Maternal and Child Health Services Title V Block Grant

Nebraska

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FY 2023 Application/ FY 2021 Annual Report

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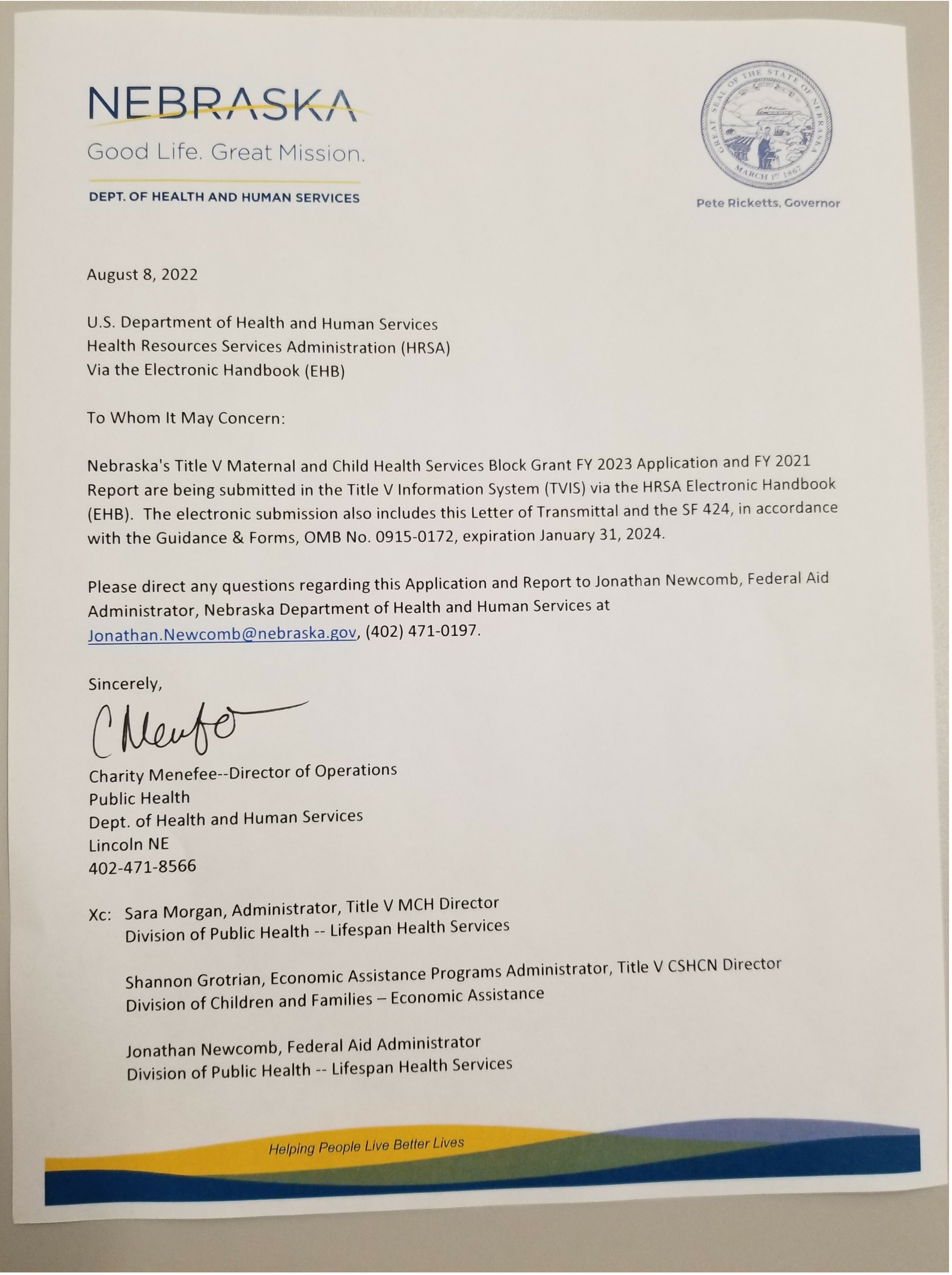
I. General Requirements

I.A. Letter of Transmittal



NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

August 8, 2022

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

To Whom It May Concern:

Nebraska's Title V Maternal and Child Health Services Block Grant FY 2023 Application and FY 2021 Report are being submitted in the Title V Information System (TVIS) via the HRSA Electronic Handbook (EHB). The electronic submission also includes this Letter of Transmittal and the SF 424, in accordance with the Guidance & Forms, OMB No. 0915-0172, expiration January 31, 2024.

Please direct any questions regarding this Application and Report to Jonathan Newcomb, Federal Aid Administrator, Nebraska Department of Health and Human Services at Jonathan.Newcomb@nebraska.gov, (402) 471-0197.

Sincerely,

Charity Menefee--Director of Operations
Public Health
Dept. of Health and Human Services
Lincoln NE
402-471-8566

Xc: Sara Morgan, Administrator, Title V MCH Director
Division of Public Health -- Lifespan Health Services

Shannon Grotrian, Economic Assistance Programs Administrator, Title V CSHCN Director
Division of Children and Families – Economic Assistance

Jonathan Newcomb, Federal Aid Administrator
Division of Public Health -- Lifespan Health Services

Helping People Live Better Lives

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

Nebraska Title V Overview

The Title V Maternal Child Health (MCH) Block Grant is administered within the Nebraska Department of Health and Human Services (NDHHS). Leadership of the Title V program is shared between the Division of Public Health (DPH) and the Division of Children and Family Services (DCFS). Core leadership, or the Title V Team, is comprised of seven DHHS staff representing both Divisions. This operational approach extends the reach of Title V activities, expands the amount of available state support, and increases the range and diversity of staff expertise available to the program.

