

NEBRASKA'S TITLE V 5-YEAR NEEDS ASSESSMENT 2010

The Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), provides detailed guidance for states receiving Title V Maternal and Child Health (MCH) Block Grant funds. The Nebraska Department of Health and Human Services (NDHHS), Division of Public Health is the recipient of the Title V Block Grant. Within the Division of Public Health the Lifespan Health Services Unit is responsible for administrating the Block Grant in coordination with the Division of Medicaid and Long Term Care, Long Term Care Section. One requirement of the Title V legislation is to conduct a statewide needs assessment every five (5) years that shall identify the need for:

- ❖ Preventative and primary care services for pregnant women, mothers, and infants
- ❖ Preventative and primary care services for children; and
- ❖ Services for Children with Special Health Care Needs (CSHCN)

This report covers the Needs Assessment conducted during the period of spring of 2009 through July, 2010 on behalf of the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) populations in Nebraska and covering the years 2010-2014.

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1. Process for Conducting Needs Assessment

Goals

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 and one goal for the capacity portion of the assessment:

- 1) To conduct an objective process that limited individual bias, by utilizing rigorous public health methods and relying on data and evidence for decision-making whenever possible.
- 2) To come to a list of ten priorities through a collaborative effort.
- 3) To determine where NDHHS needs to invest in capacity to improve the health of MCH/CSHCN.

The Needs Assessment Committee (NAC) met on November 17, 2009 to begin the formal process and determined that four elements that would lead to a successful process. They were:

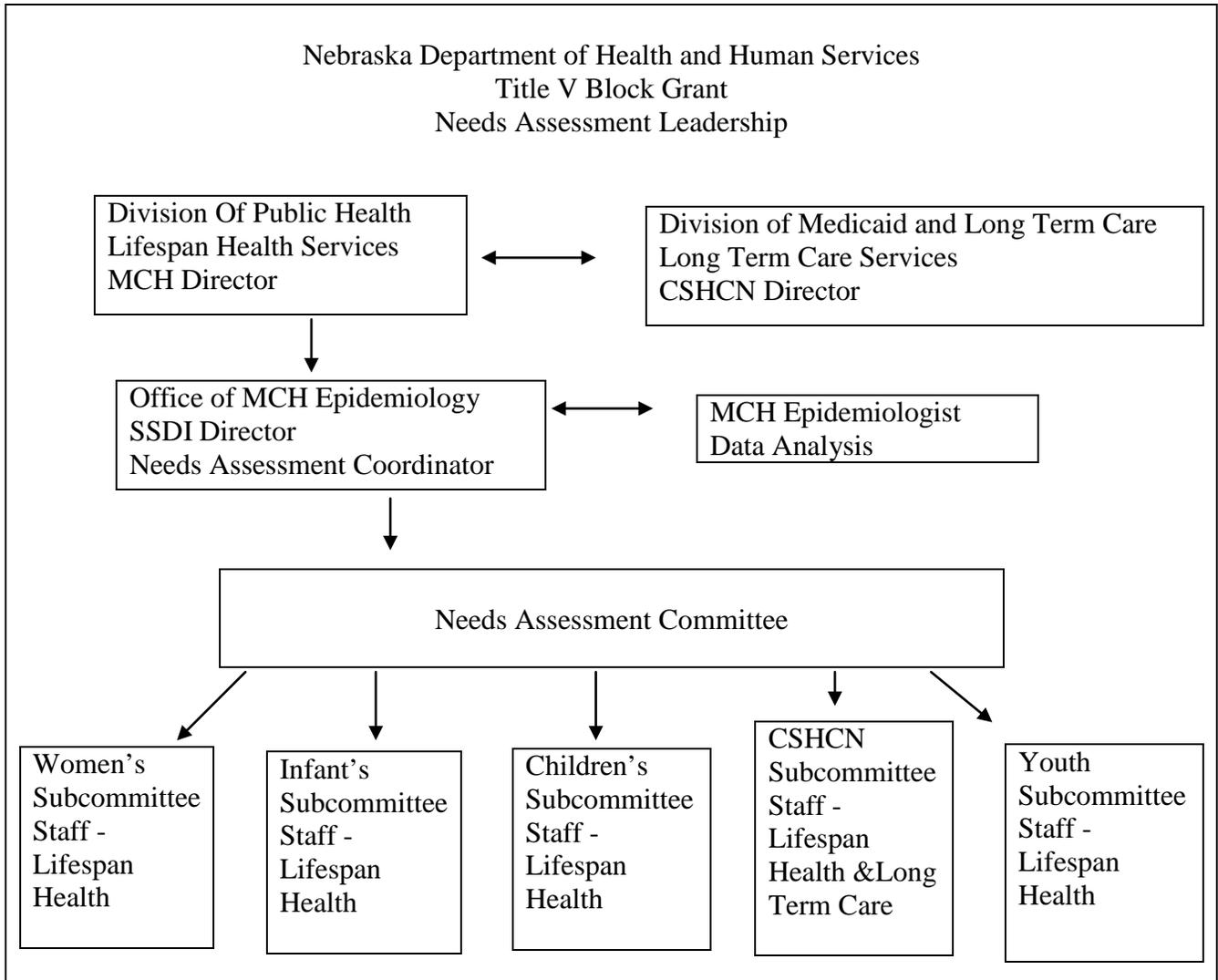
- Full participation by stakeholders
- Honoring diversity and not forgetting small groups
- Creating the opportunity to make a real difference
- Planning for sustainability

Leadership

The Needs Assessment was conducted by the Office of MCH Epidemiology, Lifespan Health Services Unit (LSHU), Division of Public Health, Nebraska Department of Health and Human Services. The Needs Assessment Coordinator manages the Office of MCH Epidemiology and reports to the Title V MCH Director/Administrator of LHSU and consults with the Title V CSHCN Director/Administrator of Long Term Care Services, Division of Medicaid and Long Term Care. Broad oversight of Nebraska's Title V Block Grant is the responsibility of the Chief Administrator of Community Health, and the Chief Medical Officer/Director of the Division of Public Health.

The Office of MCH Epidemiology led the process through out. The Needs Assessment Coordinator (State Systems Development Initiative (SSDI) Director) was responsible for maintaining and implementing the Master Plan and timeline. The Coordinator insured all data was received, analyzed, and presented. The Coordinator attended all meetings. The MCH Epidemiologist prepared and analyzed all data, and produced the data sheets. The Coordinator conducted the Capacity Assessment, managed the publication of all factsheets, and this report.

The process is resource intensive requiring an additional eight staff members to organize and facilitate the work of the five subcommittees. Staff were recruited based on their expertise and relationships within the MCH/CSHCN community, as they were the primary point of contact for the stakeholders during the assessment. Each subcommittee also had a volunteer stakeholder chair that conducted each of the meetings. All stakeholders were self selected to the subcommittee of their choice.

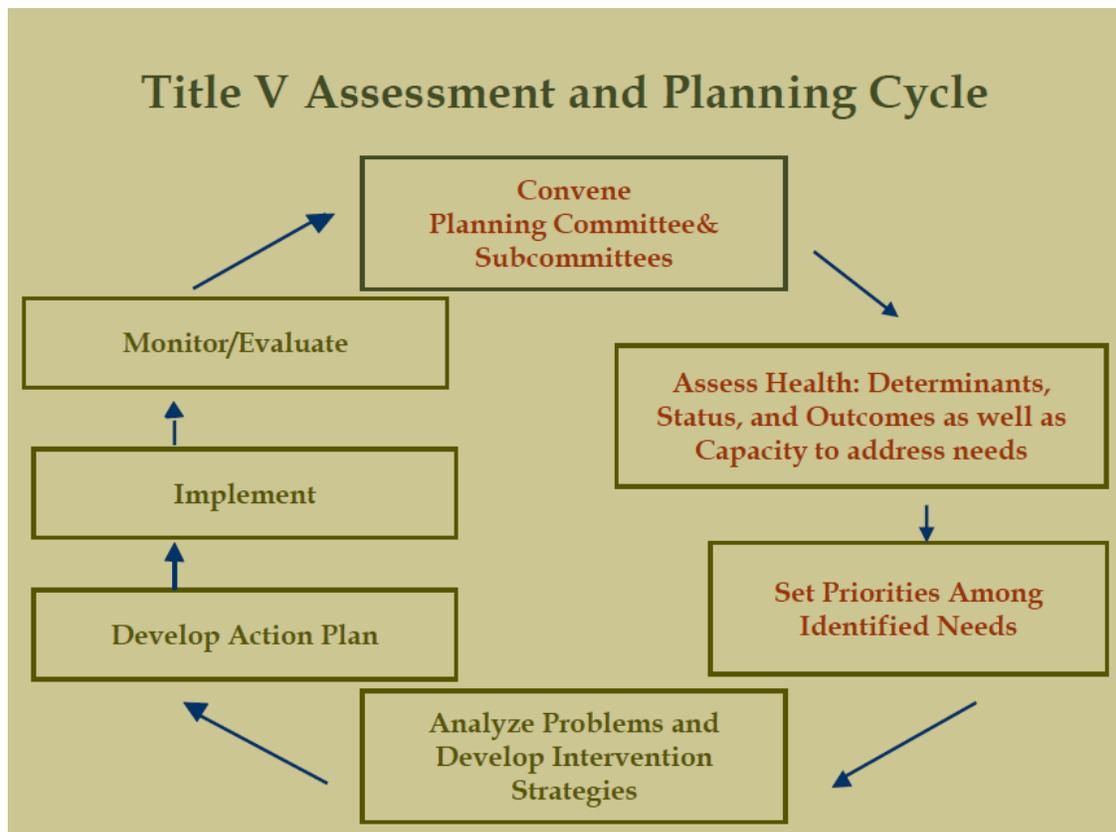


Methodology

A. Overall

Since early 2004, Nebraska has utilized the planning methodology described by the Family Health Outcome 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 process also adapts the social-ecological model into its methodology. For the 2010 process Nebraska decided to augment the FHOP process by incorporating the social/environmental determinants of health (when possible) and used the process to emphasize the life course model of health development.

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:



B. Methods for Assessing Five Sub-Populations

The methods used to assess the strengths and needs of Nebraska’s MCH/CSHCN populations consisted of developing prioritization criteria, data analysis and presentation, identification of problems, and setting priorities among the identified problems. The assessment process was conducted between November, 2009 when stakeholders came together to predetermine criteria for prioritizing needs, and April, 2010 when the same committee came together to review identified needs and determine the final list of 10 priorities. In between the two meetings the NAC broke into five subcommittees to review data analysis, identify needs, and communicate the needs by producing factsheets. The five subcommittees were: Woman 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. Step 1 began in the spring of 2009 and was ongoing though the entire process. Steps 2 and 3 were completed during the NAC meeting on November 17, 2009. Subcommittees met between November 18, 2009 and March 31, 2010 to complete Steps 6-9. Steps 10 through 12 were completed during a second NAC meeting on April 22, 2010. Step 13 was released for public input on June 7, 2010.

	Steps in Assessing Strengths and Needs
1.	Data collection and analysis
2.	Present process to NAC
3.	NAC develops criteria by consensus
4.	NAC determines 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 and experience in applying criteria to determine top 3-5 needs.
8.	Subcommittee meeting 3: Write problem statements and draft factsheets, determine presenters.
9.	Presentation of identified problems by subcommittees to the larger NAC
10.	Use weighted criteria to score problems
11.	Sum participant’s scores / rank problems
12.	Discuss and confirm results through consensus process
13.	Finalize list of 10 priorities

The steps are described in more detail as follows:

1. Data collection and analysis

Nebraska was assigned a MCHB-sponsored Graduate Student Intern Program (GSIP) intern in the spring-summer of 2009 to assist with data collection and assembly. The data process began with a comprehensive review of 18 other states' Needs Assessment Reports from 2005 to identify indicators relevant to Nebraska's MCH/CSHCN populations including National Performance Measures, National Outcomes Measures, Health Status Indicators, Health System Capacity Indicators, and stakeholder requests. Concurrently, staff researched frameworks to incorporate and present social/ecological health determinant indicators, ultimately adapting an approach from the University of Wisconsin Population Health Institute. See Appendix A for the indicator framework and list of indicators by subpopulation (women, infants, children, CSHCN, and youth).

Once the indicator list was established data were collected in the following forms (when available):

- For years 2003-current (in most cases 2008);
- By race/ethnicity and geography;
- National rates
- Healthy People 2010 objectives

A data sheet was created for each indicator, showing (as available) time trends and significance, comparisons to national data and HP2010 goals, and disparities across sub-populations.

2. Present process to NAC

The stakeholder process began with an orientation to the Title V Block Grant, the planning process and purpose of the Needs Assessment, and an introduction to the priority setting process specifically the development of criteria. Participants were encouraged to ask questions. The importance of the member's participation and their need to take a global overview and objective approach was emphasized.

3. NAC develops criteria by consensus

The NAC developed criteria to prioritize health (outcome, status, and determinant) problems/needs of Nebraska's MCH/CSHCN population through a facilitated consensus 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 selection of criteria prior to discussion of specific health problems was an essential element to the process.

The discussion generated during the consensus workshop regarding criteria was important and stimulated critical thinking. The group added, changed and removed criteria. The group was given time to discuss the proposed criteria, to assure each member has a common understanding of each criterion, and to reach consensus on the criteria selected for use.

4. NAC determines weights for each criterion

Not all of the criteria developed are of equal importance; each is 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:

- The problem is severe or increasingly worse than the benchmark. (Weight = 3)
- Disparities exist related to health outcomes. (Weight = 2)
- Strategies exist to address the problem. (Weight = 2)
- Capacity and support are available to address the problem. (Weight = 1)
- Data exists to indicate the problem. (Weight = 1)

5. Staff finalizes definitions and develops rating scales for criteria

Because the NAC had nearly 80 participants (including staff), the criteria development ran into time constraints, and it was agreed that the work of writing expanded definitions for the five selected criteria would be done by staff and stakeholder volunteers. In addition to defining the criteria, a rating scale particular to each criterion was developed. A rating scale is a way to assure that each participant is using the same, agreed upon definitions and rating system. The rating system was used to capture the degree to which a problem met a criterion on a 5-point scale. See Appendix B for the criteria, definitions, and rating scale.

6. Subcommittee meeting 1: Provide orientation and present data

A total of 8 staff (7 staff and 1 graduate student) provided direction and facilitated the organization of the five subcommittees (women, infants, children, CSHCN, and youth). Each subcommittee identified a stakeholder chair to lead the meetings. During the first meeting the Needs Assessment Coordinator provided an orientation which included an introduction to social/environmental determinants of health, the social ecological model, and life course perspective, three models that are central to Nebraska’s planning process. The coordinator presented the data analysis sheets and identified requests for additional data. These requests were met as best as possible.

7. Subcommittee meeting 2: Review additional data, identify list of needs and practice applying criteria to determine top 3-5 needs.

During the second subcommittee meetings the members reviewed additional data, identified a preliminary list of the problems/needs of its population group, and utilized the criteria and prioritization tool to narrow their list to three to five problems/needs to propose to the larger group. See Appendix C for an example of the prioritization tool.

8. Subcommittee meeting 3: Write problem statements and draft factsheets, determine presenters.

During the third and final subcommittee meeting the members wrote problem statements for their chosen indicators, began to draft fact sheets that articulated their proposed priorities and addressed the criteria, and began to plan their presentation.

9. Presentation of identified problems by subcommittees to the larger NAC

After the third subcommittee meeting the factsheets were finalized and aggregated into one packet. A total of 17 problems/needs were included. Each member of the NAC received the packet prior to the final meeting. At the final NAC meeting the subcommittees presented their findings and made their case to the larger NAC why their potential priorities were important.

10. Use weighted criteria to score problems

Following the presentations NAC members individually use the weighted prioritization criteria to score each of the 17 problems. Staff provided a copy of the problem prioritization matrix designed to use the weighted criteria with the problems imbedded. Staff instructed participants in the use of this tool and ensured that every participant used the scoring system accurately.

11. Sum participant scores / rank problems

The results of the individual scoring of each problem were 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 (17). Results of the ranking were then presented to the group.

12. Discuss and confirm ranked results

After review of the scores and ranking the full NAC used consensus to combine and refine some of the problems. Participants made proposals to narrow the list down from 17 to 10. Proposals were subjected to two criteria 1) the proposal must honor the process and, 2) the proposal must honor the priority. At the end of the consensus process, all 17 needs had been incorporated into 10 overarching priorities.

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 to the NAC through the subcommittee facilitators and published for public input on the NDHHS website. The NAC was asked to complete an on-line evaluation survey to determine agreement on the final list. See Appendix E for a copy of the survey.

C. Methods for Assessing State Capacity

While the stakeholder portion of the Needs Assessment (assessment of strengths and needs) was underway, the Needs Assessment Coordinator conducted the overall Capacity Assessment (assessment of services provided by pyramid level). To assess Nebraska's capacity to provide direct health care, enabling, population-based, and infrastructure building services, the Coordinator performed a systematic review of infrastructure and services provided/ monitored by NDHHS, other State Agencies (including the University), local government, and non-profit partners. The initial assessment was a desktop assessment that collected and synthesized agency documents and information from program managers into one document. Once the NAC recommendations for the final 10 priorities were made, the Coordinator began to assess the capacity to address each priority in a similar fashion.

The draft assessment was presented to a volunteer Capacity Committee made up of internal NDHSS staff and strategic stakeholders representing the diversity of the MCH/CSHCN population and stakeholders across the state. The committee convened on June 14, 2010 following the identification to the 2010-2015 priority needs to review current capacity and identify concerns and gaps for the purposes of this report, as well as assess level of capacity Nebraska had to address the priority. The Capacity Committee was particularly important in identifying additional information, identifying emerging needs and articulating concerns in the overall assessment and then identifying where capacity investments can be made to make progress addressing the priority needs.

The Committee was asked to determine the Nebraska capacity to address each of the priority needs. The committee reviewed a analysis of services for each priority, identified gaps in the summary and then determine the capacity level using a tool that was created loosely on a portion of Association of Maternal and Child Health Programs' (AMCHP) CAST-5 methodology. The tool identified four domains of capacity and gave examples of each domain. The domains are: 1) structural capacity or the authority, funding, and resources to work on the problem, 2) data capacity or the ability to accurately measure the problem, 3) relational capacity or the relationships required to effectively address the problem, and 4) knowledge capacity or having all the information needed to address the problem. If the committee came to the conclusion that capacity existed in domain a score of one was given and if capacity did not exist a score of zero was given. Each priority could have a total score of 0-4. A score greater than 3 meant high capacity, a score greater than 1 and less than three was moderate capacity, and a score less than one was low capacity. See Appendix E for an example of the tool.

Data Sources

The following is a list and brief description of the primary data sources utilized in the 2010 Needs Assessment:

A. Nebraska Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Problematic issues for Nebraska include the small numbers for some events and some areas of the state, and difficulties in generating sufficient sample sizes for racial/ethnic-specific estimates.

B. The Nebraska Cancer Registry (NCR) was created by the Legislature in 1986, to document new cases of cancer in Nebraska, analyze geographic patterns and long-term trends, and plan and evaluate cancer control programs. The registry also provides statistical and other information about cancer in Nebraska in response to specific requests. The data are collected at hospitals, pathology laboratories, radiation treatment centers, physician offices, and outpatient surgery centers, and from death certificates. The registry is funded using a portion of the state's cigarette tax and through funding from the federal Centers for Disease Control and Prevention (CDC).

C. The Child Death Review Team (CDRT) tracks the numbers and causes of deaths of Nebraska resident children ages 0 to 17. CDRT members also assess whether a person or community could reasonably have done something to prevent the death. The CDRT uses law enforcement, medical, and other records to review each death, and generally maintains a more accurate classification of cause of death than available solely through death certificates.

D. US Census Bureau, specifically the Current Population Survey (CPS) and the American Community Survey (ACS). The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years, and is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian non-institutional population. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas.

E. The ACS is a nationwide survey designed to provide communities a fresh look at how they are changing. Replacing the decennial Census' traditional "long form," it is a critical element in the Census Bureau's reengineered programs. The ACS collects and produces population and housing information every year instead of every ten years. Most of Nebraska's communities are much smaller than the ACS threshold of 20,000 population; in fact, 77 of the state's 93 counties (83%) have populations under 20,000. Thus, only three counties have annual data while 13 more have 3-year aggregates. Five-year aggregate figures for all counties are anticipated in late 2010.

F. Data for Child Protective Services come from the state's Statewide Automated Child Welfare Information System (SACWIS), also known as N-FOCUS (Nebraska Family Online Client User System). The data are extracted annually and are dependent upon the accuracy of the initial data entry.

G. The Nebraska Hospital Association's Nebraska Hospital Information System (NHIS) has collected and analyzed Nebraska hospital health care data since January, 1995. The NHA has participating agreements and business associate agreements to receive claims data from Nebraska hospitals. Although voluntary, hospitals are making a committed effort to send all their claims (inpatient & outpatient), including self-pay, to the NHIS. NHIS data have only recently begun including race/ethnicity identifiers.

H. Nebraska lead poisoning surveillance data are entered into the Systematic Tracking of Elevated Lead Levels and Remediation (STELLAR) database that was created by the Centers for Disease Control and Prevention. The database tracks children tested and reported to Nebraska DHHS by physicians, clinics, laboratories and hospitals, as required by Nebraska law. Limitations to these data include incomplete and inconsistent reporting, missing values for demographic variables, and the inability to identify the entire at-risk population.

I. Nebraska Medicaid data are derived from the annual EPSDT (Early Periodic Screening Diagnosis, and Treatment) Participation Report, Form CMS-416. EPSDT is the child health component of Medicaid. Required in every state, it is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. Participation in EPSDT is constricted by the availability of providers willing to accept Medicaid clients.

J. The National Immunization Survey (NIS) is sponsored by the National Center for Immunizations and Respiratory Diseases (NCIRD) and conducted jointly by NCIRD and the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention. The NIS is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. It has been collecting data since April, 1994, to monitor infant and childhood immunization coverage, including breastfeeding.

K. The National Survey of Children's Health is a national telephone survey conducted in English and Spanish during 2003-2004, and for a second time in 2007-2008. The survey provides a broad range of information about children's health and well-being collected in a manner that allows for comparisons between states and the nation. Survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

L. National Survey of Children with Special Healthcare Needs (NSCSHCN) is another national telephone survey conducted in English and Spanish. The first round took place during 2001 and then a second time in 2005-2006. The survey provides a broad range of information about CSHCN's health and well-being collected in a manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

M. The Nebraska Pediatric Nutrition Surveillance System (PedNSS) is a program-based surveillance system that monitors the nutritional status of low-income infants, children and women in federally-funded maternal and child health programs. The breastfeeding data originate from the Nebraska Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program.

N. NE Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey on topics related to pregnancy that began in 1999. PRAMS' sample of approximately 2,500 (10% of births) is drawn from the state's birth certificate file. Racial/ethnic minorities are sampled at higher rates to allow sufficient data for these smaller but higher-risk populations.

O. Sexually Transmitted Disease Surveillance data come from the DHHS STD Program, and are an aggregate of cases from notifiable disease reports.

P. Nebraska Vital Statistics are derived from vital records collected by the state of Nebraska. Birth records of events for Nebraska residents which occur in other states, territories and Canada, are received by the Department through an Inter-Jurisdictional Exchange Agreement, and thus also included.

Q. Youth Tobacco Survey was developed by the Centers for Disease Control, and the American Legacy Foundation to measure the tobacco-related beliefs, attitudes and behavior of youth, and the pro- and anti-tobacco influences to which they are exposed. The state began to conduct the survey in 1999/2000 and has been conducted every spring of each even year except for 2004. In 2008, the YTS was only conducted in the high schools due to logistical issues. The 2010 administration will be the fifth time that the YTS will be conducted in Nebraska schools.

R. Nebraska's Youth Behavioral Risk Factor Survey (YRBS) is a reliable and valid, biennial survey of 9th – 12th grade students in US public and private schools, and includes information about alcohol use and obesity among youth. Although the majority of school districts in the state participate in this voluntary endeavor, the largest and most diverse district (Omaha) did not, limiting the generalizability of the data collected. Efforts are ongoing to recruit the Omaha School District into the next survey round.

S. Since 1995, the U.S. Department of Agriculture (USDA) has collected information annually on food spending, food access and adequacy, and sources of food assistance. The information is collected in an annual food security survey, conducted as a supplement to the nationally representative Current Population Survey (CPS). A major impetus for this data collection is to provide information about the prevalence and severity of food insecurity in U.S. households. Estimates are provided for the nation as well as state-specific estimates.

Linkage between Assessment, Capacity, and Priorities

Nebraska chose to assess strengths and needs concurrently with the examination of capacity and finalize the capacity assessment after the priorities were determined. This meant that the NAC take a broad view of capacity while identifying needs. The committee developed a criterion (one of five) which would eliminate any need in which no capacity to address the needed exists. The overall capacity assessment was finalized after the selection of the 10 priority needs to ensure that each priority was assessed for capacity strengths and gaps. This analysis is extremely useful in the creation of plans to address the priorities by pointing to areas where investments might have significant impact.

Dissemination

The Needs Assessment findings were disseminated to the stakeholders and then the public. The list of 10 priorities have were disseminated through email communication and the NDHHS website. Significant public input was received. The Needs Assessment Report was published on the NDHHS website and stakeholders were notified by staff. The Office of MCH Epidemiology deconstructed the report and published the data, and capacity assessment into separate documents for stakeholder use.

Stakeholders are expected to continue to partner with NDHHS in planning and implementation activities, since the Needs Assessment is designed to direct the work over the next five years the findings of the process will be disseminated in future planning processes including strategy development. The findings will be utilized in funding community level and infrastructure activities. Finally, the findings will help direct the work of NDHHS staff.

Strengths and Weaknesses of Process

The strength of the process is in the methodology that supports objective critical thinking, such as predetermining the criteria and relying on data for identification of problems. The subcommittee work was a rich environment for utilizing these methods and building capacity among the MCH/CSHCN community for using data and literature to support decision making. This process worked well within groups with similar views and goals or that serve the same population.

Because Nebraska has cultivated strong passionate stakeholders, participation was at an all time high and remained consistent throughout the entire process. In 2005 Nebraska had 35 active stakeholders and by 2009 the number had grown to nearly 80. The process was able accommodate this number of participants without a problem.

Weaknesses lie in the nature of a state level assessment; because the state has broad levels of concern the resulting priorities are broad. In addition, it was difficult to incorporate local level assessments into a state level assessment. Most local assessments are for the entire population and are not specific to MCH/CSHCN. In addition, when findings and priorities are localized it is hard to find support among stakeholders from other areas.

Reaching consensus gives everyone a voice at the table. A consensus process has no mechanism (other than discussion) for forcing hard decisions. At opposite ends of a decision are distinct opinions which, if left unresolved, could potentially lead to division and unresolved conflict. This can happen if a few participants don't embrace the goals of the process. They have the opportunity to pull the rest of the group away from what could really be the most desirable outcome.

2. Partnership Building and Collaboration Efforts

Stakeholders play a significant role in the assessment process, specifically in identifying and prioritizing identified problems and in providing input on the development of strategies to intervene in prioritized areas. Nebraska's MCH/CSHCN 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 communication that communicate their findings. Therefore, it is essential that Nebraska had (and continues to have) an active and engaged committee. The NAC had a diverse stakeholder membership consisting of representatives from State and local MCH/CSHCN programs, NDHHS programs (Public Health, Medicaid, Children and Families), other State Agencies (Education, University Departments), other HRSA programs, local public health agencies, non-profits and families. For a complete list of participant by subcommittee, please see Appendix F.

One of the goals of the process was to determine the list of ten priorities through a collaborative effort. As the process came to a conclusion an on-line evaluation survey was promoted. An important piece of that survey was assessing if in fact collaboration had occurred. The following question was asked for the large committee and then again for the subcommittees:

Thinking about the definitions below which one best describes the work of the large committee?

Collaboration: A process which parties who see different aspects of a problem explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible to achieve a shared vision.

Coordination: A process of communication, planning, sharing of resources, for the purpose of efficiently/effectively achieving a shared goal.

Cooperation: A process where parties with similar interests negotiate mutual roles and shared resources to achieve joint goals but maintain separate identities.

Collaboration
Coordination
Cooperation
None of the above
Not applicable

There were 40 respondents. Results for the NAC meetings showed that 41% reported collaboration, 24% reported coordination, 26% cooperation, and 15% reported none/not applicable. Results for the subcommittees showed 62% reported collaboration, 35% reported coordination, 15% cooperation, and 5% answered not applicable.

One of the benefits of participating in the Needs Assessment was the opportunity to network. Participants were asked: 1) as a result of the work of the large committee, did you form new partnerships or strengthen any of your existing partnerships, and 2) as a result of the work of the subcommittee, did you form new partnerships or strengthen any of your existing partnerships? Results showed that 52% formed new or strengthened partnerships with in the large committee, and 65% did so within the subcommittees.

Other results of the partnership were the exposure too and relationships built among public health programs and family members who don't traditionally work together, as well as the increased awareness and knowledge of the MCH/CSHCN efforts. This was evident as they worked together to understand, interpret, and present data findings within their subcommittees, when they presented subcommittee finding to each other, and when the negotiated the final list of priorities. These programs and family members were exposed to data sources, analysis and planning methodologies and leadership styles should result in improved system development.

3. Strengths and Needs of the MCH/CSHCN Populations and Desired Outcomes

The health outcomes, status, and determinants for each of the MCH/CSCHN populations were analyzed by each of the five population groups. Indicators were drawn from comprehensive review of the 2005 Needs Assessments, National Performance Measures, National Outcomes Measures, Health Status Indicators, Health System Capacity Indicators, and stakeholder requests. During the process staff analyzed over 200 indicators for statistical significance in trends, against national rates, for disparities (race/ethnicity, age, income, and geographical), when appropriate against Healthy People 2010 (HP2010) and then published the findings in data sheets. These data sheets describe major morbidity, mortality, health behavior, and access to care for the MCH/CSHCN

population groups in Nebraska. See Appendix G for the data sheets by population (women, infants, children, CSHCN, and youth).

The subcommittees reviewed the data sheets, discussed the implications, came to a shared interpretation of the data and then identified their concerns. Once a list of concerns was generated they used the prioritization tool to identify three to five potential priorities that would be further analyzed and presented for possible inclusion in the final list of 10. The following narrative describes the initial findings of the subcommittees and descriptions of their purposed priorities. The descriptions of the problems were written by the stakeholders with the assistance of staff.

Women of Child-Bearing Age

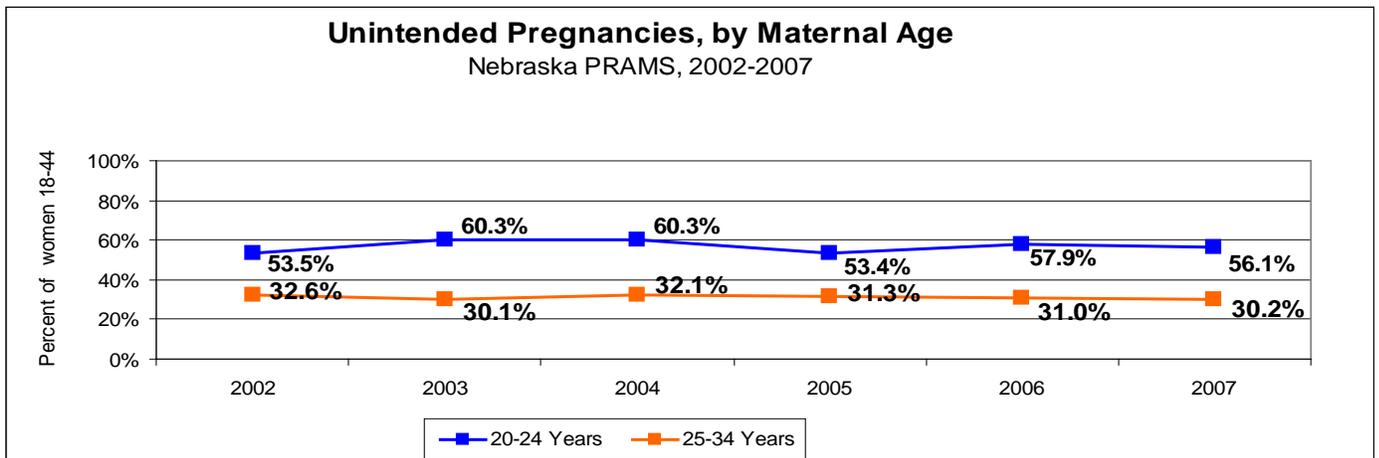
Based on data and stakeholder experience the subcommittee determined the top concerns to be:

- Rates of unintended pregnancy
- Increasing rates of STD's
- High rates of overweight/obesity including the incidence of diabetes and hypertension
- The impact of low education attainment on health
- Access to health care
- Persistent high rate of binge drinking
- Tobacco use
- Mental health issues

Using the criteria determined at the initial NAC meeting the list was narrowed to the following three problems (see Appendix H for complete Factsheets developed on each of these issues):

A. Unintended Pregnancy

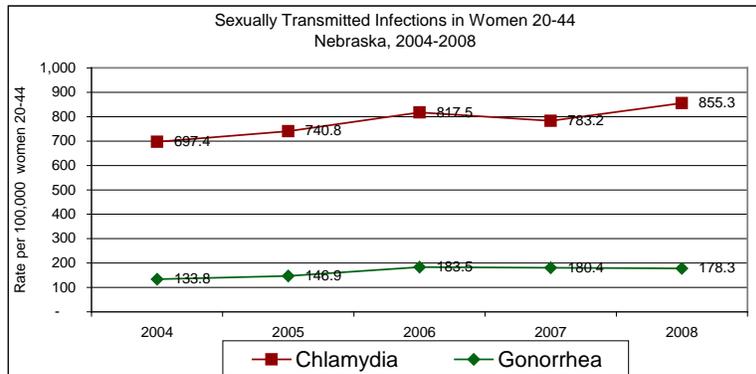
Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) has been surveying new mothers about their experiences and perspectives since 1999. Unintended pregnancies are defined as pregnancies that are either mistimed or unwanted at the time of conception. Unintended pregnancies account for a substantial proportion of all births, and are particularly common among young, unmarried women. Based on PRAMS data for 2004-2007, an estimated 40.9% of Nebraska mothers had unintended pregnancies, higher than the HP 2010 Objective of 30% for unintended pregnancy. These represent an estimated 10,366 births per year in Nebraska during this period.



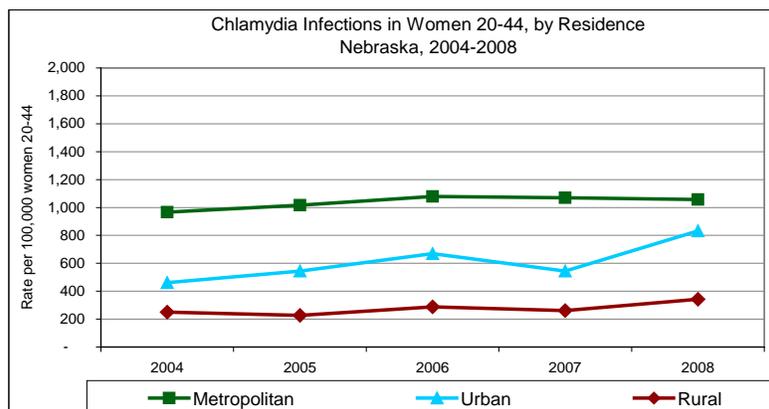
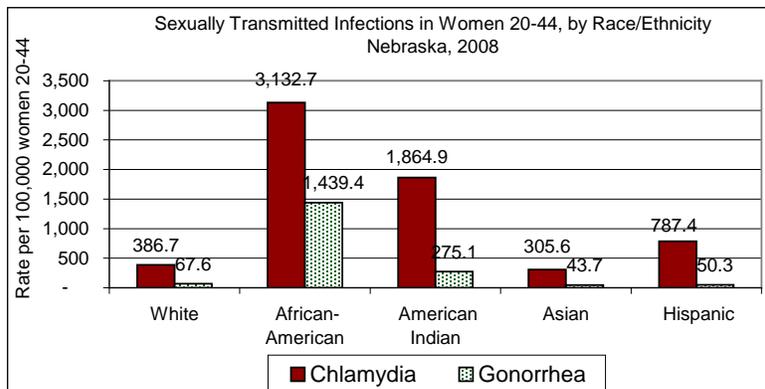
PRAMS data indicated that Nebraska mothers who had not intended to become pregnant were significantly more likely to have no health insurance or Medicaid coverage before becoming pregnant; experience physical abuse; smoke cigarettes; not take folic acid (vitamins); start prenatal care late (after the first trimester); and never breastfeed or quit within the first month.

B. STD's

According to the NDHHS, Epidemiology Communicable Diseases Sexually Transmitted Disease (DHHS STD) Program, STDs among Nebraska's women (ages 20-44) are increasing significantly overall, and specifically for chlamydia, while gonorrhea rates have shown no improvement over time. The total number of STDs reported in Nebraska increased from 5,177 (302.5/100,000) cases in 2001 to 7,611 (430.4 /100,000) cases in 2007.



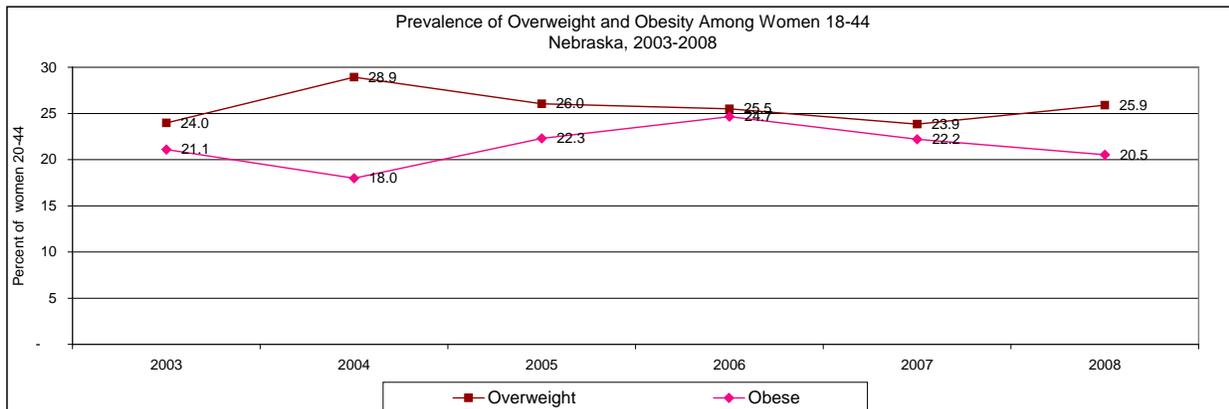
There is evidence that significant disparities exist and have been well documented. In Nebraska young women, African American women, and those who live in metropolitan and urban counties have significantly higher rates of STDs.



C. Overweight/Obesity

According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), 26.0% of Nebraska women aged 18-44 are overweight and 20.5% are obese. The prevalence of women who are overweight (26%) is higher than the Healthy People 2010 Objective (25%). Likewise, the obesity rate (20.5%) is higher than the Healthy People 2010 Objective (15%). These rates are not improving over time. Data from the NE BRFSS is limited in analysis of subpopulations; while analysis indicates that racial ethnic disparities exist the true magnitude is not known.

The percentage of women who have vigorous and regular physical activities (17.4%) and women who engage in moderate physical activities only (25.5%) are both significantly less than the Healthy People 2010 Objective (30% and 50%). Diabetes prevalence in Nebraska (3.2%) is higher than the Healthy People 2010 Objective (2.5%).



Infants

Based on data and stakeholder experience the subcommittee determined the top concerns to be:

- High rates (compared to other age groups) of substantiated abuse and neglect
- Entry into and quality of prenatal care
- Persistent prevalence of maternal smoking
- Low rates of lead screening
- The duration of breastfeeding
- The impact of racial/ethnic disparities on infant health
- The impact of poverty on infant health

Using the criteria determined at the initial NAC meeting the list was narrowed to the following five problems (see Appendix H for complete Factsheets developed on each of these issues):

A. Abuse and Neglect

In Nebraska, the rate of substantiated infant abuse and neglect was 23.02 per 1,000 infants in 2008. From 2004 to 2008, Nebraska’s substantiated infant abuse rate has not changed significantly. Nebraska’s 2008 substantiated infant abuse and neglect rate was more than two times the U.S. Healthy People 2010 benchmark of 10.3 per 1,000 and more than three times the Nebraska Healthy People benchmark of 6.8 per 1,000.

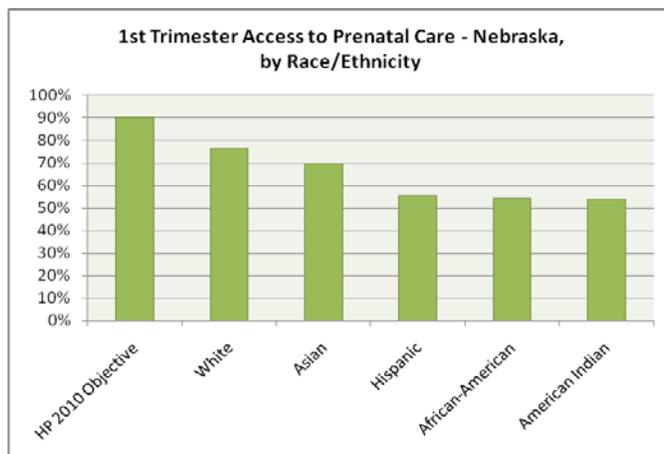
Nebraska’s infants are abused and neglected at a rate more than two times higher than the overall child abuse and neglect rate of Nebraska (10.37 per 1,000 for children birth to 18 in 2008). From 2005 to 2006, infants suffered violent, abusive or neglectful deaths disproportionately compared to other age groups—with infants being 34% of all violent child deaths.

Across Nebraska’s racial groups, known disparities in abuse and neglect exist. Among children ages 0 to 4, the rate of substantiated cases of abuse and neglect varied drastically across races in 2008. American Indian children (50.02 per 1,000) were abused or neglected at a rate four and a half times greater than the rate of White children (11.14 per 1,000). Black/African American children (32.71 per 1,000) were abused at a rate approximately three times the rate of White children. Native Hawaiian Pacific Islander children were also abused or neglected at a higher rate (19.74 per 1,000).

B. Entry into and Quality of Prenatal Care

Although women in Nebraska (72.2%¹) have a higher rate of seeking prenatal care during the first trimester than the Nation (69.0%¹), Nebraska is still far below the Healthy People 2010 Objective of 90%. Nearly 1/3 (27.8%¹) do not receive prenatal care in the first trimester and there has been no significant change to this pattern over the past four years. In addition, the percent of women receiving inadequate prenatal care (according to the Kotelchuk* Index) has not changed over the past four years and remains at 14.5%¹. The HP 2010 objective seeks a rate of no more than 3%.

Significant racial/ethnic disparities exist for prenatal care in Nebraska. Even though access to care during the first trimester for Nebraska’s white (76.4%¹) population is well below the HP 2010 objective (90%); the racial ethnic disparities that exist are extremely more significant for Asian (69.8%¹), Hispanic (55.5%¹), African-American (54.4%¹) and American Indian (53.9%¹). In addition, the four year trend for Nebraska’s African-American population to receive 1st trimester prenatal care is declining.



C. The Duration of Breastfeeding

The Healthy People 2010 Goal is to “increase the proportion of mothers who breastfeed their babies”. The goal targets the early postpartum period, at 6 months and at one year. Nebraska’s rate for 6 months breastfeeding duration is 46.2%, which is above the national average but below the Healthy People 2010 goal. Nebraska’s exclusively breastfeeding rate at 3 months is 31.7% and at 6 months 11.9%, overall, falling well below the Healthy People goals. According to the National Immunization Survey data, Nebraska’s 6 month duration and 3 and 6 month exclusivity rates have not improved over time.

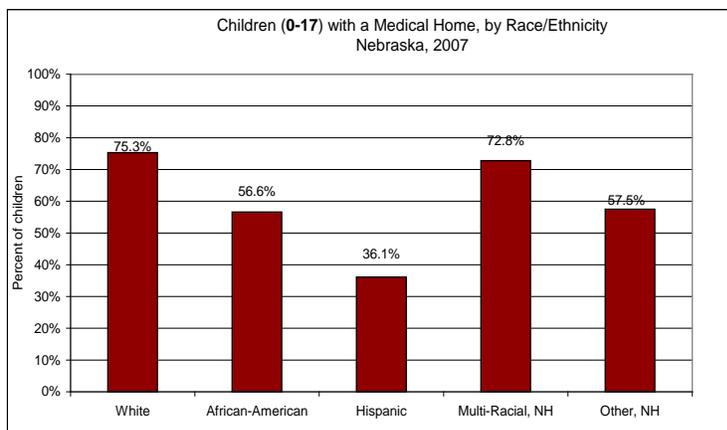
BREASTFEEDING RATES	NEBRASKA	NATION	HP 2010 GOAL
DURATION AT 6 MONTHS	46.2%	43.4%	50%
EXCLUSIVE AT 3 MONTHS	31.7%	33.1%	40%
EXCLUSIVE AT 6 MONTHS	11.9%	13.6%	17%

D. The Impact of Disparities on Infant Health

Disparities in health outcomes are fundamentally intertwined with many risk factors. Social determinants of health consider multilevel and integrated variables in social, economic, and environmental conditions. Many indicators illustrate these disparities. Three indicators are selected for Nebraska infants by race/ethnicity to feature persistent health disparities:

1. Access to Care

In 2007, 77% of Nebraska children ages 0-5 years reported having a medical home, which is higher than the national percentage (64%). However, Hispanic and African-American children (0-17) are significantly less likely to have a medical home.



2. Preterm Labor/Low Birth Weight

Nebraska preterm birth (12.5%) is higher than the 7.6% benchmark (HP 2010). Preterm birth is a persistent problem with no linear change in a five-year trend in Nebraska and the Nation. For Nebraska infants, the percentage of preterm births in African-Americans is significantly worse.

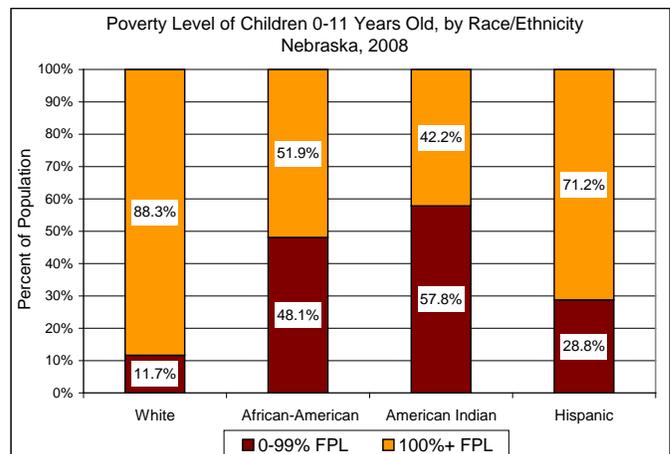
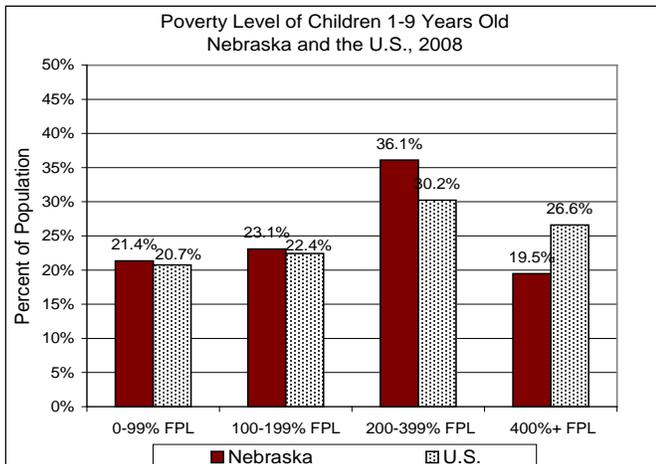
At 7.1%, Nebraska rates of low birth weight are above the 5% benchmark. (HP 2010) Nebraska births show evidence of significant racial/ethnic disparities in low birth weight African American infants (12.6%) which is notably higher than the next highest rate of Asian (9.1%). Although better than the U.S. rates, Nebraska births show similar indications of no linear change in low and very low birth weight over a five-year period.

3. Infant Mortality

The rate at which African-American and American Indian infants die in Nebraska is much greater than other races/ethnicities. In the five-year period 2001-2005, the infant mortality rate was 2.7 times higher for Native Americans as for Caucasians. It was 2.6 times as high for African-Americans.

E. The Impact of Poverty on Infant Health.

Infants and Children in Nebraska are more likely to live in poverty and near poverty than the national average. This is not improving over time. Nebraska ranks 33rd in the Nation for people living under the federal poverty level. There is strong evidence that there are historical inequities persistent among those who live in poverty and the overall population, these inequities result in disparate health outcomes. Disparities are seen within race/ethnicity, geographical locations, and age.



Children

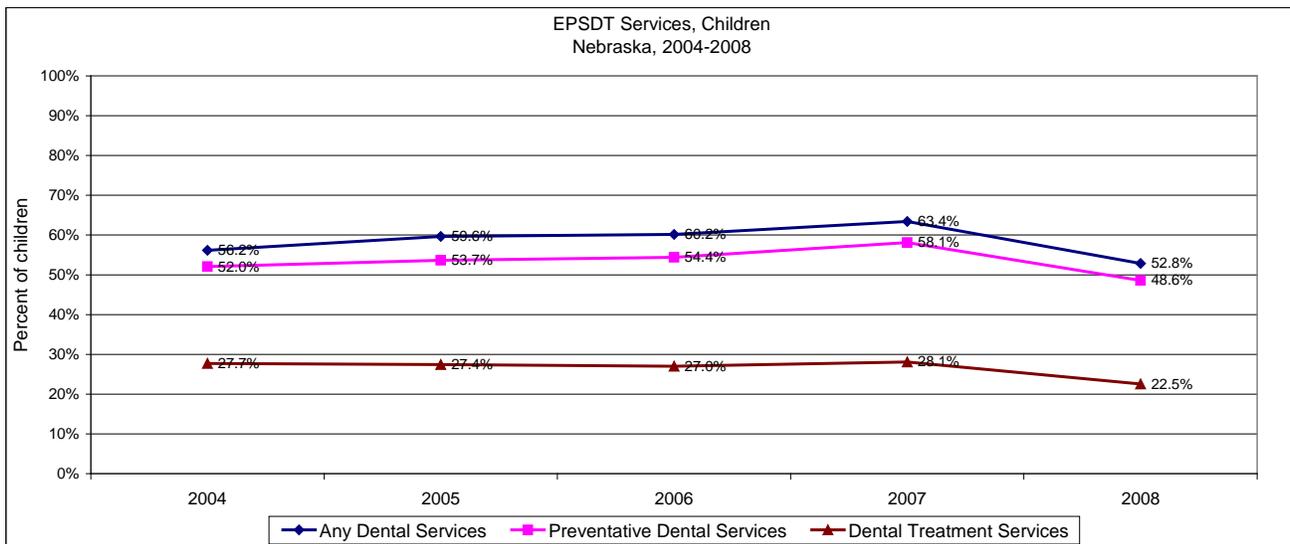
Based on data and stakeholder experience the subcommittee determined the top concerns to be:

- Access to oral health care
- Racial/ethnic disparities in access
- Lack of parent education
- Rising rate of food insecure children
- Low rates of physical activity
- School readiness
- Low rates of lead screening
- High rates of overweight/obesity

Using the criteria determined at the initial NAC meeting the list was narrowed to the following three problems (see Appendix H for complete Factsheets developed on each of these issues):

A. Access to Oral Health

Currently, Nebraska is not meeting the Healthy People (HP) 2010 objective (66%) of Medicaid eligible children receiving preventive dental services. Disparities exist related to oral health, specifically affecting low income, young children and children with special healthcare needs. If this trend continues, there will be a greater disparity in regards to the oral health status of children. Lack of pediatric dentists, shortages in funding, and the lack of coordination of existing efforts are some of the contributing factors to the poor oral health status for some of Nebraska’s children.



B. Food Insecurity among Children

USDA’s Household Food Security in the United States, 2008 documents that the prevalence of food insecurity in the United States as well as in Nebraska is on the rise. Nationally, the prevalence of food insecurity is up from 11.1 percent (13 million households) in 2007 and was the highest observed since nationally representative food security surveys were initiated in 1995. From 1996-98 to 2006-08 Nebraska saw a 1.7

percentage point increase in the prevalence of households experiencing low or very low food security. In Nebraska, 10.4 percent of households have low or very low food security which is considerably higher than the Healthy People 2010 objective goal of 6 percent.

Prevalence of low or very low household-level food insecurity

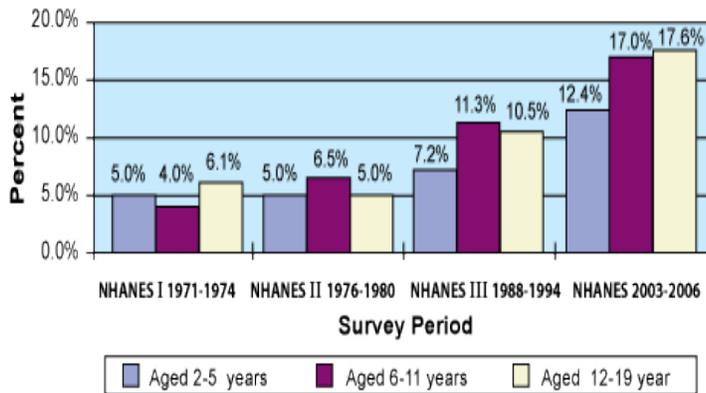
Year	Nebraska	Nation	HP 2010 ²
1996-98	8.7%	11.3%	6%
2003-05	10.3%	11.4%	6%
2006-08	10.4%*	12.0%	6%

*1.7 percentage point change 1996-98 to 2006-08 was statistically significant with 90 percent confidence ($t > 1.645$)

C. Overweight/Obesity

According to the National Health and Nutrition Examination Survey (NHANES) the prevalence of obesity has increased nationally for children since the 1970's. Data suggests that for children aged 2–5 years old, the obesity prevalence increased from 5.0% to 12.4%; for children aged 6–11 the prevalence increased from 4% to 17.0%; and for those aged 12–19 the prevalence increased from 6.1% to 17.6%.

Prevalence of Obesity among U.S. Children and Adolescents (Ages 2-19 years)



According to the National Survey on Children's Health, Nebraska's ranking for obesity and overweight among children (10-17) changed from 10 in 2003 to 31 in 2007 (1 is the best). The prevalence of overweight/obesity among Nebraska children (10-17) in 2007 was 31.4% (2007) which is above the Healthy People 2010's objective of 5%. The National Survey on Children's Health reports that the number and percent of children who engage in vigorous physical activity at least 20 minutes per day was 31.1% for NE children (6-11) years old which is lower than the respective national average of 37.7%. These rates are also significantly lower than the HP 2010 objective of 85%.

CSHCN

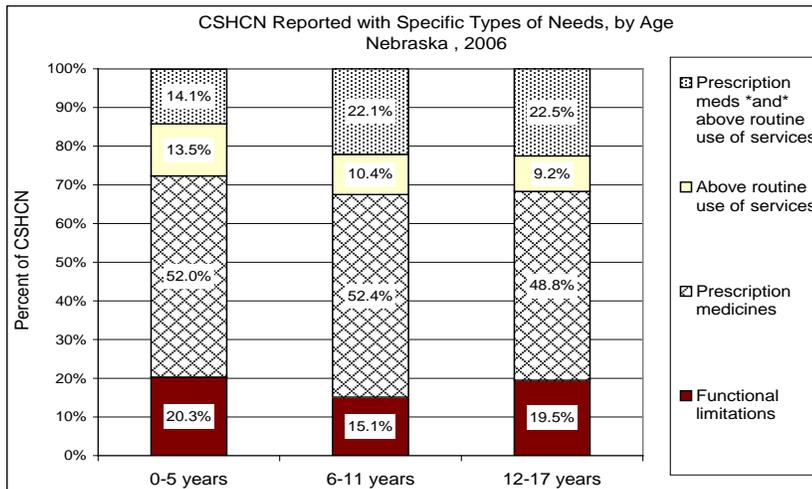
Based on data and stakeholder experience the subcommittee determined the top concerns to be:

- Poorer outcomes/health status for CSHCN with functional limitations
- High use of prescription drugs to manage health needs
- The prevalence of insured CSHCN whose coverage is inadequate
- Access to oral health care
- Racial/ethnic disparities
- Mental health needs
- Access to a Medical Home
- Transition to adulthood
- The rate of overweight/obesity
- Abuse and Neglect of CSHCN

Using the criteria determined at the initial NAC meeting the list was narrowed to the following three problems (see Appendix H for complete Factsheets developed on each of these issues):

A. Improved Outcomes for CSHCN with Functional Limitations

It is estimated the over 11,000 children in Nebraska live with functional limitations; it is alarming that 20.3% of the children 0-5 years old are already living with functional limitations. Early impact of a coordinated approach in the first days of diagnosis could help pave the road to a better outcome. Children with functional limitations were significantly less likely to report that their health insurance is adequate (47% versus 66% overall). They are also less likely to have a medical home (35% versus 54% overall), less likely to report that services are organized in ways that families can use them easily (76% versus 92% overall), and less likely to have families who are partners in decision making at all levels (47% versus 66%).

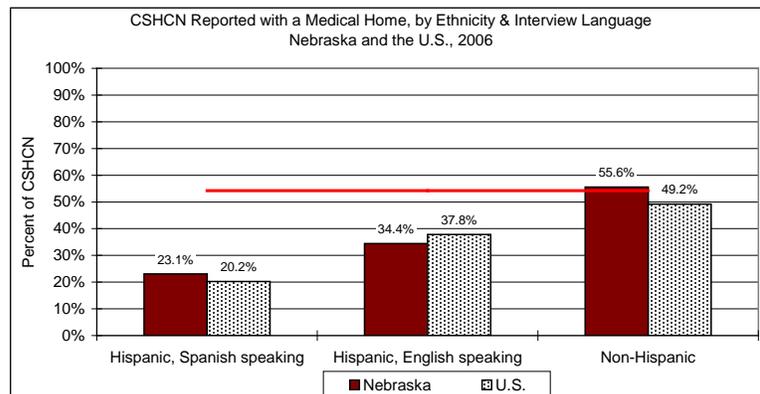


B. Access to Medical Homes

While the National Survey of Children with Special Healthcare Needs showed Nebraska CSHCN fare slightly better than the national average (45.8% outcome not achieved in Nebraska versus 54.2% nationally,) basically no change in access to Medical Home services for CSHCN from 2001 through 2005 was noted (46.2% outcome not achieved in

2001 to 45.8% in 2005). According to the National Survey on CSHCN the disparity between CSHCN and their typical counterparts was exceptionally significant. Children without special healthcare needs had improved access to Medical Home care as measured by the National Survey of Children’s Health, increasing from 49% of children in 2003 to 69% in 2005-2006.

There are significant disparities within the CSHCN population; disparities were noted for children with functional limitations (32% versus 60%), Hispanic children particularly Spanish speaking (20% versus 54.2%), and poverty (children with families at or greater than 400% of FPL had access averaging 56% versus 34% for children below the benchmark).



C. Abuse and Neglect

The benchmark in the Nebraska 2010 Health Goals and Objectives: A Midcourse Review that relates to this proposed indicator is #15-33 “Rate of children under age 18 years who are victims of maltreatment per 1000 children.”

The baseline in 1999 for Nebraska was 6.9. In 2004, it had risen to 11.3 and while the 2010 objective was 6.8. A large study conducted in Omaha found that children with disabilities were 3.4 times more likely to be maltreated than were children without disabilities. Other studies have found similar increased risk for children with disabilities. Therefore, it can be assumed that if the current rate in Nebraska for all children is rising then that for children with disabilities (special health care needs) is worsening as well.

A case can be made to take some inference from data on unintentional injuries and relate it to maltreatment. It is commonly assumed that child abuse is underreported for a variety of reasons. Therefore, data on unintentional injuries can be used as a measure of abuse, recognizing that the majority of these injuries may not be the result of maltreatment. So using this, Nebraska’s data on unintentional injuries per 100,000 youth 10 -19 for all causes is higher than the national rate especially in the area of “struck by/against.”

Youth

Based on data and stakeholder experience the subcommittee determined the top concerns to be:

- Increasing rates of STD's and rates of other reproductive health indicators
- High rates of alcohol consumption and related issues
- Depression/Suicide/Mental Health issues
- The need for medical homes
- Overweight/obesity rates
- Insurance coverage
- Disparities in morbidity and mortality

Using the criteria determined at the initial NAC meeting the list was narrowed to the following three problems (see Appendix H for complete Factsheets developed on each of these issues):

A. Alcohol Consumption

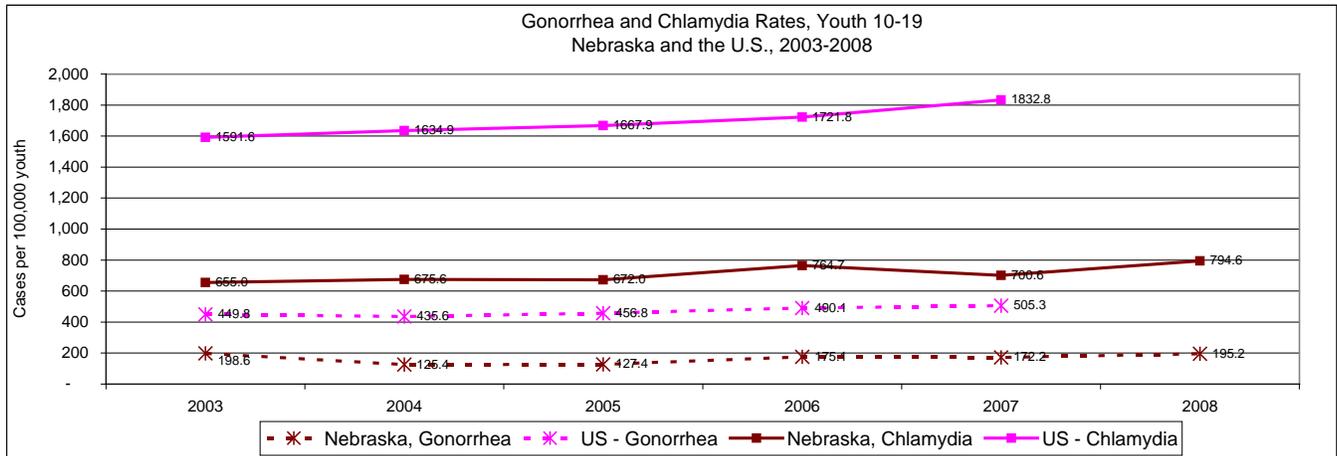
Nebraska's indicator value for youth alcohol consumption is worse than the benchmark and not changing significantly over time. In 2007 41% Nebraska youth reported drinking alcohol in past 30 days far exceeding the HP 2010 objective of 9%. This indicator has not changed over time.

Although, Nebraska's rate of binge drinking is not greater than the national rate, 1 out of 3 youth regularly engage in binge drinking (drinking more than five drinks in a sitting).

According to the Nebraska Youth Behavioral Risk Survey, youth in Nebraska have a significantly higher prevalence of drinking and driving compared to the US average. This concerning trend has continued over the past 5 years.

B. STD's and Reproductive Health

STDs and reproductive health indicators for Nebraska's youth are significantly worse than bench marks and getting worse over time, having a significant impact on the population. According to the 2007 Nebraska YRBS, 42% of Nebraska youth ages 15-19 have had sex at least once. The rate increases to 46% by 11th grade and 59% by 12th grade. According to DHHS Sexually Transmitted Disease Program the STD rates among youth in Nebraska are higher than the HP 2010 Objective. Nebraska's adolescent rates for gonorrhea are increasing while rates for chlamydia are not improving among adolescents. According to Nebraska PRAMS, unintended pregnancy among adolescent mothers (<20) was 74.3% significantly higher than the HP 2010 Objective of 30%.



C. Overweight/Obesity.

Obesity, Nutrition & Physical Activity indicators for Nebraska’s youth are worse than the benchmark and not changing significantly over time. National trends in physical activity among our youth have not changed in recent years. And national trends in the prevalence of obesity, weight control, and dietary behaviors indicate an overall worsening of the overall health of our youth. For example, since 1999, obesity levels have steadily increased and fruit/vegetable and milk consumption have steadily decreased.

The proportion of NE youth who were overweight or obese is higher (31%) than the HP 2010 objective (5%). The percentage of overweight and obese youth in NE has not improved over time.

Overall

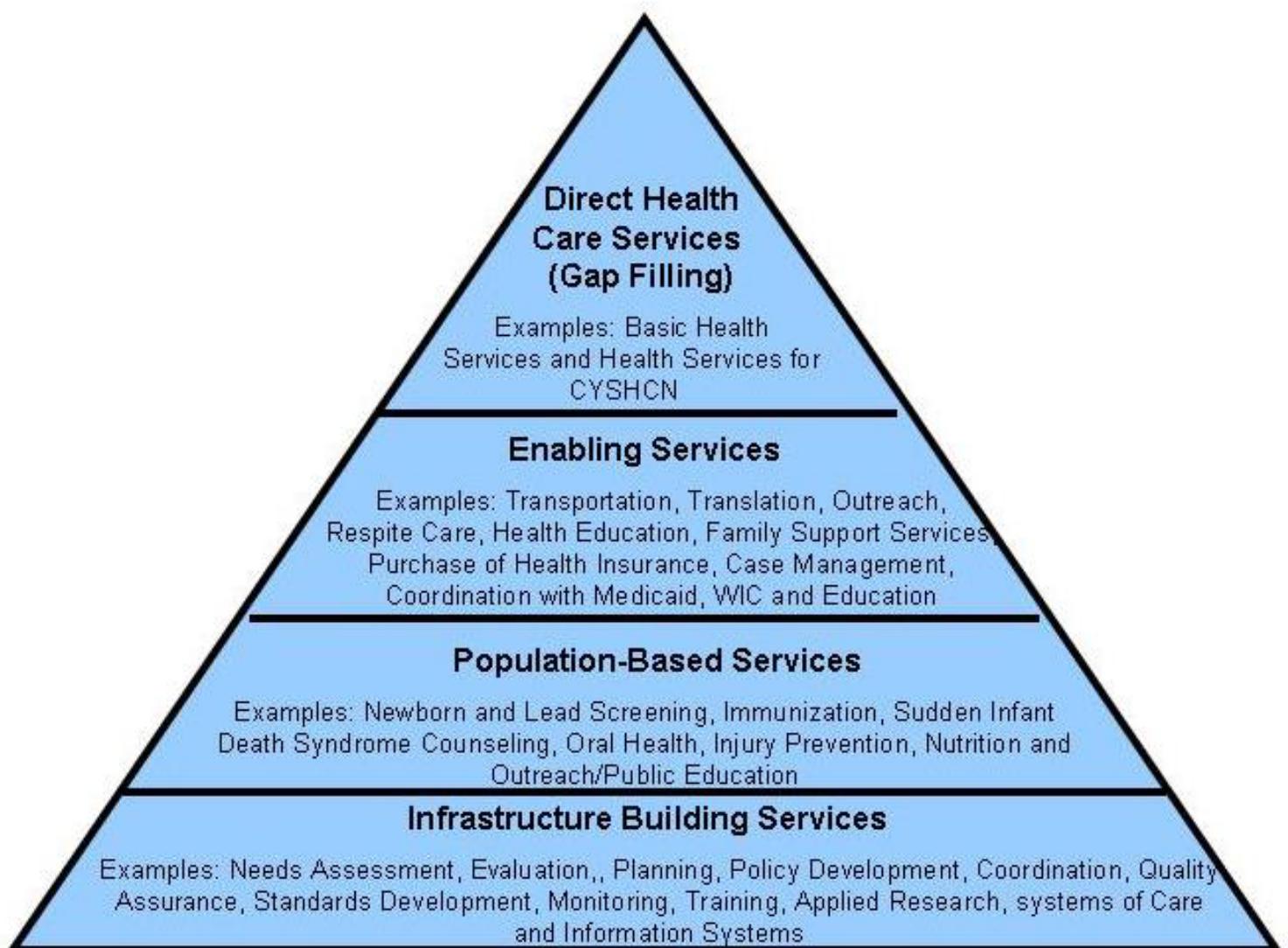
Taking a broad view of all 200+ indicators, Nebraska is doing well. Although the statistical tests used were fairly conservative it is meaningful to note that very few indicators were trending in the wrong direction, exceptions included STDs, some alcohol related indicators, and the rate of children who are uninsured, in addition very few indicators were significantly different from national rates. Nebraska’s MCH/CSHCN population is more likely to be doing better than the nation in most indicators, notable exceptions being infants/children living in poverty, infants born with Downs Syndrome, and mortality/injuries among youth. The majority of proposed priorities were identified based on disparities within the State’s data and/or not meeting the HP2010 objective.

There was a significant amount of cross-cutting issues among those identified for different population groups and among proposed priorities, most notable were overweight/obesity, the impact of racial/ethnic disparities on health, and reproductive health. When staff first proposed incorporating social/environmental determinants of health into the pool of indicators, it was predicted that the framework would have an impact on the identified needs, but to an unknown extent. In hindsight, we can see that the more traditional priorities such as tobacco use, infant mortality, or low birth weight

failed to be identified or did not make the list of proposed priorities in favor of the more distal determinants such as poverty and access to care.

4. MCH/CSHCN Capacity by Pyramid Level

The Capacity Assessment occurred concurrently with the stakeholders' identification of needs. Stakeholders considered the State's capacity to address problems/needs as a criterion for identifying and prioritizing a problem/need. The Capacity Assessment was created as a stand-alone document that was reviewed by a committee of stakeholders to determine the concerns and gaps. The final product follows:



Direct Health Care Services

Nebraska is situated 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.

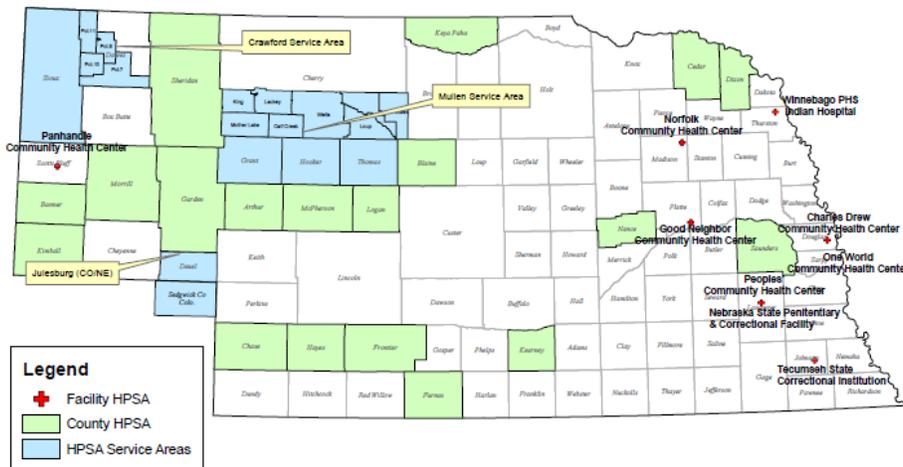
Nebraska’s large land expanse is primarily rural with more than one-third of its 93 counties classified as “frontier counties” with six or fewer inhabitants per square mile. Of the 534 incorporated communities in the state, 72% have fewer than 1,000 residents. In rural counties approximately 20% of the population is over 65 years of age. Nebraska has several population centers scattered along the Platte River and Interstate 80. Only two have a population over 50,000 (Lincoln and Omaha).

A. Availability of Preventive and Primary Care

Demographics and geography directly effect the distribution of health care services for the MCH/CSHCN population in Nebraska. A majority of the population is urban and located in the eastern portion of the state thus most of the services are located there. Many rural areas and special populations in the urban centers have an inadequate supply of primary care physicians and other health care professionals. Consequently, most of Nebraska is federally designated as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs). In 2008, 26 of Nebraska’s 93 counties and 9 healthcare facilities have been designated, either in full or in part, as primary care HPSAs. These shortage areas potentially affect more than 10% of Nebraska’s population. Further, 71% (66) of Nebraska’s 93 counties have been designated, in full or in part, as containing MUAs or MUPs. Over 28% of the state’s population live within the designated areas and are potentially affected by a shortage of health services.

Federally Designated Primary Care Health Professional Shortage Areas

Nebraska - 2008

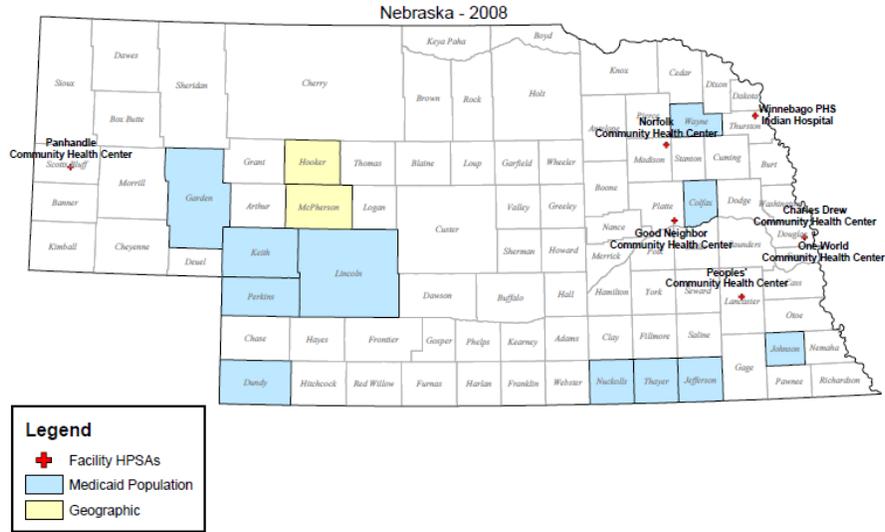


Source: Bureau of Health Professions Research - Office of Shortage Designation
<http://hpsafind.hrsa.gov> - Data current as of November, 2008.
 Nebraska Department of Health and Human Services, Office of Rural Health & Primary Care
 Areas include Counties, Political Townships, Precincts, & Census Tracts

Cartography: DHHS - Office of Rural Health & Primary Care, Thomas Rauner
 thomas.rauner@nebraska.gov, 402-471-0143

Nebraska also has federally-designated Dental and Mental Health HPSAs. In 2008, populations within two counties in Nebraska were designated as living in geographical shortage areas, an additional 10 counties were designated as shortage areas for the Medicaid population, and nine facilities who serve the most vulnerable were also designated as dental shortage areas. The State of Nebraska has designated all or a portion of 83 counties as pediatric and oral surgeon shortage areas.

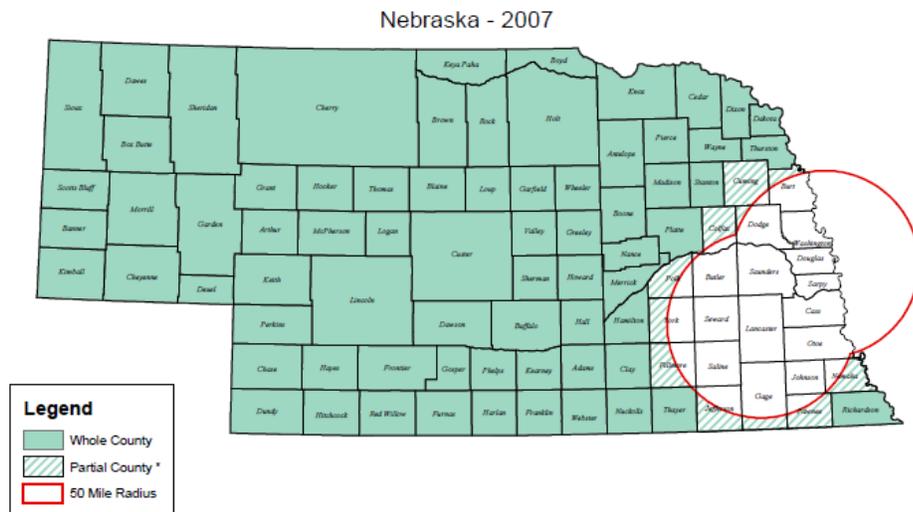
Federally Designated Dental Health Professional Shortage Areas



Source: Bureau of Health Professions Research - Office of Shortage Designation
<http://hpsafnd.hrsa.gov> - Data current as of November, 2008.
 Nebraska Department of Health and Human Services, Office of Rural Health & Primary Care

Cartography: DHHS - Office of Rural Health & Primary Care, Thomas Rauner
 thomas.rauner@nebraska.gov, 402-471-0148

State-Designated Dental Shortage Area Pediatric and Oral Surgery



* Areas within a 50-mile radius of Lincoln or Omaha are not eligible by definition.



Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update July, 2007.

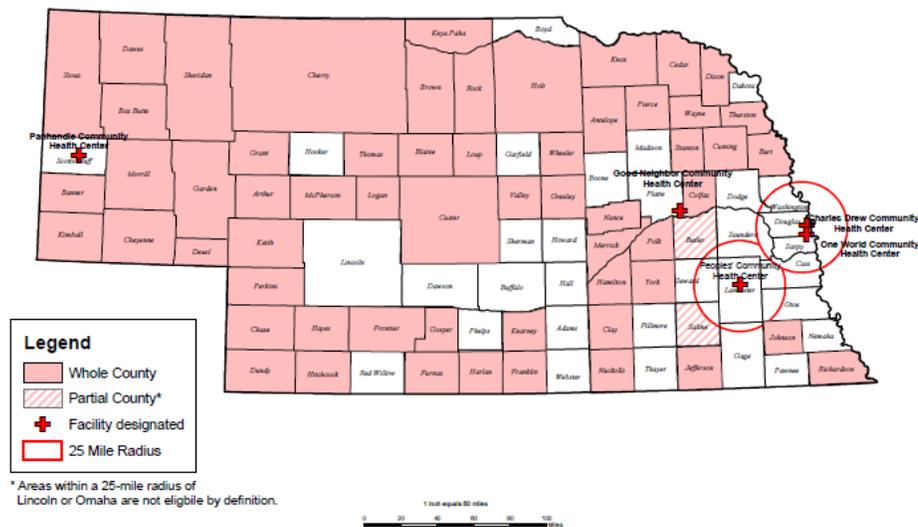
Cartography: Thomas Rauner, DHHS - Office of Rural Health
 Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

Beyond the Federally designated HPSAs, Nebraska has more specific NDHHS-designated (Nebraska Department of Health and Human Services) HPSAs. While the rate of federally designated areas has decreased (improved) since 1999 the more specialized state-designated areas have seen an increase (worsened) or remained the same. A high degree of shortage exists in each of the defined health specializations, including those directly related to MCH/CSHCN populations. For example:

- ◆ 66% of Nebraska’s counties currently have a shortage of family practice physicians (61/93);
- ◆ 93.5% have a shortage of Pediatricians (87/93);
- ◆ 92.5% have a shortage of OB/GYNs (86/93);
- ◆ 93.5% have a shortage of General Surgeons (87/93);
- ◆ 95.7% have a shortage of Internal Medicine Physicians (89/93);

State-Designated Medical Shortage Area Family Practice

Nebraska - 2007

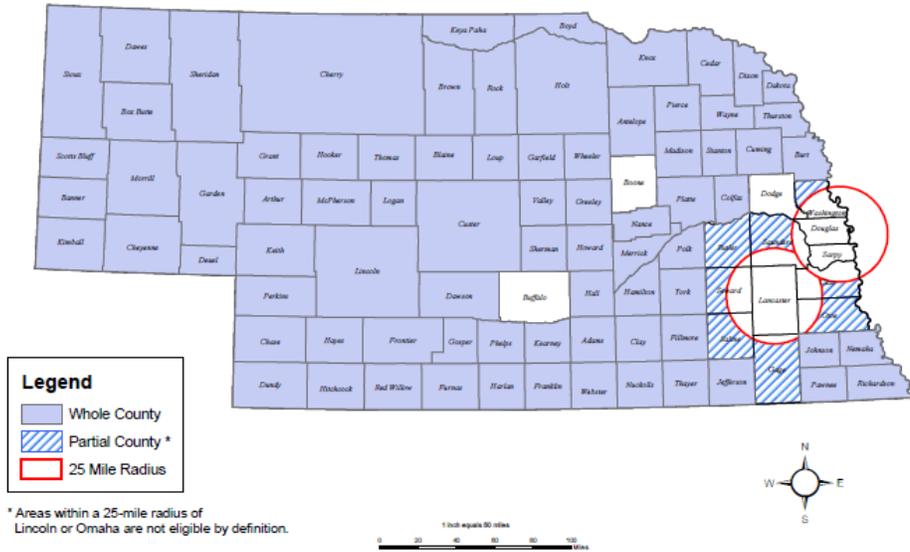


Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update November, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

State-Designated Medical Shortage Area General Pediatrics

Nebraska - 2007



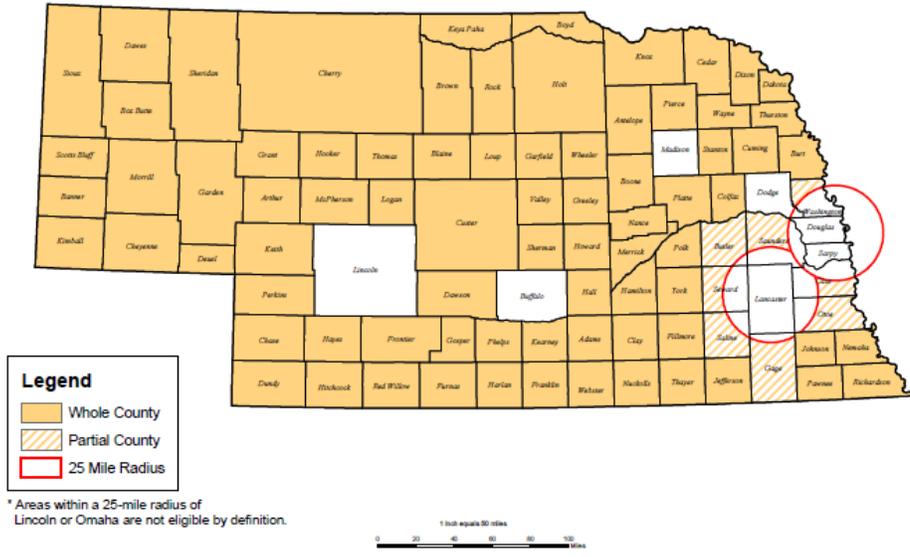
* Areas within a 25-mile radius of Lincoln or Omaha are not eligible by definition.

Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update July, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

State-Designated Medical Shortage Area Obstetrics / Gynecology

Nebraska - 2007



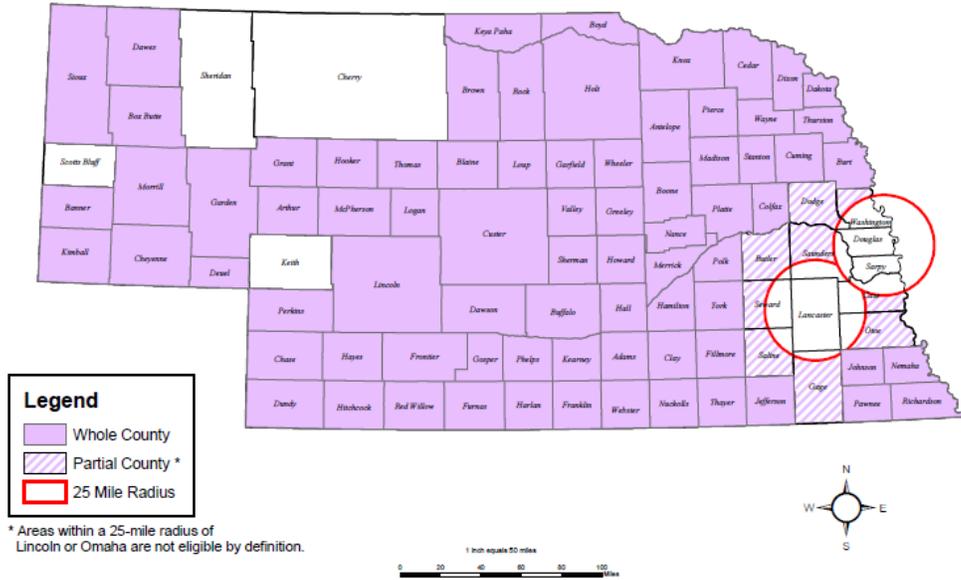
* Areas within a 25-mile radius of Lincoln or Omaha are not eligible by definition.

Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update June, 2008.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

State-Designated Medical Shortage Area General Surgery

Nebraska - 2007

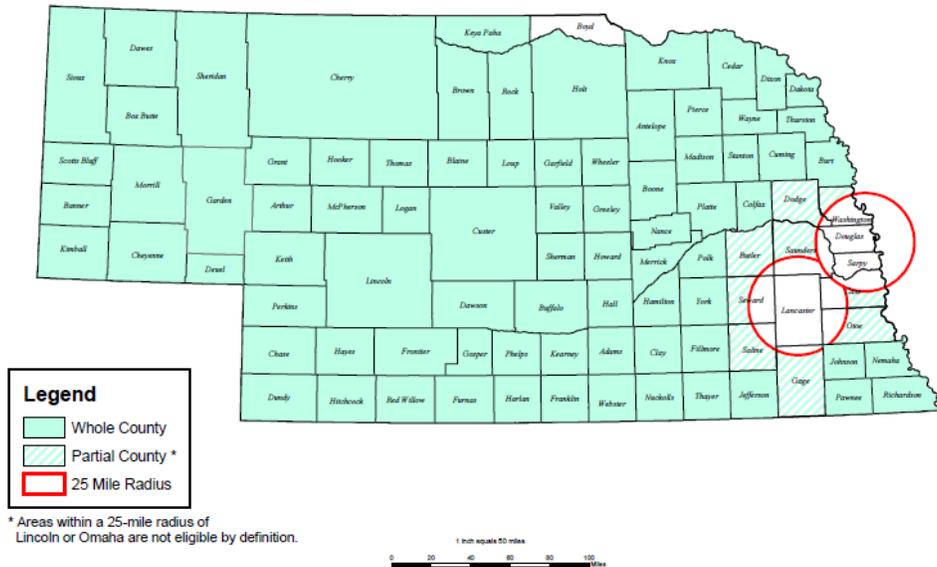


Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update July, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

State-Designated Medical Shortage Area Internal Medicine

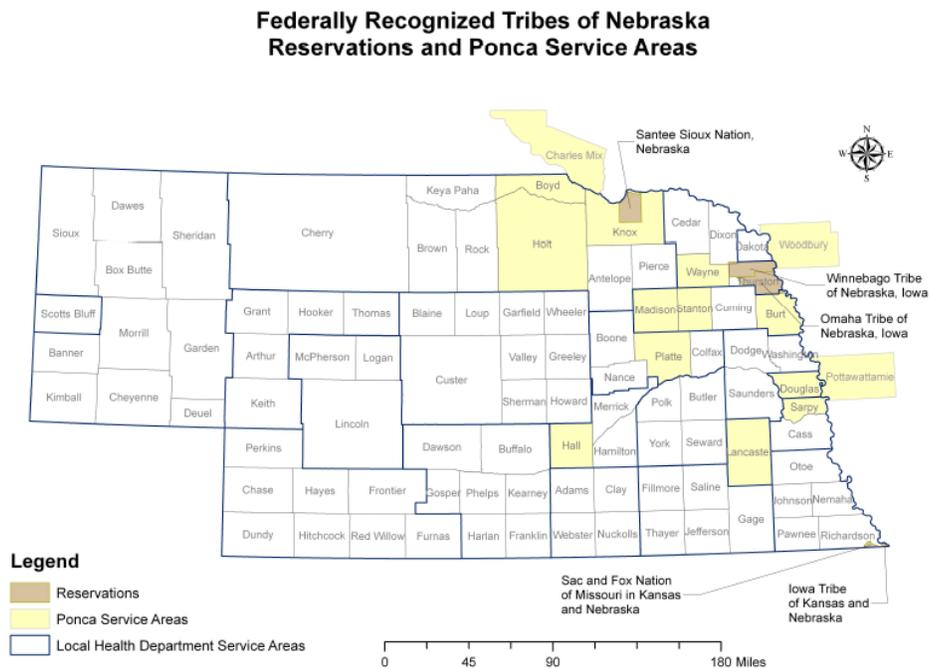
Nebraska - 2007



Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update October, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

In Nebraska, the Winnebago Tribe has an IHS operated hospital within their boundaries; the Ponca, Santee, and Omaha Tribes of Nebraska have Tribally-operated programs/facilities in their service areas. Urban Indian Health program sites exist in Lincoln (primarily medical services) and Omaha (primarily behavioral health services). Not all federal maternal child health related funding is directly accessible to Tribal or Urban Indian Health facilities. For example, in Nebraska, funding through the Maternal Child Health Block Grant program is only accessible through the State. Although IHS facilities can provide services to Tribal members who do not have insurance, access to in-house and contract specialty care services are limited by the amount of funding available to IHS—which is not enough to meet Tribal health care needs. Compared to other Federally-funded health care programs, I.H.S. is funded at a much lower level. For example, in 2005, funding for IHS services was less than half, per capita, than VA services, and 1/3rd lower than medical care for federal prisoners.



B. Availability of Family Planning Services

There are currently 11 Title X Family Planning Delegates in Nebraska providing services at 29 sites across the state. Although many of the rural Title X Family Planning sites serve relatively small numbers of users, because of the vast distances to an urban community, it is important to continue to support the services. The only stand-alone Sexually Transmitted Disease (STD) clinics in the state are located in Lincoln and Omaha therefore Title X Family Planning Clinics are all designated as Region VII Infertility Prevention Projects and all act as STD clinics (including those located in Lincoln and Omaha). The Title X Family Planning agencies have integrated HIV/AIDS services and provide HIV testing and counseling.

According to the 2009 FPAR Title X clinics retain a total of 4 FTE Physicians, 16 FTE physician assistants/nurse practitioners/ certified nurse midwives and 22 FTE RN's to provide 59,968 clinical encounters. All Delegates directly employ nurse practitioners. The need for physicians and physician assistants/nurse practitioners/ certified nurse midwives is ongoing.

The Nebraska Reproductive Health Program relies heavily on Title X funds for program activities. In FY 2009 the program received \$150,000 from Title V that is passed on to Delegates to support community education and outreach. Nebraska does not have a Medicaid family planning waiver and receives no direct financial support for family planning from State General Funds.

All Title X Family Planning delegates are involved as partners in local community inter-agency health coalitions and referral networks. Many Title X Family Planning delegates are involved with local HIV coalitions and 10 of the 11 Delegates are Counseling, Testing and Referral - Partner Counseling and Referral Services (CTR-PCRS) sites that provide both confidential (with name) and anonymous testing.

All Title X Family Planning delegates are also providers for the breast and cervical cancer screening program, Every Woman Matters (EWM). EWM, also administered in the NDHHS, Lifespan Health Services Unit, provides annual health screenings for breast and cervical cancer and cardiovascular and diabetes screening to women from age 40 to 64 to help diagnose diseases early, when they can be treated most effectively. As a program of the Nebraska Health and Human Services System, Every Woman Matters offers annual exams and personalized health information and support to women age 40 to 64 with limited or no health insurance and a low to medium income. Since EWM began in 1992, the program has provided 72,409 Pap tests for Nebraska women. During that time, EWM has diagnosed 43 cases of invasive cervical cancer. The cure rate for cervical cancer is more than 90 percent when diagnosed early. Since 2006 EWM also has managed the statewide initiative "Screening for Low-Income Women" that supports Pap tests, for women under the age of 40 utilizing State general funds. All of the Nebraska Title X Delegates participate in both of EWM's public health programs.

Two of Nebraska's Title X Delegates competitively applied for and were awarded Title V MCH sub grants for a 3 year period that began in 2008. A third Delegate is a partner with a local health districts' project. All 3 Title V funded projects focus on preconception and inter-conception health care, including reproductive health plans.

C. Free Clinics

Clinic with a Heart (CWAH) in Lincoln began in 2003 when one physician and community volunteers opened the first "Clinic with a Heart" clinic night. In, 2010 the free walk-in clinic is staffed by medical and non-medical volunteers and is paid for with community donations. There are seven clinics a month, in four locations, sponsored by seven different churches. The clinics provide medical, dental, physical therapy, vision services, chiropractic care and mental health referral.

The Peoples City Mission Medical Clinic provides health care to uninsured residents of Lincoln and Lancaster County who are homeless or low-income. The primary purpose is to fill gaps in the existing medical network where it is difficult to meet needs of the uninsured as quickly as needed. Medical services are provided through a network of practicing and retired volunteer doctors and other medical professionals, with a combination of day, evening and weekend hours. The clinic is operated entirely through volunteerism and donations from private sources. Traditional methods of funding such as insurance, Medicaid and Medicare, or government grants are not being accessed for its operation.

Hope Medical Outreach Coalition is a non-profit 501(c)(3) organization in partnership with Omaha area health centers and clinics and over 500 volunteer health care specialists. Hope coordinates medical and dental care for 8,000 men, women, and children in the Omaha-Council Bluffs metro area each year. Hope serves people who have health conditions but don't have insurance, qualify for Medicaid, Medicare or other assistance. Hope connects individuals with participating volunteers and coordinates the care throughout their system of health centers, clinics, physicians, dental, pharmacy and optical services.

Third City Community Clinic of Grand Island provides basic care to low income individuals ineligible for medial insurance or government medical assistance. The clinic provides opportunities for education, behavioral service screening, information and referral. The Third City Community Clinic is staffed by volunteer physicians and a part time dentist. The Third City Community Clinic is donation funded, and receives no Federal, State, or City funding. The clinic is a United Way organization and receives help from the St. Francis Medical Center Foundation.

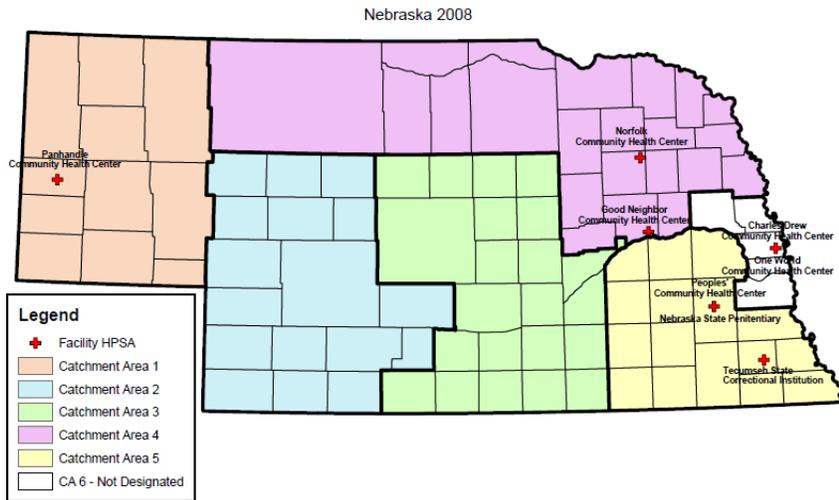
D. Availability of Specialty Care

Looking at the state shortage areas as a whole it becomes clear that there is a lack of specialty services in many parts of the state. Of the 26 pediatric specialists (representing 8 different sub-specialty areas) in Nebraska, all but five were located in Douglas County. All of the pediatric sub-specialist practiced in the Eastern part of the state (Douglas, Lancaster, Sarpy, and Cass). In addition to the 26 pediatric sub-specialists, Nebraska has 225 general pediatricians (previous total 251) located in 15 counties. This represents a net decrease in pediatrics reported in 2005, a significant decrease (down from 69) in specialists and decrease in generalists (down from 225).

The U.S. Department of Health and Human Services has designated a majority of Nebraska's counties (88/93) as mental health HPSAs. Eight facilities have also been included. The State of Nebraska has identified that 96.8% of its counties have a shortage of psychiatrists (90/93). Most of Nebraska's Behavioral Health services are managed directly by six Regional Behavioral Health Authorities (RBHAs) that contract with local providers for public inpatient, outpatient, emergency and community services. The NDHHS, Division of Behavioral Health Services provides funding, oversight and technical assistance to the RBHAs. The Division of Behavioral Health Services also manages the Regional Centers that are located in Hastings, Norfolk and Lincoln. These

Regional Centers provide longer-term care for persons committed by mental health boards or the courts. In 2008 five of the six RBHAs were designated as Federal Mental Health Shortage Areas, in addition eight facilities who serve the vulnerable were designated.

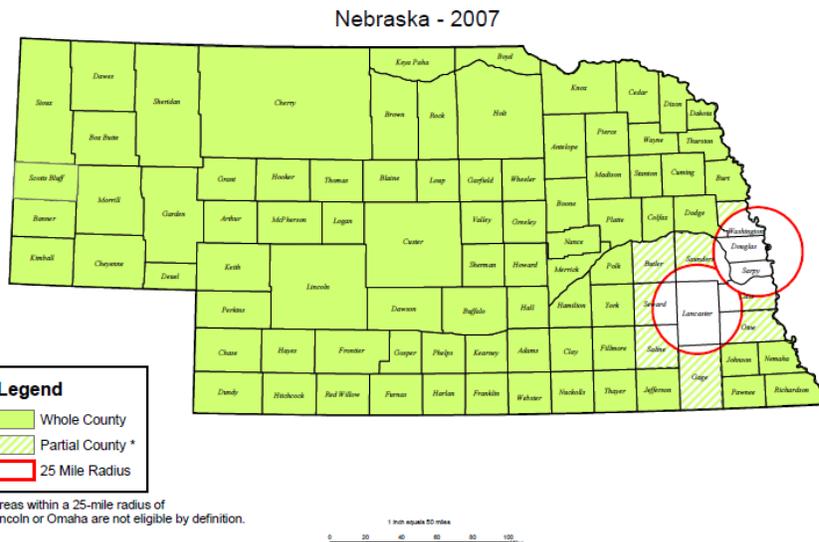
Federally Designated Mental Health Professional Shortage Areas



Source: Bureau of Health Professions Research - Office of Shortage Designation
<http://hpsafind.hrsa.gov/> - Data current as of 11/2008.
 Nebraska Department of Health & Human Services, Office of Rural Health & Primary Care

Cartography: Thomas Rauner, Department of Health & Human Services,
 Office of Rural Health, (402) 471-0148, thomas.rauner@nebraska.gov

State-Designated Mental Health Shortage Area Psychiatry and Mental Health



Source: Nebraska Department of Health and Human Services,
 Office of Rural Health. Last Update March, 2008.

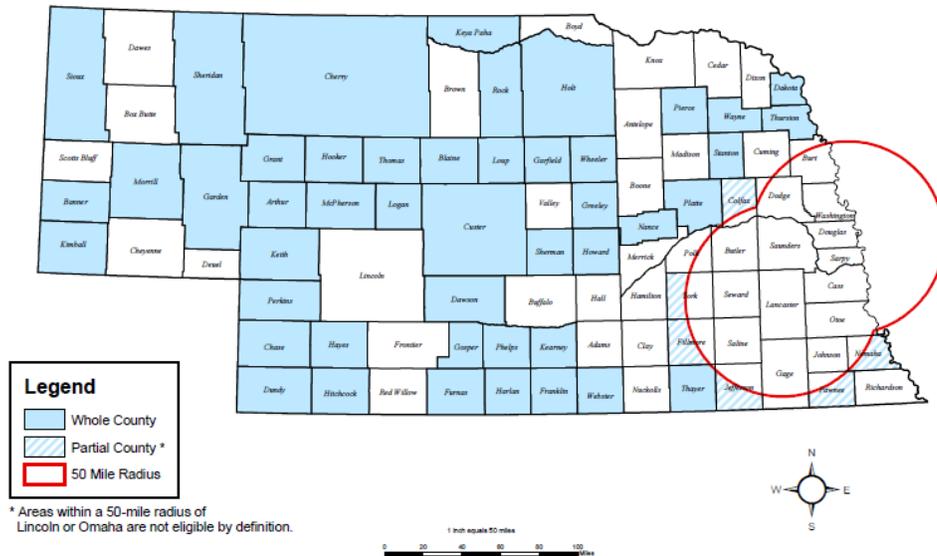
Cartography: Thomas Rauner, DHHS - Office of Rural Health.
 Phone: 402-471-2337. <http://www.dhhs.ne.gov>.

Allied Health Shortages include:

- 64.5% have a shortage of Occupational Therapists (60/93) and;
- 47.3% have a shortage of Physical Therapists (44/93).

State-Designated Allied Health Shortage Area Occupational Therapy

Nebraska - 2007

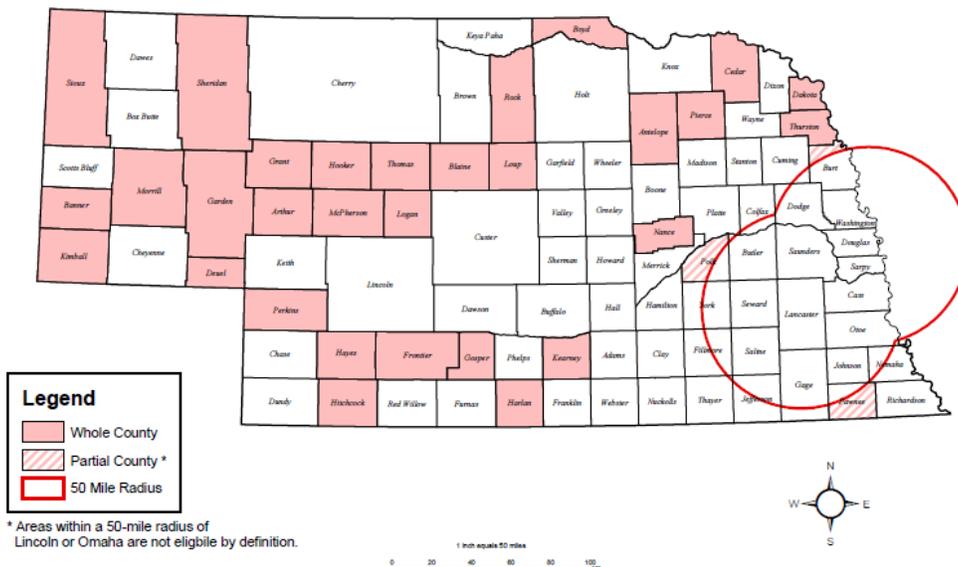


Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update July, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

State-Designated Allied Health Shortage Area Physical Therapy

Nebraska - 2007



Source: Nebraska Department of Health and Human Services, Office of Rural Health. Last Update July, 2007.

Cartography: Thomas Rauner, DHHS - Office of Rural Health. Phone: 402-471-2337, <http://www.dhhs.ne.gov>.

any point in the state to connect to any other point through interactive video. The system can also be used to transmit images, such as x-rays.

The NSTN's mission is to increase the quality, availability and accessibility of health care throughout the state while striving to increase specialty care for patients close to home and making a positive impact on the continuum of care. Teletrauma, or tele-emergency, has been in Nebraska since 2006, beginning when Good Samaritan Hospital (Kearney) first initiated its use with critical access hospitals that routinely send patients to them for advanced trauma care. It has since expanded to a total of over 50 hospitals in western, central and northern Nebraska as well as all of the major trauma centers in the state and the Saint Elizabeth Burn Center (Lincoln). Tele-emergency is also now used for mental health patients, stroke, cardiac care, code blues, burns and other emergency services.

NSTN has recently been awarded \$245,000 by the Department of Health and Human Services Health Resources and Services Administration (HRSA) for expansion of services. HRSA has also recommended an additional \$450,000 total between September, 2010 and August, 2012 for continuation of this project. The funding allows the NSTN to provide more hospitals with videoconferencing capabilities in their emergency departments, enabling them to interact with their colleagues at the American College of Surgeons verified trauma centers and other hospitals as they work to save patient lives. In addition, the NSTN will be able to initiate a beta program to place units directly in physician offices, allowing physicians to incorporate telehealth into their daily practice. This expansion will better serve the busy practitioner as well as provide increased access to specialty care for patients in rural areas. The grant award, along with funding secured through the 2008 Congressionally-Mandated Health Information Technology Program, administered by HRSA, will allow the telehealth network to install cameras in 22 emergency departments and 16 physician offices. The federal grants will fund 100 percent of equipment costs as well as provide a majority of the installation costs. The remaining costs will be through in-kind donations of time and personnel from hospitals.

E. Availability of Services for Children with Special Health Care Needs

Nebraska's CSHCN 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 Medicaid and Long Term Care Section of Long Term Care. The administrator for this unit is the Title V/CSHCN Director. Other relevant programs housed within this section include: Aged and Disabled Waiver, Autism Wavier, Developmental Disabilities Wavier, Katie Beckett Plan, Traumatic Brain Injury Wavier, Early Development Network, Respite Network, Social Services Block Grant for the Aged and Disabled (Title XX), SSI Disabled Children's Program, Genetically Handicapped Persons Program, and the Early Intervention and Medicaid in public Schools Programs, which are co-administered with the Nebraska Department of Education. The MHCP program encompasses three individual programs the SSI-Disabled Children's Program, Genetically Handicapped Person's Program, and the Medically Handicapped Program. These programs currently provide services (direct and indirect) and supports to 2,937 individuals and families.

The Medically Handicapped Program provides diagnostic and evaluation clinic services, active medical treatment, and referral services to meet the family's additional need for medical or social support for the eligible child or young adult through age 21 with an eligible diagnosis of asthma, burns, cerebral palsy, craniofacial conditions, cystic fibrosis, diabetes services, eye, hearing, heart, hemophilia, major medical, mid-line neurological defects, neoplasm, neurological, orthopedic: general, premature birth, rheumatoid arthritis, scoliosis and, urology. Currently this program provides services to 420 clients.

The SSI-Disabled Children's Program (DCP) is for children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). This program currently provides services to 981 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.

SSI-DCP provides services that enable the family to keep the child in his/her own home. These services include medical, social, developmental, rehabilitative, and referral services for disabled children based upon an assessment of need completed with the family and the child's Individual Service Plan. Services currently provided through the Nebraska SSI-DCP include architectural and vehicle modification, attendant care, medical lodging, meals, and mileage reimbursement, respite, sibling care, special equipment, and utilities.

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. This centralized program follows the regulations and policies of the Title V services for medically handicapped children, with appropriate modifications for the medical care of persons age 21 or older, including contracting with specialists in adult diseases. Currently, this program serves 14 individuals. Those under age 22 with these diagnoses are covered under the Medically Handicapped Children's Program. The MHCP provides coordination of services. MHCP, Vocational Rehabilitation, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral palsy, the Disabled Persons and Family Support Program, and other private non-profit programs all participated in coordinated funding meetings to assure that individuals receive services for which they are eligible. For nearly 25 years, this group of providers and advocates has met to discuss individual cares and find solutions, which make the most efficient use of program resources.

The Medically Handicapped Children's Programs collaborates with Monroe Meyer Institute in Omaha, Nebraska to provide clinic and medical services to clients across Nebraska through sub-specialty clinics that travel in teams to rural areas of Nebraska.

These teams include nutritionists, physical therapists, medical social workers, sub-specialty physicians and nurses. The collaboration has provided for calendar year 2009:

TIPS (Tracking Infant Progress Statewide) 539 clients
Telemedicine Services 135 clients
Specialty Clinic Services 115 clients
Diabetes Outreach 350 clients through 24 outreach clinics
Cardiology Outreach – 383 clients:
Outpatient Visits (4,319)
Omaha 3,514
Outreach: Columbus 47 Kearney 54
Grand Island 137 Norfolk 194
Hastings 100 North Platte 105
Holdrege 31 Sioux Falls, SD 28
Lincoln 10

Munroe-Meyer Institute (MMI) is located in Omaha, Nebraska on the University of Nebraska Medical Center (UNMC) campus. MMI is a federally designated University Center of Excellence for Developmental Disabilities Education, Research and Service. Since becoming part of UNMC in 1968, the Munroe-Meyer Institute has provided statewide services to individuals with developmental disabilities, physical disabilities, and special healthcare needs. MMI provides state of the art genetic and molecular genetics laboratory services. MMI also supports individuals and families in finding services in their local communities.

The mission of Munroe-Meyer Institute, the Nebraska University Center on Disabilities, is to improve the quality of life for persons with disabilities and their families.

- The Institute provides interdisciplinary family-centered services and supports for consumers and all individuals with disabilities. These services include the development of new and innovative ways to promote inclusion of the individual in the community.
- The Institute trains individuals and practitioners in the field of developmental disabilities through interdisciplinary educational experiences conducted at the University of Nebraska Medical Center and through outreach training and on-site technical assistance.
- The Institute conducts basic research in the prevention and amelioration of disabilities, and conducts applied research including program evaluation and the development of model systems to be utilized in communities to enhance inclusion of individuals with disabilities in the community.

MMI provides comprehensive medical and health care services through interdisciplinary clinics and evaluations, or single discipline assessments and treatment for individuals with disabilities. The interdisciplinary team approach used at MMI assures a family-centered, comprehensive diagnostic, and treatment program, specific to the client's needs. Parents, teachers, therapists, and community service providers are welcome team

members in the provision of services. This collaboration with MMI professionals helps ensure better coordination of services. Services are provided within MMI, at UNMC, in outreach clinics in the Omaha area, and throughout Nebraska. An individual can be referred to MMI by a physician or other health care professional, a school district, a social service agency, or a family member. Most services are covered by Medicaid, Medicare and other insurance programs. Services are provided for ADHD, autism, behavioral health, cerebral palsy/spina bifida, communication disorders, developmental delay, gait/movement disorders, genetic and metabolic disorders, muscular dystrophy, pediatric feeding disorders,

F. State Concerns

The shortage of Dentists continues to be a concern in Nebraska particularly for young children and those whose services are covered by Medicaid. Of equal concern is the shortage of mental health providers, although recent efforts to improve access for children may not be captured in the current data. The lack of local access to specialty services for rural Nebraska creates significant burdens for families. Family Planning clinics are providing an expanded role in the provision preventive care, but access is still a concern. System-wide training for adult providers who care for transitioning youth remains a need. Finally the Telehealth system is an asset that should be expanded and fully embraced.

Enabling Services

A. Transportation

Health related transportation services are provided primarily through the Social Services Block Grant by independent contractors through NDHHS, Division of Medicaid and Long Term Care to persons with disabilities and also by local level NDHHS staff through NDHHS Division of Children and Families to children and their families. Examples of eligible services include going to medical appointments, nutrition needs (for example, grocery shopping and participating in nutrition programs), locating housing, going to attorneys/Legal Aid Societies, and for appointments or functions required by- Department of Health and Human Services for benefit programs, Social Security Administration, Veteran's Administration , and or financial institutions.

The Early Childhood Transportation Task Force was chartered on October 15, 2007. The Task Force, comprised of representative early childhood stakeholders, identified as its purpose: to convene early childhood key stakeholders from state agencies, local school districts and other early childhood community-based programs, including Head Start, to address:

- common and/or conflicting standards and regulations for transportation among early childhood programs;
- commonalities and differences in early childhood partnership programs related to offering transportation; and
- safety in the broad sense regarding transportation of young children, ages birth to kindergarten entrance; and
- ability to finance transportation through local collaborative.

The Task Force is to provide recommendations for dissemination to numerous stakeholders or potential stakeholders. The objective is to consider development of and/or revisions of regulations to support transportation needs of young children in school-administered early childhood programs. The Task Force continues to meet.

B. Translation/Interpretation

Language barriers pose major obstacles in reaching immigrants with health education. Barriers include, among others, lack of health education materials in specific languages, availability and cost of interpreters and translators, difficulty recruiting bilingual outreach workers. These barriers are especially problematic in the context of treatment-based health education where communication is crucial. When bilingual interpreters and translators are available, many are not medically certified or adequately trained in health issues and terminology. This may be due in part to the significant increase in training for Medical Translation (up from \$250 to well over \$1000).

Due to the rapidly changing demographics in the state of Nebraska, interpretive services and language access provision in the health care setting has been a primary concern for Nebraska over the past few years. This was made apparent in the summer of 2007 when three statewide conferences focused exclusively or in part on the issues and challenges of interpretive service provision: Missing Links I in July, Nebraska Association of Translators and Interpreters (NATI) Conference in August, and Nebraska Minority Health Conference in August. Lincoln's New Americans Task Force, Omaha's Refugee Task Force subcommittee for health care interpreting, and the Region V CLAS Coalition are other examples of the commitment and concern among individuals and groups responding to the need for Nebraska's health care systems to reach out to all persons seeking health care regardless of ethnicity, country of origin, and English language ability.

In 2008, DHHS Office of Minority Health and Health Equity published "Interpreters Speak Out: Nebraska Language Access Survey." Among the findings were that Nebraska's medical interpreters are experienced, with almost 70% working in the field for more than two years. They are formally educated, with 86% having some college education. Across the state, 179 interpreters reported that half (52%) of Nebraska's health care organizations are fulfilling regulatory responsibilities to provide equal treatment to LEP patients, and the other half are not. Interpreters reported that 48% of the state's health care facilities are doing a poor, inadequate, or fair job offering interpretive services to LEP patients, hiring bilingual staff, informing LEP patients of their right to an interpreter, ensuring family and friends are not interpreting, and displaying signs and providing health documents in multiple languages.

C. Family Support Services

Parent Training and Information (PTI) Nebraska is a statewide resource for families of children with disabilities and special health care needs. PTI Nebraska's staff is parent/professionals and is available to talk to parents and professionals about special

education, other services and disability specific information so that children with disabilities will be prepared to lead productive, independent adult lives to the maximum extent possible. PTI Nebraska encourages and supports parents in leadership roles.

Family to Family Health Information Center at PTI Nebraska provides information to families with children with special health care needs about health care, health care options, and health care costs. They help families and professionals develop Individual Healthcare Plans for children with medical care needs at school. Family to Family provides support to families, youth and professionals through personal visits, phone, and email. They are focused on working with youth who are developing self advocacy skills so they can explain their health care conditions and understand their own health care needs.

Family Voices at PTI NEBRASKA aims to achieve family– centered care for all children and youth with special health care needs and/or disabilities. Through their national network they provide families tools to make informed decisions, advocate for improved public and private policies, build partnerships among professionals and families and serve as a trusted resource on health care.

D. Developmental Screening

In Nebraska, Early Intervention Services (EIS) for children ages birth to three is delivered through the Early Development Network (EDN), a partnership among state and local agencies. The Nebraska Departments of Health and Human Services (DHHS) and Education (NDE) serve as co-lead agencies to administer and monitor EDN activities, which are implemented through the state's 28 Planning Region Teams (PRTs). The PRTs act as local interagency coordination councils made up of school districts, services coordination contractors, public and private agencies, child care providers and families.

Nebraska has implemented a comprehensive Child Find System resulting in the identification, evaluation and assessment of infants and toddlers, birth to age three, with disabilities. Child Find is a state-led, regionally implemented set of activities to get early intervention information to the public, medical providers, schools, child protection services, Migrant and Early Head Start, tribal populations, homeless shelters and child care providers, and in some cases WIC. Regional implementation of Child Find occurs through the Planning Region Teams. Systems Support/Change grants are provided to the Planning Regions to supplement funding for training and special projects including Child Find activities. Regions use several public information strategies for Child Find.

The Early Development Network provides services coordination for infants and toddler, birth to age 3, with a disability and their families. Services coordination is a flexible, individualized process of interaction facilitated by a Services Coordinator to assist a family of an eligible infant or toddler with disabilities within a community to identify and meet the family's and child's needs through coordination of formal and informal supports, which include all services that are authorized to be provided under the early intervention program. Services coordination is administered by the co-lead agencies, DHHS and NDE. The program is administered through a co-lead arrangement between

DHHS and NDE. DHHS contracted with 22 agencies statewide to provide services coordination to infants and toddlers who are verified as eligible through special education criteria.

E. Respite

In 1999, the Nebraska Legislature created the Nebraska Respite Network through the Department of Health and Human Services. The purpose of the Nebraska Respite Network is to provide a statewide system for the coordination of respite resources that serves all ages (across the lifespan). There are six service-areas with Respite Coordinators who are responsible for Information and Referrals for families needing access to respite, recruitment or respite providers, coordinating training opportunities for providers and consumers and quality assurance and program evaluation. The Nebraska Respite Network is a free service to the public, which does not require approval through the Subsidy Program.

NDHHS has a Lifespan Respite Subsidy Program that offers money to help families with loved ones who have special needs (from birth to death) to pay for respite care. Families choose their own providers; decide how much to pay per hour or per day, and set their own schedules. This program can help only those families who do not receive services from any other governmental program. The Respite Subsidy program provided services to 489 children in state fiscal year 2009.

However the Lifespan Respite Network does not provide services to prevent abuse/neglect or serve parents with mental or physical health needs. With the support of the Together for Kids and Families' (Nebraska Early Childhood Comprehensive System Grant (ECCS)) Family Support Work Group the Nebraska Respite Coalition has been working with a past state Senator to explore expansion of funding for the network. Respite coordinators from across the state are involved with TFKF Family Support Work Group and are focused on education around the need for expansion of services and permission to provide these via the existing network and funding.

F. Coordination with Medicaid

The Nebraska Department of Health and Human Services contracts with local District Health Departments to assist Medicaid/Kids Connection clients to obtain health care through the PHONE (Public Health Outreach Nursing and Education) program. Children with Medicaid/Kids Connection receive information from public health nurses and referrals for health care, dental visits, lead testing, car seat checks, immunizations, WIC/CSFP, eye exams, and hearing checks. Clients are encouraged to seek regular medical care for their children. The PHONE nurse provides follow-up to medical, dental, and vision providers for those clients with Medicaid/Kids Connection who miss a scheduled appointment. ER follow-up is also available. As an example, during the 2008 fiscal year, over 250 residents were connected with medical, dental, and vision care in the South Heartland District Health Department coverage area through their PHONE program.

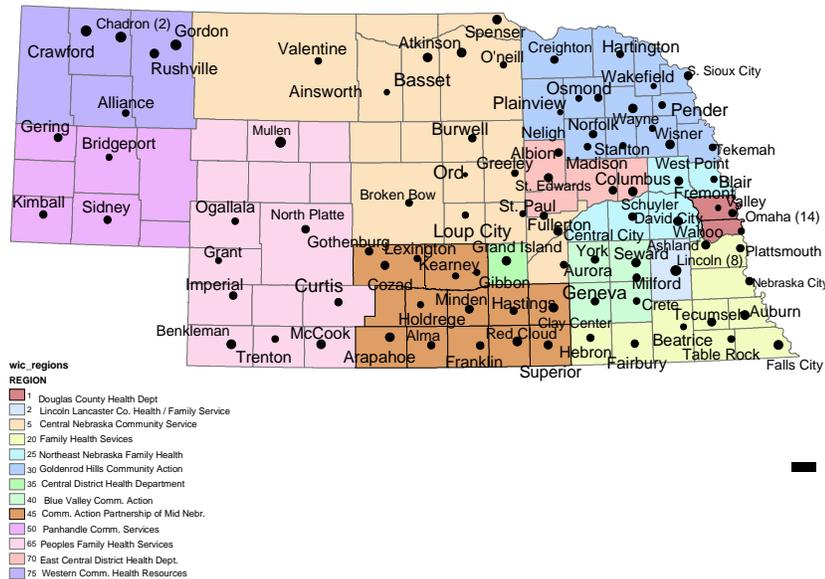
The Department of Health & Human Services is using current technology and policy efficiencies to improve client services and modernize the Economic Assistance Service Delivery system. Beginning in 2008 NDHHS launched ACCESSNebraska for clients to find and apply online for Nebraska public assistance benefits (Food Stamps, TANF, Aid Aged Blind and Disabled, Energy Assistance, Medicaid, SCHIP, and Child Care Subsidy). ACCESSNebraska is a single point of contact and is designed to increase accessibility by connecting 24/7 through the internet while increase responsiveness to customers by providing a single phone number for all services aiming to meet all needs with through one contact.

G. WIC

The Nebraska Women, Infants and Children (WIC) Program provides healthy foods and nutrition information to keep pregnant women, infants, and children under five healthy and strong. Numerous studies have shown that pregnant women who participate in WIC have longer pregnancies, fewer premature births, and fewer fetal and infant deaths. WIC helps ensure healthy infant and child growth, reduces levels of anemia, increases immunization rates, improves access to health care/social services and improves diets.

To be eligible for WIC, participants' must be Nebraska residents with an income at or below 185% of the poverty level or must participate on Medicaid, Food Stamps or Aid to Dependent Children (ADC). In January 2010, Nebraska WIC served 44,451 Nebraska residents, 10,068 Women, 10,596 Infants (approximately 57% of Nebraska infants), and 24,198 Children (up to age 5). WIC is an equal opportunity provider. Services are provided by 14 local non-profit agencies operating 110 clinics statewide (See map). Services include: breastfeeding promotion and support via trained breastfeeding specialists and breastfeeding peer counselors, nutrition education provided by dietitians, nutritionists and nurses, screening for low iron levels, referrals to community partners, and the provision of the monthly WIC food package which includes nutritious foods tailored to supplement the dietary needs of participants—with high levels of protein, iron, calcium, Vitamins A & C, whole grains and fiber.

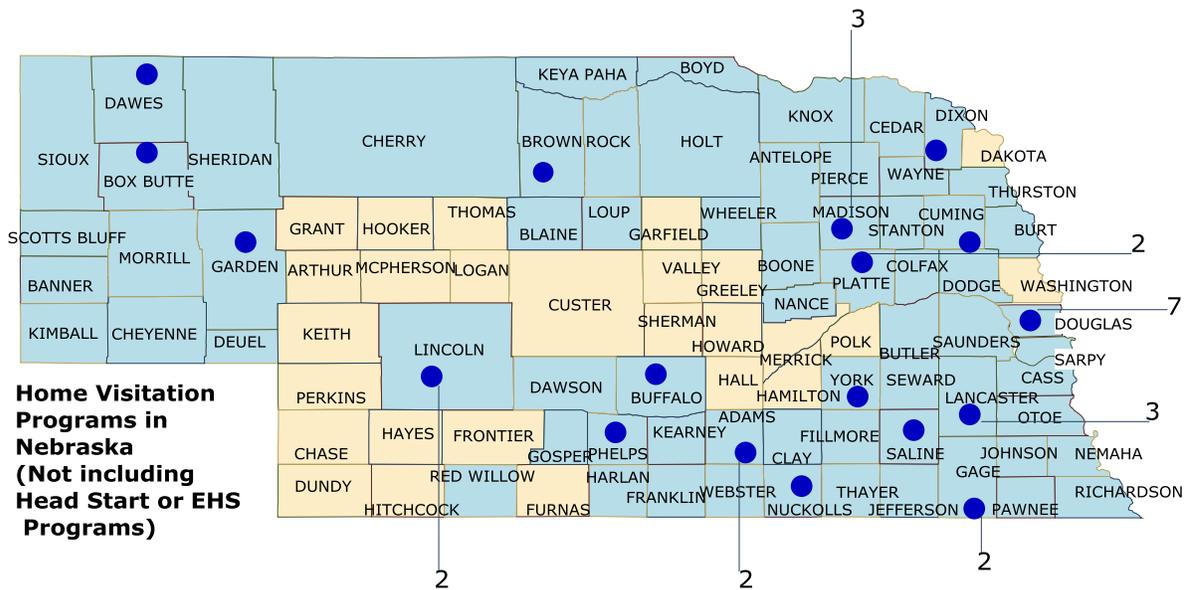
WIC CLINIC LOCATIONS 2007



H. Home Visitation

In 2006, the Nebraska Children and Families Foundation Home Visitation Survey was conducted through Together for Kids and Families (Nebraska’s ECCS) to collect data to enhance family support system through home visitation. In order to make informed recommendations regarding home visitation, a complete inventory of current home visitation programs was conducted.

Sixty-two programs reported providing a home visitation program (Early Development Network programs were not included). Most were administrated by public (49%) and private non-profit (30%) organizations. The majority (95%) of the programs served children birth through 3 years compared to 38% serving children 6-8 years of age. Programs identified risk factors such as income level, being a teen parent, or abuse and neglect as the most frequently identified criteria for inclusion into their program. The majority (89%) of the programs are based on voluntary participation; only a small number (19%) had mandatory participation. Thirty two percent of the programs’ geographic boundaries were county-specific. The majority of the programs offered home visits on a weekly (44%) basis for a 90 minute session (80%). Programs had a wide range of activities related to their home visits including parent education, coordination of services and supporting the health and development of the child. Seventy percent of the programs are based on a national model such as Parents as Teachers (44%), Head Start Standards (16%) or the Nurse Family Partnership (8%).



*Dots represent the counties in which the programs are based.
Blue shading represents the counties served by home visitation programs.*

In 2008, NDHHS Division of Children and Families issued four contracts for nearly two million dollars over two years to provide home visitation programs in 15 areas of the state: Burt, Cedar, Cuming, Dixon, Douglas, Hall, Howard, Lancaster, Madison, Merrick, Nancy, Sarpy, Stanton, Thurston and Wayne counties. From October 2009-March 2010, approximately 427 families had been referred for services.

I. Medical/Dental Home

In Nebraska the health professional shortages and the number of uninsured are limiting factors when discussing the concept and implementation of medical homes. Through Together for Kids and Families (ECCS) Nebraska has had an active Medical Home Work Group for the last six years. The work group has pursued strategies to promote the medical home concept and regular recommended pediatric visits, promotion of Bright Futures as the standard of care, and replication of effective safety net programs for increasing access for uninsured, underinsured and uninsurable children. Additionally, the work group has actively integrated oral health into its efforts.

TFKF has provided the venue for connecting a number of medical home collaborations, including National Initiative for Children’s Healthcare Quality (NICHQ) Learning Collaborative; Boys Town’s Integrated Services for Children with Special Health Care Needs, The President’s New Freedom Initiative Grant; and the Family to Family Health Information Center of PTI Nebraska. Other medical home achievements have included collaborations around oral health issues including HRSA’s State Access Workshop (SAW) Technical Assistance, PTI Nebraska’s Oral Health Forum for CYSHCN’s (white paper generated from this effort), and multiple collaborations with Head Start Oral Health activities including a HS Oral Health Forum as well as planning for the Head Start Dental Home Initiative.

J. The Uninsured/ Financial Access

Approximately 12% of Nebraskans were uninsured and many more were underinsured in 2008. The percentage of uninsured is considerably higher for racial/ethnic minorities and cultural barriers are often formidable. The numbers of uninsured women 18-44 years of age (16.5%) include 14.5% of 18 - 24 year olds and 17.3% of 25 - 44 year olds. In racial/ethnic minorities aged 18 - 24 data shows that 43.8% of African American and 42.7% of Hispanic women are uninsured. Nearly 12% of Children 1-9 were uninsured, while 7.4 % of youth 10-19 had not insurance. Similarly, 14.5% of women 18-44, 21.4% of children 1-9 (significantly higher than the national rate), and 9.7% of youth 10-19 lived in poverty in 2008. The state of the current economy affects not only the needs of the population served, but also resources and capacity of organizations to provide services. In light of the economic times, Medicaid is focused on stretching limited resources and controlling growth of expenditures.

K. Emerging Issues

Cultural competence training remains a significant need. There have been several offerings but institutionalized efforts have not been established in addition there is a real need for additional funding for translation/interpreter training. Immigration is having a significant impact on Nebraska moving beyond issues related to the provision of translation and culturally competent care to determining the provision of services. LB403 signed into law in April 2009 prohibits illegal aliens from obtaining certain public benefits. The bill requires all state agencies and political subdivisions to verify the lawful status of individuals who apply for applicable public benefits. All citizens applying for these benefits must sign an affidavit stating whether he or she is a US citizen. If the applicant is an alien, the agency or political subdivision must verify the alien's status through the US Department of Homeland Security.

Passed by the Nebraska voters in November 2008, Initiative 424 amended the state constitution by adding a new section to Article I. The Nebraska Constitution now provides, in relevant part: "The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting." This has impacts on State public health program funding set-asides based on race, which can be problematic for programs targeting racial health disparities. However, this prohibition does not apply to set-asides for Tribal organizations, because Tribal affiliation has been judged in Federal and State court cases to be a political, not racial, classification.

Another issue developed within Nebraska's Medicaid program which for over 30 years covered prenatal care for the unborn children of pregnant women regardless of a woman's immigration status. Due to a ruling made by the Centers for Medicare & Medicaid Services as of March 1, 2010 unborn children are no longer a category of eligible persons and consequently many pregnant women lost prenatal care Medicaid coverage.

Health care reform is an emerging issue that brings opportunity and the need for training. Funding for home visitation will increase Nebraska's capacity.

Population-Based Services

A. Newborn Screening

In 2009, 64 Nebraska hospitals sent specimens to Pediatrix Screening Laboratory. This laboratory is under contract with the State of Nebraska to conduct all of the newborn screens. Nebraska Newborn Screening Program (NNSP) screens for the twenty-eight disorders in the nationally recommended core panel (increased from six disorders in 2005). A total of 27,131 infants were screened for these disorders in 2009. Sixty-seven infants were not screened because they expired prior to 48 hours of age and one was born to parents traveling through the state that did not receive a Nebraska screen and was determined lost to follow-up.

Treatment services are supported through the \$10 per infant screened fee, State General Funds and Title V Block Grant funds. This includes funding for special metabolic formulas, metabolically altered/pharmaceutically manufactured foods, and support for specialty dietitian services and sub-specialist M.D. consultation services.

Quarterly meetings with the Newborn Screening Advisory Committee provide guidance to the program on several policy and quality assurance issues. Quarterly quality assurance reports are sent to every birthing hospital, as well as Children's Hospital of Omaha, a facility that completes a significant number of screens on babies transferred to them.

In 2000, the Infant Hearing Act established newborn hearing screening in Nebraska. The Nebraska Early Hearing Detection and Intervention (NE-EHDI) Program strives to fulfill the purposes of the Infant Hearing Act. Following the Act the number of birthing facilities conducting newborn hearing screening increased rapidly from 11 hospitals who were conducting either targeted or universal newborn hearing screening. Since 2003, 100% of the birthing facilities in Nebraska have been conducting hearing screenings, consistent with the Neb. Rev. Stat. §71-4742 requirement that a hearing screening test be included as part of the standard of care for newborns. In 2009 all 59 birthing hospitals conducted hearing screening during the birth admission, 901 infants were referred for follow-up screening and assessment and of those 26 were identified with permanent childhood hearing loss (1:1000).

The primary funding sources for the Nebraska Early Hearing Detection and Intervention Program are the HRSA/MCHB Universal Newborn Hearing Screening grant and the CDC Early Hearing Detection and Intervention (EHDI) Tracking, Surveillance, and Integration cooperative agreement. Additional funding has been available through the Title V Block Grant when needed.

