

Report of Public Input: Title V / Maternal and Child Health (MCH) Block Grant

**July
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This report summarizes the public input received by Nebraska Department of Health and Human Services (DHHS) during the development of the FY 2013 application for the federal Title V/Maternal and Child Health Block Grant.

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Nebraska's FY 2013 Title V/MCH Block Grant Application: a report on public input

This report summarizes the public input received by the Nebraska Department of Health and Human Services (DHHS) during the development of the FY 2013 application of the federal Title V/Maternal and Child Health Block Grant. The report features additional background information to the statewide priorities, the annual application, and the statutory purpose of public input in the development of the plan to meet the needs identified in the five-year needs assessment.

The application for the prior period (FY 2012) is available in the Title V Information System (TVIS). Visit <https://mchdata.hrsa.gov/TVISReports/> to review Nebraska's application with an added feature to compare it to other states and jurisdictions. Current applications are available typically in mid-September for the fiscal year beginning October 1.

Title V of the Social Security Act - Maternal and Child Health (MCH) Services Block Grant

Since 1935, the federal government has pledged its support of Title V of the Social Security Act, making it the oldest, continuously funded public health legislation in U.S. History. States and jurisdictions are allocated funds based on a formula through the federal Maternal and Child Health Bureau (MCHB). Acceptance of federal Title V funds imparts responsibility to the State or jurisdiction to:

- Assure the health of all mothers and children in the state;
- Provide and promote family-centered, community-based, coordinated care (including care coordination services for children with special health care needs) and to facilitate the development of community-based systems of services for such children and their families;
- Identify specific health needs of the population through a five-year statewide needs assessment and determine health priorities;
- Submit an annual plan for meeting the needs identified by the statewide needs assessment; and report annually on performance measures;
- **Make the application public within the state to facilitate comment from any person during its development and after the application is submitted;**
- Provide a toll-free "hotline" telephone number (Nebraska's Healthy Mothers Healthy Babies Helpline is 800-862-1889);
- Comply with all rules and regulations governing federal financial assistance.

Maternal Child Health (MCH) is implied to include children with special health care needs (CSHCN) in addition to where CSHCN are specifically referenced. MCH has many subpopulations, e.g. pregnant women, infants, children (including adolescents), children with special health care needs, women of childbearing age, and their families using a family-centered care approach.

Public input

Nebraska Department of Health and Human Services (DHHS) sought public input in the preparation of its annual application of Title V/Maternal and Child Health (MCH) Block Grant. The application was submitted by July 16, 2012 to the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). It provides the activities and budget for the period October 1, 2012 through September 30, 2013, the fiscal year (FY) 2013.

Methods

An email notification requesting public input was sent to a 325-address distribution group comprised primarily of representatives of Nebraska-based organizations interested in maternal and child health (MCH) and children with special health care needs (CSHCN). DHHS asked that the notice be shared with colleagues, consumer advisory boards, and clients, and as appropriate to assist consumers and families to prepare and submit their comments. The notice included the webpage link http://dhhs.ne.gov/publichealth/Pages/lifespanhealth_planning_index.aspx where additional background information and guidelines on how to prepare and submit comments were available. Visitors to the webpage may electronically subscribe to receive email notice whenever the page is updated. As a result, page subscribers received notification by that method, if not by the email group notice. Two methods, meetings and written comments, were used to receive public input.

In April 2012, information was shared in meetings held in Ogallala, Kearney, Norfolk, and Lincoln. These locations were selected based on a two-hour driving distance of population centers. Meeting facilitation was provided by DHHS staff. Paula Eurek and Rayma Delaney represented the Division of Public Health, Lifespan Health Services Unit. Heather Krieger represented the Division of Medicaid and Long Term Care, State and Grant Funded Programs Unit. An information packet was developed as a handout to correspond with brief presentations by DHHS staff. Thirty-eight persons representing a variety of organizations and communities participated in the meetings. Comments heard by the facilitators during the 2.5 hour meetings were gathered and summarized for this report. The evaluation of meeting process is summarized later in this report.

