate Services) standards and the extent to which such standards are applied throughout the health and human services system in Nebraska. Greater focus on addressing disparities, and tailoring interventions and prevention strategies to the specific needs and preferences of the population subgroups whose behaviors are of interest or concern, is evident in Nebraska's new 2015 state plan.

Description of Plan for the Coming Year:
Through the Title V Needs Assessment process, Nebraska has selected two state priorities in the Women/Maternal domain:

I. **Access to and Adequacy of Prenatal Care (State Priority #6)**
II. **Sexually Transmitted Diseases (STD) among women of childbearing age. (State Priority #8)**

The following narrative summarizes for each priority the stakeholder findings identified through the needs assessment and then elaborates on the strategies listed in the State Action Plan Table.

Nebraska State Action Plan:

I. **Access to and Adequacy of Prenatal Care – State Priority #6**

In 2013, 27.4 percent of Nebraska's pregnant women did not receive prenatal care in the first trimester of pregnancy. Over 26 percent (26.6%) did not receive adequate prenatal care. According the to the 2013 Behavioral Risk Factor Surveillance System, 78%of women aged 18-44 years reporting having a personal physician. Approximately 85% of Nebraska women aged 18 – 44 years reported having health insurance. While only 15% of Nebraska women aged 18-44 are uninsured, 26% of pregnant women did not obtain adequate prenatal care.

When stakeholders organized information for this priority in an issue brief, an emphasis was placed on systems-level perspectives on barriers and facilitators to initiating prenatal care. Consumer lack of understanding about insurance benefits and coverage, not having a source of payment, availability of transportation, and ability to get an appointment during the first trimester were all discussed from a systems perspective on essential supports for healthy birth outcomes and addressing disparities. The discussion and inputs of stakeholders illustrated plainly the

lack of understanding about how or if presumptive eligibility functions for low-income women in Nebraska and their health care providers, especially in light of significant systems changes in Nebraska Medicaid over the past few years.

Stakeholders recognize there are a number of strategies and approaches operating in the state to promote access to prenatal care, and in many of them Title V in Nebraska is already a leading partner (Healthy Mothers Healthy Babies Helpline, Text4Baby, and MIECHV). Efforts to better identify shared measures of quality in these various approaches would be timely and another area for Nebraska Title V leadership. Stakeholders also noted that early and adequate prenatal care is significant to businesses and entities in the current health care system transformation environment, where much emphasis is placed on prevention-oriented care to avoid high-end costs of adverse outcomes.

In this State Priority, Nebraska Title V will continue leadership on collaborative systems level approaches including IM CoIIN to improve disparities in birth outcomes. Nebraska Title V will also continue (and in December 2015 complete) the Young Adults in Health Transformation project, designed to identify and test consumer-informed approaches to increasing utilization of preventive health care services by young adults.

Nebraska Title V conducts critical partnerships with other MCHB-supported programs, and will continue this high level of collaboration in the coming five-year period with Family Voices (in the Young Adults in Health Transformation project); March of Dimes (participating in the IM CoIIN, and related prematurity prevention workforce development), and the Division of Medicaid. Internal programs working with Title V and engaged in working to improve women's and maternal health include the Office of Health Disparities and Health Equity, reproductive health program; Maternal Child Adolescent Health programs (school health, adolescent health, maternal infant health); and the Women's Health Initiative.

Proposed Objectives and Strategies

Objective Ia. By 2020, increase by 10% the percent of pregnant women starting prenatal care in the first trimester.

Nebraska Title V programs and staff provide leadership in Nebraska in several strategic areas leading to improved access to and utilization of prenatal care.

The proposed plan includes Strategy Ia1, a systems-level quality improvement approach to addressing the communication and awareness needs related to presumptive eligibility among providers (does it work, is it available, what is reimbursed, what are relevant and required performance measures for payers), Access Medicaid technicians, and consumers. A quality improvement project with Nebraska Medicaid will be undertaken to assess and identify barriers and facilitators in consumers and providers making timely use of presumptive eligibility in Nebraska. Specific attention will be directed to assessing the extent to which culturally- and linguistically-appropriate services standards are in place in the presumptive eligibility system. Questions to be explored include:

1. Do medical providers universally encourage and promote 1st trimester entry into prenatal care? Are systemic features such as appointment waiting times, or provider messaging, undermining early entry by giving women mixed messages?
2. Are cultural preferences among some populations with disparate rates of late entry in prenatal care counter to utilization of health care services? Can Nebraska be more specific in reaching these groups?
3. Is presumptive eligibility working in Nebraska, or is misinformation or dysfunction in the enrollment system exerting a negative influence?

4. Are some women afraid to seek out prenatal care, due to cost or fears about immigration status?

From the starting point of better understanding presumptive eligibility and knowledge/awareness needs of providers, Nebraska Title V will systematically collaborate with Medicaid Managed Care on quality improvement processes to address access to and adequacy of prenatal care among Nebraska's Medicaid-eligible women, and with Division of Medicaid and others on presumptive eligibility, including the DHHS Office of Rural Health. This collaboration will address the topic of timing of entry to prenatal care related to maternal and birth outcomes, by subgroup of the population, as well as measures of adequate care.

In Strategy Ia2, Nebraska Title V will continue to lead the Collaboration and Innovation Implementation Network (CoIIN) to reduce infant mortality. In the Preconception/interconception workgroup of the CoIIN, members have identified the postpartum visit, successfully completed, as an indicator of optimal prenatal care.

Objective Ib. By 2020, increase by 10% the percent of American Indian women starting prenatal care in the first trimester.

Nebraska Title V will partner with the staff of the DHHS Office of Health Disparities and Health Equity specifically to identify barriers and facilitators among American Indian women in accessing prenatal care in the first trimester in Strategy Ib1, and develop a strategic plan for implementation. Title V and Office of Health Disparities and Health Equity are primary partners in advancing CLAS standards and, as identified in the Nebraska CoIIN, the full adoption of Culturally and Linguistically Appropriate Services represent an important step toward addressing disparities in health care utilization of all types.

In Strategy Ib2, Title V will work with Access Medicaid to assess the degree to which CLAS standards are implemented by benefits-enrollment personnel, and the extent of accurate knowledge about presumptive eligibility among these workers.

Objective Ic. By 2020, increase by 10% the percent of pregnant women under age 20 starting prenatal care in the first trimester.

Strategy Ic1 involves Nebraska Title V promoting use of preventive health care services by at-risk adolescents and women of childbearing age, utilizing tools/strategies developed through the Young Adults in Health Transformation (YAHT) project. In Strategy Ic2, the School Health Program will mobilize school nurses to communicate messages about first trimester prenatal care.

Nebraska Title V continues to be a lead partner and champion for evidence-based home visiting serving at-risk families in Nebraska, and in that vein Nebraska Maternal Infant Early Childhood Home Visiting (N-MIECHV) will continue to be an active partner in advancing early access to prenatal care to at-risk eligible families, as noted in Strategy Ic3.

The Nebraska Reproductive Health program and sub-recipient providers assess and screen clients for future plans to becoming pregnant, offering a teaching moment on when to begin prenatal care. The provision of pregnancy testing in all clinic settings also is conducive to promoting early entry into prenatal care where appropriate (Strategy 1c4).

Nebraska Title V continues to comply with requirements to provide for a 24-hour toll free helpline for MCH populations to gain assistance in accessing health care providers. In Strategy 1c5, The Healthy Mothers Healthy

Babies Helpline offers assistance in locating prenatal care. The Maternal Infant health program, overseeing the contract relationship between Title V and HMHB, works to assure the HMHB is current on behavioral health as well as physical health and primary care resources; evidence-based parenting education and support activities to reduce the risk of child abuse and neglect; resources to respond to questions about infant and early childhood development including where to find developmental screening resources; and information about how to navigate a health insurance exchange.

Objective Id. By 2020, Nebraska will implement a strategic plan for preconception health, with data collection, quality improvement, and evaluation practices in place.

Over the past several years, Nebraska Title V has recognized that work in the area of preconception health, particularly when viewed from a life course perspective, has been occurring in several program sectors. Thus it has become abundantly clear that Nebraska's view of preconception health is holistic, includes both genders, and should support human development and achievement of self-efficacy in measures other than pregnancy, or pregnancy prevented.

Nebraska reaches out to youth and young adults through evidence-based positive youth development, evidence-based school health services, high-quality family planning, and healthy pregnancy resources. What is lacking is a shared, overarching definition of preconception health, a shared scope of what preconception health should include, and a shared vision of how several programs working together with different populations and methodologies can reach mutual goals in promoting well-being among youth and young adults including, but not limited to, preparation for healthy pregnancy. As a result, at the beginning of the coming five-year cycle in Strategy Id1, Nebraska proposes to launch a Lifespan Health Services collaboration (adolescent and school health, maternal-infant health, women's health, reproductive health) to develop a programmatic and coordinated strategic plan for promoting preconception health of both young women and young men in Nebraska.

The plan (or logic model) will address a number of priority topics: breastfeeding, prenatal care, STDs, use of preventive health care services, mental well-being, physical activity and healthy nutrition, patient satisfaction with quality, substance use avoidance including tobacco, and motor vehicle safety. The strategic plan will provide for a meaningful consumer/community involvement in implementation, including data collection, quality improvement, and evaluation.

The proposed timetable for the preconception health strategic plan spans five years, starting with a year to complete the strategic programmatic plan. In Year 2, Nebraska envisions rapid-cycle quality improvement experiences in the form of PDSA (plan-do-study-act) cycles to develop implementation steps. In Years 3 – 5, Nebraska will continue to implementation and replicate quality improvement collaborations to increase access to prenatal care in the first trimester of pregnancy, particularly among Native American and women under 20. Strategy Id2 is a place-holder for implementation, data collection, quality improvement, and evaluation activities.

I. **Sexually Transmitted Diseases (STD) among women of childbearing age - State Priority #8**

According to the Nebraska STD program surveillance, in 2013 the rate of infection for chlamydia was 1,166.5 per 100,000 women aged 20 – 44years. The rate of infections ofr gonorrhea was 166.5 per 100,000 women aged 20 – 44 years. The chlamydia rate in Nebraska is increasing while the gonorrhea rate is high but stable. Among Nebraska women, disparities for chlamydia and gonorrhea exist by race and geography.

Stakeholders in Nebraska's Title V Needs Assessment viewed the topic of STDs in Nebraska with considerable

concern, in both the domains of women/maternal health and also adolescent health. In the women/maternal health domain, Stakeholders identified high rates of gonorrhea and chlamydia among women, and also expressed awareness of the social determinants that contribute to high rates of sexually-transmitted diseases, and to disparities between sub-groups, and well as the intergenerational implications of high levels of STDs. Stakeholders were aware that prevention of sexually transmitted diseases begins before sexual activity, and attribute Nebraska's positive youth development approaches with helping address the problem. Improving access to, and utilization of, preventive health care services is a key approach in this priority area.

Proposed Objectives and Strategies

Objective IIa. By 2020, increase by 10% use of preventive health care services by young adult women.

Nebraska Title V, through the Maternal Child Adolescent Health Program, is currently participating with the Maternal Child Health Workforce Development Center and the Association of Maternal and Child Health Programs, to conduct a short-term project – or Practice Laboratory – to examine topics related to the current environment of health systems transformation, through the lens of access, systems integration, quality improvement, and change management. Nebraska's project is about Young Adults aged 20 – 24 years) and increasing their use of preventive health care services, particularly for three sub-populations of Young Adults with Autism, Young Adult Females with Behavioral Health conditions, and Young Adults with experience in the Foster Care System. A significant objective of the project is to engage and sustain meaningful involvement from Young Adults and consumers throughout the life of the project. Strategy IIa1 identifies that through this project, Nebraska expects to have some "lessons learned" regarding possible approaches to increasing utilization of health care services by young adults for the purposes of prenatal care.

Nebraska Title V recognizes that intrinsic to promoting improved access to health care services is improving access to insurance coverage for young adult women through the health insurance exchange and the private insurance market, in Strategy IIa2. While Nebraska Title V does not work in the area of "health reform,"' per se, Nebraska Title V has long been engaged in promoting access to health care. Access strategies in the environment of health care transformation are transforming as well, and Nebraska Title V working with partners to broaden the constructive dialogue from "Medicaid expansion" to practical (and familiar) systems topics of Access, Quality Improvement, and Systems Integration. Strategy IIa2 identifies that Nebraska Title V has a role in assuring MCH populations receive and understand sufficient actionable information about health insurance to be able to successfully enroll for coverage and benefits.

In Strategy IIa3, Nebraska Title V's approach to developing a cross-program coordinated approach to strategic promotion of preconception health is also expected to contribute to Nebraska's programmatic approaches to increasing awareness and utilization patterns to prevent and treat STDs.

Related to the topic of increasing preventive health care services to reduce STDs is a plan in Nebraska to promote HPV vaccination (Strategy IIa4) through collaborations between the Immunization Program, Comprehensive Cancer Program, Reproductive Health Program, and Every Woman Matters Program. Performance measures in this effort should relate to progress on increasing utilization of preventive health care services during adolescence and young adulthood.

Objective IIb. By 2020, decrease by 10% rates of chlamydia among African American women ages 20 – 44 years.

The Reproductive Health program is actively involved in the Douglas County-focused Adolescent Health Project sponsored by the Women's Fund of Omaha. In this project, local funders are seeking high-impact on the area's population of adolescent and young adult African American women. As a project partner, the Reproductive Health program is positioned to identify aspects of program success that may be replicable or adaptable statewide, as well as influencing in positive ways project standards for evidence-based practice and performance measurement (Strategy IIb1).

Objective IIc. By 2020, decrease by 10% rates of chlamydia among Nebraska women ages 20 – 44 years.

In the area of decreasing rates of chlamydia, Nebraska Title V will continue support of and collaboration with the Reproductive Health Program to increase STD screening and follow-up services; support funding for STD testing, counseling, education, and treatment, including expedited partner therapy; and provide access to, and education regarding, protection against STDs (Strategy IIc1). The Reproductive Health program is an invested partner in addressing STDs in family planning agencies, and delivering such services to an accepted standard of culturally- and linguistically- appropriateness.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	59.4	60.6	61.8	63	64.3

WOMEN/MATERNAL HEALTH DOMAIN
Annual Report

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For the purposes of organizing the annual report by population domain, in this section, Nebraska will report on accomplishments and activities in the **Women/Maternal Domain** in the following 2014 National Performance Measures (NPM) and State Performance Measures (SPM):

NPM 15: percentage of women who smoke in the last three months of pregnancy;
NPM 18: percentage of infants born to women starting prenatal care beginning in the first trimester;
SPM 1: Percent of women of childbearing age with healthy weight; and
SPM 2: Percent of live births intended at time of conception.

Overall, 2014-2015 was an active period of growth in the Women/Maternal domain for Nebraska. As a state with comparatively small infrastructure for maternal and child health, a few key individuals and activities can have significant impact. In 2014, Nebraska hired a new team member in the Maternal Infant Health program, fully funded by MCH Title V. Jackie Moline, RN, BSN, Community Health Nurse Sr. contributed significant growth and credibility to the Maternal Infant Health program, and developed new resources and educational approaches for safe sleep, breastfeeding, and infant feeding in her first year with Title V.

Nebraska Title V initiated engagement in the Collaborative Improvement and Innovation Network (CoIIN) on Infant Mortality in 2014 which, as expected, is having far-reaching implications for collaborations and project development.

NPM 15 Percentage of women who smoke in the last three months of pregnancy.

The objective for NPM 15 for 2014 was 11.5%, which was exceeded with 8.5% of women smoking in the last three months of pregnancy.
Nebraska continued engagement in long-term activities and collaborations to reduce the use of tobacco in MCH populations. The Maternal Infant Health program partners with Tobacco Free Nebraska to distribute free materials about reducing tobacco use risks during and after pregnancy; the Nebraska free Quitline service is used by pregnant women, and Nebraska Medicaid reimburses for smoking cessation support during pregnancy; Adolescent Health and positive youth development programs promote tobacco avoidance.

In 2014, MCH Title V partnered with the Nebraska Office of Health Equity and Health Disparities to conduct focus groups among diverse minority subpopulations of women in Nebraska to better identify facilitators and barriers to tobacco use in American Indian and other groups. In growing awareness of behavioral health (substance use) topics among MCH populations in Nebraska, the Maternal Infant Health program began a collaborative planning activity in late 2014 to address maternal behavioral health and substance use behaviors before, during, and after pregnancy as a workforce development/professional development topic. Nebraska is organizing the state's first ever Maternal Behavioral Health Conference for health care professionals statewide.

Partnerships are significant to MCH Title V progress in the area of addressing tobacco use in pregnancy, most significantly including partnerships with: Partnership with Office of Health Equity and Health Disparities; Tobacco free Nebraska; PRAMS data and educational materials; and the PREP/Adolescent Health/positive youth development programs.

NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Nebraska did not meet its 2014 objective for NPM 18 of 74.6%, with only 71.5% of infants born to pregnant women receiving prenatal care beginning in the first trimester, and won from a level of 73.1% reported for 2013.

With the advent of Managed Care Organizations in Nebraska, prospects for improved outreach and enrollment services to eligible clients, and entry of newly-eligible low income pregnant women into care, seemed assured. And indeed, the Medicaid Managed Care Organizations are actively engaged in quality of care topics for pregnant enrollees. However, there was no significant change in the percent of infants born to women receiving care in the first trimester of pregnancy, with over 25% initiating care at some point after the first trimester.

Among the barriers to early enrollment are technical problems with on-line enrollment in Medicaid (Access Nebraska), which are currently being addressed and resolved. Outreach and referral processes, including use of presumptive eligibility, should also be examined for efficiencies and effectiveness.

The methodology and framework of the national Collaboration and Innovation Implementation Network to address infant mortality, initiated by Title V in 2014, influenced Nebraska's approaches to tackling maternal health and birth issues quite significantly. The framework for analysis and planning, the use of the PDSA (plan-do-study-act) cycle for quality improvement approaches, and the role of Nebraska Title V in taking the lead as backbone organization all contributed to sustained participation and progress using the CoIIN oices and influence of families and consumers in the MCH population.

Nebraska, in accordance with Title V requirements, continued investments in the statewide, toll free, Healthy Mothers Healthy Babies Helpline in order to assist women and families locate and access health care.

Partnerships are significant in MCH Title V progress in advancing early and timely entry into prenatal care. Among these were collaborations with March of Dimes to reduce prematurity; and with PRAMS for data and educational materials for providers on prenatal care.

SPM 1: Percent of women aged 18-44 with healthy weight (BMI)

For several years, Nebraska Title V has increasingly invested in lifecourse approaches to promote healthy weight, physical activity, and healthy nutrition among MCH populations, in Early Childhood Comprehensive Systems, School Health, Maternal Infant, Adolescent Health, and Reproductive Health. All of these activities, while not always aimed specifically at women of child-bearing age, contribute to an overarching strategy of building a culture of healthy food and activity habits to last for a lifetime of good health and healthy weight. Nevertheless, there was no change in the data indicator.

Nebraska adopted of a quality rating system for child care settings in 2014, and related policy developments and philanthropic investments continue to impact the landscape of resources for Nebraska's youngest children. More and more young Nebraska children enrolled in expanding preschool and early education programs designed to improve readiness for school. Nebraska Title V was at the forefront of advocating for quality practices at every level for healthy food and activity environments for young children.

Comparisons of 2011, 2012 and 2013 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 and 2012 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.

SPM 2: Percent of live births that were intended at the time of conception.

The objective of 63.3% established for SPM 2 in 2014 was achieved with 65.5% of live births that were intended at time of conception.

Prevention of teen and unintended pregnancy has long been a priority for Nebraska, though disagreements have occurred over approach. Addressing the "intendedness" of a pregnancy across the childbearing years is one way that Nebraska formulated prevention approaches.

Nebraska's Adolescent Health Program initiated a new adolescent health advisory council in 2014 that reinforces that for young people, it's not all about pregnancy, now or later. Young people need access to a wide range of sexual health information. The Adolescent Health program expanded programming to include continuing education for health and education professionals working with youth, on emerging science of adolescent brain development, executive function, and pre-frontal controls on the emerging impulsive risk-taking. The Adolescent Health Program has shifted the focus of adolescence from "teen pregnancy prevention" to "positive youth development," from instilling fear to understanding how to enhance the processes of normal brain development.

Another relatively new input to working in the area of teen pregnancy prevention has been the expansion of trauma-informed principles of practice in Nebraska, and a fresh understanding that early initiation of sexual activity may not be limited to impulsive behavior of a developing brain (complex as that may be) but a symptom of a past of trauma experiences that have contributed to risk behaviors on a trajectory far more severe and far-reaching than an infant born to a young mother.

Teen pregnancy prevention activities continuously occur through the programs of Adolescent Health (PREP and AbEd) and Reproductive Health in Nebraska, serving at-risk youth and women with educational, health, and prevention resources. Persistently a challenge in Nebraska is reaching the most at-risk and disadvantaged teens in Nebraska, in order to impact the groups most affected by early and unintended pregnancy. Yet, these very teens, often marginalized and disenfranchised, can be so very difficult to reach and sustain in prevention activities.

As noted in discussion regarding National Performance Measure 18, above, expansion of Nebraska Medicaid Managed Care, essential benefits including prevention services, and coverage of young adults on parents' insurance policies until age 26 should all combine to provide improved access to health care services to youth and young adults, including reproductive health care and contraception. Yet, as with obesity and infant mortality, in Nebraska the barriers and facilitators to changing disparities in our most at-risk populations may lie in other directions, for example educational and career opportunities in high-disadvantage neighborhoods.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
1. Infant Mortality (III)	IIIa. By 2020, decrease by 10% infant death rate due to SUID among African American and American Indian infants, and	IIIa1. Utilize strategies being developed through the Infant Mortality	Infant mortality rate per 1,000 live	Percent of infants placed to sleep on their backs		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
	IIIb.By 2020, decrease infant death rate by 10% due to SUID among Nebraska infants. IIIc. By 2020, Nebraska Title V will develop and implement a strategic plan for place-based initiatives to improve maternal and infant outcomes, with an emphasis on reducing/eliminating disparities in infant mortality rates. IIId. By 2020, the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) will collect, analyze, and utilize data to address disparities and improve treatment and outcomes in birthing facilities. IIId. By 2020, the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) will collect, analyze, and utilize data to address disparities and improve treatment and outcomes in birthing facilities.	CoIIN Safe Sleep Learning Network to promote high quality safe sleep practices in hospitals and by caregivers IIIa2. Revise, develop, and/or adapt targeted safe sleep messages for African American and American Indian parents and caregivers including extended family and friends, in collaboration with community stakeholders and consumers; launch messages in selected communities. IIIa3. Collaboratively formulate and disseminate consistent messages and education regarding co-sleeping with infants and associated risks. IIIb1. Educate regarding safe sleep in N-MIECHV and Together for Kids and Families workgroups, stakeholders, and	births Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births			

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
		audiences. IIIc1. Continue participation in Infant Mortality CoIIN Social Determinants of Health Learning Network to identify promising practices. IIIc2. Launch a Learning Community of internal/external stakeholders to identify public health role and priorities in place-based initiatives IIIc3. Incorporate life course metrics into on-going MCH needs assessment updates and strategy development. IIId1. Implement a contractual relationship with University of Nebraska Medical Center and the NPQIC in accordance with LB657 (2015) IIId2. Assure data collection by the NPQIC includes racial, geographic,				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
		and economic disparities. IIId3. Utilize data in quality improvement activities to address disparities in care and outcomes.				
3. Infant Abuse and Neglect (IV)	IVa. By 2020, increase by 10% the percentage of young children routinely screened for social/emotional/developmental status in the Medicaid pediatric medical home. IVb. By 2020, Nebraska will develop and implement a plan for using multiple platforms and modes of delivery for evidence-based parenting education to reduce child abuse and neglect. IVc. By 2020, reduce by 10% the estimated prevalence of maternal depression.	IVa1. Operationalize Strategic Plan for the Mitigation of Toxic Stress in Infancy and Early Childhood as developed through the Early Childhood Comprehensive Systems (ECCS) Program. IVa2. Deliver parenting education and support regarding early child development and safety, screening and referral, through N-MIECHV evidence-based home visiting. IVa3. Collaborate with Medicaid Managed Care Program in increasing screening through the plans. IVb1. Complete study of barriers				

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
		being conducted through ECCS, and develop actions steps to promote uptake of evidence-based parenting education and support IVb2. Enhance and expand role of N-MIECHV evidence-based home visiting in delivering evidence-based parenting education to reduce risk of child abuse and neglect. IVb3. Investigate evidentiary base for effective parenting education and support via virtual media. IVc1. Launch Maternal Infant Health program initiative on mental well-being in pregnancy				
7. Breastfeeding of Infants (V)	Va. By 2020, increase by 10% the percentage of African American women who are breastfeeding their infants exclusively at 6 months of age.	Va1. Collaborate in the State Health Improvement Action Plan steps to increase	Post neonatal mortality rate per 1,000 live	A) Percent of infants who are ever breastfed and B) Percent of		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
	Vb. By 2020, increase by 10% the percentage of American Indian women who are breastfeeding their infants exclusively at 6 months of age. Vc. By 2020, increase by 10% the percentage of all Nebraska women who are breastfeeding their infants exclusively at 6 months of age. Vd. By 2020, increase from baseline the percentage of Nebraska birthing hospitals adopting 6 or more standards of Baby Friendly Hospitals.	breastfeeding in Nebraska through increased access to Internationally Board Certified Lactation Consultants (IBCLCs). Va2. Conduct the Project LEARN , with objectives to increase the Certified Lactation Consultant workforce statewide and measure adoption of baby friendly criteria in Nebraska hospitals and out-patient clinic settings. Va3. Collaboratively formulate and disseminate consistent messages and education regarding co-sleeping with infants and associated risks. Vb1. Promote recruitment and training of African American and American Indian community-based lactation consultants, collaborating with	births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**S**
		PRAMS on data-driven support for strategies. Vc1. Enhance skill set in promoting breastfeeding initiation and longevity among home visitors in N-MIECHV. Vc2. Incorporate breastfeeding promotion/education into preconception health strategic planning. Vd1. Develop and implement educational outreach to birthing facilities on baby-friendly hospital standards Vd2. Through Project LEARN, introduce a cohort of 50 qualified certified lactation consultants into practice settings in rural Nebraska				

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

PERINATAL/INFANT HEALTH DOMAIN
Plan for the Application Year

Analysis of Effectiveness of Current Program Activities and Strategies

Nebraska Title V has been addressing the following priorities identified in 2010 that correspond all or in part with the Perinatal/Infant Health Domain:

- Reduce the impact of poverty on infants/children including food insecurity;
- Reduce the health disparities gap in infant health status and outcomes;
- Reduce the rates of abuse and neglect of infants and CSHCN; and
- Increase the prevalence of infants who breastfeed exclusively through six months of age.

Progress has been mixed, as noted in the Annual Report for this domain. And stakeholders recognized that more work needs to be done by selecting similar priorities during the current needs assessment. The plan for the application year acknowledges the need to better target strategies for specific populations and to better assess the impact of and address the social determinants of health. It will also build on the infrastructure largely in place in 2014, such as the Nebraska Prevention Partnership, the Early Childhood Comprehensive Systems (ECCS) project, and the NE Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) program.

Description of plan for the coming year

Three priorities identified through the recently completed needs assessment correspond to the Perinatal/Infant Health domain. As labeled in the State Action Plan Table, those priorities are:

III. Infant Mortality - State Priority #1

IV. Infant Abuse and Neglect - State Priority # 3

V. Breastfeeding of Infants - State Priority #7

The following narrative summarizes for each priority the stakeholder findings identified through the needs assessment and then elaborates on the strategies listed in the State Action Plan Table.

Nebraska State Action Plan:

III. Infant Mortality - State Priority #1

When stakeholders organized information for this priority in an issue brief, they noted that 139 infants died in Nebraska in 2013 and that death resulted primarily from birth defects, prematurity, and Sudden Infant Death Syndrome/ Sudden Unexpected Infant Death. They also noted that Nebraska infants died at a rate of 5.3 per 1,000 live births in 2013, an increase from 2012, and that although Nebraska's rate overall is lower than the US average (5.98), African Americans and American Indians have a significantly higher death rate than other racial/ethnic groups in Nebraska. A large disparity exists between Asian Americans- the lowest group at 2.4-and African Americans -the highest group at 11.4 (2009-2013 Vital Records). For the last 15 years African Americans have remained at the highest risk for infant mortality in Nebraska.

The issue brief emphasized the need to address disparities, better target interventions, and provide culturally and linguistically appropriate services. The action plan thus includes objectives and strategies that reflect these stakeholder concerns.

Proposed Objectives and Strategies

Objective IIIa. By 2020, decrease by 10% infant death rate due to SUID among African American and American Indian infants, and

Objective IIIb. By 2020, decrease infant death rate by 10% due to SUID among Nebraska infants.

