



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

**State Narrative for
Nebraska**

**Application for 2014
Annual Report for 2012**



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Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	8
C. Needs Assessment Summary	8
III. State Overview	9
A. Overview.....	9
B. Agency Capacity.....	19
C. Organizational Structure.....	27
D. Other MCH Capacity	28
E. State Agency Coordination.....	31
F. Health Systems Capacity Indicators.....	38
Health Systems Capacity Indicator 02:	38
Health Systems Capacity Indicator 03:	39
Health Systems Capacity Indicator 07B:.....	40
IV. Priorities, Performance and Program Activities	41
A. Background and Overview	41
B. State Priorities	42
C. National Performance Measures.....	46
Performance Measure 01:.....	46
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	49
Performance Measure 02:.....	50
Performance Measure 03:.....	53
Performance Measure 04:.....	55
Performance Measure 05:.....	58
Performance Measure 06:.....	61
Performance Measure 07:.....	64
Performance Measure 08:.....	66
Performance Measure 09:.....	69
Performance Measure 10:.....	71
Performance Measure 11:.....	72
Performance Measure 12:.....	75
Performance Measure 13:.....	78
Performance Measure 14:.....	80
Performance Measure 15:.....	82
Performance Measure 16:.....	84
Performance Measure 17:.....	86
Performance Measure 18:.....	88
D. State Performance Measures.....	89
State Performance Measure 1:	89
State Performance Measure 2:	91
State Performance Measure 3:	92
State Performance Measure 4:	94
State Performance Measure 5:	95
State Performance Measure 6:	97
State Performance Measure 7:	100
E. Health Status Indicators	101
Health Status Indicators 03A:.....	101
Health Status Indicators 03B:.....	102

Health Status Indicators 03C:.....	102
F. Other Program Activities.....	103
G. Technical Assistance	105
V. Budget Narrative	107
Form 3, State MCH Funding Profile	107
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	107
Form 5, State Title V Program Budget and Expenditures by Types of Services (II).....	108
A. Expenditures.....	108
B. Budget	110
VI. Reporting Forms-General Information	113
VII. Performance and Outcome Measure Detail Sheets	113
VIII. Glossary	113
IX. Technical Note	113
X. Appendices and State Supporting documents.....	113
A. Needs Assessment.....	113
B. All Reporting Forms.....	113
C. Organizational Charts and All Other State Supporting Documents	113
D. Annual Report Data	113

I. General Requirements

A. Letter of Transmittal

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

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

B. Face Sheet

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

C. Assurances and Certifications

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

An attachment is included in this section. IC - Assurances and Certifications

D. Table of Contents

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

E. Public Input

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

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

The bulletin was sent to the following groups of people:

Subscribers of Community-Based Services (Developmental Disabilities), Advocacy, Alcohol and

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

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

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

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

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

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

We interpret the requirement for public input to be specific to the grant application. More generally, public engagement and the critical importance to public health is recognized and valued. Often the same community representatives, and typically primarily health and human services professionals, participate in multiple, overlapping processes of gaining stakeholder

input. This can lead to burn-out, limited participation in future endeavors, and may not fully represent the public.

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

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

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

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

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

/2014/ The Report of Public Input attached to Section I.E. of the FY 2014 application fully describes the method and process evaluation of public input on the FY 2014 application.

//2014//

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

//2014/

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

In 2013 Nebraska has taken steps to maintain and increase capacity around the 10 priorities. Of note are efforts to continue the WIC surveillance systems (Pediatric Nutrition Surveillance System (PedNSS) and the Pregnancy Nutrition Surveillance System (PNSS)), work on a capstone project that investigates the availability and utilization of family planning in Nebraska, data linkage projects with Nebraska PRAMS (Pregnancy Risk Assessment and Monitoring System), and participating as one of seven states in AMCHP's Life Course Metrics Project.

In the fall of 2013 Nebraska will start to convene the internal steering committee of the NAC (Needs Assessment Committee) with the intent of developing the master plan for the 2015 Needs Assessment. The charge will be to incorporate the lessons learned and some of the methodology from the MIECHV Needs Assessment, incorporate Life Course indicators developed by the AMCHP Lifecourse Metrics project, and refine/improve on the capacity assessment and planning phases of the process. It is anticipated that data collection/aggregation and analysis will begin the late winter/early spring of 2014. //2014//

III. State Overview

A. Overview

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

a. Large geographic area

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

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

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

b. Urban and rural

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

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

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

c. Increasing diversity

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

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

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

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

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

(1) Immigration

(a) Hispanic origin

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

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

(b) Asian and Pacific Islander

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

(2) Native American

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

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

(3) African American

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

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

(4) Minority Health Professionals

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

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

(5) Racial and ethnic health disparities

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

d. Aging population

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

The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000 and 35.8 in 2009 /2013/ 36.2 in 2010//2013//.This trend has important implications for the delivery of health and

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

e. Special populations

(1) Incarcerated

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

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

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

(2) Homeless

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

f. Rural poverty

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

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

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

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

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

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

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

/2014/ The DHHS Division of Children and Family Services, with the Nebraska Child Abuse Prevention Partnership, held a child abuse prevention summit in April 2013. As a member of the Partnership, the Division of Public Health participated in the planning with the Title V/MCH Director an active member of the planning committee. The Summit included a presentation of Nebraska specific ACE data collected through BRFSS and a session on evidence-based home visiting presented by the Title V/MCH Director, SSDI director, and Program Manager for Maternal, Child, Adolescent Health. Since the summit, the membership of the Partnership has met twice to review goals and objectives and identify key strategies. Members of the Partnership include the CEO of NE DHHS, the Directors of the NE DHHS Divisions of Behavioral Health, Children and Family Services, and Public Health, the President of the Nebraska Children and Families Foundation (Nebraska's CB-CAP agency), and the chair of Nebraska's Child Abuse Prevention Fund Board. A particular action already taken was the submission of an application to CDC for "Implementation of Essentials for Childhood: Safe, Stable, Nurturing Relationships and Environments." Prepared and submitted by the Division of Public Health, this grant if funded would build the capacity of the Partnership to carry out its prevention work within a collective impact framework.//2014//

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

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

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

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

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

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

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

During the 2009 session, the Legislature considered many options for addressing unmet

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

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

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

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

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

As required by LB 790, the Nebraska Medicaid Reform Plan was presented to the Governor and the Legislature on December 1, 2005. This plan included a wide range of findings, recommendations and strategies. The plan made it clear that no major changes in eligibility or benefits were being recommended at this time. The recommendations of most significance to the MCH and CSHCN populations were: establishing a separate SCHIP program (currently a Medicaid expansion); requiring a contribution from parents with incomes in excess of 150% of poverty for children participating in the Katie Beckett program, Aged and Disabled Waiver program, Children's Developmental Disability Waiver, the Early Intervention Waiver, and the

State Ward Program; and including as a covered services, a nurse home visitation program for high-risk pregnant teens. Other recommendations, such as those related to prescription drugs, had potential impacts as well.

The initiatives of Medicaid reform have since been revisited with plans to implement various components. The priorities of the current administration are the standardization of services statewide, transparency and accountability of our programs, and long term the sustainability of Medicaid. The Medicaid Reform Plan proposed twenty-six initiatives intended to focus the program on its core mission to provide medical assistance for truly needy Nebraskans in a manner that promotes access to appropriate services, fosters the development and utilization of less intensive care, encourages consumer responsibility and Medicaid alternatives, and expends limited resources prudently. Several of the initiatives targeted management of prescribed drugs, as the fastest growing expenditure category, and long-term care services, as the largest expenditure category. Other initiatives emphasize the involvement of the consumer in appropriate health care utilization, the development of alternatives to Medicaid-financed care, and the alignment of program growth with available resources. Service limitations resulting from Medicaid Reform are generally being applied to Medicaid-eligible adults and should not directly impact the CSHCN population.

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

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

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

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

Largely through the findings of the preterm birth/low birth weight and healthy weight work groups, the Lifespan Health Services Unit adopted a new emphasis on a life course health development model and social determinants of health framework. Funding guidelines for community based

projects, released in 2008, incorporated the model and framework, and the infant mortality disparity work group's findings have reinforced our emphasis going forward.

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

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

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

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

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

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

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

/2012/ Nebraska applied for and received an ACA Public Health Infrastructure Grant, both

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

In addition, the Nebraska DHHS Division of Public Health submitted an application for the Prevention and Public Health Fund Community Transformation Grants to Reduce Chronic Disease and an application for that fund's Coordinated Chronic Disease Prevention and Health Promotion Program. Both of these grant programs would provide a planning opportunity to address life course health strategies and the role of maternal and child health programs in the prevention of chronic disease.//2012//

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

/2014/ Nebraska DHHS Division of Public Health has been actively pursuing the prerequisites needed for public health accreditation. These activities when complete will provide further direction and focus for Title V activities. In summary, the following have been completed:

State Health Assessment - Completed in January 2012. The comprehensive written report will be in final draft format is under review.

Strategic Plan - Completed and final draft is also under review.

State Health Improvement Plan - Completed final draft in January 2013 and is in the review process. Once it is approved, next step is to create performance measures and implement.//2014//

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

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

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

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

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

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

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

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

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

B. Agency Capacity

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

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

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

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

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

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

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

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

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

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

farmers' markets and immunization clinic.

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

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

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

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

Lincoln Lancaster County Health Department (Lincoln) - Implements "A Family Approach to Prevention of Childhood Obesity" in three census tracts of Lincoln with a 34% minority population, > 25% of population is < 18 years of age, and with a high rate of poverty. Convenes community partners and resources to pilot "54321 GO" project (participants focus on achieving 5 servings of fruits and vegetables, 4 servings of water, 3 servings, of low-fat dairy products, 2 hours or less of screen time, and 1 hour or more of physical activity each day) and evaluates effectiveness of this approach.

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

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

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

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

infrastructure building.

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

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

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

/2014/ Subgrant proposals submitted in response to the May 31, 2012 competitive RFA were reviewed and scored. The following summarizes the seven community based projects which received awards through this process for the 2 year period ending September 31, 2014:

East Central District Health Department

Youth substance abuse prevention activities include Responsible Beverage Server Training, sobriety checkpoints, mass media campaigns, school-based program and compliance checks.

Four Corners Health Department

Nutrition and physical activities focus on childcare sites and community events to emphasize healthy lifestyle habits in families with the goal that children enter Kindergarten at a healthier weight.

Lincoln Lancaster County Health Department

Expansion of 'A Family Approach to Prevention of Childhood Obesity' project utilizes existing partnerships and develop new ones to reduce childhood obesity in four focus areas.

Northeast Nebraska Community Action Partnership

Continue Operation Great Start home visiting in seven counties in northeast Nebraska. Conduct an assessment and planning process that focuses on the system of services and supports for pregnant women and young children in Dakota and Thurston Counties. Findings and recommendations will be reported.

Northeast Nebraska Public Health Department

Continuation of a local area Child Fetal Infant Mortality Review (CFIMR) process. Lead

focused conversations about programmatic expansion and/or geographic expansion of CFIMR.

Southeast District Health Department

Assess early childhood systems in the counties of Nemaha and Richardson with a report of findings and recommendations. Subsequent activities to implement evidence-based home visiting model with fidelity are contingent on the community assessment.

Two Rivers Public Health Department

The Young Children Priority One Dental Program provides preventive dental care for young children and their families. Wrap-around services support families with patient navigation, referrals, and education.

In addition, non-competitive awards were also made to the four Native American Tribes headquartered in Nebraska. These awards support the following projects:

Omaha Tribe of Nebraska

The MCH nurse is involved in prenatal and postpartum clinic visits, visits newborns and mothers in their homes to do assessments and promote healthy childcare and breastfeeding. Educational classes are among a variety of activities to promote healthy lifestyles in women of childbearing age and to educate pregnant women on prenatal care, labor, and delivery. Services ensure that children receive immunizations on schedule.

Ponca Tribe of Nebraska

Activities strive to decrease use of tobacco by women of childbearing age, pregnant and postpartum women, and to decrease environmental tobacco smoke exposure among infants and children. Other activities identify and reduce depression, nutrition imbalance, and overall risk factors of the women and children. Ponca is engaging community members and providers to assess and produce an action plan to address obesity among the American Indian population residing in the service area.

Santee Sioux Nation

The MCH nurse provides clinical care and case management for women of childbearing age and prenatal patients at the Santee Health Clinic, and helps ensure children receive immunizations on schedule.

Winnebago Tribe of Nebraska

The Diabetes Prevention Program Lifestyle Change Program includes as the focus for this subgrant prenatal and postpartum women who are at risk for developing diabetes and families with children whose weight is greater than the 85th percentile. The goal is to develop healthier eating habits and incorporate physical activity into the daily routine to decrease the incidence of obesity and reduce the risk for developing diabetes mellitus. Activities include nutritional assessment, nutrition education and hands-on cooking classes, and breastfeeding support services.//2014//

Based on the recently completed needs assessment, additional contracts with a range of Nebraska organizations will be considered to address short-term capacity issues.//2012/ A contract was awarded to the University of Nebraska Medical Center to conduct a pilot project titled "Connections." This project seeks to address poor birth outcomes that disproportionately impact African American families in Douglas County (Omaha). The project has 3 major components: a peer support program conducted through a WIC clinic; community-based lectures/discussions focusing on community based strategies to foster healthy pregnancy; and the development of community leaders committed to advancing healthy birth outcomes in Omaha's African American community.//2012// ***/2014/ The contract in support of the "Connections" project was not renewed.//2014//***

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

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

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

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

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

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

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

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

Plans are underway to further enhance this project, including adding additional music and messages to better reach a more diverse audience. Lifespan Health Services staff members are working with other state-level programs to incorporate messaging and social media approaches./2012/ The First Time Motherhood/New Parents Initiative is completing a one-year no-cost extension in September 2011. Underway are contracts with community-level providers to deliver life course health training to health, social service, and education professionals in their communities, using TUNE materials. Also completed during 2011 was an update to the web site

with new music and messages. //2012// /2013/ Though the First Time Motherhood/New Parents Initiative grant has expired, the Lifespan Health Services Unit continues to maintain the TUNE website as well as a web page titled Tune Into Life Course Health for Providers. This page includes tools for classroom teachers and community and health care providers. A particularly well-received resource is the Life Course Health Plan, which is a reproductive health plan adapted for both men and women.//2013//

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

For CSHCN, one state-level program provides the majority of Title V-funded services to CSHCN - the Medically Handicapped Children's Program (MHCP). Located in **/2014/ Division of Children and Family Services //2014//**, MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multidisciplinary team diagnostic and treatment planning clinic sessions, and they also offer medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

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

/2013/ MHCP and DCP are housed in the **/2014/ Division of Children and Family Services//2014//** which allows access to a number of other state and federal programs that provide services to children and youth with special health care needs to enhance the networking of both local and state resources. The programs include: Early Development Network, Aged and Disabled Waiver, Lifespan Respite, Disabled Person and Family Support Program, and the Ticket to Work Program.//2013// **/2014/ MHCP and DCP have been transition to the Division of Children and Family Services within the Department of Health and Human Services as of July 1, 2013. The transition supports access to a number of other state and federal programs that provide services to children and youth with special health care needs to enhance the networking of both local and state resources. The transition also allows for coordination of services and benefits for children, youth and disabled individuals. Special Services for Children and Adults are administered within the Economic Assistance Unit in the Division of Children and Family Services. The Unit houses the following programs: Medically Handicapped Children's Program (MHCP), Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Genetically Handicapped Persons Program and the Lifespan Respite Program. This same Unit includes the SNAP (formerly known as Food Stamps), TANF, Child Care, Low Income Home Energy Assistance Program, Homelessness Prevention Grants, Refugee Resettlement Program, and Community Services Block Grant.//2014//**

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth

defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

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

/2014/ During the 2013 Legislative session, a number of bills were passed and signed into law related to MCH programming and capacity. Included were the following: LB 195, the appropriations bill which appropriated \$1.1 million for evidence-based home visitation; LB 225 which requires screening of newborns for Critical Congenital Heart Disease; LB 361 which expanded the Child Death Review Act to also include maternal deaths (now the Maternal, and Child Death Review Act); and LB 507, the Step Up to Quality Child Care Act which creates quality rating and improvement system (QRIS).//2014//

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

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

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

The Lifespan Health Services Unit has had ongoing working relationships with Northern Plains Healthy Start and Aberdeen Area Tribal Health Directors' programs, and works closely with the

Native American Liaison in the Office of Health Disparities & Health Equity. Individual programs work with specific communities and community leaders in developing culturally relevant initiatives. ***/2014/ During the past year, the NE DHHS Division of Public Health has engaged in planning activities for Great Plains Tribal Chairmen's Health Summit to be held in Aberdeen, SD in August 2013. This summit will focus on the Chairmen's MCH priorities, particularly addressing the impact of Adverse Childhood Experiences (ACES) on health outcomes. The Title V/MCH Director, Federal Aid Administrator, and SSDI Director have been engaged in planning and data related activities in preparation for the summit. Together with the NE DHHS Office of Health Disparities and Health Equity will continue to work with Nebraska Tribal leadership after the summit to continue with planning and strategy development. A CDC Public Health Associate will be assisting with this effort.//2014//***

Since FY 2003, the Lifespan Health Services Unit maintains a set-aside of Title V funds for those federally recognized Tribes headquartered in Nebraska. This set-aside recognizes the special government-to-government relationship between NDHHS and the Tribes, as well as a priority to meet the health needs of the Native American MCH populations. In allocating funds for other community based programs, the needs of culturally diverse groups are directly addressed in the RFPs, through expectations for addressing the needs of racial and ethnic minorities and engaging representatives from culturally diverse groups in program planning and development. Further, the CLAS standards are an expectation outlined in the Title V RFP for communities and these standards are thus incorporated by reference into the awards made to community sub grantees.

