

Nebraska State Abstinence Education Grant Program

State Plan FY 2010

Introduction

There has never been a better opportunity to provide public health programming for youth in Nebraska. Investing in the state's youth through appropriate and effective health programming and services is a priority for Nebraska's Department of Health and Human Services (DHHS). The diversity of Nebraska's rural and urban communities, dispersed over a large geographical area and the emerging needs and circumstances of a changing racial/cultural profile have influenced and directed the development and implementation of many of the state's public health programs. Reaching our young people to effectively address their needs, while factoring in the state's demographic and racial/cultural needs, lies at the heart of realizing positive outcomes for our youth. Nebraska will meet the increasing needs of the youth population through the strategic implementation of abstinence education across the state.

A. Problem and Need

Identifying the problems and needs associated with Nebraska's adolescents was achieved through an in-depth review of a comprehensive compilation of indicators and related data resulting from multiple needs assessment processes conducted within the last year. Nebraska's Title V comprehensive needs assessment, just completed in 2010 for the upcoming five-year period, revealed ten priority needs specific to the state's maternal and child populations. Of these, over half (6) directly impact or are related to the state's youth population. Likewise an assessment for the Affordable Care Act (ACA) home visitation program under Title V provides additional insight into the problem and needs of the state's youth. Birth data from Nebraska Vital Records and the state's Pregnancy Risk Assessment Monitoring System (PRAMS) further

defines problem and need. Expanded information contained in the following four categories underscore the growing problems and related needs facing Nebraska's adolescents aged 10-19.

Demographics and Special Populations: Nebraska's estimated population for 2009 was 1,796,619 (U.S. Census). Of the 1.7 million plus Nebraska citizens, 389,008 are between the ages of 10 and 24. Over half of Nebraska's population is concentrated within the state's three largest urban areas (Douglas, Lancaster, Sarpy Counties) located in the eastern one third of the state with the remaining residents scattered among communities and counties considered rural to frontier. There are 10,383 youth in state custody either under the state's Child Welfare Unit or Office of Juvenile Services (2009 State Custody Report). Of these, 6114 youth are between the ages of 11 and 19 (58.8%). Nebraska is currently home to the highest percentage of foreign-born residents in the state since the 1870's. Racial and ethnic populations are growing rapidly in both the rural and urban sectors of Nebraska, increasing 39% between 2000 and 2009 (US Census Bureau) and minorities now make up 15.4% of the state's total population. Growth is the largest in the Hispanic population which grew by 298% between 2000 and 2009. This dynamic is disproportionately represented within the child welfare system. Of youth ages 0-19 in state custody, 57% are white, 16.8 % are African American and 14.4% are Hispanic. Population relocation and a changing racial, ethnic and cultural landscape are impacting health programming and service delivery in Nebraska. While the youth population is decreasing in rural areas, this age group is increasing in the state's metropolitan cities (Omaha and Lincoln) and smaller urban communities. The growing diversity within Nebraska provides challenges to reaching and serving youth with abstinence education in a culturally and linguistically appropriate manner.

Geography, Access to Programs and Counties at Risk: With a majority of the population located in the eastern portion of the state, most services are located there. Seventy six per cent (71/93) of Nebraska's counties have been designated, in full or in part, as containing Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP) affecting over 83% of the state's population (2007 data). Conclusions drawn from these data are that access to health care providers and related services are analogous to the adequacy and frequency of prevention programs for hard-to-reach youth populations in many geographic areas of the state. Rural and frontier communities simply do not have the resources to adequately implement and sustain prevention programming, particularly abstinence education. Local health departments serving multiple-county regions are limited in how much and to what extent they can provide prevention programs as well. The outcome has been scattered abstinence programming in past years resulting in piecemeal prevention efforts. This reality is leaving many of the state's rural and frontier counties with gaps in public health prevention programming and high teen birth and STD rates.

Lastly, to address requirements of the Affordable Care Act (ACA) Home Visitation Program, Nebraska completed an in-depth analysis/assessment that describes and catalogs at-risk communities as determined by needs and existing resources to meet those needs. Information was collected and analyzed regarding a large range of health and social factors, including pregnancy outcomes and other indicators of maternal, child and infant risk; poverty; crime; domestic violence; high-school drop-out rates; substance abuse; unemployment; and child maltreatment. The end result was the identification of the state's counties with the highest risk for poor health outcomes for the maternal and child population, including youth. This analysis, though not focused on teen pregnancy prevention provides a demonstration of the correlating risk factors

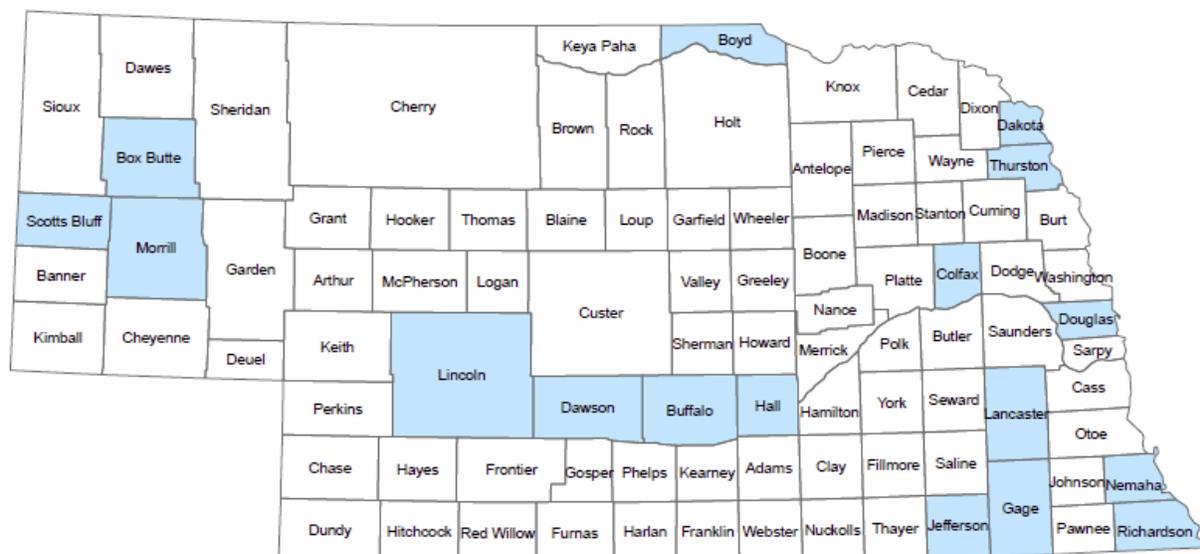
associated with teen sexual activity. Of the 34 risk “indicators” falling within eight risk factor categories, close to 75 percent directly correspond to teen behaviors and outcomes. To adequately address teen pregnancy in the state, providers should also understand and address the correlating risks. The following table provides a listing of the identified indicators within the eight risk factor categories. County indicator data were applied, scored and ranked (high to low) for data in each of the eight categories. Those counties with data scoring within the top 10% for six or more categories were identified as most at risk. Those counties are illustrated in the corresponding state map.