The following services are provided by NE-EDHI, along with partners:

- Integrated electronic reporting, tracking and follow-up data system for all birthing facilities, in coordination with the State of Nebraska Vital Records Unit
- Periodic early childhood hearing screening programs, in coordination with Early Head Start Programs and National Center for Hearing Assessment and Management
- Nebraska Children's Hearing Aid Loaner Bank in coordination with the University of Nebraska-Lincoln and Nebraska Association for the Education of Young Children
- Advisory committee with evaluation, audiology and family support sub-committees
- Partial funding of new hearing screening equipment for birthing facilities
- Coordinated Point of Entry for Early Intervention services, in coordination with Early Development Network (Part C) and Regional Programs for Students who are Deaf/Hard of Hearing
- Family Support Services include Parent Weekend Workshop ("Roots and Wings") for families with children recently identified with hearing loss, in coordination with Boys Town National Research Hospital, and development of a Guide By Your Side program, in coordination with the Nebraska Chapter of Hands and Voices
- Professional Development services include pediatric audiologic diagnostic course for rural audiologists, newborn hearing screening coordinator day-long workshop available for all birthing facilities, in coordination with Boys Town National Research Hospital and guest lectures (3 annually) to graduate students (audiology, special education/deaf education) at University of Nebraska-Lincoln

B. Lead Screening

Lead can have significant detrimental physical, behavioral, and cognitive development effects on young children. The Center for Disease Control and Prevention (CDC) level of concern is 10 µg per deciliter. However, there have been an increasing number of studies that have shown lead to effect at levels lower than 10 µg per deciliter. The primary sources of lead exposure for children are deteriorating lead-based paint, lead contaminated dust, and lead contaminated soil. Lead-based paint was banned for residential use in 1978. Young children living in homes built prior to 1950 are at significantly greater risk of exposure to lead. Homes built before 1950 almost always contain lead-based paint and approximately 32 % of the homes in Nebraska were built prior to 1950.

The State of Nebraska Department of Health and Human Services (DHHS) requires all blood lead test results to be reported under Title 173 Nebraska Administrative Code, Chapter 1, Rules and Regulations Concerning the Reporting and Control of Communicable Diseases and Poisonings. The Nebraska DHHS Office of Environmental Health Hazards & Indoor Air collects blood lead test results for all Nebraskan residents. Children age 6 and under with blood lead levels above CDC level of concern, receive educational materials and the appropriate case management is determined. In Nebraska,

26,150 children were reported having been screened for blood lead levels in 2008. Of these children screened, 441 had blood lead levels above 10µg/dL.

Currently the State does not receive any funding to support blood lead testing. The Office of Environmental Health Hazards collaborates with local health departments, community action groups, and non-profit organizations to provide other services that may not be available at the state level.

C. Nutrition and Physical Activity

Nebraskans are at risk for overweight and obesity, ranking 20th in the nation for obese adults. Less than half of Nebraska adults are meeting the requirements of daily physical activity, and just one in five adults is meeting the recommended intakes for fruits and vegetables. Based on these critical gaps, the Nutrition and Activity for Health Program (NAFH) focuses on three objectives: 1) improving state and local capacity to support nutrition, physical activity, and obesity initiatives, 2) implementing and monitoring the Nebraska Physical Activity and Nutrition State Plan (updated in 2005), and 3) evaluating nutrition, physical activity, and obesity rates in the state.

The NAFH Program secured funding from the Centers for Disease Control and Prevention (CDC), Division of Nutrition, Physical Activity and Obesity Prevention in 2008. Previously, the program had been funded by the Preventive Health and Health Services Block Grant. The new funding opportunity marked an important achievement in the program's ability to lead statewide efforts with more program dollars, increased staff, and training/technical assistance from CDC.

The key program activities include the creation of a statewide coalition focused on State Plan implementation; providing educational opportunities for staff and partners; fostering active partnerships; providing funding opportunities for local public health departments and working on policy and/or environment change based upon the six core messages from CDC (1. Increase physical activity. 2. Increase the consumption of fruits and vegetables. 3. Decrease the consumption of sugar sweetened beverages. 4. Increase breastfeeding initiation, duration and exclusivity. 5. Reduce the consumption of high energy dense foods. 6. Decrease television viewing.)

Implementation of the Nebraska State Plan is overseen by the newly formed Nebraska Nutrition, Physical Activity and Obesity (NPAO) Advisory Group. This group convenes quarterly and is comprised of 20 members selected through an application process to represent various sectors of the public health community, including local and state public health, academia, health care, and education. The NPAO Advisory Group will be involved in the efforts to revise the current State Plan which is due to be released at the end of 2011.

D. Immunization

Nebraska has 84 public immunization sites and 245 private Vaccines for Children providers serving 86 of Nebraska's 93 counties. The Nebraska Immunization Program

provides vaccines, training, and site visits to all of the providers. The goal of the Immunization Program is to have at least 90% of all children immunized by 2 years of age. Currently the immunization rate for 2 year olds in the U.S. is 68.4% and Nebraska's immunization rate is 63%. In 2009 the CDC adopted a new standard which increased the number of vaccines required by two years of age this has affected coverage levels in Nebraska and nationally. The unavailability of the Hib vaccine has also contributed to a lower coverage level. Funding for the Immunization Program comes from the CDC Immunization and Vaccines for Children Grant and the Title V Block Grant.

In 2008 Nebraska's State Immunization Information System (NESIIS) replaced Immunet, transforming the registry into a web-based, centralized, HL7 compliant system. The Nebraska Department of Health and Human Services manages NESIIS in collaboration with EDS, a contracted service used to maintain and update the software. NESIIS represents a significant increase in capacity.

NESIIS keeps immunization records for all ages, recommends which vaccines are still needed based on recorded data, manages vaccine inventory, produces monthly usage reports, creates reminder/recall cards. The system can be used to conduct assessments of immunization coverage levels, to query immunization information during disease outbreaks, pandemics or bioterrorism events. NESIIS is a modified program that was supplied free of charge from the Wisconsin Immunization Registry (WIR). The Wisconsin system was funded entirely with federal funds so it has been available to other immunization programs funded by CDC. EDS, who developed the Wisconsin system, has been contracted with to provide Nebraska-specific details and upgrades.

E. Injury Prevention

The NHHSS Injury Prevention & Control Program in conjunction with the Nebraska Injury Prevention Advisory Committee focus their efforts on providing education and materials, surveillance, and a great deal of collaboration with already existing public health programs, including those funded by Title V. In the past year they have produced the Childhood Injury Report (currently in internal review) which covers the MCH/CSHCN population.

A recent example of the collaboration between the Injury Prevention & Control Program and other entities in the state is regarding suicide prevention. In 2008, Nebraska received Garret Lee Smith funding from SAMHSA of \$500,000 for three years. The funds were awarded through the Division of Behavioral Health, with activities being carried out by the UNL Public Policy Center and Nebraska Interchurch Ministries. In addition to funding community projects focused on youth suicide prevention, the grant also includes working with returning military.

The Nebraska SAFE KIDS Coalition works to prevent the leading cause of death and disability to children age 14 years and under: unintentional injuries. Coalitions and chapters have been established across the state. Emphasis is placed on education of both children and parents through media campaigns, direct education, and community events. Nebraska SAFE KIDS Campaign, coordinated through the Nebraska Health and Human

Services System, was established in 1993 to address unintentional injuries to children 14 and under. The Campaign is part of the National SAFE KIDS Campaign founded by the Children's National Medical Center in Washington, D.C. During 2010, the SAFE KIDS program will provide a Playground Safety Training and the NHTSA School Bus Safety training.

F. Oral Health

In 2009, Nebraska used MCH Title V Block Grant and Preventive Health and Health Services (PHHS) Block Grant funding to leverage additional Federal funding to support preventive oral health activities. A \$1.5 million, 3 year grant from the Health Resources and Services Administration (HRSA) was awarded to Nebraska to address access shortages in preventive oral health care among children under the age of 8 years.

For FY2010, three sources of funding combine to reactivate the NDHHS Office of Oral Health and Dentistry. MCH Title V funds support the position of Director of the Office of Oral Health and Dentistry, filled in October 2009 after a three year vacancy. The PHHS Block Grant funds were used to develop and operate model prevention programs aimed at children in the central part of Nebraska. HRSA funds are being used to add a Dental Health Coordinator to manage the day-to-day operation of the HRSA grant, along with a Dental Health Assistant (support staff). The funding will also develop an oral health strategic plan with the help of an Oral Health Advisory Panel, including representatives of a wide range of oral health stakeholders including Nebraska's two colleges of dentistry, Nebraska Dental Association, Boys Town pediatrics, Nebraska's schools of dental hygiene, local health departments and consumers of services. In addition, the HRSA grant will fund up to 10 local programs across the state to address the preventive oral health needs of young children who would not otherwise have access to care.

G. Newborn Safety and Sudden Infant Death

On April 12, 2006, Governor Heineman signed LB 994 into law establishing new requirements pertaining to Sudden Infant Death Syndrome and Shaken Baby Syndrome. LB 994 states that every hospital, birth center, or other medical facility that discharges a newborn child shall request that each maternity patient and father of a newborn child, if available, view a video presentation and read printed materials, approved by the Department of Health and Human Services, on the dangers of shaking infants and children, the symptoms of shaken baby syndrome, the danger associated with rough handling or the striking of an infant, safety measures which can be taken to prevent sudden infant death, and the dangers associated with infants sleeping in the same bed with other children or adult.

NDHHS produced informational videos titled "Safe Sleep for Your Baby" and "Never, Never Shake a Baby" with companion brochures in 2007. The brochures (English and Spanish) and videos may be viewed at: <http://www.dhhs.ne.gov/sids>. A Spanish version of the video was produced and distributed in 2008. DHHS publicized the availability of the new resources for SIDS and Shaken Baby Syndrome, and promoted the existing hot

lines and helplines. The website (www.dhhs.ne.gov/SIDS) is in the process of being updated with current resources and information. A press release titled “Chief Medical Officer warns About the Danger to Infants of Bed-sharing” appeared in several newspapers across the State in March 2008. A letter was sent from NDHHS Directors Children and Families and of Public Health /Chief Medical Officer to approximately 1,800 Nebraska health care providers encouraging them to give clear and consistent messages to parents of newborns in March 2008.

Finally, the child care licensing area of DHHS is coordinating the child care provider training. The training has been developed and piloted on the three topics: prevention of SIDS, Shaken Baby Syndrome, and Child Abuse. The licensing unit is in the process of changing the rules and regulations in response to the legislation. Eventually, this training will be required for all licensees, directors, and centers.

H. Public Education/Outreach

In 1994, Nebraska established a Healthy Mothers, Healthy Babies Helpline in response to the federal Title V/Maternal Child Health block grant requirement for a toll-free line. The toll-free line provides information to families regarding health care providers and practitioners who provide services under Title V (MCH Block Grant) and Title XIX (Medicaid). The Lifespan Health Services Unit of NDHHS has a long standing contract with Methodist Hospital in Omaha to provide this service. The helpline is staffed by professional nurses who provide a 24-hour service statewide. The helpline provides information and referrals for health and social services across the state of Nebraska. The helpline can answer questions about prenatal care, child development, Medicaid, Kids Connection, pregnancy-related depression, breastfeeding, immunization, nutrition and food resources, and family planning.

The Nebraska Tobacco Quitline is sponsored by the Nebraska Department of Health and Human Services’ Tobacco Free Nebraska program. The Quitline offers free calls for pregnant women around the clock access to counseling and support services. Nebraska Medicaid covers counseling and certain drugs specifically approved to help clients quit using tobacco. In order to be eligible, the client must be at least 18 years of age and must be enrolled and actively participating in the Tobacco Free Quitline. There is a special protocol for pregnant women enrolled in the Medicaid program. Pregnant women do not receive medication, but have unlimited use of the Tobacco Free Quitline, and may access the tobacco cessation counseling visits.

Nebraska’s Answers4Families.org provides information, opportunities for dialogue, education, and support to Nebraskans with special needs and their families; by developing and providing Internet resources; and by encouraging others to do the same. The project began in 1994 with a grant from the Maternal and Child Health Bureau (HRSA). This grant served 40 families in the Early Intervention and Katie Beckett programs. The Answers4Families.org project (formerly the Nebraska Network for Children & Families) was extended in 1996 by a grant from the U.S. Department of Commerce TIIAP program which created the Partnership IDEAS Network. Since 1999, the Answers4Families project has been a project of the Center on Children, Families, and

the Law at the University of Nebraska-Lincoln and is supported by funding from the Nebraska Department of Health and Human Services (Medically Handicapped Children's Program State and Grant Funded Programs Unit, Child Welfare Unit, and Lifespan Health Services Unit) Early Development Network, and the Nebraska Department of Education.

Answers4Families is a tremendous resource for families. The website provides information for families and consumers so that they have options based on what each family or individual needs. User Services include Discussion Groups, Ask An Expert, Ask Rx and other public forums where users with similar interests can share information and support one another or where users can post questions for experts to answer. In addition to online discussions moderated by Answers4Families staff.

First Connections with Families is a statewide resource developed by the Nebraska Department of Education, in cooperation with the Nebraska Department of Health and Human Services, to meet the requirements of the Nebraska Read, Education and Develop Youth Act. This resource sent to all new parents and contains information about child development, reading to children, and child health and safety. This resource can be downloaded in English or Spanish at: <http://www.nde.state.ne.us/ech/fcwf.html>.

Children and Family Behavioral Health Support Act of LB603 created the children's behavioral health Help Line and Family Navigator Services. The Help Line operated by Boys Town and funded by NDHHS Division of Behavioral Health began on January 1, 2010. The Help Line provides assistance to families with a youth experiencing behavioral health challenges. It is a single point of contact that's available 24 hours a day, seven days a week, operated by trained personnel and supervised by licensed behavioral health professionals. Family Navigator Services follow within 24 to 72 hours when needed, providing family peer support and helping the family identify existing services. The Help Line focuses on reducing stress of a crisis being experienced by a caller, identifying immediate safety concerns, and giving recommendations or referrals to resources.

Nebraska's 2-1-1 Hotline is operated by a collaborative group of organizations from across the state working to ensure that individuals have an easy means to search the entire state for health and human service agencies and programs serving their area, and find the help they need. The Information and Referral Network (I&RN) partners maintain databases containing information on several thousand agencies, programs, and services across the state. The database is updated on an ongoing basis. The project partners work to ensure that its information is current and updated. Each agency is contacted twice per year for updates. 2-1-1 is funded by businesses, government agencies, and non-profit entities. These public-private partnerships vary by county.

Infrastructure Building Services

A. Lifespan Health Services

In 2007, within Nebraska's Health and Human Services, Division of Public Health the Unit of Lifespan Health Services was developed by combining Family Health and

Women's Health. This organizational change is a reflection of the change in how the Maternal and Child Health programs in Nebraska view their work, moving away from discrete independent periods of an individual's life toward a life course approach and social ecological interpretation of public health. This transition is ongoing but stems largely from planning activities conducted on behalf of the Title V Block Grant focusing on preterm and low birth weight births as well as overweight/obesity of women, children and youth.

These planning methods focused on literature reviews that described the problem, data analysis, problem analysis diagrams that identified precursors at the individual, family/community, society level, as well as "causal" pathways, identification of intervention points, followed by literature review of evidence-based interventions and development of logic models. Through these efforts it was clear that life course approach was required for MCH/CSHCN programs to effectively proceed.

These planning efforts directly led to Nebraska receiving a Maternal and Child Health Bureau (HRSA) grant in September 2008 to develop an information campaign for women and men that will help them prepare for their future roles as parents. Nebraska's initiative focuses on a life course approach to pre/interconception health among young at-risk women and among providers. Extensive social marketing research was conducted with young women 16-25 years of age across the state in 2009. The research focused on their interests and needs, barriers to achieving a healthy lifestyle, messaging and the most effective ways to reach them. From this research emerged TUNE my life.

TUNE uses original music to engage young women and men and encourage them to learn more about life course health. Through music, we are reaching young adults in a new way that will help them connect to different health topics. TUNE emphasizes five areas of health: physical health, emotional well-being, friends and family, dating, and education. Tunemylife.org is a web site offering many interactive and engaging elements for the campaign. It features the TUNE music, downloadable songs, artist interviews, health information that ties into messages of particular songs and links to additional health and wellness resources. TUNE was developed with the intention to be a grassroots effort that is primarily spread through word of mouth and social media with lots of opportunities for young women to engage, share and interact.

Currently, provider education and training are being developed based on the life course model for health, human services, educational, and faith-based providers. Providers were assessed earlier to determine their needs, and a framework was designed to deliver life course education to providers across Nebraska. In addition, tool kits of resources were created for providers to use with young women. The tool kits will be available online at www.dhhs.ne.gov/tune. A competitive sub grant process will be used later this year to select community based providers to develop targeted life course, pre/interconception education and interventions within their practice settings. The competitive Request for Applications (RFA) will identify providers with the greatest potential for reaching at risk, low income women, including but not limited to local health departments, Federally Qualified Health Centers, Tribal health centers, Title X/Family Planning clinics, WIC

clinics, faith-based organizations, hospital-based out patient clinics, school health and family and consumer science programs, and college health centers. These contracts will support staff time to develop practice modifications needed for new and expanded messaging within these community based settings, and to plan for system capacity to support a life course approach.

B. Nebraska Healthy People 2020

NDHHS received a Healthy People 2020 (HP2020) Planning grant in the spring of 2009 and began implementation in July, 2009. This is collaborative effort lead by staff from Community Health Planning and Protection Unit and Lifespan Health Services Unit and represents a diverse stakeholder group including several MCH/CSHCN stakeholders. The main focus has been on incorporating social determinants, life course development, and evidence-based interventions into the work product. This approach has been very well received by health promotion, chronic disease, and local public health representatives and should have a lasting impact on the MCH/CSHCH populations in Nebraska.

C. MCH Epidemiology

The Office MCH EPI provides leadership and coordination for needs assessments (Title V/ MCH Block Grant and Title X/Family Planning), evaluation, planning/policy development, data management for the Title V/ MCH Block Grant, as well as data collection and analysis for MCH/CSHCN programs at the state and local levels.

MCH EPI is lead by State System Development (SSDI) Director. SSDI is utilized to provide overall management for the Office and for the MCH/CSHCN Block Grant. SSDI is focused on developing, maintaining, improving, and promoting activities and methodologies that increase and build on Nebraska's data capacity especially for MCH/CSHCN population and community of stakeholder/programs. MCH EPI has contracted with the University of Nebraska Medical Center, for a Doctoral prepared Epidemiologist since 1999. The MCH Epidemiologist originally established the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) and now also manages the Child Death Review Team (CDRT). NE PRAMS has been collecting data since 1999 and currently has a staff of 4.5 FTE and contracted data analyst.

The CDRT was created by the Nebraska Legislature in 1993. At that time, 300 Nebraska children were dying each year but there was no process to understand why and how the deaths happened. The CDRT reviews the numbers and causes of deaths of children ages 0 to 17. CDRT members also try to identify cases where a person or community could reasonably have done something to prevent the death. All child deaths are reviewed, not just "suspicious" or violent ones. The goals of these reviews are to: identify patterns of preventable child death, recommend changes in health care and social services systems' responses to child deaths, refer any previously unsuspected cases of abuse, malpractice, or homicide to law enforcement, and, report to the public and state policy makers about child deaths. These reports include recommendations on changes that might prevent future deaths. The CDRT has produced reports that cover years 1996-2006, and special

analyses on SIDS/SUIDS (2005) and child abuse deaths (2005). The CDRT has been working diligently over the past several years to migrate paper data into the National Center for Child Death Review electronic database. Finally, CDRT has been instrumental in the establishment of a Douglas County Fetal Infant Mortality Review and Northeast Nebraska Public Health Department Child-Fetal Infant Mortality Review.

NE PRAMS is a monthly survey of new mothers from across the state. NE PRAMS partners with the Centers for Disease Control & Prevention (CDC), to identify and monitor selected maternal behaviors and experiences before, during, and right after pregnancy. Nebraska has data from 2000- 2008. Nebraska has consistently had one of the best response rates in the country yielding high quality data. Findings from PRAMS' population-based data can be generalized to the entire population of Nebraska women whose pregnancies resulted in a live birth. Examples of data use include: enhancing and expanding the understanding of maternal behaviors and experiences, and their relationship to unfavorable pregnancy outcomes; developing and implementing new maternal and child health programs, as well as evaluate and modify existing programs, influencing public health policy, assisting health professionals to incorporate the latest research findings into their standards of practice, and monitoring progress on local, state and national health objectives and goals. Recently NE PRAMS has published in-depth analysis on Maternal Depression, Breastfeeding, and soon will publish on Post-Partum Contraception.

The Office of MCH EPI relies on several secondary data sets to conduct activities and fulfill responsibilities. Example of datasets include: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), Nebraska Cancer Registry (NCR), US Census Bureau, specifically the Current Population Survey (CPS) and the American Community Survey (ACS), Data for Child Protective Services, Nebraska Hospital Association's Nebraska Hospital Information System (NHIS) Nebraska Medicaid Claims, The Nebraska Pediatric Nutrition Surveillance System (PedNSS) , Sexually Transmitted Disease Surveillance data, Nebraska Vital Statistics, and Nebraska's Youth Behavioral Risk Factor Survey (YRBS). There are several opportunities for quality improvement specifically in the BRFSS, NHIS and YRBS that staffs are pursuing. There are also several data gaps that need to be addressed specifically mental health data across the MCH/CSHCH population.

D. Early Childhood Infrastructure

The overall goal of Nebraska's Early Childhood Comprehensive Systems (ECCS) Project, Together for Kids and Families (TFKF) is to achieve optimum outcomes for Nebraska's young children and their families through comprehensive system planning and collaborative effort among stakeholders. First implemented in 2003, the ECCS planning effort enabled early childhood stakeholders to avoid duplication of strategic planning and fostered collaboration to better meet the needs of Nebraska's youngest citizens. The organizational structure during the planning phase consisted of the Early Childhood Interagency Coordinating Council (ECICC) serving as the advisory committee. The council is established to advise the state agencies, legislature, and Governor around issues and services for Nebraska's young children and families. The ECICC is comprised of stakeholders in early childhood with members being appointed by

the Governor to meet several statutory requirements. In addition to the interagency council, a Leadership Team consisting of 50+ members representing a variety of stakeholders was formed to act as the working advisory group for the project. Additionally, eight work groups were formed to concentrate on the topic areas of medical home, mental health, family support, parent education and early care and education with three cross-cutting teams focused on the areas of data, policy alignment and family involvement. The result of the two and a half year planning process was the Together for Kids and Families Strategic Plan approved for Implementation in March of 2006. The strategic plan contains twenty-one strategies designed to promote positive child and family outcomes as well as enhancement of early childhood system integration.

As Together for Kids and Families moved from planning to implementation, the project's organizational structure was modified. The ECICC continued to serve as the advisory body, while an Implementation Team of stakeholders divided into eight strategy work groups was formed to carry out implementation. These groups have met regularly to carry out strategy implementation for the past three years as well as meeting quarterly as the overall Implementation Team to further communication regarding early childhood initiatives and issues.

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During planning was for the next three years of TFKF (2009-2012) implementation, stakeholders worked together to create a governance structure that can be maintained beyond the life of any grant in NE. An Early Childhood Systems Team was chartered as a permanent standing subcommittee of the Early Childhood Interagency Coordinating Council (ECICC) in May of 2009. While the ECICC would remain as the overall advisory body for the project, the Systems Team operates as a working committee that will share leadership responsibilities, decision making, and resource coordination as well as guide the ongoing early childhood work group activities. While the ECICC meets quarterly, the Systems Team has agreed that they will need to meet more frequently to maintain collaborative relationships and complete systems development work. Additionally, the ECICC was designated by the Governor as the State Advisory Council on Early Childhood Education and Care in accordance with the Head Start Reauthorization requirements. Nebraska's early childhood stakeholders have worked diligently to create comprehensive early childhood governance structure that is diverse, inclusive and coordinated.

E. Adolescent Health Infrastructure

The Nebraska Adolescent Comprehensive System Initiative was launched in FY 2009 with two statewide stakeholder meetings were convened in March and June 2009. The

effort was facilitated by the Konopka Institute and the Association of Maternal and Child Health Programs (AMCHP) and utilized Nebraska's Early Childhood Comprehensive System (Together for Kids and Families) initiative as a blueprint. Stakeholders have identified six components of an adolescent system and the principles or assumptions of each component.

F. University of Nebraska Medical Center – College of Public Health

In 2002, the joint University of Nebraska Medical Center (UNMC) /University of Nebraska–Omaha (UNO) Master’s of Public Health program were first accredited and by July 2006 the University of Nebraska, Board of Regents approved the formation of the UNMC, College of Public Health (CoPH). The CoPH has been formally approved by the Council on Education for Public Health (CEPH) to begin the process to obtain college-wide accreditation. The Master of Public Health Program was re-accredited in 2009 for the full seven years (until July 1, 2016). The MPH program will retain its accreditation as the college is undergoing the college-wide accreditation process. In addition in 2008, the CoPH received gift from Omaha philanthropists Ruth and Bill Scott resulting in the Harold M. and Beverly Maurer Center for Public Health. The 52,500-square-foot facility will boast three levels and is expected to be completed in 2010.

On the September 1, 2009 UNMC CoPH welcomed a new Dean of Public Health an academic leader with expertise in maternal-neonatal health and the elimination of health disparities, Ayman El-Mohandes, M.B.B.Ch., M.D., M.P.H., followed shortly with the selection of Magda Peck, Sc.D., as Associate Dean for Community Engagement and Public Health Practice. Dr. Peck is the founding CEO of CityMatCH and is a nationally recognized leader in public health and expert in maternal and child health. The College added ten faculty in all in 2009 and plans to add ten more by 2011.

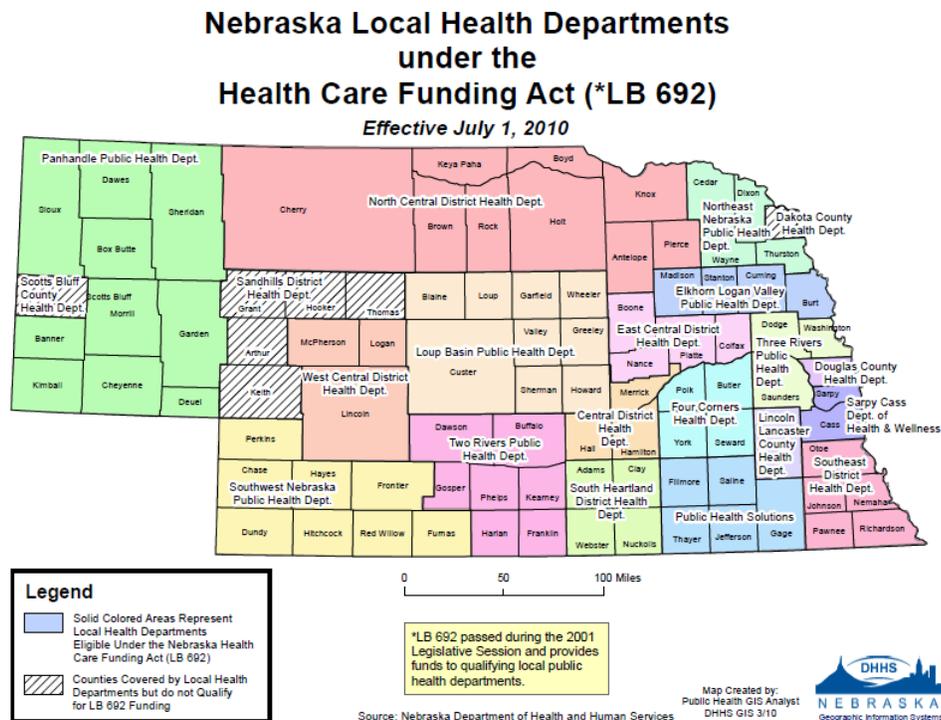
G. City MatCH

City MatCH located in Omaha, NE and associated with UNMC, Department of Pediatrics is a freestanding national membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States. The mission of CityMatCH is to improve the health and well-being of urban women, children and families by strengthening the public health organizations and leaders in their communities.

CityMatCH was initiated in 1988 as a special project of the Boston Department of Health and Hospitals with the goal of improving the organization and delivery of services to urban families and children. Initial project activities centered on developing and information base on what major health departments across the United States were doing to address shared urban MCH problems such as increasing racial disparities in infant mortality, inadequate access to prenatal care, substance abuse in pregnancy, and interpersonal violence. The CityMatCH project, under the leadership of urban MCH program directors in cities across the county, evolved into a national organization in 1991. Since then CityMatCH staff has added a great deal to the MCH capacity in Nebraska in various roles of leader, stakeholder, contractor, advisor, and colleague.

H. District Health Departments

In 2000 only 22 of the state's counties were served by a local health department. In 2010 there are now 25 local and district health departments covering all of Nebraska's 93 counties. The Nebraska Legislature passed the Health Care Funding Act (LB 692) in 2001, providing funds to local public health departments to implement the ten essential services and the three core functions of public health. As of June 30, 2010, a total of 18 local or district public health departments covering 86 counties were eligible to receive funds under the Health Care Funding Act. NDHHS continues to work toward the goal of having all counties covered by a public health department under the LB 692 umbrella. However, Dakota and Scotts Bluff Counties have single county health departments, and Sandhills District (four frontier counties) does not meet the minimum population eligibility requirements (30,000) of the Health Care Funding Act.



In 2008, all local health departments began a needs assessment process. Seventeen utilized the Mobilizing for Action through Planning and Partnerships (MAPP) methodology to update their local public health improvement plans. This process involves a rigorous assessment of health needs, community health risks, and the accessibility of health services. This process also involves extensive input from a diverse group of stakeholders and the development of high priority implementation initiatives. The remaining health departments used a different process to conduct a comprehensive health assessment.

All local health departments have contracted with the Department of Health and Human Services (DHHS) to complete an oversample of the Behavioral Risk Factor

Surveillance System survey for their districts. This will allow them to continue to monitor behavioral risk factors in their local areas. Most departments also invested in the TRALE health risk assessment tool which analyzes health risk factors on an individual level.

All local health departments participate in a statewide school surveillance program to monitor and report absences due to illness (e.g., flu and asthma). This system allows state and local health officials to respond more promptly to disease outbreaks. The departments are also working with the infection control nurses in hospitals to identify patients with influenza-like illnesses. This activity allows them to work with local businesses and the community at large to make appropriate disease prevention recommendations. All local health departments continue to participate in the National Electronic Disease Surveillance System (NEDSS). The system is designed so that state and local health departments as well as the Centers for Disease Control and Prevention (CDC) can monitor and assess disease trends and guide prevention and intervention programs. The local health department staffs are the foundation of the system and can intervene more quickly when there is a communicable disease or food borne illness outbreak.

MCH infrastructure capacity is inconsistent for department to department, however some highlights include:

1. The Baby Blossoms Collaborative (BBC) convened by the Douglas County Health Department. The BBC is comprised of 35+ maternal child health partner agencies and small businesses. Before the BBC was established (1999), the separate agencies were attempting to address the high infant mortality rate and the health disparity between African Americans and Caucasians. Their efforts were met with numerous barriers, minimal success and a widening disparity gap. Recognizing the value of collaboration, and utilizing the locally based national resources of the CityMatCH Perinatal Periods of Risk Approach (PPOR) for reducing fetal-infant mortality, they formed a coalition. Together they create an opportunity for non-traditional partners like police officers, physicians, childcare providers and medical examiners to share their observations, data and concerns.

The BBC has designed and implemented several initiatives such as a Fetal Infant Mortality Review (FIMR) process to assist the collaborative in identifying and resolving community issues contributing to poor reproductive outcomes and poor infant health. After identifying primary risk factors affecting infant mortality locally through Perinatal Periods of Risk (PPOR) analysis and the FIMR process, the BBC developed three specific interventions to address preconception health, prenatal health and safe sleep messaging

2. Northeast NE Public Health Department In 2009, The Northeast Nebraska Public Health Department began a district wide Child-Fetal Infant Mortality Review (C-FIMR). The C-FIMR team brings together medical, public health, law enforcement and community professionals from the four member counties. The goal of the project is to gain a better understanding of the risk factors and situations leading to infant and child

injury/death, and also to better coordinate interventions and referral systems. The work is being conducted under the authority of the Nebraska Child Death Review Team, and mentored by the Douglas County FIMR program.

5. Selection of State Priority Needs

List of Potential Priorities

When the subcommittees completed their work a final meeting of the NAC was scheduled. In the final meeting the following list of priorities were considered for inclusion:

1. Obesity in Women
2. Sexually Transmitted Diseases among Women
3. Unintended Pregnancy among Women
4. Abuse & Neglect of Infants
5. Duration and Exclusivity of Breastfeeding of Infants
6. Evidence of Health Disparities in Infancy
7. Entry Into and Adequacy of Prenatal Care
8. The Impact of Poverty on Infant Health
9. Food Insecurity among Children
10. Childhood Obesity and Physical Inactivity
11. Access to Oral Health Care for Children
12. Abuse and Neglect among CSHCN
13. Functional Limitations among CSHCN
14. Access to Medical Homes for CSHCN
15. Alcohol Use among Youth
16. Obesity, Nutrition, & Physical Activity among Youth
17. STD and Reproductive Health among Youth

Each of the subcommittees presented their finding to the NAC and there was opportunity to ask questions of clarity.

Methods for Ranking/Selecting Priorities

Once the NAC had heard all presentations each individual received the criteria definitions and a prioritization tool (see Appendix B and C) and scored the 17 purposed priorities. Staff and volunteers aggregated the individual scores and presented the following ranking:

1. Childhood Obesity and Physical Inactivity
2. STD and Reproductive Health among Youth
3. The Impact of Poverty on Infant Health
4. Sexually Transmitted Diseases among Women
5. Access to Oral Health Care for Children

6. Obesity in Women
7. Unintended Pregnancy among Women
8. Abuse & Neglect of Infants
9. Abuse and Neglect among CSHCN
10. Alcohol Use among Youth
11. Entry Into and Adequacy of Prenatal Care in
12. Food Insecurity among Children
13. Obesity, Nutrition, & Physical Activity among Youth
14. Duration and Exclusivity of Breastfeeding of Infants
15. Evidence of Health Disparities in Infancy
16. Access to Medical Homes for CSHCN
17. Functional Limitations among CSHCN

After review of the scores and ranking the full NAC used consensus to combine and refine some of the problems. Participants made proposals to narrow the list down from 17 to 10. Proposals were subjected to two criteria 1) the proposal must honor the process and, 2) the proposal must honor the priority. At the end of the consensus process, all 17 needs had been incorporated into 10 overarching priorities. This was not a goal of the process, but a consequence of consensus methodology. Following the final meeting staff analyzed and refined the recommendations and presented to the leadership within NDHHS for final approval. The final list of priorities as approved by the Chief Medical Officer/Director of the Division of Public Health, Nebraska Department of Health and Human Services is:

Nebraska's MCH/CSHCN Priorities 2010-2015

- Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight.
- Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.
- Reduce the impact of poverty on infants/children including food insecurity.
- Reduce the health disparities gap in infant health status and outcomes.
- Increase access to oral health care for children and CSHCN.
- Reduce the rates of abuse and neglect of infants and CSHCN.
- Reduce alcohol use and binge drinking among youth.

- Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care.
- Increase the prevalence of infants who breastfeed exclusively through six months of age.
- Increase access to Medical Homes for CSHCN particularly for those with functional limitations.

Priorities Compared with Prior Needs Assessment

A. Priorities Continued from Previous Needs Assessment

Three priorities remained essentially the same from the 2005 Needs Assessment : 1) Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight, 2) Reduce the rates of abuse and neglect of infants and CSHCN, and 3) Reduce alcohol use and binge drinking among youth. These priorities continue primarily because data indicate they are significant problems that persist for the designated population groups.

B. Priorities Replaced

A total of seven priorities were replaced. Three were CSHCN priorities that changed due to the availability of more data. Two priorities were modified/merged: 1) Reduce the rates of infant mortality, especially racial/ethnic disparities, and 2) Reduce rates of premature and low birth weight births for all women, with attention to adolescent pregnancy. The new priority, Reduce the health disparities gap in infant health status and outcomes, is broader but more targeted at reducing the rates related to infant health status and outcomes. The NAC and the infant subcommittee determined that reducing disparities in infant health would reduce rates of infant mortality, preterm and low birth weight births, as well as impact many other indicators across the remaining life course. Tobacco use was addressed in the women's and infants subcommittees, but was not as compelling a need as it had been in the past. Finally, the data on unintentional injuries had improved for children (but not youth) since the last review.

C. Priorities Added

The remaining six priorities are new. Most of the additions are a result of changes in the Needs Assessment process and new or additional data/indicators. Three of the new priorities had been identified in the 2005 process but did not make the final list. However in 2010 due to additional data being available, breastfeeding, access to oral health, and STDs/reproductive health were selected. The social/environmental health determinant framework had an effect on the final priorities with the selection of impact of poverty, and health disparities.

Priority Needs and Capacity

The following is a discussion of Nebraska's 2010-2015 priorities as they relate to the four service levels of the pyramid that was conducted as a component of the Capacity Assessment after the discussion is a summary of the capacity findings. The capacity tool utilized by the committee to determine capacity can be found in Appendix E.

A. Capacity by priority

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

The Nebraska Dietetic Association (NDA) was established in 1935 as an affiliate of the American Dietetic Association (ADA) and currently has 630 members. These members include: Registered Dietitian (RD), Dietetic Technicians Registered (DTR), and Student members. Many of our members are licensed for medical nutrition therapy (LMNT).

The WIC Program serves around 45,000 women, infants, and children each month. The program has incorporated a number of strategies and performance measures focused on healthy weight and have an extensive breastfeeding promotion and support component.

In 2008 Nebraska Title V finalized a planning effort targeted at women and their young children that resulted in recommendations for improved access to pre/interconception health that includes a focus on healthy weight and primary prevention, wellness programs and breastfeeding policies in the work and school place, as well as improved local access to healthy nutrition and physical activity. Title V currently has 4 sub-grantees addressing this priority. Since 2008, NDHHS has received funding from the Centers for Disease Control and Prevention (CDC), Division of Nutrition, Physical Activity and Obesity Prevention to coordinate the states efforts, including support for Nebraska's breastfeeding coalition. Other, state level efforts include capacity building effort to conduct a second point in time survey collecting the BMI's of Nebraska's school aged children to be implemented the fall of 2010 and a larger effort to establish a school health surveillance program that would among other things track BMI.

NDHHS Nutrition and Activity for Health Program has begun two new efforts one in conjunction with the Nebraska Medical Association called the Childhood Obesity Project which has produced the Foster Healthy Weight in Youth Tool Kit targeted at Family Physicians and Pediatricians and launched in July 2009. The program has also received funds from the American Recovery and Reinvestment Act which are supporting activities in child care settings.

Most recently (December 2009) Omaha was one of 41 cities selected to receive a Healthy Kids, Healthy Communities grant from the Robert Wood Johnson Foundation. The \$360,000 grant will help the Live Well Omaha organization develop policies to reduce the childhood obesity rates in Omaha. Such as policies that will build connectivity for neighborhoods and schools as well as evaluating land and water use policy that would pave the way for the start-up and support of community gardens. Plans also include activities to improve access to

healthy foods and help children increase their physical activity through opportunities to safely bike or walk to school.

The following data sources are available to document the problem and progress towards improvement, Nebraska Behavioral Risk Factor Surveillance System (BRFSS), the Nebraska's Youth Behavioral Risk Factor Survey (YRBS) the National Survey of Children's Health (NSCH), and the Nebraska Pediatric Nutrition Surveillance System (PedNSS).

Capacity Gaps

- The quality of data on overweight and obesity, nutrition, and physical activity comes from multiple data and varies in completeness and quality from one population group to another.
- Nebraska has not focused on CSHCN in the past.

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

The majority of the services are currently provided under the administration of the Nebraska Reproductive Health Program both for sexually transmitted diseases and preventing unintended pregnancy. In addition the Nebraska Sexually Transmitted Disease Program provides services to control and prevent sexually transmitted diseases and reduce the burden and cost of these infections. The program assists state, local, and community efforts to help prevent the spread of chlamydia, gonorrhea, syphilis, hepatitis, and other STDs. The NDHHS STD Program provides for free testing at over 100 sites statewide with additional referrals available through local health departments. The program also contracts directly with two county health departments (Lincoln and Omaha) and one health clinic (Grand Island) to operate full service confidential STD clinics. HIV testing is also available at these locations. For STD services in rural Nebraska, STD program health professionals work with local health care providers.

Health professionals' interview infected people to identify, locate, and treat sex partners, to ensure proper treatment, and to provide information to help prevent re-infection. Nebraska is divided up into 20 health districts across the state. Of those, 10 health districts have active DIS.

Nebraska Infertility Prevention Project (NIPP) is administered by the NDHHS STD Program and focuses on the prevention and early treatment of chlamydial and gonococcal infection through the collaborative effort of health care providers through out Nebraska. NIPP services are provided at 78 sites across the state in the following settings: Adolescent (1), Community Health Center (4), Corrections (15), Family Planning (22), I.H.S. (6), Private (16), STD Clinic's (6), Substance Abuse (2).

To help teen and young women set goals for their life in relation to their health and reproductive plans, Nebraska's Department of Health and Human Services, Lifespan Health Services is focusing on an approach that recognizes the complex interaction of

biological, behavioral, psychological, and social protective and risk factors that contribute to health outcomes across the lifespan. The “Tune My Life” initiative applies the model of preconception and interconception care, broadening the approaches to improving birth outcomes beyond clinical care to pre- and interconception health among young at-risk women and among providers.

Section 510 of Title V, the Abstinence Education Program was re-established through the Health Care Reform Law. The law also appropriated funds for evidenced-based teen pregnancy prevention efforts through a Personal Responsibility Education program.

The following data sources are available to document the problem and progress towards improvement, Nebraska Vital Statistics, DHHS Epidemiology for Communicable Disease STD Program, and Nebraska Behavior Risk Factor Surveillance System (BRFSS)

Capacity Gaps

- Political Climate
- Insufficient Funding

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

The Department of Health & Human Services is using current technology and policy efficiencies to improve client services and modernize the Economic Assistance Service Delivery system. Beginning in 2008, NDHHS launched ACCESSNebraska for clients to find and apply online for Nebraska public assistance benefits (Food Stamps, TANF, Aid Aged Blind and Disabled, Energy Assistance, Medicaid, SCHIP, and Child Care Subsidy). ACCESSNebraska is a single point of contact and is designed to increase accessibility by connecting 24/7 through the internet while increase responsiveness to customers by providing a single phone number for all services aiming to meet all needs with through one contact.

Many families and individuals across the state live in poverty and struggle to meet basic needs such as food, housing, and transportation; which are a higher priority for them than health education, or even health care. Recommendations on healthy diets are likely to seem irrelevant to parents who experience food insecurity. Those in poverty often lack transportation to health programs and services and appropriate child care arrangements. They often lack health coverage, which severely limits their options to health services. Even if they receive health screenings, they may lack the funds to pay for medication or other treatments. Time constraints and basic needs priorities are major obstacles to reaching low-income parents with health education programs and can be a contributing factor to lack of parental involvement in programs that serve children and youth. This especially impacts single parents, which has a relatively high percentage of low income, a group that is likely to place priority on basic needs and have time constraints.

The capacity, at all levels, that is necessary to address the complexity of poverty may not be sufficient. At the least, to adequately address poverty necessitates improved coordination of roles and activities among many players. Stemming from the “war on

poverty” originating in 1964, a number of federal legislative bills were enacted and programs were instituted by the end of the decade, e.g. Head Start, the Job Corps, Volunteers in Service to America (VISTA), Amendments to the Social Security Act creating Medicaid, Medicare, the Food Stamp Act, Community Action Program, etc.

The Community Action Program, in particular, working in partnership with state governments and community organizations, began to address poverty by providing immediate assistance to individuals and families and also implementing long-term strategies to overcome barriers to achieve economic self-sufficiency through methods such as job training and community economic development. Today, the national membership organization, Community Action Partnership (CAP), includes 1,100 Community Action Agencies (CAAs) across the nation. CAP’s promise: “Community action changes people’s lives, embodies the spirit of hope, improves communities, and makes America a better place to live. We care about the entire community, and we are dedicated to helping people help themselves and each other.” The state association, Community Action of Nebraska, orchestrates a network of nine CAAs that cover all counties in Nebraska.

Building Bright Futures of Omaha is a 501(c)(3) that was created in 2006 when a group of business, civic and political leaders came together to assess the status of our youth in Douglas and Sarpy County and ask whether young people were receiving the support and services they needed. Driven by the stark impact of poverty youth the mission is to improve academic performance, raise graduation rates, increase civic and community responsibility and ensure that all students are prepared for post-secondary education by developing partnerships with existing providers and creating new evidence-based programs to develop a comprehensive, community-based network of services.

The following data source is available to document the problem and progress towards improvement, US Census Bureau, The Current Population Survey (CPS) and the American Community Survey (ACS).

Capacity Gaps

- Public Health is not significantly involved
- Hard to measure the impact of poverty

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

Omaha Healthy Start (OHS), an initiative of Charles Drew Health Center, is one of the 96 federally funded Healthy Start projects in the United States, which promotes community-based maternal and child health programs, particularly those that focus on the reduction of infant mortality, low birth weight and racial disparities in perinatal outcomes. The mission of Omaha Healthy Start is to reduce the rate of infant mortality in North and Northeast Omaha by means of partnership with families, community members and organizations through the delivery of case management, outreach, health education and leadership training.

Northern Plains Healthy Start administrated by he Aberdeen Area Tribal Chairmen's Health Board promotes healthy families and improving birth outcomes for Native American women by providing Targeted Case Management Services (TCM). TCM services are a culturally relevant program, which empowers individuals to make better health care choices. Services are planned and coordinated through needs assessments, case service planning, referrals and assessing community services, advocating for women and children, and monitoring progress and outcomes. Northern Plains Healthy Start and the TCM program is a holistic approach respecting the importance of family, extended family, physical, emotional, psycho-social and spiritual health and the continued support for Indian family values.

Douglas Counties' Baby Blossom Coalition has designed and implemented several initiatives such as a Fetal Infant Mortality Review (FIMR) process to assist the collaborative in identifying and resolving community issues contributing to poor reproductive outcomes and poor infant health. After identifying primary risk factors affecting infant mortality locally through Perinatal Periods of Risk (PPOR) analysis and the FIMR process, the BBC developed three specific interventions to address preconception health, prenatal health and safe sleep messaging

In 2009, The Northeast Nebraska Public Health Department began a district wide Child-Fetal Infant Mortality Review (C-FIMR). The C-FIMR team brings together medical, public health, law enforcement and community professionals from the four member counties. The goal of the project is to gain a better understanding of the risk factors and situations leading to infant and child injury/death, and also to better coordinate interventions and referral systems. The work is being conducted under the authority of the Nebraska Child Death Review Team, and mentored by the Douglas County FIMR program.

The Minority Health Initiative funds are used to impact health disparities in racial/ethnic minority population groups. Projects must demonstrate cultural competence in their design and focus on one of the following: Obesity, Heart disease, Infant mortality, Diabetes, and or Asthma. The following projects are dedicated to infant mortality:

a) Elkhorn Logan Valley Public Health Department's Project MEGA Health (Minority Education for Greater Access to Health) is a continuation of programs developed during the past three grant cycles and seeks to expand the services provided as well as increase the number of minority and low income clients served. The project addresses several health disparities, which disproportionately impact racial ethnic minority populations, including: 1) reducing risk factors for diabetes, obesity and cardiovascular disease; 2) beginning an education program on asthma; 3) continuing to work address prenatal/postpartum care related to gestational diabetes and infant mortality; and 4) continuing dental hygiene education.

b) Blue Valley Community Action Agencies' "VITAL LINK TO BEBES SANOS" (Healthy Babies) will provide prenatal case management services to pregnant Hispanic

women throughout their pregnancy and two months after the birth of the baby. The expected outcomes will be a reduction in low birth weight infants and improved maternal health (including mental health). A bilingual 'lay health educator' or 'promotoras/promotoros' will provide the majority of case management services and partner with local agencies to improve access the expectant parent's access and utilization of community resources.

c) The Doral Group's Sarpy County Minority Health Partnership works to increase utilization of early prenatal care and reduce infant mortality among African American and Hispanic residents. Members of the partnership will receive cultural competency training and then provide educational forums and printed materials on importance of first trimester prenatal care and infant mortality at health agencies, schools, community and faith based agencies

The Nebraska Minority Public Health Association (NeMPHA) was formed as an outcome of the 1997 Minority Health Conference as a not-for-profit corporation committed to providing leadership that result in a better quality of life for racial/ethnic minorities in Nebraska. To achieve its mission, the NeMPHA works towards the following goals: Advocacy - To advocate for and solicit funding for the development of effective health promotion and risk reduction strategies and services/programs for racially and ethnically diverse communities; and Empowerment - To empower Nebraska's racial/ethnic minority communities by strengthening indigenous leadership by ensuring representation in the membership and committees of the Association; sponsoring workshops, forums and conferences; conducting briefing sessions with public officials and the media; and providing technical assistance to providers in their efforts to develop and achieve their goals and conduct fund raising.

The mission of the UNMC Center for Reducing Health Disparities is to improve public health and the quality of health and wellness of racial/ethnic minorities, underserved, and rural populations by reducing and ultimately eliminating health disparities. The center focuses on building infrastructure capacity to address health disparities, developing and increasing health disparities research, programs, and activities; community engagement, and, increasing knowledge about health disparities including causes, preventative techniques, and interventions

The Lifespan Health Service Unit of NDHHS completed a strategic planning initiative in the 2009/2010 that focused on eliminating the disparities in infant mortality. Recommendations included raising awareness of health equity among healthcare entities, women, communities, and policy makers that result in quality improvements, increased access/utilization as well as community- based research, identifying protective factors, and improving our understanding of the social and environmental determinates of health.

The following data sources are available to document the problem and progress towards improvement, Nebraska Vital Statistics, NE PRAMS, the American Community Survey (ACS) and the National Survey of Children's Health (NSCH).

Capacity Gaps

- Complex intergenerational problem
- Need for partners outside of public health

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

Currently there are 36 pediatric dentists in Nebraska, and only four outside of Omaha and Lincoln. Rural Nebraska is in short supply of pediatric dentistry. The UNMC College of Dentistry is developing a telehealth and service learning program for its pediatric dental residents. A \$1 million, three-year grant from the Human Resources and Service Administration (HRSA) was given to the college to use technology to implement rural health rotations as part of the dental pediatric residency training process. This technology will allow residents at three designated rural sites to participate in required lectures via the internet for residency completion. High tech cameras will allow directors of the dental residency program the opportunity to see first hand procedures being performed and help with anything that may arise. In 2008, the UNMC Pediatric Dental Residency Training Program will place 24 residents in three underserved areas. In the first year, each resident will spend two weeks at their designated rotation site with an additional week added the next two years of the grant for a total of four weeks. The training experience gives residents an appreciation for, as well as a link to, rural communities.

The UNMC College of Dentistry has been very active over the last few years in providing dental care to underserved communities in Nebraska through its program called Dental Day. Since the fall of 2001, this annual event brings students, staff and faculty together to provide dental care for underserved Nebraska children. In 2004, the program was expanded to include a visit to the Nebraska panhandle. In 2005, the community of Hastings was added to the list with other rural communities being evaluated. Over the last seven years, nearly \$1 million in dental care has been provided at no cost to patients. It is anticipated that exposure to rural health care issues will spark student interest in working for an underserved community.

The UNMC College of Dentistry has partnered with state dental associations in Nebraska, Wyoming, Kansas, and South Dakota, to form a consortium addressing oral health access problems of underserved populations in rural areas. The consortium's strong interest in the oral health of their citizens prompted them to form a partnership called Target Access: Great Plains Oral Health. Funding for the consortium was made possible by an appropriation in 2004 Omnibus Appropriation Bill approved by the U.S. Congress. Congressional delegation members in Nebraska secured the funds and received \$250,000 to attract more students from rural areas into the field of dentistry. The program concentrates on rural dental practice exposure during schooling, incentives to practicing in rural areas, and retention of practitioners in rural communities.

The Office of Rural Health coordinates several efforts to ameliorate workforce disparities, such as loan repayment, recruitment efforts and other incentives for dentists who opt to practice in rural NE. In 2009 Nebraska Medicaid began reimbursing for fluoride varnish application completed in a physician's office. In 2009 NDHHS received

a HRSA grant entitled, Oral Health Access for Young Children with the primary focus on preventative care for very young children. Strategies are under development. In 2011 Nebraska will implement the American Academy of Pediatric Dentistry/Head Start Dental Home Initiative to develop a network of pediatric and general dentists to provide oral health services to young children.

Currently in NE there are a number of oral health initiatives occurring, but there is a need for coordination of efforts to generate an approach to address the problem in a more systemic manner. For example, multiple leadership committees for various initiatives exist that could be more efficient and far reaching if integrated. In October of 2009 the Director of the Office of Oral Health and Dentistry was filled after a three year vacancy having this position filled should fill the leadership void. In addition, NDHHS has received a new oral health grant from HRSA to support a Dental Health Coordinator, along with a Dental Health Assistant (support staff). The funding will also develop an oral health strategic plan with the help of an Oral Health Advisory Panel. In addition, the HRSA grant will fund up to 10 local programs across the state to address the preventive oral health needs of young children who would not otherwise have access to care helping to fill gaps in services.

In 2004/2005 NDHHS and UNMC conducted the first Open Mouth Survey, an assessment of the oral health of third graders in the State of Nebraska The survey methodology was adapted from the “Basic Screening Survey Planning Guide” produced by the Association of State and Territorial Dental Directors (ASTDD). ASTDD also provided training and data analysis. Currently there is discussion to conduct a second survey.

The Family to Family Health Information Center at PTI Nebraska has been conducting Oral Health Forums with support provided by the Association of State and Territorial Dental Directors (ASTDD) over the past 2 years. Forum discussions were around access, treatment and payment for dental care for children with special health care needs. In August of 2008, a statewide oral health forum for families with children with special health care needs and professionals was held. Sixteen families from across Nebraska, six professionals and 2 staff from PTI attended. A white paper was developed with the findings from the forum. In February 2009, Family to Family staff and Title V representative from Nebraska presented at the AMCHP conference.

It was recognized that the statewide forum revealed accurate and factual information from families across the state, but did not reflect the cultural impact of oral health needs in the state. With funds offered by the ASTDD a forum focused on representation from the African American community was scheduled and held in September 2009. Four families of CSHCN and one dentist participated in dinner and discussion. Another paper was developed with information obtained from the rich conversation with families.

After two successful forums it was decided to explore oral health issues with Latino families. On March 25, 2010, an oral health forum for Latino families was held in South Omaha. The ASTDD allowed use of the remaining funds available to conduct another

forum. Eight parents of children with special health care needs were invited and agreed to attend. Six dental professionals attended. The discussion was in Spanish and translation was provided for English speakers. The information has not yet been analyzed, but the discussion was rich with many stories of families and children getting and needing oral health services. Another paper will be written and shared.

Nebraska's Dental Colleges' support a number of safety net oral health projects such as dental days, mission of mercy, etc., which periodically provide oral health services to underserved populations in different communities across NE. The wait time and number served is extensive, indicating the need for ongoing oral health services in NE.

The following data sources are available to document the problem and progress towards improvement, Nebraska Medicaid and the National Survey of Children's Health (NSCH).

Capacity Gaps

- Medicaid reimbursement
- Surveillance
- Fragmented services

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

NDHHS, Division of Children and Families is the primary entity responsible for the welfare of Nebraska's children. They are organized into five Service Areas and the two Youth Rehabilitation and Treatment Centers in Kearney and Geneva. The Child Welfare and Juvenile Services' Protection and Safety System works in partnership with law enforcement, county attorneys, judges, guardians ad litem and court appointed special advocates, medical personnel, therapists, foster parents, group homes and institutional care providers, schools, and care providers to provide services for the abused, neglected, dependent, or delinquent populations.

The Division focuses on increasing their capacity in public awareness, investigating reports, and protecting children. They have in recent years funded several preventative efforts from public awareness, prevention plans, and home visiting demonstrations.

There are several other significant agencies working to address infant abuse and neglect that are coordinated under the umbrella of the Nebraska Statewide Child Abuse Prevention Partnership. These agencies are Nebraska Children & Families Foundation, Nebraska Child Abuse Prevention Fund Board, and NDHHS. Nebraska Statewide Child Abuse Prevention Partnership published Growing Communities of Hope: The Nebraska Statewide Child Abuse Prevention Plan in 2006 with the Goal of reducing childhood maltreatment 20% in Nebraska by 2010. The plan promotes home visitation, respite care, parent education and training, family resource centers, and sexual abuse prevention programs.

Nebraska Children and Families Foundation's (NCFF) Prevent Child Abuse Nebraska brings partners together to develop a systematic approach to preventing child abuse and promoting positive relationships between children, parents, relatives', and caregivers.

The program coordinates collaborative projects that result in tools and resources to guide communities in their prevention effort. Examples include Rethink Your Reaction Campaign and Safe with You Curriculum. NCFE more recently has launched a child wellbeing initiative in five Nebraska communities (Sioux City, Columbus, Grand Island, North Platte, and the 11 counties of the Panhandle).

The Nebraska Child Abuse Prevention Fund Board is comprised of nine members: two representatives of NDHHS appointed by the CEO and seven members appointed by the Governor and approved by the Legislature. Activities of the Fund Board include: disbursement of funds to support local child abuse prevention programs, facilitating information exchange among groups concerned with prevention programs, encouraging statewide educational and public awareness regarding the problems of families and children and supporting and encouraging the formation of local child abuse councils.

Title II of CAPTA is administered by the NDHHS Division of Children and Family Services and the NCFE is the CB-CAP Agency.

Preventive efforts at NDHHS include a public awareness campaign: You Have the Power to Protect a Child. The campaign informs Nebraskans that they can make a difference when it comes to reporting suspected child abuse. The campaign focuses on four topics, child abuse prevention, shaken baby education, domestic violence, and methamphetamine abuse. Children and Family Services administers state general funds that support 4 home visiting programs as secondary prevention of child abuse and neglect. Implementation of LB 994 stipulating that every hospital, birth center, or other medical facility that discharges a newborn child shall request that each maternity patient and father of a newborn child, if available, view a video presentation and read printed materials, approved by the Department of Health and Human Services, on the dangers of shaking infants and children, the symptoms of shaken baby syndrome, the danger associated with rough handling or the striking of an infant, safety measures which can be taken to prevent sudden infant death, and the dangers associated with infants sleeping in the same bed with other children or adult. Together for Kids and Families' Family Support Workgroup that focuses on home visitation and respite services, and Child Death Review Team who provide analysis of all child deaths in an effort prevent future deaths.

The following data sources are available to document the problem and progress towards improvement: Data for Child Protective Services is information that is entered in the states Statewide Automated Child Welfare Information System (SACWIS) also known as N-FOCUS (Nebraska Family Online Client User System) and The Child Death Review Team (CDRT). Despite the existence of data documenting the problem among CSHCN, much of it is not Nebraska specific other than the large study in Omaha.

Capacity Gaps

- Child Maltreatment Surveillance
- Data for CSHCN

7. Reduce alcohol use and binge drinking among youth

Nebraska's behavioral health system is divided into six regions (see pages 8-9 of overall capacity). As of July, 2009 there were 513 active licenses for Alcohol and Drug Counselors and 284 Provisional Alcohol and Drug Counselors.

Nebraska Health and Human Services has been developing the infrastructure to reduce alcohol and binge drinking among youth for a number of years. In 2001 Nebraska received \$7.5 million in funding for the State Incentive Cooperation Agreement (SICA) which strove to eliminate or significantly reduce substance abuse in youth ages 12-17 by creating a coordinated state prevention system that assists communities to assess local substance abuse needs and select and implement locally-appropriate, effective, and scientifically-defensible substance abuse prevention policies, practices, and programs. The Nebraska Partners in Prevention formed in and community coalitions were established.

In order to enhance and sustain the substance abuse prevention at the State, regional, and community levels the SICA developed into the State Prevention Framework- State Infrastructure Grant (SPF SIG) that exists today. The SPF SIG works to impact the following three priorities: 1) youth initiation 2) drinking and driving, and 3) binge drinking. The SPF SIG has developed the Nebraska Substance Abuse Prevention Strategic Plan to describe how the program will address each step in the SPF model, including assessment, capacity building, planning, implementation, and evaluation as well as the cross-cutting issues of sustainability and cultural competency. The SPF-SIG continues to work with 16 community and regional coalitions across the state.

In December of 2007, the Substance Abuse and Associated Consequences in Nebraska, an Epidemiological Profile was published. This report contained 19 Nebraska data sources that include information on the patterns of use and consequences associated with the use of alcohol, tobacco, and illicit drugs within Nebraska. It was intended to help guide substance abuse prevention efforts in the state, including the selection of prevention priorities for the Nebraska Strategic Prevention Framework State Incentive Grant Program (SPF SIG).

In March 2009 SPF SIG released the Nebraska SPF SIG Strategy Approval Guide and Nebraska SPF SIG Implementation Toolkit. The Nebraska SPF SIG Strategy Approval Guide provides SPF SIG grantees with information to help them identify and select evidence-based prevention strategies for their communities. The guide describes population level behavior change theory, criteria to help determine if a strategy is a good fit for the community, a set of strategies that are pre-approved for SPF SIG communities, and the process for seeking approval of strategies for community prevention efforts. Implementation Toolkit provides SPF SIG grantees with information to help them successfully implement their SPF SIG strategic plans. It provides guidance to help them

effectively execute their strategies, including instruction in developing detailed action plans, as well as tools for monitoring each step of the implementation process. The following data sources are available to document the problem and progress towards improvement, Nebraska's Youth Behavioral Risk Factor Survey (YRBS). The YRBS is quantitative, high quality data, but not necessarily generalizable.

Capacity Gaps

- YRBS

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

Nebraska's provider shortages have a direct effect on perinatal services in Nebraska. According to the Nebraska Family Physician Survey, 2009 over a third (37%) of family medicine physicians have discontinued obstetric care sometime in the past. Another third (36%) intend to make no changes and continue offering obstetric care for the foreseeable future. Over a fifth (21%) has never provided obstetric care. Urban physicians were far more likely to have discontinued care than rural physicians, likely due to the availability of OB/GYN specialists. Physicians in Medicare certified rural health clinics are far more likely to have provided and will continue providing obstetric services, likely due to the lack of OB/GYN specialists in those areas. This generally matches trends for all small town and rural physicians, not just those working at rural health clinics.

Many family medicine physicians have discontinued obstetric care in the recent past. Of the survey respondents, 181 (46%) reported why they discontinued or were considering discontinuing obstetric care. The most commonly cited reason was due to the malpractice risk and associated cost of malpractice insurance, which appeared in the comments 41 times, or for about 23% of the responding physicians. Physicians often cited multiple reasons for ending their obstetric practice. The next most common reason given was the generic term "lifestyle" appearing 28 times, followed by declining demand at 24 times, and no call coverage. While malpractice risk/cost was by far the most common single factor, if we group the reasons into categories, we can see that lifestyle factors, such as the age of the physician, wanting to spend more time with one's own family, stress, and the desire for a set schedule (as well as the generic response 'lifestyle'), occurred far more often than financial concerns such as malpractice risk/cost and lower reimbursement. Practice considerations, such as a decline in demand for such services, lack of on-call coverage, inability to perform a C-section under anesthesia, and providing outpatient care only were also more common than financial concerns.

Omaha Healthy Start (OHS), an initiative of Charles Drew Health Center, is one of the 96 federally funded Healthy Start projects in the United States, which promotes community-based maternal and child health programs, particularly those that focus on the reduction of infant mortality, low birth weight and racial disparities in perinatal outcomes. OHS HealthNet is a community of health care services networked together by Omaha Healthy

Start (OHS). The goal of OHS HealthNet is to: Build unity and mobility among health care and social service programs serving families in the project area; Provide support to women of childbearing age and mothers, fathers, infants and their families in accessing medical care and social services; and create a “seamless” system of care that will provide these core set of services through outreach and participant recruitment, case management, health education and training, and consumers leadership and advocacy training.

Medicaid Presumptive eligibility is a process whereby a qualified provider can presumptively (based on a declaration of income) determine pregnant women eligible for Medicaid and deliver service with a knowledge that they will be reimbursed by Medicaid. Pregnant women are eligible for all services but inpatient hospital. This eligibility continues until NDHHS determines continuing eligibility for Medicaid.

Nebraska has the Healthy Mothers Healthy Babies Hotline since 1994. For many years the focus has been on prenatal care and individual behaviors. NDHHS last established Perinatal Guidelines in the 1980’s and it has been studying perinatal regionalization the last few years with graduate students.

Since the publication of MMWR’s Recommendations to Improve Preconception Health and Health Care --- United States A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care in 2006 the focus has begun to change. Nebraska has been moving incrementally to a pre/interconception focus. The University of Nebraska Medical Center had been developing curriculum for residents funded by the Title V block grant. Omaha Healthy Start and Nebraska Family Planning have been implementing various components. Lifespan Health Services has received funding for building infrastructure through the TUNE project.

Nebraska’s Title V / MCH Block Grant funds are supporting community-level activities in 2009-2011 that include the life course approach to improve health outcomes. The importance of preconception and interconception health is being implemented through different strategies. One promising strategy is promoting and supporting adolescent girls and women of reproductive age to develop Reproductive Life Plans. The plans set goals and identify methods to achieve the holistic wellbeing needed to produce a healthy baby and to become a successful parent someday to nurture wellbeing throughout their child’s entire life.

The following data sources are available to document the problem and progress towards improvement, a Nebraska Vital Statistics and NE Pregnancy Risk Assessment Monitoring System (PRAMS).

Capacity Gaps

- Changing political environment
- Adequacy of safety net providers for women without health care coverage

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

In 2007, the Center for Disease Control and Prevention reported that Nebraska had one Baby-Friendly Hospital (13/5% of births), 42 International Board Certified Lactation Consultants, and 20 La Leche League groups. Other than providing an exemption for jury duty Nebraska has no legislation related to advocacy of breastfeeding.

The WIC State Plan includes a statewide goal related to breastfeeding: By August 1st, 2013, increase the percent of exclusively breastfed infants at 6 months of age. As part of the New WIC Food Package implementation on October 1, 2009, there is a stronger focus on promoting and supporting exclusive breastfeeding, especially in the first month of life. All WIC staff in Nebraska will attend Breastfeeding Competency Training in 2010.

WIC currently has four local agencies with breastfeeding peer counselor programs (Central District Health Department in Grand Island, Family Service WIC in Lincoln, Douglas County Health Department in Omaha, and Western Community Health Resources in Chadron). In addition to providing client services, breastfeeding peer counselors in these agencies develop and participate in breastfeeding promotion and support activities throughout their communities and collaborating with community partners whenever possible. In 2010 WIC received additional federal funding to expand to eight additional local agencies. These WIC agencies are in process of implementing their new peer counseling programs.

NDHHS WIC, Lifespan Health Services and Nutrition and Physical Activity, and Nutrition staff participate in the Nebraska Breastfeeding Coalition, in addition to organizational partners such as Millworks, Bluestem Interactive, Visiting Nurses Association, and others. Formation of the Nebraska coalition was supported with Title V/MCH Block Grant funds through a contract with an organizational development company in 2008 and again in 2009. Currently the coalition is supported through the Nutrition and Activity for Health Program with funds from the CDC Division of Nutrition, Physical Activity and Obesity grant. Annual membership dues also provide funding for the coalition. The Coalition is an independent free standing organization; a network of individual members and organizational partners working together to share information and partner in activities that advance the breastfeeding mission.

Still a relatively young organization, the Coalition has been focusing on building relationships among the membership and with partners. Activities include expanding the website, <http://www.nebreastfeeding.org/>, holding strong and well-attended quarterly Action Team meetings, growing the membership, and identifying organizational partners. There are 176 people who receive coalition emails. On average, about 55 people (30%) are opening the emails. The Coalition's Facebook page has 245 fans. Generally, each post gets at least a response or two.

Passage of the workplace breastfeeding support provision in the Patient Protection and Affordable Care Act, also known as the health care reform package states that employers shall provide reasonable, unpaid break time and a private, non-bathroom place for an employee to express breast milk for her nursing child for one year after the child's birth. Employers with less than 50 employees are not subject to the requirement if it would cause "undue hardship."

The following data sources are available to document the problem and progress towards improvement, the National Immunization Survey (NIS), Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) and Nebraska Pediatric Nutrition Surveillance System.

Capacity Gaps

- Work place polices that meet new federal statutory requirements
- Training and systemic support needed

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

CSHCN in Nebraska have difficulty accessing needed health care services. There is a lack of primary care physicians in many areas of the state as well as an overall lack of pediatric specialists.

Project DOCC (Delivery of Chronic Care) at the Munroe-Meyer Institute improves the quality of care for chronically ill children by educating pediatric residents about their special needs from a parent's perspective. The Project DOCC curriculum is taught by parent teachers and made up of three components: 1) Annual Grand rounds panel presentation; 2) Home visit – 2 training parents meet with the residents to discuss medical and more holistic aspects of family life for children with special healthcare needs and their families at a family's home; and 3) Parent interview using a Chronic Illness History tool – the resident interviews the parent using the tool which includes a broad range of questions regarding child and family issues, ranging from finances to personal relationships.

Nebraska is fortunate to have many organizations currently collaborating to increase access to medical homes for CSHCN. The Family to Family Health Information Center at the Nebraska Parent Training and Information, (PTI-Nebraska), working with its partners at NDHHS, the Munroe-Meyer Institute, and the Boys Town Institute for Child Health Improvement can expand its program to pilot a family-led care coordination program in support of primary care practices in Nebraska, using best practices from Rhode Island and North Carolina to increase access to comprehensive, coordinated, quality care in accordance with the medical home model.

Boys Town's Integrated Services for Children with Special Health Care Needs is as MCHB-funded Integrated Community Systems for Children and Youth with Special Health Care Needs (CYSHCN) grant that has been working with 10 quality improvement teams, representing 10 pediatric primary care clinics in Eastern Nebraska since 2008.

These practices represent a wide-range of practice type and patient profiles, from privately owned and operated to federally qualified health centers, clinics serving primarily populations of African American or Hispanic children, clinics in academic settings, inner-city clinics, and those in both suburban and rural locations.

Clinic	Location	Patient Population Profile	Clinic-Type
One World Community Health Center	South Omaha	90% Hispanic, Medicaid, no insurance, English second language	Federally-qualified health center
University of Nebraska Medical Center (UNMC) Physicians	Plattsmouth	Rural	University-affiliate community-based clinic
Children’s Physicians (3)	Creighton University Medical Center (1) LaVista, NE West Omaha	Majority Hispanic/African-American – Inner city Caucasian/Suburban Caucasian/Suburban	Large Hospital-based employed physician group with community-based satellite primary care clinics /academic-center affiliation
Children and Adolescent Clinic	Hastings, NE	Rural, moderate-low income	Private
Boys Town Pediatrics (2)	South Omaha Central Omaha	90% Hispanic, 80% Medicaid Mixed Caucasian, African-American, Hispanic 60% Medicaid	Large Hospital-based employed physician group with community-based satellite primary care clinics
Complete Children’s Health	Lincoln, NE	Suburban/Rural Majority Caucasian, privately insured	Private, for-profit
Charles Drew Health Center	North Omaha	Majority African-American, Medicaid, no health insurance, large refugee and immigrant population (Sudanese, Somali)	Federally-qualified health center

Each practice team consists of at least 1 physician, 2 parent partners (parents of children or youth with special health care needs) and 2 other clinic staff (typically nurse and office manager). These teams have been provided training based on the Institute for Healthcare Improvement model for practice improvement which includes testing new strategies for improvement on a few patients, reviewing with the team and family as to how those strategies worked or didn't work, and then making changes as indicated. Practice improvements are not taken to scale until they have been tested and re-tested on several patients and/or families over time. At each Learning Session, the practice teams come together to share with one another new strategies for practice improvements, learn about successes from other MHLC's nationally, and gain advice from local and national experts on a variety of topics from how to embrace your parent partners to eligibility criteria for state and local programs serving CYSHCN in the State of Nebraska. Each team, then, establishes their own priorities for improvements within their practices.

Some teams have created parent resource rooms in their practices; developed pre-visit questionnaires to help parents prioritize concerns for the visit; enhanced collaborations with subspecialists, family advocacy groups and non-traditional partners in the community such as Legal Aid; and identify CYSHCN in the practice. All of these activities have in some way improved the care delivery system for all patients and families in their practice. All teams are struggling with coordinating care. Nearly all of the practice teams have identified a need for additional resources within the practice or in the community to assist families with care coordination. We will address this concern through this proposal by developing a community-based model of parent-to-parent support and care coordination.

The following data source is available to document the problem and progress towards improvement, the National Survey of Children with Special Healthcare Needs (NSCSHCN).

Capacity Gaps

- Lack of working definition of functional limitations

B. Capacity Findings

1. Low capacity (Score less than or equal to 1)

Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies. (Score 1)

Increase:

- Structural capacity – increase funding and human resources
- Relational capacity – increase formal networks/coalitions
- Knowledge capacity – increase knowledge of problem within communities

Reduce the rates of abuse and neglect of infants and CSHCN. (Score 1)

Increase:

- Structural capacity – create a primary prevention system

- Data capacity – create child maltreatment surveillance, improve data to include CSHCN
- Relational capacity – increase the reach of networks/coalitions
- Knowledge capacity – increase knowledge of abuse/neglect of CSHCN. Improve knowledge of prevention

2. Moderate capacity (Score greater than 1 and less than 3)

Reduce the impact of poverty on infants/children including food insecurity. (Score 1.5)

Increase:

- Data capacity – improve ability to measure the impact of poverty
- Relational capacity – increase public health’s involvement in networks
- Knowledge capacity – increase knowledge of problem in public health

Reduce the health disparities gap in infant health status and outcomes. (Score 1.5)

Increase:

- Structural capacity – increase funding and human resources
- Relational capacity – increase effectiveness of networks/coalitions
- Knowledge capacity – increase knowledge of problem

Increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care. (Score 1.5)

Increase:

- Structural capacity – increase authority, funding, and human resources
- Relational capacity – increase effectiveness of networks/coalitions
- Knowledge capacity – increase knowledge of problem, Medicaid’s role

Increase access to Medical Homes for CSHCN particularly for those with functional limitations. (Score 1.5)

Increase:

- Structural capacity – increase the reach of resources to statewide
- Data capacity – increase number of data sources
- Knowledge capacity – increase knowledge , disseminate emerging findings

Increase access to oral health care for children and CSHCN. (Score 2)

Increase:

- Structural capacity – increase number of providers (total, # serving children, #taking Medicaid)
- Data capacity – Need population based data on children

3. High capacity (Score greater than 3)

Increase the prevalence of the MCH/CSHCN population who are physically active, eating healthy, and are at a healthy weight. (Score 3.5)

Increase:

- Data capacity- Increase data collection on children

Reduce alcohol use and binge drinking among youth. (Score 3.5)

Increase:

- Structural capacity – Sustain and increase funding

Increase the prevalence of infants who breastfeed exclusively through six months of age. (Score 3.5)

Increase:

- Structural capacity – increase resources targeted at all women (not just recipients of categorical programs)

4. Capacity Summary Table

Capacity	Priority Need
LOW	Improve the reproductive health of youth and women by decreasing the rates of STD's and unintended pregnancies.
	Reduce the rates of abuse and neglect of infants and CSHCN
MODERATE	Reduce the impact of poverty on infants/children including food insecurity.
	Reduce the health disparities gap in infant health status and outcomes.
	Increase quality of and access to perinatal health services.
	Increase access to Medical Homes for CSHCN particularly for those with functional limitations.
HIGH	Increase access to oral health care for children and CSHCN.
	Increase the prevalence of MCH/CSHCN who are physically active, eating healthy, and are at a healthy weight
	Reduce alcohol use and binge drinking among youth.
	Increase the prevalence of infants who breastfeed exclusively through six months of age.

MCH Population Groups

As seen in the final list of priorities, all MCH/CSHCN populations have been addressed. This is a result of the purposeful inclusive process and methodology. The process was diligent to review all available data, create appropriate subcommittees, and invite all interested stakeholders to participate. Inclusiveness resulted in a diverse cross-cutting stakeholder group that assured all MCH/CSHCN population groups were assessed.

Priority Needs and State Performance Measures

Nebraska has chosen performance measures (SPM) to track progress on the priorities. The measures were chosen based on several criteria: 1) to assure that the priorities are adequately measured, 2) to avoid duplication of National Performance Measures (NPM), Outcome Measures (OM), Health Status Indicators (HSI), and Health System Capacity

Indicators (HSCI), and 3) to continue the use of pertinent previously identified State Performance Measures. The following is the list of priorities with the performance measures that have been identified to measure change in addressing the priorities.

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

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

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

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

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

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

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

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

D.) Reduce the health disparities gap in infant health status and outcomes.

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

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

E.) Increase access to oral health care for children and CSHCN.

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

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

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

F.) Reduce the rates of abuse and neglect of infants and CSHCN.

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

G.) Reduce alcohol use and binge drinking among youth.

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

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

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

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

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

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

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

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

6. Outcome Measures - Federal and State

The following table illustrates relationships among National and State Performance Measures, Outcome Measures, and Nebraska activities.

Outcome Measure	National Performance Measures	State Performance Measure
01 Infant Mortality Rate	01, 15, 17, and 18	SPM 01: Percent women with a healthy weight
<p>Activities: Nebraska has placed an increased focus on preconception health as a life course strategy to address infant mortality, including such factors as preconception weight. Beginning in 2008, community-based Title V funded projects were added that incorporated reproductive life plans, and the TUNE My Life project was launched with</p>		

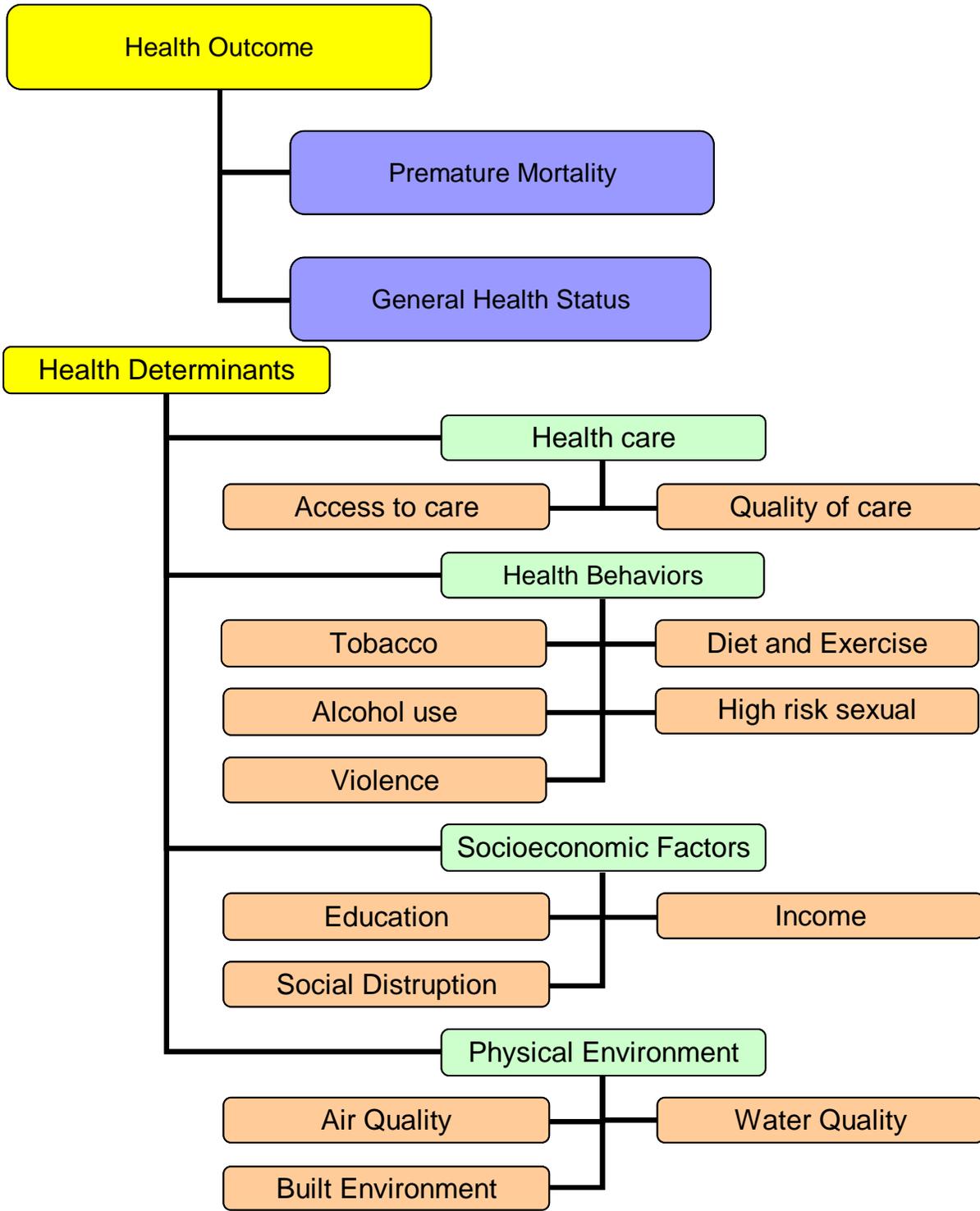
Outcome Measure	National Performance Measures	State Performance Measure
First Time Motherhood/New Parents Initiative funding. Nebraska Title V works with local initiatives such as Baby Blossoms and Omaha Healthy Start to develop community capacity to address infant mortality. Then, Nebraska Title V has begun to more closely examine issues related to perinatal care, including level of care and maternal transport.		
02 Ratio of Black IMR to White IMR		NEW: The ratio of the African American premature birth rate to the Caucasian rate.
Activities: Nebraska Title V developed strategies to address this outcome, with the assistance of stakeholders, just before we launched into the 2010 needs assessment. Those strategies will be rolled out in 2011, and focus on the capacity of communities to assess and implement the necessary supports for women in families, in accordance with a life course model. These strategies include increasing awareness of concepts such as health equity, and developing public supports for comprehensive programs that include not only access and utilization of high quality medical care but also social supports.		
03 Neonatal Mortality Rate	08, 17, 18	NEW: Percent of live births intended at time of conception
Activities: Again, Nebraska Title V sees this outcome being impacted by improved maternal health prior to pregnancy, and that intendedness is an important factor impacting birth outcomes. See other activities under Outcome 1.		
04 Post-neonatal Mortality Rate		NEW: Rate of infants with substantiated reports of abuse/neglect
Activities: Nebraska will continue activities addressing SIDS/SUID, particularly safe sleep practices. For instance, in accordance with Nebraska statute, birthing hospitals have an obligation to provide information on both Safe Sleep and Shaken Baby Syndrome to all new parents. Nebraska Title V provides the needed resources. There has been a long standing relationship with Nebraska's CB-CAP agency in the area of primary prevention of abuse and neglect, and that work will continue and be expanded particularly in the area of home visitation (new ACA funds) and in exploring concerns specific to infants and CSHCN. Among the models being considered is Triple P.		
05 Perinatal Mortality Rate	17, 18	
Activities: Using Perinatal Periods of Risk (PPOR) as a framework, again, maternal health is considered significant in addressing perinatal mortality. See earlier references to preconception health.		
06 Child Death Rate, children ages 1-14	01, 02, 03, 04, 05, 06, 07, 09, 10, 11, and 13	NEW: Percent of children living in poverty who have health insurance
Activities: Collectively, a number of programs and activities have reduction in child mortality as an ultimate goal. More proximally, these programs and activities address childhood morbidity through improving access to community-based, comprehensive, family-centered care, through population-based primary and secondary prevention, and through social and economic supports for families. Throughout Nebraska's Title V		

Outcome Measure	National Performance Measures	State Performance Measure
application and annual report examples are provided, such as Newborn Screening, Safe Kids, Medicaid/EPSDT, breastfeeding promotion and support, Immunizations, and oral health services.		

What can be noted regarding the National Outcome Measures is that they are all specific to reduction in mortality and do not include measures specific for adolescents. Even so, Nebraska is not adding State Outcome Measures. Much needs to be learned and considered to develop the right array of measures for a life course health development approach to MCH. Should we measure socio-economic factors, such as levels of poverty? What are the right measures to determine our progress in improving preconception health, or health equity? Nebraska Title V looks forward to additional dialog with the MCH Bureau and other State Title V agencies in considering these issues.

Appendix A: Indicator Lists

Indicator Framework



Women

Health Outcome

Mortality	Top Causes	Vitals	Top 3 causes of death among women (20-44)
			Unintentional injury
			Heart Disease
			Cancer
		CanReg	The number and rate of breast cancer deaths per 100,000 women (age-adjusted)
		CanReg	Cervical cancer deaths (age-adjusted)
	Injury	Vitals	The number and rate of suicides among women 20-44, per 100,000
Health Status	Cancer	CanReg	The number and rate breast cancer diagnoses (age-adjusted)
		CanReg	Cervical cancer diagnosis (age-adjusted)
	CVD	BRFSS	The percentage of women with diabetes
		BRFSS	The percentage of women with hypertension
		BRFSS	The percentage of women who are overweight (BMI 25-29)
		BRFSS	The percentage of women who are obese (BMI 30+)
	Mental Health	BRFSS	The % of women reporting poor mental health 10+of the past 30 days
		HDD	The number and rate of women hospitalized with depression anywhere mentioned
	Injuries	HDD	Rates of hospitalization for nonfatal injuries, per 100,000 women (15-44)
			Intentional
			Assault
			Self Harm
			Unintentional
			Falls
			Motor Vehicle Crashes
			Poisoning
	Reproductive Health		
	STD'S	STDs	The number and rate per 100,000 women (20-44) of Chlamydia
		STDs	The number and rate per 100,000 women (20-44) of Gonorrhea

Women

Health Determinants

Health Care	Access to Care	PRAMS	The percentage of women who visited a dentist within the past 12 months	
		Census	The percentage of women 18+ who have health insurance	
		Census	The percentage of women who have health insurance, by age	
			18-24	
			25-44	
		BRFSS	The percentage of women 18+ who have a personal physician	
		PRAMS	The percentage of women who had a prenatal care visit during the first trimester	
		Vitals	The percentage of women who had a prenatal care visit during the first trimester	
		Quality of Care	Vitals	The percentage of women with adequate PNC (Kotelchuck Index)

Health Behavior	Alcohol and Tobacco	BRFSS	The percentage of women who currently smoke
		BRFSS	The percentage of women who currently drink alcohol
		BRFSS	The percentage of women who binge drink (5+ drinks, 1+ times in the past month)

Injury	BRFSS	Seatbelt use (nearly always)
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Preventive Health	BRFSS	The percentage of women 18+ who have ever had a clinical breast exam
	BRFSS	The percentage of women over 40 years of age who have ever had a mammogram
	BRFSS	The percentage of women over 18 years of age who have ever had a Pap smear
	BRFSS	The percentage of women 18-44 who take vitamins

CVD risk factors	BRFSS	The percentage of women who lack exercise (none outside of work)
	BRFSS	The percentage of women who consume 5+ servings of fruits and vegetables/day

Reproductive	PRAMS	The percentage of women (18-24 yrs) whose pregnancy was unintended
	PRAMS	The percentage of women (25-34 yrs) whose pregnancy was unintended

SES/ Demographics	Education	Census
	Income	Census
	Age	Census

Infants

Health Outcome

Mortality	Rates	Vitals	The number and rate of fetal deaths per 1,000 live births + fetal deaths
		Vitals	The number and rate of perinatal deaths, per 1000 live births
		Vitals	The number and rate of infant deaths per 1,000 live births
		-----	neonatal deaths
		-----	postneonatal deaths
Top Causes		Vitals	Birth defects
		Vitals	Prematurity
		Vitals	Infections
		Vitals	SIDS
			The number of deaths due to motor vehicle crashes, per 100,000 live births

Health Status

Birth Condition		Vitals	The percentage of infants born with anemia
		Vitals	The percentage of births with diagnosed birth defects (at least one defect)
		Vitals	The number and rate of births with neural tube defects per 100,000 live births
		Vitals	The number and rate of births afflicted with spina bifida per 100,000 live births
		Vitals	The number and rate of Down's Syndrome per 100,000 live births
		Vitals	The number and rate of Fetal Alcohol Syndrome per 1,000 live births
		Vitals	
		Vitals	The number and percentage of singleton preterm births (<37 weeks gestation)
		Vitals	The number and percentage of preterm births (<37 weeks gestation)
		Vitals	The number and rate of very low birth weight (<1500g) per 100 live singleton births
Vitals	The number and rate of low birth weight (<2500g) per 100 live singleton births		
Vitals	The number and rate of very low birth weight infants (<1500g) per 100 live births		
Vitals	The number and rate of low birth weight infants (<2500 g) per 100 live births		
Vitals	The number and percentage of preterm low birth weight births (<37 weeks gestation & <2500g)		
Child Abuse		CPS	The number of substantiated reports of abuse/neglect, per 1,000 infants
		CPS	The total number of infants involved in substantiated abuse/neglect, per 1,000
Injuries		HDD	Rates of hospitalization for nonfatal unintentional injuries, per 100,000
Lead Blood		Enviormental HLTH	Children ages 0-6 with blood levels <10 ug/dl

Infants

Health Determinant

Health Care

Access to Care	Medicaid/EPSTD	The percent of eligible infants receiving at least one initial or periodic screen
	Medicaid/EPSTD	The percent of eligible infants receiving any dental services
	Medicaid/EPSTD	Number and percent of infants with blood lead screening tests
	CDC NIS	The percent of infants who received AAP/ACIP recommended immunizations
		The number and percent of newborns screened according to state guidelines for genetic & metabolic disorders
Prenatal care	Vitals	The percent of mothers obtaining first trimester care
	Vitals	The number and rate of mothers receiving adequate prenatal care (Kotelchuck index > 79.99%), per 100 live births

Health Behavior

ATOD	PRAMS	The percentage of infants whose mother drank 3 months before pregnancy
	PRAMS	The percentage of women who used alcohol pregnancy
	PRAMS	The percentage of infants whose mother smoked 3 months before pregnancy
	PRAMS	The percentage of women who smoked tobacco during pregnancy
Breastfeeding	PRAMS	The percent of infants ever breastfed
	PRAMS	The percent of newborns breastfed for more than six weeks
	PRAMS	The percent of infants breastfed at least six months
Injury	PRAMS	The percentage of infants who always ride in a car seat
	PRAMS	Percent of infants put on back to sleep

Physical Environment

Air Quality	PRAMS	The percent of infants who are ever in the same room with someone who is smoking (1-24 hrs)
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SES/ Demographics

Children

Health Outcome				
Mortality	Top Causes	Vitals	Deaths to Children age 1-9 (per 100,000)	
			The number and rate of deaths due to homicide per 100,000	
			The number and rate of fatalities due to unintentional injuries (including MVC) per 100,000	
			The number and rate of fatalities due to MVC per 100,000	
			The number and rate of deaths due to cancer per 100,000	
Health Status	Asthma	HDD	Hospital discharges with asthma as the primary diagnosis, per 100,000 children	
	CVD	WIC	The percent of WIC children 1-4 years who are overweight	
		WIC	The percent of WIC children 2-4 years who are at risk for overweight	
		WIC	The percent of WIC children 2-4 years who are overweight	
		NSCH	Children ages 10-17 who are overweight according to BMI-for-age	
	CSHCN	NSCH	Percent of Children with Special Health care Needs	
	Child Abuse	CPS	The number of substantiated reports of abuse/neglect, per 1,000 children 1-9	
		CPS	The total number of children involved in substantiated abuse/neglect, per 1,000	
	Injuries	HDD	Rates of hospitalization for nonfatal injuries, per 100,000 children	
			Intentional	
			Assault	
Unintentional				
Fall				
		Struck by/against		
Lead Blood	Environmental HLTH	Children ages 0-6 with blood levels <10 ug/dl		

Children

Health Determinants

Health Care

Access to Care **Medicaid/EPSTD** The percent of eligibles who received at least one initial or periodic screen (age 1-9)
Medicaid/EPSTD Number of blood lead screenings (1-5yrs)
Medicaid/EPSTD The percent of eligible children receiving any dental services

Health Behavior

NSCH children ages 0-17 who have medical care that meets AAP criteria for medical home
NSCH children ages 0-17 who have health insurance
NSCH children ages 0-17 who have a personal doctor or nurse
NSCH children ages 1-17 who received some type of mental health care or counseling during the past 12 months
NSCH Activities outside of school--% of children age 6-17 who participate in activities outside of school
NSCH Screen time--% of children age 1-5 who watched more than one hour of TV or video during a weekday
NSCH children ages 6-17 who engage in vigorous physical activity every day
NSCH children ages 6-17 who spend 4 or more hours watching TV or playing video games on an average school day

Physical Environment

Air Quality **Tobaco Survey** % of children (5-12) exposed to tobacco smoke inside the home (household)
Tobaco Survey % of children (5-12) with current exposure to tobacco smoke inside the vehicle
NSCH Neighborhood Amenities--% of children who live in neighborhoods with a park, sidewalk, a library, and a community center
NSCH Neighborhood Conditions--% of children who live in neighborhoods with poorly kept or diapidated housing
NSCH Safety of child in Neighborhood--% of children living in neighborhoods that are usually or always safe

SES/ Demographics



CSHCN	MCH CORE OUTCOMES		
		SLAITS	CSHCN whose families are partners in decision making at all levels, and who are satisfied with the services they receive
		SLAITS	CSHCN who receive coordinated, ongoing, comprehensive care within a medical home
		SLAITS	CSHCN whose families have adequate private and/ or public insurance to pay for the services they need
		SLAITS	CSHCN who are screened early and continuously for special health care needs
		SLAITS	CSHCN whose services are organized in ways that families can use them easily
	SLAITS	youth with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independent	

Health Outcome

Mortality

Health Status

SLAITS	% of CSHCN whose health conditions consistently and often greatly affect their daily activities
SLAITS	% of CSHCN with 11 or more days of school absences due to illness

Mental Health

NSCH	children with special health care needs ages 3-17 who have an on-going emotional, developmental or behavioral conditions
NSCH	children with special health care needs ages 2-17 who have ever been told by a health professional that they have depression or anxiety problems

Health Determinants

Health Care

Access to Care

SLAITS	% of CSHCN currently uninsured
SLAITS	% of currently insured CSHCN with coverage that is not adequate
SLAITS	% of CSHCN without a usual source of care (or who rely on the emergency room)
SLAITS	% of CSHCN without a personal doctor or nurse

Health Behavior

Physical Environment

Youth

Health Outcome

Mortality	Top Causes	Vitals	Deaths to youth ages 10-19, per 100,000	
			The number and rate of deaths due to homicide per 100,000 youth ages 10-19	
			The number and rate of deaths due to suicide per 100,000 youth ages 10-19	
			The number and rate of deaths due to cancer per 100,000 youth ages 10-19	
			The number and rate of deaths due to unintentional injuries (excluding MVC) per 100,000 youth ages 10-19	
			The number and rate of deaths due to MVC per 100,000 youth ages 10-19	
			The number and rate of deaths due to MVC involving alcohol per 100,000 youth ages 10-19	
	Birth Outcomes	Vitals	Fetal deaths to teen moms (10-19), per 1,000	
		Vitals	Infant deaths to teen moms (10-19) per 1,000	
Health Status	Asthma	HDD	Hospital discharges with primary diagnosis of asthma, per 100,000 youth (10-19)	
	CVD	NSCH	Overweight (>95%)--Age 12-19	
	Child Abuse		CPS	The number of substantiated reports of abuse/neglect, per 1,000 youth 10-19
			CPS	The total number of youth involved in substantiated abuse/neglect, per 1,000
	Injuries		HDD	Rates of hospitalization for nonfatal injuries, per 100,000 women youth
				Intentional
				Assault
				Self Harm
				Unintentional
				Struck by/against
		Fall		
			Motor Vehicle Traffic	
	Mental Health		YRBS	Hospital discharges with depression anywhere mentioned, per 100,000 youth
			YRBS	Felt sad/hopeless every day for two+ weeks, stopped usual activity, in last year, youth 15-19.
			YRBS	Seriously considered attempting suicide in the past 12 months, youth 15-19.
Reproductive		Vitals	Birth rate to adolescent females, per 1,000	
			Age 10-14	
			Age 15-19	
		YRBS	Percent of teens who have ever had sexual intercourse	
			Percent of teens ever physically forced to have sexual intercourse	
STD'S		STDs	The number and rate per 100,000 youth (10-19) of reportable STD's	
				Chlamydia (10-19)
				Gonorrhea (10-19)

Youth

Health Determinants

Health Care	Access to Care	Medicaid/EPSDT	The percent of eligibles who received at least one initial or periodic screen (age 10-20)
		Medicaid/EPSDT	The percent of eligibles who have received any dental services
		Census	Percentage of youth (10-18) covered by health insurance

Health Behavior

ATOD	YRBS	Percent of youth who smoked cigarettes, cigars or used smokeless tobacco during the past 30 days
	YRBS	Percent of youth who had at least one alcohol drink in the last 30 days
	YRBS	Percent of youth who had 5 + drinks of alcohol in one sitting in the past 30 days
	YRBS	Percent of youth who used marijuana in the past 30 days
Injury	YRBS	Percent of youth carried a weapon (gun, knife, club) on 1 or more of the past 30 days
	YRBS	Percent of youth in a physical fight 1 or more time in last 12 months.
	YRBS	Percent of youth that drove a car after drinking alcohol in past 30 days
	YRBS	Percent of youth that rode with driver who had been drinking in past 30 days
	YRBS	Never or rarely use passenger restraints when riding in car driven by someone else

Physical Environment

Air Quality	Youth Tobacco Survey	Percent of youth (13-17) exposed to tobacco smoke inside the home
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SES/ Demographics

Age
Graduation rates

Appendix B: Criteria, Definitions, and Rating Scale

Criteria Developed for Nebraska Prioritization Framework on November 17, 2009

The following is a summary of the work done by the Nebraska MCH/CSHCN Needs Assessment Committee (NAC) in reaching consensus on a set of Criteria for use in setting priorities among the issues/problems identified by its five workgroups. Criteria were weighted by the NAC group using a scale of 1 to 3 with 3 being the most important.

Criterion Name: The Problem is Severe or Increasingly Worse than the Benchmark
Expanded Definition/Concepts included: A “benchmark” is defined as the standard by which something can be measured or judged, such as the U.S. rate or the applicable Healthy People 2010 objective. “Increasingly worse” means that the problem identified is worsening to the point it is statistically significant when compared to a benchmark. “Problem is severe” means illness, death, or adverse health outcome(s) will become worse among the given population if the problem is not addressed. It also incorporates the concept that even if there is not a significant difference when compared to a benchmark the problem has been getting significantly worse over time, i.e., the trend is worsening.

Criterion Weight: 3

Rating Scale:

- 1= No significant difference between Nebraska’s indicator value and the benchmark and no negative trend
- 2= Nebraska’s indicator value is worse than the bench mark but significantly improving over time, impact on the population is improving
- 3= Nebraska’s indicator value is better than the benchmark level but getting worse over time and potential exists for significant impact on the population
- 4= Nebraska’s indicator value is worse than the bench mark and not changing significantly over time
- 5= Nebraska’s indicator value is significantly worse and getting worse over time with significant impact on the population

Criterion Name: Disparities Exist Related to Health Outcomes

Expanded Definition/Concepts included: This criterion indicates that one or more population subgroups as defined by race, ethnicity, income, gender, disability, or geography have significantly worse indicator values of illness/condition or service access when compared to the applicable benchmark. This criterion is meant to include the concept of “health equity”. Health Equity is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged and or disenfranchised at further disadvantage/disenfranchisement with respect to their health.

Criterion Weight: 2

Rating Scale:

- 1= No group is disproportionately effected
- 2= Emerging evidence that disparity exists
- 3= Known disparity exists
- 4= Known disparity exists and is worsening overtime
- 5= Strong evidence of long standing/historical inequities resulting in documented disparities in outcomes

Criterion Name: Strategies Exist to Address the Problem

Expanded Definition/Concepts included: This criterion is based on whether evidenced-based/informed or promising strategies exist that are likely to improve outcomes.

Strategies encompass programs, practices, and policies that affect individuals, groups of individuals, or entire communities. This criterion is intended to incorporate two concepts: 1) the importance of evidence based/informed strategies and 2) the importance of primary prevention strategies that are intended to lead to changes in outcomes.

Evidence based/informed means the strategies have been proven effective by established objective investigation(s). A promising strategy is one that has demonstrated the potential to foster effective and innovative public health practice. This criterion acknowledges that effective strategies are tailored for the target population(s) and necessitate community involvement in the implementation of the strategy.

Criterion Weight: 2

Rating Scale:

- 1= No known intervention likely to be effective with the intended population
- 2= Promising strategies exist but effectiveness with population is unknown
- 3= Promising strategies shown to be potentially effective with intended population
- 4= Preventative strategies shown to be potentially effective with intended population
- 5= Strong evidence for preventative strategy to be effective with intended population

Criterion Name: Capacity and Support are Available to Address the Problem

Expanded Definition/Concepts included: This criterion is dependent on whether the current context would be supportive of choosing a problem as a priority and existing resources are in place that could be directed towards improving outcomes associated with this problem. "Context" includes the concepts of public and political will, partnerships and collaborations, and human resources.

Criterion Weight: 1

Rating Scale:

- 1= No evidence of any capacity to address the problem
- 2= Capacity and support are currently not available but potential is in the environmental context
- 3= Capacity and support exist but are limited or of unknown duration
- 4= Capacity and support are growing with potential for more development
- 5= Strong evidence that the context supports and will continue to support addressing the problem

Criterion Name: Data Exists to Document the Problem

Expanded Definition/Concepts included: This criterion means that high quality data that is valid and reliable data are available to describe and document the problem. “Valid” refers to data that describe a problem in the manner it was intended. “Reliable” means the data has been shown to be accurate and consistent over time. Data can be qualitative or quantitative but must be collected in a manner consistent with proscribed professional statistical standards and should be generalizable to represent the entire state and or selected population subgroups.

Criterion Weight: 1

Rating Scale:

- 1 = No data is available or data exists that is not generalizable or unknown reliability
- 2 = Qualitative, high quality data, not necessarily generalizable or is collected at one point in time
- 3 = Quantitative, high quality data, not necessarily generalizable or is collected at one point in time
- 4 = Qualitative, high quality data, generalizable
- 5 = Quantitative, high quality data, generalizable

Appendix C: Prioritization Tool

Problem Prioritization Tool

CRITERION #1: The Problem is Severe or Increasingly Worse than the Benchmark	CRITERION #4: Capacity and Support are Available to Address the Problem					
CRITERION #2: Disparities Exist Related to Health Outcomes	CRITERION #5: Data Exists to Document the Problem					
CRITERION #3: Strategies Exist to Address the Problem						
Problem	In the line below score each criterion (use agreed upon rating scale) and multiply the score by the assigned weight for each problem. Add weighted criterion scores to obtain Total Score for problem.					Total Score For Problem
	C1	C2	C3	C4	C5	
	3	2	2	1	1	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Appendix D: Stakeholder Survey

MCH/CSHCN Needs Assessment Stakeholder Evaluation

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Disable Browser "Back" Button: False

MCH/CSHCN Needs Assessment Stakeholder Evaluation

Page 1 - Heading

Large Committee Work

Page 1 - Question 1 - Yes or No

[Mandatory]

Did you participate in the November 17, 2009 meeting at the Cornhusker Marriott in Lincoln?

- Yes
- No

Page 1 - Question 2 - Choice - Multiple Answers (Bullets)

[Mandatory]

Was the purpose of the Needs Assessment clear to you when you started?

- Yes
 - No
 - Not applicable
 - Other, please specify
-

Page 1 - Question 3 - Yes or No

[Mandatory]

Did you participate in the April 22, 2009 meeting at the Embassy Suites in Lincoln?

- Yes
- No

Page 1 - Question 4 - Choice - Multiple Answers (Bullets)

[Mandatory]

Is the purpose of the Needs Assessment clear to you now?

- Yes
 - No
 - Not applicable
 - Other, please specify
-

Page 1 - Question 5 - Choice - Multiple Answers (Bullets)

[Mandatory]

Did the process and tools utilized result is a quality product?

- Yes
- No
- Not applicable

Other, please specify

.....

Page 1 - Question 6 - Choice - Multiple Answers (Bullets)

[Mandatory]

Do you believe the work conducted was objective – that is, free from bias and preconceived conclusions?

- Yes
- No
- Not applicable

Page 1 - Question 7 - Open Ended - Comments Box

Why or why not?

.....
.....
.....
.....

Page 1 - Question 8 - Choice - Multiple Answers (Bullets)

[Mandatory]

Thinking about the definitions below which one best describes the work of the large committee?

Collaboration: A process which parties who see different aspects of a problem explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible to achieve a shared vision.

Coordination: A process of communication, planning, sharing of resources, for the purpose of efficiently/effectively achieving a shared goal.

Cooperation: A process where parties with similar interests negotiate mutual roles and shared resources to achieve joint goals but maintain separate identities.

- Collaboration
- Coordination
- Cooperation
- None of the above
- Not applicable

Page 1 - Question 9 - Yes or No

As a result of the work of the large committee, did you form new partnerships or strengthen any of your existing partnerships?

- Yes
- No
- Additional Comment

.....

Page 1 - Question 10 - Rating Scale - One Answer (Horizontal)

[Mandatory]

Consensus was difficult and the process at times was uncomfortable. Given that, how satisfied were you with the results of the large committee work?

Very Satisfied

Satisfied

Neutral

Dissatisfied

Very Dissatisfied



Page 2 - Heading

Subcommittee Work

Did you participate in a subcommittee (such as Women, Infants, Children, CSHCN, or Youth)?

- Yes
- No
- If yes, which one?

.....

Was the purpose of the subcommittee clear to you?

- Yes
- No
- Not applicable
- Other, please specify

.....

Do you believe the work conducted was objective - that is, free from bias and preconceived conclusions?

- Yes
- No
- Not applicable
- Other, please specify

.....

Why or why not?

.....

.....

.....

.....

Thinking about the definitions below which one best describes the work of the large committee?

Collaboration: A process which parties who see different aspects of a problem explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible to achieve a shared vision.

Coordination: A process of communication, planning, sharing of resources, for the purpose of efficiently/effectively achieving a shared goal.

Cooperation: A process where parties with similar interests negotiate mutual roles and shared resources to achieve joint goals but maintain separate identities.

- Collaboration
- Coordination
- Cooperation
- None of the above
- Not applicable

As a result of the work of the subcommittee, did you form new partnerships or strengthen any of your existing partnerships?

- Yes
 - No
 - Additional Comment
-

Final Draft of Priorities

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

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

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

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

Increase access to oral health care for children and CSHCN.

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

Reduce alcohol use and binge drinking among youth.

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

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

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

In your opinion does the final draft of priorities "adequately" reflect the highest needs of the MCH/CSHCN population in Nebraska?

- Yes
- No

Do you support the final draft of priorities?

- Yes
 - No
 - Why or why not?
-

Can you see you/your organization addressing some or all of these needs?

- Yes
- No

Are you interested in participating in future planning activities around these MCH and/or CSHCN priorities?

- Yes
- No

Overall

What in the whole Needs Assessment process worked the best?

.....
.....
.....
.....

What would you improve on in the future?

.....
.....
.....
.....

Other comments / input?

.....
.....
.....
.....

[Mandatory]

Would you participate in the Needs Assessment process again? The next cycle is due in 2015.

- Yes
- No

(Standard - Zoomerang branding)

(Standard - Zoomerang branding)

(Standard - Zoomerang branding)

(Standard - Zoomerang branding)

Appendix E: Capacity Tool

Analysis of MCH/CSHCN System Capacity to Address Needs

Criteria	Strength	Weakness/Gaps	Capacity No=0 Yes=1
<p>Structural Capacity Are we able to work on the problem?</p> <hr/> <p>Examples: Sufficient authority</p> <p>Sufficient funding</p> <p>Sufficient human resources</p>			
<p>Data Capacity Can we adequately measure the problem?</p> <hr/> <p>Examples: Access to timely program and population data</p> <p>Supportive environment for data sharing</p>			
<p>Relational Capacity Is everyone working together/is the state involved?</p> <hr/> <p>Examples: Sufficient network of organizations/constituencies</p> <p>DHHS with other players (National, Other State, Local, Stakeholders)</p> <p>Collaborative exist at state level</p>			
<p>Knowledge Capacity Do we know all we need to know?</p> <hr/> <p>Examples: Knowledge and understanding of state context and content area</p> <p>Ability to influence policymaking process</p>			
	<p>Score 0-1 = Low Capacity 1<Score<3 = Medium Capacity Score >3 = High Capacity</p>	Total Capacity Score	

Appendix F: Participant List

Women's Subcommittee Participant List

Abosi, Nene
Omaha Healthy Start
402-455-2229
nenea@cdhcmmedical.com

Brockman, Margaret
DHHS-Medicaid
PO Box 95026
Lincoln, NE 68509
402-471-9368
margaret.brockman@nebraska.gov

Coufal, Brenda – **Needs Assessment Staff**
DHHS-PRAMS
PO Box 95026
Lincoln, NE 68509
402-471-9044
brenda.coufal@nebraska.gov

Daniels, Jianping
DHHS-Women's & Men's Health
PO Box 95026
Lincoln, NE 68509
402-471-1693
jianping.daniels@nebraska.gov

Deethardt, Shirley
DHHS-Tobacco Free Nebraska
301 Centennial Mall South
Lincoln, NE 68509
402-471-0101
shirley.deethardt@nebraska.gov

Dillon, Cathy – **Needs Assessment Staff**
DHHS-Women's & Men's Health
PO Box 95026
Lincoln, NE 68509
402-471-1806
cathy.dillon@nebraska.gov

Dreibelbis, Jennifer
DHHS-CSBG/Child Welfare Unit
301 Centennial Mall South
Lincoln, NE 00006-8509
402-471-9346
Jennifer.Dreibelbis@nebraska.gov

Frei, Barb
Hastings Family Planning, Inc.
422 North Hastings, # 204
PO Box 288
Hastings, NE 68901
402-463-5687
Barbara3201@gmail.com

Hergott, Teresa
Douglas County Health Department
1819 Farnam St.
Omaha, NE 68183
402-444-7219
teresa.hergott@douglascounty-ne.gov

Monjaraz, Connie
UNMC
402-559-6337
cmonjaraz@unmc.edu

Tumbleson, Brandi – ---**CHAIR**
VNA
10411 S. 26th Street
Bellevue, NE 68123
402-930-4168
btumbleson@thevna cares.org

Tyree, Kathy
Omaha Healthy Start
402-455-2229 ext 247
katherinet@cdhcmmedical.com

Ward, Kathy
DHHS – Woman & Men's Health
PO Box 95026
Lincoln, NE 68509-5026
402-471-3914
kathy.ward@nebraska.gov

Infant's Subcommittee Participant List

Boeke, Lisa ---**CHAIR**
CNCS
PO Box 509
Loup City, NE 68852
lboeke@cennecs.org

Delaney, Rayma – **Needs Assessment Staff**
DHHS-Lifespan Health Services
PO Box 95026
Lincoln, NE 68509-5026
rayma.delaney@nebraska.gov

Heller, Stacey
Goldenrod Hills Community Action
PO Box 280
Wisner, NE 68853
ogs@gpcom.net

Goodwin, Tina
DHHS –Perinatal Nurse
PO Box 95026
Lincoln, NE 68509
tina.goodwin@nebraska.gov

Balluff, Mary
Douglas County Health Dept
1819 Farnam Street, # 403
Omaha, NE 68183
mballuff@co.douglas.ne.us

Voegele, Larry
DHHS-Minority Health
PO Box 95026
Lincoln, NE 68509
larry.voegele@nebraska.gov

Trouba, Peggy
DHHS- State WIC Director
PO Box 95026
Lincoln, NE 68509
peggy.trouba@nebraska.gov

M. Jane Ford Witthoff
Director Public Health Solutions HealthDept
975 East Highway 33, # 1
Crete, NE 68333

jfordwitthoff@phsneb.org

Bargmann, Dusti
Goldenrod Hills Community Action
PO Box 280
Wisner, NE 68853
imm@gpcom.net

Mennenga, Pat
Visiting Nurses Association
12565 West Center Road, Suite 100
Omaha, NE 68144
pmennenga@thevnacares.org

Severe, Kris
Olsen Center for Women's Health
989450 NE Medical Center
Omaha, NE 68198-9450
ksevere@unmc.edu

Rother, Julie
Northeast NE Public Health Dept.
117 West 3rd Street
Wayne, NE 68798
phndirector@NNPHD.ORG

Lynn Lowry, Director of Nursing
Winnebago Tribe of Nebraska
P.O. Box C
Winnebago, Nebraska 68701
Lynn.lowry@ihs.gov

Children's Subcommittee Participant List

Brand, Gail
University of Nebraska Lincoln
216 S. 9th Street
Seward, NE 68434
gbrand@unl.edu

Brehm, Lynne– **Needs Assessment Staff**
DHHS-Lifespan Health Services
1033 O Street, Suite 540
Lincoln, NE 68508
lynne.brehm@nebraska.gov

Chilese, Maya
DHHS-Behavioral Health
301 Centennial Mall South
Lincoln, NE 68509
maya.chilese@nebraska.gov

Faber, Renee
DHHS-Behavioral Health
PO Box 98925
Lincoln, NE 68509
renee.faber@nebraska.gov

Goshorn, Amy
Family Service WIC
501 S. 7th Street
Lincoln, NE 68508
amassie30@yahoo.com

Hansel, Kerry
Central NE Community Services
626 N Street
PO Box 509
Loup City, NE 68853
khansel@cennecs.org

Hobson, Melody
Dept. of Education
301 Centennial Mall South
Lincoln, NE 68509
melody.hobson@nebraska.gov

Kvasnicka, Diane
Dept. of Education
PO Box 94987

Lincoln, NE 68509
diane.kvasnicka@nebraska.gov

Lewis, Diane
DHHS
PO Box 95026
Lincoln, NE 68509
diane.lewis@nebraska.gov

Pankoke, Claudia
Lincoln Lancaster Co. Health Department
3140 N Street
Lincoln, NE 68516
cpankoke@lincoln.ne.gov

Schram, Sarah
Douglas County Health Department
1819 Farnam St.
Omaha, NE 68183
sarah.schram@douglascounty-ne.gov

Sorouri, Mona---**CHAIR**
– **Needs Assessment Staff**
Graduate Student –College of Public Health
Omaha, NE
msorouri1844@gmail.com

Urzedowski, Pat
Office Children's Service Licensing
PO Box 94986
Lincoln, NE 68509
pat.urzedowski@nebraska.gov

Vaughn, Katherine
Lockewood & Meeske
610 N. St. Joseph Ave
Hastings, NE 68901
ktegisler@hotmail.com

CSHCN's Subcommittee Participant List

Alber, Marcia
DHHS
301 Centennial Mall South
Lincoln, NE 68509
marcia.alber@nebraska.gov

Baker, Nina
Family to Family Information Center
3135 N. 93rd Street
Omaha, NE 68134
nbaker@pti-nebraska.org

Bloom, Sherri
WCHR
821 Morehead Street
Chadron, NE 68337
specialprojects@wchr.net

Bunnell, Amy
DHHS-Medicaid
301 Centennial Mall South
Lincoln, NE 68509
amy.bunnell@nebraska.gov

Carlson, Marsha
Two Rivers Public Health Department
701 4th Avenue, Suite 1
Holdrege, NE 68949
marsha.carlson@tworiverspublichealth.org

Carpenter, DeAnn
Mary Lanning Memorial Hospital
715 N Saint Joseph Ave
Hastings, NE 68901-4451
dcarpenter@mlmh.org

Clifton, Janelle
YWCA Nebraska Respite Network
PO Box 95123
Lincoln, NE 68508
jclifton@ywcalincoln.org

Chilese, Maya
DHHS-Behavioral Health
301 Centennial Mall South
Lincoln, NE 68509

maya.chilese@nebraska.gov

Delay, Harriet
DHHS
1050 N Street, Suite 200
Lincoln, NE 68509
harriet.delay@nebraska.gov

Gibson, Amy
Boystown Institute for Children
14080 Hospital Road
Boys Town, NE 68010
GibsonA@boystown.org

Gordon, Mary
DHHS-Development Disability
PO Box 95026
Lincoln, NE 68509
mary.gordon@nebraska.gov

Houser, Sandy
Munroe-Meyer Institute
985450 NE Medical Center
Omaha, NE 68198-5450
shouser@unmc.edu

Johnson, Cathy PLMHP
Consumer and Family Advocate
Magellan Health Services
1221 N St., Ste 700
Lincoln, NE 68502
CMJohnson1@magellanhealth.com

Karstenig, Kathy – **Needs Assessment Staff**
DHHS-Lifespan Health Services
PO Box 95026
Lincoln, NE 68509-5026
Kathy.Karstenig@nebraska.gov

Krieger, Heather – **Needs Assessment Staff**
DHHS-Medicaid
301 Centennial Mall South
Lincoln, NE 68509
Heather.Krieger@nebraska.gov

Leibowitz, J. Michael
Munroe-Meyer Institute
985450 NE Medical Center

Omaha, NE 68198-5450
mleibowi@unmc.edu

Lewis, Charlie---**CHAIR**
Answers4Families
PO Box 880227
206 S. 13 St., Suite 1000
Lincoln, NE 68588-0227
clewis@answers4families.org

Miller, Julie
DHHS - Lifespan Health Services
PO Box 95026
Lincoln, NE 68509-5026
julie.miller@nebraska.gov

Needelman, Howard
UNMC
University of NE Medical Center
985380 Medical Center
Omaha, NE 68198-5380
hneedelm@unmc.edu

Smith, Mark A. ---**CHAIR**
Munroe-Meyer Institute
985450 NE Medical Center
Omaha, NE 68198-5450
msmitha@unmc.edu

Sunken, Kris
ESU 6, 210 5th Street
Milford, NE 68405
ksunken@esu6.org

Youth's Subcommittee Participant List

Chilese, Maya
Manager, Children's Behavioral Health
DHHS Behavioral Health
Lincoln
maya.chilese@nebraska.gov

Cooper, Stan
Administrator, Vital Records
DHHS Public Health
Lincoln
Stan.Cooper@nebraska.gov

Faber, Renee
DPI Program Specialist
DHHS Behavioral Health
Lincoln
Renee.Faber@nebraska.gov

Golden, Katie
Assistant Project Director
UNMC/Munroe-Meyer Institute
Omaha
kgolden@unmc.edu

Henningsen, Linda– **Needs Assessment Staff**
Manager, Adolescent Health
DHHS Public Health
Lincoln
Linda.Henningsen@nebraska.gov

Kasehagen, Laurin MA, PhD
MCH Epidemiologist, CDC Assignee
CityMatCH/UNMC Dept. of Pediatrics
Omaha
lkasehagen@unmc.edu

Larsen, Lynette ---**CHAIR**
Loup Basin Public Health Dept.
Burwell
llarsen@nctc.net

Emily Ortner
Douglas County Health Department

Omaha
emily.ortner@douglascounty-ne.gov

Reno, Julie
Manager, Reproductive Health
DHHS Public Health
Lincoln
Julie.Reno@nebraska.gov

Skolkin, Andrea CEO
One World Community Health Center
Omaha
askolkin@oneworldomaha.org

Tibbits, Melissa PhD
UNMC College of Public Health
Omaha
mtibbits@unmc.edu

Appendix G: Datasheets

Women

Fact Sheet: **DEMOGRAPHICS**

Distribution of Population

Definition: Distribution of women, by age
Percentage of total U.S. population that comprised of women ages 18-44

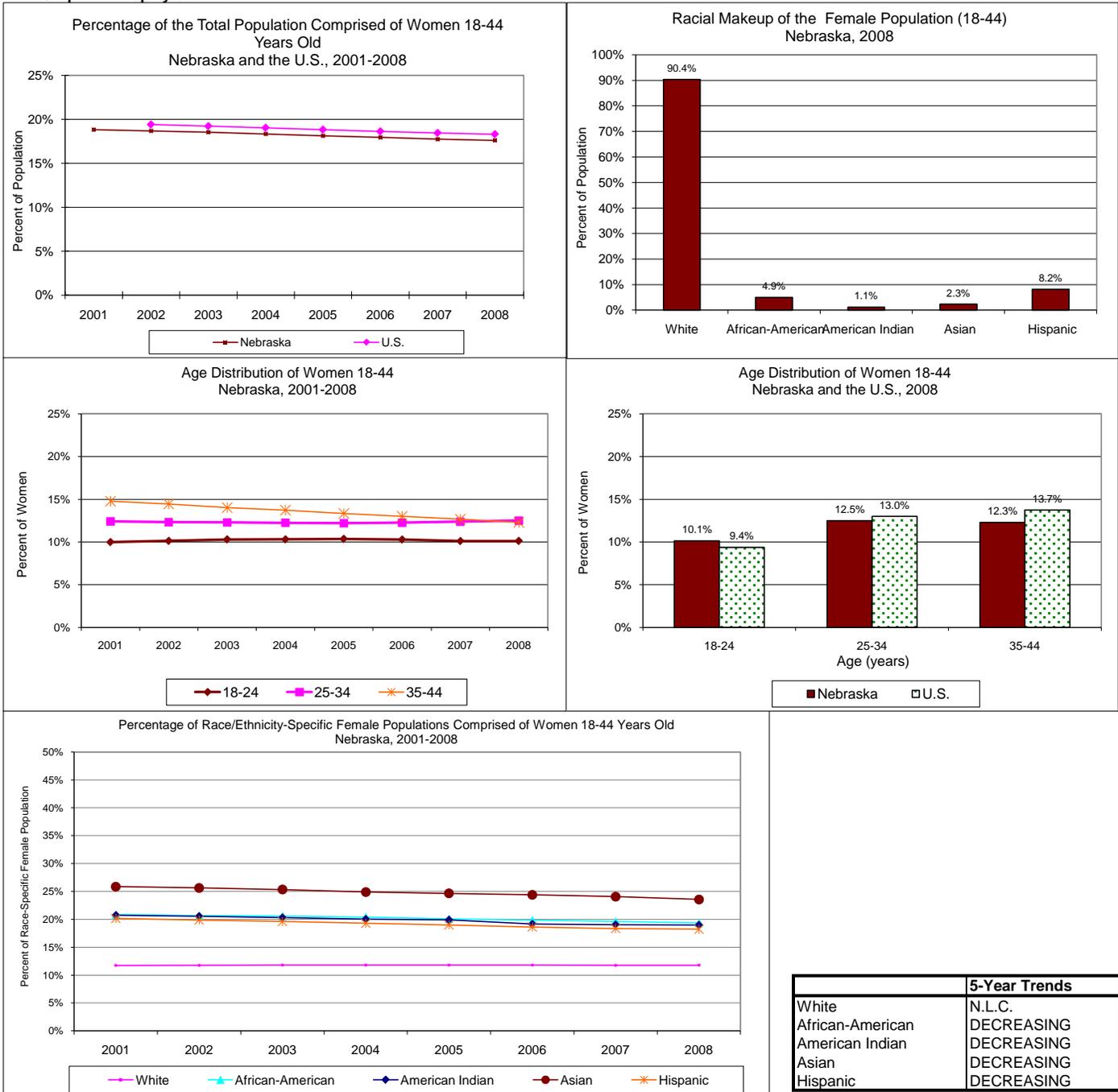
Data Source: U.S. Census

Data & Disparities:

	18-24		25-34		35-44		Women 18-44 as % of total population		Nebraska rate was...
	Number	%	Number	%	Number	%	Number	%	
Nebraska (2008)	91,038	10.1%	112,391	12.5%	110,530	12.3%	313,959	17.6%	Lower
United States (2008)	14,448,603	9.4%	20,031,526	13.0%	21,186,773	13.7%	55,666,902	18.3%	
HP 2010 Objective	-		-		-		-		
Nebraska 5-year trend	N.L.C.		INCREASING		DECREASING		DECREASING		
Racial / Ethnic Differences	YES		YES		YES		YES		

xx

Graphical Display of Data:



Nebraska Title V
2010 Needs Assessment

Fact Sheet: **DEMOGRAPHICS**

Education

Definition: Educational attainment of women 18-44 years of age

Data Source: U.S. Census - American Community Survey.

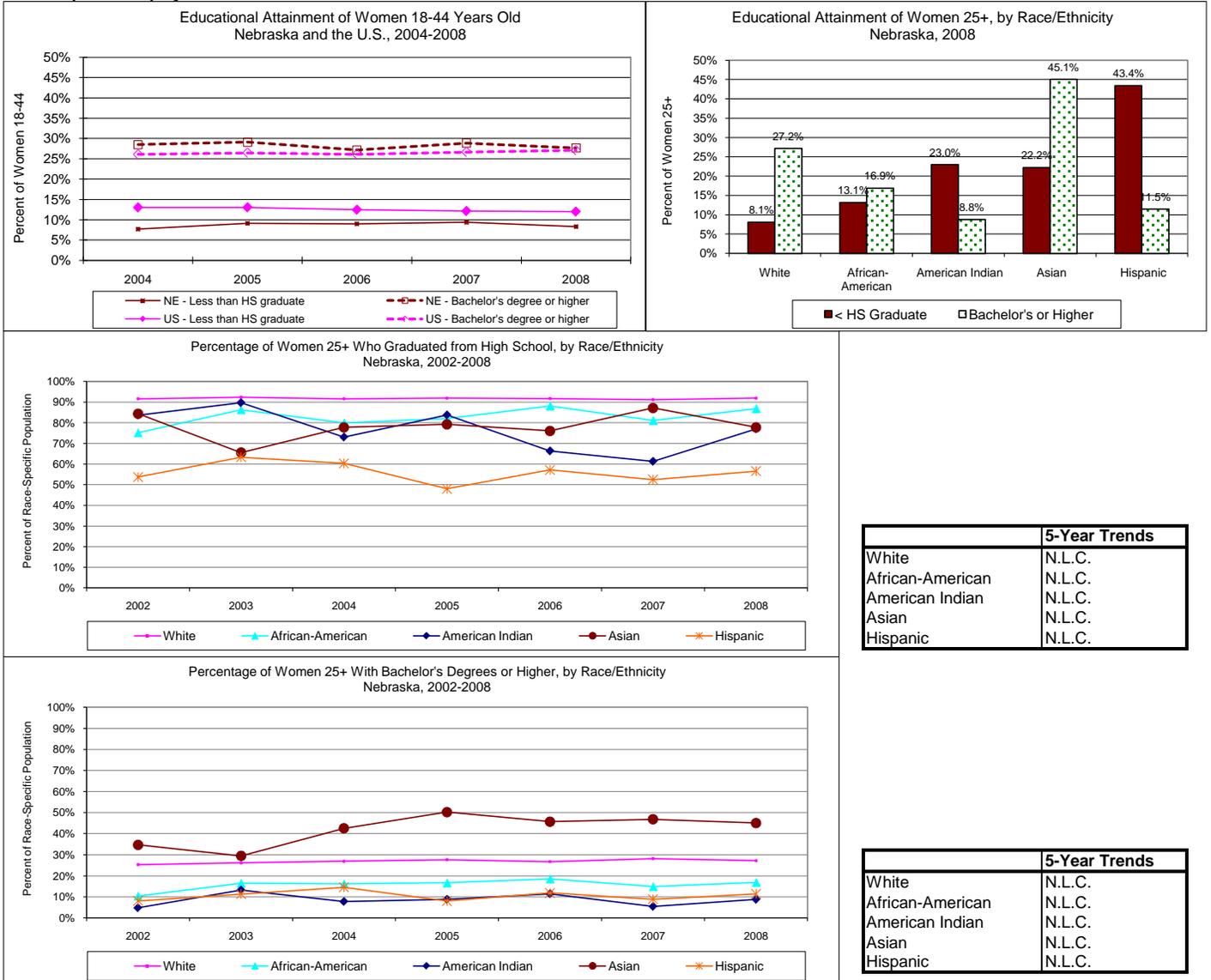
Data & Disparities:

	< HS Graduate								
	18-24		25-34		35-44		Women 18-44		
	Number	%	Number	%	Number	%	Number	%	
Nebraska (2008)	8,705	9.6%	9,187	8.1%	8,433	7.5%	26,325	8.3%	Nebraska rate was... Lower
United States (2008)	2,087,686	14.3%	2,263,657	11.4%	2,327,644	10.9%	6,678,987	12.0%	
HP 2010 Objective	-		-		-		-		
Nebraska 5-year trend	N.L.C.		N.L.C.		N.L.C.		N.L.C.		
Racial / Ethnic Differences*								YES	

	Bachelor's Degree or Higher								
	18-24		25-34		35-44		Women 18-44		
	Number	%	Number	%	Number	%	Number	%	
Nebraska (2008)	9,584	10.6%	39,890	35.3%	37,926	33.7%	87,400	27.7%	Nebraska rate was... Higher
United States (2008)	1,625,051	11.1%	6,562,908	33.2%	6,898,375	32.4%	15,086,334	27.1%	
HP 2010 Objective	-		-		-		-		
Nebraska 5-year trend	N.L.C.		N.L.C.		N.L.C.		N.L.C.		
Racial / Ethnic Differences*								YES	

*Race/ethnicity-specific data are for women 25 and older.

Graphical Display of Data:



	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Fact Sheet: **DEMOGRAPHICS**

Education (continued)

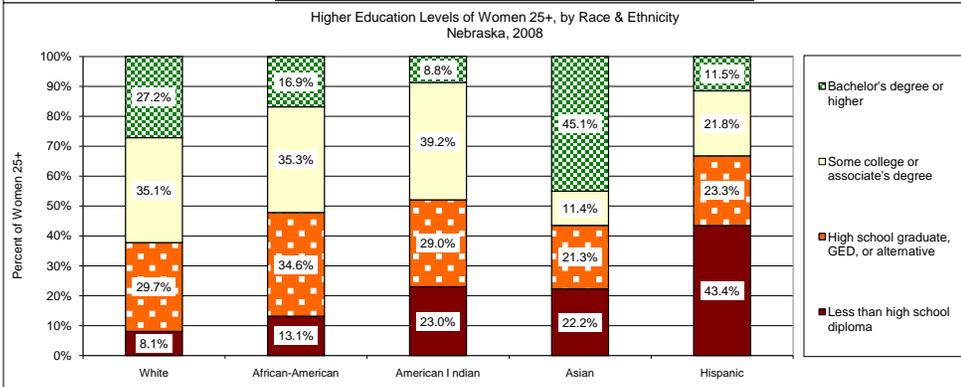
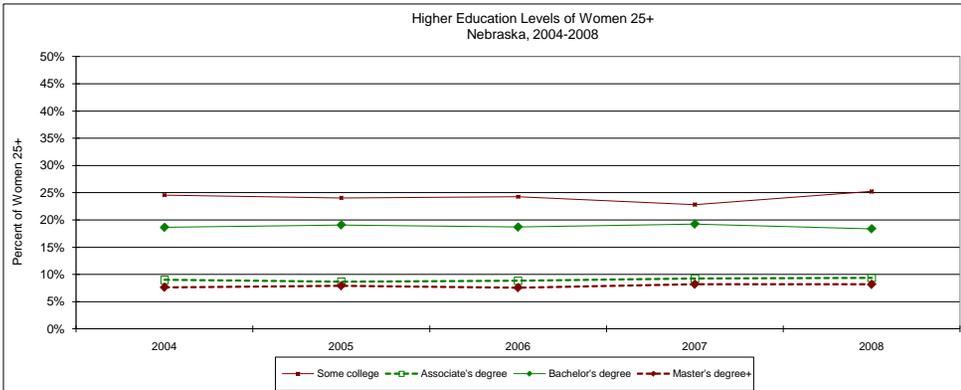
Definition: Higher educational levels of women 25+ years of age

Data Source: U.S. Census - American Community Survey.