C. Organizational Structure

During the 2007 legislative session, LB 296 was passed and signed into law by the Governor. This bill reorganized the three agencies that formerly formed the Health and Human Services System into one agency: the Department of Health and Human Services. This new structure went into effect July 1, 2007. The single agency is headed by a Chief Executive Officer. The Department has six divisions: Public Health, Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long-Term Care, and Veterans Homes. Title V/MCH functions are located in the Division of Public Health. Title V/CSHCN functions are within the ***/2014/Division of Children and Families.//2014//***

The Division of Public Health, is administered by Joanne Schaefer, MD, Chief Medical Officer and Division Director. Division functions and activities include environmental health, epidemiology, communicable disease programs, vital records, health data, facility and professional credentialing, community health planning and protection, health promotion, and public health services for various populations, including MCH. ***/2014/ Dr. Schaefer resigned as Chief Medical Officer and Division Director in March 2013. The newly appointed Chief Medical Officer and Division Director is Joseph Acierno, MD, JD.//2014//***

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

The Lifespan Health Services Unit was formed in 2007, with the merging of the Office of Family

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

/2014/ Thomas Pristow is the Director of the Children and Family Services Division. He earned his Bachelor's Degree in Sociology and Social Work in 1984, and a Master's Degree of Social Work in 1985 from the University of Maryland, Baltimore County. Previously, Pristow served as Director of the Louisa County Department of Human Services in Louisa, Virg., and Deputy Director and Director of Human Services for the City of Norfolk, Virg. He was a Regional Director and District Director of the Department for Children and Families Services Division for the State of Vermont. The Division of Children & Family Services serves thousands of Nebraska children, adults and families every day. Services within the Division focus on safety for children, adults and communities, Economic assistance benefits; Child support; and Youth Rehabilitation and Treatment Centers.//2014//

/2014/ Special Services for children and adults as of July 1, 2013, are administered in the Economic Assistance Unit in the Division of Children and Family Services. The Unit houses the following programs: Medically Handicapped Children's Program (MHCP), Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, SSI Disabled Children's gram, Genetically Handicapped Persons Program. This same Unit includes the SNAP (formerly known as Food Stamps), TANF, Child Care, Low Income Home Energy Assistance Program, Homelessness Prevention Grants, Refugee Resettlement Program, and Community Services Block Grant.//2014// This Unit coordinates with other Units within Medicaid that house the Medicaid State Plan and Home and Community Based Waiver Services for children with special health care needs. The Early Intervention Waiver ended and EI Waiver clients are now being served by the Home and Community Based Waiver program.

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

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

D. Other MCH Capacity

As described earlier, Planning and Support within Lifespan Health Services has primary responsibility for the ongoing administration of the Title V/MCH Block grant. Programmatic activities are carried out by various staff within the Lifespan Health Services. Maternal, Child Adolescent Health (MCAH) is responsible for school health, adolescent health, child health,

Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal depression and the First Time Motherhood/New Parents Initiative grant, and the Early Childhood Comprehensive Systems (ECCS) grant. This unit is staffed by 5.0 full time staff./2012/ The First Time Motherhood/New Parents Initiative will be ending in September 2012 as the one-year no cost extension expires. MCAH is now administering Abstinence Education, PREP, and Maternal, Infant and Early Childhood Home Visiting. This unit is now staffed by 7.0 FTE./2012//

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

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

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

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides supplemental food, nutrition and health education, and related services through 14 local agencies across the state. The program currently serves over 45,000 participants each month. WIC has provided leadership in MCH nutrition activities, including breastfeeding promotion and support. The State WIC Director is Nebraska's representative to the Association of State and Territorial Public Health Nutrition Directors (ASTPHN). The program is staffed by 10 full-time FTEs, with an additional information technology FTE under contract./2012/ A WIC Farmers Market Nutrition Program Grant was received by the Nebraska Department of Agriculture. This project is being implemented with the 2011 growing season, in collaboration with the WIC Program and its local agency serving a targeted neighborhood in Omaha./2012//

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

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

The Office of Women's and Men's Health within the Lifespan Health Services Unit has 23 FTEs. Though its major programs focus on older adults, it also administers State General Funds that support cervical cancer screening for women of reproductive age. The Women's Health Council, which is supported by the Office, addresses a wide range of issues for women. Currently, the Council has an active workgroup examining access issues for women experiencing pregnancy related depression. /2013/ The Council has largely completed its work on perinatal depression, but during 2012 was a key partner in promoting greater awareness of employer responsibilities for accommodating breastfeeding employees in the work place./2013// The Council has also partnered with other organizations to launch an initiative to address health disparities./2014/ ***With the retirement of the Administrator for the Office of Women's and Men's Health, initial reorganization is underway. CDC supported cancer screening programs will report directly to the Administrator of the Lifespan Health Services Unit. To be formed will be 3-person "Women's and Lifespan Health Initiatives" team which will support the work of the Women's Health Council, and also undertake broader initiatives of importance to the Unit, such as health literacy, cultural competency, social media, and community engagement./2014//***

The Patient Protection and Affordable Care Act offers much potential for additional MCH capacity, including that home visiting, abstinence education, personal responsibility education, and the pregnancy assistance fund. The Division of Public Health is actively considering the FOA's for

these funding opportunities as they are released.//2012/ The Division of Public Health applied for and received funding for Abstinence Education, PREP, and Maternal, Infant and Early Childhood Home Visiting programs. All three programs are administered in the Lifespan Health Services Unit, in close collaboration with Title V supported activities. //2012//

//2014/ Nebraska's MCH capacity in the area of continuous quality improvement activities has been steadily built over the past year. As part of a Public Health Improvement initiative, a newborn screening quality improvement team completed a successful quality improvement project using the Plan, Do, Study, Act model. The team increased the ability and confidence of staff members to utilize quality improvement methods in their work. The team was able to reduce the response time of mothers to obtain confirmatory testing for newborns who have potential hemoglobinopathies (e.g., sickle cell). This success is important because the sooner a disease is confirmed, the sooner a newborn can be treated. Gathering input from those affected (mothers and providers) was very important to determining the appropriate solutions to this problem. Having access to a quality improvement expert and training helped us make this project a success.

The Home Visiting quality improvement team is in the process of increasing the reach in terms of screening, assessment and enrollment, and successful engagement of services past 6 months in the target population. The team is working with two local home visiting programs to 1) implement creative outreach efforts to reach a wide number of the target population in the Panhandle and West Central Nebraska, 2) implement creative community outreach to reach the target population prenatally, and 3) evaluate and implement creative outreach methods, reduce consumer barriers, and implement strategies to keep families engaged. The team is currently implementing potential solutions.//2014//

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

In addition to administering MHCP, ***//2014/ Division of Children and Family Services //2014//*** is responsible for CSHCN services and activities. It partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website hosts Email Discussion Groups (Listserv) for these populations as well as information and resources for other populations with special needs. Answers4Families offers "Ask an Expert" and "Ask Rx," two services that allow users to confidentially ask questions via email to a registered pharmacist or family specialist. The website also includes the Nebraska Resource Referral System (NRRS), which offers over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, is accessible through this web portal. Addresses: <http://www.answers4families.org> and <http://www.answers4families.org/nrrs/>.

The MHCP clinic list and addresses of local workers are available on Answers4Families. Address: <http://www.hhs.state.ne.us/hcs/programs/MHCP.htm>. ***//2014/MHCP and Answers4Families are working to enhance the list of clinic staff and clinic staff bio of information to provide families looking at clinic services, information on the medical providers their child would receive services from.//2014//***

Nebraska Resource Referral System (NRRS) includes over 15,000 social services-type resources, including child care, respite coordinator information, medical/health and public health

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

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

//2014/For FFY 2012 (October 1, 2011 -- September 30, 2012), the Answers4Families/NRRS websites reported 98,458 unique visitors. The total number of visits for this time period was 145,481 with a total number of hits to the site at 5,878,857. //2014//

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

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

//2013/The Medically Handicapped Children's Program and the Disabled Children's Program offer services throughout Nebraska providing medical and supportive services to children and youth with special health care needs and their families. MHCP has 8 full-time employees and 2 half-time staff which are located in six local offices across Nebraska: Gering, Grand Island, Lincoln, Norfolk, North Platte, and Omaha. MHCP provides medical coverage and clinic services for this population to CYSHCN ages birth through 21 years of age. DCP offers support services such as respite, medical mileage reimbursement, lodging and meal reimbursement, home modification, vehicle modification, special equipment, sibling care, and attendant care to children and youth under 16 years of age to support family outcomes such as empowerment, care assistance, stress reduction, and access to medical supports.//2013//

//2014/ Title V/CSHCN Director, Teri Chasten, Economic Assistance Policy Chief, has been with the Nebraska Department of Health and Human Services (DHHS) since 2002. Teri began her career with the Department as a Social Services Worker completing determinations for Economic Assistance and Medicaid programs. Teri is currently the Administrator over multiple Economic Assistance programs which include, SNAP (formerly known as Food Stamps), TANF, Child Care, MHCP and DCP. //2014//

E. State Agency Coordination

Nebraska DHHS is part of a coordinated funding committee that encompasses Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral Palsy, the Disabled

Persons and Family Support Program, and other private non-profit programs to assure that individuals receive services for which they are eligible. This committee of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources for the past 27 years.

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

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

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

/2014/Additional trainings and workshops occurred to complement the Helping Babies from the Bench training series and to assist in local implementation of evidence-based practices to ensure improved outcomes for maltreated infants/toddlers and those experiencing social-emotional delays. Infant/Toddler Social-Emotional Regional Forums were held in 6 locations throughout the state in 2012 and 2013. These multidisciplinary forums were led by Child and Family Psychologist and infant mental health expert, Dr. Mark Hald, of Scottsbluff, NE and focused on local collective responses to social emotional interventions and treatment of maltreated infants/toddlers. Bridges out of Poverty was presented by Jodi Pfarr, national consultant, in 3 locations in the state throughout 2012 and 2013. Additionally, Jodi Pfarr conducted an intensive workshop with select EDN services coordinators and the Parent Resource Coordinators employed by the medical home clinics in Nebraska. The objective of this workshop was to ensure coordination between EDN and the medical home practices as well as improved access to services/resources for children with special health care needs who live in poverty. Dr. Karen Frankel, national consultant regarding infant mental health, conducted 2 workshops in 2012 and 2013 in 2 locations in Nebraska, focusing on the assessment and identification of infant mental health delays utilizing the Diagnostic and Classification Manual, Revised, 0-3 (DC: 0-3R) and provided critical interventions and treatment strategies for those infants diagnosed under DC:0-3R. The participants involved in these workshops included mental health therapists, psychologists, early interventionists, early childhood educators, child care providers, community action agency providers, Head Start/Early Head Start providers, child protection workers and family support specialists, and families.//2014//

/2014/The collaborative partnership between Early Development Network and Center for Children Families and the Law, Through the Eyes of the Child project, provided a regional

training on the utilization of the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire-Social Emotional (ASQ-SE) screening tools. This training was conducted in 2013 by a national consultant in which participants included the Project Safe Start therapists working specifically with court-involved maltreated infants and toddlers and the Early Development Network providers in the Project Safe Start Court communities. This training ensured that these therapists and EDN providers are correctly utilizing both the ASQ and ASQ-SE as a screening tool to provide accurate information leading to further needs for assessment, evaluation and interventions/services for infant mental health and early intervention.//2014//

/2014/A state-wide collaboration between the Nebraska Department of Education, Nebraska Department of Health and Human Services, University of Nebraska, and the Nebraska Children and Families Foundation focuses on the implementation of the Teaching Pyramid across the state in early childhood care/education programs. A state-wide strategic plan is in place to implement the Teaching Pyramid in several communities over the next 5 years.//2014//

As part of the Nebraska Newborn Hearing Screening Program's Early Hearing Detection & Intervention (EHDI) State Plan one of the System Goals/Activities is: All infants with a confirmed hearing loss will begin receiving early intervention services prior to six months of age. Under Program Objective 3.1, Health care providers and audiologists will refer all newborns and infants with suspected or confirmed hearing loss to the EDN for eligibility determination.

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

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

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

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

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

Referral System to attempt to provide referral assistance.

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

Within the larger Department of Health and Human Services, Lifespan Health Services has ongoing and active partnerships with Child Care Subsidy and Child Welfare within the Division of Children and Family Services, and Child Care Licensing within the Division of Public Health. It has expanded its collaboration with Behavioral Health, in conjunction with the Mental Health Component of the ECCS grant, the SAMHSA SIG project, and the perinatal depression grant. /2013/ During the past year, the Title V/MCH Director participated as a member of the Core Team and the Protocol Work Group of Nebraska's In-Depth Technical Assistance Project (IDTA). Support for the IDTA is provided by the National Center on Substance Abuse and Child Welfare, and Nebraska's project has been focused on families entering the child welfare/juvenile services system due to problems related to parental substance use, with particular emphasis on substance exposed infants, methamphetamine dependent parents, and children in out-of-home care. Representing Public Health, the Title V/MCH Director is working with representatives of the Court system, Medicaid, child protective services, and behavioral health to achieve systems integration and coordination for the benefit of children and families.//2013//

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

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

One member of the team participated on a planning group that developed the agenda and in June 2012 the team traveled to Chicago to participate in the State Policy Action Team on Integrating Quality Home visiting Services in State Early Childhood Systems meeting. The meeting offered both "expert" and peer technical assistance with the state teams sharing their expertise to explore possible solutions to current challenges. The meeting design afforded the team time to discuss each presentation and engage in action planning. The diversity of Nebraska's team proved to be a great asset and the team returned to Nebraska with several key ideas related to home visiting staff in early childhood professional development systems, collecting outcome data and integrating it into early childhood data systems, linking home visiting with Part C and other health/mental health services, including home visiting in quality improvement efforts, and leveraging existing funding sources to support a strong home visiting system. The team in partnership with Nebraska MIECHV is convening a group of home visiting stakeholders in August to share ideas and engage in collaborative planning. Team members have already implemented several action steps identified at the meeting, such as creating an early childhood framework and the private partner is piloting integration around having home visitors from their early childhood program include home visits to enrolled children's child care providers. The other states participating were: Connecticut, Michigan, New Mexico, Georgia, Ohio and Oklahoma. //2013//

//2014/ In 2012, the Nebraska Chapter of the American Academy of Pediatrics (AAP) applied for and received funding for a Building Bridges Project. Nebraska's ECCS Program Coordinator joined the NE AAP Chapter President in attending a Building Bridges planning session in Chicago in January 2013, which laid the groundwork for a Nebraska Building Bridges meeting held in April 2013. This meeting brought together NE AAP Chapter leadership and key stakeholders engaged in early childhood care and education as well as public health. The NE AAP Chapter President and the NE Title V/MCH Director will be following up on strategies identified during this meeting, with particular attention to incorporate into Nebraska's ECCS project when/if refunded. Nebraska has chosen mitigation of toxic stress among young children 0-3 as its focus for the upcoming ECCS project period.//2014//

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, representatives of the Douglas County Health Department actively participated in the recently completed needs assessment and were active participants in strategy development work groups. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) also participated in the needs assessment process and has been active work groups. Both urban health departments had representatives participated in a Infant Mortality Disparity work group. This work group will be described in greater detail later in this report/application. In addition, the Douglas County Health Department, through a contract, is developing specific capacity to further develop and promote preconception health interventions in the Omaha area./2012/ Work has been completed through the contract with the Douglas County Health Department (DCHD). DCHD is a collaborator with the Connections Project, being carried out through a contract with the University of Nebraska Medical Center. In addition, DCHD is the WIC local agency implementing the WIC Farmers Market Nutrition Program within the targeted Omaha community./2012// ***//2014/Nebraska applied for and received Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Development funds lste in FFY 2012. These fund are supporting enhancement and expansion activities in both DCHD and LLCHD. //2014//***

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

counties.//2012//**2014/ During FFY 2013, MIECHV funds were awarded through a contract to West Central District Health Department to support evidence based home visiting in Lincoln County.//2014//**

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

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

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

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including development and support of internet-based services for families of CSHCN and for school nurses./2014/ **A contract has been awarded to the Munroe-Meyer Institute to conduct the evaluation of Nebraska's MIECHV Development grant.//2014//**

The UNMC College of Public Health was formed in 2007. This college, along with the Great Plains Public Health Leadership Institute, provide opportunities for collaborations around staff development and building public health capacity. Of particular note are plans to develop a MCH emphasis at the CoPH. In addition, CityMatCH, with its administrative home in Nebraska and with partial support from UNMC, has been a valuable partner in a number of MCH initiatives.