Written input was another option for the public to comment on the annual application. The background information and guidelines how to prepare and submit comments were available at the DHHS webpage. The original request was to submit comments by April 23. The date was extended to June 1. Representatives of three local health departments and one Nebraska-based national organization submitted written comments.

Statewide MCH/CSHCN priorities

The annual application requires a plan to meet the needs identified in the statewide assessment which is required be conducted every five (5) years. Under Title V, the assessment shall identify the need for:

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

The most recent statewide Needs Assessment was conducted during the period of spring of 2009 through July 2010. DHHS called upon a large group of persons across Nebraska representing MCH and CSHCN to provide their perspectives. This Needs Assessment addresses the Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) populations in Nebraska and establishes priorities for the years 2010-2014. The assessment guides the priority-setting to invest resources such as time, expertise, and money. Not all priorities identified in the Needs Assessment can be addressed by MCH Block Grant funds. If a priority need(s) is being addressed by other resources, the Block Grant funds may be invested in priorities that do not have enough resources to address the needs sufficiently and/or where strategies can be used that impact more than one priority. It should also be noted, that while the MCH Needs Assessment is a requirement of Title V, it informs and guides planning and program development beyond that supported by the MCH Block Grant. The statewide priorities are used in this report to organize comments in the subsection 'areas of need'.

The full report of the five-year, statewide needs assessment is available at <http://dhhs.ne.gov/publichealth/Documents/NeedsAssesmen2010FINAL.pdf>.

Summary of comments

The following are comments summarized from 38 participants in four meetings and four persons submitting written comments. All input came from representatives of organizations, many of which are providers of services to MCH/CSHCN. Family members or consumers of services were represented based on comments from provider organizations. Comments are summarized by categories and organized in subsections: A. Areas of need; B. Interventions; C. Barriers & gaps; and, D. Suggested improvements.

A. Areas of need. *How do the state-level priorities compare to the most important health needs of mothers, infants, children, and adolescents in your local community?*

This subsection includes community insight to the statewide MCH/CSHCN priorities, and other needs in their communities. The comments are summarized by state-wide priorities, followed by additional comments that are listed by categories indirectly aligned with the statewide priorities. Comments are from all four meetings and from written input.

Comments by statewide MCH/CSHCN priorities (*numbered for reference*).

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

- A number of women are entering pregnancy overweight.
- Obesity is a cross-cutting issue.
- Schools have made progress in increasing physical activity, but more needs to be done to improve nutrition of food service programs.

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

- In remote areas it is more than a one-hour drive to access reproductive health services.
- STDs can affect a woman's ability to conceive and can infect and harm her baby. A pregnant woman with an STD may experience miscarriage or preterm delivery. The STD can have harmful effects on her baby, including still birth, birth defects, blindness, pneumonia, and neurologic damage, to name a few.
- There are no providers for uninsured and undocumented women; the federally qualified health center is the only place to refer and it is overtaxed.
- HIV positive clients are very sexually active, as stated by a family planning organization.
- Teen pregnancy seems to be increasing in Northeast Nebraska, seeing 11 pregnant teen clients in the last three months, believed by them to be associated with limited hours for family planning services in the region. Reproductive life plans are being promoted through schools, but some schools' policies limit this. More parents than in prior years are asking to preview videos due to interest and support, not to censor content. Physicians' offices take the reproductive life plan document but do not implement using it with patients, believed may be due to time rather than hesitancy to introduce the topic.
- Local physicians concerned with chlamydia rates.
- Sexual partners must be tested and treated if their partner has STDs, otherwise the female comes back in repeatedly.

Statewide priority 3: **Reduce the impact of poverty on infants/children including food insecurity.**

- Strategies are needed to address issues of poverty which are often centered around race. There are many issues, e.g. financial and political.
- Figure out balance between interventions with individuals and community-level interventions to really make a difference.
- Increasing impact of poverty in rural counties, with decreasing engagement of parents; more apathy.