Risk Category	Risk “Indicators”	Risk Category	Risk “Indicators
Child Welfare	Child abuse/neglect	Health Behaviors	Inadequate Prenatal Care *
Child Welfare	Child abuse/neglect substantiated *	Health Behaviors	No Prenatal Care *
Child Welfare	Office of Juvenile Svcs.*	Health Behaviors	Births To Teens *
Child Welfare	Out of Home Care *	Pregnancy Outcome	Low Birth Weight *
Child Welfare	State Wards *	Pregnancy Outcome	Very Low Birth Weight *
Child Welfare	Unintentional Injuries *	Pregnancy Outcome	Prematurity *
Crime	Juvenile Arrests *	Pregnancy Outcome	Infant Mortality *
Crime	Juvenile Drug Arrests *	Health Outcomes	Poor/Fair Health *
Crime	Juvenile DUI *	Health Outcomes	Poor Mental Health Days *
Crime	Juvenile Violent Crime Arrests *	Health Outcomes	Poor Physical Health Days *
Economic	Food Stamps *	Health Outcomes	Premature Death *
Economic	Poverty, All Ages *	Social Welfare	Aggravated Domestic Violence Complaints *
Economic	Unemployment Change, 2009-2010	Social Welfare	Domestic Violence Crisis Line Calls *
Economic	Unemployment *	Social Welfare	Simple Domestic Violence Complaints *
Education	High School Dropouts*	Social Welfare	Single Parent Household *
Education	Education Less than 9th Grade *		
Health Behaviors	Adult Smoking		
Health Behaviors	Binge Drinking *		
Health Behaviors	Chlamydia *		

Table #1

*corresponding to teen behaviors and outcomes

Nebraska Counties at Risk



Map created by
DHHS GIS
8/10



Map #1

Disparities in health status and outcomes: Compelling evidence of problem and need is represented in data associated with health status and outcomes. Though Nebraska’s teen birth numbers are modest compared to more populated states, each teen birth in the state has the same negative impact to health and outcomes experienced by teen moms nationally. According to a recently released 2010 report from CDC and the National Center for Health Statistic, Nebraska’s teen birth rate (number of births to teens aged 15-19 per 1000 teens of the same age) for 2008 was 36.5 compared to a national rate of 41.5 for the same year. Nebraska teen births (age 19 and under) accounted for 8.6% of all births in 2008. County data for 2008 provides a clearer picture with many counties reporting percentages between 9% and 17%. Disparities are found

within racial/ethnic minority youth populations where rates for births are significantly higher than for Caucasians as noted in the following table denoting births to teens.

Teen Birth rate per 1,000	2009	Overall	Caucasian	African American	Native American	Asian	Hispanic
	Aged 10-14	1.36	1.10	1.71	2.06	0.70	1.39
Aged 15-19	33.85	25.47	69.32	71.82	19.16	100.33	

Teen Pregnancy rate* per 1,000	2009	Overall	Table #2				
	Aged 10-14	2.07		*Pregnancy rate: Live births + fetal deaths + abortions.			
Aged 15-19	27.82						

Data on births to unmarried women further illustrates the status of teen pregnancy in Nebraska. National data provides evidence that children born to two-parent families are statistically more likely to experience healthy outcomes along the life span. The following chart illustrates births to unmarried youth ages 15-19 and the distribution of this factor within racial/ethnic populations.

Births to Unmarried Women by Age, Race and Hispanic Origin

NE 2009 Vital Statistics Report
% of live births each age category

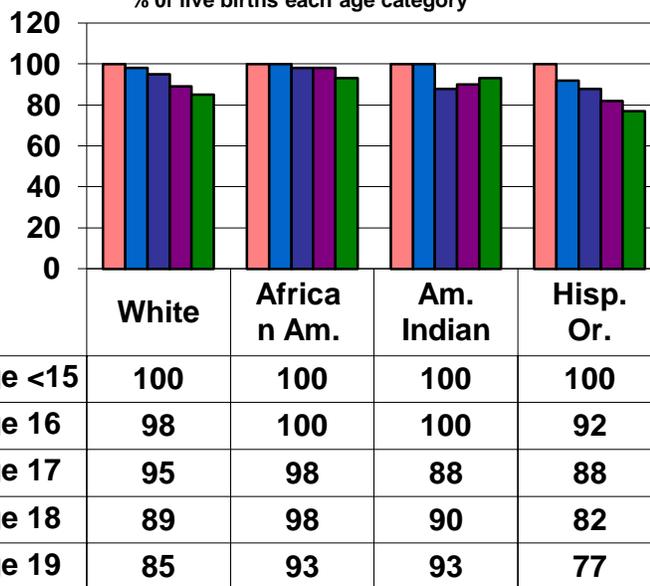


Chart #1

Though there is no state birth or STD data specific to youth in state custody, we do know that nationally, sexual activity among this population group is alarmingly high. Sexual debut is reported to occur earlier (by age 13) and nearly half of youth in foster care report a pregnancy by the age of 19.¹

Nebraska’s “New Families at Risk” (NFR) indicator (NE Vital Statistics), defined as an unmarried mother younger than 20 with no previous live births and has not completed high school, gives evidence to the scope of problems facing parenting teens within the state. In 2009 Nebraska births identified as NFR totaled 832 and the state rate (percentage) for NFR was 8.2 per 100 first live births. Close to half (44) of the state’s 93 counties reported a NFR rate at or above the state percentage with some single county rates as high as 33%. NFR rates are higher within the state’s racial and ethnic minority populations as demonstrated in the following table.