Assessing Needs of the Maternal-Child Population in Nebraska

Nebraska's Title V is built on a strong framework of data collection and analysis; collaborative planning; implementation of strategies; and evaluation of process, outcomes, and impact as reflected in the five-year Needs Assessment. This robust process applies a deliberate methodology to determine the 10 priorities which govern activities for the next five years and is highly inclusive – intentionally bringing in stakeholders and family/consumer voices at various stages throughout the overall process.

The 2020 Needs Assessment determined the following priorities (in alphabetical order):

- Access to Preventative Oral Health Services
- Access to and Utilization of Mental and Behavioral Health Care across the Lifespan
- Behavioral Health in School for Children and Youth with Special Health Care Needs
- Cardiovascular Disease among Women aged 18 through 44 years
- Child Abuse and Neglect
- Infant Safe Sleep
- Motor Vehicle Crashes among Youth aged 10 through 19 years
- Premature Birth
- Sexually Transmitted Disease Prevention
- Suicide Prevention

Women/Maternal Health

Cardiovascular Disease

Like national trends, cardiovascular disease including diabetes, obesity, and hypertension continues to burden Nebraska women, particularly those of African American, American Indian, or Hispanic descent. Addressing this disease is difficult due to the multifactorial nature of the issue, containing medical, behavioral, and socio-economic root causes. Title V supports a systems approach that focuses on ensuring access to health care, culturally and linguistically appropriate services, and available wrap around services such as case navigation and community health worker involvement for women.

Perinatal/Infant Health

Infant Safe Sleep

While data from the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) indicates that Nebraska

parents routinely place infants in the supine position for sleep and the incidence of SIDS has decreased, the number of infants dying from accidental suffocation and strangulation in bed (ASSB) has steadily increased. PRAMS data shows that significant racial and ethnic differences exist in numbers and percentages of infants who routinely share their sleep surface with others, the highest rates among African American, Asian, and American Indian mothers.

Title V work includes promoting the protective practice of infants sharing a bedroom with a parent, but close to the parents' bed, on a separate surface designed especially for infants; promoting initiation of and sustained breastfeeding; and providing culturally and linguistically appropriate education for new parents and birthing hospital staff.

Premature Birth

In Nebraska, approximately 2,600 babies are born prematurely (earlier than 37 weeks gestation) every year, which in 2018 was 10% of all births. This was higher than both the Healthy People 2020 and March of Dimes 2020 goals. Additionally, significant demographic disparities exist between racial/ethnic, income, and educational attainment groups. Babies born prematurely are at high risk for mortality and morbidity, and when compared to full-term babies, they are at significant risk for cerebral palsy, chronic lung disease, hearing loss, and intellectual disabilities. Title V will partner with stakeholders to implement screening women for social determinants of health, offering appropriate information and tools for clinicians, and encouraging women to become healthy before becoming pregnant.

Child Health

Child Abuse and Neglect

According to the NDHHS, 2,369 Nebraska children experienced substantiated abuse and/or neglect during 2020. Poverty is often associated with a greater risk of child maltreatment, and data indicates that neglect is the primary reason most children enter foster care. Additionally, approximately 45% of children who enter out-of- home care are ages 0-5 and in significant numbers do so because of parental substance use. This provides a compelling case for providing family supports prenatally and during early childhood, as well as to identify and serve families dealing with substance use. Title V seeks to leverage the strong existing partnership with the Division of Children and Family Services to expand Home Visiting services across Nebraska, particularly in the Child Welfare Protocol within the Healthy Families America model, as well as to implement system changes around screening for and serving families with infants born exposed to substances.

Access to Preventive Oral Health Services

The NDHHS Office of Oral Health and Dentistry (OOHD) reports in 2015-2016 that 63.9% of 3rd grade children had decay experience, 32% of 3rd grade children had untreated caries, and 15% of children ages 1-17 reported active oral health problems; all are higher than the U.S. averages. Further, hospital emergency room dental visits have doubled over 10 years, with 16% being for children ages 0-17. Access to care is one root cause to this problem, since more than half of Nebraska is considered a state designated general dentist shortage area, and.a significant percentage of Nebraska's population lives in rural locations, including approximately 125,000 children aged 1- 9 years. As a result, many low-income children and youth eligible for Medicaid benefits do not receive mandated preventive dental services. In partnership with the OOHD, Title V work includes providing culturally and linguistically appropriate education and dental health supplies to new parents and engaging in surveillance of young children's oral health.

Children and Youth with Special Health Care Needs

Behavioral Health in School

Students with disabilities are more than twice as likely to receive an out-of-school suspension as students without disabilities, and those receiving special education supports have a disproportionate rate of school-related arrests.

These practices lead to higher incarceration rates which are positively associated with academic failure, high school dropout, and involvement with the juvenile justice system, grade retention, and illegal substance abuse. Title V will utilize existing relationships with partners serving CYSHCN and school staff to increase screening and referrals for mental/behavioral health issues, to explore training that is trauma-informed and designed to de-escalate, and to ensure that families are aware of their rights, available resources, and educational opportunities.