Statewide priority 4: **Reduce the health disparities gap in infant health status and outcomes.**

- Health disparity has an economic connection. The ability to earn money and have health care provides access to prenatal care.
- The gap in racial disparities is evident when looking at the preterm birth rate by race/ethnicity with the high for Blacks (17.2%) and the low of 11.0% for Asians. While the infant mortality rate in Nebraska has declined by more than 9%, rates still show large disparities by race/ethnicity.
- Co-sleeping is across age and culture.
- Medicaid non-coverage of a service that is covered by private insurance widens disparities.
- Translation and interpretation services are a huge cost to agencies. If the translation/interpretation is not good, disparities persist.

Statewide priority 5: **Increase access to oral health care for children and CSHCN.**

- Issues continue with dental hygienist scope of practice.
- Follow-up with Medicaid clients who missed appointments will no longer be contracted separately. Starting July 1, follow-up will be provided through the Medicaid managed care contracts expanded to the remaining 83 counties, however it will not include dental and mental health as did the prior public health nursing contracts with local/regional service providers.
- Lots of dentists won't take kids because that age is more difficult, and there's limited pediatric dental training.
- Many dentists will not accept Medicaid-covered clients.
- Case treatment plans require a case manager to ensure patient follow through.

Statewide priority 6: **Reduce the rates of abuse and neglect of infants and CSHCN.**

- Lots of referrals to the hotline, but we stopped calling because there's no response. They say it's hard to substantiate; it's neglect if not abuse.
- Reports are made but with no or limited response through the hotline; negative outweighs the positive.
- There can be issues of law enforcement jurisdiction.
- A warning sign is that reports are going to public health and law enforcement if protective service does not intervene.
- Children are at greater risk during holiday breaks.
- There is a supreme lack of coping skills, a generational shift in parenting skills. Less personal responsibility.
- The sex offender statute does not include distance from daycare homes even if the daycare home is licensed.
- Case management is a critical component across organizations to wrap around the person.
- A positive parenting approach is needed, and one that works around parents' schedules.

- Several participants said incentives work to increase participation. Another participant emphasized that incentives are not used because they have discovered a Hispanic group leader helped bring others along. They are considering trying this approach with the Anglo culture.
- Increase teen parenting skills.
- By observation there are three components of abuse/neglect: mental health issues, domestic violence, and cognitive impairment.

Statewide priority 7: **Reduce alcohol use and binge drinking among youth.**

- Funding is ending for Strategic Prevention Framework State Incentive Grant (SPF SIG) Program. At a minimum, beverage server training, compliance checks, and sobriety checks should continue.
- Underage and binge drinking go hand-in-hand with juvenile justice.
- Support is needed to engage communities to address, and to do so in cooperation with existing but related community initiatives, i.e. teen pregnancy prevention, Safe Kids, Safe Routes to School, etc.)
- Treatment for substance abuse is limited, and it affects parenting.

Statewide priority 8: **Increase quality of and access to perinatal health services, including pre/inter-conception health care, prenatal care, labor and delivery services, and postpartum care.**

- We support the priority to increase quality of and access to perinatal health services, including pre/interconception health care, prenatal care, labor and delivery services, and postpartum care.
- Interconception care is not ‘well woman care’.
- We see a lot of maternal depression, and the cycle is hard to break. There are long waiting lists to treat maternal depression and even a few days may as well be a few years. There are a lot of crises not well addressed.
- There is a shortage of certified diabetes educators and no endocrinologist in Northeast Nebraska. Endocrinologists from outside the region are reluctant to use telehealth because there is no education available to provide diabetes management.
- Guidelines are needed on early screening for diabetes. A1c testing is done at the first prenatal visit, which may actually be the first detection of Type II, and not gestational diabetes.
- The process to determine Medicaid eligibility using the new eligibility system (AccessNebraska) is not as specialized or a customer-friendly approach as before. Pregnant women have reported an abruptness when asked about documentation of citizenship. A three-hour wait time is costly.
- Clients that are in the application process for citizenship are fearful of messing up that process by seeking a service, e.g. translation. A reversal of parent/child roles is seen in clients of a minority race or culture.
- Pregnant teens may be insured under their parents’ private insurance coverage, but not for prenatal care services. They are ineligible for Medicaid.