Through the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) project, Nebraska chose to participate in the Safe Sleep Learning Network, identifying the prevention of SUID/SIDS as an area of focus to address disparities. American Indians had the highest infant death rate (per 10,000 live births) from SIDS in Nebraska (Vital Records 2008-2013) at the rate of 23.2 closely followed by African Americans at 20.0. African Americans had the highest death rate from SUID at 21.1. Although these rates represent a fairly small number of actual deaths, SIDS/SUID account for a sizeable proportion of all deaths of American Indian and African American babies. Strategy IIIa1 activities during FFY 2016 will be based on the learnings gained through the Safe Sleep Learning Network and its iterative Plan-Do-Study-Act (PDSA) cycles, which will then be applied to Strategies IIIa2, which will include activities to better target and deliver safe sleep messages to African American and American Indian parents and caregivers, including extended family and friends. To do so, Title V staff will work collaboratively with community level stakeholders and consumers in revising, developing, and/or adapting the messages and delivery methods.

Strategy IIIa3 focuses specifically on the topic of co-sleeping, a SUID risk factor that is not consistently addressed in the public health community. Title V staff will convene a working group to develop agreed-upon messaging, that takes into account the views of those public health professionals who consider co-sleeping as supportive of successful breastfeeding. Strategy IIIb1 will utilize N-MIECHV home visitors and the ECCS work groups (Together for Kids and Families) as vehicles for delivering the messages developed through Strategies IIIa1 through IIIa3.

Objective IIIc. By 2020, Nebraska Title V will develop and implement a strategic plan for place-based initiatives to improve maternal and infant outcomes, with an emphasis on reducing/eliminating disparities in infant mortality rates.

The Social Determinants of Health (SDOH) Learning Network of the IM CoIIN has offered Nebraska Title V an opportunity to learn about place-based strategies to improve maternal and infant outcomes. Strategy IIIc1 will consist of continued gathering of knowledge on place based strategies through the IM CoIIN during FFY 2016, with Strategy IIIC2 being the application of the knowledge gained through a Nebraska-based Learning Community focused on place-based initiatives. This Learning Community will allow Title V staff and its traditional stakeholders to engage and work with non-traditional partners such as housing authorities, economic development, land use planners, criminal justice, and others.

To augment this work, Strategy IIIc3 will include activities to utilize life course metrics to better understand community level issues. During the current year, Nebraska participated in the Association of Maternal and Child Health's (AMCHP's) Life Course Indicator Intensive Technical Assistance. Nebraska received analytic assistance calculating a subset of the life course indicators and expert consultation to create a communications product from the results of their analysis. Nebraska chose "concentrated disadvantage" as the life course indicator to develop a life course communication product. This product is currently being field tested in selected communities, and the results will guide further work to use life course metrics in planning and program development.

Objective IIId. By 2020, the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) will collect, analyze, and utilize data to address disparities and improve treatment and outcomes in birthing facilities.

LB 657, passed in 2015, appropriated $100,000 in State General Funds in each of the next two state fiscal years to support a Perinatal Quality Improvement Collaborative. The Title V/MCH Director is responsible for developing and overseeing the contract with the University of Nebraska Medical Center. Such perinatal quality improvement

initiatives are among the strategies outlined by the IM CoIIN SDOH Learning Network, and Nebraska's newly emerging collaborative will be an important adjunct to the place-based strategies. Strategies 1 – 3 outlines the steps to occur in 2016 to establish the contract, incorporate data collection by the Collaborative to assess disparities, and then utilize the data in quality improvement activities.

IV. Infant Abuse and Neglect - State Priority # 3

Stakeholders participating in Nebraska's Title V Needs Assessment noted that Nebraska's incidence of infant abuse and neglect is not changing significantly over time. In 2009 the rate of substantiated maltreatment (evidence of child abuse/neglect after investigation) was 25.2 per 1,000 infants; in 2013 the rate was non-significantly lower at 22.7. Their issue brief went on to describe that child abuse is a complex problem rooted in unhealthy relationships and environments. Safe, stable, and nurturing relationships and environments for all children and families can prevent child abuse. However, the solutions are as complex as the problem. Increasing factors that protect children can reduce the occurrence of abuse. Preventing child maltreatment means influencing individual behaviors, relationships among families and neighbors, community involvement, and the culture of a society. The stakeholders also listed a number of potential strategies potentially effective in preventing abuse and neglect, including evidence-based home visiting, education related to child development, and maternal depression screening.

The action plan thus includes objectives and strategies that take into consideration stakeholder observations.

Proposed Objectives and strategies

Objective IVa. By 2020, increase by 10% the percentage of young children routinely screened for social/emotional/developmental status in the Medicaid pediatric medical home.

During FFY 2016, planned activities will build on work already underway. Strategy IVa1 references the Strategic Plan for the Mitigation of Toxic Stress in Infancy and Early Childhood. This plan was finalized by the Toxic Stress Steering Committee in accordance with the Year Two work plan for Nebraska's Early Childhood Comprehensive Systems (ECCS) grant. The working theory is that toxic stress in infants can be associated with abuse or neglect (or care giver behaviors that could result in abuse and neglect), and that interventions to mitigate toxic stress in infants also must address current or potential abuse and neglect.

The four goal areas and associated strategies in this strategic plan for the upcoming year are:

Goal 1: Messages describing toxic stress and its impact on young children are clear and well understood and are readily available to families, providers, and policy makers.
Strategies: • Utilize qualitative methods to measure current levels of understanding and determine optimal methods for disseminating messages. • Utilize social marketing concepts to develop/refine messages. • Disseminate messages through methods appropriate for each audience. • Carry out these strategies in collaboration with stakeholders, including families, using the collective impact model.

Goal 2: Nebraska has suitable resources and policies that support systems in effectively addressing toxic stress and its impact on infants and young children.

Strategies:

- Through literature review, identify policies needed to support effective systems.
- Conduct analysis of existing policies and supports.
- Utilize collective impact structure to effect needed changes.

Goal 3: Nebraska system stakeholders have access to and utilize accurate data and research-based information on toxic stress to describe and address its impact on infants and young children in the state.

Strategies:

- Identify and define indicators based on best-practices for measuring risk factors for toxic stress and for the detrimental impacts it has on infants and young children.
- Collect indicators and analyze.
- Establish methods for disseminating data.
- Carry out these strategies in collaboration with stakeholders, using the collective impact model.

Goal 4: Nebraska system stakeholders implement mutually reinforcing evidence-informed and evidence-based strategies to prevent and reduce the impact of toxic stress on infants and young children.

Strategies:

- Utilize collective impact model to mobilize system stakeholders and sustain collaborative actions.
- Establish and/or identify a clearinghouse on evidence-informed and evidence-based strategies for preventing and mitigating toxic stress and its impact on infants and young children.

Nebraska's ECCS project is part of Maternal Child Adolescent Health, a grouping of programs and activities in the Lifespan Health Services Unit that is also responsible for Nebraska's Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) Program and a number of Title V supported activities. With ECCS integrated into the overall Title V work, this strategic plan provides the logical framework for addressing this priority need.

Strategy IVa2 recognizes the important role that N-MIECHV plays in the prevention of abuse and neglect. All of Nebraska's sites, both federally and state funded, utilize Healthy Families America, an evidence-based model designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment. It is the primary home visiting model best equipped to work with families who may have histories of trauma, intimate partner violence, and mental health and/or substance use issues. Title V staff are key members of the N-MIECHV leadership team, and Title V funds help support state-level programmatic activities, such as training, particularly for the state-funded sites.

Social/emotional and developmental screening of infants and young children can help identify issues related to infant

–parent interactions and thus help identify and/or prevent potential abuse and neglect. Initiated under the ECCS Program, Strategy IVa3 will further build the collaboration with Medicaid Managed Care in increasing such screening through its plans. As described in Section IIA, Overview of the State, NE DHHS is going through many transitions in leadership, including the appointment of a new Director for the Division of Medicaid and Long Term Care. This transition has provided the opportunity to re-visit working relationships between Nebraska Title V and Medicaid (see Section IV, Title V-Medicaid IAA/MOU). Activities under this strategy for FFY 2016 will include identifying key Medicaid staff to guide work with the plan and identify specific options for increasing screening via QI, training, reimbursement, or other methods.

Objective IVb. By 2020, Nebraska will develop and implement a plan for using multiple platforms and modes of delivery for evidence-based parenting education to reduce child abuse and neglect

This objective recognizes the ongoing concern of families encountering various barriers in participating in educational and supportive activities, such as group classes and home visiting. A previous ECCS pilot project to implement Circle of Security-Parenting documented low participation and retention rates. In addition, N-MIECHV retention data underscores the challenges in providing evidence-based interventions in the duration required for positive outcomes, including the prevention of abuse and neglect. Strategy IVb1 will utilize the findings of an ECCS study currently examining these barriers and then to identify models and methods to better engage families over time. As part of Strategy IVb2, Title V staff, as part of the N-MIECHV leadership team, will integrate these strategies into home visiting practice. Finally, Strategy IVb3 will include the engagement of a contractor or graduate student to review the literature regarding the effectiveness of electronic media in the delivery of parent education, particularly as it applies to the prevention of abuse and neglect. A report of this review will inform specific strategies for FY 2017.

Objective IVc. **By 2020, reduce by 10% the estimated prevalence of maternal depression.**

Maternal depression is a known risk factor for abuse and neglect. Strategy IVc1 will be an initiative to address maternal depression, including reducing the risks associated with it:

- Stressful events during the past year, such as pregnancy complications, illness or job loss
- Problems in the woman's relationship with her spouse or significant other
- Weak support system
- Financial problems
- Pregnancy unplanned or unwanted
- History of mental illness

During FFY 2016, Title V staff will review the literature, conduct an environmental scan of current cross system activities to screen, diagnose, and treat women, identify and engage key partners, and develop a detailed action plan for FFY 2017.

V. Breastfeeding of Infants - State Priority #7

In the issue brief prepared for the Title V Needs Assessment, stakeholders cited the CDC's 2014 Breastfeeding Report Card, showing that 82.4 % of Nebraska moms report ever breastfeeding their infants. However, this report shows that less than one half (46.5%) of Nebraska infants are breastfeeding at six months and only one fifth (20.2%) are exclusively breastfeeding at six months. Breastfeeding initiation, duration, and exclusivity rates vary across racial, ethnic, and socioeconomic groups, and disparities exist. The stakeholders stated that several factors influence a woman's breastfeeding intentions. The persistent gap among African American, Native American, and White mothers may be due to cultural and historical influences, perceptions that formula is better, lack of partner support and unsupportive work environments.

The stakeholders noted disparities in access to professional breastfeeding support, particularly in rural areas, and proposed consideration of the evidence-based strategies recommended by the CDC: Maternity care practices; Professional education; Access to professional support; Peer support programs; Workplace support; Support in early care and education; Access to breastfeeding education and information; Social marketing; and Addressing the marketing of infant formula. The Action Plan for this priority incorporates a number of these strategies.

Proposed Objectives and Strategies

Objective Va. By 2020, increase by 10% the percentage of African American women who are breastfeeding their infants exclusively at 6 months of age, and

Objective Vb. By 2020, increase by 10% the percentage of American Indian women who are breastfeeding their infants exclusively at 6 months of age, and

Objective Vc. By 2020, increase by 10% the percentage of all Nebraska women who are breastfeeding their infants exclusively at 6 months of age.

Breastfeeding initiation, duration, and exclusivity rates vary across racial, ethnic, and socioeconomic groups, with breastfeeding duration rates lower for African American and American Indian infants as soon as 4 weeks postpartum. These objectives thus address increasing exclusive breastfeeding duration for all women who breastfeed their infants, as well as objectives specific for African American and American Indian women.

Strategy Va1 will include participation of Title V staff in carrying out Nebraska's State Health Improvement Plan to increase breastfeeding. Activities will focus on increasing the numbers of International Board Certified Lactation Consultants (IBCLCs) available across the state, through training and developing "pipe lines" for identifying the practitioners with both the interest and necessary prerequisites for certification. Strategy Va2 focuses specifically on increasing Certified Lactation Consultants in rural areas of the state, along with promotion of baby-friendly criteria in Nebraska hospitals and clinic settings as part of Project LEARN (Lactation Education Across Rural Nebraska). Project LEARN, led by Title V staff, is offering scholarship opportunities to attend a Certified Lactation Counselor (CLC) Training provided by The Center for Breastfeeding, Healthy Children's Project, Inc. hosted by Regional West Medical Center in Scottsbluff, Nebraska on Monday, August 17 through Friday, August 21, 2015. Similar activities will continue into FFY 2016.

Strategy Va3 focuses specifically on the topic of co-sleeping, a SUID risk factor that is not consistently addressed in the public health community. Title V staff will convene a working group to develop agreed-upon messaging, that takes into account the views of those public health professionals who consider co-sleeping as supportive of successful breastfeeding.

Strategy Vb1 will be carried out in collaboration with the Nebraska Breastfeeding Coalition, which has recently established a work group to address disparities in breastfeeding rates and availability of African American and American Indian lactation consultants through targeted outreach, recruitment and training. Among the resources to support this strategy is a breastfeeding promotion fact sheet currently in development. It will include state PRAMS data, examples of data and information that may be helpful in planning, and relevant information from published research. Strategies Vc1 will include ongoing and enhanced training for home visitors in N-MIECHV, through activities such as connecting rural home visitors to the Project LEARN activities described above. Strategy Vc2 will incorporate breastfeeding promotion into the preconception health strategic plan described in the Women/Maternal Health Domain, recognizing that knowledge of breastfeeding and its benefits needs to begin and be supported before pregnancy.

Objective Vd. By 2020, increase from baseline the percentage of Nebraska birthing hospitals adopting 6 or more standards of Baby Friendly Hospitals.

Hospital practices influence breastfeeding initiation and duration, therefore this objective and the associated strategies address these practices. Project LEARN, described under the previous objective, is currently collecting baseline information on hospital practices, which will be used to inform Strategies Vd1, educational outreach to birthing facilities. This activity will be carried out by the Maternal Infant Community Health Nurse Sr., the Title V staff person responsible for Project LEARN. Strategy Vd2 will draw upon the certified lactation constants identified and trained through Project LEARN to work with their respective organizations. The conceptual model is to develop an ever expanding circle of practitioners skilled in promoting and supporting baby-friendly hospital practices.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.0	85.7	87.4	89.2	91.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.4	20.8	21.2	21.6	22.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	83.3	85	86.7	88.4	90.2

PERINATAL/INFANT HEALTH DOMAIN
Annual Report

For the purposes of organizing the annual report by population domain, in this section Nebraska will report on accomplishments and activities in the **Perinatal/Infant Health Domain** for the following 2014 National Performance Measures (NPM) and State Performance Measures (SPM):

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age;
NPM 12: The percentage of newborns who have been screened for hearing before hospital discharge;
NPM 17: The percent of very low birth weight infants delivered at facilities for high risk deliveries;
SPM 4: The preterm birth disparity (ratio) between African American and Caucasian nfants; and
SPM 6: The rate per 1000 infants of substantiated reports of child abuse and neglect.

The report year of 2014 saw incremental growth in capacity and collaborative efforts to impact these measures. A new Community Health Nurse Sr. was hired, bringing labor and delivery expertise to Title V supported activities. The Women's Health Initiative, created by state statute in 2000, continued and expanded its engagement in breastfeeding promotion and support. The Nebraska Prevention Partnership launched into a reorganization and refocusing effort to better support child abuse and neglect prevention across agencies and systems. The NE Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) program expanded its reach and quality of service provision. And Nebraska began its participation in the Infant Mortality Collaborative Improvement and Innovation Network. These accomplishments and others are provided below in greater detail for each measure, along with the challenges encountered.

NPM 11: The percent of mothers who breastfeed their infants at 6 month of age

Nebraska did not make progress with this measure, with 48.1 percent of infants breastfed at 6 months of age in 2014 compared to 48.3 in 2013 and the objective set at 49.3 percent, despite well-established multi-program efforts. Title V, WIC, and Women's Health Initiative staff continued their active participation in the Nebraska Breastfeeding Coalition (http://nebreastfeeding.org/) and its outreach and educational activities, including its breastfeeding-friendly employer recognition (http://nebreastfeeding.org/business-of-breastfeeding/nebraska-breastfeeding-friendly-business-award-application/). WIC's breastfeeding peer support program continued. N-MIECHV home visitor's enhanced their skills in delivering education and consultation to new moms. A breastfeeding module was added to the community health worker training provided by NE DHHS (http://dhhs.ne.gov/PublicHealth/HealthNavigation/Pages/Home.aspx). And the Maternal Child Adolescent Health programs continued to maintain and expand its offerings of materials and educational offerings.

In addition, Nebraska's State Health Improvement Plan was finalized in September 2013, and established a goal to increase professional lactation support across Nebraska through the use of International Board Certified Lactation Consultants (IBCLCs). Improving rates of breastfeeding thus has a state-wide public health commitment, in addition to the efforts of Title V. With breastfeeding again being identified as a priority for 2016 – 2020, the Plan for the Application Year includes a number of enhanced and expanded activities that build on the efforts that were underway in 2014, and continued in 2015, particularly in focusing on disparity of rates among African American and American Indian women who breastfeed their infants, and access to education and supports in rural areas.

NPM 12: The percentage of newborns who have been screened for hearing before hospital discharge

Nebraska continued to have high levels of newborn hearing screening, with 99.7% of newborns screened before discharge in 2014, the same level of screening performed in 2013 and nearly achieving the objective of 99.8%.

The Infant Hearing Act became a state law in Nebraska in 2000 and required the hearing screening of newborns in birthing facilities in Nebraska as a standard of care. Since 2003, 100% of the birthing facilities in Nebraska have been conducting hearing screenings. In 2014, there were 56 birthing facilities conducting hearing screenings. The following shows the hearing screening/testing status of the 27,118 births for 2014:

- 26,096 Passed inpatient screening;

- 707 Passed outpatient screening and/or diagnostic testing;
- 113 Expired (inpatient or outpatient);
- 46 Parents refused screening and/or diagnostic testing;
- 65 Diagnosed deaf or hard of hearing;
- 64 Pending final screening or diagnostic testing;
- 19 Lost (no response to NE-EHDI letters and phone calls); and
- 8 Moved out of Nebraska.

Educating parents about newborn hearing screening, hearing loss, and normal communication development is required by Neb. Rev. Stat. §71-4740. The Nebraska Early Hearing Detection and Intervention (NE-EHDI) Program provides print and video education materials free of charge to hospitals to help fulfill this requirement. Print materials are available in 10 languages. The NE-EHDI Program's tracking and follow-up procedures were followed for each baby who was reported as not passing the hearing screening during birth admission and for infants not receiving the inpatient hearing screening. In 2014, a total of 904 infants (hospital and nonhospital births) were tracked by the Nebraska EHDI Program to encourage the parent(s) to have the infant receive an outpatient hearing screening or audiologic evaluation. Over 97% of infants received an inpatient screening within one month of age. For the newborns who were recommended for an audiologic diagnosis, 67% received the evaluation by three months of age according to individual data received by the NE-EHDI Program from audiologists.

NE-EHDI continues to support HearU Nebraska, which began providing loaner hearing aids to young children in January 2008. In 2014 there were 64 hearing aids provided to 37 children (age range of two months – 18 years) by HearU Nebraska. Since 2008 over 194 children have been provided hearing aids. NE-EHDI also sponsored parent workshops and conferences in 3 sites in 2014.

The NE-EHDI Program is not supported by the Title V block grant allocation to Nebraska but it continued to receive funding from the Health Resources Services Administration/Maternal and Child Health Bureau (HRSA/MCHB), as well as from the Centers for Disease Control and Prevention (CDC). The HRSA/MCHB grant funded the basic operations of the NE-EHDI Program. The CDC Cooperative Agreement funded the development, implementation, and maintenance of the integrated electronic data reporting and tracking system.

NPM 17: The percent of very low birth weight infants delivered at facilities for high risk deliveries

In 2014, 84.8% of very low birth weight infants were delivered at facilities for high risk deliveries in 2014, compared to 76.8% in 2013 and exceeding the objective of 78.3%. This improvement is largely attributed to the addition of a second Level Three hospital in Lincoln.

There are no statutory or regulatory requirements for perinatal regionalization in Nebraska. Based on ongoing reviews conducted by the Child and Maternal Mortality Review Team, and by the Fetal-Infant Mortality Review (FIMR) in Douglas County, no change is actively being considered in the voluntary system of care for high risk deliveries, and Title V staff will continue to monitor. In addition, Title V staff will be administering funds recently appropriated by the Nebraska Legislature to support a perinatal quality improvement collaborative through a contract with the University of Nebraska Medical Center.

SPM 4: The preterm birth disparity (ratio) between African American and Caucasian infants

Some improvement was seen in this measure between 2013 and 2014, with the ratio decreasing from 1.5 to 1.4, but not achieving the objective of 1.3. Beginning in 2013, NE Title V worked with the Nebraska Hospital Association and

individual hospitals and practitioners to reduce rates of early elective deliveries. Such activities, though, did not adequately target factors associated with preterm births among African American infants. The Child and Maternal Death Review Committee (a Title V supported activity) continued to asses these factors, in conjunction with the Douglas County Fetal/Infant Mortality Review (FIMR) project. Based on these reviews, as well as Douglas County's Perinatal Periods of Risk (PPOR) assessment, pre- and inter-conception care can and should be an area of increased focus to reduce this disparity.

Though "Access to and Adequacy of Prenatal Care" was one of the identified priorities for 2016 - 2020, pre- and inter-conception care are part of a continuum of care. According to the Current Population Survey (CPS), in 2013, 84.6% of Nebraska women ages 18-44 had health insurance coverage, however only 58.2% of women reported having a preventive healthcare visit in the past year (Behavioral Risk Factor Surveillance System (BRFSS), 2013). Women who are receiving care before and between pregnancies, are more likely to enter prenatal care earlier and with better health status. Thus, the strategies proposed in the Women's Health Domain for this priority includes the development of a strategic plan for preconception health. See the Plan for the Application Year, Women/Maternal Health Domain for details.

SPM 6: The rate per 1000 infants of substantiated reports of child abuse and neglect

Nebraska's rate per 1000 infants of substantiated reports of child abuse and neglect in 2014 was 20.4, improving from the rate of 21.7 in 2013 and surpassing the objective of 21.7.

Nebraska Title V has been actively engaged in the Nebraska Prevention Partnership, a collaborative facilitated by the Nebraska Children and Families Foundation (Nebraska's CB-CAP agency), with the Title V/MCH Director being one of the representatives for the Division of Public Health. She is also the Division's designee on the Child Abuse Prevention Fund Board. Through these engagements, the Title V/MCH Director has led planning and program development efforts that consider and address Adverse Childhood Experiences (ACEs), mitigation of toxic stress, and life course/social determinants of health strategies.

The Nebraska Prevention Partnership went through a self-assessment and re-organization process in 2014. By the end of FFY 2014, a new charter was drafted, establishing:

- A Vision – Communities are involved in assuring that Nebraskans have good health, a place to live, a job or daily activity, and lasting social connections;
- A Mission – State leaders work across systems and support community collaboration to promote child wellbeing and provide safe, stable, nurturing relationships and environments for children and families in Nebraska; and
- A Common Agenda – Improve wellbeing of children and families in Nebraska.

With an expanded membership and more clearly articulated purpose, the Prevention Partnership will continue to be the arena in which Nebraska Title V will explore, develop, and coordinate its Title V child abuse and prevention activities.

Title V staff, as members of the N-MIECHV leadership team, guided the ongoing development and implementation of evidence-based home visiting in Nebraska. Title V staff played a particular role in supporting the development and launching of evidence-based home visiting supported with State General Funds. Beginning July 1, 2013, the State General Funds appropriated for home visiting were designated to be evidence-based, and Title V staff led the development of the requirements for providers and oversees their service delivery. All four state funded sites selected Healthy Families America (HFA), as had all of the federally supported sites. HFA, delivered with fidelity,

was thus a major strategy in 2014 to address abuse and neglect.

Also late in 2014, Nebraska's Early Childhood Comprehensive Systems (ECCS) grant project began its work in the area of the mitigation of toxic stress in infants and young children. This work continued into 2015 with the development of a strategic plan in May 2015. Associated with the work of the ECCS has been active engagement with the Department's activities to promote trauma informed care. Taken together, a significant degree of synergy has developed between the Division of Public Health and its Title V staff with staff in the Divisions of Behavioral Health, and Children & Family Services. These synergetic relationships will foster and support Title V strategies outlined in the Plan for the Application Year to address abuse and neglect of infants.

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State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes (VI and X)	VIa. By 2020, decrease child (age 0-9 years) injury due to motor vehicle crashes by 10% through increased proper use of appropriate-for-size child safety seats. VIb. By 2020, increase the number and percentage of women (18-44) from baseline who always wear a seatbelt.	VIa1. Collaborate with workforce development activities for the state's cadre of Child Safety Passenger safety technicians to enhance and expand geographic availability of training, technical assistance, and outreach to target populations. VIa2. Develop and or adapt educational messages to promote use of seat belts, decrease distracted driving, and increase correct seat restraints for all ages, delivered through maternal-infant health, school health program, N-MIECHV, ECCS, and other MCH partners. VIa3. Participate with the Safe Kids Coalitions efforts to improve road	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		safety policies and implementation activities VIb1. a. Include motor vehicle safety in parenting education provided through ECCS and N-MIECHV, and incorporate into preconception health plan. VIb2. Participate in the Drive Smart Nebraska Coalition's efforts to improve road safety polices and implementation of activities.				
9. Access to Preventive and Early Intervention Mental Health Services for Children (VII)	VIIa. By 2020, increase by 10% the percentage of young children aged 0-3 years receiving age-appropriate social and emotional development screening through EPSDT/Medicaid. VIIb. By 2020, increase delivery of professional development to health care professionals by	VIIa1. Collaborate with Division of Behavioral Health in the development and implementation of System of Care, with attention to geographic availability of services and a continuum of care for children and youth with identified special needs. VIIa2. Collaborate with Medicaid Managed Care Program in increasing screening through the plans.				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	10% on topics related to maternal and child mental/behavioral health. VIIc. By 2020, the behavioral health system of care approach will increase access to integrated behavioral health/primary health services by 10%. VIId. By 2020, increase by 10% the number of children served in a medical home.	VIa3. Deliver screening services through N-MIECHV evidence-based home visiting. VIIa4. Launch Maternal Infant Health program initiative on mental well-being in pregnancy, , raising awareness about significance of postpartum depression as obstructing successful attachment and bonding necessary for healthy infant development VIIa5. Promote universal, periodic social emotional/developmental screening for all young children by qualified providers using accurate tools for age. Promote cultural and linguistic appropriateness among early childhood providers serving families. VIIb1. Through Department contract with the Behavioral Health Education Center of Nebraska, develop and implement educational offerings for health care professionals. VIIb2. Plan and hold a Maternal Infant health program statewide conference on Maternal				

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		Behavioral Health in April 2016. VIIc1. Participate in the development and implementation of the Division of Behavioral Health's System of Care plan. VIIc2. As part of State Health Improvement Plan, carry out activities to further the integration of behavioral health services into primary care. VIId1. a. Participate in public and private efforts to promote Patient-Centered Medical Home (Medicaid pilot, BC/BS initiatives, legislative interim studies, etc.)				

Child Health

Child Health - Plan for the Application Year

CHILD HEALTH DOMAIN

Plan for the Application Year

Analysis of Effectiveness of Current Program Activities and Strategies

Nebraska Title V has been addressing the following priorities identified in 2010 that correspond all or in part with the Child Health Domain:

1. Increase the prevalence of the MCH/SHCN population who are physically active, eating healthy, and are at a healthy weight;
3. Reduce the impact of poverty on infants/children including food insecurity; and
5. Increase access to oral health care for children and CSHCN;

As noted in the Annual Report for this domain, progress was made in addressing the impact of poverty on infants

and children as measured by improved insurance coverage (NPM 13 and SPM 03), little change was made in healthy weight for children as measured by BMI of 2 to 5 year olds participating in WIC (NPM 14), and no progress made in increasing access to oral health care as measured by young children who have excellent/very good dental health (SPM 05).

This "mixed bag" of results based on the NPMs and SPMs gives only a partial picture of progress in addressing the health needs of children in Nebraska. The steady expansion and enhancement of federally and state supported evidence-based home visiting, the implementation of Step Up to Quality, Nebraska's quality rating and improvement system for child care, and the BMI measurements as a required component of school health screening are illustrations of child health infrastructure built in some part with Title V support or involvement. Sub-awards of Title V funds have also supported community-level efforts related to healthy weight and oral health access. A robust School Health Program, active engagement in systems of care for children's behavioral health, promotion of trauma informed care, and collaboration across agencies in the prevention of child abuse and neglect have also helped build and sustain system level strategies.

Moving ahead to 2016, the needs assessment brought forward a different array of child-related priorities. Oral health was not identified as a priority nor was the impact of poverty. Obesity/ overweight was identified as a priority for children, as it was for women and youth, and because of the implications across populations, obesity/overweight has been placed in the Cross-Cutting or Life Course Domain. Newly identified child health priorities were unintentional injury among children and access to preventive and early intervention mental health services for children. This new array of priorities offers opportunities for Nebraska Title V to expand and enhance some well-established activities and develop new ones in areas with less-developed capacity.