Adolescent Health

Motor Vehicle Crashes

Motor Vehicle Crashes are the leading cause of unintentional injury related death for Nebraska youth aged 10-19 years. In 2017, teen drivers aged 19 and younger were involved in 21% of all reported crashes but only represented 7.3% of all licensed drivers. Also in 2017, 72.7% of teen traffic fatalities were not wearing seat belts, and the Nebraska Youth Risk Behavioral Survey (YRBS) reported that nearly half of students reported texting or emailing while driving in the past 30 days. Continuing a strong partnership with the NDHHS Injury Prevention program, Title V will support the Teens in the Driver's Seat program and engage in surveillance of youth driving behaviors and needs across the state.

STD Prevention

According to the Centers for Disease Control and Prevention (CDC), young people aged 15 to 24 years acquire approximately half of all new Sexually Transmitted Diseases (STD) while making up only about one quarter of the sexually active population. Chlamydia and gonorrhea are the most prevalent STD for this age group, both nationally and in Nebraska. In 2018, the reported rate of gonorrhea infections per 100,000 Nebraska youth aged 15 to 19 years was 137.3 and 788.9 for chlamydia. Significant disparities exist in chlamydia and gonorrhea infections by race and ethnicity. Title V work supports other programs focused on reducing STD rates in NE youth by providing culturally and linguistically appropriate educational materials and distributing funds to local organizations.

Suicide Prevention

Suicide has been, and continues to be, a top cause of death in the state for young people. Nebraska Vital Records show that in 2017, the rate of youth (aged 10-19 years) deaths due to suicide was 11.4 per 100,000 compared to the national suicide rate of 7.2 per 100,000. Further, the number of deaths due to suicide for youth has been steadily increasing since 2009 according to NE Vital Statistics data. Title V will collaborate with state and local partners focused on suicide prevention and seek to expand that collaboration to include school staff with the goal of describing how state training requirements are being met and what gaps exist.

Cross-Cutting

Access to and Utilization of Behavioral Health Care

Unmet mental health and behavioral health needs significantly impact the MCH population. One in five Nebraskans are reported to experience mental illness; a significant number of others also experience behavioral health concerns. The prevalence of mental health disorders among persons with Intellectual or Developmental Disorders range from 15% to 41% depending on the diagnosis. Title V work in this area leans heavily on partnerships with the Division of Behavioral Health and the Pediatric Mental Health Care Access project. The focus is to ensure access to care through Medicaid expansion, to increase screening and referral services, and to offer training and resources specific to mental/behavioral health services for Community Health Workers.

Emerging Needs

Maternal and child health is never static and identifying priorities/needs once every five years does not limit the focus of Title V – significant attention is paid to emerging needs and the flexibility required to quickly pivot and address those needs when necessary. Lingering effects of the COVID pandemic remain and continue to be felt most strongly

by vulnerable populations. Mental/behavioral health continues to be a major concern across the lifespan – affecting children, youth, and women alike.. Challenges within the Public Health workforce have risen to the forefront, with many professionals leaving the field after experiencing burnout and recruitment issues delaying the onboarding of new staff. Regional Data from deBeaumont Foundation PH Wins Survey of over 45,000 public health workers across the country show that most respondents experience post-traumatic stress symptoms and over a quarter are considering leaving within the next year. More than half of the existing workforce have served for 5 years or less, and only a small portion have a specialized degree in public health. These points illustrate the fragile nature of the public health workforce today, and underscore the need for strategies addressing recruitment, retention, and ongoing development.

The framework to address the needs of the maternal and child population in Nebraska mentioned above is broad and inclusive. Title V staff have significant expertise and partnering with other NDHHS programs enhances the options to address Nebraska's priorities. In addition to those mentioned earlier, partners such as the Office of Health Disparities and Health Equity, Medicaid and Long-Term Care, and the Office of Rural Health bring significant subject matter expertise.

Equally important to this work are several external partnerships. These partners bring not only expertise, but their own networks of participants, partners, and contacts who are vital to informing and performing Title V work. Partners include the NE Perinatal Quality Improvement Collaborative (NPQIC), the University of Nebraska system (Munroe-Meyer Institute, College of Public Health, and Public Policy Center), public schools and school staff, Local and Tribal Health Departments, and the Nebraska Children and Families Foundation, among others. Partnerships such as these amplify the work of Title V in priority areas involving MCH populations and their professional health providers, ultimately benefitting Nebraska MCH, regardless of whether it is an informal relationship or formal in nature through an executed agreement. Additionally, these affiliations mean opportunities for involvement including participating in the five year Needs Assessment, serving on the Title V Steering Committee, and providing feedback on various initiatives.

Comprehensive and Family-centered Care

Nebraska Title V also works to develop approaches promoting comprehensive and family-centered services across the state. These approaches include making space for family members or consumers on Advisory Committees, planning work, and evaluation efforts; compensating non-professionals for their time serving on Title V priorities; and funding work to stabilize and increase partnerships with Community Health Workers, Parent Resource Coordinators, or other community level roles within a system of health. Many of these approaches began within the population of children/youth with special health care needs and are expanding to serve all other domains within MCH.

Program Evaluation

Evaluation is an important part of any program, ensuring that funds are spent effectively in ways that truly reach intended goals. Title V incorporates evaluation in several ways, beginning at the strategy level and extending to an overall review of the work as a whole. As strategies are drafted, implementation teams are encouraged to build evaluation into their activities and review the evidence base for any activity, often using the MCH Evidence data base. Evaluation can be based on easily quantifiable metrics or more qualitative metrics and often are described throughout the action plan narrative as our Results Based Accountability (RBA) measures. Additionally, Title V seeks to describe overall performance to such stakeholders as our Steering Committee members, by looking at high level performance measures that can indicate success at the priority level over a longer period.