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

- Financial resources are needed for continued training and support to providers.
- There are no baby-friendly standards in hospitals for breastfeeding. Labor and delivery nurses have mandatory training. It seems hospitals rely on financial incentives from formula companies.
- A former lactation consultant let their certification expire because it was inadequate in the hospital where lactation support is too little, and then it is too late upon hospital discharge.
- A large hospital in central Nebraska is losing lactation consultants.
- After hospital discharge, with increasingly short stays, there are separate charges for breastfeeding support.
- Visiting Nurses Association (VNA) has three lactation consultants, but restricted to home visiting program.
- System issues; it is hard to know what resources are available.
- Doctors are giving bad information regarding breastfeeding.
- Seeing great success in duration from WIC breastfeeding peer counseling.
- Peer support with professional-level support is important.

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

- A public clinic seems to get difficult clients referred there from private clinics.
- Besides resources, it requires motivation of families to engage in self-care and health promotion.
- A federally-qualified health center promotes medical home, but not as much dental home, and not having a medical home is worsening. It is a shortage area for both medical and dental.
- Clients say they have a medical home, but are not using it, and then need it and they cannot get in as soon as needed.
- If the new Managed Care Organization (MCO) works as it should, it may be good, although there has been a loss of client rapport with the change to AccessNebraska. Concern that gains may be lost. The change in process was more challenging relative to language and culture differences. Undocumented persons are fearful of phone numbers they do not recognize.
- Need brokerage activities to ensure bridging for medical home
- Navigators are especially needed in medically-complicated cases to help patient get through healthcare system.

Input by other categories indirectly aligned to state priorities
(numbered for reference)

11. Injury

- See lots of need for car seats.
- Parents are recycling car seats, so there is a need to inspect for safe re-use of seats.

12. Early development

- Late identification of developmental delays occurs in geographically remote areas.
- Public health nursing program does good job with early identification of needs.
- Children with special health care needs “screen out”, i.e. do not qualify for school services due to schools’ limited funding.

13. Immunizations

- There are multiple, complex issues related to provider type, if shots are incorporated into another type of service, third-party payer and insurance plan coverage, e.g. in a Medicaid-covered well child visit the provider cannot bill the administration fee, resulting in the consumer not getting shots, yet unlikely to travel back to the provider to get the shots later. “It’s a lost opportunity.” Coordinated billing is needed.
- Immunization waivers get signed more from convenience rather than concern with safety, limiting opportunity for medical home.
- The Vaccines for Children (VFC) program has restrictions and the unrestricted* Section 317 funded vaccines are a much smaller funding source. There is not enough funding for public vaccine clinics, and would like to have VFC providers required to use NESIIS (Nebraska State Immunization Information System); it would help schools get records.

*to change effective October 1, 2012, as per the Center for Disease Control (CDC).

14. Mental health and substance abuse

- There is limited access to mental health services across all age groups.
- Employee Assistance Program (EAP) through business supports is one solution.
- Very limited facilities to treat severe mental illness and up to 6-month wait, resulting in emergency protective custody being the option.
- Compliance with prescription drugs for treatment of mental illness requires follow-up.
- Bullying is a problem, and perhaps worsening due to social media.
- Identifying maternal depression is difficult, and referral does not guarantee follow through probably due mostly to money, transportation, child care, and scheduling.
- Increasing suicide rates in western Nebraska.
- Lack of substance abuse treatment programs, especially transportation and child care.
- Accessing linguistically appropriate services is difficult for refugee women experiencing post-traumatic stress.

15. Non-medically indicated inductions and C-sections

- Good Samaritan Hospital in Kearney does not schedule C-section before 39½ weeks.
- A clear definition is needed for non-medically indicated inductions and in conjunction with tubal ligation.
- The risk of vaginal birth after Cesarean (V-BAC) is a consideration.

16. Preterm birth

- There is limited prenatal education, e.g. teaching pregnant women to count the number of baby kicks.
- Fetal Infant Mortality Review (FIMR), a component of the Baby Blossoms Collaborative, recognizes circumstances of preterm labor that led to infant deaths in Douglas County (Omaha).

One commenter conducted its own online survey of local stakeholders who indicated that 6 of the 10 state-level priorities do not align with their local issues or concerns. Another commenter stated that 7 of the 10 priorities are among the high priorities in its local community health improvement plan.