Nebraska, 2009	State Rate	White, Not Hispanic	Native American	African American	Hispanic
New Families at Risk	8.2%	5.8%	23%	16.9%	21.2%

Table #3

Compared to the White non-Hispanic rate of 5.8% (below the state rate), disparities among minority NFRs are significant.

Similar disparities are found in data associated with unintended pregnancy rates. Unintended pregnancies are defined as pregnancies which, at the time of conception, are either mistimed (the woman did not want to be pregnant until later) or unwanted (the woman did not want to be pregnant at any time). The state’s Pregnancy Risk Assessment Monitoring Survey (PRAMS) asks new mothers how they feel about becoming pregnant and respondents could answer: I wanted to be pregnant: “sooner”, “later”, “then” or “not then or in the future”. If a mother

¹ Fast Facts, July 2009, National Campaign to Prevent Teen and Unplanned Pregnancy

answers “later” or “never” the pregnancy is considered to be unintended. Though response numbers for the age category of <20 are generally too small to accurately report within race/ethnicity categories, results overall fell predominately in the “later” or “never” categories across all race/ethnicity groups in this age group. According to the state’s PRAMS data for 2007, the following documents the disparity for unintended pregnancy among all women of child-bearing age.

<u>Indicator</u>	<u>State</u>	<u>White Not Hispanic</u>	<u>African American</u>	<u>Native American</u>	<u>Hispanic</u>	<u>Data Source/Date</u>
Unintended Pregnancy	39.8%	36.6%	64.6%	57.1%	44.9%	NE PRAMS 2007

Table #4

STD rates among the adolescent population indicate the reality of Nebraska’s sexually active youth. As noted below, state rates for Chlamydia and Gonorrhea among youth ages 10-19 are lower than the national rates for the same age group. However STDs are disproportionately affecting racial/ethnic teen populations as noted in tables 7 and 8.

Reportable STD per 100,000 Youth Ages 10-19 by Cause						
	Gonorrhea			Chlamydia		
	Number	Rate	NE Rate was....	Number	Rate	NE Rate was....
Nebraska 2008	482	195.2		1,962	1,051.4	
U.S. 2007	102,537	505.31	Lower	393,047	1,832.8	Lower
HP 2010 Objective	19.0		Higher	-		-
NE 5-year trend	Increasing			No Linear Change		
Racial/Ethnic Differences	Yes			Yes		

Table #5

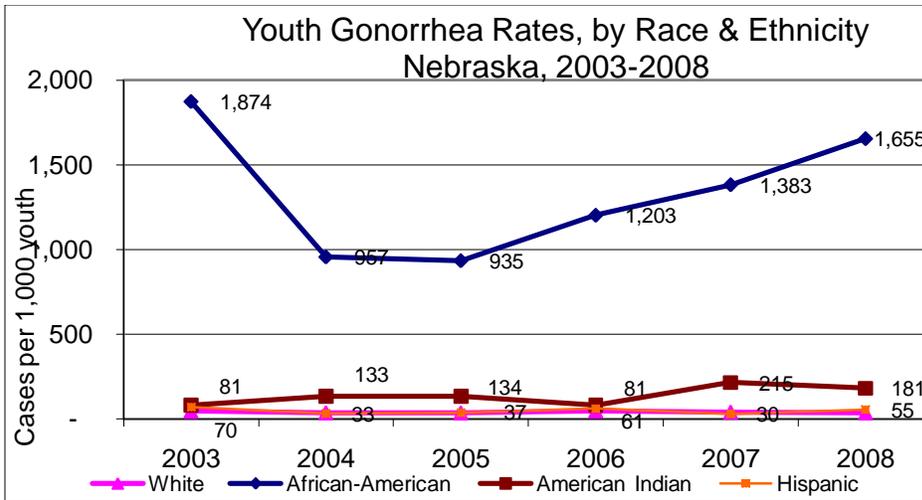


Chart #2

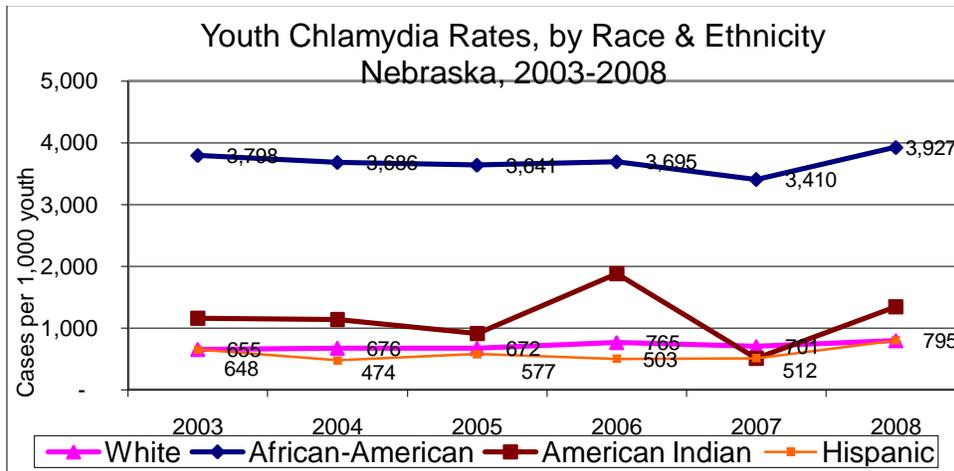


Chart #3

Education deficits: The consequences for youth who fail to complete their high school education have staggering implications for the state’s economy as well as families. Youth who do not graduate from high school or fail to receive a diploma perpetuate a cycle of poverty, poor health outcomes for themselves and set themselves up for diminished futures. This is particularly true for pregnant and parenting teens. The state’s total enrollment for grades 6-12 in public and private schools in 2008/2009 was 169,479². Though Nebraska’s overall dropout rate is well below the national rate, dropout trends within the state’s racial and ethnic minority

² Nebraska Department of Education

populations presents an alternate picture. Data for the 2008/2009 school year indicates that the dropout rate for Nebraska was 1.53%. For the same school year, the rate for Whites, non-Hispanic was 1.07%, yet increases to 3.86% for Blacks, 3.23% for Native Americans and 3.29% for Hispanics. Comparatively Nebraska graduation rate for 2008/2009 was 89.86%. However some school districts in the state are experiencing graduation rates below 75%. Omaha Public Schools for example had an overall graduation rate for 2009-2010 of 69.84%³. Though there is no available data linking the state's graduation rates to the state's teen pregnancy/birth rates, we do know that pregnancy is a frequent contributing factor impacting dropout rates. It is reasonable to correlate then that teen pregnancy and high school completion are connected. Reducing teen sexual activity and resulting pregnancies, births and STDs is one realistic approach to increasing the state's graduation rates.