Data & Disparities:

	Some College			Associate's Degree			Bachelor's Degree			Master's Degree or Higher		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	149,409	25.2%	-	55,511	9.4%	-	108,785	18.4%	-	48,443	8.2%	-
United States (2008)	22,580,693	21.8%	Higher	8,545,190	8.3%	Higher	18,033,181	17.4%	Higher	9,947,071	9.6%	Lower
HP 2010 Objective	-	-	-	-	-	-	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-			-			-		

Graphical Display of Data:



Fact Sheet: **DEMOGRAPHICS**

Income

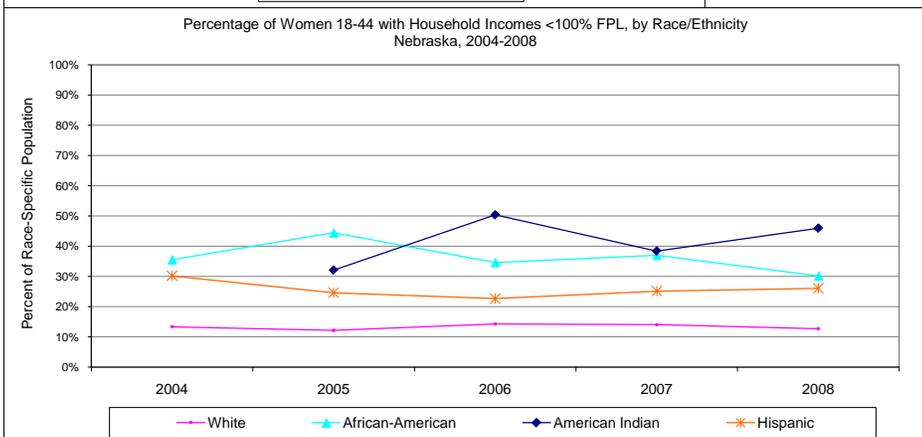
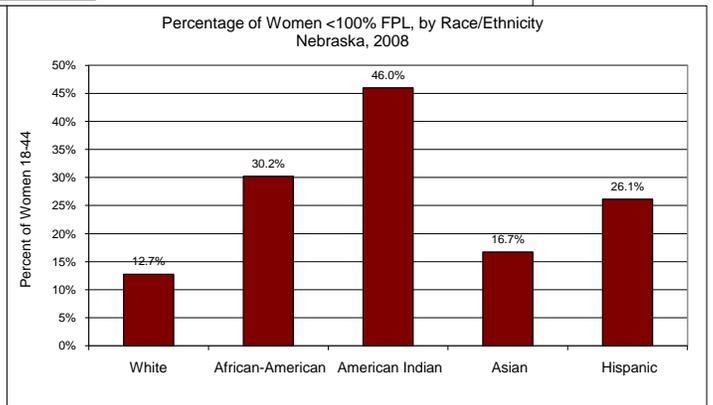
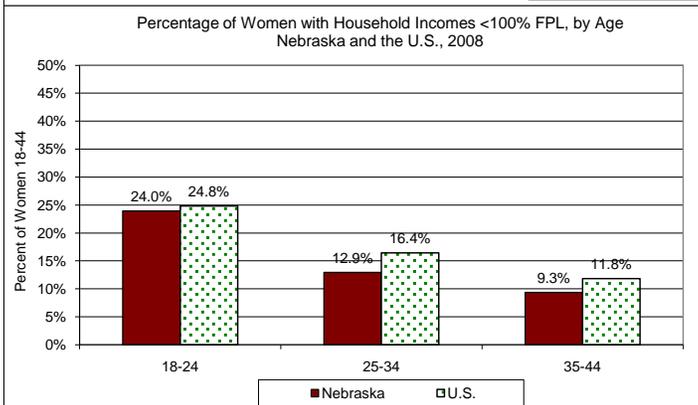
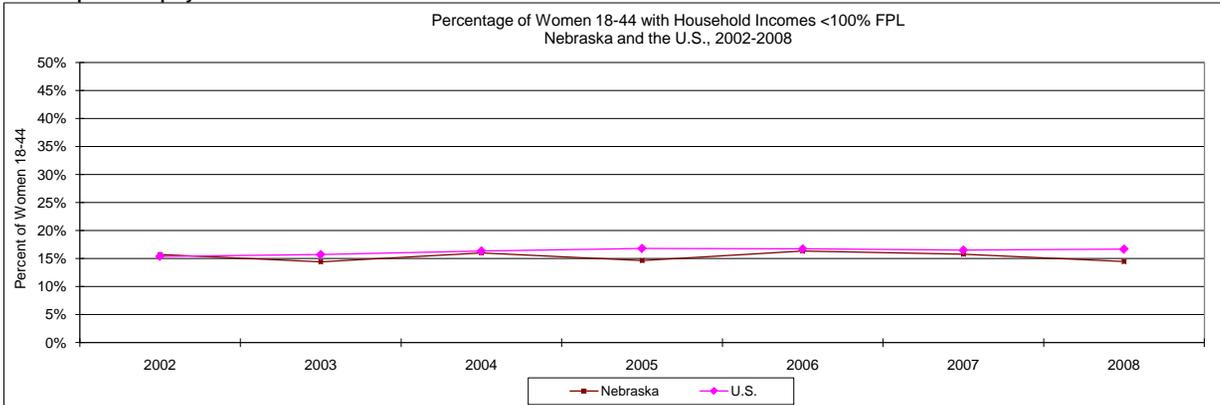
Definition: Percentage of women 18-44 with household incomes below 100% of federal poverty limits

Data Source: U.S. Census - American Community Survey

Data & Disparities:

	18-24			25-34			35-44			18-44 Total		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	18,796	24.0%	N.S.D.	14,598	12.9%	Lower	10,464	9.3%	Lower	43,858	14.5%	Lower
United States (2008)	3,304,548	24.8%		3,235,286	16.4%		2,510,020	11.8%		9,049,854	16.7%	
HP 2010 Objective	-	-		-	-		-	-		-	-	
Nebraska 5-year trend	-	-		-	-		-	-		-	N.L.C.	
Racial / Ethnic Differences	-	-		-	-		-	-		-	YES	

Graphical Display of Data:



	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Hispanic	N.L.C.

Asian sample sizes were too small for valid longitudinal estimates.

Fact Sheet: **DEMOGRAPHICS**

Homelessness

Definition: Unaccompanied women as a percentage of homeless persons served
Unaccompanied women as a percentage of "near homeless" persons served

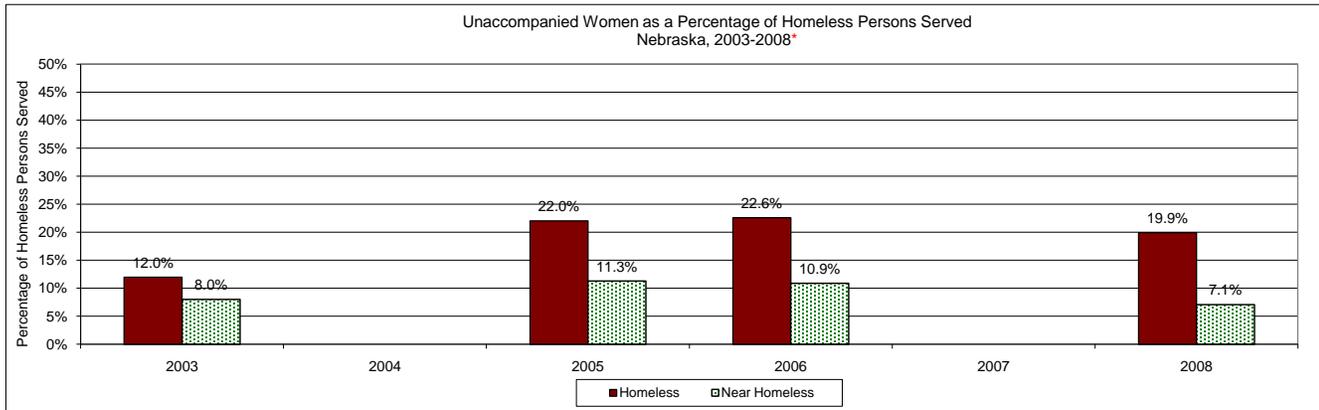
Data Source: Nebraska Homeless Assistance Project

Data & Disparities:

	% Women Among Homeless			% Women Among Near Homeless		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008*)	3,623	19.9%		3,047	7.1%	
United States (2008)	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	-	-	-	-	-	-
Racial / Ethnic Differences	-	-	-	-	-	-

*Years represent the 12-month period beginning in June of the indicated year.

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality

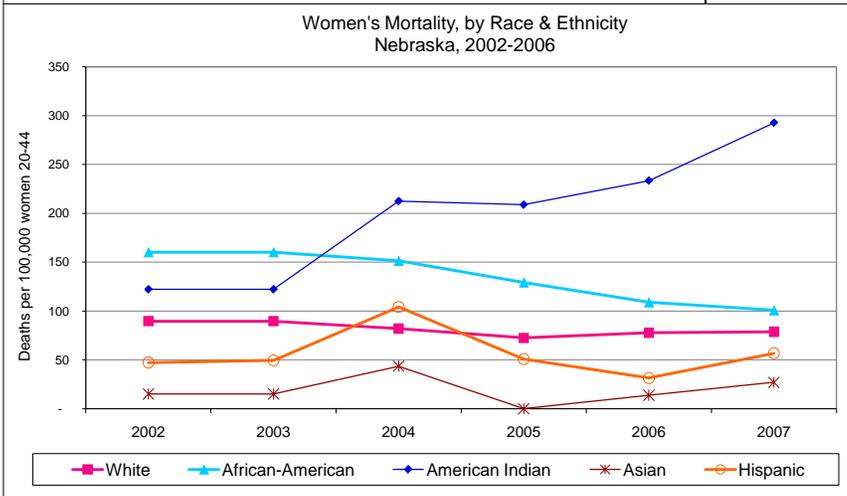
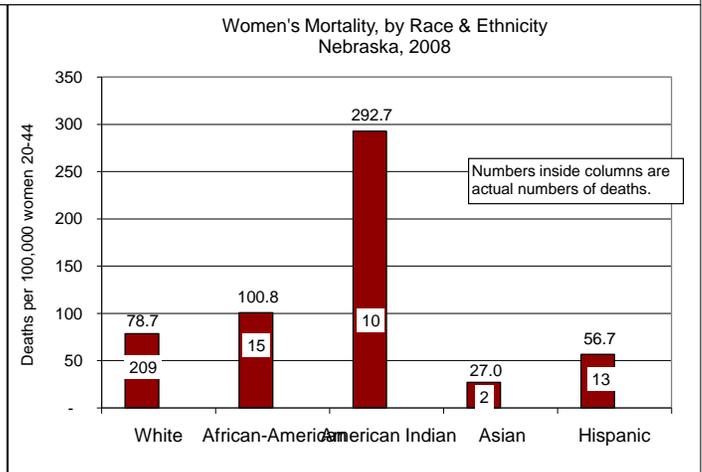
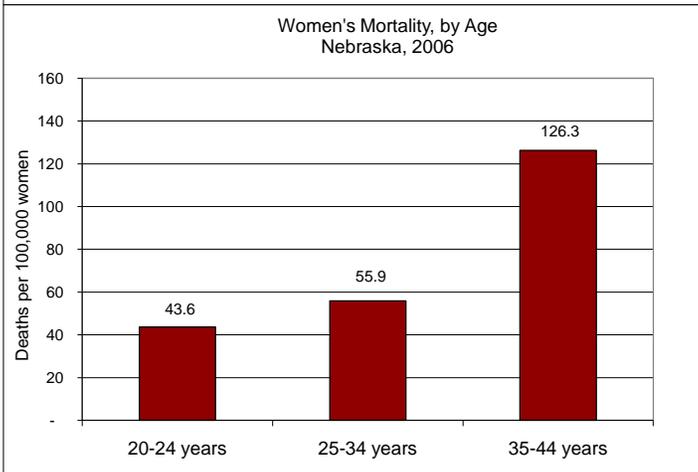
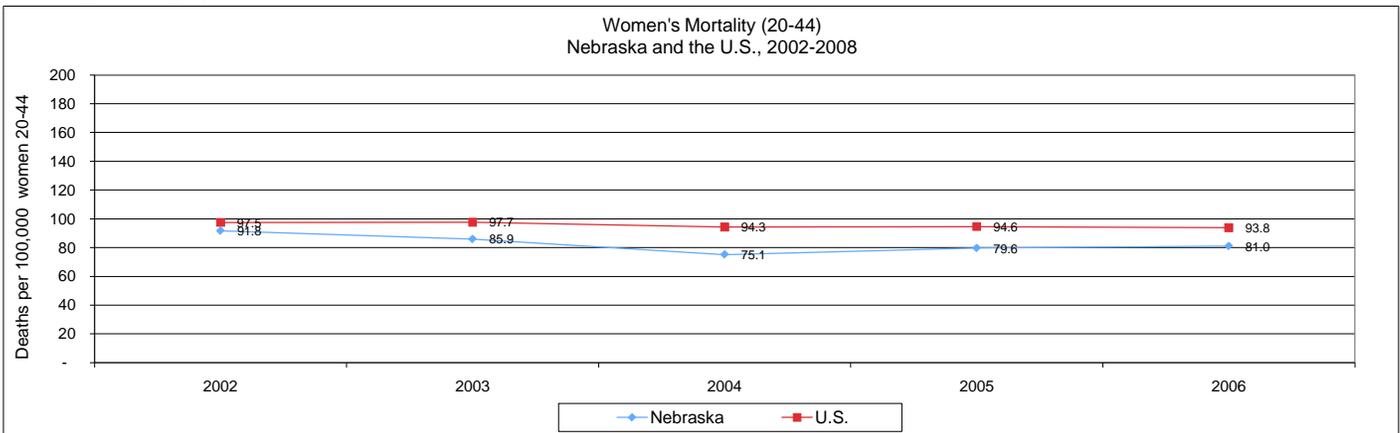
Definition: Deaths to women ages 18-44, per 100,000, all causes

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	All Causes		Nebraska rate was...
	Number	Rate	
Nebraska (2006)	236	81.0	
United States (2006)	48,653	93.8	Lower
HP 2010 Objective	4.3		Higher
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:



	5-Year Trends
White	N.L.C.
African-American	DECREASING
American Indian	INCREASING
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH OUTCOMES

Mortality - Unintentional Injury

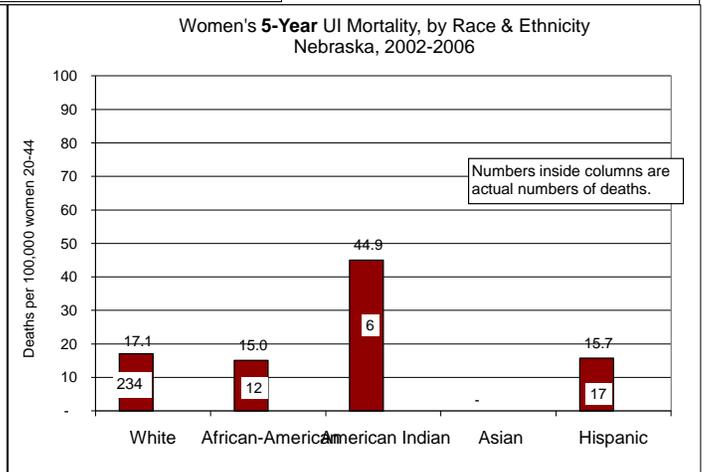
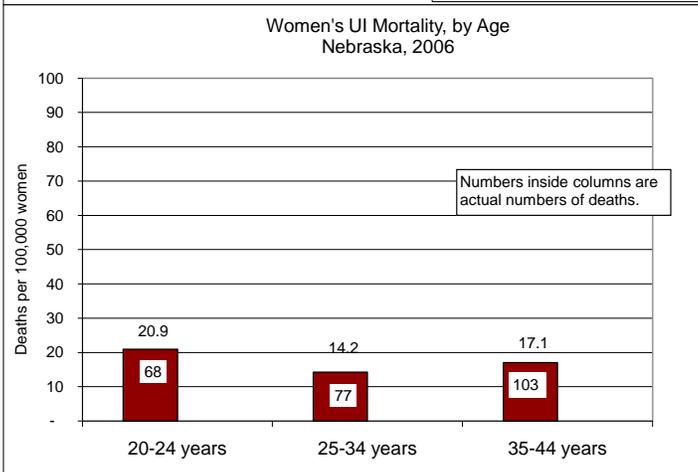
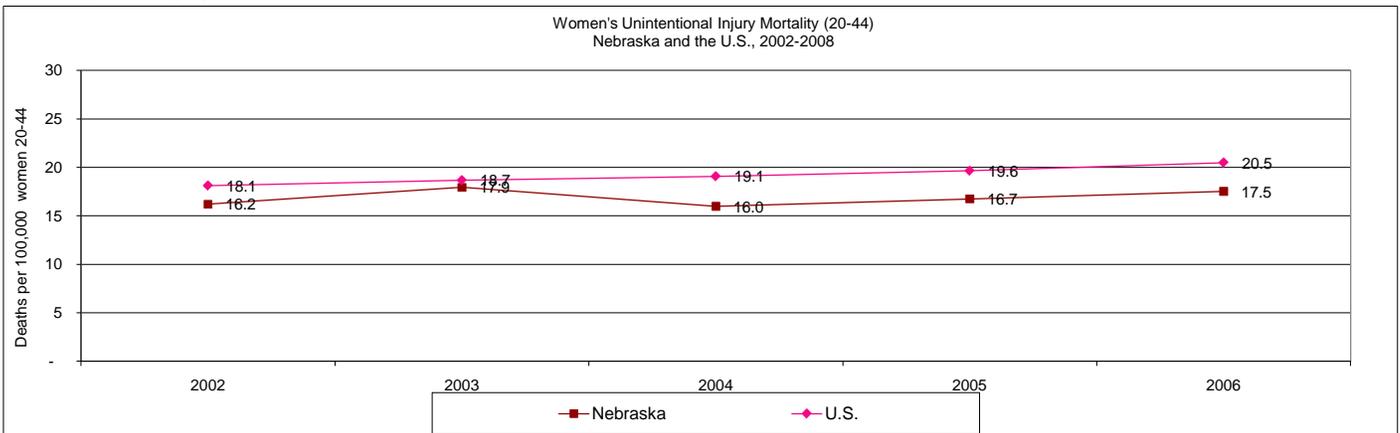
Definition: Deaths to women ages 18-44 from unintentional injuries (ICD10 V01-X59), per 100,000 women 18-44

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Unintentional Injury		
	Number	Rate	Nebraska rate was...
Nebraska (2006)	51	17.5	N.S.D.
United States (2006)	10,624	20.5	
HP 2010 Objective	0.0		Higher
Nebraska 5-year trend	N.L.C.		
Racial / Ethnic Differences	YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Heart Disease

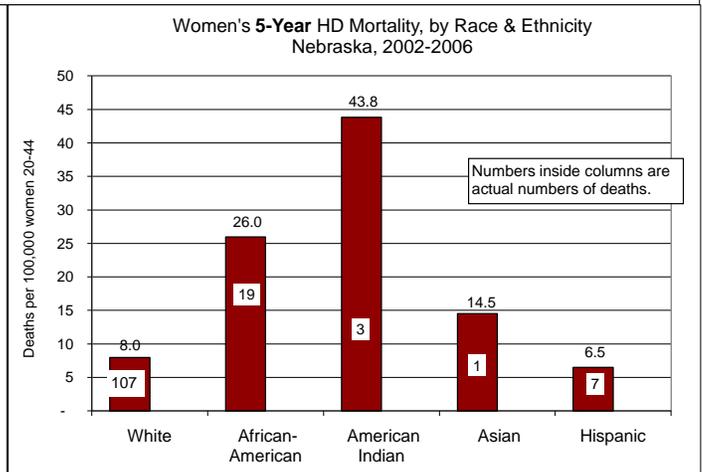
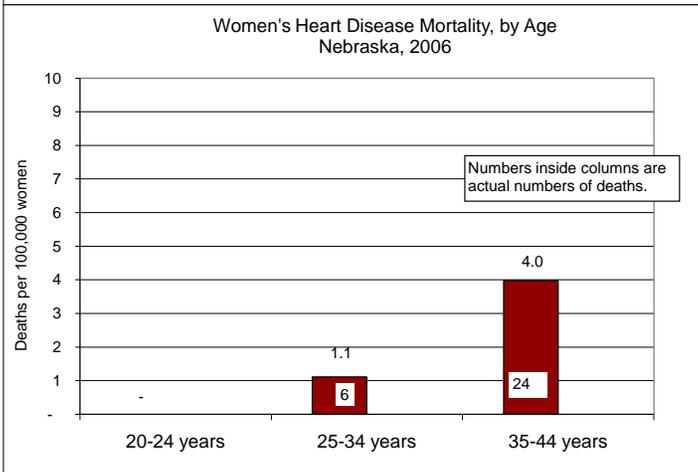
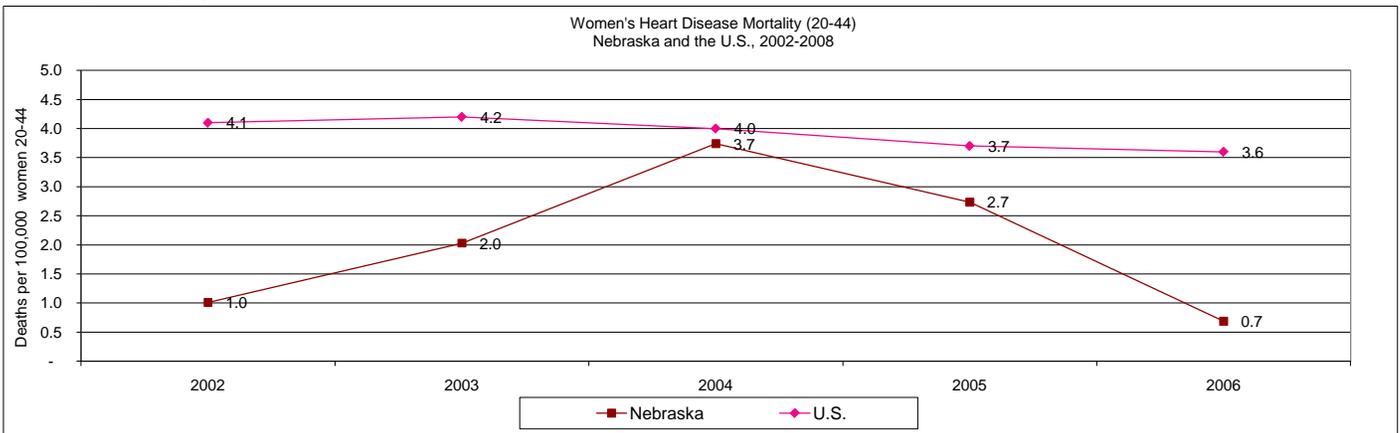
Definition: Deaths to women ages 18-44 from heart disease (ICD10 I20-I25), per 100,000 women 20-44

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Heart Disease		
	Number	Rate	Nebraska rate was...
Nebraska (2006)	2	0.7	
United States (2006)	1,873	3.6	Lower
HP 2010 Objective	0.0		N.S.D.
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Cancer

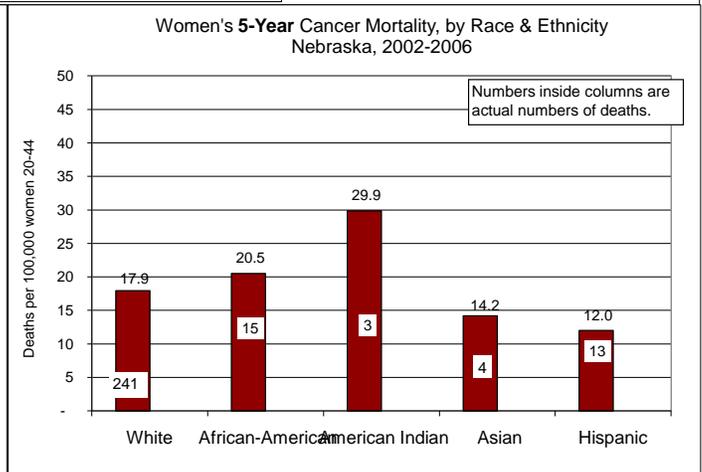
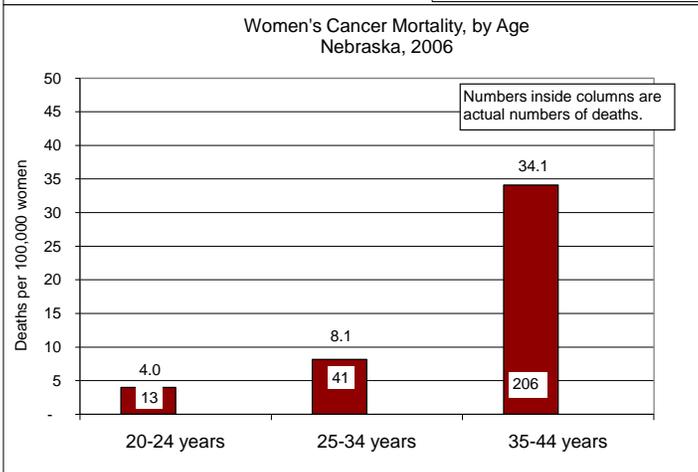
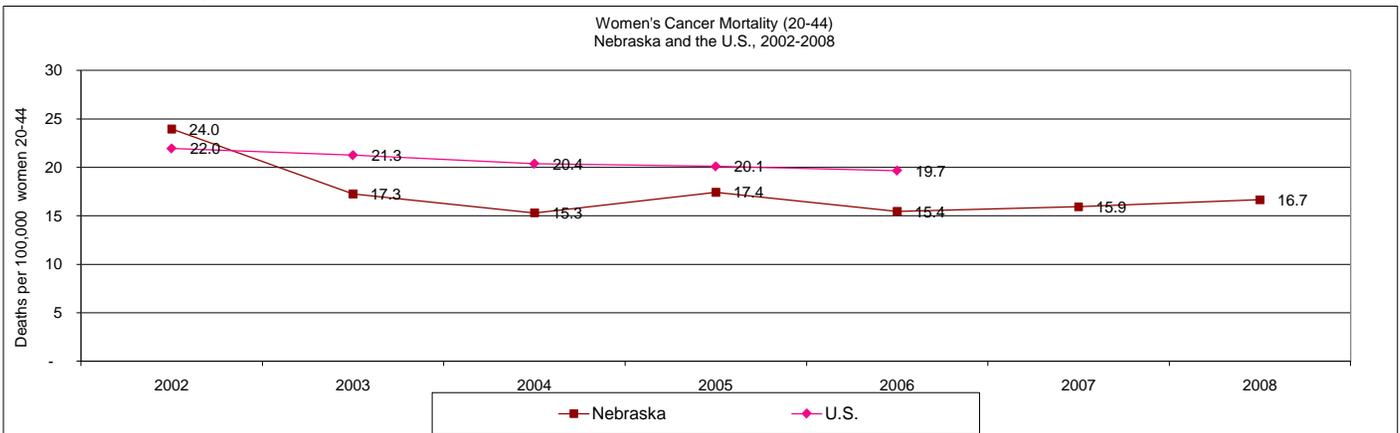
Definition: Deaths to women ages 20-44 from cancer (ICD10 C00-C97), per 100,000 women 20-44

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Cancer Deaths		
	Number	Rate	Nebraska rate was...
Nebraska (2008)	48	16.7	
United States (2006)	10,202	19.7	N.S.D.
HP 2010 Objective	0.0		Higher
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Cancer (continued)

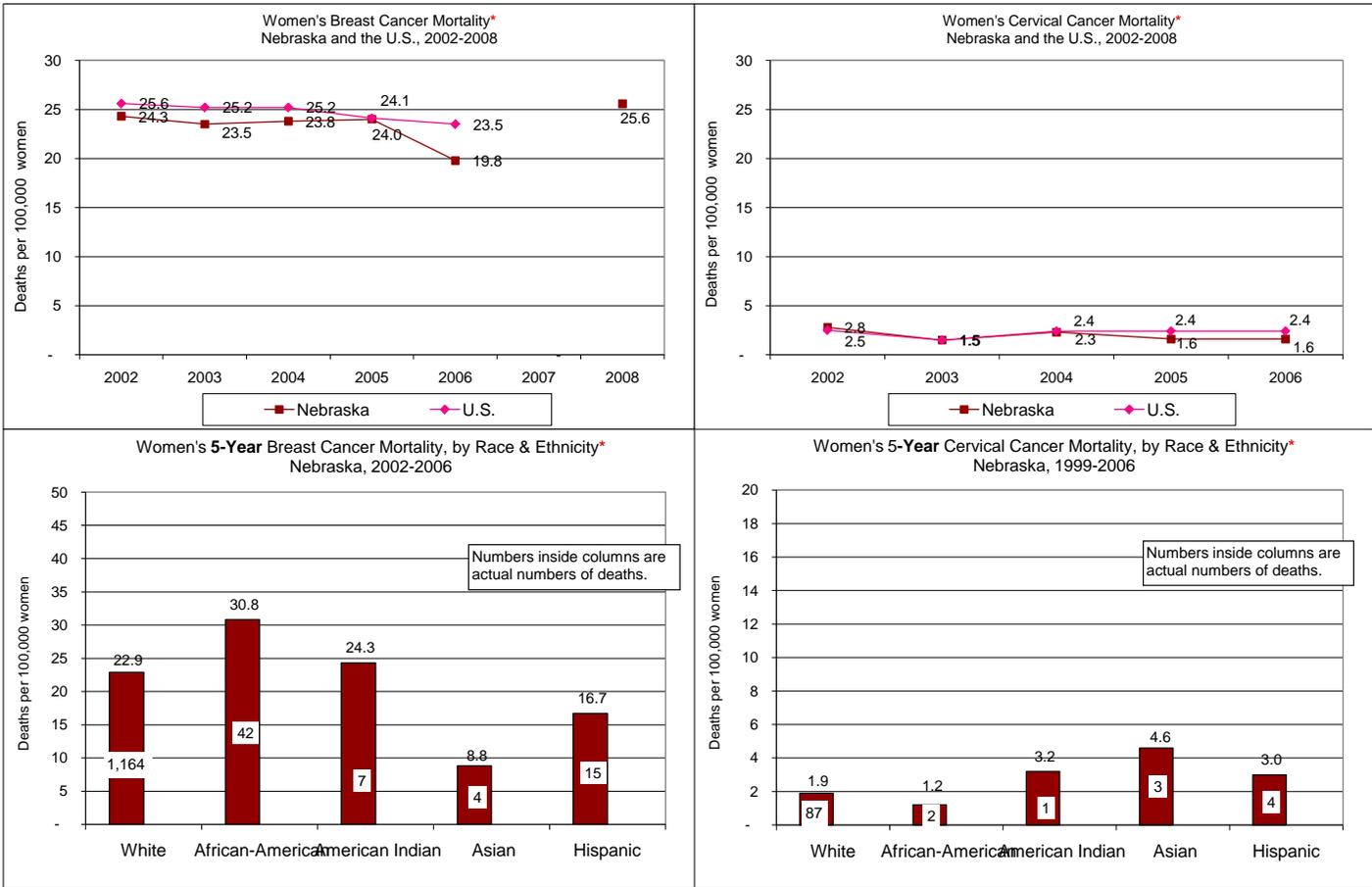
Definition: The number and rate of breast cancer deaths per 100,000 women (age-adjusted)
The number and rate of cervical cancer deaths per 100,000 women (age-adjusted)

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Breast Cancer Deaths			Cervical Cancer Deaths		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	230	25.6		16	1.6	
United States (2006)	41,116	23.5	Lower	3,976	2.4	Lower
HP 2010 Objective	21.3		Lower	2.0		Lower
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



*Note: Data are age-adjusted to the 2000 U.S. Standard Population.

Data Sheet: HEALTH OUTCOMES

Mortality - Injury

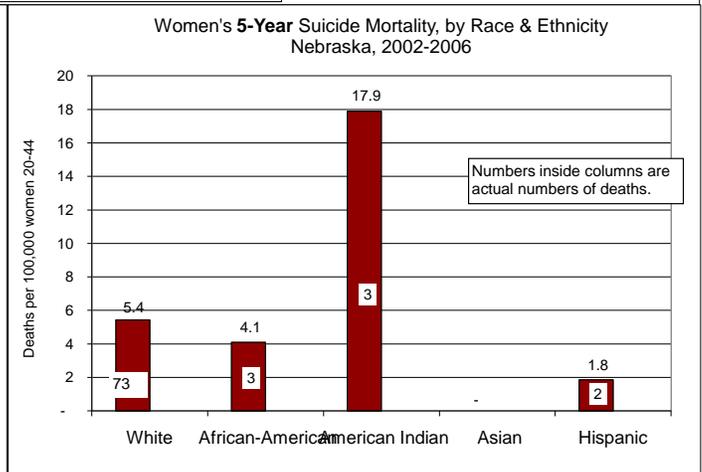
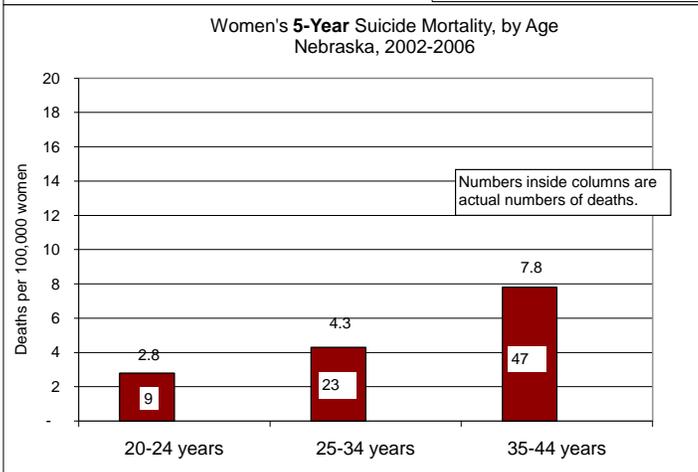
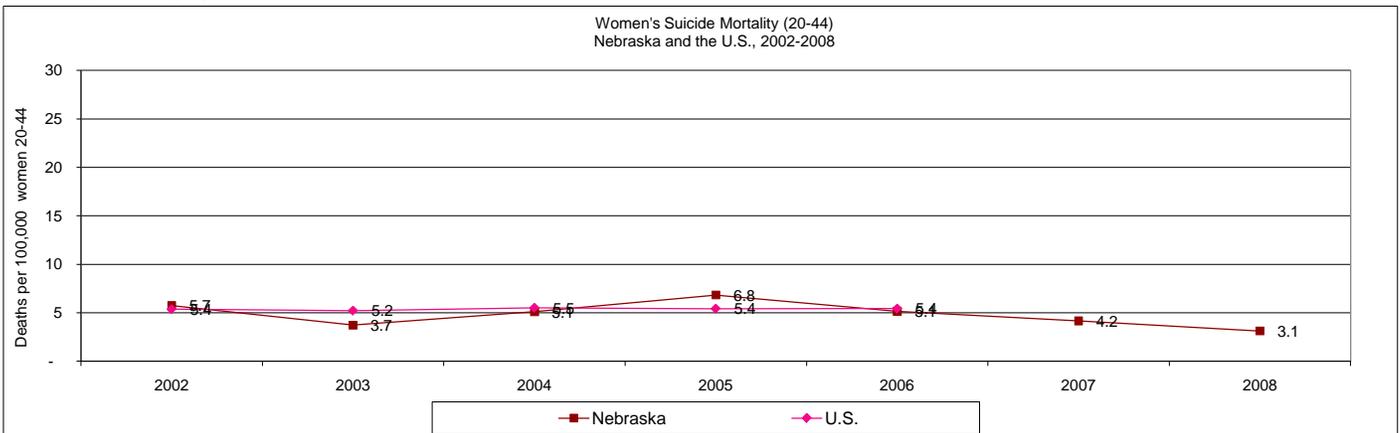
Definition: Deaths to women ages 18-44 from suicide, per 100,000 women 18-44

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Suicide		
	Number	Rate	Nebraska rate was...
Nebraska (2006)	15	5.1	
United States (2006)	2,814	5.4	N.S.D.
HP 2010 Objective	6.0		N.S.D.
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Cancer

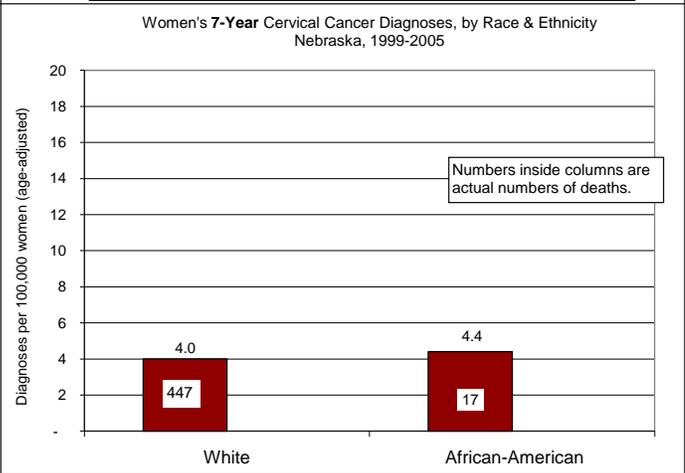
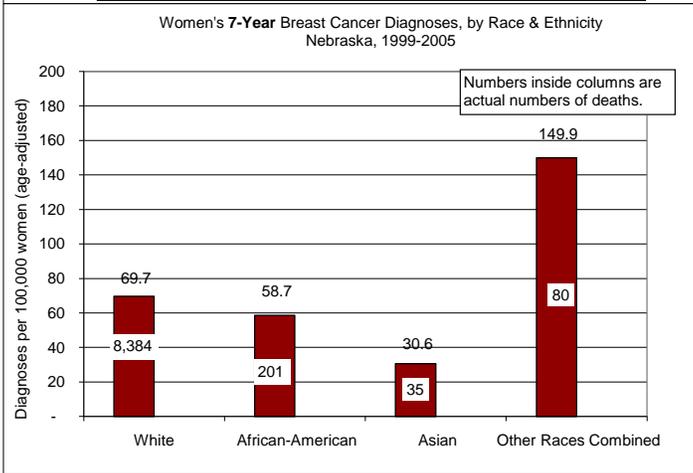
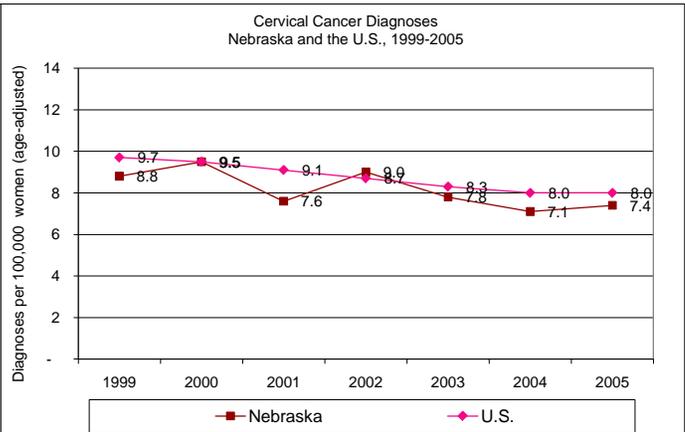
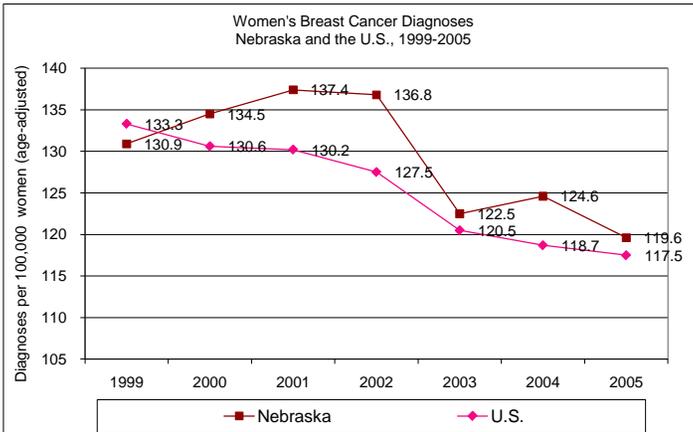
Definition: The number and rate of breast cancer diagnoses (age-adjusted)
The number and rate of cervical cancer diagnoses (age-adjusted)

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Breast Cancer (2005)			Cervical Cancer (2006)		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska	1,171	119.6		63	7.4	
United States	186,075	117.5	N.S.D.	11,959	8.0	N.S.D.
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	DECREASING			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Cardiovascular Disease

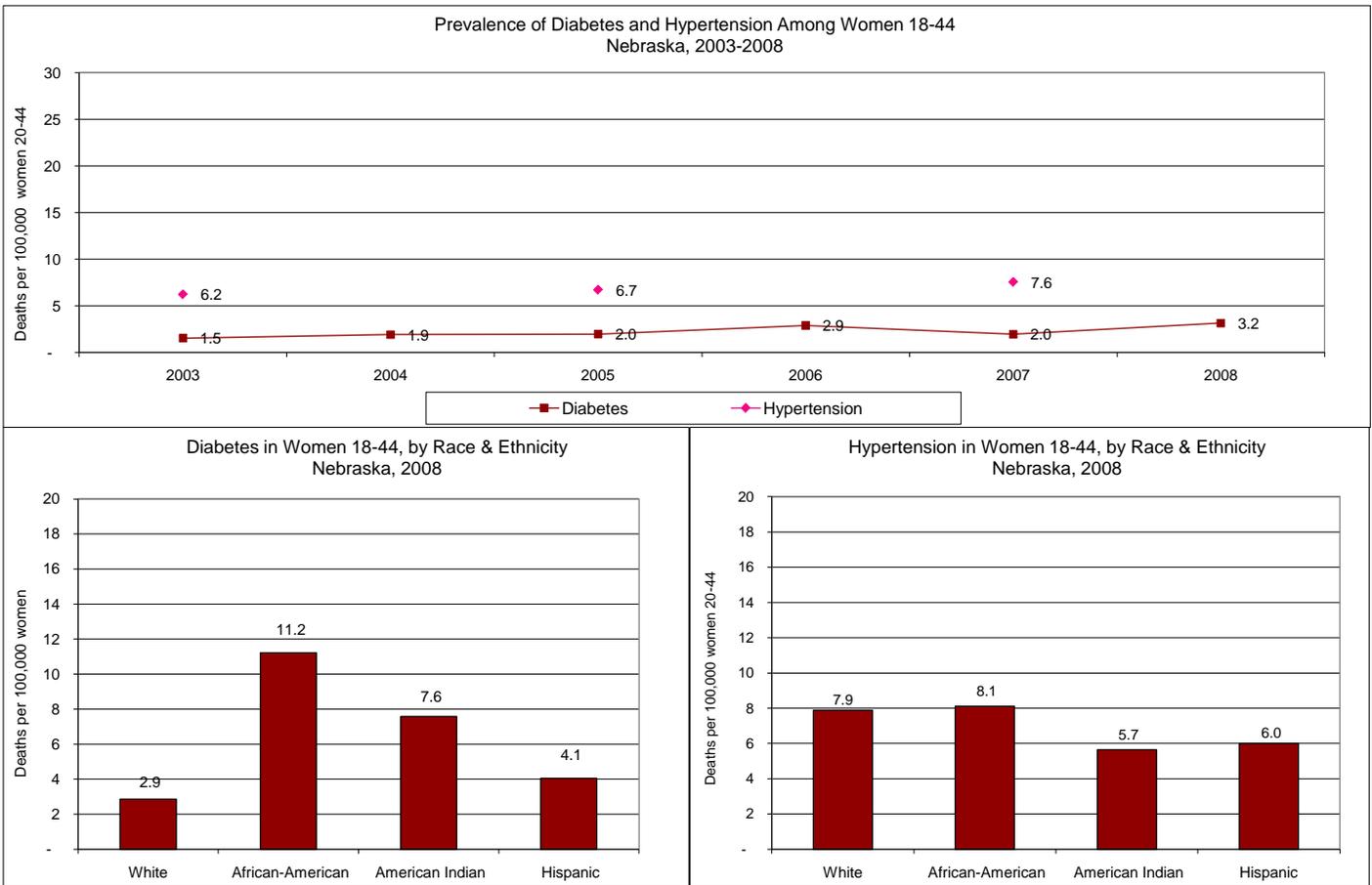
Definition: The number and percentage of women 18-44 with diabetes
The number and percentage of women 18-44 with hypertension

Data Source: BRFSS

Data & Disparities:

	Diabetes			Hypertension		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	9,946	3.2%		24,314	7.6%	
United States	-	-	-	-	-	-
HP 2010 Objective	2.5%		Higher	16%		Lower
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Cardiovascular Disease (continued)

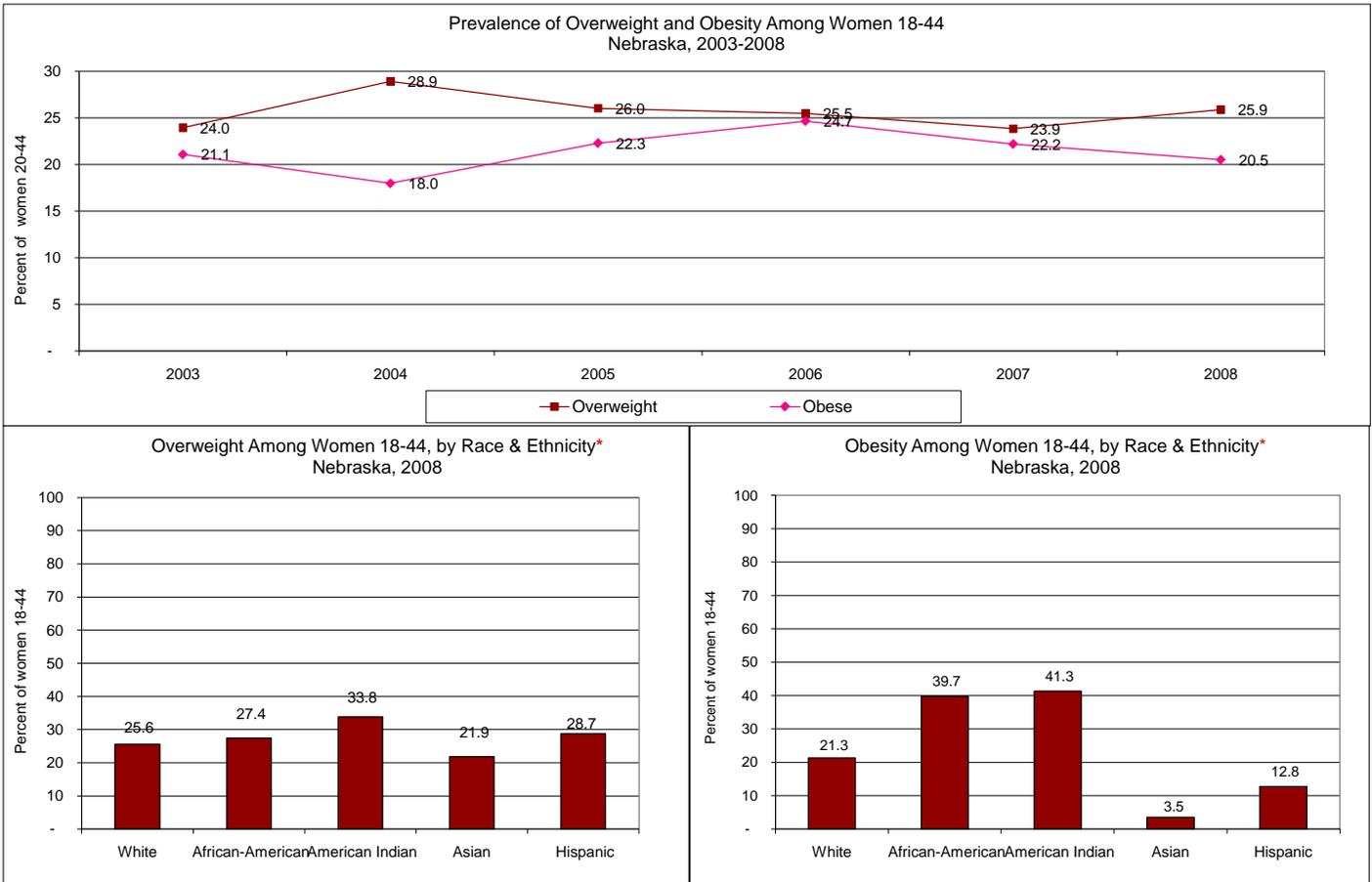
Definition: The number and percentage of women 18-44 who are overweight (BMI 25-29)
The number and percentage of women 18-44 who are obese (BMI 30+)
The number and percentage of women 18-44 who are obese (BMI 30+)

Data Source: BRFSS

Data & Disparities:

	Overweight			Obese		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	75,535	26.0%	-	59,577	20.5%	-
United States	-	-	-	-	-	-
HP 2010 Objective	25.0%		Higher	15%		Higher
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



*Note: American Indian and Asian estimates are unstable.

Data Sheet: HEALTH OUTCOMES

Health Status - Mental Health

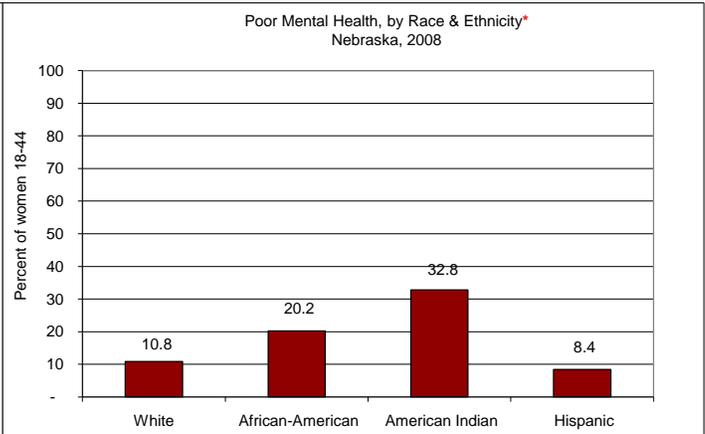
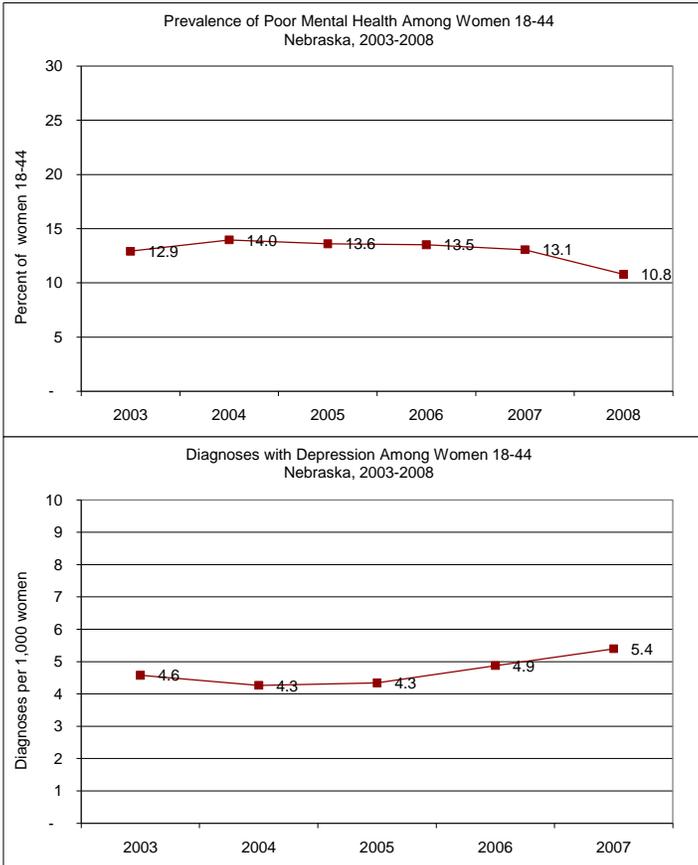
Definition: The number and percentage of women reporting poor mental health in 10 or more of the past 30 days
The number of women hospitalized with depression anywhere mentioned, per 1,000 women

Data Source: BRFSS
Hospital Discharge Dataset

Data & Disparities:

	Poor Mental Health			Depression		
	Number	%	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	33,897	10.8%		1,899	5.40	
United States	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			-		

Graphical Display of Data:



*Note: Asian estimates are unstable.

Data Sheet: **HEALTH OUTCOMES**

Health Status - Intentional Injuries

Definition: The number of hospital discharges for intentional, nonfatal (**assault**) injuries, per 100,000 women 15-44

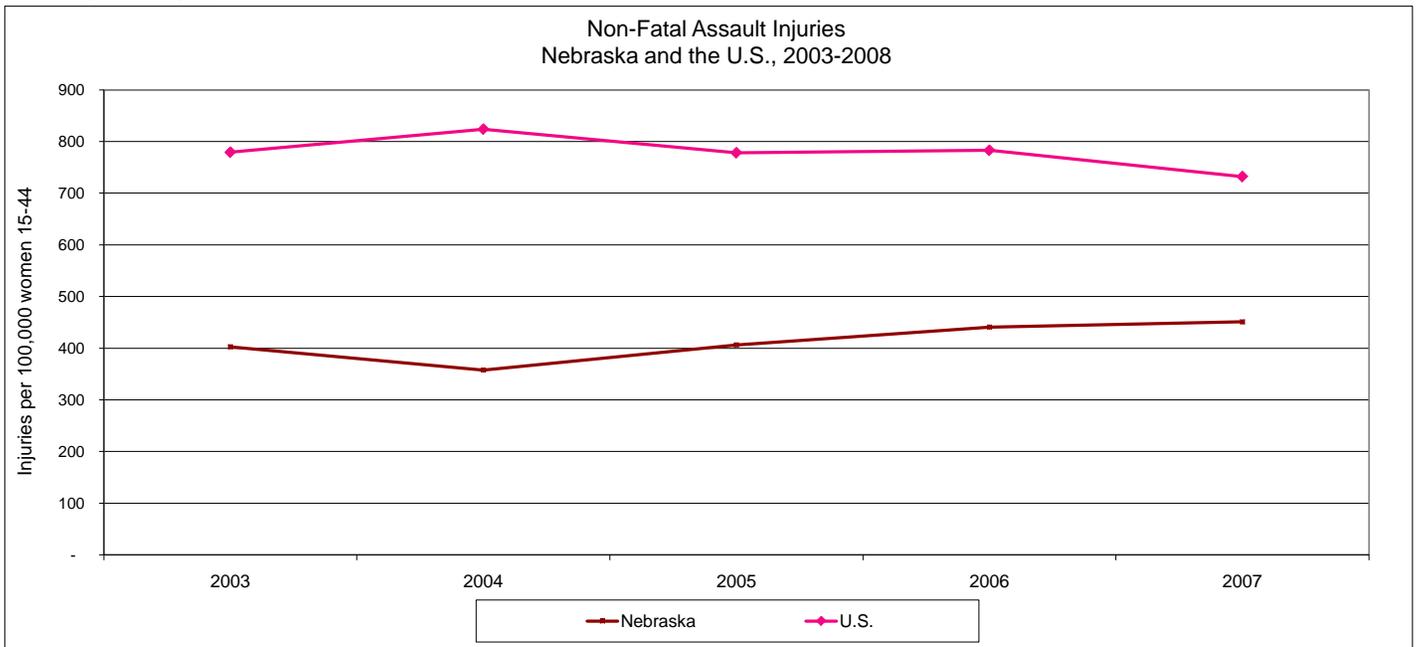
Data Source: Hospital Discharge Dataset

Data & Disparities:

	Assault		Nebraska rate was...
	Number	Rate	
Nebraska (2007)	1,586	450.9	
United States (2007)	453,377	732.0	Lower
HP 2010 Objective	1,360.00		Lower
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		-	

Data may not be comparable.

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Unintentional Injuries

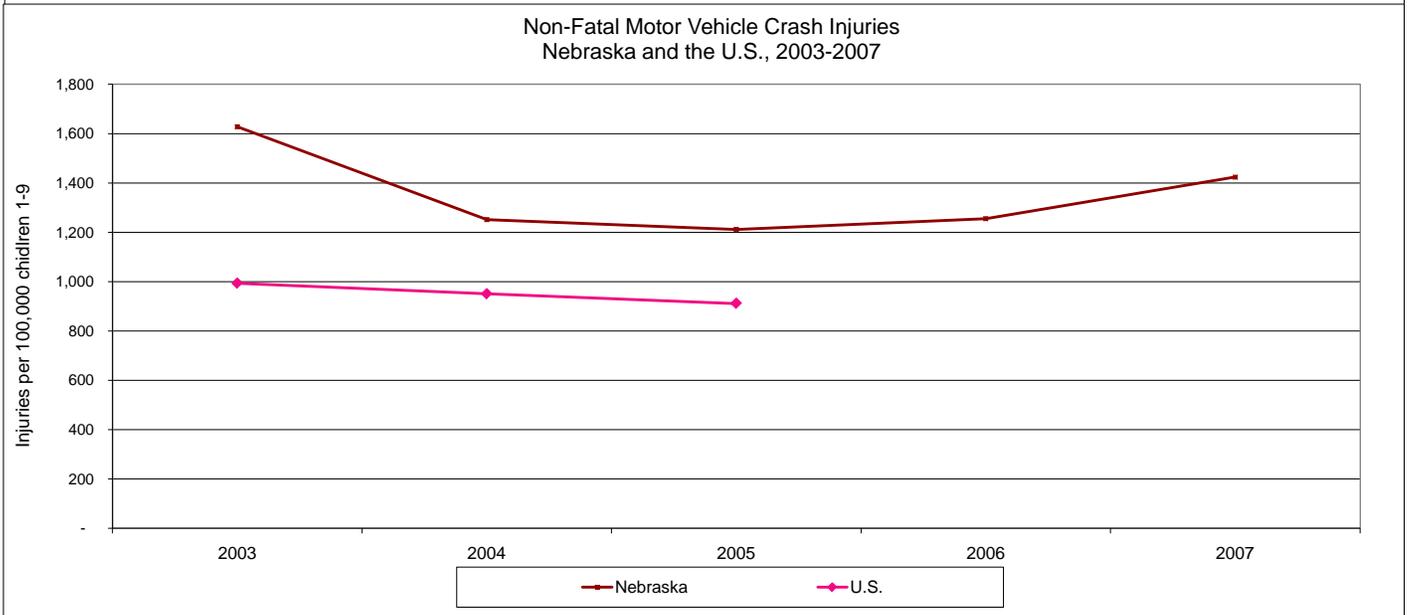
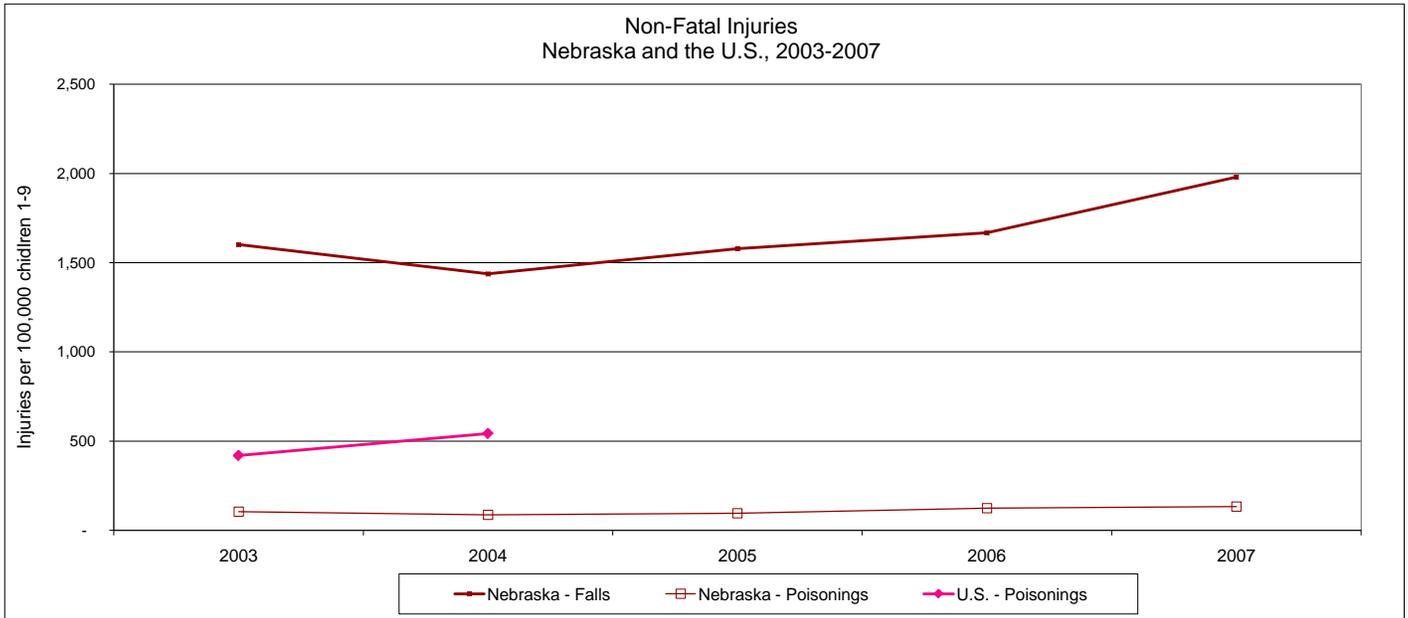
Definition: The number of hospital discharges for unintentional, nonfatal injuries, per 100,000 women 15-44, by cause

Data Source: Hospital Discharge Dataset

Data & Disparities:

	Falls			Motor Vehicle Crashes			Poisoning		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	6,962	1,979	was...	4,303	#####	was...	308	86.3	was...
United States (2007)	-	-	-	506,749	911.0	Higher	302,085	541.9	Lower
HP 2010 Objective	-	-	-	933	-	Higher	292	-	Lower
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-			-		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Sexually Transmitted Diseases

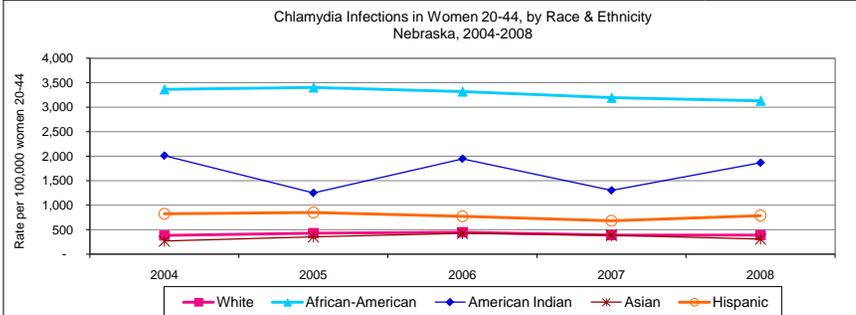
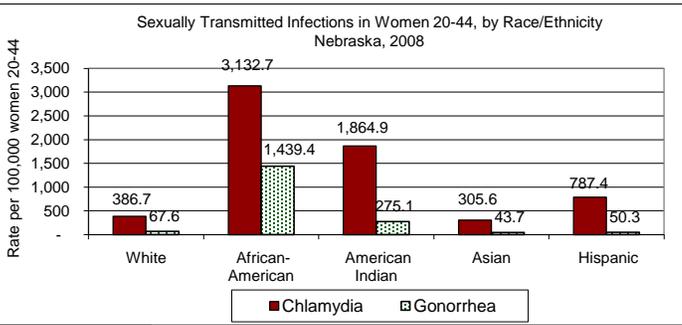
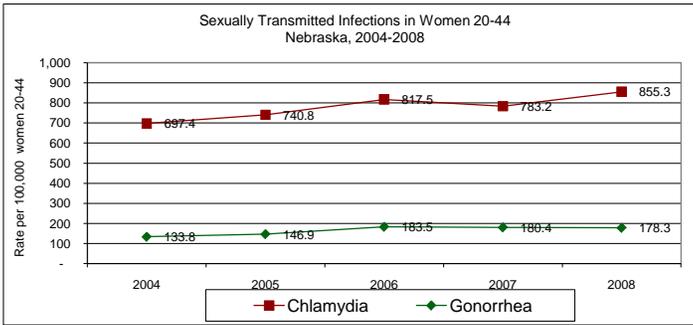
Definition: The number of women (20-44) diagnosed with a chlamydia infection, per 100,000 women
The number of women (20-44) diagnosed with a gonorrhea infection, per 100,000 women

Data Source: DHHS Epidemiology - Communicable Diseases

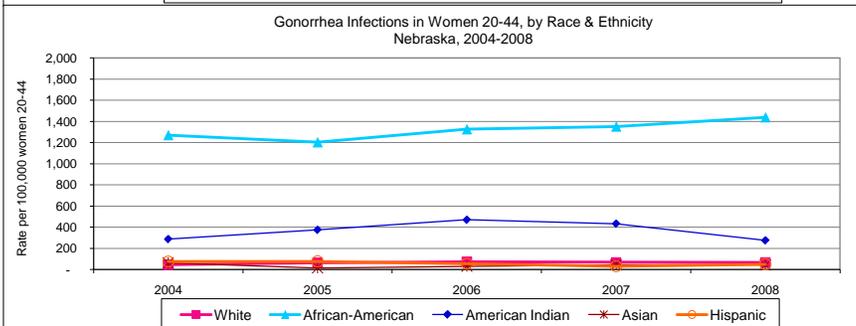
Data & Disparities:

	Chlamydia			Gonorrhea		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	2,465	855.3		514	178.3	
United States	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	INCREASING			N.L.C.		
Racial / Ethnic Differences	YES			YES		

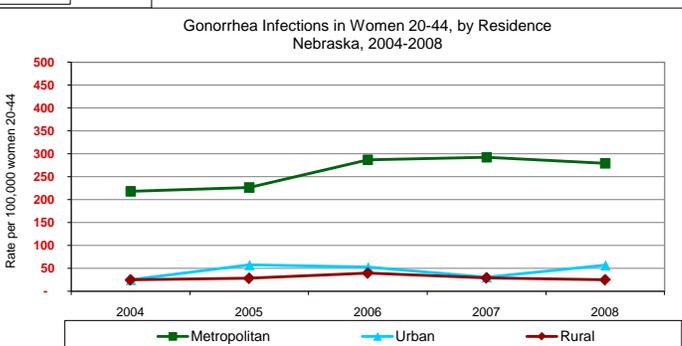
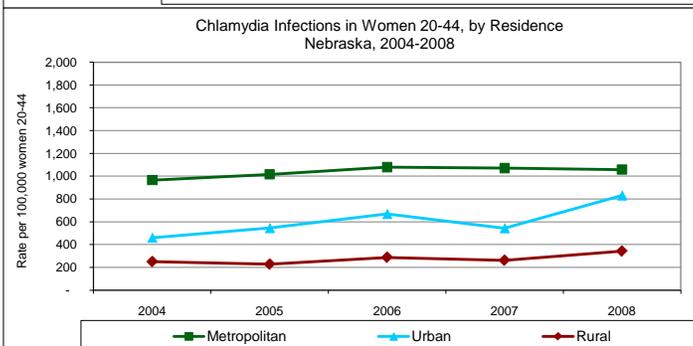
Graphical Display of Data:



White	N.L.C.
African-American	DECREASING
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.



White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.



Chlamydia 5-Year Trends: N.L.C.

Gonorrhea 5-Year Trends: N.L.C.

Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

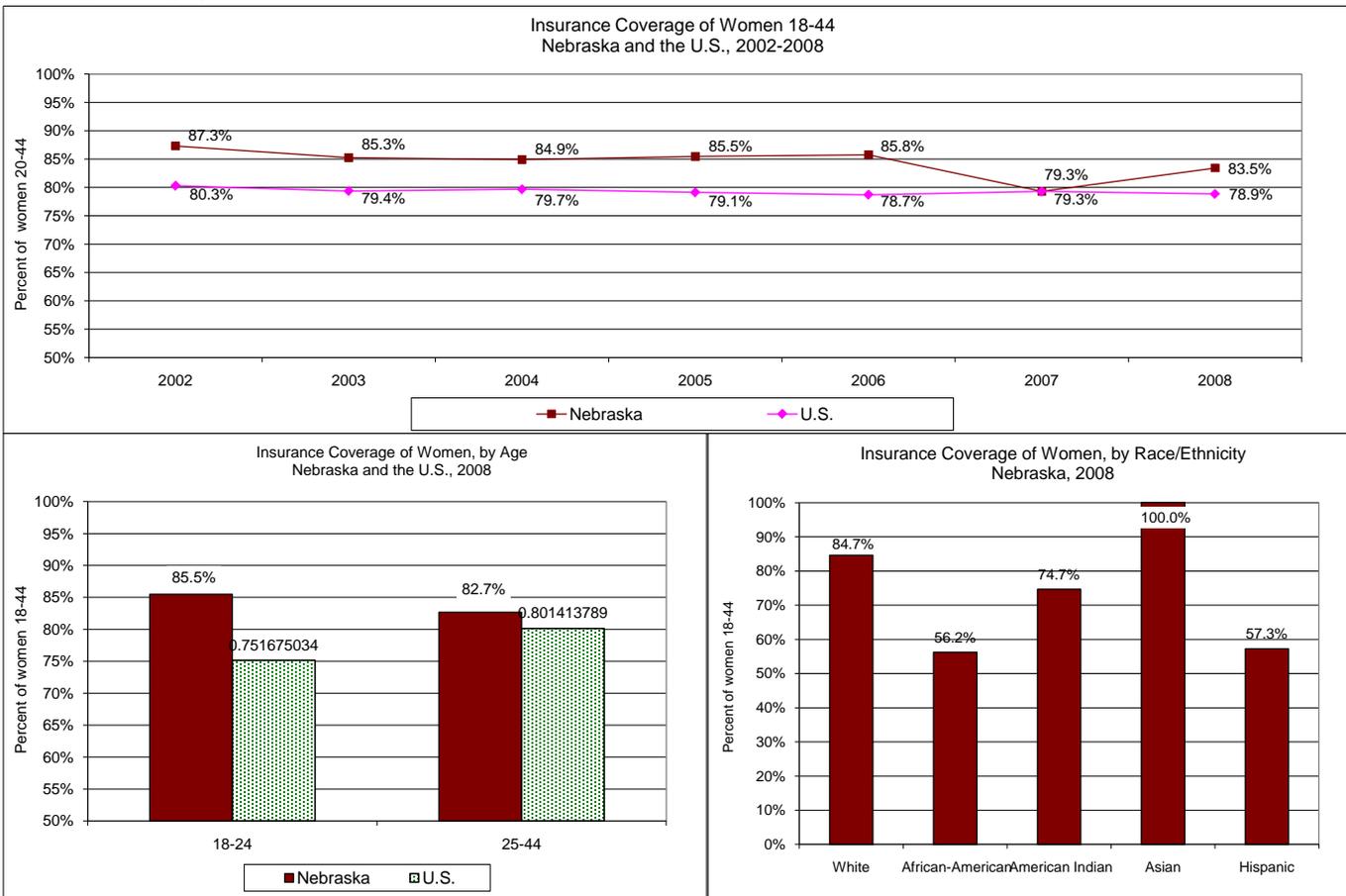
Definition: The number and percentage of women who have health insurance, by age

Data Source: U.S. Census - Current Population Survey

Data & Disparities:

	18-24			25-44			18-44		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	72,550	85.5%		185,862	82.7%		258,412	83.5%	
United States	10,659,097	75.2%	Higher	32,786,109	80.1%	Higher	43,445,206	78.9%	Higher
HP 2010 Objective	100.0%		Lower	100.0%		Lower	100.0%		Lower
Nebraska 5-year trend	N.L.C.								
Racial / Ethnic Differences?	YES								

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

Definition: The number and percentage of post-partum women who visited a dentist before the pregnancy.

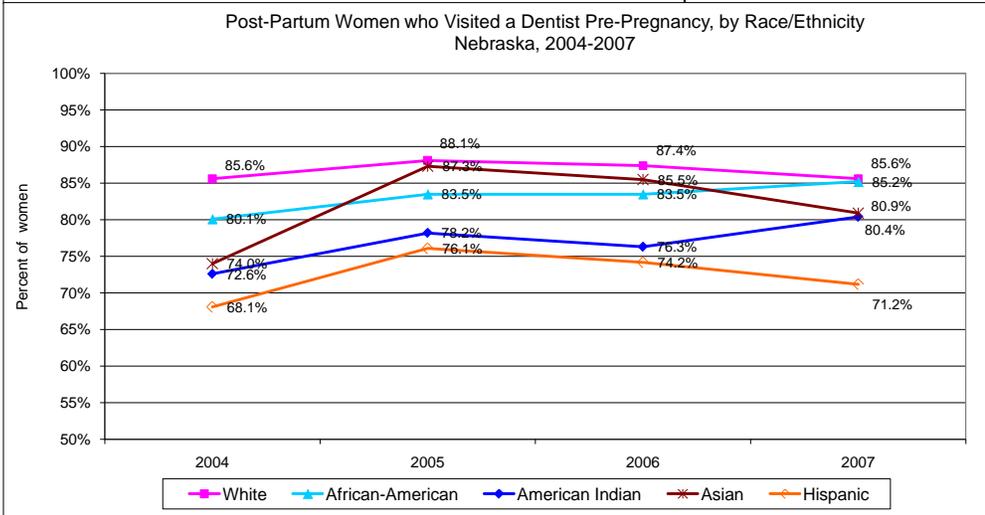
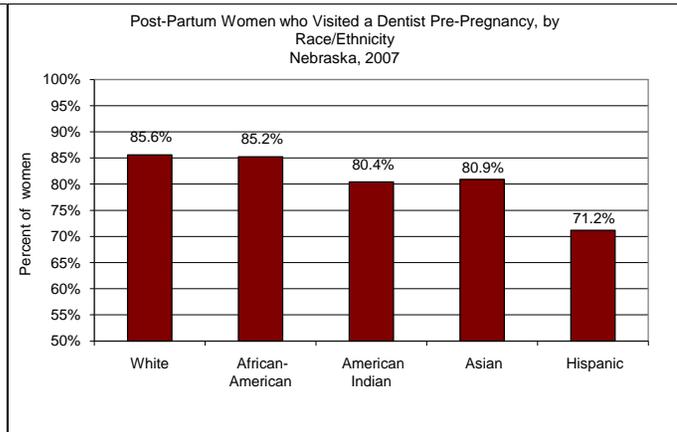
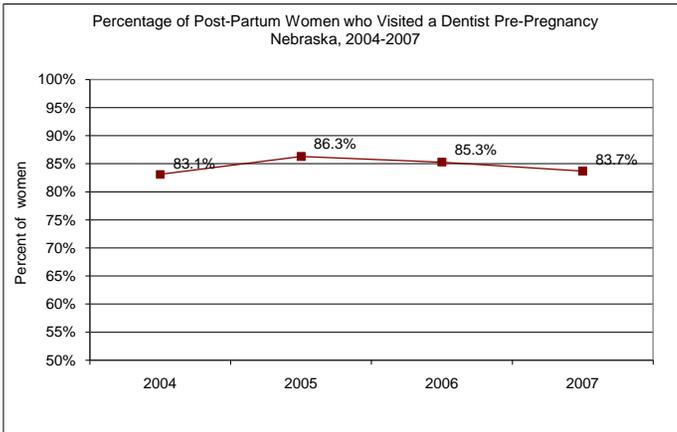
Data Source: Nebraska PRAMS

Data & Disparities:

	Dentist		Nebraska rate was...
	Number	%	
Nebraska (2007)	18,728	83.7%	-
United States	-	-	-
HP 2010 Objective*	56.0%		Higher
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences?		YES	

*Note: HP2010 Objective is for visits in "past 12 months."

Graphical Display of Data:



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

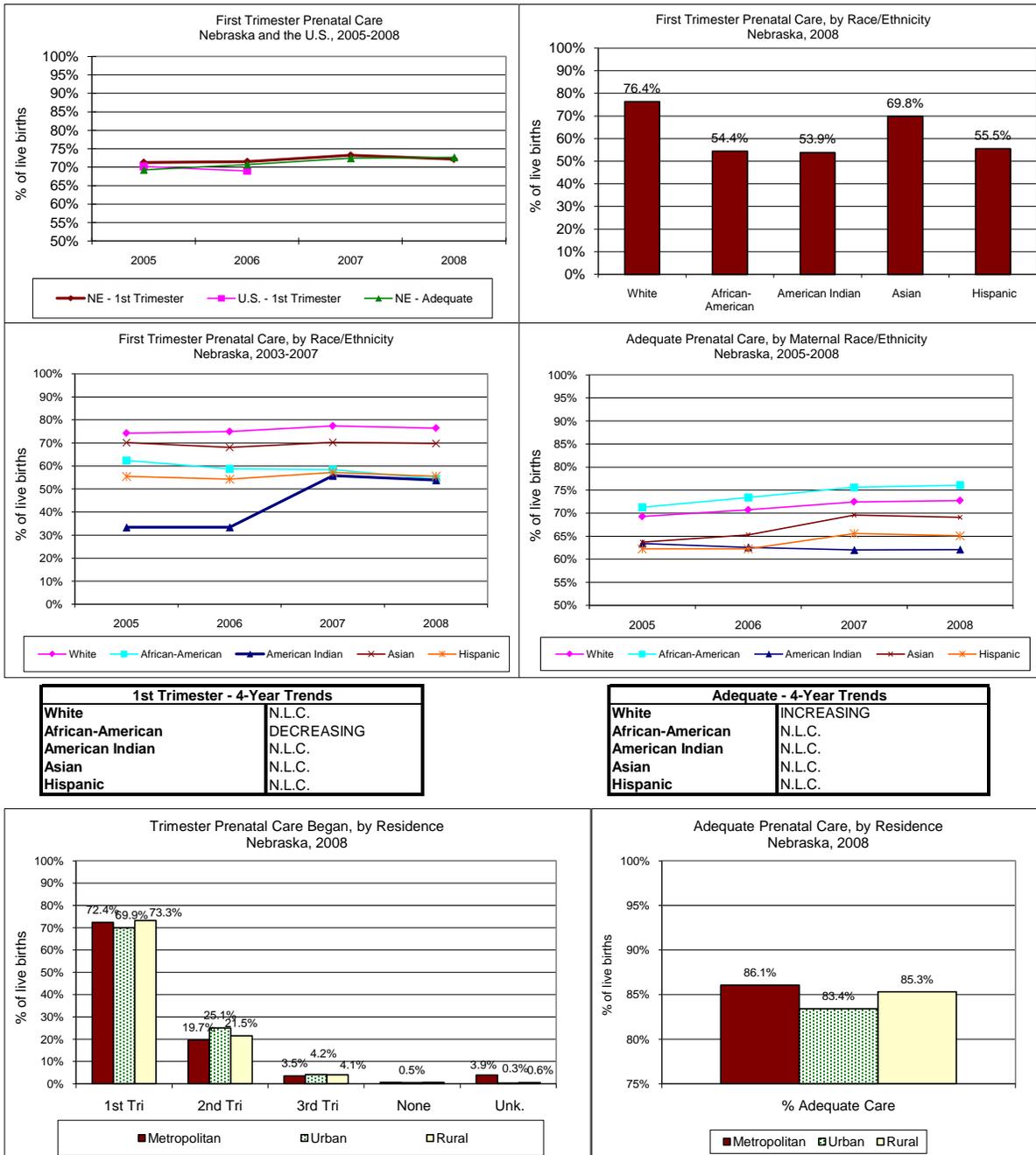
Definition: The number and percentage of postpartum women who obtained adequate/adequate+ prenatal care
The number and percentage of postpartum women who obtained prenatal care during the first trimester

Data Source: Nebraska Vital Records

	1st Trimester PNC		Nebraska rate is...	Adequate/Adequate+		Nebraska rate is...
	Number	%		Number	%	
Nebraska (2008)	19,051	72.2%		18,700	72.7%	
United States (2006)	2,943,233	69.0%	Higher	-	0.0%	-
HP 2010 Objective		90%	Lower			Lower
Nebraska 4-year trend*		N.L.C.		INCREASING		
NE Racial / Ethnic Disparities?		YES		YES		

*States' changes to the birth certificate make timing of prenatal care information non-comparable to years before 2005.

Graphical Display of Data:



Nebraska Title V
2010 Needs Assessment

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Alcohol and Tobacco

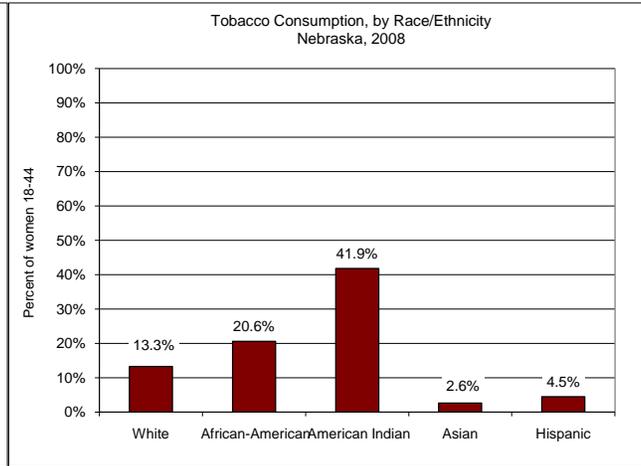
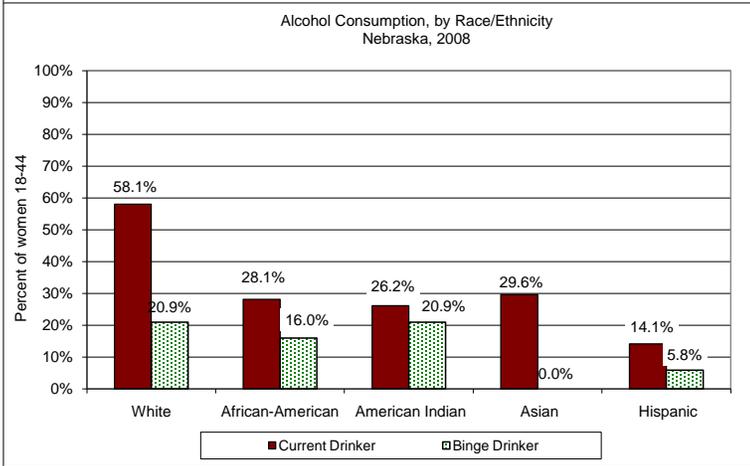
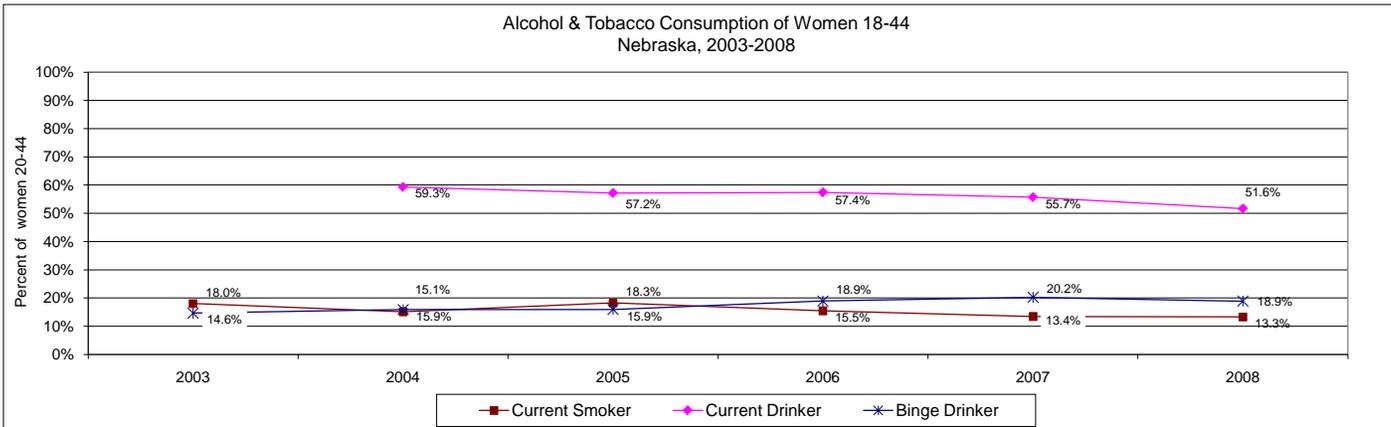
Definition: The number and percentage of women who currently smoke
The number and percentage of women who currently drink alcohol
The number and percentage of women who binge drink (5+ drinks, 1+ times in the past month)

Data Source: BRFSS

Data & Disparities:

	Smoke			Drink			Binge Drink		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	41,832	13.3%		162,929	51.6%		59,119	18.9%	
United States (2005)	8,738,769	20.8%	N.S.D.	21,349,287	50.8%	Higher	3,841,450	18.4%	N.S.D.
HP 2010 Objective		12%	Higher		12%	Higher		6%	Higher
Nebraska 5-year trend	N.L.C.			DECREASING			N.L.C.		
Racial / Ethnic Differences?	YES			YES			YES		

Graphical Display of Data:



	Alcohol - 5-Year Trends	
	Current	Binge
White	DECREASING	N.L.C.
African-American	N.L.C.	N.L.C.
American Indian	N.L.C.	N.L.C.
Asian	N.L.C.	N.L.C.
Hispanic	N.L.C.	N.L.C.

	Tobacco - 5-Year Trends
	Smoker
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Injury

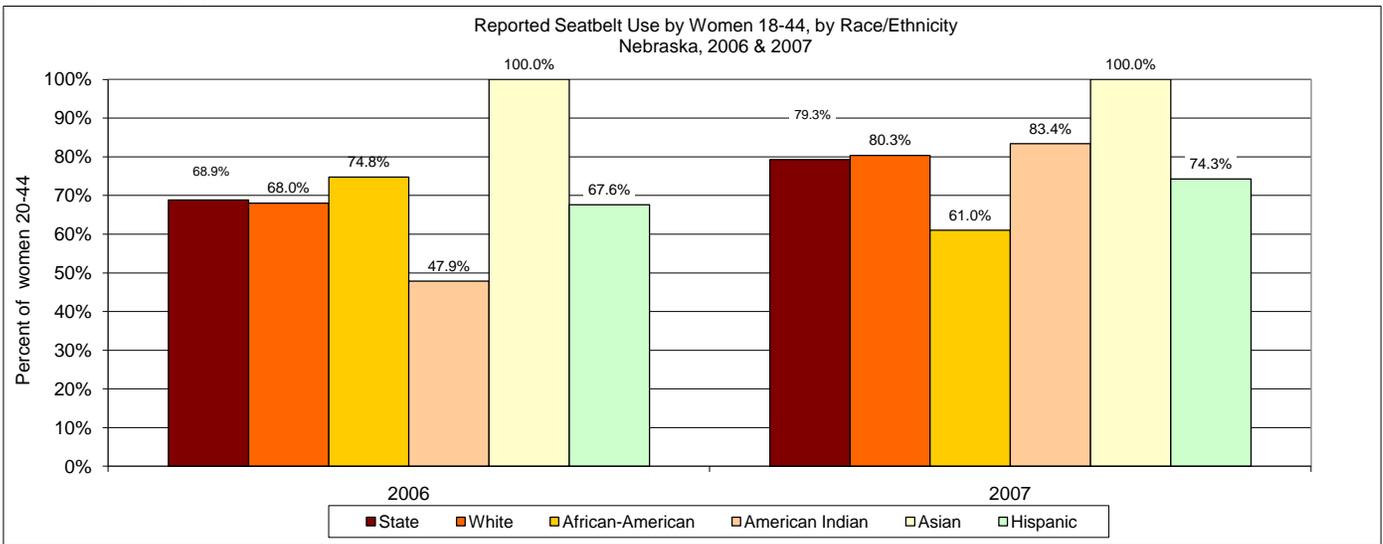
Definition: The number and percentage of women who report always or nearly always wearing a seatbelt

Data Source: BRFSS

Data & Disparities:

	Seatbelt		Nebraska rate was...
	Number	%	
Nebraska (2008)	248,873	79.3%	-
United States	-	-	-
HP 2010 Objective	92%		Lower
Nebraska 2-year change	Increased		
Racial / Ethnic Differences?	YES		

Graphical Display of Data:



2-Year Change?	
State	Increased
White	Increased
African-American	Decreased
American Indian	Unchanged
Asian	N.S.D.
Hispanic	Increased

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Preventive Health

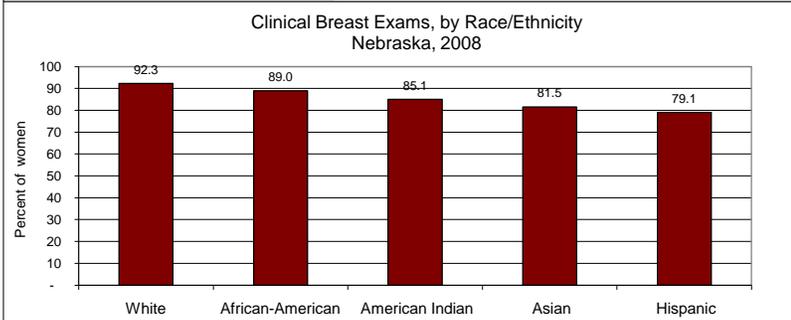
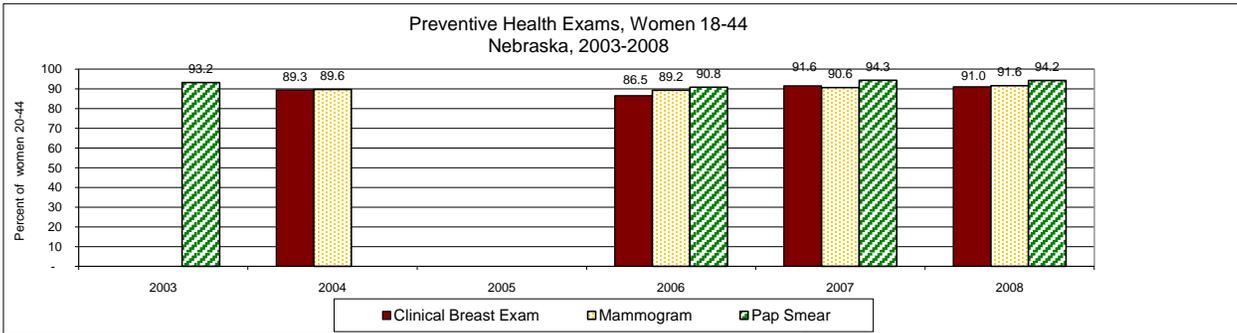
Definition: The number and percentage of women 18+ who have ever had a clinical breast exam
The number and percentage of women 40+ who have ever had a mammogram
The number and percentage of women 18+ who have ever had a Pap smear

Data Source: BRFSS

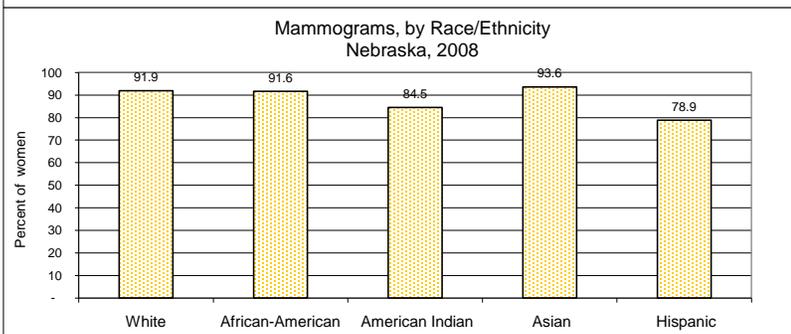
Data & Disparities:

	Clinical Breast Exam			Mammogram			Pap Smear		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	284,059	91.0%	-	377,200	91.6%	-	292,690	83.8%	-
United States	-	0.0%	-	42,306,846	76.0%	Higher	46,147,862	82.9%	Higher
HP 2010 Objective	-	-	-	70%	-	Higher	97%	-	Lower
Nebraska 2-year change	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences?	YES			YES			YES		

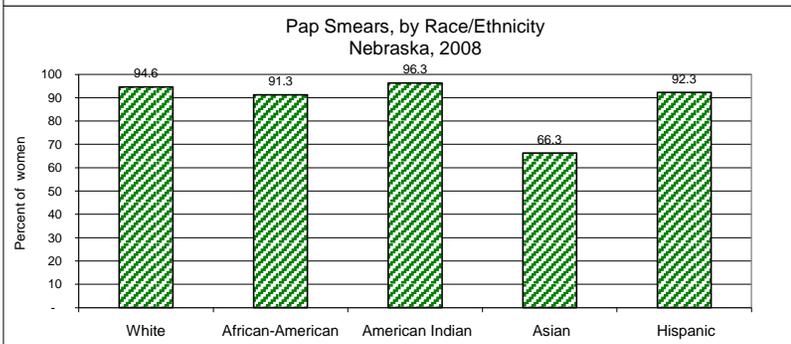
Graphical Display of Data:



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Preventive Health (continued)

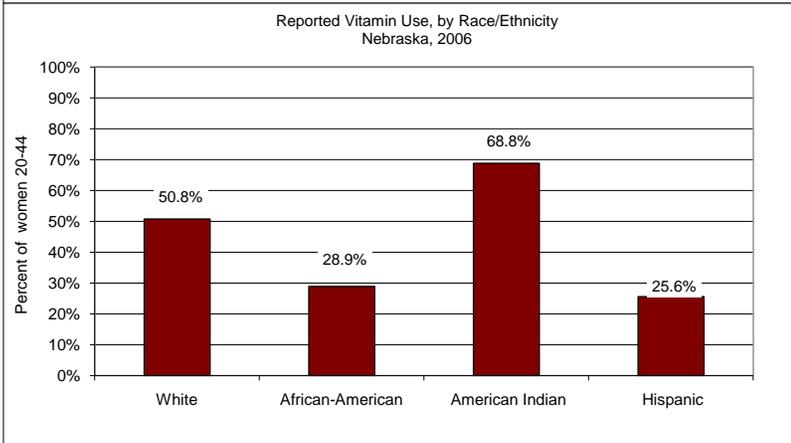
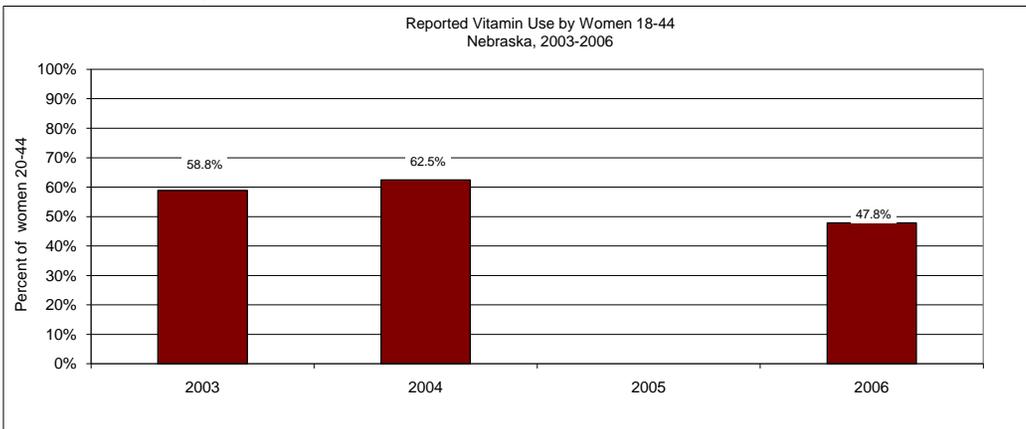
Definition: The number and percentage of women 18-44 who report taking vitamins daily

Data Source: BRFSS

Data & Disparities:

	Vitamins		Nebraska rate was...
	Number	%	
Nebraska (2008)	72,948	47.8%	
United States	-	-	-
HP 2010 Objective	80%		Lower
Nebraska 4-year Trend	N.L.C.		
Racial / Ethnic Differences?	YES		

Graphical Display of Data:



4-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	INCREASING
Asian*	-
Hispanic	N.L.C.

*Asian responses were too unstable for comparison.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - CVD Risk Factors

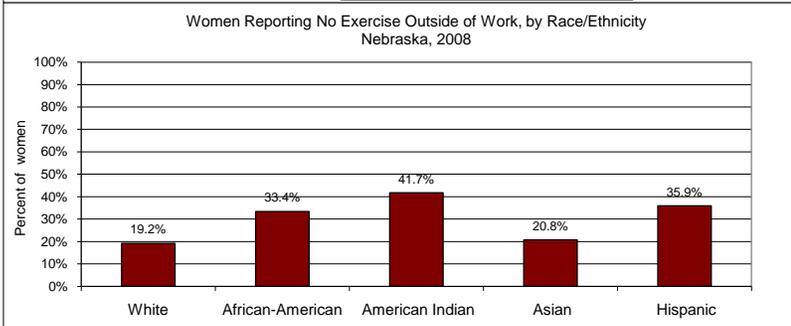
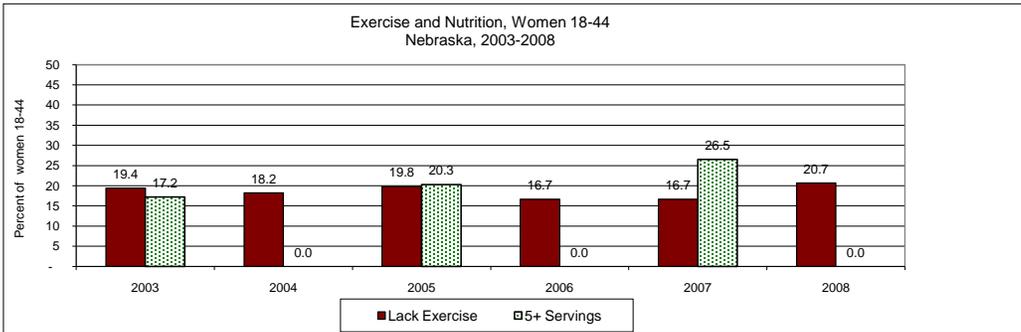
Definition: The number and percentage of women who lack exercise outside of work
The number and percentage of women who consume 5+ servings of fruit and vegetables per day

Data Source: BRFSS

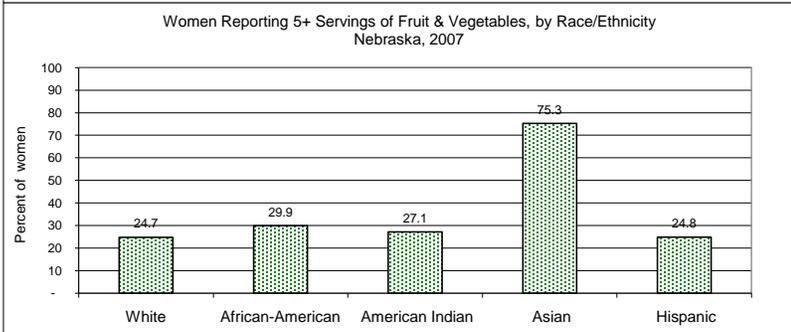
Data & Disparities:

	Lack Exercise			5+ Servings		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	65,391	20.7%		83,795	26.5%	
United States	-	-	-	-	-	-
HP 2010 Objective	20%		N.S.D.			
Nebraska 2-year change	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	YES			YES		

Graphical Display of Data:



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Preventive Health

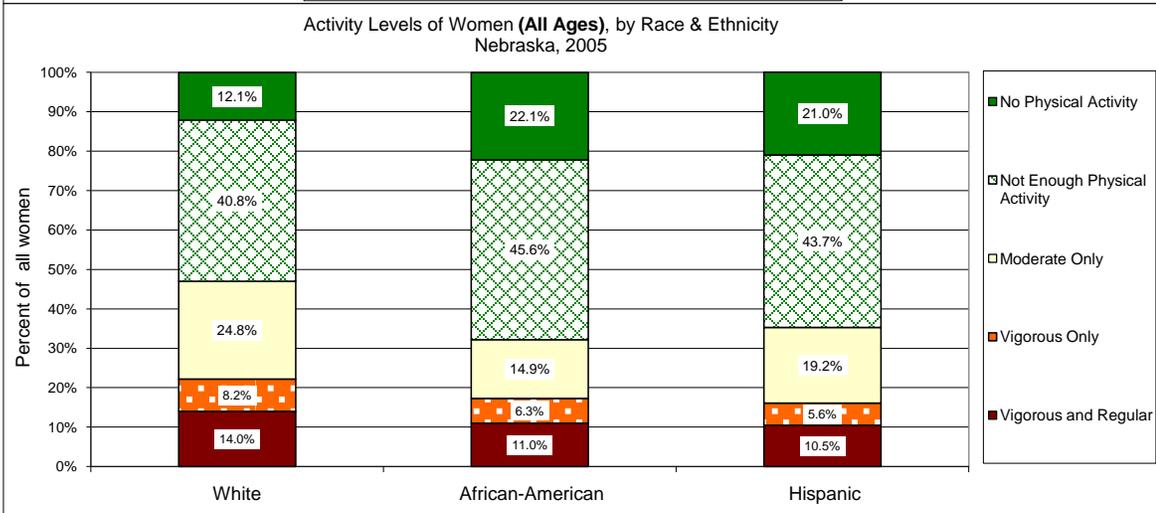
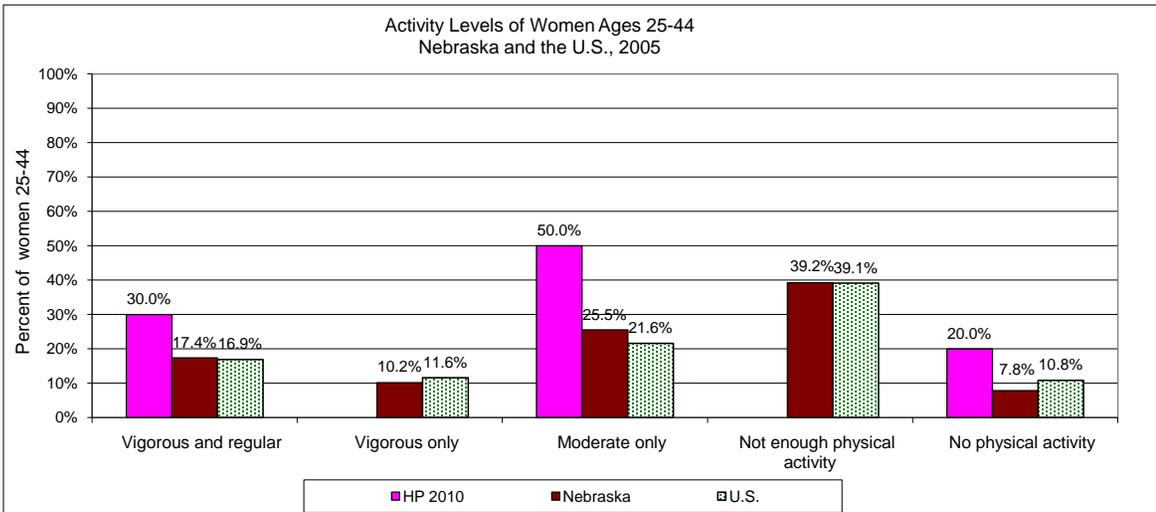
Definition: The number and percentage of women ages 25-44 at each level of the recommendation for physical activity

Data Source: BRFSS

Data & Disparities:

	Vigorous and Regular			Vigorous Only			Moderate Only		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2005)	-	17.4%	rate was...	-	10.2%	rate was...	-	25.5%	rate was...
United States (2005)	-	16.9%	N.S.D.	-	11.6%	N.S.D.	-	21.6%	Higher
HP 2010 Objective	30%			-			50%		
Nebraska 5-year trend	-			-			-		
Racial / Ethnic Differences?	-			-			-		
	Not Enough Physical Activity			No Physical Activity					
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...			
Nebraska (2005)	-	39.2%	rate was...	-	7.8%	rate was...			
United States (2005)	-	39.1%	N.S.D.	-	10.8%	N.S.D.			
HP 2010 Objective	-			20%					
Nebraska 5-year trend	-			-					
Racial / Ethnic Differences?	-			-					

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Behavior - Reproductive Health

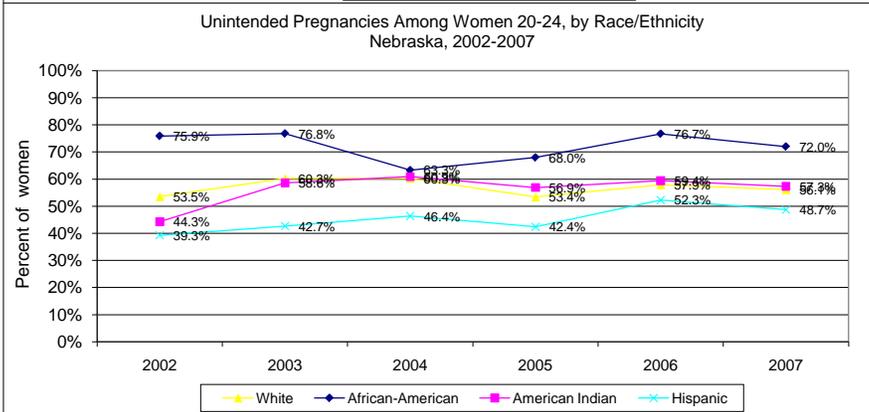
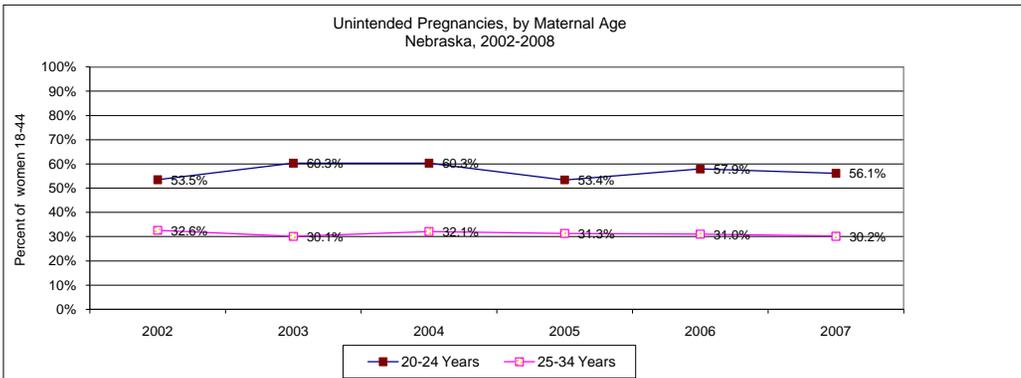
Definition: The number and percentage of women whose pregnancy was unintended, by age

Data Source: Nebraska PRAMS

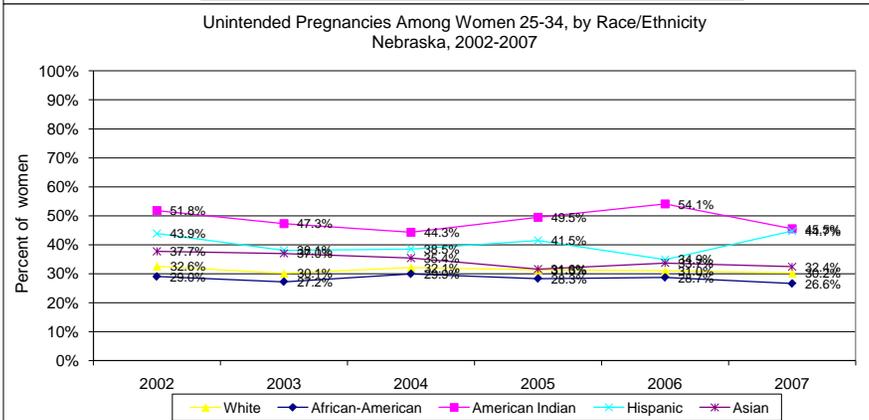
Data & Disparities:

	20-24			25-34		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2007)	3,678	56.1%		4,125	30.2%	
United States	-	-	-	-	-	-
HP 2010 Objective	30%			30%		
Nebraska 2-year change	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	YES			YES		

Graphical Display of Data:



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Hispanic	N.L.C.



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
Asian	N.L.C.
American Indian	N.L.C.
Hispanic	N.L.C.

Data Sheet: HEALTH DETERMINANTS

Nutrition

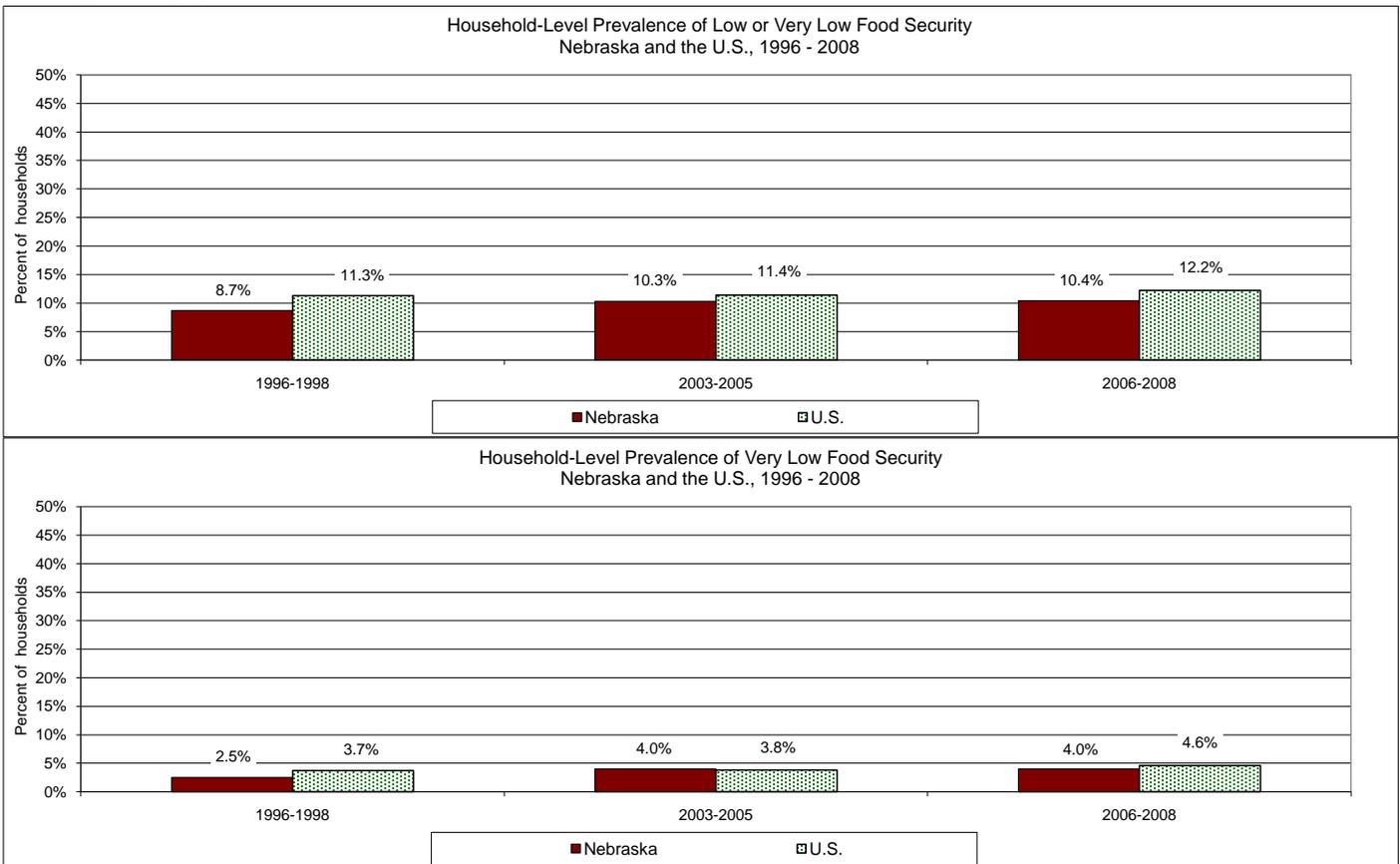
Definition: Prevalence of household-level food insecurity

Data Source: U.S. Census - Current Population Survey, Food Security Supplement

Data & Disparities:

	Low or very low food security			Very low food security		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2006-2008)	73,038	10.4%	Higher	28,092	4.0%	-
United States (2006-2008)	13,711,128	12.2%		5,169,770	4.6%	
HP 2010 Objective	6%			-		
Nebraska change, 1996-98 v. 2006-	p<.10			p<.10		
Nebraska change, 2003-05 v. 2006-	N.S.C.			N.S.C.		

Graphical Display of Data:



Infants

Data Sheet: DEMOGRAPHICS

Maternal age

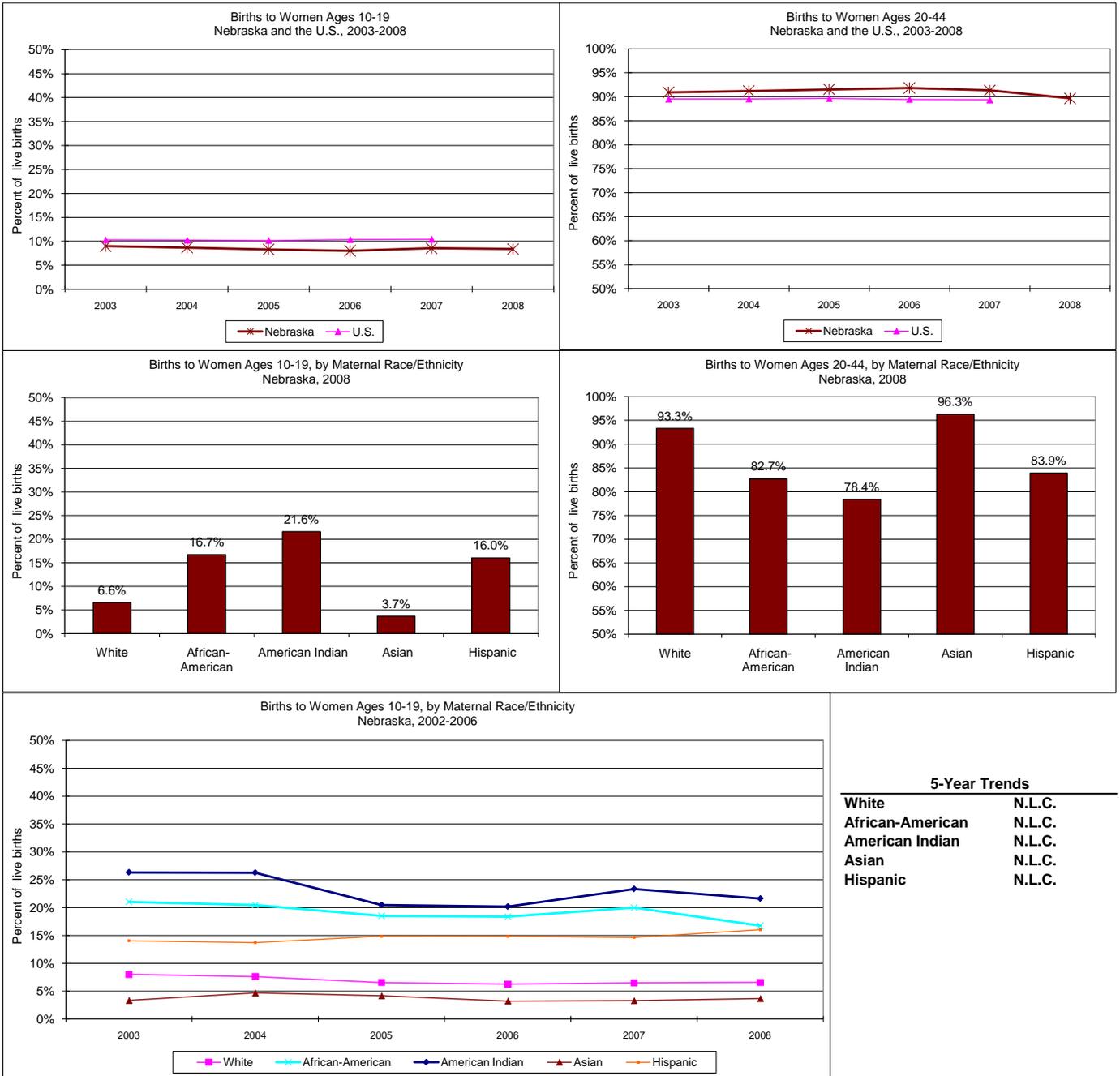
Definitions: The percentage of births to women ages 10 - 19
 The percentage of births to women ages 20-44
 The percentage of births to women ages 45+

Data Source: Nebraska Vital Records

Data & Disparities:

	10-19			20-44			45+		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2008)	2,256	8.4%	was...	24,118	89.7%	Higher	30	0.11%	was...
United States (2007)	451,263	10.5%	Lower	3,858,507	89.4%	Higher	7,349	0.2%	Lower
HP 2010 Objective	-			-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES			NO		

Graphical Display of Data:



Data Sheet: **DEMOGRAPHICS**

Maternal Race/Ethnicity

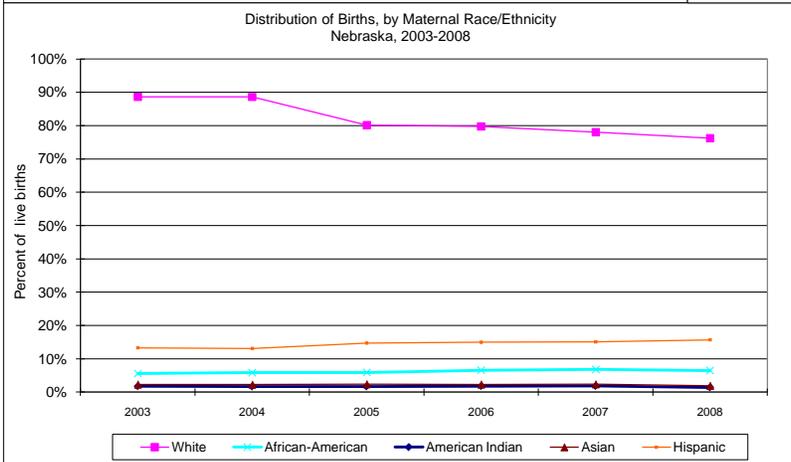
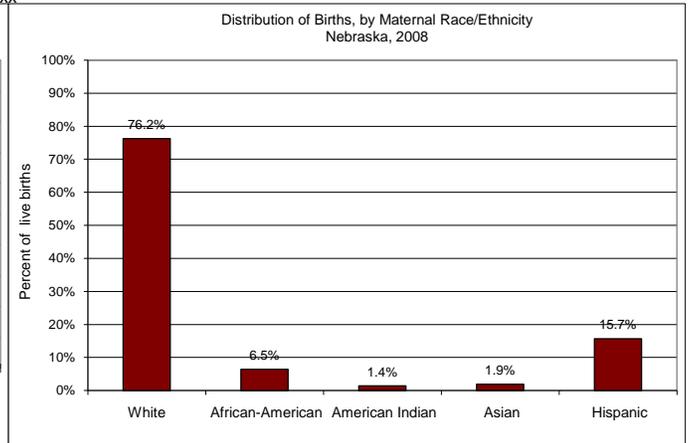
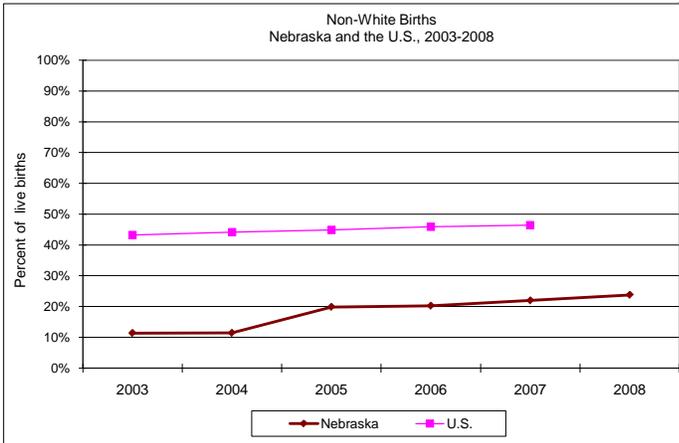
Definition: The distribution of births by maternal race & ethnicity

Data Source: Nebraska Vital Records

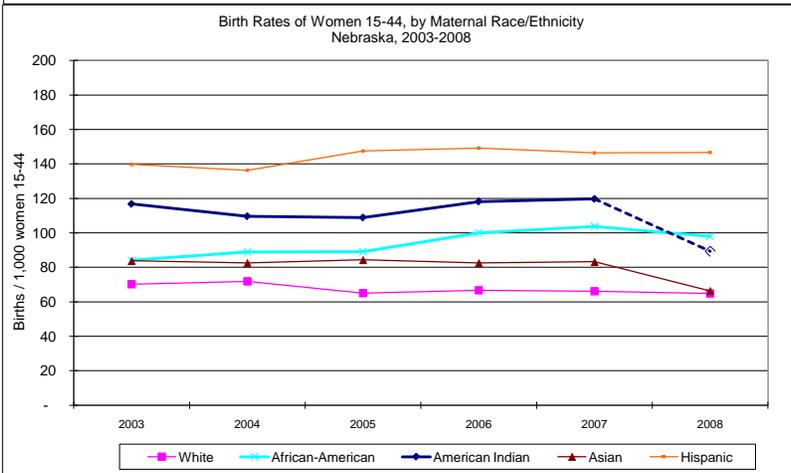
Data and Disparities

	Non-White Births		
	Number	%	Nebraska %
Nebraska (2008)	6,392	23.8%	was...
United States (2007)	2,004,646	46.4%	Lower
HP 2010 Objective		-	
Nebraska 5-year trend		INCREASING	
NE Racial / Ethnic Disparities?		-	

Graphical Display of Data



5-Year Trends	
White	DECREASING
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	INCREASING



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: DEMOGRAPHICS

Maternal education

Definition: The distribution of births to women by completed years of education

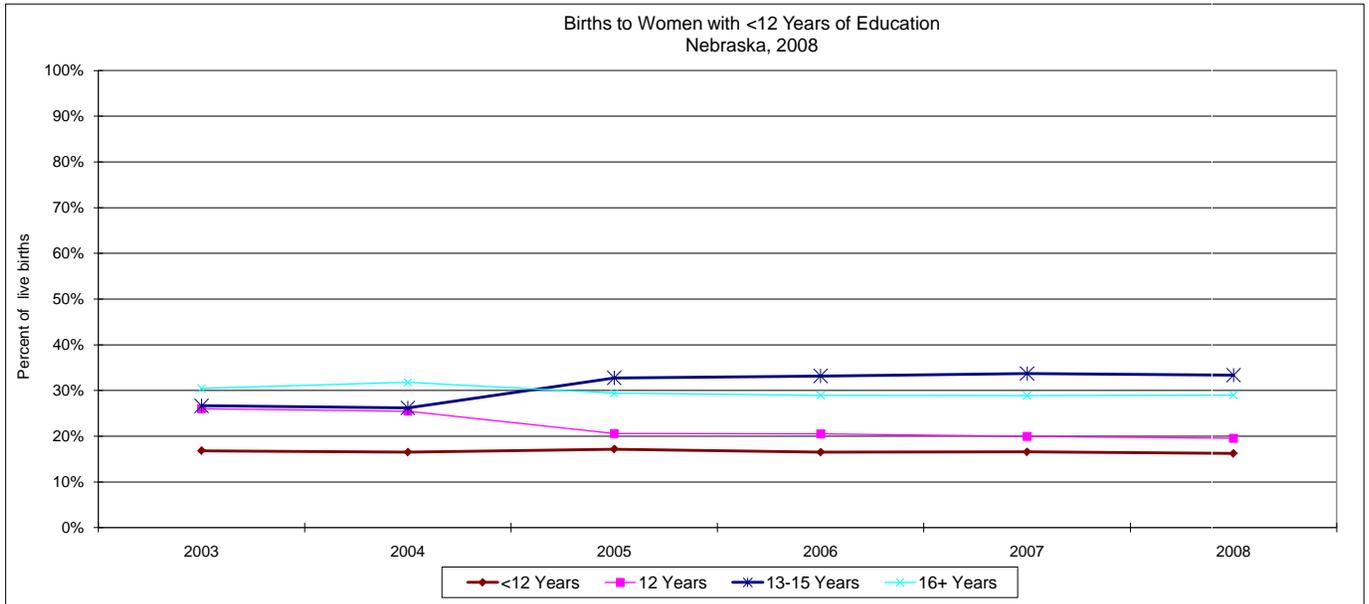
Data Source: Nebraska Vital Records

	0-11 Years			12 Years		
	Number	%	Nebraska %	Number	%	Nebraska %
Nebraska (2008)	4,362	16.2%	was...	5,252	19.5%	was...
United States (2003*)	822,123	20.1%	Lower	1,162,697	28.4%	Lower
HP 2010 Objective		-			-	
Nebraska 5-year trend		N.L.C.			N.L.C.	
NE Racial / Ethnic Disparities?		-			-	

	13-15 Years			16+ Years		
	Number	%	Nebraska %	Number	%	Nebraska %
Nebraska (2008)	8,975	33.4%	was...	7,807	29.0%	was...
United States (2003*)	811,985	19.9%	Higher	1,012,730	24.8%	0
HP 2010 Objective		-			-	
Nebraska 5-year trend		N.L.C.			N.L.C.	
NE Racial / Ethnic Disparities?		-			-	

*States' changes in the standard U.S. death certificate make

Graphical Display of Data:



5-Year Trends

0-11 Years	N.L.C.
12 Years	N.L.C.
13-15 Years	N.L.C.
16+ Years	N.L.C.

Data Sheet: DEMOGRAPHICS

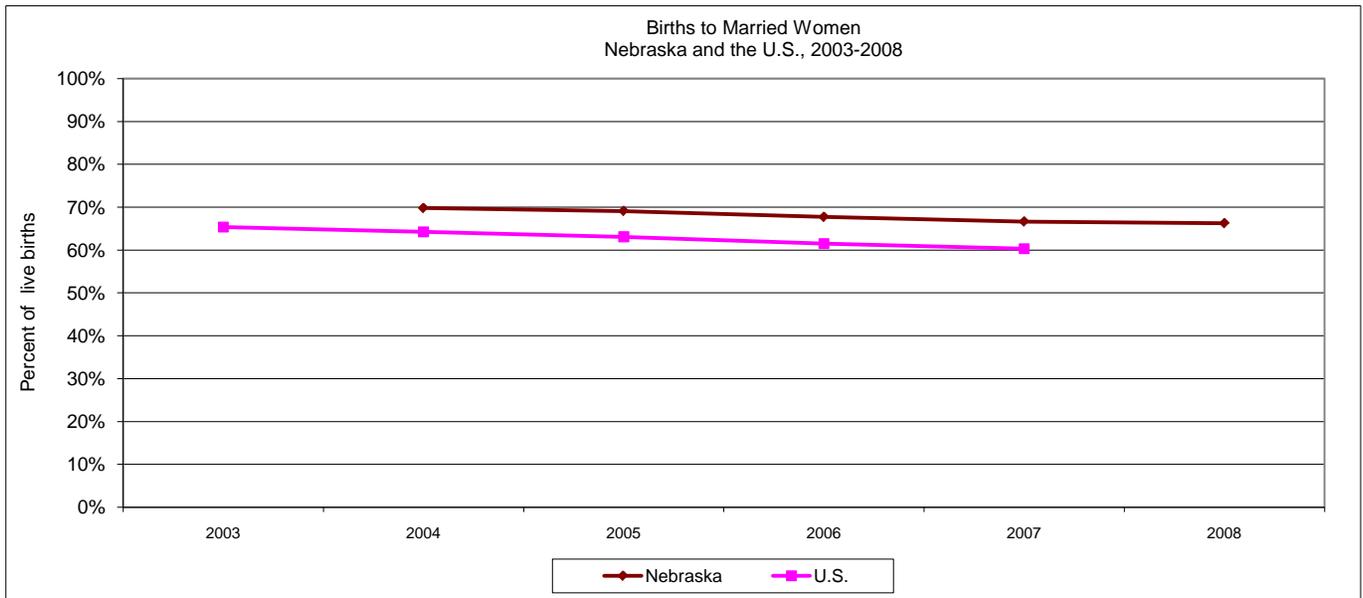
Marital Status

Definition: The percentage of births to married women

Data Source: Nebraska Vital Records

% Married			Nebraska rate is...
	Number	%	
Nebraska (2008)	17,948	66.6%	Higher
United States (2007)	2,655,028	61.5%	
HP 2010 Objective	-	-	-
Nebraska 5-year trend	DECREASING		
NE Racial / Ethnic Disparities?	-		

Graphical Display of Data:



Data Sheet: DEMOGRAPHICS

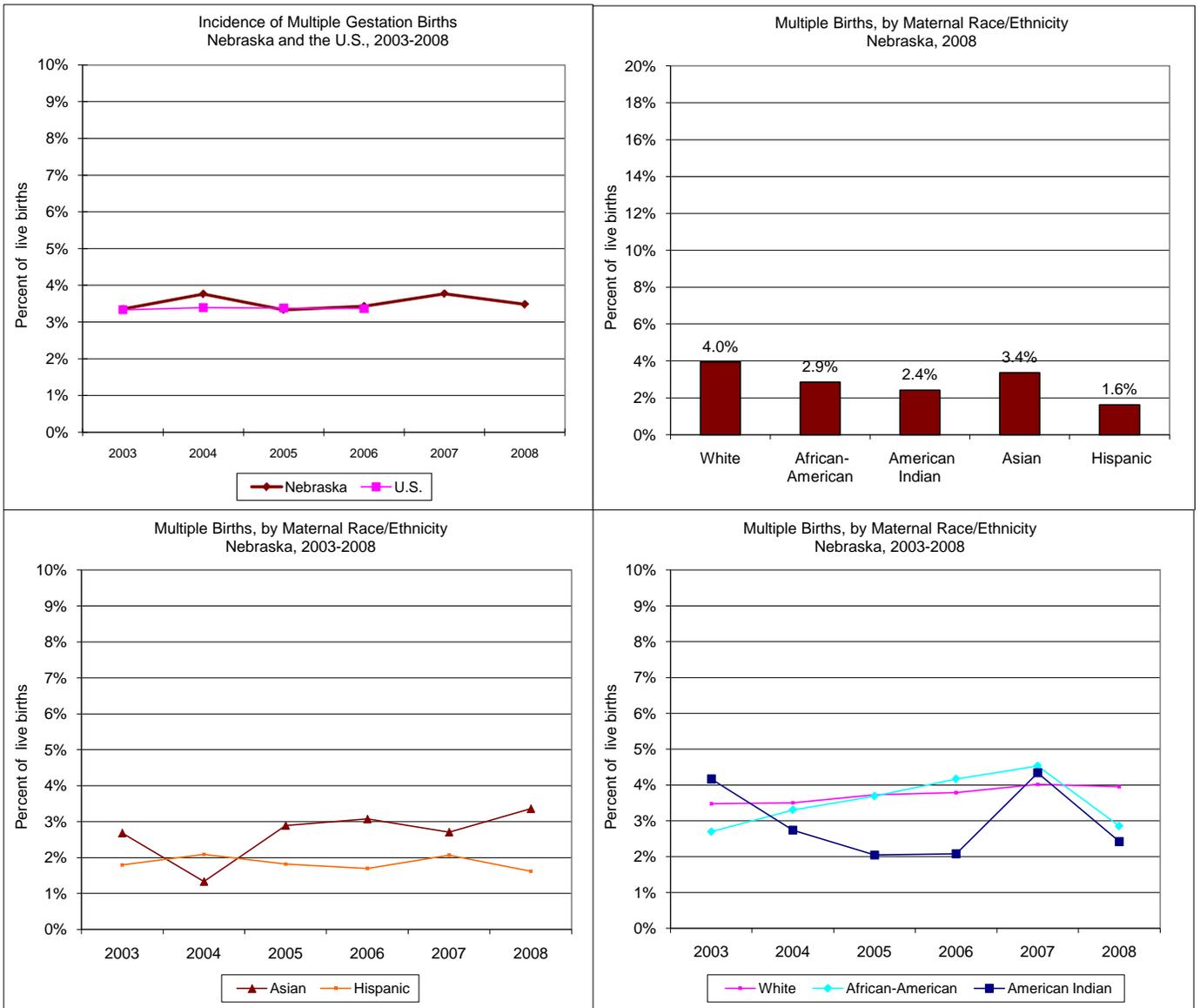
Multiple births

Definition: Percentage of live births that are multiple gestation

Data Source: Nebraska Vital Records

% Multiple birth			
	Number	%	Nebraska rate is...
Nebraska (2008)	916	3.4%	
United States (2006)	143,625	3.4%	N.S.D.
HP 2010 Objective		-	
Nebraska 5-year trend		N.L.C.	
NE Racial / Ethnic Disparities?		YES	

Graphical Display of Data:



5-Year Trends

Asian	N.L.C.
Hispanic	N.L.C.