B. Interventions. *What programs and services do communities have to help address these priorities?*

This subsection summarizes comments regarding a variety of interventions to address needs. These comments are from all four meetings and from written input. The webpage links are added to this report for additional information regarding these interventions.

- Baby Blossoms Collaborative (BBC) is a partnership convened by the Douglas County Health Department, and includes MCH providers serving the Omaha area. BBC's mission is to create an atmosphere where all babies have an opportunity to blossom.
<http://babyblossomsomaha.org/images/stories/BBC%20one%20pager/bbc%20who%20what%20when%20why%20flyer%202011.pdf>
- Work on good 'safe sleep' messaging from doctors, e.g. nap and night. Need open dialogue to problem solve solutions that take an intergenerational approach. Finish child care regulations.
- The Maternal Care Program at the University of Nebraska Medical Center (UNMC) posts in its facility's bathrooms illustrations comparing a baby's brain at 36 weeks and 40 weeks to emphasize the critical importance of full-term delivery.
http://www.unmc.edu/obgyn/maternal_care_program.htm
- A Medicaid Managed Care provider offers a 'PakNPlay' as an incentive to pregnant women upon completion of seven prenatal care visits, and also a gift card at the 6-month postpartum visit.
- Worksite wellness is changing community norms, along with reproductive life planning.

- Workplace wellness addresses nutrition and physical activity. Biometric screens done as part of workplace wellness helps detect diabetes.
- North Platte has coordinated school health with physical activity, e.g. walking before school.
- Cooking classes are offered at the food pantry in North Platte.
- “Stewards of Children” is an excellent training for the prevention of child sexual abuse.
- ACES (adverse child experiences) is an indicator of risk for many events.
<http://blog.unmc.edu/publichealth/2012/06/05/the-wide-ranging-public-health-impact-of-adverse-childhood-experiences-2/>
- “Babies from the Bench” training is part of the Through the Eyes of the Child Initiative <http://www.throughtheeyes.org/about.php>. A principal tenet is that Nebraska’s judges must take an active leadership role in improving the court process in child protection cases. Judges have enormous respect from the community and court stakeholders, as well as great responsibility in the judicial system. Judges have the greatest ability to improve the lives of foster children through systems change and procedural improvements within their courts.
- West Central District Health Department and Third City (Grand Island) have dental programs.
- Public Health Solutions, a local health department in southeast Nebraska, is involved in dental day program with the dental college. It has a school sealant program. Sixty community and hospital nurses are trained in breastfeeding within the local health district but only 6 certified due to limited resources. Safe Routes to Schools allowed removal of one barrier in each county, and made significant increases in physical activity. Promote breastfeeding in the hospital, and do not offer free formula. Milk Works has option for human milk to premature babies. Plant the idea of breastfeeding early in reproductive life planning. Case management program for Medicaid-eligible and uninsured has been effective in controlling diabetes through education and case management, which has a positive influence on diabetic mothers’ children. Attended Healthy Families of America training to prepare for expanded home visitation. We have established strong partnerships with critical access hospitals in our area as they are the backbone of rural health service delivery.
- WIC local agencies have breastfeeding peer support.
- “Ready, Set, Deliver” education and a nurse on staff in the Grand Island schools helps pregnant teens know the signs of labor.