Through a framework of assessment, inclusive planning, and regular evaluation Nebraska Title V seeks to promote systems change that will directly benefit families, and ultimately improve the health of the maternal and child population in Nebraska.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Federal Support of Overall Nebraska MCH Efforts

A federal-state partnership is evident with Nebraska Title V. The block grant dollars and technical resources available to the state expands opportunities afforded with state funds. State general fund appropriations and cash are the primary non-federal resources for Nebraska Title V work. In some cases, state legislative language specifies the amount of money, target audience(s), allowable activity, and/or intended outcomes of fund expenditures. Many state appropriations align very well with current Title V MCH priorities and where non-federal resources do not strictly align; they do address other pressing MCH/CYSHCN needs in the state. In addition, subrecipients often offer third-party contributions and non-federal cash to broaden the partnership and possibilities.

A four-year average of federal expenditures by service level are 60% (Public Health Services and Systems), 38% (Enabling Services), and 2% (Direct Services). Non-federal dollars are allocated differently, averaging over the same period 25% (Public Health Services and Systems), 65% (Enabling Services), and 10% (Direct Services). The importance of consistent, complementary roles is illustrated with data from Title V reports (2017-2020) over the four-year period, showing larger contributions from the federal funds in areas where state funding is limited (Public Health Services and Systems) and federal expenditures are less where more state funds are expended (Direct Services).

Similarly, by MCH populations, Nebraska invests federal compared to non-federal funds fairly consistently over time, as illustrated in the following table:

Federal-State Partnership: expense comparison 2018-2021
by Types of Individuals served (TVIS Form 3a)

Types of Individuals	2018 federal / non-federal		2019 federal / non-federal		2020 federal / non-federal		2021 federal / non-federal*	
Pregnant Women	11.8%	12.9%	12.4%	12.9%	7.6%	11.5%	10.2%	11.9%
Infants < 1 year of age	18.5%	23.4%	12.0%	23.3%	12.0%	15.7%	13.0%	18.6%
Children 1 to 22 years of age	32.4%	24.0%	31.2%	25.6%	38.2%	21.7%	34.6%	15.9%
Children with Special Health Care Needs	33.9%	15.3%	38.3%	16.2%	35.6%	27.5%	36.5%	30.1%
Others	3.4%	24.5%	6.0%	22.1%	6.5%	23.6%	5.6%	23.6%

*The 2021 grant is not fully liquidated at the time of the 2022 submission.

This federal-state partnership has been invaluable to build and maintain our public health infrastructure (for adequate and well-trained workforce) and expand MCH direct and enabling services to improve outreach and support to vulnerable populations across the state.

III.A.3. MCH Success Story

MCH Success Story

The COVID-19 pandemic had a significant impact on the Nebraska Department of Health and Human Services (NDHHS) and, especially, on the Division of Public Health (DPH). As the need for data to inform decision-making grew during the pandemic response, the Epidemiology and Informatics Unit within DPH was particularly impacted. The Unit had begun collecting data for the COVID-19 module of SET-NET (Surveillance for Emerging Threats to Mothers and Babies Network) by August 1, 2020. SET-NET is a component of the Centers for Disease Control and Prevention's Epidemiology and Laboratory Capacity funding and collects information on people exposed to certain infectious diseases during pregnancy and their infants. Although the Epidemiology and Informatics Unit made a strong start with COVID-19 and SET-NET, it quickly became clear that they did not have the capacity to continue surveillance along with the other duties they had related to overall COVID-19 response.

The Office of MCH EPI is embedded in the Lifespan Health Services Unit with the MCH programs. Though housed in a different Unit, Infectious disease epidemiologists began reaching out to MCH EPI for support, particularly with SET-NET, when they began experiencing challenges. It became evident to MCH EPI that SET-NET needed more capacity than the infectious disease team could provide, considering its breadth of responsibilities. The team developed a proposal for the SET-NET project to be managed and staffed by the Office of MCH EPI, which was approved beginning August 1, 2021. Since then, the project has accelerated data collection and is preparing to add an additional module (syphilis) in 2022, while awaiting direction on the potential use of SET-NET follow-up for monkeypox. To date, Nebraska's SET-NET data has contributed to more than 5 scientific publications highlighting the risks to women and their infants of COVID-19 during pregnancy.

This is an MCH EPI success story for a team who has in one year broken into the infectious and communicable disease arena – offering much needed insight into the special considerations required when conducting public health surveillance and practice within MCH populations. Building on the SET-NET workplan, the Office of MCH EPI is positioned to advance into the domain of emergency preparedness by conducting an assessment and promoting recommendations.

III.B. Overview of the State

Overview of the State

Nebraska is a state that covers a large geographic area, but has a smaller population base, much of which is located in the eastern half of the state. Measuring 387 miles across with a total area of approximately 77,000 square miles, almost 20% larger than all of New England, much of the land is utilized in the state's large agricultural sector. 58.9% of the state's population reside in the population centers of Grand Island, Lincoln, and Omaha, which represent Metropolitan Statistical Areas (MSA) with populations larger than 50,000. In contrast, 55.5% of all square miles in Nebraska are considered to be frontier and remote (level three), which includes ZIP code areas with majority populations living 60 minutes or more from urban areas of 50,000 or more
people; and 45 minutes or more from urban areas of 25,000-49,999 people; and 30 minutes or more from urban areas of 10,000-24,999 people. Many residents of frontier and remote areas find it hard to access "high order" goods and services, such as advanced medical procedures, stores selling major household appliances, regional airport hubs, or professional sports franchises *and* "low order" goods and services, such as grocery stores, gas stations, and basic health-care services.