5-Year Trends

White	INCREASING
African-American	N.L.C.
American Indian	N.L.C.

Data Sheet: DEMOGRAPHICS

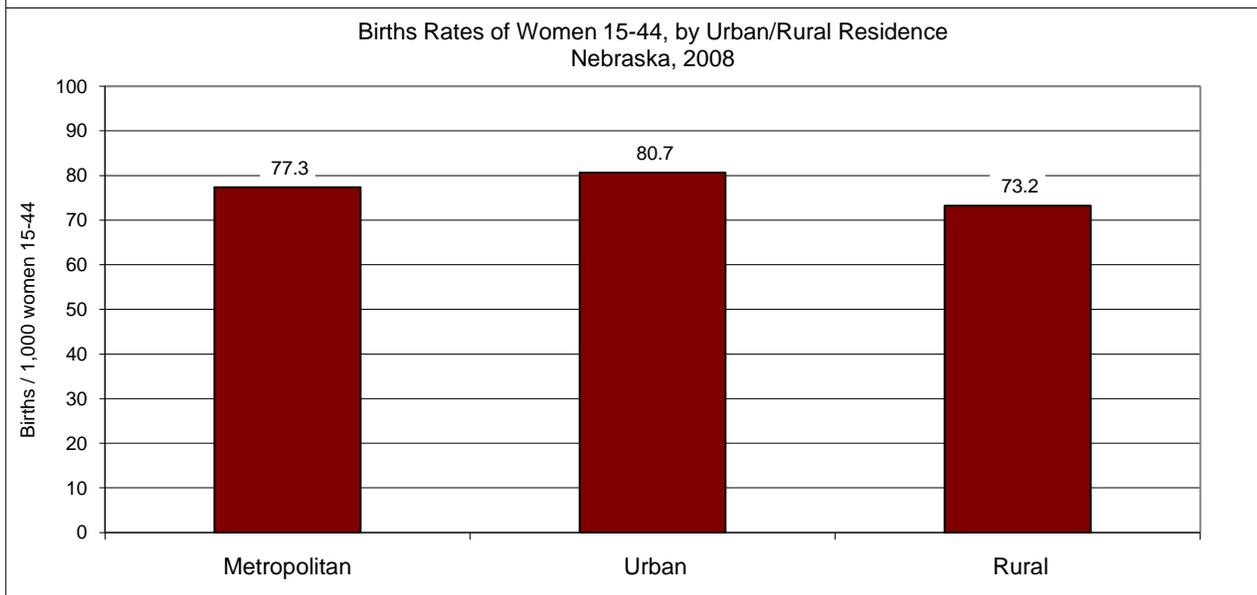
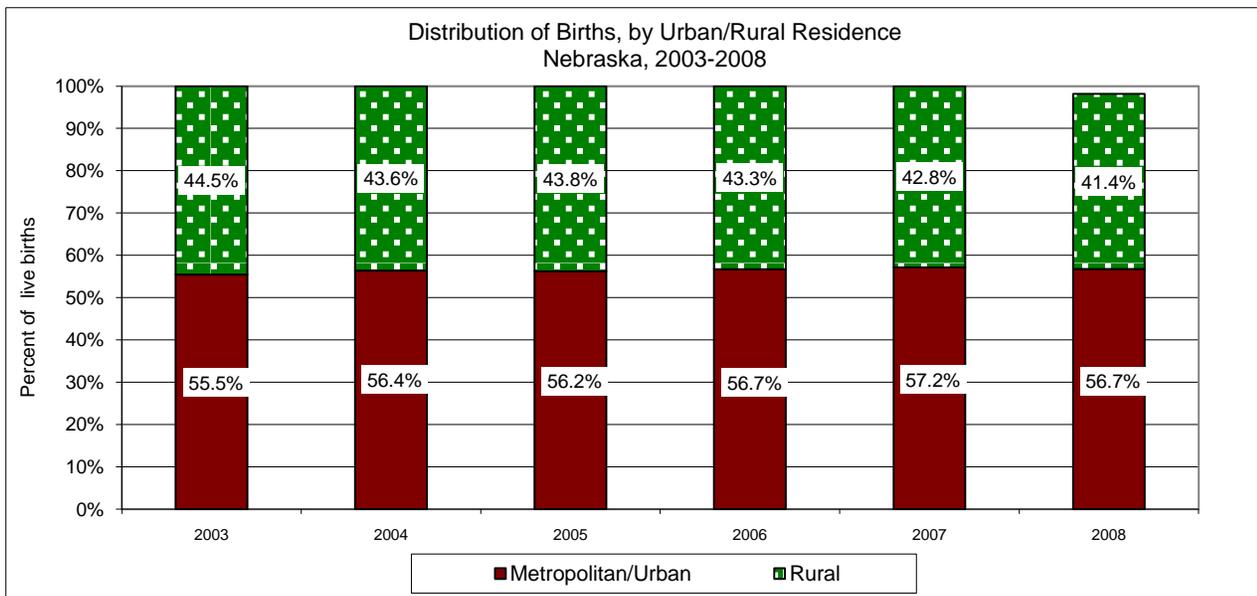
Urban / Rural

Definition: The percentage and rate of births to women residing in metropolitan (Douglas, Lancaster & Sarpy), urban (Adams, Buffalo, Dakota, Dawson, Dodge, Gage, Hall, Lincoln, McPherson, Platte, Scotts Bluff) and rural (all other) counties.

Data Source: Nebraska Vital Records

	Urban			% Rural		
	Number	%	Nebraska rate is...	Number	%	Nebraska % was...
Nebraska (2008)	15,262	56.7%	-	11,142	41.4%	-
United States	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			DECREASING		
NE Racial / Ethnic Disparities?	-	-	-	-	-	-

Graphical Display of Data:



Nebraska Title V 2010 Needs Assessment

Data Sheet: **DEMOGRAPHICS**

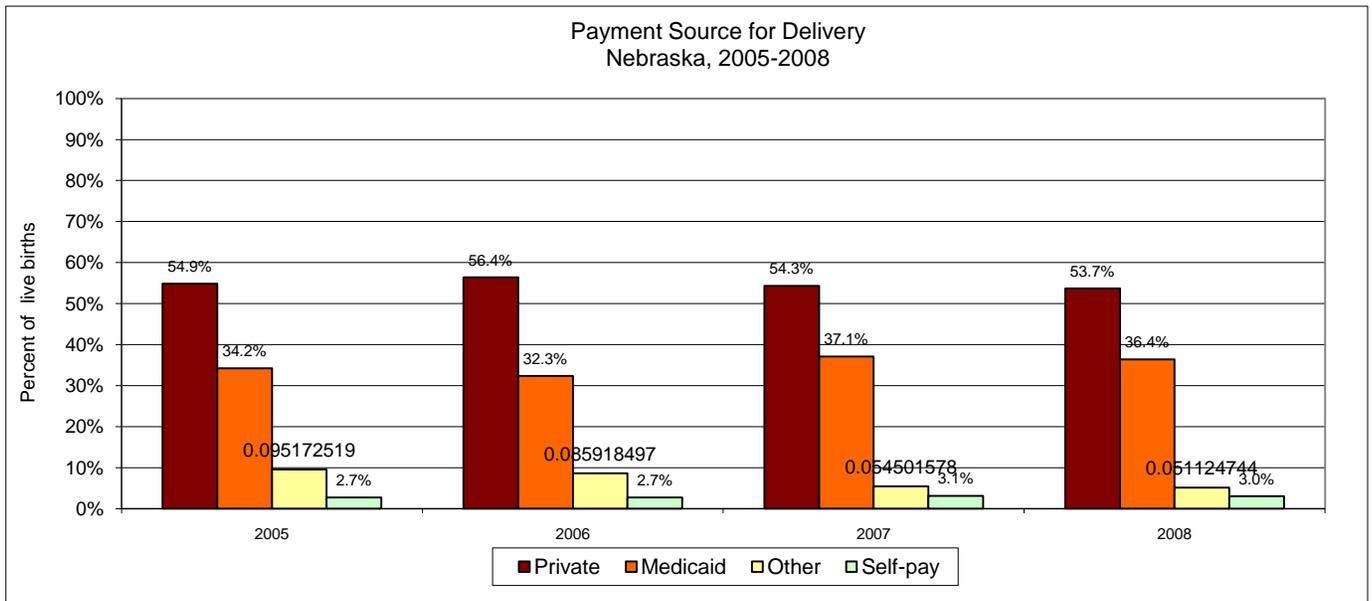
Payor

Definition: Payment source for delivery. This question was added to the Nebraska birth certificate in 2005, and may be subject to reporting errors.

Data Source: Nebraska Vital Records

	Medicaid			Private		
	Number	%	Nebraska rate is...	Number	%	Nebraska rate is...
Nebraska (2008)	9,790	36.4%		14,431	53.7%	
United States	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	-	-		-	-	

Graphical Display of Data:



5-Year Trends

Private insurance	N.L.C.
Medicaid	N.L.C.
Other sources	DECREASING
Self-pay	N.L.C.

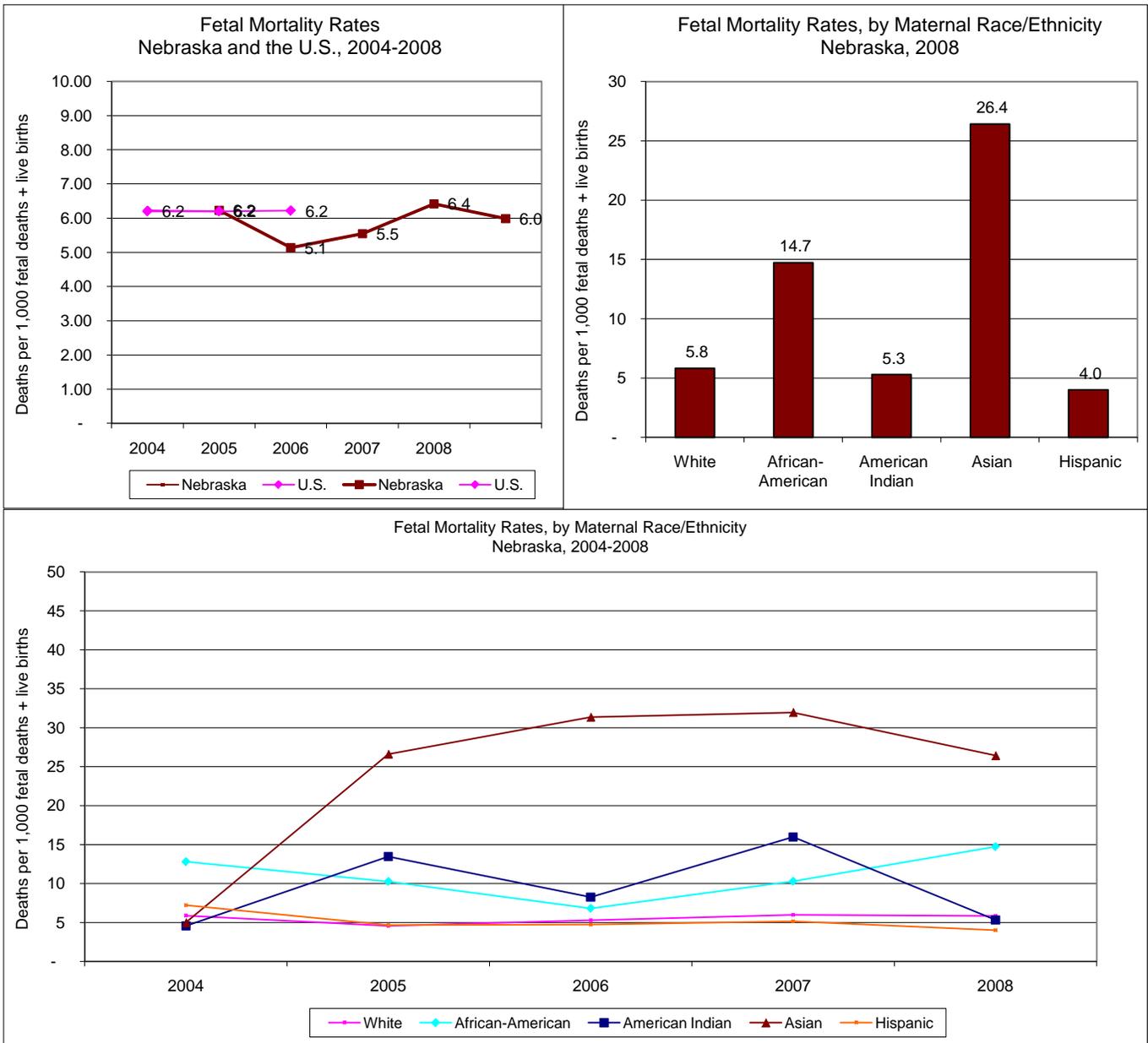
Data Sheet: Mortality

Fetal Mortality Rate

Definition: The rate of fetal deaths per 1,000 live births + fetal deaths

Data Source: Nebraska Vital Records

	Fetal Mortality		
	Number	Rate	Nebraska rate was...
Nebraska (2008)	162	6.0	Lower
United States (2005)	25,894	6.2	Higher
HP 2010 Objective	4.1		
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	YES		



Data Sheet: Mortality

Perinatal Mortality Rates

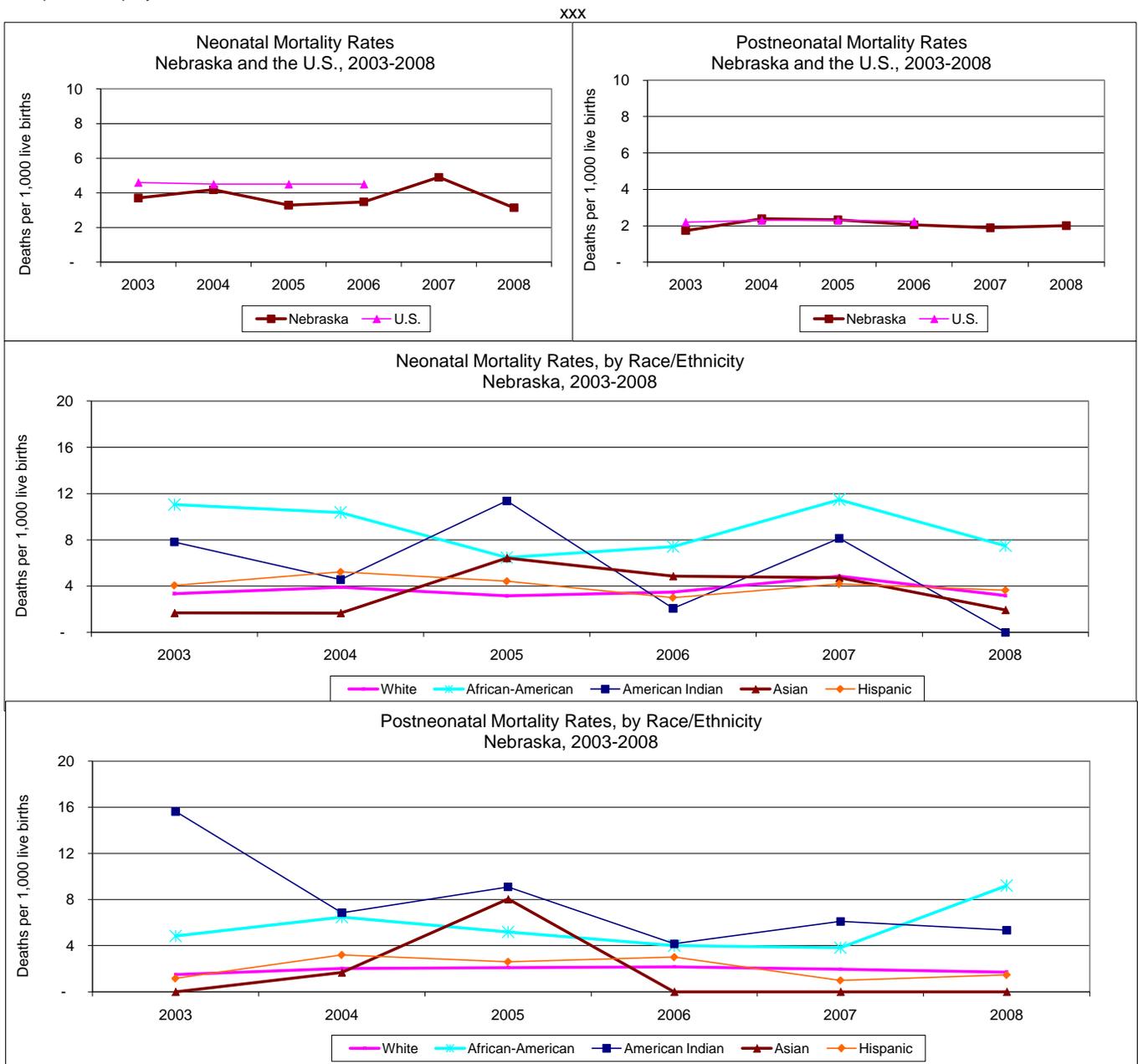
Definition: The number and rate of neonatal deaths (0-28 days), per 1,000 live births
 The number and rate of post-neonatal deaths (29-364 days), per 1,000 live births

Data Source: Nebraska Vital Records

	Neonatal Death			Postneonatal Death		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	83	3.15	was...	53	2.01	was...
United States (2006)	19,195	4.50	Lower	9,555	2.24	N.S.D.
HP 2010 Objective	2.9		N.S.D.	1.2		Higher
Nebraska 5-year trend*	N.L.C.			DECREASING		
NE Racial / Ethnic Disparities?	NO			YES		

*Race/ethnicity-specific trends in postneonatal death are not significant.

Graphical Display of Data:



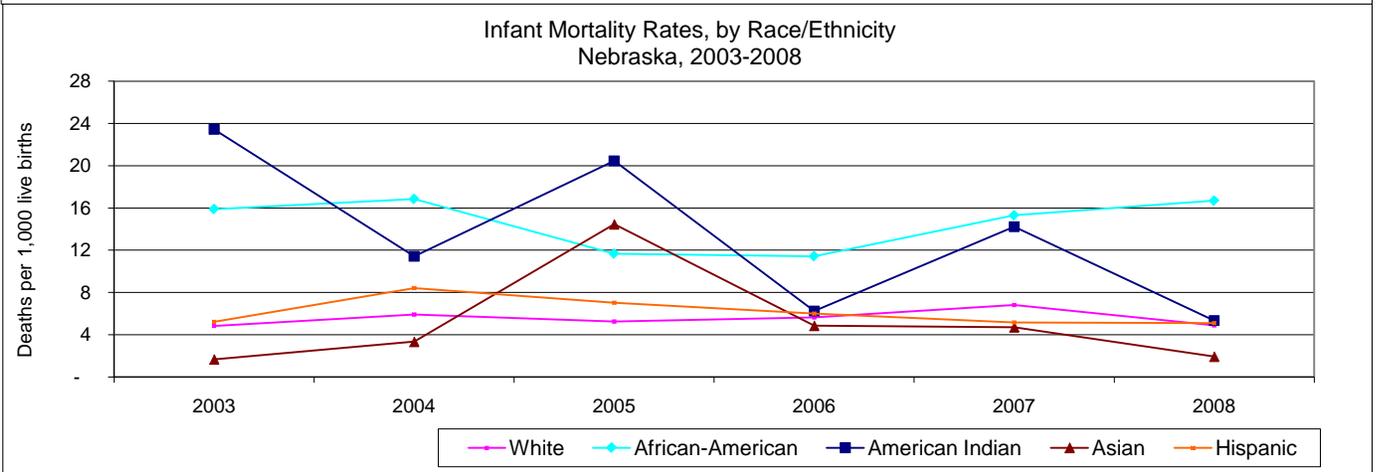
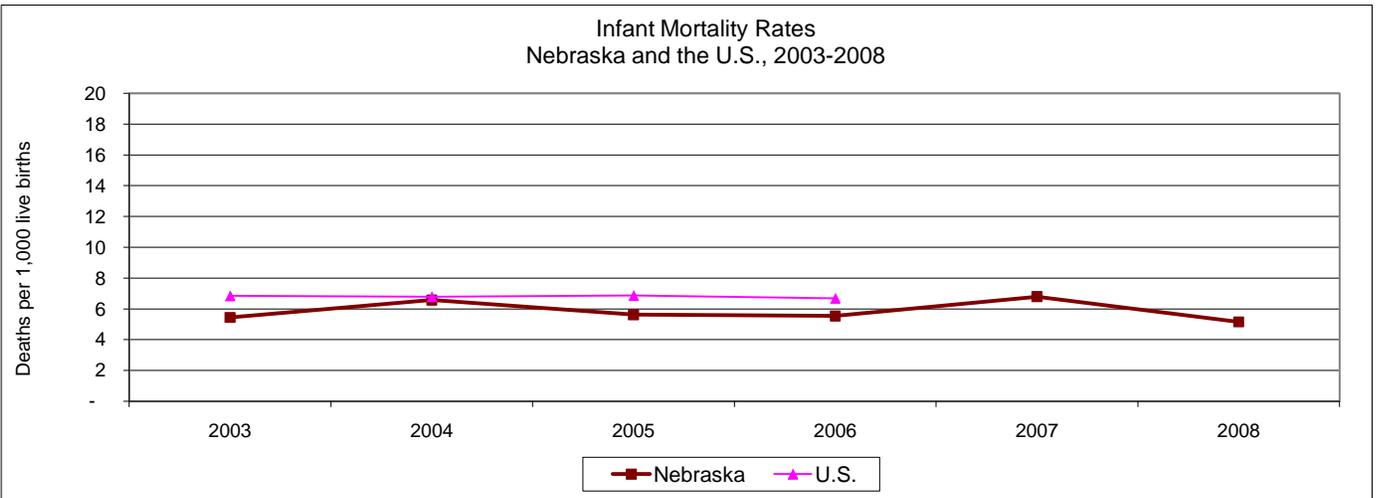
Data Sheet: Mortality

Perinatal and Infant Mortality Rates

Definition: The number and rate of infant deaths (0-364 days), per 1,000 live births

Data Source: Nebraska Vital Records

	Infant Death		
	Number	Rate	Nebraska rate was...
Nebraska (2008)	136	5.2	Lower
United States (2006)	28,537	6.7	Higher
HP 2010 Objective	4.5		
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	YES		



	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	DECREASING

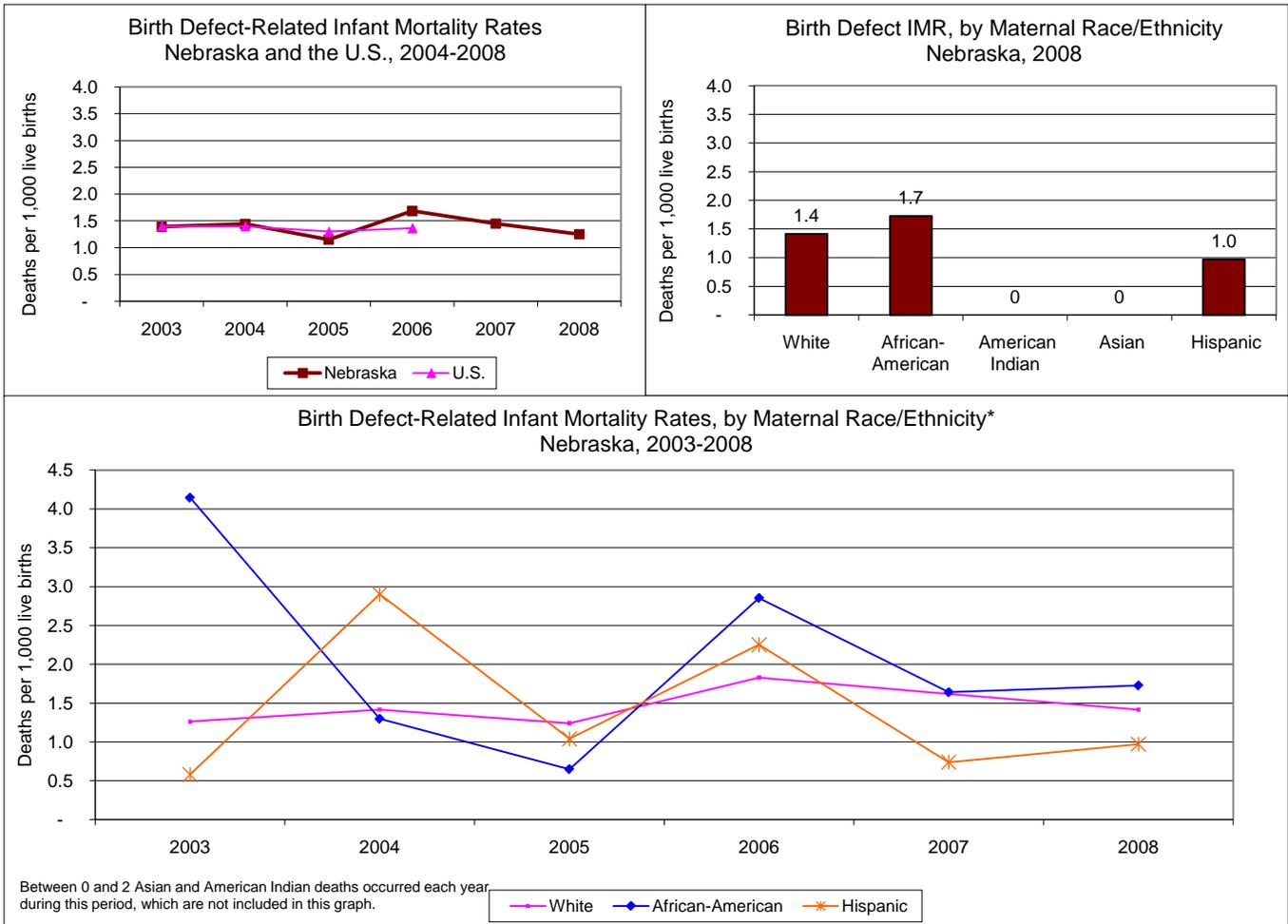
Data Sheet: Mortality

Infant Mortality Rates - Birth Defects

Definition: The number and rate of infant deaths (0-364 days) due to birth defects, per 1,000 live births

Data Source: Nebraska Vital Records

	Birth Defects		Nebraska rate was...
	Number	Rate	
Nebraska (2008)	33	1.25	N.S.D.
United States (2006)	5,819	1.36	N.S.D.
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	NO		



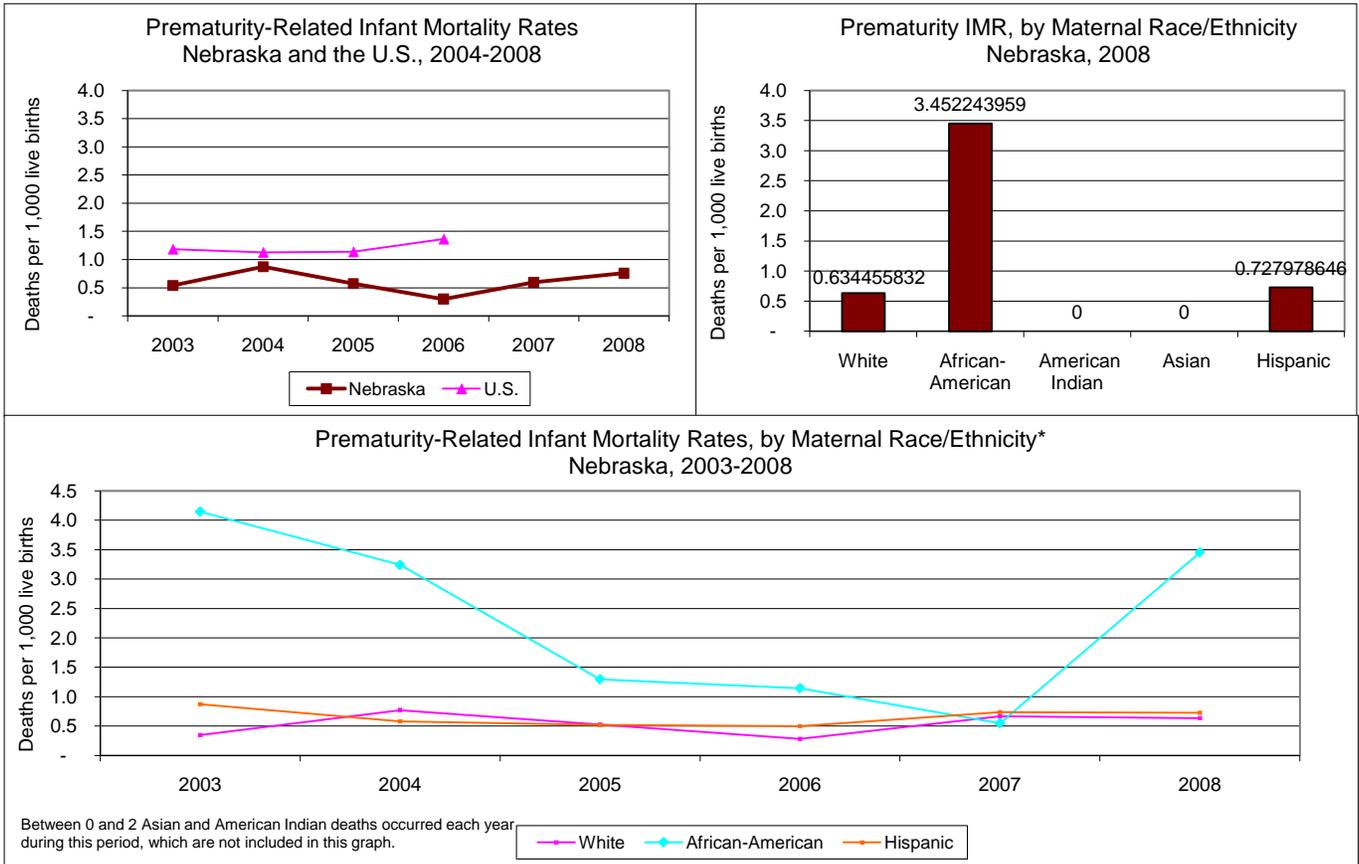
Data Sheet: Mortality

Infant Mortality Rates - Prematurity

Definition: The number and rate of infant deaths (0-364 days) due to disorders related to prematurity (<37 weeks gestation), per 1,000 live births

Data Source: Nebraska Vital Records

	Prematurity		
	Number	Rate	Nebraska rate was...
Nebraska (2008)	20	0.76	Lower
United States (2006)	4,841	1.13	Lower
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	NO		



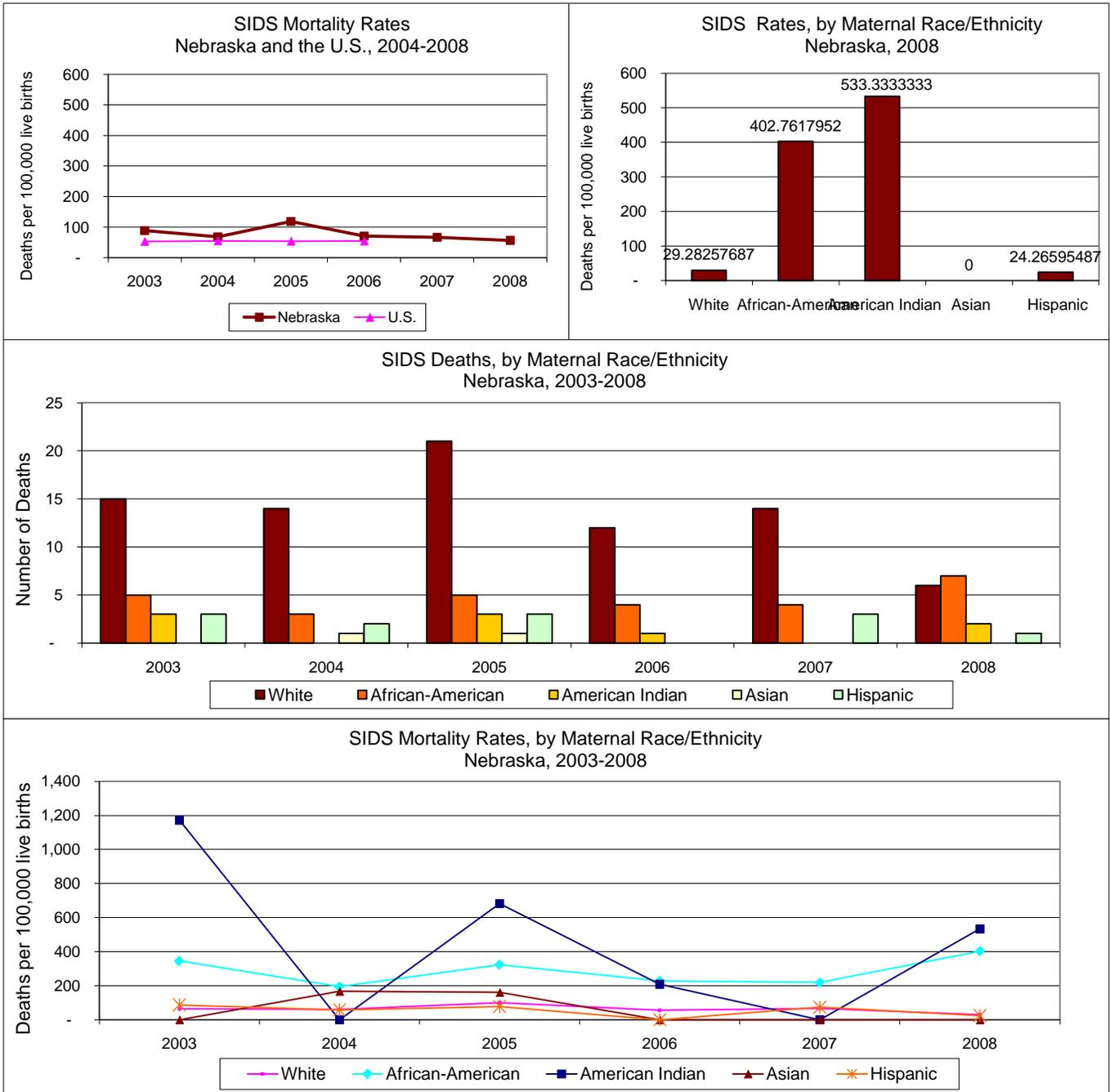
Data Sheet: Mortality

Infant Mortality Rates - SIDS

Definition: The number and rate of infant deaths (0-364 days) due to SIDS (Sudden Infant Death Syndrome), per 100,000 live births

Data Source: Nebraska Vital Records

	Sudden Infant Death Syndrome		Nebraska rate was...
	Number	Rate	
Nebraska (2008)	15	56.8	N.S.D.
United States (2006)	2,323	54.5	Higher
HP 2010 Objective	25.0		
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	YES		



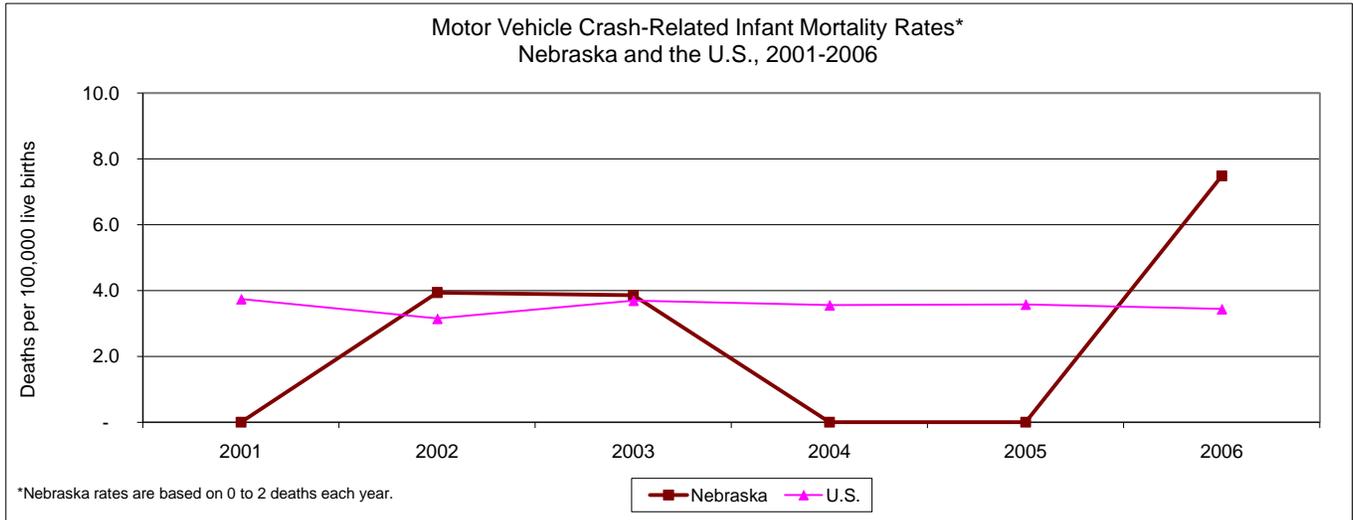
Data Sheet: Mortality

Infant Mortality Rates - MVC

Definition: The number and rate of infant deaths (0-364 days) due to motor vehicle crashes, per 100,000 live births

Data Source: Nebraska Vital Records

	Motor Vehicle Crashes		
	Number	Rate	Nebraska rate was...
Nebraska (2006)	2	0.07	N.S.D.
United States (2006)	142	0.03	N.S.D.
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	-	-	-



Data Sheet: Health Status

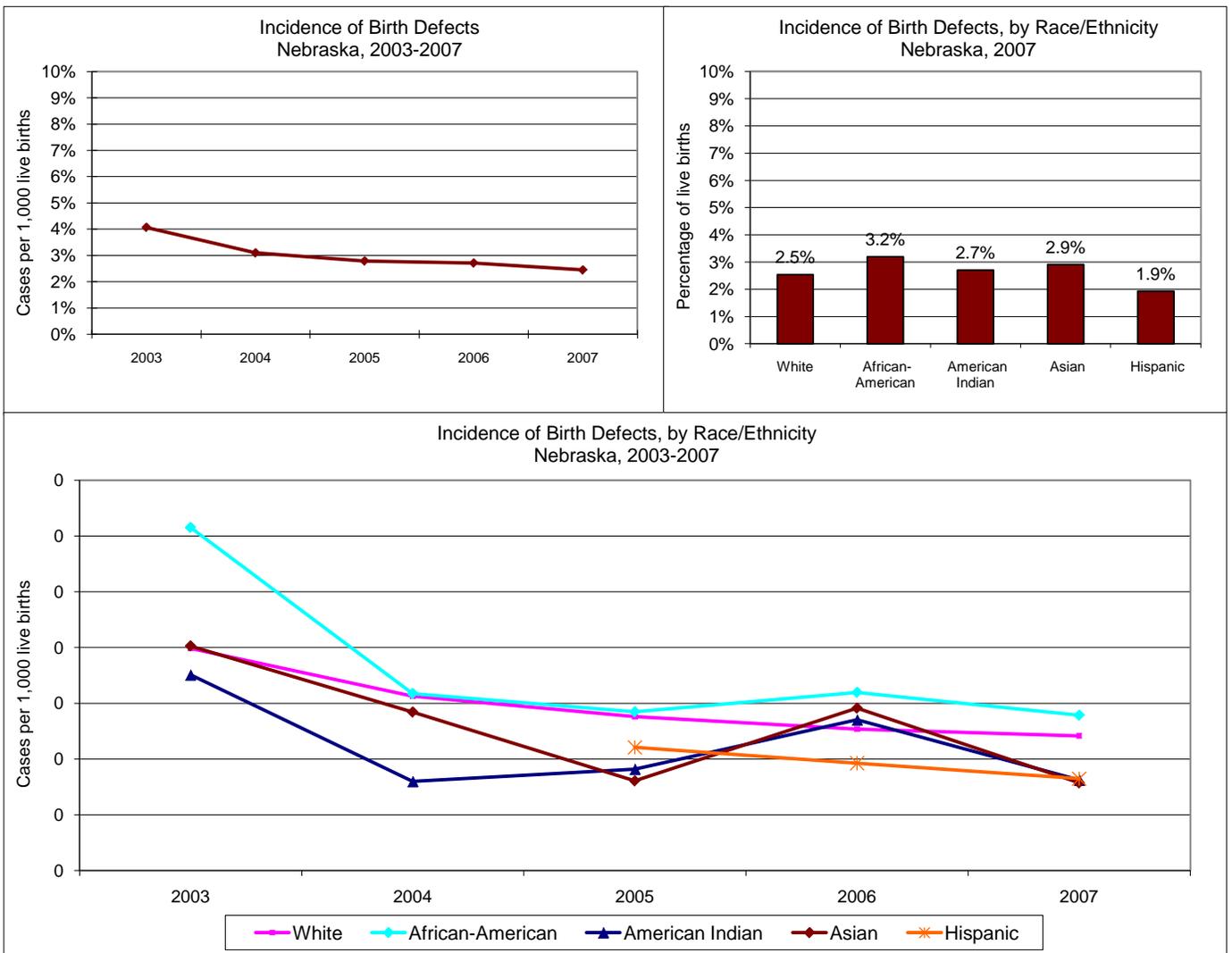
The percentage of births with one or more diagnosed birth defects

Definition: The number and percent of births with one or more congenital defects diagnosed by age 1, per 100 live births

Data Source: Nebraska Birth Defects Registry

1+ Birth Defects			Nebraska rate was...
	Number	%	
Nebraska (2007)	659	2.45%	
United States	-	-	-
HP 2010 Objective	-	-	-
Nebraska 5-year trend	DECREASING		
NE Racial / Ethnic Disparities?	YES		

Graphical Display of Data:



	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	DECREASING

Data Sheet: Health Status

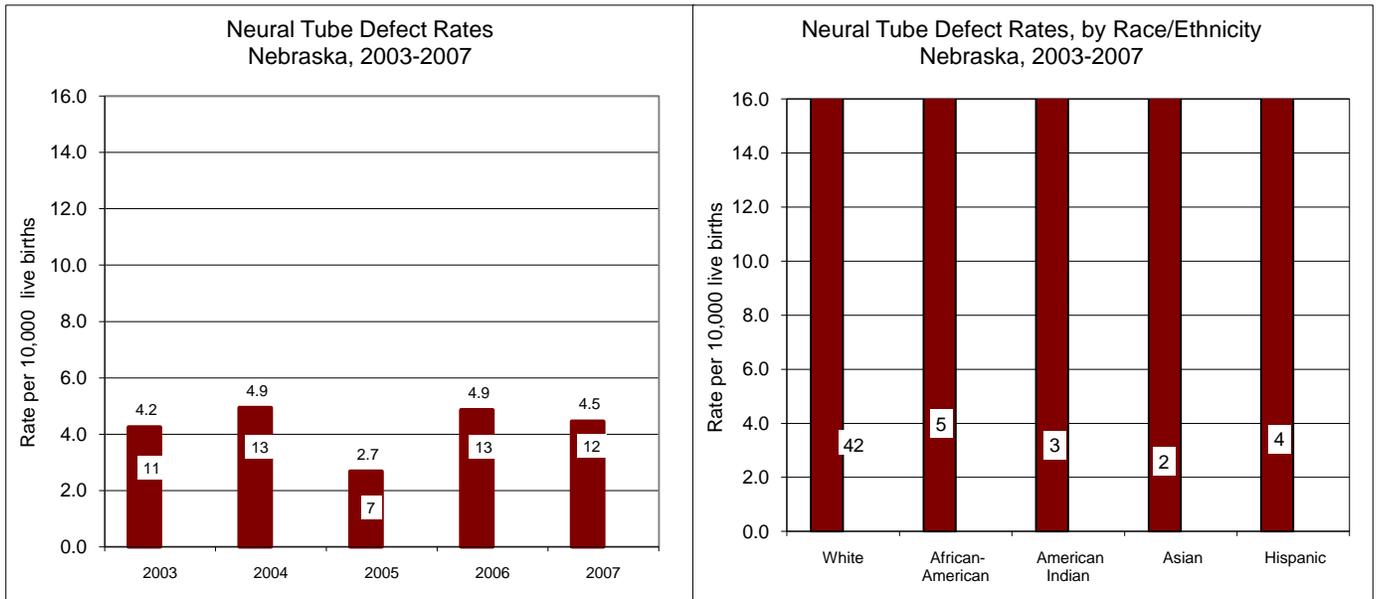
Neural Tube Defects

Definition: Rate of live births with neural tube defects, per 10,000 live births

Data Source: Nebraska Birth Defects Registry

NTDs			Nebraska rate was...
	Number	rate	
Nebraska (2007)	12	4.5	-
United States (2006)	-	-	
HP 2010 Objective	3.0		N.S.D.
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	NO		

Graphical Display of Data:



Data Sheet: Health Status

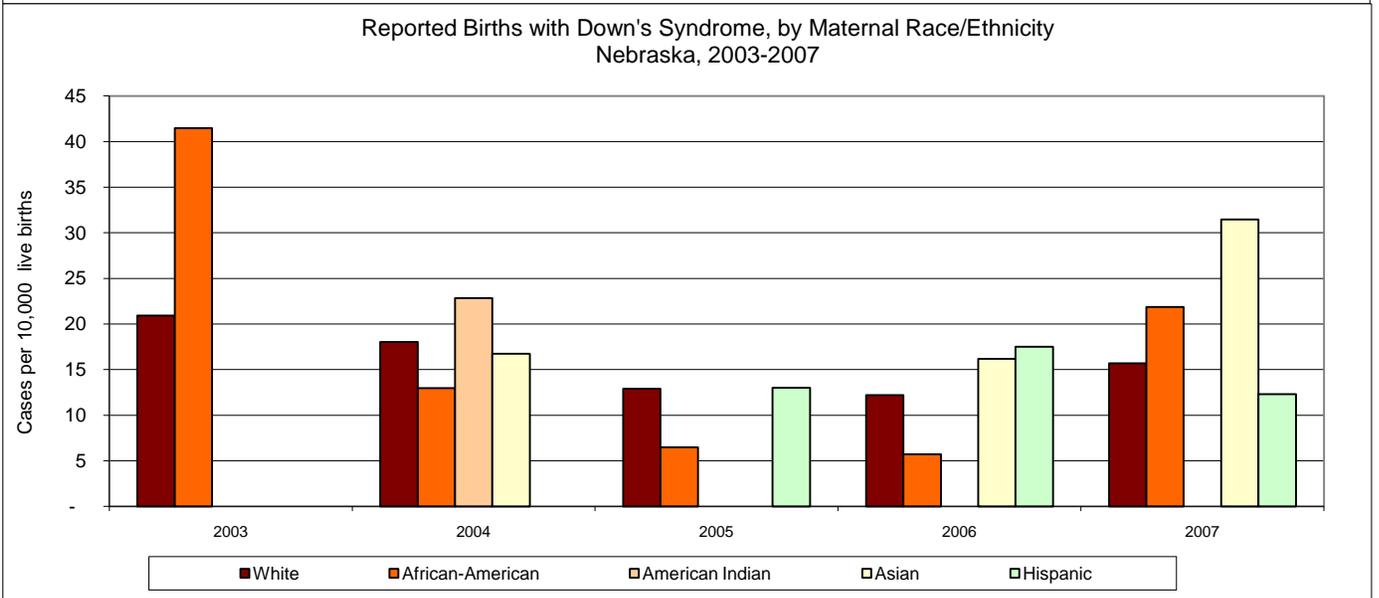
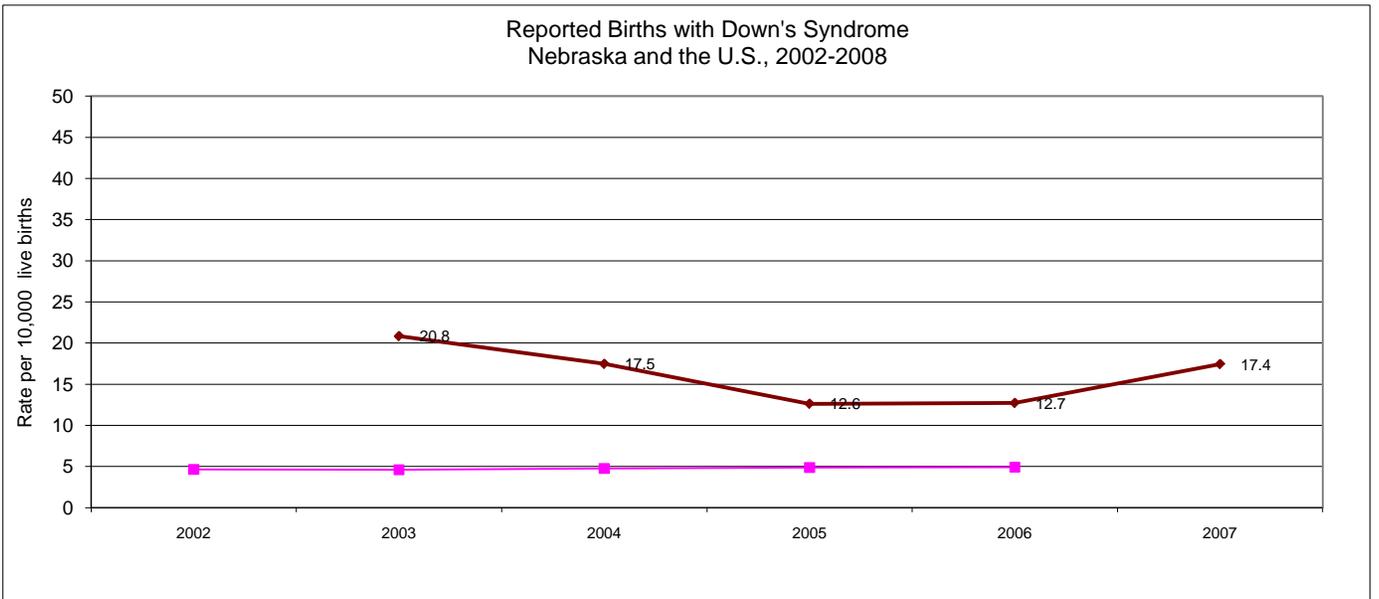
Down Syndrome

Definition: Infants reported with Down's Syndrome, per 10,000 live births

Data Source: Nebraska Birth Defects Registry

Down Syndrome			
	Number	rate	Nebraska rate was...
Nebraska (2007)	34	12.7	Higher
United States (2006)	2,085	4.9	
HP 2010 Objective	-		-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	NO		

Graphical Display of Data:



Data Sheet: Health Status

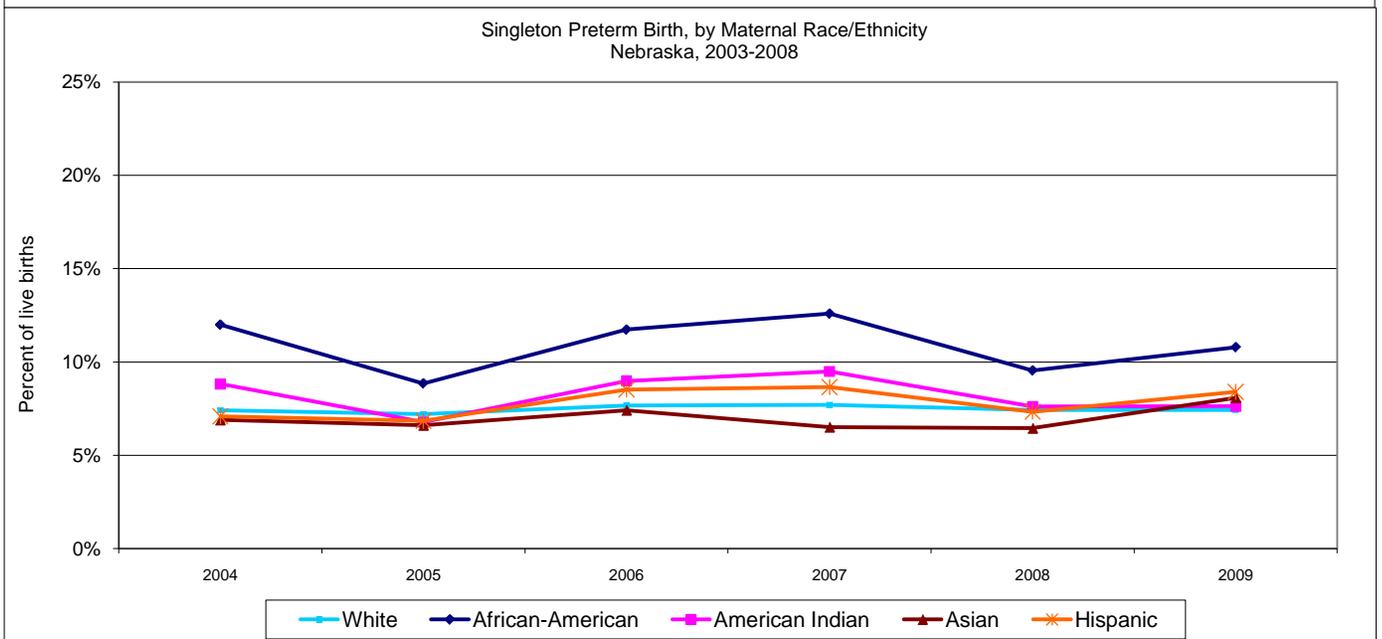
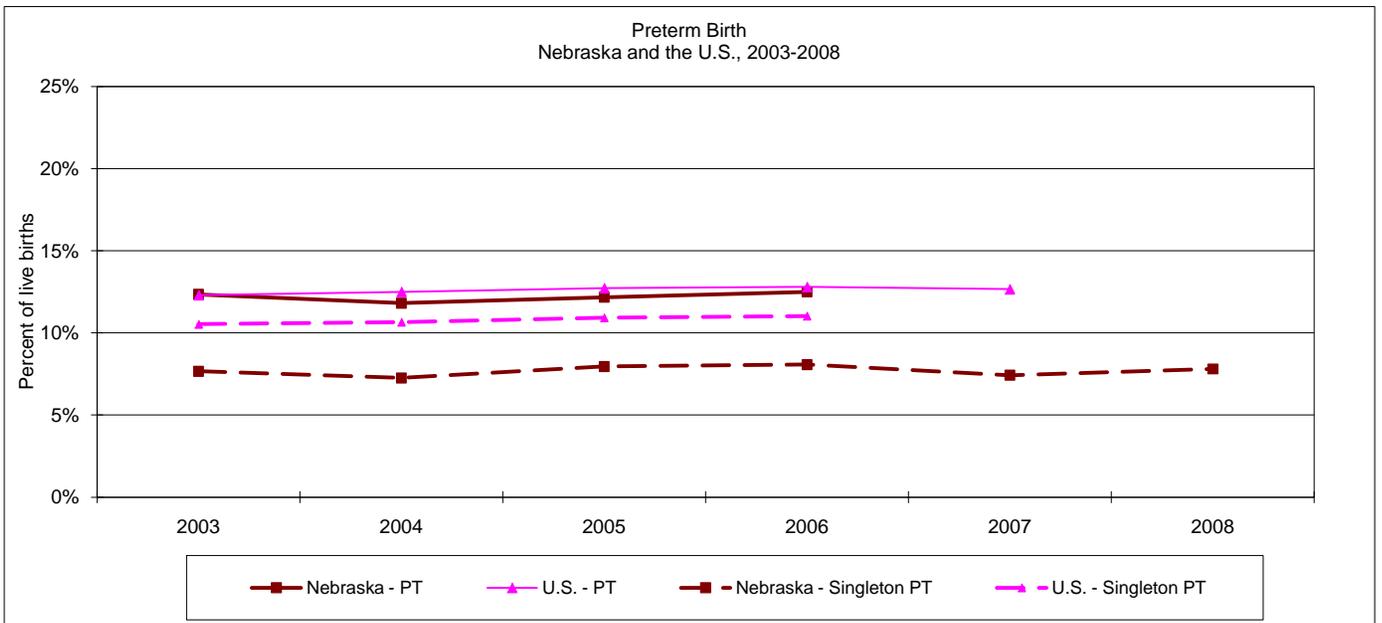
Preterm birth

Definition: The number and percentage of preterm births (<37 weeks gestation)
 The number and percentage of *singleton* preterm births (<37 weeks gestation)

Data Source: Nebraska Vital Records

	Preterm			Singleton Preterm		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2006)	3,084	11.9%		1,989	7.8%	
United States (2006)	546,547	12.7%	Lower	454,583	11.0%	Lower
HP 2010 Objective	7.6%		Higher	-		-
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES		

Graphical Display of Data:



Data Sheet: Health Status

Low and very low birth weight

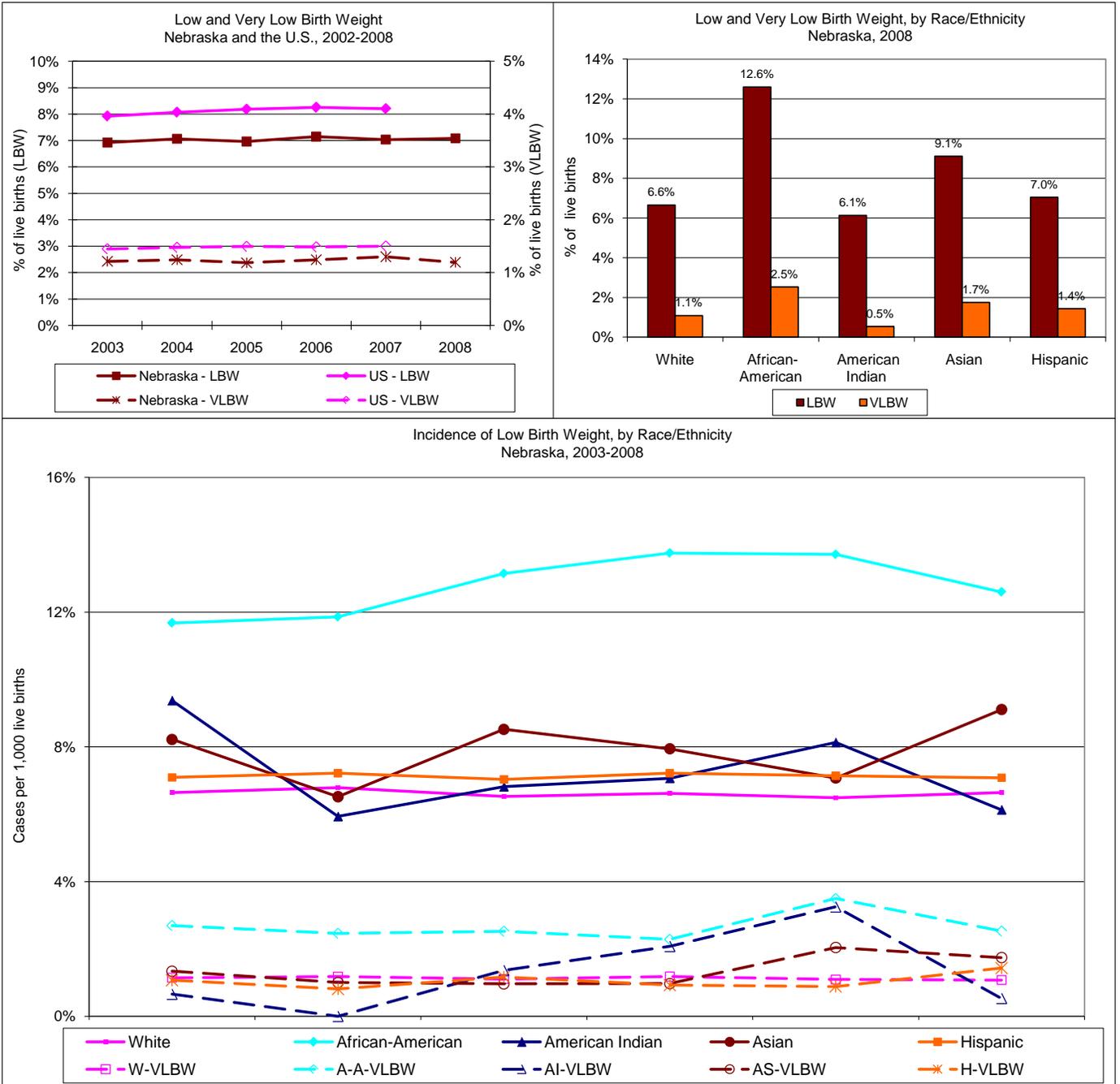
Definition: The number and rate of low birth weight infants (<2500 g) per 100 live births
 The number and rate of very low birth weight infants (<1500 g) per 100 live births

Data Source: Nebraska Vital Records

	Low birth weight			Very low birth weight		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	1,869	7.1%	was...	315	1.2%	was...
United States (2007)	354,004	8.2%	Lower	64,757	1.5%	Lower
HP 2010 Objective	5%		Higher	1%		Higher
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES		

XXX

Graphical Display of Data:



Data Sheet: Health Status

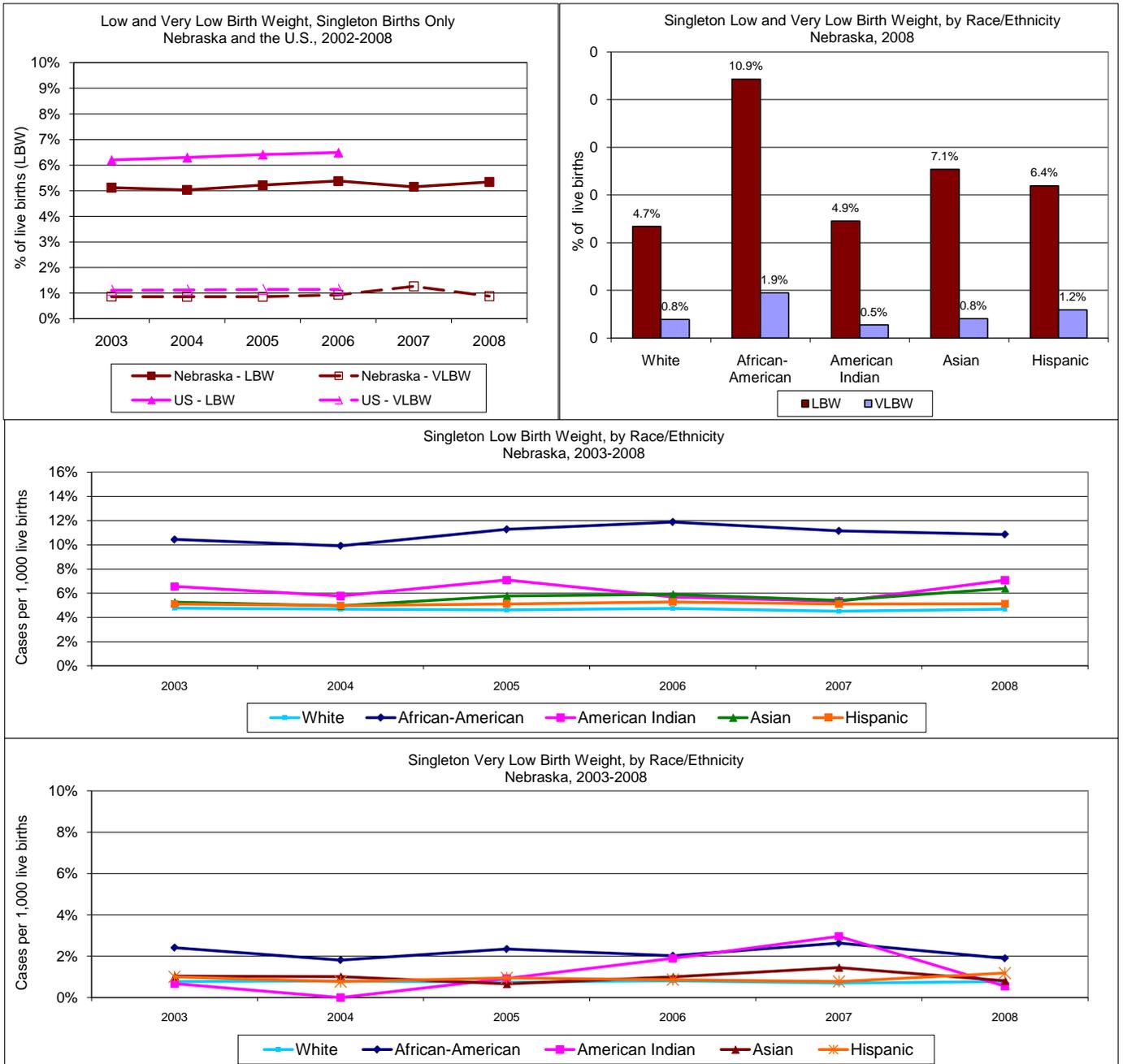
Low and very birth weight - Singletons

Definition: The number and rate of low birth weight singleton infants (<2500 g) per 100 singleton live births
 The number and rate of very low birth weight singleton infants (<1500 g) per 100 singleton live births

Data Source: Nebraska Vital Records

	Low birth weight			Very low birth weight		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	1,359	5.4%		223	0.9%	
United States (2006)	267,218	6.5%	Lower	46,961	1.1%	Lower
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES		

Graphical Display of Data:



Data Sheet: Health Status

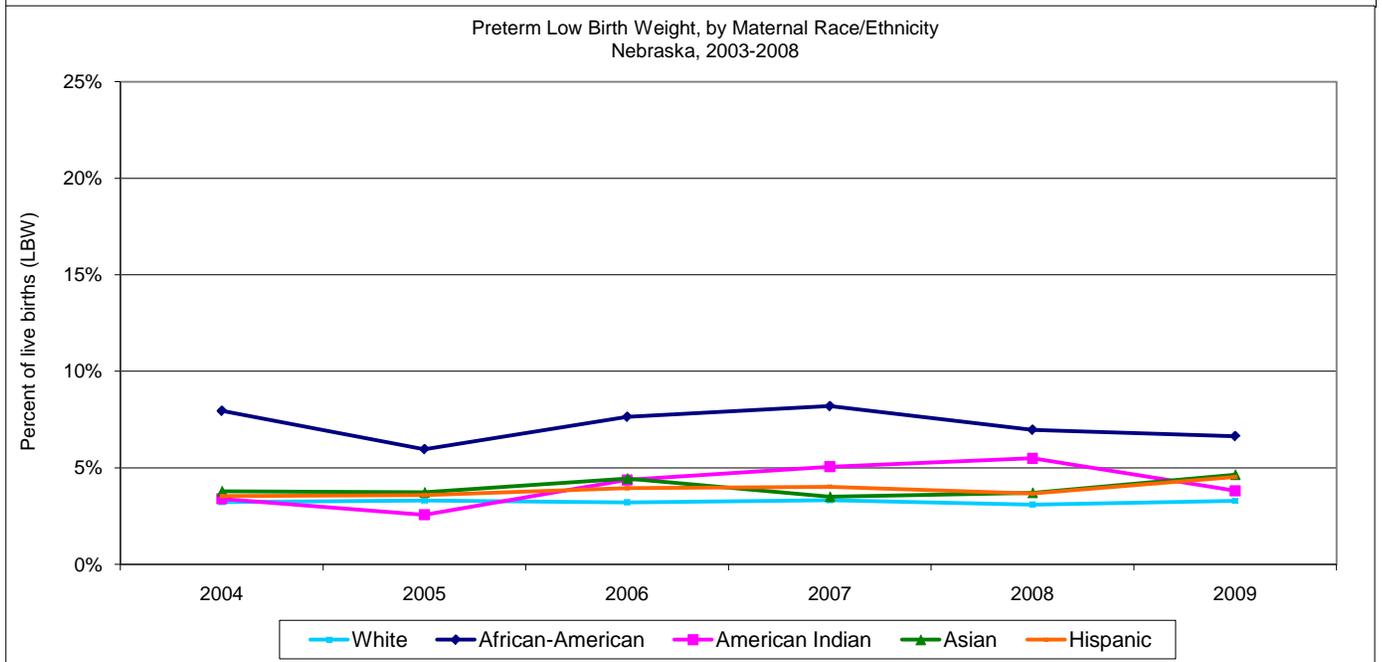
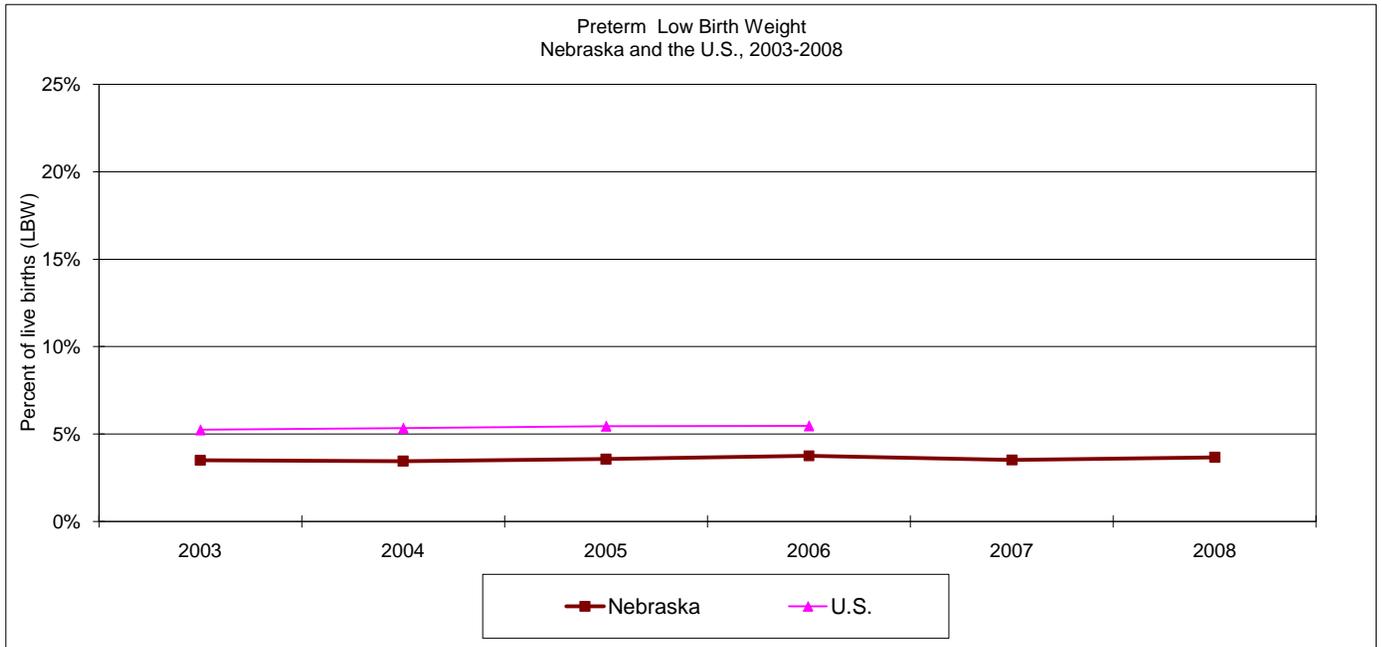
Preterm / Low Birth Weight Birth

Definition: The number and percentage of low birth weight births that are also preterm (<2500 grams & <37 weeks gestation)

Data Source: Nebraska Vital Records

	Preterm		Nebraska rate was...
	Number	%	
Nebraska (2008)	936	3.7%	Lower
United States (2006)	233,497	5.5%	
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	YES		

Graphical Display of Data:



Data Sheet: Child Abuse

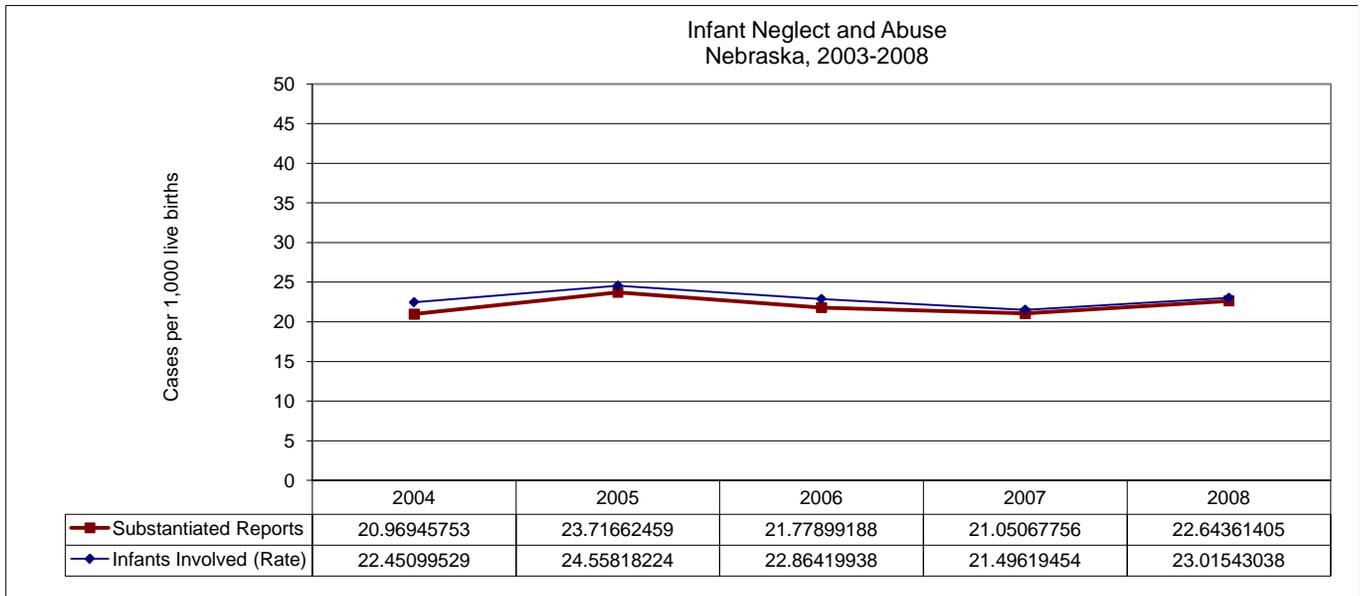
Child Abuse / Neglect

Definition: The number of infant neglect or abuse reports that were substantiated by Child Protective Services (CPS), per 1,000 infants
 The total number of infants involved in substantiated reports of abuse or neglect, per 1,000 infants

Data Source: Nebraska Vital Records

Data Source:	Substantiated Reports			Number of Infants Involved		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	609	22.6		619	23.02	
United States (2006)	-	-	-	-	-	-
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	-			-		

Graphical Display of Data:



Data Sheet: Health Care

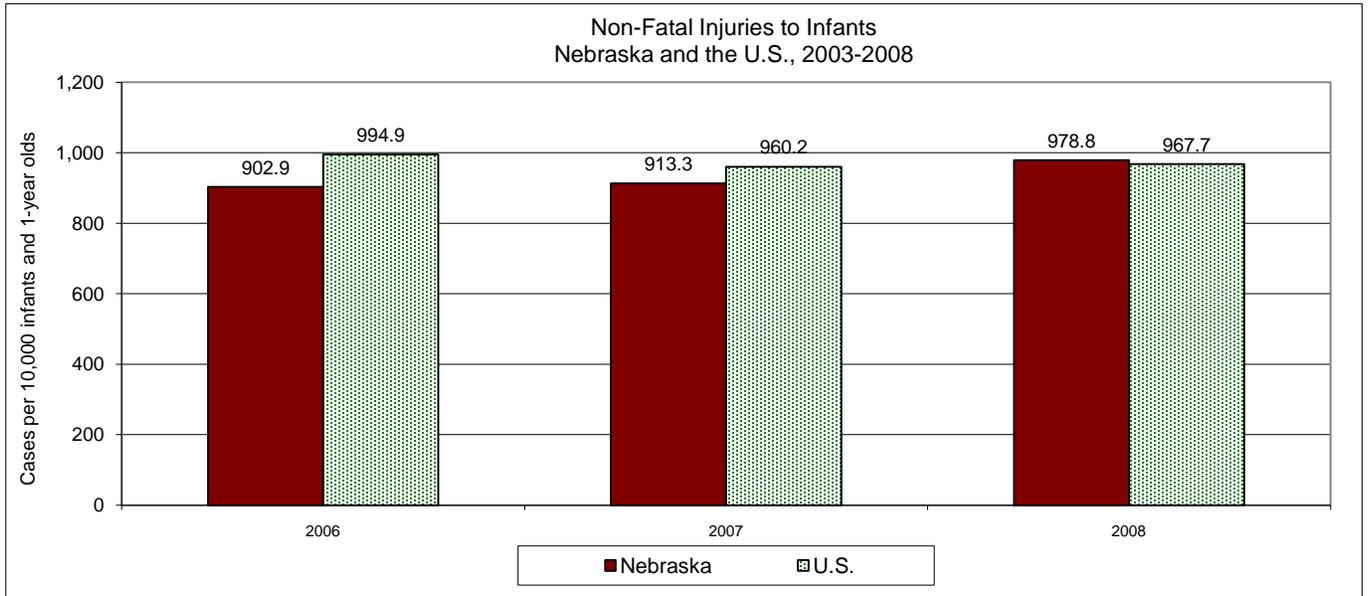
Non-fatal Injuries

Definition: The number and rate of non-fatal injuries, per 10,000 infants and 1-year olds

Data Source: Hospital Discharge Data

Non-fatal Injuries			
	Number	Rate	Nebraska rate was...
Nebraska (2008)	5,320	978.8	N.S.D.
United States (2008)	831,113	967.7	N.S.D.
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	-		

Graphical Display of Data:



Data Sheet: Health Care

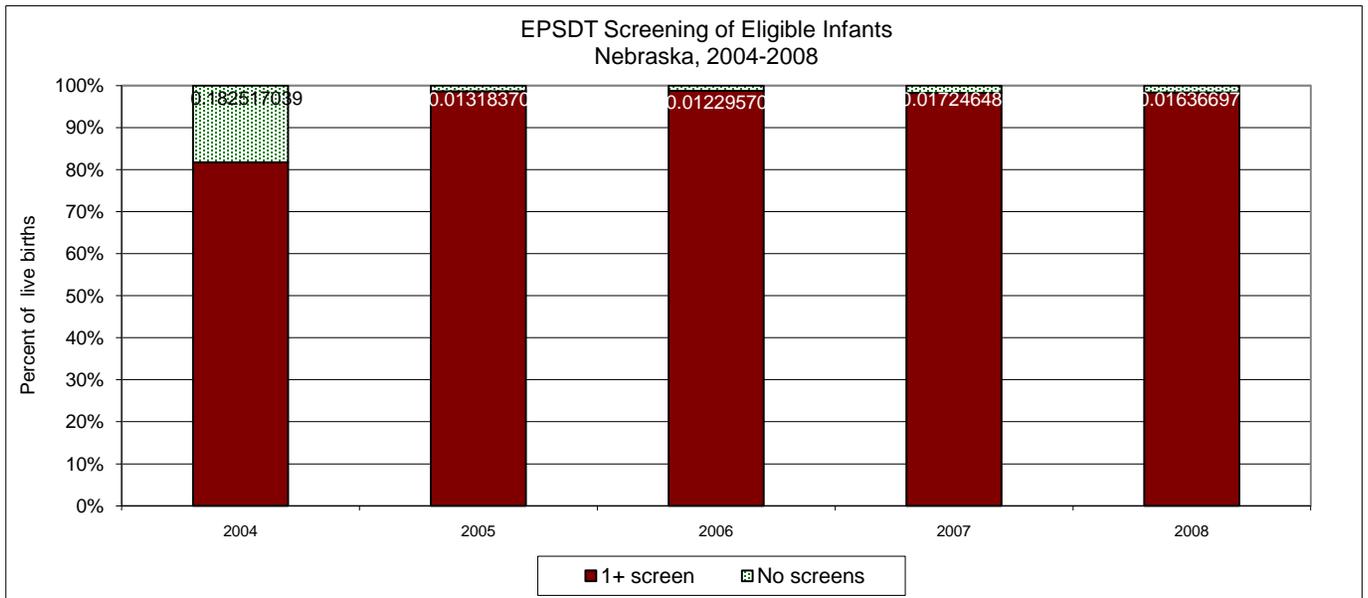
EPSDT Screening

Definition: The percentage of eligible infants receiving at least one initial or periodic health screen

Data Source: DHHS Medicaid Program

EPSDT Screening			
	Number	%	Nebraska rate is...
Nebraska (2008)	13,402	98.4%	
United States	-	-	-
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	-		

Graphical Display of Data:



Data Sheet: Health Care

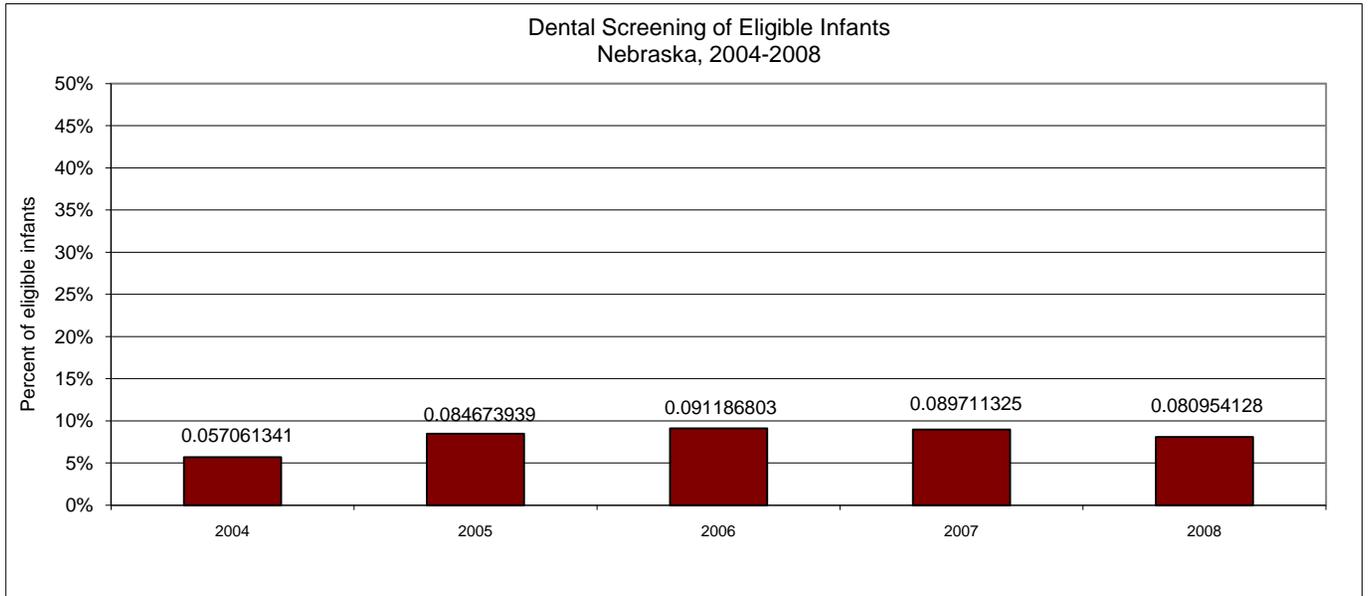
Dental Screening

Definition: The percentage of eligible infants receiving any dental services

Data Source: DHHS Medicaid Program

Dental Screening			
	Number	%	Nebraska rate is...
Nebraska (2008)	1,103	8.1%	
United States	-	-	-
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	-		

Graphical Display of Data:



Data Sheet: Health Care

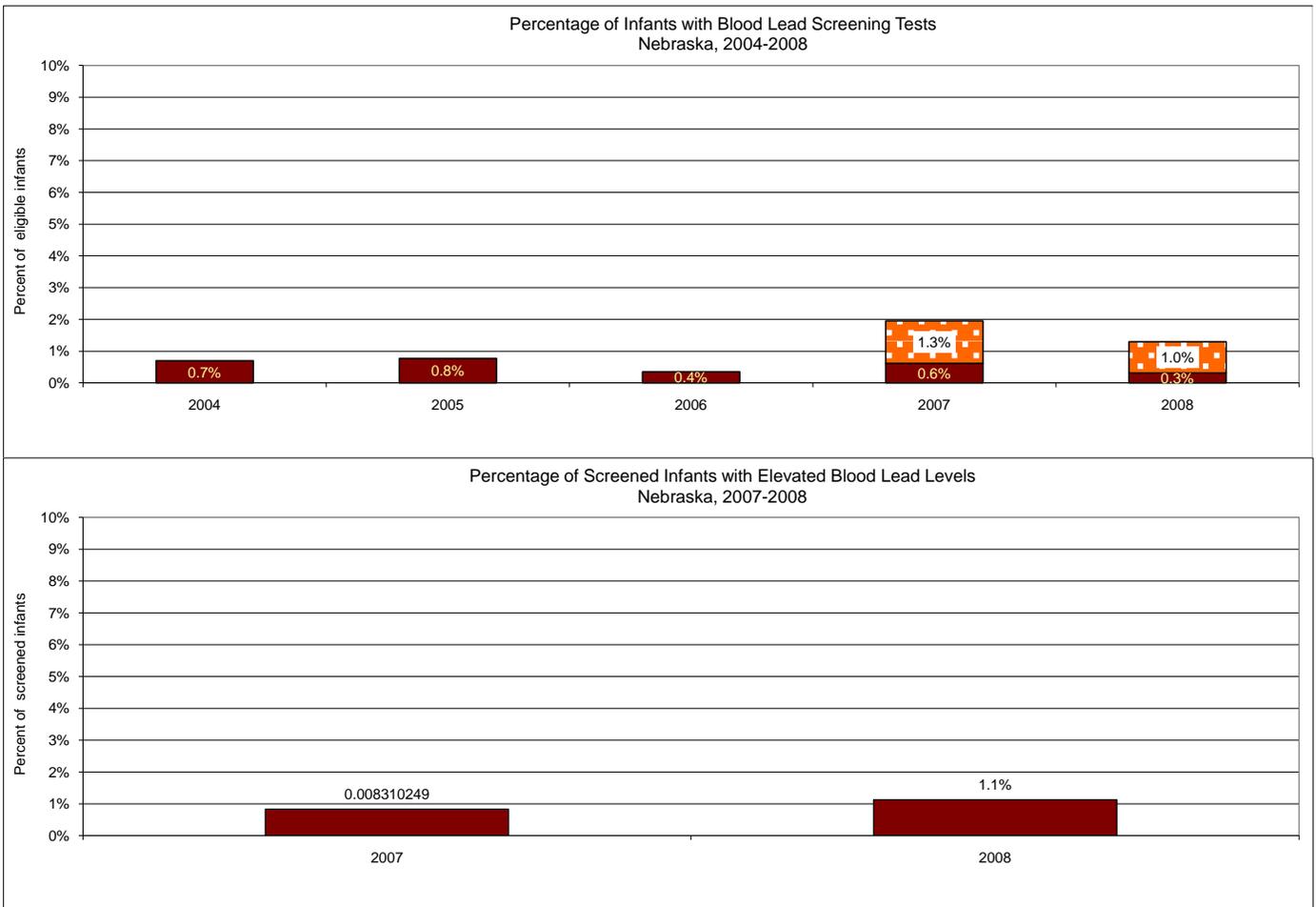
Infant blood lead screening

Definition: The number and percentage of EPSDT-eligible infants with blood lead screening tests
 The number and percentage of Nebraska infants with blood lead screening tests (DHHS EH)
 The number and percentage of screened infants with blood lead levels of 10+ (DHHS EH)

Data Source: Nebraska EPSDT Program
 DHHS Environmental Health Program

	Blood Lead Screening Tests			Elevated Blood Lead Levels		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska EPSDT (2008)	42	0.3%		-	-	
DHHS Environmental Health (2008)	265	0.99%		3	1.1%	
HP 2010 Objective		-			-	
5-Year Trend (EPSDT)		N.L.C.			-	
Racial / Ethnic Differences		-			-	

Graphical Display of Data:



Data Sheet: Health Care

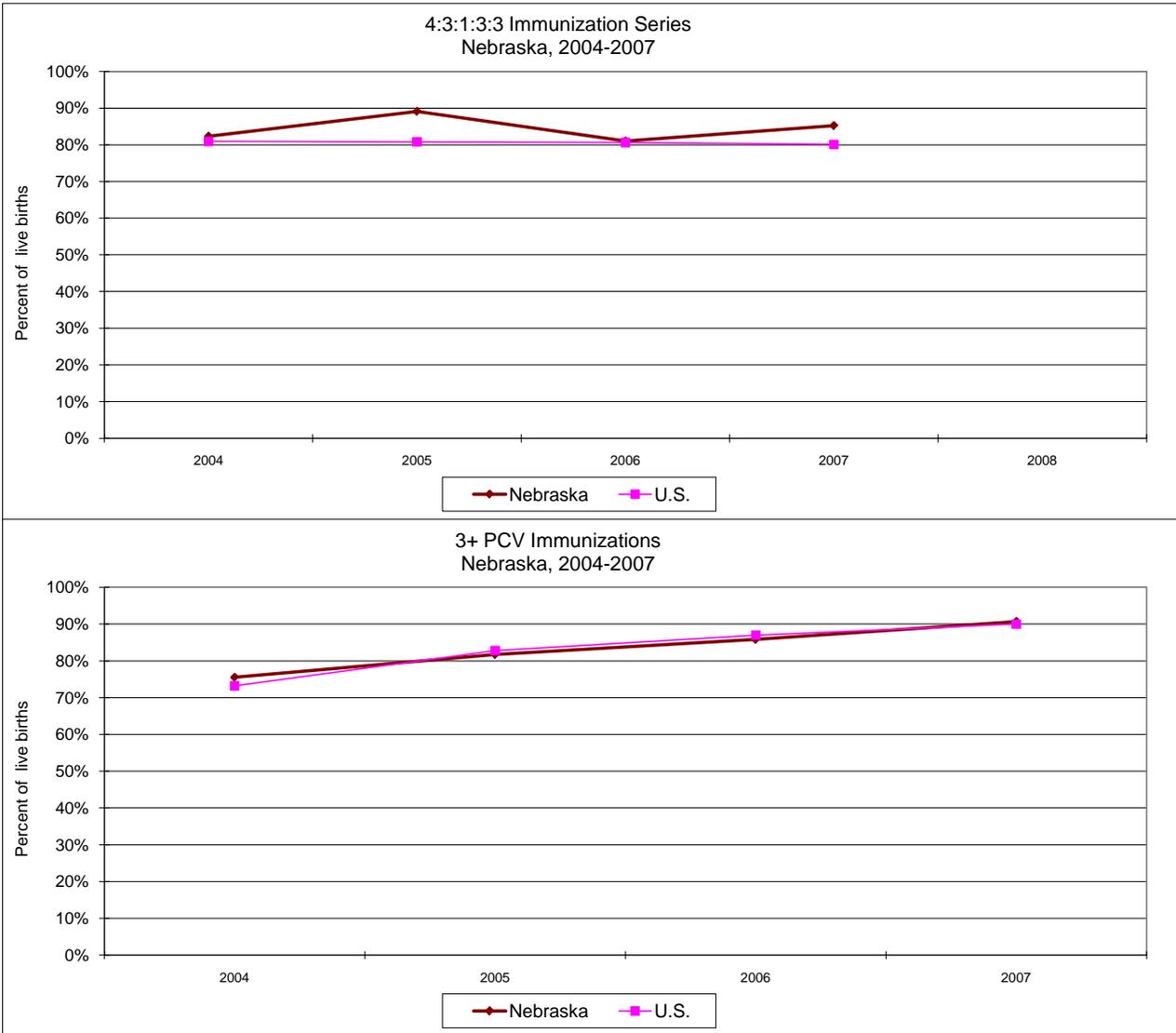
Immunizations

Definition: The percent of infants who went on to complete the 4:3:1:3:3 series of vaccinations by age 36 months
The percent of infants who received 3+ PCV

Data Source: CDC National Immunization Survey

	4:3:1:3:3			3+ PCV		
	Number	%	Nebraska rate is...	Number	%	Nebraska rate is...
Nebraska (2007)	22,949	85.2%		24,430	90.7%	
United States (2007)	3,458,012	80.1%	Higher	3,885,407	-	Higher
HP 2010 Objective	90%		Lower	-		Higher
Nebraska 5-year trend	N.L.C.			INCREASING		
NE Racial / Ethnic Disparities?	-			-		

Graphical Display of Data:



Other vaccination series that showed no linear change:

Series	% in 2007	Series	% in 2007	Series	% in 2007
4+ DTaP	87.8%	3+ HepB	96.9%	4:3:1 (2006)	83.2%
3+ Polio	95.9%	1+ Varicella (19-35 yr)	93.8%	4:3:1:3	85.2%
1+ MMR (19-35 m)	94.0%	4+ PCV	80.5%	4:3:1:3:3:1	82.9%
3+ Hib	96.0%				

Nebraska Title V 2010 Needs Assessment

Data Sheet: Health Care

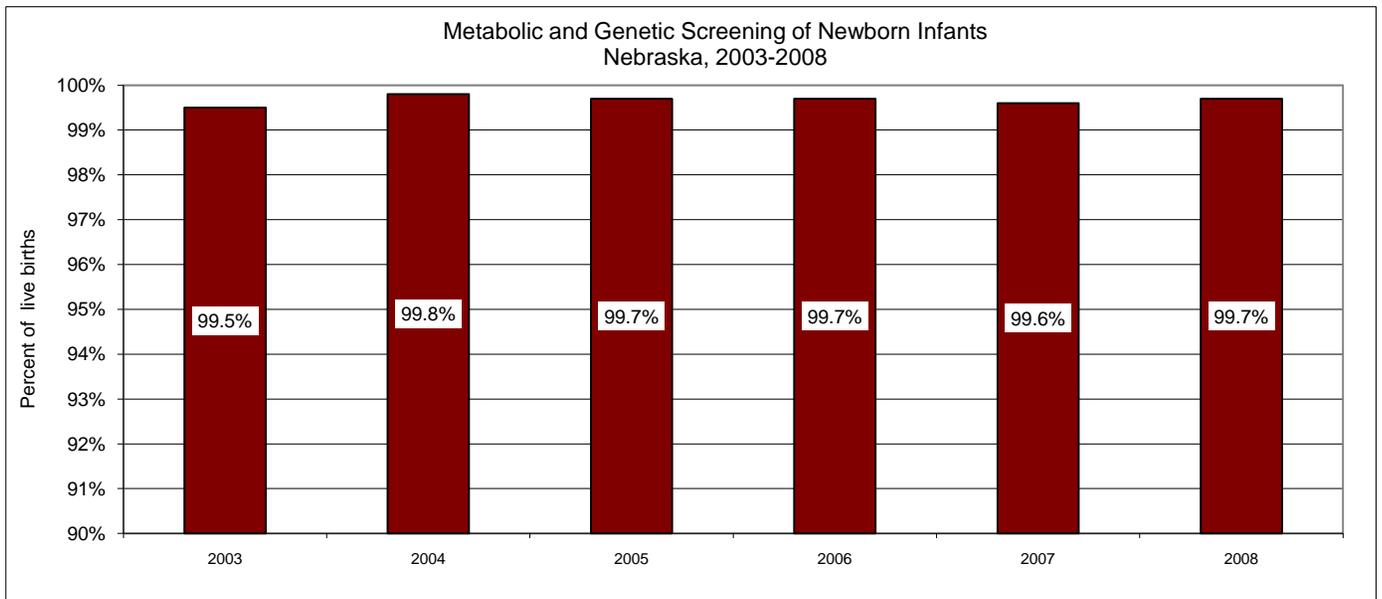
Newborn Screening

Definition: The number and percent of newborns screened according to state guidelines for genetic & metabolic disorders

Data Source: DHHS Newborn Screening Program

Newborn Metabolic Screening			
	Number	%	Nebraska rate is...
Nebraska (2008)	27,021	99.7%	
United States (2008)	4,295,879	99.6%	Higher
HP 2010 Objective	-	-	-
Nebraska 5-year trend	N.L.C.		
NE Racial / Ethnic Disparities?	-	-	

Graphical Display of Data:



Data Sheet: Health Care

Prenatal Care

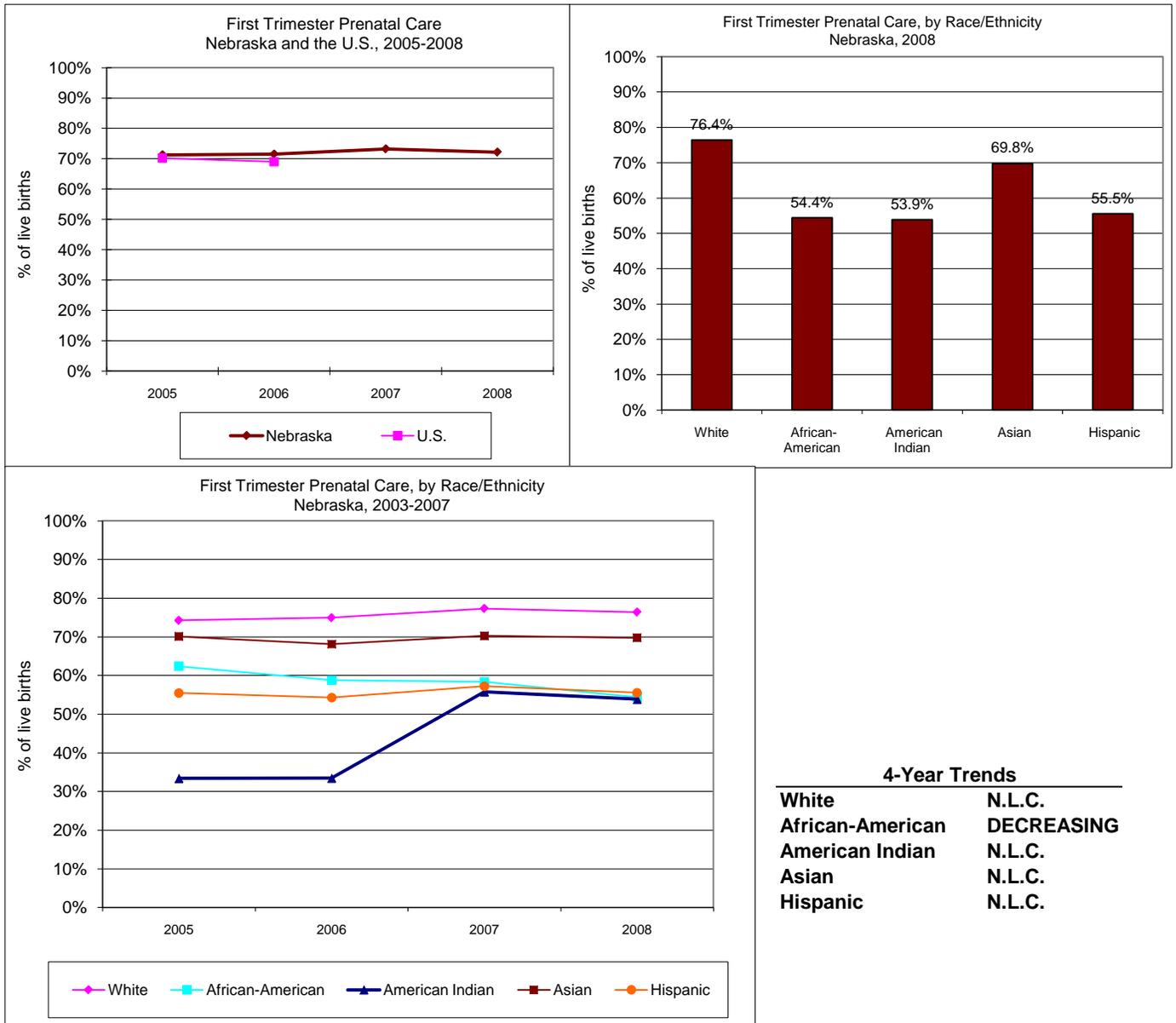
Definition: The number of infants whose mother obtained prenatal care during the first trimester, per 100 live births

Data Source: Nebraska Vital Records

	1st Trimester PNC		Nebraska rate is...
	Number	%	
Nebraska (2008)	19,051	72.2%	
United States (2006)	2,943,233	69.0%	Higher
HP 2010 Objective		90%	Lower
Nebraska 4-year trend*		N.L.C.	
NE Racial / Ethnic Disparities?		YES	

*States' changes to the birth certificate make timing of prenatal care information non-comparable to years before 2005.

Graphical Display of Data:



Data Sheet: Health Care

Adequacy of Prenatal Care

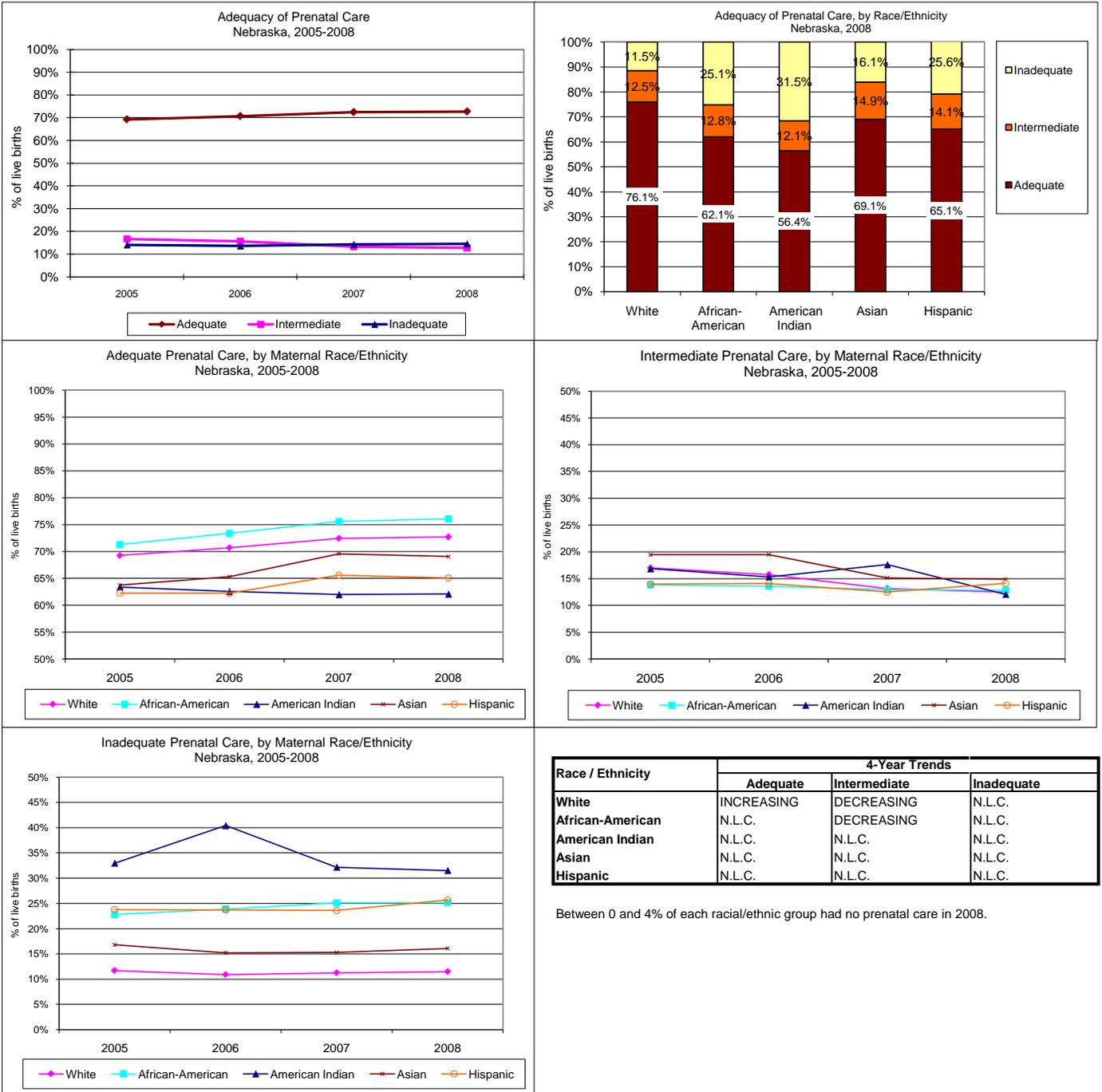
Definition: The number and percent of infants whose mother obtained specific levels of prenatal care, according to the Kotelchuck Index*

Data Source: Nebraska Vital Records

	Adequate PNC (>79.99%)			Intermediate PNC (50-80%)			Inadequate PNC (<50%)		
	Number	%	Nebraska rate is...	Number	%	Nebraska rate is...	Number	%	Nebraska rate is...
Nebraska (2008)	18,700	72.7%		3,286	12.8%		3,737	14.5%	
United States	-	-	-	-	-	-	-	-	-
HP 2010 Objective	90%			7%					
Nebraska 4-year trend**	INCREASING			DECREASING			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES			YES		

**States' changes to the birth certificate make timing of prenatal care information non-comparable to years before 2005.

Graphical Display of Data:



Data Sheet: Health Behavior

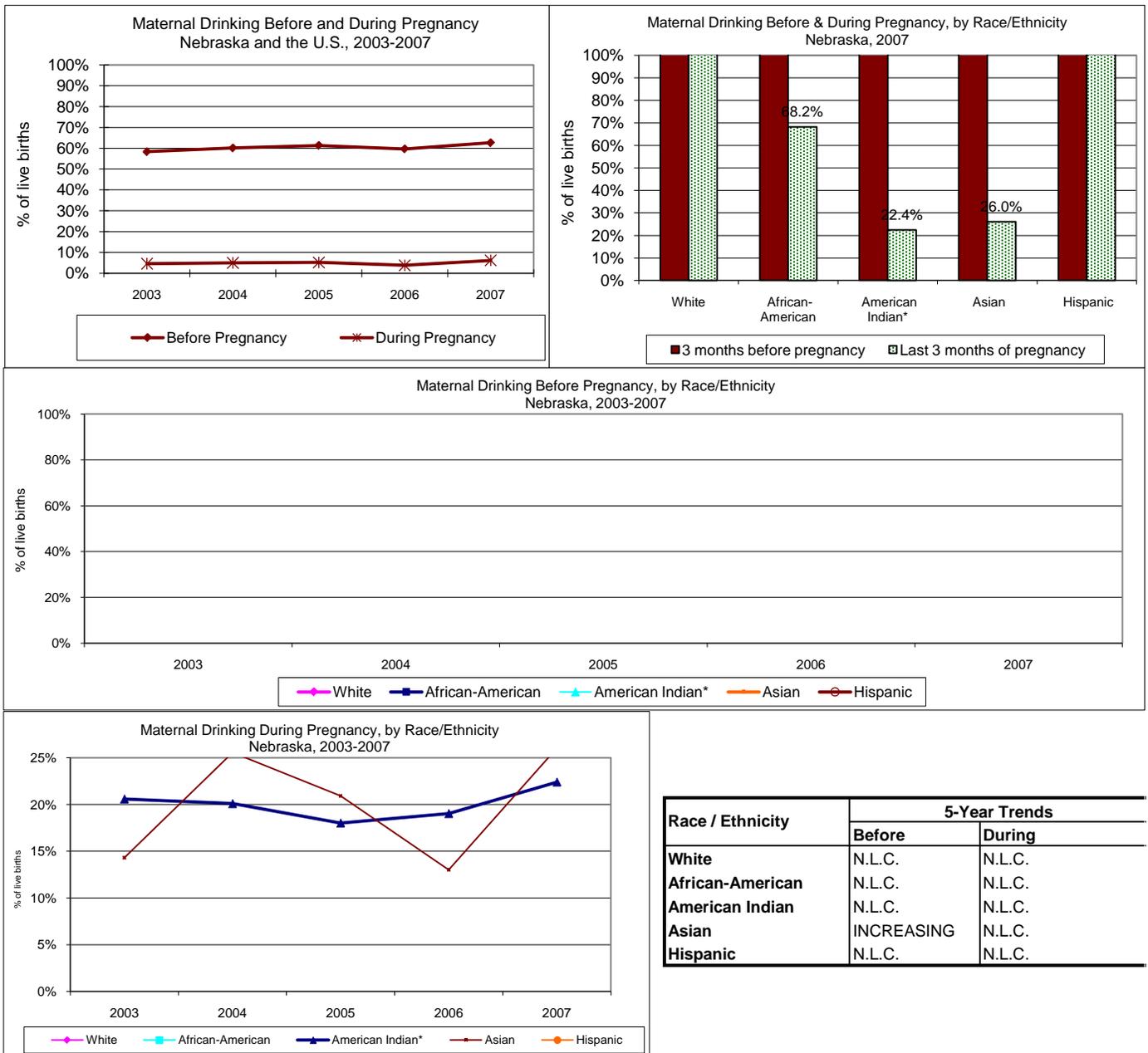
Maternal alcohol consumption

Definition: The percentage of infants whose mother drank alcohol 3 months before pregnancy
The percentage of infants whose mother drank alcohol during the last 3 months of pregnancy

Data Source: Nebraska PRAMS

	Alcohol before pregnancy		Nebraska rate is...	Alcohol last 3 months of pregnancy		Nebraska rate is...
	Number	%		Number	%	
Nebraska (2007)	15,562	62.6%		1,535	6.2%	
United States	-	-	-	-	-	-
HP 2010 Objective	-	-	-	6%	-	N.S.D.
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES		

Graphical Display of Data:



Data Sheet: Health Behavior

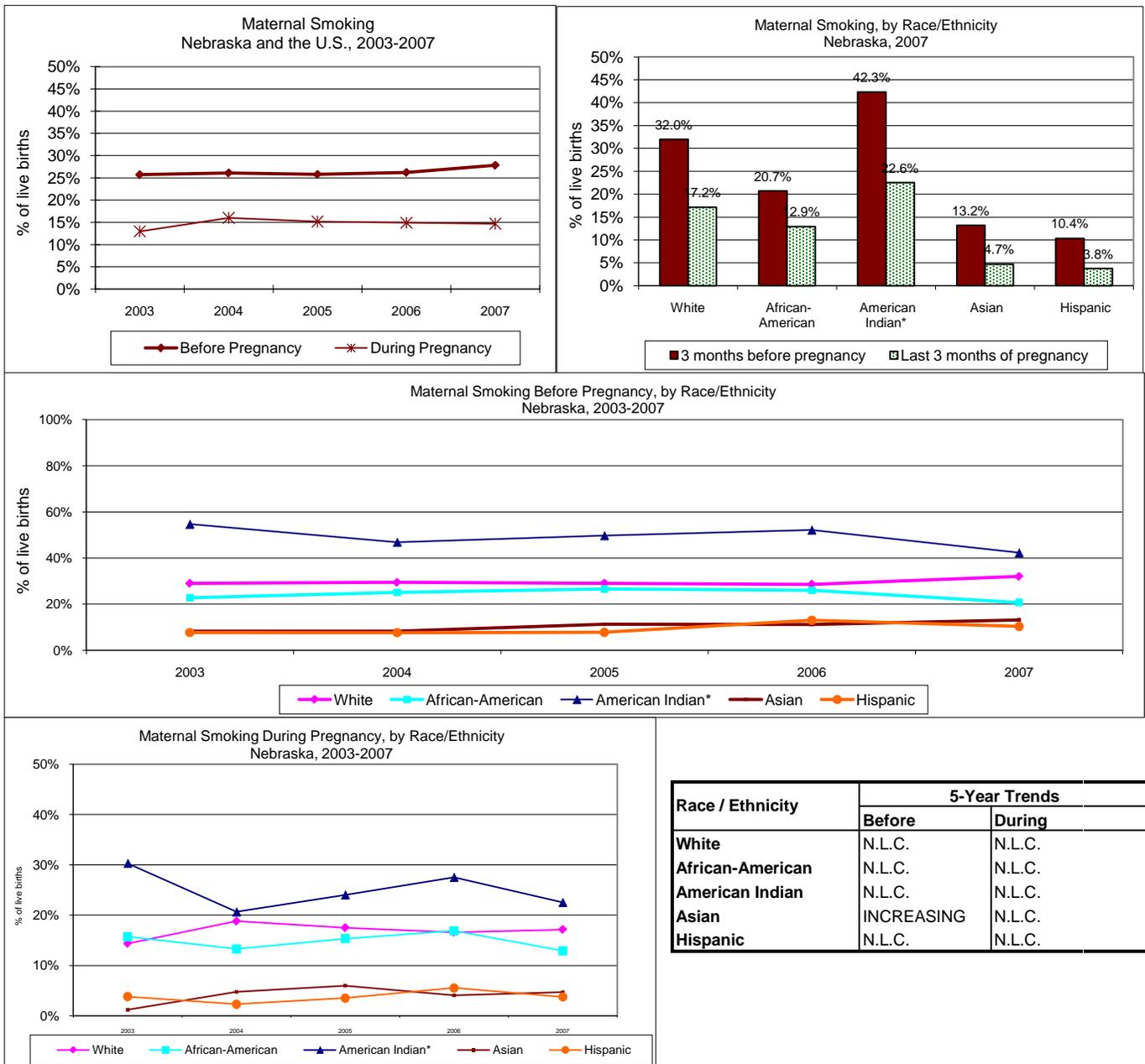
Maternal smoking

Definition: The percentage of infants whose mother smoked 3 months before pregnancy
 The percentage of infants whose mother smoked during the last 3 months of pregnancy

Data Source: Nebraska PRAMS

	Smoking before pregnancy		Nebraska rate is...	Smoking last 3 months of pregnancy		Nebraska rate is...
	Number	%		Number	%	
Nebraska (2007)	28	27.8%		15	14.7%	
United States	-	-	-	-	-	-
HP 2010 Objective	1%		Higher	1%		Higher
Nebraska 5-year trend	N.L.C.			N.L.C.		
NE Racial / Ethnic Disparities?	YES			YES		

Graphical Display of Data:



Data Sheet: Health Behavior

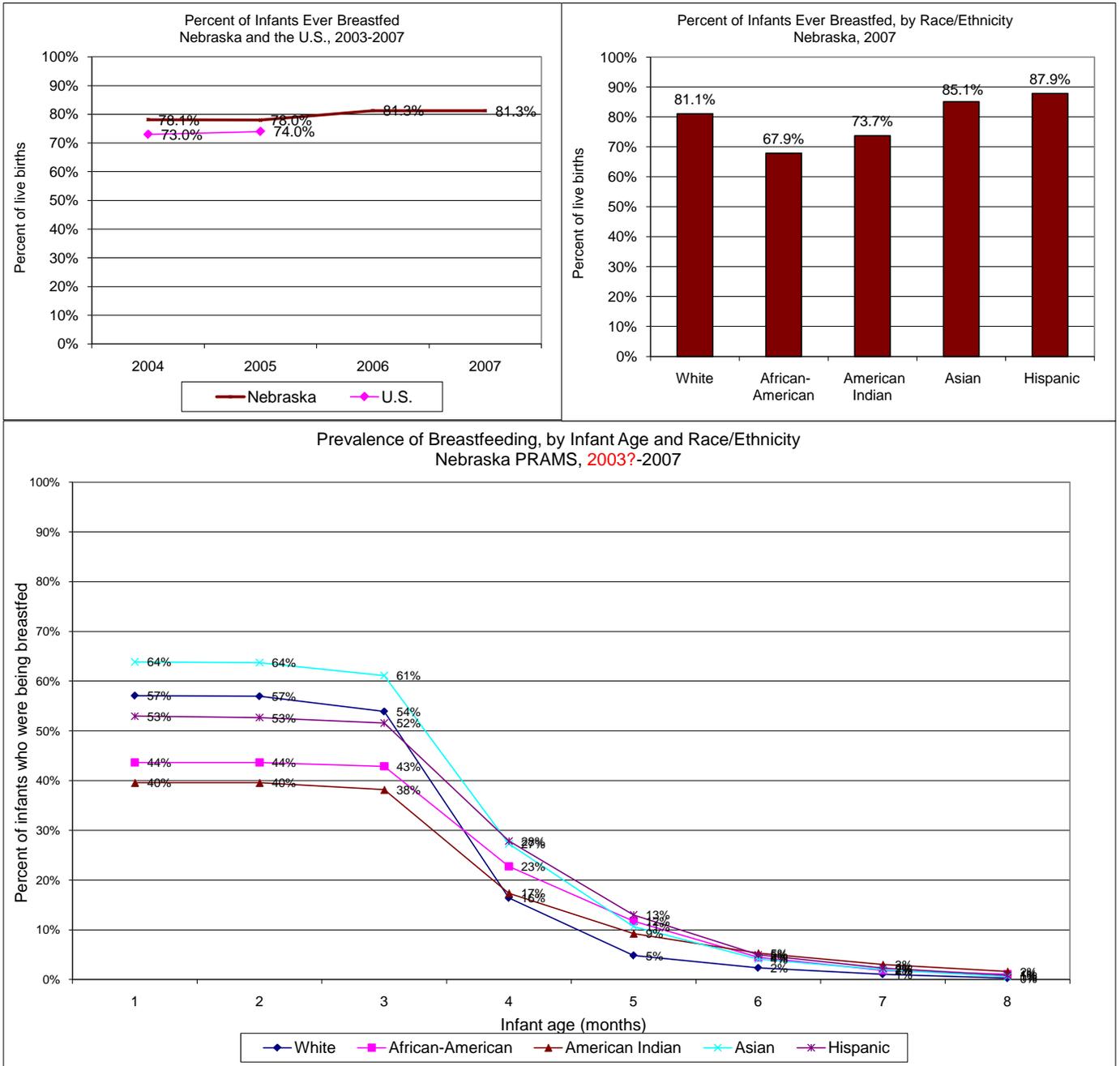
Breastfeeding

Definition: The percent of infants ever breastfed
The percent of infants breastfed between 1 and 8 months

Data Source: Nebraska PRAMS

	Ever Breastfed		Nebraska rate is...
	Number	Rate	
Nebraska (2007)	19,616	78%	
United States (2005)	3,062,378	74%	Higher
HP 2010 Objective		75%	Higher
Nebraska 5-year trend		N.L.C.	
NE Racial / Ethnic Disparities?		-	

Graphical Display of Data:



Data Sheet: Health Behavior

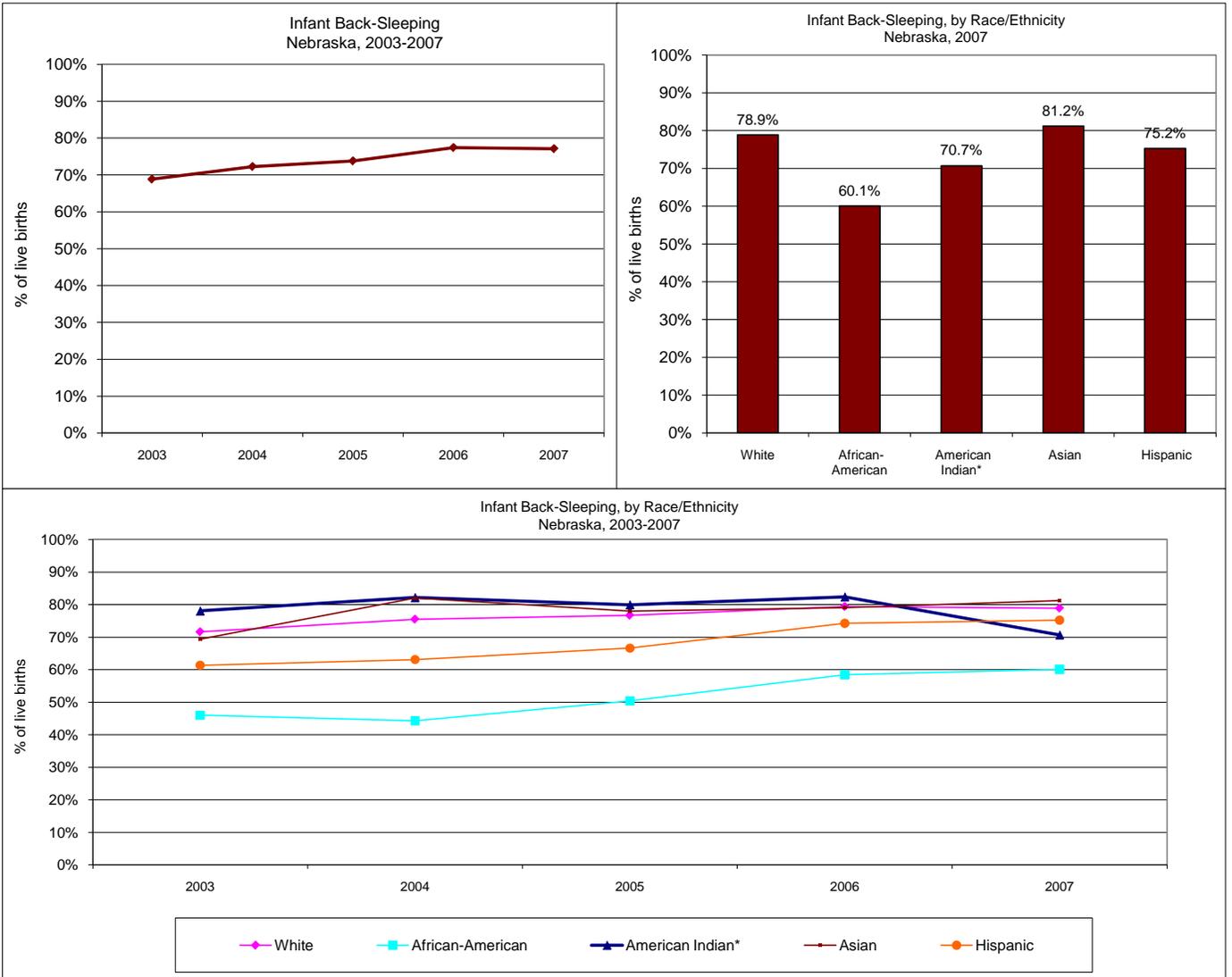
Sleep Position

Definition: The number and percentage of infants who are always placed to sleep on their backs, per 100 live births

Data Source: Nebraska PRAMS

	Back Sleeping		Nebraska rate is...
	Number	%	
Nebraska (2007)	20,767	77.1%	-
United States	-	-	-
HP 2010 Objective	70%		Higher
Nebraska 5-year trend	INCREASING		
NE Racial / Ethnic Disparities?	YES		

Graphical Display of Data:



Race / Ethnicity	5-Year Trends
White	INCREASING
African-American	INCREASING
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	INCREASING

Data Sheet: Physical Environment

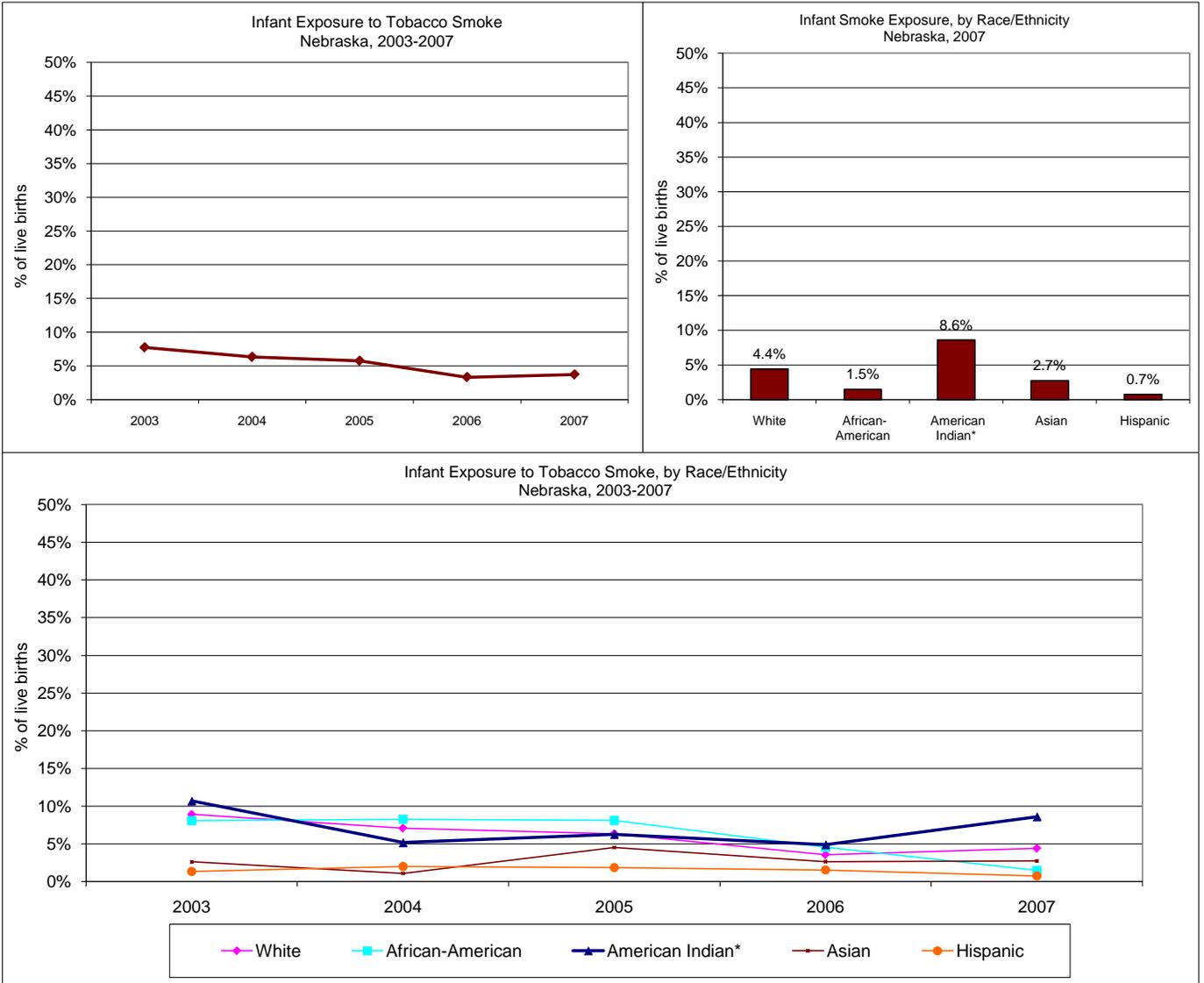
Smoke Exposure

Definition: The number and percentage of infants reported as ever exposed to tobacco smoke, per 100 live births

Data Source: Nebraska PRAMS

	Back Sleeping		Nebraska rate is...
	Number	%	
Nebraska (2007)	997	3.7%	
United States	-	-	-
HP 2010 Objective	-	-	-
Nebraska 5-year trend	DECREASING		
NE Racial / Ethnic Disparities?	YES		

Graphical Display of Data:



Race / Ethnicity	5-Year Trends
White	DECREASING
African-American	DECREASING
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

Data Sheet: Health Behavior

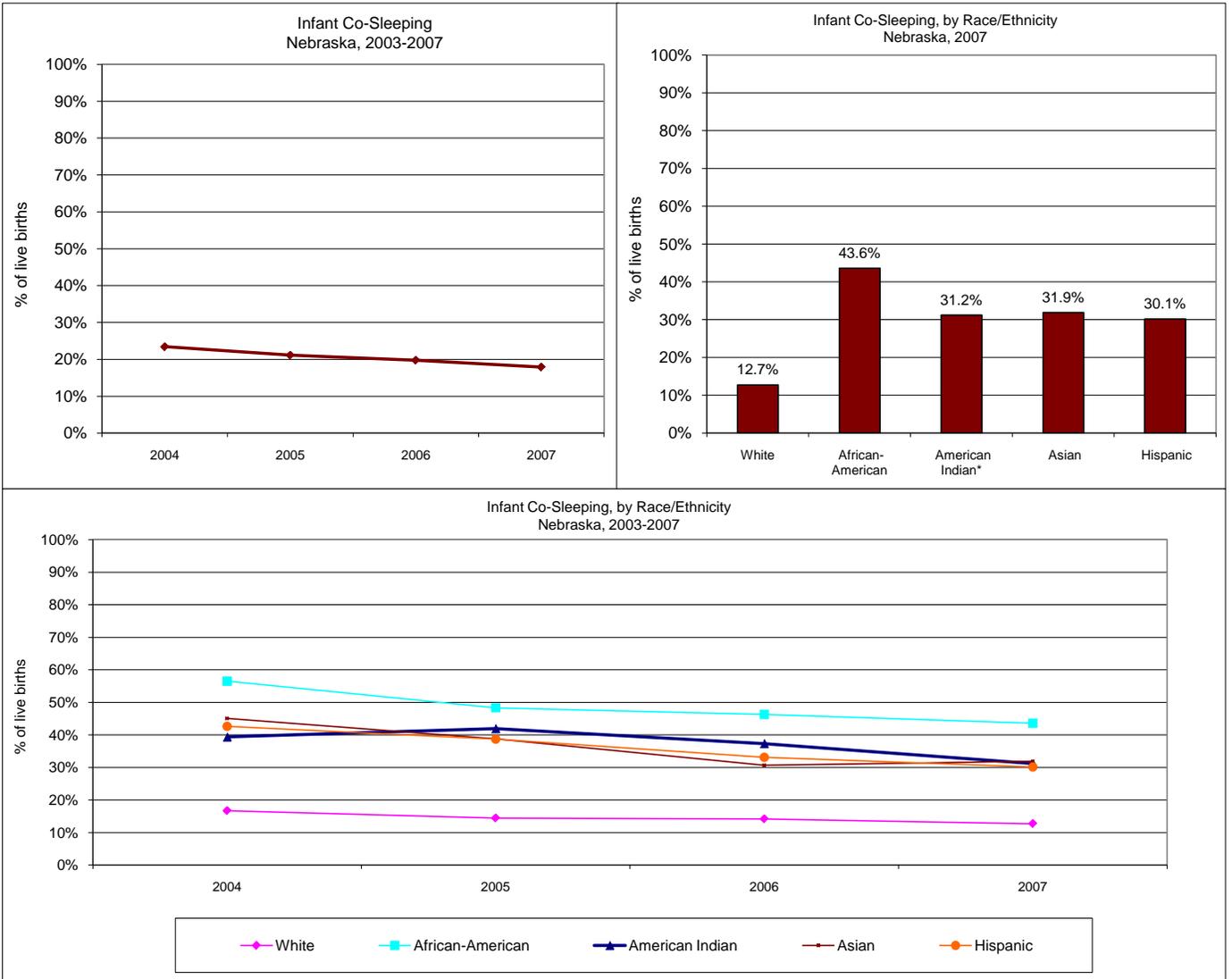
Sleep Position

Definition: The number and percentage of infants who routinely share their sleep surface with one or more other persons

Data Source: Nebraska PRAMS

	Co-Sleeping		Nebraska rate is...
	Number	%	
Nebraska (2007)	4,819	17.9%	-
United States	-	-	-
HP 2010 Objective	-		-
Nebraska 5-year trend	DECREASING		
NE Racial / Ethnic Disparities?	YES		

Graphical Display of Data:



Race / Ethnicity	4-Year Trends
White	DECREASING
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	DECREASING

Children

Data Sheet: **DEMOGRAPHICS**

Percentage of Population

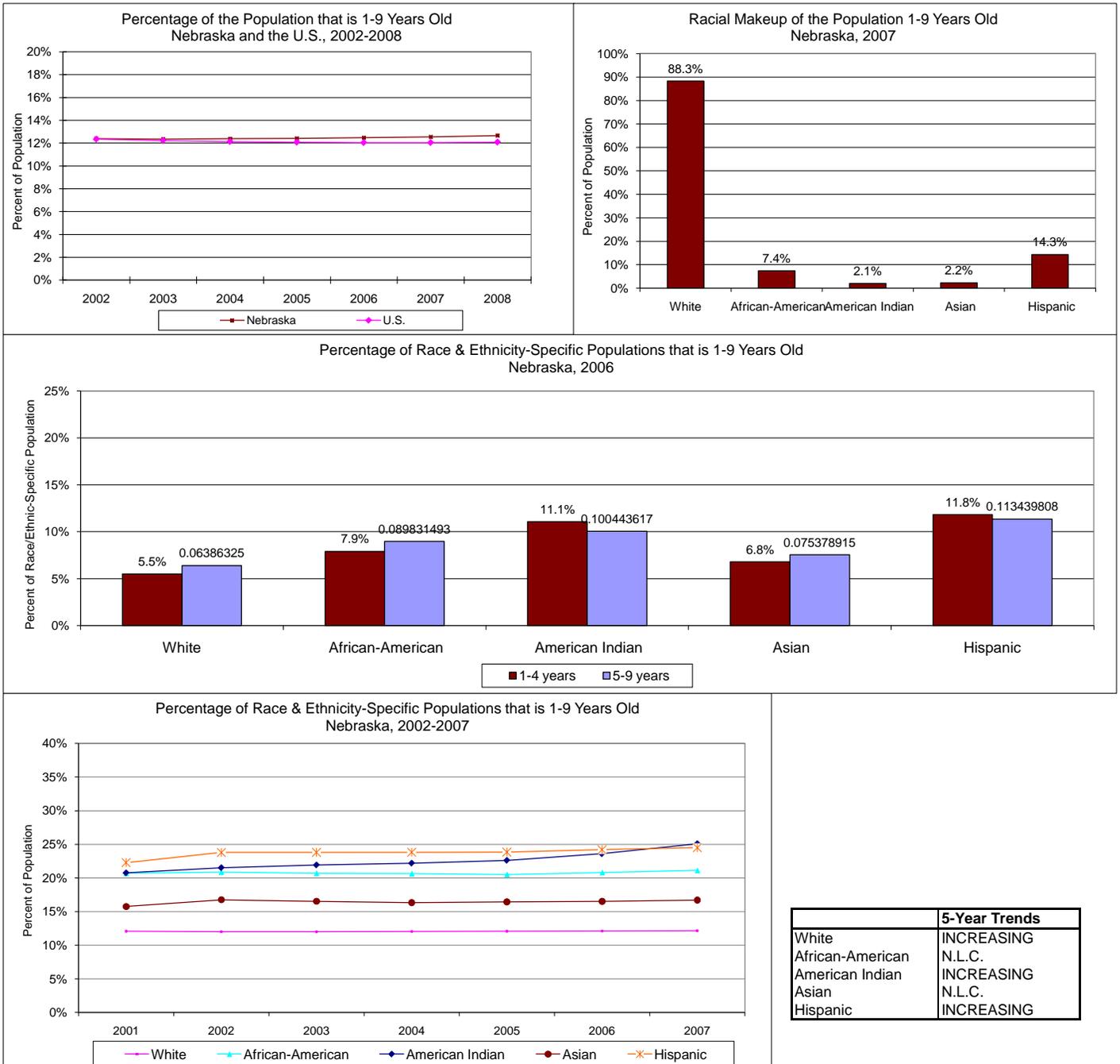
Definition: Percentage of total Nebraska population that is 1-9 years of age

Data Source: U.S. Census

Data & Disparities:

	1-4		5-9		1-9 Total		Nebraska % was...
	Number	%	Number	%	Number	%	
Nebraska (2008)	104,538	5.86%	121,352	6.80%	225,890	12.7%	Higher
United States (2008)	16,692,720	5.49%	20,065,249	6.60%	36,757,969	12.1%	
HP 2010 Objective	-		-		-		
Nebraska 5-year trend	INCREASING		N.L.C.		INCREASING		
Racial / Ethnic Differences	YES		YES		YES		

Graphical Display of Data:



Data Sheet: **DEMOGRAPHICS**

Gender

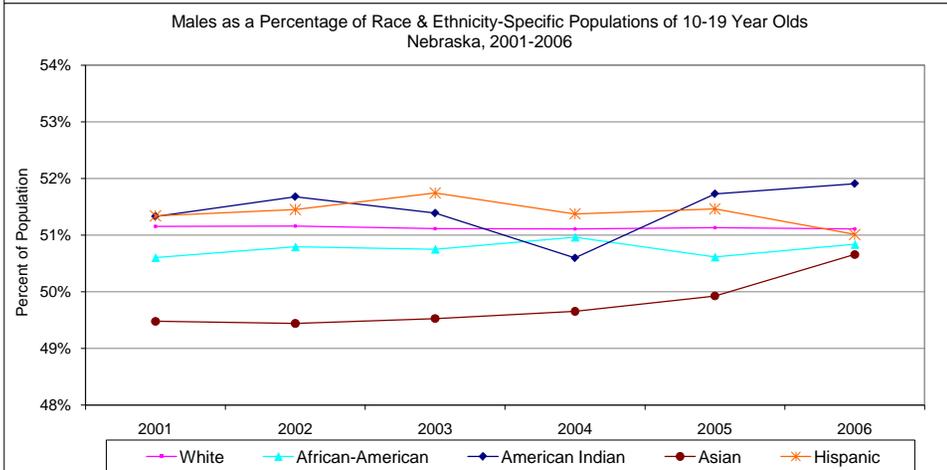
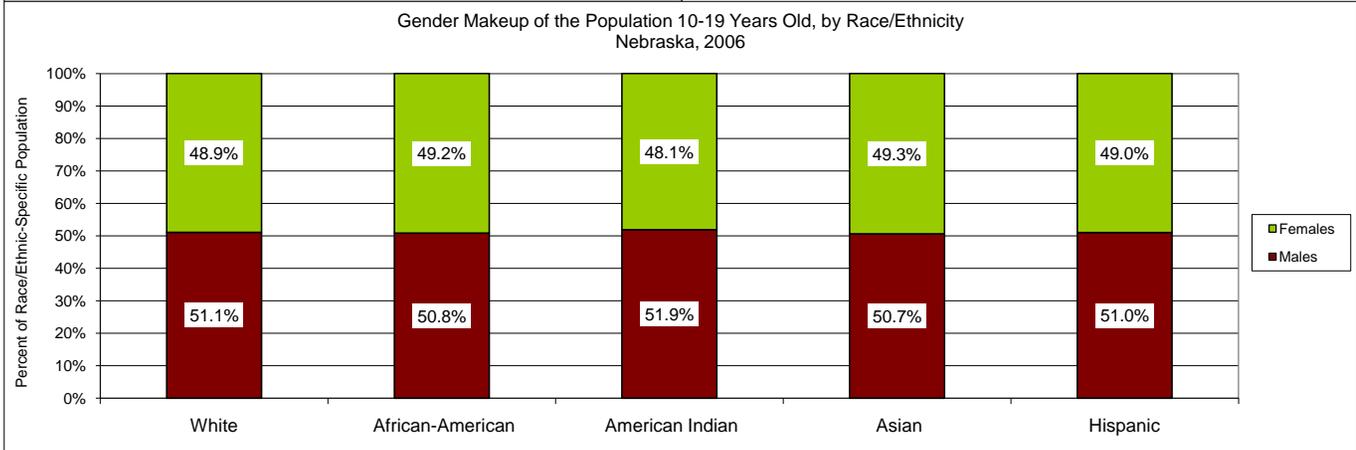
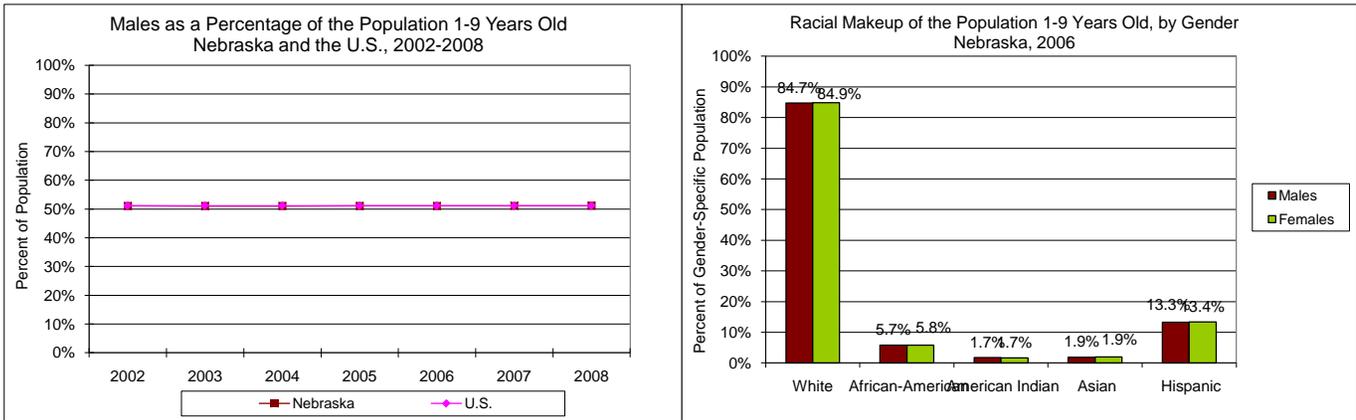
Definition: Gender distribution of population 1-9 years of age

Data Source: U.S. Census

Data & Disparities:

	Male		Nebraska % was...	Female		Nebraska % was...
	Number	%		Number	%	
Nebraska (2008)	115,583	0.51		110,307	0.49	
United States (2008)	18,799,282	0.51	N.S.D.	17,958,687	0.49	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	NO			NO		

Graphical Display of Data:



	5-Year Trends
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	INCREASING
Hispanic	N.L.C.