Description of plan for the coming year

Two priorities identified through the recently completed needs assessment correspond to the Child Health domain. As labeled in the State Action Plan Table, those priorities are:

VI. Unintentional injury among children (and youth), including motor vehicle crashes – State Priority #5

VII. Access to preventive and early intervention mental health services for children – State Priority #9

See the Cross-Cutting or Life Course Domain for: **Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity.**

Planned activities for 2016 will build on and utilize existing frameworks and delivery systems, such as the MIECHV program, ECCS, and School Health. Through a competitive process to be carried out in 2016, community-level providers will be identified to implement projects in 2017 addressing these priorities.

The following narrative summarizes for each priority the stakeholder findings identified through the needs assessment and then elaborates on the strategies listed in the State Action Plan Table.

Nebraska State Action Plan:

VI. Unintentional injury among children (and youth), including motor vehicle crashes – State Priority #5

When stakeholders organized information for this priority in an issue brief, they noted that unintentional injuries are the leading cause of death for Nebraska children ages 1-9. In 2012, the Nebraska death rate due to unintentional injuries for children ages 1-9 was 7.5 per 100,000 children compared to a national rate of 5.7. For Nebraska children ages 1 to 9, the leading cause of inpatient hospitalization due to injury is falls and the second leading cause is motor vehicle crashes. The issue brief points to Safe Kids Nebraska and MIECHV as programs through which to deliver prevention strategies.

With the stakeholders identifying motor vehicle crashes as a priority for adolescents, Nebraska Title V has chosen to focus its child-related injury prevention strategies on motor vehicle crashes as well. Doing so will help concentrate Title V's efforts to build capacity and expertise in injury prevention, an area that has not had significant Title V attention in the past. In order to carry out its objectives and develop successful strategies, Nebraska Title V will expand on its current working relationship with the Injury Prevention Program, continue its involvement with key groups such as Drive Smart Nebraska, and seek out community-level providers to implement evidence-based strategies to prevent injuries due to motor vehicle crashes.

Proposed Objectives and Strategies

Objective VIa. By 2020, decrease child (age 0-9 years) injury due to motor vehicle crashes by 10% through increased proper use of appropriate-for-size child safety seats.

NE DHHS's Injury Prevention Program and Safe Kids Nebraska, (http://dhhs.ne.gov/PublicHealth/InjuryPrevention/Pages/MotorVehicle.aspx) along with its eight local Safe Kids programs across the state address unintentional injuries to children. Safe Kids Nebraska provides support to the local Safe Kids coalitions to promote safety through education and awareness campaigns, community programming, distribution of safety devices and local events/celebrations. The programs conduct community car seat check events and car seat inspection stations and also address various other unintentional injuries. Strategy VIa1 includes developing closer collaborations with these programs in promoting and supporting work force development for Child Safety Passenger technicians. Specific activities will include outreach for recruitment of technicians, augmenting training events, and the potential for supporting local child passenger safety activities through sub-awards. Strategy VIa2 will capitalize on existing Title V supported or coordinated programs as venues for providing education on motor vehicle safety topics such as use of seat belts and restraints and distracted driving. Educational materials and methods will be developed and/or adapted for delivery through maternal-infant health (http://dhhs.ne.gov/publichealth/MCAH/Pages/MaternalAndInfant.aspx), school health (http://dhhs.ne.gov/publichealth/Pages/schoolhealth.aspx), N-MIECHV, and with ECCS collaborators (such as Head Start). Strategy VIa3 will include Title V partnering with Safe Kids Coalitions to implement policies and activities.

Objective VIb. By 2020, increase the number and percentage of women (18-44) from baseline who always wear a seatbelt.

There is some evidence that parental modeling of seat belt use is positively associated with child use. As efforts are made to educate about and promote proper child safety restraint usage, parallel efforts with mothers of young children will have a reinforcing effect and will optimize the efforts. Strategy VIb1 will include activities to incorporate parental use of seatbelts into ECCS and N-MIECHV education. Strategy VIb2 will include action steps to participate in ongoing planning for road safety as part of the Drive Smart Nebraska Coaltion.

VII. Access to Preventive and Early Intervention Mental Health Services for Children - State Priority #9

The issue brief developed by Nebraska stakeholders that informed the needs assessment process regarding this issue emphasized the critical nature of early childhood mental health, or social-emotional development of young children. The issue brief described the importance of a young child's capacity to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and experience other learning activities within the context of the family, community, and culture. The stakeholders pointed out the increasing recognition that healthy social-emotional development in the early years is especially important for positive social relationships and overall health and mental health later in life.

Nebraska's Title V staff have had extensive experience in the area of early childhood mental health and have led a number of initiatives directly or through closely associated programs, such as N-MIECHV and ECCS. N-MIECHV has worked to identify and strengthen community-level referral networks for families needing mental health and related supportive services. It has trained home visitors on related topics, such as trauma informed care. Nebraska's ECCS project, known as Together for Kids and Families, has supported collaborative planning and systems development around early childhood mental health for over ten years. An example of this work is "Nebraska's Early Childhood Integrated Skills and Competencies for Professionals," most recently revised in collaboration with N-MIECHV and other early childhood stakeholders: (http://dhhs.ne.gov/publichealth/TFKF/Documents/Nebraska's_Early_Childhood_Integrated_Skills_and_Competenci Indicators_and_Self-Assessment-2015Final.pdf). Over the past 2 years, Nebraska's ECCS project has focused on the HRSA delineated component on the mitigation of toxic stress in children 0 -3. Accomplishments include the development of a strategic plan, selection of a screening tool, and building provider capacity to screen.

System collaborations are well established. The Maternal Child Adolescent Health Program Manager is an active member of the Division of Behavioral Health's committee developing a plan for a children's behavioral health system of care. And the Title V/MCH Director is a co-lead for implementing an objective in the State Health Improvement Plan for the integration of behavioral health and public health. And the ECCS mental health workgroup continues to be active (see its most recent work plan at http://dhhs.ne.gov/publichealth/TFKF/Documents/MH-WorkPlan.pdf). Nebraska Title V and its partners are thus well positioned to address this priority need.

It should be noted that an interim Legislative study (LR 304) has been proposed for 2015-2016 to study and assess the behavioral health needs of children and youth in Nebraska and the resources available to meet those needs. Title V staff will monitor the status of this study and contribute information as requested and in accordance with agency protocol. Study findings will be considered as applicable in developing strategies for 2017.

Proposed Objectives and strategies

Objective VIIa. By 2020, increase by 10% the percentage of young children aged 0-3 years receiving age-appropriate social and emotional development screening through EPSDT/Medicaid.

As stated above, Nebraska Title V has well established working relationships in the area of children's behavioral health. Strategies VIIa1 and VIIa2 will build on activities currently underway. The Division of Behavioral Health's implementation plan for a System of Care (SOC) is near final, and a Title V staff member is part of the steering committee responsible for guiding this effort. Activities proposed to be carried out under the SOC implementation plan include establishment of Youth and Family Advisory Councils and cross-cutting work teams to address a number of system level issues such as training, quality improvement, and the potential for braided funding. Work started through the ECCS project to increase social-emotional screening of young children by Medicaid Managed Care Providers will continue in 2016, as an integrated ECCS/Title V effort to move from concepts to concrete action steps. A new ECCS program coordinator will start full time in August 2015, and as part of the Maternal Child Adolescent team, will provide the logistical facilitation needed to move this strategy forward.

Strategy VIa3 recognizes the ongoing role of N-MIECHV in screening and referring young children with social-emotional development needs. Again, with N-MIECHV a part of Maternal Child Adolescent Health, these efforts will be guided by Title V staff and integrated into larger Title V efforts.

Strategy VIIa4 will connect social-emotional development activities for young children with a mental well-being in pregnancy project. Healthy social-emotional development of young children must consider the mother/infant dyad. Education for women and providers on pregnancy related depression and other maternal behavioral health needs will thus include complementary messages on the impact of the mother's mental health on the healthy infant development.

Again building on ECCS activities, Strategy VIIa5 will include action steps to engage providers in use of evidence-based screening tools. During 2015, an ECCS subcommittee examined 26 screeners and selected the Survey of Wellbeing of Young Children (SWYC) as the recommended tool. The current usage of this particular tool and other tools by providers will be assessed, and a determination made on the viability of promoting SWYC within clinical and early childhood care and education settings. This assessment will also examine cultural and linguistic appropriateness of existing screening and associated services, so as to incorporate CLAS standards into this strategy.

Objective VIIb. By 2020, increase delivery of professional development to health care professionals by 10% on topics related to maternal and child mental/behavioral health.

During 2015, the Divisions of Behavioral Health, Public Health, and Children & Family Services executed a contract with the Behavioral Health Education Center of Nebraska. This contract provides for the development of curricula and other resources for Trauma Informed Care training. Again, Title V staff (Maternal Child Adolescent Health Program Manager) has participated in a steering committee guiding this work. As the curricula and associated resources are developed, Title V staff will facilitate its delivery to MCH and CSHCN providers (Strategy VIIb1). Title V, through its Maternal Infant Health program, will sponsor a Maternal Behavioral Health conference in 2016, including presentations highlighting the significance of the infant/mother dyad. Strategy VIIb2 will thus continue to build greater awareness of the continuum of behavioral services for women and for their children.

Objective VIIc. By 2020, the behavioral health system of care approach will increase access to integrated behavioral health/primary health services by 10%.

Strategy VIIc1 references the System of Care described under Objective VIIa, above. This effort led by the Division of Behavioral Health will provide a venue for exploring and developing action steps to better integrate behavioral health into primary care for children. Another venue is the work being carried out through the State Health Improvement Plan (SHIP), which is referenced in Strategy VIIc2. Though not specific to children's behavioral health, SHIP implementation is led by the Division of Public Health and provides a second route to accomplishing this objective. Both strategies are exploratory and developmental, but reflect where Nebraska is situated in its efforts to achieve behavioral health/primary care integration and Title V will continue to be an active player in both arenas.

Objective VIId. By 2020, increase by 10% the number of children served in a medical home.

A medical home could be considered a pre-requisite for the delivery of preventive and early intervention mental health services for children. Strategy VIId1 outlines a role for Title V to be engaged in public and private efforts to promote patient-centered medical homes. For example, LR22 is an interim Legislative study to examine medical

care transformation including the health care delivery process of patient-centered medical homes. The Nebraska Medicaid Medical Home Pilot Program (http://dhhs.ne.gov/medicaid/Pages/med_pilot_index.aspx) is informing Medicaid's role in promoting medical homes under Managed Care. Title V staff will monitor these and related activities, contribute information and resources when applicable, and identify means for further increasing access to medical homes. Included is the potential for identifying community-based MCH providers through a competitive sub-granting process to enhance local adoption and promotion of medical homes.

Child Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	114.4	112.1	109.7	107.6	105.5

CHILD HEALTH DOMAIN
Annual Report

For the purposes of organizing the annual report by population domain, in this section, Nebraska will report on accomplishments and activities in the **Child Health Domain** for the following 2014 National Performance Measures (NPM) and State Performance Measures (SPM):

NPM 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.
NPM 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 10: The rate of deaths of children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 13: Percent of children without health insurance.
NPM 14: Percentage of children, ages 2 to 5 years receiving WIC services with a BMI at or above the 85th percentile.
SPM 03: The percent of children living in poverty who have health insurance.
SPM 05: The percent of young children (1-5) who have excellent/very good dental health.

To assure that Nebraska complies with Section 505 (a)(3)(A), sub-awards of Title V funds to community based providers have been prioritized for those projects providing preventive services to children. Therefore, a range of local entities have played an important role in impacting several of these national and state performance measures. At the state level, Title V funds invested related to this domain have largely been directed to public health services and systems. Together, these investments have had an impact on the health and wellbeing of Nebraska children.

NPM 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.

Nebraska's immunization rates for the population of 19 to 35 month olds improved in 2014, from 78.5 percent to 81.3 percent, and nearly reaching the objective of 81.4 percent. Strategies to achieve this improvement are largely attributable to investments of Vaccine for Children (VFC) funds and VFC purchased vaccine. VFC is administered by the Immunization Program in the Lifespan Health Services Unit, so thus has a close organizational and collaborative relationship with Title V, also administered in this Unit. An internal allocation of Title V funds has helped support the operation of Nebraska's Immunization Information System, or NESIIS. For information on NESIIS, see http://dhhs.ne.gov/publichealth/Pages/nesiis_index.aspx. Title V thus has played a role in supporting the infrastructure necessary to provide, track, and promote childhood immunizations. This support is being phased out for 2016.

In addition, through a Tribal set-aside of Title V funds, Santee Sioux Nation provided clinical care and case management for women of childbearing age and prenatal patients at the Santee Health Clinic, and helped ensure children received immunizations on schedule.

Immunizations had not been identified as a Nebraska Title V priority in 2010, nor in the 2015 needs assessment. No new strategies are proposed for the application year.

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

Nebraska does not have a source of data for reporting progress related to this measure. Since access to oral health for children, including CSHCN, was a Title V priority identified in 2010, a SPM was chosen for which data is available on an annual basis:

SPM 05: The percent of young children (1-5) who have excellent/very good dental health.

Nebraska did not achieve its objective of 84.3% in 2014, with 81% of young children reported having excellent/very good dental health. This is a decline from the 2013 level of 82.6%.

Title V investments during 2014 included an internal allocation of funds to the Office of Oral Health and Dentistry. During this period, the new Dental Director assumed duties April 2014, providing leadership for the Office of Oral Health and Dentistry, building on existing partnerships and leveraging funding to increase availability of preventive dental services and advance oral health status. State funds support this position. The new Dental Health Coordinator assumed duties, overseeing the operations of the Office of Oral Health and Dentistry (OOHD) in February 2014. Nebraska Title V Block Grant funds supported this position during this period.

The Coordinator submitted a proposal to the NE Preventive Health and Health Services (PHHS) Block Grant for funding to support local oral health preventive programs targeting children and the development of an Oral Health Surveillance System in March 2014. The PHHS Block Grant funding was awarded to the OOHD. The Coordinator then wrote, released, and conducted a Request for Applications Process for the Oral Health Access for Young Children (OHAYC) Program during August and September 2014. Five community programs received PHHS funding to support OHAYC activities. In September 2014 the OOHD hired an intern to assist with Oral Health Surveillance and data analysis.

The Coordinator arranged Oral Health Advisory Panel meetings and meetings with Oral Health Stakeholders across the State of Nebraska. The Stakeholder meetings served as a means for the new Dental Director and Coordinator to learn about what is currently taking place in Nebraska related to oral health.

During 2014, through a sub-award of Title V funds, Two Rivers Public Health Department Administered its Young Children Priority One Dental Program, which provided preventive dental care for young children and their families. Wrap-around services supported families with patient navigation, referrals, and education. The Young Children Priority One Dental Program at Two Rivers Public Health Department will continue with Title V support through 2016, as will a project at Public Health Solutions, which targets children ages birth to 3rd grade who have dental risk factors. Both local health departments were awarded funds for a two year period, beginning October 1, 2014, based on the Title V priorities identified in 2010. A competitive sub-award process for FFY 2017 will address the priorities identified in 2015, which did not include children's oral health.

Title V support for NE DHHS's Office of Oral Health and Dentistry has been phased out, in part due to the change in Title V priorities, and in part due to recent appropriations of State General Funds for the Office. Title V staff will continue collaborative relationships with the Office, through the work of the School Health Nurse Consultant and the ECCS program.

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

Nebraska surpassed its objective of 2.1 deaths per 100,000 children for this measure, with 1.9 deaths per 100,000 children occurring in 2014. This compares to 2.1 in 2013.

Childhood injuries and deaths resulting from motor vehicle crashes was not a priority identified through the needs assessment completed in 2010. Consequently, the major strategies to impact this measure during 2014 were supported and carried out through other grant programs. The Injury Prevention Program and Safe Kids Nebraska coordinates and supports child passenger safety activities across Nebraska. Safe Kids Nebraska funds the purchase of car seats for about 12 car seat check events a year. They partner with the Nebraska Office of Highway Safety (NOHS) to conduct a minimum of 4 Child Passenger Safety Technician (CPST) training courses and also organize a yearly CPST update attended by about 165 CPST. SK NE provides on going technical assistance to the more than 325 CPSTs across the state. SKNE also coordinates the SK NE Child Care Transportation Training which is a mandatory training for child care providers who transport children.

Title V staff have played a collaborative role with the Injury Prevention Program, including participating in the development and implementation of the Drive Smart Nebraska Coalition's strategic plan (http://dhhs.ne.gov/PublicHealth/InjuryPrevention/Pages/MotorVehicle.aspx). With unintentional injury among children and youth, including motor vehicle crashes, identified as a priority in 2015, Title V involvement with this coalition will be expanded and additional strategies developed for 2016. See the Annual Plan for this domain.

NPM 13: Percent of children without health insurance.
SPM 03: The percent of children living in poverty who have health insurance.

In 2010, Nebraska identified "reduce the impact of poverty on infants/children including food insecurity" as a priority. SPM 03 was chosen to better reflect impacts of poverty on children than that of NPM 13. Nebraska has shown improvements in both measures. For NPM 13, the percent of children without health insurance dropped to 9.1 in 2014, from 15.7 in 2013 and surpassing the objective of 15.4. For SPM 03, the percent of children living in poverty who had health insurance increased to 96.7 in 2014, from 89% in 2013 and again surpassing the objective, which was set at 90.8%.

An assumption that could be made is that implementation of the ACA health exchanges in FFY 2014 was a contributing factor to the improved rates of coverage, as well as individual mandates and elimination of pre-existing conditions as a barrier to coverage. Title V's role would have been limited to referrals and education provided though the Medically Handicapped Children's Program and Title V sub-recipient projects.

But despite the higher level of insurance coverage, stakeholders in 2015 identified a number of issues related to adequacy of the coverage, and accessing and utilizing services even when covered. In response to these issues identified by stakeholders across a number of domains (CSHCN, Children, Perinatal/Infants, and Women) and priorities, access to and utilization of health care was identified as requiring Cross Cutting strategies. See the Plan for the Application Year for that domain.

NPM 14: Percentage of children, ages 2 to 5 years receiving WIC services with a BMI at or above the 85th percentile.

During 2014, Nebraska saw little change in this measure, with 30.4% of children at or above the 85th percentile, compared to 30.7% in 2013 and an objective set at 30.1%. Using WIC data for this measure will inherently limit the degree of change in this measure since overweight is among the nutritional risk criteria for eligibility, and thus overweight children continually enter into the program.

"Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight" was identified as a Title V priority in 2010. Community based projects addressing healthy weight for children were awarded Title V funds in 2014. These included:

- Four Corners Health Department, for nutrition and physical activities focused on childcare sites and community events to emphasize healthy lifestyle habits in families with the goal that children enter Kindergarten at a healthier weight.
- Lincoln Lancaster County Health Department, for an expansion of 'A Family Approach to Prevention of Childhood Obesity' project that utilized existing partnerships and developed new ones to reduce childhood obesity in four focus areas.

Title V staff also engaged in infrastructure building to promote healthy weight in young children. Among these was the leadership of the Title V/MCH Director in the development of nutrition and physical activity standards for Nebraska's Quality Rating and Improvement System for child care. The Step Up to Quality Child Care act was passed by the Nebraska Legislature in 2013 (http://www.education.ne.gov/StepUpToQuality/index.html). Implementation planning began in 2013 and continued into 2014, with implementation on July 1, 2014. The Title V/MCH Director led a work group that identified Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) as an evidence-based program to measure best practices in the areas of child nutrition and physical activity, and assisted with incorporating NAP SACC into the standards.

Though not directly related to the age group specified in this NPM, Title V, through the School Health Program, coordinated the development of school health screening regulations to include height, weight and BMI measurements. These regulations went into effect for the 2014 -2015 school year. The School Health Program also facilitated the collection and analysis of voluntarily submitted BMI data from schools, to update a report from 2010. The new report is in the final stages of editing and not yet published. To see the 2010 report, see http://dhhs.ne.gov/publichealth/Documents/2010-2011YouthBMISurveillanceProjectReport.pdf. These activities again illustrate the infrastructure building supported by Title V related to childhood overweight/obesity, nutrition and physical activity.

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State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes (VI and X)	Xa. By 2020, decrease youth (age 10 – 16 years) injury due to motor vehicle crashes by 10% through increased seat belt use and decreased distracted driving, and recognizing risks of night/drowsy driving, speed, and alcohol use.	Xa1. Develop and or adapt educational messages to increase use of seat belts, decrease distracted driving, delivered through maternal-infant health, school health program, N-MIECHV, and ECCS.Xa2. Participate in the Drive Smart Nebraska Coalition's road safety policies and activities.Xa3. Implement evidence-based teen driver safety education, targeting teens and/or parents of pre-teens and teen drivers.	Child Mortality rate, ages 1 through 9 per 100,000 Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		
8. Sexually Transmitted Disease among Youth and Women	XIa. By 2020, decrease by 10% rates of chlamydia	XIa1. Continue Wyman's Teen Outreach Program® (TOP)	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17,		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
of Child Bearing Age (II and XI)	among Nebraska youth. XIb. By 2020, increase by 10% adolescent use of preventive health care services. XIc. By 2020, Nebraska will implement a strategic plan for preconception health, with data collection, evaluation and quality improvement practices in place.	as an evidence based practice for engagement with and support of adolescents.XIa2. Reproductive Health Program to increase STD screening and follow-up services. Assure implementation of CLAS standards. XIa3. Monitor local implementation projects to identify effective strategies replicable statewide to reduce STD. XIb1. Implement tools and strategies developed through MCH Workforce Development Center Project - Young Adults in Health Transformation XIb2. Continue TOP as an evidence based practice for engagement with	Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents,	with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		and support of adolescents. XIb3. Implement a quality improvement project with Nebraska School Nurses to investigate impact of school nurses on preventive health care utilization by youth. XIb4. Develop preconception health strategic plan as previously described.XIb5. Promote HPV vaccination through collaborations with the Immunization Program, Comprehensive Cancer Program, Reproductive Health Program, and Every Woman Matters Program. XIc1. Cross-program strategic planning for coordinated and collaborative approaches to promoting	ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		Preconception Health.XIc2. Cross-program coordination of implementation strategies with measurable outcomes on selected target measures.				
2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity (XII)	See Cross-cutting Objectives XIIa-XIIc	See Cross-Cutting Strategies XIIa-XIIc	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

Adolescent Health

Adolescent Health - Plan for the Application Year

ADOLESCENT HEALTH DOMAIN

PLAN

Analysis of Effectiveness of Current Program Activities and Strategies

In the Adolescent Health Program, effectiveness is strong and performance measurement is improving steadily, as a result of intentional efforts to move the program solidly into evidence-based and proven programs to improve youth outcomes. The Adolescent Health program is a certified Wyman TOP® provider, and in the coming year Abstinence Education funds will go to the TOP® abstinence-only version. In addition, the Adolescent Health Program has invested in workforce development on the science of adolescent brain development and positively framed approaches to teaching about abstinence, formed an Adolescent Health Advisory Council, ventured into creative approaches to gathering a youth voice to inform program development, and made significant contributions to the Behavioral Health System of Care planning collaborative.

Another aspect of change in the Adolescent Health Program has been the cast of partners and stakeholders involved in communication and collaborations for the Adolescent Health Advisory committee, and the Behavioral Health System of Care. The Adolescent Health Program now is a sought-after partner positioned to collaborate with the Division of Children and Family Services (and reach youth in the child welfare system), the Division of Behavioral Health (and youth in the behavioral health system), the Juvenile Justice System, and the Nebraska Reproductive Health Program.

In the past year, the methods and approaches in the Adolescent Health Program have also developed and evolved. The program manager joined a team working in an intensive TA project with the Association of Maternal and Child Health Programs, to develop messaging on a life course development topic and disparities, resulting in breakthrough work still under development on Concentrated Disadvantage and Teen Pregnancy. Later, the Adolescent Health Program stepped into a co-lead role on a project with the national MCH Workforce Development Center, on Young Adults in Health Transformation, looking at utilization of preventive health services by young adults. The program manager undertakes regular professional development activities, including an upcoming multi-day course on evidence-based practice.

The Adolescent Health Program conducted a Request-for-Applications activity recently to conduct evidence-based Wyman TOP® and Wyman Abstinence-adapted TOP® programs in Nebraska. For the first time, demand far exceeded available resources. Communities are embracing TOP® and local community partners want to expand. An evidence-based model to produce positive youth development outcomes, within an abstinence framework, makes a great addition to the program menu of evidence-based programs.

In the Reproductive Health Program, adolescents are routinely served in family planning sub-recipient agencies. The Reproductive Health program is actively involved in the Douglas County-focused Adolescent Health Project sponsored by the Women's Fund of Omaha. The Reproductive Health program collaborated in the Concentrated Disadvantage project. The Reproductive Health Program, along with the Adolescent Health Program and others, will participate in the collaborative program strategic planning for preconception health described in strategies below.

Description of Plan for the Coming Year

Nebraska's Title V Needs Assessment Stakeholders selected two state priorities in the Adolescent Health Domain: **X. Unintentional Injury among children and youth, including motor vehicle crashes - State Priority #5; and XI. Sexually transmitted diseases among youth and women of childbearing age - State Priority #8.**

In the coming year, Title V priorities will take a significant shift for adolescent health, from teen pregnancy prevention, suicide prevention, and reducing underage alcohol consumption, to focus on injury prevention including motor vehicle crashes, and addressing sexually transmitted diseases with a specific effort to reduce chlamydia among African American young women.

Motor vehicle crashes are the one cause of death responsible for the loss of more young Nebraskan lives than suicide. From the perspective of life course development, the stakeholders involved in the Needs Assessment delivered not one but two state priorities on addressing the mental health and behavioral health needs of children as *early* as possible, fueling suicide prevention with early identification and early intervention. For another priority, infant abuse and neglect, stakeholders identified screening and prevention for maternal depression as an additional life course approach to improving attachment and mental wellbeing from early life.

The state priority of addressing sexually transmitted disease among youth moves the state's focus to a broader scope of sexual health for young people, targeting a specific disparity, not unlike the Adolescent Health program in

moving from teen pregnancy prevention to positive youth promotion.

Proposed Objective and Strategies

X. Unintentional Injury among youth: motor vehicle crashes - State Priority #5

According to the Nebraska Health and Human Services Vital Records, motor vehicle crashes are the leading cause of death for Nebraska teens aged 10 - 19 years. In 2102, the Nebraska death rate due to motor vehicle crashes for youth ages 10 - 19 was 15 per 100,000 youth compared to 7.8 per 100,000 youth nationally.
Stakeholders working on the Title V Needs Assessment for the Adolescent Health domain emphasized motor vehicle crashes as the primary cause of death for adolescents in Nebraska. Stakeholders were specific about concerns: not wearing seatbelts, and texting or emailing while driving. Stakeholders noted young males in Nebraska are more at risk for death or severe injury as a result of motor vehicle crashes, and also noted that race data are not reliably collected in moto vehicle crash reports in Nebraska. Stakeholders pointed to driver education in schools, and graduated drivers' license programs, as Nebraska has in place, for effective prevention approaches.

Objective Xa. By 2020, decrease youth (age 10 – 16 years) injury due to motor vehicle crashes by 10% through increased seat belt use and decreased distracted driving, and recognizing risks of night/drowsy driving, speed, and alcohol use.

In the coming period, in Strategy Xa1, Nebraska Title V will collaborate with the Nebraska Injury Prevention Program to develop and/ or adapt educational messages to increase use of seat belts and decrease distracted driving, delivered and distributed through maternal-infant health, school health program, N-MIECHV, and ECCS. The impact of such message diffusion will be assessed by followup survey with organizations agreeing to distribute the materials.

The Title V School Health Program is a regular participating member of the Drive Smart Nebraska Coalition. This group was formed as an external, independent community body in order to promote and advocate for road safety policies and activities. Through Drive Smart Nebraska, and Strategy Xa2, Title V has a presence in policy development. At present, Nebraska does not have a primary seat belt law. Data collection on distracted driving as a factor in motor vehicle crashes is not uniformly gathered or reported.

The Nebraska Injury Prevention program has begun limited implementation of school-based teen driver safety education, with promising participation and short term results. The Injury Prevention Program is seeking greater Title V leadership and investment in these efforts. On a limited scale at least, in Strategy Xa3, Title V should be involved in quality improvement approaches with the effort to reach teen drivers. In addition, advocates point to the life course impact of the driving behaviors of parents of teens. As a result, Title V will engage in related preconception- and maternal health education efforts as noted in the Child Health Domain, to influence maternal seat belt use.

XI. Sexually Transmitted Disease (STD) among youth - State Priority #8.

According to data from the DHHS Sexually Transmitted Disease Surveillance Program (2012) both chlamydia and gonorrhea rates among youth in Nebraska are lower than national rates. Nebraska's adolescent rates of gonorrhea and chlamydia have been stable since 2008. While chlamydia rates are not increasing for youth less than the age of 19, they are increasing significantly for those over the age of 20.

When Needs Assessment stakeholders tackled Adolescent Health topics, they considered sexual health, and related

risk behaviors, to be of broad and significant interest. In the issue brief produced by the stakeholder group for addressing sexually transmitted diseases, stakeholders clearly discussed concerns about teen pregnancy, yet articulated teen pregnancy not as the core problem but as a symptom of youth at risk. Stakeholders identified foster care youth as a group of particular concern, experiencing concentrated risk factors for early initiation of sexual activity. Stakeholders described how risk factors for pregnancy and STDs are found closely associated with disadvantage and adversity. Stakeholders developed their topics into a broader need for communities and systems that support the sexual health of youth, not only with pregnancy prevention, but with knowledge and information, HPV vaccination, and STD screening and treatment, delivered by compassionate, approachable, non-judgmental providers.