Nebraska has experienced shifts in its demographic composition of the state between 2010 to 2020, according to the U.S. Census, which includes an overall aging of the population as well as an increasing diversity. Statewide, as of 2020, 15.7% of the population was 65 and over, a 17% increase from 2010. While the population is aging statewide, the percentage of the population over age 65 was over 20% in 60 counties and over 25% in 26 of those counties. In terms of increased diversity, Nebraska has seen its minority population grow 82% from 2010 to 2020 – which represents 19.5% of the total population. These demographic shifts can have significant implications for healthcare delivery, creating a need to focus on services that are relevant to an older population as well as those that are culturally and linguistically appropriate.

In addition to providing services that are culturally and linguistically appropriate overall, health care providers should be aware of the specific minority populations that exist in their areas in order to provide quality care and to address existing health disparities. While this is a standard of care that all providers should adhere to, there is an increased stress on providers in metropolitan areas the state as the density of the population of color and the number of spoken languages is much higher in urban parts of the state.

Within its minority populations, Nebraska saw the largest percent increase in the Asian population, which increased 64% from 31,919 in 2010 to 52,359 in 2020 according to the U.S. Census estimates. Though this population had the largest percent of growth, it is still a relatively small population within Nebraska, comprising 2.7% of the state's overall population in 2020. The second largest percent increase during this same time-period was seen in the Hispanic population. Hispanic Americans now comprise 12% of the state's population, with a gain of 40.2% between 2010 and 2020 (an increase of 67,310 people). The African American population saw a 16.6% increase and the White population decreased by 1% in the 10-year period between 2010 and 2020.

The Native American population in Nebraska increased by 1.7% between 2010 and 2020. Four federally recognized Native American Tribes are headquartered in Nebraska - the Omaha, Ponca, Santee Sioux, and Winnebago. Though many Native Americans live on reservations, the majority do not. Omaha, Thurston, and Lancaster have the largest Native American populations in Nebraska. In northeastern Nebraska, Thurston County is home to the Winnebago Tribe and Omaha Tribe. A sizable number of Native Americans also reside in the northwestern part of Nebraska adjoining the Pine Ridge Reservation in South Dakota. The Santee Sioux Nation resides in Knox County. The Ponca Tribe operates within a designated service area covering 15 counties in Nebraska, South Dakota, and

Iowa. Tribal offices exist in four Nebraska locations, with a fifth in Iowa. The Iowa and the Sac and Fox Indian Reservation is on the Nebraska-Kansas border, but this reservation accounts for a small percentage of Nebraska's total Native American population.

Health disparities exist in Nebraska and impact many issues relevant to maternal and child health. The DHHS Office of Health Disparities and Health Equity's 2021 Nebraska Minorities Disparity Facts Chart Book included a "Socioeconomic and Health Disparities Report Card" that identified disparity ratios of 2.0 or greater to require intervention. The report also identified disparity ratios over 2.5 as "Unacceptable disparity. Immediate intervention needed." A number of issues relevant to maternal and child health had disparities over 2.0. American Indian women in Nebraska had 2.7 times higher rate of inadequate prenatal care, Hispanic women had 2.1 times higher rates of inadequate prenatal care, and African American women had 2.0 times higher rates of inadequate prenatal care than White women. Teen birth rates were disparate as well, with American Indian (3.1 times the White teen birth rate), Hispanic (2.6 times the White teen birth rate), and African American (2.3 times the White teen birth rate) teens having higher teen birth rates than White teens. Disparities in sexually transmitted diseases by race/ethnicity are large. African Americans have 12 times high rates of sexually transmitted disease than Whites. American Indian rates of sexually transmitted disease were 5.3 times higher than White rates.

Mental health disparities exist as well. From 2013-2017, the age-adjusted suicide rate per 100,000 people was 13.5 for American Indians and 13.2 for Whites. These populations have higher rates than African American, Asian, and Hispanic populations. The Hispanic population had the lowest death rate due to suicide from 2013-2017 at 5.3 per 100,000.

Finally, according to CDC Wonder, the 2017-2019 infant mortality rate (expressed as per 1,000 live births) among African Americans was 10.8, compared to that among the White population at 4.8.

The ability to physically access care remains a challenge for this primarily rural, low-population state. Rural areas have difficulty recruiting and retaining providers and health care professionals, and in supporting facilities such as hospitals or other comprehensive care centers, despite multiple student loan repayment programs geared towards these professions. These challenges have resulted in a proliferation of shortage areas throughout the state. The NDHHS Office of Rural Health tracks state-designated shortage areas by discipline. In May 2022, 58 counties out of 93 had this designation for the Family Practice discipline. For the OB/GYN discipline, the entirety of 76 counties had this designation along with portions of counties surrounding Lancaster and Douglas counties. A similar situation exists for the Psychiatry and Mental Health disciplines, with the majority of Nebraska's 93 counties designated as shortage areas - only 3 counties (and a portion of the counties surrounding Lancaster and Douglas counties) were not considered a shortage area as of May 2022.