Nebraska Title V
2010 Needs Assessment

Data Sheet: **DEMOGRAPHICS**

Income

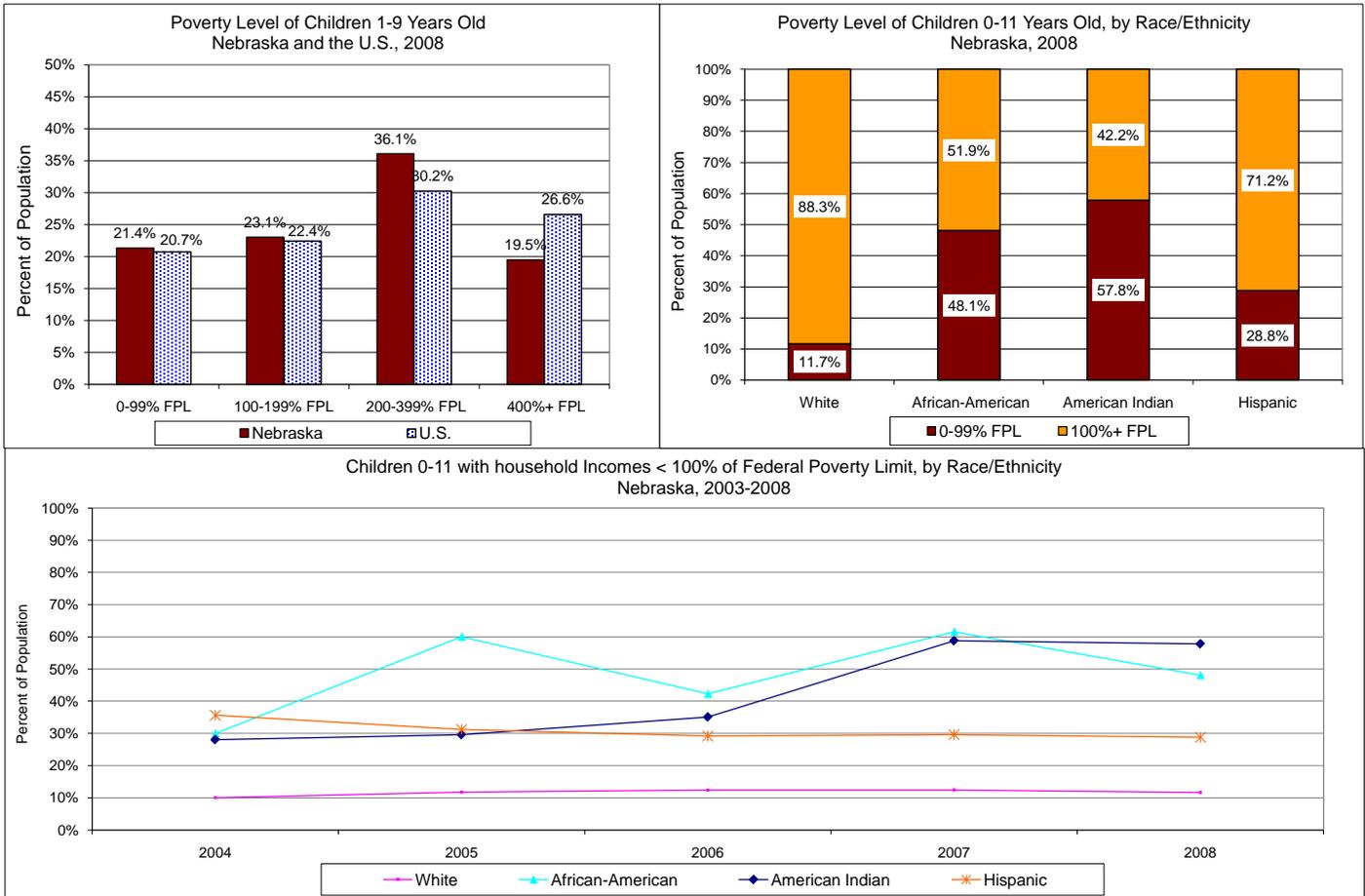
Definition: Children 1-9 (CPS) or 0-11 (ACS) with household incomes as a percentage of the Federal Poverty Level

Data Source: US Census: Current Population Survey
American Community Survey (race/ethnicity-specific data)

Data & Disparities:

	0-99% of Poverty			100-199% of Poverty		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (CPS; 2008)	47,805	21.4%		51,638	23.1%	
United States (CPS; 2008)	7,652,108	20.7%	Higher	8,273,977	22.4%	Higher
HP 2010 Objective	-			-		
Nebraska 5-year trend (CPS)	N.L.C.			N.L.C.		
Racial / Ethnic Differences (ACS)	YES			-		
	200-399% of Poverty			400% Poverty or higher		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (CPS; 2008)	80,816	36.1%		43,628	19.5%	
United States (CPS; 2008)	11,157,628	30.2%	Higher	9,812,268	26.6%	Lower
HP 2010 Objective	-			-		
Nebraska 5-year trend (CPS)	N.L.C.			N.L.C.		
Racial / Ethnic Differences (ACS)	-			-		

Graphical Display of Data:



	5-Year Trends		
	<5 years	5 years	6-11 years
White	N.L.C.	N.L.C.	N.L.C.
African-American	N.L.C.	N.L.C.	N.L.C.
American Indian	N.L.C.	N.L.C.	INCREASING
Hispanic	N.L.C.	N.L.C.	DECREASING

*NOTE: The American Community Survey is an annual survey of approximately 3,000,000 households nationwide, designed to produce community-level demographic, housing, social, and economic data. Nebraska sample sizes for Native American children were too small for valid estimates.

Data Sheet: **DEMOGRAPHICS**

Family Structure

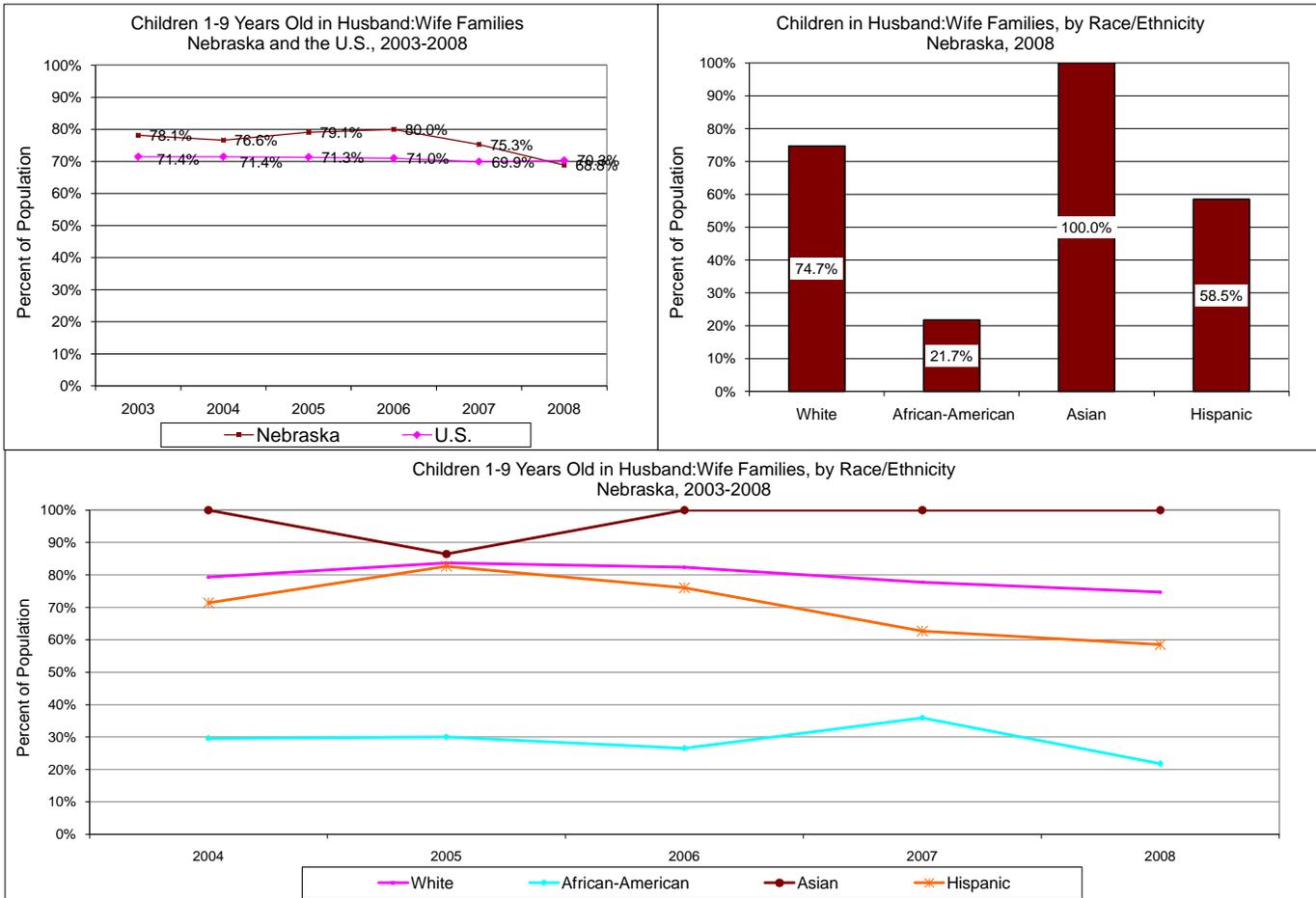
Definition: Husband-Wife family versus all other types

Data Source: US Census: Current Population Survey*

Data & Disparities:

	Husband-Wife		Nebraska % was...	All Others		Nebraska % was...
	Number	%		Number	%	
Nebraska (2008)	154,823	68.8%		70,104	31.2%	
United States (2008)	26,096,154	70.3%	Lower	11,034,798	29.7%	
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



5-Year Trends	
White	N.L.C.
African-American	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

*NOTE: The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Nebraska sample sizes for Native American children were too small for valid longitudinal estimates.

Data Sheet: HEALTH OUTCOMES

Mortality

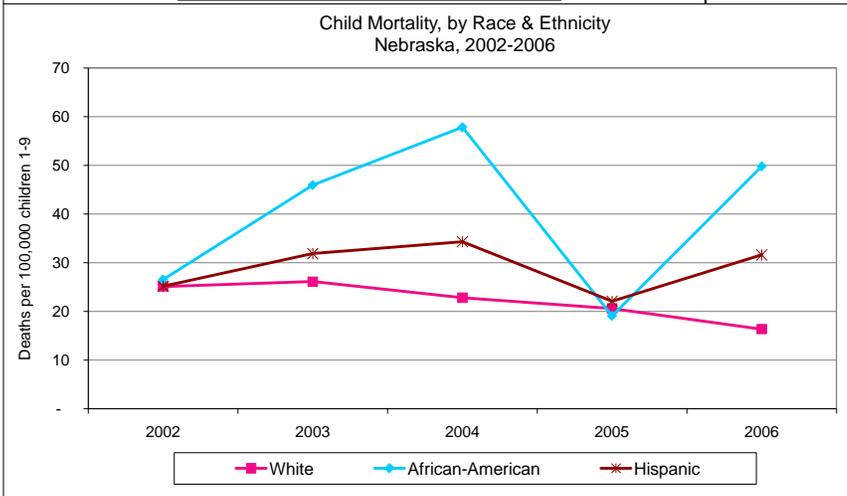
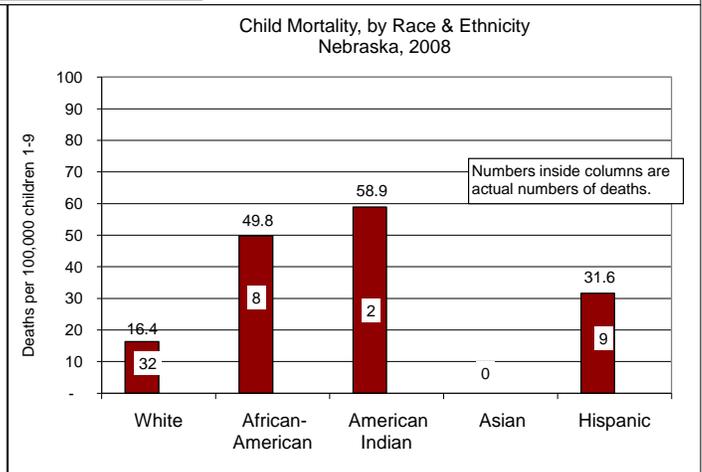
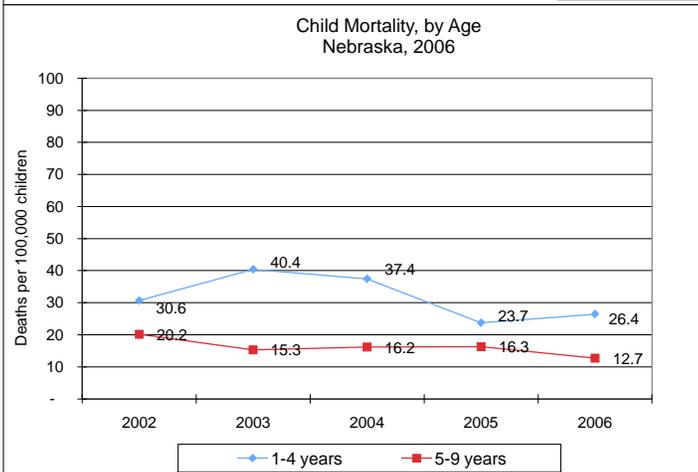
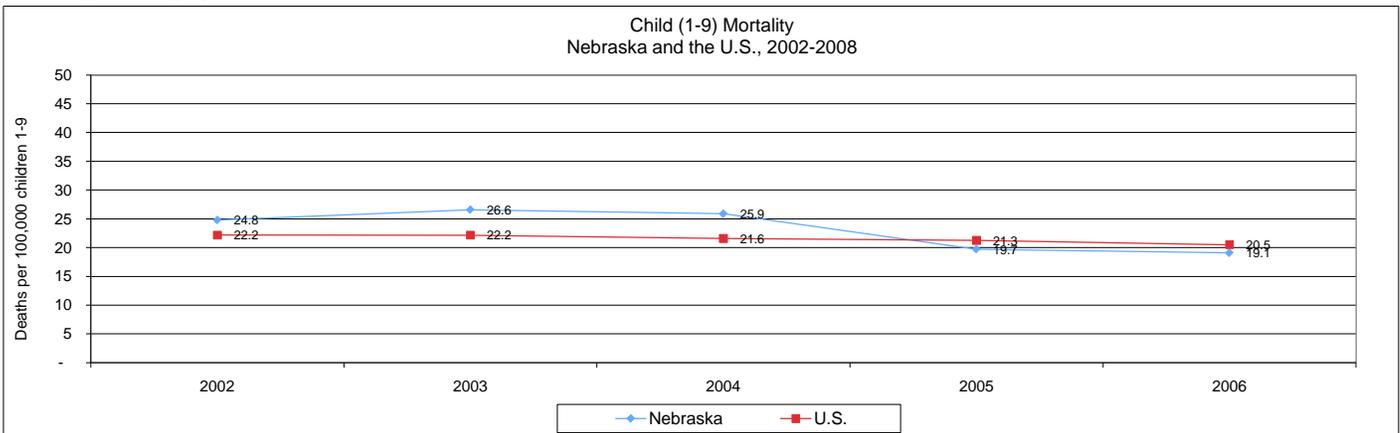
Definition: Deaths to children ages 1-9, per 100,000, all causes

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	1-4			5-9			1-9 Total		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2006)	27	26.4		15	12.7		42	19.1	
United States (2006)	4,631	28.5	N.S.D.	2,735	13.9	N.S.D.	7,366	20.5	N.S.D.
HP 2010 Objective	20.0		N.S.D.	13.0		N.S.D.	-		
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES			YES		

Graphical Display of Data:



	5-Year Trends
White	DECREASING
African-American	N.L.C.
Hispanic	N.L.C.

There were between 0 and 2 Asian and American Indian deaths each year during this time period.

Data Sheet: HEALTH OUTCOMES

Mortality - Gender

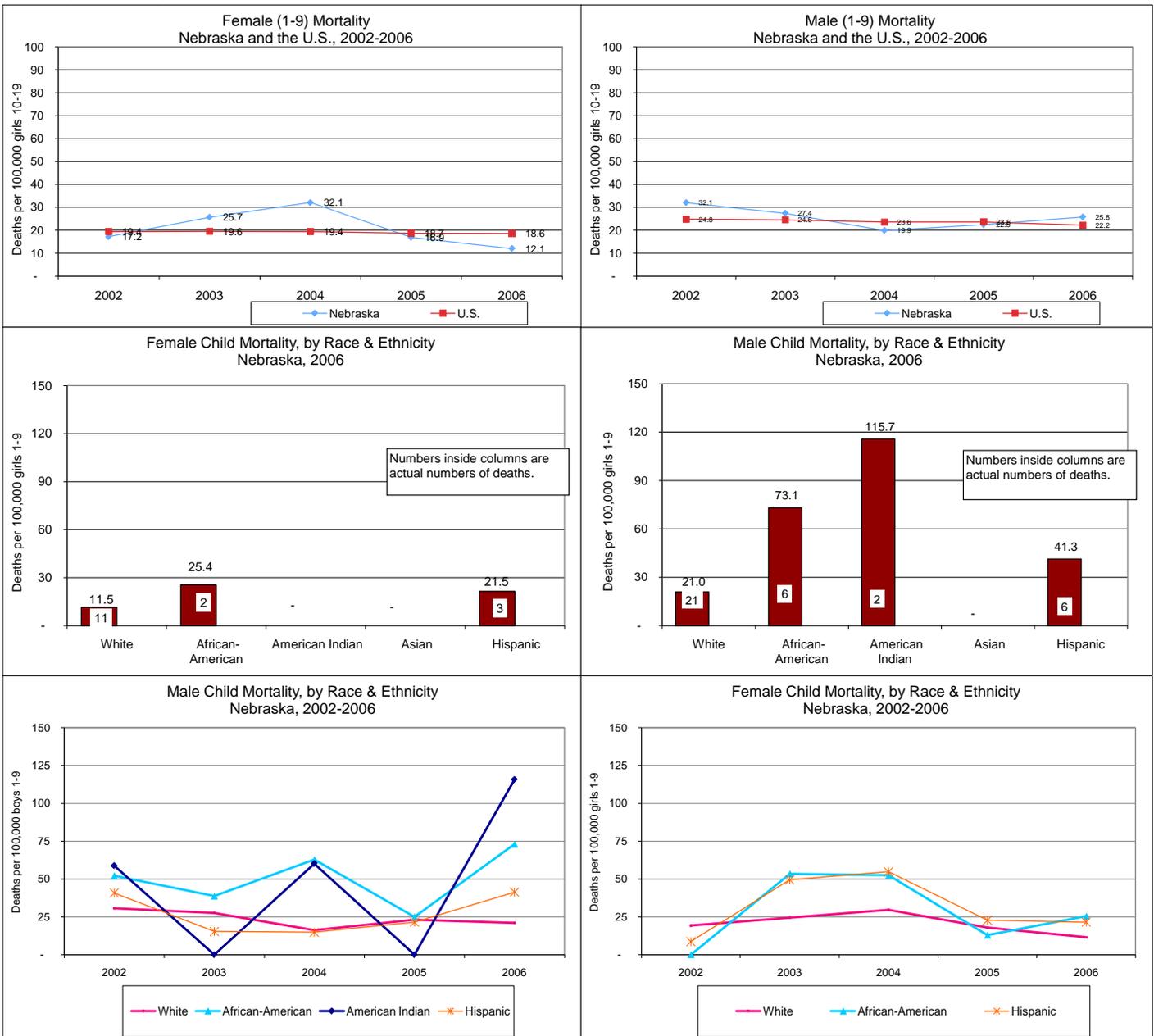
Definition: Deaths to children ages 1-9, per 100,000, all causes, by gender

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Girls			Boys			Total		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2006)	13	12.1	was...	29	25.8	was...	42	19.1	was...
United States (2006)	3,274	18.6	N.S.D.	4,092	22.2	N.S.D.	7,366	20.5	N.S.D.
HP 2010 Objective		-			-			-	
Nebraska 5-year trend		N.L.C.			N.L.C.			N.L.C.	
Racial / Ethnic Differences		-			-			-	

Graphical Display of Data:



There were no Asian male child deaths during this period.

There were 0 American Indian female child deaths and 2 Asian female child deaths during this period.

Data Sheet: HEALTH OUTCOMES

Mortality - Homicide

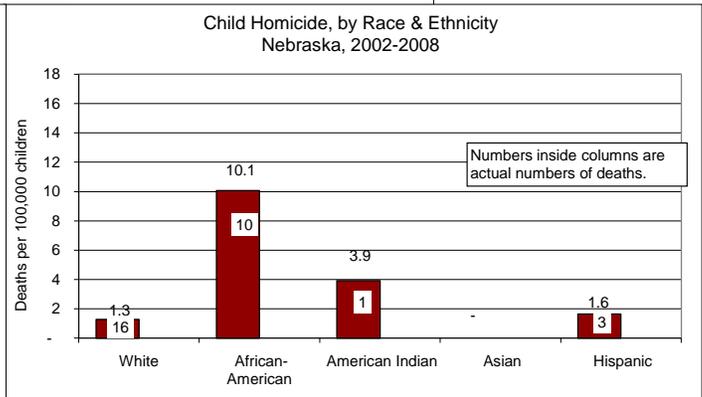
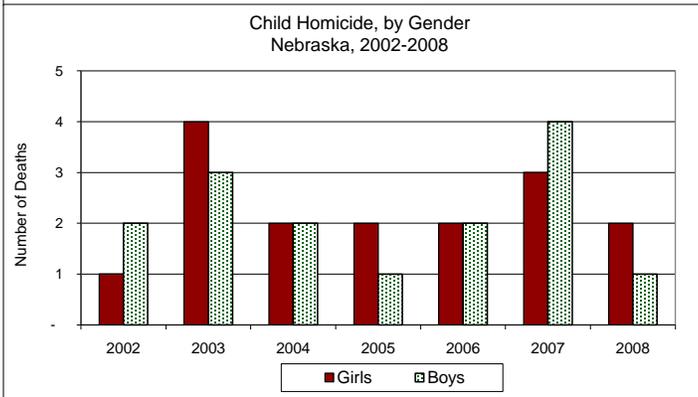
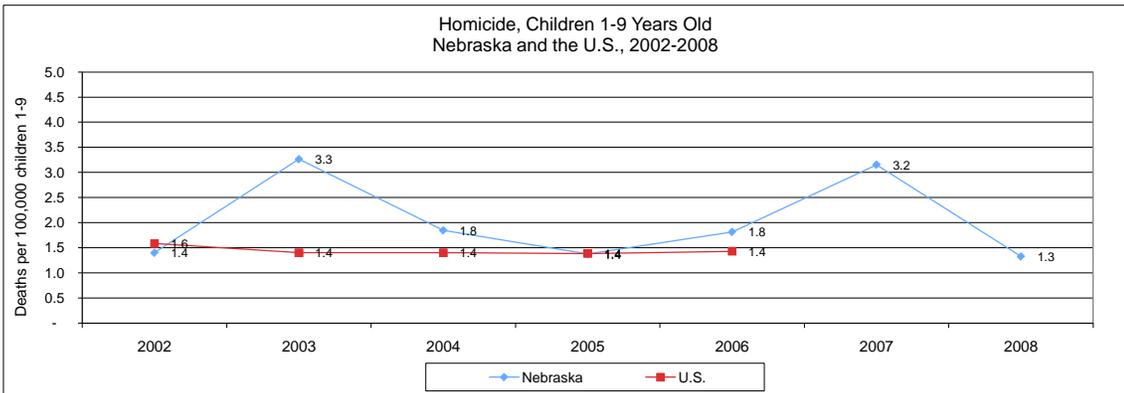
Definition: The number and rate of fatalities due to homicide, per 100,000 children ages 1-9

Data Source: National Center for Health Statistics - Vital Records
Nebraska Child Death Review Team

Data & Disparities:

	Homicide		
	Number	Rate	Nebraska rate
Nebraska (2006)	4	1.8	was...
United States (2006)	515	1.4	N.S.D.
HP 2010 Objective	2.7		N.S.D.
Nebraska 5-year trend	N.L.C.		
Racial / Ethnic Differences	YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Unintentional Injury & Motor Vehicle Crashes

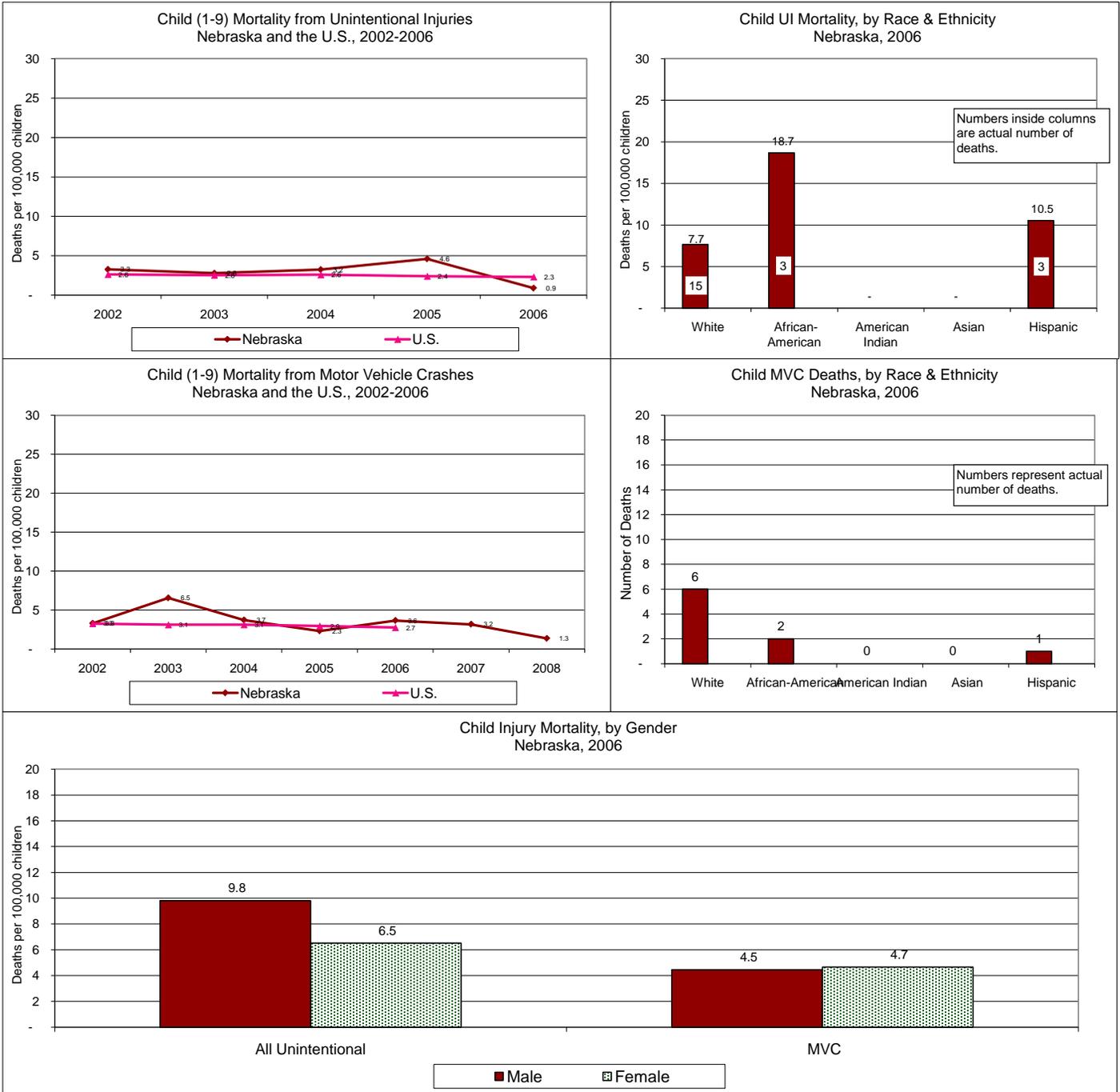
Definition: The number and rate of fatalities due to unintentional injuries (including MVC), per 100,000 children ages 1-9
The number and rate of fatalities due to Motor Vehicle Crashes per 100,000 children ages 1-9

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Unintentional Injuries			MVC		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska (2006)	18	8.2	was...	8	3.6	was...
United States (2006)	2,654	7.2	N.S.D.	986	2.7	N.S.D.
HP 2010 Objective	17.5		Lower	9.2		Lower
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Cancer

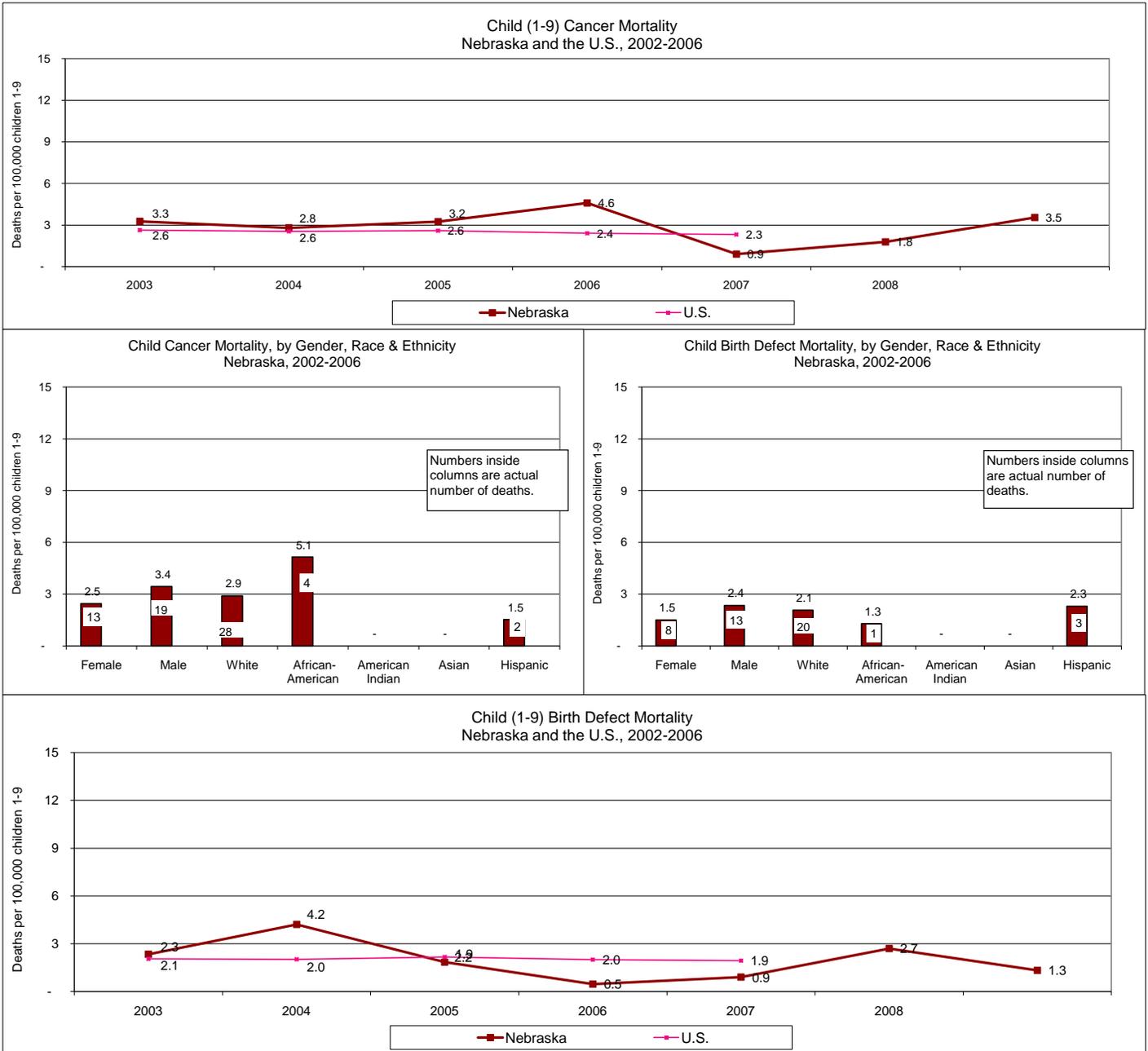
Definition: The number and rate of fatalities due to cancer, per 100,000 children age 1-9
The number and rate of fatalities due to birth defects per 100,000 children age 1-9

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Cancer			Birth Defects		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	8	3.5	was...	3	1.3	was...
United States (2006)	836	2.3	N.S.D.	697	1.9	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	NO			NO		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Asthma

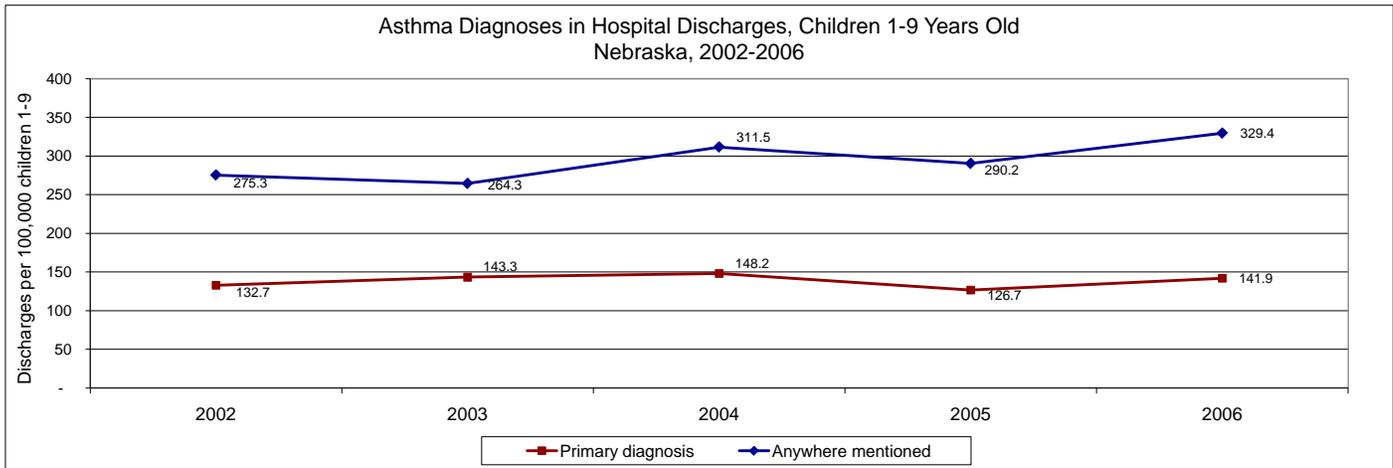
Definition: The number and rate of hospital discharges with asthma as the primary diagnosis, per 100,000 children ages 1-9
The number and rate of hospital discharges with asthma anywhere mentioned, per 100,000 children ages 1-9

Data Source: National Hospital Discharge Dataset

Data & Disparities:

	Primary Diagnosis			Anywhere mentioned		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	315	141.9	was...	731	329.4	was...
United States	-	-	-	-	-	-
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Graphical Display of Data:



Data Sheet: **HEALTH OUTCOMES**

Health Status - Nutritional Status

Definition: The number and percent of WIC children 1-4 years who are underweight (<5% weight/age) or overweight (>95% weight/age)
The number and percent of WIC children 2-4 years who are at risk for overweight (>85% & <95% weight/age) or overweight (>95% weight/age)

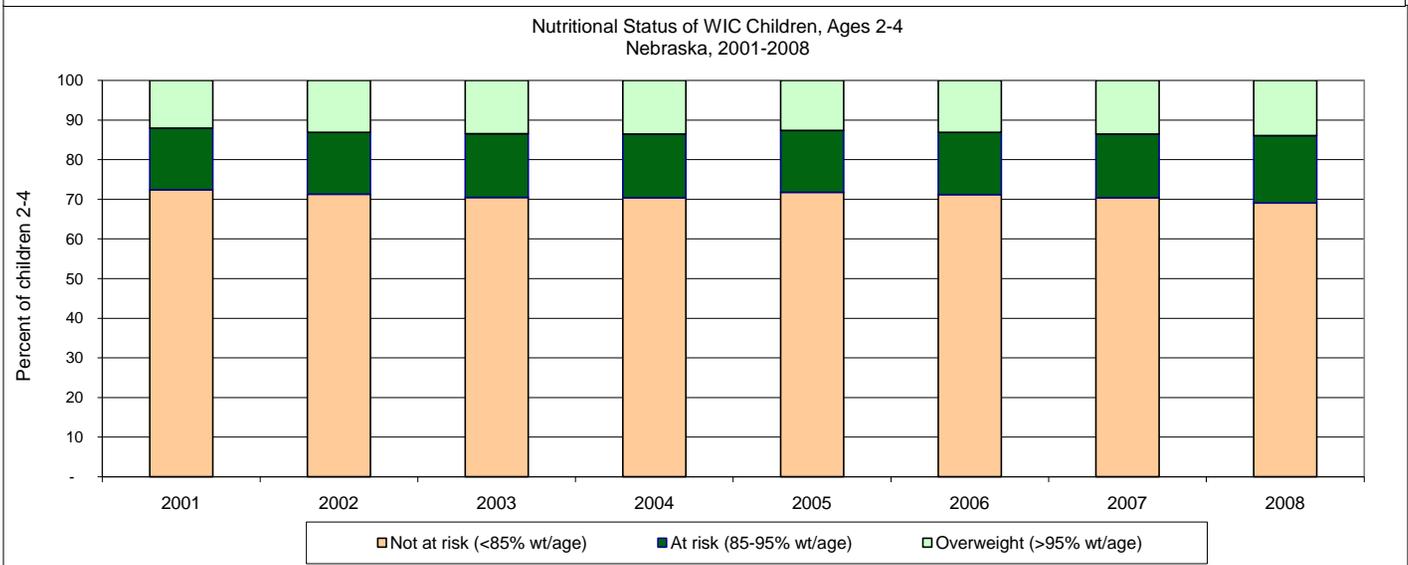
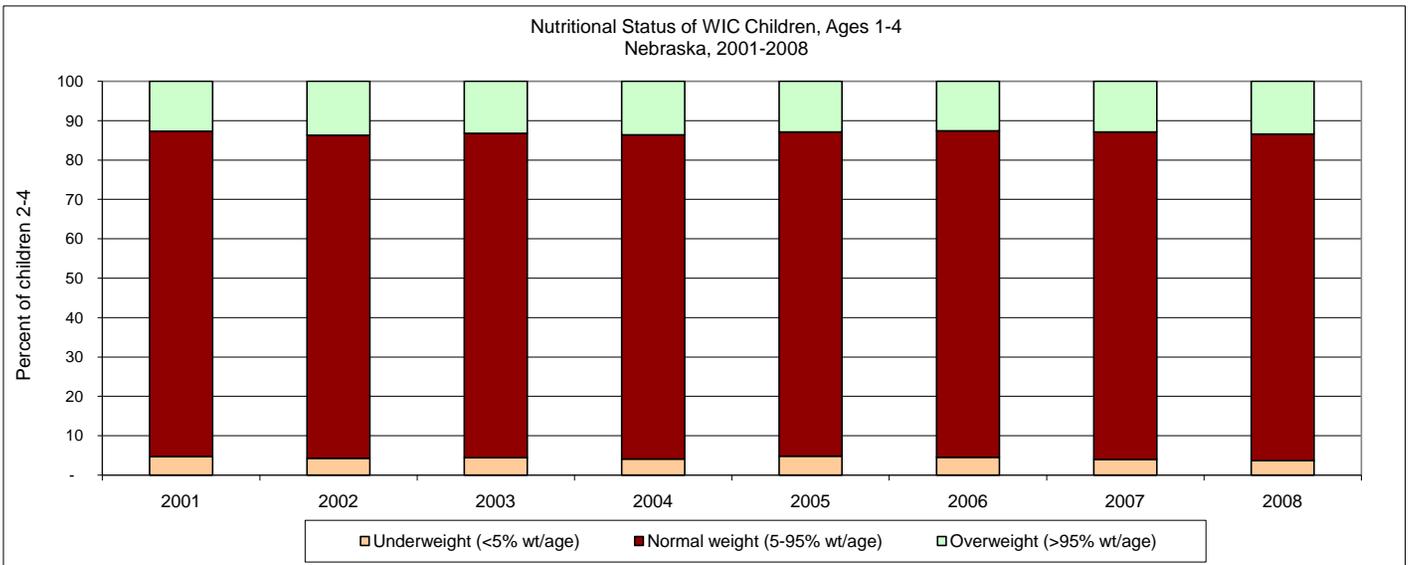
Data Source: Nebraska WIC Program

Data & Disparities:

	1-4, Underweight			1-4, Overweight		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	1,791	3.7%	was...	6,486	13.4%	was...
United States	-	-	-	-	-	-
HP 2010 Objective	5%		Lower	5%		Higher
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	-			-		

	2-4, At risk for overweight			2-4, Overweight		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2008)	3,512	17.0%	was...	2,871	13.9%	was...
United States (2008)	485,759	16.5%	N.S.D.	435,711	14.8%	Lower
HP 2010 Objective	5%		Higher	5%		Higher
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	-			-		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Children with Special Health Care Needs

Definition: The number and percent of children ages 1-9 with special health care needs, by age

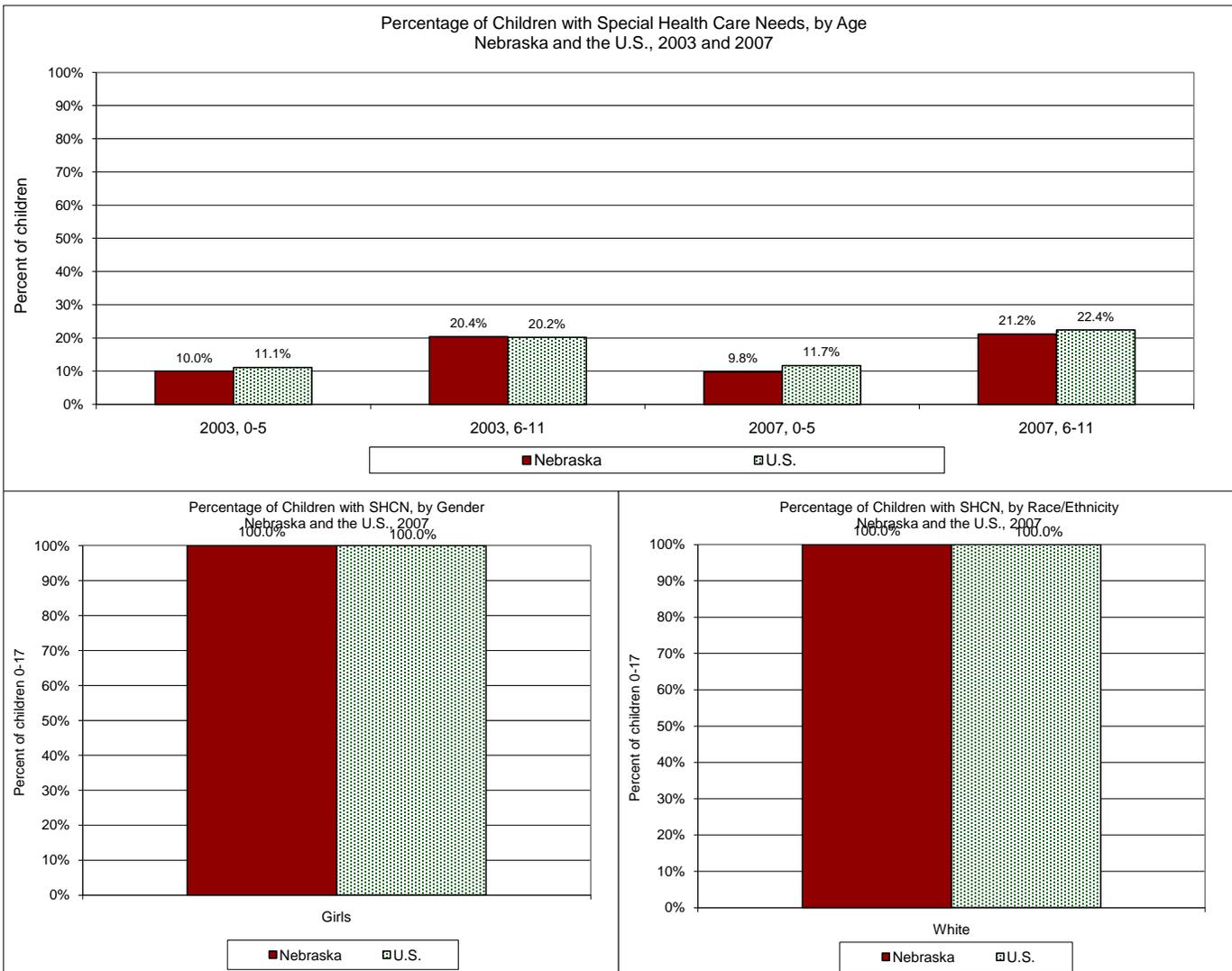
Data Source: National Survey on Children's Health

Data & Disparities:

	Children 0-5			Children 6-11		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska (2007)	15,245	9.8%	was...	30,976	21.2%	was...
United States (2007)	2,854,907	11.7%	N.S.D.	5,368,257	22.4%	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.S.D.			N.S.D.		
Racial / Ethnic Differences?*	#REF!					

*Note: Racial/ethnic differences are based on children 0-17.

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Child Abuse

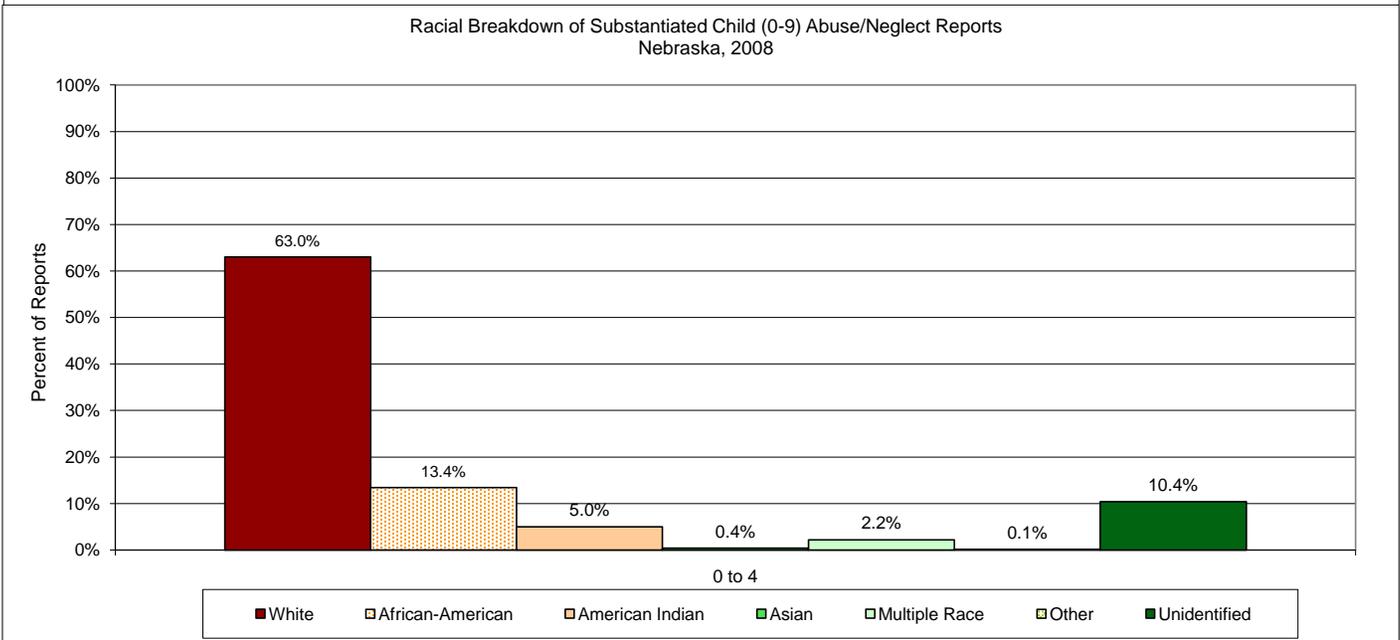
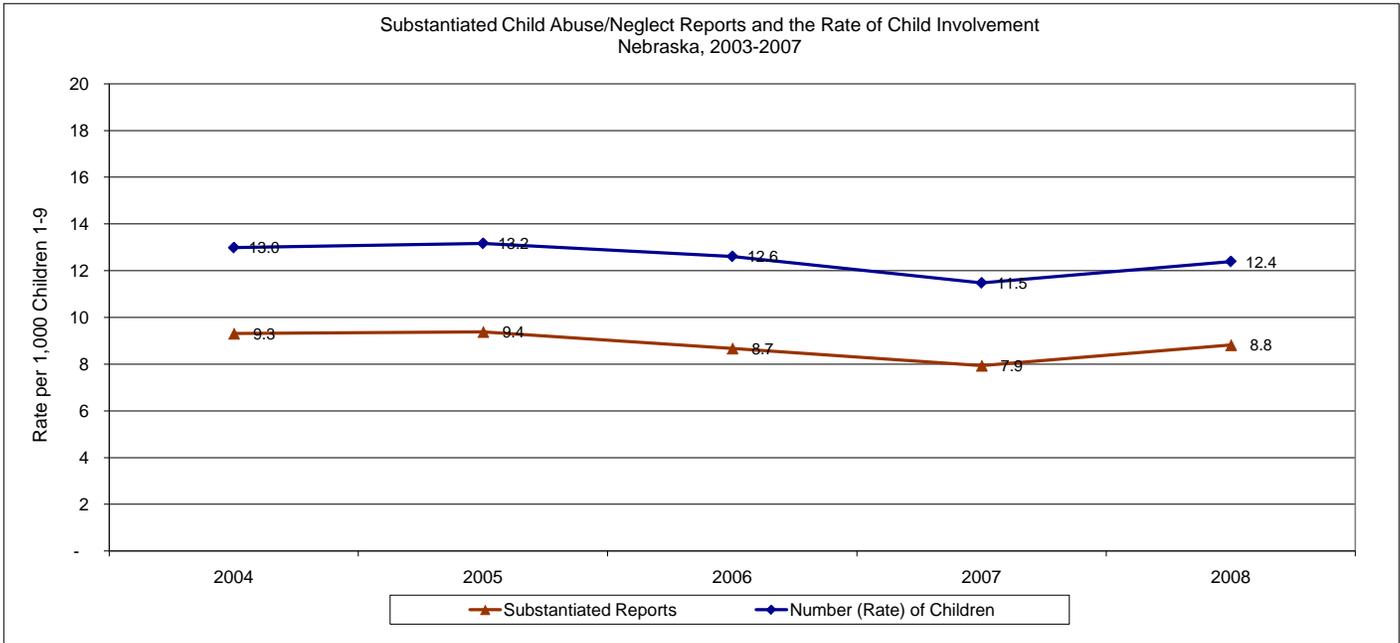
Definition: The numbers of child neglect or abuse reports that were substantiated by Child Protective Services (CPS), per 1,000 children 1-9
The total numbers of children involved in substantiated reports of abuse or neglect, per 1,000 children 1-9

Data Source: Nebraska DHHS - Children and Family Services

Data & Disparities:

	Substantiated		# Children Involved	
	Number	Rate	Number	Rate
Nebraska (2008)	1,992	8.8	2,799	12.4
United States	-	-	-	-
HP 2010 Objective	-	-	-	-
Nebraska 5-year trend	N.L.C.		N.L.C.	
Racial / Ethnic Differences	-	-	-	-

Graphical Display of Data:



Data Sheet: **HEALTH OUTCOMES**

Health Status - Intentional Injuries

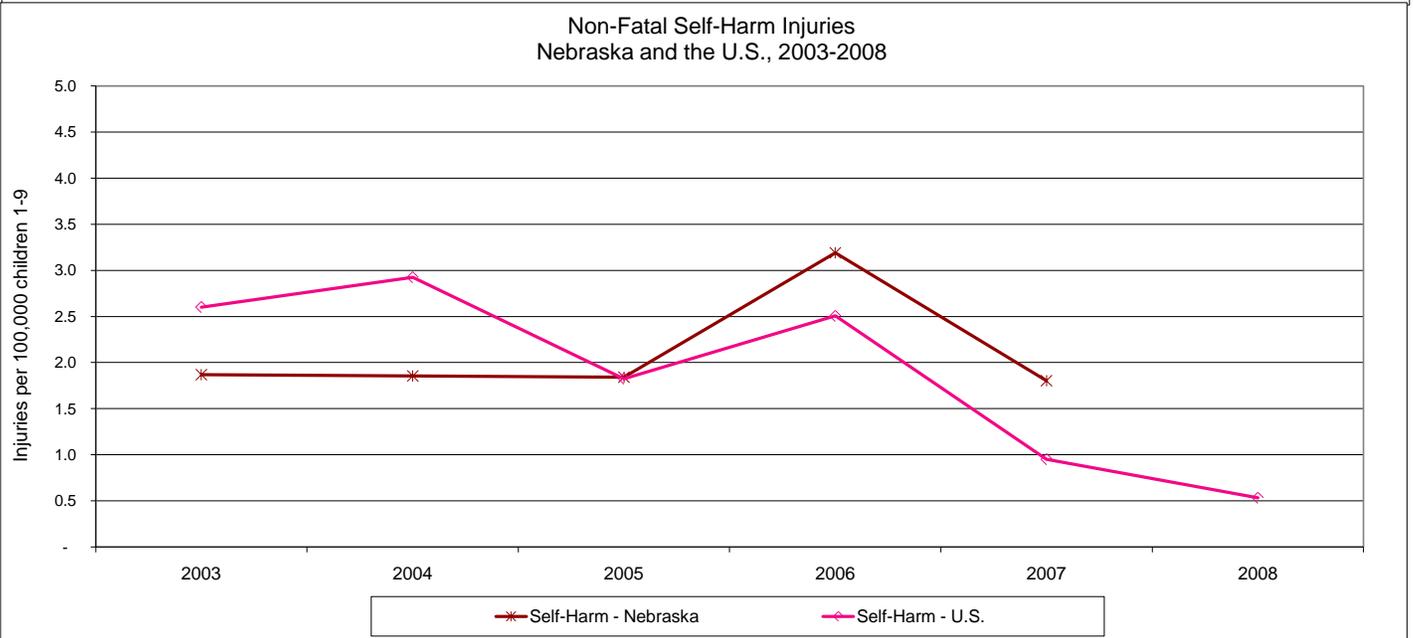
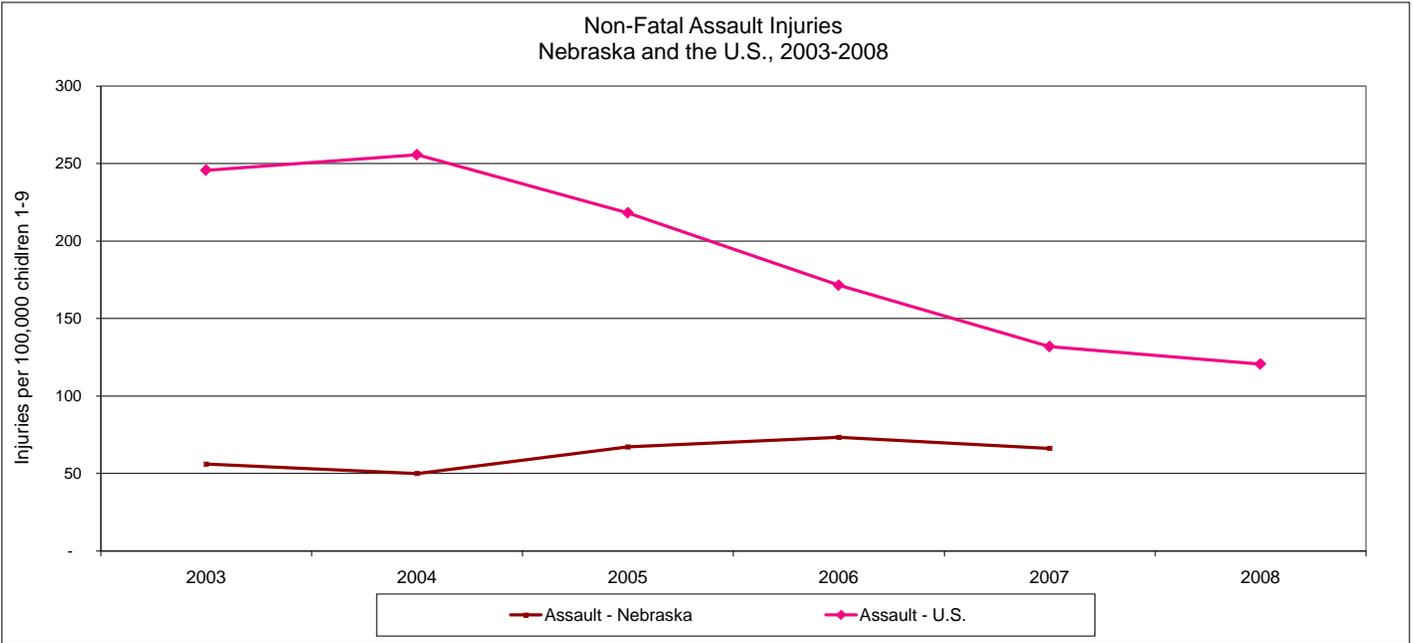
Definition: The rate of hospital discharges for intentional, nonfatal (**assault**) injuries, per 100,000 children 1-9
The rate of self-inflicted injuries to youth by cause, per 100,000 children 1-9

Data Source: Hospital Discharge Dataset

Data & Disparities:

	Assault			Self-Inflicted		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	147	66.2		4	1.8	
United States (2007)	47,852	131.8	Lower	345	1.0	N.S.D.
HP 2010 Objective		-			-	
Nebraska 5-year trend		N.L.C.			N.L.C.	
Racial / Ethnic Differences		-			-	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Unintentional Injuries

Definition: The rate of hospital discharges for unintentional, nonfatal injuries, per 100,000 children 1-9

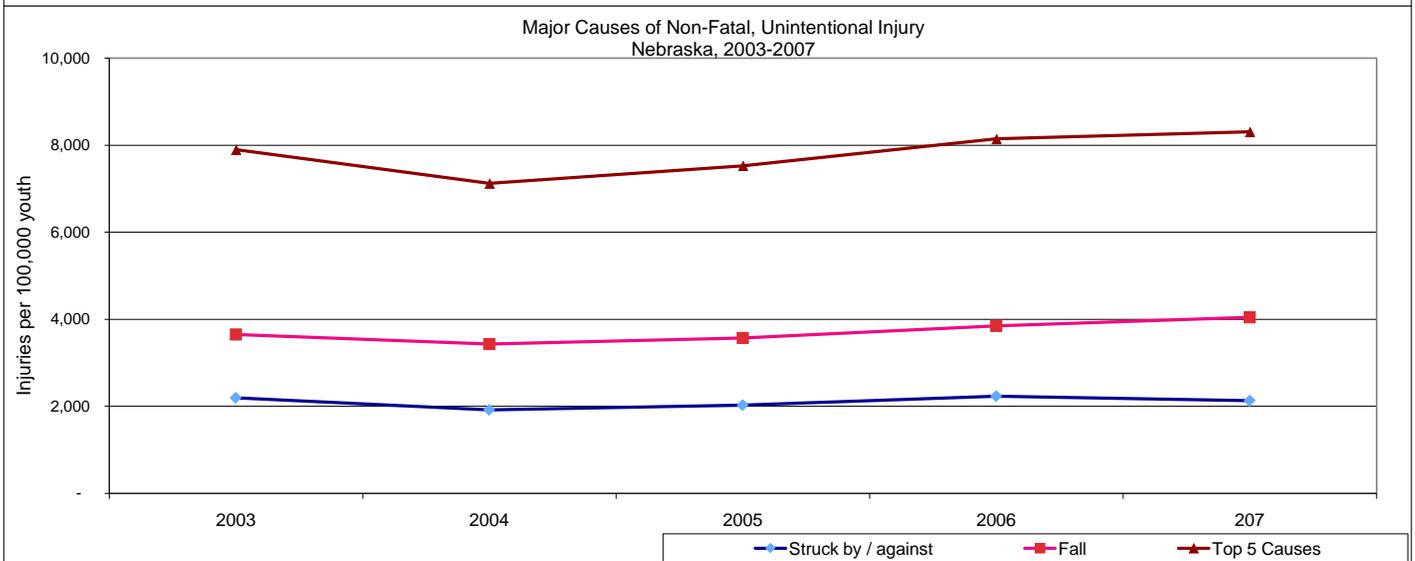
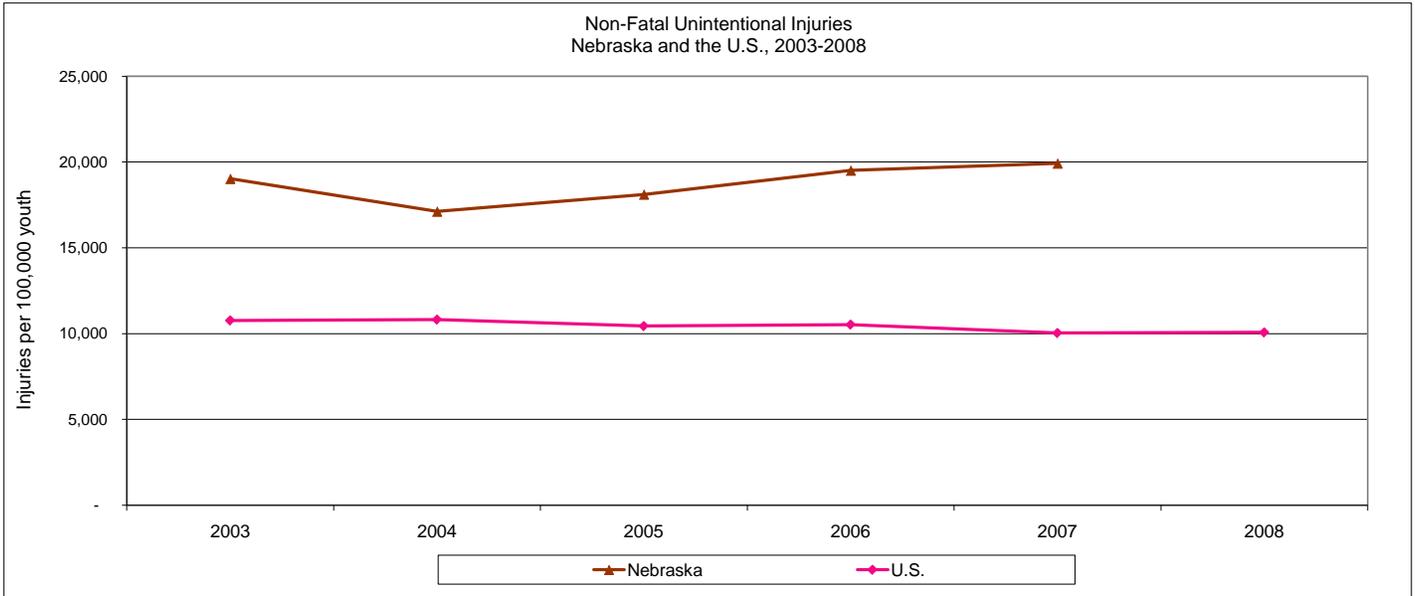
Data Source: Hospital Discharge Dataset

Data & Disparities:

	Fall			Struck by/against		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska (2007)	8,982	4,047.4	was...	4,721	2,127.3	was...
United States (2007)	1,428,312	3,935.4	N.S.D.	769,833	2,121.1	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	-			-		

	Top 5 Causes			All Causes		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska (2007)	18,434	8,306.5	was...	44,209	19,921.0	was...
United States (2007)	2,791,159	7,690.5	Higher	3,643,587	10,039.2	Higher
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences?	-			-		

Graphical Display of Data:



Data Sheet: Health Care

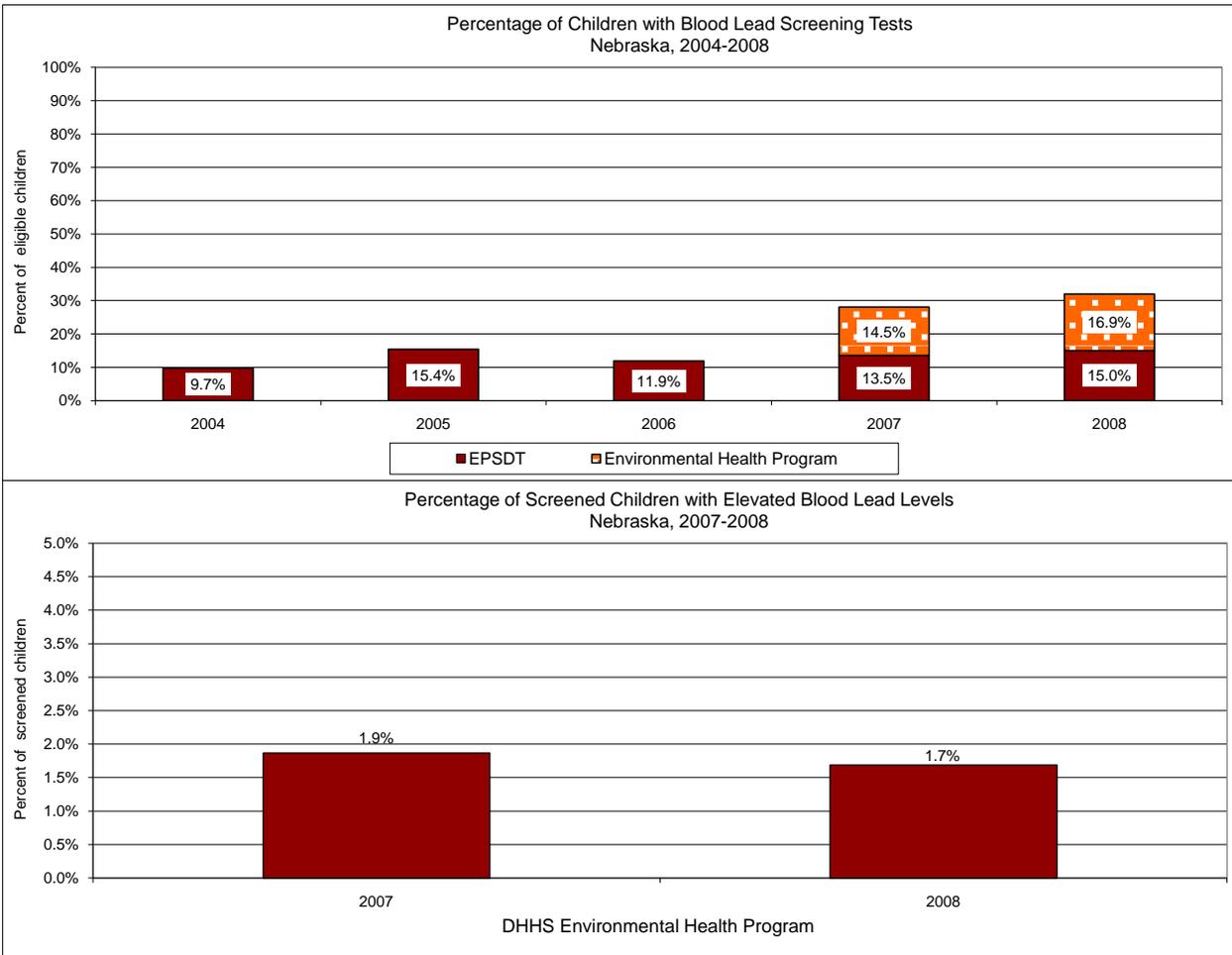
Infant blood lead screening

Definition: The number and percentage of EPSDT-eligible children (1-5) with blood lead screening tests
 The number and percentage of Nebraska children (0-6) with blood lead screening tests (DHHS EH)
 The number and percentage of screened children (0-6) with elevated (10+) blood lead levels (DHHS EH)

Data Source: Nebraska EPSDT
 DHHS Environmental Health Program

	Blood Lead Screening Tests			Elevated Blood Lead Levels		
	Number	%	Nebraska rate was...	Number	%	Nebraska rate was...
Nebraska EPSDT (2008)	8,366	15.0%		-	-	
DHHS Environmental Health (2008)	26118	16.9%		441	1.7%	
HP 2010 Objective		-			0%	Higher
5-Year Trend (EPSDT)		N.L.C.			-	
Racial / Ethnic Differences		-			-	

Graphical Display of Data:



Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

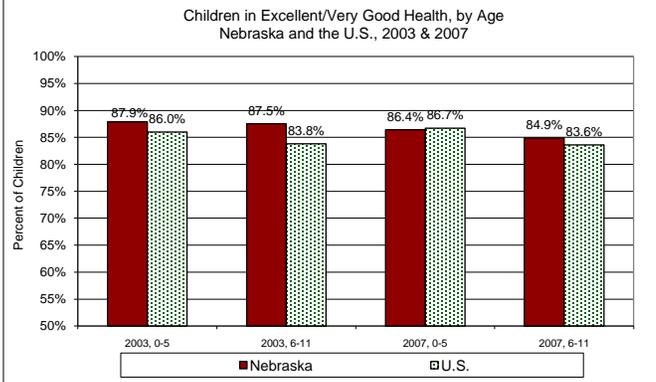
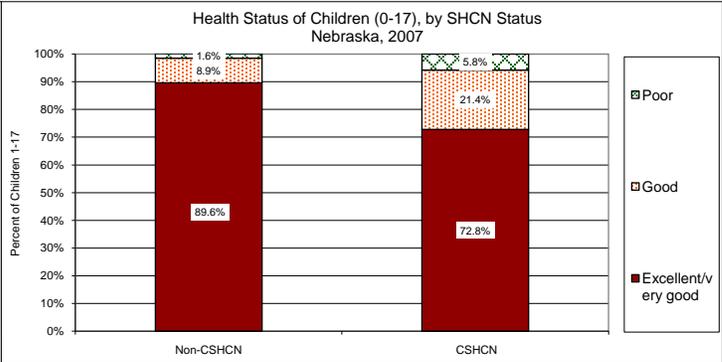
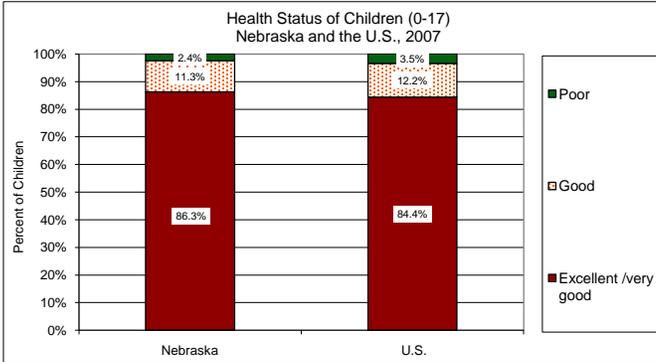
Definition: The number and percent of children reported to be in excellent or very good health

Data Source: National Survey of Children's Health

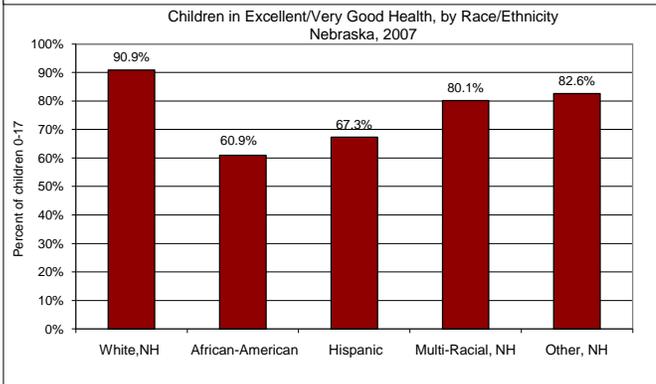
Data & Disparities:

	Very good or excellent health								
	Children 0-5			Children 6-11			Children 0-17		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska
Nebraska (2007)	134,342	86.4%		123,871	84.9%		395,150	86.3%	
United States (2007)	21,210,743	86.7%	N.S.D.	19,997,665	83.6%	N.S.D.	62,216,654	84.4%	N.S.D.
HP 2010 Objective									
2003 vs. 2007	N.S.D.			N.S.D.			nsd		
Racial / Ethnic Differences									

Graphical Display of Data:



% of CSHCN with	than Nebraska average
Excellent/very good health	is Lower
Good health	is Higher
Fair/poor health	is N.S.D.



Race / Ethnicity	than Nebraska average
than White	is N.S.D.
than Black	is Lower
than Indian	is N.S.D.
than Asian	is N.S.D.
than Hispanic	is Lower
Significant Differences by...	Race / Ethnicity ? YES

Data Sheet: HEALTH OUTCOMES

Health Status - Overall Health

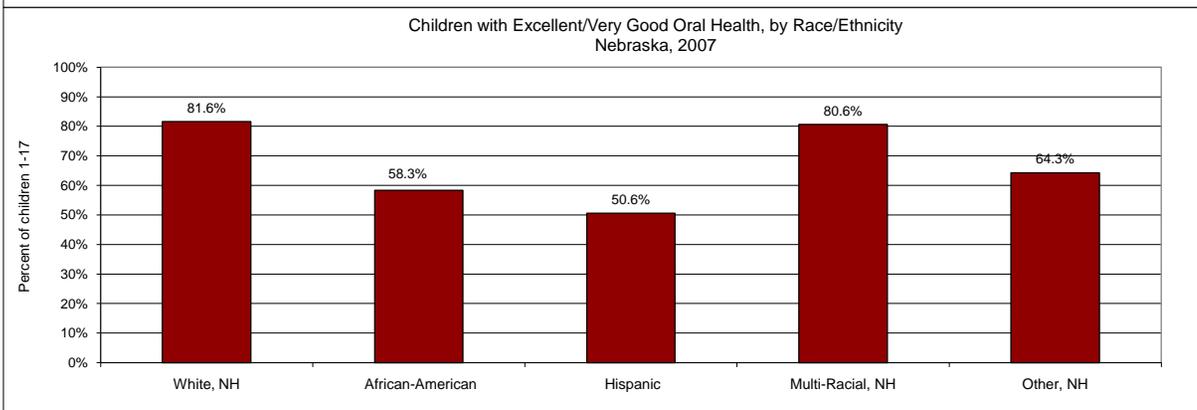
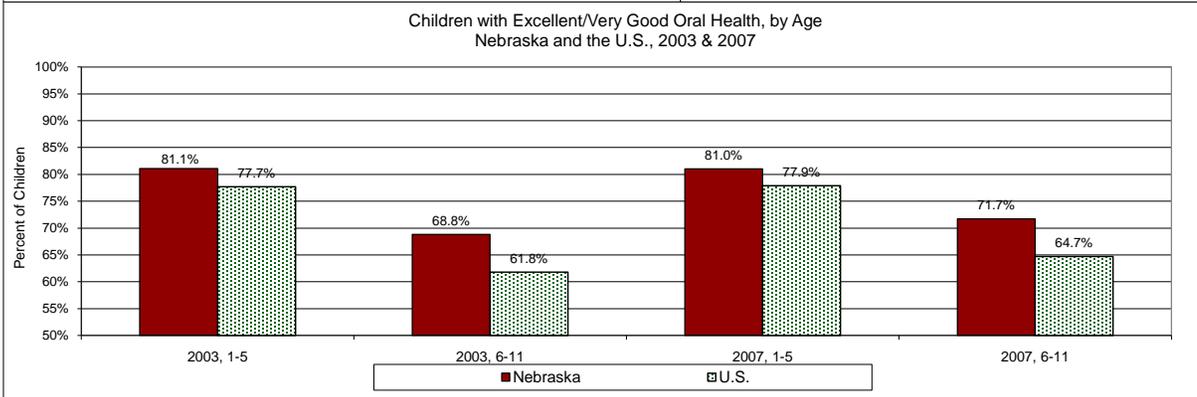
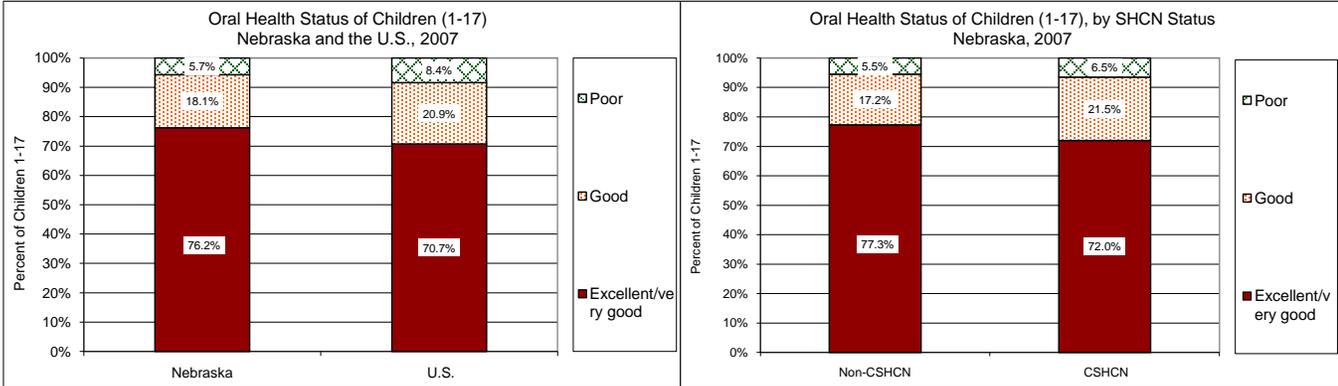
Definition: The number and percent of children (1-17) reported to have excellent or very good oral health

Data Source: National Survey of Children's Health

Data & Disparities:

	Very good or excellent oral health								
	Children 0-5			Children 6-11			Children 1-17		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	106,941	81.0%	was...	104,624	71.7%	was...	331,068	76.2%	was...
United States (2007)	15,736,318	77.9%	N.S.D.	15,475,575	64.7%	N.S.D.	49,118,729	70.7%	Higher
HP 2010 Objective	-			-			-		
2003 vs. 2007	N.S.D.			N.S.D.			nsd		
Racial / Ethnic Differences	YES								

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Overall Health

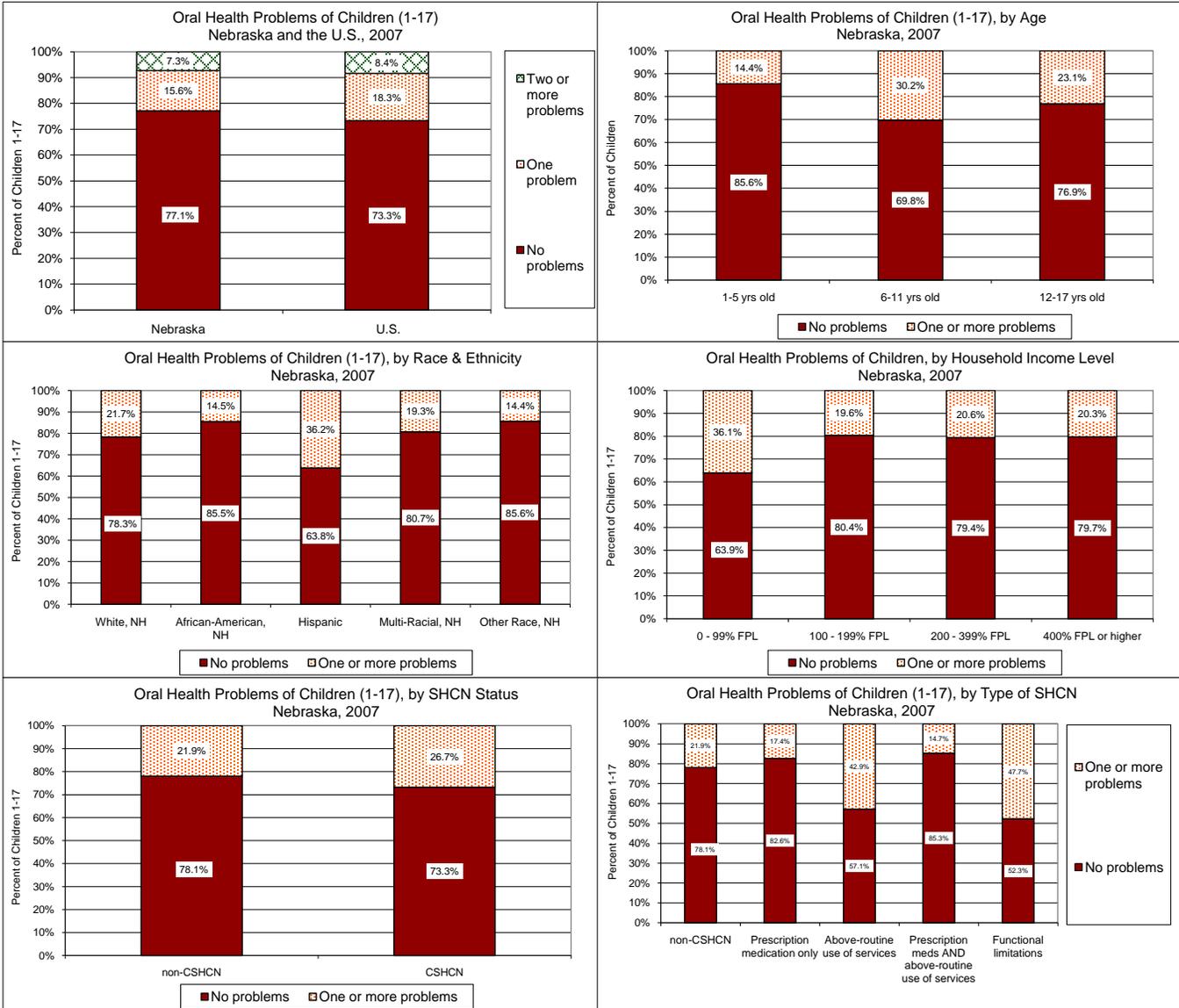
Definition: The number and percent of children (1-17) with oral health problems in the past six months

Data Source: National Survey of Children's Health

Data & Disparities:

	No problems			One problem			2+ problems		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	335,025	77.1%		67,745	15.6%		31,508	7.3%	
United States (2007)	51,004,238	73.3%	Higher	12,724,496	18.3%	N.S.D.	5,849,397	8.4%	N.S.D.
HP 2010 Objective	-	-		-	-		-	-	
2003 vs. 2007	-	-		-	-		-	-	
Racial / Ethnic Differences	-	nsd		-	-		-	-	

Graphical Display of Data:



Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

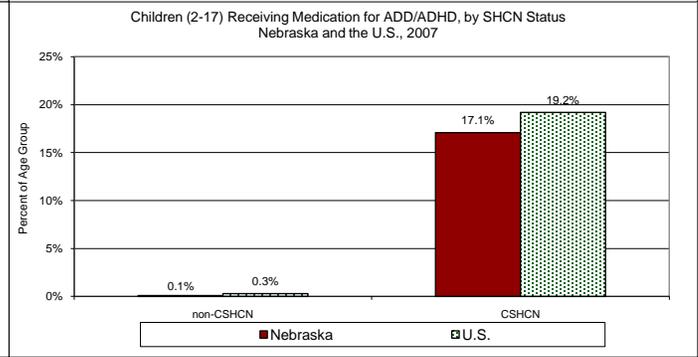
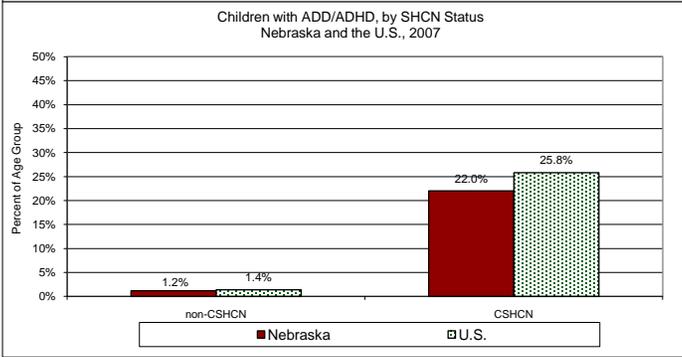
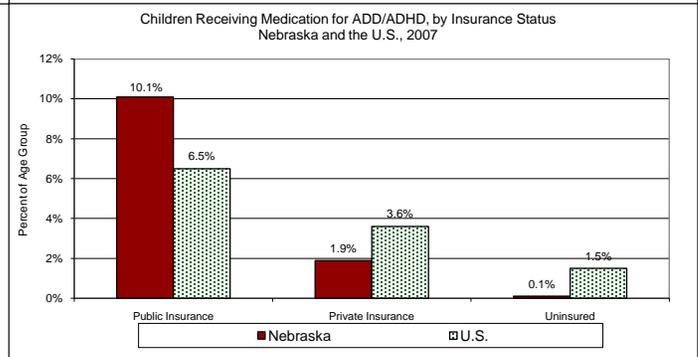
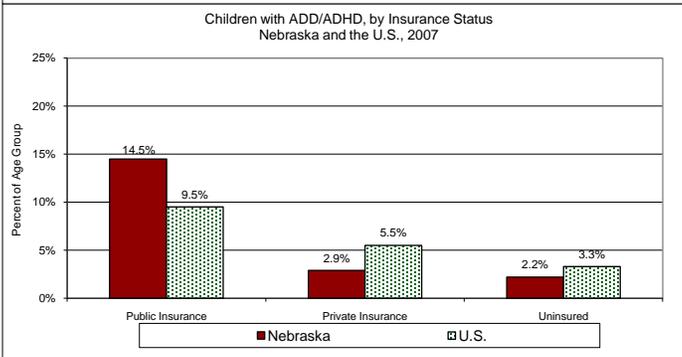
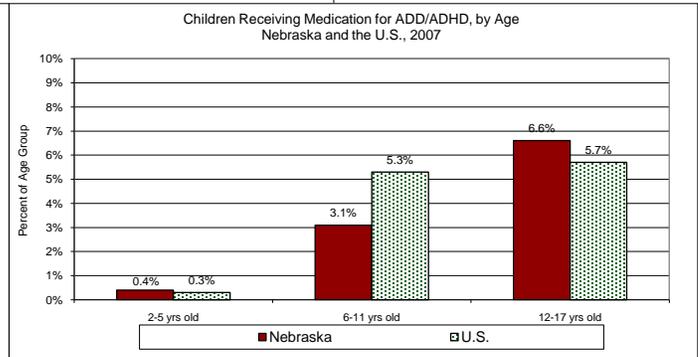
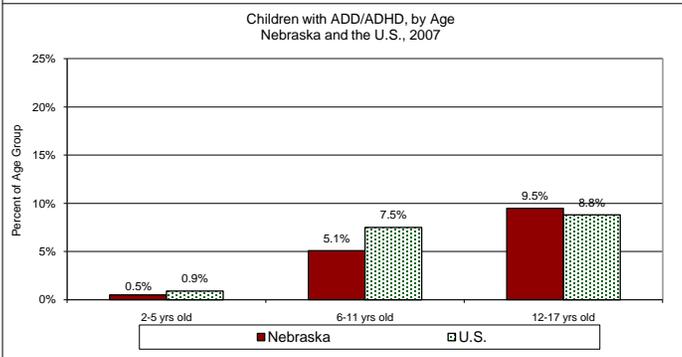
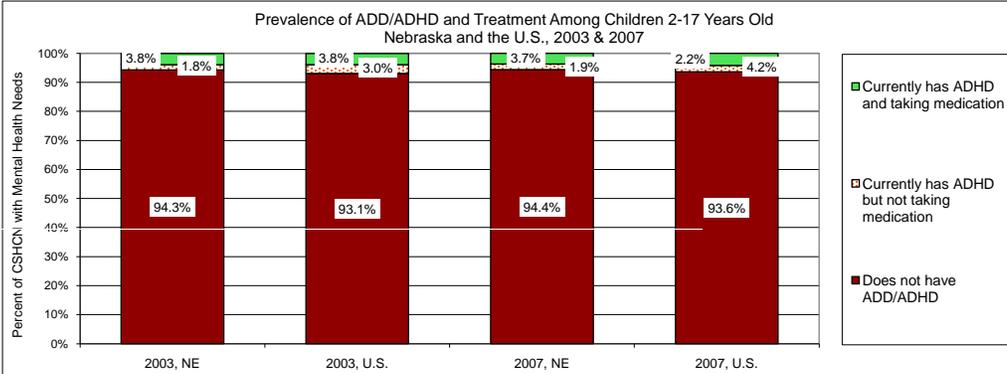
Definition: The number and percentage of children (2-17) whose parents have ever been told the child has ADD/ADHD and are taking medication for the condition

Data Source: National Survey of Children's Health

Data & Disparities:

	Currently Taking ADHD Meds		
	Number	%	Nebraska % was...
Nebraska (2007)	15,216	3.7%	was...
United States (2007)	2,744,082	4.2%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2007		nsd	
Racial / Ethnic Differences		no	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Overall Health

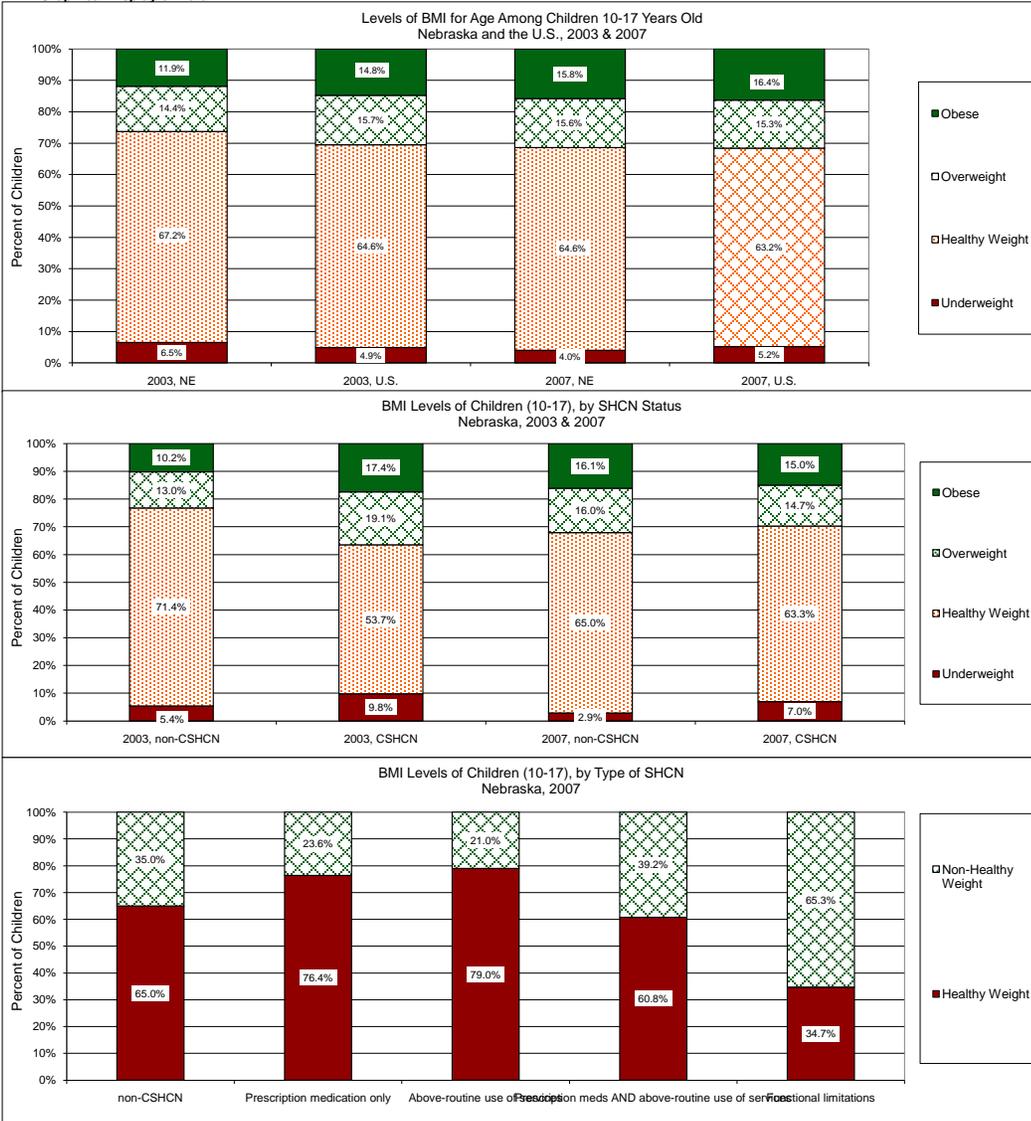
Definition: The number and percentage of children (10-17) at levels of Body Mass Index (BMI) for age

Data Source: National Survey of Children's Health

Data & Disparities:

	Underweight (<5th %ile)			Healthy Weight (5th-85th %ile)			Overweight (85th-95th %ile)			Obese (>95th %ile)		
	Number	%	Nebraska %	Number	%	Nebraska %	Number	%	Nebraska %	Number	%	Nebraska %
Nebraska (2007)	7,816	4.0%	was...	127,366	64.6%	was...	30,860	15.6%	was...	31,175	15.8%	was...
United States (2007)	1,631,791	5.2%	N.S.D.	19,977,432	63.2%	N.S.D.	4,825,739	15.3%	N.S.D.	5,175,940	16.4%	N.S.D.
HP 2010 Objective	-			-			-			-		
Nebraska change, 2001 vs. 2007	nsd			nsd			nsd			nsd		
Racial / Ethnic Differences	no			no			no			no		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Intentional Injuries

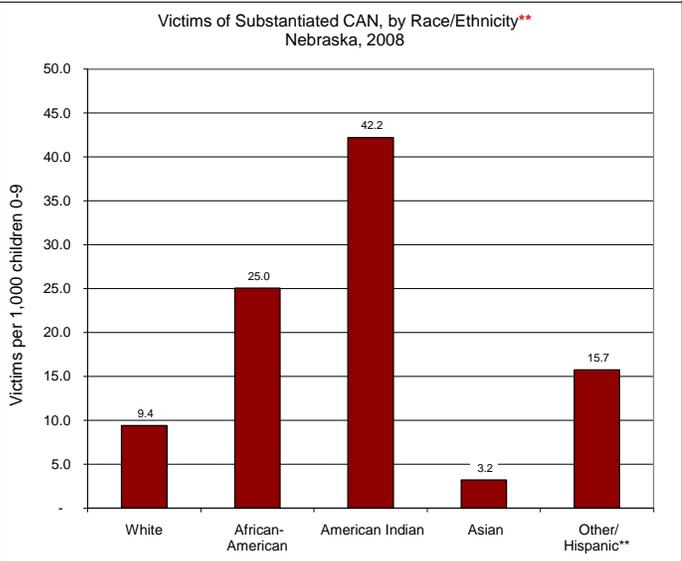
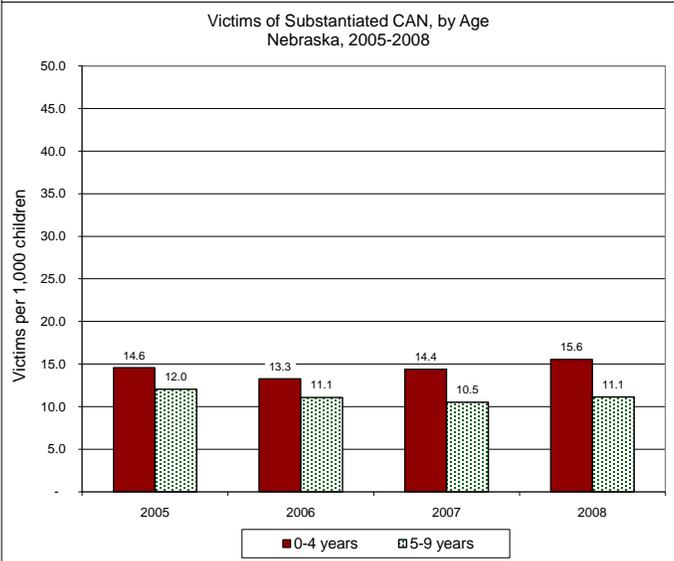
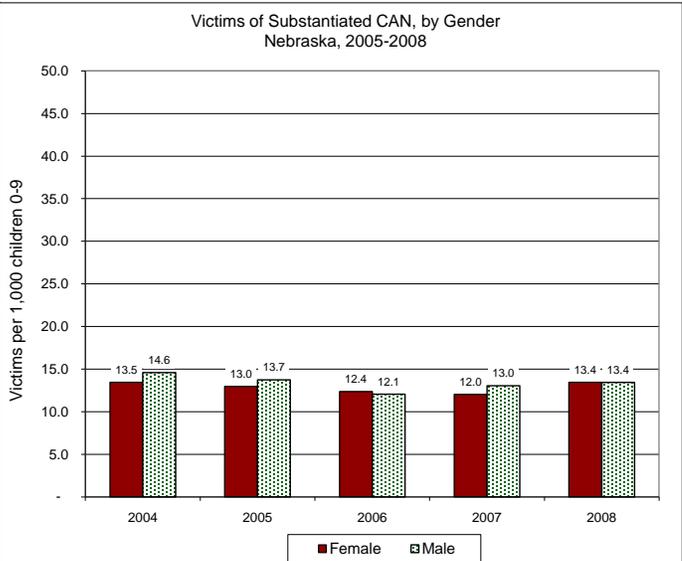
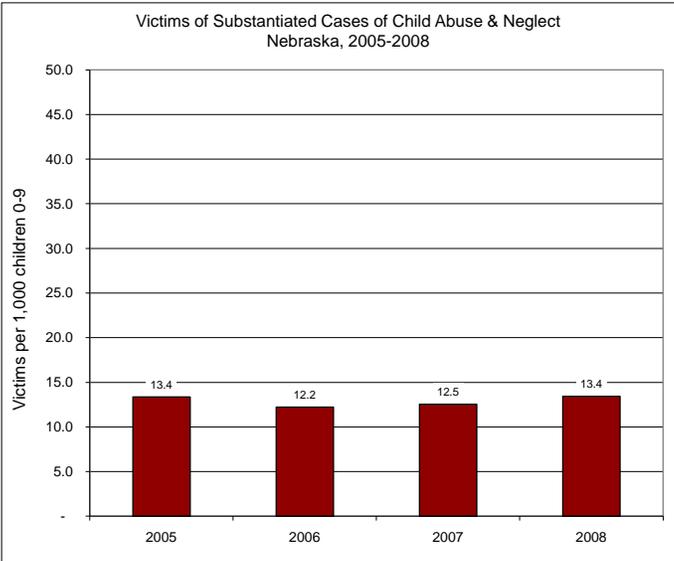
Definition: The number and rate of children (0-9) who are victims of substantiated abuse or neglect, per 1,000 children (unduplicated counts)
katiem

Data Source: DHHS Children and Family Services

Data & Disparities:

	0-4 Years			5-9 Years			0-9 Total		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	1,869	14.4		1,250	10.5		3,407	13.4	
United States (2008)	-	-	-	-	-	-	-	-	-
HP 2010 Objective									
Nebraska 5-year trend		N.L.C.			N.L.C.			N.L.C.	
Racial / Ethnic Differences		-			-			YES	

Graphical Display of Data:



**This category was officially labelled "Other Race" but presumably primarily represents Hispanics.

Data Sheet: HEALTH DETERMINANTS

Access to Care - Services

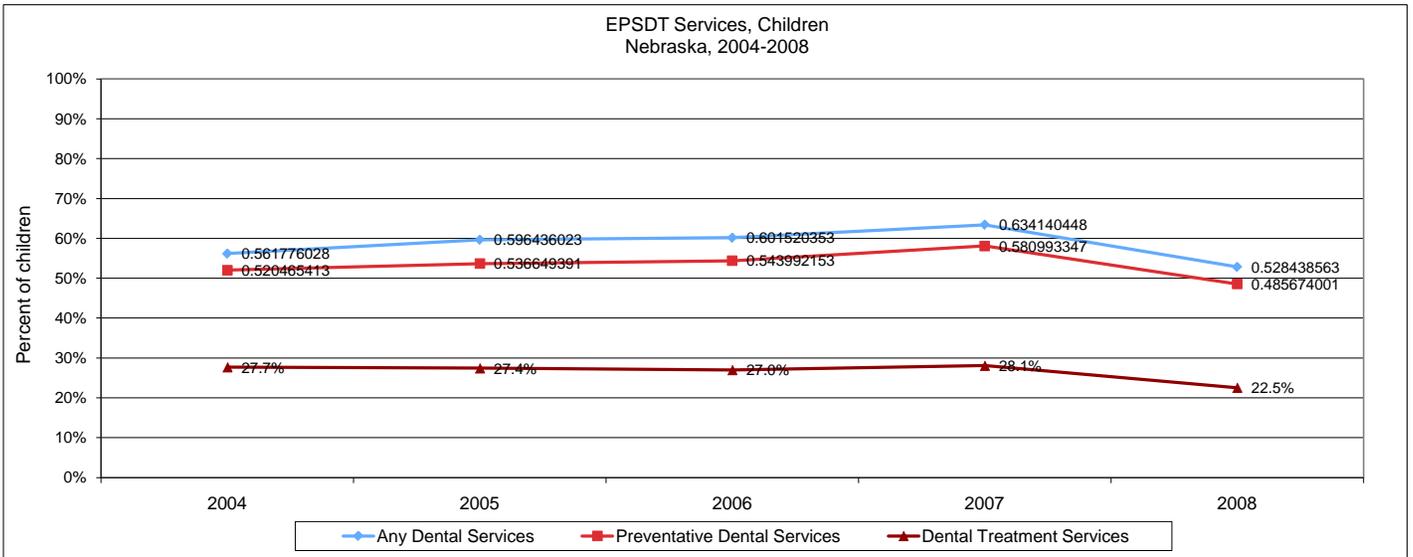
Definitions: The percentage of EPSDT-enrolled children who have received any dental services
 The percentage of EPSDT-enrolled children receiving **preventative** dental services
 The percentage of EPSDT-enrolled children receiving dental **treatment** services

Data Source: Nebraska EPSDT

Data & Disparities:

	Any Dental Services			Preventative Dental Services			Dental Treatment Services		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	40,852	52.8%		37,546	48.6%		17,432	22.5%	
United States (2008)	-	-		-	-		-	-	
HP 2010 Objective				66.0%		Lower			
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-			-		

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

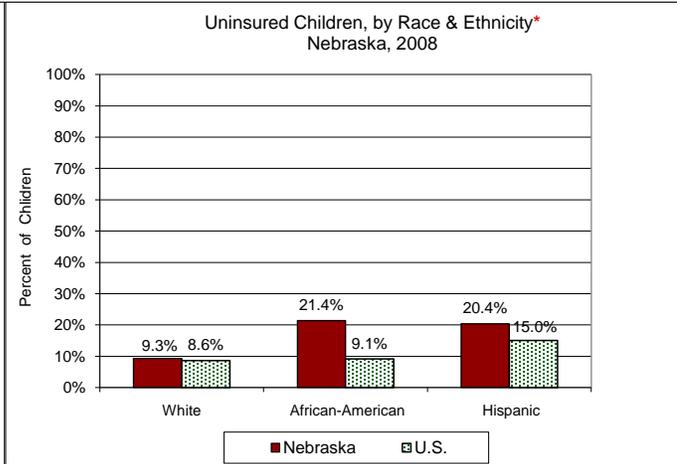
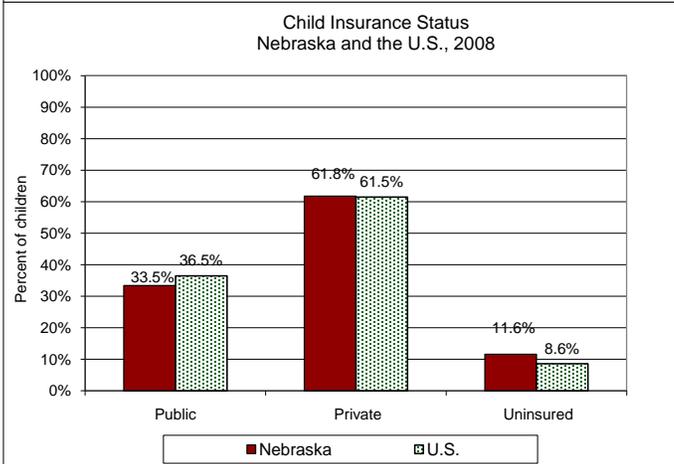
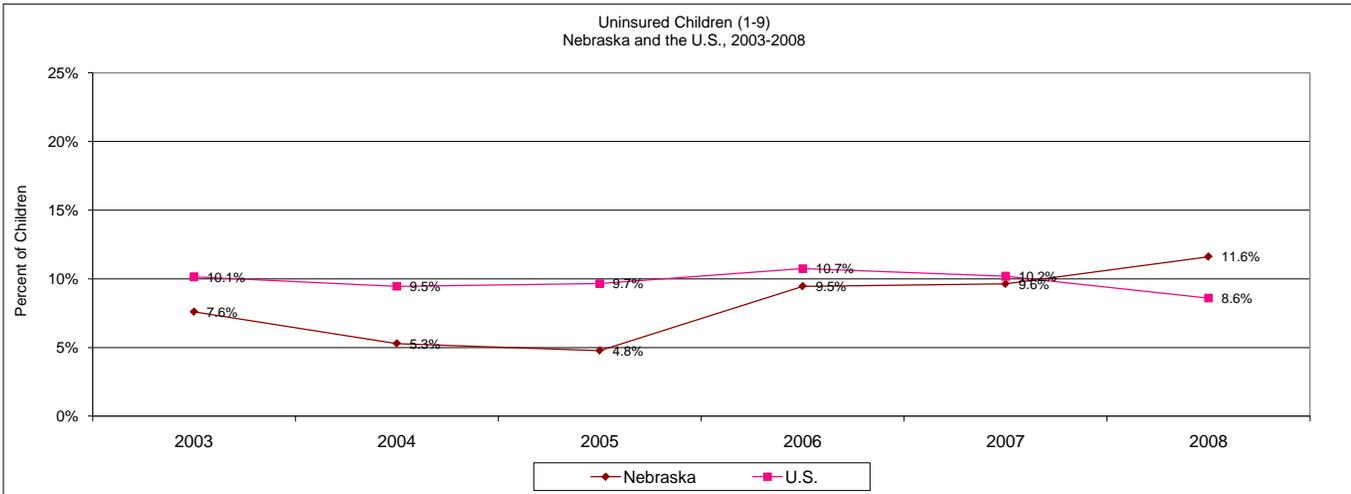
Definition: The number and percentage of children 1-9 who have health insurance

Data Source: U.S. Census - Current Population Survey

Data & Disparities:

	Public Insurance			Private Insurance			Uninsured		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	75,259	33.5%		139,004	61.8%		26,131	11.6%	
United States (2008)	13,553,140	36.5%	Lower	22,838,346	61.5%	Higher	3,192,495	8.6%	Higher
HP 2010 Objective	-			-			0.0		
Nebraska 5-year trend	N.L.C.			N.L.C.			INCREASING		
Racial / Ethnic Differences	YES			YES			YES		

Graphical Display of Data:



*Data for American Indian and Asian children were not stable enough for comparisons.

Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

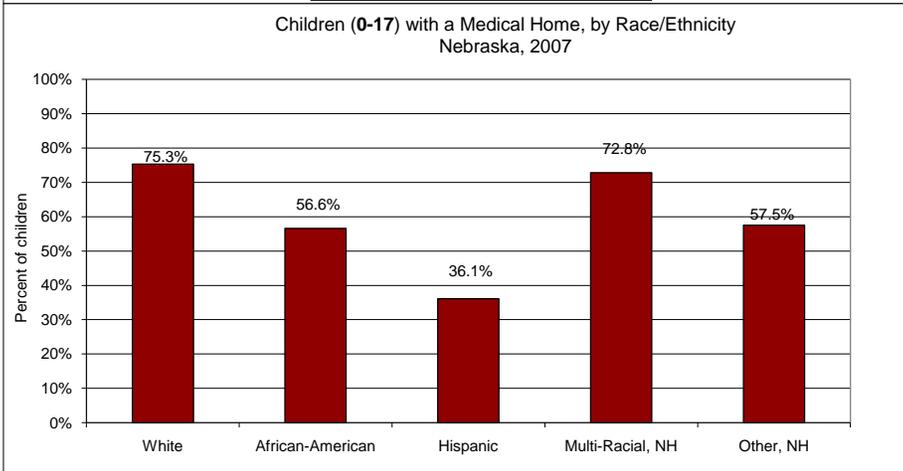
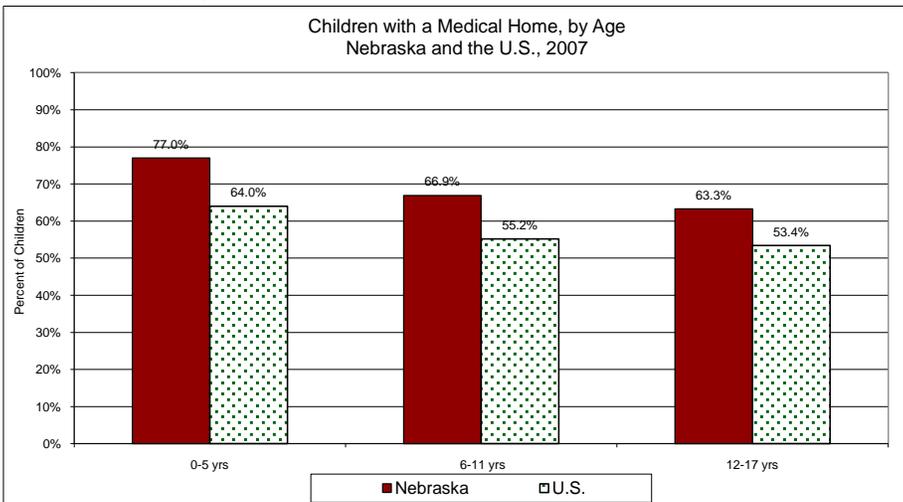
Definition: The number and percent of children who have medical care that meets the AAP criteria of medical home

Data Source: National Survey of Children's Health

Data & Disparities:

	0-5 years			6-11 years			0-17 years		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	116,588	77.0%	rate was...	94,347	66.9%	rate was...	306,836	69.1%	rate was...
United States (2007)	15,117,184	64.0%	Higher	12,614,693	55.2%	Higher	40,602,320	57.5%	Higher
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska 5-year trend	-	-	-	-	-	-	-	-	-
Racial / Ethnic Differences	-	-	-	-	-	-	YES	-	-

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

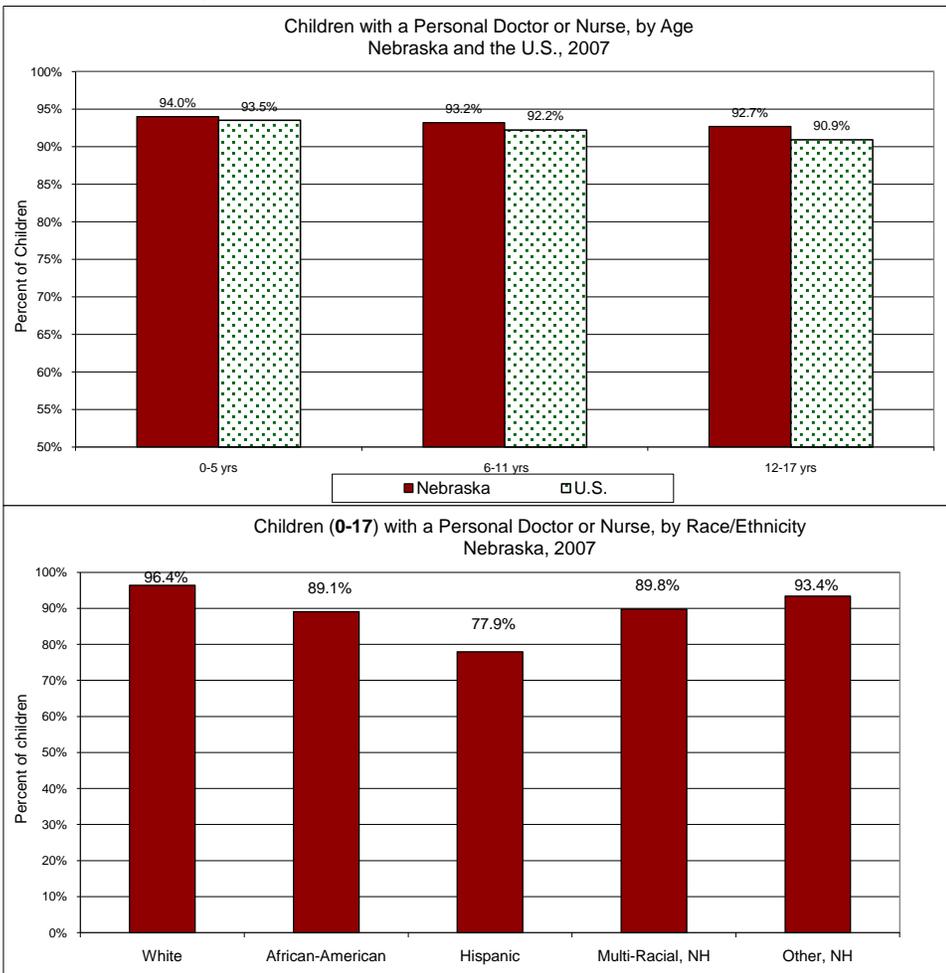
Definition: The number and percent of children who have a personal doctor or nurse

Data Source: National Survey of Children's Health

Data & Disparities:

	0-5 years			6-11 years			0-17 years		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	146,260	94.0%	rate was...	136,060	93.2%	rate was...	426,410	93.3%	rate was...
United States (2007)	22,828,412	93.5%	N.S.D.	21,931,060	92.2%	N.S.D.	67,685,757	92.2%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska change, 2003 vs. 2007	N.S.D.			N.S.D.			Increased		
Racial / Ethnic Differences	-			-			YES		

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Access to Care

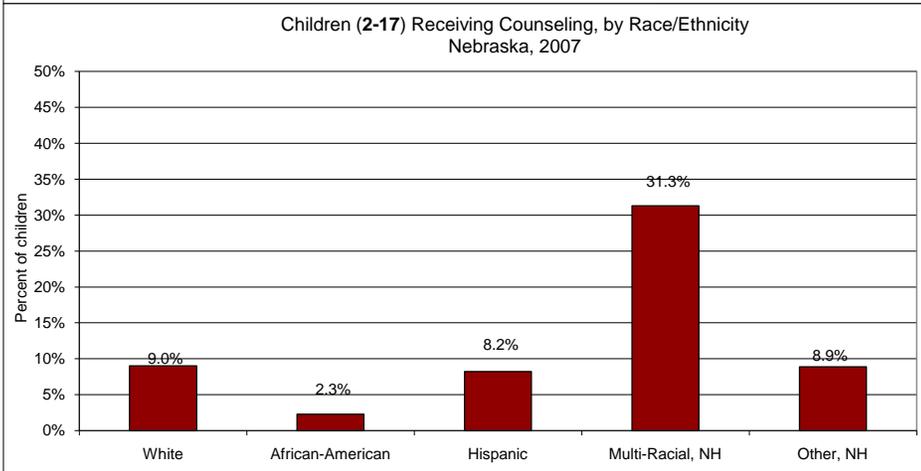
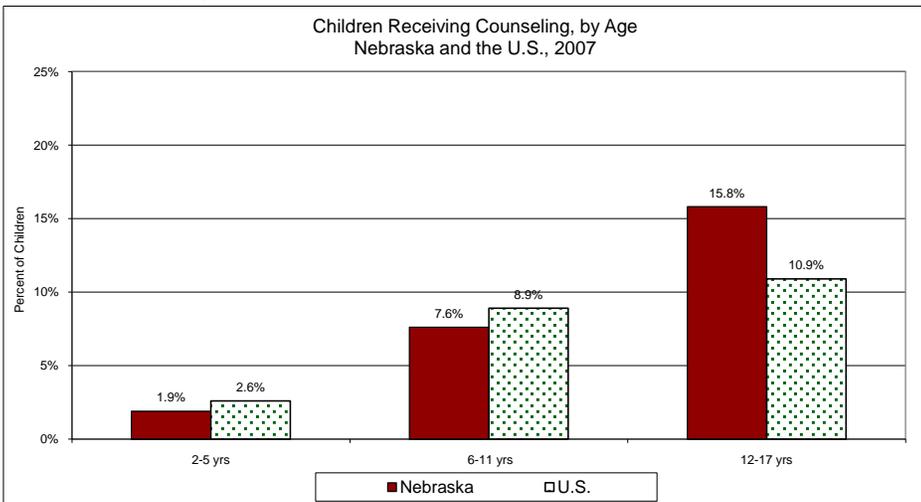
Definition: The number and percent of children who received some type of mental health care or counseling during the past 12 months

Data Source: National Survey of Children's Health

Data & Disparities:

	2-5 years			6-11 years			2-17 years		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	1,941	1.9%		11,147	7.6%		37,710	9.3%	
United States (2007)	418,304	2.6%	N.S.D.	2,123,360	8.9%	N.S.D.	5,290,094	8.1%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska change, 2003 vs. 2007	-	-	-	-	N.S.D.	-	-	N.S.D.	-
Racial / Ethnic Differences	-	-	-	-	-	-	-	YES	-

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Health Behavior

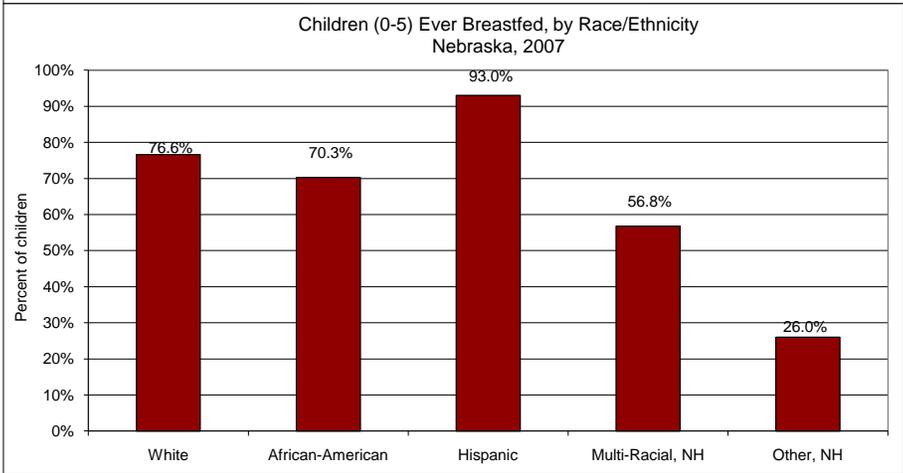
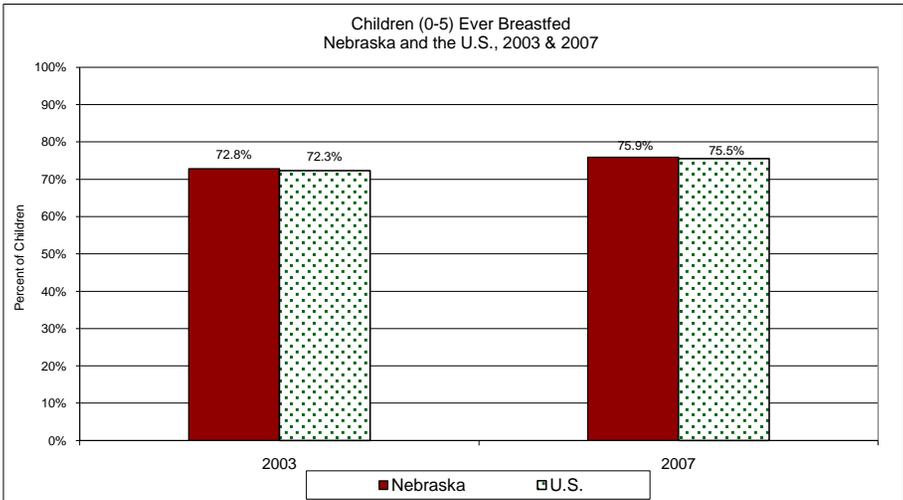
Definition: The number and percent of children (0-5) who were ever breastfed

Data Source: National Survey of Children's Health

Data & Disparities:

	Ever breastfed		
	Number	Rate	Nebraska rate was...
Nebraska (2007)	116,933	75.9%	N.S.D.
United States (2007)	18,391,356	75.5%	N.S.D.
HP 2010 Objective	75%		N.S.D.
Nebraska change, 2003-2007			N.S.D.
Racial / Ethnic Differences			YES

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Health Behavior

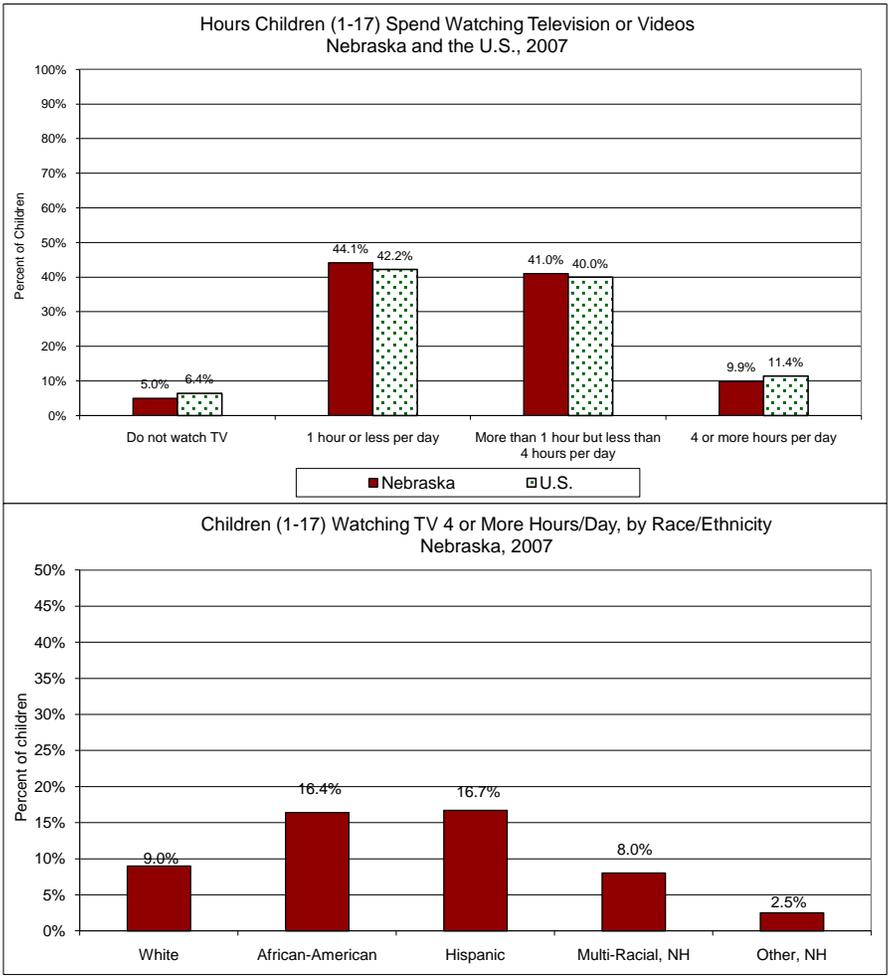
Definition: The number and percent of children who spend 4 or more hours watching TV or playing video games on an average school day

Data Source: National Survey of Children's Health

Data & Disparities:

	1-5			6-11			1-17		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	12,820	9.7%	N.S.D.	9,630	6.6%	N.S.D.	43,036	9.9%	N.S.D.
United States (2007)	2,580,130	12.8%	N.S.D.	2,170,759	9.1%	N.S.D.	7,881,975	11.4%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska change, 2003-2007	-	-	-	N.S.D.			N.S.D.		
Racial / Ethnic Differences	-			YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Health Behavior

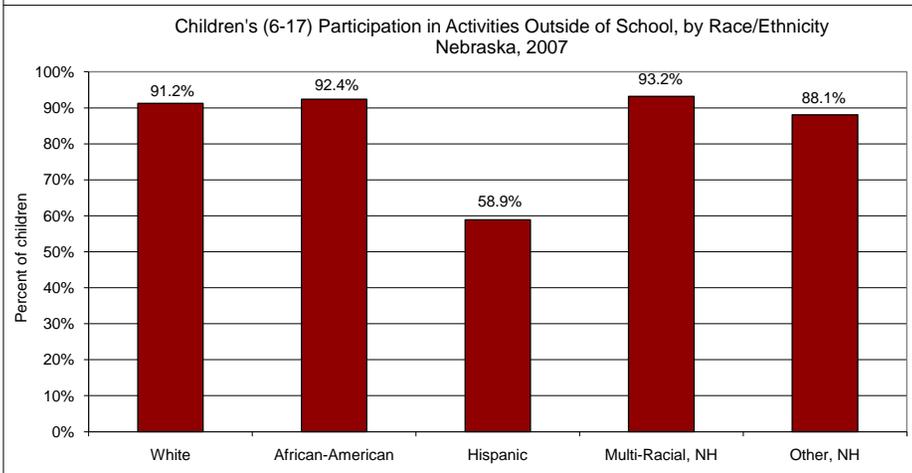
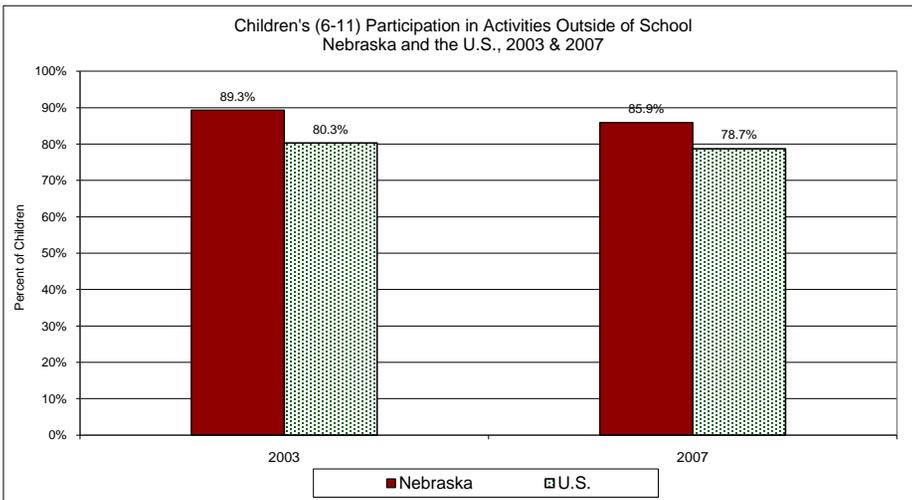
Definition: The number and percent of children who participate in activities outside of school

Data Source: National Survey of Children's Health

Data & Disparities:

	6-11			6-17		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	125,352	85.9%		264,211	87.6%	
United States (2007)	18,799,065	78.7%	Higher	39,681,211	80.7%	Higher
HP 2010 Objective	-	-	-	-	-	-
Nebraska change, 2003-2007	N.S.D.			N.S.D.		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Care - Health Behavior

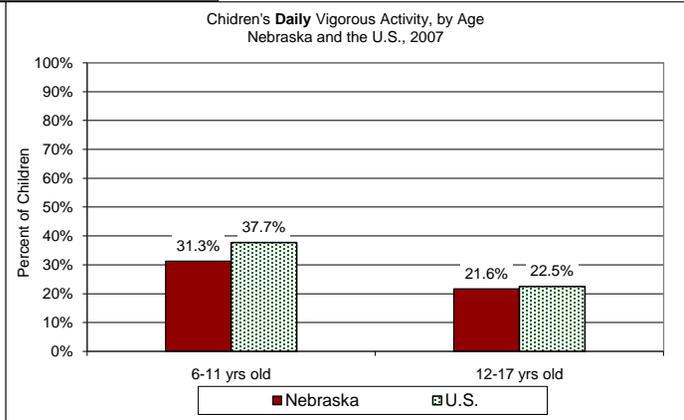
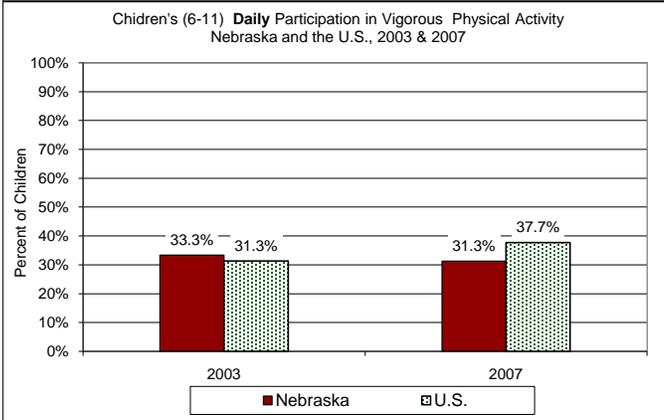
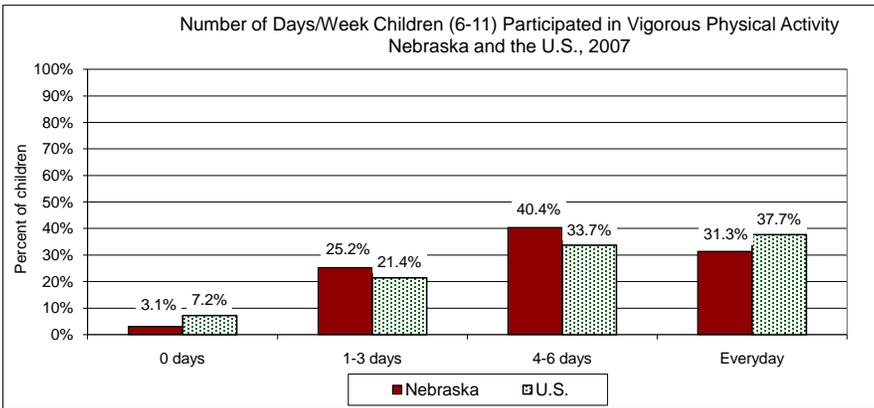
Definition: The number and percent of children 6-17 years old who engage in vigorous physical activity at least 20 minutes per day

Data Source: National Survey of Children's Health

Data & Disparities:

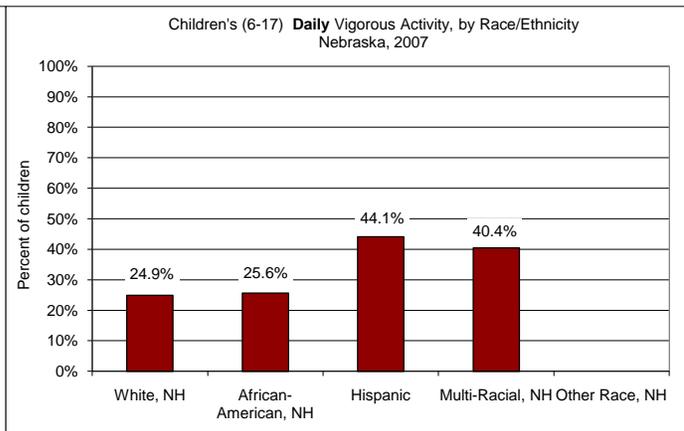
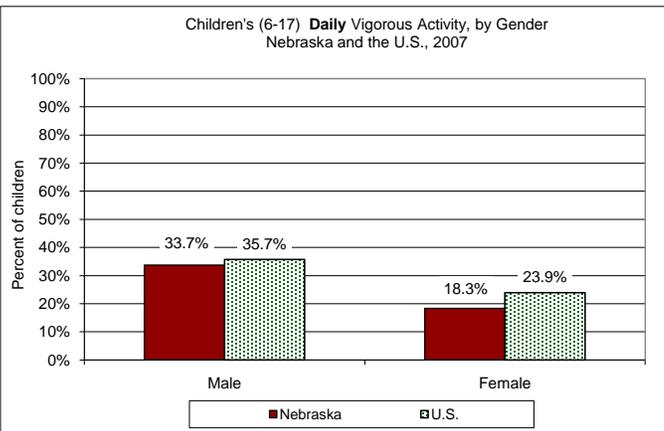
	6-11 years			6-17 years		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	45,288	31.3%	rate was...	78,617	26.2%	rate was...
United States (2007)	8,938,266	37.7%	N.S.D.	14,565,413	29.9%	N.S.D.
HP 2010 Objective	85%		Lower	85%		Lower
Nebraska change, 2003-2007	-			nsd		
Racial / Ethnic Differences	-			nsd		

Graphical Display of Data:



U.S. increase over time is significant.