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

An important partner for both Title V MCH and CSHCN is PTI Nebraska. PTI Nebraska is a statewide resource for families of children with disabilities and special health care needs. PTI Nebraska's staff are parent/professionals and are available to talk to parents and professionals about special education, other services and disability specific information. PTI Nebraska conducts relevant, no cost workshops statewide and provides printed and electronic resources. PTI Nebraska encourages and supports parents in leadership roles. Its Mission is to provide training, information and support to Nebraska parents and others who have an interest in children from birth through twenty-six and who receive or who might need special education or related services

and to enable parents to have the capacity to improve educational outcomes for all children. PTI and particularly its Family Voices Program, Family to Family Health Information Center has collaborated with Nebraska Title V on activities ranging from the needs assessment, to oral health access, and to medical home initiatives. ***/2014/The Family To Family Health Information Center provided one-to-one consultation to 559 families and 424 professional in FFY 2013. This entity serves as a valuable partner to the Title V CYSHCN population in Nebraska.//2014//***

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

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

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

*/2012/*The Medically Handicapped Children's Program is partnering with the University of Nebraska Medical Center's Munroe-Meyer institute on the Innovative Epilepsy Services Expansion in Nebraska Project Access. This is a three year grant with a work plan to provide expanded service delivery for rural pediatric patients with epilepsy as well as epilepsy educational opportunities for community stakeholders and school professionals.*//2012//*

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

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

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

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

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

DHHS will move to a full-risk capitated managed care program for the Medicaid Behavioral Health services effective July 1, 2013. This move will offer expanded case management opportunities for those with chronic mental health needs and will facilitate coordination between the medical and behavioral health services and needs of Medicaid clients.//2013// ***/2014/ Implementation for the Behavioral Health Managed Care services is scheduled for September 1, 2013, with Magellan selected as the managed care provider. //2014//***

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 02 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	98.4	97.4	100.0	91.5	90.7
Numerator	13402	13284	12077	8537	8471
Denominator	13625	13641	12077	9333	9343
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

Actual denominator is 11,381 with a rate of 106.12%. Reporting by NE Medicaid to CMS has changed. They have provided the following footnote:

Nebraska has changed its data-gathering process for this report. We can now more accurately count our medically needy population, and can now exclude state-funded enrollees from our data. This caused our overall enrollment figures to appear to increase our medically needy enrollment figures.

Narrative:

In January of 2012 Nebraska's ECCS Project Coordinator shared Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders developed by U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau with the Dental/Medical Home work group. This work group consists of early childhood stakeholders that are engaged in the implementation of the early childhood state strategic plan developed through the ECCS initiative. The two strategies of the TFKF plan that the Dental/Medical group focus efforts on are: 1) Implement and sustain the dental/medical home as a standard of care and 2) Establish the infrastructure to support a comprehensive system promoting access to oral health services including preventive oral health care. Started in 2012, this work continued into 2013 and will be built on in 2014.

During 2013, the Title V/MCH Director began meeting with some regularity with the key staff of the Medicaid Managed Care Organizations (MCOs) to begin identifying areas of collaboration.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 03 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	85.9	64.0	59.9	57.5	57.5
Numerator	972	438	431	416	443
Denominator	1131	684	719	724	770
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

NE Medicaid has exclude LPR (Legal Permanent Residents) <5 and all state funded enrollees from their 2010 data. They have submitted a State Plan Amendment to CMS and project the data to improve next year.

Narrative:

In January of 2012 Nebraska's ECCS Project Coordinator shared Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders developed by U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau with the Dental/Medical Home work group. This work group consists of early childhood stakeholders that are engaged in the implementation of the early childhood state strategic plan developed through the ECCS initiative. The two strategies of the TFKF plan that the Dental/Medical group focus efforts on are: 1) Implement and sustain the dental/medical home as a standard of care and 2) Establish the infrastructure to support a comprehensive system promoting access to oral health services including preventive oral health care. This work began in 2013, continued in 2013, and will be built on in 2014.

During 2013, the Title V/MCH Director began meeting with some regularity with the Medicaid Managed Care Organizations (MCOs) to begin identifying areas of collaboration.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 07B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	64.2	65.6	60.5	61.1	61.7
Numerator	20948	22709	20684	22282	23258
Denominator	32633	34629	34216	36480	37687
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

The ECCS Dental/Medical Home work group agreed that the toolkit was useful in assisting with further development of action steps and designated a small group to review the tool in depth and make recommendations regarding its use. In May 2012 the large group met for a facilitated planning session around three sections of the document that had been recommended by the review team. The three sections chosen were; Section 2: Medicaid's EPSDT mandates financing for child health services and supports to improve access to care; Section 6: States play a central role in maximizing the impact of EPSDT comprehensive well-child screening visits and Section 8: A dental home and appropriate dental services are essential to the health of every child. Many questions and ideas were generated from this discussion and group members agreed to follow-up with colleagues to answer questions those at the table could not answer, bring this back to the group and then reach consensus on actionable items for the work plan. This work continued into FY 2013 and will be built on in FY 2014.

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

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

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

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

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

/2014/ Public input provided during the preparation of this application included a number of comments regarding better communication on issues, policy and programmatic changes, and new resources. The challenges of clear communication will only increase as health care reform progresses into 2014. The role of Nebraska Title V in creating and

supporting more effective communication methodologies will need to be explored within NE DHHS and with partners.//2014//

B. State Priorities

Nebraska completed its most recent comprehensive needs assessment in 2010. Ten priority needs were identified. Below is a description of each priority need, NE's capacity and resource capability to address each, and the relative National and State performance measures. It must be noted that community-based projects addressing priority needs will NOT be known until planning for state-level strategies is conducted in FFY 2012.

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

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

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

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

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

/2014/ Public input for this application again pointed out mixed progress in some school districts in improving nutrition quality of meals.//2014//

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

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

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

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

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

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

/2014/ Public input noted that knowledge of and access to family planning services was noted to be inadequate among young women in the Omaha area. Importance of good preconception care was also noted.//2014//

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

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

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

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

/2014/ Public input pointed out the impact of sequestration on the Head Start Program and its subsequent impact on young children, including food insecurity.//2014//

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

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

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

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

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

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

/2014/ Public input noted that small communities have less resources for interventions to address language and cultural differences that impact access to care.//2014//

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

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

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

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

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

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

/2014/ Public input included concerns with limited pediatric dentists to meet the needs of CSHCN, especially outside of Lincoln, Omaha, and the I-80 corridor.//2014//

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

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

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

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

7. Reduce alcohol use and binge drinking among youth.

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

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

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

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

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

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

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

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

/2014/ Public input was similar for this application, but even more barriers were noted for accessing prenatal care, such as upfront payments required while Medicaid eligibility is pending.//2014//

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

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

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

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

/2014/ Sever commenters pointed out barriers to teen moms who choose to breastfeed, often tied to perceptions by hospital and other personnel regarding the likelihood of the teen mom being successful. The roles of schools, school nurses and teachers was also noted as critical for better support of teen moms who breastfeed.//2014//

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

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

systemic implementation. Nebraska will use the following measure to track progress:

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

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

/2014/ Among the public comments received were: the need to improve medical providers' knowledge of referral for disability evaluation, better relationship between medical provider and teen moms, and families not staying with the same provider because of insurance and/or frequent moves.//2014//

C. National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	545	600	644	838	771
Denominator	545	600	644	838	771
Data Source	Program Data				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100

Notes - 2012

166 babies had a presumptive positive and 605 had inconclusive screening result for a disease requiring confirmatory or repeat testing (follow up). This number does not include the 392 infants with hemoglobinopathy patterns that were indicative of trait/carrier status. Total infants that were tracked with presumptive positive, abnormal or inconclusive results is 1,163 for 2012.

Notes - 2011

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

Notes - 2010

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

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

a. Last Year's Accomplishments

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

All newborn specimens from Nebraska newborns were sent to PerkinElmer Genetics Inc. Laboratory. As a result of a negotiated rate of \$38.50 for testing and NBS fee. The fee is billed to the specimen submitters. For each infant screened the laboratory retained \$28.50 for shipping, laboratory testing services and reporting, and \$10 per infant was returned to the state program to help support the provision of metabolic formula and food, dietitian consultation and part of an FTE for a Pediatric Metabolic Specialist to assist the program with initial follow-up communication with newborns' medical homes. The contracts to provide metabolic foods and formula and medical/dietary services were supported via Cash funds from revenue generated by the fee, State General funds and the Title V Block grant allocation to the program. In addition, Title V funding helped support a consultant agreement with the Accredited Cystic Fibrosis Center to assist with follow-up and a consultant agreement with a pediatric hematologist.

Statistics

The numbers screened can only be reported by calendar year. In 2012 Nebraska had 26,287 births reported to the Newborn Screening Program of which 26,225 were screened or 99.7%. Sixty-two were not screened as they expired by 48 hours of birth. There were 97 home births, of which all were screened. Fifty four (54) newborns with disorders were identified and treated early to prevent mental retardation, physical disabilities and disease, and infant death. The following list identifies which conditions and the number of babies who were picked up on the screen and for whom early intervention was initiated:

- 5 Partial Biotinidase Deficiency
- 2 Congenital Adrenal Hyperplasia (Classical)
- 7 Cystic Fibrosis
- 2 Cystic Fibrosis Related Metabolic Syndrome
- 4 Classical PKU
- 1 Hyperphenylalaninemia
- 13 Congenital Primary Hypothyroidism
- 2 Primary Hypothyroidism (not congenital)
- 2 Hypothyroidism
- 1 Transient Hypothyroidism
- 3 Sickle Cell Disease S/S

- 1 SC Disease
- 1 Hgb. D/Beta 0 Thal
- 1 Hgb. C Disease
- 1 Hgb. E Disease
- 4 MCAD
- 2 SCAD
- 2 Transient Tyrosinemia (treated till resolve)
- 1 Mild Hypermethioninemia (not treated)

Other conditions detected not likely to be clinically significant during infancy:

- 152 Sickle Cell Trait (FAS)
- 37 Hb-C Trait (FAC)
- 17 Hb-E Trait (FAE)
- 4 Hb-D Trait (FAD)
- 22 Trait + Other
- 17 Misc. Traits

The program continued to implement in collaboration with the Early Hearing Detection and Intervention (EHDI) program, the NBSAC & EHDI Advisory Committee's recommendation for incorporating/integrating testing of dried blood spots for genetic causes of hearing loss such as Connexin 26 & 30, CMV, Pendred and mitochondrial causes. The Department monitored proposed regulation revisions to add SCID (severe combined immune deficiency) to the screening panel. A decision was made to not move forward with these at this time in 2013 .

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened, referred, tracked & facilitated treatment for 28 required disorders as per Neb. rev. Stat. 71-519 to 525.			X	
2. Conducted quality assurance activities with hospitals, contracted laboratory, and referral networks.				X
3. Provided metabolic foods, special formula, and consultation to patients/families through contractual arrangements.	X			
4. Provided leadership both nationally and regionally in promoting high quality newborn screening.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The program developed a RFP and underwent a competitive bid process for the laboratory services for newborn screening testing. The contract was again awarded to PerkinElmer Genetics Inc., and the price per screen will increase from \$38.50 to \$40 per infant screened. The program continues to screen for 28 required conditions in accordance with the ACMG core panel recommendation. Education, NBS testing, follow-up, referral and treatment and ongoing evaluation and quality assurance activities continue. The Program worked with a subcommittee of stakeholders on newborn screening for critical congenital heart disease and will continue to collaborate with them in developing regulations for recently passed legislation. In 2012 into 2013 the Nebraska Newborn Screening Advisory Committee (NBSAC) met quarterly and advised the program on many issues resulting in program staff making procedural, policy and working on

regulatory changes or at a minimum development of a Committee position or recommendation. The program continued its continuous quality improvement monitoring and submission of individual hospital QA reports (providing statewide averages for comparison). Two quality improvement initiatives were undertaken, one to reduce the unsatisfactory specimen rate, and one to improve the turn around time for when positive hemoglobinopathy screens are confirmed. Both of these initiatives continue in 2013.

c. Plan for the Coming Year

The program and its advisory committee will be developing the regulations to implement LB 225, Critical Congenital Heart Disease Screening. The program will also be evaluating the Secretary's Discretionary Advisory Committee on Heritable Diseases in Newborns and Children latest recommendation to add Pompe to the Recommended Universal Screening Panel (RUSP), pending the Secretary's determination to endorse the recommendation or not. Ongoing operation of the program will continue as described above.

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

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

Total Births by Occurrence:	26283					
Reporting Year:	2012					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	26221	99.8	12	4	4	100.0
Congenital Hypothyroidism (Classical)	26221	99.8	95	18	18	100.0
Galactosemia (Classical)	26221	99.8	0	0	0	
Sickle Cell Disease	26221	99.8	3	3	3	100.0
Congenital Adrenal Hyperplasia	26221	99.8	9	2	2	100.0
Cystic Fibrosis	26221	99.8	29	7	7	100.0
Hyperphenylalaninemia	26221	99.8	12	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	26221	99.8	17	4	4	100.0
Hearing Screening	26021	99.0	842	31	24	77.4
Short Chain Acyl-CoA Dehydrogenase Deficiency	26221	99.8	7	2	2	100.0
Partial Biotinidase	26221	99.8	7	5	5	100.0

Deficiency						
Hemoglobin C-Disease	26221	99.8	1	1	1	100.0
Hemoglobin E-Disease	26221	99.8	1	1	1	100.0
Cystic Fibrosis Related Metabolic Syndrome (Non classical)	26221	99.8	2	2	2	100.0
SC - Disease	26221	99.8	1	1	1	100.0
Hb D - Punjab/Beta 0 Thalassemia	26221	99.8	1	1	1	100.0

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	67	68.4	69.7	71.1	77.1
Annual Indicator	65.7	65.7	65.7	75.6	75.6
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	78.6	80.2	81.8	83.5	85.2

Notes - 2012

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

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

Continued promotion of the comprehensive Child Find System.