- Incentives work, e.g. “Baby Bucks” to get pregnant women and fathers parenting education.
- Parent Partners is a case management model that focuses on family support through physician practices in Hastings, Lincoln, Omaha, and Plattsmouth. While the physicians attend to the medical needs of children with special health care needs, case management strives to minimize stressors in the family. Using Parent Partners, doctors can see more patients in a day, which lowers costs. As of April 2012, there is almost 18 months experience with this grant and will evaluate soon.
- Aged & Disabled Resource Center (ADRC) has an 800 # for the geographic area. There are 8-10 regional hubs, need one primary contact by community. ADRC has all types of partners and is building local networks, e.g. the public library in Syracuse. May evolve into case management. Universal not just for aged or disabled. Looking for leadership model in each community in Nebraska; models will vary by community.
- Local health departments expect to continue receiving calls, despite the public health nursing follow-up services going to the expanded Medicaid Managed Care contracts. Local health department directors are coordinating an effective response to these inquiries.
- Connect to the 211 system as a method to recognize the many good things happening in the public health system. Answers4Families <http://www.answers4families.org/> and 211 <http://www.uwmidlands.org/211> are in planning now.
- A local Lyons Club in Northeast Nebraska can provide eye glasses to non-Medicaid eligible children, but it does not have enough financial resources to meet all requests.
- Although there is limited funding for mental health services, there are partnerships that help with coordination of services.
- Utilize telehealth for mental health services.
- Nebraska ChildFind <http://www.childfind.ne.gov/> evaluate children for developmental delays, assists family with appropriate educational services to meet the needs of the child.
- “Safe with You” curriculum is used to train child care providers to meet safety and developmental needs of children.
http://www.nebraskachildren.org/what/prevent_child_abuse.html/title/safe-with-you-curriculum
- Schools are a venue to reach groups of children and teens on various topics through assemblies and programs, e.g. Rachel’s Challenge
<http://www.rachelschallenge.org/LearnMore/MeetRachel.php>.

- Use Bright Futures <http://brightfutures.aap.org/> in school-based health centers and expand into child care centers, e.g. EduCare in Omaha (two locations) <http://www.educareomaha.com/> and EduCare in Lincoln (opening January 2013) <http://www.educareschools.org/locations/lincoln.php>.
- Mental health and substance abuse often interact. Treatment for pregnant women with addiction does not work in outpatient setting and inpatient treatment is unavailable. In Sidney, an influential judge convinced landowner to co-locate supports in an apartment complex to increase effectiveness of treatment.

C. Barrier and gaps. *What barriers or gaps could be overcome through better coordination?*

This is a summary of comments regarding barriers or gaps. Comments are from all four meetings and from written input.

- Lack of connectivity and awareness by lay and MCH providers of available resources provide the greatest deficits for coordination. Communication and better coordination of priorities and services were highlighted as the two primary ways of overcoming gaps and barriers. These concepts appear to be galvanized under the framework of a 'medical home' model.
- Limited access in this rural area to STD tests. Rural and parochial schools have limited access to physical education in school.
- Coordination is needed for payments for services based on provider type, e.g. Medicaid pays for circumstances in clinic, but not in the hospital at birth.
- Get robust program evaluation is important. Funding sources are getting much smaller, and take as much work as larger funding. We need to make projects big enough to do something.

D. Suggested improvements. *What would improve the health of MCH/CSHCN?*

This is a summary of suggested improvements. Comments are from all four meetings and from written input.

- We are trying to get kids connected to dental homes but lack access due to badly needing resources to develop alternatives. Portable dental equipment is needed to support the growing dental day program, and we will bill Medicaid when program is established.
- Overall we believe it is important for funders to recognize the importance of supporting the integration of services and integrated community initiatives. Local health

departments have assurance role which can only be accomplished if recognized and supported by funders.

- Getting involved is the best way to promote the health of women, infants, children, adolescents, children with special health care needs, and their families.
- Legislation is needed to ensure all women receive prenatal care regardless of citizenship status, contributing to a positive health trajectory.
- Focus on early childhood, access to mental health services, and place greater emphasis on father involvement.
- Use the telehealth network as much as possible to increase access to services.
- Reach mothers to impact their children. In Omaha the percent of working moms is 80%, so daycare is a good outlet for information, e.g. Bright Futures. Co-locate services in daycare, e.g. Early Development Network and AccessNebraska at EduCare facilities.
- Certain issues are often generational, e.g. poverty and unhealthy relationships, making the need harder to break the cycle.
- Incorporate information on breastfeeding into reproductive life plans.
- Co-locate supports
- Need to address issues at a policy-level, e.g. welfare and single motherhood. We've created a 'perfect storm' where even informal supports are not available. For example, grandparents are working longer due to the economic conditions and cannot provide child care assistance to their adult child raising children in poverty.

Evaluation of meeting process

A process evaluation was conducted at each meeting location using a written instrument. Responses were summarized by site.