Significant Differences by.. Age ? **ALMOST** (p<.10)



Significant Differences by... Gender ? **YES**

Significant Differences by.. Race/Ethnicity ? **NO**

CSHCN

Data Sheet: **DEMOGRAPHICS**

Income

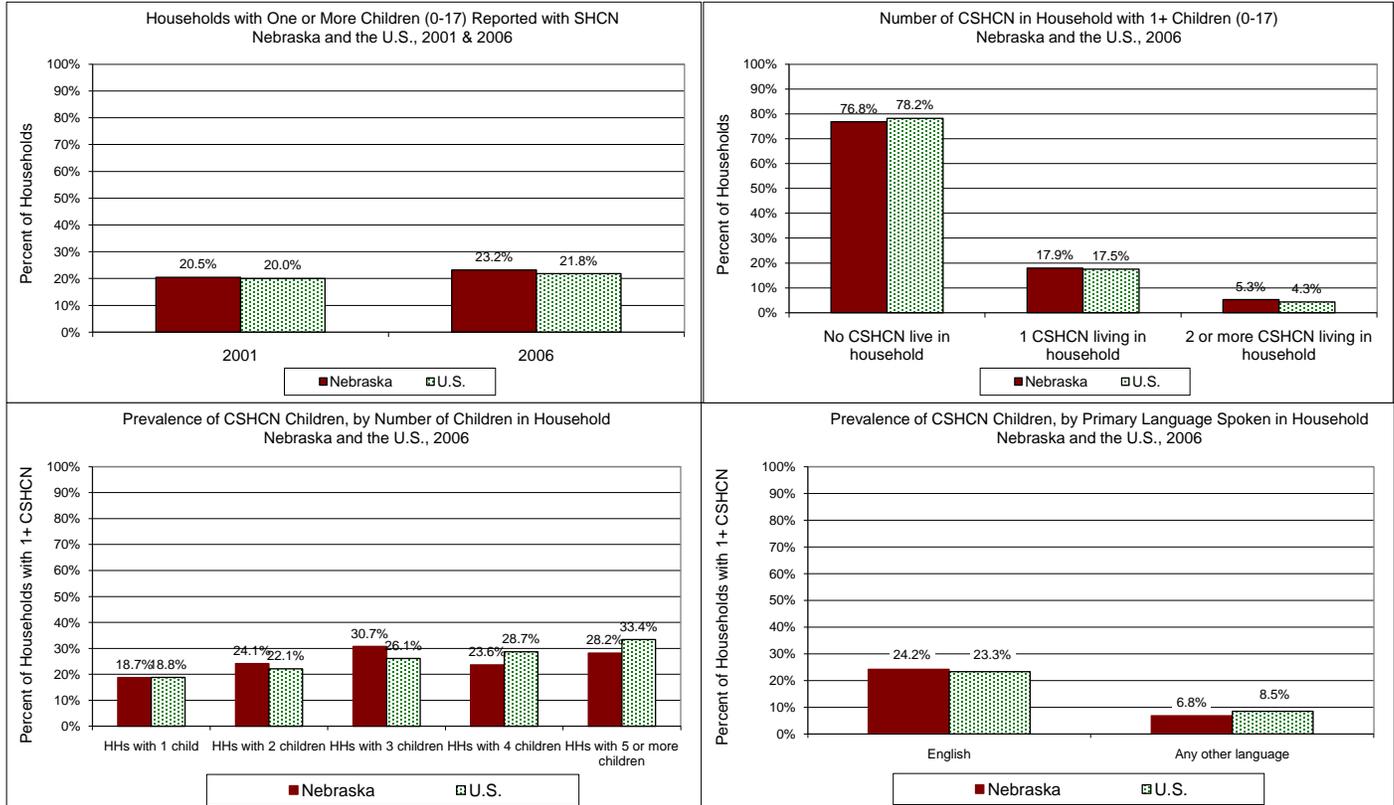
Definition: Number and percentage of households with one or more children (0-17) reported with special health care needs

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Households		
	Number	%	Nebraska %
Nebraska (2006)	57,031	23.2%	was...
United States (2006)	8,764,639	21.8%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		-	

Graphical Display of Data:



Data Sheet: **DEMOGRAPHICS**

Percentage of Population

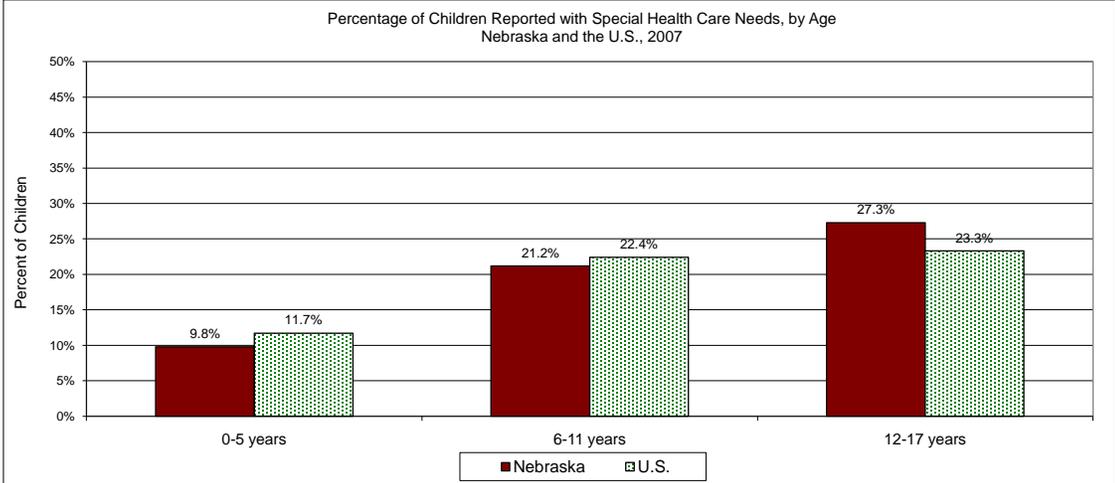
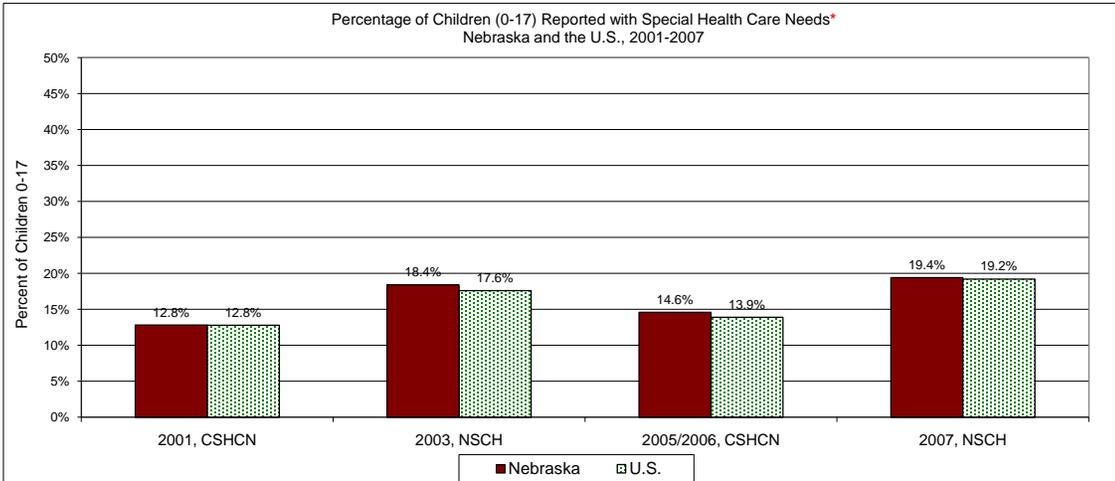
Definition: Percentage of Nebraska child (0-17) population reported with special health care needs, by age

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)*
National Survey on Children's Health (2003, 2007)*

Data & Disparities:

	0-5			6-11			12-17			0-17 Total		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2007)	15,245	9.8%	was...	30,976	21.2%	was...	42,766	27.3%	was...	88,988	19.4%	was...
United States (2007)	2,854,907	11.7%	N.S.D.	5,368,257	22.4%	N.S.D.	5,913,290	23.3%	N.S.D.	14,136,454	19.2%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	-	-	-	-	-	-
Nebraska change, 2001 vs. 2007	-	N.L.C.	-	-	N.L.C.	-	-	N.L.C.	-	-	N.L.C.	-
Racial / Ethnic Differences	-	-	-	-	-	-	-	-	-	-	YES	-

Graphical Display of Data:



***Note:** Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results across surveys and years.

Data Sheet: **DEMOGRAPHICS**

Prevalence by Race & Ethnicity

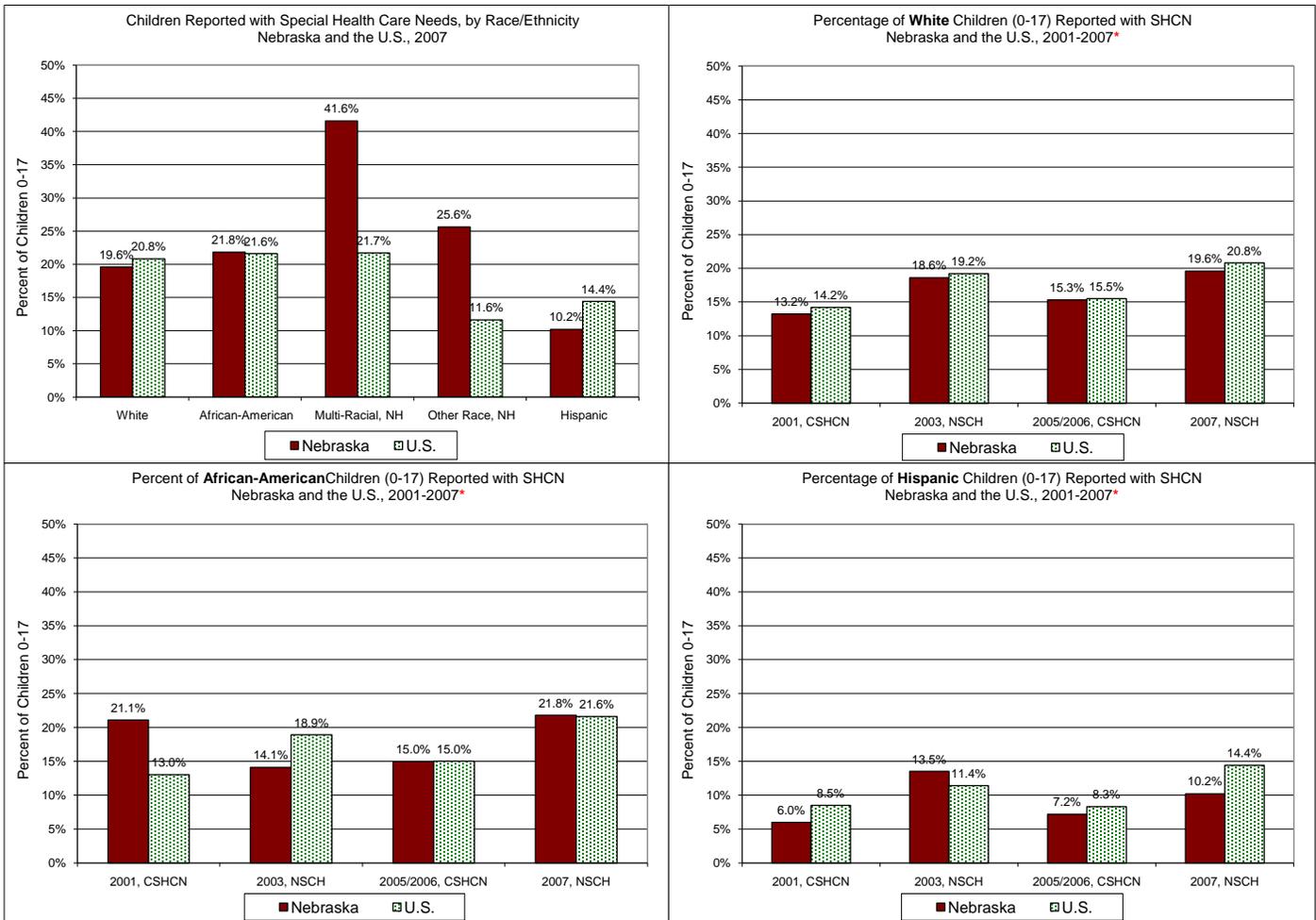
Definition: Percentage of Nebraska child (0-17) population reported with special health care needs, by race and ethnicity**

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)*
National Survey on Children's Health (2003, 2007)*

Data & Disparities:

	White			African-American			Multi-Racial		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2007)	67,537	19.6%	was...	4,470	21.8%	was...	7,038	41.6%	was...
United States (2007)	8,466,048	20.8%	N.S.D.	2,226,310	21.6%	N.S.D.	677,549	21.7%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska change, 2001 vs. 2007	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences									
	Other Race, NH			Hispanic					
	Number	%	Nebraska % was...	Number	%	Nebraska % was...			
Nebraska (2007)	3,294	25.6%	was...	5,551	10.2%	was...			
United States (2007)	401,518	11.6%	N.S.D.	2,129,675	14.4%	N.S.D.			
HP 2010 Objective	-	-	-	-	-	-			
Nebraska change, 2001 vs. 2007	N.L.C.			N.L.C.					
Racial / Ethnic Differences									

Graphical Display of Data:



*Note: Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results across surveys and years.

**Note: Data for Multi-Racial and Other Race categories were too unstable for valid longitudinal comparisons.

Data Sheet: **DEMOGRAPHICS**

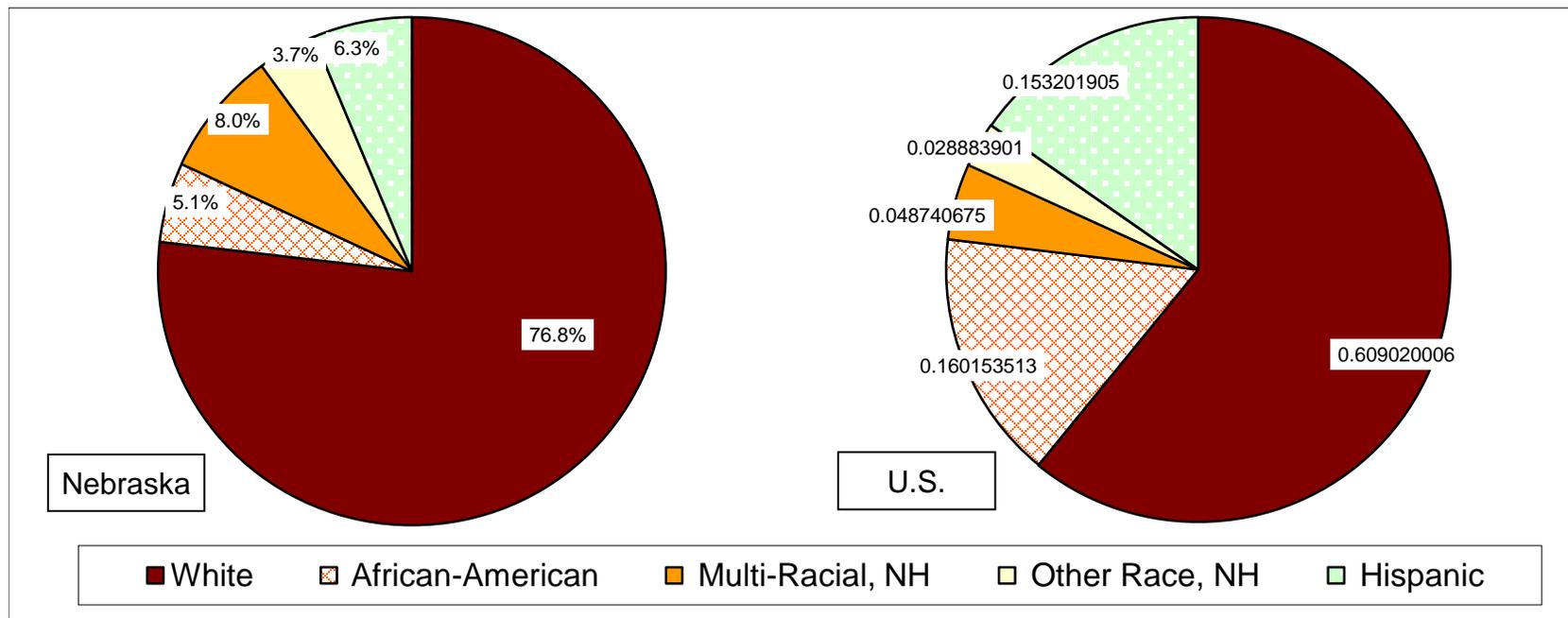
Distribution by Race & Ethnicity

Definition: Racial & ethnic distribution of Nebraska child (0-17) population reported with special health care needs

Data Source: National Survey on Children's Health

Graphical Display of Data:

Racial/Ethnic Distribution of Children Reported with Special Health Care Needs
Nebraska and the U.S., 2007



Data Sheet: **DEMOGRAPHICS**

Prevalence by Gender

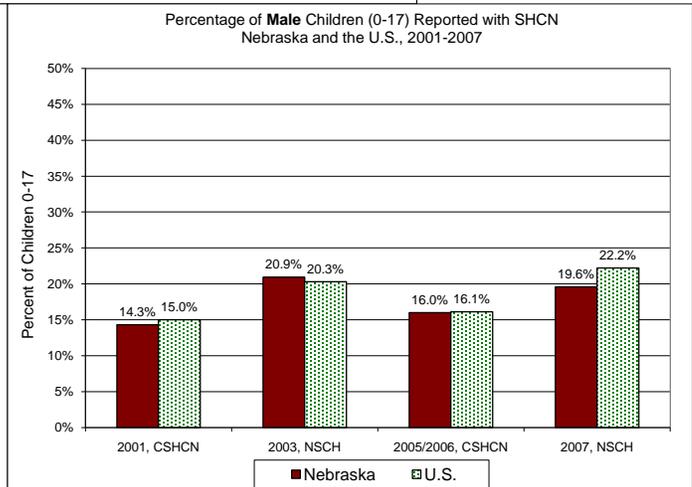
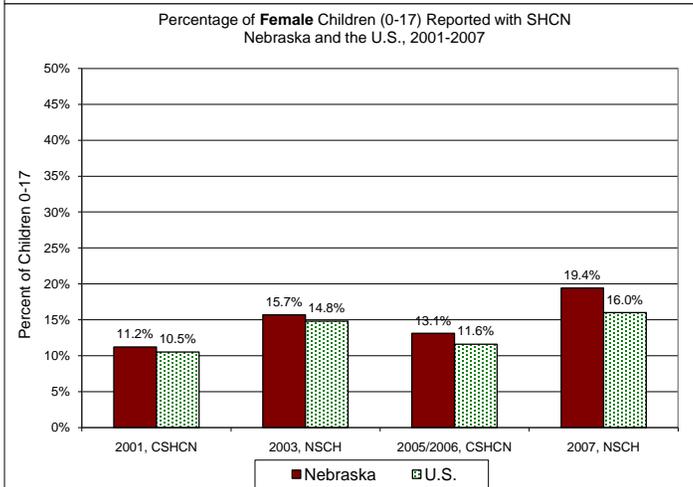
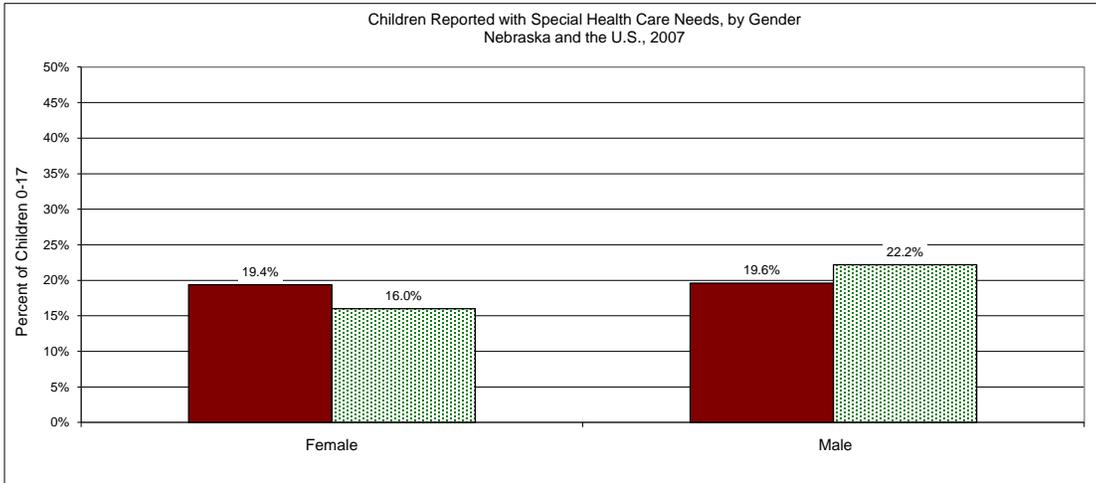
Definition: Percentage of Nebraska child (0-17) population reported with special health care needs, by gender

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)*
National Survey on Children's Health (2003, 2007)*

Data & Disparities:

	Female			Male		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2007)	42,885	19.4%	was...	46,103	19.6%	was...
United States (2007)	5,746,728	16.0%	N.S.D.	8,374,749	22.2%	N.S.D.
HP 2010 Objective	-			-		
Nebraska change, 2001 vs. 2007	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Graphical Display of Data:



***Note:** Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results across surveys and years.

Data Sheet: **DEMOGRAPHICS**

Income

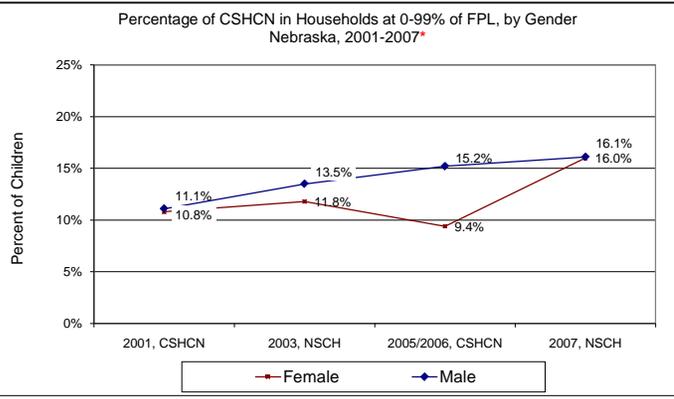
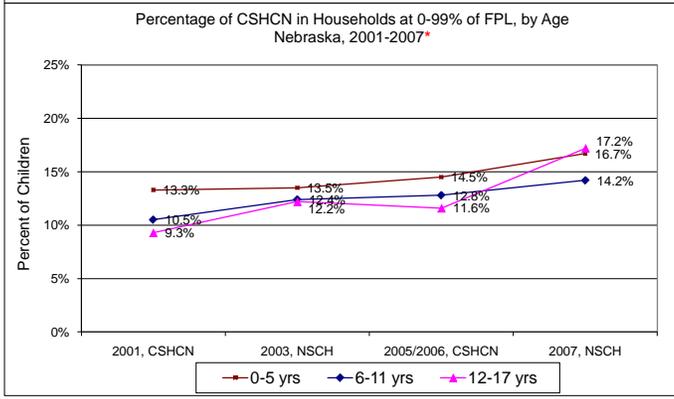
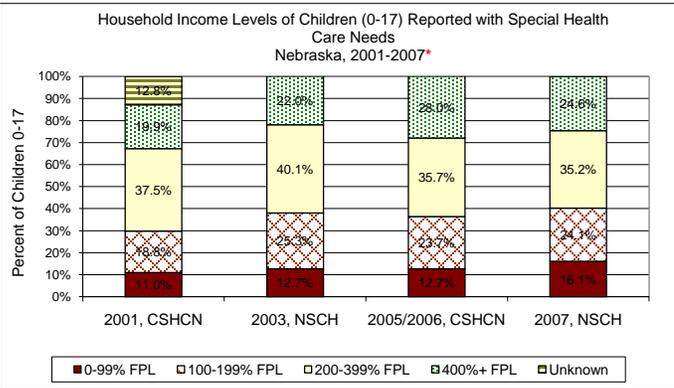
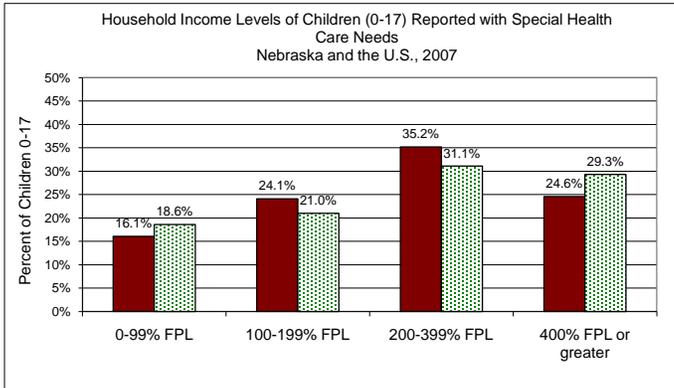
Definition: Income status of Nebraska households with one or more children (0-17) reported with special health care needs, relative to Federal Poverty Limit

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)*
National Survey on Children's Health (2003, 2007)*

Data & Disparities:

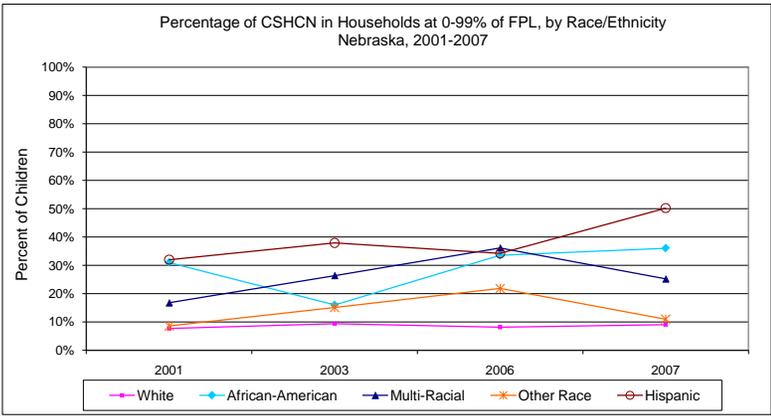
	0-99% of FPL			100-199% FPL			200-399% FPL			400%+ FPL		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2007)	73,589	16.1%		110,416	24.1%		161,296	35.2%		112,555	24.6%	
United States (2007)	13,696,186	18.6%	N.S.D.	15,481,847	21.0%	N.S.D.	22,938,041	31.1%	Higher	21,642,542	29.3%	Lower
HP 2010 Objective		-			-			-			-	
Nebraska change, 2001 vs. 2007		N.L.C.			-			-			-	
Racial / Ethnic Differences		YES			-			-			-	

Graphical Display of Data:



Age	Time Trends
0-5 years	N.L.C.
6-11 years	N.L.C.
12-17 years	N.L.C.

Gender	Time Trends
Female	N.L.C.
Male	INCREASING



Gender	Time Trends
White	N.L.C.
African-American	N.L.C.
Multi-Racial	N.L.C.
Other Race, NH	N.L.C.
Hispanic	N.L.C.

*Note: Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results across surveys and years.

Data Sheet: **DEMOGRAPHICS**

Types of Special Needs

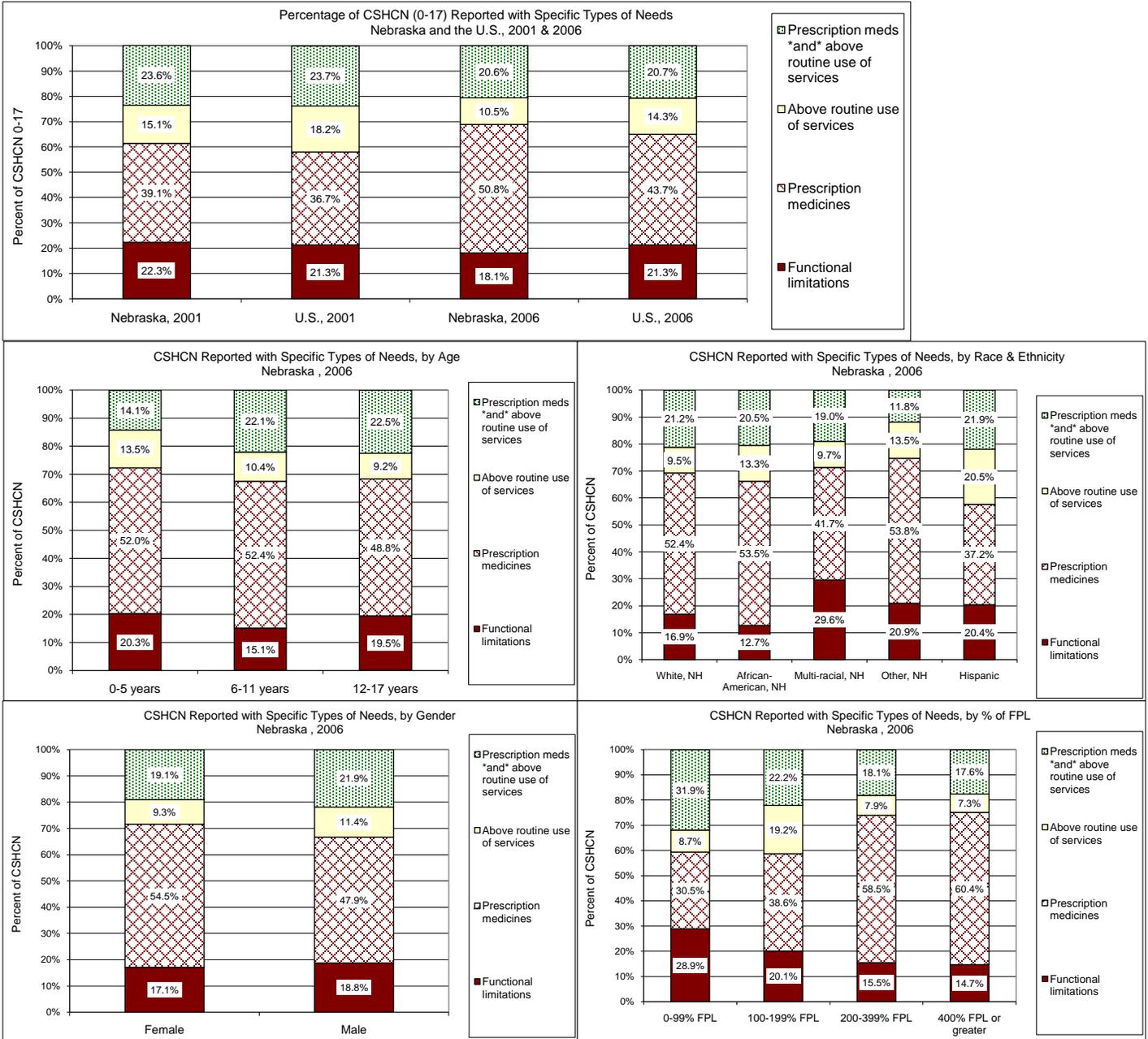
Definition: Number and percentage of Nebraska child (0-17) population that qualified on specific types of special health needs criteria

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Functional Limitations			Prescription Medicines			Above Routine Use			Medicines & Services		
	Number	%	Nebraska %	Number	%	Nebraska %	Number	%	Nebraska %	Number	%	Nebraska %
Nebraska (2006)	11,332	18.1%	was...	31,860	50.8%	was...	6,609	10.5%	was...	12,958	20.6%	was...
United States (2006)	2,179,841	21.3%	N.S.D.	4,465,840	43.7%	Higher	1,459,087	14.3%	Lower	2,116,871	20.7%	N.S.D.
HP 2010 Objective	-			-			-			-		
Nebraska change, 2001 vs. 2006	N.S.D.			Increased			N.S.D.			N.S.D.		
Racial / Ethnic Differences	NO			NO			NO			NO		

Graphical Display of Data:



Special Need Type	Significant Differences by...			
	Age?	Race/Ethnicity?	Gender?	% FPL?
Functional limitations	NO	NO	NO	YES
Managed by Rx meds	NO	NO	NO	YES
Above routine need/use of services	NO	NO	NO	YES
Rx meds AND service use	NO	NO	NO	NO

Data Sheet: MCH CORE OUTCOMES

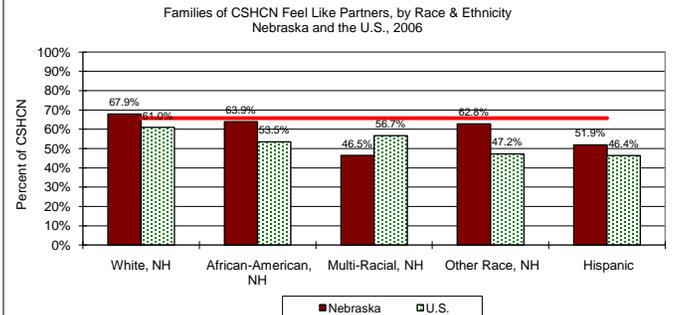
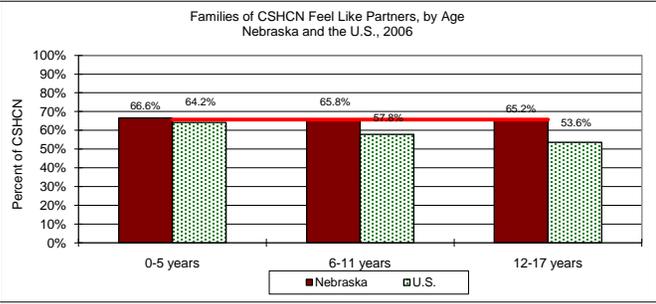
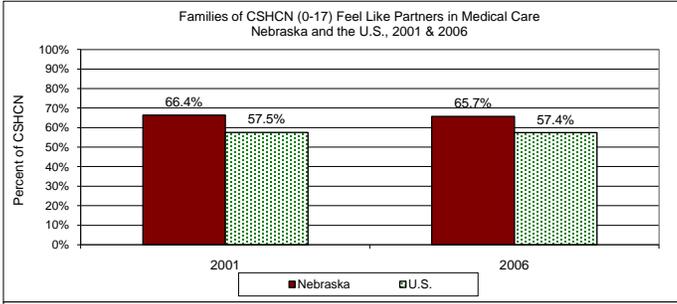
Definition: Core Outcome #1: The number and percentage of CSHCN whose families are partners in decision making at all levels, and who are satisfied with the services they receive

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

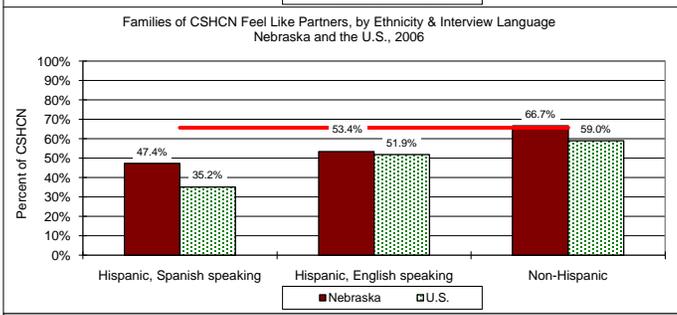
Data & Disparities:

	Partners		Nebraska % was...
	Number	%	
Nebraska (2006)	40,145	65.7%	Higher
United States (2006)	5,714,315	57.4%	Higher
HP 2010 Objective	-		
Nebraska change, 2001 vs. 2006	N.S.D.		
Racial / Ethnic Differences	NO		

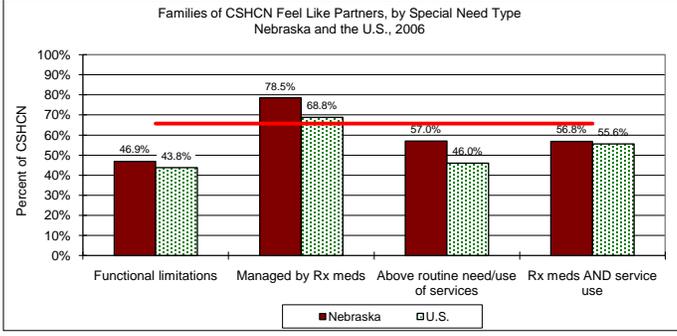
Graphical Display of Data:



Significant Differences by... Age ? **NO**



Significant Differences by... Race/Ethnicity ? **NO**



Significant Differences by... Language ? **NO**

Special Need Type	than Nebraska average
Functional limitations	is Lower
Managed by Rx meds	is Higher
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.

Significant Differences by... Special Need Type ? **YES**

Significant Differences by... Gender ? **NO**

Data Sheet: MCH CORE OUTCOMES

Definition: Core Outcome #2: The number and percentage of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)**
National Survey on Children's Health (2003, 2007)*

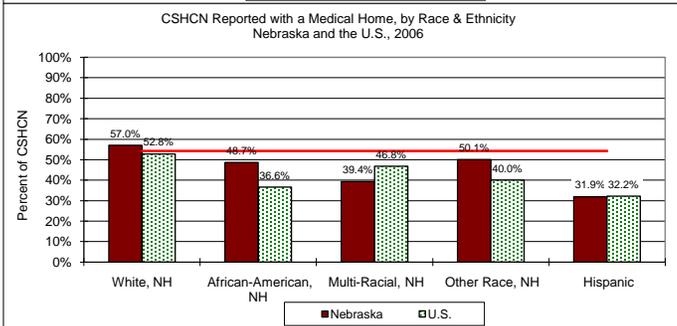
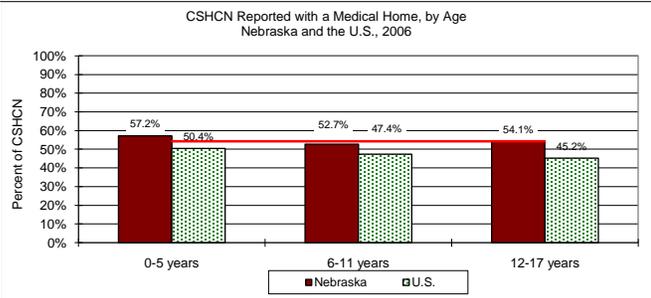
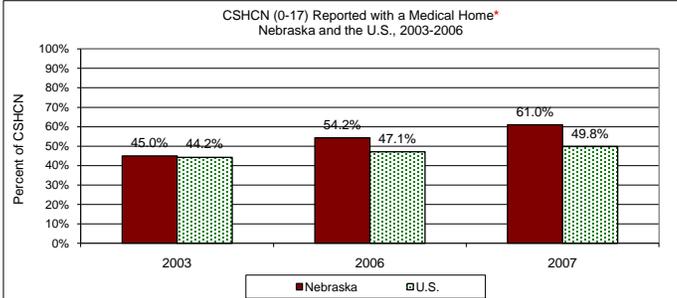
Data & Disparities:

	Medical Home		
	Number	%	Nebraska % was...
Nebraska (2007)	52,839	61.0%	Higher
United States (2007)	6,805,059	49.8%	Higher
HP 2010 Objective	-		
Nebraska change, 2003 vs. 2007	Increased		
Racial / Ethnic Differences	YES		

***Note:** Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results across survey years.

****Note:** Questions on medical home were changed substantially between 2001 and 2005/2006, thus survey results are compared for the 2003 and 2007 NCHS surveys.

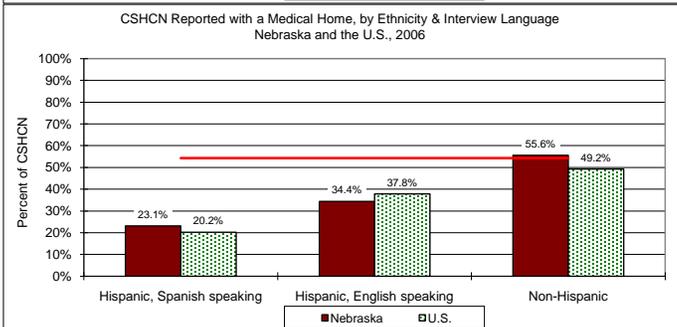
Graphical Display of Data:



Significant Differences by... Age ? **NO**

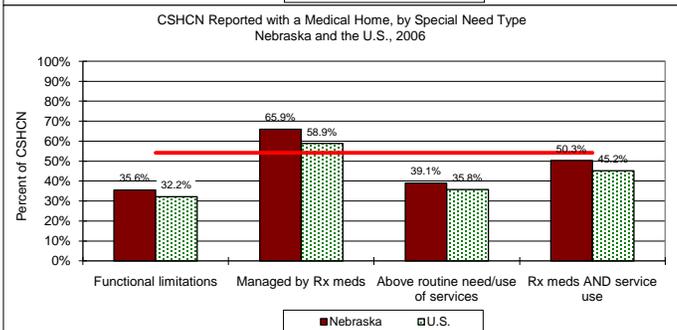
Race / Ethnicity	than Nebraska average
White, NH	is N.S.D.
African-American, NH	is N.S.D.
Multi-Racial, NH	is N.S.D.
Other Race, NH	is N.S.D.
Hispanic	is Lower

Significant Differences by... Race / Ethnicity ? **YES**



Language	from Nebraska average
Hispanic/Spanish	is N.S.D.
Hispanic/English	is N.S.D.
Non-Hispanic	is N.S.D.

Significant Differences by... Language ? **YES**



Special Need Type	than Nebraska average
Functional limitations	is Lower
Managed by Rx meds	is Higher
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.

Significant Differences by... Special Need Type ? **YES**

Significant Differences by... Gender ? **NO**

Data Sheet: MCH CORE OUTCOMES

Definition: Core Outcome #3: The number and percentage of CSHCN whose families have adequate private and/ or public insurance to pay for the services they need

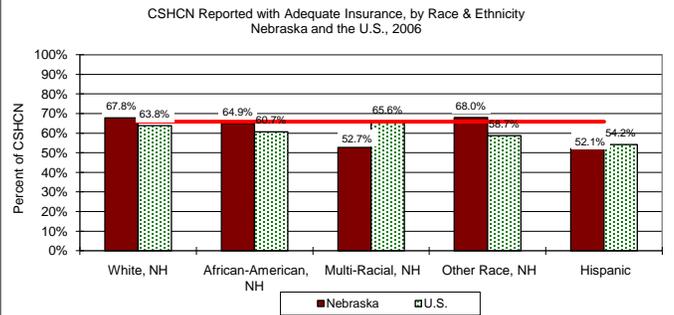
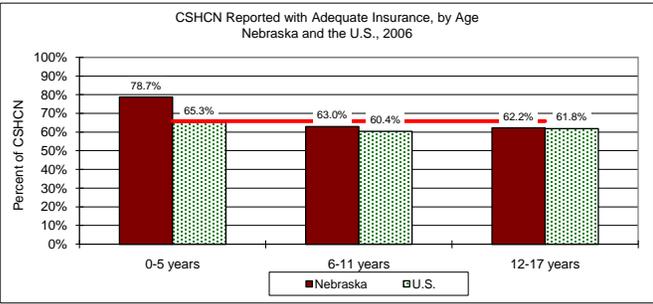
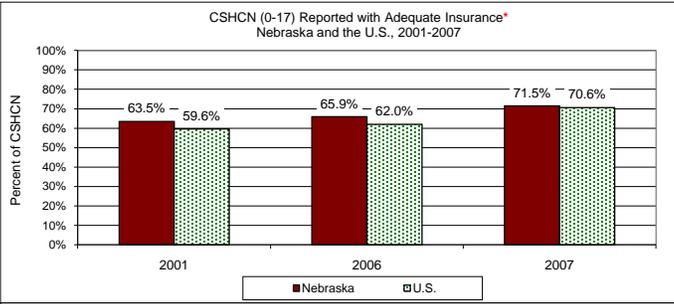
Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)*
National Survey on Children's Health (2003, 2007)*

Data & Disparities:

	Adequate Insurance		Nebraska % was...
	Number	%	
Nebraska (2006)	41,051	65.9%	N.S.D.
United States (2006)	6,239,897	62.0%	N.S.D.
HP 2010 Objective	-		
Nebraska change, 2001 vs. 2007	N.S.D.		
Racial / Ethnic Differences	NO		

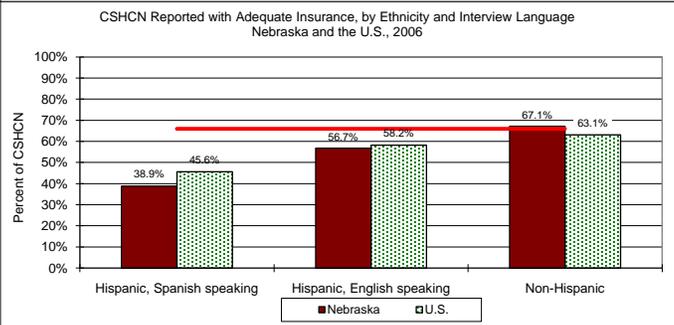
***Note:** Because of methodological differences, the 2001 and 2005/2006 CSHCN surveys captured a slightly smaller group of children with more concentrated symptoms, whereas the 2003 and 2007 NSCH surveys captured a broader/larger group of children with more general symptoms. These changes should be taken into consideration when comparing results

Graphical Display of Data:

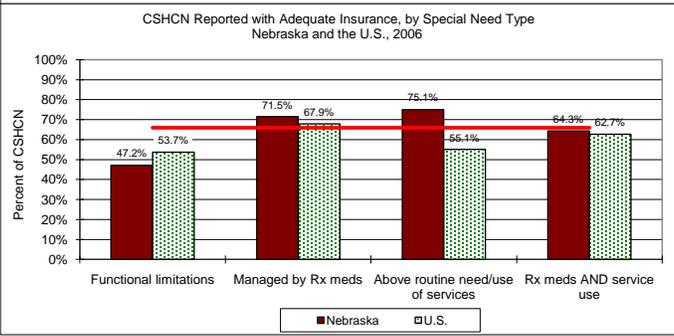


Age	than Nebraska average
0-5 years	is Higher
6-11 years	is N.S.D.
12-17 years	is N.S.D.
Significant Differences by... Age ? YES	

Significant Differences by... Race/Ethnicity ? NO



Significant Differences by... Language ? NO



Special Need Type	than Nebraska average
Functional limitations	is Lower
Managed by Rx meds	is N.S.D.
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.
Significant Differences by... Special Need Type ? YES	

Significant Differences by... Gender ? NO

Data Sheet: MCH CORE OUTCOMES

Definition: Core Outcome #4: The number and percentage of CSHCN who are screened early and continuously for special health care needs

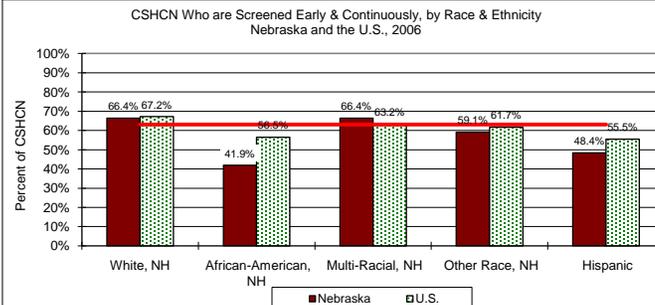
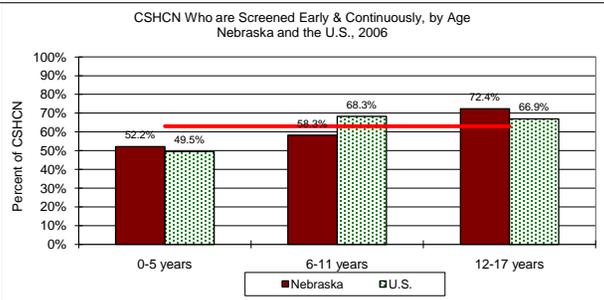
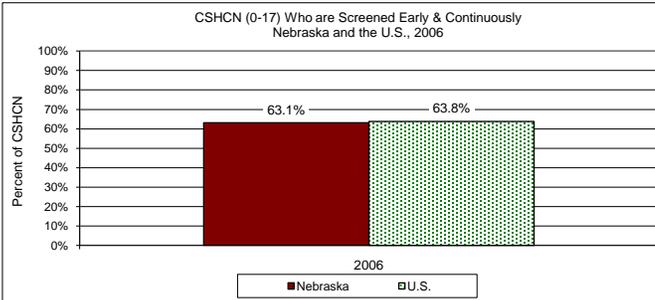
Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Partners		Nebraska % was...
	Number	%	
Nebraska (2006)	39,490	63.1%	was...
United States (2006)	6,485,870	63.8%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		-	
Racial / Ethnic Differences		NO	

*Note: This question was only assessed in 2006.

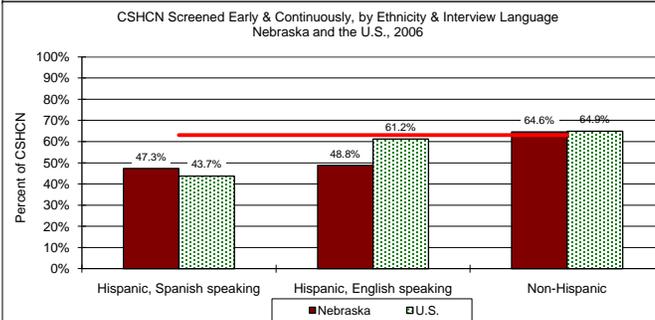
Graphical Display of Data:



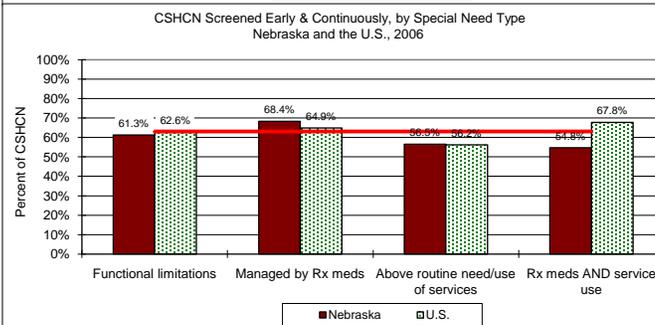
Age	than Nebraska average
0-5 years	is N.S.D.
6-11 years	is N.S.D.
12-17 years	is Higher

Significant Differences by.. Age ? **YES**

Significant Differences by.. Race/Ethnicity ? **NO**



Significant Differences by.. Language ? **NO**



Significant Differences by.. Special Needs Type ? **NO**

Significant Differences by... Gender ? **NO**

Data Sheet: MCH CORE OUTCOMES

Definition: Core Outcome #5: The number and percentage of CSHCN whose services are organized in ways that families can use them easily

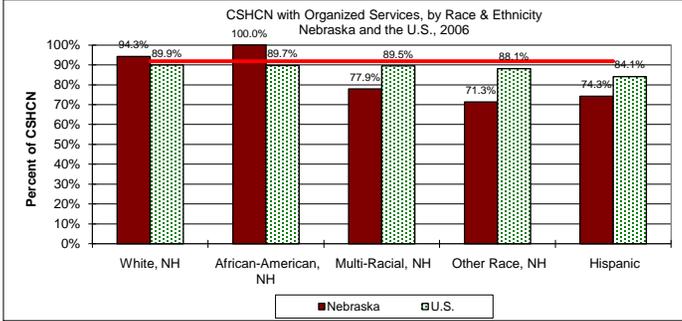
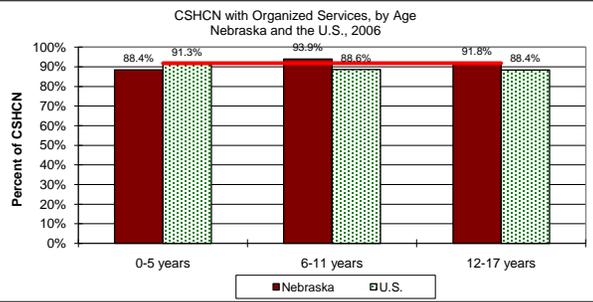
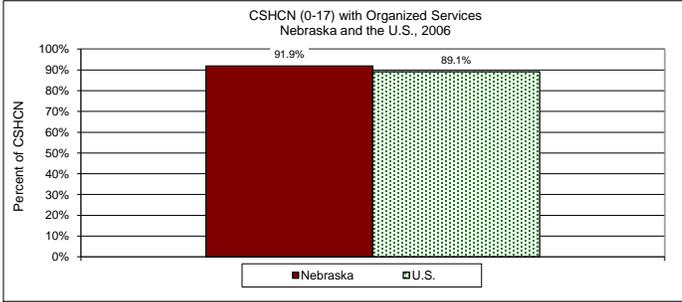
Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Organized Services		
	Number	%	Nebraska %
Nebraska (2006)	57,460	91.9%	was...
United States (2006)	9,024,504	89.1%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		-	
Racial / Ethnic Differences		YES	

***Note:** This question was changed substantially between 2001 and 2005/2006, thus the 2001 values are not reported here.

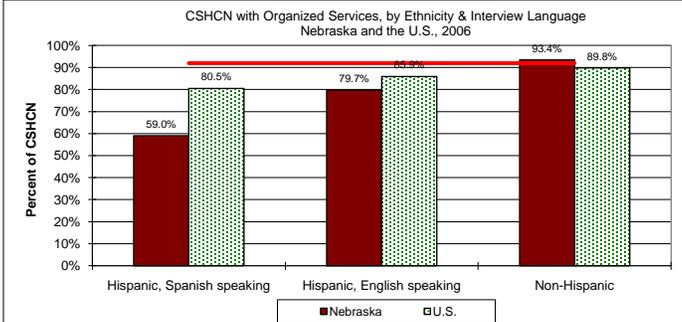
Graphical Display of Data:



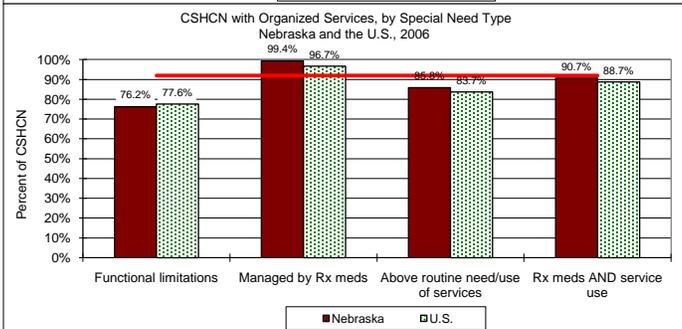
Significant Differences by.. Age ? **NO**

Race / Ethnicity	than Nebraska average
White, NH	is N.S.D.
African-American, NH	is Higher
Multi-Racial, NH	is N.S.D.
Other Race, NH	is N.S.D.
Hispanic	is Lower

Significant Differences by.. Race / Ethnicity ? **YES**



Significant Differences by.. Language ? **NO**



Special Need Type	than Nebraska average
Functional limitations	is Lower
Managed by Rx meds	is Higher
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.

Significant Differences by.. Special Need Type ? **YES**

Significant Differences by... Gender ? **NO**

Data Sheet: MCH CORE OUTCOMES

Definition: Core Outcome #6: The number and percentage of youth (12-17 only) with special health care needs who receive the services necessary to make appropriate transitions to adult health care, work, and independence

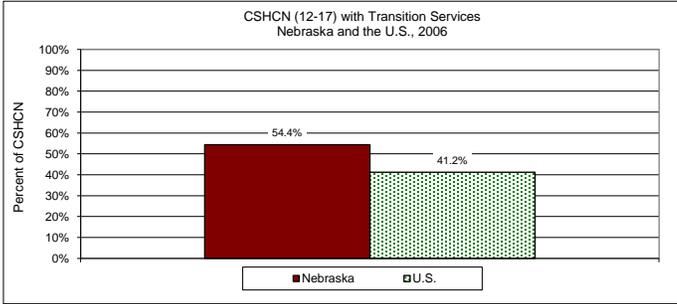
Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

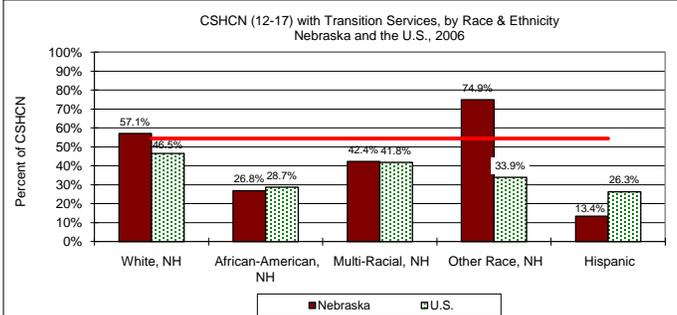
	Transition Services		Nebraska % was...
	Number	%	
Nebraska (2006)	13,373	54.4%	
United States (2006)	1,630,947	41.2%	Higher
HP 2010 Objective	-	-	
Nebraska change, 2001 vs. 2006	-	-	
Racial / Ethnic Differences	YES		

***Note:** This question was changed substantially between 2001 and 2005/2006, thus the 2001 values are not reported here.

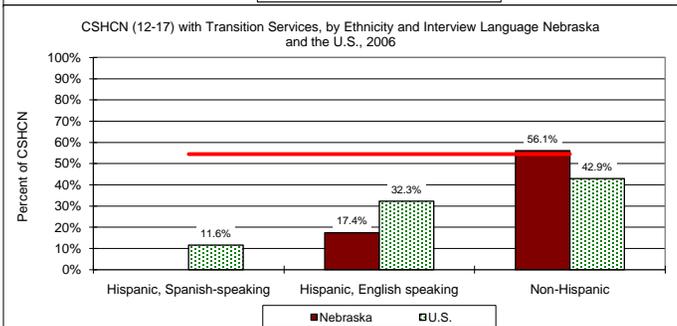
Graphical Display of Data:



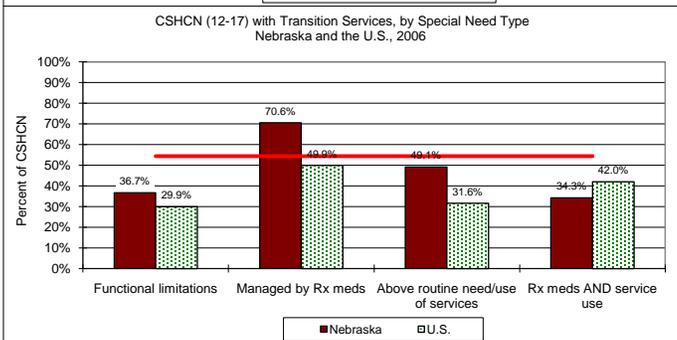
Age-specific results were not available.



Race / Ethnicity	than Nebraska average
White, NH	is N.S.D.
African-American, NH	is N.S.D.
Multi-Racial, NH	is N.S.D.
Other Race, NH	is N.S.D.
Hispanic	is Lower
Significant Differences by.. Race / Ethnicity ? YES	



Language	than Nebraska average
Hispanic/Spanish	is -
Hispanic/English	is Lower
Non-Hispanic	is N.S.D.
Significant Differences by.. Language ? YES	



Special Need Type	than Nebraska average
Functional limitations	is N.S.D.
Managed by Rx meds	is Higher
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is Lower
Significant Differences by.. Special Need Type ? YES	

Significant Differences by.. Gender ? NO

Data Sheet: **HEALTH OUTCOMES**

Health Status - Mental Health

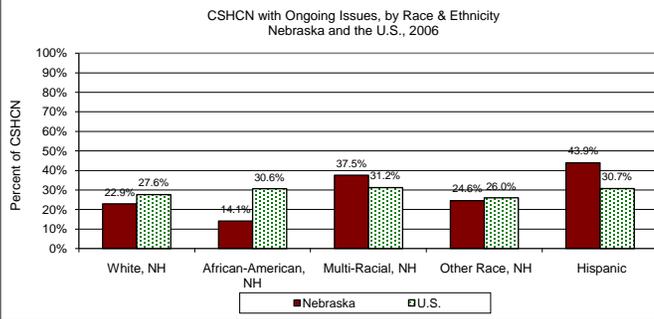
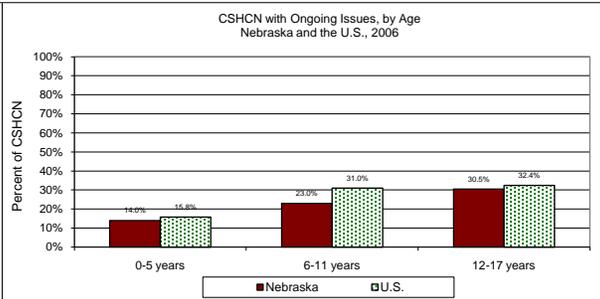
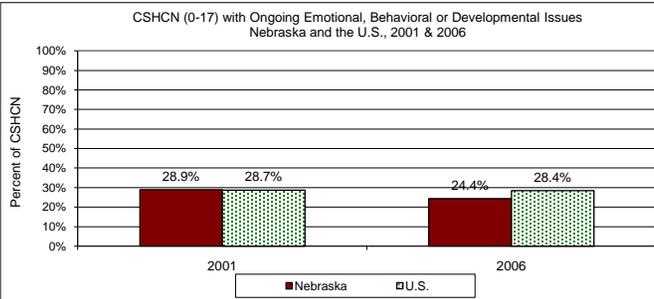
Definition: The number and percentage of CSHCN who have ongoing emotional, behavioral or developmental issues

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Ongoing Issues		Nebraska %
	Number	%	
Nebraska (2006)	15,318	24.4%	
United States (2006)	2,900,593	28.4%	Lower
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:

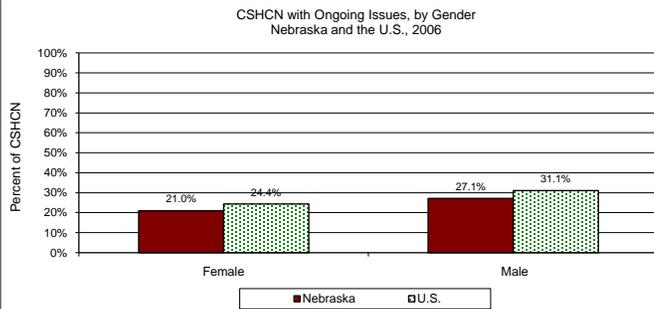


Age	than Nebraska average
0-5 years	is Lower
6-11 years	is N.S.D.
12-17 years	is N.S.D.

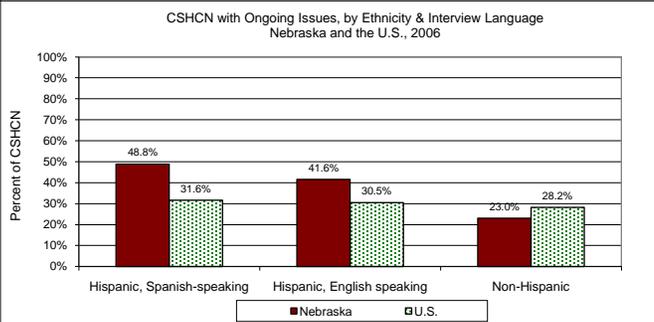
Significant Differences by... Age ? **YES**

Race / Ethnicity	than Nebraska average
White, NH	is N.S.D.
African-American, NH	is N.S.D.
Multi-Racial, NH	is N.S.D.
Other Race, NH	is N.S.D.
Hispanic	is Higher

Significant Differences by... Race / Ethnicity ? **YES**



Significant Differences by... Gender ? **NO**



Significant Differences by... Language ? **NO**

Data Sheet: **HEALTH OUTCOMES**

Health Status - Mental Health

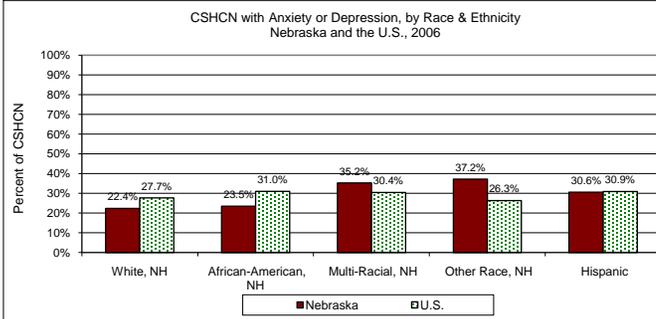
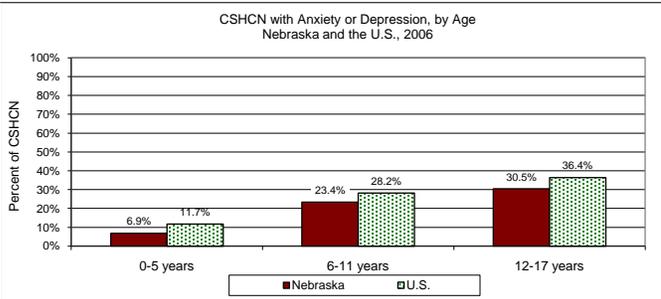
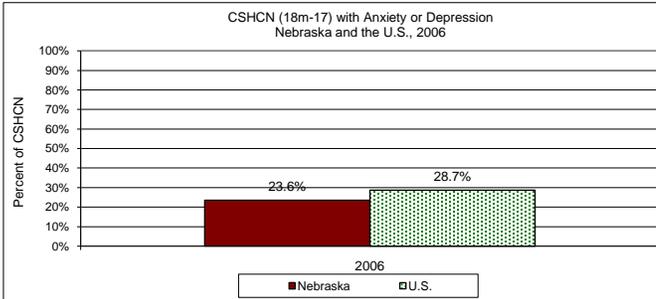
Definition: The number and percentage of CSHCN (18 mos - 17 yrs) who, when compared to other children that age, are reported to experience difficulty with feeling anxious or depressed.

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Anxiety/Depression		
	Number	%	Nebraska %
Nebraska (2006)	14,277	23.6%	was...
United States (2006)	2,823,079	28.7%	Lower
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		-	
Racial / Ethnic Differences		NO	

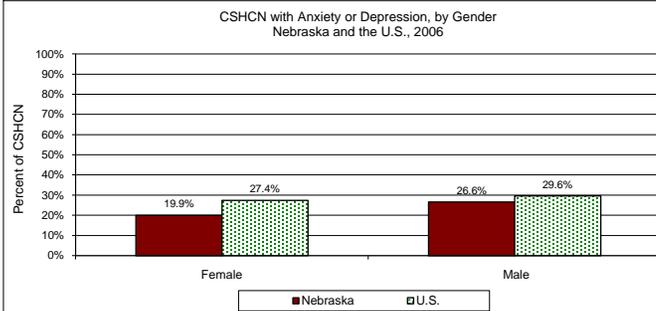
Graphical Display of Data:



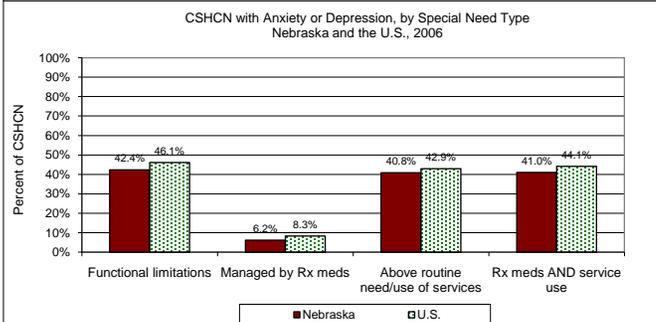
Age	than Nebraska average
0-5 years	is Lower
6-11 years	is N.S.D.
12-17 years	is N.S.D.

Significant Differences by... Age ? **YES**

Significant Differences by... Race/Ethnicity ? **NO**



Significant Differences by... Gender ? **NO**



Special Need Type	than Nebraska average
Functional limitations	is Higher
Managed by Rx meds	is Lower
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is Higher

Significant Differences by... Special Need Type ? **YES**

Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

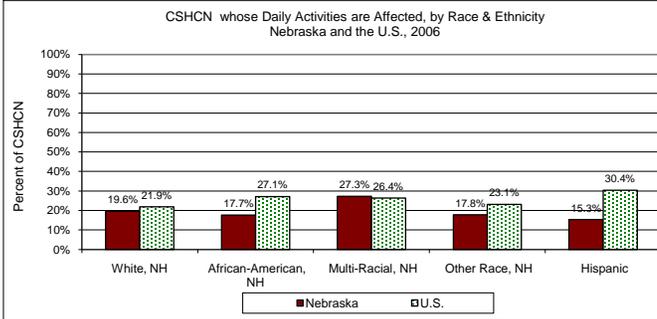
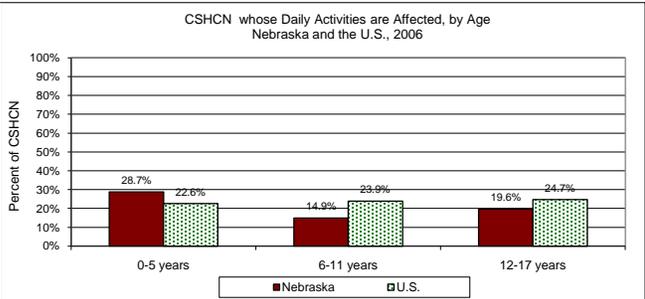
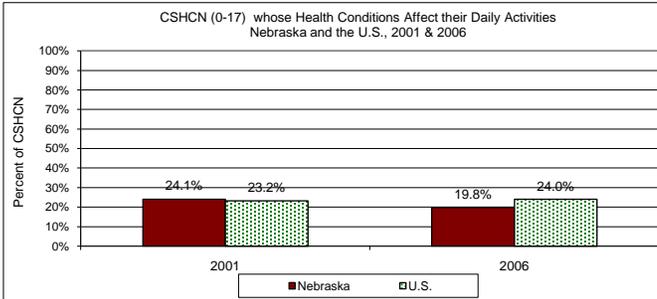
Definition: The number and percentage of CSHCN whose health conditions consistently and often greatly affect their daily activities

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

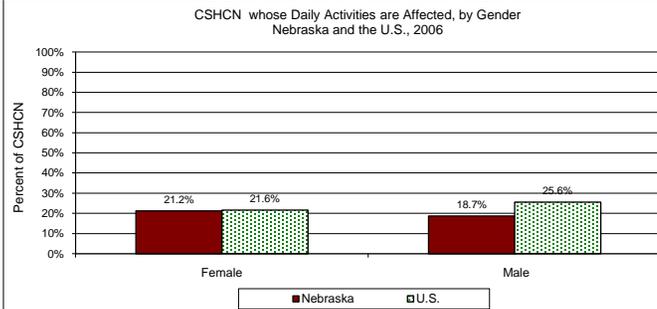
Data & Disparities:

	Anxiety/Depression		
	Number	%	Nebraska %
Nebraska (2006)	12,360	19.8%	was...
United States (2006)	2,440,742	24.0%	Lower
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		NO	

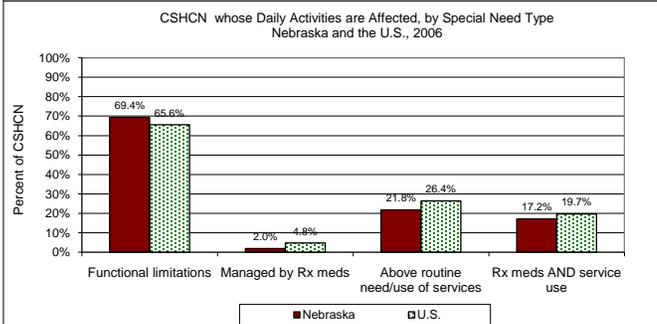
Graphical Display of Data:



Significant Differences by... Age ? **NO**



Significant Differences by... Race/Ethnicity ? **NO**



Significant Differences by... Gender ? **NO**

Special Need Type	than Nebraska average
Functional limitations	is Higher
Managed by Rx meds	is Lower
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.
Significant Differences by... Special Need Type ? YES	

Data Sheet: **HEALTH DETERMINANTS**

Health Care - Access to Care

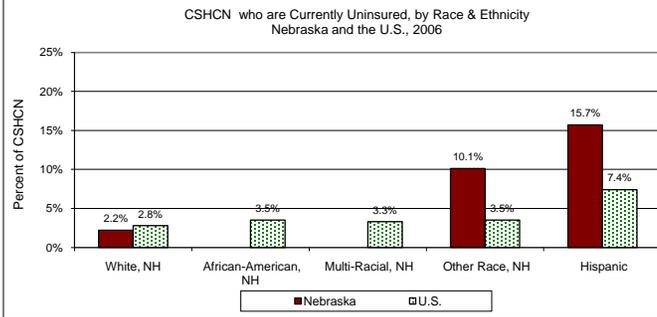
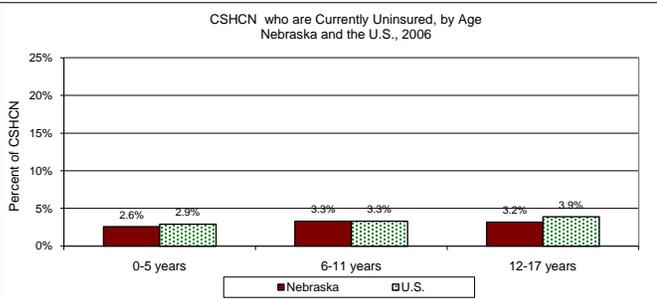
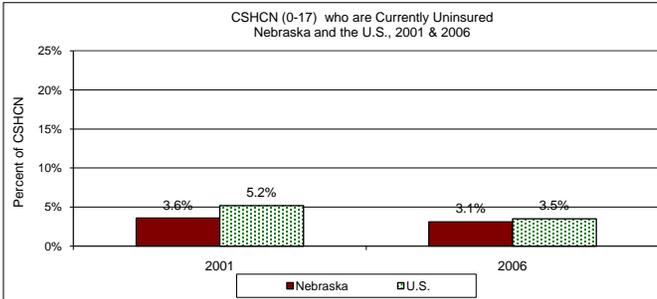
Definition: The number and percentage of CSHCN currently uninsured

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Currently Uninsured		
	Number	%	Nebraska %
Nebraska (2006)	1,972	3.1%	was...
United States (2006)	355,094	3.5%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		YES	

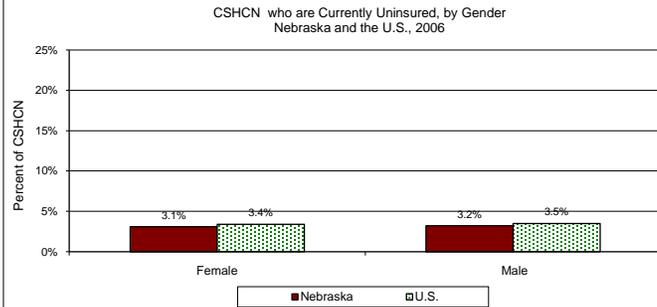
Graphical Display of Data:



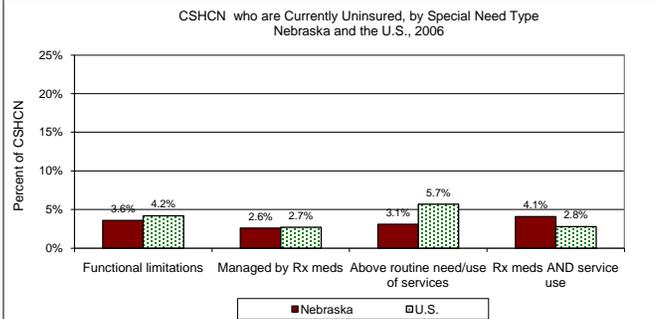
Significant Differences by... Age ? **NO**

Race / Ethnicity	than Nebraska average
White, NH	is N.S.D.
African-American, NH	is -
Multi-Racial, NH	is -
Other Race, NH	is N.S.D.
Hispanic	is N.S.D.

Significant Differences by... Race / Ethnicity ? **YES**



Significant Differences by... Gender ? **NO**



Significant Differences by... Special Need Type ? **NO**

Data Sheet: **HEALTH DETERMINANTS**

Health Care - Access to Care

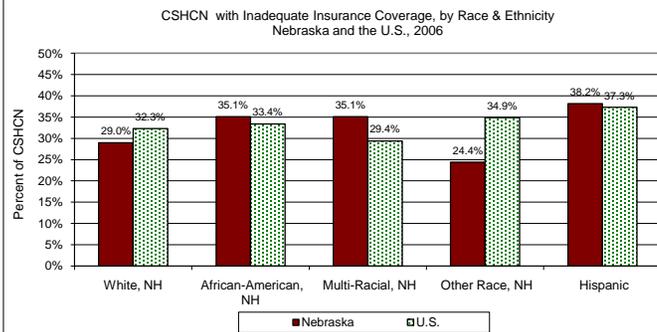
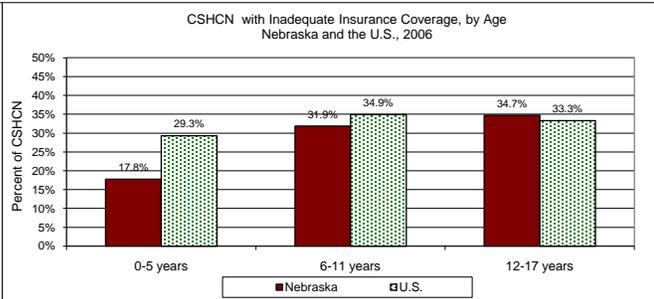
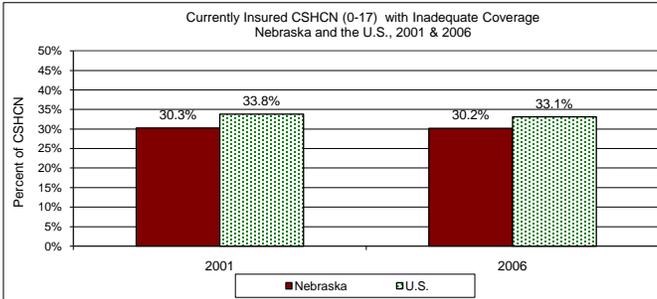
Definition: The number and percentage of currently insured CSHCN with coverage that is not adequate

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Inadequate Coverage		
	Number	%	Nebraska %
Nebraska (2006)	18,340	30.2%	was...
United States (2006)	3,252,252	33.1%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		NO	

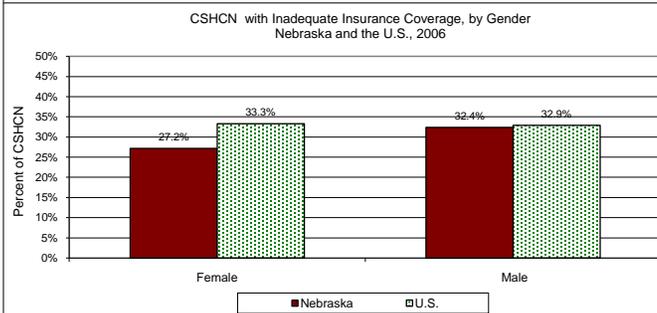
Graphical Display of Data:



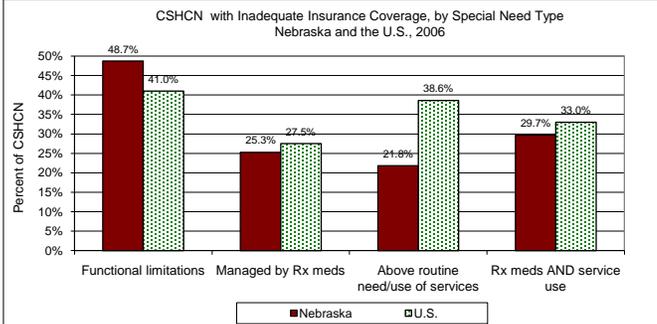
Age	than Nebraska average
0-5 years	is Lower
6-11 years	is N.S.D.
12-17 years	is N.S.D.

Significant Differences by... Age ? **YES**

Significant Differences by... Race/Ethnicity ? **NO**



Significant Differences by... Gender ? **NO**



Special Need Type	than Nebraska average
Functional limitations	is Higher
Managed by Rx meds	is N.S.D.
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.

Significant Differences by... Special Need Type ? **YES**

Data Sheet: **HEALTH DETERMINANTS**

Health Care - Access to Care

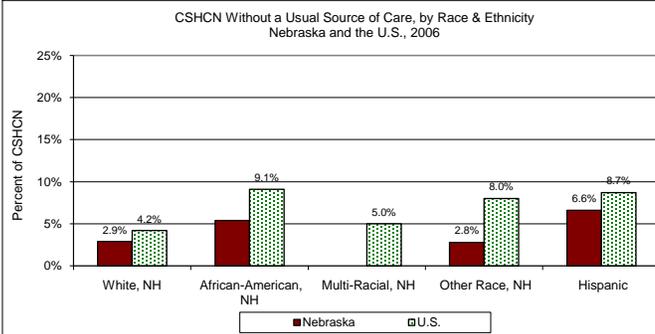
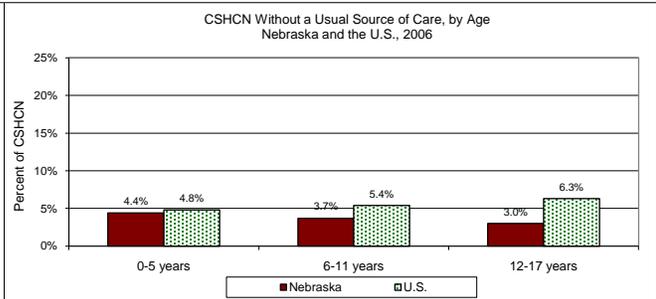
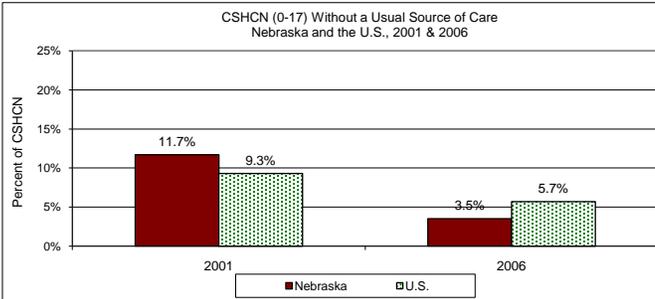
Definition: The number and percentage of CSHCN without a usual source of care when sick (or who rely on the emergency room)

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

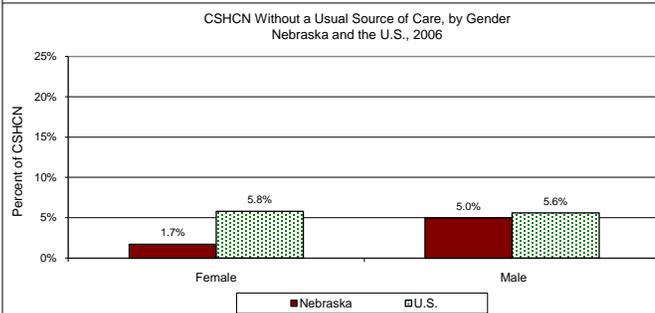
Data & Disparities:

	No Usual Source of Care		
	Number	%	Nebraska %
Nebraska (2006)	2,194	3.5%	was...
United States (2006)	575,910	5.7%	Lower
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		Decreased	
Racial / Ethnic Differences		NO	

Graphical Display of Data:

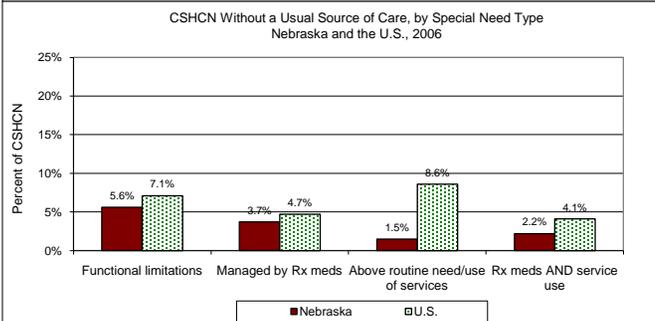


Significant Differences by... Age ? **NO**



Significant Differences by... Race/Ethnicity ? **NO**

Significant Differences by... Gender ? **NO**



Significant Differences by... Special Need Type ? **NO**

Data Sheet: **HEALTH DETERMINANTS**

Health Care - Access to Care

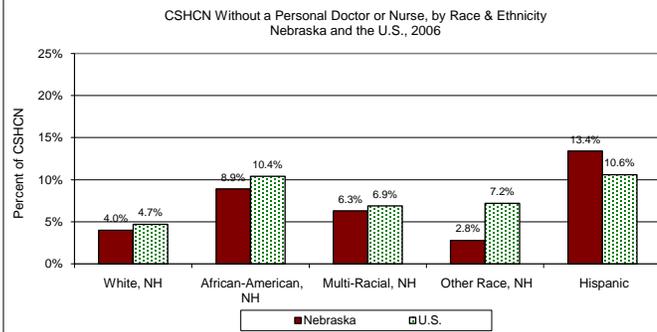
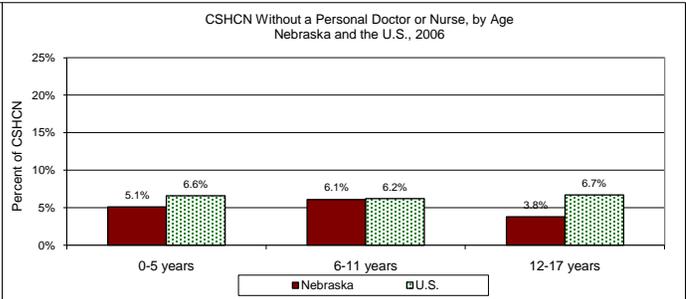
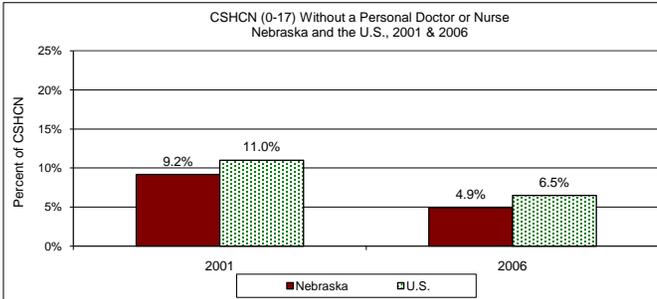
Definition: The number and percentage of CSHCN without a personal doctor or nurse

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

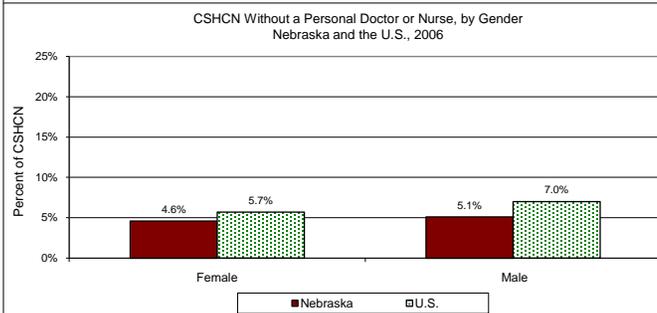
Data & Disparities:

	No Personal Doctor/Nurse		
	Number	%	Nebraska %
Nebraska (2006)	3,074	4.9%	was...
United States (2006)	662,416	6.5%	N.S.D.
HP 2010 Objective	-		
Nebraska change, 2001 vs. 2006	Decreased		
Racial / Ethnic Differences	0		

Graphical Display of Data:

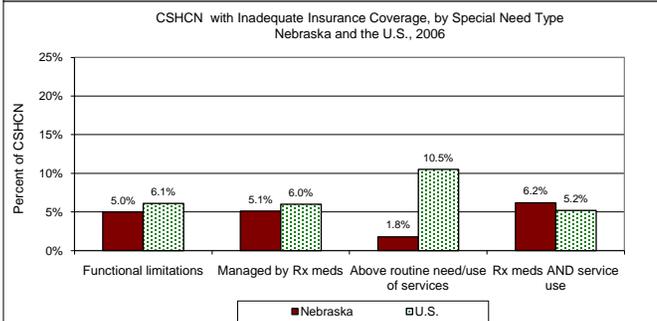


Significant Differences by... Age ? **NO**



Significant Differences by... Race/Ethnicity ? **NO**

Significant Differences by... Gender ? **NO**



Significant Differences by... Special Need Type ? **NO**

Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

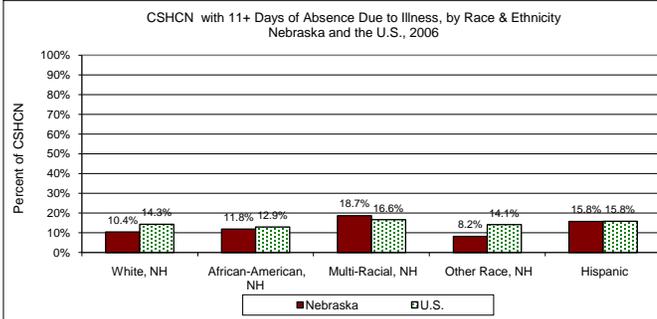
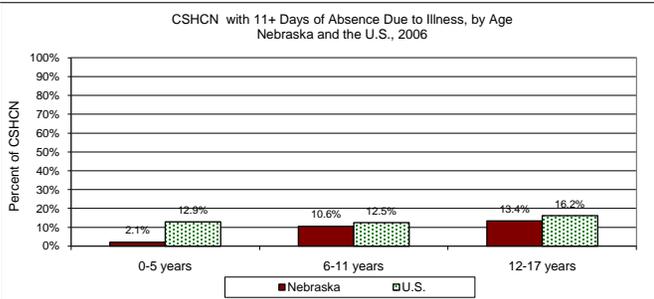
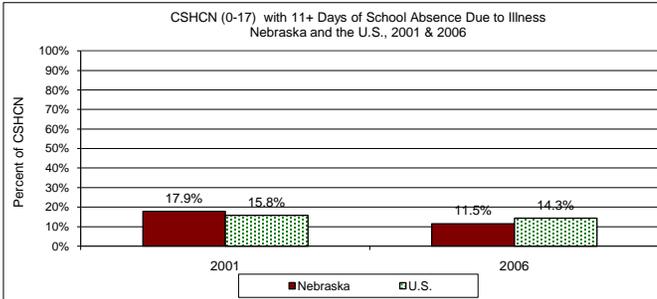
Definition: The number and percentage of CSHCN with 11 or more days of school absence due to illness

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	11+ Days Absence		
	Number	%	Nebraska %
Nebraska (2006)	6,058	11.5%	was...
United States (2006)	1,199,336	14.3%	N.S.D.
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		N.S.D.	
Racial / Ethnic Differences		NO	

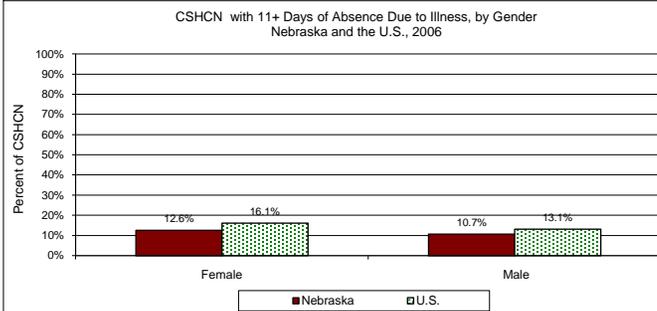
Graphical Display of Data:



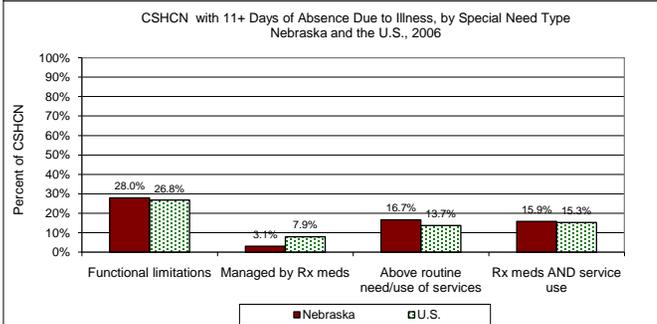
Age	than Nebraska average
0-5 years	is Lower
6-11 years	is N.S.D.
12-17 years	is N.S.D.

Significant Differences by... Age ? **YES**

Significant Differences by... Race/Ethnicity ? **NO**



Significant Differences by... Gender ? **NO**



Special Need Type	than Nebraska average
Functional limitations	is Higher
Managed by Rx meds	is Lower
Above routine need/use of services	is N.S.D.
Rx meds AND service use	is N.S.D.

Significant Differences by... Special Need Type ? **YES**

Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

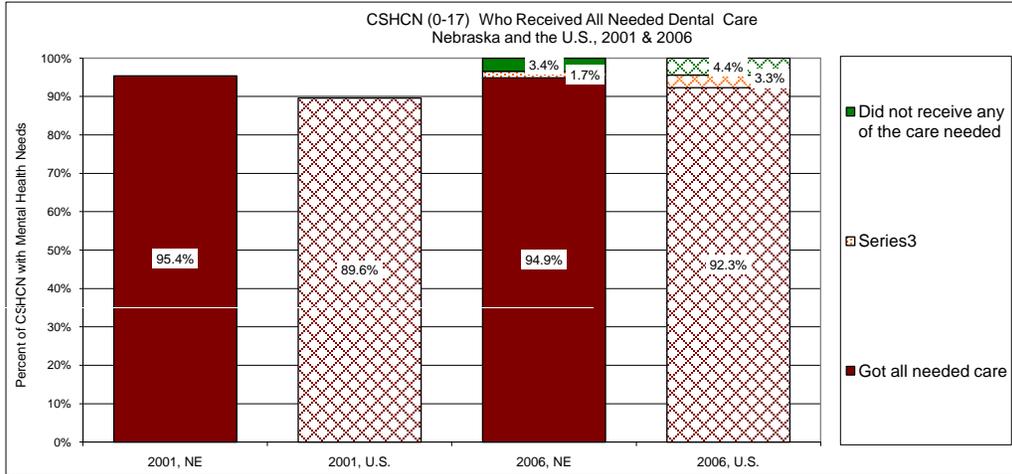
Definition: The number and percentage of CSHCN who received all the receive all the dental care that he/she needed.

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Received All Needed Dental Care		Nebraska % was...
	Number	%	
Nebraska (2006)	50,613	94.9%	Higher
United States (2006)	7,629,051	92.3%	Higher
HP 2010 Objective		-	
Nebraska change, 2001 vs. 2006		nsd	
Racial / Ethnic Differences		-	

Graphical Display of Data:



Data Sheet: **HEALTH OUTCOMES**

Health Status - Overall Health

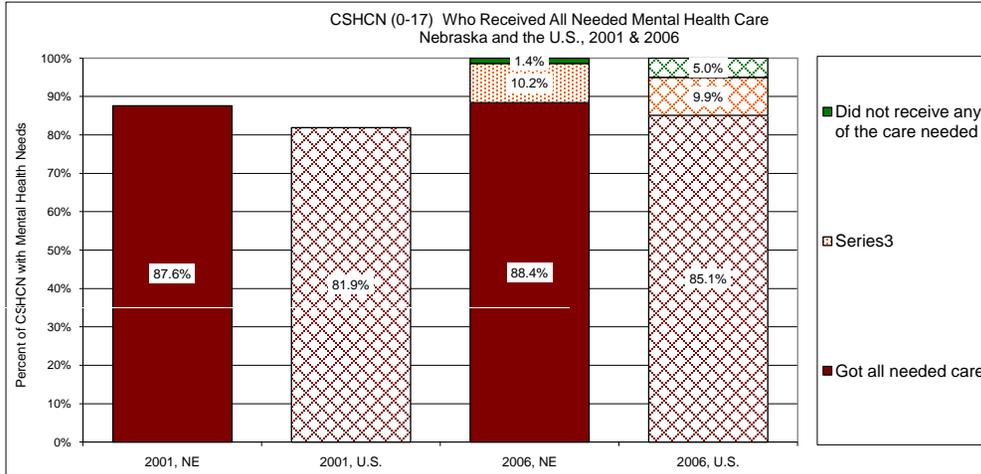
Definition: The number and percentage of CSHCN who received all the mental health care or counseling that they needed.

Data Source: National Survey of Children with Special Health Care Needs (2001, 2005/2006)

Data & Disparities:

	Received All Needed Care		
	Number	%	Nebraska %
Nebraska (2006)	11,650	88.4%	was...
United States (2006)	2,152,167	85.1%	N.S.D.
HP 2010 Objective	-	-	-
Nebraska change, 2001 vs. 2006	-	nsd	-
Racial / Ethnic Differences	-	-	-

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Child Abuse and Neglect

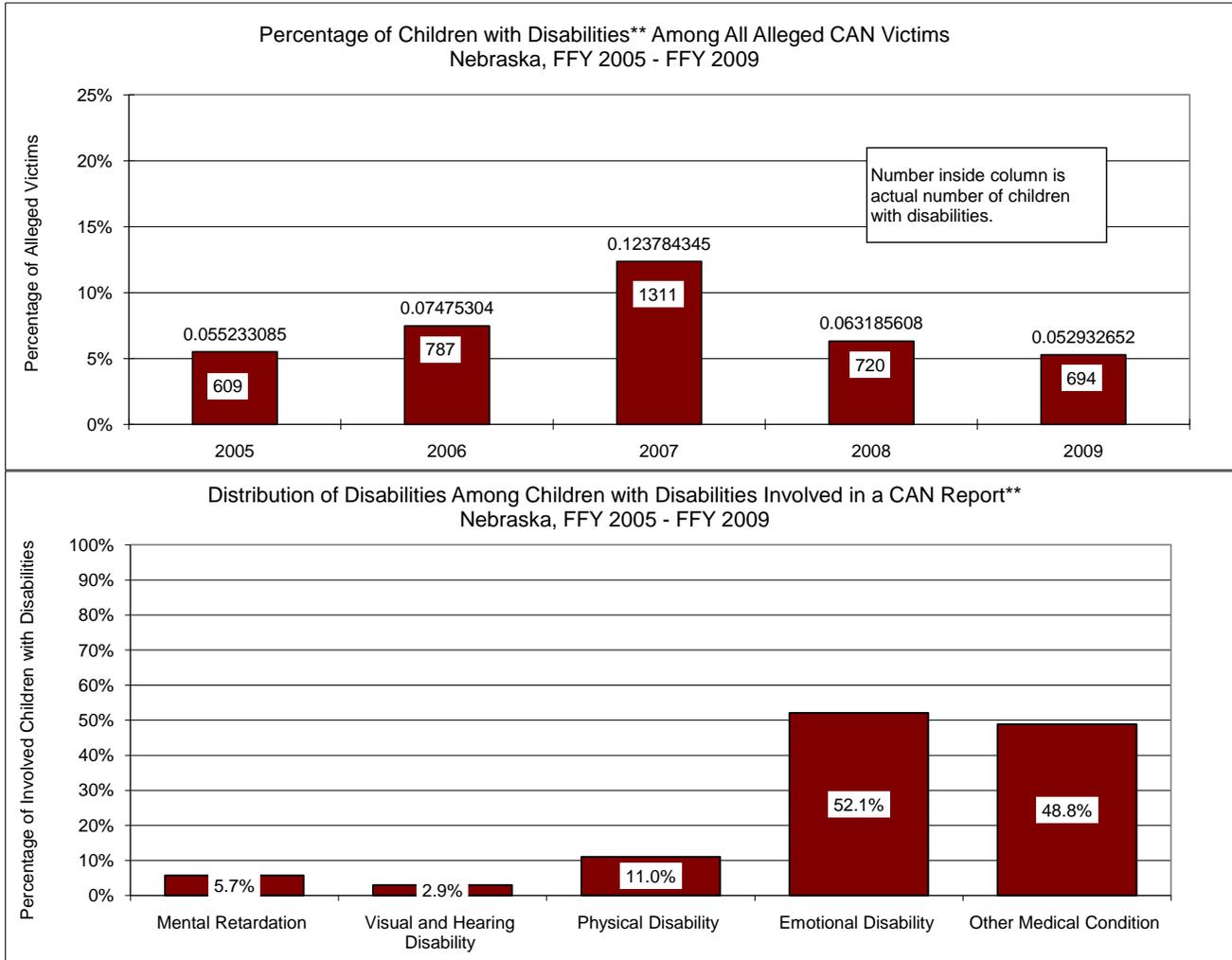
Definition: The number of children (1-9 years) with disabilities involved in a CAN report, per 100 alleged CAN victims

Data Source: DHHS - Children and Family Services

Data & Disparities:

	Involved		
	Number	%	Nebraska % was...
Nebraska (2009)	694	5.3%	
United States (2009)	-	-	-
HP 2010 Objective		-	
Nebraska 5-year trend		-	
Racial / Ethnic Differences		-	

Graphical Display of Data:



**Children may have more than one type of disability.

Youth

Fact Sheet: **DEMOGRAPHICS**

Percentage of Population

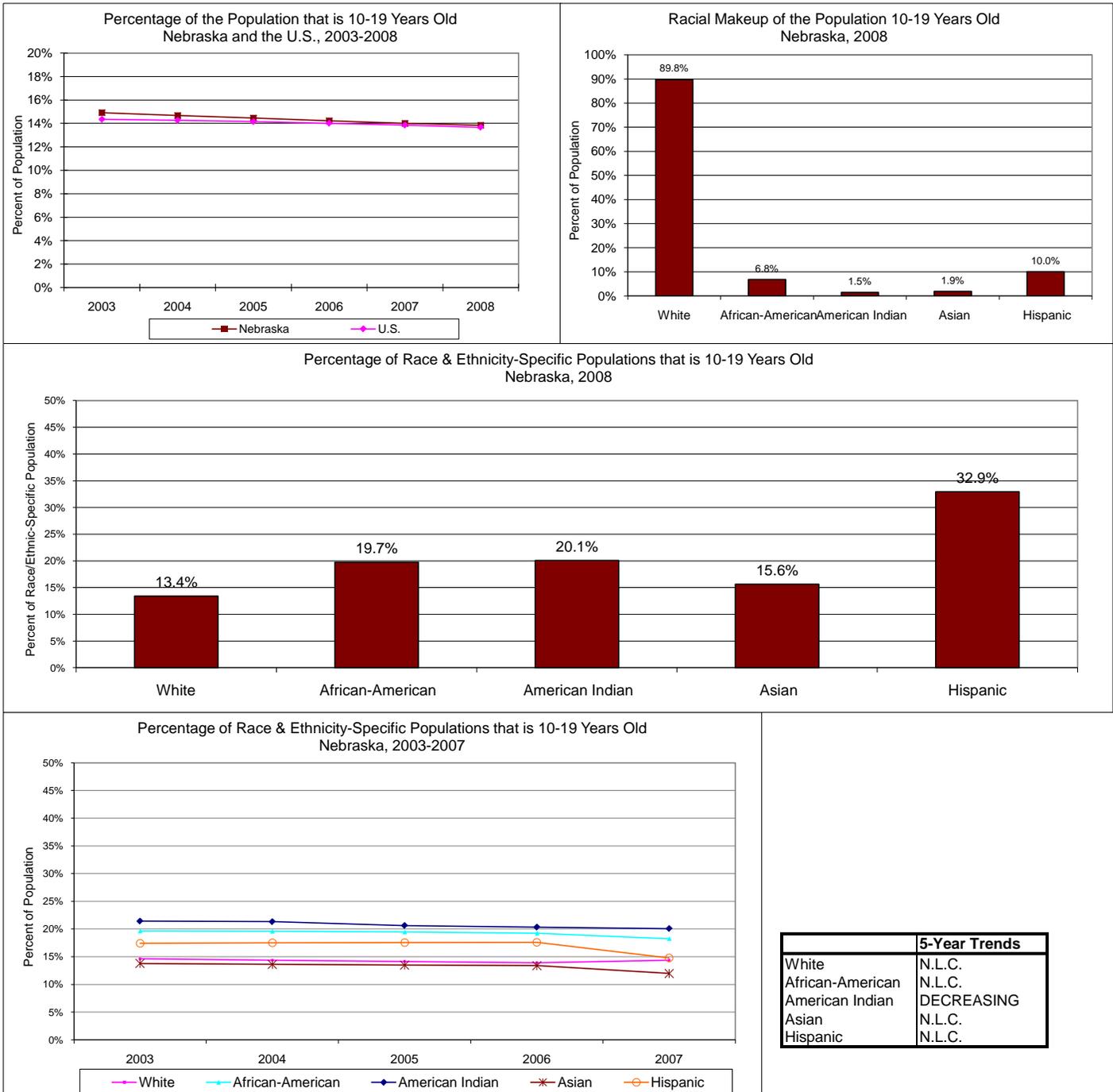
Definition: Percentage of total Nebraska population that is 10-19 years of age

Data Source: U.S. Census

Data & Disparities:

	10-14		15-19		10-19 as % of total population		Nebraska rate was...
	Number	%	Number	%	Number	%	
Nebraska (2008)	118,018	6.62%	128,885	7.23%	246,903	13.8%	Higher
United States (2008)	20,054,627	6.60%	21,514,358	7.08%	41,568,985	13.7%	
HP 2010 Objective	-						
Nebraska 5-year trend	DECREASING		DECREASING		DECREASING		
Racial / Ethnic Differences	YES						

Graphical Display of Data:



Fact Sheet: **DEMOGRAPHICS**

Gender

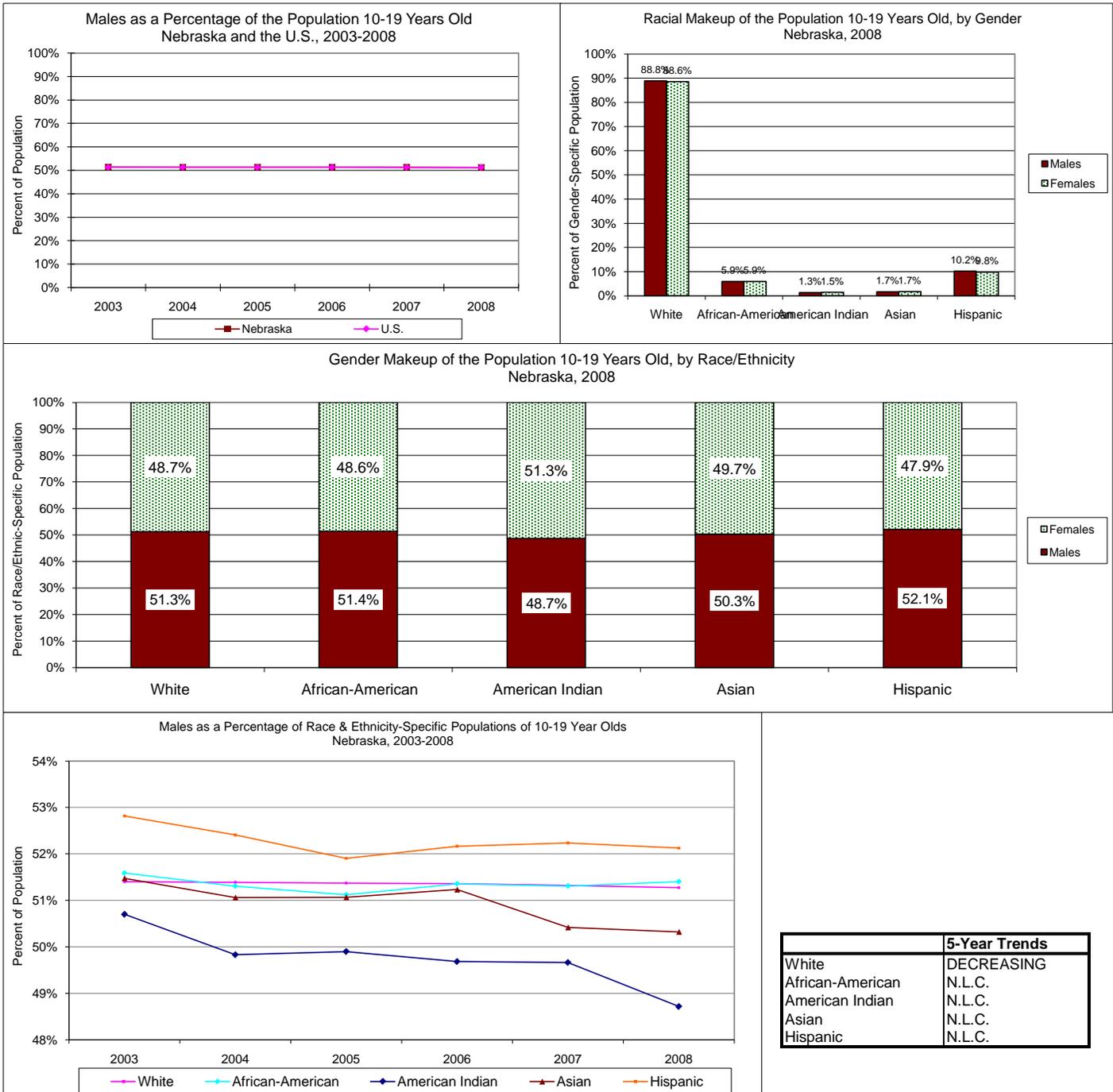
Definition: Gender distribution of population 10-19 years of age

Data Source: U.S. Census

Data & Disparities:

	Male		Nebraska rate was...	Female		Nebraska rate was...
	Number	%		Number	%	
Nebraska (2008)	126,417	51.2%		120,486	48.8%	
United States (2008)	21,289,733	51.2%	N.S.D.	20,279,252	48.8%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	DECREASING			INCREASING		
Racial / Ethnic Differences	YES			YES		

Graphical Display of Data:



Nebraska Title V
2010 Needs Assessment

Data Sheet: **DEMOGRAPHICS**

Income

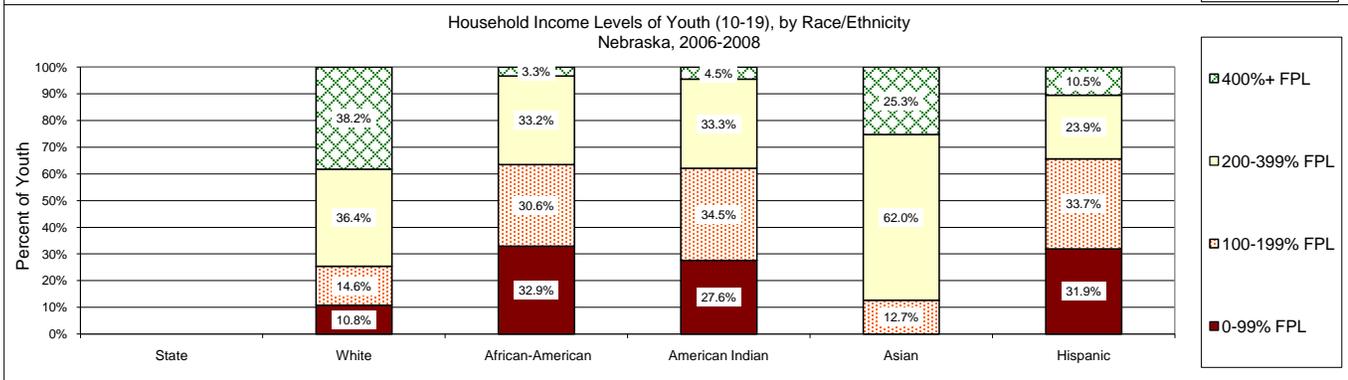
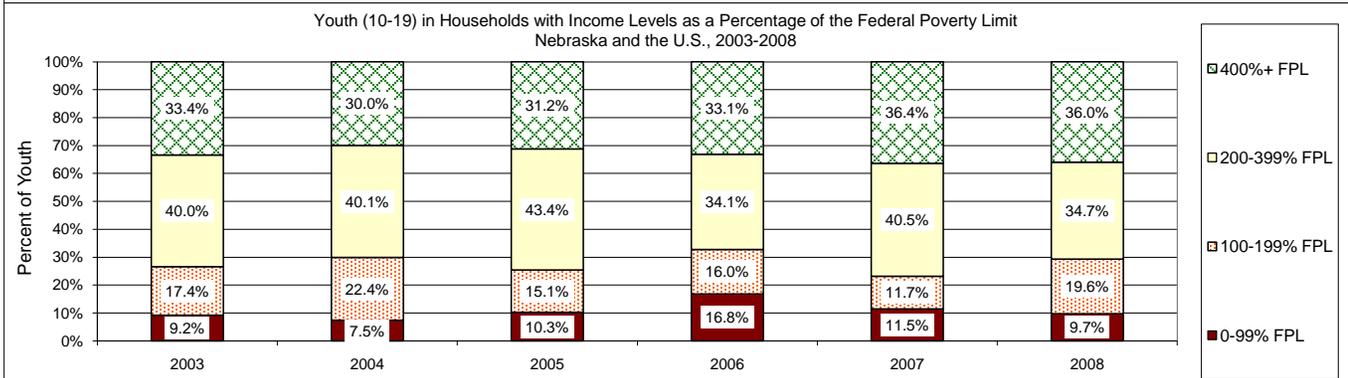
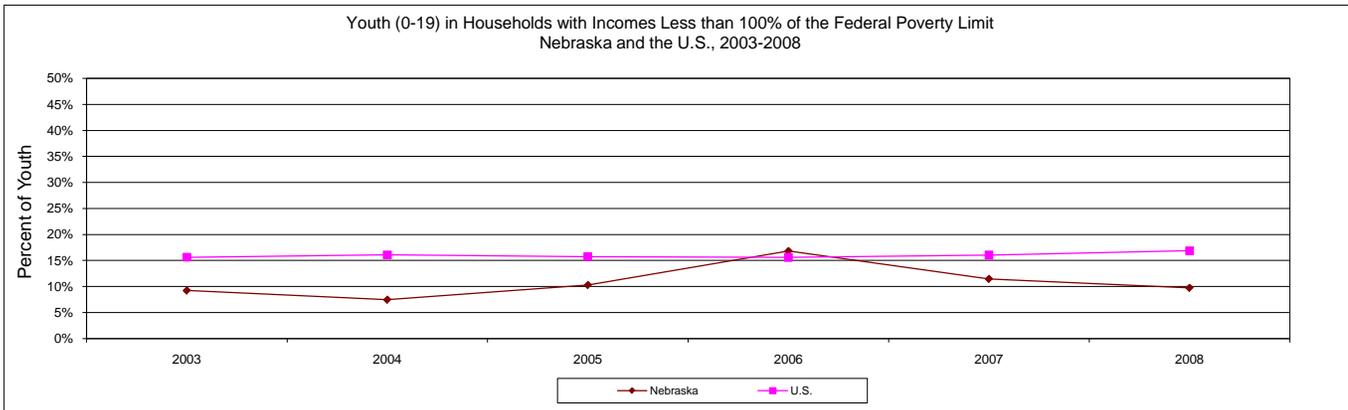
Definition: Youth (10-19) with household incomes as a percentage of the Federal Poverty Level (FPL)

Data Source: US Census: Current Population Survey

Data & Disparities:

	0-99% of Poverty			100-199% of Poverty		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (CPS; 2008)	23,558	9.7%		47,377	19.6%	
United States (CPS; 2008)	6,905,168	16.9%	Lower	8,417,321	20.6%	Lower
HP 2010 Objective	-			-		
Nebraska 5-year trend (CPS)	N.L.C.			N.L.C.		
Racial / Ethnic Differences (ACS)	yes			yes		
	200-399% of Poverty			% Poverty or higher		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (CPS; 2008)	84,034	34.7%		87,086	36.0%	
United States (CPS; 2008)	13,227,974	32.3%	Higher	12,396,939	30.3%	Higher
HP 2010 Objective	-			-		
Nebraska 5-year trend (CPS)	N.L.C.			INCREASING		
Racial / Ethnic Differences (ACS)	yes			yes		

Graphical Display of Data:



NOTE: The Current Population Survey Annual Social and Economic Supplement is an annual survey of approximately 78,000 households nationwide. Therefore, use extreme caution when making inferences when the cell sizes are small.