Summary of Need and Target Populations: Support for and understanding of the abstinence message is needed among all who engage with, provide for and support our youth: families and parents, supporting adults and youth workers, physical and mental health care providers, educators and communities as a whole. We must become unified in providing abstinence education, in setting the expected behavioral standard and in supplying a consistent message.

Nebraska is poised to implement abstinence education programming that is purposeful, strategic and comprehensively applied. The needs assessment completed for the ACA Home Visitation Program has revealed counties where youth are at highest risk. The data also suggests that in addition to impacting youth populations that experience negative outcomes resulting from early sexual activity, directing abstinence funding to these counties and populations in need can impact youth support systems, infrastructure and service recipients in a positive manner.

³ Nebraska Department of Education: State of the Schools Report, 2009- 2010

The state's birth and STD data reveals that negative outcomes associated with youth risk behaviors increase with each advancing age group. **Strategically and comprehensively targeting abstinence programming to reach younger youth populations that are just learning how to make healthy choices is a wise investment** that will have a positive impact on the state's birth and STD rates among the adolescents and produce positive teen health outcomes for years to come. With this in mind, and considering the data presented, Nebraska's has identified the following focal populations for FY 2010:

- **African American, Hispanic and Native American youth who are:**
 - **aged 10-14, and**
 - **reside within the counties of Douglas/Sarpy, Lancaster, Nemaha, Richardson, Gage, Colfax, Thurston, Dakota, Boyd, Jefferson, Hall, Buffalo, Lincoln, Dawson, Box Butte, Morrill and Scotts Bluff, and**
- **Youth aged 10-14 in state custody under the state's Child Welfare Unit or Office of Juvenile Services.**

Nebraska's population demographic illustrates that these focal groups are interspersed among the larger teen population within communities statewide. Though the objective of Nebraska's plan is to impact these focal populations, it can be expected that a larger segment of the adolescent population will also be reached during program delivery.

B. Implementation Plan

Nebraska is proud of its historical accomplishments in implementing an abstinence education program on a statewide basis. Though the state's funding allocation has been modest in comparison to other states, Nebraska's success is due in part to careful and appropriate use of this funding. The necessity to stretch program dollars was a primary consideration in developing and tailoring the program as it evolved from year to year. The program plan for FY 2010 takes

into consideration this necessity while factoring in the needs identified in the state's birth and STD data, identification of locations of need and building on prior successes and lessons learned.

Existing Programs and Gaps in Services: Opportunities that support and enhance community environments that shape the possibilities for optimal health for youth are at the foundation for Nebraska's abstinence education program. Programming supportive of these opportunities can be found spread across Nebraska's Department of Health and Human Services, within school systems statewide and provided by private youth serving organizations. Existing Nebraska programming supportive of the foundational aspects abstinence education include:

- Department of Health and Human Services: Temporary Assistance to Needy Families (TANF), MCH Title V and a contractual program for Women Who are Pregnant.
- Past community-based Abstinence Education (CBAE) programs in Norfolk and Omaha.
- Past Title V Abstinence Education sub grantees reaching youth in all of the state's 93 counties.
- Boys Town, Omaha, NE, Tier II PREP Research Project.
- Local school districts including Gretna, Ashland and Falls City.

Gaps in services are connected to cultural, geographic, demographic and fiscal limitations as previously described. Limited teen pregnancy prevention programs, centered in abstinence and sensitive to the demographic and cultural needs of populations and communities served, create a gap in consistent, effective programming. With no one approach to teen pregnancy prevention mandated at the state level, decisions specific to addressing teen pregnancy, out-of-wedlock births and rising STD rates among youth are frequently made at the local community and district health department levels. These decisions are often relative to the amount and availability of

fiscal support. The results are competing messages (abstinence-only vs. abstinence-based or abstinence-plus) and programming that is piecemeal, scattered or non-existent.

Challenges and Barriers: In addition to the challenges identified earlier in the Problem and Need section (demographic, geographical, health outcome disparities etc.), there are inherent barriers to abstinence education in particular and in public health programming directed to teen pregnancy prevention in general. Heightened emphasis will be placed on these additional “secondary” barriers or challenges that have been identified as unique to the abstinence initiative and teen sexual health programming. These secondary challenges include:

- Infrastructure challenges – lack of sufficient health care and social service provider collaborations grounded in medically accurate knowledge and understanding of the abstinence initiative;
- Community challenges – insufficient unified community support and approach for programs targeting teen pregnancy prevention leading to piecemeal programs that give “mixed messages” to youth;
- Educational challenges – Misconceptions of actual adolescent sexual behavior and lack of youth and adult knowledge about adolescent development and reproductive health;
- Attitudinal challenges – attitudes some among teens in Nebraska that teen parenting and births to unmarried teens is “OK” as well as attitudes among parents and other adults that they can have little effect on the behaviors of their children, and
- Cultural challenges – the power of mass media to influence teen attitudes and behaviors towards sexual and other health behaviors.

Goals and Objectives: In today's electronic era, Nebraska youth are no longer isolated from the risks and difficulties that were once associated with youth in more populous states. Nebraska teens are "connected" to the world at large providing them an opportunity to experience a wide array of challenges and opportunities while navigating adolescence - like their peers across the nation. Based on science and emerging practice we know that youth behaviors, whether positive or negative, are likewise inextricably connected. In this way it is important for youth and all who work with them to understand how physical health, emotional health, relationships, stress, education and goal setting are all connected and play an important role in youth achieving success in all aspects of life. Staying in school, healthy behaviors, (e.g. abstaining from sex, alcohol and tobacco or engaging in healthy eating habits and physical exercise) setting goals and understanding health risks are among a host of positive behaviors all of which help youth live healthy, safe and productive lives. Abstinence education is the means by which we help our young people recognize and adopt all aspects of "good health" (physical, intellectual, emotional, social and spiritual) and achieve the life they want.