Proposed Objectives and Strategies

Objective XIa. By 2020, decrease by 10% rates of chlamydia among Nebraska youth.

Chlamydia rates among Nebraska youth is selected as the target objective because it is often without symptoms and as a result increased screening and treatment would be a stronger indicator of preventive health care service utilization.

In the Adolescent Health Program, the Personal Responsibility Education Program (PREP) programming addresses STD rates among young people by implementing TOP® (Wyman's Teen Outreach Program) which provides positively-framed education about birth control, STDs , values, communication and other life skills that may have an effect on STD rates. The PREP performance measures surveys ask youth about sexual intercourse, use of birth control, condoms, and abstinence from sexual intercourse. Continuing implementation of TOP evidence based programming with sub-recipient agencies is Strategy XIa1.

In the Reproductive Health Program, funds are provided for STD testing, counseling, education, and treatment, including expedited partner therapy (Strategy XIa2). All Title X sub-recipient sites screen all individuals between 15 and 25 years for chylamydia, supported by the Nebraska Infertility Prevention Project. The Reproductive Health Program implements programs and services incorporating CLAS (culturally- and linguistically-appropriate services) standards.

The Reproductive Health Program also is an active participant in the Adolescent Health Project sponsored by the Omaha Women's Fund, which seeks, among other goals, to reduce STDs among Douglas County youth, particularly young African American women. As Strategy XIa3, this is potentially a significant project to the Nebraska population, as the greatest population of African American Nebraskans reside in the greater Omaha area. Through this project participation, the Reproductive Health Program and Nebraska Title V are positioned to identify effective practices that may be adapted or replicated in other locations in the state.

Objective XIb. By 2020, increase by 10% adolescent use of preventive health care services.

Through a project with the national MCH Workforce Development Center occurring in 2015, Nebraska Title V is engaged in exploration and quality improvement around utilization of preventive health care services by MCH populations in the area of health reform or health systems transformation. As a result, in Strategy XIb1, Title V anticipates tools, strategic priorities, and recommendations developed through the project, called Young Adults in Health Transformation, that can be used to inform and advance preventive health care utilization in other MCH populations as well, including youth in need of sexual and reproductive health care services.

In the Adolescent Health Program, Nebraska will continue to fund Wyman's Teen Outreach Program as an evidence

based practice for engagement with and support of adolescents in Strategy XIb2. Through TOP, including the abstinence only adaptation, Nebraska will continue to provide positively framed education about sexual health, values, communication and life skills, through a project design that includes performance measurement.

In the Nebraska School Health Program, the state school nurse consultant will implement a plan-do-study-act quality improvement project with Nebraska School Nurses to investigate impact of school nurses on preventive health care utilization by youth, in Strategy XIb3.

Prevention health care behaviors will also be addressed in the proposed cross-program strategic planning activity for preconception health, Strategy XIb4.

A specific task-force has formed in Lifespan Health Services for the purpose of increasing rates of Human Papilloma Virus (HPV) vaccination as a life course approach to cervical cancer prevention, which constitutes Strategy XIb5. Nebraska Reproductive Health Program and the Immunization Program are currently laying the groundwork for an HPV vaccination pilot project in two Lincoln NE Title X clinics using Vaccines for Children (VfC) funds. This collaboration will cross-walk with the preconception health strategic planning and coordination effort to make best use of resources and clarity in mutual objectives.

Preventive health care behaviors will also be addressed in the proposed cross-program strategic planning activity for preconception health.

Objective XIc. By 2020, Nebraska will implement a strategic plan for preconception health, with data collection, evaluation and quality improvement practices in place.

The cross-program strategic planning and coordination effort planned for Preconception Health in late 2015 in the Division of Public Health, Lifespan Health Services, will include consideration of drivers or influencers of preventive health care services, including medical care, dental care, behavioral health, prenatal care, vaccination, and sexual health.

Three supervisors, representing Reproductive Health, Maternal Child Adolescent Health, and Women's Health Initiatives in the Lifespan Health Services Unit, will plan a cross-program retreat involving 12 – 15 program-level staff with external key informants. When convened, the preconception strategic planning collaborative will work to develop a programmatic and coordinated strategic plan for promoting preconception health of both young women and young men in Nebraska, Strategy XIc1. The plan will include a consensus definition and scope. Planners will take into account priority behaviors of life course significance: intention to breastfeed, prenatal care, sexual risk taking, substance use prevention, toxic environmental exposures, use of preventive health care services, obesity and physical activity, patient satisfaction with quality, motor vehicle safety, mental health, dental health, CLAS standards, etc. In this work, project designs will include culturally and linguistically appropriate standards of communication and messaging; and meaningful consumer/community involvement.

The Preconception Health Strategic plan is intended to identify inputs and outputs of the following Title V programs in Nebraska: Reproductive Health, Maternal Infant Health, Adolescent Health, School Health, Women's Health Initiatives, Cancer and Cardiovascular Disease Prevention.

The proposed time line for the Preconception Health Strategic Planning and Implementation Project is as follows: Year 1: Complete strategic programmatic plan. Initial planning is following by at least two episodes of revisiting/updating plan by each participating program during the ensuing year.

Year 2: Plan-Do-Study-Act (PDSA) quality improvement cycles are planned and delivered in at least two program areas, to develop implementation steps
Year 3-5: Implementation of rapid cycle quality improvement collaborations specifically to increase access to prenatal care in the first trimester of pregnancy (particularly among Native American and women under 20), decrease STDs, and/or improve seat belt use among adolescents or women. Strategy XIc2 serves as a placeholder for implementation, data collection, quality improvement, and evaluation activities that will take place subsequent to the plan.

Adolescent Health - Annual Report

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	114.4	112.1	109.7	107.6	105.5

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33	33.6	34.3	34.9	35.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.1	86.8	88.5	90.3	92.1

ADOLESCENT HEALTH DOMAIN
Annual Report

In the Adolescent Health domain, for the purposes of the 2015 Annual Report, Nebraska reports on the following 2014 National Performance Measures (NPM) and State Performance Measure (SPM):

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
SPM 7: Percent of teens who report use of alcohol in the last 30 days.

In Nebraska, as elsewhere in the nation, teen births have been declining, although this has not affected all racial/ethnic or economic groups equally. Sadly, the rate of youth suicide in Nebraska continues to inch upward, as

Nebraska enters its second cycle of Garrett Lee Smith funds for a five-year prevention project focusing on suicide risk among youth and young adults. Binge drinking among youth, while reported as slightly declining, continues to shock communities with tragedy when a young person dies or kills another and underage alcohol intoxication is involved.

In Nebraska Title V, the past year has been one of transformation in the Adolescent Health Program. The scope of program activities evolved from teen pregnancy prevention to a far broader and collaborative scope of positive youth development, and to served a population of more diverse and at-risk youth, as well reaching significant numbers of youth-serving workers with professional development activities.

The Nebraska Adolescent Health Advisory Council formed. A series of focus groups with young people statewide were completed with a report developed for use by the program and the Council.

Several significant workforce development activities have been developed and offered by the Adolescent Health Program, large statewide conference events for multidisciplinary youth-serving audiences in Nebraska (Understanding Adolescence with the State Adolescent Health Resource Center; Making Sense of Abstinence with the Center for Sex Education; Healthy Youth Nebraska conference). Planning and conducting these events have in themselves highly collaborative, with more diverse partners and stakeholders willingly stepping forward to help.

The Adolescent Health program became a leader in evidence-based practice and performance measurement, with Abstinence Education funds in 2015 going to the abstinence-only version of the evidence-based Teen Pregnancy Prevention Program (TOP ®) and adolescent brain development research education for the youth-serving workforce statewide.

The Adolescent Health program manager was a key participant in the Needs Assessment; in an Intensive TA project with AMCHP on messaging about diversity and life course health topics; and a co-lead on a project with the national MCH Workforce Development Center, funded by MCHB. In this project, Young Adults in Health Transformation, the project explores utilization of preventive health care services by young adults in three subpopulations (young adults with autism, young adult females with behavioral health needs, and young adults with experience in foster care). A second goal of the project is to test methods of engaging and sustaining meaningful participation by family members and young adult consumers.

Nebraska is a state with much geographic as well as racial and ethnic diversity. One county, Douglas, serving the greater Omaha area, is home to the state's majority of African American citizens. As a result, local-level projects in this single urban area provided a significant opportunity to influence disparities and inequalities for the statewide population. The Adolescent Health Project of the Women's Fund of Omaha is such as example. Individual and Community philanthropies targeting young children and adolescence are making a significant impact on life course outcomes for substantial numbers of citizens in the Omaha area, and other locations as well.

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

As noted, the rate of birth of Nebraska teenagers declined to 9.7 per 1000 teenagers, achieving and exceeding the objective of 10.8, though not equally among all racial/ethnic groups.

In the 2013 Annual Report/2014 Application, Nebraska reported on trends in developing activities in the area of preconception health, with a vision of preconception health that encompasses both young men and young women, and considers future health and well-being (and parenting) from a holistic and strengths-based perspective, that takes into account the science of normal adolescent brain development. Developments continue in the area of

strategic coordination and communication, as well as interventions, in the area of preconception health.

The Adolescent Health Program, recipient of federal PREP and AbEd funds as well as Title V support, provides increasingly visible and credible leadership in positive youth development approaches and evidence-based practice directed toward empowering youth to live goal-driven and healthy lives, with decreased teen pregnancy as a by-product, rather than a goal, of youth reaching for their full potential.

In the past year, the Adolescent Health Program has begun forming relationships and potential collaborations in the area of addressing human trafficking and exploitation. As an emerging issue in rural America, Nebraska as an interstate through-way apparently hosts serious potential as a site for human trafficking. Raising awareness of this among all audiences positioned to help is clearly necessary, and the Adolescent Health Program is positioned to help communicate key messages that human trafficking is not a problem of youth delinquency. The relationship between this crime and early initiation of sexual activity, teen pregnancy, and sexually-transmitted diseases makes identification and prevention of trafficking a mutual interest among many partners.

The Nebraska Reproductive Health Program and delegate family planning agencies in Nebraska provide an essential point of entry for youth to enter the health care system and receive preventive health care, including but not limited to contraception.

Nebraska intends to continue PREP and Abstinence Education projects as long as possible in order to bring resources into local communities for positive youth promotion. In 2015, all PREP and AbEd locally-funded sites become evidence-based in the respect of offering the Abstinence version of the evidence-based model Teen Outreach Program. In a 2015 Request for Application process conducted by the Adolescent Health Program, requests/demands for PREP funds exceeded resources available. The opportunities to reach youth through these partners are so great that the Maternal Child Adolescent Health program will support a PREP local club in the coming year.

From a lifecourse perspective, the need for preconception health activities becomes more apparent every year. Working with the CoIIN to address infant mortality in Nebraska suggests opportunities to apply the CoIIN model to social determinants of adolescent teen pregnancy, and exploring opportunities to replicate or adapt place-based interventions to impact youth.

In Nebraska, as other states, teen pregnancy has been on the decline. While racial/ethnic data are not part of the National Performance Measure, social determinants influence how the decline has or has not impacted all groups.

Important partnerships in teen pregnancy prevention are many and increasingly varied. In Nebraska, Title V is working to evolve the lifecourse topics of youth and young adults toward positive youth development, expanding the formerly narrow perspective of pregnancy prevention to a more holistic view of the lives of youth.

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

The rate of suicide among Nebraska Youth continues to increase, from 11.4 per 100,000 reported for 2013 to 11.7 for and not meeting the objective for this measure set at 11.2.. Title V has long been involved in youth suicide prevention and maternal depression awareness in Nebraska, more recently tackling toxic stress among very young children as a life course approach to improving the mental health of the MCH population in Nebraska. .

Title V participates with the Garrett Lee Smith grant award to Nebraska, the UNL Public Policy Center, and the

Nebraska State Suicide Prevention Coalition to implement the current strategic, federally-funded five year plan to address youth suicide as well as other priorities. The grant will provide training for community and child-serving systems to implement suicide prevention strategies, through a strengthened statewide infrastructure of established behavioral health regions. Training for mental health professionals will also increase capacity for receiving referrals on youth at risk of suicide or in crisis. The grant provides for replication of the LOSS team approach to suicide response and post-vention in communities, also with infrastructure support from the behavioral health regions. The grant also includes a communications campaign to raise awareness of restriction of lethal means of suicide (particularly guns and prescription medications) as a prevention approach. The grant augments a legislatively-mandated requirement for teachers and other personnel in Nebraska public schools to receive suicide prevention education on an annual basis.

Title V has been a leader advocating for evidence-based approaches in suicide prevention in the Garret Lee Smith grant including QPR (Question-Persuade-Refer) and in the Behavioral Health System of Care. Title V funding of the DHHS School Health program and state school nurse consultant allow leverage in policy-driven activities to increase suicide prevention activities in Nebraska schools. Related to suicide prevention, members of the Nebraska Title V team have been active in cross-program efforts to promote trauma-informed schools, trauma-informed child welfare services, juvenile justice, and behavioral health.

Youth suicide was not selected in 2015 as a state priority, despite its alarming significance in the minds of many youth advocates. Instead, in 2015, stakeholders selected the only other cause of death higher than suicide in the youth and young adult population in Nebraska: motor vehicle crashes. On the other hand, such a focus on motor vehicle crashes may lead to greater awareness of the possible use of a motor vehicle as a means of suicide.

Youth suicide is increasing in Nebraska, yet not enough data are available to clearly see the shape of the problem. Youth depression, youth substance use, child abuse and neglect, characteristics and experiences of home environments of at-risk youth, toxic exposures, parental characteristics, all suggest possible antecedents for the life experiences that result in suicide as well as the antecedents for disparities and inequities.

Suicide prevention is a community, systems-wide, top-to-bottom concern, and the partners working in Nebraska are many. Lead among them are the Nebraska State Suicide Prevention Coalition, the DHHS Injury Prevention program, UNL Public Policy Center, and the DHHS Division of Behavioral Health.

SPM 7: Percent of teens who report use of alcohol in the last 30 days.

The percent of teens reporting alcohol use in the last 30 days remained the same the past year, at 22.1% and not meeting the objective of 21.7%.

The DHHS School Health Program, funded by Title V, is a partner is numerous activities to promote healthy youth behaviors in schools, including the Nebraska Coordinated School Health Program. Most substance use prevention education reaching youth in Nebraska occurs in the school setting, through school-delivered or school-sponsored prevention education campaigns and curricula.

The Adolescent Health Program participates in the delivery of workforce development education to teachers and other youth-services workers to address positive youth development through the formation of authentic relationships with trusted adults, role modeling, goal-setting, and personal development.

Data for this State Performance Measure are derived from the Youth Risk Behavior Survey, administered on an every-other-year basis. While alcohol use by youth has long been a concern in Nebraska, emerging is a trend toward increasing use of prescription medications, indiscriminately in combination or with alcohol, and the so-called marijuana synthetic products of unknown and variable, and toxic, origin.

State Action Plan Table					
Children with Special Health Care Needs					
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ES**
4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (VIII)	VIIIa. By 2020, increase CYSHCN family and consumer involvement in Medicaid Managed Care for Behavioral Health and the Behavioral Health System of Care VIIIb. By 2020, address workforce needs in primary care, behavioral health, and early care and education, on serving CYSHCN and their families to promote optimal inclusion in early identification/early intervention services for mental/developmental/behavioral health needs VIIIc. By 2020, increase by 10% the percentage of CYSHCN receiving age-appropriate social and emotional development screening by a qualified provider. VIIId. By 2020, increase the number and percentage of CYSCHN (2-17) who received all the mental health care or counseling they needed	VIIIa. Title V advances family and consumer involvement in activities with behavioral health. VIIIb1. Collect data on mental health and behavioral health issues experienced by children birth to age 5.VIIIb2. Workforce development activities on identification of mental health/behavioral health co-morbidities in CYSHCN, CLAS standards, and accessing early interventions and therapies needed as early as possible. VIIIb3. Collaborate with Division of Behavioral Health and University of Nebraska Medical Center- Munroe Meyer Institute (UNMC-MMI) for training and mentoring of primary care providers. VIIIc1. Support early detection efforts through local family physicians, evidence-based home visiting, community support			

State Action Plan Table					
Children with Special Health Care Needs					
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ES**
		groups, and schools; offer education opportunities for parents. Identify provider resource information VIIIc2. Promote developmental screening in the pediatric medical home. (ECCS/Medicaid collaboration).			
		VIIId1. Collaborate with the Division of Behavioral Health System of Care, Magellan, and other statewide resource and referral services to identify mental health providers statewide who are skilled in the diagnosis and treatment of young children/youth and their support systems.VIIId2. Collaborate with UNMC-MMI to identify and expand innovative technological solutions to increasing availability of and access to qualified mental/behavioral health providers for children. VIIId3. Collaborate with Behavioral Health			

State Action Plan Table					
Children with Special Health Care Needs					
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ES**
		System of Care on monitoring and quality improvement activities related to the measure.			
10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports (IX)	IXa. By 2020, increase by 10% care coordination services in medical clinics statewide for families of children with special health care needs. IXb. By 2020, increase by 10% the number and percentage of CYSHCN whose families are partners in decision making at all levels, and who are satisfied with the services they receive. IXc. By 2020, increase by 10% the number and percentage of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home. IXd. By 2020, increase by 10% the number and percentage of CYSHCN covered by health insurance.	IXa1. Utilize best practices and standards for systems of care for CYSHCN as a foundation. IXa2. Expand availability of training for families to empower them to partner with medical professionals in decision-making for the care of their CYSHCN. IXa3. Identify/disseminate target provider competencies for family-centered care coordination for families and CYSHCN IXb1. Advocate for and facilitate inclusion and involvement of families and consumers in systems development, to engage family inputs on statewide gaps and barriers to accessing quality care. IXb2. Assure CLAS standards are incorporated into care coordination and medical home	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal	Percent of children with and without special health care needs having a medical home	

State Action Plan Table					
Children with Special Health Care Needs					
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ES**
		approaches serving families. IXc1. Develop marketing and dissemination approaches for revised medical/dental home brochure in Together for Kids and Families workgroup to promote medical home approach. Include CLAS standards. Gather data on utilization and impact of information. IXc2. Promote medical home approach in N-MIECHV.IXc3. Collect data from Munroe Meyer Institute statewide genetic clinics to identify needs of families for support in establishing/accessing medical homes IXd1. Continue to promote health insurance exchange statewide as well as options to pursue Medicaid and Medically Handicapped Children's Program for special health care needs.	influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine		

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN) DOMAIN Plan for the Application Year

Analysis of Effectiveness of Current Program Activities and Strategies

Historically, Title V investments in CYSHCN in Nebraska have been in the form of support to the Medically Handicapped Children's Program (MHCP). Through this approach, children and families received continuous and coordinated care from a Social Service Worker. MHCP has established effective partnerships with the University of Nebraska Medical Center Munroe Meyer Institute and also PTI Nebraska/Family Voices. UNMC provides care coordination, specialty medical clinics, telemedicine services, and professional development for providers serving CYSHCN. PTI Nebraska/Family Voices provides a vital lifeline for families navigating school and transitions with their CYSHCN, with counseling, referral, advocacy, and family-centered educational services statewide.

Nebraska Title V invests in how CYSCHN are served by the school system in Nebraska, with the DHHS School Health Program and State School Nurse Consultant providing extensive technical assistance, consultation, and professional development for school nurses and school administrators on meeting the medical, learning, and social-developmental needs of CYSCHN in the school environment. Nebraska's School Health Program Manager has participated in the past year in a multistate project to develop the individualized health care planning process for children with special needs at school.

In the past two years, Nebraska Title V has been very involved in this state's Behavioral Health System of Care planning, which has been instructive in the number of family members and consumers who have been engaged, have been vocal about feeling dissatisfied and disenfranchised, and the commitment of systems partners to honor family voices and continue to pursue change and greater responsiveness.

In the Title V Needs Assessment process, stakeholders spoke clearly of the needs families have for advocacy, education, empowerment, and support as they navigate the service array over years and transitions with their children with special health care needs, particularly under the duress of co-occurring conditions and morbidities. Advocates desire more robust investment in the role of families in making decisions and lives for their CYSHCN, and their needs for the means (insurance) and support to carry out their roles. In particular, the stakeholders spoke of the need to better identify and address mental health and behavioral needs among CYSHCN that may occur or emerge as co-morbidities, as early in the child's life as possible.

With this plan, Nebraska Title V moves not only to continue these important infrastructure investments, but also to become more active in strategies to:

- promote greater involvement and partnership between families and systems/providers;
- increase awareness and competence of the community health and health care professionals regarding mental health and behavioral health issues of the MCH population in Nebraska;
- increase the level of developmental screening in primary care settings for young children; and
- engage with Medicaid partners to impact the percentage of CYSHCN with mental health or behavioral health needs who receive the care needed.

In planning and implementing approaches to improve systems and services for CYSHCN, Nebraska Title V will make use of "Standards for Systems of Care for Children and Youth with Special Health Care Needs,' (retrieved

6/30/2015) http://www.amchp.org/AboutAMCHP/Newsletters/member-briefs/Documents/Standards%20Charts%20FINAL.pdf
Several of the System Principles, Standards and Quality Measures align closely with selected Nebraska State Priorities. These are discussed in more detail below.

Description of Plan for Coming Year for CYSHCN
In the Nebraska Needs Assessment process, two state priorities were selected in the population domain of Children and Youth with Special Health Care Needs (CYSHCN).

VIII. Mental and Behavioral Health Needs of Children and Youth with Special Health Care Needs (CYSHCN) – State Priority #4.
IX. Medical Home for CYSHCN, including empowerment of families to partner in decision making and access to additional family supports - State Priority #10.
The following narrative summaries, for each priority, stakeholder findings and emphasis in the Needs Assessment process, and the strategies as found in the State Action Plan Table.

Nebraska State Action Plan:
Almost 20% of CYSHCN do not receive all the mental health services they needed. Stakeholders for CYSHCN clearly saw the need for improved services. The group identified the value and feasibility of increasing developmental screening for all children, and particularly discussed how improved screening might promote the early identification of autism, ADHS, anxiety, and other co-occurring disorders that may emerge as co-morbidities. The stakeholder group also spoke to the need to improve awareness, knowledge, and competencies related to early identification and effective, sensitive, family communication, statewide.

Infusing all discussions of priorities in this population was a profound emphasis on Family Support, through the provision of evidence-based parenting education and supports; through effective care coordination and communication services sensitive to the life experiences of CYSHCN and their families; and with training, advocacy, inclusion, and empowerment for families themselves.

Proposed Objectives and Strategies

Objective VIIIa. By 2020, increase CYSHCN family and consumer involvement in communication with Medicaid Managed Care and Behavioral Health System of Care.

In Strategy VIIIa1, Nebraska Title V will continue to work within the Behavioral Health System of Care Project Management Team to promote family and consumer involvement in developing effective systemic approaches to meet CYSHCN and family needs. This is accomplished through such approaches as proactively speaking with meeting organizers about family inclusion and collaboration with Family Voices and the Family to Family Health Education Center.

Soon, Nebraska will be implementing managed care in its long-term service and support programs, and this will include Nebraska's medically-complex CYSHCN. Title V will strive to be at the table, with family members and consumers, to insure that the needs of CYSCHN and their families are continuously met, as the state makes more significant changes to Medicaid and Medicaid Waiver programs.

Objective VIIIb. By 2020, address workforce needs in primary care, behavioral health, and early care and education, on serving CYSHCN and their families to promote optimal inclusion in early identification/early

intervention services for mental/developmental/behavioral health needs.
With the assistance of the Medically Handicapped Children's Program, in Strategy VIIIb1, Nebraska will collect and create an aggregate data profile on the mental health and behavioral health issues experienced by children birth to age 5 as reported by parents/guardians. The purpose of such a profile, or "snapshot," will be to illustrate for Nebraska primary care providers examples of the needs of young children with special health care needs. From Medicaid Managed Care Organizations, Title V will request (through the Division of Medicaid) data and trends to identify communities or regions of the state where EPSDT screening is underutilized.

In Strategy VIIIb2, Nebraska Title V will carry out workforce development activities for primary care providers on identification of mental health/behavioral health comorbidities in CYSHCN, and accessing early interventions and therapies needed as early as possible. The delivery of resource information and education for families will be emphasized. The Division of Behavioral Health and University of Nebraska Medical Center-Munroe Meyer Institute (UNMC-MMI), and the UNMC Behavioral Health Education Center all will be important partners for training and mentoring (Strategy VIIIb3).

Stakeholders have provided additional priorities for training. Training on fetal alcohol syndrome, and other genetic conditions that cause behavioral health issues in children is needed for workers in the child protective system, for families that adopt children, within the Early Development Network and services coordination system, for Access Nebraska (Medicaid) staff, and other community-level, family-serving groups. The training needs to include how prenatal exposures affect and impact brain development, how these influence mental health and also provide connections to programs that can help to treat these conditions, and also provide connections to programs that can help to treat these conditions. A training on dual diagnosis (those that have both mental health and developmental disabilities) is also needed.

Objective VIIIc. By 2020, increase by 10% the percentage of CYSHCN receiving age-appropriate social and emotional development screening by a qualified providers.

Increasing the level of accurate, age-appropriate, developmental screening is an important objective in Nebraska tied to improving early childhood outcomes, educational readiness for school, early intervention successes, as well as better meeting the needs of CYSCHN. The Early Childhood Comprehensive System grant in Nebraska provides additional momentum to Title V objectives to increase screening, as does the emphasis on periodic and accurate screening methods in MIECHV home visiting, and increasing child care providers' competencies in recognizing and addressing developmental concerns with parents. With Strategy VIIIc1,Title V supports multi-sector approaches to screening children in the venues where they live and learn, while also supports building competencies for early detection efforts through local family physicians and other primary care providers, evidence-based home visiting, early childhood education settings, community support services and schools. Aligned with ECCS in Strategy VIIIc2, Title V also supports ECCS efforts to increase screening of young children in the pediatric medical home.

Also needed are educational resources and opportunities for parents, and resource information providers can use to augment or complement communications with families about their child's needs.

Objective VIIId. By 2020, increase the number and percentage of CYSCHN (2-17) who received all the mental health care or counseling they needed.

Critical to assuring an effective screening program is the need for effective referrals and followup. Many consumers and providers are "convinced" there are inadequate treatment resources and behavioral health providers statewide. With Strategy VIIId1, and Strategy VIIId2, Title V has a responsibility to assure that providers are up-to-date on

referral resources using new and available technologies, including but not limited to telehealth consultations and the Behavioral Health Network of Care, an online provider resource, and the new web-based resources released by Magellan Behavioral Health, Nebraska's behavioral health managed care provider. Through collaboration with the Division of Behavioral Health System of Care and Magellan Behavioral Health, Title V shares mutual and reinforcing objectives to identify mental health providers statewide who are skilled in the diagnosis and treatment of young children/youth and their support systems, and to make this information available to primary care providers statewide. In collaboration with UNMC-MMI, Title V will work to identify and expand innovative technological solutions to increasing availability of and access to qualified mental/behavioral health providers for children.

In the Behavioral Health System of Care in Nebraska, Title V shares cooperative and mutually reinforcing objectives to increase the percentage of children who receive the behavioral health or mental health care need they need. As a result in the coming year, Title V will align with the BH SOC to identify shared measures for this priority objective, Strategy VIIId3.

IX. Medical Home for CYSHCN, including empowerment of families to partner in decision making and access to additional family support - State Priority #10

In Nebraska, the percent of CYSHCN served by a medical home is lower than the national average. The topic of medical home arose in several ways in the Nebraska Needs Assessment, most specifically in this priority area. Stakeholders defined the medical home approach for children, particularly for children and youth with special health care needs. The discussion and affirmation of stakeholders for medical home as a standard for quality care corresponds with work in the Early Childhood Comprehensive Systems area to advance the medical home approach. In the Needs Assessment, stakeholders particularly examined and emphasized the need for care coordination as an essential benefit needed by families of CYSHCN.

Stakeholders developed themes around medical home and disparities, noting that for some conditions, such as autism, a medical home may be especially difficult to find; poverty, lack of insurance, and race also were noted as possible barriers to accessing a medical home.

Stakeholders also emphasized the need to develop a health care workforce capable of delivering a medical home approach that truly meets the needs of families with CYSHCN. Peer or parent consultants, community health workers, family trainees through a project with UNMC/MMI all were seen as valid and vital supports for families in a medical home.

Proposed Objectives and Strategies

Objective IXa. By 2020, increase by 10% care coordination services in medical clinics statewide for families of children with special health care needs.

Nebraska Title V will implement a framework for care coordination for CYSCHN using the AMCHP Standards for Systems of Care as a starting point. Title V will assure CLAS standards are included in care coordination models for CYSCHN (Strategy IXa1). Strategies IXa2 and IXa3 provide for family training activities in collaboration with the Family to Family Health Information Center and Munroe-Meyer Institute.

Objective IXb. By 2020, increase by 10% the number and percentage of CYSHCN whose families are partners in decision making at all levels, and who are satisfied with the services they receive.