Facilities located in federal shortage areas provide affordable and accessible primary and public health care services, including 138 Medicare-certified Rural Health Clinics (RHC), eight Federally Qualified Health Centers (FQHC), nine Indian Health Service (IHS) funded clinics and local public health departments. These facilities not only address access issues, but also make up the safety net healthcare system in Nebraska; serving the 8.1% of Nebraskans who do not have health insurance as well as other vulnerable groups. Expectations are that more Nebraskans will have coverage moving forward since Medicaid expansion, called Heritage Health Adult (HHA), was implemented October 1, 2020.

The Nebraska Medicaid program has also been a driving force towards integration of services in Nebraska. Beginning in 2017, Medicaid offered enrollees a single plan combining physical health, behavioral health, and pharmacy benefits in an integrated health care program – a practice that has continued throughout recent changes to the overall program. Since Community Health Centers and many private providers are connected to larger health

systems serving both private pay and Medicaid patients, integration of health services is not unique to Medicaid enrollees.

Nebraska's Behavioral Health System of Care (NeSOC) began in 2013 and continues to maximize services provided by Divisions of DHHS as well as other system partners. NeSOC is not a program but rather a different way of doing business. It is youth-guided, family-driven, trauma-informed, and culturally responsive to improve outcomes for children and youth with mental and behavioral health challenges and their families. NeSOC serves children and youth aged 0-19 years and their families who are experiencing mental and/or behavioral health challenges. Nebraska's SOC is active in all six Behavioral Health regions in Nebraska, each of whichhosts a local system of care that shares a common philosophy in the approach to care. One of the services provided is Crisis Services, which is an evidence-based continuum of services provided to individuals experiencing a psychiatric crisis. Another example of the services provided is the Youth Mobile Crisis Response (YMCR). The YMCR is a free resource for families and youth of any age who are experiencing a behavioral health crisis anywhere in the state. YMCR therapists are available 24/7 through the Nebraska Family Helpline and help is provided in the community, home, or through video consultation within one hour of the call. Currently, services are either funded as applicable through DHHS Division of Behavioral Health or Medicaid.

The population of children and youth with special health care needs (CYSHCN) in Nebraska is especially vulnerable, as they often face confounding challenges and barriers. By creating a partnership between the DHHS Medically Handicapped Children's Program and the Munroe-Meyer Institute (MMI) within the University of Nebraska Medical Center (UNMC), a network of clinics exists across the state to provide a range of services for individuals with disabilities. In addition, the partnership has created a strong referral network, ensuring that services are covered by insurance as much as possible, and by training and supporting parent resource coordinators as family support. However, it should be noted that not every child with complex medical needs is eligible for services and supports through the Medically Handicapped Children's Program.

An additional component of the CYSHCN health care system is how newborns and infants are screened for metabolic diseases and hearing issues. 100% of Nebraska's birthing facilities collect a bloodspot sample from every baby born in Nebraska and send to the screening laboratory for analysis; those facilities also conduct hearing screenings consistent with state statutes governing standard of care for newborns. These timely screenings ensure that debilitating and sometimes deadly conditions are identified and, if possible, treated to prevent negative health effects or developmental delays. Staff at these facilities also undertake parent education regarding the screening and, if necessary, follow up care. Staff with the Newborn Screening programs also conduct follow up on screened infants to ensure that any additional screening, testing, or connection to care occurs – a process that can often involve healthcare staff, data, and communication with families.

As tele-health continues to advance throughout Nebraska – with the COVID pandemic a large driver of uptake – it is important to call out the tele-audiology framework that was initiated by the NE Early Hearing Detection and Intervention (EHDI) program. For those families in western NE with a newborn who did not pass the hearing screen, a follow up re-screen or diagnostic hearing test can be conducted via tele-audiology with the University of Nebraska-Lincoln's Barkley Speech Language and Hearing Clinic. Appointments are conducted using end-to-end encryption via Zoom HIPAA-compliant conferencing. The testing is completed by a Doctor of Audiology in Lincoln, with a Teacher of the Deaf and Hard of Hearing as a trained facilitator at the test site.

NDHHS Title V has many strengths to facilitate the ongoing engagement needed to address the daunting challenges faced by CYSHCN and their families – particularly with experienced staff and a strong administrative foundation. This expertise asserts itself across all MCH populations as Title V facilitates statewide, systems-level work such as

engaging partners, ensuring quality improvement, and/or developing system supports. The success in these activities is a testament to the leadership that Title V staff have consistently demonstrated for years.

Administratively, Nebraska Title V takes advantage of having co-leads who are housed in separate Divisions. Nebraska Title V is jointly administered by the Title V MCH Director and the Children and Youth with Special Health Care Needs (CYSHCN) Director. The Unit Administrator for the Lifespan Health Services Unit within the Division of Public Health is designated as the Title V MCH Director. The CYSHCN Director role lies with the Economic Assistance Policy Administrator II within the Division of Children and Family Services (CFS), Programs and Services Unit. Having state co-leads in two Divisions of NDHHS extends the reach of Title V activities, expands the amount of available state support, and extends the staff expertise on the Title V Team. This framework helps to ensure that Title V priorities are fully aligned with those of the larger state agency and of other statewide efforts.

The MCH Director oversees multiple programs, many of which align directly with the mission of Title V, including Newborn Screening, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Immunizations, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Adolescent/Reproductive Health, Office of Women's and Men's Health, Women's Health Initiatives, and more. Likewise, the CYSHCN Director is responsible for numerous program areas, including the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance to Needy Families (TANF), Child Care and Development Fund (CCDF), the Medically Handicapped Children's Program (MHCP), and more. Additional key staff in both Public Health and CFS lead the Title V MCH Block Grant and partner with stakeholders statewide. These are the Maternal Child Health (MCH) team, the MCH Epidemiology team, a Federal Grants Administrator, the Disabled Persons Program Administrator, and the MHCP Program Coordinator.