Data Sheet: HEALTH OUTCOMES

Mortality

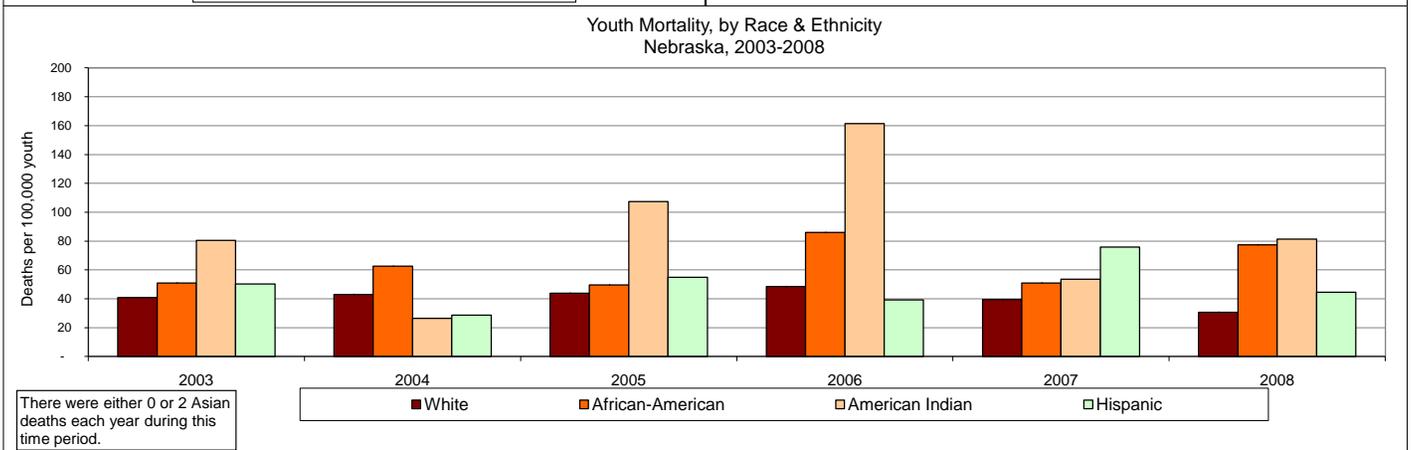
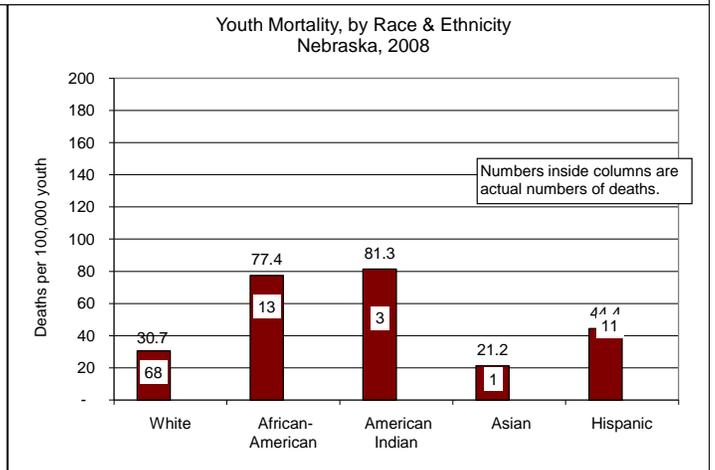
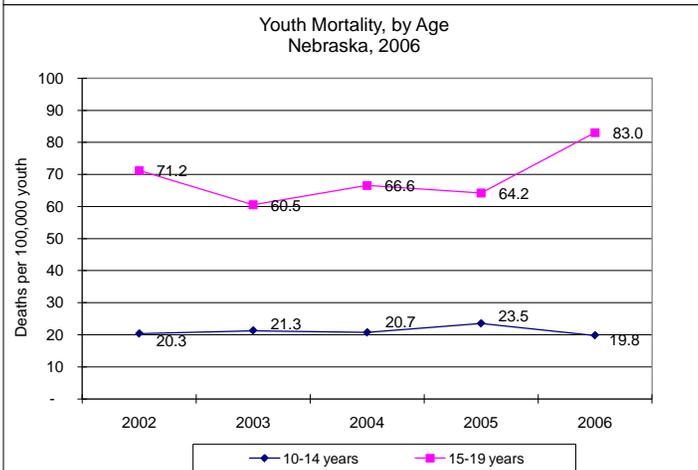
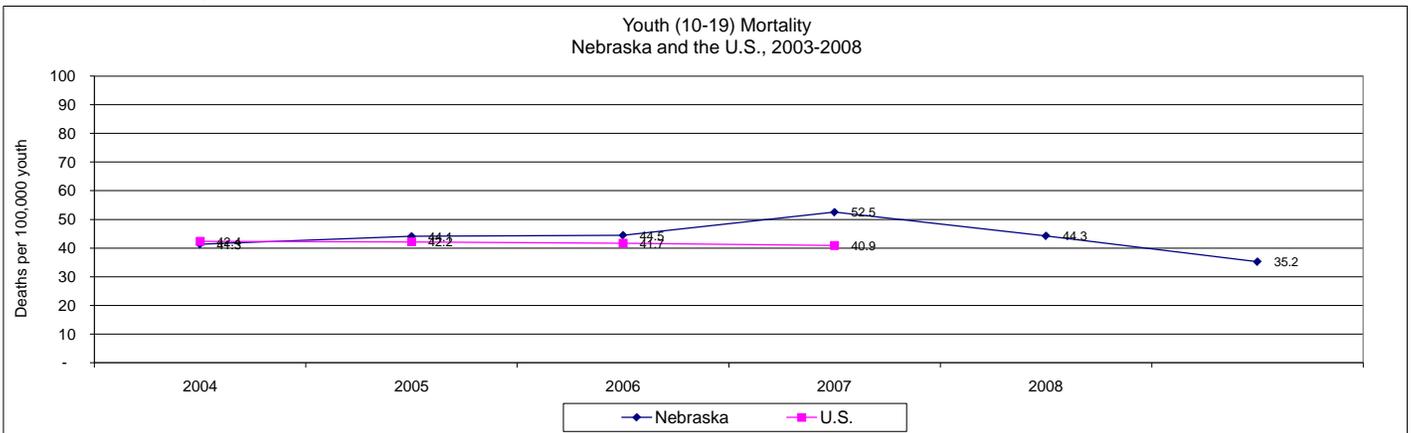
Definition: Deaths to youth ages 10-19, per 100,000, all causes

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	10-14 (2006)			15-19 (2006)			10-19 (2008)		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska	24	19.8		108	83.0		87	35.2	
United States (2006)	3,414	16.6	N.S.D.	13,739	64.4	Higher	17,153	40.9	Higher
HP 2010 Objective	16.8		N.S.D.	39.8		Higher	-		
Nebraska 5-year trend		N.L.C.			N.L.C.			N.L.C.	
Racial / Ethnic Differences		NO			NO			YES	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Gender

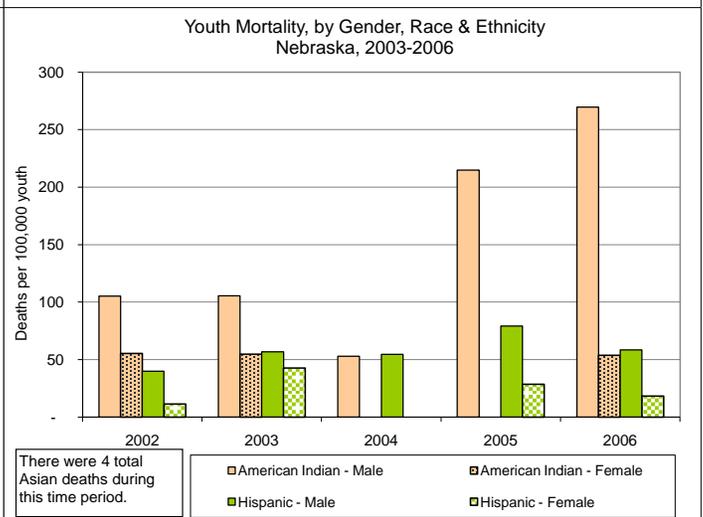
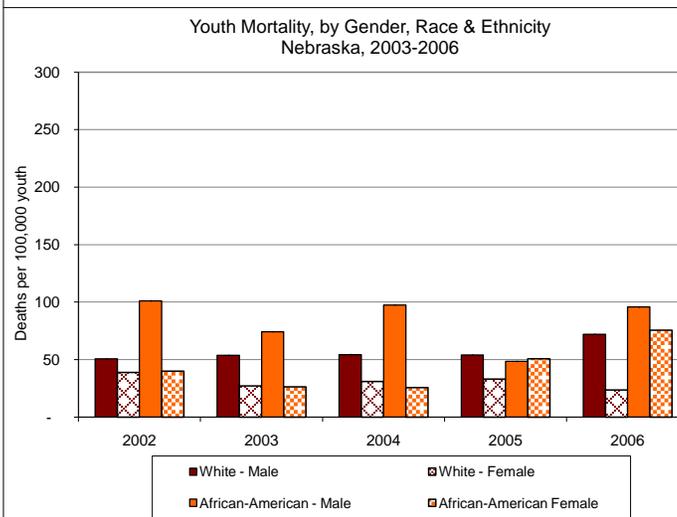
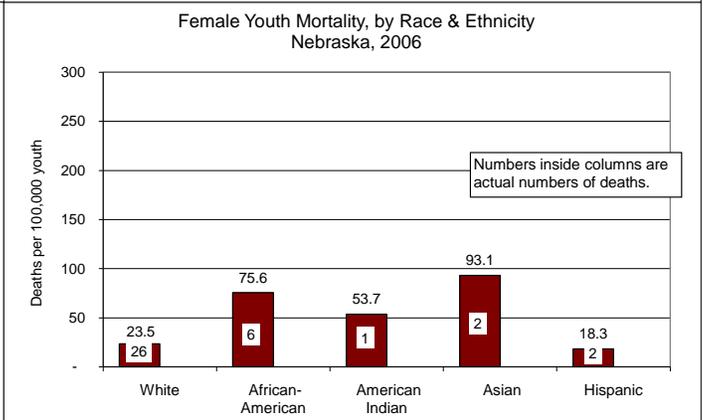
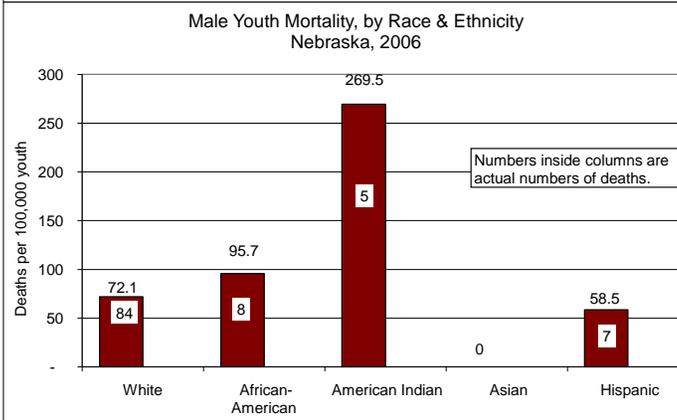
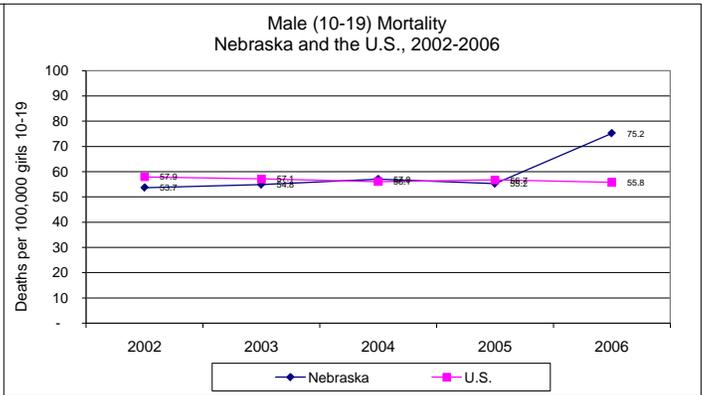
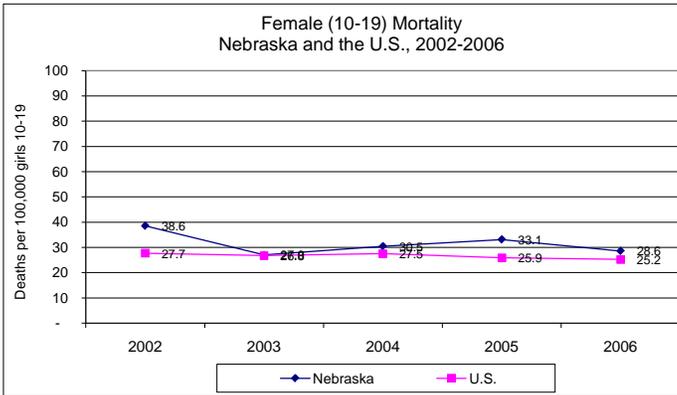
Definition: Deaths to youth ages 10-19, per 100,000, all causes, by gender

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Girls			Boys			Total		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska	35	28.6	was...	97	75.2	was...	87	35.2	was...
United States (2006)	5,161	25.2	N.S.D.	11,992	55.8	Higher	17,153	40.9	Higher
HP 2010 Objective	-	-	-	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	NO			NO			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Top Causes

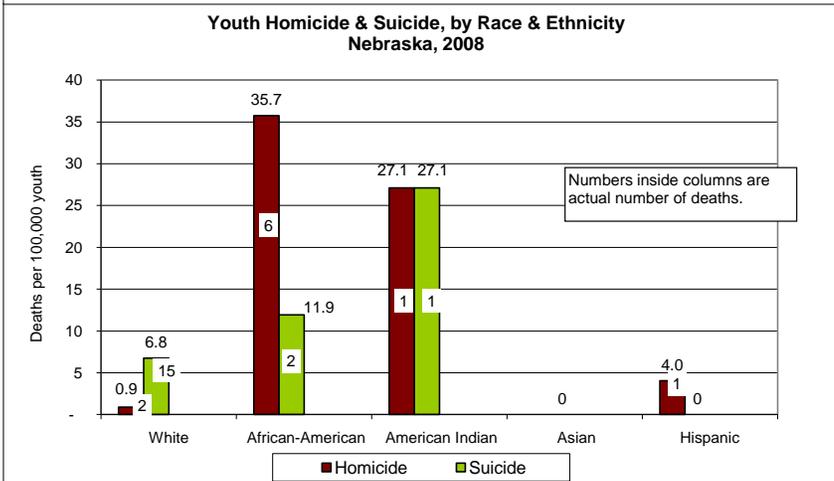
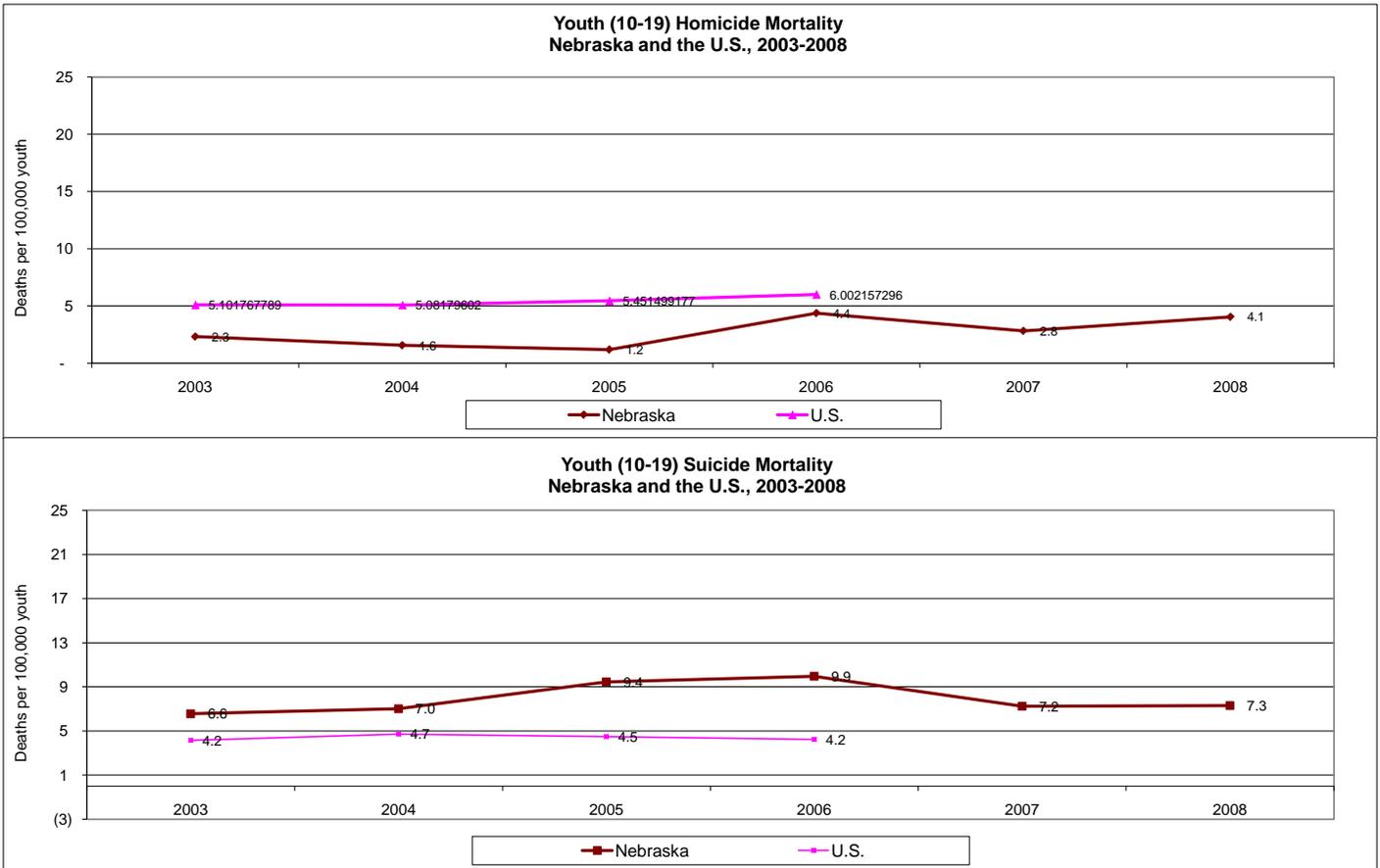
Definition: The number and rate of fatalities due to homicide per 100,000 youth ages 10-19
The number and rate of fatalities due to suicide per 100,000 youth ages 10-19

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Homicide			Suicide		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska (2008)	10	4.05	was...	25	9.9	was...
United States (2006)	2,518	6.00	N.S.D.	1,771	4.2	Higher
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			NO		

Graphical Display of Data:



	5-Year Trends	
	Homicide	Suicide
White	N.L.C.	N.L.C.
African-American	N.L.C.	N.L.C.
American Indian	N.L.C.	N.L.C.
Asian	-	N.L.C.
Hispanic	N.L.C.	N.L.C.

Data Sheet: HEALTH OUTCOMES

Mortality - Top Causes (continued)

Definition: The number and rate of fatalities due to MVC per 100,000 youth ages 10-19
The number and rate of fatalities due to MVC involving alcohol per 100,000 youth ages 10-19

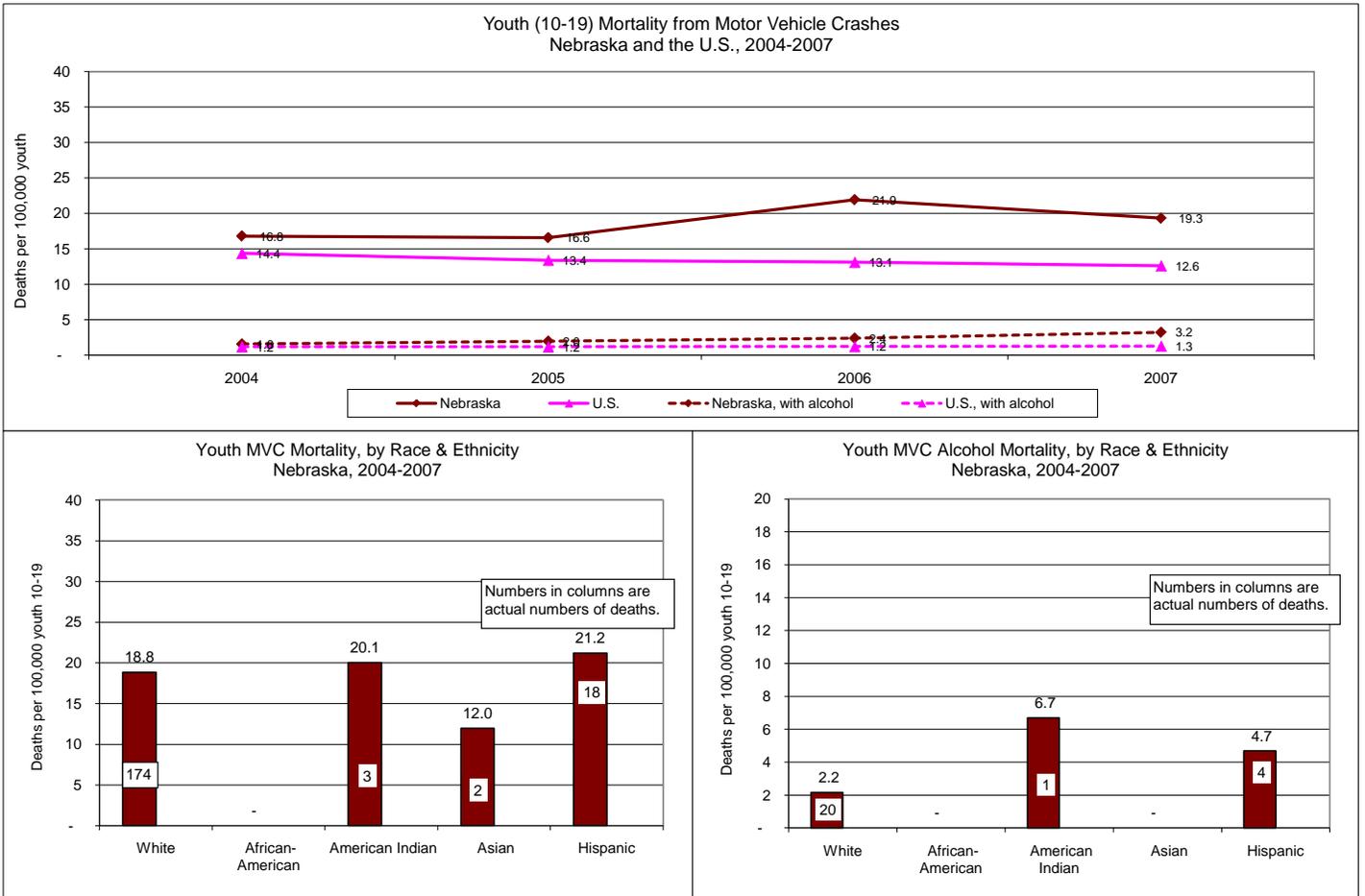
Data Source: National Fatality Analysis Reporting System

Data & Disparities:

	Motor Vehicle Crash			Motor Vehicle Crash Involving Alcohol		
	Number	Rate	Nebraska rate	Number	Rate	Nebraska rate
Nebraska (2007)	48	19.3	was...	8	3.2	was...
United States (2007)	5,260	12.6	Higher	524	1.3	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences*	NO			NO		

*Based on 2004-2007 aggregate data.

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Top Causes (continued)

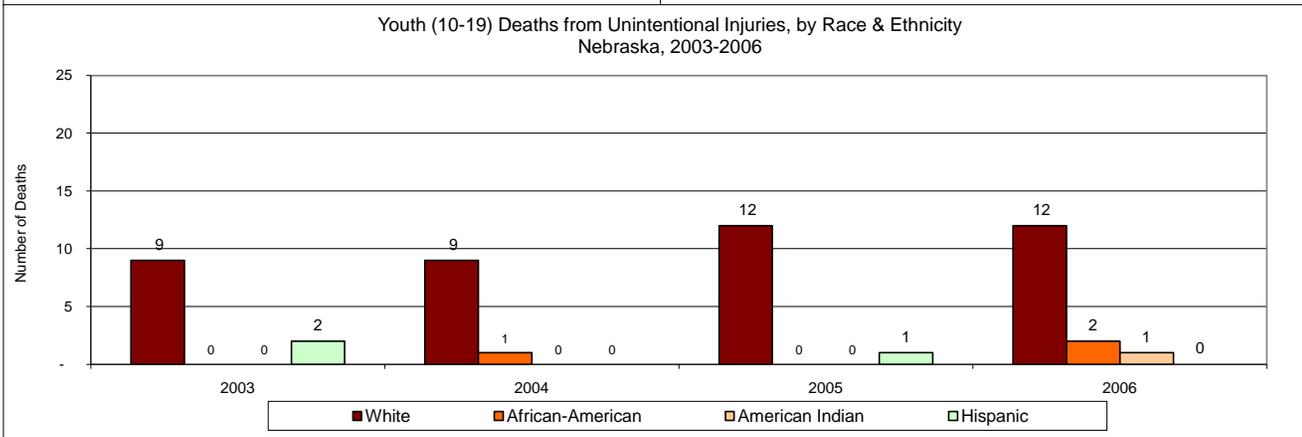
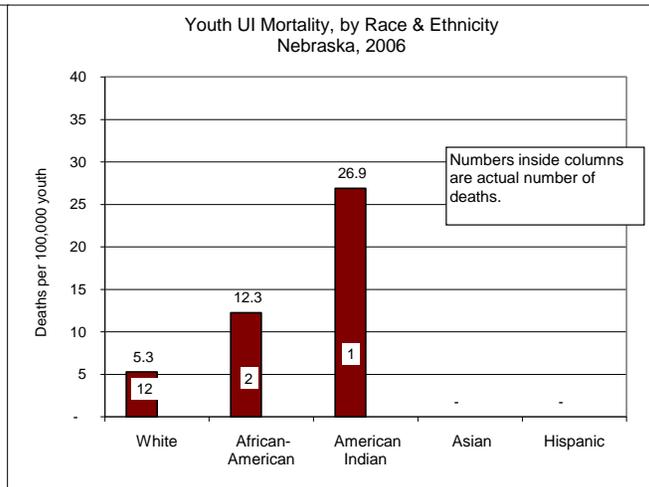
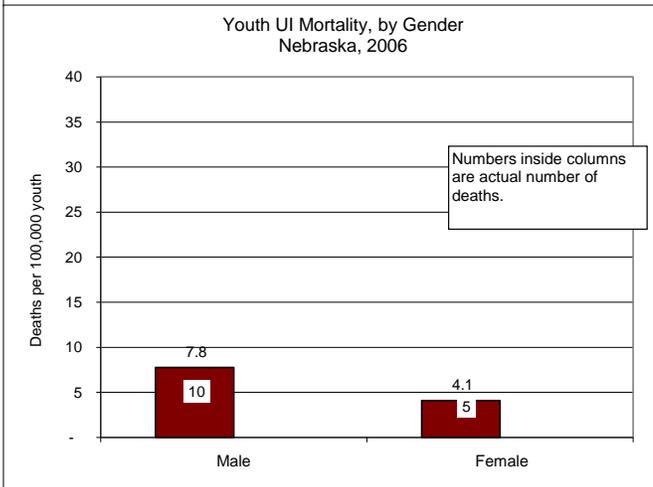
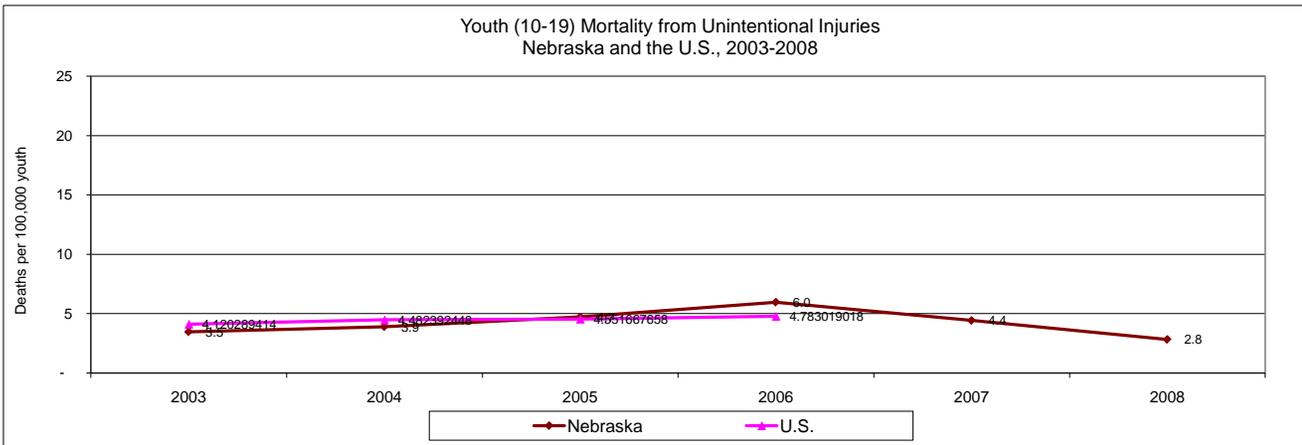
Definition: The number and rate of fatalities due to unintentional injuries (not including MVC), per 100,000 youth age 10-19

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Unintentional Injuries		
	Number	Rate	Nebraska rate
Nebraska (2008)	7	2.8	was...
United States (2006)	1,919	4.6	N.S.D.
HP 2010 Objective	-		
Nebraska 5-year trend	N.L.C.		
Racial / Ethnic Differences	NO		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Top Causes (continued)

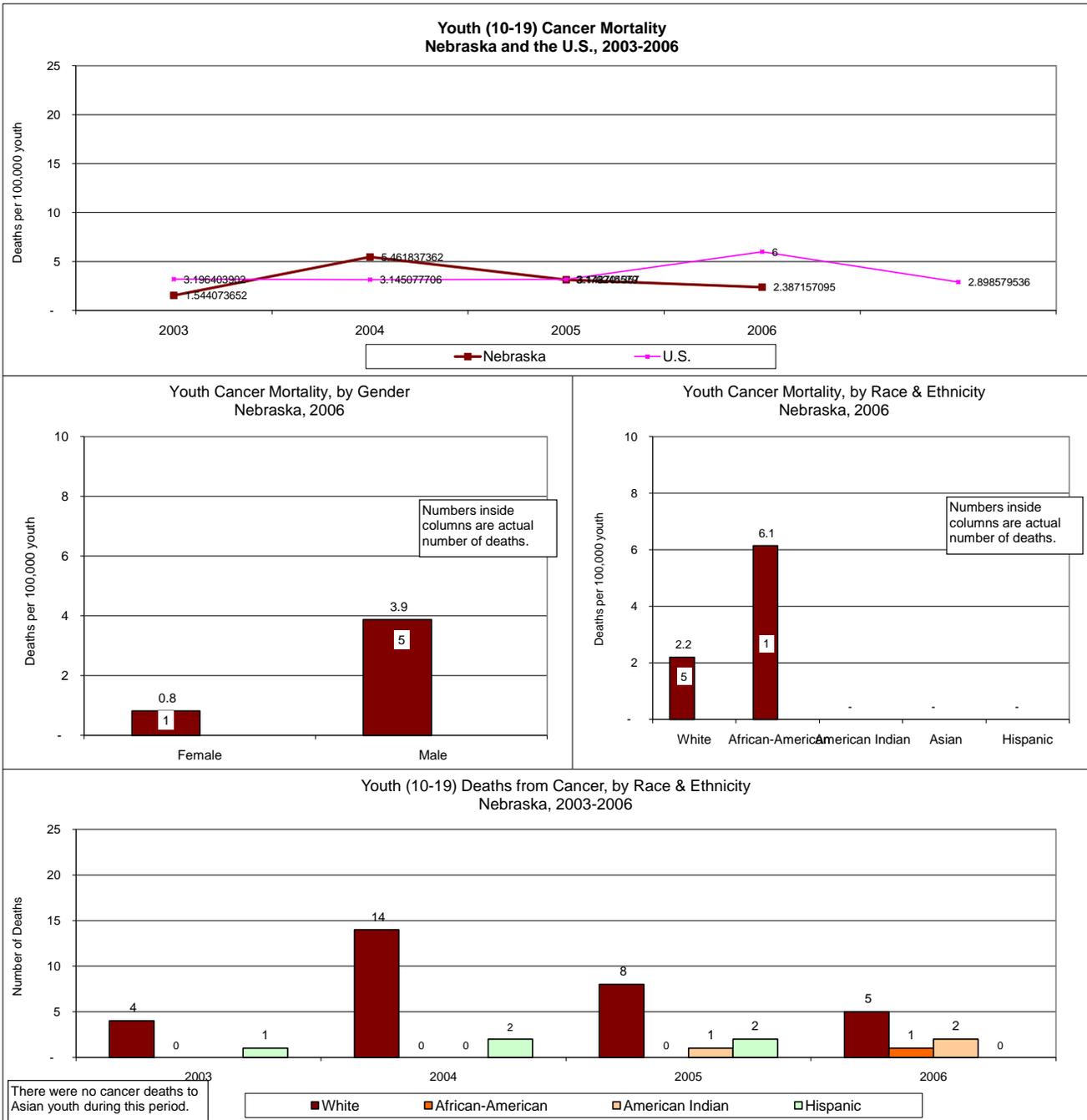
Definition: The number and rate of fatalities due to unintentional injuries (not including MVC), per 100,000 youth age 10-19
The number and rate of fatalities due to cancer, per 100,000 youth age 10-19

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Unintentional Injuries			Cancer		
	Number	Rate	Nebraska rate was...	Number (2006)	Rate	Nebraska rate was...
Nebraska (2008)	7	2.8		6	2.4	
United States (2006)	1,919	4.6	N.S.D.	1,216	2.9	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	NO			NO		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Mortality - Birth Outcomes

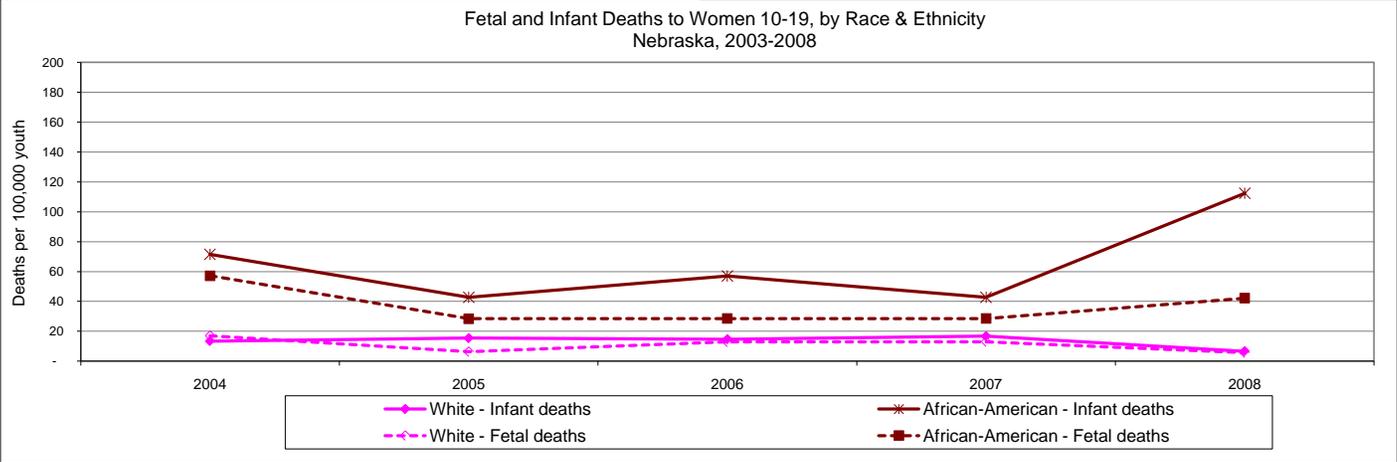
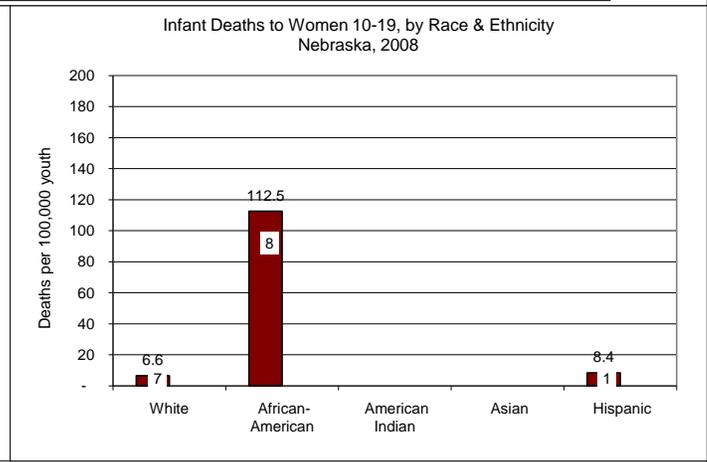
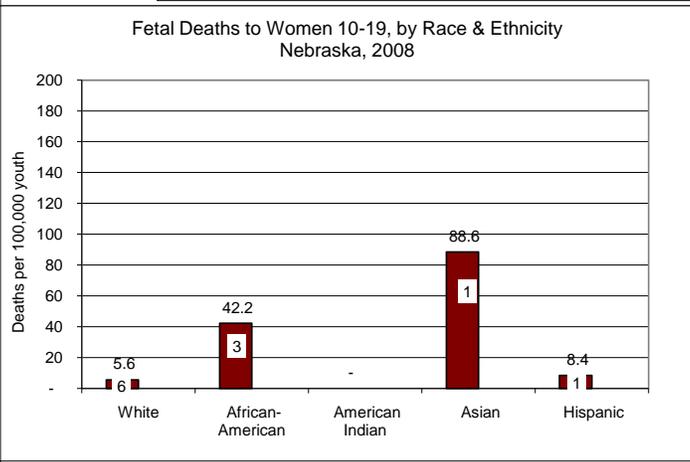
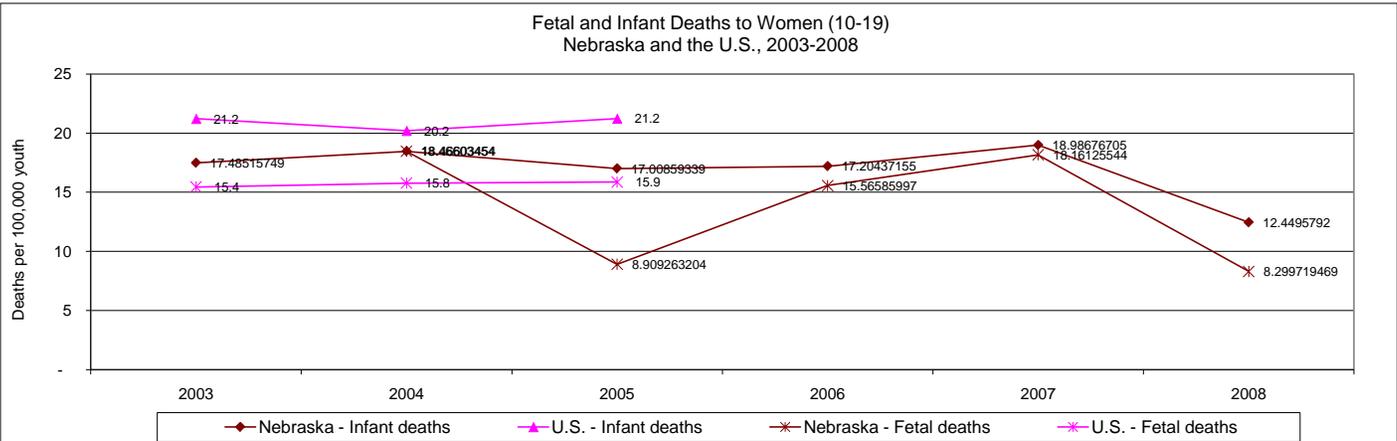
Definition: Fetal deaths to women under age 20, per 100,000 girls 10-19. **Note:** This is not a Fetal Mortality Rate.
 Infant deaths to women under age 20, per 100,000 girls 10-19. **Note:** This is not an Infant Mortality Rate.

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Fetal Deaths			Infant Deaths		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	10	8.3	was...	15	12.4	rate was...
United States (2005)	3,235	15.9	Lower	4,330	21.2	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	NO			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Asthma

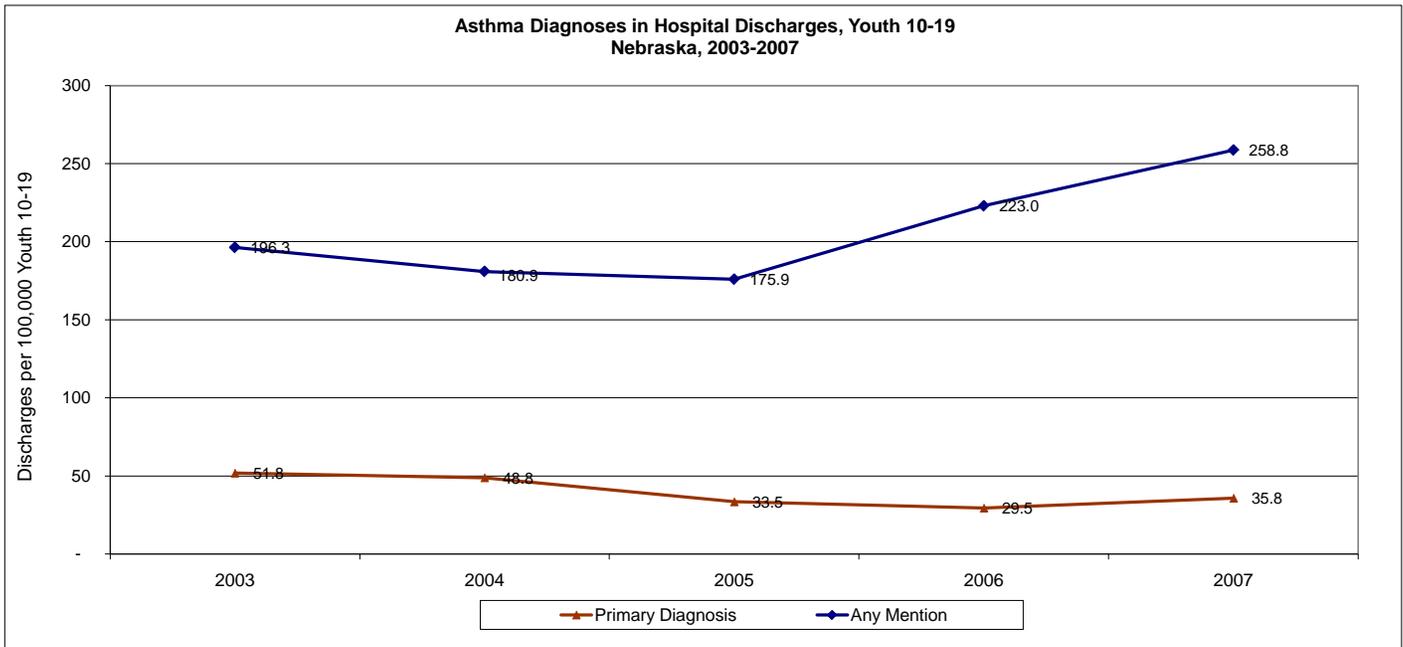
Definition: Hospital discharges with asthma as the **primary** diagnosis, per 100,000 youth age 10-19
Hospital discharges with **any mention** of asthma, per 100,000 youth age 10-19

Data Source: Hospital Discharge Dataset

Data & Disparities:

	Primary Diagnosis		Any Mention	
	Number	Rate	Number	Rate
Nebraska (2007)	89	35.8	643	258.8
United States	-	-	-	-
HP 2010 Objective	-	-	-	-
Nebraska 5-year trend	N.L.C.		N.L.C.	
Racial / Ethnic Differences	-		-	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Child Abuse

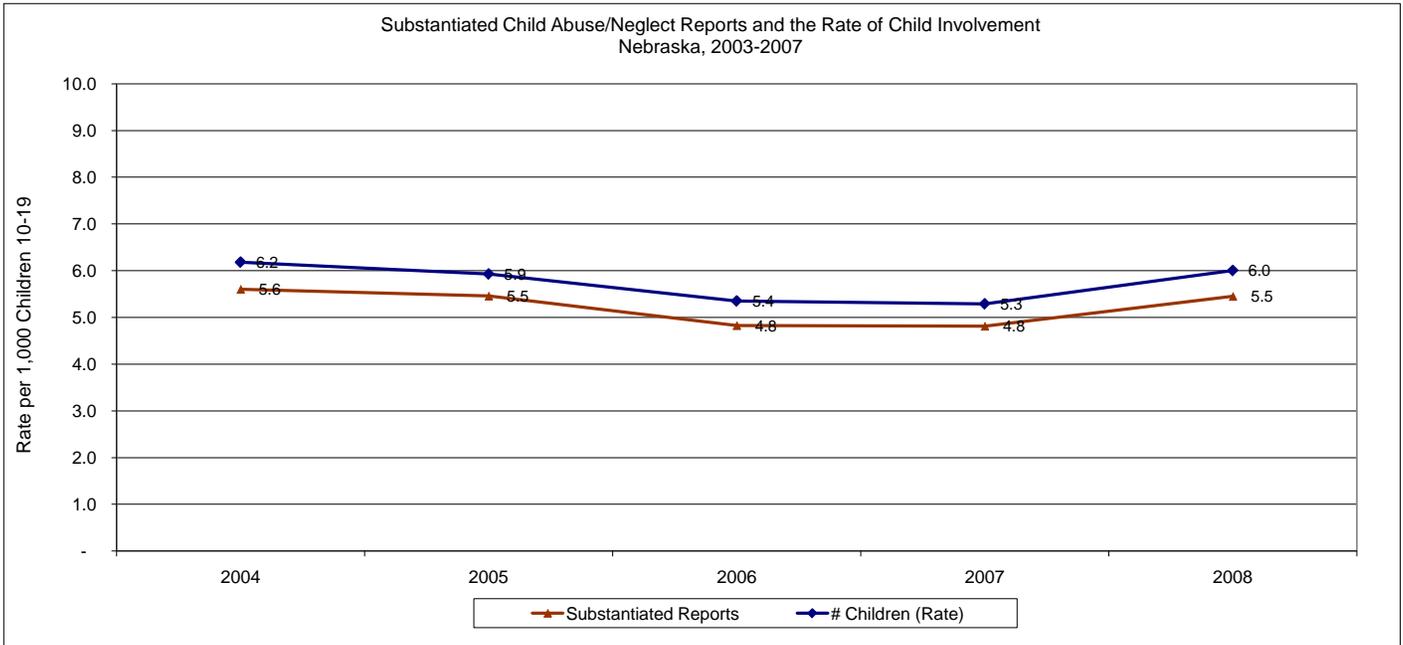
Definition: The numbers of child neglect or abuse reports that were substantiated by Child Protective Services (CPS), per 1,000 youth 10-19
The total numbers of children involved in substantiated reports of abuse or neglect, per 1,000 youth 10-19

Data Source: Nebraska DHHS - Children and Family Services

Data & Disparities:

	Substantiated		# Children Involved	
	Number	Rate	Number	Rate
Nebraska (2008)	1,346	5.5	1,483	6.0
United States	-	-	-	-
HP 2010 Objective	-	-	-	-
Nebraska 5-year trend	N.L.C.		N.L.C.	
Racial / Ethnic Differences	-		-	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Intentional Injuries

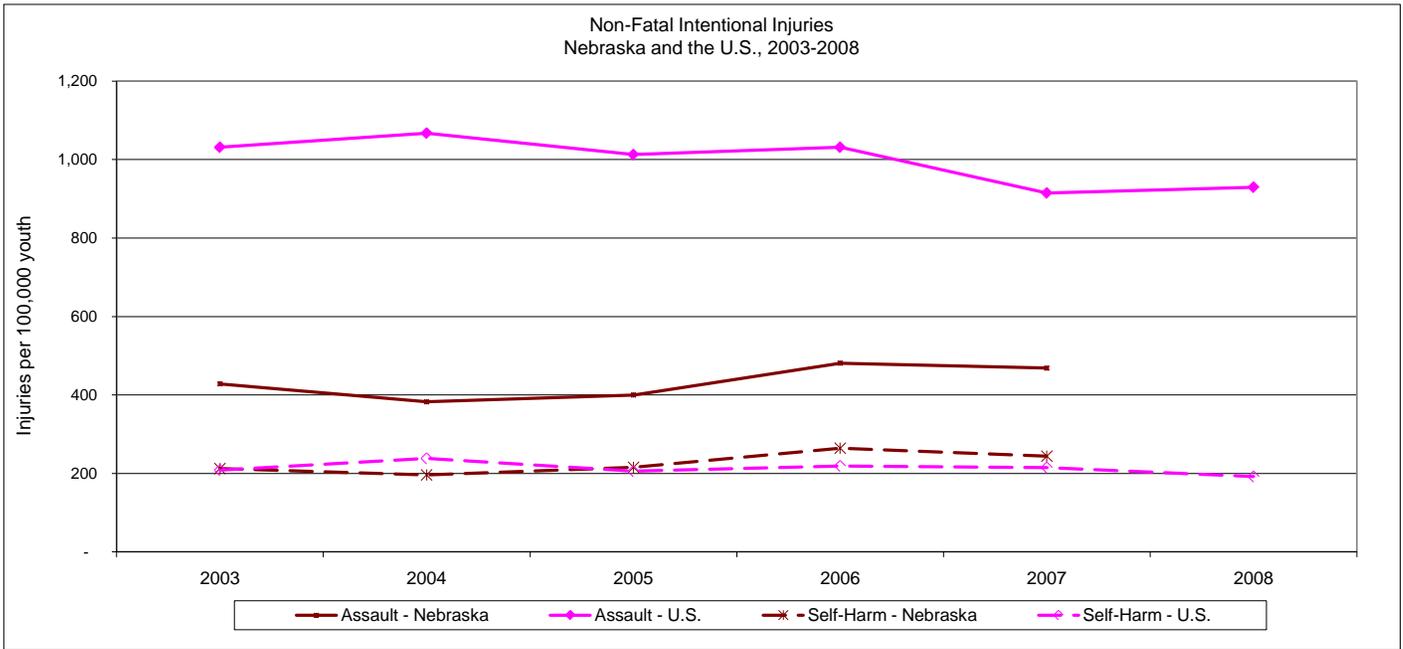
Definition: The rate of hospital discharges for intentional, nonfatal (**assault**) injuries, per 100,000 youth
The rate of self-inflicted injuries to youth by cause, per 100,000 youth

Data Source: Hospital Discharge Dataset

Data & Disparities:

	Assault			Self-Inflicted		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	1,164	468.4	was...	607	244.3	rate was...
United States (2007)	381,708	914.5	Lower	89,383	215.0	Higher
HP 2010 Objective	-	-	-	-	-	-
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Unintentional Injuries

Definition: The rate of hospital discharges for unintentional, nonfatal injuries, per 100,000 youth 10-19

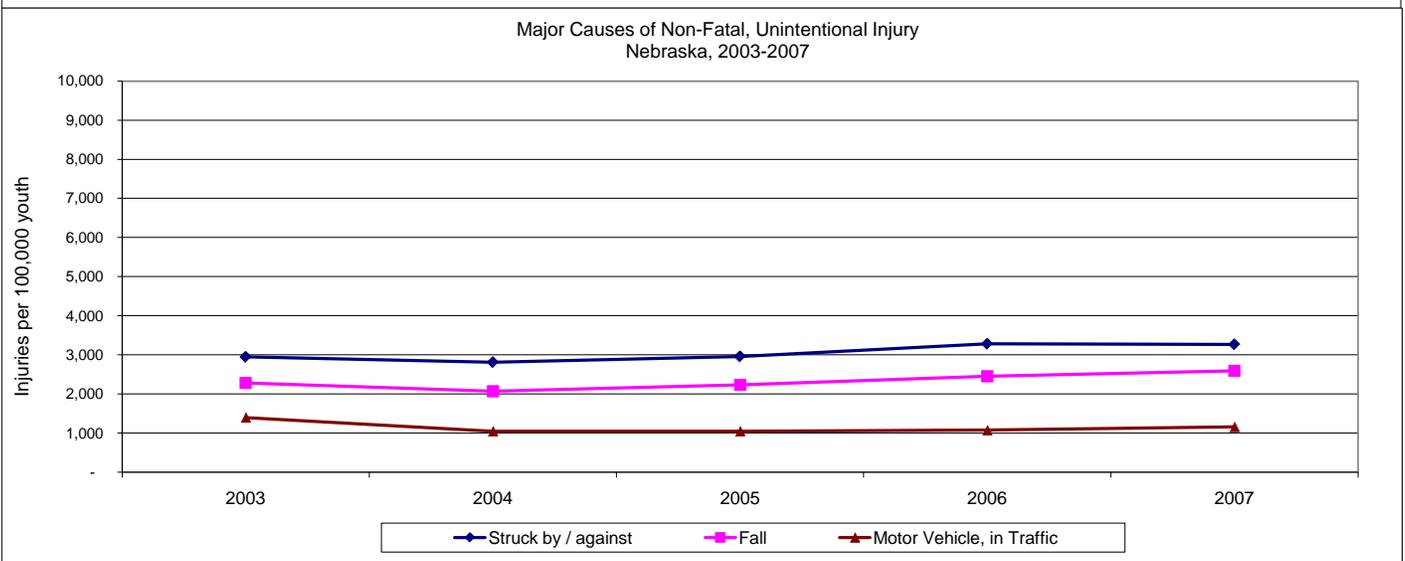
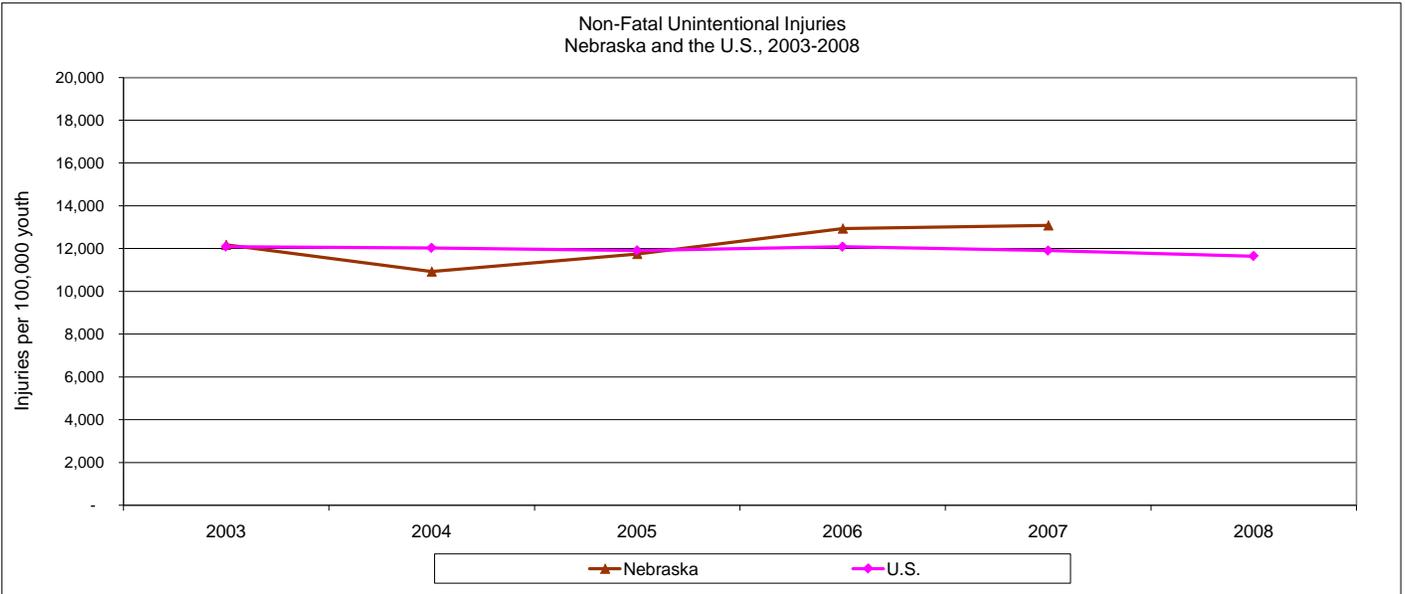
Data Source: Hospital Discharge Dataset

Data & Disparities:

	Struck by/against			Fall		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	8,115	3,265.7	was...	6,437	2,590.4	was...
United States (2007)	1,190,941	2,853.4	Higher	1,086,259	2,602.6	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

	Motor Vehicle			All Causes		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2007)	2,873	1,156.2	was...	32,512	13,083.6	was...
United States (2007)	465,078	1,114.3	N.S.D.	4,967,088	11,900.8	Higher
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Mental Health

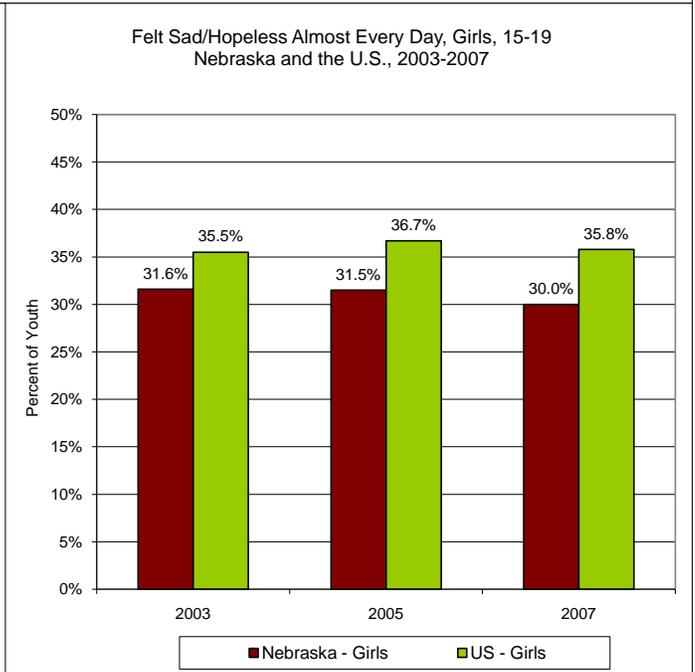
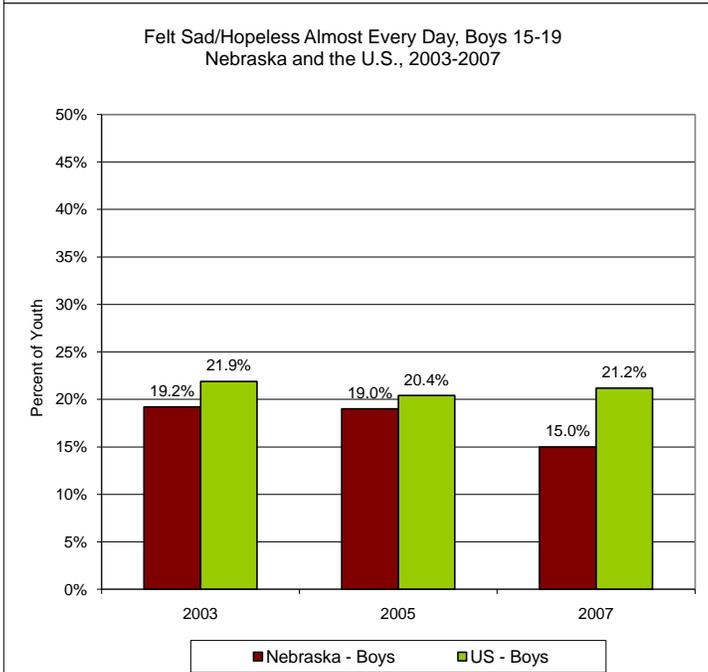
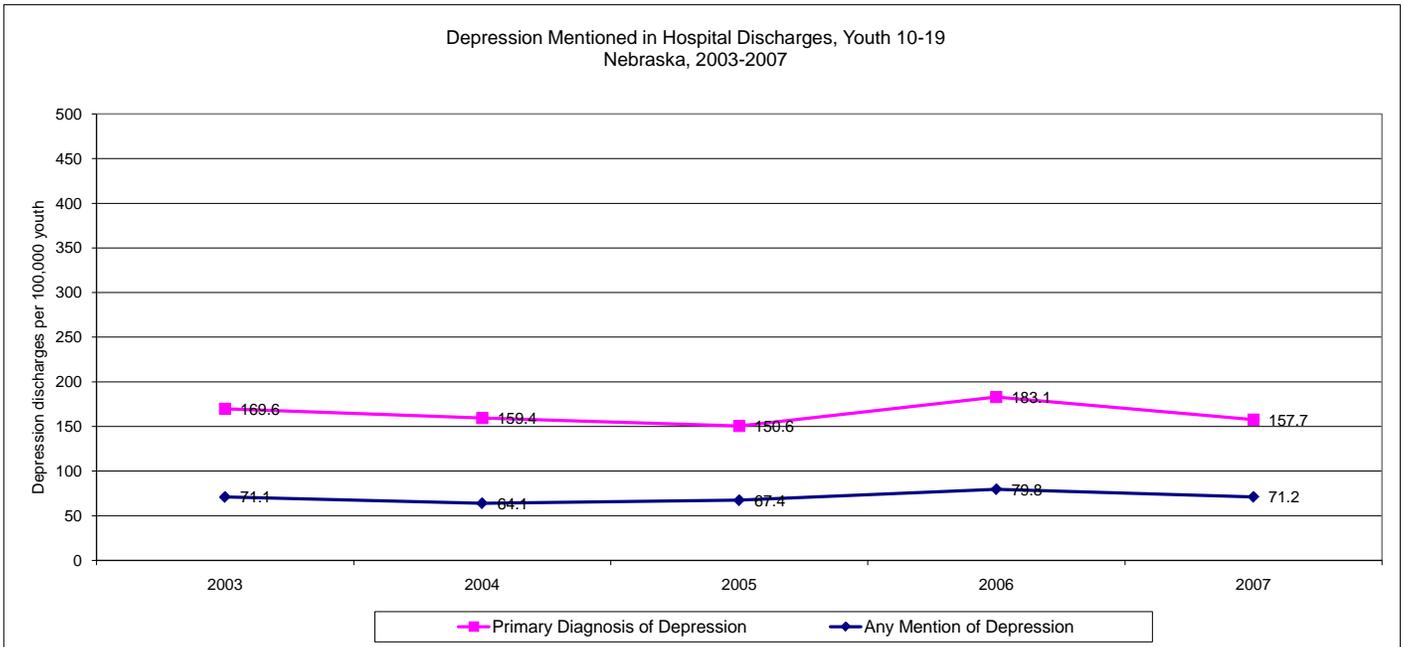
Definition: Hospital discharges with depression as **primary** diagnosis, per 100,000 youth 10-19
Hospital discharges with **any mention** of depression, per 100,000 youth 10-19
Felt sad/hopeless almost every day for two+ weeks that stopped doing a usual activity, in last year, per 100 youth 15-19.

Data Source: Hospital Discharge Dataset
Youth Risk Behavior Survey

Data & Disparities:

	Primary Diagnosis		Anywhere mentioned		Sad / Hopeless		Nebraska rate was...
	Number	Rate	Number	Rate	Number	%	
Nebraska (2007)	177	71.2	392	157.7	54,000	22.0%	Lower
United States (2005)	-	-	-	-	6,000,000	28.5%	
HP 2010 Objective	-	-	-	-	-	-	
Nebraska 5-year trend	N.L.C.		N.L.C.		N.L.C.		
Racial / Ethnic Differences	-	-	-	-	-	-	

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Mental Health (continued)

Definition: Seriously consider attempting suicide in the past 12 months, per 100 youth 15-19.
Made a plan about how attempt suicide during past 12 months, per 100 youth 15-19.
Actually attempted suicide 1 or more times in last 12 months, per 100 youth 15-19.
Attempted suicide during the past 12 months resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse, per 100 youth 15-19

Data Source: Youth Risk Behavior Survey

Data & Disparities:

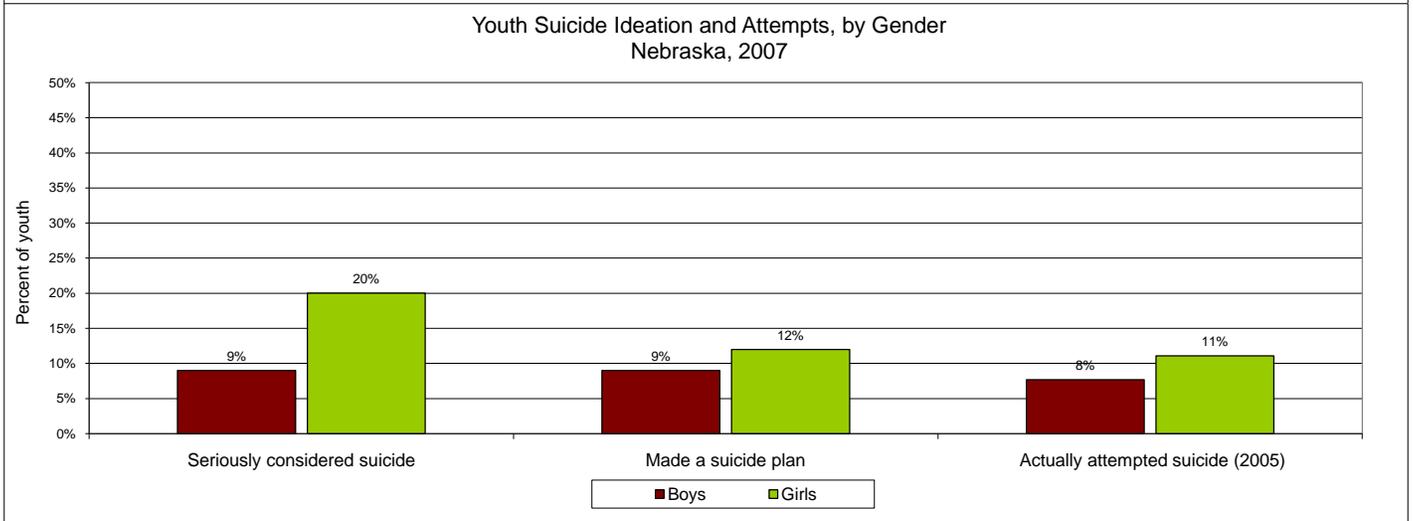
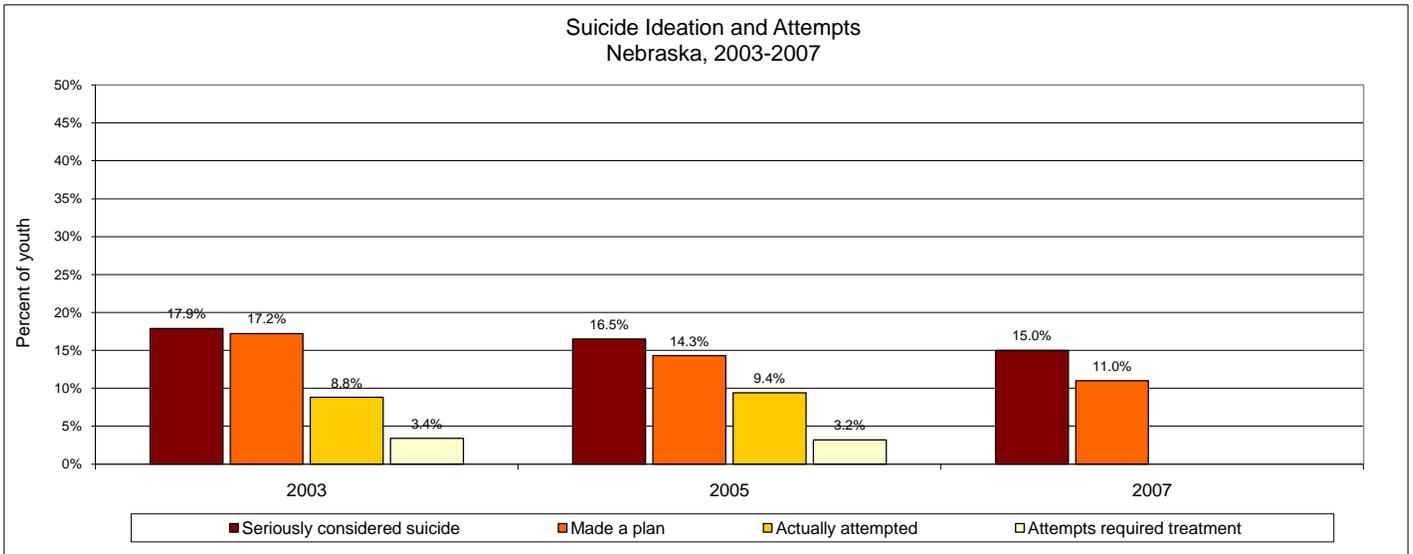
	Seriously considered			Made a plan		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	37,000	15.0%		27,000	11.0%	
United States (2007)	3,000,000	14.5%	N.S.D.	2,000,000	11.3%	N.S.D.
HP 2010 Objective		-			-	
Nebraska 5-year trend		DECREASING			DECREASING	
Racial / Ethnic Differences		-			-	

*Note: Projected estimates of numbers of youth are rounded down to nearest million.

	Actually attempted			Required treatment		
	Number*	Rate	Nebraska rate was...	Number**	Rate	Nebraska rate was...
Nebraska (2005)	0	9.4%		0	3.2%	
United States (2005)	0	8.4%	N.S.D.	0	2.0%	N.S.D.
HP 2010 Objective		-			1%	Higher
Nebraska 5-year trend		-			-	
Racial / Ethnic Differences		-			-	

**Note: Projected estimates of numbers of youth are rounded down to nearest hundred thousand.

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Health Status - Reproductive Health

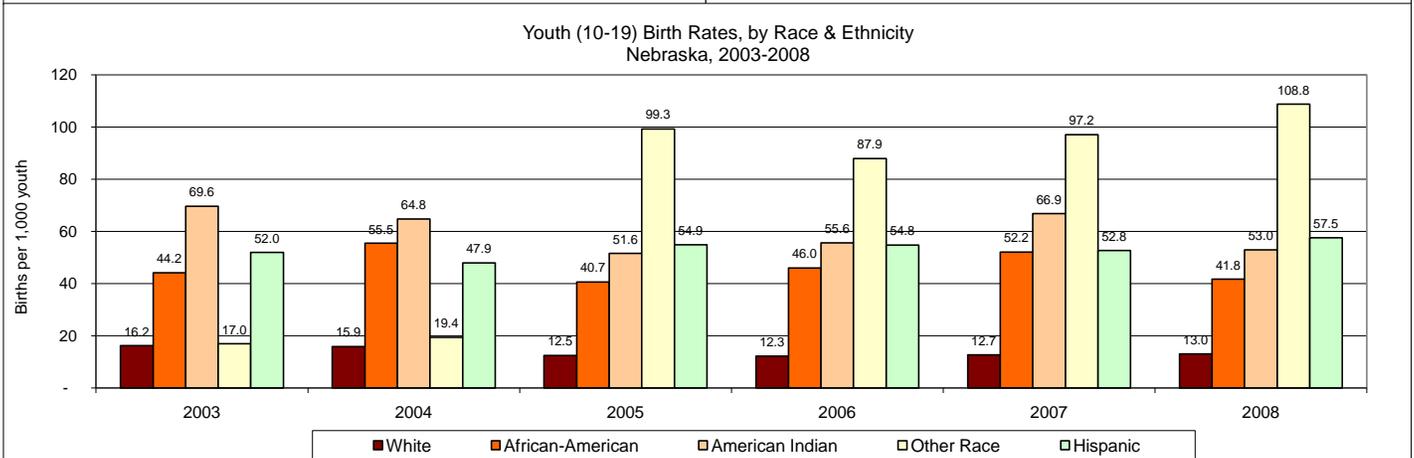
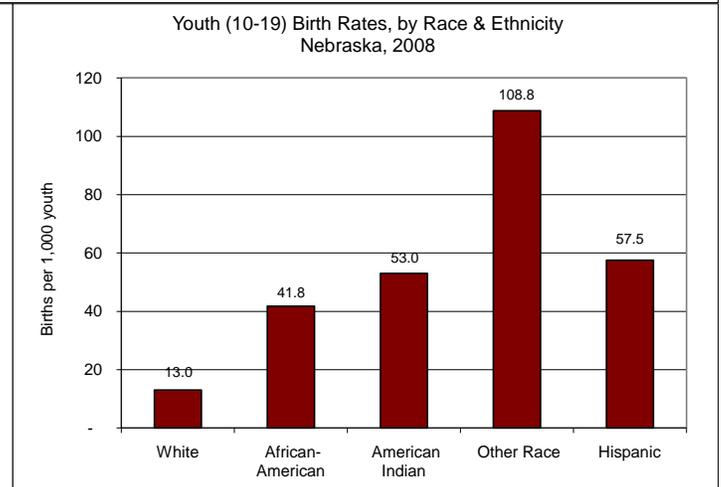
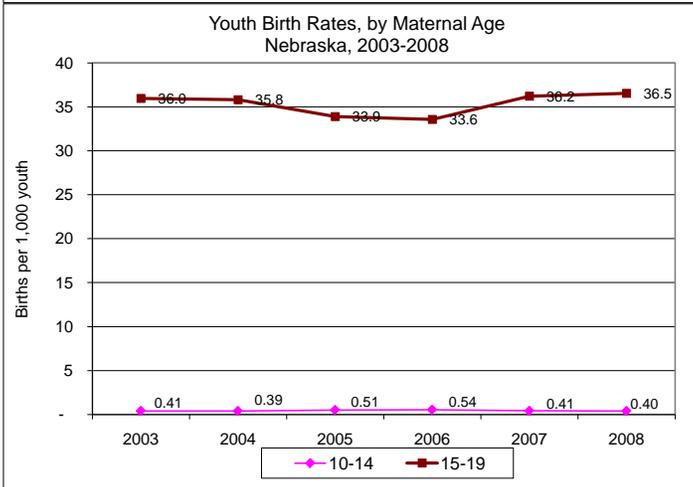
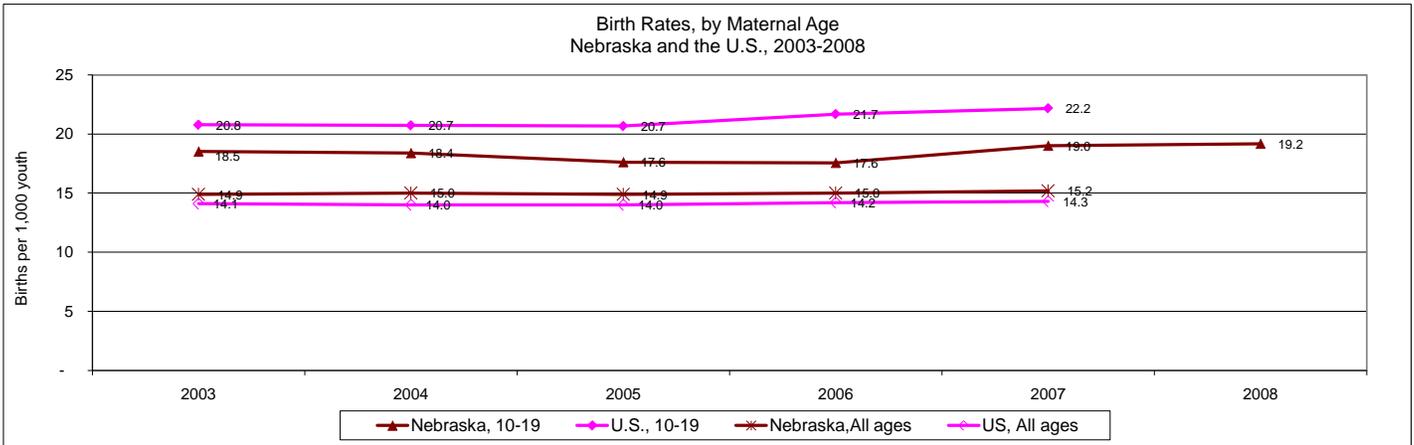
Definition: Birth rate to adolescent females, per 1,000

Data Source: National Center for Health Statistics - Vital Records

Data & Disparities:

	Ages 10-14			Ages 15-19			Ages 10-19		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	23	0.4	was...	2,288	36.5	was...	2,311	19.2	was...
United States (2007)	6,218	0.63	Lower	445,045	42.6	Lower	451,263	22.2	Lower
HP 2010 Objective	-			-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES			YES		

Graphical Display of Data:



Data Sheet: HEALTH OUTCOMES

Reproductive Health (continued)

Definition: Ever had sexual intercourse, per 100 youth 15-19
Ever physically forced to have sexual intercourse when they did not want to, per 100 youth 15-19

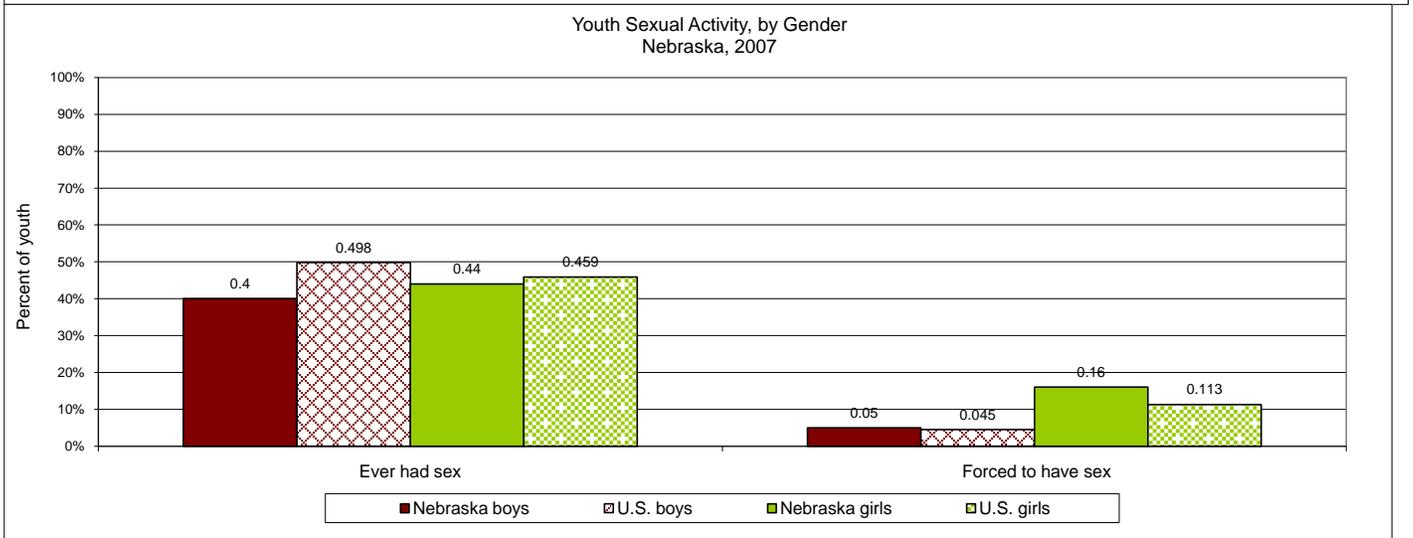
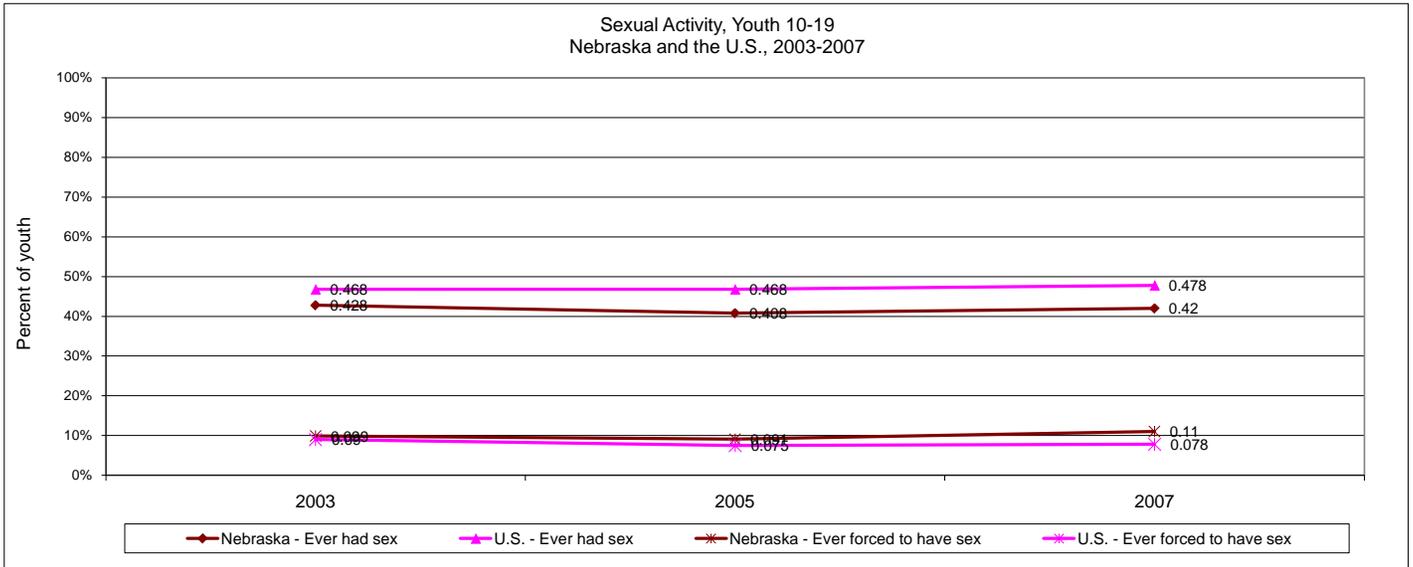
Data Source: Youth Risk Behavior Survey

Data & Disparities:

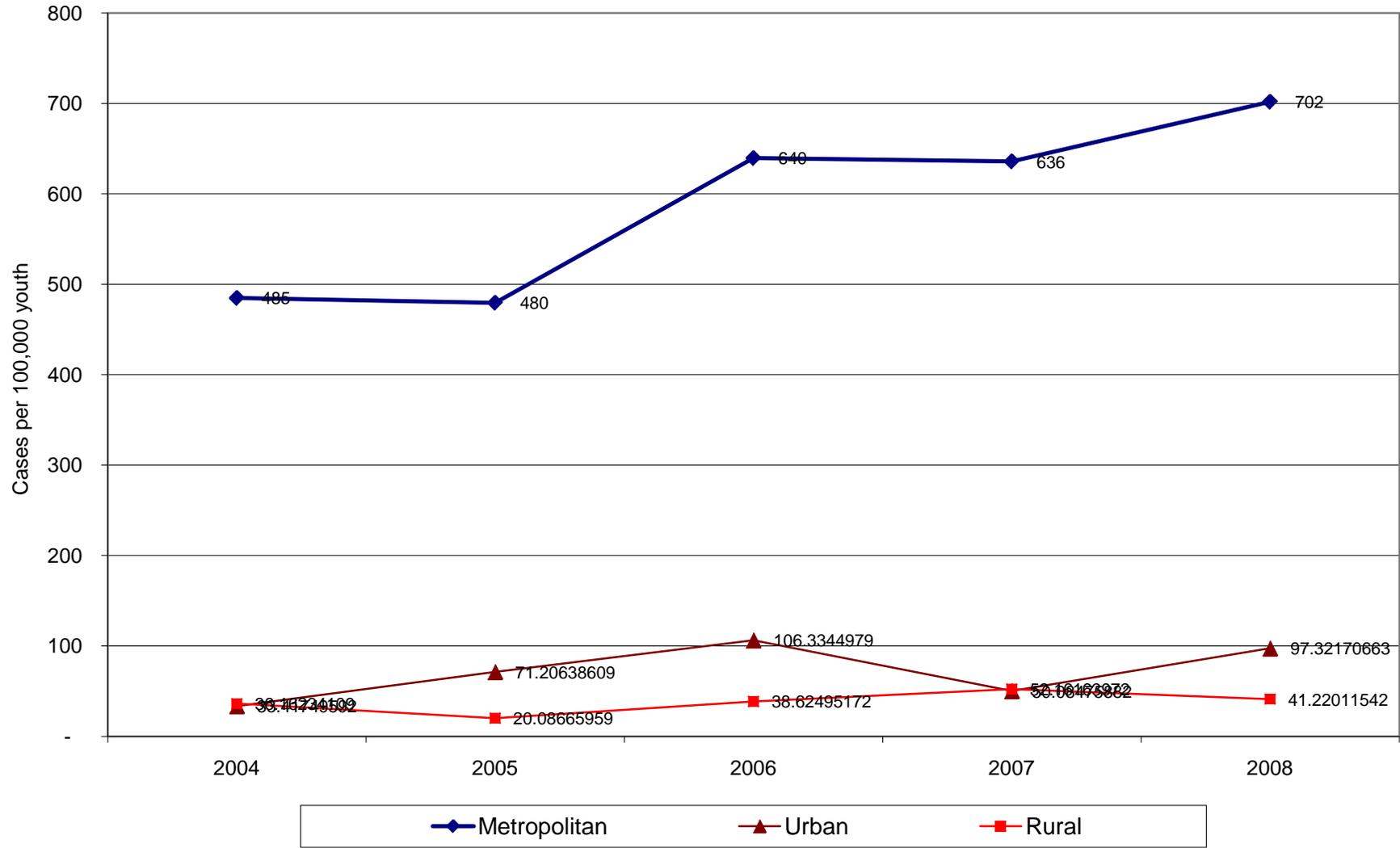
	Ever Had Sex			Ever Forced to Have Sex (2005)		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	54,000	42.0%		14,000	11.0%	
United States (2005)	9,800,000	46.8%	N.S.D.	1,500,000	7.5%	N.S.D.
HP 2010 Objective	-			-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

*Note: Projected estimates of numbers of youth are rounded down to nearest million.

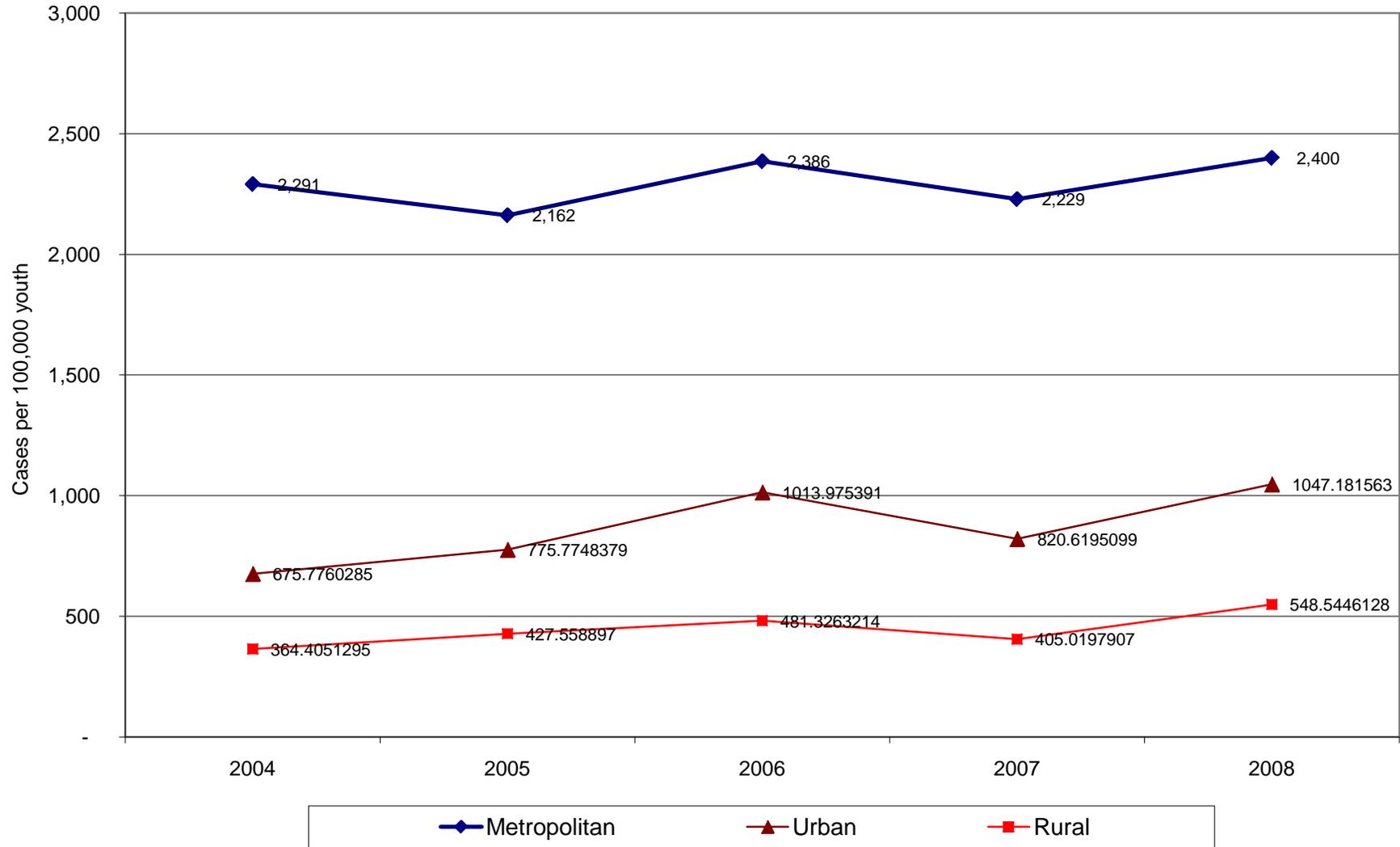
Graphical Display of Data:



Youth Gonorrhea Rates, by Urban/Rural Residence
Nebraska, 2004-2008



Youth Chlamydia Rates, by Urban/Rural Residence
Nebraska, 2004-2008



Data Sheet: HEALTH OUTCOMES

Reproductive Health - Sexually Transmitted Disease

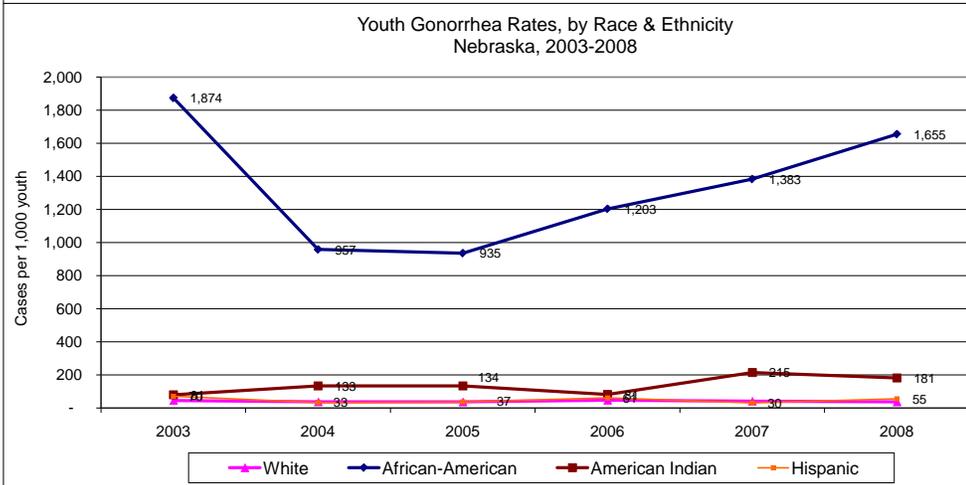
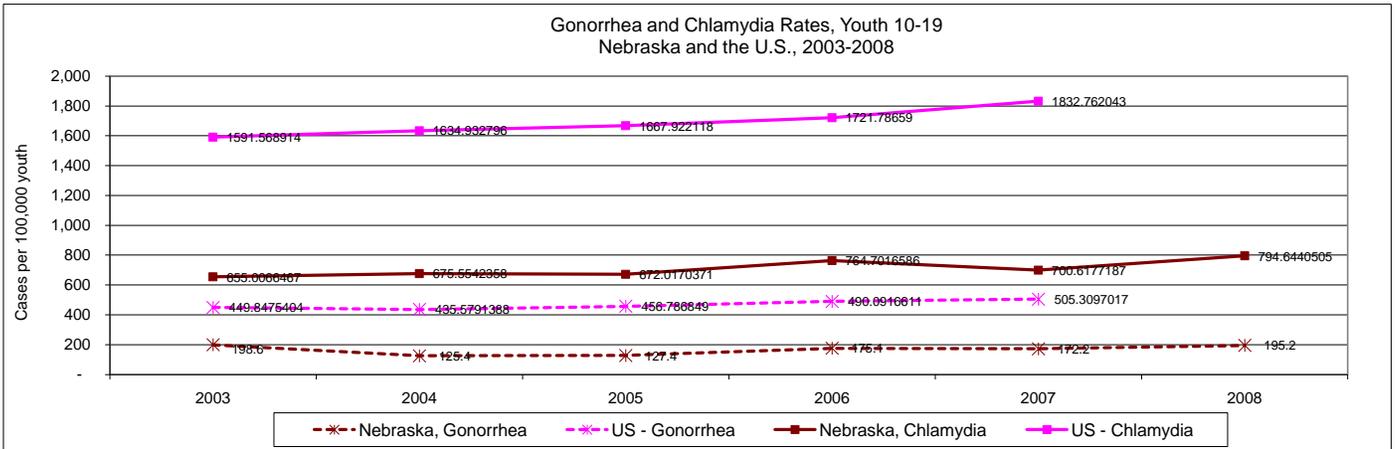
Definition: Reportable sexually transmitted diseases, per 100,000 youth ages 10-19, by cause:

Data Source: Nebraska DHHS Epidemiology - Communicable Diseases

Data & Disparities:

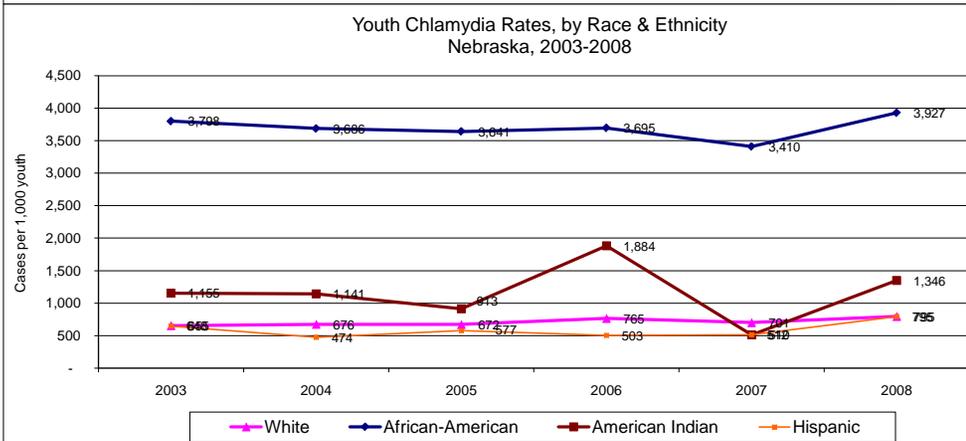
	Gonorrhea			Chlamydia			All Reported STDs		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2008)	482	195.2	was...	1,962	794.6	was...	2,596	1,051.4	was...
United States (2007)	102,537	505.31	Lower	393,047	1,832.8	Lower	-	-	-
HP 2010 Objective	19.0		Higher	-	-	-	-	-	-
Nebraska 5-year trend	INCREASING			N.L.C.			N.L.C.		
Racial / Ethnic Differences	YES			YES			YES		

Graphical Display of Data:



	5-Year Trends
	Gonorrhea
White	N.L.C.
African-American	INCREASING
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

There were between 0 and 2 cases of gonorrhea per year among Asian youth during this period.



	5-Year Trends
	Chlamydia
White	N.L.C.
African-American	N.L.C.
American Indian	N.L.C.
Asian	N.L.C.
Hispanic	N.L.C.

There were between 0 and 12 cases of chlamydia per year among Asian youth during this period.

Data Sheet: **HEALTH OUTCOMES**

Health Status - BMI

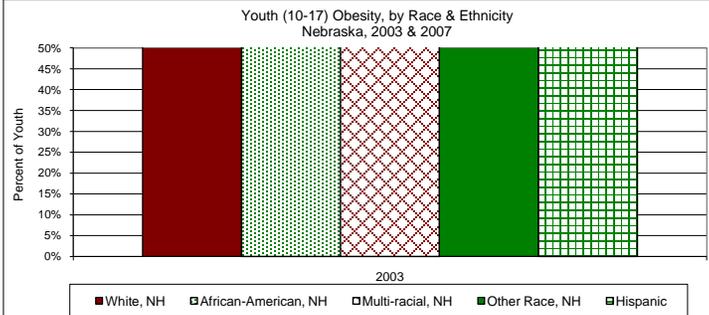
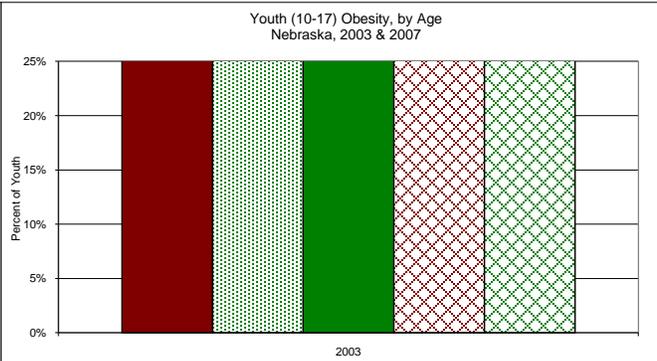
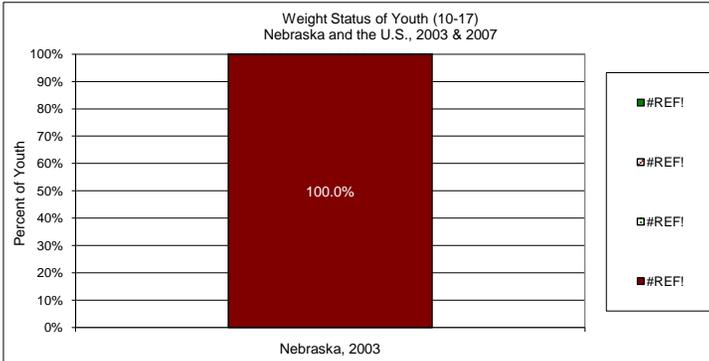
Definition: The number and percentage of children (10-17) who are overweight based on a BMI-for-age in the 85th to 94th percentiles.
The number and percentage of children (10-17) who are obese based on a BMI-for-age in the 95th percentile or higher.

Data Source: National Survey of Children's Health (2003, 2007)

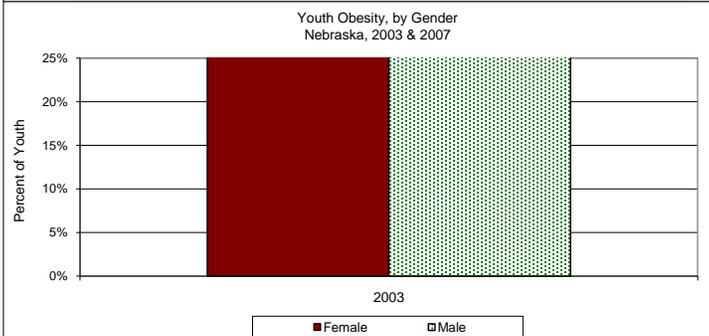
Data & Disparities:

	Overweight			Obese		
	Number	%	Nebraska % was...	Number	%	Nebraska % was...
Nebraska (2007)	30,860	15.6%	was...	31,175	15.8%	% was...
United States (2007)	4,825,739	15.3%	N.S.D.	5,175,940	16.4%	N.S.D.
HP 2010 Objective		5%	Higher	5%		Higher
Nebraska change, 2001 vs. 2007		N.S.D.			N.S.D.	
Racial / Ethnic Differences		NO			NO	

Graphical Display of Data:



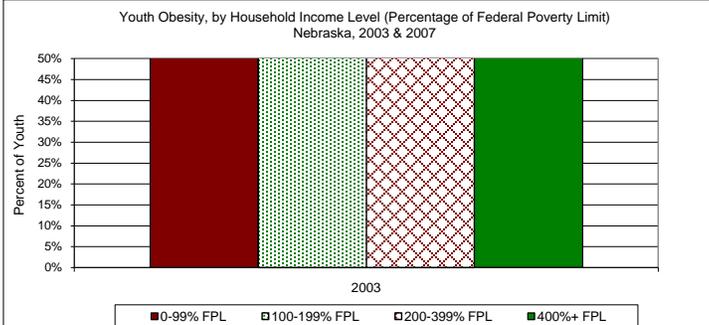
Significant Differences (2007) by... Age ? **NO**



Significant Differences (2007) by... Race/Ethnicity ? **NO**

Gender	is	than Nebraska average
Female	is	Lower
Male	is	N.S.D.

Significant Differences (2007) by... Gender ? **YES**



Household Income Level	is	than Nebraska average
0-99% FPL	is	N.S.D.
100-199% FPL	is	N.S.D.
200-399% FPL	is	N.S.D.
400%+ FPL	is	N.S.D.

Significant Differences (2007) by... Income ? **YES**

Data Sheet: HEALTH DETERMINANTS

Access to Care - Services

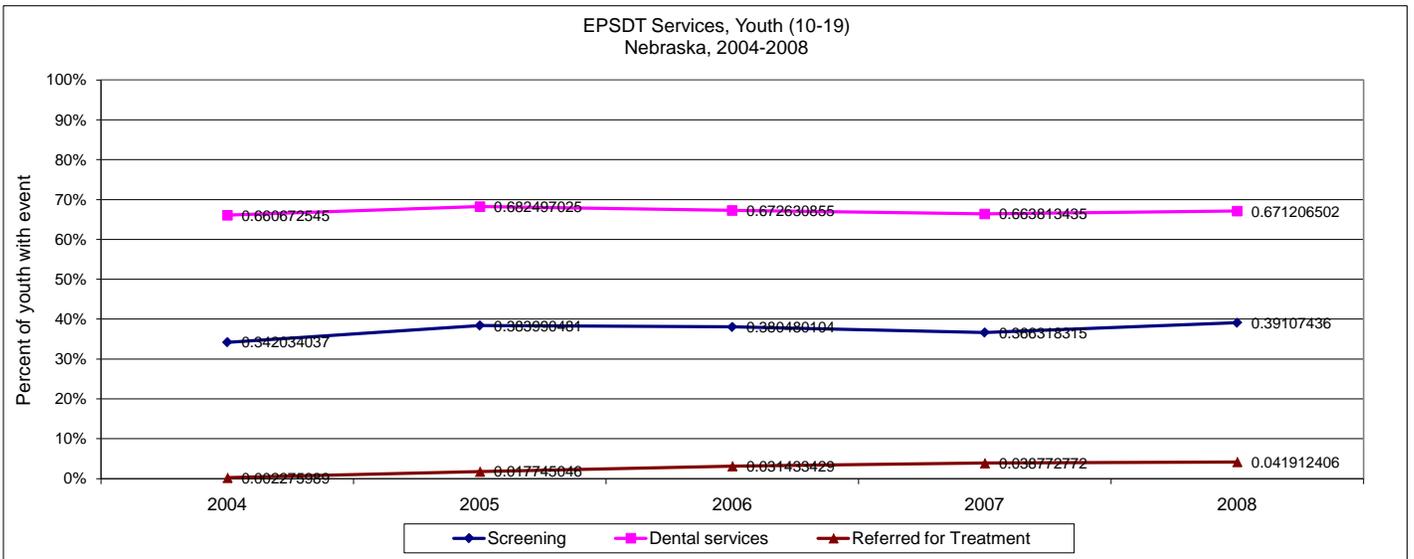
Definitions: The percent of EPSDT-enrolled youth who received at least one initial or periodic health screen
The percent of EPSDT-enrolled youth referred for corrective treatment
The percent of EPSDT-enrolled youth who have received any dental services

Data Source: Nebraska EPSDT

Data & Disparities:

	Screening			Referred for Treatment			Dental services		
	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...	Number	Rate	Nebraska rate was...
Nebraska (2006)	19,296	39.1%		2,068	4.2%		33,118	67.1%	
United States (2006)	-	-	-	-	-	-	-	-	-
HP 2010 Objective		-			-			-	
Nebraska 5-year trend		N.L.C.			INCREASING			N.L.C.	
Racial / Ethnic Differences		-			-			-	

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Access to Care - Insurance

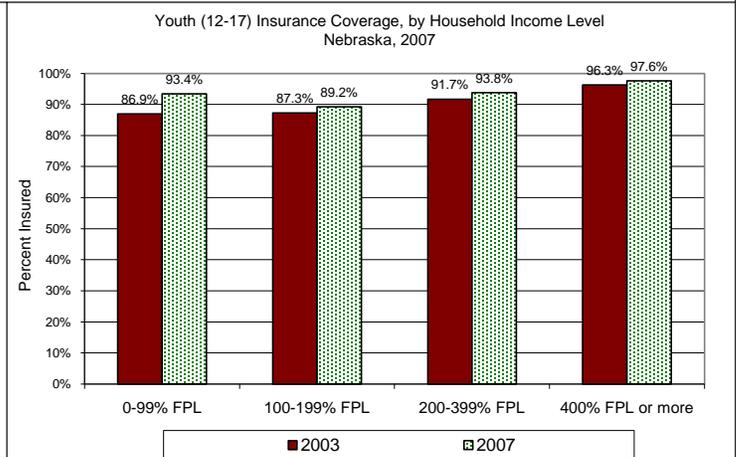
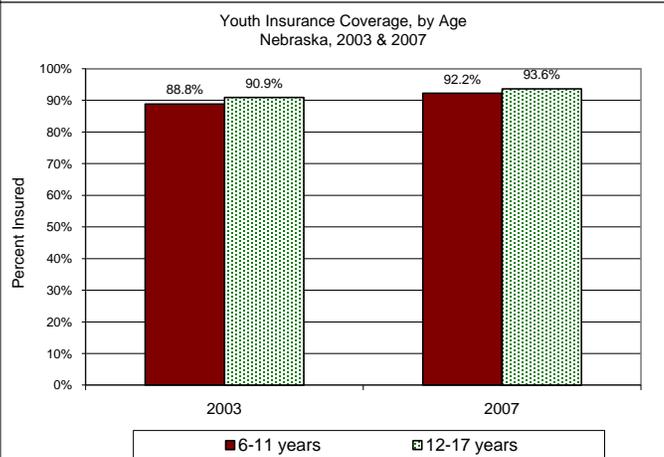
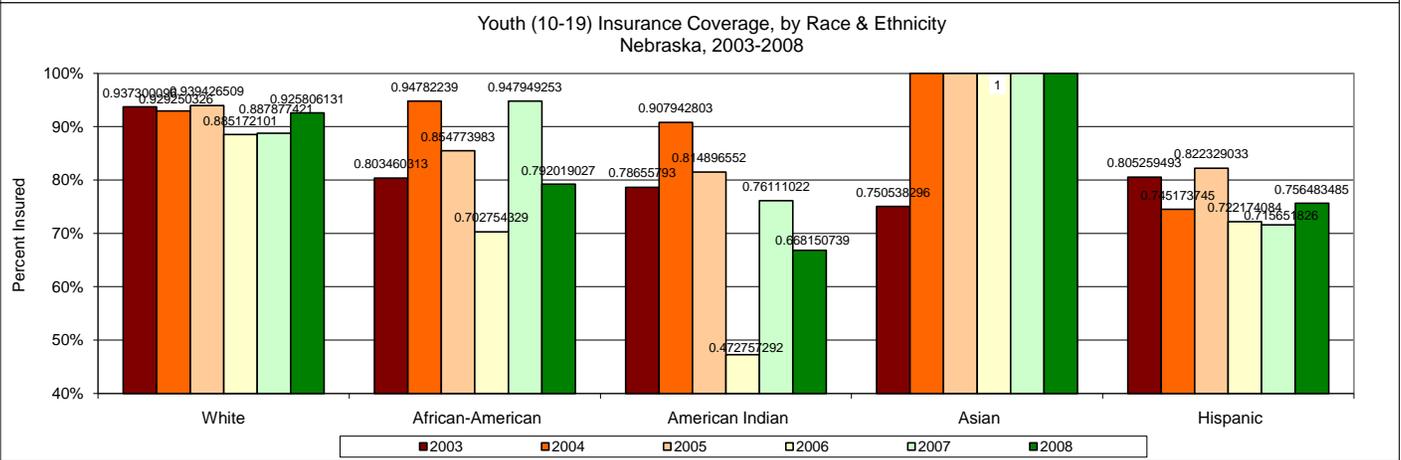
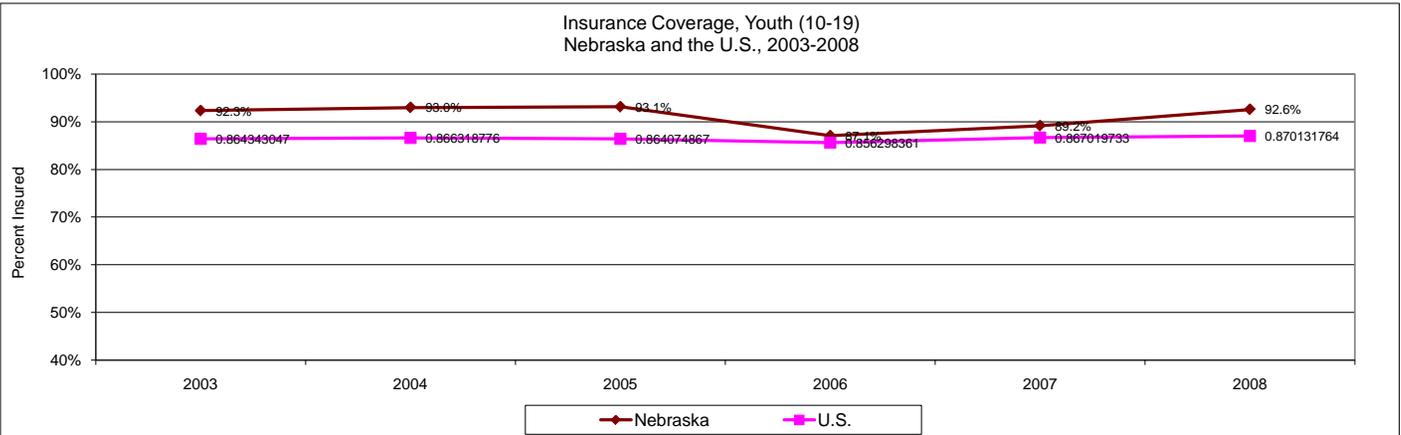
Definition: Percentage of youth 10-19 covered by health insurance

Data Source: U.S. Census Bureau - Current Population Survey (2003-2008)
National Survey of Child Health (2003, 2007)

Data & Disparities:

	Percentage Insured		Nebraska rate was...
	Number	Rate	
Nebraska (2008)	204,655	92.6%	was...
United States (2008)	35,792,000	87.0%	Higher
HP 2010 Objective	100%		Lower
Nebraska 5-year trend		N.L.C.	
Racial / Ethnic Differences		YES	

Graphical Display of Data:



Data Sheet: HEALTH DETERMINANTS

Health Behavior - ATOD

Definition: The percentage of students who had at least one drink of alcohol on one or more of the last 30 days
 The percentage of students who had 5 + drinks of alcohol in a row in 1 sitting on one or more of the past 30 days
 The percentage of students who smoked cigarettes, used smokeless tobacco, or smoked cigars during the past 30 days
 The percentage of students who used marijuana in the past 30 days

Data Source: Youth Risk Behavior Survey

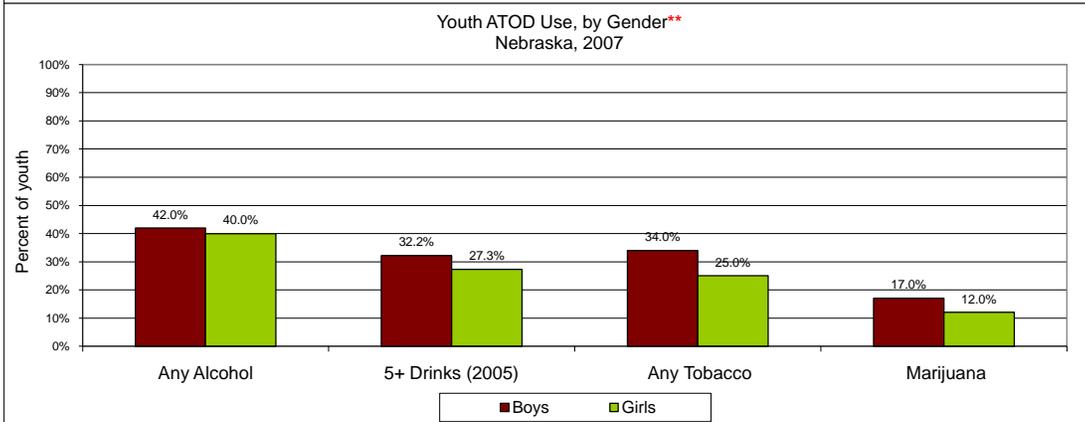
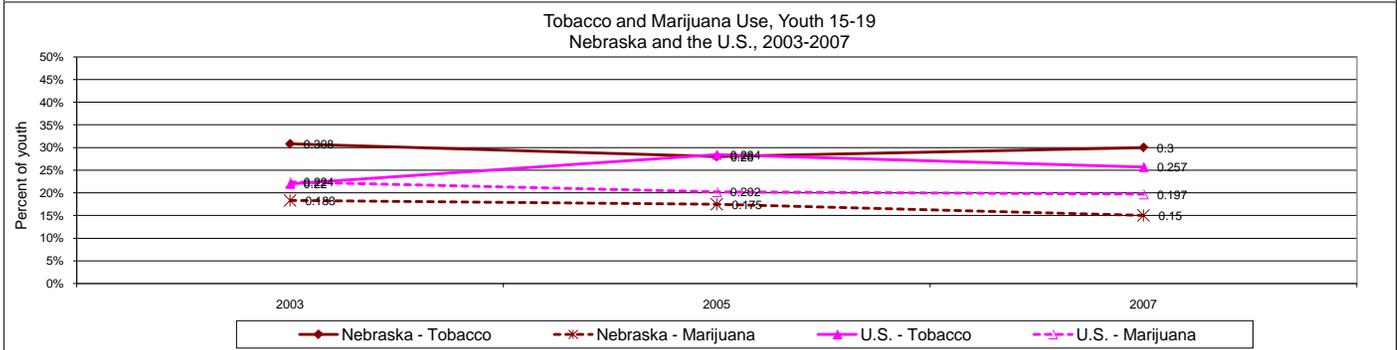
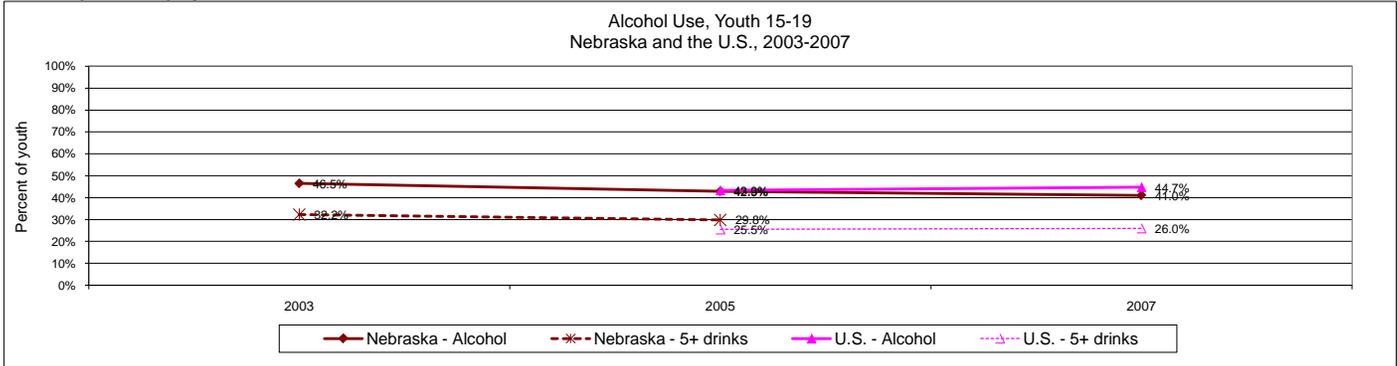
Data & Disparities:

	Any Alcohol			5+ Drinks (2005)		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	53,000	41.0%	was...	75,563	29.8%	was...
United States (2005)	9,000,000	43.3%	N.S.D.	5,300,000	25.5%	N.S.D.
HP 2010 Objective		-			-	
Nebraska 5-year trend		N.L.C.			-	
Racial / Ethnic Differences		-			-	

	Any Tobacco			Marijuana		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	38,000	30.0%	was...	44,374	17.5%	was...
United States (2005)	5,900,000	28.4%	N.S.D.	4,200,000	20.2%	N.S.D.
HP 2010 Objective		-			-	
Nebraska 5-year trend		N.L.C.			N.L.C.	
Racial / Ethnic Differences		-			-	

***Note:** Projected estimates of numbers of youth are rounded down to nearest thousand or hundred thousand.

Graphical Display of Data:



****Note:** Values for girls and boys are not significantly different.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Injury

Definition: The percentage of students who carried a weapon (gun, knife, club) on 1 or more of the past 30 days
The percentage of students who were in a physical fight 1 or more time in last 12 months

Data Source: Youth Risk Behavior Survey

Data & Disparities:

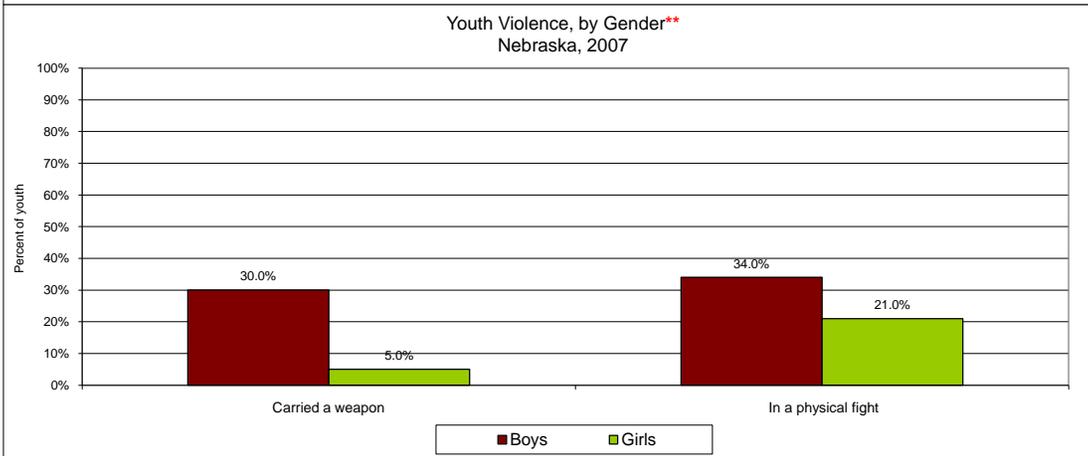
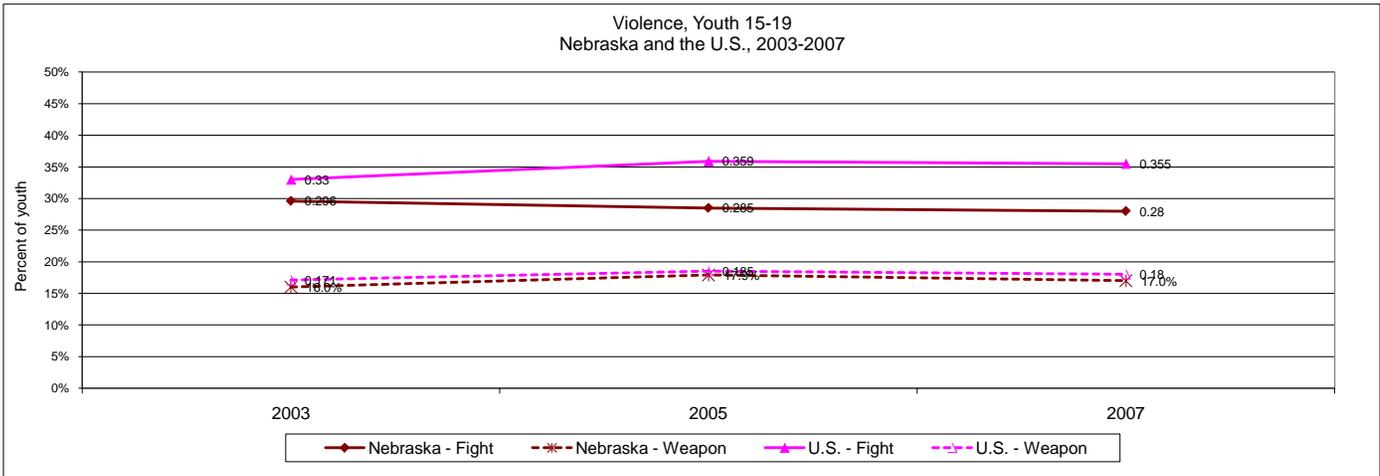
	Weapon			Physical Fight		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	21,000	17.0%	was...	36,000	28.0%	rate was...
United States (2005)	3,800,000	18.5%	N.S.D.	7,500,000	35.9%	Lower
HP 2010 Objective	4.9%		Higher	-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Boys	Weapon**			Physical Fight**		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	19,000	30.0%	was...	22,000	34.0%	rate was...
United States (2005)	3,207,000	29.8%	N.S.D.	4,671,000	43.4%	Lower
HP 2010 Objective	4.9%		Higher	-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

Girls	Weapon**			Physical Fight**		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	3,000	5.0%	was...	13,000	21.0%	rate was...
United States (2005)	726,000	7.1%	N.S.D.	2,874,000	28.1%	Lower
HP 2010 Objective	4.9%		N.S.D.	-		
Nebraska 5-year trend	N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-		

*Note: Projected estimates of numbers of youth are rounded down to nearest thousand or hundred thousand.

Graphical Display of Data:



**Note: Values for boys are significantly higher than those for girls.

Data Sheet: HEALTH DETERMINANTS

Health Behavior - Injury

Definition: The percentage of students who drove a car after drinking alcohol in past 30 days
 The percentage of students who rode with a driver who had been drinking alcohol during the past 30 days
 The percentage of students who never or rarely use passenger restraints when riding in car driven by someone else

Data Source: Youth Risk Behavior Survey

Data & Disparities:

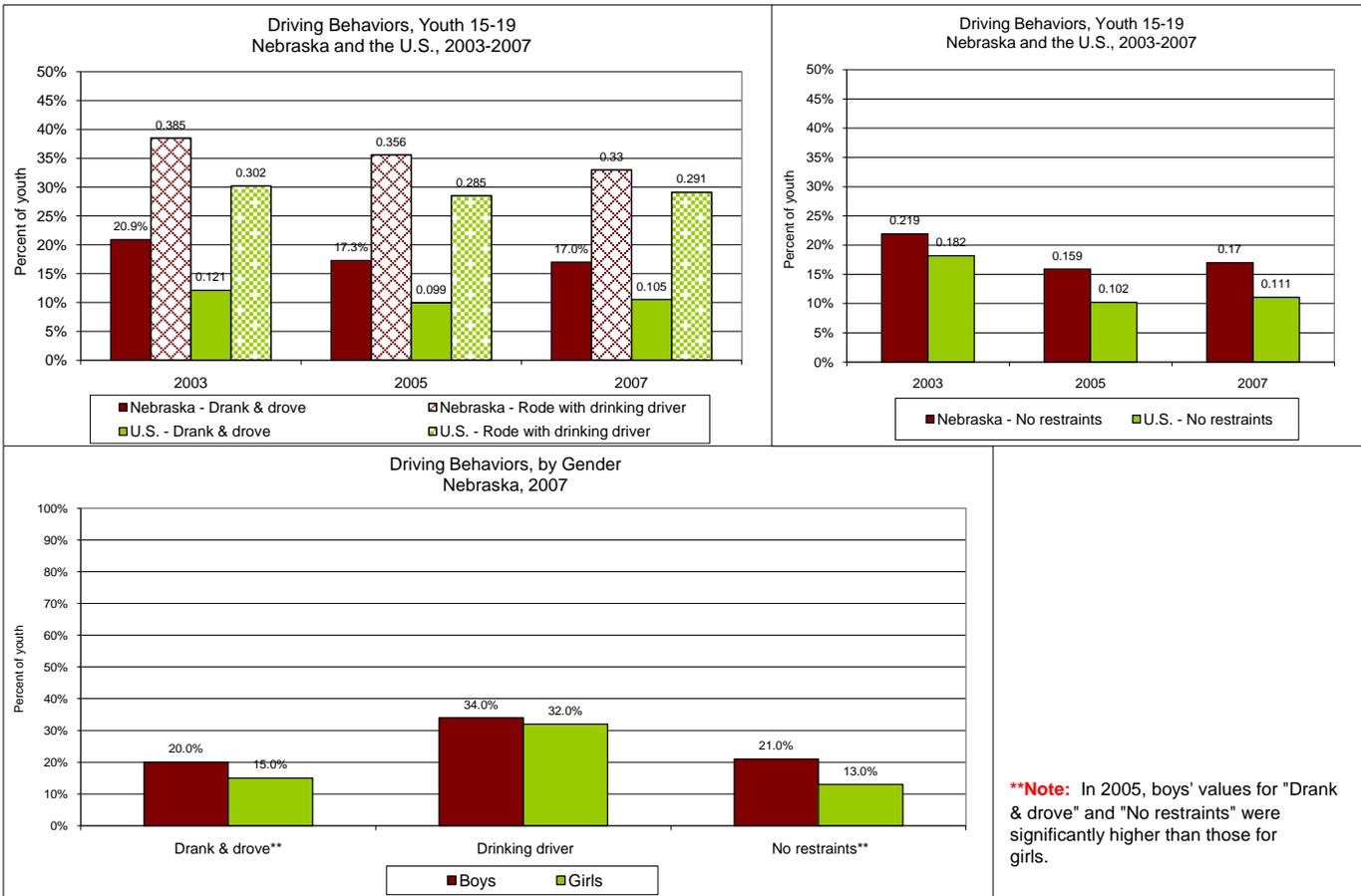
	Drove After Drinking			Drove with Drinking Driver			Not Use Passenger Restraints		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	21,000	17.0%	was...	42,000	33.0%	was...	21,000	17.0%	rate was...
United States (2005)	2,000,000	9.9%	Higher	5,900,000	28.5%	Higher	2,100,000	10.2%	Higher
HP 2010 Objective	-	-	-	-	-	-	8%	-	Higher
Nebraska 5-year trend	N.L.C.			DECREASING			N.L.C.		
Racial / Ethnic Differences	-			-			-		

Boys	Drove After Drinking			Drove with Drinking Driver			Not Use Passenger Restraints		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	13,000	20.0%	was...	22,000	34.0%	was...	13,000	21.0%	rate was...
United States (2005)	1,259,000	11.7%	Higher	2,928,000	27.2%	Higher	1,345,000	12.5%	Higher
HP 2010 Objective	-	-	-	-	-	-	8%	-	Higher
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-			-		

Girls	Drove After Drinking			Drove with Drinking Driver			Not Use Passenger Restraints		
	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...	Number*	Rate	Nebraska rate was...
Nebraska (2007)	9,000	15.0%	was...	20,000	32.0%	was...	8,000	13.0%	rate was...
United States (2005)	828,000	8.1%	Higher	3,027,000	29.6%	Higher	797,000	7.8%	N.S.D.
HP 2010 Objective	-	-	-	-	-	-	8%	-	N.S.D.
Nebraska 5-year trend	N.L.C.			N.L.C.			N.L.C.		
Racial / Ethnic Differences	-			-			-		

*Note: Projected estimates of numbers of youth are rounded down to nearest thousand or hundred thousand.

Graphical Display of Data:



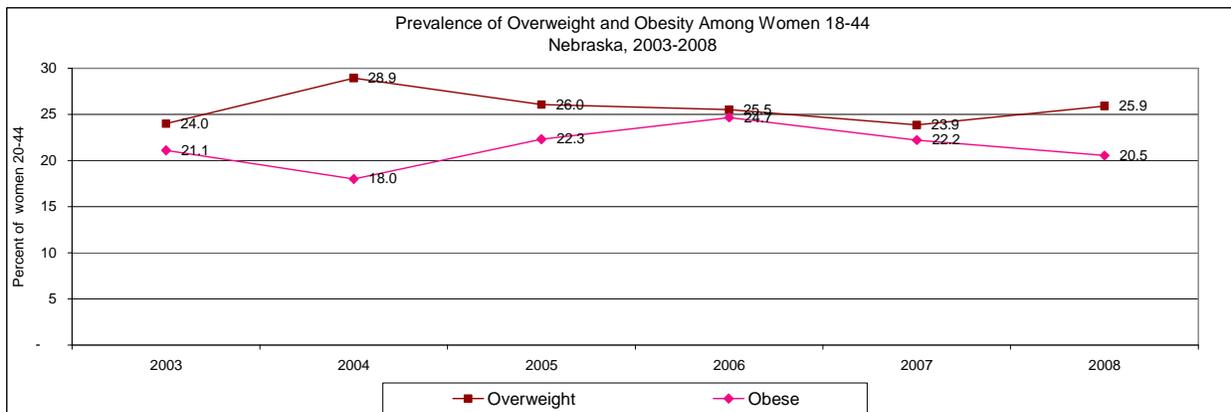
**Note: In 2005, boys' values for "Drank & drove" and "No restraints" were significantly higher than those for girls.

Appendix H: The Fact Sheets

Obesity in Nebraska Women

According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), 26.0% of Nebraska women aged 18-44 are overweight and 20.5% are obese. Overweight and obesity result from an energy imbalance. This involves eating too many calories and not getting enough physical activity. Body weight is the result of genes, metabolism, behavior, environment, culture, and socioeconomic status. Behavior and environment play a large role causing people to be overweight and obese. These are the greatest areas for prevention and treatment actions.¹

Obesity and overweight are factors in a number of health problems including: type 2 diabetes, hypertension, coronary heart disease, cancers (endometrial, breast, and colon), liver and gallbladder disease, sleep apnea and respiratory problems, osteoarthritis, and gynecological problems (abnormal menses, infertility).²



Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to NE BRFSS almost one out of two women aged 18-44 are either overweight or obese. The prevalence of women who are overweight (26%) is higher than the Healthy People 2010 Objective (25%). Likewise, the obesity rate (20.5%) is higher than the Healthy People 2010 Objective (15%). These rates are not improving over time.

The percentage of women who have vigorous and regular physical activities (17.4%) and women who engage in moderate physical activities only (25.5%) are both significantly less than the Healthy People 2010 Objective (30% and 50%).

Diabetes prevalence in Nebraska (3.2%) is higher than the Healthy People 2010 Objective (2.5%).

Criterion 2: Disparities Exist Related to Health Outcomes

There is emerging evidence that disparities exist. Data from the NE BRFSS is limited in analysis of subpopulations; while analysis indicates that racial ethnic disparities exist the true magnitude is not known.

According the NE BRFSS in 2008, African American (67.1%) women are more likely to be overweight (27.4) or obese (39.7%) than their counterparts. In addition, African American (67.7%) women and Hispanic (64.7%) women are

more likely to report insufficient physical activity or no physical activity at all compared to Caucasian women (52.9%).

Criterion 3: Strategies Exist to Address the Problem

Over the last two decades, multiple studies have helped define important risk factors and preventive interventions.³ The Centers for Disease Control and Prevention (CDC) identifies effective interventions and practices for preventing heart disease with a focus on weight management and high blood pressure and cholesterol control. Becoming more physically active, making healthful food choices and controlling weight can address overweight-related health problems such as diabetes, hypertension, and cardiovascular disease.

According to CDC, American society has become characterized by environments that promote increased food intake, non-healthful foods, and physical inactivity. Policy and environmental change initiatives that make healthy choices in nutrition and physical activity available, affordable, and easy will likely prove most effective in combating obesity.

The Surgeon General's Vision for a Healthy and Fit Nation released in January of 2010 include the recommendations listed below:

- **Individual Healthy Choices and Healthy Home Environments** - Change starts with the individual choices Americans make each day for themselves, their families and those around them. To help achieve and maintain a healthy lifestyle, Americans of all ages should: reduce consumption of sodas and juices with added sugars; eat more fruits, vegetables, whole grains, and lean proteins; drink more water and choose low-fat or non-fat dairy products; limit television time to no more than 2 hours per day; and be more physically active.

- **Creating Healthy Child Care Settings** - It is estimated that over 12 million children ages 0–6 years receive some form of child care on a regular basis from someone other than their parents. Child care programs should identify and implement approaches that reflect expert recommendations on physical activity, screen time limitations, good nutrition, and healthy sleep practices. Parents should talk with their child care providers about changes to promote their children's health.
- **Creating Healthy Schools** - Each school day provides multiple opportunities for students to learn about health and practice healthy behaviors such as regular physical activity and good nutrition. To help students develop life-long healthy habits, schools should provide appealing healthy food options including fresh fruits and vegetables, whole grains, water and low-fat or non-fat beverages. School systems should also require daily physical education for students allowing 150 minutes per week for elementary schools and 225 minutes per week for secondary schools.
- **Creating Healthy Work Sites** - The majority of the 140 million men and women who are employed in the United States spend a significant amount of time each week at their work site. Because obesity reduces worker productivity and increases health care costs, employers are becoming more aware of the need to help promote health within the workplace. Employers can implement wellness programs that promote healthy eating in cafeterias, encourage physical activity through group classes and stairwell programs and create incentives for employees to participate.
- **Mobilizing the Medical Community** - Doctors and other health care providers are often the most trusted source of health information and are powerful role models

for healthy lifestyle habits. Medical care providers must make it a priority to teach their patients about the importance of good health. When discussing patients' Body Mass Index (BMI), providers should explain the connection between BMI and increased risk for disease and, when appropriate, refer patients to resources that will help them meet their physical, nutritional, and psychological needs.

- **Improving Our Communities** - Americans need to live and work in environments that help them practice healthy behaviors. Neighborhoods and communities should become actively involved in creating healthier environments. Communities should consider the geographic availability of their supermarkets, improving residents' access to outdoor recreational facilities, limiting advertisements of less healthy foods and beverages, building and enhancing infrastructures to support more walking and bicycling, and improving the safety of neighborhoods to facilitate outdoor physical activity.

Criterion 4: Capacity and Support are Available to Address the Problem

The NDHHS Nutrition and Activity for Health (NAFH) program is implementing an existing state plan and building infrastructure and capacity for nutrition, physical activity, and obesity programs within the state and local public health agencies. The program is providing training teleconferences for local public health departments/partners in the state, on topics such as evidence-based practice and social marketing. NAFH also provides a monthly electronic newsletter which communicates new and existing research, resources, reports, and grant opportunities to 300+ partners statewide. NAFH collaboratively provides intervention grants to local public health departments across the state with funds from the cardiovascular health, cancer

control, diabetes, Preventive Health and Human Services Block Grant, Tobacco Free Nebraska programs, and the Office of Community Health Development. Ten of the thirteen grantees focus on implementing nutrition, physical activity, or obesity prevention activities.

The program has future plans to implement the Body and Soul program, an evidence-based program from the National Cancer Institute, with African Americans in North Omaha through church-based health ministries.

Through these activities, Nebraska and CDC are addressing obesity by creating places where Nebraska residents can make healthy choices about nutrition and physical activity.

Criterion 5: Data Exists to Document the Problem

Data utilized to identify overweight and obesity as an issue was from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.

References:

1. U.S. Department of Health and Human Services. *U.S. Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, 2001* Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General. 2001.
<http://www.surgeongeneral.gov/topics/obesity/>
2. NIH, NHLBI Obesity Education Initiative. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. Available online:
http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf
3. *Screening for Obesity in Adults*, Topic Page. December 2003. U.S. Preventive Services Task Force. Agency for Healthcare Research and Quality, Rockville, MD.
<http://www.ahrq.gov/clinic/uspstf/uspsobes.htm>
4. U.S. Department of Health and Human Services. *The Surgeon General's Vision for a Healthy and Fit Nation*.

Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General, January 2010.
<http://www.surgeongeneral.gov/library/obesityvision/obesityvision2010.pdf>

Sexually Transmitted Diseases among Nebraska's Women

According to the NDHHS, Epidemiology Communicable Diseases Sexually Transmitted Disease (DHHS STD) Program, STDs among Nebraska's women (ages 20-44) are significantly increasing overall, and specifically for chlamydia, while gonorrhea rates have shown no improvement over time.

Chlamydia is caused by the bacterium, *Chlamydia trachomatis*, transmitted during sexual relations or from an infected mother to her baby during vaginal childbirth. Even though symptoms of chlamydia are usually mild or absent, serious complications that cause irreversible damage, including infertility, can occur "silently" before a woman ever recognizes a problem. Untreated chlamydia in women can spread into the uterus or fallopian tubes and cause pelvic inflammatory disease (PID) causing permanent damage. The damage can lead to chronic pelvic pain, infertility, and potentially fatal ectopic pregnancy (pregnancy outside the uterus). Women infected with chlamydia are up to five times more likely to become infected with HIV, if exposed.¹

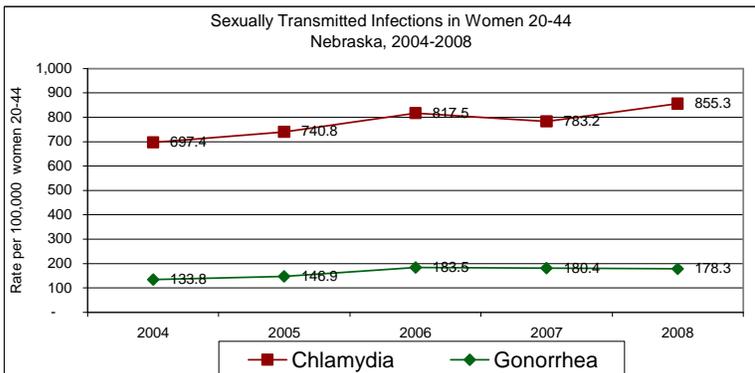
Young women are disproportionately affected by STD's/chlamydia, likely because the cervix (opening to the uterus) of teenage girls and young women is not fully matured and is more susceptible to infection; thus young women are at particularly high risk for infection if sexually active. While any sexually active person can be infected, the greater the number of sex partners the greater the risk of infection.¹

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to DHHS STD Program the total number of STDs reported in Nebraska increased from 5,177 (302.5/100,000) cases in 2001 to 7,611 (430.4 /100,000) cases in 2007.