With Strategies IXb1 and IXb2, Title V will explore new and innovative approaches to advocating for, and facilitating inclusion and involvement of, families and consumers in systems development, in order to engage family inputs on

statewide gaps and barriers to accessing quality care.

To further the availability of family-centered care coordination services in health care settings serving children, Title V will partner with Medicaid to identify and disseminate provider competencies for family-centered care coordination in the medical home setting for families and CYSHCN.

Objective IXc. By 2020, increase by 10% the number and percentage of CYSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

Title V will continue to collaborate with the Division of Medicaid to establish standards for medical home approach for Medicaid Managed Care Organizations, and conduct quality improvement efforts. Title V will monitor state policy efforts by partners to identify payment systems for care coordination services in a medical home.

In Strategy IXc1, Title V will continue collaborating with Together for Kids and Families (Nebraska's Early Childhood Comprehensive Systems project) to finalize an updated medical/dental home brochure for providers and families, and develop a marketing and dissemination approach for the material. CLAS standards are included in the medical home description. The medical home approach and family-centered quality care are promoted in NMIECHV home visiting (Strategy IXc2). Title V will incorporate to the extent feasible the framework of AMCHP Standards for Systems of Care for CYSCHN as a reference in describing standards for a medical home. Munroe Meyer institute will be an important collaborator.

Objective IXd. By 2020, increase by 10% the number and percentage of CYSHCN covered by health insurance.

Medical home access requires a reliable source of ongoing coverage by insurance or other payer systems. Therefore Nebraska Title V has identified a specific objective for this priority that measures health insurance coverage.

While health care access has long been a concern of public health, in the era of the Affordable Care Act Nebraska public health has been slow to engage in dialogue and discovery about changes in the health care system. Realistically, however, the health care system has changed and continues to change, and Title V is an important agent in assuring that changes do not disadvantage the MCH population.

In Strategy IXd1, Title V will be working with partners in the CYSHCN system of care to identify strategies to increase health insurance coverage among CYSHCN families through collaboration with Medicaid, the Medically Handicapped Children's Program, large health system providers such as University of Nebraska Munroe Meyer institute and the Family to Family Health Information Center to identify messaging and educational approaches with impact to improve health insurance coverage of CYSHCN.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	51.9	53	54	55.1	56.2

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSCHN) DOMAIN
Annual Report

For the purposes of organizing the annual report by population domain, in this section, Nebraska will report on accomplishments and activities in the CYSHCN Domain the following 2014 National Performance Measures (NPM):

NPM 1: 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.

NPM 2: The percent of children with special health care needs age 0 – 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

NPM 3: The percent of children with special health care needs age 0 -18 years who receive coordinated, ongoing comprehensive care within a medical home.

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

NPM 5: Percent of children with special health care needs age 0 – 18 whose families report the community-based services systems are organized so they can use them easily.

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence.

The Nebraska Newborn Screening and Genetics Program continues to manage a growing list of mandated screening tests of newborns, with a high level of quality, efficiency, and compliance. Supported by the Nebraska Newborn Screening Advisory Committee, the program sets and maintains high standards of timely followup for screen-positive newborns.

The Nebraska Medically Handicapped Children's Program also provides Title V-funded related services and benefits programs for eligible Nebraska children. Previously housed organizationally in the Division of Medicaid and Long-term Care, the Nebraska Medically Handicapped Children's Program has relocated to the Division of Children and Family Services, still within the Department of Health and Human Services.

Also important in Maternal Child Health Bureau investments and leadership for CYSHCN families in Nebraska is the Nebraska Family to Family Health Information Center at PTI Nebraska, a parent education and advocacy organization serving the state. Activities of the Family to Family Health Information Center enhance and complement the achievement of Title V in the areas of serving CYSHCN and their families.

NPM 1: 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.

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 from Jan 1-Sept 30 2015, and added Severe Combined Immune Deficiencies October 1, 2015 for a total of 29

conditions screened.

Numbers screened can only be reported by calendar year. In 2014, 26,037 of 27,117 births reported to the Newborn Screening Program or 96% were screened. Seventy eight of the 80 babies not screened expired by 48 hours of birth. Two were lost to follow-up after statutory reporting requirements were met.

Sixty (60) 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:

Condition Screened:	**Test Positive**
Arginino Succinic Aciduria (ASA)	1
Profound Biotinidase Deficiency (BIO)	1
Partial Biotinidase Deficiency	5
Congenital Primary Hypothyroidism (CPH)	7
Congenital Hypothyroidism	9
Hypothyroidism	3
Primary Hypothyroidism (not congenital)	1
Cystic Fibrosis (CF)	8
CF Related Metabolic Syndrome (CRMS)	1
Classic Galactosemia (GAL)	2
Sickle Cell Disease	4
Sickle Hemoglobin C Disease	3
Sickle Cell Beta Thalassemia	2
Hemoglobin E Beta Thalassemia	1
Beta Thalassemia Major	1
Beta Thalassemia + Alpha Thalassemia Trait	1
Sickle Hemoglobin C Disease plus Alpha Thalassemia Major	1
Maple Syrup Urine Disease (MSUD)	1
Medium Chain Acyl Co-A Dehydrogenase Deficiency (MCAD)	1
Classical Phenylketonuria (PKU)	2
Transient Tyrosinemia (1 treated/resolved)	2
Hypertyrosinemia of Prematurity / Infancy	1
Very Long Chain Acyl Co-A Dehydrogenase Deficiency (VLCAD)	1
3-Methyl Crotonyl Carboxylase Deficiency (3-MCC)	1

Other conditions detected that are not likely to be clinically significant during infancy included 446 hemoglobinopathy and cystic fibrosis carriers.

The program also 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 re-requested proposed regulation revisions to add SCID (severe combined immune deficiency)

and received permission in December 2013 to go to public hearing. Public hearing was held in the Spring of 2014, and regulations were signed in the Summer, for an implementation date of 10/4/2014. Much preparation of screening algorithms, laboratory result report language, physician ACT sheets, parent information sheets, and an update of the Parent's Guide to Your Baby's Newborn Screening were completed before implementation.

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 recommendations.
A primary activity in 2014 was the development of a new procedure for monitoring quality parameters in hospitals, and reporting to Acute Facility Licensing when hospitals are repeatedly out of compliance with state newborn screening regulations. The development of the policy and procedure was concurrent with revision of the QA benchmarks around timeliness of screening and other measures such as specimen quality. The program invited participation from all hospitals and received input from a stakeholder group of 16 individuals from 13 facilities. The NBS Advisory Committee also played an important role in shaping the new reports and procedure. The NBS Advisory Committee membership includes family members and consumers.

In addition to the educational efforts around SCID described above, the program continued to provide all hospitals with parent education brochures, a special brochure on early discharge; introductory one-page parent information sheet to prenatal and OB/GYN care and education providers; and updated the web site with a link to the "Baby's First Test" web-site's parent education video.

NPM 2: The percent of children with special health care needs age 0 – 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

MHCP served medically and financially eligible CYSHCN for specialized diagnoses including but not limited to cerebral palsy, diabetes, cleft lip and palate, asthma, cystic fibrosis, as well as heart, hearing, orthopedic, neurological and eye disorders. Eligible children were also served at the MHCP-sponsored Craniofacial and Specialty Clinics for Children and Youth (SCCY) Team clinics where parents/guardians are integral decision makers for planning/pursuing the child's treatment plan recommendations. Parents/guardians are empowered to ask questions and select medical providers. Clinic reports are made available to the parents and the child's health care providers to assist with Individualized Medical Treatment Plan (IMTP) follow through. Whether the family is seeking pharmacy options or community/educational supports, referral options are shared by the Social Service Workers (SSW). SSW continued to provide support to families with CYSHCN eligible for Medicaid, coordinating the child's health care through the selected Medicaid Managed Care Plan primary care physician.

Medical clinics, including Specialty Clinics for Children and Youth (SCCY) and Craniofacial Clinics, were held statewide to provide teams of medical professionals to assess the medical issues and provide treatment recommendations. Parents/guardians make the final decisions about their children's care and select the medical professionals to implement the treatment recommendations. These services are further enhanced by a contractual relationship between the University of Nebraska Medical Center and Division of Children and Family Services, helping support the statewide clinics as well as telehealth options.

The Family to Family Health Information Center at PTI Nebraska provided information and training for family decision making in 1-1 contacts with families (195 in grant year 2014-15), and professionals (69 in grant year 2014-15), and in trainings statewide (480 people in trainings that discuss families partnering in decision making at all levels in grant year 2014-15). Families recognize the experience of staff at PTI Nebraska who are and have raised their own children using the information and empowerment of the techniques shared with families of newly diagnosed CSHCN.

There are many important partners in Nebraska working together to address the concerns and well-being of CYSHCN families. PTI Nebraska, ECICC, and UNMC Monroe Meyer are among these partners. The Department of Education, the Early Childhood Comprehensive Systems organization Together for Kids and Families, the School Health Program, as well as family and consumer organizations are all important parts of the system of care for children and youth with special needs in Nebraska.

NPM 3: The percent of children with special health care needs age 0 -18 years who receive coordinated, ongoing comprehensive care within a medical home.

The expansion of Medicaid Managed Care Organizations (MCO) in Nebraska has resulted in families being required to have a medical home, and the MCO assists with care coordination for families. In the Medically Handicapped Children's Program, Social Service Workers (SSW) assisted enrolled clients with care coordination and helped families identify medical homes. SSW assist with obtaining medical records, clinic team coordination, and keep the primary care physicians involved and updated on clinic team recommendations. When needed, the SSW request primary care physician reports and educational information prior to clinics to help the clinic team make informed recommendations. The parents/guardians are the final decision makers on physician/provider selection and overall care for their enrolled child.

With few program exceptions, children eligible for Medicaid statewide have a designated primary care physician (PCP), and thus access to a medical home for coordination of care. For children/youth outside the Medicaid Managed Care system.

The Family to Family Health Information Center at PTI Nebraska routinely shares information with families about quality care for children and standards of a medical home practice. With Title V and the Nebraska Early Childhood Comprehensive Systems grant, Family to Family works with the Dental/Medical Home Workgroup of Together for Kids and Families to promote and advance the family-centered medical home approach in Nebraska. The Family to Family Health Information Center has provided information by 1-1 contacts to 179 families, 18 professionals and in trainings to 385 persons in grant year 2014-15 specific to quality care in a medical home approach.

In Nebraska, key partners with Title V in advancing the medical home approach through the system of health care include: the Early Childhood Comprehensive Systems grant project, Together for Kids and Families (TFKF) and the TFKF Dental/Medical Home Workgroup; Nebraska Medicaid and the system of Medicaid Managed Care Organizations in Nebraska, who have been early drivers in advancing medical home; an advisory committee formed by a Nebraska state senator to study payment approaches and performance measures to support care coordination services in the medical home approach. In Nebraska additional supporters for medical home include Head Start, and other early childhood and CYSHCN systems partners. The medical home approach is an important vehicle for advancing the concept of integrated service delivery, coordinating primary health care with behavioral health and mental health services, and dental services, as well as with community resources and services.

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Funding for children's medical needs is an ongoing challenge as treatment plan needs/recommendations and family income/resources fluctuate. In addition to determining eligibility for MHCP, Social Service Workers make need-based referrals to Medicaid, Aged and Disabled Waiver, Social Security (SSI), United Healthcare Children's Foundation, ACA navigators, community health agencies, local non-profit organizations, and pharmaceutical assistance programs among others. Hospital social workers are also tapped for resource options. Although the

ACA process has increased access to insurance coverage options, there are still children/families with no health coverage plan by choice or exemption. Of the current population, approximately 14% do not have private insurance or Medicaid benefits.

SSW refer clients, as appropriate, to the Aged and Disabled Waiver Program with the State of Nebraska. Clients who eligible for the Waiver Program are eligible for Medicaid without regard to parent income. SSW also refer families to www.healthcare.gov to check options for insurance plans that are available to the child with special healthcare needs.

Family to Family at PTI Nebraska responds to many contacts from Nebraska families about the need for private/public insurance funding to cover the costs of care. In each call Family to Family staff work intensively with families to review all aspects of information available. Staff provide trainings statewide to empower families with the information and education they need to access the services due them. Staff assist families with access to Healthcare.gov for insurance coverage, and refers families to Navigators at Community Action of Nebraska or Certified Assisters through the federally-qualified health centers in the state. Many parents and YSHCN fall into the gap that exists in because the Nebraska legislature hasn't expanded Medicaid, leaving these people without access to insurance coverage. The Family to Family Health Information Center at PTI Nebraska served 182 families, 63 professionals and trained 480 persons in grant year 2014-15 specific to adequate insurance coverage.

NPM 5: Percent of children with special health care needs age 0 – 18 whose families report the community-based services systems are organized so they can use them easily.

In the Medically Handicapped Children's Program, the Social Service Workers (SSW) provide referrals to numerous community resources and support. These include: Aged and Disabled Waiver Program, Medicaid, Respite Network, SNAP, TANF, Disabled Person's and Family Support, Lifespan Respite Subsidy, Child Care Subsidy, Early Development Network, and Developmental Disabilities Program. SSW maintain relationships and communication with referred organizations and programs to stay current on services and eligibility. Coordinated case management by Social Service Workers provided a single point of contact for Medically Handicapped Children's Program, Disabled Children's Program, and Genetically Handicapped Children's Program services. Efforts continued to enhance the access and availability for resource options. Other resources frequently accessed include the Assistive Technology Project and the League of Human Dignity. These resources provide evaluations for home and vehicular modifications for the children with special healthcare needs. Additionally, they provide the research and coordination necessary to coordinate funding streams for larger projects.

Through contractual relationships between the University of Nebraska Medical Center Monroe Meyer Institute and the Division of Children and Family Services, the Medically Handicapped Children's Program provides access to coordinated community-based services through clinics, telemedicine, special projects, and education.

At PTI Nebraska, the Family to Family Health Information Center assists families in identifying what community services are available to them and how to find such services in their communities. There are great differences in what services are available for families in urban areas and which ones might exist in rural/frontier regions of the state. For statewide programs like A&D Waiver, Medicaid, Respite Network, SNAP, TANF, DPFS, Lifespan Resptie Subsidy, Child Care Subsidy, EDN, and DDS, F2F staff assists families with applications, registrations and contact with program coordinators to ensure families can navigate the systems to get the services they are eligible for. Staff at all levels of DHHS are valuable partners with F2FatPTI Nebraska for factual information when helping families understand eligibility requirements. F2F staff had 1-1 contact with 163 families, 47 professionals regarding questions about services and provided training to 285 persons specific to community-based services and their

organized for ease of use

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence.

The Medically Handicapped Children's Program serves youth up to age 21, while Nebraska Medicaid discontinues benefits at age 19. SSW assist families whose children "age out" of Medicaid benefits but still rely on assistance for eligible specialized medical care needs. Transition into the Genetically Handicapped Children's program for age 21 was an option if the young adult had an eligible diagnosis (cystic fibrosis, hemophilia, sickle cell). For youth who aged out of the Disabled Children's Program at age 16, those with ongoing needs were referred to the LifeSpan Respite Subsidy and Disabled Persons and Family Support programs. Transition referrals were made to the ACA navigators or health insurance plan options, Social Security (SSI) to apply for adult benefits, medication assistance programs, PTI Nebraska staff and webinars, and hospital care coordinators. Staff have supported efforts to access the Affordable Health Care Act for insurance options to ensure continued coverage benefits well beyond age 21.

For individuals with a diagnosis of cystic fibrosis, hemophilia, and sickle cell disease, the Genetically Handicapped Persons' Program provides continuity of medical care coverage from age 21 forward. Social Service Workers provide information and support for individuals transitioning to the adult SSI service to ensure continued benefits, if eligible.
The MHCP clinic staff encourage participants to begin planning the change from pediatric to adult medical providers in their communities. Clinic reports were available to families to share with new providers to complete the medical history. Provider options and community resource information was made available, including supports that PTI Nebraska offers.

Transition needs may also occur as children's medical, developmental, or residential changes occur. If a family leaves the state, for example, staff provide contact information for similar services in the new location, if available.

Family to Family at PTI Nebraska offers trainings for YSHCN and their families regarding transition to adult living, learning, working and healthcare. Individual, independent skills paired with needed supports to enable young adults with special needs to be as independent as possible is difficult, scary, and confusing for families. Many systems teach families to be deficit-oriented in order to establish eligibility for adult supports like Development Disabilities Services and Supplemental Security Income, both of which is based on the adult's own income and resources. Strengths-based education for families and YSCHN can feel unfamiliar and contrary to their world view.

F2F staff guides families with information that helps them to understand the change in program eligibility criteria as the young adult comes of age, both in the federal systems and in Nebraska, inclusive of health care, education, legal, and social and community-based services. Health care providers may be lax in informing parents or individuals about their need to transition to adult services providers. Health care providers may be unfamiliar with the transition experiences of young adults with special needs. Family to Family assists with locating providers statewide, using the Nebraska Resource and Referral System (online). In the past year, Family to Family staff had 1-1 contact with 123 families, 184 self-advocates age 16-21 and 30 professionals regarding questions about services and provided training to 480 persons specific to healthcare transformation and educational transition of young adults.

State Action Plan Table						
Cross-Cutting/Life Course						

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity (XII)	XIIa By 2020, increase by 10% the number of schools participating in BMI data collection and contributing healthy weight data in the Nebraska DHHS school health data project. XIIb. By 2020, increase by 10% the place-based initiatives to increase physical activity of children, youth and women in local neighborhoods. XIIc. By 2020, increase by 10% the percent of women in active or highly active levels of recommended physical activity.	XIIa1. Through School Health Program, continue promotion of Coordinated School Health programs, and educational outreach to Nebraska school administrators. XIIa2. Collaborate with public/private partnerships to develop state-wide data collections methodologies. XIIb1. Utilize geo-mapping to identify communities/neighborhoods at greatest risk for overweight, food insecurity, and physical inactivity. XIIb2. Through School Health Program, increase school-community collaborations to promote health in children in identified communities. XIIc3. Research promising practices in place-based initiatives to promote healthy weight and address food insecurity and work with identified communities in exploring these practices for potential implementation XIIc1. Include evidence-based practices for promoting physical activity for women as feasible in preconception health strategic planning, evidence based positive youth development activities, home visiting, and parenting education.				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	XIIIa. By 2020, increase by 10% the percentage of Nebraska children and youth who are adequately insured. XIIIb. By 2020, increase by 10% the percentage of Nebraska children and youth with special health care needs who are adequately insured. XIIIc. By 2020, increase by 10% the percentage of Nebraska women of reproductive health who appropriately access well woman care	XIIIa-c1. Research state and national best practices, and brief new leadership on issues and options. Create blue print for further development of the plan. XIIIa-c2. Develop and implement incremental approaches and methods in collaboration with Medicaid, local health departments, federally qualified health centers, and others.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children without health insurance	Percent of children ages 0 through 17 who are adequately insured		

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

CROSS-CUTTING OR LIFE COURSE DOMAIN
Plan for the Application Year

Analysis of Effectiveness of Current Program Activities and Strategies

Title V activities in 2014 cannot be clearly linked to or identified with this domain, but it must be noted that the Lifespan Health Services Unit and its Title V supported programs and initiatives had been early adopters of the life course model. As a result, concepts such as social determinants of health, critical periods of development, and Adverse Childhood Experiences have influenced planning and strategy development across many programs and initiatives. Nebraska Title V will draw on this experience and apply it in carrying out strategies across all domains, as well as this one, going forward into 2016.

Description of plan for the coming year

One priority identified through the recently completed needs assessment corresponds to the Cross-Cutting or Life Course domain. As labeled in the State Action Plan Table, this priority is:

XII. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity – State Priority #2

In addition, five priorities that had been identified as applicable to other domains also had cross cutting themes which could be best addressed through integrated, system-level strategies. Therefore Nebraska's Title V Action Plan presents these integrated strategies as:

XIII. Access to and utilization of health care as it relates to State Priorities #4, #6, #8, #9 and #10

The following narrative summarizes for each priority the stakeholder findings identified through the needs assessment and then elaborates on the strategies listed in the State Action Plan Table.

Nebraska State Action Plan:

XII. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity – State Priority #2

As part of the needs assessment process, stakeholder work groups independently reviewed data related to overweight and obesity for women, youth, and children, and each brought forward this issue as a priority for its population of interest. The decision to combine into one, cross-cutting priority was based on the similar issues contributing to the problem across populations (particularly physical inactivity), and the lack of progress in reducing rates of overweight and obesity in each of the populations.

Stakeholders were also very clear in considering overweight and obesity as a life course issue. In their issue brief titled "Overweight and Obesity, Food Insecurity and Physical Inactivity in Nebraska Children," the children's stakeholder group noted that obesity, food insecurity, and physical inactivity are risk factors not only for chronic disease such as heart disease and diabetes, but also impact a child's mental and medical health, oral health, educational attainment, life expectancy, and overall life course trajectory. These stakeholders also pointed out that the Hunger-Obesity Paradigm acknowledges the important relationship between obesity and food insecurity, specifically that individuals who live in food insecure households experience hunger, leading to unhealthy eating behaviors such as feast or famine eating style, low intake of fruits and vegetables, high intake of high calorie/low nutrient dense foods and use of food as a mechanism to cope with stress. The stakeholder issue brief for

adolescents pointed out that, according to the 2012 National Survey of Children's Health, nearly 30% of Nebraska youth ages 10-17 are overweight or obese, and that studies have shown that once overweight is established during adolescence, it is likely to remain in adulthood. And finally, the women's stakeholder group noted that the weight of women entering pregnancy has important implications to both the long-term health of women and the health of infants.

Proposed Objectives and Strategies

Objective XIIa. By 2020, increase by 10% the number of schools participating in BMI data collection and contributing healthy weight data in the Nebraska DHHS school health data project.

Nebraska has collected BMI data voluntarily from schools, first in 2010 and again in 2014. The 2014 report is in the final stages of editing and not yet published. To view the 2010 report, see http://dhhs.ne.gov/publichealth/Documents/2010-2011YouthBMISurveillanceProjectReport.pdf.
This objective addresses the need to enhance this voluntary reporting system so as to have a more representative set of data on childhood overweight and obesity, which will be key to monitoring progress, evaluating strategies, and supporting community-level interventions. Strategy XIIa1 will be carried out through the Title V supported School Health Program and will include education to Nebraska school administrators on the importance of monitoring BMI in school children and the usefulness of the data in developing local level programs and strategies for the populations of children enrolled in their schools.
Strategy XIIa2 acknowledges the work that has and is expected to continue to occur in the Legislature, within education organizations, and among other interested community stakeholders. The School Health Program will monitor these activities as they unfold, provide information as applicable, and perform the role of liaison with Division of Public Health leadership.

Objective XIIb. By 2020, increase by 10% the place-based initiatives to increase physical activity of children, youth and women in local neighborhoods.

This is the truly cross-cutting, life course objective related to the priority need of overweight and obesity among women, youth and children. It will press Nebraska Title V staff and stakeholders to tackle the social determinants of health contributing to overweight across MCH populations and to do so within the neighborhoods and communities at greatest risk. Strategy XIIb1 will involve use of geo-mapping to identify communities at greatest risk. The most significant challenge in carrying out this strategy is to identify the relevant indicators that are available at the community level (zip code, census tract, county, etc.). Once the methodology is established and the communities identified, the remaining strategies for 2016 and those to be planned for 2017 can be appropriately targeted.
Strategy XIIb2 action steps will be made through the School Health Program. Utilizing information on most at-risk communities as identified in the previous strategy, the School Health Nurse Consultant will engage schools in those communities to form collaborations with other local entities, such as local health departments, YMCAs, community centers, and Cooperative Extension. Strategy XIIc3 has two major actions steps. The first is to research promising practices in place-based initiatives to promote healthy weight and address food insecurity. With this knowledge, Nebraska Title V funds will be made available as sub-awards to competitively selected providers in the identified communities to implement those practices most appropriate for the community and its MCH population.

In addition, during 2016, competitive sub-awards made for the two year period of October 2014 to September 2016 will continue. A number of the projects supported through these sub-awards have already established many features of place-based strategies. These projects include:

- Alegent Creighton Health *dba* CHI Health is using a socio-ecological approach to improving healthy habits for 5-11 year olds in Douglas, Sarpy, Cass, Colfax, and Otoe Counties using the *5-4-3-2-1 Go!*® countdown. This project has five key strategies that aim to "change the context" and make individual children's default health decisions healthier: 1) School Campaigns; 2) Out-of School Time Campaigns and organizational policy/environment change; 3) Mass Media; 4) Medical Provider consultation; and 5) Teen driven community campaigns and education.
- Lincoln-Lancaster County Health Department has also implemented a *5-4-3-2-1 Go!*® Initiative which has a significant reach in Lincoln with over 30 community-based partners' efforts disseminating and integrating the message through community organizations, pediatrician offices, schools, faith communities, media campaigns, and others. The initiative targets toddlers through elementary school age or from about 2 – 11 years of age.
- East Central District Health Department's project, Healthy Eating and Active Lifestyles to Help Youth (HEALTHY), is working with the Nebraska Department of Education (NDE) and six local schools within the four county district to reach youth ages 5-14 through the development and implementation of Coordinated School Health Plans which was a new endeavor for the health district. The ECDHD HEALTHY project is also reaching children one year to five years of age by building on previous relationships and extending current programs and offering new strategies to day care providers, day care centers and preschools, bringing two evidence-based programs to this age youth, Go NAP SACC (Nutrition and Physical Activity Self-Assessment for Child Care) and LANA (Learning About Nutrition through Activities).
- Four Corners Health Department's Early Childhood Health project works toward the goal that children will enter Kindergarten at a healthier weight. Local partners, such as child care providers and local businesses, are key to achieving the outcomes. The selected interventions promote physical activity and better nutrition in children 5 and younger through programs, such as Nutrition and Physical Activity Self-Assessment for Child Care, and Choosy Kids. Activities at Farmers' Markets, grocery stores, and community events promote healthier home environments and family habits. The health of families will be approached also through worksites, including activities that encourage area businesses to become breastfeeding friendly.
- North Central District Health Department's project, titled "Healthy Habits 4 Little Huskers" centers on implementing the evidence-based Go Nutrition and Physical Activity Self-Assessment in Child Care (NAP SACC) program for district children between one and 10 years of age in childcare settings. The NCDHD project coordinator serves as a trained Go NAP SACC consultant, assisting district childcare providers to conduct self-assessment surveys in key program areas, and providing targeted technical assistance and support as childcare providers develop and implement their action plan.
- South Heartland District Health Department's "Student Wellness Works!" project is addressing the issue of overweight in children in Adams, Clay, Nuckolls and Webster Counties. The project builds on an evidence-based Coordinated School Health (CSH) initiative started in 2014 in partnership with the NE Dept. of Education and area schools., continuing to build a culture of health improvement and facilitate implementation and evaluation of policy, systems and environment changes in the four current schools/districts (impacting 1725 students) and by providing CSH training to six additional schools or school districts.
- Three Rivers Public Health Department, through its project titled "Healthy Kids Healthy Bodies," is working with five elementary schools located in its district, in the implementation of the research based program HealthTeacher.com, an online resource that integrates health into school curriculum. HealthTeacher.com's subject material on nutrition and physical activity is being used to create the Healthy Kids Healthy Bodies focus of the project.

For all strategies under this objective, community engagement will be important. Family and youth participation in studying the data, reviewing practices, and designing local projects will be emphasized and supported.

Objective XIIc. By 2020, increase by 10% the percent of women in active or highly active levels of recommended physical activity.

Specific to women, the strategy addressing this objective is placed within the context of pre and inter-conception health and that physical activity is part of well-woman care. Strategy XIIc1 will include these action steps: research evidence-based practices for promoting physical activity for women and youth; incorporate these practices in preconception health strategic plan and positive youth development, home visiting, and parent supports programming. Through a competitive sub-award process, community-based providers will be identified to select and implement evidence-based practices appropriate for their populations.

XIII. Access to and utilization of health care as it relates to State Priorities #4, #6, #8, #9 and #10

These five priority needs have been separately addressed under the CYSHCN, Woman/Maternal, Adolescent, and Children's Health domains. It should be clear that Nebraska Title V is not establishing an eleventh priority, but rather is recognizing that access to and utilization of health care is in issue that needs to be addressed in a comprehensive, systematic way in order to appropriately address those five priorities, which are:

4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (CYSHCN);
6. Access to and Adequacy of Prenatal Care;
8. Sexually Transmitted Disease among Youth and Women of Child Bearing Age;
9. Access to Preventive and Early Intervention Mental Health Services for Children; and
10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports.

The stakeholders engaged in the Adolescent, Women's, CYSHCN, and Children's work groups identified a range of issues impacting access to and utilization of health care, including insurance coverage, type and cost of coverage (deductibles, co-pays, premiums, conditions and treatments not covered, etc.), availability of providers, education and language barriers, and geographic barriers. Strategies to address these issues need to be comprehensive and supported by policies and practices that cross programs and funding sources. Too often and too long, public health has "nibbled around the edges" in addressing access and utilization issues. Nebraska Title V proposes to facilitate and promote agency-level cross-cutting planning and policy development that includes Title V but goes beyond it in scope and impact.

Proposed Objectives and Strategies

Objective XIIIa. By 2020, increase by 10% the percentage of Nebraska children and youth who are adequately insured.