The logic model found in **Appendix Item 1** was developed to provide a framework and identity to the flow of processes that lead to our correlating goals, objectives and measures. Nebraska's plan for abstinence is thus aligned to reflect the inputs, outputs and outcomes identified in the logic model. The goals and objectives address the connectedness and universality⁴ of youth behaviors associated with positive life outcomes and support the strategic and comprehensive application of Nebraska's Abstinence Education Program. Nebraska goals, objectives and measures identified for FY 2010-11 are as follows:

⁴ Occurring within all cultures across all populations.

Goals

- 1. Nebraska adolescents are healthy, safe and productive.**
- 2. State and community environments are supportive of adolescents.**

Objectives and Measures

Process Objectives:

1. By January 3, 2011 RFP seeking program sub grant(s) is developed and executed.
2. By March 1, 2011 one to three project sub grant recipient(s) are identified and implemented.
3. By June 1, 2011, sub grantee(s) and their partnering agencies/organizations are trained in identified abstinence education curriculum.
4. By September 30, 2011, abstinence education programs are implemented in a minimum of 5-8 targeted counties.

Outcome Objectives:

1. By December 31, 2011, targeted youth aged 10-14 residing within counties identified as “at risk” will receive a minimum of eight hours of abstinence education instruction.
2. By December 31, 2011, targeted youth aged 10-14 receiving abstinence education are able to identify behaviors associated with positive health outcomes including those corresponding to reducing risk for pregnancy and STDs.
3. By December 31, 2011 targeted youth aged 10-14 receiving abstinence education instruction have a personal goal for adopting a minimum of three positive health behaviors including regular school attendance.
4. By December 31, 2011 sub grant recipient(s) will have a minimum of three effective community engagement and/or support tools (i.e. mentoring counseling, adult supervision) specific to abstinence education for use within targeted counties.

Outcome Measures:

1. The number of youth aged 10-14 residing in counties identified as “at risk” receiving abstinence education.
2. The number of targeted youth aged 10-14 who are able to identify behaviors associated with positive health outcomes including abstinence as the means of preventing teen pregnancy, birth and/or STDs/STIs.

3. The number of targeted youth aged 10-14 demonstrating adoption of at least three positive health behaviors including school attendance of 95% or greater.
4. The number of communities in targeted counties reporting an increase in supports within community youth environments.

Mechanism for Implementation: Nebraska has a long and successful history of administering federal grant programs on a statewide level. This success is due in part to efficient and careful implementation of the sub grant process. The sub grant mechanism has proven to be the most effective and efficient means of meeting the diverse needs of the state's population and will be employed for implementation of the state's abstinence education program. Doing so allows the Department to reach the identified target populations and locations thus maximizing and leveraging the state's limited funding allocation. Up to three sub grants will be implemented using the Department's standard operating procedures for sub grant selection and will be executed by using the Department of Health and Human Services template for Request For Proposals (RFP). Federal program requirements specific to medical accuracy and prohibition of religious instruction as well as sub grant reporting requirements (including efficiency measures and use of federal forms), fiscal documentation, use of approved curriculum and audit requirements will be incorporated into the Terms and Assurances section of the RFP. (See **Appendix Item 2** for example) The state's 1) issued RFP and by incorporation the Terms and Assurances, 2) the applicant's signed proposal, and 3) the Department's letter of award, becomes the binding legal agreement between the state and successful applicant(s).

Development of the state's RFP will include provisions specific to the abstinence education program to be incorporated into the RFP template. These provisions include the following:

1. Description of eligible applicants:

Eligible applicants include any public or private non-profit entity, coalition of entities or

federally recognized Native American Tribe headquartered in Nebraska. A non-profit

Applicant proposing to provide services on a Native American reservation or federally

recognized Tribal land must include a letter of support from the applicable Tribal Council.

The applicant must also assure that it has a non-profit status at the time of application, has

capacity to receive funds, and:

- a. Provides services and/or programs on a statewide basis in Nebraska, or
- b. Provides services on a multiple-county level of not less than four Nebraska counties, and
- c. Has a history of providing abstinence education programs and/or services to youth in Nebraska for at least two years, and
- d. Demonstrates the capacity to carry out and sustain their proposed plan for implementing a statewide abstinence education program, and
- e. Can meet the specified cost-sharing (match) requirements.

2. Program requirements and/or scope of services:

- a. Applicant must provide a five-year plan that addresses providing abstinence education to at least one of the state's identified target populations and within a minimum of five of the state's identified target counties.
- b. Applicant's proposed plan must describe how contact and coordination with Nebraska DHHS, Division of Children and Family Services will occur if youth in state custody are the proposed target population.

- c. Applicant's proposed plan must identify the program model and/or mechanism to be used for program delivery including curriculum and materials to be implemented as selected from the state's approved list. (See **Appendix Item 3**).
- d. Applicant's proposed plan must describe how and to what extent the applicant provided for the proposed target community(s) and/or population(s) engagement in the development of their proposed plan including input from proposed service recipients (youth).
- e. Applicant's proposed plan must address provision of, adherence to and methods of reporting on the state's identified outcome measures.
- f. Applicant's proposed plan must address the provision of training and/or technical assistance to be provided to any proposed partners and/or contractors.
- g. Applicant's proposed plan must address how it will meet the federal requirements in upholding and addressing all elements of the A-H definition for abstinence education. (See **Appendix Item 4**)

Additional language will be included in the RFP specific to other applicant provisions not outlined above. These include; 1) identification of lead agency and/or fiscal agent if applying as a coalition of entities, 2) supportive documentation including evaluation results, if known, for any curriculum or materials proposed for use but not on the state's approved list of such materials, and 3) documentation/evidence of medical accuracy for any curriculum and/or materials proposed for use in the applicant's plan. Applicants will be required to obtain approval prior to implementing or using any curriculum or materials not listed on the state's approved list.