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

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in the Family to Family Health Information Center Advisory Board which partners with partners with parents in working to streamline communication and improve systems for CSHCN.				X
2. Promotion of Child Find System through the Early Development Network.		X		
3. Continued participation in the Early Childhood Interagency Coordinating Council which brings together stakeholders, schools, parents, families, policymakers, and business and civic organizations to support and enhance seamless early childhood		X		

care.				
4. Maintain collaborative efforts through support to local 28 Planning Region Teams to monitor and lead their areas in working towards streamlined services and supports for children needing and receiving Early Intervention Services.				X
5. Facilitation of parent leadership/mentoring activities to enhance Early Development Services.				X
6. Maintain the Early Hearing and Detection Advisory Committee which works alongside parents to maintain an ongoing voice in enhancing hearing services for infants.				X
7. Participation in the development of the Aging and Disabilities Resource Center for Nebraska (ADRC) to support access to services and supports to all populations including CYSHCN.				X
8.				
9.				
10.				

b. Current Activities

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

Continue promotion of the comprehensive Child Find System.

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

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

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

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

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

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

c. Plan for the Coming Year

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

Will continue promotion of the comprehensive Child Find System.

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

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

Continue participation in the Family to Family Advisory Board to encourage communication

among all participants to enhance services of all types for children and youth with special health care needs.

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

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

Support and collaborate on the development and implementation of the Nebraska's Aging and Disability Resource Center (ADRC). The Advisory Board will include families and partners of CYSHCN.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	55.2	56.4	57.5	58.6	49.2
Annual Indicator	54.2	54.2	54.2	48.2	48.2
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	50.2	51.2	52.2	53.2	54.3

Notes - 2012

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

surveys are comparable.

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Early Development Network continued to support the Parents Partners Project through the Parent Training Center.				X
2. MHCP staff support the medical home model for children receiving program services.			X	
3. Continued collaboration through CAPTA process to inform families of the medical home model.			X	
4. Implementation of the Aged and Disabled Resource Center to support the medical home model.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continued partnership in the Medical Home Project through the Parent Training Center with four medical practice Parent Partner sites.

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

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

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

Continue to utilize HRSA resource material to support staff delivery of Medical Home resources.

c. Plan for the Coming Year

Continue the partnership in the Medical Home Project through the Parent Training Center with four medical practice Parent Partner sites.

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

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

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

Utilize HRSA resource material to support staff delivery of Medical Home resources.

Develop training for MHCP staff on the medical and dental home models to support information sharing to families.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	67.2	68.6	69.9	71.3	60.9

Annual Indicator	65.9	65.9	65.9	59.7	59.7
Numerator					
Denominator					
Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	62.1	63.4	64.6	65.9	67.2

Notes - 2012

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Physical Health Managed Care implemented statewide July 1, 2012.				X
2. Medicaid CHIP coverage to children and families with incomes up to 200% of the Federal Poverty Level.				X
3. Implementation of expanded CHIP (Children's Health Insurance Program) coverage to the unborn child of mothers who do not qualify for any other Medicaid programs offered by DHHS.				X
4. Development of the Aging and Disabilities Resource Center to support access to information, application, and referral for health care coverage.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

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

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

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

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

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

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

Implementation of expanded CHIP (Children's Health Insurance Program) coverage to the unborn child of mothers who do not qualify for any other Nebraska Medicaid programs.

c. Plan for the Coming Year

Complete draft recommendations for an increase/change to financial guidelines for the Medically Handicapped Children's Program.

Will continue collaborative efforts with the Family to Family Health Information Center.

Implement Behavioral Health Managed Care statewide through a Magellan, the selected vendor.

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

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

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

Continue CHIP (Children's Health Insurance Program) coverage to the unborn child of mothers who do not qualify for any other Nebraska Medicaid programs.

Collaborating on ACA planning and determining impact on CYSHCN population.

Collaborate on the Aging and Disabilities Resource Project to provide information, referral, and program application for medical coverage.

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

Tracking Performance Measures

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

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

Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective	73.5	75	76.5	78.1	79.6

Notes - 2012

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

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

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

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

EDN administered a yearly satisfaction survey reporting on services coordination and delivery of service.

The MHCP program continued to use the parent clinic satisfaction survey.

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

and partnerships.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in the Family to Family Health Information Center Advisory Board for family input to service delivery models to CYSHCN.				X
2. Yearly state-wide survey of families who have a child enrolled in Early Development services to assess the previous year's service delivery experience.				X
3. Continued enhancement of the Transportation Brokerage services to streamline access for all populations including CYSHCN.				X
4. MHCP Clinic family experience surveys to continuously review the delivery of services model.				X
5. Implementation of the Aging and Disabilities Resources Center Advisory Group to promote awareness and access to statewide services and supports.				X
6. Partnership with Parent Training Center.				X
7. July 1, 2013 transition of Medicaid eligibility determinations to the Division of Medicaid and Long-Term Care.				X
8.				
9.				
10.				

b. Current Activities

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

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

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

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

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

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

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

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

c. Plan for the Coming Year

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

Continue to evaluate the delivery of services by the Transportation Brokerage to ensure streamlined access to authorized program services using one statewide entity for access for families.

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

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

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

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

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

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

Transition Medicaid eligibility determination work tasks to the Division of Medicaid and Long-Term Care to support Medicaid program eligibility determinations.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	55.4	56.6	57.7	58.8	48.5
Annual Indicator	54.4	54.4	54.4	47.6	47.6
Numerator					
Denominator					

Data Source	National Survey of CSHCN				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	49.5	50.5	51.5	52.5	53.6

Notes - 2012

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

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

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of a transition model which includes both educational and medical transition components through one streamlined service.				X
2. Development of transition tools for families accessing MHCP clinics to those ages 8 and up to support child-center independent tools for improved outcomes of transition.				X
3. Collaboration with Easter Seals Nebraska's Work Choice Program who administers the Nebraska's Ticket To Work website.				X
4. Development of the Aging and Disabilities Resource Center to support providing transition information/resources and linking families to state/local transition resources.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

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

Enhance partnership with Parent Training Center to provide training clients and care providers on transition planning and services.

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

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

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

c. Plan for the Coming Year

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

Continue to utilize HRSA materials to assist in educating MHCP staff on transition practices and develop staff training.

Enhance partnership with Parent Training Center to provide training clients and care providers on transition planning and services.

Continue collaboration with Easter Seals of Nebraska to develop useful age appropriate tools to support preparing MHCP clients and their families for transition. This will include a transition model that encompasses education, health, independent living, work placement as well as other identified barriers to independent living.

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

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	83.5	83.6	76.2	73.2	78.2
Annual Indicator	74.8	59.9	78.9	77.8	74.8
Numerator					
Denominator					
Data Source	CDC NIS				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	79.8	81.4	83	84.7	88.1

Notes - 2012

Provisional rate represents the first 6 months of 2012. The full year will be released late August/early September. This rate is 74.8% +/-6.6.

Notes - 2011

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

Final rate is 77.8+/-6.4

Notes - 2010

78.9+/-5.9

a. Last Year's Accomplishments

It should be noted that CDC uses a different standard for measuring immunization coverage than the one stated for this national performance measure. As the number of recommended immunizations has increased so has the CDC performance measure. The CDC considers a full schedule of age appropriate immunization to include varicella and pneumococcal vaccines as well as the immunizations listed above. The National Immunization Survey for calendar year 2012 will not be released until late August 2013. The 2011 coverage rate for Nebraska is 77.6% for the full list of vaccines CDC uses; the national coverage level is 68.5%.

The Nebraska Immunization Program is located within the Lifespan Health Services Unit. Primarily funded through the CDC, this program administers the Section 317 and Vaccines for Children (VFC) funds as well as the perinatal hepatitis B prevention program. In 2012 the program supported public immunization clinics across the state, 45 public VFC providers and 232 private VFC providers.

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

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

In the Maternal Child Adolescent Health Program within Lifespan Health Services, a senior community health nurse provides consultation, education, and information services to the public and Nebraska providers on the importance of immunization and assists in education to correct misperceptions about risks, barriers, or contraindications of immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported public immunization clinics, including 45 public VFC providers, and supported 232 private VFC providers.			X	
2. Continued support of and enhancements to Nebraska's State				X

Immunization Information System (NESIIS).				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Immunization Program continued to support 86 counties with public immunization clinics and private VFC providers. The Program will use the allocation of Title V funds this year as partial support for NESIIS as it continues to develop new modules and upgrades its functions, particularly the ability to download immunization data from other electronic health systems. New providers are being enrolled and trained throughout the state. Immunization records in NESIIS have increased from 1,133,000 records last year to at least 9,338,896 records so far this year, largely due to electronic data exchanges. Provider organizations participating in NESIIS has grown from 974 to 1,167.

In the Maternal Child Adolescent Health program area within Lifespan Health Services, the team is joined by three regional DHHS nurses who are staffed to the immunization program (0.83 FTE each) and to MCAH (0.17 FTE). This blending of expertise through monthly meetings and shared learning activities has enhanced the programmatic connections between MCAH and Immunization.

c. Plan for the Coming Year

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

At the policy level, CDC has restricted use of Section 317-funded vaccine. Formerly, Nebraska's public immunization clinics vaccinated any child presenting regardless of insurance status, with free will donations the only compensation sought. The Program received a CDC grant to explore options for public immunization clinics to bill 3rd party payers. A contractor was selected competitively, and is currently beginning work in evaluating capacity of the public clinics and infrastructure needed to bill. This work will continue into FY 2014.

In Maternal Child Adolescent Health within Lifespan Health Services, a preconception health project offers opportunities to address HPV and Hep B immunization recommendations for the target population, aged 12-16 years.

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

Tracking Performance Measures

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

Annual Objective and	2008	2009	2010	2011	2012
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Performance Data					
Annual Performance Objective	16.6	17.4	17.1	15.2	11.8
Annual Indicator	18.2	17.4	15.3	12.1	12.2
Numerator	671	633	562	456	453
Denominator	36878	36349	36734	37584	37206
Data Source	Birth File, Census Est.	Birth File, Census Est.	Birth File, Census	Birth File, Census	Birth File, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	11.9	11.7	11.5	11.3	11.1

a. Last Year's Accomplishments

Contract oversight utilizing TANF funds to deliver services statewide to women who are pregnant or think they are pregnant continues. With these resources, the contractor is promoting access to crisis pregnancy, adoption, parenting education and outreach services, including fathers. New to the contract agreement this year was the contractor's agreement to gather information from client women on their perceived social, economic, and environmental barriers to accessing prenatal care.

The Adolescent Health Program in Nebraska DHHS continued administration of the Personal Responsibility Education Program, entering the second year of sub-grants to support a total of 11 local clubs using the approved evidence-based curriculum called TOP(c) Teen Outreach Program. Approximately 150 youth are served by these clubs.

The Adolescent Health Program also operated a federally-funded Abstinence Education program in three project locations in the state. Program or contact duration with youth varies by activity.

The TUNE MY LIFE life course plan booklet for teens underwent further revision, expanded to address both male and female perspectives. Even so, the intent to use the booklet in the Personal Responsibility Education Program was dropped due to lack of clarification and appropriateness regarding expectations of adult behavior in auditing, reviewing, or responding to youth responses.

In the maternal-infant health area in Lifespan Health Services, a senior community health nurse provides consultation, education, and resources on maternal and infant health topics of a general scope. Included in this scope is the role of clarifying or providing resource information on state laws regarding teen sexual activity in Nebraska.

Calendar year 2012 saw a 9% decrease in adolescent Title X Family Planning unduplicated users. For the age group 19 and under there is a 16% decrease. This decrease follows two years of increasing utilization of services by adolescents. The decrease is attributed to lack of resources to effectively promote services. With the expectations outlined in the Affordable Care Act, any extra resources are being used to ensure the implementation of electronic health records in all of the Title X clinic sites to meet the requirements of meaningful use.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided ongoing Title X Family Planning services to adolescents statewide via delegate agencies.	X			
2. Delivered Abstinence Education activities to youth in three multi-county project locations via sub-grantees.		X		
3. Delivered PREP project activities to youth in eleven project sites via sub-grantees.		X		
4. Applied for additional funding from the Pregnancy Assistance Fund to deliver services to expectant and parenting teens, with benchmark measure of reducing subsequent pregnancies during teen years.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the Adolescent Health Program area, the previous long-time Adolescent Health Coordinator has retired. New leadership in the program is now in place, and thorough review and assessment of strategic directions and program effectiveness is underway.

The PREP (Personal Responsibility Education Program) and Abstinence Education Programs continue via oversight of sub-grantees. While all sub-grantees are delivering activities within expectations, projected target populations, in terms of numbers, diversity, and existing risk factors, are not being reached at an adequate pace to fulfill the approved state plan for these program areas. Sub-grantees are receiving input from the program coordinator on outreach, spending, reporting, and grant compliance. Program sites are being evaluated to determine whether plans can be revised to a) reach more youth and b) provide meaningful state-level and state-wide activities in addition to activities in local project sites.

In the Adolescent Health Program, a new strategic goal is the development of a collaborative preconception health initiative, geared to reaching youth audiences with the preconception health key messages campaign recently introduced by the Centers for Disease Control and Prevention.

Title V funds support community based education offered by Title X Family Planning agencies. Topics for adolescents typically include: abstinence, refusal skills, life-planning, healthy relationships, and healthy pregnancy/birth planning.

c. Plan for the Coming Year

DHHS plans to expand the scope of the DHHS School Health Program, funded by Title V, to incorporate content and approaches of the Personal Responsibility Education Program and Abstinence Education Program via cross-training in program leadership. This will magnify the impacts of those programs.

The development and expansion of a Preconception Health Initiative for youth aged 12- 16 years old, is planned building on the CDC messaging campaign for preconception health and ADDING dental health and avoidance of prescription and over the counter drug abuse.

The TUNE MY LIFE life course plan will be revised and reformatted as follows: Revise language to a less-complex "youth voice;" Add key prevention messages, embedded within each topic area; onstruct questions relative to the key message areas of the preconception health initiative; Include a do-it-yourself simple method for youth to assess responses and derive meaningful action steps -- without adult intermediary. For example a scoring system, with interpretations and or suggestions pertaining to health development in the topic area; and, Clarify and state the objectives of the life course plan: to stimulate the mental processes in youth of reflection and introspection; expression of goals and interests; encourage sequential and longitudinal thought processes relative to reaching goals; promote the development of these executive functions in youth and young adults.

In the family planning area, financial support received through the MCH block grant will continue to play an integral role in the ability of the Nebraska Title X sub-recipients to meet the expectations that the Office of Population Affairs outlines for Title X service providers. Those expectations include community education programming to enhance knowledge delivery systems available in their service areas offering evidence-based sexual and reproductive health information. In addition Nebraska Reproductive Health has applied for funds to support the implementation of electronic health records. If awarded, this should help take the financial pressure off of providers so that resources can be redirected to marketing. Additionally, Nebraska Reproductive Health participated with Nebraska MCAH in the application for funds to support programming for pregnant and parenting teens. This funding, includes a marketing component that would assist in marketing the services available through The Title X service delivery system.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	48.9	50	50	50	50
Annual Indicator	44.6	44.6	44.6	44.6	44.6
Numerator	10489	10489	10489	10486	10486
Denominator	23518	23518	23518	23518	23518
Data Source	NE Open Mouth Survey 2004	NE Open Mouth Survey			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	50	50	50	50	50

a. Last Year's Accomplishments

The Dental Director position continued to be vacant. Interviews were held during the spring of 2012, but the qualified candidates were either unable to relocate or unwilling to accept the

position at the compensation level offered. The Dental Health Coordinator sustained partnerships with oral health stakeholders by convening three meetings of the Nebraska Oral Health Advisory Panel (February 21, 2012, May 22, 2012, and August 30, 2012). The Dental Health Coordinator attended the National Oral Health Conference in Milwaukee, Wisconsin on April 29 to May 3, 2012. She was able to attend sessions on health literacy and cultural competence, collaborative models for school-based prevention, state oral health coalitions, and partnerships with MCH programs. The Dental Health Coordinator also participated in Nebraska Mission of Mercy, July 13-14, 2012 in Alliance, NE. The two day event provided restorative and preventive care to 749 children and families with significant oral health needs and low access to care. The Dental Staff Assistant distributed oral health supplies and materials and provided day-to-day help to the Dental Health Coordinator.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the work of the Office of Oral Health and Dentistry, including the work of the Dental Health Coordinator.				X
2. Nebraska Oral Health Advisory Committee met regularly.				X
3. Participated in the Nebraska Mission of Mercy dental day, providing access to dental care to low income children and families.	X			
4. Provided educational materials and supplies to community based organizations.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nebraska Title V Block Grant funds are being used to sustain activities of the Office of Oral Health and Dentistry. The full time Dental Health Coordinator position was supported in the NDHHS Office of Oral Health and Dentistry beginning January 1, 2013. (HRSA funds ended on December 31, 2012 at the end of a 4 month no-cost extension). A part time Support Staff position is also being supported, starting January 1, 2013. The Dental Health Coordinator sustained partnerships with oral health stakeholders by convening two meetings of the Nebraska Oral Health Advisory Panel. A meeting of the Advisory Panel was also convened later by the acting Dental Health Coordinator on May 15, 2013 (the Coordinator having resigned). The Dental Health Coordinator was instrumental in arranging for the initial meetings of the Nebraska Oral Health Coalition (October 25, 2012 and Feb 14, 2013). The Dental Health Coordinator arranged for a survey of licensed Dental Hygienists who hold Public Health Authorization Permits to ascertain their performance of public health dental services, location and interests. The survey was conducted under contract with the UNMC College of Public Health, Health Professional Tracking Service. The Coordinator has since resigned. In June 2013, Nebraska Legislature approved state funding to support the Dental Director position. The administrative process, including seeking permission to hire, posting, and interviewing are anticipated to be completed by Sept 2013.

c. Plan for the Coming Year

The new Dental Director will assume duties, providing leadership for the Office of Oral Health and Dentistry, building on existing partnerships and leveraging funding to increase availability of

preventive dental services and advance oral health status. State funds will support this position.