Solidifying this operational approach is an Intra-Agency Protocol between the Divisions of CFS, PH, and Medicaid and Long-Term Care. While the agreement is statutorily required, it also provides a means to formalize the long-standing relationships between the Divisions by describing shared and individual responsibilities of each Division.

Another part of the administrative framework for Nebraska Title V work are the statutes pertaining to the broad authority to carry out maternal and child health services in the state, found in Nebraska Revised Statutes (Neb. Rev. Stat.) §§71-2201 to 71-2208. Additional related authorities include the statute requiring a Birth Defects Registry (found in §§71-645 through 71-648), Child Maternal Death Review (found in §§71-3404 through 71-3411), the Childhood Vaccine Act (found in §§71-526 through 71-530), metabolic screening and associated responsibilities (found in §§71-519 through 71-524), newborn hearing screening (found in §§71-4734 through §§71-4744), WIC (found in §71-2227), and the Women's Health Initiative program (found in §§71-701 through 71-707). The statutes pertaining to the Medically Handicapped Children's Program are found in Neb. Rev. Stat. §43-522, §68-309, and §68-717 with the associated NDHHS regulations found in Title 467 Chapters 1 through 7.

NDHHS Title V additionally relies on established relationships with key stakeholders to ensure that the public health and direct care infrastructures have CLAS and health equity standards in place to inform how staff interact with clients, and that services are offered in a family-centered, comprehensive way. These relationships are enhanced by the technical expertise that Title V offers to others. The programmatic staff within Title V offer a significant output of high-quality continuing education and professional development activities every year for professionals statewide. While training participants are frequently licensed health professionals, particularly nurses, training opportunities also are delivered to youth-serving professionals and home visitors. Additionally, Title V participates in developing new roles for MCH workers, such as home visitors, parent resource coordinators, and the TOP ® educators working in positive youth development.

In the area of data collection and analysis, Nebraska has an experienced MCH Epidemiology team who work with MCH data regularly and maintain a deep understanding of health indicators. Examples of the collaborative contributions of these staff include building linkages between separate datasets, providing learning opportunities

and technical assistance to colleagues, and participating on Division- and Department-wide workgroups on data governance, collection, and release policies and procedures. The addition of a CDC assignee with the Office of MCH Epidemiology has deepened the expertise and capacity available to the state.

With issues around health disparities, medical shortage areas, a shifting demographic, and health care access, Nebraska certainly has challenges to improving the health of Nebraska's maternal and child population. However, as discussed above, there is a solid framework in place to address these issues. The blend of experienced staff, technical expertise, long-term relationships with stakeholders, as well as statute and general fund availability make up an infrastructure that is in place to support Nebraska's priorities and vulnerable populations. This existing infrastructure provides fertile ground for Title V funds to enhance efforts and bring additional resources to this important work. Through a framework of assessment, inclusive planning, and regular evaluation Nebraska Title V seeks to promote systems change that will directly benefit families, and ultimately improve the health of the maternal and child population in Nebraska.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

Needs Assessment Update

The Office of MCH Epidemiology (MCH EPI) is responsible for conducting needs assessment activities for Nebraska's Title V Block Grant and MCH (Maternal and Child Health) populations. To that end they employ myriad activities to engage stakeholders, establish partnerships, monitor health, measure performance, and evaluate projects and programs. These activities include ongoing surveillance of births, health status, mortality, and social determinants of health.

Below is information regarding assessment updates and changes in Nebraska's priority needs and health status along with various activities that MCH EPI have participated in or conducted. Assessment activities are largely driven by workforce capacity, stakeholder input and programmatic needs in a given year.

Women/Maternal Health Domain

CVD Including Diabetes, Obesity, and Hypertension

Obesity is associated with serious health risks, including hypertension and diabetes. The Nebraska Behavioral Risk Factor Surveillance System (BRFSS) reports obesity at 33.3% for women over 18 years of age and a combined overweight obesity rate of 64% for 2020. Further, the BRFSS reports that 31.1% of women have been told they have high blood pressure, 7.5% have been told they are pre-diabetic, and 9.3% have been told they have diabetes. The prevalence of each indicator increases with age, and there are disparities by race/ethnicity, income, and geography. These indicators have all increased since the 2020 Needs Assessment.

In 2021, the Office of MCH EPI conducted descriptive analysis of preterm birth to inform the Nebraska Perinatal Quality Improvement Collaborative's review and recommendation process. The analysis highlighted the impact of CVD on preterm birth (more information below).

Perinatal/Infant Health Domain

Premature Birth

In 2020, the Office of MCH EPI conducted descriptive analysis of preterm birth using birth certificate and Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) data to inform the Nebraska Perinatal Quality Improvement Collaborative's review and recommendation process. From 2015 through 2019, the overall preterm birth rate in Nebraska was 10.5%; the preterm rate for singleton births was 8.3%. Several chronic-disease-related risk factors were related to higher rates of preterm birth including maternal smoking, maternal obesity, pre-pregnancy diabetes, and pre-pregnancy hypertension. Also related to higher rates of preterm birth were previous preterm birth, young or advanced maternal age, use of fertility treatment, and relatively low maternal education. A long-term approach should be implemented to address pre-pregnancy chronic disease to improve maternal health and reduce risk of preterm birth. In 2021, this effort concluded with a recommendation to address maternal tobacco use. MCH EPI worked with partners to publish "Call to Action: Improve Future Pregnancy Outcomes by Screening for Tobacco Use Now" in the Nebraska Medical Association Newsletter.