State Work Plan and Timeline: The following activity tables provide a brief synopsis and overview of the intended activities, broad steps and time frame necessary to address the

objectives (process) identified for FY 2010. It is recognized that these tables reflect the shortened funding period for FY 2010 only. Time frames represented in the tables also present ideal scenarios and do not reflect potential delays due to DHHS internal review and approval processes (RFP) or delays due to the federal approval of the state’s final plan. **Expanded work plan tables, reflecting the five-year funding period, will be developed and included in the state’s FY 2011 continuation application. These tables will incorporate additional process objectives, activities and broad steps identified as result of the state’s selection and implementation of a sub grantee(s) that is intended to occur in the remaining funding period of FY 2010 (through September 30, 2011).**

Process Objectives:				
1. By January 3, 2011 RFP seeking program sub grant(s) is developed and executed.				
2. By March 1, 2011 one to three project sub grant recipient(s) are identified and implemented.				
Activities: Identify and select sub grantee(s) for statewide program implementation.				
Broad Steps to Accomplish: Develop and execute RFP document, review applications, select grantee(s).				
STEP	Responsible Party	Expected Output	Start	End
Develop and execute RFP document	State Project Director	Document posted and promoted	12/1/10	1/3/11
Identify and convene application review committee	State Project Director	Committee Convened	2/1/11	2/28/11
Review Sub Grant applications	Review Committee	Sub Grantee(s) for funding selected	2/1/11	3/1/11

Table #6

Process Objectives:				
3. By June 1, 2011, sub grantee(s) and their partnering agencies/organizations are trained in identified abstinence education curriculum.				
Activities: Develop, promote and facilitate training workshops for program providers in selected sites				
Broad Steps to Accomplish: Materials review, set dates and locations. Conduct training.				
STEP	Responsible Party	Expected Output	Start	End
Identify and gather materials/curriculum for consideration	Project Director(s) for Sub Grantee(s)	Grantee(s) project materials selected	3/1/11	4/1/11
Identify training locations and targeted participants	Project Director(s) for Sub Grantee(s)	Training scheduled and promoted	4/1/11	5/1/11
Secure training facilitator (contract), conduct training	Project Director(s) for Sub Grantee(s), Grantee(s) contractor	Identified program providers trained in use of selected curriculum	5/1/11	6/1/11

Table #7

Process Objectives:				
4. By September 30, 2011, abstinence education programs are implemented in a minimum of 5-8 targeted counties.				
Activities: Trained providers conduct abstinence education programs/instruction to targeted youth populations.				
Broad Steps to Accomplish: Program setting selection, instruction coordination, participant recruitment				
STEP	Responsible Party	Expected Output	Start	End
Identify and secure program settings within identified targeted counties.	Sub Grantee(s)-Project Director, Identified grantee(s) Personnel	Program instruction locations and settings selected.	6/1/11	7/1/11
Coordinate program implementation with selected setting personnel	Sub Grantee(s) Project Director, Selected setting personnel	Abstinence Education instruction programs scheduled to begin.	6/1/11	7/1/11
Develop participant pre/post test corresponding to and reflective of state's outcome measures	Sub Grantee(s) Project Director, State Project Director, Identified grantee(s) personnel	Program pre and post test developed, approved and available for use by targeted populations in grantee(s) identified settings	7/1/11	8/1/11
Deliver abstinence education instruction to identified/targeted youth in identified settings	Sub Grantee(s) – Trained Instructor and/or identified personnel	Abstinence Education instruction initiated	8/1/11	9/30/11
Grantee(s) obtain appropriate consent and conduct pre and post tests among program participants.	Sub Grantee(s) – Trained Instructor and/or identified personnel	Pre and Post tests conducted.	8/1/11	12/31/11

Table #8

Monitoring: Nebraska will monitor its formal partners through multiple avenues in place as a matter of Department policies. Progress and financial reports will be required of all sub grantee(s) at a frequency agreeable to all parties while at the same time allowing adequate/timely disbursement of funds. At a minimum, sub grantee(s) will be required to submit progress and data reports (federal forms A-D) in a routine manner that will allow the State to fulfill its federal reporting requirements, i.e. semi-annually. Sub grant expenditures will be monitored to guarantee adherence to their itemized budgets submitted and approved in their application for funds. A minimum of two site visits to review performance will be completed each grant year to include a site visit of the sub grantee(s) to review and assess compliance to state and federal policies specific to receipt of federal grant funds (audit and match requirements etc.) and compliance to federal requirements for the federal A-H definition of abstinence education. A review of at least two sub grant program sites will occur to assess the degree and effectiveness of the program sites in reaching the target populations. Implementation process and fidelity to selected curriculum will also be assessed. Assurance of medical accuracy and compliance to the legislative definition of abstinence education (A-H) will be met through language incorporated into the Terms and Assurances section of the RFP. By signing and returning the Terms and Assurances as part of their proposal, selected sub grantee(s) will be agreeing to uphold all program requirements including federal provisions for medical accuracy, religious instruction and state/federal reporting requirements. The Terms and Assurances also provide the means, by incorporation, to provide for certification of sub grantee(s) specific to lobbying and environmental tobacco smoke.

Sub grantee(s) will be required to use only those materials and curriculum identified and approved by the Department as medically accurate and complying with the legislative definition

of abstinence education. Applicants will be required to obtain approval prior to implementing or using any curriculum or materials not listed on the state's approved list. A list of materials being considered and pending approval for medical accuracy is found in **Appendix, Item 3**.

Coordination: Nebraska seeks to assure that our adolescents have the needed services and opportunities to develop competencies and behaviors that will provide for a healthy and productive adulthood. The Department of Health and Human Services, Adolescent Health Program, has multiple projects and initiatives new or currently underway addressing the health, development and well-being of the state's adolescent population. Chief among them are the federal Personal Responsibility Education Program (PREP) and the Nebraska Adolescent Comprehensive System Initiative. Coordination with these programs/initiatives is necessary to eliminate duplication of efforts, expand/enhance available resources (funding), support programming that is holistic from a youth development approach and assures that Nebraska youth in greatest need of abstinence education programming are being reached. A brief summary of these projects/initiatives follows:

- **Personal Responsibility Education Program (PREP)** – PREP programming will compliment, support and continue the efforts provided by the Abstinence Education grant. Though specifics of Nebraska's PREP are yet to be defined, a stakeholder group will be convened post submission of this document to define aspects of a statewide plan that addresses the selection of program curriculum/models, target populations and age groups. Similar to the abstinence education grant, it is expected that the disbursement of PREP funds and statewide program implementation will occur through the sub grant process. At a minimum, the state will require that PREP sub grant(s) target those counties previously identified as most at risk and that

target populations include, at a minimum, racial/ethnic minority populations. The state will work closely with both the Abstinence Education and PREP sub grantee(s) to coordinate efforts of both programs to assure that the targeted populations do not receive a duplication of efforts or competing messages. The selected abstinence education sub grantee(s), if feasible and as appropriate, will be incorporated into the provision of selected aspects of the adult preparation subject matter required of the PREP program, i.e. healthy relationships, parent-child communication and healthy life skills. Through this coordinated effort between both the Abstinence and PREP programs, Nebraska will achieve a continuum of pregnancy and STD prevention programming that spans all ages groups and reaches youth populations most in need of these messages.