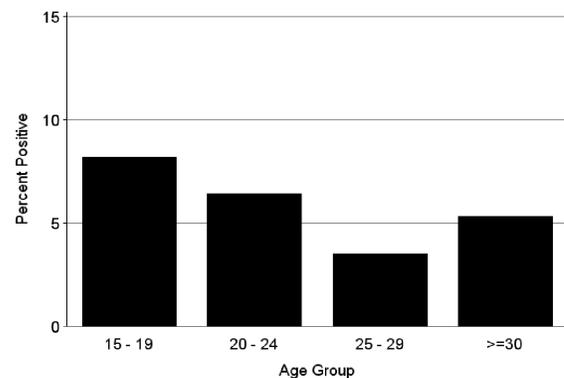
Criterion 2: Disparities Exist Related to Health Outcomes

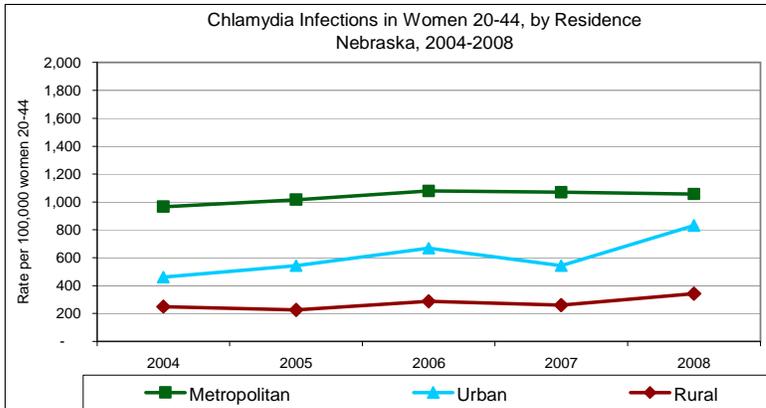
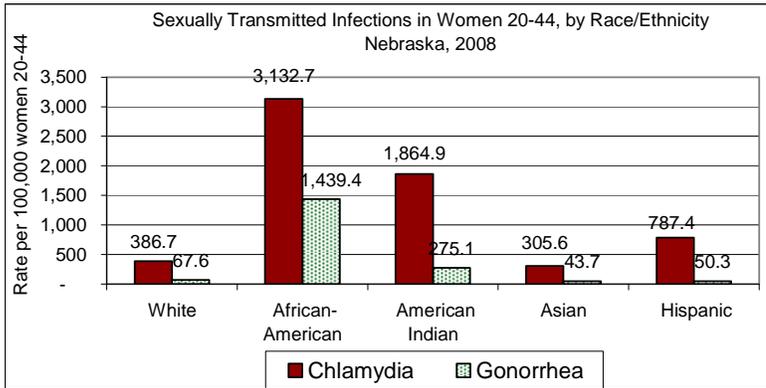
There is evidence that significant disparities exist and have been well documented. In Nebraska young women, African American women, and those who live in metropolitan and urban counties have significantly higher rates of STDs.



Chlamydia among women of reproductive age (20-44) is increasing significantly over time, and gonorrhea rates are not improving.

Chlamydia positivity by age group in women attending family planning clinics in Nebraska, 2008²





Criterion 3: Strategies Exist to Address the Problem

Preventive strategies exist to lower the rates of STDs.

Primary Interventions: Promote responsible sexual behavior by targeting protective behaviors that reduce the risks of STDs, such as promotion of abstinence from intercourse, limiting the number of sexual partners and using condoms correctly and consistently.

Data from the 2004 (most recent data available) Nebraska Behavior Risk Factor Surveillance System (BRFSS) found that 14% of sexually active women aged 18-44 reported not having a regular partner, and 16% reported no use of birth control. Of the 70% of women reported using birth control, 14% reported using condoms. Strategies for these women include:

- 1) Increasing the level of STD screening by making urine-based Chlamydia and gonorrhea testing routine, free and readily available in

nontraditional health care settings. CDC recommends yearly chlamydia testing of all sexually active women age 25 or younger, older women with risk factors for chlamydia infections (those who have a new sex partner or multiple sex partners), and all pregnant women.¹

- 2) Promote the use of rapid HIV testing.
- 3) Increase the proportion of individuals receiving Human Papillomavirus (HPV) vaccine.
- 4) Additionally, continue efforts to increase education and awareness (particularly related to asymptomatic STDs) and reaching earlier education

Criterion 4: Capacity and Support are Available to Address the Problem

Public and political will to address the problem is increasing both at the federal and local levels. The reality of the STD epidemic is gaining recognition as an issue in need of prevention.

Multiple local supports are in place to address the problem including:

- o DHHS STD Program - Clinical environments for free testing - 100 sites statewide. Additional referral services through local health departments statewide.
- o Federally Qualified Health Centers including Charles Drew, One World Health Center, Peoples Health Clinic, Panhandle Community Services, Good Neighbor Community Health Center, Norfolk Community Health Center.
- o Title X Family Planning Delegates – 29 sites (30 by Summer 2010).

Criterion 5: Data Exists to Document the Problem

Data was drawn from National Center for Health

Statistics, DHHS STD Program, and Nebraska Behavior Risk Factor Surveillance System (BRFSS)

Surveillance data for DHHS STD Program is an aggregate of cases from notifiable disease reports.

The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. In Nebraska data on contraception has not been collected since 2004.

References:

1. Department of Health and Human Services. Centers for Disease Control and Prevention. CDC Factsheet Chlamydia. December, 2007.

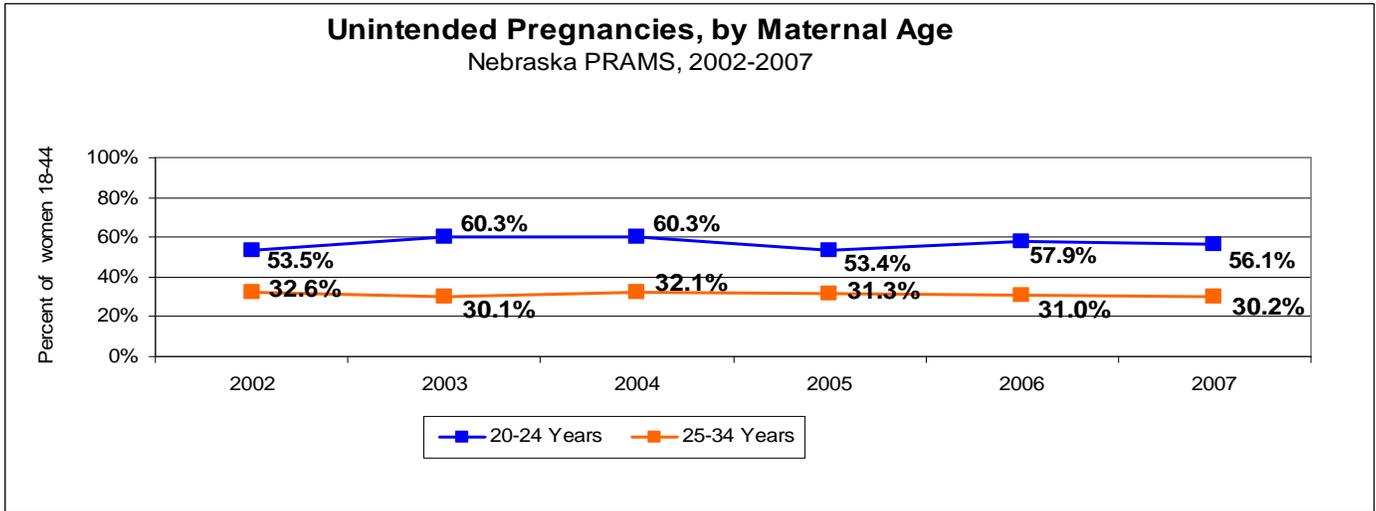
<http://www.cdc.gov/std/Chlamydia/STDFact-Chlamydia.htm>

2. Department of Health and Human Services. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Surveillance Reports, 2008: Chlamydia Profiles, Nebraska. 2008

<http://www.cdc.gov/STD/chlamydia2008/default.htm>

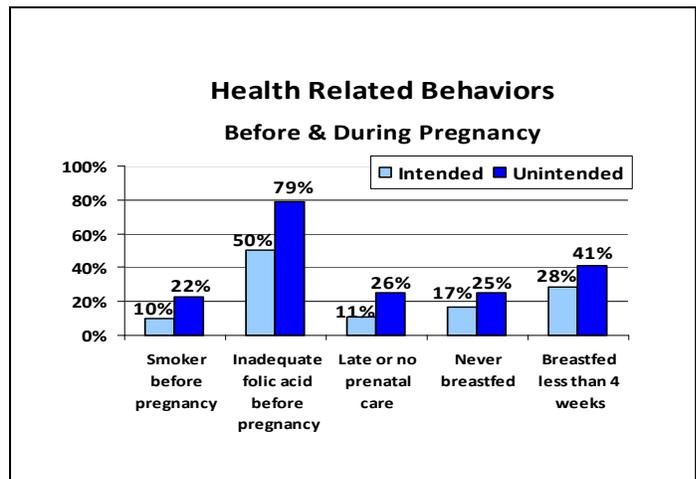
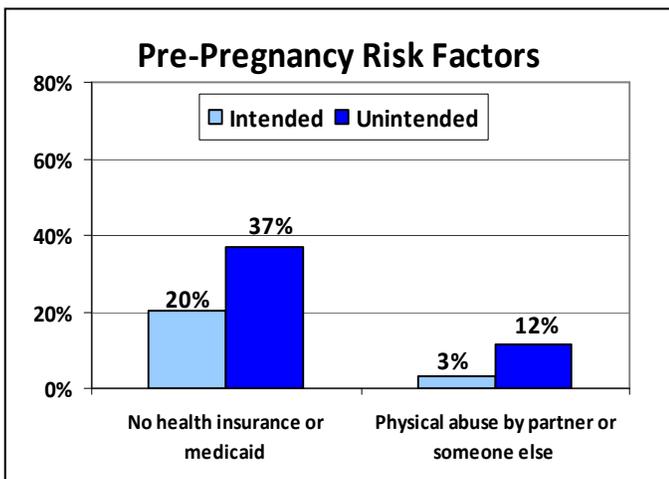
Unintended Pregnancy among Nebraska Women

Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) has been surveying new mothers about their experiences and perspectives since 1999. One significant topic Nebraska mothers have been reporting on is their intention to become pregnant. Unintended pregnancies are defined as pregnancies that are either mistimed or unwanted at the time of conception. Unintended pregnancies account for a substantial proportion of all births, and are particularly common among young, unmarried women.¹ Based on PRAMS data for 2004-2007, an estimated 40.9% of Nebraska mothers had unintended pregnancies, higher than the HP 2010 Objective of 30% for unintended pregnancy. These represent an estimated 10,366 births per year in Nebraska during this period.



An unintended pregnancy can have a negative impact on the mother’s physical, emotional or economic well-being. Since an unintended pregnancy can impact a woman’s choice to adopt healthy prenatal behaviors, the risk of experiencing a poor birth outcome such as prematurity may be greater. These in turn affect the baby and the family.^{2,3}

PRAMS data indicated that Nebraska mothers who had not intended to become pregnant were **significantly more likely** to have no health insurance or Medicaid coverage before becoming pregnant; experience physical abuse; smoke cigarettes; not take folic acid (vitamins); start prenatal care late (after the first trimester); and never breastfeed or quit within the first month.⁴



Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to NE PRAMS (2007), 39.8% of live births were unintended at the time of conception; this is higher than the HP 2010 benchmark of 30%. The rate has not improved, showing no progress towards reaching the 30% goal.

Because PRAMS is not yet conducted in all states or cover all births in the United States there is not a national rate of unintended pregnancy. The Centers for Disease Control and Prevention (CDC) reported in 2006 that unintended pregnancies ranged from for 33.4% to 59.5% in the 24 states with PRAMS data. Nebraska ranked 12th in the middle.⁵

Nearly half (47.2%) of Nebraska mothers with unintended pregnancies reported they had not been doing anything to keep from getting pregnant. These represent an estimated 4,491 births per year.⁴

The remaining 52.8% of mothers with unintended pregnancies were doing something to prevent the pregnancy, but their contraceptive efforts failed. These represent an estimated 5,031 Nebraska births each year. This is apparently due to inconsistent or incorrect use of contraceptives.⁴

Criterion 2: Disparities Exist Related to Health Outcomes

NE PRAMS (2007) shows the risk for unintended pregnancy is higher for certain groups:

- Among adolescent mothers (<20) unintended pregnancy that resulted in a live birth was 74.3%, Of this 74.3% of young mothers 67.9% reported wanting pregnancy later and 6.4% not wanting pregnancy then or at any time in the future.
- African American women report the highest rate of unintendedness at 64.6%, with American Indians next highest at 57.1%.

- Unmarried women (54.2%) reported wanting to be pregnant later compared to 22% of married women and 10.2% (unmarried) did not want to ever be pregnant compared to 5% of married women.
- Among income groups the highest rate of unintended pregnancies (51%) were reported by women with an income of less than \$10,000/year and 51.9% making \$10,000-\$14,999. Intention to become pregnant increased with income.

Criterion 3: Strategies Exist to Address the Problem

Women who are uninsured or have lower incomes, have higher rates of wanting to be pregnant later or did not want to be pregnant ever.⁴

Providing women of all ages, including teenagers access to age-appropriate and culturally sensitive reproductive health care including reproductive life plan services is a critical strategy.

Family physicians provide much of the health maintenance, family planning, and chronic disease care for women, often before, after, and between pregnancies. Many times women feel more comfortable and prefer to receive preconception health information from their primary care physician. Educating primary care physicians about the importance of asking every woman about her reproductive intentions gives the woman the idea that pregnancies should be planned and intended.⁶

Women who do not receive adequate prenatal care are less likely to routinely access any preventive health-care services. Therefore, the period after delivery and before hospital discharge may be an opportunity for providers to discuss the use of effective contraception and adequate birth spacing.⁷

A woman's spouse or partner is a large part of

pregnancy intention and may help in the decision of the contraception that a woman chooses. Therefore, not only women, but men should also be included in family planning counseling and education.^{8,9,10,11}

Educational strategies include working with schools to educate the importance of being healthy at a young age and throughout life in health classes and during reproductive education classes while emphasizing the difficulties of a teenage pregnancy. Additional strategies include media campaigns targeted at teens and young adults about unintended pregnancy. Media helps shape the social script of teenagers' lives—what's hot, what's not, what behavior seems “normal,” what seems out of the mainstream, etc. Three-quarters of teens (68% of boys and 82% of girls) say that when a TV show or character they like deals with teen pregnancy, it makes them think more about the consequences of sex. It is also the case that most adults (72%) and teens (76%) wish the media showed or talked more about the consequences of sex, including teen pregnancy.¹²

Criterion 4: Capacity and Support are Available to Address the Problem

To help teen and young women set goals for their life in relation to their health and reproductive plans, Nebraska's Department of Health and Human Services, Lifespan Health Services is focusing on an approach that recognizes the complex interaction of biological, behavioral, psychological, and social protective and risk factors that contribute to health outcomes across the lifespan. The “Tune My Life” initiative applies the model of preconception and interconception care, broadening the approaches to improving birth outcomes beyond clinical care to pre- and interconception health among young at-risk women and among providers.

To make progress on improving the health of women and their infants, programs need to be in place to help women plan each pregnancy. A woman who plans her pregnancy can take steps to

become healthier before she conceives: take folic acid, quit smoking, abstain from alcohol, and address medical conditions.¹³

The following supports are in place to address the problem of unintended pregnancies:

- University programs and/or health clinics including UNMC, UNO, UNK, UNL, Creighton, Wayne and Peru State.
- Non-profit organizations across the state including Boys Town, NE Children's Home, crisis pregnancy centers, Visiting Nurse Association and Child Saving Institute .
- Local/county level health departments on site health clinics including DCHD, LLCHD, and East Central District Health Department.
- Federally qualified health centers including Charles Drew, One World Health Center, Peoples Health Clinic, Panhandle Community Services, Good Neighbor Community Health Center and Norfolk Community Health Center.
- Title X Family Planning Delegates – 29 sites (30 by Summer 2010).
- Indian Health Services.

Criterion 5: Data Exists to Document the Problem

The data utilized to identify this problem was quantitative, high quality and generalizable. Data was drawn from CDC PRAMS and Nebraska PRAMS.

NE PRAMS is a population-based survey on topics related to pregnancy. The PRAMS sample of approximately 2,500 (10% of births) is drawn from the state's birth certificate file. Some groups are sampled at a higher rate to allow sufficient data for smaller but higher-risk populations.

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Abuse & Neglect of Nebraska's Infants

According to Nebraska's Child Protective Services, the incidence of abuse and neglect in infancy is higher than the Nebraska's HP 2010 objective and is not improving over time. Racial and ethnic disparities exist and there are higher rates of abuse and neglect in infants than older children. Child Death Review Team reports 35% of violent deaths to children 0-17 were infants suffering from abuse and neglect in 2005-2006. The specificity of present data is limited; however, no infant should ever be abused or neglected!

Adverse childhood experiences such as child maltreatment have significant life long consequences. Impacts include disruption to growth and development, depression, higher incidence of illness and chronic diseases as well as a shortened lifespan. With improved data collection and awareness, prevention and intervention resources could be better targeted towards elimination of abuse and neglect.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

Nebraska's incidence of infant abuse and neglect is worse than Federal and State benchmarks and not changing significantly over time.

In Nebraska, the rate of substantiated infant abuse and neglect was **23.02 per 1,000** infants in 2008. From 2004 to 2008, Nebraska's substantiated infant abuse rate has not changed significantly.

Nebraska's 2008 substantiated infant abuse and neglect rate was more than two times the U.S. Healthy People 2010 benchmark of 10.3 per 1,000 and more than three times the Nebraska Healthy People benchmark of 6.8 per 1,000.

In 2007, Nebraska's rate (21.5 per 1,000) was similar to the National rate of 21.9 per 1,000.

Nebraska's infants are abused and neglected at a rate more than two times higher than the overall child abuse and neglect rate of Nebraska (10.37 per 1,000 for children birth to 18 in 2008).

From 2005 to 2006, infants suffered violent, abusive or neglectful deaths disproportionately compared to other age groups—with infants being 34% of all violent child deaths.

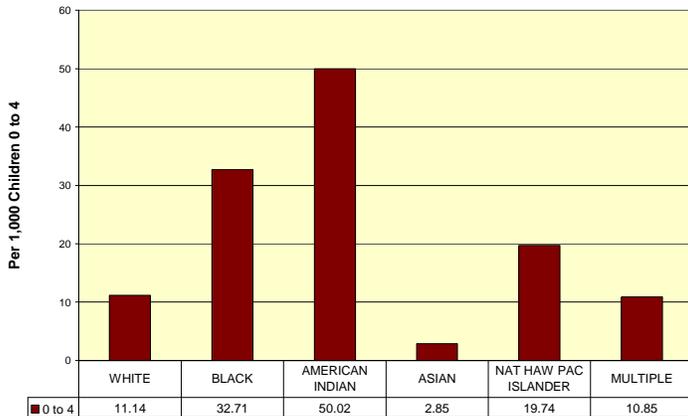
Adverse childhood experiences such as child maltreatment have significant life long consequences. Impacts include disruption to growth and development, depression, higher incidence of illness and chronic diseases as well as a shortened lifespan. With improved data collection and awareness prevention and intervention resources could be better targeted towards elimination of abuse and neglect.

Criterion 2: Disparities Exist Related to Health Outcomes

Across Nebraska's racial groups, known disparities in abuse and neglect exist.

Among children ages 0 to 4, the rate of substantiated cases of abuse and neglect varied drastically across races in 2008. American Indian children (50.02 per 1,000) were abused or neglected at a rate four and a half times greater than the rate of White children (11.14 per 1,000). Black/African American children (32.71 per 1,000) were abused at a rate approximately three times the rate of White children. Native Hawaiian Pacific Islander children were also abused or neglected at a higher rate (19.74 per 1,000).

Victims of Substantiated CAN by Race: Ages 0 to 4, 2008.



Criterion 3: Strategies Exist to Address the Problem

Practices shown to be potentially effective exist, including:

- Home visitation specifically by public health nurses (Nurse Family Partnership Model)
- Respite for parents, especially single parents
- Education related to child development
- Rehab programs offered to addicted parents
- Domestic violence resources
- Teen pregnancy prevention
- Social supports to decrease prevalence of isolation

Criterion 4: Capacity and Support are Available to Address the Problem

Major agencies working to address infant abuse and neglect include:

- Nebraska Children & Families Foundation
- Nebraska Child Abuse Prevention Fund Board
- Nebraska Statewide Child Abuse Prevention Partnership
- Prevent Child Abuse Nebraska

DHHS has multiple grants and contracts that support home visiting in various organizations both public and non-profit. With passage of the Health Care Reform Act a new section of home visiting has been added to Title V of the Social Security Act with likely impacts on Nebraska.

In 2007, 15,066, or approximately 33.8 per 1,000 of Nebraska’s Children received preventive services funded by Community-based Grants for the Prevention of Child Abuse and Neglect and Promoting Safe and Stable Families vs. 50.2 per 1,000 among all reporting states funded by various qualifying Federal sources. In Nebraska, 2,248 abuse/neglect victims (54.7%) received post-investigation services in 2007 vs. 62.1% among all reporting states. In-home services were provided to 908 (22.1%) of Nebraska’s child victims vs. 41.9% among all reporting states

Existing State laws addressing infant abuse include, but are not limited to: the Child Protection Act (Neb. Rev. Stat. §28-710 – 28-727); Safe Haven (Neb. Rev. Stat. §29-121); Child Abuse and Neglect Central Register, Reporting and Investigation Team (Neb. Rev. Stat. §28-718; 28-720, 28-711 – 28-717; 28-729); and secondary prevention under the Social Security Act (Neb. Rev. Stat. §68-1202).

Criterion 5: Data Exists to Document the Problem

Quantitative, high quality, but not generalizable, data on infant abuse and neglect is available.

Data for Child Protective Services is information that is entered in the states Statewide Automated Child Welfare Information System (SACWIS) also known as N-FOCUS (Nebraska Family Online Client User System). The data is extracted annually and is dependent upon the accuracy of

the data entered in NFOCUS at the time the data is extracted.

Although rates of substantiated infant abuse and neglect and associated details are available from DHHS, the 4th National Incidence Study of Child Abuse and Neglect considers such cases the tip of the iceberg. Not reflected in such counts are cases not yet substantiated by CPS, but are:

- Known to police, juvenile probation, and public health
- Known to schools, hospitals, day care centers, mental health agencies, and social service agencies
- Known to other agencies and individuals
- Not known to anyone

The Child Death Review Team (CDRT) reviews the numbers and causes of deaths of children ages 0 to 17. CDRT members also try to identify cases where a person or community could reasonably have done something to prevent the death. The CDRT uses law enforcement, medical, and other records to track causes of child death.

References:

1. Nebraska Health and Human Services, Child Death Review Team. Nebraska Child Death Review Report For 2005-2006. July, 2009.
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Duration and Exclusivity of Breastfeeding of Nebraska Infants

According to Nebraska Pregnancy Risk Assessment Monitoring System 78% of moms reported breastfeeding their infants at birth. However, the National Immunization Survey reports that less than one-half (46%) of Nebraska infants are still receiving breast milk at six months. Breastfeeding initiation, duration, and exclusivity rates vary across racial, ethnic, and socioeconomic groups. Duration and exclusivity should be increasing.

Infants that do not receive breast milk have a higher risk for obesity, type 2 diabetes, leukemia, SIDS/SUIDS, ear infection, respiratory tract infections, gastroenteritis, atopic dermatitis, and necrotizing enterocolitis.¹

If breastfeeding duration and exclusivity increases, improvements could be realized in lowered obesity and chronic disease rates and improved infant health and development.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

The Healthy People 2010 Goal is to “increase the proportion of mothers who breastfeed their babies”. The goal targets the early postpartum period, at 6 months and at one year.

Since the 2010 Healthy People Goals were developed, significant advances have been made in the scientific knowledge of the benefits of breastfeeding. The American Academy of Pediatrics (AAP) Section on Breastfeeding, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, Academy of Breastfeeding Medicine, World Health Organization, United Nations Children’s Fund, and many other health organizations all now recommend exclusive breastfeeding for the first 6 months of life.

In spite of these recommendations, according to the US Acting Surgeon General, rates of exclusive and sustained breastfeeding remain low. Less than one-third of infants are exclusively breastfeeding at 3 months of age, and almost 80% of infants in the United States stop breastfeeding before the recommended minimum of one year.²

As indicated in Table 1, Nebraska’s rate for 6 months breastfeeding duration is 46.2%, which is above the national average but below the Healthy People 2010 goal. Nebraska’s exclusively breastfeeding rate at 3 months is 31.7% and at 6 months 11.9%, overall, falling well below the Healthy People goals.

According to the National Immunization

Table 1:

Breastfeeding Rates	Nebraska	Nation	HP 2010 Goal
Duration at 6 months	46.2%	43.4%	50%
Exclusive at 3 months	31.7%	33.1%	40%
Exclusive at 6 months	11.9%	13.6%	17%

Survey data, Nebraska’s 6 month duration and 3 and 6 month exclusivity rates have not improved over time.

Criterion 2: Disparities Exist Related to Health Outcomes

Unfortunately, not all infants in Nebraska are receiving the benefits provided by longer breastfeeding and exclusive breastfeeding. Nebraska’s breastfeeding rates remain low among infants whose mothers are young, African American, below the federal poverty

threshold, unmarried, or less than college educated (NE PRAMS).

The US Acting Surgeon General reports that nationally, unacceptable racial/ethnic and socioeconomic disparities in breastfeeding persist. Compared with white children, breastfeeding rates are about 50% lower among African American children at birth, 6 months of age, and 12 months of age, regardless of the family’s income or education status. Compared with middle and upper-income families, children in low-income families are less likely to be breastfed.²

Disparities exist in Nebraska for infants in some racial/ethnic groups and those living in lower income families. According to the Nebraska “PRAMS and Breastfeeding” Fact Sheet, there were statistically significant differences in breastfeeding rates by race/ethnicity, with African Americans and Native Americans less likely to initiate breastfeeding. Though the association between continued breastfeeding and race/ethnicity is also statistically significant, differences are not as large. In addition, infants whose mothers were enrolled in Medicaid for prenatal care were significantly less likely to continue to breastfeed or be breastfed exclusively. Figures 1 and 2 illustrate those differences.

Figure 1:

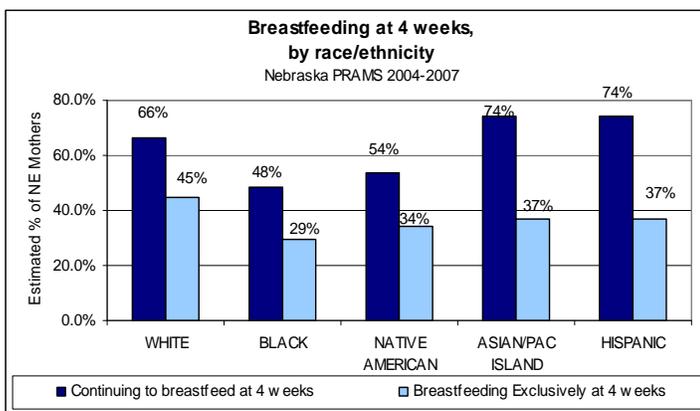
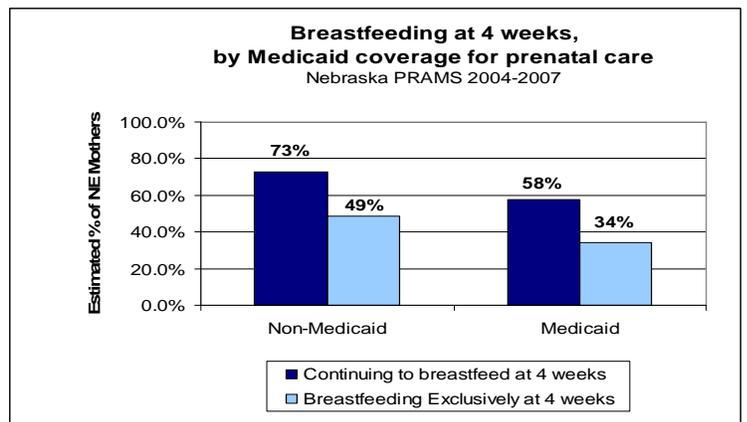


Figure 2:



Criterion 3: Strategies Exist to Address the Problem

The Centers for Disease Control and Prevention (CDC) Guide to Breastfeeding Interventions provides a synthesis of the published peer review literature on the effectiveness of various interventions. The Guide builds upon the research evidence demonstrating effective interventions as well as the expertise of the nation's leading scientists and experts in breastfeeding management and interventions.

The Guide includes two sections: 1) six evidence-based interventions whose effectiveness has been established, and 2) four interventions whose effectiveness has not been established. In the first category, the evidence must be significant, with a systematic review concluding effectiveness of an intervention. The six interventions with evidence of effectiveness are:

- Maternity care practices
- Support for breastfeeding in the workplace
- Peer support
- Educating mothers
- Professional support
- Media and social marketing

Criterion 4: Capacity and Support are Available to Address the Problem

There is strong national governmental support for addressing the need to increase the initiation, duration and exclusivity of breastfeeding. Most of the active support lies within the US Department of Health and Human Services (USDHHS), the principle contributors are:

CDC is committed to increasing breastfeeding initiation, duration and exclusivity throughout the United States. Their activities include support of research, program evaluation and policy analysis relative to breastfeeding and the distribution of these results across the nation. In 2005, The CDC Guide to Breastfeeding Interventions was released as a result of the latter efforts. In 2003, CDC initiated the State Nutrition and Physical Activity Programs to Prevent Obesity and Other Chronic Diseases. This federal funding supports the development and implementation of statewide evidence-based nutrition and physical activity interventions. The promotion of breastfeeding is mandated area for inclusion by participating states. CDC provides training and technical assistance to states that are among those that received funding to develop a Nutrition and Physical Activity Program to Prevent Obesity and Other Chronic Diseases. The training and technical assistance is based on the "Using Loving Support to Create a Breastfeeding Friendly Community" curriculum. This curriculum uses a social marketing approach and will provide states with skills and resources.

Office of the Secretary, Office of Women's Health In June 2004, the U.S. Department of Health and Human Services Office on Women's Health and the Ad Council launched a national campaign encouraging first-time mothers to breastfeed exclusively for six months. With the tag line: "Babies were born to

be breastfed," the campaign is targeting the general population.

Health Resource and Services

Administration (HRSA) is a vast agency with great influence on health policy and funding in the US. It plays a major role in research, education, technical assistance, resource provision and funding for infrastructure development. It is the source of Title V funds used by states to build infrastructure for addressing the health needs of mothers and children.

HRSA has funded a lot of practical research to influence policies and practices within the US for example; The Business Case for Breastfeeding: Steps for Creating a Breastfeeding Friendly Worksite was developed, published and distributed. Likewise, a presentation of five practices of pro-breastfeeding hospitals was produced to influence hospital practices.

The United States Department of Agriculture (USDA) has great influence on the capacity and support for breastfeeding is the USDA. Through its Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) it promotes breastfeeding as the preferred method for feeding infants. The breastfeeding rates among women participating in WIC, although improving, continue to be significantly lower than the Healthy People 2010 target.

Other Organizations and Initiatives

American Academy of Family Physicians
American Academy of Pediatrics
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Dietetic Association
Association of Women's Health, Obstetric and Neonatal Nurses

National Association of Pediatric Nurse Practitioners
Washington Business Group

Nebraska Breastfeeding Coalition
La Leche League of Nebraska
The Baby-Friendly Hospital Initiative
Milkworks
Nebraska Department of Health and Human Services

State Laws

Other than providing an exemption for jury duty Nebraska has no legislation related to advocacy of breastfeeding. Forty-four states, have laws with language specifically allowing women to breastfeed in any public or private location. Twenty-eight states exempt breastfeeding from public indecency laws. Twenty-four states have laws related to breastfeeding in the workplace. Twelve states exempt breastfeeding mothers from jury duty. Five states have implemented or encouraged the development of a breastfeeding awareness education campaign. Several states have unique laws related to breastfeeding.

Public Acceptance and Discourse on Breastfeeding The acceptance of breastfeeding is growing as demonstrated by the previously listed rates. It should also be noted that breastfeeding rates are higher among those with higher socioeconomic status. Because those with higher socioeconomic status generally include policy makers, more laws favorable to breastfeeding would have an increasing potential for passage.

Criterion 5: Data Exists to Document the Problem

The following data sources were utilized to document the problem and progress towards improvement, the National Immunization Survey (NIS), Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) and

Nebraska Pediatric Nutrition Surveillance System.

The (NIS) is sponsored by the National Center for Immunizations and Respiratory Diseases (NCIRD) and conducted jointly by NCIRD and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The NIS is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers that began data collection in April 1994 to monitor childhood immunization coverage, including breastfeeding an infants first immunization.

NE PRAMS is a population-based survey on topics related to pregnancy. The PRAMS sample of approximately 2500 (10% of births) is drawn from the state's birth certificate file. Some groups are sampled at a higher rate to allow sufficient data for smaller but higher-risk populations.

The Nebraska PedNSS is a program-based surveillance system that monitors the nutritional status of low-income infants, children and women in federally-funded maternal and child health programs. The breastfeeding data is from the Nebraska Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program.

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Evidence of Health Disparities in Infancy

Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as health disparities. Most health disparities impact groups that are marginalized because of socioeconomic status, race/ethnicity, age, sexual orientation, gender, disability status, geographic location, or a combination of these.¹ Those populations are at greater risk of health disparities due to obstacles associated with being in marginalized groups. This creates conditions that allow disparities to take shape which further compound the difficulty to address underlying issues.

According to Nebraska Vital Statistics, and supported by data from the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) and the March of Dimes, significant health disparities exist already in infancy in many health indicators. Disparities are evident at birth or within the first year of life which suggests that the problem originates well before birth or perhaps even before conception. Infants with health disparities likely will experience ongoing negative impacts throughout life in various ways, e.g. financial, medical, educational, and social. Left unaddressed, health disparities will worsen, and compounded by generational impact, will become even more difficult to resolve.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

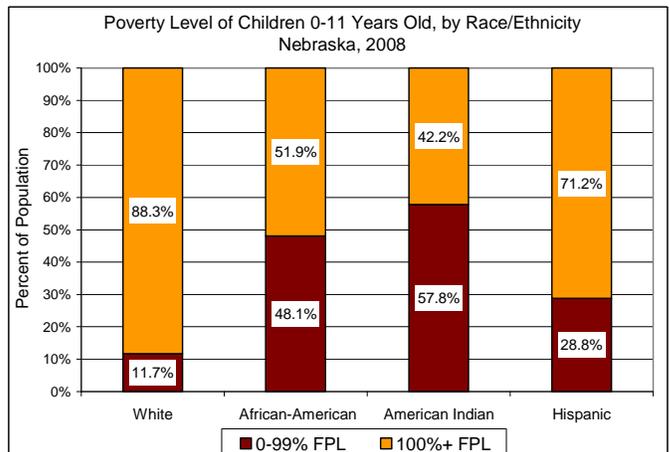
Unequal health status is evident at birth or within the first year of life and is documented in nearly every indicator of infant health determinants, health status, and health outcomes. In Nebraska these disparities are persistent and not changing overtime. Nebraska is not reaching the benchmark in several infant indicators overall, and this is even more true for infants of various racial and ethnic backgrounds.

Starting life at a disadvantage compounds the challenges to achieve equal results throughout life and may result in intractable, lifelong disparity. The disparity indicated in birth outcomes and during the first year of life are compelling enough to not limit the look at disparities to just the infant population, but to prioritize it within a life course approach.

Criterion 2: Disparities Exist Related to Health Outcomes

Disparities in health outcomes are fundamentally intertwined with many risk factors. Social determinants of health consider multilevel and integrated variables in social, economic, and environmental conditions. One key social determinate, poverty, is featured here:

The most impoverished Nebraska children age 0-11 years living below the poverty line, i.e. less than 100% Federal Poverty Level (FPL), are American Indians (57.8%) and African Americans (48.1%). This is compared to 28.8% of Hispanic and 11.7% of Caucasian children. American Indians and African American populations also have the most significant disparities among Nebraska infants in a number of social and economic indicators.

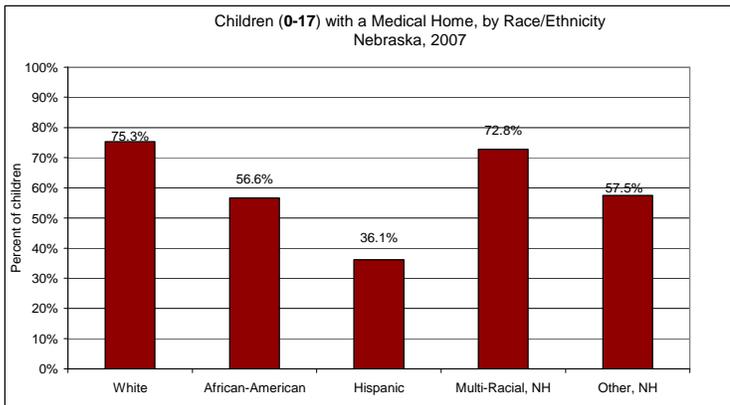


Many indicators illustrate these disparities. Three indicators are selected for Nebraska infants by race/ethnicity to feature persistent health disparities:

1) Access to Care

In 2007, 77% of Nebraska children ages 0-5 years reported having a medical home, which is higher

than the national percentage (64%). However, Hispanic and African-American children (0-17) are significantly less likely to have a medical home.



2) Preterm Labor/Low Birth Weight

Nebraska preterm birth (12.5%) is higher than the 7.6% benchmark (HP 2010). Preterm birth is a persistent problem with no linear change in a five-year trend in Nebraska and the Nation. For Nebraska infants, the percentage of preterm births in African-Americans is significantly worse.

At 7.1%, Nebraska rates of low birth weight are above the 5% benchmark. (HP 2010) Nebraska births show evidence of significant racial/ethnic disparities in low birth weight African American infants (12.6%) which is notably higher than the next highest rate of Asian (9.1%). Although better than the U.S. rates, Nebraska births show similar indications of no linear change in low and very low birth weight over a five-year period.

3) Infant Mortality

The rate at which African-American and American Indian infants die in Nebraska is much greater than other races/ethnicities. In the five-year period 2001-2005, the infant mortality rate was 2.7 times as high for Native Americans as for Whites. It was 2.6 times as high for African-Americans.²

Criterion 3: Strategies Exist to Address the Problem

Research aids in the growing understanding of the vast scope and complexity of health disparities.

Moving from research to practice requires several critical components: 1) targeted actions must address the intersection of social determinants; 2) a life course approach is essential; and 3) a whole-stream strategy which requires addressing both societal-level policies that are upstream from the problem and individual-level behaviors that are downstream.

Strategies to adequately address disparity, if not eliminate it, must include attacking poverty and other social determinants of health. Successfully addressing disparities in infant health across the life course will have a significant impact on multiple indicators of health status and outcomes.

Criterion 4: Capacity and Support are Available to Address the Problem

Eliminating health disparities has global momentum, indirectly if not directly, through the United Nations' Millennium Development Goals (MDGs). The MDGs include, among other goals, the eradication of extreme poverty and hunger, achieving universal primary education, and empowering women, and promoting gender equality.

Our Nation is focused on Healthy People 2010 with two overarching goals; one is to eliminate health disparities. The Nebraska 2010 shares the Healthy People national goals with objectives customized for our state.

Before a first pregnancy or between pregnancies, the wholistic wellbeing of women of reproductive age is critically important to eliminate health disparities in infancy. As such, Nebraska's Department of Health and Human Services, Lifespan Health Services is focusing on an approach that recognizes the complex interaction of biological, behavioral, psychological, and social protective and risk factors that contribute to health outcomes across the lifespan in the "Tune My Life" initiative. Applying this model of preconception and interconception care broadens the approaches to improving birth outcomes

beyond clinical care to pre- and interconception health among young at-risk women and among providers. This work is just beginning and has much potential to impact on disparities in infant health over the years to come.

In concert with this, Nebraska's Title V / MCH Block Grant funds are supporting community-level activities in 2009-2011 that include the life course approach to improve health outcomes. The importance of preconception and interconception health is being implemented through different strategies. One promising strategy is promoting and supporting adolescent girls and women of reproductive age to develop Reproductive Life Plans. The plans set goals and identify methods to achieve the wholistic wellbeing needed to produce a healthy baby and to become a successful parent someday to nurture wellbeing throughout their child's entire life.

Criterion 5: Data Exists to Document the Problem

Data was drawn from Nebraska Vital Statistics, NE PRAMS, the American Community Survey (ACS) and the National Survey of Children's Health (NSCH).

Nebraska Vital Statistics is an aggregate of the vital records collected by the state of Nebraska. Birth records of events for Nebraska residents which occur in other states, territories and Canada, and which the Department receives through an Inter-Jurisdictional Exchange Agreement, are also included.

NE Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey on topics related to pregnancy. The PRAMS sample of approximately 2500 (10% of births) is drawn from the state's birth certificate file (Vital Records). Some groups are sampled at a higher rate to allow sufficient data for smaller but higher-risk populations.

The ACS is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census

Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years.

The National Survey of Children's Health is a national survey that was conducted by telephone in English and Spanish during 2003-2004 and for a second time in 2007-2008. The survey provides a broad range of information about children's health and well-being collected in a manner that allows for comparisons between states and the nation. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state

Data delineated by race/ethnicity exists in a number of infant indicators. Caution should be exercised when considering the relationship of multiple determinants, i.e. race/ethnicity is not an exclusive risk factor of health disparities. Further, the root causes of disparities, e.g. poverty, should consider variables other than, but possibly related to race/ethnicity.

Connecting data for women of reproductive age to infant data relevant to root causes of disparities is needed. Identifying the origins of disparity is essential to adequately address how to eliminate unequal results of health outcomes.

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<http://www.dhhs.ne.gov/minorityhealth/docs/MCHReportCard3-09.pdf>

Entry Into and Adequacy of Prenatal Care in Nebraska

Nearly one-third (27.3%¹) of infants born to Nebraska residents in 2008 were at risk of premature birth, birth defects, low birth weight, and mortality because their mothers did not obtain adequate prenatal care. The risk varies across racial and ethnic groups. This is likely because women are not receiving preconception care, not following a Reproductive Life Plan, or having less than adequate social support and economic resources making it difficult to seek care or have continuity of care throughout the childbearing years.

A female infant born prematurely has a higher risk in adult life to deliver her own premature baby. Poor birth outcomes and health determinants can have lifelong impacts, e.g. financial, medical, educational, and social. Left unaddressed, the generational impact will continue.

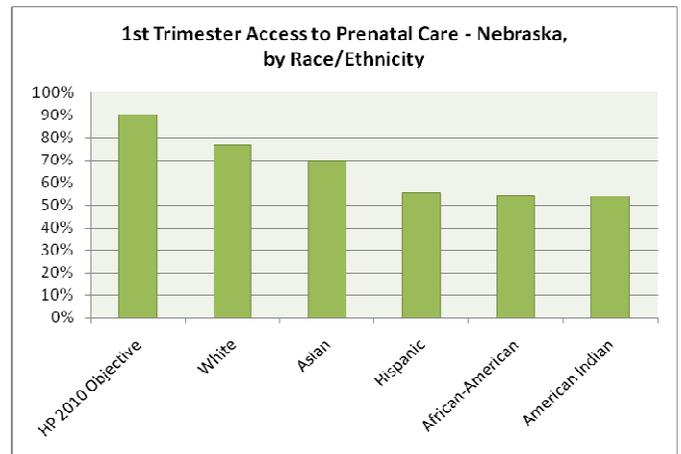
Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

Although women in Nebraska (72.2%¹) have a higher rate of seeking prenatal care during the first trimester than the Nation (69.0%¹), Nebraska is still far below the Healthy People 2010 Objective of 90%. Nearly 1/3 (27.8%¹) do not receive prenatal care in the first trimester and there has been no significant change to this pattern over the past four years.

In addition, the % of women receiving inadequate prenatal care (according to the Kotelchuk* Index) has not changed over the past four years and remains at 14.5%¹. The HP 2010 objective seeks a rate of no more than 3%.

Criterion 2: Disparities Exist Related to Health Outcomes

Significant racial/ethnic disparities exist for prenatal care in Nebraska. Even though access to care during the first trimester for Nebraska's white (76.4%¹) population is well below the HP 2010 objective (90%); the racial ethnic disparities that exist are extremely more significant for Asian (69.8%¹), Hispanic (55.5%¹), African-American (54.4%¹) and American Indian (53.9%¹). In addition, the four year trend for Nebraska's African-American population to receive 1st trimester prenatal care is declining.



Nebraska four year trends show no improvement in the percent of minority women receiving inadequate prenatal care. In fact, between 0-4%¹ of each racial/ethnic group in Nebraska continued to have no prenatal care in 2008.

Criterion 3: Strategies Exist to Address the Problem

Two separate yet related strategies can significantly impact birth outcomes and infant health: a system change to assure that women have access to care via financial support for health care and that women receive guidance and support to seek care early and consistently throughout their pregnancy.

A recent Morbidity and Mortality Weekly Report (MMWR)² stated that women of childbearing age suffer from various chronic conditions and are exposed to (or consume) substances that can have an adverse effect on pregnancy outcomes, leading to pregnancy loss, infant death, birth defects, or other complications for mothers and infants. For example, in 2002, ~6% of adult women aged 18-44 years had asthma, 50% were overweight or obese, 3% had cardiac disease, 3 % were hypertensive, 9% diabetes and 1% had thyroid disorder. **Evidence of these risk factors for adverse outcomes establishes the need to start, and sometimes finish, interventions before conception occurs.**

This same MMWR report stresses that “As states seek to expand Medicaid coverage to persons with low incomes and adults who do not have health insurance, women of childbearing age should receive priority for qualifying for Medicaid coverage.”

Nurse Home Visitation Projects utilizing the David Olds model of home visitation have shown to be effective in 1) Improving prenatal health, 2) Preventing child abuse, and 3) Improving economic self-sufficiency. These improvements have been identified from published research through ongoing data collection and the use of randomized trials.³

It is also important that the Kotelchuk index continue to be calculated and reported annually by racial ethnic groups to assure that changes in health disparity are monitored and reported so that this disparity can be addressed across the state.

Criterion 4: Capacity and Support are Available to Address the Problem

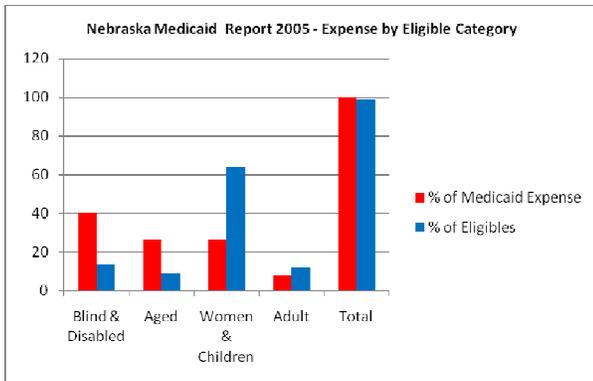
Addressing our state’s capacity to improve the inter-conception health of women of childbearing age can have long-lasting impact

on the health of current and future citizens of our state. The question lies in whether or not we chose to invest resources in a historically under-served population, our women, particularly women of color, in order to have a positive impact on future generations.

Stakeholders believe it is vitally important to rely on research and past outcome data when attempting to make decisions about who is eligible to receive health care and not simply rely on the bottom dollar when making critical access to care funding decisions. Our country has historically ignored the importance of funding prevention and has chosen instead to provide more acute care measures to address health and healthcare issues.

While Medicaid expenditures cannot be ignored when making budgetary decisions, it is important to realize just where these public dollars are being spent. According to 2000 through 2005 Medicaid expenditure data, women and children ranked 3rd out of 4 categories for total dollars spent. The largest category for Medicaid expenditures was “Blind and Disabled” at 40% of expenditure though they represent 14% of the population followed by “Aged” at 26% of expenditures though they represent 9% of the population and then women and children with 26% of expenditures though they make up 64% of the population; the adult category was last with 8% expenditures and 12% of the population.

Expert recommendation based on data (MMWR report referenced above) suggests that if we invest in women of child-bearing age in an attempt to improve birth outcomes it could potentially have an impact on the amount of Medicaid dollars our state would spend for the disabled category.



Criterion 5: *Data Exists to Document the Problem*

Data was drawn from Nebraska Vital Statistics, an aggregate of the vital records collected by the state of Nebraska. Birth records of events for Nebraska residents which occur in other states, territories and Canada, and which the Department receives through an Inter-Jurisdictional Exchange Agreement, are also included.

NE Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey on topics related to pregnancy. The PRAMS sample of approximately 2500 (10% of births) is drawn from the state’s birth certificate file (Vital Records). Some groups are sampled at a higher rate to allow sufficient data for smaller but higher-risk populations.

Additional Sources:

- March of Dimes Perinatal Data
- Additional data from Indian Health Services and various Maternal Child Health programs across the state can be analyzed to provide additional supportive evidence

References:

1. Nebraska Department of Health and Human Services, Division of Public Health Public Health Support Unit. Vital Statistics

2. Recommendations to Improve Preconception Health and Health Care – United States. MMWR Recommendations and Reports 2006 April ,21; 55(RR06);1-23.

<http://www.cdc.gov/mmwr/pdf/rr/rr5506.pdf>

3. Nurse Family Partnership. Published Research, as of April 5, 2010.

<http://www.nursefamilypartnership.org/proven-results/published-research>

*The Kotelchuk Index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses two crucial elements obtained from birth certificate data-when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services).

The Impact of Poverty on Infant Health

In 2009 nearly 24% of infants in Nebraska were born into poverty (less than 100% of Federal Poverty Level (FPL))¹ Infants and children in Nebraska are more likely to live in poverty compared to the nation, ranking 33rd.²

Infants and children living in poverty do not reach development milestones, have higher rates of emotional and behavior problems, increased incidence of learning disabilities, decreased ability to problem solve, higher disease rates due to less healthy lifestyles, asthma, and obesity that affect them later in life. Poverty impedes an infant’s ability to learn and contribute to social, emotional, and behavioral problems.³ Poverty can also contribute to poor health and mental health. Risks are greatest for children who experience poverty when they are young and/or generational poverty.⁴ Rates of poverty are significantly higher in racial and ethnic groups.

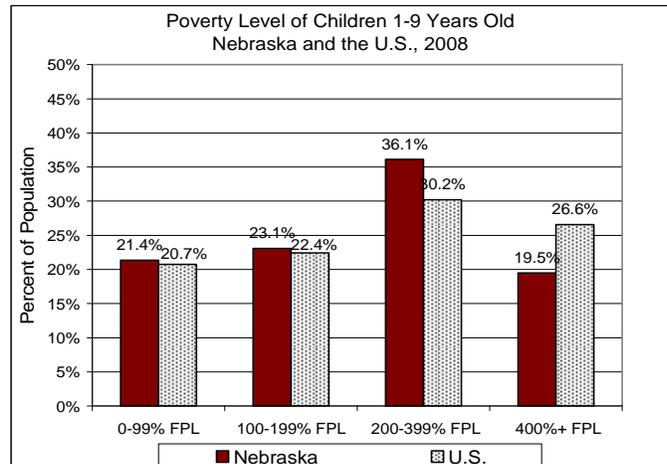
If poverty is not addressed, there will be a higher burden on individuals, families, communities and the state as a whole. Addressing poverty would positively impact access to health care and education that would improve health literacy and health outcomes overall. Health literacy is the degree to which individuals have the capacity to share, explain and be understood relative to basic health information and services needed to make appropriate health decisions. This includes interacting effectively with people of different cultures.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

A significant percentage of Nebraska’s Maternal and Child Health population are living in poverty. Families living in poverty are generally less healthy, lack preventative healthcare, have less educational opportunities and tend to live in inadequate housing conditions. As a result, the maternal population is more at risk for having heart disease, diabetes, obesity, poor prenatal care and low birth weight babies.

Infants and Children in Nebraska are more likely to live in poverty and near poverty than the national average. This is not improving over time.

Nebraska ranks 33rd in the Nation for people living under the federal poverty level.²



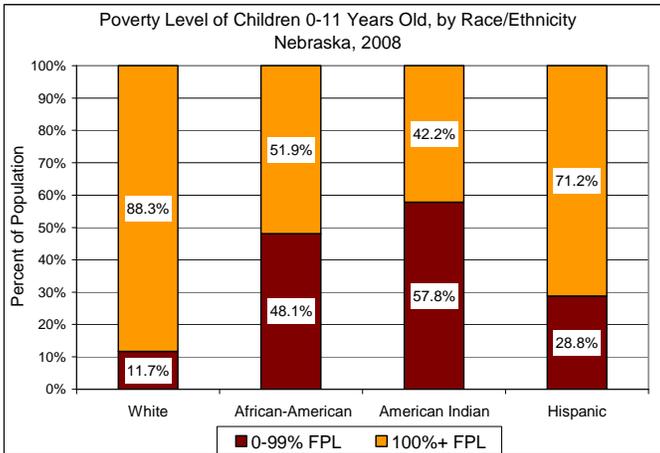
Poverty Rate in Nebraska (2000 and 2008)

	2000	2008
Children	10.0%	13.4%
Family/Household	6.5%	6.8%
Overall	9.6%	10.8%

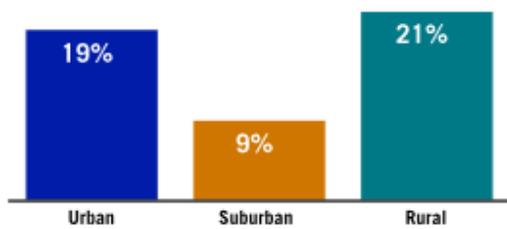
Source: U.S. Census Bureau, 2008 American Community Survey, Tables B17001, B17010, and B17001, respectively.

Criterion 2: Disparities Exist Related to Health Outcomes

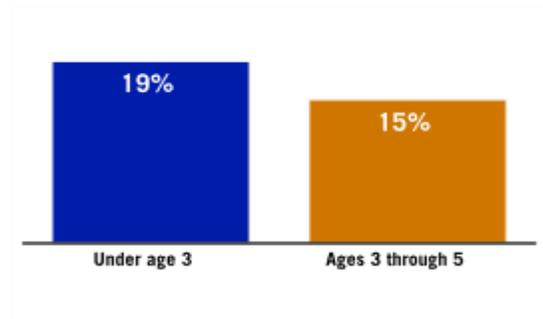
There is strong evidence that there are historical inequities persistent among those who live in poverty and the overall population, these inequities result in disparate health outcomes. Disparities are seen within race/ethnicity, geographical locations, and age.



Young Children in Poor Families in Nebraska, by Residence, 2008-Census Bureau



Young Children in Poor Families in Nebraska, by Age, 2008-Census Bureau



Criterion 3: Strategies Exist to Address the Problem

There are several proven evidence based programs available to address the problem of poverty among infants and increase the population health status. Those include: LA Best Babies which addresses issues to improve pregnancy and birth outcomes, Northern Manhattan Perinatal Partnership whose mission is to save babies and help women take control of their reproductive, social and economic lives, Spaces for Hope in Harlem which establishes interventions to improve the health of mothers and babies and Life Course Initiative through Contra Costa Health Services which reduces disparities in birth outcomes and builds economic security to improve stability of families.

Criterion 4: Capacity and Support are Available to Address the Problem

The capacity, at all levels, that is necessary to address the complexity of poverty may not be sufficient. At the least, to adequately address poverty necessitates improved coordination of roles and activities among many players.

Stemming from the “war on poverty” originating in 1964, a number of federal legislative bills were enacted and programs were instituted by the end of the decade, e.g. Head Start, the Job Corps, Volunteers in Service to America (VISTA), Amendments to the Social Security Act creating Medicaid, Medicare, the Food Stamp Act, Community Action Program, etc.

The Community Action Program, in particular, working in partnership with state governments and community organizations, began to address poverty by providing immediate assistance to individuals and families and also implementing long-term strategies to overcome barriers to achieve economic self-sufficiency through

methods such as job training and community economic development. Today, the national membership organization, Community Action Partnership (CAP), includes 1,100 Community Action Agencies (CAAs) across the nation.

CAP's promise: "Community action changes people's lives, embodies the spirit of hope, improves communities, and makes America a better place to live. We care about the entire community, and we are dedicated to helping people help themselves and each other." The state association, Community Action of Nebraska, orchestrates a network of nine CAAs that cover all counties in Nebraska.

Organizations whose missions or programs include improving specific conditions often focus primarily or solely on assistance to address the more immediate issue, e.g. drug addiction, homelessness, food insecurity and hunger, etc. Policies, systems, and organizational missions contribute to the capacity to address poverty. Adequate capacity must be well-orchestrated policies, programs, and activities to understand that poverty often causes or at least co-exists with needs requiring immediate assistance.

Criterion 5: Data Exists to Document the Problem

Data utilized to identify this problem are collected by the US Census Bureau, The Current Population Survey (CPS) and the American Community Survey (ACS).

The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years.

The CPS is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected

to represent the civilian non-institutional population. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas.

The ACS is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program. The ACS collects and produces population and housing information every year instead of every ten years.

References:

1. Nebraska Department of Health and Human Services, Division of Public Health Public Health Support Unit. Vital Statistics
2. US Census, American Community Survey, 2003
3. Voices for Children. Kids Count in Nebraska 2007 Report.
4. "Best Practices for Parent Education Programs Seeking to Prevent Child Abuse" Lisa C. Shannon, Ph.D. Extension Associate: Children, Youth, and Families, 2003

Food Insecurity among Nebraska’s Children

Food security is defined as access by all people at all times to enough nutritious food for an active, healthy life.⁴ According to the United States Department of Agriculture (USDA), one out of ten children in Nebraska is food insecure. According to the US Census 21.4% of Nebraska’s children are living in poverty (2008, 100% Federal Poverty Level (FPL)) and an additional 23% are living near poverty (100-200% FPL) both rates are significantly higher than the national rate with significant disparities among racial and ethnic groups. Poverty can impact access to healthy food necessary to live an active healthy life. Data suggest that if unaddressed food insecurity is likely to increase for children.

The Hunger-Obesity Paradigm developed by the Center for Human Nutrition illustrates that individuals who live in food insecure households experience hunger which leads 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.¹

According to the American Dietetic Association, negative nutritional and non-nutritional outcomes have been associated with food insecurity in adults, adolescents, and children. These outcomes include poor dietary intake and nutritional status, poor health, increased risk for the development of chronic diseases, poor psychological and cognitive functioning, and substandard academic achievement.³

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

The USDA’s Household Food Security in the United States, 2008 documents that the prevalence of food insecurity in the United States as well as in Nebraska is on the rise. Nationally, the prevalence of food insecurity is up from 11.1 percent (13 million households) in 2007 and was the highest observed since nationally representative food security surveys were initiated in 1995.

From 1996-98 to 2006-08 Nebraska saw a 1.7 percentage point increase in the prevalence of households experiencing low or very low food security.

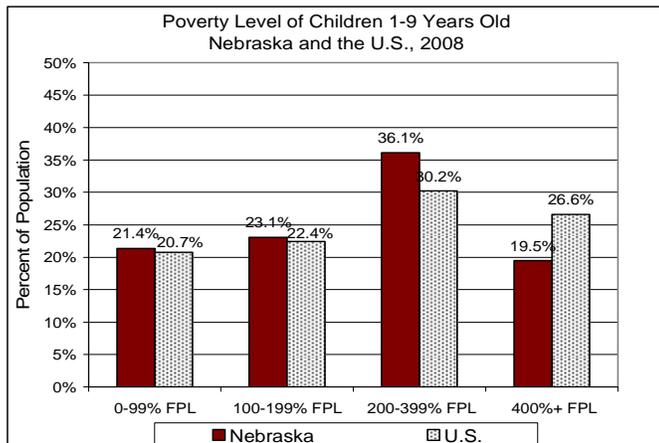
Figure 1: Prevalence of low or very low household-level food insecurity

Year	Nebraska	Nation	HP 2010 ²
1996-98	8.7%	11.3%	6%
2003-05	10.3%	11.4%	6%
2006-08	10.4%*	12.0%	6%

*1.7 percentage point change 1996-98 to 2006-08 was statistically significant with 90 percent confidence ($t > 1.645$)

In Nebraska, 10.4 percent of households have low or very low food security which is considerably higher than the Healthy People 2010 objective goal of 6 percent.¹⁰

Criterion 2: Disparities Exist Related to Health Outcomes



According to US Census Current Population Survey the prevalence of children living in poverty in Nebraska is higher than the national average. In 2008, 21.4% of children were living in poverty (0-100% FPL) and an additional 23.1% of Nebraskan children were living in near poverty (100-199% FPL) of poverty compared to 22.4% nationally.

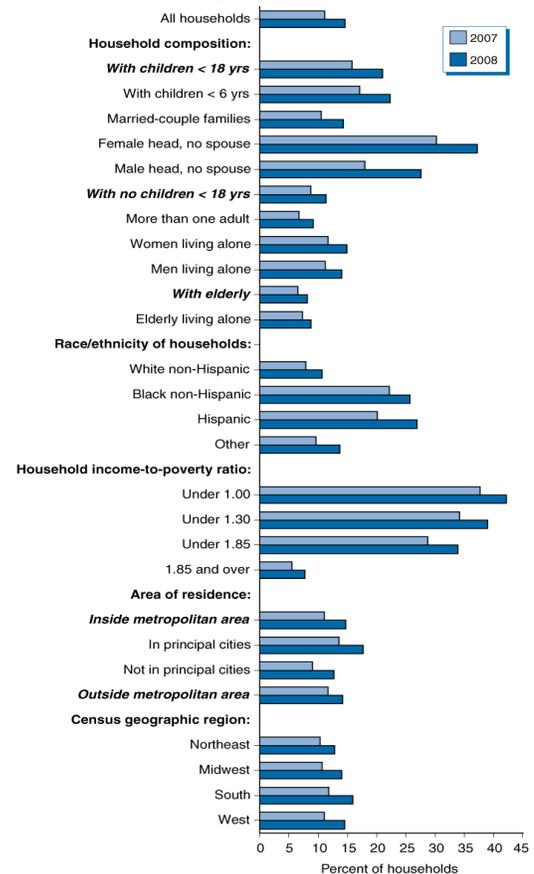
According to the results of the Census Bureau survey, those at greatest risk of being hungry or on the edge of hunger (i.e., food insecure) live in households that are: headed by a single woman; Hispanic or Black; or with incomes below the poverty line. Overall, households with children experience food insecurity at almost double the rate for households without children. Geographically, food insecurity is more common in central city households. The survey data also show that households are more likely to be hungry or food insecure if they live in states in the Midwest and South.¹⁰

The U.S. Department of Agriculture (USDA) reported that in 2008:

1) Of the 49.1 million people living in food insecure households (up from 36.2 million in 2007), 32.4 million are adults (14.4 percent of all adults) and 16.7 million are children (22.5 percent of all children).³

2) African American (25.7 percent) and Hispanic (26.9 percent) households experienced food insecurity at higher rates.³

Figure 3
Prevalence of food insecurity, 2007 and 2008



Source: Calculated by ERS based on Current Population Survey Food Security Supplement data, December 2007 and December 2008.

Criterion 3: Strategies Exist to Address the Problem

It is the position of the American Dietetic Association that systematic and sustained action is needed to bring an end to domestic food insecurity and hunger and to achieve food and nutrition security for all in the United States.

Recommended approaches include;

- Immediate and long-range interventions
- Adequate funding for an increased utilization of food and nutrition assistance programs
- Including food and nutrition education in all programs providing food and nutrition assistance

- Innovative programs to promote and support the economic self-sufficiency of individuals and families ⁴

From 2004 to 2005, staff with the Food Research and Action Center, through support from the Robert Wood Johnson Foundation, produced a white paper on the relationships between poverty, hunger and food insecurity as well as the potential role of federal food and nutrition programs in reducing both hunger and obesity. The paper, entitled *Obesity, Food Insecurity and the Federal Child Nutrition Programs: Understanding the Linkages*, concluded that the federal child nutrition programs can play a crucial role in preventing both food insecurity and obesity, as well as in increasing economic security and improving nutritional intake. When the full potential of the nutrition programs is achieved, they also can contribute to improvements in the general nutrition environment in schools and students' physical activity levels. Thus, it is of paramount importance to protect and increase broad access to federal nutrition programs, to assure that the nutrition programs provide optimal benefits, and to maintain and strengthen the programs' national nutrition standards.⁹

Criterion 4: Capacity and Support are Available to Address the Problem

The primary focus of the U.S. Department of Agriculture's nutrition assistance programs is providing food security -- access by all people at all times to enough nutritious food for an active, healthy life. Programs aim to provide nutrition education, access to nutritious foods, and empowerment through knowledge of the link between diet and healthy.

The Food Research and Action Center (FRAC) is the leading national nonprofit organization working to improve public policies and public-private partnerships to eradicate hunger and under nutrition in the United States. FRAC works with hundreds of national, state and local nonprofit

organizations, public agencies, and corporations to address hunger and its root cause, poverty.

The Food and Nutrition Project works in coalition with grassroots organizations, educators, academics, government agencies, members of the faith community, and other community groups to sponsor policy and legal initiatives for responsible food policy in Nebraska.⁸ The purpose of the Food and Nutrition Project is to ensure Nebraska's children, seniors, disabled, and working families are able to meet their food and nutrition needs. The focus is on the role of food programs that transition families to self-sufficiency

As a state, Nebraska has taken strides to impact food insecurity and hunger. Nebraska's food stamp system called Supplemental Nutrition Assistance Program (SNAP) serves income eligible families and has made efforts to streamline application and verification processes. Further, the use of Electronic Benefit Transfer (EBT) cards provided by SNAP has made using food stamps easier and more secure, as well as reduced stigma. The Women, Infants, and Children (WIC) program in Nebraska has 120 clinic sites that serve over 45,000 participants each month, providing both food and nutrition education programs. 984 schools participate in the school lunch programs, which are as much a part of learning in Nebraska as pencils and books. Through programs including Food Stamps, the Child and Adult Care Food Program, WIC, School Breakfast, School Lunch, and Summer Food Nebraska has laid a solid foundation for food security.⁸

Criterion 5: Data Exists to Document the Problem

Since 1995, the U.S. Department of Agriculture (USDA) has collected information annually on food spending, food access and adequacy, and sources of food assistance for the U.S. population and at the state level. A major impetus for this data collection is to provide information about the prevalence and severity of food insecurity in U.S. households.

The information is collected in an annual food security survey, conducted as a supplement to the nationally representative Current Population Survey (CPS). The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years. The sample provides estimates for the nation as a whole and serves as estimates for individual states and other geographic areas.

References:

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2. Healthy People 2010. U.S. Department of Health and Human Services
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3. Nord, Mark, Margaret Andrews, and Steven Carlson. *Household Food Security in the United States, 2008*. ERR-83, U.S. Dept. of Agriculture, Econ. Res. Serv. November 2009.
4. Position of the American Dietetic Association: Food Insecurity and Hunger in the United States, 2006
5. Hunger and Food Insecurity in Nebraska-Resources: Food Research and Action Center,
www.frac.org
6. Feeding America, www.feedingamerica.org
7. Food and Nutrition Service, USDA,
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8. Portrait of Hunger in Nebraska, Nebraska Food Security Series Part I Released June 3, 2004 ,
www.neappleseed.org
9. Lynn Parker. Robert Wood Johnson Foundation White Paper. OBESITY, FOOD INSECURITY AND THE FEDERAL CHILD NUTRITION PROGRAMS: UNDERSTANDING THE LINKAGES
http://www.frac.org/pdf/obesity05_paper.pdf
10. U.S. Census- Current Population Survey, Food Security Supplement

Childhood Obesity and Physical Inactivity in Nebraska

Overweight and obesity increase the risk for heart disease, diabetes, and other chronic diseases including cancer and arthritis.^{3,10} Obesity and its related health problems also negatively affect the U.S. health care system by increasing the cost for treatment of obesity-related diseases.¹³ The Hunger-Obesity Paradigm developed by the Center for Human Nutrition, illustrates that obese children are more likely to be socially stigmatized, physiologically distressed, and have impaired immune function. Such factors suggest that obesity negatively impacts mental and medical health, oral health, educational attainment, chronic disease, life expectancy, and life course trajectory for children.¹

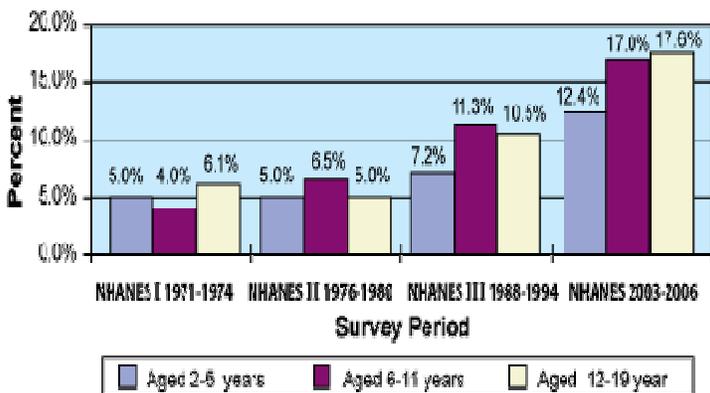
Nationally, the prevalence of overweight among children and adolescents has substantially increased during 1999-2004,¹⁰ and approximately 31% of Nebraska’s children and adolescents (10-17) are obese (BMI ≥30.0) or overweight (BMI 25.0-29.9).⁷ If this continues, the rate of childhood obesity will grow even greater as seen in the National Survey on Children’s Health data where Nebraska’s ranking for prevalence of overweight/obese children/adolescents (10-17) changed from 10 in 2003 to 31 in 2007 (1 is the best).⁷

It is essential to address the problem of childhood obesity in the early years of children’s life as it can cause health, psychological, and social problems for children continuing into their adulthood.¹¹

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to the National Health and Nutrition Examination Survey (NHANES) the prevalence of obesity has increased nationally for children since the 1970’s. Data suggests that for children aged 2–5 years old, the obesity prevalence increased from 5.0% to 12.4%; for children aged 6–11 the prevalence increased from 4% to 17.0%; and for those aged 12–19 the prevalence increased from 6.1% to 17.6%.⁵ (Figure 1)

Figure 1: Prevalence of Obesity among U.S. Children and Adolescents (Ages 2-19 years)⁵



According to the National Survey on Children’s Health, Nebraska’s ranking for obesity and overweight among children (10-17) changed from 10 in 2003 to 31 in 2007 (1 is the best).⁷

The prevalence of overweight/obesity among Nebraska children (10-17) in 2007 was 31.4% (2007)⁷ which is above the Healthy People 2010’s objective of 5%.²

The National Survey on Children’s Health reports that the number and percent of children who engage in vigorous physical activity at least 20 minutes per day was 31.1% for NE children (6-11) years old which is lower than the respective national average of 37.7%.⁷ These rates are also significantly lower than the HP 2010 objective of 85%.²

Criterion 2: Disparities Exist Related to Health Outcomes

Although Nebraska’s estimates of childhood obesity by race/ethnicity did not show a statistical difference, the national data provides a signal that disparities exist related to childhood obesity.

National rates of overweight/obesity in children suggests that Non-Hispanic African American children have a higher prevalence of overweight/obesity compared to children of white-non-Hispanic origin (41.1% vs. 26.8%) and the childhood overweight/obesity rate among Hispanic children is higher than the non-Hispanic children (41.0% vs. 29.6%).⁶

Socioeconomic status is a known disparity that relates to the problem of obesity and overweight. According to Nebraska Pediatric Nutrition Surveillance System (PedNSS) data, 30.9% of children ages 2-5 from low income families (WIC enrolled) are overweight/obese, which also exceeds the HP 2010 objective of 5%.⁸

The National Survey of Children’s Health reports that 55.1% of Nebraska’s children living in families with income less than 100% of the federal poverty level were overweight/ obese.⁷

Criterion 3: Strategies Exist to Address the Problem

The “Common Community Measures for Obesity Prevention Project,” (CDC) recommends 24 strategies, that focus on obesity prevention along with suggested measurements for each strategy. The categories include: 1) strategies to promote the availability of affordable healthy food and beverages, 2) strategies to support healthy food and beverage choices, 3) a strategy to encourage breastfeeding, 4) strategies to encourage physical activity or limit sedentary activity among children and youth, 5) strategies to create safe communities that support physical activity, and 6) a strategy to encourage communities to organize for change.⁴

The Center for Disease Control (CDC) has also identified a list of top ten school-based promising policies and practices addressing childhood obesity. Such strategies fall into two main categories: 1) building a strong foundation (strategies 1-4) and 2) taking action to address the problem (strategies 5-10). Available resources to plan and implement initiatives are also listed for each strategy.¹²

- 1) Addressing physical activity and nutrition through a coordinated school health program (CSHP). Ex. *Health Is Academic: A Guide to Coordinated School Health Programs*
- 2) Designating a school health coordinator, and maintaining an active school health council. Ex. *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Councils, and Effective School Health Advisory Councils: Moving from Policy to Action*
- 3) Assessing the school’s health policies and programs, and developing a plan for improvement. Ex. *CDC’s School Health Index (SHI)*
- 4) Strengthening the school’s nutrition and physical activity policies. Ex. *Fit, Healthy, Ready to Learn: A School Health Policy Guide (FHRTL); Wellness Policy Guidance; Local Wellness Policy Tools & Resources; Wellness Policy Tool*
- 5) Offering a high-quality health promotion program for the school’s staff. Ex. *School Employee Wellness: the Assets of Our Nation’s Schools*
- 6) Offering a high-quality course of study in health education. Ex. *CDC’s Health Education Curriculum Analysis Tool (HECAT)*
- 7) Offering a high quality course of study in physical education. Ex. *CDC’s Physical Education Curriculum (PECAT)*
- 8) Increasing opportunities for students to engage in physical activity. Ex. *CDC’s KidsWalk-to-School, CDC’s VERB Campaign Materials*
- 9) Offering a quality school meals program. Ex. *Changing the Scene: Improving the School Nutrition Environment*
- 10) Ensuring that students have appealing, healthy choices in foods and beverages offered outside the school meals program. Ex. *Making it Happen: School Nutrition Success Stories, Nutrition*

Criterion 4: Capacity and Support are Available to Address the Problem

The mission of the Nebraska DHHS is “Helping people live better lives.” To fulfill its mission, NE DHHS has created a broad scheme of resources, including partnership with other organizations, communities, and individuals across the state to provide the support and resources that are needed to prevent and treat obesity. Such approaches incorporate a healthy diet and increase in physical activity levels for all ages, including children. A number of programs are in place to help address the problem of obesity. Example of such programs include: “Be Active, your Way, Everyday!”, “Fruits and Vegetables more Matters”, “Breastfeeding, the healthy choice for moms & babies”, “Rethink your Drink: with no added sugar-save on calories”, “Lighten up...cut portions in half”, “Teach a Kid to Fish: Creating Community Solutions for Children’s Health”, “Go Lean with screen...turn off the TV and be active”, “All Recreate on Fridays (ARF)”, and “Whatcha doin? Campaign.”⁹

Criterion 5: Data Exists to Document the Problem

Data were obtained from National Health and Nutrition Examination Survey (NHANES),⁵ the National Survey of Children’s Health (NSCH),⁷ and the Nebraska Pediatric Nutrition Surveillance System (PedNSS).⁸

NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. The survey examines a nationally representative sample of about 5,000 persons each year. These persons are

located in counties across the country, 15 of which are visited each year.

The NSCH is a national survey that was conducted by telephone in English and Spanish during 2003-2004 and for a second time in 2007-2008. The survey provides a broad range of information about children’s health and well-being collected in a manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

The Nebraska PedNSS is a program-based surveillance system that monitors the nutritional status of low-income infants, children and women in federally-funded maternal and child health programs. The data on weight status is from the Nebraska Women, Infant and Children (WIC) program.

References:

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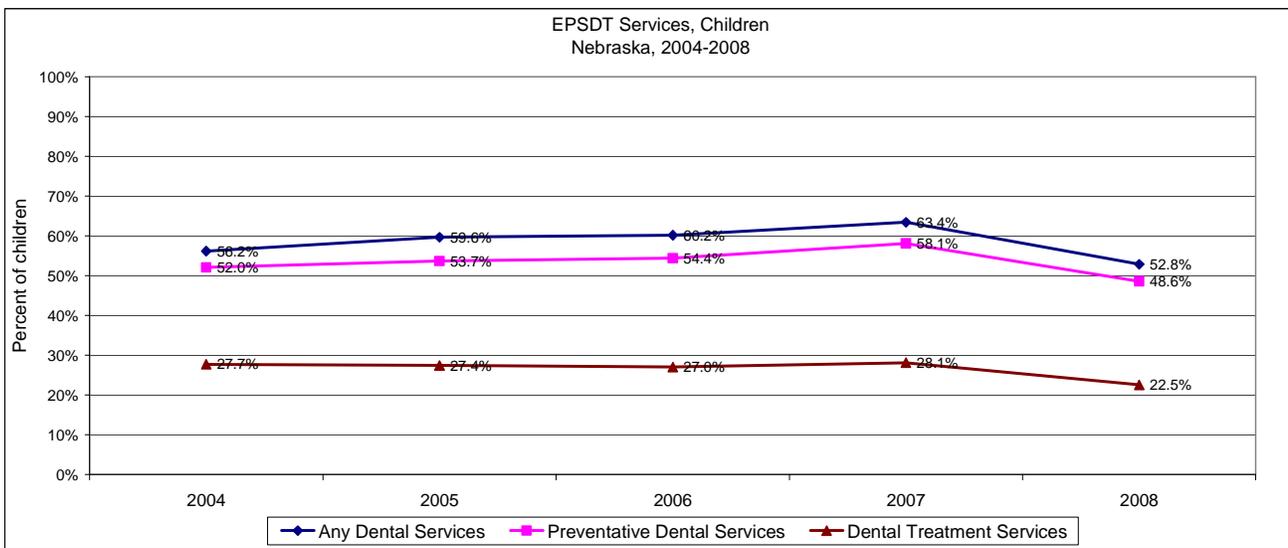
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Access to Oral Health Care for Nebraska's Children

Poor oral health for children relates to a number of problems including chronic pain, inadequate nutrition, impaired speech development, decreased school performance, poor social relationships, and even rare, but severe infectious diseases. According to the Maternal and Child Oral Health Resource Center, an estimated 51 million school hours are lost nationwide per year because of dental-related illness¹.

Currently, Nebraska is not meeting the Healthy People (HP) 2010 objective (66%) of Medicaid eligible children receiving preventive dental services. Disparities exist related to oral health, specifically affecting low income, young children and children with special healthcare needs. If this trend continues, there will be a greater disparity in regards to the oral health status of children. Lack of pediatric dentists, shortages in funding, and the lack of coordination of existing efforts are some of the contributing factors to the poor oral health status for some of Nebraska's children.



Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

Nebraska is not meeting the HP 2010 objective (66%) for Medicaid eligible (EPSDT) children receiving preventive dental services. More than half (51.4%) of the children (1-9 years old) enrolled in Medicaid received no preventive services in 2007. This rate has not improved over time.

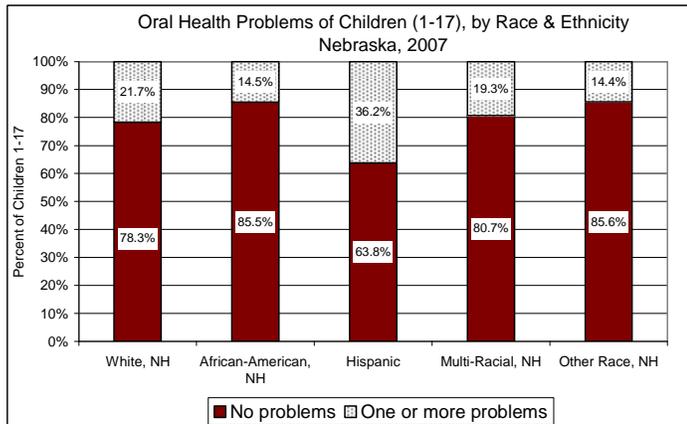
According to the National Survey of Children's Health in 2007 over 30% of children in Nebraska (6-11 yrs) had one or more dental problems that need to be addressed in the past six months.

In April 2010 the PEW Center on the States² gave Nebraska a grade of "C" on the existence of effective policies, specifically relating to the fluoridation of community water supplies, in place to ensure proper dental health for Nebraska's children. Nebraska is not meeting the national goal of having fluoridated water to 75% of the population on community systems. Currently, approximately 70% of the state's population has fluoridated water.

Criterion 2: Disparities Exist Related to Health Outcomes

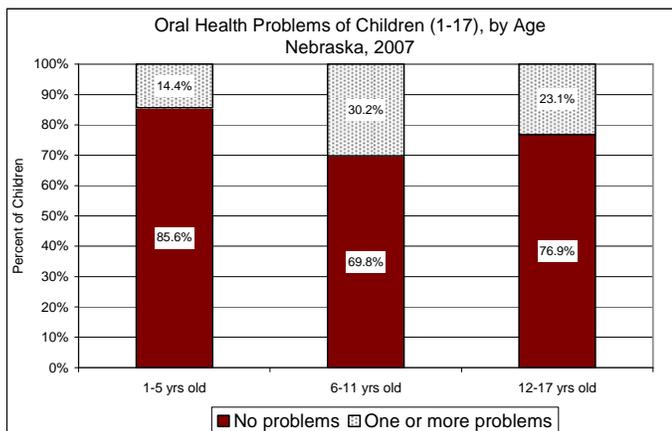
Disparities are present by race and ethnicity in Nebraska's children. Hispanic children (1-17)

experience oral health problems at a rate of 36.2%, more than twice the state rate of 15.6%.

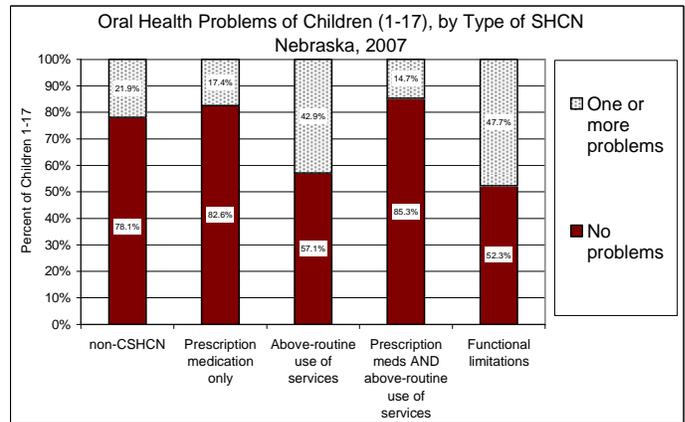


Socioeconomic status, specifically income status is a known disparity affecting oral health in children. In Nebraska 36.1% of children and families with income less than 100% of the Federal Poverty Level reported more than one oral health problem in the past six months, more than twice the state rate of 15.6%.

There is an increase in oral health problems between the ages of 1-5 and 6-11.



Among Children/Youth with Special Healthcare Needs (CYSCHN) 27% reported more than one problem. However the most vulnerable of those children: those requiring above routine use of services (43%) and those with functional limitations (48%) reported one or more problems.



Disparities exist related to urban vs. rural access in Nebraska. In April 2002 there were a reported eighteen rural counties without a licensed dentist. As of December 2007, there were twenty rural counties without a licensed dentist. Additionally, there were thirty counties with only 1 or 2 dentists which remained unchanged since in 2002³. Access to pediatric dentists is only possible in Douglas and Lancaster counties.

Criterion 3: Strategies Exist to Address the Problem

The American Academy of Pediatric Dentists recommends that children be assessed and provided with preventative treatment upon eruption of their first tooth.

Strong evidence suggests that applying fluoride varnish and dental sealants is effective preventive care that reduces the occurrence of caries.

Strong evidence supports fluoridation of water supplies in an effort to prevent tooth decay.

General dentists can be trained/educated on techniques and strategies to serve children with special healthcare needs and young children.

Criterion 4: Capacity and Support are Available to Address the Problem

In 2009 Nebraska Medicaid began reimbursing for fluoride varnish application completed in a physician's office.

Nebraska has current legislation that requires fluoridation in water systems. However, this law, which was passed in 2008, allows for communities to "opt out". Nearly 75% of Nebraska communities have taken this option.

Currently in NE there are a number of oral health initiatives occurring, but there is a need for coordination of efforts to generate an approach to address the problem in a more systemic manner. For example, multiple leadership committees for various initiatives exist that could be more efficient and far reaching if integrated.

The Office of Rural Health coordinates several efforts to ameliorate workforce disparities, such as loan repayment, recruitment efforts and other incentives for dentists who opt to practice in rural NE.

In 2009 NE received a HRSA grant entitled, Oral Health Access for Young Children with the primary focus on preventative care for very young children. Strategies are under development.

In 2011 Nebraska will implement the American Academy of Pediatric Dentistry/Head Start Dental Home Initiative to develop a network of pediatric and general dentists to provide oral health services to young children.

Nebraska's Dental Colleges support a number of safety net oral health projects such as Dental Days, Mission of Mercy, etc., which periodically provide oral health services to underserved populations in different communities across NE. The wait time and number served is extensive, indicating the need for ongoing oral health services in NE.

Criterion 5: Data Exists to Document the Problem

Data were obtained from Nebraska Medicaid and the National Survey of Children's Health (NSCH).

Nebraska Medicaid data is derived from the annual EPSDT (Early Periodic Screening Diagnosis, and Treatment) Participation Report, Form CMS-416. EPSDT is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.

The NSCH is a national survey that was conducted by telephone in English and Spanish during 2003-2004 and for a second time in 2007-2008. The survey provides a broad range of information about children's health and well-being collected in a manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

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Abuse and Neglect among Children with Special Health Care Needs

National data as well as a study done in Nebraska indicate children and youth with special health care needs/disabilities have a three times greater incidence of maltreatment than their peers without special health care needs or disabilities. Left unaddressed, this can exacerbate their health condition as well as increase the likelihood they will experience long term negative impacts on their health, productivity, and emotional well-being as adults. Although not specific to children and youth with special needs, the Adverse Childhood Experiences Study¹ show that abuse and neglect, among other negative childhood experiences are major risk factors for the leading causes of illness and death as adults. Since evidence shows children and youth with disabilities are at increased risk to be abused and neglected, the impact is proportionally greater on this population. Implementation of strategies that increase preventive and protective factors for these children and their families will have a positive impact on their well-being and prevent abuse and neglect.

Criterion 1: *The Problem is Severe or Increasingly Worse than the Benchmark*

The benchmark in the **Nebraska 2010 Health Goals and Objectives: A Midcourse Review** that relates to this proposed indicator is #15-33 “Rate of children under age 18 years who are victims of maltreatment per 1000 children.”²

The baseline in 1999 for Nebraska was 6.9. In 2004, it had risen to 11.3 and while the 2010 objective was 6.8. A large study conducted in Omaha found that children with disabilities were 3.4 times more likely to be maltreated than were children without disabilities. Other studies have found similar increased risk for children with disabilities. Therefore, it can be assumed that if the current rate in Nebraska for all children is rising then that for children with disabilities (special health care needs) is worsening as well.

A case can be made to take some inference from data on unintentional injuries and relate it to maltreatment. It is commonly assumed that child abuse is underreported for a variety of reasons. Therefore, data on unintentional injuries can be used as a measure of abuse, recognizing that the

majority of these injuries may not be the result of maltreatment. So using this, Nebraska’s data on unintentional injuries per 100,000 youth 10 -19 for all causes is higher than the national rate especially in the area of “struck by/against.”

Criterion 2: *Disparities Exist Related to Health Outcomes*

Children with disabilities are at increased risk of maltreatment than children without disabilities.

Nationally, Westat, Inc. found that children with disabilities were 1.7 times more likely to experience abuse and neglect compared to children without disabilities.³

A more robust study in Omaha (Sullivan and Knutson, 2000) looked at the total enrollment in public schools including early intervention programs and compared the children with substantiated CPS and law enforcement investigation. They found that children in special education were 3.4 times more likely to be maltreated than those who were not.⁴ Data from the Denver Department of Welfare reported that nearly 70% of the children exhibited

either mental or physical deviation prior to their reported abuse.⁵

“Crime Against People with Disabilities – 2007 Bureau of Justice Statistics” reported that violent victimization of persons with and without disabilities for ages 12 to 15 showed 81.2 vs. 40.0 as the unadjusted rate per 1000 persons, for ages 16 to 19, 82.7 vs. 47 per thousand.⁶

Child Protective Services are required to refer all children below age 3 to the Early Development Network for assessment. In Nebraska 24% of the 266 referred children were verified for special education services. This is likely to be an underestimate as their young age makes verification difficult and it may be several years before the disability is apparent.

Criterion 3: Strategies Exist to Address the Problem

There is strong evidence that preventive strategies can be effective for vulnerable populations, in particular children with special health care needs and/or developmental disabilities.^{7,8,9}

Principles of Effective Prevention Programs:

Protective Factors are conditions in families and communities that increase the health and well being of children and families. There are 5 key conditions that by virtue of yielding strengths have been shown to reduce the likelihood of abuse and neglect. These are:

-Parental resilience The most important factor is developing the capacity to empathize with the self and others through the medium of a safe, caring relationship. Communities can help develop this by fostering parents’ pro-social connections and linking them to needed mental health services.

-Social connections through faith based groups, other parent to parent support/advocacy, close relationships with people to prevent social isolation.

-Knowledge of parenting and child and youth development Medical Home providers and Early Childhood Development programs are uniquely positioned to be able to support this. Parent education programs reducing inappropriate expectations of children’s abilities help parents understanding.

-Concrete supports for parents at the time they need it like home visitation/parenting support during the high stress periods: infancy, first time home with new baby, adolescence.

-Social and Emotional Competence of Children- is critical in their cognitive, skill building, social competence, mental health, and overall well being. Key strategies include developing a “therapeutic classroom” and establishing partnerships with early childhood mental health consultants. Home visitation programs both health visitation and early childhood development visitation can support the development of caregivers as nurturers.

-**Prevention strategies** that include multiple components and affect multiple settings to address a wide range of risk and protective factors of the population.

-Effective programs offer a wide variety of activities to address the target problem, which usually has multiple risk factors. These activities may include several components such as curriculum-based interventions, media campaigns, systems change, and environmental strategies that can affect economic-social conditions.

Considerations for biggest impact on CYSHCN/DD

-Family focused for building protective strategies, but should focus these same community strategies for out-of-home and foster caregiver strength building.

-Strategies to support economic sufficiency of families

-Earliest intervention ages 0-2 or 3, or as soon as special health care need can be identified, families should be linked to services coordination. Service coordinators must have adequate support and training on the principles of building protective factors, to recognize where families need help in strengthening factors, and communities must have the services available to be able to provide the supports.

-Community-based (State policies support, do not present barriers)

-Multi-organization/agency/group collaboration w/ commonly understood mission

-Measured/evaluated

Criterion 4: Capacity and Support are Available to Address the Problem

Primary prevention of abuse and neglect of CSHCN by development and support of protective factors must be a priority for Nebraska to address.

Nebraska has the means to address this through capacity that already in place in communities across the state by a) building access to medical homes, development of medical home capacity for care coordination, ongoing assessment, referral and follow-up b) early development network and early childhood education programs c) recognition of other health and education professionals to expand communities' capacity to recognize families at risk and make referrals for community and family supports d) building collaborations with other community, faith based and advocacy supportive organizations.

With the passage of the Health Care Reform Act the provision for home visitation for MCH populations and improving access to this in underserved communities may also have an impact on the capacity to address the issue of abuse and neglect for children and youth with special health care needs.

Criterion 5: Data Exists to Document the Problem

Various data sources have been cited under the relevant criteria but the following are highlighted. The study done by Sullivan and Knutson in Omaha which showed that children with disabilities were 3.4 times more likely to be abused than children without disabilities is used frequently to show this health disparity not only in Nebraska but nationally.

Data from Nebraska's child abuse system shows that when looking at the distribution of disabilities among maltreated children with disabilities, emotional disability and other medical conditions are the two highest categories. This is a similar finding than that of Sullivan and Knutson who found children with behavioral disorders were at highest risk, followed by children with speech/language disorders, mental retardation, and health impairments.

There is also data which seems to show the causal relationship between abuse and neglect and disability. Baladerian (1992) estimated that 25% of all developmental disabilities are caused by abuse while 50% of child victims of severe neglect sustain permanent disabilities. United Cerebral Palsy estimates that 11% of their constituents have cerebral palsy as a result of physical abuse.

Despite the existence of data documenting the problem, much of it is not Nebraska specific other than the large study in Omaha. The current empirical data shows a high incidence of abuse and neglect among children with special health care needs and disability; therefore, it is critical that data on disability be included in data collection for abuse and neglect. This may not be as easy as it sounds as caseworkers may not be skilled at identifying disability or special health care needs. The current data factors do not distinguish who has the disability – the caregiver or the child – so it is hard to draw conclusions. Maltreatment is typically underreported and that issue may be

worse for children with special needs as their communication skills may be poor and society tends to devalue them. As better data is collected, effective prevention strategies will be developed that meet the risk factors identified.

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Functional Limitations among Nebraska's CSHCN

Functional Limitations, according to the *National Survey of Children with Special Health Care Needs* (CSHCN) encompasses a wide range of health conditions, including those with more obvious physical challenges, such as cerebral palsy and spina bifida, but also those with less obvious conditions and necessities such as those with migraines and asthma, as well as those children with emotional, developmental and behavioral challenges. Children with functional limitations are defined here not by the types of conditions or diagnoses that children have, but by the *consequences* of their conditions—that is, the types of services or treatments that children require or the effect of the condition on the child's functional abilities.

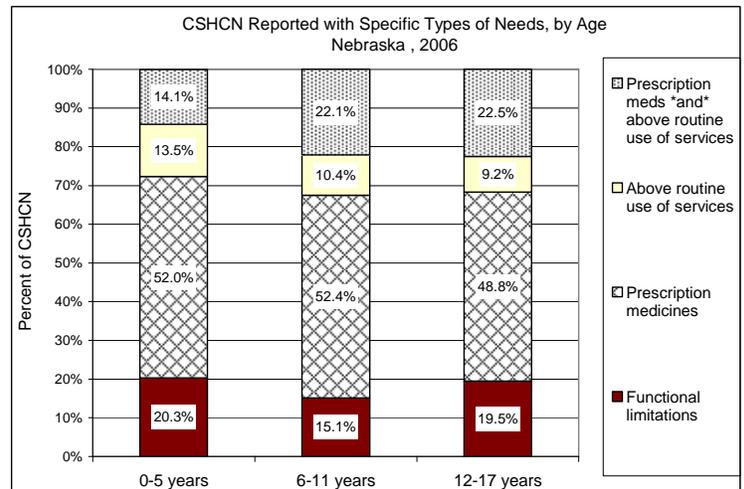
CSHCN with functional limitations have statistically significantly poorer outcomes than do children without these limitations. Comprising 18.1% of Nebraska's CSHCN population, these children often experience diminished health outcomes. Children from families with lower incomes have higher rates of functional limitations.

Designing a coordinated system of care, rather than a piecemeal approach, may help to decrease the gap between those CSHCN with functional limitations and those without. Perhaps, the processes for family support and inclusion have addressed the physical barriers more often than the barriers of heart - that is full and meaningful membership in their communities for these children and their families. Too often, the first response families experience when confronted with their child's diagnosis is a sense of isolation, a feeling that they are alone in confronting the challenges that lie ahead. Comprehensive care management that addresses needs in a global, holistic way could help families' better access information and services and, also, promote opportunities for the family - to- family connections that may form the soft bridges of the heart.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to the National Survey of Children with Special Healthcare Needs (NCSHCN), however, the rate of CSHCNs with Functional Limitations is not significantly different from national rate, the demographic measure is **not improving** to a statistically significant degree. It is important to address the needs of these children simply due to the lifelong cost of ignoring them and their potential contributions.

It is estimated the over 11,000 children in Nebraska live with functional limitations; it is alarming that 20.3% of the children 0-5 years old are already living with functional limitations. Early impact of a coordinated approach in the first days of diagnosis could help pave the road to a better outcome.¹



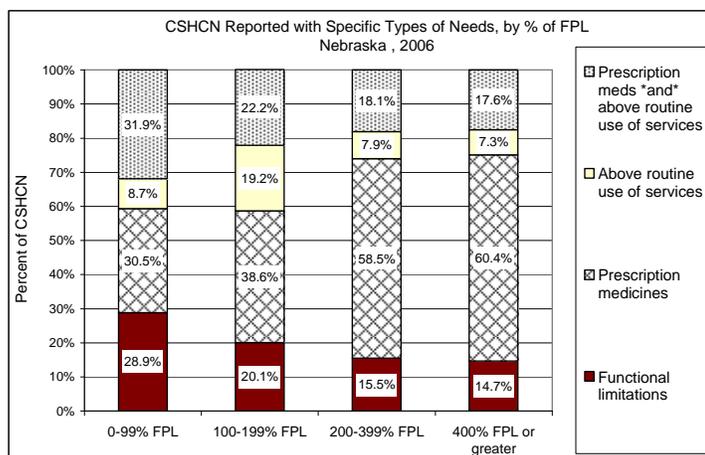
Children with functional limitations were significantly less likely to report that their health insurance **is adequate** (47% versus 66% overall). They are also less likely to have a medical home (35% versus 54% overall), less likely to report that services are organized in ways that families can use them easily (76%

versus 92% overall), and less likely to have families who are partners in decision making at all levels (47% versus 66%).¹

In addition, data shows that CSHCN with Functional Limitations, “when compared to other children that age, are reported to experience **difficulty with feeling anxious or depressed**” at a higher level. It stands to reason that CSHCN would report **higher levels of school absence and health conditions that more often than their peers affect their daily activities.**¹

Criterion 2: Disparities Exist Related to Health Outcomes

Disparities exist in regard to income with lower income families impacted at a higher rate with functional limitations.



Criterion 3: Strategies Exist to Address the Problem

Nebraska’s CSHCN with functional limitations and their families might especially benefit from programs discussed in the February 2010 State Innovations in EPSDT,² such as, Oklahoma’s care management department that employs Registered Nurses to assist in facilitating medical services for Medicaid clients with complex conditions. Supporting a medical home concept, nurses not only assist with care

coordination, but beyond that, assist with community support and social service systems.³ Public Health Nurses, through the Public Health Nursing Program, already in place throughout Nebraska, might be a first step

Criterion 4: Capacity and Support are Available to Address the Problem

Public health nurses, statewide, presently assist families to access medical and dental homes and promote optimum relationships between Medicaid recipients and their providers. Public health nurses also build and maintain relationships with a variety of community resources. Increased and dedicated funding for care management for public health nurses could make the difference of a lifetime for these children and their families.

Respite programs and other community supports could be further organized to be reachable. Repurposing existing facilities, such as Richard Young Hospital, for use as a respite center might also be a possibility.

While Nebraska may have made steps towards helping those children with functional limitations in the past, data concludes that it has not been enough. Helping children with functional limitations and their families, in concrete ways, will show the heart of Nebraska and acknowledge the value of all children in our state.

Criterion 5: Data Exists to Document the Problem

Data utilized to identify this problem is from the National Survey of Children with Special Healthcare Needs (NSCSHCN) The NSCSHCN is a national survey that was conducted by telephone in English and Spanish during 2001 and for a second time in 2005-2006. The survey provides a broad range of information about CSHCN’s health and well-being collected in a

manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

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Access to Medical Homes for Children and Youth with Special Health Care Needs

All Nebraska children with special healthcare needs (CSHCN) should receive comprehensive, coordinated care through a medical home from the time of birth through their transition to adult health care services. A medical home is defined as a partnership between a family and a primary health care professional working together with the health care team to manage chronic conditions, coordinate care, access community resources, and continuously work on quality improvement. Research has shown that children who do not have a medical home have increased emergency room utilization, miss more days from school and have caregivers who report higher levels of stress and decreased productivity at work.¹

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

According to the National Survey of Children with Special Healthcare Needs there are approximately 63,000 children who meet special healthcare need status in Nebraska.

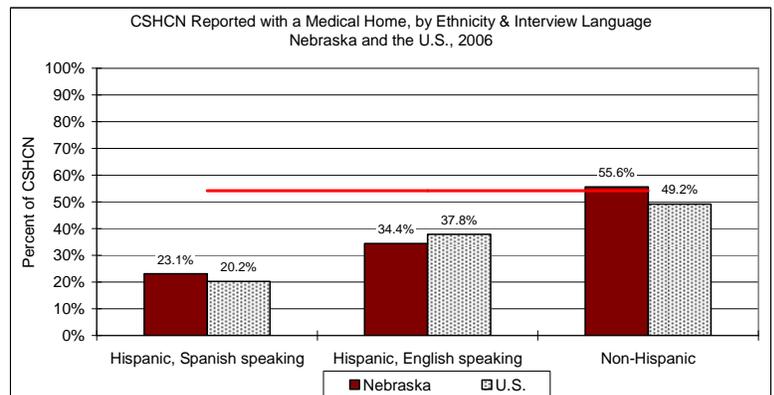
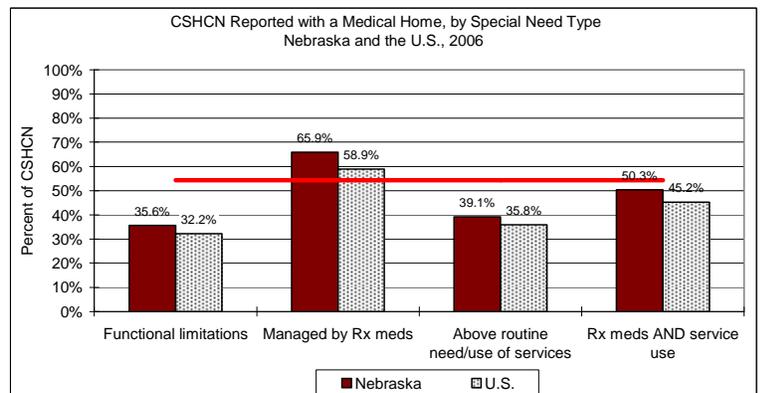
While the National Survey of Children with Special Healthcare Needs showed Nebraska CSHCN fare slightly better than the national average (45.8% outcome not achieved in Nebraska versus 54.2% nationally,) basically no change in access to Medical Home services for CSHCN from 2001 through 2005 was noted (46.2% outcome not achieved in 2001 to 45.8% in 2005).

Criterion 2: Disparities Exist Related to Health Outcomes

According to the National Survey on CSHCN the disparity between CSHCN and their typical counterparts was exceptionally significant. Children without special healthcare needs had improved access to Medical Home care as measured by the National Survey of Children's Health, increasing from 49% of children in 2003 to 69% in 2005-2006.

There are significant disparities within the CSHCN population; disparities were noted for children with functional limitations (32% versus 60%), Hispanic children particularly Spanish speaking (20% versus 54.2%), and poverty (children with families at or greater than 400%

of FPL had access averaging 56% versus 34% for children below the benchmark.)



Without access to services through a Medical Home the data showed the likelihood for decreased health outcomes for these children. For example, the data show children without these services have an increased risk of functional limitations, decreasing children's opportunities to be independent and integrated into their communities.¹ The data also indicate CSHCN who lack Medical Homes utilize medical services and medication at increased

rates. The anticipated outcomes of these circumstances can include increased stress on families with CSHCN and increased potential for maltreatment (2000, Sullivan et al.)²

Given that access figures have not improved over the past five years, the projection is that approximately half of the 63,000 Nebraska CSHCN¹ will be unable to access Medical Homes in the future, with the associated consequences, appears supportable.

Criterion 3: Strategies Exist to Address the Problem

Many strategies exist in Nebraska and across the nation that can be used to improve access to medical homes for CSHCN including:

1. Increased education about the medical home model of care to families, health professionals (pre and post training), and child-serving organizations (including public health)
2. Develop practice-based care coordination to improve access to medical homes, community-services, and family support.
3. Improve collaboration between medical home and subspecialists while also working to increase numbers of health care professionals serving CSHCN.

Since 2008, the Boys Town Institute for Child Health Improvement has been working in partnership with the Nebraska Family to Family Health Information Center, Munroe Meyers Institute, NDHHS and 10 pediatric primary care practices in Eastern Nebraska through a **Medical Home Learning Collaborative** to develop and implement quality improvement strategies toward increasing chronic condition management, care coordination and early identification of CSHCN. Physicians often express interest in making

improvements in the way they deliver care to CSHCN but don't have the time, expertise or resources to implement the changes on their own. They need a facilitated approach to quality improvement that actively engages families as partners. This could be accomplished by expanding the current MHLC to other practices across the State of Nebraska.

There are many successful models for supporting care coordination in primary care practices that have demonstrated improvements in health outcomes for CSHCN as well as increased efficiencies and cost savings:

Rhode Island's Pediatric Practice Enhancement Project (PPEP) trains and places parent consultants into pediatric primary and specialty care practices to help families with CSHCN coordinate and access the health system, as well as other services (e.g., social services, education, housing). Parent consultants, who are parents of CSHCN themselves, assist physicians in providing comprehensive, coordinated medical homes to children with special needs in the state. A recent evaluation suggests that PPEP participants have more outpatient encounters but fewer inpatient admissions and less intensive resource use than children with special needs who are not in PPEP practices (savings to the state Medicaid program in excess of \$5 million per year).

Community Cares of North Carolina (CCNC) is an enhanced medical home model consisting of several key components that include 1) local non-profit community networks comprised of physicians, hospitals, social service agencies, and county health departments who provide and coordinate care; 2) primary care clinicians who serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care, and provides 24/7 on-call assistance; and 3) care coordinators who work in concert with physicians to identify and manage chronic

conditions. The program has built-in data monitoring and reporting to facilitate continuous quality improvement on a physician, network, and program-wide basis. Analysis by the Mercer consulting group found that in every year examined (FY2003-FY2006), CCNC achieved savings relative to what the state would have spent under its previous primary care case management (PCCM) program. Estimated savings for FY2006 were \$150-\$170 million.

Criterion 4: Capacity and Support are Available to Address the Problem

CSHCN in Nebraska have difficulty accessing needed health care services. There is a lack of primary care physicians in many areas of the state as well as an overall lack of pediatric specialists. In 2008, 96.7% (90/93) of Nebraska counties had a shortage of pediatricians.³ Diminished access to pediatric subspecialty care harms children and their families and creates costly inefficiencies for the health care system.

Nebraska is fortunate to have many organizations currently collaborating to increase access to medical homes for CSHCN. This infrastructure could be used to pilot a program that would increase capacity for care coordination and expand the medical home model to other primary care practices across Nebraska. The Family to Family Health Information Center at the Nebraska Parent Training and Information, (PTI-Nebraska), working with its partners at NE HHS, the Munroe-Meyer Institute, and the Boys Town Institute for Child Health Improvement can expand its program to pilot a family-led care coordination program in support of primary care practices in Nebraska, using best practices from Rhode Island and North Carolina to increase access to comprehensive, coordinated, quality care in accordance with the medical home model.

Project DOCC (Delivery of Chronic Care) at the Munroe-Meyer Institute improves the quality of care for chronically ill children by

educating pediatric residents about their special needs from a parent's perspective. The Project DOCC curriculum is taught by parent teachers and made up of three components: 1) Annual Grand rounds panel presentation; 2) Home visit – 2 training parents meet with the residents to discuss medical and more holistic aspects of family life for children with special healthcare needs and their families at a family's home; and 3) Parent interview using a Chronic Illness History tool – the resident interviews the parent using the tool which includes a broad range of questions regarding child and family issues, ranging from finances to personal relationships.

Project DOCC's mission is to promote an understanding of the issues involved in caring for a family living with special health care needs regardless of age, diagnosis, or prognosis; to put the family at the center of the health care system.

Criterion 5: Data Exists to Document the Problem

Data utilized to identify this problem is from the National Survey of Children with Special Healthcare Needs (NSCSHCN). The National Survey was conducted by telephone in English and Spanish during 2001 and for a second time in 2005-2006. The survey provides a broad range of information about CSHCN's health and well-being collected in a manner that allows for comparisons between states and at the national level. The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

References:

1. National Survey of Children with Special Healthcare Needs, 2001 and 2005-2006.
2. Sullivan, P., and Knutson, J. Maltreatment and Disabilities: A Population –Based Epidemiological Study. *Child Abuse and Neglect*, Vol.24, No. 10, pp.1257-1273, 2000.
3. Office of Rural Health. Nebraska Department of Health and Human Services. Shortage Areas. 2008.

Post Script:

Why Families Need a Medical Home

The following statements were made by families of patients served in NE MHLC practices. Each practice sent anonymous surveys to 750 patient families to gain insight into how a medical home makes a difference for families. Family experiences from those who DO NOT have a medical home:

- While we always desire anything and everything that can help our son live a healthy life, we are facing yet another year of being buried under medical bills. We would be grateful for coordinated care among doctors to avoid unnecessary or redundant doctor visits, tests, etc.
- I don't feel that enough thought and effort is put into each visit. I felt they want to pass you on to specialists and put you through more expense even when not necessary, just to pass the "buck". Over priced for "on-call" and don't consult worried parents. Overall not very happy with our children's care.
- We went to our doctor, then emergency room, back to our doctor and still ended up with a several day stay at the hospital. We did not feel that our process was well managed. It seemed to be a lack of oversight, (and was) disappointing.
- We have always had good healthcare from our PCP, but no one has ever offered to help with communication or support organizations. I feel the staff could be better educated about our child's health condition (celiac disease) I have made all contacts outside the doctor's office on my own. Many healthcare professionals do not seem to understand celiac disease.

Family experiences from those who DO have a medical home:

- Dr. A's office (as well as herself) is amazing! They remember my son to a "T" every time I call and/or visit. They all assist with any and every need. I don't know if I will ever find such an amazing staff and physician again.
- Dr. B has been an excellent care provider for our family. As a baby our 4 year experienced gross motor delays and Dr. B was very proactive in getting us connected with the public school PT program. We have a perfectly normal and healthy 4y/o now. Recently our 9 mos old started to experience similar problems and once again we were referred to the help we will need.
- I so appreciate Dr. C's expertise and her interest in working with special needs children. It's nice to know she can help me with nonmedical issues as well, such as transitioning to adulthood, vocational training, etc.

Leisha Suckstorf, mother of 7 talks about her 2 children with MCAD and their absolute need for a medical home, given the life-threatening nature of the disorder: "The symptoms of their disease make it imperative for my children to be in constant communication with not only our Genetic Metabolic Specialist, but our primary pediatrician, and our Metabolic Nutritionist. We need to have all our medical providers to be on the "same page" as far as treatment for our child on a moment's notice."

Alcohol Use among Nebraska's Youth

According to the Nebraska Youth Behavioral Risk Survey (2007)ⁱ, 41% of Nebraska youth engaged in alcohol consumption in the past month, and 30% had five or more drinks in one setting (Binge Drinking). Alcohol use, and specifically binge drinking, places youth at serious risk of physical and psychological harm and is a significant precursor to other risky behaviors such as tobacco and drug use, sexual activity, and drunk driving. Research conducted by the National Institute of Alcohol Abuse and Alcoholism shows that youth who use alcohol before the age of 15 are four times more likely to abuse alcohol into adulthood than those who begin at 21¹. Alcohol abuse is the third leading cause of preventable death in the United States and a factor in 41% of all motor vehicle deaths. Unintentional injury is a leading cause of death among Nebraska's youth, overwhelmingly due to motor vehicle crashes.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

Nebraska's indicator value for youth alcohol consumption is worse than the benchmark and not changing significantly over time.

In 2007 41% Nebraska youth reported drinking alcohol in past 30 days far exceeding the HP 2010 objective of 9%. This indicator has not changed over time.

Although, Nebraska's rate of binge drinking is not greater than the national rate, 1 out of 3 youth regularly engage in binge drinking (drinking more than five drinks in a sitting).

According to the Nebraska Youth Behavioral Risk Survey, youth in Nebraska have a significantly higher prevalence of drinking and driving compared to the US average. This concerning trend has continued over the past 5 years.

Criterion 2: Disparities Exist Related to Health Outcomes

Known disparities exist. Males have a higher prevalence of drinking and driving compared to females. This is concerning because males also are significantly more likely to not use seatbelts. There is not a gender difference in binge drinking, but the prevalence is high for both males and females.

National YRBS data reports the Caucasian and Hispanic youth are significantly more likely than their African American counterparts to drink alcohol, binge drink, drive when drinking, engage in sexual intercourse after drinking, and have a lifetime use of alcohol.

Criterion 3: Strategies Exist to Address the Problem

Strong evidence shows preventive strategies to be effective for the youth population.

Numerous alcohol prevention programs have consistently been shown to reduce and prevent alcohol use among diverse youth in both urban and rural settings as well as racial/ethnic backgrounds. Examples of Proven Programs that focus on risk prevention of youth include Life Skills Training, Project Star- Midwestern Prevention Project, Guiding Good Choices, and Project Alert among many others. In addition there are many environmental strategies that include policy and enforcement changes targeted at limiting access to and enhancement of deterrents that are proven to impact adolescent alcohol.

Criterion 4: Capacity and Support are Available to Address the Problem

Capacity and support are growing with potential for more development

With several public and private agencies devoted to alcohol prevention, Nebraska is positioned to combat the alcohol use problem among youth. Alignment and enhancement of these efforts would more effectively serve this cause.

Nebraska Health and Human Services has been working on this issue for many years. In 2001 Nebraska received \$7.5 million in funding for the State Incentive Cooperation Agreement (SICA) which strove to eliminate or significantly reduce substance abuse in youth ages 12-17 by creating a coordinated state prevention system that assists communities to assess local substance abuse needs and select and implement locally-appropriate, effective, and scientifically-defensible substance abuse prevention policies, practices, and programs.

In order to enhance and sustain the substance abuse prevention at the State, regional, and community levels the SICA developed into the State Prevention Framework- State Infrastructure Grant (SPF SIG) that exists today. The SPF SIG works to impact the following three priorities: 1) youth initiation 2) drinking and driving, and 3) binge drinking.

The SPF SIG has developed the **Nebraska Substance Abuse Prevention Strategic Plan** to describe how the program will address each step in the SPF model, including assessment, capacity building, planning, implementation, and evaluation as well as the cross-cutting issues of sustainability and cultural competency. The SPF-SIG continues to work with 16 community and regional coalitions across the state.

Criterion 5: Data Exists to Document the Problem

The data utilized to identify alcohol use as a problem among Nebraska's youth was Nebraska's Youth Behavioral Risk Factor Survey (YRBS). The YRBS is quantitative, high quality data, but not necessarily generalizable.

The YRBS is a reliable and valid survey which includes information about alcohol use among

youth. Although there is YRBS data for Nebraska, urban school districts such as Omaha did not participate, which limits the generalizability of the data collected.

References:

1. Windle, M., Spear, L., Fuligni, A., Angold, A., Brown, J., Pine, D., Smith, G., Giedd, J., and Dahl, R., Transitions Into Underage and Problem Drinking *Summary of Developmental Processes and Mechanisms*. Alcohol Research and Health. Volume 32, Number 1, 2009
2. Brown, S., McGue, M., Maggs, J., Schulenberg, J., Hingson, R., Swartzwelder, S., Martin, C., Chung, T., Tapert, S., Sher, K., Winters, K., Lowman, C., and Murphy, S. Underage Alcohol Use *Summary of Developmental Processes and Mechanisms: Ages 16–20* Alcohol Research and Health. Volume 32, Number 1, 2009

ⁱ These data are based on a non-random, non-representative sample of 1,201 Nebraska high school students and likely underestimate alcohol use and drinking-related behaviors in the urban areas of the state

Obesity, Nutrition, & Physical Activity among Nebraska Youth

Nebraska youth are not meeting daily national nutritional and physical activity recommendations. Failure to meet minimum daily recommendations places youth at increased risk for obesity, high blood pressure, type 2 diabetes, chronic diseases such as coronary heart disease, and even cancer; all positively associated with excess body weight. According to the National Survey of Children’s Health, 2003 & 2007, the percentage of Nebraska youth who are overweight or obese is higher (about 3-fold) than the Health People 2010 objective. While there is no statistical difference between Nebraska and the US with regard to the proportion of youth who were overweight or obese, Nebraska’s ranking fell from 10 in 2003 to 31 in 2007 (1 is best).

Studies have shown that once overweight is established during adolescence, it is likely to remain in adulthood. Addressing the issue at this stage of life has the potential for long-term impact on mental and physical health outcomes.

Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

Obesity, Nutrition & Physical Activity indicators for Nebraska’s youth are worse than the benchmark and not changing significantly over time

National trends in physical activity among our youth have not changed in recent years. And national trends in the prevalence of obesity, weight control, and dietary behaviors indicate an overall worsening of the overall health of our youth. For example, since 1999, obesity levels have steadily increased and fruit/vegetable and milk consumption have steadily decreased.

The proportion of NE youth who were overweight or obese is higher (31%) than the HP 2010 objective(5%).

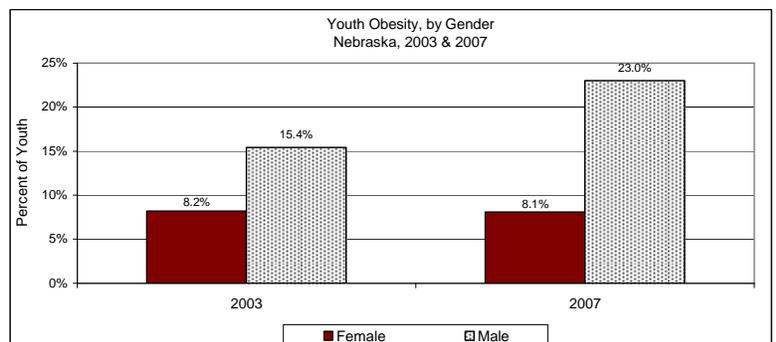
The percentage of overweight and obese youth in NE has not improved over time.

Criterion 2: Disparities Exist Related to Health Outcomes

There is emerging evidence that disparity exists.

Youth at the highest poverty levels carry a disproportionate burden of the youth population’s overweight and obesity problems

Young males are significantly more likely to be overweight/obese. There does not appear to be an erosion of youth physical activity levels. However, young women are more likely to be less physically active than young men.



Criterion 3: Strategies Exist to Address the Problem

There are promising strategies exist but effectiveness with youth is unknown.

Recommendations already proposed in Nebraska:

- Increase availability of fresh fruit and vegetable in schools and communities
- Ensure that milk available at schools is low fat or non-fat.
- Limit or remove soda/junk food vending machines from schools
- Create a structural environment that makes it easy and safe for young people to walk, ride bicycles, and use close-to-home physical activity facilities.
- Encourage school programs to address policies to provide quality daily physical education and health education to help students develop the knowledge, attitudes, skills, behaviors, and confidence to adopt and maintain physically active lifestyles.

Recommendations, evidence-based programs and promising practices can also be found in, *Recommended Community Strategies and Measurements to Prevent Obesity in the US.*¹

Criterion 4: Capacity and Support are Available to Address the Problem

Capacity and support are growing with potential for more development as evidenced by:

- Title V priority the last 5 years
- Nebraska Physical Activity & Nutrition State Plan, promoting health weight and preventing chronic disease (2005 to 2010). The following programs reflect current efforts:
 - All Recreate on Fridays
 - Fruit and Veggies More Matters
 - Whatcha doin? Campaign
 - Project Drink Milk
 - Walk to School Day
 - Youth Physical Activity and Nutrition Assessment Form
 - Local Public Health Department “Blue Print” grants
 - Media-Smart Youth Grants
 - Community Grants
- Michelle Obama’s “Lets Move” campaign

Criterion 5: Data Exists to Document the Problem

Data utilized was quantitative, high quality data, but not necessarily generalizable.

Data are drawn from National and Nebraska YRBS, as well as the National Survey of Children’s Health.

National Youth Risk Behavior survey (YRBS) of 9th – 12th grade students in US public and private schools. Nebraska YRBS is a reliable and valid survey which includes information about obesity among youth. Although there is YRBS data for Nebraska, urban school districts such as Omaha did not participate, which limits the generalizability of the data collected.

The National Survey of Children’s Health is a national survey that was conducted by telephone in English and Spanish during 2003-2004 and for a second time in 2007-2008. The survey provides a broad range of information about children’s health and well-being collected in a manner that allows for comparisons between states and at the national level including Weight Status of Youth (10-17 years). The survey results are weighted to represent the population of non-institutionalized children 0-17 nationally, and in each state.

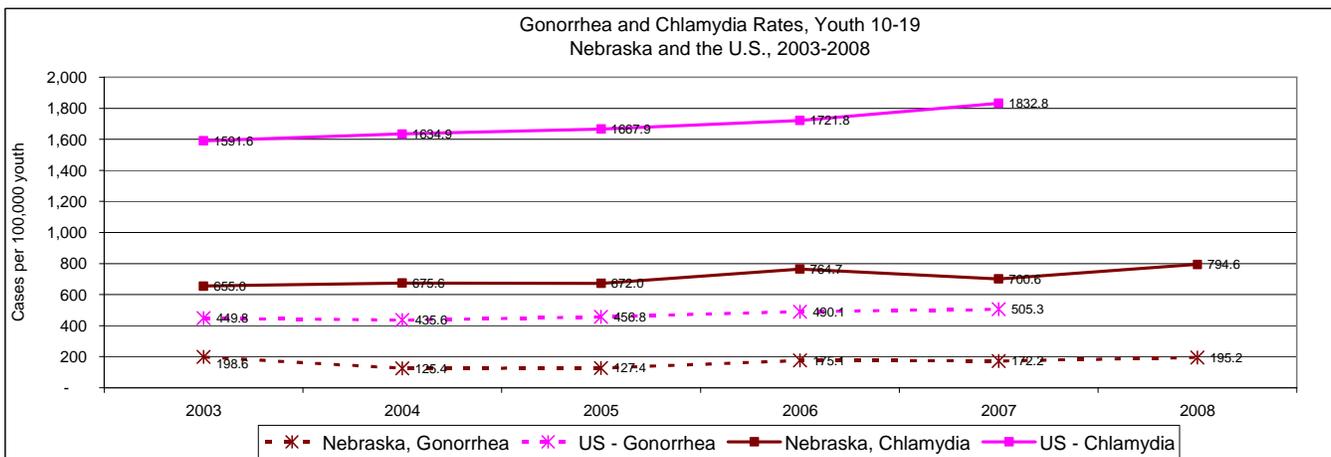
References:

1. Recommended Community Strategies and Measurements to Prevent Obesity in the United States. MMWR Recommendations and Reports 2010 July 24; 58 (RR07);1-26

Sexually Transmitted Disease and Reproductive Health among Nebraska Youth

Nebraska youth are engaging in risky sexual behavior which is leading to increasing rates of STDs and unintended pregnancies. Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on adolescent parents and their children¹. Unintended pregnancies prevent our youth from realizing their full potential and can continue a cycle of poverty. Likewise, sexually transmitted disease (STD) among young people can result in serious health consequences. Immature adolescent reproductive and immune systems make adolescents more vulnerable to infection by various STD agents². Repeated and untreated STDs increase the risk for chronic disease, HIV/AIDS, infertility, cancer and impede healthy adult reproductive lives.

According to the Nebraska DHHS Sexually Transmitted Disease Program, Nebraska rates for chlamydia and gonorrhea are lower than the national rates. However, these rates are higher than the 2010 Objectives increasing 5-year trends. Chlamydia specifically, while not increasing for youth less than the age of 19, is increasing significantly for those over the age of 20. Significant disparities exist. Without prevention and intervention the STD rates among Nebraska youth are likely to continue to rise.



Criterion 1: The Problem is Severe or Increasingly Worse than the Benchmark

STDs and reproductive health indicators for Nebraska's youth are significantly worse than bench marks and getting worse over time, having a significant impact on the population.

According to the 2007 Nebraska YRBS, 42% of Nebraska youth ages 15-19 have had sex at least once. The rate increases to 46% by 11th grade and 59% by 12th grade.

According to DHHS Sexually Transmitted Disease Program the STD rates among youth in

Nebraska are higher than the HP 2010 Objective. Nebraska's adolescent rates for gonorrhea are increasing while rates for chlamydia are not improving among adolescents.

According to Nebraska PRAMS, unintended pregnancy among adolescent mothers (<20) was 74.3% significantly higher than the HP 2010 Objective of 30%.

Criterion 2: Disparities Exist Related to Health Outcomes

There is strong evidence of long-standing and historical inequities resulting in documented disparities in outcomes.

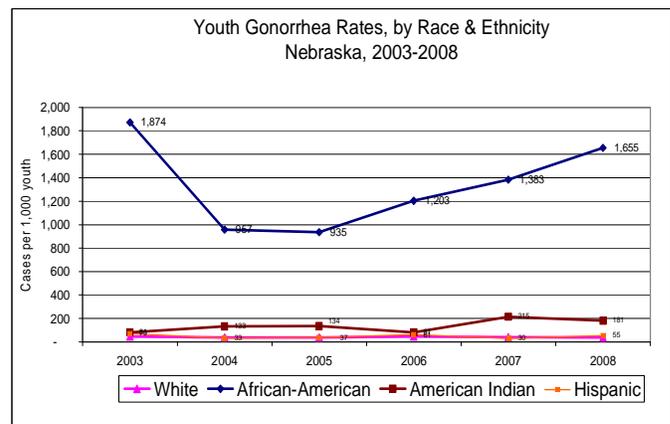
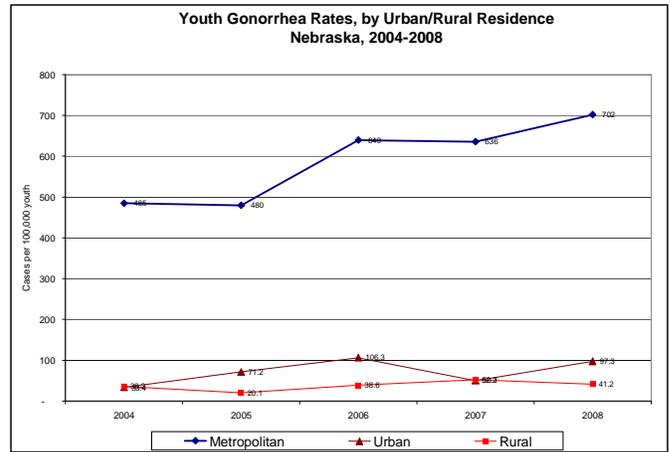
According to Nebraska PRAMS, unintended pregnancy among adolescent mothers (<20) was 74.3% compared to 39.8% for all women who had a live birth in 2007. Of this 74.3% of young mothers 67.9% reported wanting pregnancy later and 6.4% not wanting pregnancy then or at any time in the future.

According to the National Center for Health Statistics, African American and Hispanic youth are more likely to become teen mothers.

Adolescents and young adults have a disproportionate number of sexually transmitted diseases (STDs) compared to adults. In fact, worldwide, the highest reported rates of STDs are found among young people aged 15-19 and 20-24. This is especially true for racial and ethnic minority youth populations, youth living in low socio-economic neighborhoods and among youth in metropolitan and urban areas.

According to DHHS Communicable Disease Program, 36% of all chlamydia cases, 31% of all gonorrhea cases and 15% of all genital herpes cases occurring in Nebraska presented in youth aged 19 and under during 2006

According to DHHS Communicable Disease Program, rates for Gonorrhea and Chlamydia are significantly higher in metropolitan/urban areas than in rural areas and among African American females.



Criterion 3: Strategies Exist to Address the Problem

There is strong evidence that preventive strategies can be effective with youth.

Evidence at the national level confirms that strategies are available to address sexual behaviors that contribute to unintended pregnancies and sexually transmitted diseases among our youth. Strategies that address the broad spectrum of high-risk sexual activity among youth including preventive strategies that decrease the age of sexual debut, and improves use of contraception favorably impacts the rates of STDs and unintended pregnancy.

According to the National Campaign to Prevent Teen Pregnancy resource *What Works*, 24

programs have been proven to be effective through evaluation using an experimental design. That is, participants are randomly assigned to treatment and control groups. As a general matter, programs that have been evaluated using an experimental design provide stronger evidence of effectiveness than those using a quasi-experimental design resulting in weaker evidence of effectiveness. Six additional programs fall in the latter category.³

Criterion 4: Capacity and Support are Available to Address the Problem

Capacity and support to address the problem exist but are limited or of unknown duration.

Public and political will to address the problem is increasing both at the federal and local levels. The reality of the STD epidemic is gaining recognition as an issue in need of prevention. Federal funding to address teen pregnancy and sexual responsibility has been included in the President's FY 2010 budget as well as the Health Reform bill recently signed into law.

Multiple local supports are in place to address the problem including:

- o University programs and/or health clinics including UNMC, UNO, UNK, UNL, Creighton, Wayne and Peru State.
- o Non-profit organizations across the state including Girls & Boys Clubs, Boys Town, NE Children's Home, crisis pregnancy centers.
- o Local/county level health department on-site health clinics including DCHD, LLCHD and East Central District Health Department.
- o DHHS STD Program - Clinical environments for free testing - 100 sites statewide. Additional referral services through local health departments statewide.
- o Federally Qualified Health Centers including Charles Drew, One World Health Center, Peoples Health Clinic, Panhandle Community

Services, Good Neighbor Community Health Center, Norfolk Community Health Center.

- o Title X Family Planning Delegates - 29 sites (30 by summer 2010).
- o Indian Health Services.

Criterion 5: Data Exists to Document the Problem

The data utilized to identify this problem was quantitative, high quality and generalizable. Data was drawn from National Center for Health Statistics, state YRBS and PRAMS, and DHHS Sexually Transmitted Disease Program

The 2007 YRBS data are based on a non-random, non-representative sample of 1,201 Nebraska high school students. Urban school districts such as Omaha did not participate, which limits the generalizability of the data collected. Therefore the results likely underestimate sexual behaviors in urban areas of the state and among racial/ethnic populations.

NE PRAMS is a population-based survey on topics related to pregnancy. The PRAMS sample of approximately 2500 (10% of births) is drawn from the state's birth certificate file. Some groups are sampled at a higher rate to allow sufficient data for smaller but higher-risk populations.

Surveillance data for DHHS STD Program is an aggregate of cases from notifiable disease reports.

References:

1. Adolescent Reproductive Health, CDC
2. Cates W, McPheeters M *Adolescents and Sexually Transmitted Diseases, National Research Council Workshop, Washington, D.C. 1997*
3. National Campaign to Prevent Teen Pregnancy, *What Works*