The new Dental Health Coordinator will assume duties, overseeing the operations of the Office of Oral Health and Dentistry. The position will arrange Oral Health Advisory Panel meetings and facilitate further development of the Oral Health Coalition. Nebraska Title V Block Grant funds will support this position.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	3.4	3.3	3.2	2.7	2.7
Annual Indicator	1.7	3.4	3.6	1.1	5.6
Numerator	6	12	13	4	20
Denominator	343908	349420	357420	359412	356941
Data Source	Death file, Census Est.	Death file, Census Est.	Death file, Census	Death file, Census	Death file, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	5.5	5.4	5.3	5.2	5.1

Notes - 2010

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

a. Last Year's Accomplishments

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

In 2012, child passenger safety technician certification trainings were held in Scottsbluff, Omaha, and Lincoln. A total of 69 participants were certified. These courses have been implemented since 1999 in Nebraska. These activities have contributed to an increase in the number of children being properly restrained in car seats; the rate for 2011 was 95.9%. This is a significant increase from 1999 at which time only 56% of children were restrained. Currently, there are 345 Certified Child Passenger Safety Technicians (CPST) across the state. The Safe Kids program provides technical assistance and grant opportunities to these technicians and their communities. Certification courses are sponsored by Safe Kids and the Nebraska Office of Highway through funding and staff time. The Nebraska Office of Highway Safety and Safe Kids Nebraska co-hosted a Child Passenger Safety Technician update in Kearney, Nebraska in March, 2012 with

over 160 technicians from across the state in attendance.

A "Safe Travel for All Children" class, which addresses child passenger safety for children with special needs, was held in Lincoln, Nebraska in November, 2012. Ten people attended the class.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted child passenger safety technical certification trainings.			X	
2. Conducted a "Safe Travel for All Children" class for families with special needs children.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Nebraska Office of Highway safety is supporting statewide child passenger safety efforts by funding 23 fitting stations and four child passenger safety technician certification classes. In 2013, class has been held in Norfolk with additional classes scheduled in Hastings, Omaha and Lincoln. The Safe Kids Buckle Up program continues to support Safe Kids programs throughout the state with funding to plan and implement child passenger safety activities in their communities. Child Passenger Safety events are held routinely in these communities along with advocacy training and educational events for parents/caregivers. In May 2013, new child care regulations became effective which require child passenger safety training for child care centers that transport children. The Safe Kids Nebraska program developed the Safe Kids Nebraska Child Care Transportation Training curriculum to train child care centers. There are more than 50 CPST across the state trained to teach the curriculum to about 500 centers across Nebraska.

c. Plan for the Coming Year

The Nebraska Child Passenger safety Advisory Committee will convene its meeting in the fall to discuss the 2014 training schedule as well as other issues affecting child passenger safety. Safe Kids Nebraska will continue to utilize safe Kids Buckle Up grants to help communities conduct child passenger safety check up events, educational programs and trainings.

Through the public comment process, it was noted that it is difficult in some communities to get an appointment for a car seat check, and that there a limited resources to procure car seats for low income families. Title V and Safe Kids Nebraska will explore possible solutions.

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

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

Annual Objective and	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective	56	66.5	47	67.8	51
Annual Indicator	65.2	46	66.5	49.5	50.7
Numerator					
Denominator					
Data Source	National Immunization Survey				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	52	53	54	55	56

Notes - 2012

79.8% of woman reported initiating breastfeeding of those 50.7% reported breastfeeding longer than 180 days. However, only 24% reported exclusive breastfeeding over 180 days.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

In the Maternal Child Adolescent Health Program, staff collaborated on an educational program for community health and public health nurses statewide, which included a contact hour session on breastfeeding and food introduction practices as a continuum of behaviors in combatting childhood obesity. Several hundred professional nurses attended one of a series of programs delivered in multiple locations. One of the breastfeeding objectives in the MCAH area is to

increase the competency of all nurses in the community to support and raise awareness of breastfeeding. This session has been followed by planning for a follow up activity with more in-depth lactation support education for licensed nurses, due to audience response.

Strategic planning in MCAH about breastfeeding activities and objectives resulted in the following priorities: enhance competence of professional nurses in community practice in Nebraska in the area of breastfeeding support and education; address the education needs of trained lay health workers in Nebraska communities (home visitors, lay health ambassadors) in breastfeeding support and encouragement; and contribute to the Nebraska Physical Activity and Nutrition State Plan by conducting a breastfeeding survey of birthing hospitals in Nebraska.

A senior community health nurse on staff in MCAH is a member of the statewide breastfeeding coalition. In addition to education and training for nurses statewide, the Sr. CHN also provides information to providers, employers and the public on legal protections for breastfeeding at work.

Seven WIC Local agencies sent staff to attend the Certified Lactation Counselor training program in June of 2012. State WIC program continued to collaborate with the Nutrition and Activity for Health Program to implement appropriate activities as part of Nebraska's Physical Activity and Nutrition Plan - Breastfeeding Action Plan Goal to Increase Breastfeeding. WIC state and local agency staff continued collaboration with the NE Breastfeeding Coalition, on breastfeeding support and promotion activities, training opportunities, resource sharing, and promoting breastfeeding friendly workplace education. State WIC Breastfeeding coordinator attended the Fourth Annual Conference on Coalitions sponsored by the United States Breastfeeding Committee.

In December 2012, WIC Program Dietetic Intern completed an informal survey of breast pump availability and breast pump concerns in counties across Nebraska served by WIC agencies. Findings from this survey were shared with DHHS staff and NEBFC members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided coursework on breastfeeding support for community and public health nurses across the state.				X
2. Conducted strategic planning for MCAH activities related to breastfeeding support.				X
3. Participated in Nebraska Breastfeeding Coalition.				X
4. Local WIC staff attended Certified Lactation Counselor training.				X
5. Collaborated with Nutrition and Activity for Health program in implementing its Breastfeeding Action Plan.				X
6. Completed an informal survey of breast pump availability and shared results with Coalition.				X
7.				
8.				
9.				
10.				

b. Current Activities

In MCAH, A breastfeeding survey of Nebraska birthing hospitals has been conducted and data gathered on policies and practices in 49 of 59 birthing hospitals.

The Sr. Community Health Nurse is a certified lactation counselor. The Sr. CHN has engaged in a collaborative activity with the DHHS Office of Health Disparities and Health Equity to develop

BF support education for lay health ambassadors serving multicultural groups.

In August of 2013, WIC local agency directors and breastfeeding coordinators will attend a two-day workshop, "Loving Support Through Peer Counseling: A Journey Together", by trainers from Every Mother, INC. This workshop will allow local agencies to implement the updated information using an innovative and cutting edge presentation design with high visual, flexible navigation approach to training peer counselors. In August of 2013, State WIC breastfeeding coordinator and two local agency breastfeeding coordinators will present the breakout session; "Peer Counseling, Making a Difference for WIC Families" at the 10th Biennial Breastfeeding, Babies Natural Choice Conference". WIC will also provide a display for this well attended conference. WIC state and local agency are developing a statewide joint strategy for breastfeeding support and the goal of increased breastfeeding and exclusive breastfeeding at 6 months of age, incorporating the strategies from the National WIC Association Plan and the NWA Six Steps to Achieve Breastfeeding Goals Checklist.

c. Plan for the Coming Year

MCAH will report and release results of hospital survey. Add two breastfeeding support materials developed to be culturally and linguistically appropriate and accessible to diverse readers. Develop and produce web-based on-demand education for the lay home visitor on breastfeeding support and education. Deliver every-other year continuing education to nursing audiences in the state on breastfeeding support and education, relevant to maternal and infant health, weight control, and life course health.

For FY2014, the WIC program will be working on the new 3 year strategies and actions steps associated with implementation of the NWA National Breastfeeding Strategic Plan to assist agencies in improving and sustaining breastfeeding rates among WIC clients. State WIC program staff will continue to provide technical assistance and administrative support for the Breastfeeding Peer Counseling Programs, collaboration with NAFH program and NEBFC activities, and participation in the USBC bimonthly webinars and conference calls.

Public input regarding the lack of supports for teen moms who choose to breastfeed as a significant barrier. Strategies to address in both hospital and school settings will be explored.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	99.9	100	100	100	100
Annual Indicator	99.3	98.9	99.4	99.4	99.6
Numerator	26791	26804	25908	25749	26019
Denominator	26972	27103	26059	25915	26127
Data Source	Program Data				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Nebraska Revised Statute SS71-4742 established that newborn hearing screening would voluntarily become the standard of care and that 95% of newborns would be screened for hearing prior to hospital discharge. During calendar year 2012, 100% of the 56 birthing facilities were conducting newborn hearing screenings; 55 conducted the screenings during birth admission and one conducted outpatient screenings. The 55 inpatient screening hospitals reported screening the hearing of 99.6% of the newborns during birth admission. The average refer rate (failed inpatient screening rate) was 3.3%. Outpatient re-screenings and/or diagnostic evaluations were completed for over 90% of those needing follow-up services. There have been 31 infants identified with a permanent childhood hearing loss, an incidence of 1.2 per thousand newborns. Of the 31 infants identified with a permanent hearing loss, 54.8% were identified prior to three months of age; 92.6% were verified prior to six months of age.

"Lost to Follow-up:" The NE-EHDI Program has continued to successfully reduce the "lost to follow-up" percentage from approximately 10% for babies born in 2010 to under 5% in 2011 to under 4% in 2012. This reduction has been achieved because of access to more resources that can assist in locating and contacting parents and the persistence and dedication of the follow-up staff. In past years, the NE-EHDI Program would consistently be tracking around 100 -- 120 babies at a time who needed an outpatient hearing screening. However, due to the follow-up efforts of the Community Health Educators and Community Outreach Coordinator, the number of babies currently being followed in "working status" has stayed consistently below 60. This statistic shows the out-patient results are being reported in a more timely manner than in past years.

The Nebraska Early Hearing Detection and Intervention (NE-EHDI) Program continues to make strides in reaching home births and ensuring that the babies have hearing screenings. Efforts addressing the importance of newborn hearing screenings have been initiated with primary doctors frequently involved in planned home births.

After successful data entry by Boys Town National Research Hospital (BTRNH), efforts are underway to encourage other audiologists, in the state, to enter hearing screening data into the Nebraska Electronic Registration System (ERS). This will streamline the data entry process with complete and accurate data for a majority of the outpatient screenings and diagnostic evaluations completed in Nebraska. It will also help the NE-EHDI Program ensure that children identified with a hearing loss have the opportunity to receive timely early intervention services through the Nebraska Early Development Program/Part C (EDN).

During this time period, a primary focus of the NE-EHDI Program has been to strengthen family support for families with young children recently identified with hearing loss. The NE-EHDI Program worked with Hands and Voices in hopes of establishing the Guide by Your Side program in Nebraska. The Nebraska Program has been approved by the national Hands and Voices and initial funding secured. The sixth parent Roots and Wings weekend was held at the Lied Lodge in Nebraska City, Nebraska on September 28 -- 30, 2012. Topics included information about growing up with a hearing loss, language development, small group discussions, how to read an audiogram, and other issues related to children with a hearing loss and parenting. The workshop provides lodging, child care, and social activities for the families and exhibit space for related organizations, including the NE-EHDI Program. The workshop continues to be rated very highly, on the evaluation forms, both for content of the sessions and the opportunities to network with other families. Information about Roots and Wings and survey results were shared in a presentation to the NE-EHDI Program Advisory Committee.

In the fall of 2012, NE-EHDI Program staff made site visits to four hospitals in western Nebraska. The sites were chosen based on responses to a professional development survey that was sent

to all birthing hospitals and hospitals with high inpatient refer rates. At the site visit NE-EHDI Program staff reviewed the facilities most recent quality assurance report, discussed ways to improve refer rates and reduce lost to follow-up, and demonstrated how to use the Nebraska Vital Records ERS system to report hearing screening results.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Current program objectives include but are not limited to:

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

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

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

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

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

Finish development of a Web site for the Nebraska Early Hearing Detection and Intervention Program and implement the Web site in 2013.

In cooperation with the Nebraska Immunizations program, send weekly data exports of hearing screening as well as audio evaluations to the Nebraska State Electronic Immunizations Information System (NESIIS). The data will be available through NESIIS to parents, health care

providers, schools and early head start programs authorized to access the data.

c. Plan for the Coming Year

With the benchmark of 95% of newborns screened during birth admission having been consistently met, program activities for calendar year 2014 will continue on implementing the ongoing mandates of Nebraska's Infant Hearing Act: expansion, enhancement, and maintenance of the reporting and tracking system, collection of required data, application for federal funding, and providing consumer and professional education. The goals and objectives identified in the federal funding applications (HRSA/MCHB and CDC/NCBDDD/EHDI) will be implemented to reduce the lost to follow-up rate by furthering the development of the screening, diagnostic, and services system; expanding the reporting and tracking system, and refining the quality assurance mechanisms.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	13.6	15.9	18.6	16.2	17.6
Annual Indicator	16.2	19.0	16.6	18.0	10.2
Numerator	24000	30000	27000	30000	16000
Denominator	148000	158000	163000	167000	157000
Data Source	Census	Census	Census, Current Population Survey	Census, Current Population Survey	Census, Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	10	9.8	9.6	9.4	9.2

a. Last Year's Accomplishments

Nebraska Medicaid proceeded with implementation of Medicaid Managed Care in 83 rural counties bringing coverage statewide, with contracts issued to three Medicaid Managed Care Organizations to serve the state.

These developments stimulated demands among health professional and other audiences to understand how managed care operates in the Medicaid-eligible community. All the managed care organizations were very willing to engage with audiences and inform the public, as

recruitment of enrollees is beneficial to the managed care organization in a competitive environment. As a result, information on Medicaid enrollment now received from MCO's is being perceived as being more transparent, consumer-friendly, and accessible.

On the other hand, for the Medicaid consumer, particularly those not attentive to mailings and communications regarding changes in Medicaid administration, the transition has been confusing and distressing.

The Nebraska Legislature determined that on-line only access to enrollment procedures for applicants was not sufficient to serve the public's interest, and with LB 825 reinstated enrollment centers in the state where applicants could present in person for assistance with applications.

A working group affiliated with Early Childhood Comprehensive Systems (ECCS), the Medical-Dental Home Workgroup, is using the HRSA document, Collaboration and Action to Improve Child Health Systems: A Toolkit for State Leaders to examine EPSDT and medical care access issues for children in Nebraska. While this activity has not yet resulted in action planning, certainly it has stimulated gains in communication and information sharing from Medicaid partners.

The Medical Home Pilot project continued (2-1-2011 through 1-31-2013).