- **Nebraska Adolescent Comprehensive System Initiative** – In 2009 Nebraska began the important work of state-level systems development to support adolescent health and well-being. The work arose from the need to allocate resources to effectively address the unique needs of adolescents so that they can develop healthy life-long behaviors. The objective is to reach out across divisions and sectors to create a comprehensive systems approach aimed at providing youth and their families with more well-integrated programs, services and resources. A comprehensive system promotes partnerships and collaboration between people and organizations that work to address adolescent health and well-being⁵. To date Nebraska has identified the structure of its adolescent comprehensive system including the system domains or sectors and goals of each (see **Appendix Item 5**) and begun the work of identifying the indicators that will reveal whether or not we are achieving the desired outcomes for our adolescent population. By incorporating programming and services (including abstinence

⁵. Association of Maternal and Child Health Programs, 2009; White Paper – Making the Case: A Systems Approach to Adolescent Health and Well-Being

education) into a systems approach we are building a structure that addresses adolescent needs from all “spheres of influence” and builds capacity for addressing these needs in years to come. We are providing that continuum of preventive, intervention, youth engagement, treatment, and maintenance implemented throughout various settings in support of our youth. Incorporating these elements including youth asset building can help enhance efforts to improve health outcomes for all adolescents and promote successful transitions into adulthood⁶. Thus, to uphold and support the Department’s systems approach, applicants seeking abstinence education sub grants will be required to show how their proposal will address and incorporate each system domain into their work plan. In this regard, other programs and projects whether internal or external to the Department, will be coordinated with and supported by the state’s abstinence education programs as demonstrated in the figure below.

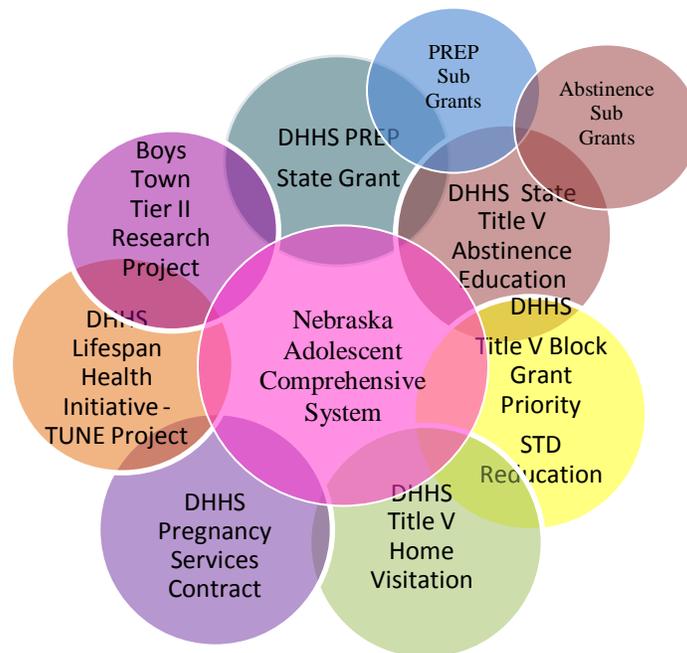


Figure #1

⁶ Association of Maternal and Child Health Programs, 2009; White Paper – Making the Case: A Systems Approach to Adolescent Health and Well-Being

Community teen pregnancy prevention coalitions and other prevention efforts underway at the local level across the state, as well as other adolescent health and development initiatives, will be identified and incorporated into the coordination efforts on an on-going basis.

Service Recipient Involvement: Posting of Nebraska's state plan for Abstinence Education will occur on the Departments web site. Public comment and input will be solicited via messages delivered through distribution lists and other network opportunities. Information and suggestions gained will be incorporated into the state's plan for FY 2011 and beyond. Time limitations prohibited the opportunity to achieve service recipient involvement in the development of this final plan. Nebraska recognizes the need to engage racial and ethnic groups in developing and implementing the abstinence program at the local level. Doing so provides for community commitment and ownership by those targeted to receive programming. As a result community engagement and service recipient (youth) involvement will be a required planning phase of any/all sub grantee(s) seeking funding through the state. Successful sub grantee(s) will demonstrate how the outcomes and products of this involvement will be incorporated into their work plan and desired outcome objectives. It is expected that community engagement and service recipient involvement at the state level will develop and expand in future years of the grant. The state will coordinate this involvement with our Comprehensive System Initiative in a manner that provides for a statewide network of adolescent program stakeholders, providers, families and youth.

Referrals: Referrals to other health programs and services relative to adolescent health will be handled on a case-by-case basis. As needs of the target population receiving the state's program are identified, linking those in need to appropriate services, i.e. children's health insurance program, Medicaid etc., will be the responsibility of the sub grantee(s). The state's

project director for Abstinence Education will serve as a resource and liaison in directing the sub grantee(s) to appropriate resources and services provided by Nebraska DHHS. Referrals for physical needs (e.g. STD testing and/or treatment) will be made to those providers who support and uphold the principles of abstinence programming and adhere to the definition of abstinence education as defined by law. Sub grantee(s) will be required to describe the mechanism to be used for external referrals in their application for funding.

Objective Performance and Efficiency Measures: Nebraska has identified four outcome measures by which we will measure success (performance) in reaching our goals (refer to page 15 for state outcome measures). Of these, two have been selected for the federal reporting requirements. They are as follows:

A. State Outcome Measure #2: The number of targeted youth aged 10-14 who are able to identify behaviors associated with positive health outcomes including abstinence as the means of preventing teen pregnancy, birth and/or STDs/STIs.

Baseline Measure: By December 31, 2011, 60% of youth served in identified grantee(s) locations, receiving a minimum of eight hours of program instruction are able to identify a minimum of three positive health behaviors to include abstinence as the means of preventing teen pregnancy, birth and/or STDs/STIs

Long-term Target: By the end of FY 2014, 90% of youth served within the target counties and receiving a minimum of 14 hours of program instruction are able to identify a minimum of three positive health behaviors to include abstinence as the means of preventing teen pregnancy, birth and/or STDs/STIs

Annual Targets: Year 1- 60%; Year 2 - 70%; Year 3 - 80%; Year 4 - 85%; Year 5 - 90%.