Objective XIIIb. By 2020, increase by 10% the percentage of Nebraska children and youth with special health care needs who are adequately insured.

Objective XIIIc. By 2020, increase by 10% the percentage of Nebraska women of reproductive health who appropriately access well woman care.

A single set of strategies are proposed for these objectives. Strategy XIII a – c 1 will include action steps to: research and document state and national best practices for improving access to and utilization of health care by

MCH and CSHCN populations; brief agency leadership on the findings; and facilitate/support the development of an agency-level blue print for implementing selected practices and policies. These activities will be carried out by Title V staff in partnership with Medicaid staff, Office of Rural Health/Primary Care staff, staff with the Office of Health Disparities and Health Equity, families, community-based providers, medical centers and universities, and third-party-payer representatives. Strategy XIII a – c 2 will move the blue print to implementation. Title V will have a variety of roles in doing so, including facilitation of work groups, community engagement, resource development, and revision/addition of programmatic policies to align service delivery with the blue print.

Cross-Cutting/Life Course - Annual Report

NPM 15 - Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.8	77.4	78.9	80.5	82.1

CROSS-CUTTING OR LIFE COURSE DOMAIN
Annual Report

All National Performance Measures (NPMs) and State Performance Measures (SPMs) for 2014 have been addressed in the Annual Report narratives for the other domains. Of those measures, the one which was most closely associated with the life course related work of Nebraska Title V was: ***SPM 03: The percent of children living in poverty who have health insurance.***

As stated earlier in the Child Health Domain, Nebraska identified “reduce the impact of poverty on infants/children including food insecurity” as a priority in 2010. SPM 03 was chosen to reflect impacts of poverty on children. Nebraska has shown improvement in this measure, with the percent of children living in poverty who had health insurance increasing to 96.7 in 2014, from 89% in 2013 and surpassing the objective, which was set at 90.8%. Again it is assumed that this improvement was likely associated with more families having health care coverage through the health care marketplaces.

During 2014, Nebraska Title V continued to build its infrastructure in support of life course strategies. Along with teams from Alaska, Arizona, Illinois, Iowa, Louisiana, Maine, and Wyoming, Nebraska completed the first round of AMCHP's Life Course Indicator Intensive Technical Assistance in February 2014. Nebraska received analytic assistance calculating a subset of the life course indicators and expert consultation to create a communications product from the results of their analysis. Nebraska’s communications product focuses on the metric of concentrated disadvantage. The communication piece is currently being piloted within selected communities. This project builds on Nebraska’s earlier work in 2013, again as one of several state teams that distilled 413 proposed indicators down to approximately 100 by assessing the indicators on three data and five life course criteria in a project sponsored by AMCHP. The final set of 59 were selected by a voting procedure at an in-person meeting in June 2013, where states discussed supporting written narratives for each indicator after consulting state expertise and the literature. Throughout July, AMCHP invited public comments on the draft final set of indicators, and these comments were used to refine and clarify the indicators.

Nebraska Title V has continuously provided leadership within Nebraska's public health community to promote the adoption of life course strategies, particularly those that address the social determinants of health. This effort can be seen in documents such as Nebraska's State Health Improvement Plan (SHIP), which may be found at http://dhhs.ne.gov/publichealth/Documents/2013%20SHIP%20Plan%20Final.pdf. See pages 12 to 14. Nebraska Title V, through its Lifespan Health Services Unit staff, continues to be actively engaged in implementing this plan.

Other Programmatic Activities

Other Programmatic Activities

Women/Maternal Health

Women's Health Initiative

Title V provides partial support to the Women's Health Initiative. Nebraska Revised Statute 71-702 created the Initiative within NE DHHS in 2000. It purpose is to 1) serve as a clearinghouse for information regarding women's health issues, 2) perform strategic planning within NE DHHS to develop department-wide plans for implementation of goals and objectives for women's health, 3) conduct department-wide policy analysis on specific women's health issues, 4) coordinate pilot projects, 5) communicate and disseminate information and perform a liaison function, 6) provide technical assistance to communities and other entities, and 7) encourage innovative responses by public and private entities addressing women's health issues.

The Initiative's program manager and staff work closely with Title V staff in planning and implementing initiatives, including Cohort 2 of the National MCH Workforce Development Center's Advancing Health Reform Implementation project. The intended purpose of Nebraska's Young Adults in Health Transformation project is to convene a group of interested partners and stakeholders to undertake a learning and message formulation project related to access to health care in the environment of health transformation, for young adults aged 20-24 years in Nebraska. The Women's Health Initiative Program Manager and Community Health Educator are participating in the focus area of young adult females with behavioral or mental health conditions (YAFBH). They will also be key partners in developing the pre- and inter-conception health plan described in the Women/Maternal Health Domain.

The Title V/MCH Director is designated in statute as a member of the Women's Health Initiative Advisory Council, thus providing an important linkage to the broader work of the Initiative. Other members are appointed by the Governor. The Council provides a unique arena for exploring the health issues of women of reproductive age and to integrate into agency level plans.

Adolescent Health

Reproductive Health

Title V funds augment Title X Family Planning funds awarded to Family Planning delegate agencies for the purposes of outreach to and community-based education for adolescents. This enabling service is a good fit for Title V by utilizing these Family Planning agencies as partners in reaching at-risk teens and connecting them to services that do address priority needs, such as STDs. Additional working relationships between Title V and the Reproductive Health Program are described in the Adolescent Health Domain.

Perinatal/Infant Health

Birth Defects Registry
Nebraska Revised Statute 71-646 created the Birth Defects Registry in 1972. Title V funds partially support the work of data collection for the registry. Birth defects data is important for the ongoing assessment of birth outcomes and factors related to infant morbidity and mortality. Birth defects registry data was utilized in the recently completed needs assessment and will continue to inform Title V's work in addressing the priority of infant mortality.

Newborn Screening
Title V is a significant source of support for Nebraska's Newborn Screening Program (NSP). Other sources include fees and state general funds. Together these financing strategies assure the detection and timely treatment to prevent the effects of conditions that are screened for, such as brain and nerve cell damage resulting in severe intellectual disability, damage to the infant or child's heart, kidney, liver, spleen, eyes, and/or hearing, problems with physical growth, stroke and infant death. Title V identifies newborn screening as an essential and foundational program related to reducing infant mortality and providing services for CSHCN through these key functions:

- Education of health care professionals and parents and efforts to increase public awareness.
- Proper and timely collection of quality specimens.
- Appropriate and timely transport of specimens to the Newborn Screening laboratory.
- Rapid quality testing methods.
- Timely notification of the infant's physician and parents.
- Timely recall of the infant for confirmatory or repeat testing.
- Appropriate referral of family to specialists for diagnosis, treatment and counseling.
- Assuring access to needed specialized services and treatment.
- Evaluation and Quality Assurance/Quality Improvement efforts.

Children's Health

Child and Maternal Death Review Team
Title V is the sole source of financing for the Nebraska Child and Maternal Death Review Team (CMDRT). It was established by the Nebraska Legislature in 1993, and charged with undertaking a comprehensive, integrated review of existing records and other information regarding each child death. Authority to conduct a similar process with maternal deaths was added in 2013, and will begin with 2014 deaths. The purpose of the CMDRT includes developing an understanding of the number and causes of child and maternal deaths, and advising the Governor, Legislature, other policymakers and the public on changes that might prevent them in the future. All deaths are reviewed, not just "suspicious" or violent ones. The team uses information in written records from state and local agencies, hospitals, private medical providers and others, along with the expertise of its members, to identify situations where, in retrospect, reasonable intervention might have prevented a death. The specific goals of these reviews are to: Identify patterns of preventable deaths; Recommend changes in system responses to deaths; Refer to law enforcement newly-suspected cases of abuse, malpractice, or homicide; and, Compile findings into reports designed to educate the public and state policymakers about child and maternal deaths.

Nebraska Title V has determined that the work of the CMDRT is essential for the ongoing assessment of child mortality. The team members represent a wide range of disciplines (neonatologists, child welfare specialists, county attorney, injury prevention specialists, community leaders, pathologists, and law enforcement). The expertise of these members provides an in-depth understanding of child mortality that is not available from data sources such a vital records.

Multiple Domains/Infrastructure

Pregnancy Risk Assessment Monitoring System (PRAMS)
Title V provides partial support to NE PRAMS. The objectives of PRAMS clearly align with those of Title V:

- Collect population-based data of high scientific quality on topics related to pregnancy and early infancy;
- Conduct comprehensive analyses in order to better understand relationships between the behaviors, attitudes, and experiences of a woman during and right after pregnancy;
- Translate results from analyses into information to be used for planning and evaluating public health programs and policy; and
- Build capacity to collect, analyze and translate data that address relevant and timely maternal and child health issues.

PRAMS is an important source of data for the Title V needs assessment, for monitoring progress over time, and for the development of targeted strategies.

Critical Partnerships

The number and range of partnerships important to the work of Title V in Nebraska would exceed page limits to thoroughly describe in this section. The following is a summary of some of the types of partnerships that are important to Title V in Nebraska.

Partnerships with other NE DHHS programs.

- With administration of Title V organizationally placed in the Lifespan Health Services Unit, collaborative planning and strategy development is carried out with WIC, Newborn Screening, Newborn Hearing Screening, Reproductive Health, Immunizations, Breast & Cervical Cancer Screening, Women's Health Initiatives, PRAMS, Child and Maternal Morality Review Team, N-MIECHV, ECCS, PREP, and Abstinence Education. Activities solely supported by Title V within the Unit include School Health and Maternal Infant Health. Working relationships with many of these programs are described throughout this application.
- Title V has ongoing working relationships with other programs in the Division of Public Health, including: Infectious Disease Program (including STD testing & treatment), Nutrition and Physical Activity, Injury Prevention, Oral Health and Dentistry, Tobacco Free Nebraska, Office or Rural Health, Office of Health Disparities and Health Equity, Developmental Disabilities Planning, Epidemiology and Informatics Unit, and Vital Records. Partnership activities include work groups implementing the State Health Improvement Plan and the Division's strategic plan, data collection and analysis, financing strategies, and community engagement activities.
- Being a part of a larger agency that includes the Divisions of Behavioral Health, Developmental Disabilities, Children and Family Services, and Medicaid and Long Term Care has fostered partnerships on topics such as trauma informed care, child abuse prevention, systems of care for children with behavioral health needs, early childhood developmental and social emotional screening, promotion of medical homes, and many others that are described throughout this application and annual report.

Partnerships with other State of Nebraska agencies.
Nebraska Title V works closely with the Department of Education in the following areas: Head Start State Collaboration, Step Up to Quality (Nebraska's child care quality rating and improvement program), Early Childhood Coordinating Council, Coordinated School Health, Part C IDEA (Early Development Network), and the Child and Adult Care Food Program. Communications and collaborations are well established and ongoing, with staff participating in each agency's projects and initiatives.

Partnerships with local health departments, federally qualified health centers, and medical centers. Title V's partnerships with this wide range of entities includes sub-grants for community-based projects, participation in the needs assessment process, participation in Nebraska's Infant Mortality CoIIN team and learning network activities, and contracted services such as support for data projects and community engagement. The University of Nebraska Medical Center and its College of Public Health have particularly extensive relationships, including contracted support for the Child and Maternal Death Review Team and staff development through projects such as the Great Plains Public Health Leadership Program. Working relationships with the Munroe Meyer Institute are described in detail in the CYSHCN domain.

Partnerships with other entities, including MCHB supported programs. Other major partnerships include ongoing working relationships with the Nebraska Children and Families Foundation (Nebraska's CB-CAP agency) in planning and strategy development in the areas of early childhood programming, child abuse prevention, and engagement with adolescents. Nebraska Title V works with the Nebraska Chapter of the AAP on a regular basis, most recently on developmental screening and mitigation of toxic stress in young children. Omaha Healthy Start representatives are members of Nebraska's Infant Morality CoIIN.

II.F.2 MCH Workforce Development and Capacity

MCH Workforce Development and Capacity

Workforce Development

Assuring the public health and primary care workforce at the community level is prepared and competent to meet the needs of Nebraska's MCH population is included in the essential functions of the Division of Public Health broadly and in Title V specifically. Workforce development is a priority of the State Health Improvement Plan, and professional development is a performance parameter for many professional staff working in MCH.

In the Maternal Child Adolescent Health program, high quality continuing education events for health professionals and youth-serving professionals are consistently undertaken throughout the year with large numbers of satisfied professionals participating. Examples include numerous child health topics offered by the school health program, adolescent health promotion and risk reduction topics, brain development topics and more. Newer to program delivery in professional development is outreach and education for lay trained community health workers, including home visitors. The N-MIECHV has significantly been expanding professional development opportunities and coordination for home visitors. All MCAH programs, to some extent, are participating in initiatives to advance integrated services provision between primary care or behavioral health, or are delivering professional development on trauma-informed care and mental health and behavioral health topics.

In the plan for the application year, numerous workforce development activities are identified related to state priorities, objectives and strategies:

I. Access to and Adequacy of Prenatal Care - assess and improve knowledge of Medicaid gatekeepers on presumptive eligibility benefits; improve practices of school nurses in promoting early prenatal care; include workforce development topics in preconception health strategic planning. (Responsible: MCH Title V partnership with state Medicaid and Managed Care Organizations)

II. Sexually Transmitted Diseases among women - increase knowledge and improve practices of work force in assisting MCH populations with health insurance navigation and enrollment. (Responsible: MCH Title V, Maternal Child Adolescent Health Program, other Lifespan Health Services Programs and Division of Public Health/DHHS, including Reproductive Health Program.)

III. Infant Mortality - increase consistency in messaging from MCH workforce on the topics of co-sleeping, breastfeeding, and safe sleep promotion. (Responsible: MCH Title V leadership, Maternal Infant Health Program, state Breastfeeding Coalition, other Division of Public Health and external partners.)

IV. Infant abuse and neglect - improve knowledge and practices in MCH workforce in assessing and addressing perinatal depression as an intergenerational life course topic of significant consequence to infant development. (Responsible: MCH Title V, Maternal Infant Health Program, DHHS partners including Behavioral Health, external partners including Behavioral Health Education Center of Nebraska.)

V. Breastfeeding - increase the community-level lactation education and support workforce, specifically with goals for American Indian and African American recruitment into breastfeeding support workforce. (Responsible: MCH Title V, Maternal Infant Health Program, DHHS partners including Office of Health Disparities and Health Equity.)

VI. Unintentional Injuries among children - build state's workforce of child safety passenger seat technicians; promote child safety education among the state's MCH workforce, particularly emphasizing impact of parent behaviors. (Responsible: DHHS Injury Prevention Program leads with MCH Title V collaboration; Title V programs active in implementation of safety messaging and education.)

VII. Access to Mental Health Services for children - increase the knowledge and practice of primary care providers in routinely screening young children for development and social and emotional stress; increase knowledge of MCH workforce on mental health and behavioral health topics of children, youth, and women of childbearing age. (Responsible: Early Childhood Comprehensive Systems lead with MCH Title V collaboration.)

VIII. Mental and Behavioral Health Needs of CYSHCN - workforce development on identification of mental health and behavioral health needs continuously through the life course of CYSHCN, screening, early intervention, and culturally and linguistically appropriate standards. (Responsible: MCH Title V leadership in partnership with Behavioral Health Education Center of Nebraska and Division of Behavioral Health.)

IX. Medical Home for CYSHCN, including empowerment and partnership of families - workforce development for providers on competencies of care coordination in the family centered medical home approach for CYSHCN; also noted here is MCH Title V involvement with other partners in training opportunities for families. The workforce development activities to improve approaches to assisting MCH populations with health insurance navigation and enrollment also are relevant here. Responsible: MCH Title V with Early Childhood Comprehensive Systems medical home project; partners including University of Nebraska Medical Center Munroe-Meyer Institute, and PTI-Nebraska Family to Family Health Information Center.)

X. Unintentional Injury among youth, including motor vehicle crashes - workforce development strategies for this state priority are intended to influence MCH programs statewide to include motor vehicle safety messaging and promotion among all clients and services. (Responsible: MCH Title V and Maternal Child Adolescent Health program.)

XI. Sexually Transmitted Diseases among youth - workforce development strategies include continuation of the current MCH Workforce Development project on health transformation and MCH populations; increasing the knowledge and practice of school nurses statewide on promoting preventive health care utilization for MCH populations. (Responsible: MCH Title V, Reproductive health program, Adolescent Health Program, School Health Program.)

In Nebraska, MCH Title V has a long history of contributing to the development of the community-based work force serving MCH populations, with the Maternal Child Adolescent Health Program alone delivering 50 or more events per year of varying size and using various media including telehealth and webinar, reaching well over 1,000 individuals annually. Other programs within NDHHS are equally active in this essential public health function. Title V consistently works to assure MCH priorities and related competencies are available to the community health work force.

Title V invests in developing and maintaining the knowledge and expertise of state MCH personnel in timely and emerging topics, in order to continue leadership for the MCH work force in relation to priorities and needed and emerging skill sets. In addition to the use of state staff experts to develop, deliver, and lead planning for high quality professional and workforce development, MCH Title V also is increasingly investing in strategic relationships with other recognized experts to future amplify delivery and penetration with traditional and non-traditional work force groups. Among these collaborations for work force development are contractual relationships with the University of Nebraska Medical Center Behavioral Health Education Center to infuse more behavioral health expertise into the public health workforce. MCH Title V increasingly collaborates with partners to improve quality practices in the work force in child care, preschool, home visiting, and school settings. Numerous new partners have come on board to broaden the scope of adolescent health from pregnancy prevention to holistic, positive youth development, and as a result work force development activities offered by the Adolescent Health Program have significantly grown in attendance by new audiences.

The explosion of science about the developing brain, and the significance of severe social and emotional stress to normal development, has significantly altered the knowledge base for child and youth development. Title V staff have been actively engaged in assimilating this information and assuring its interpretation and meaning for MCH populations in Nebraska. Life course development, continuous quality improvement methods including rapid-cycle process improvement, and the evidence-based practice movement in public health, all have significantly impacted professional development in the Nebraska Title V team. Title V staff are now certified trainers in suicide prevention, evidence-based home visiting, evidence-based teen pregnancy prevention, prematurity prevention, and breastfeeding. Identifying and addressing continuous learning needs are a common element of performance management in Nebraska Title V and professional development in new and emerging topics is encouraged.

A new opportunity and challenge in the area of workforce development in Nebraska for MCH Title V is the emerging Community Health Worker movement. Quickly gaining recognition as a function in the health care system in Nebraska, community health workers have originated in the chronic disease sector to improve outreach and screening of traditionally hard-to-reach populations, and also as "health ambassadors" to reach immigrant and non-English speaking individuals with health promotion and disease prevention information. Lay, trained, health workers in Nebraska also have expanded with the advent of evidence-based home visiting programs, further building the network and infrastructure for communication and professional development of these groups. Ahead for Nebraska are several considerations, among them providing opportunities and motivation for this emerging group of workers to build competencies to address MCH population priorities, addressing chronic disease topics from a life course perspective; identifying unique MCH inputs to contribute; and understanding and monitoring professional practice topics related to nursing, public health, and the health care system, including compensation and regulation/certification and scope of practice.

Workforce Capacity

Within NE DHHS, staffing is somewhat limited, with several professional and managerial positions responsible for multiple programs and initiatives. Building and sustaining sufficient manpower for MCH data functions in particular

has been an ongoing challenge. There has been a long-term dependence on a contractual relationship with the University of Nebraska Medical Center for a doctoral-level MCH epidemiologist. The MCH Epidemiology Surveillance Coordinator has broad responsibilities for SSDI, PRAMS, N-MIECHV, the Title V needs assessment, and cross-division initiatives within NE DHHS. Time limited contracts with various University of Nebraska programs and colleges has supplemented in-house staff support, but assuring coordinated, ongoing, high quality data functions is at times difficult.

To understand MCH workforce capacity overall, background on Nebraska's public health infrastructure is informative. In 1997, local public health departments in Nebraska served only8 of the state's 93 counties. In 1998, investments from the Robert Wood Johnson Foundation and W.K. Kellogg Foundation's Turning Point Initiative provided resources for Nebraska to develop a public health improvement plan, which enabled Nebraska to successfully advocate for funding for public health infrastructure from state tobacco settlement funds. When the state legislature passed the Nebraska Health Care Funding Act in 2001, it appropriated $5.7 million annually to establish regional public health departments throughout the state. By 2004, 16 regional public health departments covered every county in the state, providing the core functions of public health.

These local health departments, along with 7 federally qualified health centers, are the primary employers of the local MCH work force at the local level, with many staff having multiple duties beyond MCH programming. Other key employers include community action agencies, community hospitals, schools/colleges, family planning agencies, and Tribal/IHS clinics. Title V funding is awarded to Tribes and to a limited number of other sub-recipients, with Title X, WIC, MIECHV, and Medicaid reimbursement being the other primary funding sources.

II.F.3. Family Consumer Partnership

FAMILY/CONSUMER PARTNERSHIP

Nebraska Title V has historically done a great job of including families and consumers in the five-year needs assessment, particularly in the CYSHCN domain. This is facilitated in part by the fact that in the CYSHCN system of care and advocacy in Nebraska, staff represent CYSHCN families to a high proportion. As a result, these consumers are particularly well-informed and systems-savvy.

Title V participation in the 2014 Behavioral Health System of Care provided a different picture of family and consumer involvement, including approaches to engagement, pitfalls, and successes, and "lessons learned" on family engagement – and satisfaction with the process. The role *for* Nebraska Title V, to continue not only as an advocate but a supporter and facilitator, for family and consumer engagement became increasingly clear. No matter how impassioned and well-placed family and consumer input may be, it can easily be overlooked or forgotten in future meetings attended by professionals but lacking family presence. As a result, Title V is gathering an inventory of approaches presently in use in Lifespan Health Services programs to recruit and sustain engagement of MCH populations.

At the crux of building the capacity of women, children and youth, including those with SHCN, and families to be partners in decision making with Title V programs in Nebraska is how value is placed on participation, or other inputs as partners, and families and consumers are compensated for their time and expertise. When cross-sector meetings convene to address priorities of MCH populations, chances are the majority of those present are being compensated for their time and travel expenses through their work-related roles. The exception is the consumer or

family member, whose input is so valued, but is present as a volunteer. While Nebraska is a rich state precisely because of the generous spirit of its citizens, Title V is looking at models to move toward other necessary supports to build capacity for consumers and families to be true partners on equal footing with others at the table, so to speak.

In the Nebraska Adolescent Health Advisory Council, youth services providers and advocates have come from numerous community sectors previously not partnering with the program to join in a mission to inform youth-guided, at-risk youth informed, program directions. In the course of this work, members recognized they were in touch with youth populations, but wanted to include authentic youth voices in a more first-hand way. As a result, the Council worked with a local member organization to deepen understanding of youth engagement approaches (as opposed to expecting youth to attend regular meetings, sit quietly, and join "business as usual"). The Adolescent Health Program contributed to the next phase of work through a contractual relationship with the Nebraska Children and Families Foundation to conduct focus groups with youth statewide, resulting in a very informative report.

The NAHAC is an example of one model of youth or consumer engagement, where Title V invests in a contractual mechanism to engage a "broker" of youth voices. In this model, parties agree that it will be hard to sustain involvement of specific youth over a period of time, but the broker is in a position to interact with the target population directly in such a way as to gather inputs to inform specific questions or decisions a group is wishing to inform with youth voices. Youth who participate are provided an incentive to do so. Administrative and logistical costs go to the broker. An advantage of this model is the opportunity for Title V to specify the nature of at-risk youth groups who comprise the target population of interest.

Another model Title V is using to support and facilitate young adult and family/consumer involvement in project work is in a collaborative project involving the Nebraska Maternal Child Adolescent Health program and the national MCH Workforce Development Center. As described more in the following section on health reform, Title V is working in various ways to tentatively advance health reform in this deeply conservative state. Using the model of Health Transformation designed by the MCH Workforce Development Center, Nebraska Title V is experimenting with the four constructs of Access, Systems Integration, Quality Improvement, and Change Management in a project entitled "Young Adults in Health Transformation (YAHT)," which seeks approaches to increase young adult utilization of preventive health care services. As a part of this work, project leads are committed to young adult, family, and consumer involvement.

In the YAHT project, the project design identifies the involvement of young adults, sustained over the life of the project, as key to project integrity and authenticity. The Maternal Child Adolescent Health program has entered into a contractual relationship with one young adult using an expert consultant approach with agreements for participation and compensation in formal agreement. Other similarly small contracts are expected in order to facilitate participation of young adults and consumers in a variety of ways, including the broker approach to engage a group of young adults with previous experience in the foster care system in a single event approach to gathering youth voice on experiences with preventive health care services. (The YAHT project identifies three sub-populations of interest among Nebraska's young adult population: Young Adults with Autism, Young Adult Women with Behavioral Health/Reproductive Health care needs, and Young Adults with Prior Experience in the Foster Care System.)

A model used by the Behavioral Health System of Care collaborative planning activity in Nebraska in 2014 involved recruitment of family-representing advocacy organizations, representing families with experience in the behavioral health, juvenile justice, and child welfare system. These organizations, in turn, recruited membership to attend key stakeholder meetings. This resulted in interesting outcomes. Through this family advocacy organization network, participants were both vocal and ingrained with experience. Such participants also exercised their voices when dissatisfied with their involvement in systems work, and took the group to task when family input was being disregarded or minimized. The challenges of assuring family input was sustained over the period of time needed to

undertake this collaborative systems work (nearly two years) far exceeded the time frames originally posed to family and consumer participants.

Other programs with the scope of Nebraska Title V are successful at sustaining family and consumer involvement on a volunteer basis, and will continue. These include:

- The Nebraska Women's Health Advisory Council (WHAC). Created by legislative mandate in 2000, there are 20 governor-appointed positions including three consumers. One is a woman health care consumer aged 18-30 years, one a woman consumer aged 31 -40 years, and one a woman consumer aged 40- 65 years.
- The Nebraska Breast and Cervical Cancer Program works with consumers to review materials and education prior to release.
- The Nebraska Newborn Screening Advisory Committee includes four family members who provide input on policy, procedure, and quality assurance, as well as reviewing consumer materials as they are developed.
- The Newborn Hearing Screening program has strong family engagement with family members, who contribute to strategic planning, materials development, and advocacy.

As energized as these engagement efforts are in Nebraska Title V, the relative success in assuring that the most at-risk and underserved MCH populations are represented among families and consumers remains daunting. In this regard, Nebraska Title V is working on additional systemic supports to assure culturally- and linguistically-appropriate services throughout the Title V program area. For the first time, Nebraska Title V objectives and strategies, organized by a total of thirteen state priorities, including CLAS-related approaches in six significant areas: QI approaches to improving rates of developmental screening among very young children; integrated into workforce development strategies that appear in many of the state priorities; integrated into medical home approaches; in targeted STD prevention; in injury prevention activities including safe sleep; and in preconception health.

Working to promote health equity and address deep, intergenerational disparities in Nebraska involves more than working towards diversity in family/consumer engagement as partners in Title V decision-making. Also new to the Nebraska Title V application, within the framework of state priorities by population domain, explicit objective statements related to addressing disparities in the following areas: access to prenatal care in the first trimester (American Indian women); chlamydia rates among African American women; sudden unexplained infant death among American Indian and African American families; and increasing breastfeeding among African American and American Indian women.

Nebraska Title V also recognizes that family leadership, while highly valued, deserves a longer-view of empowerment that extends beyond the immediacy of incentive and travel costs. In state priorities in the population domain of CYSHCN, Nebraska Title V identifies two commitments related to developing family leadership and systemically providing a place for families to become truly embedded in the system of care, as peer consultants or family care coordinators.
In a state priority on addressing mental and behavioral health needs of children and youth with special health care needs, Nebraska identifies a specific objective of increasing CYSHCN family and consumer involvement in the behavioral health system of care and in Medicaid Managed Care. Title V will accomplish this on a small scale by specifically bringing one or more family voices into Title V-led quality improvement projects to increase developmental screening in the pediatric medical home; improve adequacy of prenatal care; and collaborate with the Behavioral Health System of Care to assure CYSHCN receive all the mental health care or counseling needed.

In a state priority on Medical Home for CYSHCN including empowerment of families to partner in decision-making, Nebraska Title V will seek approaches to expand availability of training for families to partner in decision-making

with their child's providers. This will likely occur in collaboration with other Title V partners, including the University of Nebraska Medical Center Monroe Meyer Institute, and PTI Nebraska and the Family to Families Health Information Center.

Also related to this state priority is an objective to increase family-centered care coordination services in the pediatric medical home, through systems approaches including identification of standard competencies for providers in the area of family-centered care coordination, informed by the experiences of families and consumers.

Nebraska Title V will continue to seek new opportunities to support meaningful family and consumer partnerships, participation in advisory communities, in planning, quality improvement, workforce development, when developing materials, and in the block grant review and development.

II.F.4. Health Reform

HEALTH REFORM

"Health Reform," has not been clearly defined or prescribed within the NE DHHS and has had a complicated history at the policy level. Medicaid expansion votes brought forward by the Nebraska Unicameral have failed three times. In the Division of Public Health, there has been no overarching guidance on how public health programs would address health reform and the Affordable Care Act. As a result, efforts to advance health reform *per se* have been piecemeal and low key.