The Nebraska legislature passed legislation to permit Medicaid to pay for visits of eligible children to school-based health centers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Managed Care Organizations expanded statewide for physical health care services.				X
2. Medicaid Managed Care expanded to Behavioral Health with contract awarded to single , Magellan Behavioral Health.				X
3. Operated the Healthy Mothers Healthy Babies Helpline to assist with locating and accessing providers and services.		X	X	
4. Monitored impact of health care reform and the Affordable Care Act on delivery of EPSDT, and utilization of safety net providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

By administrative directive, staffing for eligibility determinations for Medicaid versus other public assistance programs has been reorganized. Previously, Children & Family Services staff determined all eligiiblity. Medicaid eligibility is now the responsibility of Medicaid staff. This transition is targeted for completion in July 2013.

Medicaid Managed Care has expanded from physical health to include behavioral health services, through the issuance of contract to a Behavioral Health Managed Care Organization in Nebraska. The Nebraska Legislature did not vote to expand Medicaid, as available to states through the Affordable Care Act.

Education for health professional and child advocates on Medicaid Managed Care and EPSDT in Nebraska continues.

A state-level working group, a Youth Suicide Community of Practice, utilized the HRSA toolkit, Collaboration and Action to Improve Child Health Systems, as a basis for exploring systems of care for suicide prevention and risk response among adolescents and young adults.

c. Plan for the Coming Year

Within the Maternal Child Adolescent Health program area, identify key messages for the eligible consumer public, and the health professionals serving them, regarding Medicaid and EPSDT enrollments and benefits. Key messages are to not only encompass Medicaid in the managed care organization model and EPSDT minimum standards, but also benefits for pregnant adolescents, dental and behavioral health and mental health standards, and developments related to implementation of the Affordable Care Act.

Continue strategic use of the HRSA toolkit, Collaboration and Action to Improve Child Health Systems. In the MCAH program area. Identified prospects for use include: systems of care to support expectant and parenting teens and their offspring; systems and strategies to promote preconception health among youth; an integrated and collaborative approach to trauma-informed systems of care in Nebraska serving children and families; review and updating of collaborations and agreements between Title V and Title XIX in Nebraska.

Identify and implement approaches through Maternal Child Adolescent Health program activities (Maternal Infant Early Childhood Home Visiting, Early Childhood Coordinated Systems, Adolescent Health, School Health, Maternal-Infant Health activities) to inform potentially eligible persons about Medicaid and assist in accessing enrollment.

Monitor the ways in which health insurance availability and utilization under the Affordable Care Act impacts children, youth, and pregnant women.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	33.7	35.7	37.1	29.5	30.8
Annual Indicator	36.4	38.1	30.1	31.4	30.1
Numerator	6204	4928	2965	2959	2552
Denominator	17034	12918	9841	9409	8491
Data Source	NE WIC	NE WIC	NE WIC	NE WIC	NE WIC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017

Annual Performance Objective	29.5	28.9	28.3	27.8	27.2
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a. Last Year's Accomplishments

WIC State and Local Agencies continued work on action steps of the five-year goal to reduce the percentage of WIC children ages 2-4 that at or above the 85th percentile BMI-for-age. The WIC program is worked toward implementing consistent nutrition education messages and activities using the My Plate materials. Nutrition education materials targeting reducing consumption of sugar sweetened beverages, increasing fruit and vegetable consumption, and responsive child feeding practices were included.

Other program areas within Lifespan Health Services actively promote WIC Enrollment statewide, including the Maternal Child Adolescent Health program and the many associated activities occurring statewide to connect pregnant women and young children to food resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC program implemented action steps of five-year plan to reduce percentage of WIC children with BMI's above 85th percentile.				X
2. Implemented consistent messages using My Plate materials.			X	
3. Utilized nutrition education materials targeting reduced consumption of sugar sweetened beverages, increasing fruit and vegetable consumption, and responsive feeding practices.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2013, the WIC program implemented use of the WHO growth standards for children ages birth to 2 years old, including implementation of new nutritional risk criteria using cut-off values for overweight and obesity. WIC state and local agency staff continue to work on action steps related to goal of reducing childhood overweight. Nutrition Coordinator will remain current on recommended practices for early childhood obesity prevention and include these practices and interventions in 2013 activities. WIC state and local agencies are developing a statewide joint strategy for nutrition education; including obesity prevention action steps appropriate for children ages 2-5. This new strategy will be included as part of the FY2014 WIC State Plan. August -- December of 2013, State WIC Nutrition Coordinator will serve as preceptor for dietetic intern that will be involved in nutrition education/obesity prevention activities and projects. As of calendar year 2012, CDC has discontinued data collection and reporting for the Pediatric Nutrition Surveillance System. PedNSS data was the primary source of BMI information for WIC children ages 2 through 4. At this point, an alternative source for this depth of information has not been identified.

WIC and the Maternal Child Adolescent Health program, are collaborating on shared and differentiated breastfeeding objectives. Breastfeeding is identified throughout program areas as a strategy for obesity prevention.

c. Plan for the Coming Year

For 2014, the WIC program will implement action steps to support the newly developed joint strategy for nutrition education/obesity prevention among WIC agencies. State WIC agency will provide technical assistance and program support for implementing these actions steps, working toward achieving the goal. The WIC program will work toward implementation of a WIC MIS according to USDA protocol. A new MIS may have the ability to provide consistent BMI data on WIC children.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	11.3	11.5	10.3	9.8	9
Annual Indicator	11.8	10.6	10.0	9.2	12.1
Numerator	3184	2852	2590	2358	3145
Denominator	26992	26931	25898	25677	25914
Data Source	Birth file				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	11.8	11.6	11.3	11.1	10.9

Notes - 2011

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

a. Last Year's Accomplishments

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

In 2012, the Nebraska Tobacco Quitline had 3,505 unique callers. The Quitline provided services to 25 pregnant women, twelve women planning to become pregnant within three months, and 10 breast feeding women.

Tobacco Free Nebraska (TFN) continued to expand outreach to Nebraska health care providers and provide materials, resources and technical assistance on tobacco cessation.

In the Maternal Child Adolescent Health program within Lifespan Health Services, significant amounts of patient education materials are distributed to health care professionals in order to

support tobacco use cessation and prevention efforts of clinicians with their smoking patients. The materials provided are a resource developed collaboratively between MCAH and Tobacco Free Nebraska. MCAH provides the time and effort to respond to resource requests and manage inventory.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Tobacco Quitline provides a pregnancy-specific protocol for pregnant women seeking quit-support services.			X	
2. Conduct culturally- and linguistically-appropriate assessment activities to identify behaviors and supports for Native American women adopting tobacco behaviors prior to pregnancy.				X
3. Education for health professionals on making referrals to the Nebraska Tobacco Quitline.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the Maternal Child Adolescent Health Program area, activities during the current period have included strategic planning in the Maternal-infant health area on the topic of prematurity prevention, and also initiating new levels of collaboration with the Office of Health Disparities and Health Equity within DHHS. In the area of prematurity prevention, noted is the relationship between tobacco use during pregnancy and prematurity, and also that Native American women in the Nebraska PRAMS survey have the highest rate of tobacco use during pregnancy.

Collaboration has led to addition of questions about initiating tobacco use among youth, and during pregnancy, for racial-ethnic specific groups recruited by HDHE for focus group participation on MCH topics.

Preconception health key messages for youth include avoidance of tobacco use before and during pregnancy.

Tobacco Free Nebraska has placed ads in health care provider publications regarding tobacco cessation and the Nebraska Tobacco Quitline. The contract with Quitline vendor Allere Wellbeing to continue easy to access cessation services statewide for all Nebraskans including pregnant women has been renewed. TFN continues to monitor and evaluate the service including the number of calls from women who are currently pregnant. PRAMS along with TFN will be releasing soon a Tobacco and Pregnancy Issue Brief. The brief will be distributed widely including to health care providers.

c. Plan for the Coming Year

The Maternal Child Adolescent Health program will continue to develop messaging for youth about tobacco use and preconception health. Collaboration with the Office of Health Disparities and Health Equity will continue to develop culturally and linguistically appropriate messages and resources for diverse youth and young adults, and other strategic approaches, to reducing

tobacco use specifically among Native American young women of reproductive age.

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	12.8	12.9	12.6	5.3	6.7
Annual Indicator	13.2	4.6	6.2	6.9	10.6
Numerator	17	6	8	9	14
Denominator	128885	130498	128930	130443	132294
Data Source	Death file, Census Est.	Death file, Census Est.	Death file, Census	Death file, Census	Death file, Census
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	10.4	10.2	9.9	9.7	9.5

Notes - 2010

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

a. Last Year's Accomplishments

The Nebraska Statewide Suicide Prevention Coalition (NSSPC) continued implementation of training activities and local prevention seed grants, including LOSS (Local Outreach to Suicide Survivors), QPR (Question-Persuade-Refer) Gatekeeper training, and Assessing and Managing Suicide Risk (AMSR) for Clinicians. The Nebraska Statewide Suicide Prevention Coalition has worked to establish local suicide prevention coalitions in Norfolk and Hastings, in addition to Lincoln. Significant populations of interest to NSSPC continue to be returning veterans in Nebraska communities without adequate veteran support services, and their families, and youth, in addition to suicide survivors. Three Title V staff have regularly participated in suicide prevention activities, representing School Health, Adolescent Health, and MCH.

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

Nebraska participated with a state team in the national Children's Safety Network Youth Suicide Community of Practice.

QPR Gatekeeper Training continued to be delivered to groups and audiences particularly those working with youth.

The state refugee health program collaborated with the Maternal Child Adolescent Health team (certified QPR gatekeeper trainer in the staff group) to deliver suicide prevention gatekeeper training into the community of refugee service providers and local leadership serving Nebraska's refugee population, both youth and adults. This work is supported by collaborative efforts between the national Refugee Health Technical Assistance Center and QPR suicide prevention model developers.

A working group affiliated with Early Childhood Comprehensive Systems (ECCS) finalized a set of competencies for providers, and tools for community level assessment of resources, to support early childhood social and emotional development.

Maternal Infant Early Childhood Home Visiting services deliver evidence-based interventions to maximize family resilience, assess and identify needs for services and resources and assist in referrals to providers, as well as systemic approaches to meeting the needs of families with young children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nebraska Statewide Suicide Prevention Coalition involvement, focused on building capacity statewide for youth suicide prevention.				X
2. QPR Gatekeeper Training delivered to provider audiences serving youth and families.		X		
3. Education for Health Professionals and others on Adverse Childhood Experiences and relationship to poor social and emotional outcomes for children and youth.			X	
4. Strategies to improve community systems of care and competencies of early childhood providers to support the optimal social and emotional development of young children, contributing to resilience in youth and families.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

As of June 2013, 24 QPR Gatekeeper Trainers had been trained; 3,748 persons had completed QPR Gatekeeper training, 257 clinicians completed AMSR training; and a total of 52 seed grants totaling \$222,906.24 had been awarded to local NE communities for suicide prevention. (Nebraska was a Garret Lee Smith funding recipient, for a three year project period Oct. 1, 2009 to Sept. 30, 2012.)

The Coalition has worked to establish local suicide prevention coalitions in Norfolk and Hastings, in addition to Lincoln. Work of the coalition continues despite expiration of Garrett Lee Smith funding.

The Nebraska state team in the national community of practice for youth suicide prevention completed the course of study and planning, selecting the relationship between bullying and suicide risk as topic of interest.

Nebraska has two initiatives relating to social and emotional health of young children, to improve mental health in adolescence. A working group affiliated with Early Childhood Comprehensive Systems (ECCS) has developed a set of competencies for providers, and tools for community-level assessment of resources to support.

c. Plan for the Coming Year

The Nebraska Statewide Suicide Prevention Coalition continues planning, development, networking, and outreach with partners in preparation for re-applying for Garrett Lee Smith funding.

Educating the provider community and the general public about the importance of safe and nurturing environments for infants and children, in order to support healthy emotional and mental health development throughout the lifespan is a goal of numerous activities in the Maternal Child Adolescent Health program at DHHS:

Through evidence-based home visiting, providers engage families at the individual level, perform assessments, provide education and support, and seek referral sources.

In the Early Childhood Comprehensive Systems area, stakeholders and partners are working to advance the practice of screening for social and emotional development in the pediatric medical home, in collaboration with the Building Bridges initiative of the American Academy of Pediatrics, for which Nebraska has a member-team.

In school health arena, the school health program is exploring a "task force" approach to engage school nurses, school social workers, and others in development of competencies for various levels of school personnel (classroom teacher, resource teacher, school psychologist or community mental health professional) for the appropriate and non-traumatizing management of problem behaviors of children at school.

In Lifespan Health Services, leadership participates in a multi-division partnership encompassing public health, behavioral health, and Children and Family Services to develop integrated and comprehensive approaches to prevention-oriented services for families needing mental health services and other supports to relieve stress.

Throughout the Maternal Child Adolescent Health program, program staff are studying and engaging stakeholders and partners in mobilizing to develop a statewide strategic plan for trauma-informed care for children and families in multiple community and services environments. The HRSA tool, Collaboration and Action to Improve Child Health Systems will be used as a resource in this work.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	69.2	69.8	59	83.6	82.4
Annual Indicator	63.5	57.9	82.0	80.8	76.6
Numerator	207	184	259	202	209
Denominator	326	318	316	250	273
Data Source	Birth file				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	78.6	79.7	81.3	82.9	84.6

Notes - 2010

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

a. Last Year's Accomplishments

The Maternal Child Adolescent Health Program identified prematurity prevention as a topic of programmatic and strategic interest, enlarging collaborations with March of Dimes and the Nebraska Hospital Association and Nebraska Medical Association to address the following priorities: reducing elective induced deliveries prior to 39 weeks gestation through influencing physician practice and birthing hospital procedures; educating the public about the importance of 39+ weeks for optimal infant outcomes.

Level of care in Nebraska's birthing facilities is self-designated. Nebraska has four Level III NICU's, all concentrated in the eastern, urban area of a largely rural state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborative and cross-systems efforts to reduce risks of premature delivery.			X	X
2. Monitor impact of the Affordable Care Act on high-risk deliveries and neonates, through the experience of safety-net providers statewide and the four concentrated NICUs found in eastern Nebraska.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal Child Adolescent Health Program has selected prematurity prevention activities for development in the maternal-infant health area. In examining the relationship between risk behaviors and premature delivery, Native American women are most at risk for smoking during pregnancy in our state, according to PRAMS. A collaborative initiative has been undertaken between MCAH and the DHHS Office of Health Disparities and Health Equity, leading to plans for gathering more information about attitudes toward smoking in pregnancy, and cultural and social factors prompting initiation of tobacco use by women, within Nebraska's various diverse population groups.

c. Plan for the Coming Year

The work initiated between DHHS Maternal Child Adolescent Health program and the DHHS Office of Health Disparities and Health Equity, as described above in "current activities" is intended to inform a preconception health project being developed to influence reproductive health outcomes of young Nebraskans. By identifying Native American female use of tobacco prior to pregnancy onset, the intended outcome is reduction of premature and very low birth weights among this group, and of the state rate overall.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	74.8	73.6	75.1	74.7	76.2
Annual Indicator	72.1	72.0	73.2	75.2	74.7
Numerator	19464	19382	18979	18857	19131
Denominator	26992	26931	25916	25077	25618
Data Source	Birth file				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	76.2	77.7	79.2	80.8	82.5

Notes - 2011

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

a. Last Year's Accomplishments

Nebraska Maternal Child Adolescent Health (MCAH) program area conducts several activities in support of access to prenatal care:

Oversight of contract to operate the statewide Healthy Mothers Healthy Babies toll-free telephone line to assist women and families access prenatal and other health care and support services to support optimal outcomes.

Representing Nebraska and DHHS in the national and state-level efforts to promote enrollment by pregnant women in Text4Baby.

Education of health care professionals in statewide events with professional continuing education credit fro nurses about prematurity and prematurity prevention.