Data Collection Method(s). Sub grantee site director/instructor data collection using ACF/FYSB Forms A-C, pre and post test delivery and analysis.

B. State Outcome Measure #3: The number of targeted youth aged 10-14 demonstrating adoption of at least three positive health behaviors including school attendance of 95% or greater.

Baseline Measure: By December 31, 2011, 60% of youth served in identified grantee(s) locations, receiving a minimum of eight hours of program instruction have identified and adopted a minimum of three positive health behaviors including school attendance of 95%.

Long-term Target: By the end of FY 2014, 90% of youth served within the target counties and receiving a minimum of 14 hours of program instruction have identified and adopted a minimum of three positive health behaviors including school attendance of 95%.

Annual Targets: Year 1- 60%; Year 2 - 70%; Year 3 - 80%; Year 4 - 85%; Year 5 - 90%.

Data Collection Method(s). Sub grantee site data collection using ACF/FYSB Forms A-C, pre and post test delivery and analysis, youth participant self-reports.

Objective Efficiency Measures: Collection of data and reporting on the required efficiency measures will begin following implementation of the sub grantee(s) to occur during the third quarter of FY 2011. Data will be submitted beginning with the state's final progress report for FY 2010 (due December 31, 2011). Due to the shortened plan year, the following data has not been included in the submission of the state's final plan for FY 2010:

- **Form A, B and C – Unduplicated Count of Clients Served, Hours of Service and**

Program Completion: Data will be collected as required of the sub grantee(s) in place beginning on or after March 1, 2011. This data will be tallied using the required forms

and included in the state's final progress report for FY 2010. Updates to the data will be reflected within the submission of Forms A-D for each grant year beyond FY 2010.

- **Form D – Communities Served:** Nebraska will track communities served following implementation of the sub grantee(s) and identification of the target counties to be served. Communities to be served will be restricted to those located within the counties identified as “at risk” as noted on the map in the Problem and Needs section of this plan (see page 5). A full list of communities served will be submitted in the state's final progress report for FY 2010 and updates, changes incorporated into final progress reports for the remaining grant years.

Programmatic Assurances: Nebraska will meet the following programmatic assurances as noted below. Language specific to this requirement will be incorporated into the state's RFP - Terms and Assurances section (see **Appendix Item 2**, page 44, Item E & F) as previously described. By signing the Terms and Assurances, the sub grantee(s) assure that:

- a. They will uphold fidelity to Section 510 (b)(2) (A-H definition of Abstinence Education)
- b. they will address all eight A-H elements in the provision of abstinence education programming, and
- c. any/all materials and curriculum used by the sub grantee(s) will not contradict any element of Section 510 (b)(2) (A-H).
- d. materials presented for use by sub grantee(s) and not included on the State's approved curriculum/materials list have been reviewed for medical accuracy and that all materials presented as factual will be grounded in scientific research.

Additional assurances will be implemented to meet these legislative priorities including site visits and sub grant reporting requirements. To address Section 317P (c) (2) of the **Public Health Service Act** the state will if necessary and as appropriate, convene an oversight committee comprised of medical providers to review mass produced educational materials designed to address sexually transmitted diseases/infections. The committee will evaluate for medical accuracy any materials proposed for use by sub grantee(s) including those, if any, designed to inform on the effectiveness or lack of effectiveness of condoms in preventing the STDs/STIs addressed by the materials.

Budget Discussion: Nebraska's allocation of federal Abstinence Education grant funds is \$210, 484 for each grant year FY 2010-2014. Administrative and programmatic activities have been appropriately aligned with the availability of funds and budgeted to meet the needs of the program plan and federal requirements. The budget as outlined and reported on SF-424A has been aligned to meet the state's program plan as previously described. Of note are costs associated with program oversight and administration and implementation of up to three sub grant awards.

The state has calculated a .15 FTE necessary for program oversight and administration to be provided by Linda Henningsen, Adolescent Health Coordinator in DHHS. Ms. Henningsen holds a degree in Education and has served as Nebraska's Adolescent Health Coordinator and project director of Nebraska's abstinence grant programs since 1999. Her professional experience includes community development, facilitation of needs assessments, grant administration and project coordination. Time devoted to oversight and administration will include development and execution of a Request for Proposals for sub grants, review and

assessment of required sub grant reports including compilation of required data specific to efficiency measures, and development and submission of the required federal progress reports.

The nominal budget allocation for grant oversight and administration allows for a significant portion (93%) of the state's grant award to be available for sub grant purposes. This assures that the majority of the state's funding allocation will be used to directly reach and impact the target population. Actual sub grant award amounts will be identified and documented following selection of successful applicants during the state's RFP process (January 1-March 1, 2011).

Sub grant award amounts, including match provided will be reflected in a revised SF-424A form to be submitted with the state's first progress report. Travel costs associated with the federal funding agency's annual meeting have been included in the state's budget with those associated with the regional training events to be passed on to the expected sub grantee(s). Cost sharing/match requirements will be realized through non-federal funds (cash and/or in-kind contributions) provided as a requirement of the selected sub grantee(s). Sub grants will be monitored for adherence to their submitted budgets through the implementation of the state's Expenditure Reporting Form (see **Appendix Item 6**). Nebraska has a negotiated indirect rate agreement (see **Appendix Item 6**) and the calculated amount is reflected on the appropriate line of the state's budget. A detailed budget justification including calculations and corresponding to the budget line items on SF-424A is included following the SF-424A form.

Incomplete provisions in Nebraska's State Plan for FY 2010

As allowed, Nebraska has identified the following provisions yet to be identified and/or requirements yet to be fulfilled. This omission is due to the shortened time frame for submission of the state's FY 2010 plan and the impact of this factor upon the RFP implementation process and selection of the state's sub grantee(s). As a result the following required documents are incomplete and will be finalized and included with the state's first progress report:

1. **SF-P/PSL** - Included but incomplete. Justification: Sub grant recipients are yet to be identified, thus locations of Project/Performance Site Locations are unknown at the time of submission of this state plan.
2. **SF-424A** – Included but incomplete. Justification: One sum is listed for each grant funds and matching funds for line item "Contracts" representing the total amount budgeted for all sub grantee(s) awards in both grant and match categories. Individual sub grantee(s) award amounts and match contributed are unknown at the time of submission of this state plan.

APPENDICES