On the other hand, in Nebraska as in other states, health care systems are very obviously transforming irrespective of these gaps in policy direction. Insurers both public and private, as well as hospital and health care systems, have been changing. Nebraska Medicaid has dramatically expanded Managed Care Organizations and, through the MCOs, set best practice standards for a medical home approach to deliver coordinated, comprehensive care to the state's Medicaid enrollees. Managed Care is set to further expand with an innovative approach to deliver comprehensive and coordinated services to the state's highly medically complex children. Nebraska is seeing the emergence of Accountable Care Organizations, as provided for in the ACA, changing how small town hospitals can become regional partners with clinical providers to better manage chronic disease.

Nebraska is a federal grantee of the Maternal Infant Early Childhood Home Visiting program, also established by passage of the Affordable Care Act in 2010 to improve early childhood and family outcomes through evidence-based home visiting interventions delivered to at-risk eligible families. In another new development, Title V and the Division of Public Health will be participating in the Nursing Action Coalition in Nebraska, also a product of the ACA, to promote a statewide Culture of Health.

In 2015 Nebraska Title V joined the federally-funded MCH Workforce Development Center, with the intention of evaluating the Center's four-part paradigm for Health Transformation for usefulness in Nebraska. Specifically, the project team is exploring whether addressing health reform in the following terms is useful/not useful in Nebraska:

- Health care Access
- Quality Improvement
- Systems Integration
- Change Management.

These four core principles of Health Transformation for MCH populations suggest that “health reform” is within the realm of that which is already known and understood about the work of public health in advancing access of the underserved to health care; to improve quality through performance measurement and evidence-based practice; to boldly seek approaches to integrating care for the benefit of consumer satisfaction and systems efficiencies; and managing change in the population. In the Nebraska project, Young Adults in Health Transformation, the project team not only seeks to unlock the doors to “access” in the form of health insurance coverage in the age of health reform, but also unlock the doors to “utilization” of preventive health care services by young adults.

Not specifically prompted by the Affordable Care Act but a priority that has emerged for Nebraska Title V is doing more to assure Culturally- and Linguistically-Appropriate Services standards are adopted and delivered with fidelity in Nebraska public health programs and services. Nebraska Title V, through the work of the Collaborative Improvement and Innovation Network (CoIIN) activity to reduce infant mortality, identified an interest among stakeholders in working in the area of social determinants of health. In exploring opportunities and priorities in this strategic area, stakeholders were clear in dissatisfaction over how CLAS standards are applied very inconsistently across programs and approaches. Top-level leadership in this area has been lacking, and stakeholders seek more leadership from Title V.

As a result, for the first time, Nebraska Title V objectives and strategies include CLAS-related approaches in six significant areas: QI approaches to improving rates of developmental screening among very young children; integrated into workforce development strategies that appear in many of the state priorities; integrated into medical home approaches; in targeted STD prevention; in injury prevention activities including safe sleep; and in preconception health. In addition, within the framework of state priorities by population domain, Nebraska Title V makes explicit objective statements related to addressing disparities and advancing equity in the following areas: access to prenatal care in the first trimester (American Indian women); chlamydia rates among African American women; sudden unexplained infant death among American Indian and African American families; and increasing breastfeeding among African American and American Indian women.

Moving forward, Nebraska Title V articulates a state priority that is cross-cutting across population domains involving access to health care, where access is viewed as a complex outcome of utilization behaviors, insurance eligibility and coverage, and appropriate, high-quality services. Several additional state priorities (reducing sexually transmitted disease, improving prenatal care, mental health screening and treatment, medical home approach) are also embedded with strategies to assure the target population is insured, knowledgeable about benefits, and making use of opportunities for preventive care.

II.F.5. Emerging Issues

As stated in II.A. Overview, the Nebraska Department of Health and Human Services is currently experiencing a period of significant change. Nebraska elected its first new governor in 10 years, and NE DHHS leadership has changed over the subsequent 6 months. A new Chief Executive Officer joined the agency in April 2015, and is serving as the interim Director of the Division of Public Health as a result of the previous director’s resignation in May 2015. The Division of Children and Families, the organizational home for Nebraska’s Title V/CHSHCN program, has a newly appointed director who will start work in August 2015. These changes at the organization level will likely have a number of implications for Title V that will emerge over time as new leadership becomes familiar with the needs, challenges and opportunities related to the MCH and CSHCN populations.

At the program level, Title V staff will be monitoring a number of issues that emerged as potential future priorities. The issue of human trafficking certainly is not a new issue of concern in Nebraska at the policy level, but was

expressed as a Title V concern for the first time by stakeholders participating in the 2015 needs assessment. Legislative Bill (LB) 255, signed into law in 2013, increased the penalties for pandering, solicitation, keeping a place of prostitution and for debauchery of a minor in an effort to deter individuals from engaging in these crimes. LB 255 also provided that the names of those convicted of solicitation shall be made public. LB 255 aggressively addressed sex trafficking as it relates to children, noting that the average age of entry into the commercial sex industry is 12 to 14 years old. This bill provided that a child under the age of 18 shall be immune from prosecution for prostitution and will be placed in the temporary custody of the state.

Nebraska Title V staff will monitor the data and related research on human trafficking and the impact of the policy changes made in 2013. Strategies to address the priority on STDs among women and adolescents will be modified accordingly and additional strategies developed as needed to address other adverse outcomes.

Another emerging issue pertinent to adolescents and young adults are the impacts resulting from the implementation of LB 561 in 2013. This bill transferred certain responsibilities of the Office of Juvenile Services in the NE DHHS to the Office of Probation Administration. The bill requires this office to treat and rehabilitate court involved youth as opposed to punishing them, allowing the state to assess current gaps in the system and create a continuum of care which includes diversion services, mental health treatment and reentry programming that is evidence-based. Now two years after the implementation of LB 561, stakeholders are uncertain of the impacts these changes have made on the health status of the juveniles in the court systems, particularly on various measures of health and wellbeing including access to care. Again, Title V staff will monitor the available data and modify strategies as needed.

Potentially impacting several populations and priority needs, the community health worker movement should be further explored as to its viability as a MCH/CSHCN strategy. NE DHHS has developed an online Health Navigation course designed for community health workers, as well as health navigators, social workers, nurses, advocates, survivors and other individuals interested in helping their communities. For more information on this training see http://dhhs.ne.gov/publichealth/HealthNavigation/Pages/CHWTraining.aspx. External to NE DHHS, the Public Health Association of Nebraska (PHAN) established a Community Health Worker section. This section recently released a policy paper in order to develop a more concise picture of the community health workforce in Nebraska, adopt core competencies for Community Health Workers, identify training and education needs, and develop a sustainability plan. The paper may be found at http://publichealthne.org/community-health-worker-policy-paper-april-2015/. Specifically related to the MCH population, a community research partnership between UNMC, central Nebraska health providers and insurers seeks to cut the high rate of premature births through education and regular health care. The study, which is to include 100 pregnant women in the Lexington and Kearney areas, uses smartphones and a special text messaging program to send tailored information to pregnant women. Some study participants receive periodic visits from a community health worker to reinforce prenatal education and care.

As these and other activities continue to develop the infrastructure necessary to support community health workers, possible roles for these workers in addressing Title V priorities include: 1) augmenting evidence-based home visiting for those families at lower risk or who graduate; 2) providing supportive services to families with CYSHCN; 4) serving as breastfeeding peer counselors, and 4) reinforcing a wide range of educational messages, such as motor vehicle safety and safe sleep practices.

Finally, standards and expectations around grants management have changed at both the federal and state level, with the new Uniform Grant Guidance (UGG) as an example. Title V administrative staff is working through the various changes and determining impact on budgeting, sub-awards, and making optimal Title V investments to address the identified priorities for 2016 – 2020. Underlying these considerations is sustainability of ongoing programs while taking on new activities and initiatives. The various implications are still emerging and are expected to become clearer as work progresses in 2016.

II.F.6. Public Input

Nebraska's Application / Annual Report is made available to the public for comment during its development and after its transmittal. Several methods are used to invite public input. Under the new Guidance, the application framework begins with the Five-Year State Action Plan, providing a good focal point for input in the development of the application. NDHHS staff proposed the first draft of the State Action Plan based on the 10 priorities identified in the Needs Assessment, setting five-year objectives and identifying strategies to address these objectives, all within the 6 health domains prescribed by the grant Guidance. The proposed Plan, being the backbone for development of the application, was presented to invite public comment prior to development of the application. Two methods were used to direct attention to the NDHHS webpage devoted to Nebraska Title V public input http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/PublicInput.aspx where the proposed State Action Plan was linked. A total of 11 responses were received during a 20-day period, and reviewed for inclusion in the 2016 State Action Plan.

First, the stakeholder portion of the Needs Assessment was a logical segue to invite public input on the proposed State Action Plan. The Needs Assessment stakeholders represent organizations that work with individuals and families, and consumers were also actively engaged. The group had recently completed the six-month process that culminated with 10 priority needs, so the issues were particularly well understood by the participants. An email inviting their review and feedback on the proposed State Action Plan included a link to the public input webpage. A reminder email sent a few days prior to the response date prompted additional input.

The second method to facilitate comment capitalizes on technology. Webpage visitors can subscribe to be automatically alerted by email when updates are made. Recent applications used this method for inviting comment, increasing the number of subscribers over several years. In this case, persons who subscribed previously to the public input page were made aware of the proposed 2016 State Action Plan and invited to comment. Visits to the webpage during the 20-day period totaled 307, with 266 unique visitors. Subscribers likely include the Needs Assessment stakeholder group, and an estimated 175 – 200 additional visitors.

Additional efforts were made to communicate directly to stakeholders in meetings during the open comment period. For example, all workgroup members of the Early Childhood Comprehensive Systems project, Together for Kids and Families, were updated on the selected priorities, relevance to early childhood system priorities, and invited to comment. The Project Management Team of the Nebraska Behavioral Health System of Care planning project were advised regarding the selection of state priorities, those relevant to priorities identified in the System of Care work, and encouraged to participate in the comment period.

Specific effort was made to reach out to the Family Voices representative in Nebraska during the open comment period. The MCH Title V writing team acknowledges the numerous comments and contributions from Family Voices that inform this application, particularly with regard to the priorities in the CYSHCN domain.

After its development and submission, the application and report will again be made available at http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/home.aspx, also having the subscription option, by linking to the Title V Information System (TVIS) where the most current information is always available.

II.F.7. Technical Assistance

The Lifespan Health Services Unit and its Title V staff have taken advantage of a number of technical assistance opportunities from a variety of sources over the past few years, including participation in AMCHP's Life Course Indicators Intensive Technical Assistance project and participation in the National MCH Workforce Development Center's Training Cohort 2. Training related to grants management has been accessed from a number of State of Nebraska agencies, as well as a leadership program for State of Nebraska employees. The Great Plains Public Health Leadership Program at the University of Nebraska Medical Center has also been a valuable source of technical assistance and learning for Title V staff.

Title V staff members are also finding that the Infant Mortality CoIIN to be useful in better understanding and utilizing CQI tools and in identifying evidence-based strategies relevant to a number of Nebraska's Title V priorities.

The preparation of this application and annual report, based on revised guidance and reporting formats, has raised a number of questions regarding budgeting and reporting. Title V staff will explore these questions as part of the review to be held in August 2015, and technical assistance needs may be identified at that time.

Consequently, Nebraska Title V has not identified any specific needs for MCHB-supported technical assistance at this time. Should a need be identified during 2016, a request will be made to Nebraska's MCHB Project Officer.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 3,989,608	$ 3,602,604	$ 4,036,191	$ 3,071,876
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 3,141,759	$ 2,886,218	$ 3,742,315	$ 3,896,412
Local Funds	$ 409,300	$ 435,680	$ 236,525	$ 294,194
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 7,540,667	$ 6,924,502	$ 8,015,031	$ 7,262,482
Other Federal Funds	$ 134,805,658	$ 0	$ 130,293,903	$ 0
Total	$ 142,346,325	$ 6,924,502	$ 138,308,934	$ 7,262,482

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 3,845,677	$ 3,982,922	$ 3,960,844	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 3,882,315	$ 3,035,018	$ 3,502,315	$
Local Funds	$ 324,282	$ 354,425	$ 508,792	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 8,052,274	$ 7,372,365	$ 7,971,951	$
Other Federal Funds	$ 121,378,102		$ 213,691,119	$
Total	$ 129,430,376	$ 7,372,365	$ 221,663,070	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 4,011,731	$
Unobligated Balance	$ 0	$
State Funds	$ 2,800,000	$
Local Funds	$ 450,000	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 7,261,731	$
Other Federal Funds	$ 214,819,652	$
Total	$ 222,081,383	$

III.A. Expenditures

1. Investments in MCH Priorities and other State Needs

With the 2014 federal allotment, NE DHHS continued support of 14 state-level public health programs/units administered within the Department. Internal allocations of the Block Grant complement state funds and/or other federal awards. Most of these internal allocations are within the Division of Public Health, while one, the Medically Handicapped Children's Program, is organizationally within the Division of Children & Family Services. Other NE DHHS program/units supported with 2014 funds include the Reproductive Health Program for outreach and education subgranted to organizations providing Title X Family Planning services, MCH Epidemiology Unit for Child and Maternal Death Review and PRAMS, Nebraska State Immunization Information System (NESIIS), Women's Health Initiatives, Office of Health Disparities and Health Equity, Oral Health & Dentistry, Birth Defect Registry, and the Maternal, Child & Adolescent Health (MCAH) unit. MCAH led a variety of initiatives and coordinated state-level activities with other units to address many of Nebraska MCH priorities.

The 2014 federal allotment also supported 11 subgrants totaling expenditures of $852,988. Seven subrecipients were in the continuation year of two-year projects originally awarded through the competitive subgrant component, 6 being Local Public Health Departments and 1 Community Action Agency. Projects supported had a wide range of goals, objectives and strategies to address state-level priorities. The Tribal setaside, a non-competitive process to subgrant to the 4 federally-recognized Tribes headquartered in Nebraska (Omaha, Ponca, Santee Sioux, and Winnebago) is a year-to-year process. The setaside was established in 2003 in recognition of Tribal sovereignty and respect for our special government-to-government relationship. As such, each Tribe presents a work plan to address their Tribe's MCH priorities, which often fit Nebraska MCH priorities. Tribes are eligible to apply under the competitive subgrant component if they choose. At all local levels, Title V support for community-based activities is enhanced by subrecipient organizations sharing in the costs. NE DHHS requires subrecipients match a minimum

20% of total project costs with non-federal resources. Subrecipients often exceed the amount required from local support, which includes cash and in-kind. This demonstration of local support is one indicator of genuine partnerships, steadfast commitment, and appreciation for community-specific solutions to Nebraska's MCH priorities.

2. Spending Authority; 30-30-10 Compliance

As allowed by statute, Nebraska typically exercises its spending authority in the succeeding fiscal year of the allotment. Variations year-to-year are believed to be largely due to preparation of an annual budget, yet exercising two-year spending authority. The final 2014 award was $137,245 greater than the budget projection at the time of application. An increase was beneficial in order to maintain state-level programs and capacity.

The 2014 allotment of Title V federal funds to Nebraska was $3,982,922, of which 97.9% ($3,899,396) is expended for the five types of individuals served (Form 3a, IA). Nebraska's investments in children (31.6%) and CSHCN (36%) surpass the 30%-30% requirements. NDHSS uses accounting codes by MCH populations to track payments by federal allotment and to identify compliance with the 30%-30% requirement. The final 2014 appropriation was greater than the budget projection, contributing to the variance greater than 10% for CSHCN.

An additional $83,526 (2.1%) is charged as administrative costs, far below the 10% statutory cap. Together, these expenditures will zero out the allotment (Form 3b, IIA). Administrative costs include the allocable salary/wage, benefits and indirect cost for the management of the 2014 Title V allocation.

3. MCH Pyramid of Services

Nebraska invested the federal allotment more heavily in the base of the MCH pyramid, i.e. Public Health Services and Systems 50.6% ($2,015,164) and 42% for Enabling Services ($1,671,371). Expenditures for Direct Services totaled $296,387 (7.4%). (Form 3b II.A.) Similarly, 40.5% of the non-federal expenditures for Public Health Services and Systems ($1,374,052), 40.7% Enabling Services ($1,378,012), and 18.8% Direct Services ($637,379) complement the Title V allocation (Form 3b II.B.).

4. MOE and Match

The source of non-federal expenditures is a combination of state funds ($3,035,018) plus local funds and in-kind support ($354,425). The total value of matching resources is 85% ($3,389,443) of the 2014 federal Title V allotment, which exceeds the 3:4 match minimum ($2,987,192) by $402,252 and also surpasses the Maintenance of Effort ($2,626,360) by $763,083. The budget-to-expenditure variance of non-federal resources is the result of state funds budgeted based on the state fiscal year (July 1 – June 30) appropriation, although expenditures are reported during the federal fiscal year (October 1 – September 30). The fiscal periods being different necessitates reporting state fund expenditures within the federal fiscal year. The 2014 budget of non-federal resources ($4,206,597, or 91.4%) far exceeded the 3:4 compliance, allowing sufficient margin to accommodate the actual non-federal to federal expenditures during the federal fiscal year. As described in the budget narrative, the difference in fiscal years is considered in the 2016 budget projection to minimize the variance in future reports.

5. Other Federal Funds

Other federal funds (Form 2, Line 9) under the control of the Title V administration is defined by Nebraska as the broad oversight by the MCH Director and the CSHCN Director. Many other program managers supervised by the MCH Director and CSHCN Director of Title V are more directly responsible for the administration of the other federal

awards. Those expenditures do not neatly fit into this report because of the varying fiscal years and report dates which do not correspond with the Title V / MCH Block Grant. Additionally, not all prior awards are fully expended because each has different periods of spending authority. Other federal funds expended and reported total $43,856,758. Form 2 notes provide additional information. There may be opportunity going forward to establish methods to improve the coordination of financial and programmatic planning/reporting relative to MCH populations between all federal awards within NE DHHS.

III.B. Budget

1. Planned Investments for MCH Priorities and 30-30-10 Compliance

The 2016 budget for Title V / MCH Block Grant ($4,011,731) is based on an estimate of the final authorized amount for 2015 federal funds. The budget includes 37.5% for children ($1,506,273) primarily due to 12 subgrants' children-focused work, adding in a smaller portion in state-level activities. Another 32.7% of the budget is earmarked for CSHCN ($1,310,810) largely supporting NE DHHS programs, e.g. the Medically Handicapped Children's Program, Birth Defects Registry, and Newborn Metabolic Screening & Genetics. Administrative costs are budgeted at $124,894 (3.1%).

NE DHHS plans to continue Block Grant support to most of the same state-level public health programs/units administered within the Department. Activities may adjust in some areas to address new priorities, and in other areas be more stable to maintain capacity for Title V/MCH emerging issues. These internal allocations will again complement state funds and/or other federal awards in most cases. Title V support for Newborn Metabolic Screening and Genetics is expected to increase due to the non-federal sources from screening fees and state general funds remaining relatively static while follow-up costs for personnel and metabolic foods/formulas increasing. Several NE DHHS programs/units supported with 2015 allotment will be shifted to other sources where there are alignments of priorities.

The 2016 allocation is expected to continue supporting, through September 30, 2016, 16 subgrants that began October 1, 2014 with the 2015 federal allotment. Twelve subrecipients will begin Year 2 of the competitive subgrant component. Projects are underway in 9 Local Public Health Departments, 1 Community Action Agency and 2 other non-profit organizations. These projects have a wide range of goals, objectives and strategies to address state-level priorities for projects primarily focused on children. The Tribal setaside, a non-competitive process to subgrant to the 4 federally-recognized Tribes headquartered in Nebraska (Omaha, Ponca, Santee Sioux, and Winnebago) will continue the process that was established in 2003 in recognition of Tribal sovereignty and respect for our special government-to-government relationship.

2. MOE and Match.

Breaking from prior practice, and new for the 2016 budget, state funds matching the block grant are budgeted less than the Nebraska Unicameral appropriation of the various match sources for the state fiscal year 2016 (July 1, 2015 – June 30, 2016), totaling $3,844,271. The reasoning behind this is based on the future report of non-federal expenditures within the federal fiscal year 2016 period, which subsequently may cause a budget-to-expenditure variance greater than 10% as it did for 2014. This logic has two lines of reasoning: First, the total of state appropriations in the 2016 match budget ($2,800,000) is greater than Nebraska's Maintenance of Effort ($2,626,360). Also, the local match budget, based on the current subrecipient percentage expended year-to-date, added to the state funds budget, exceeds the minimum 3:4 match requirement. It will not be problematic to report an increased level of match expenditures than budget, if that occurs. At the time of this application, NE DHHS expects to report in July 2017 the state appropriations expended in the federal fiscal year 2016 (October 1, 2015 –

September 30, 2016). Subrecipients will continue on the federal fiscal year, thereby more easily aligning local match with 2016 federal expenditure for the report due July 2017.

3. Other Federal Funds.

Other federal funds in the Title V Administration budget total $214,819,652. Nebraska defines this as those awards broadly overseen by the MCH Director and CSHCN Director. These include grants made by the U.S. Department of Health and Human Services (DHHS) Administration of Children & Families (ACF), DHHS Centers for Disease Control (CDC), DHHS Health Resources and Services Administration (HRSA), DHHS Office of Population Affairs, U.S. Department of Agriculture (USDA) Food and Nutrition Services, and the U.S. Department of Housing and Urban Development (HUD) Office of Community Planning and Development. Specific grants include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Commodity Supplemental Food Program (CSFP), Supplemental Nutrition Assistance Program (SNAP), Title X Family Planning, Immunizations, Pregnancy Risk Assessment Monitoring System (PRAMS), Temporary Assistance for Needy Families (TANF), Community Services Block Grant (CSBG), State Personal Responsibility Education Program (PREP), and the Maternal, Infant and Early Childhood Home Visiting (MIECHV), State Systems Development Initiative (SSDI), and Early Childhood Comprehensive Systems (ECCS), to name a few. Form 2, Line 9 entries and notes provide additional detail.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Intra-agency Protocol-Nebraska.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - SYNOPSIS FY 2015-FY 2016 Title V subgrants.pdf

Supporting Document #02 - Nebraska org chart.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nebraska

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 4,011,731	$ 3,982,922
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 1,506,273	$ 1,259,701
B. Children with Special Health Care Needs	$ 1,310,810	$ 1,434,661
C. Title V Administrative Costs	$ 124,894	$ 83,526
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 2,800,000	$ 3,035,018
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 450,000	$ 354,425
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 3,250,000	$ 3,389,443
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 2,626,360	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 7,261,731	$ 7,372,365
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 214,819,652	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 222,081,383	$ 7,372,365
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 3,845,677
A. Preventive and Primary Care for Children	$ 1,379,907
B. Children with Special Health Care Needs	$ 1,212,573
C. Title V Administrative Costs	$ 132,408
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 3,882,315
4. LOCAL MCH FUNDS	$ 324,282
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 4,206,597

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	$ 282,627
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 242,472
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG);	$ 9,200,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF);	$ 57,000,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs;	$ 150,098
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS);	$ 145,318
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations;	$ 2,693,564

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 1,912,030
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 249,678
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 2,072,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP);	$ 764,080
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 32,604,127
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Cmnty Svcs Blck Grnt;	$ 5,700,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement;	$ 1,700,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Enrgy Ast;	$ 29,000,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care Devlp Fnd;	$ 39,600,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Breast/Cervical Canc;	$ 2,681,284
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Wisewoman;	$ 730,000
US Department of Agriculture (USDA) > Food and Nutrition Services > SNAP;	$ 14,000,000

US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution ;	$ 13,000,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Emerg Food Asst Prog;	$ 202,000
US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > NE Homeless Asst;	$ 655,000

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The final 2014 appropriation was greater than the budget projection.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Administrative costs include the allocable salary/wage, benefits and indirect cost for the management of the 2014 Title V allocation. Costs were less than budgeted primarily due to clarification that the FY 2014 report is to be based on the 2014 allocation, rather than the expenditures in the fiscal year period.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: State funds were budgeted based on the state fiscal year. Expenditures are reported during the federal fiscal year which is a different period.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The $309,463 prior award was fully expended.	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

	Field Note: The $221,214 prior award was fully expended.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior SSBG award.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior TANF award.	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The $136,100 prior award was fully expended.	
9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: $135,148 was expended in the prior award.	
10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2016**

	Column Name:	**Application Budgeted**
	Field Note: $1,978,750 was expended in the prior award.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Current MIECHV awards are: $1,000,000 formula funds and $912,030 development grant, totaling $1,912,030. $850,000 was expended in the prior formula grant, and $1,543,000 was expended in development grant.	
12.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The $140,000 prior award was fully expended.	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: $86,533 was expended in the prior award, with unexpended funds requested to carryover and included in the $95,374 budget amount.	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The $249,678 prior award was fully expended.	
15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2016**

	Column Name:	**Application Budgeted**
	Field Note: The $2,031,000 prior award was fully expended.	
16.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The $808,076 prior award was fully expended.	
17.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The total includes WIC food, Nutrition Services Administration, and Breastfeeding Peer Counseling funds. $31,517,796 was expended in the prior award.	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Cmnty Svcs Blck Grnt**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior CSBG award.	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior Refugee Resettlement award.	
20.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Enrgy Ast**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior Low Income Energy Assistance award.	
21.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care Devlp Fnd**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior Child Care Development Fund award.	
22.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Breast/Cervical Canc**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: $2,300,000 was expended in the prior award for Breast and Cervical Cancer Early Detection.	
23.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Wisewoman**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: $650,000 was expended in the prior award.	
24.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > SNAP**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior SNAP award.	
25.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still	

expending obligations of the prior Food Distribution Program award.

26.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Emerg Food Asst Prog**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Not all prior awards are fully expended because each has different periods of spending authority. NE DHHS is still expending obligations of the prior Emergency Food Assistance Program award.	
27.	**Field Name:**	**Other Federal Funds, US Department of Housing and Urban Development (HUD) > Health Homes and Lead Hazard Control > NE Homeless Asst**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The grant is awarded from the Office of Community Planning & Development, within the U.S. Department of Housing and Urban Development (HUD).	

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Nebraska

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 460,059	$ 493,961
2. Infants < 1 year	$ 519,547	$ 520,956
3. Children 1-22 years	$ 1,506,273	$ 1,259,701
4. CSHCN	$ 1,310,810	$ 1,434,661
5. All Others	$ 90,148	$ 190,117
Federal Total of Individuals Served	$ 3,886,837	$ 3,899,396
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 469,800	$ 573,984
2. Infants < 1 year	$ 273,400	$ 328,519
3. Children 1-22 years	$ 771,400	$ 562,603
4. CSHCN	$ 1,402,250	$ 1,524,109
5. All Others	$ 333,150	$ 400,229
Federal Total of Individuals Served	$ 3,250,000	$ 3,389,444
Federal State MCH Block Grant Partnership Total	$ 7,136,837	$ 7,288,840

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Title V Block Grant award was more than requested due to the final appropriation.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Title V Block Grant award was more than requested due to the final appropriation.	