LB 599 was passed and enacted, providing prenatal care to certain low-income families regardless of immigration status of the pregnant women. LB 599 required a SCHIP program specific to the unborn as an eligible category for prenatal care services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor utilization of the Healthy Mothers Healthy Babies toll-free helpline to support access to prenatal care.			X	
2. Monitor utilization of Medicaid for prenatal care; the experience of safety-net providers; and on PRAMS birth outcomes data during transitional phases of Affordable Care Act.			X	
3. Promote enrollment in Text4Baby.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Safety net providers continue to be a critical resource for pregnant women, filling in gaps for those low income women who may not be eligible for Medicaid or who may be hesitant to access Medicaid because of concerns with their immigration status. The MCAH program area continues to support the activities described above.

c. Plan for the Coming Year

Within the Maternal Child Adolescent Health program area, identify key messages for the eligible consumer public, and the health professionals serving them, regarding Medicaid and EPSDT enrollments and benefits. Key messages are to not only encompass Medicaid in the managed care organization model and EPSDT minimum standards, but also benefits for pregnant adolescents, dental and behavioral health and mental health standards, and developments related to implementation of the Affordable Care Act.

D. State Performance Measures

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

Tracking Performance Measures

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

Annual Objective and	2008	2009	2010	2011	2012
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Performance Data					
Annual Performance Objective				48.5	47.8
Annual Indicator	53.5	49.4	47.6	50	51.7
Numerator					
Denominator					
Data Source	NE BRFSS	NE BRFSS	NE BRFSS	NE BRFSS	NE BRFSS
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	52.7	53.8	54.9	55.9	57.1

Notes - 2012

Comparisons of 2011 and 2012 to prior data should not be made. The weighting methodology for BRFSS changed from post-stratification to raking in 2011. Raking creates the weights in different manner by iterations and it also allows for inclusion of more control variables in the weighting scheme as opposed to just age, gender, race/ethnicity and region. In addition the 2011 and 2012 BRFSS has 20% of the sample from cell phone interviews. Cell phone interviews were not included in the sample prior to 2011.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

In the Maternal Child Adolescent Health (MCAH) area, the School Health Program Manager, a Registered Nurse Consultant, participates in leadership and collaborative activities related to Coordinated School Health, Nebraska Action for Healthy Kids, the Nebraska Physical Activity and Nutrition state plan, delivers peer-approved contact hour events for licensed nurses in community and public health practice statewide addressing obesity prevention. The school health program conducts a school data project and gathers information from local schools on BMI measurement. Transforming the food and activity environments of schools, collaborating on policy development, engaging medical partners in addressing childhood obesity, all contribute to a life course approach to reducing obesity during the reproductive years among Nebraska women.

In WIC and in MCAH, breastfeeding support and promotion are considered integral to promoting healthy weight among women during reproductive years, as well as to life course approaches to weight management in the infant and young child. Breastfeeding activities are described in National Performance Measure #11.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in implementation of the Nebraska Physical Activity and Nutrition state plan.				X
2. Breastfeeding support and education as a primary prevention strategy to combat obesity.			X	
3. Health Professional education on gestational diabetes and		X		

obesity risks among women of reproductive age.				
4. Support and technical assistance to advance Coordinated School Health approaches and provide improved food and activity environments at school			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCAH staff are working with partners to develop and deliver a refreshed preconception health project, targeting health behaviors of teens aged 12 - 16 years of age. The Key Messages work is underway, adapting topics from the CDC's new preconception health initiative. This opens the opportunity to revamp and evaluate the use of TUNE My Life life course planning tools, with youth engagement to guide the process. Weight management, healthy nutrition, and physical activity all are embedded in the preconception health key messages campaign.

c. Plan for the Coming Year

The preconception health project in MCAH includes healthy weight management, as well as nutrition and physical activity.

The MCAH school health program will conduct the next iteration of the school health screening data project, which is scheduled to include BMI data.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				61.3	65.5
Annual Indicator	60.2	59.1	60.1	64.2	60.8
Numerator					
Denominator					
Data Source	NE PRAMS				
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	62	63.3	64.5	65.8	67.1

Notes - 2012

NE PRAMS is a weighted survey. So, only weighted estimates are provided. There is a year lag on PRAMS data. So, 2012 will be provided in 2013, etc.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

Nebraska DHHS continued delivery of Title X Family Planning Services via delegate agencies.

Nebraska delivered training in positive youth behaviors under funding for Abstinence Education and Personal Responsibility Education Program via sub-grantees in multiple project locations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Deliver Title X Family Planning services statewide through delegate agencies	X			
2. Deliver Abstinence Education and Personal REsponsibility Education Program services and activities in local sites through sub-grantee agreements to diverse and at-risk youth.		X		
3. Preconception Health initiative inclusive of life course planning		X	X	
4. PRAMS monitoring and reports			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Maternal Child Adolescent Health Program, with partners, is undertaking a collaborative preconception health project adapting key messages and themes of the CDC preconception health and reproductive health for teens and young adults resources.

One aspect of this work is the ongoing evolution of TUNE MY LIFE, and life course health planning instrument for youth and young adults, intended to stimulate goal-setting and individual life course planning which contributes to intentional deferral (or timing of) offspring.

Title X/Family Planning services continue as an important source of reproductive health care for low income Nebraska women.

c. Plan for the Coming Year

Continue to develop preconception health key messages, resources, and activities in the Maternal Child Adolescent Health program area, particularly with continued development, testing, and evaluation of the TUNE MY LIFE life course planning resources.

Continue PRAMS monitoring of pregnancy intendedness in Nebraska.

Continue delivery of Title X/Family Planning services through delegate agencies across the state.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				94	91.2
Annual Indicator	72.3	77.8	93.7	89.4	90.5
Numerator	24838	43136	39297	37908	40170
Denominator	34372	55433	41918	42387	44404
Data Source	Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	92.3	94.2	96	97.9	99

a. Last Year's Accomplishments

Children living in poverty continue to be a significant concern of many stakeholders and partners in Nebraska, particularly where measures of poverty also are reflected or measured as disparities in social and emotional development of young children, readiness for school, special needs including behavioral health, and high school graduation.

The measure is of interest as an attempt to measure a social determinant of health outcomes, and is informed by the work on Life Course Metrics, sponsored by AMCHP, in which Nebraska participates with a team.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation in national Life Course Metrics project sponsored by AMCHP.				X
2. Build communication and collaboration with Medicaid program and Medicaid Managed Care Organizations, to support collaboration and action to improve child health systems.				X
3. MIECHV home visiting intervention as a means to improve access to and utilization of primary health care services.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Improved monitoring approaches for EPSDT eligibility and enrollment have been made more available to programs in Lifespan Health at DHHS in part through an ECCS workgroup making use of the HRSA tool, Collaboration and Action to Improve Child Health Systems, and also through an intentional effort on the part of Lifespan Health administrative leadership to stimulate meaningful and regular communication with the Division of Medicaid and contracted Medicaid Managed Care Organizations.

Delivery of Maternal Infant Early Childhood Home Visiting via subcontracts with various entities and partners, including oversight and monitoring activities by the state, has resulted in the the Maternal Child Adolescent Health program, and others, having a greatly heightened awareness of the life experience of Nebraskans with very young children living in poverty.

c. Plan for the Coming Year

Continue to assess the ways in which poverty status of children and families informs strategic planning and implementation of activities to improve life course outcomes.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				1.4	1.3
Annual Indicator			1.4	1.4	1.5
Numerator			13.5	12.1	13.3
Denominator			9.8	8.9	9.1
Data Source			Birth file	Birth file	Birth file
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	1.3	1.3	1.3	1.3	1.3

Notes - 2011

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

a. Last Year's Accomplishments

Visible, state-level approaches to address preventable causes of prematurity through the ASTHO initiative to reduce elective inductions of delivery prior to 39 weeks gestation occurred, resulting in the Nebraska Hospital Association nurturing the development of hospital scheduling procedures to provide hard-stop interventions when a pre-term elective induction is scheduled; and the Nebraska March of Dimes disseminating public and provider education resources on the concern of pre-term elective inductions.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Address Adverse Experiences in Childhood as a potential precursor to disparities in life course outcomes, inclusive of reproduction, through education, awareness, and strategic planning			X	X
2. Deliver Personal Responsibility Education Program, Abstinence Education, and Family Planning Services to diverse and high risk populations as a means of improving reproductive health outcomes and reducing disparities.	X	X	X	X

3. Strategic planning to prevent and mitigate the effects of toxic stress experiences and environments in infancy and early childhood, to address disparities in life course outcomes including reproduction.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the Maternal Child Adolescent Health program, a selected priority for prematurity prevention is the smoking behavior of Native American women during the reproductive years. A collaborative development activity is underway, partnering with the DHHS Office of Health Disparities and Health Equity.

Nebraska's plan for Adolescent Health identifies high risk populations for early and unintended births, including minority populations for whom unplanned early pregnancies and births precipitate life course health disparities. Through the Personal Responsibility Education Program, now in the latter half of the second year of a four-year project life, the Adolescent Health Program is evaluating effectiveness in reaching target populations. By assuring program activities are delivered in response to disparities in risk for teen pregnancy, the result should be impact on birth disparities.

In addition to this strategy, Nebraska has begun to focus more strongly on the topic of Adverse Childhood Experiences, and to examine Nebraska-specific data on the occurrence of ACEs. Because ACE are related to later health outcomes and disparities, by working strategically on addressing issues of abuse, neglect, and trauma in childhood, the prospect is to impact health disparities that manifest later in life and subsequent generations.

c. Plan for the Coming Year

DHHS Lifespan Health continues to advocate, lead, and work for, comprehensive, integrated, coordinated systems level approaches to reducing adverse experiences in childhood, recognition and mediation of toxic-stress, and trauma-induced adverse sequelae in life course outcomes. At the heart of this work is recognition that such stressors and adverse life experiences are strongly related to unequal manifestations of poor health outcomes that are recognized as health disparities.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				82.6	84.3

Annual Indicator	81	81	81	81	81
Numerator					
Denominator					
Data Source	National Survey of Children's Health, 2007	National Survey of Children's Health, 2010/11			
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	82.6	84.3	85.9	87.7	89.4

Notes - 2012

Data is from a weighted survey so, only estimates are provided

Notes - 2011

National Survey of Children's Health, 2007

Notes - 2010

National Survey of Children's Health, 2007

a. Last Year's Accomplishments

Within Nebraska's Early Childhood Comprehensive Systems effort, a workgroup collaborating on increasing participation in a recognized primary medical home expanded their vision to include a dental home for each child in Nebraska. Taking the approach of embracing dental health access as a systems level activity, combined with application of the HRSA instrument, Collaboration and Action to Build Child Health Systems, proved very fruitful in terms of uncovering information and new partners.

In the School Health Program, like ECCS found within Lifespan Health Services, work was ongoing in both policy and practice of school health screening, including dental screening. Preschool children are included in the scope of the screening regulations. Competencies for screeners in school health settings have been developed for dental screening as well as vision, hearing, and BMI.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve the quality of school health screening practices, including dental screening for young children.			X	X
2. Provide materials, resources, and training to improve the competency of screeners at school, including dental screening.		X		
3. Continue collaborative workgroup in support of dental homes for every child.				X
4. Continue participation in state level Oral Health Advisory committee			X	X
5. Tooth care supplies with health promotion message distributed to pregnant women, infants, young children through home visiting, early childhood programs, lay healthy ambassadors.	X			

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The School Health Program Manager has been invited to sit on the state-level Oral Health Advisory Committee, forging new levels of communication and collaboration between the two offices and staff.

In the Together for Kids and Families area, also within Lifespan Health Services, the Dental/Medical Home Workgroup has launched an activity to distribute toothbrushes, paste, and floss to pregnant women and young children. Avenues of distribution will be through Head Start, Home Visiting, Lay Health Ambassadors working in minority communities, and other community-level distribution activities. Each set of oral care items is attached to a book mark with contact info for Nebraska's public health dental clinics and a brief dental health promotion message suited to child, pregnant woman, or infant.

In the School Health Program, an ongoing annual data project focused on dental screening of children in Nebraska schools with de-identified data released voluntarily to the school health program for assessment. This data project also serves to provide a convenience sample of "baseline" measures on dental screening prior to the effective date of new state regulations for school health screening.

c. Plan for the Coming Year

In the Maternal Child Adolescent Health program team in Lifespan Health Services, team strategic planning has resulted in all members agreeing to promote dental health through at least one asset-building activity in the respective concentration (school, home visiting, adolescent health, maternal-infant health, early childhood) during the coming year. For example, the School Health Program has determined to join the toothbrushing health promotion effort and distribute toothbrushes to adolescents participating in PREP activities statewide.

The School Health Program will release the dental data report; continue to actively develop resources and materials to support schools in achieving regulatory requirements for competence-based school health screening including dental; sit on the state-level oral health advisory committee.

The Dental/Medical Home Workgroup of Together for Kids and Families, Nebraska's Early Childhood Comprehensive Systems effort, plans to continue. This group continues a high level of interest, information seeking, and analysis regarding access and insurance issues in Nebraska. As a result, this group provides a well-informed lens for understanding developments in Medicaid and the Affordable Care Act in Nebraska.

With funds appropriated for the Dental Director, it is anticipated that recruitment will occur during this upcoming year, bringing into the Division of Public Health increased capacity to address oral health issues in the MCH population.

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

Tracking Performance Measures

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

Annual Objective	2008	2009	2010	2011	2012
------------------	------	------	------	------	------

and Performance Data					
Annual Performance Objective				21.8	21.4
Annual Indicator		20.2	22.2	21.3	19.3
Numerator		583	579	551	532
Denominator		28791	26082	25907	27534
Data Source		Child Protective Services, Census			
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	18.9	18.5	18.2	17.8	17.4

Notes - 2011

a. Last Year's Accomplishments

The Maternal Child Adolescent Health program provides statutorily-directed resources on the subject of shaken baby and safe sleep.

The MCAH school health program manager developed new materials, educational activities for nurses and school professionals, and resources on child abuse prevention, recognition, and reporting.

Delivered Maternal Infant Early Childhood Home Visiting via sub-contracts in local service locations, utilizing Healthy Families America curriculum with goal of reducing risk for child abuse and neglect.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of education and resources to prevent shaken baby syndrome.			X	
2. Provision of education and resources on child abuse and neglect, toxic stress, adverse childhood experiences, and trauma-informed care encompassing multiple domains, settings, and services.				X
3. Prevention Partnership as a means to mobilize and integrate the child abuse prevention efforts and leadership of multiple stakeholder agencies.				X
4. Deliver evidence-based home visiting services via sub-contractors as a direct means to educate and support at-risk parents and families to prevent child abuse.	X	X	X	X
5. Continue breastfeeding support and promotion in numerous venues as a strategy to enhance maternal bonding and infant safety and nurturing.			X	
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Nebraska successfully passed new child care licensing regulations for the first time in nearly two decades. Included in the new regulations are requirements for licensed child care providers to receive training in a curriculum, referred to as Safe With You, which encompasses safe sleep practices for infants, prevention of shaken baby syndrome, and child abuse prevention.

The Prevention Partnership, an agency collaborative, delivered a statewide leadership conference on child abuse prevention.

In the MCAH program, activities addressing child abuse and neglect are ongoing. By incorporating Adverse Childhood Experiences and emerging literature and evidence on trauma-informed care in response to pervasive childhood stress and trauma, the subject is enlarged statewide to consider strategic approaches to preventing and recognizing toxic stress, and engaging in community-level and systemic approaches to better support families with parenting education and support.

The Nebraska MIECHV continues to evolve and expand. System-wide support in Nebraska for the evidence-based home visiting effort to prevent child abuse and build parenting ability to provide safe and nurturing environments has grown to the extent the program now implements home visiting services with an allocation of state general funds in addition to federal MIECHV dollars.

In the Maternal-infant area of MCAH, breastfeeding support, promotion, and education is linked to prevention of child abuse through maternal bonding

c. Plan for the Coming Year

Continue to work in the area of evidence-based home visiting as an effective strategy to support and educate parents, reduce social isolation of vulnerable families, and create safe and nurturing environments for the benefit of infants and children.

Continue to work in the adolescent health area, building positive behaviors in youth prior to onset of reproductive activity, in order to build resilience and other assets important for effectively coping with the demands of parenting.

Participate in partnership and collaborative efforts to develop a statewide strategic plan for implementing trauma-informed care in multiple sectors of community level family and child services, including schools and child care settings.