1. **Ogallala, Nebraska** (n = 6; 100% response rate)

Six participants at the Ogallala site represented Gering, Hemingford, Ogallala, Scottsbluff, and the counties of Keith, Arthur, Grant, Hooker, and Thomas. All attendees heard about the meeting by email notification. Participants indicated the meeting location was acceptable and that enough locations were offered. One person suggested videoconferencing as an option for future meetings. The timing of the meeting was rated excellent by two participants, three rated the timing good, and one rated it as fair. All indicated there was enough time allotted for

the meeting, the content was appropriate for their interest and needs, and that they were satisfied with the opportunities to participate.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

Better outcomes/strategies, improve program. Affirming the priorities and evidence-based strategies. Facilitators seemed to really care about what was said and I think they will use it to guide planning. More understanding by MCH team regarding area programs and lack of resources.

“Please provide feedback on the structure of the meeting . . . “

Went very well, good interaction for a small group. OK. Well facilitated and facilitators listened and are knowledgeable. Structure worked well for the small group.

“Please provide your recommendations for soliciting public input in the future . . .”

Social media, local health departments. Keep us informed so we can get word out. Hard to get people to travel. Encourage local professionals to engage in soliciting invites. Thanks for coming to Ogallala; further west is OK, too. Learned a lot; glad I attended. More planning members invited (mental health, law enforcement, probation, school/Head Start). Send information to civic groups or task a person to contact those groups.

2. Kearney, Nebraska (n = 11; 100% response rate)

Eleven persons participated at the Kearney location, representing Grand Island, Holdrege, Lexington, Kearney, and North Platte. Two persons were notified about the meeting by someone else; others received the information by email. All participants said the location of the meeting was acceptable, and that enough locations were offered. The timing of the meeting was rated excellent by four attendees, good for six persons, with one participant giving it a fair rating. All 11 persons stated there was enough time allotted for the meeting, that they had enough time to express their views, the content was appropriate for their interest and needs, and that they were satisfied with the opportunities to participate in the meeting.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

Knowledge gained from this meeting will be valuable to take back to the community to create more awareness. Information will be shared. More education provided to the populations discussed. Funding provided to rural community to educate. The facilitators provided great information. Input from various service providers was helpful. There are services in this area that I wasn't aware were available for clients. Improve health of reproductive age women, infants, and improve access to health care. The information is expected to be utilized in planning and decision making. Issues and concerns to be addressed and hopefully put in MCH priorities and plans. Appreciate the opportunity to participate in discussions. Hopefully our views will be heard and incorporated into future plans and funding priorities.

“Please provide feedback on the structure of the meeting . . . “

I appreciated the openness of the meeting and the willingness to share information. Like the opportunity for the entire group to participate on the subject rather than limiting it to several smaller groups. Enjoyed being able to share as a fairly small group. It helped to facilitate discussion. Good. Meeting structure allowed open participation and communication. I thought it was great! Allowed for open discussion.

“Please provide your recommendations for soliciting public input in the future . . .”

I appreciate being able to meet in person. Like face-to-face. Although I enjoyed the small group I was surprised that the attendance wasn't higher. More advertising to draw more attendance. Include school representative/school nurse, possibly a hospital social worker.

3. Norfolk, Nebraska (n = 7; 100% response rate)

Seven participants in Norfolk represented Macy, Norfolk, Pender, Wayne, and Wisner. One person learned about the meeting from someone else, and other respondents received notification by email. All participants said the meeting location was acceptable. Two responded that there were not enough locations offered. Four attendees rated the timing of the meeting good, three rated it excellent. All participants felt there was enough time allotted for the meeting, that they had the right amount of time to express their views, the content of the meeting was appropriate for their interest and needs, and that they were satisfied with the opportunity to participate in the meeting.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

More feedback and quicker response for child protection. Outlines and expectations for new grant. Reconsideration of priorities and possibly of funding allocations.

“Please provide feedback on the structure of the meeting . . . “

Small group is great, questions proposed by facilitators helps to get conversations going. I liked that it was open. Great input; good participation from everyone. Very effective. Very good; informal; nice to be in a group where a conversation-like atmosphere works.

“Please provide your recommendations for soliciting public input in the future . . .”