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Nebraska

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 300,000	$ 296,387
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 300,000	$ 296,387
2. Enabling Services	$ 1,666,814	$ 1,671,371
3. Public Health Services and Systems	$ 2,044,917	$ 2,015,164
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
direct services total		$ 296,387
Direct Services Total		$ 296,387
Federal Total	$ 4,011,731	$ 3,982,922

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 625,000	$ 637,379
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 625,000	$ 637,379
2. Enabling Services	$ 1,272,315	$ 1,378,012
3. Public Health Services and Systems	$ 1,352,685	$ 1,374,052
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
direct services total		$ 637,379
Direct Services Total		$ 637,379
Non-Federal Total	$ 3,250,000	$ 3,389,443

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Nebraska

Total Births by Occurrence 27,117

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	27,037 (99.7%)	0	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	27,037 (99.7%)	0	0	0 (0%)
Methylmalonic acidemia (cobalamin disorders)	27,037 (99.7%)	0	0	0 (0%)
Isovaleric acidemia	27,037 (99.7%)	0	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	27,037 (99.7%)	1	1	1 (100.0%)
3-Hydroxy-3-methyglutaric aciduria	27,037 (99.7%)	0	0	0 (0%)
Holocarboxylase synthase deficiency	27,037 (99.7%)	0	0	0 (0%)
ß-Ketothiolase deficiency	27,037 (99.7%)	0	0	0 (0%)
Glutaric acidemia type I	27,037 (99.7%)	0	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	27,037 (99.7%)	0	0	0 (0%)
Medium-chain acyl-CoA dehydrogenase deficiency	27,037 (99.7%)	1	1	1 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	27,037 (99.7%)	2	1	1 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	27,037 (99.7%)	0	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	27,037 (99.7%)	0	0	0 (0%)
Argininosuccinic aciduria	27,037 (99.7%)	1	1	1 (100.0%)
Citrullinemia, type I	27,037 (99.7%)	0	0	0 (0%)
Maple syrup urine disease	27,037 (99.7%)	1	1	1 (100.0%)
Homocystinuria	27,037 (99.7%)	0	0	0 (0%)
Classic phenylketonuria	27,037 (99.7%)	2	2	2 (100.0%)
Tyrosinemia, type I	27,037 (99.7%)	3	0	0 (0%)
Primary congenital hypothyroidism	27,037 (99.7%)	89	7	7 (100.0%)
Congenital adrenal hyperplasia	27,037 (99.7%)	9	0	0 (0%)
S,S disease (Sickle cell anemia)	27,037 (99.7%)	4	4	4 (100.0%)
S, βeta-thalassemia	27,037 (99.7%)	2	2	2 (100.0%)
S,C disease	27,037 (99.7%)	4	4	4 (100.0%)
Biotinidase deficiency	27,037 (99.7%)	9	6	6 (100.0%)
Critical congenital heart disease	0 (0.0%)	0	0	0 (0%)
Cystic fibrosis	27,037 (99.7%)	31	8	8 (100.0%)
Severe combined immunodeficiences	6,736 (24.8%)	1	0	0 (0%)
Classic galactosemia	27,037 (99.7%)	2	2	2 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	26,951 (99.4%)	769	68	63 (92.6%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

There is long term follow-up management / treatment done for cystic fibrosis through the Nebraska Cystic Fibrosis Center in Omaha, NE for infants / children who are seen in Nebraska. Some babies born in Nebraska receive long term care at the Colorado Cystic Fibrosis Center in Denver, CO since the distance to CO may be closer for some families. All pertinent medical history and information is obtained and evaluations are conducted.\r\n\r\nThere is long term follow-up management / treatment conducted for metabolic diseases through the Nebraska Metabolic Center in Omaha, NE for infants / children who are seen in Nebraska. Some babies born in Nebraska receive long term care at the Colorado Metabolic Center in Denver, CO since the distance to CO may be closer for some families. All pertinent medical history and information is obtained and evaluations are conducted.\r\n\r\n

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2014**
	Column Name:	
	Field Note: 27,117 births occurred in the state of Nebraska in 2014. Of those, 27,037 were screened in accordance with state law. Births not screened expired prior to 48 hours of life.	
2.	**Field Name:**	**Tyrosinemia, type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: 3 cases of transient tyrosinemia (1 hypertyrosinemia; 2 transient tyrosinemia) 2 cases treated, 1 not treated	
3.	**Field Name:**	**Primary congenital hypothyroidism - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: In addition to the 7 cases confirmed with Congenital Primary Hypothyroidism there was also 9 cases of Congenital Hypothyroidism, 3 Hypothyroidism, 1 Primary Hypothyroidism.	
4.	**Field Name:**	**Congenital adrenal hyperplasia - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: 1 newborn expired before confirmation could be done.	
5.	**Field Name:**	**S,C disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: 3 cases of SC disease, 1 case of SC disease plus possible Alpha Thalassemia	
6.	**Field Name:**	**Biotinidase deficiency - Referred For Treatment**

	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	1 case of Profound Biotinidase Deficiency, 5 cases of Partial Biotinidase Deficiency
7.	**Field Name:**	**Critical congenital heart disease - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	Nebraska hospitals are required under state law to screen newborns for CCHD. However, the state of Nebraska does not have authority to collect the data.
8.	**Field Name:**	**Critical congenital heart disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	Nebraska law requires hospitals to screen for CCHD however there are no regulations/requirements for hospitals to report to the state.
9.	**Field Name:**	**Cystic fibrosis - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	1 case of Cystic Fibrosis Related Metabolic Syndrome (CRMS). This is in addition to the 8 confirmed positive cases of CF.
10.	**Field Name:**	**Severe combined immunodeficiences - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	Nebraska starting mandating screening for SCID October 1, 2014.
11.	**Field Name:**	**Severe combined immunodeficiences - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	1 case pending diagnosis from specialist.

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Nebraska

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,881	22.4	0.0	21.6	54.9	1.1
2. Infants < 1 Year of Age	27,037	32.3	0.0	60.4	4.5	2.8
3. Children 1 to 22 Years of Age	27,831	34.4	9.5	39.0	16.4	0.7
4. Children with Special Health Care Needs	2,274	59.6	16.5	11.3	12.5	0.1
5. Others	25,454	20.4	0.0	37.0	42.6	0.0
Total	84,477					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Nebraska

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	21,379
2. Infants < 1 Year of Age	25,903
3. Children 1 to 22 Years of Age	233,291
4. Children with Special Health Care Needs	2,274
5. Others	16,039
Total	298,886

Form Notes For Form 5b:

The actual recipient count of individuals served is likely much greater than reported in Form 5b. NE DHHS had not collected data for Nebraskans served by these categories for all programs supported by other federal funds reported in Form 2. Data available was collected prior to issuance of the new Guidance and Forms. NE DHHS will make reasonable efforts to report data by these categories for future reports.

Field Level Notes for Form 5b:

None

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Nebraska

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	27,113	21,428	1,876	296	949	0	0	2,564
Title V Served	402	51	2	326	0	0	1	22
Eligible for Title XIX	9,706	5,019	1,103	292	233	0	0	3,059
2. Total Infants in State	25,903	21,891	1,502	479	638	46	1,347	0
Title V Served	27,037	21,368	1,871	295	946	0	0	2,557
Eligible for Title XIX	3,693	1,804	451	97	98	4	871	368

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	23,130	3,962	21	27,113
Title V Served	374	26	2	402
Eligible for Title XIX	8,159	1,547	0	9,706
2. Total Infants in State	21,432	4,471	0	25,903
Title V Served	23,065	3,951	21	27,037
Eligible for Title XIX	2,564	761	368	3,693

Form Notes For Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Census 2014 estimate	
2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**
	Field Note: Occurrant births screened by the Nebraska Newborn Metabolic Screening Program	

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Nebraska

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 862-1889	(800) 862-1889
2. State MCH Toll-Free "Hotline" Name	Nebraska Healthy Mothers, Healthy Babies Hotline	Nebraska Healthy Mothers, Healthy Babies Hotline
3. Name of Contact Person for State MCH "Hotline"	Jackie Moline	Jackie Moline
4. Contact Person's Telephone Number	(402) 471-0165	(402) 471-0165
5. Number of Calls Received on the State MCH "Hotline"		191
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	http://dhhs.ne.gov/publichealth/Pages/lifespanhealth.aspx	http://dhhs.ne.gov/publichealth/Pages/lifespanhealth.aspx
4. Number of Hits to the State Title V Program Website		1,246
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

Visits to the Lifespan Health Services webpage in B.3. were 1246; unique visitors 872. The Medically Handicapped Children's Program's webpage is http://dhhs.ne.gov/Pages/hcs_programs_mhcp.aspx#FAQs. Visits 1425; unique visitors 1217.

Form 8
State MCH and CSHCN Directors Contact Information

State: Nebraska

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Paula Eurek
Title	Administrator, DHHS Lifespan Health Services
Address 1	301 Centennial Mall South
Address 2	PO Box 95026
City / State / Zip Code	Lincoln / NE / 68509
Telephone	(402) 471-0196
Email	paula.eurek@nebraska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Teri Chasten
Title	DHHS Economic Assistance Policy Chief
Address 1	301 Centennial Mall South
Address 2	PO Box 95026
City / State / Zip Code	Lincoln / NE / 68509
Telephone	(402) 471-2738
Email	teri.chasten@nebraska.gov

3. State Family or Youth Leader (Optional)

Name	Nina Baker
Title	PTI Nebraska, Health Information Coordinator
Address 1	2564 Leavenworth Street, Suite 202
Address 2	
City / State / Zip Code	Omaha / NE / 68105
Telephone	(402) 403-3908
Email	nbaker@pti-nebraska.org

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Nebraska

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	1. Infant Mortality (III)	New	
2.	2. Obesity/overweight among women, youth, and children, including food insecurity and physical inactivity (XII)	Continued	
3.	3. Infant Abuse and Neglect (IV)	Replaced	Nebraska will develop a SPM
4.	4. Mental and Behavioral Health Needs of Children/Youth with Special Health Care Needs (VIII)	New	
5.	5. Unintentional Injury among Children and Youth, including Motor Vehicle Crashes (VI and X)	New	
6.	6. Access to and Adequacy of Prenatal Care (I)	Replaced	
7.	7. Breastfeeding of Infants (V)	Continued	
8.	8. Sexually Transmitted Disease among Youth and Women of Child Bearing Age (II and XI)	Replaced	
9.	9. Access to Preventive and Early Intervention Mental Health Services for Children (VII)	New	Nebraska will develop a SPM
10.	10. Medical Home for CYSHCN, including Empowerment of Families to Partner in Decision Making and Access to Additional Family Supports (IX)	Replaced	Nebraska will develop a SPM

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Nebraska

Form Notes for Form 10a NPMs and NOMs:

NPM 7: The objective is for children (0-9). NPM 8: The objective is based of the YRBSS and adolescents 12-17. NPM 11: The objective is based off of the NS-CSHCN.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	73.6 %	0.3 %	18,950	25,758
2012	74.9 %	0.3 %	19,180	25,606
2011	75.2 %	0.3 %	19,077	25,377
2010	75.1 %	0.3 %	19,002	25,308
2009	74.3 %	0.3 %	19,465	26,209

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	115.5	6.9 %	283	24,507
2011	114.2	6.8 %	284	24,879
2010	115.1	6.8 %	290	25,194
2009	101.1	6.3 %	262	25,904
2008	101.5	6.5 %	244	24,031

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	14.6	3.3 %	19	130,611
2008_2012	14.5	3.3 %	19	131,505
2007_2011	15.1	3.4 %	20	132,497
2006_2010	13.5	3.2 %	18	133,504
2005_2009	14.2	3.3 %	19	133,731

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.5 %	0.2 %	1,682	26,086
2012	6.7 %	0.2 %	1,734	25,939
2011	6.6 %	0.2 %	1,702	25,716
2010	7.1 %	0.2 %	1,839	25,914
2009	7.1 %	0.2 %	1,922	26,935

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.1 %	0.1 %	294	26,086

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	1.1 %	0.1 %	293	25,939
2011	1.1 %	0.1 %	279	25,716
2010	1.3 %	0.1 %	329	25,914
2009	1.2 %	0.1 %	315	26,935

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3 %	0.1 %	1,388	26,086
2012	5.6 %	0.1 %	1,441	25,939
2011	5.5 %	0.1 %	1,423	25,716
2010	5.8 %	0.2 %	1,510	25,914
2009	6.0 %	0.1 %	1,607	26,935

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.7 %	0.2 %	2,274	26,063
2012	9.3 %	0.2 %	2,417	25,907
2011	9.1 %	0.2 %	2,327	25,692
2010	9.8 %	0.2 %	2,547	25,905
2009	9.7 %	0.2 %	2,597	26,898

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.5 %	0.1 %	650	26,063

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	2.5 %	0.1 %	645	25,907
2011	2.4 %	0.1 %	618	25,692
2010	2.7 %	0.1 %	692	25,905
2009	2.7 %	0.1 %	714	26,898

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.2 %	0.2 %	1,624	26,063
2012	6.8 %	0.2 %	1,772	25,907
2011	6.7 %	0.2 %	1,709	25,692
2010	7.2 %	0.2 %	1,855	25,905
2009	7.0 %	0.2 %	1,883	26,898

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	23.2 %	0.3 %	6,053	26,063
2012	23.8 %	0.3 %	6,165	25,907
2011	24.8 %	0.3 %	6,360	25,692
2010	25.4 %	0.3 %	6,578	25,905
2009	25.0 %	0.3 %	6,728	26,898

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	4.0 %			

Legends:
Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.4	0.5 %	140	26,156
2012	5.8	0.5 %	152	26,027
2011	5.6	0.5 %	143	25,782
2010	5.9	0.5 %	153	25,991
2009	5.9	0.5 %	160	27,023

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.2	0.5 %	136	26,095
2012	4.7	0.4 %	121	25,942
2011	5.6	0.5 %	144	25,720
2010	5.3	0.5 %	136	25,918
2009	5.4	0.5 %	145	26,936

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.7	0.4 %	96	26,095
2012	3.1	0.4 %	80	25,942
2011	3.7	0.4 %	96	25,720
2010	3.7	0.4 %	96	25,918
2009	3.3	0.4 %	88	26,936

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.5	0.2 %	40	26,095
2012	1.6	0.3 %	41	25,942
2011	1.9	0.3 %	48	25,720
2010	1.5	0.2 %	40	25,918
2009	2.1	0.3 %	57	26,936

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	183.9	26.6 %	48	26,095

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	142.6	23.5 %	37	25,942
2011	140.0	23.3 %	36	25,720
2010	189.1	27.0 %	49	25,918
2009	144.8	23.2 %	39	26,936

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	61.3	15.3 %	16	26,095
2012	84.8	18.1 %	22	25,942
2011	85.5	18.2 %	22	25,720
2010	57.9	15.0 %	15	25,918
2009	85.4	17.8 %	23	26,936

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	6.0 %	0.7 %	1,494	25,002
2010	5.1 %	0.6 %	1,267	25,021
2009	4.4 %	0.6 %	1,153	25,998
2008	6.1 %	0.8 %	1,514	24,900
2007	6.2 %	0.8 %	1,536	24,797

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	2.7	0.3 %	66	24,507
2011	1.5	0.2 %	37	24,879

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010	1.7	0.3 %	42	25,194
2009	1.3	0.2 %	34	25,904
2008	0.8	0.2 %	19	24,031

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	15.7 %	1.2 %	67,472	430,564

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	13.9	2.4 %	33	237,379
2012	18.1	2.8 %	43	237,734
2011	17.8	2.8 %	42	235,374
2010	20.0	2.9 %	47	234,754
2009	17.3	2.7 %	40	231,449

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	37.7	3.8 %	96	254,911
2012	39.4	3.9 %	100	253,527
2011	25.5	3.2 %	65	254,481
2010	33.0	3.6 %	83	251,636
2009	32.1	3.6 %	81	252,712

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	18.1	2.2 %	70	386,062
2010_2012	16.0	12.3 %	62	387,494
2009_2011	17.2	13.3 %	67	389,569
2008_2010	21.5	17.2 %	84	390,349
2007_2009	26.9	21.8 %	106	393,438

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	10.1	7.2 %	39	386,062
2010_2012	8.3	5.7 %	32	387,494
2009_2011	6.2	4.0 %	24	389,569
2008_2010	7.9	5.4 %	31	390,349
2007_2009	9.7	6.8 %	38	393,438

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.1 %	1.2 %	87,252	457,759
2007	19.4 %	1.4 %	88,988	457,857
2003	18.4 %	1.1 %	80,542	438,253

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	19.0 %	1.7 %	10,624	55,824

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.3 %	0.3 %	4,744	378,647
2007	0.9 %	0.5 %	3,464	380,353

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	7.6 %	0.9 %	28,665	378,306
2007	6.0 %	1.0 %	22,754	379,841

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	73.0 %	5.3 %	24,523	33,616
2007	72.3 %	7.2 %	21,883	30,262
2003	72.3 %	5.5 %	19,419	26,867

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	87.4 %	1.1 %	399,322	457,044
2007	86.3 %	1.3 %	395,150	457,857
2003	86.4 %	1.0 %	378,828	438,253

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	28.9 %	2.2 %	58,517	202,397
2007	31.5 %	2.3 %	62,035	197,217
2003	26.3 %	1.8 %	51,326	194,966

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	35.3 %	0.4 %	6,182	17,521

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.5 %	1.2 %	22,698	85,518
2011	25.1 %	0.8 %	20,033	79,744
2005	24.6 %	0.8 %	21,773	88,471

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.9 %	0.6 %	27,316	464,212
2012	5.4 %	0.6 %	25,213	465,331
2011	7.3 %	0.7 %	33,722	459,193
2010	5.2 %	0.6 %	23,723	457,767
2009	6.3 %	0.8 %	28,174	447,403

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	79.0 %	3.0 %	28,932	36,626
2012	72.6 %	3.3 %	27,353	37,687
2011	77.6 %	3.3 %	30,209	38,926
2010	66.3 %	3.6 %	25,617	38,617
2009	38.1 %	3.7 %	14,645	38,422

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	62.7 %	2.0 %	271,156	432,321
2012_2013	60.0 %	2.4 %	259,816	432,952
2011_2012	50.7 %	2.7 %	214,947	424,012

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2011	50.0 %	3.3 %	1,095,627	2,119,202
2009_2010	44.5 %	2.9 %	1,071,779	2,265,918

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	65.2 %	4.7 %	39,257	60,259
2012	67.5 %	5.1 %	40,205	59,548
2011	59.0 %	5.1 %	35,331	59,929
2010	52.3 %	4.8 %	31,478	60,225
2009	49.4 %	4.7 %	29,676	60,080

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	38.2 %	4.5 %	24,072	63,080
2012	19.6 %	3.5 %	12,261	62,702
2011	14.2 %	4.1 %	8,864	62,613

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	86.1 %	2.4 %	106,198	123,339
2012	81.4 %	3.0 %	99,453	122,250
2011	81.8 %	2.6 %	100,197	122,542
2010	70.3 %	3.0 %	86,793	123,466
2009	51.6 %	3.3 %	63,417	123,014

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	77.5 %	2.7 %	95,629	123,339
2012	75.5 %	3.1 %	92,300	122,250
2011	76.0 %	2.9 %	93,109	122,542
2010	65.7 %	3.2 %	81,105	123,466
2009	53.2 %	3.3 %	65,470	123,014

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Nebraska

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	59.4	60.6	61.8	63.0	64.3

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	84.0	85.7	87.4	89.2	91.0

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.4	20.8	21.2	21.6	22.1

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	83.3	85.0	86.7	88.4	90.2

NPM-7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	114.4	112.1	109.7	107.6	105.5

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	33.0	33.6	34.3	34.9	35.7

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	85.1	86.8	88.5	90.3	92.1

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	51.9	53.0	54.0	55.1	56.2

NPM-15 Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	75.8	77.4	78.9	80.5	82.1

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Nebraska

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Nebraska

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Nebraska

Form Notes for Form 10d NPMs and SPMs

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	838	771	718	639	
Denominator	838	771	718	639	
Data Source	Program Data	Program Data	Program Data	Program Data	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 165 babies had a presumptive positive and 474 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .This number does not include the 430 infants with hemoglobinopathy patterns that were indicative of trait/carrier status. Total infants that were tracked with presumptive positive, abnormal or inconclusive results is 1,069 for 2014. There are many other reasons for tracking and following up such as drawn early (prior to 24 hours of life) screens, babies that weigh <_2000 grams at birth that require multiple screens collected, unsatisfactory specimens, and transfusions that are not included in the above numbers.	
2.	**Field Name:**	**2013**
	Field Note: 153 babies had a presumptive positive and 565 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .This number does not include the 386 infants with hemoglobinopathy patterns that were indicative of trait/carrier status. Total infants that were tracked with presumptive positive, abnormal or inconclusive results is 1,104 for 2013. There are many other reasons for tracking and following up such as drawn early (prior to 24 hours of life) screens, babies that weigh = 2000 grams at birth that require multiple screens collected, unsatisfactory specimens, and transfusions that are not included in the above numbers.	
3.	**Field Name:**	**2012**

Field Note:
166 babies had a presumptive positive and 605 had inconclusive screening result for a disease requiring confirmatory or repeat testing(follow up) .This number does not include the 392 infants with hemoglobinopathy patterns that were indicative of trait/carrier status. Total infants that were tracked with presumptive positive, abnormal or inconclusive results is 1,163 for 2012.

4.	**Field Name:**	**2011**

Field Note:
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 .

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	71.1	77.1	78.6	80.2	81.8
Annual Indicator	75.6	75.6	75.6	75.6	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data

processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	58.6	49.2	50.2	51.2	52.2

	2011	2012	2013	2014	2015
Annual Indicator	48.2	48.2	48.2	48.2	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	71.3	60.9	62.1	63.4	64.6
Annual Indicator	59.7	59.7	59.7	59.7	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	99.4	72.1	73.5	75.0	76.5
Annual Indicator	70.7	70.7	70.7	70.7	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	58.8	48.5	49.5	50.5	51.5
Annual Indicator	47.6	47.6	47.6	47.6	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip

pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
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.

4.	**Field Name:**	**2011**

Field Note:
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.

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	73.2	78.2	79.8	81.4	83.0
Annual Indicator	77.8	74.8	78.5	81.3	

	2011	2012	2013	2014	2015
Numerator					
Denominator					
Data Source	CDC NIS	CDC NIS	CDC NIS	CDC NIS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: This rate is 81.3%+/-5.5	
2.	**Field Name:**	**2013**
	Field Note: This rate is 78.5%+/-6.0.	
3.	**Field Name:**	**2012**
	Field Note: Provisional rate represents the first 6 months of 2012. The full year will be released late August/early September. This rate is 74.8% +/-6.6.	
4.	**Field Name:**	**2011**
	Field Note: 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. Final rate is 77.8+-6.4	

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	15.2	11.8	11.9	10.8	9.5
Annual Indicator	12.1	12.2	11.0	9.7	

	2011	2012	2013	2014	2015
Numerator	456	453	411	352	
Denominator	37,584	37,206	37,430	36,415	
Data Source	Birth File, Census	Birth File, Census	Birth File, Census	Birth File, Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	50.0
Annual Indicator	44.6	44.6	44.6	44.6	
Numerator	10,486	10,486	10,486	10,486	
Denominator	23,518	23,518	23,518	23,518	
Data Source	NE Open Mouth Survey	NE Open Mouth Survey	NE Open Mouth Survey	NE Open Mouth Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Nebraska is preparing to conduct a second Open Mouth Survey over the 2015/2016 school year.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	2.7	2.7	5.5	2.1	1.8
Annual Indicator	1.1	5.6	2.1	1.9	
Numerator	4	20	8	7	
Denominator	359,412	356,941	382,753	366,225	
Data Source	Death file, Census	Death file, Census	Death file,Census	Death file,Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
The rate is unstable form year to year due to very small numbers.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	67.8	51.0	52.0	49.3	49.1
Annual Indicator	49.5	50.7	48.3	48.1	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 82.9% of woman reported initiating breastfeeding of those 48.1% reported breastfeeding longer than 180 days. However, only 22.1% reported exclusive breasting over 180 days.	
2.	**Field Name:**	**2013**
	Field Note: 81.7% of woman reported initiating breastfeeding of those 48.3% reported breastfeeding longer than 180 days. However, only 20% reported exclusive breasting over 180 days.	
3.	**Field Name:**	**2012**
	Field Note: 79.8% of woman reported initiating breastfeeding of those 50.7% reported breastfeeding longer than 180 days. However, only 24% reported exclusive breasting over 180 days.	
4.	**Field Name:**	**2011**
	Field Note: 80.63% of woman reported initiating breastfeeding of those 49.5% reported breastfeeding longer than 180 days. However, only 19.5% reported exclusive breasting over 180 days.	

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	99.8	100.0
Annual Indicator	99.4	99.6	99.7	99.7	
Numerator	25,749	26,019	26,175	26,872	
Denominator	25,915	26,127	26,249	26,941	
Data Source	Program Data	Program Data	Program Data	Program Data	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	16.2	17.6	10.0	15.4	8.9
Annual Indicator	18.0	10.2	15.7	9.1	
Numerator	30,000	16,000	29,000	18,000	
Denominator	167,000	157,000	185,000	198,000	
Data Source	Census, Current Population Survey	Census, Current Population Survey	Census, Current Population Survey	Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2013

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	29.5	30.8	29.5	30.1	30.0
Annual Indicator	31.4	30.1	30.7	30.4	
Numerator	2,959	2,552	2,470	2,383	
Denominator	9,409	8,491	8,042	7,849	
Data Source	NE WIC	NE WIC	NE WIC	NE WIC	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	9.8	9.0	11.8	11.5	8.3
Annual Indicator	9.2	12.1	11.7	8.5	
Numerator	2,358	3,145	3,047	2,281	
Denominator	25,677	25,914	26,063	26,793	
Data Source	Birth file	Birth file	Birth file	Birth file	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

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

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.3	6.7	10.4	11.2	11.5

	2011	2012	2013	2014	2015
Annual Indicator	6.9	10.6	11.4	11.7	
Numerator	9	14	15	15	
Denominator	130,443	132,294	131,764	127,733	
Data Source	Death file, Census	Death file, Census	Death file, Census	Death file, Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	83.6	82.4	78.6	78.3	86.5
Annual Indicator	80.8	76.6	76.8	84.8	
Numerator	202	209	212	251	
Denominator	250	273	276	296	
Data Source	Birth file	Birth file	Birth file	Birth file	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

None

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	74.7	76.2	76.2	74.6	73.0
Annual Indicator	75.2	74.7	73.1	71.5	
Numerator	18,857	19,131	18,840	18,728	
Denominator	25,077	25,618	25,770	26,201	
Data Source	Birth file	Birth file	Birth file	Birth file	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

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

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Nebraska

SPM 1 - Percent women (18-44) with healthy weight (BMI)

	2011	2012	2013	2014	2015
Annual Objective	48.5	47.8	52.7	52.8	46.7
Annual Indicator	50.0	51.7	51.8	45.8	
Numerator					
Denominator					
Data Source	NE BRFSS	NE BRFSS	NE BRFSS	NE BRFSS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: Comparisons of 2011, 2012 and 2013 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 ans 2012 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.	
2.	**Field Name:**	**2012**
	Field Note: Comparsions of 2011 and 2012 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 additon the 2011 ans 2012 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.	
3.	**Field Name:**	**2011**
	Field Note: Comparsions 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 additon the 2011 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.	

Data Alerts:

None

SPM 2 - The percentage of live births that were intended at the time of conception.

	2011	2012	2013	2014	2015
Annual Objective	61.3	65.5	62.0	63.3	67.1
Annual Indicator	64.2	60.8	65.8	65.8	
Numerator					
Denominator					
Data Source	NE PRAMS	NE PRAMS	NE PRAMS 2012	NE PRAMS 2012	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Due to Administrative Technological changes at CDC PRAMS the PRAMS data has been delayed.	
2.	**Field Name:**	**2013**
	Field Note: Due to administrative changes at the CDC level 2012 is not yet available.	
3.	**Field Name:**	**2012**
	Field Note: NE PRAMS is a weighted survey. So, only weighted estimates are provided. There is a year lag on PRAMS data. So, 2012 will be provided in 2013, etc.	
4.	**Field Name:**	**2011**
	Field Note: 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.	

Data Alerts:

None

SPM 3 - The percent of children living in poverty who have health insurance.

	2011	2012	2013	2014	2015
Annual Objective	94.0	91.2	92.3	90.8	98.6
Annual Indicator	89.4	90.5	89.0	96.7	
Numerator	37,908	40,170	60,408	45,106	
Denominator	42,387	44,404	67,899	46,625	
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

None

Data Alerts:

None

SPM 4 - The preterm birth disparity (ratio) between African American and Caucasian infants.

	2011	2012	2013	2014	2015
Annual Objective	1.4	1.3	1.3	1.3	1.3
Annual Indicator	1.4	1.5	1.5	1.4	
Numerator	12	13	13	12	
Denominator	9	9	8	9	
Data Source	Birth file	Birth file	Birth file	Birth file	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2011**

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

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	82.6	84.3	82.6	84.3	85.9
Annual Indicator	81.0	81.0	81.0	81.0	
Numerator					
Denominator					
Data Source	National Survey of Children's Health, 2007	National Survey of Children's Health, 2010/11	National Survey of Children's Health, 2011/12	National Survey of Children's Health, 2011/12	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Data is from a weighted survey so, only estimates are provided.	
2.	**Field Name:**	**2013**
	Field Note: Data is from a weighted survey so, only estimates are provided.	
3.	**Field Name:**	**2012**
	Field Note: Data is from a weighted survey so, only estimates are provided	
4.	**Field Name:**	**2011**
	Field Note: National Survey of Children's Health, 2007	

Data Alerts:

None

SPM 6 - The rate per 1,000 infants of substantiated reports of child abuse and neglect.

	2011	2012	2013	2014	2015
Annual Objective	21.8	21.4	18.9	21.7	19.9
Annual Indicator	21.3	19.3	21.7	20.4	
Numerator	551	532	588	528	
Denominator	25,907	27,534	27,081	25,903	
Data Source	Child Protective Services, Census	hild Protective Services, Census	Child Protective Services, Census	Child Protective Services, Census	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2011**
	Field Note:	

.

Data Alerts:

None

SPM 7 - Percent of teens who report use of alcohol in last 30 days

	2011	2012	2013	2014	2015
Annual Objective	30.6	26.5	25.9	21.7	21.2
Annual Indicator	27.0	27.0	22.1	22.1	
Numerator					
Denominator					
Data Source	NE YRBS	NE YRBS	NE YRBS	NE YRBS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

	Field Note: NE YRBS is a weighted survey. So, only weighted estimates are provided. The YRBS is administered every other year, new data will be available in 2015.	
2.	**Field Name:**	**2013**
	Field Note: NE YRBS is a weighted survey. So, only weighted estimates are provided. The YRBS is administered every other year, new data will be available in 2015.	
3.	**Field Name:**	**2012**
	Field Note: NE YRBS is a weighted survey. So, only weighted estimates are provided. The YRBS is administered every other year, new data will be available in 2013.	
4.	**Field Name:**	**2011**
	Field Note: NE YRBS is a weighted survey. So, only weighted estimates are provided.	

Data Alerts:

None

Form 11
Other State Data

State: Nebraska

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Nebraska

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table