With partners, plan and deliver statewide educational and planning events to stimulate collective action to more effectively address child abuse and neglect, the environments in which trauma occurs for children, the risk and protective factors related to child abuse and safe and nurturing environments, and a call to action for many partners with a shared agenda to focus on common and shared measures of progress.

An application was submitted to the CDC for funding through its "Implementation of Essentials for Childhood: Safe, Stable, Nurturing Relationships and Environments" program. If the application is successful, the resources will help build the capacity of Nebraska's Child Abuse Prevention Partnership to carry out prevention strategies within a collective impact framework.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				30.6	26.5
Annual Indicator			31.3	27	27
Numerator					
Denominator					
Data Source			NE YRBS	NE YRBS	NE YRBS
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	25.9	25.4	24.9	24.4	24

Notes - 2012

NE YRBS is a weighted survey. So, only weighted estimates are provided. The YRBS is administered every other year, new data will be available in 2013.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The DHHS School Health Program participates annually in the planning and delivery of the statewide Youth Risk Behaviors conference, delivered to school and youth program personnel to raise awareness about and skills and strategies for addressing high risk behaviors including sexual activity and substance use.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate in the delivery of the annual statewide Youth Risk Behaviors Conference, reaching school and youth services personnel with knowledge and skills to prevent youth substance use.		X	X	
2. Promote alcohol and substance avoidance as a key message of preconception health and life course planning.			X	
3. Conduct programmatic, stakeholder, and resource assessment of youth binge drinking and associated behaviors and risks, in order to identify key messages/strategies for action.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Avoidance of alcohol and other substances is a key message in the emerging preconception health project in the Maternal Child Adolescent Health program targeting youth and young adults. Reduction of risk behaviors, and an awareness of how alcohol use may contribute to higher risk

of additional risky actions, is an objective of the Abstinence Education and Personal Responsibility Education program activities conducted in the DHHS Adolescent Health Program.

Due to cuts in funding to the Nebraska Dept. of Education, the future of the statewide Youth Risk Behavior conference has been placed in jeopardy. Through collaboration between Dept. of Ed, the DHHS Adolescent and School Health Programs, the conference is planned to continue.

c. Plan for the Coming Year

In the MCAH program, conduct a review of available data on youth binge drinking in Nebraska. Include assessment of relationship between alcohol use and suicide risk, bullying, and depression. Identify the effectiveness, if known, of local community and statewide coalitions and initiatives addressing youth alcohol use. From this review, identify 2-3 key messages and/or strategies reflecting opportunities for prevention impact.

E. Health Status Indicators

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 03A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	7.9	5.4	7.8	3.9	8.7
Numerator	27	19	28	14	31
Denominator	343908	349420	357420	359412	356941
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2011

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

Notes - 2010

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

Narrative:

The increase in this rate may be only a product of small numbers, it does warrant monitoring over the next year. Unintentional injuries has not been a priority or area of focus for Nebraska Title V in recent years, though the School Health Program has begun to devote additional attention to issues such as distracted driving. The Maternal and Child Death Review Team and the Safe Kids program will be important resources for tracking this indicator and determining any necessary actions.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 03B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.7	3.4	3.6	1.1	5.6
Numerator	6	12	13	4	20
Denominator	343908	349420	357420	359412	356941
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2011

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

Notes - 2010

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

Narrative:

The increase in this rate may be only a product of small numbers, it does warrant monitoring over the next year. Unintentional injuries has not been a priority or area of focus for Nebraska Title V in recent years, though the School Health Program has begun to devote additional attention to issues such as distracted driving. The Maternal and Child Death Review Team and the Safe Kids program will be important resources for tracking this indicator and determining any necessary actions.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 03C - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	24.8	23.2	14.7	13.1	20.2
Numerator	65	63	38	34	54
Denominator	262190	271201	258206	259775	267156
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2011

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

Notes - 2010

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

Narrative:

The increase in this rate may be only a product of small numbers, it does warrant monitoring over the next year. Unintentional injuries has not been a priority or area of focus for Nebraska Title V in recent years, though the School Health Program has begun to devote additional attention to issues such as distracted driving. The Maternal and Child Death Review Team and the Safe Kids program will be important resources for tracking this indicator and determining any necessary actions.

F. Other Program Activities

Healthy Mothers, Healthy Babies Helpline:

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

Subsequently, efforts were made to promote the HMHB help line. In 2007, brochures, posters, and magnets were redesigned. Brochures were made available in English and Spanish. Sample materials were sent to over 2,300 Nebraska physicians, nurses, health departments, and agencies to promote the helpline. Other promotion efforts included a HMHB webpage and a presentation to WIC agency directors. The HMHB helpline number is listed in the community service pages of local telephone books, and an ad was placed in the Journal-Start Baby Steps publication which reaches families in southeastern Nebraska. The helpline was also promoted through the Nebraska Perinatal Depression Project website, brochures, posters, and exhibit.

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

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

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

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

/2014/ The Nebraska Healthy Mothers Healthy Babies (HMHB) helpline fielded 164 calls in the 2012 reporting year. The HMHB contract remains with United Way of the Midlands. The numbers continue to decrease despite efforts to promote the line as a resource through exhibits and educational presentations given to health care providers. By request, over 3,100 brochures were sent to agencies and hospitals. //2014//

MCH and Public Health Infrastructure Development:

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

Health Disparities:

The Office of Health Disparities and Health Equity (OHD&HE) provides leadership for a number of initiatives. The Office of Women's and Men's Health and its Women's Health Council has been working with OHD&HE to conduct a series of community viewings of "Unequal Treatment" later this summer. This activity is seen as essential to increase awareness of health equity issues and will further efforts to move policies and programs towards a life course model that recognizes the additive effects of factors such as stress and racism. With Title V support, OHD&HE is planning additional initiatives for 2011./2012/ OHD&HE is conducting a number of "Unequal Treatment" seminars this summer, and is working with communities on a number of local initiatives.//2012//

New Opportunities:

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

/2013/ In June 2012, the Chief Medical Officer - Director of the Division of Public Health signed the ASTHO/March of Dimes Pledge to improve birth outcomes by reducing infant mortality and prematurity. The Division and its Lifespan Health Services Unit have had a long-standing working relationship with the March of Dimes, and this pledge will now provide additional focus on collaborative efforts. Initial work has begun on building capacity to address non-medically

indicated inductions and C-sections prior to 39 weeks gestation, including forming working relationships with the Nebraska Hospital Association. Details of specific activities are to be developed over the next several months.//2013//

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

G. Technical Assistance

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

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

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

The needs for which Nebraska Title V would request MCHB assistance are therefore those specific to the management of the Block Grant. For FFY 2011, Nebraska specifically requests technical assistance in budgeting for and reporting activities in accordance with Block Grant statutory requirements and within the framework of the Guidance and Forms for the Title V Application/Annual Report while at the same time moving towards a life course health model and a social determinants framework.

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

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

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

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

/2014/ July 1, 2013, administration of the Medically Handicapped Children's Program and other related services for CSHCN have been transitioned to the Division of Children and Families. With a new administrative home and leadership for Title V/CSHCN, this is an

opportune time for focused orientation and training for the new Title V/CSHCN Director and staff on Title V, including history, philosophy, and technical requirements.//2014//

V. Budget Narrative

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

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	3989608	3602604	4036191		3845677	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	3141759	2886218	3742315		3882315	
4. Local MCH Funds <i>(Line4, Form 2)</i>	409300	435680	236525		324282	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	7540667	6924502	8015031		8052274	
8. Other Federal Funds <i>(Line10, Form 2)</i>	134805658	0	130293903		121378102	
9. Total <i>(Line11, Form 2)</i>	142346325	6924502	138308934		129430376	

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

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	560350	814530	661489		870325	
b. Infants < 1 year old	983225	822730	936093		1304099	
c. Children 1 to	1643228	1562184	2501984		2279635	

22 years old						
d. Children with Special Healthcare Needs	3274671	2714179	3136132		2929163	
e. Others	964435	906235	652149		536644	
f. Administration	114758	104644	127184		132408	
g. SUBTOTAL	7540667	6924502	8015031		8052274	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		66392	
c. CISS	0		0		0	
d. Abstinence Education	217136		250930		229135	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	33541652		33535039		32104995	
h. AIDS	0		0		0	
i. CDC	7910810		7848707		8146575	
j. Education	0		0		0	
k. Home Visiting	0		1000000		2543573	
k. Other						
see field note					78287432	
See note			87559227			
See Note	93036060					

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

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	1402440	1472013	1780526		1618367	
II. Enabling Services	2576483	2158339	2623080		2895700	
III. Population-Based Services	1687469	1920950	1837744		2038944	
IV. Infrastructure Building Services	1874275	1373200	1773681		1499263	
V. Federal-State Title V Block Grant Partnership Total	7540667	6924502	8015031		8052274	

A. Expenditures

/2012/ This narrative replaces previous narrative.

The first two paragraphs are an introduction to Section V.

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

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

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

The annual reporting requirement is stated more generally in Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706]. The audit requirement in Section 506(a)(3)(E)(b)(1) [42 U.S.C. 706] states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds. We believe the financial forms in the annual report are not designed for an audit of the two-year period in which an allotment is available for expenditure. This audit limitation is especially critical for the 30%-30% expenditure requirement established in statute. We maintain a separate expenditure accounting from the annual report to capture the 30%-30% expenditure requirements of an allotment. /2013/ We have used the same methodology to project funds available in 2013. //2013// **/2014/ The same methodology, as in prior reports and applications, was used to report expenditures in FY 2012 and to project funds available in FY 2014. //2014//**

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

Nebraska has typically exercised carry-over authority with unliquidated obligations, but not due to an unobligated balance. Our annual report reports expenditures in the reporting year (12-month period) from two different federal allotments. Specifically, the 2010 report Nebraska reports expenditures in FY 2010, a combination of the 2009 and 2010 allotments. /2013/ The 2011 report is a report of expenditures in FY 2011, a combination of the 2010 and 2011 allotments. //2013// We use accounting codes to track payments by federal allotment and types of individuals to identify compliance with the 30% - 30% requirements and the 10% limit for administration. This is particularly important since the expenditure requirements are federal allotment only, and Forms 3, 4, and 5 combine federal with state and local expenditures. **/2014/ The 2012 Report is a report of expenditures in FY 2012, a combination of the 2011 and 2012 allotments. //2014//**

Nebraska's considerable year-to-year expenditure variation on Forms 3, 4, and 5 is largely due to unevenness in carry-over of the federal allotment, and to a lesser extent the changeability of state and local resources. Differences are also due to a change in our interpretation of the types of services in the MCH pyramid, particularly between direct versus enabling and population-based services. **/2014/ Nebraska continues to exercise its carry-over authority given by the two-year period of availability of an annual federal allotment. The budget-to-expenditure variance is, as in prior years, due to several circumstances. The increase in the level of state funds has steadily increased while the level of federal funds has gradually been decreasing. Often times the federal appropriation is not known when the budget is submitted. The variance is also due to the unevenness in carry-over of the federal allotment into the second year. //2014//**

Expenditures largely correspond to the investments in our state's priorities based on the five-year needs assessment. Some of Nebraska's MCH priorities are addressed through resources other

than, or in addition to, the federal Title V/MCH Block Grant. Expenditures of the federal allotment, and state funds, include support for a variety of MCH state statutory requirements, e.g. screening and follow-up of newborns for inherited and metabolic disorders, child death review, school health screening, and state-level dental health office and full-time dental director. //2012// **/2014/ There has been a steady increase in costs to maintain state-level programs and infrastructure, such as salary increases for all state personnel. Investments of Title V in state-level capacity, described in other state narrative, are critically important for federal and state funds. While the percentage of Title V funds to subgrant to support local partners addressing Nebraska priorities continues to decrease, local funds continue to exceed the minimum match expectation placed on subrecipients by Nebraska DHHS. Another positive note is an increase, for example, in state funds to support home visiting in Nebraska communities. The state-funded contracts for home visiting, working in concert with the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, is a good example of maximizing the State-Federal Partnership. More information about the investments of Title V Block Grant in Nebraska is available at <http://dhhs.ne.gov/publichealth/MCHBlockGrant/Pages/Home.aspx>. //2014//**

B. Budget

//2012/ This narrative replaces previous narrative.

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

Federal Title V support clearly complements Nebraska's total effort to promote and improve the health of all Nebraska mothers and children. Nebraska's maintenance of effort based on FY 1989 state support (\$2,626,360) has consistently been surpassed. Exclusive state support is budgeted \$3,141,759 for FY 2012, which is a \$208,759 increase from 2011, and exceeds the minimum by over \$515,000. /2013/ Exclusive state support is budgeted \$3,742,315 for FY 2013, which is an increase of over \$600,000 from 2012, and exceeds the minimum requirement by over \$1.1 million. //2013// **/2014/ State funds in the amount of \$3,882,315 are budgeted for FY 2014, a \$140,000 increase over the 2013 budget of state funds. For what may be the first time, the state funds slightly exceed the projected federal funds in Nebraska's budget. //2014//**

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

pap smears), the Immunization Program for vaccine purchase (\$346,556), Newborn Metabolic Screening Program which also includes a cash fund from screening fees (\$302,000), CSHCN respite services (\$100,000), and Birth Defects Prevention Fund for terratagon service at the University of Nebraska Medical Center (\$34,369). Local match (\$236,525, a projection due to a competitive subgranting process at the time of this writing) rounds out our matching resources to demonstrate commitment at the community-level as well. //2013// **/2014/ The total value of matching resources is 109% of the projected federal 2014 allotment, \$324,282 budgeted by local communities. The composition of internal allocations to programs and units within DHHS is not expected to change for 2014. The salary increase effective July 1, 2013 requires roughly a \$25,000 budget increase. //2014//**

The 30%-30% requirements are tracked and monitored through separate accounting codes to identify expenditures by types of individuals of a federal allotment. Internal accounting reports are produced at least quarterly and reviewed by population coding. Similarly, the 10% limit on administration is maintained by having identified what is needed for the administration of the federal allotment, then concentrating it within a work unit, and budgeting costs for the unit to associate with administration. Due to a staffing change in 2011, we re-evaluated critical roles and essential duties associated with the administration of the Title V/MCH Block Grant and determined less staff time was needed for administration. The added value of well-established systems and procedures leads to effective administrative effort with a budget decrease of nearly \$50,000 from 4% in 2011(\$164,284) to under 3% for 2012 (\$114,758). /2013/ Administrative costs are budgeted \$127,184 for 2013, which is 3.1% of the projected new allocation. //2013// The increased efficiencies in administration will help to minimize the impact of potential funding reductions, thereby resulting in maximized resources for services and infrastructure. **/2014/ Administrative costs are budgeted \$132,408, a modest increase. //2014//**

Nebraska is knowledgeable regarding carry-over authority established in statute, and routinely exercises it for unliquidated obligations, i.e. obligations not expended that can be re-obligated in the succeeding year. We have typically chosen to fully obligate funds as a method to maximize investments, however in the present economic uncertainty, we are initially planning to carry over an unobligated balance of 2012 funds into FY 2013. Our internal budget for FY 2012 reserves a buffer to minimize the impact of any further federal resource reductions in a final FY 2012 appropriation and beyond. The projection of the federal Title V funds is broadly summarized:

2011 funds carry-over.....	\$1,329,284
2012 funds (based on level FY 2011).....	\$3,992,877
Projection of funds available in FY 2012.....	\$5,322,161
Community-based and Tribal subgrants, contracts.....	\$1,197,638
Internal allocations, state-level capacity.....	\$3,274,857
Total obligations.....	\$4,472,495

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

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

/2013/

2012 funds carry-over.....	\$ 985785
2013 funds (projected pending final appropriation)	\$4036191
Projection of funds available in FY 2013.....	\$5021976
Community-based and Tribal subgrants, contracts.....	\$1047002
Internal allocations, state-level capacity.....	\$3334874
Total obligations.....	\$4381876

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

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

//2013//

/2014/ At the time of this application the 2013 funds carry-over has not been confirmed, although is projected to be roughly \$800,000. Internal allocations are budgeted \$3,424,635, community-based subgrants and Tribal setaside subgrants \$991,874, with \$250,000 projected as a buffer for the tentative carry-over and 2014 appropriation. If available, that amount will be invested in one-year initiatives. //2014//

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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