Maybe a couple more meeting spots; it gave great information. Telehealth is nice as well as email, although I prefer face-to-face. Federally-qualified Health Centers. Put notices in healthcare facilities and through public health program clinics and services.

4. Lincoln, Nebraska (n = 14; 86% response rate)

Fourteen participants in Lincoln were from Hastings, Lincoln, Niobrara, Norfolk, and Omaha. Most attendees received notification by email, and several received the information from others. All participants replied that the location of the meeting was acceptable and that enough locations were offered. Two persons stated they would have liked an Omaha meeting location. The majority rated the convenience of the meeting time as 'good', several rated it

excellent, and one gave it an average rating. The majority felt the amount of time was right to express their views, with one person commenting that the two-hour format was good and another statement was that it was perfect. Three persons would have liked more time to express their views. All respondents felt the meeting content was appropriate for their interest and needs, and that they were satisfied with the opportunities to participate in the meeting.

Additional responses to evaluation questions:

“What do you anticipate will come from your input?”

Report back in how the scarce funds will be used to address issues raised. Potential for improvement in systems that affect my community. Priorities for funding. Future resources in the community. Would hope input from those ‘doing the work’ would impact program/policy decisions. Great to be able to express what is working and then issues in the community. I would anticipate the input will be taken to the state level. Suggestions will be looked at and evaluated as priorities for new dollars available. Unsure; but I trust the thoughtfulness of the state MCH team. Ideas will be looked at and needs implemented. Our input will help shape the state emphasis on next grants.

“Please provide feedback on the structure of the meeting . . . ”

Liked the open forum. Great structure for the number of people there. Very good. Nicely done. Liked it. OK; disappointed there was not a bigger turnout, but agencies are stretched very thin. Good structure. Everyone had an opportunity to give input. Good set up. Good; I liked the flexibility allowed for different discussion threads. Great. Open discussion was excellent.

“Please provide your recommendations for soliciting public input in the future . . . ”

Continue to use both face-to-face and internet access. More sites, especially one in Omaha. In-person meetings are good. No changes. I think there were a number of voices missing from the conversation, not due to lack of interest but timing and conflicting priorities. I would recommend additional meetings at other times and in other cities. This type of public input worked well, generated discussion. Provide questions and materials before the meeting. As it was today!! Did you include educators?

Conclusion

Public input meetings were conducive for interactive dialogue between facilitators and participants, and between participants. Several participants said they left with more knowledge about their community than they had when they arrived. It is believed that this method contributed to an increased understanding on the part of both facilitators and participants. The commitment of time by facilitators and participants is an important factor in this method. Calculating round trip travel time and the meeting length, the time investment by an individual participant was a minimum 3 hours and as much as 6.5 hours or more depending on participants’ availability to attend the site closest to their place of origin. The facilitators individually logged 26.5 hours for the four meetings. Participation in public input meetings was

voluntary. Presumably, participants representing organizations were paid by their employer for their time, however, no expenses for mileage or meals were reimbursed.

The method of written comment eliminated the travel investment of time and expense. However, this method may or may not have minimized the time investment to prepare comments. Commenters were thoughtful in their presentation of ideas, including one commenter that surveyed stakeholders to prepare written comment that represented a group. Three commenters solely used the written comment method. One commenter was also a meeting participant. Written input allows flexibility to prepare and submit comments when it is most convenient. On a less positive note, the method of written comment does not lend itself to interaction with DHHS staff or with other commenters. Written comments eliminate DHHS staff time to document the comments, i.e. because it has been submitted already in written form. In prior requests for input, the written input method garnered more than the four written responses received in the present request for input, however, less than 38 responses which represents the number of persons participating in meetings in the present comment period.

In the present comment period the number of meeting participants (n=38) exceeded the number of persons submitting written comment (n=4). Based on the participation numbers alone, meetings were the preferred method, despite the time and expense investment.

Future requests for public input on the Title V / MCH Block Grant will consider these results. The DHHS team responsible for the Annual Application appreciates the opportunity to receive public input in the development of the FY 2013 application. Thank you to those who submitted comments in writing and participated in meetings.