Infant Safe Sleep

Data from the Nebraska PRAMS indicates that Nebraska parents have received the "back to sleep" message; in 2020 88.5% of respondents were placing infants in the supine position for sleep, this is an increase from 87% in

2017. Nonetheless, as the incidence of Sudden Unexplained Infant Death (SUID) in both the United States and Nebraska has decreased, the number of infants dying from accidental suffocation and strangulation in bed (ASSB) and other sleep-associated causes has steadily increased. Nebraska PRAMS data also indicates a slight decrease in parent/child sleep surface sharing, with 21.4% of respondents indicating sleep surface sharing in 2020 as compared to 23.7% in 2017.

Nebraska PRAMS updated the provider factsheets in 2020 and published social media posts for partners and stakeholders to share (https://dhhs.ne.gov/PRAMSDocuments/SafeSleepSocialMediaPosts.pdf).

Child Health Domain

Access to Preventive Oral Healthcare

The Nebraska Department of Health and Human Services' Office of Oral Health and Dentistry (OOHD) reports in 2015-2016 that 63.9% of 3rd grade children had decay experience, 32% of 3rd grade children had untreated caries, and 15% of children aged 1-17 years reported active oral health problems; all are higher than the U.S. averages. Although delayed by one year due to COVID-19, the Open Mouth Survey was conducted during the 2021-2022 school year. This survey was conducted among third graders as well as Head Start sites.

Child Abuse and Neglect

Exposure to abuse and/or neglect as a child is considered an Adverse Childhood Experience (ACE). The presence of one or more ACE has been found to have negative, long-lasting effects on physical and mental health and well-being. According to the NDHHS 1,765 Nebraska children (aged 1-9 years) experienced substantiated abuse and/or neglect during 2021, a rate of 7.4/1,000. This is a significant decrease from 10.0 in 2020, which was most likely affected by the pandemic. The 2021 rate is inline with what Nebraska was reporting pre-pandemic (7.2 in 2019). Physical neglect is by far the leading reason for removal, and often is linked to a parent's substance use. There are disparities that exist in both alleged and substantiated cases of child abuse/neglect.

Adolescent Health Domain

Motor Vehicle Crashes

Motor Vehicle Crashes are the leading cause of unintentional injury related death for Nebraska youth aged 10 through 19 years. According to the Nebraska Department of Transportation in 2020, teen drivers aged 19 and younger were involved in 14% of all reported crashes but only represented 5.2% of all licensed drivers. This is an increase from 2019, when teens were involved in 13% of crashes, and represented 7.4% of all drivers.

Also in 2019:

- 78% of the 18 teen traffic fatalities (drivers and passengers) were NOT wearing seat belts.
- At least 31% of teen drivers involved in crashes were using a cell phone.

Sexually Transmitted Diseases/Infections

Both chlamydia and gonorrhea rates among youth in NE are lower than national rates and have been stable since 2008. While chlamydia rates are not increasing for youth under age 19, they are increasing significantly for those over age 20 – demonstrating the continuing need for Title V to focus on this priority.

According to the Centers for Disease Control and Prevention (CDC), young people (aged 15 through 24 years) acquire approximately half of all new STDs while making up only about one quarter of the sexually active population. Chlamydia is the most prevalent STD both nationally and in Nebraska. In 2021, the reported rate of chlamydia infections per 100,000 Nebraska youth aged 15 to 19 years was 1,805 for chlamydia. This is an increase from the 2020 rate of 1,776. Significant disparities by race and ethnicity exist.

Nebraska is seeing a rate increase in both syphilis among women of reproductive age as well as congenital syphilis. While the numbers remain small, the rate increase is of concern. Nebraska will begin tracking maternal and infant syphilis cases with SET-NET (Surveillance of Emerging Threats to Mothers and Babies Network) in FY 2022.

Suicide

Suicide has been, and continues to be, a top cause of death in the state for young people. According to the Nebraska Vital Records in 2020 the rate of youth (aged 10 through 19 years) suicide deaths was 7.5 per 100,000; the national rate for 2020 was 6.7 per 100,000. Further, the number of deaths due to suicide for youth (aged 10 through 19 years) in Nebraska has been steadily increasing since 2009.

CYSHCN Domain

Behavioral and Mental Health in School

Students with disabilities are more than twice as likely to receive an out-of-school suspension (14.6%) than students without disabilities (6%). While students in Nebraska receiving special education supports make up only 14% of total students, they account for 32% of all school-related arrests. These practices lead to higher incarceration rates which are positively associated with academic failure, high school dropout, and involvement with the juvenile justice system, grade retention, and illegal substance abuse.

Cross-cutting or Life Course Domain

Improved Access to and Utilization of Mental Health Care Services

Unmet mental and behavioral health needs significantly impact the MCH population. One in five Nebraskans are reported to experience mental illness; a significant number of others also experience behavioral health concerns (Nebraska Behavioral Health Needs Assessment, 2016). According to the Behavioral Health Barometer: Nebraska, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services:

- 13.6% of youth aged 12-17 years had a major depressive disorder in 2016-2019
- 39.7% of youth aged 12-17 years who had a major depressive disorder received depression care in the past year (2016-2019)

Emerging Issues

- *Workforce*

As the field of public health emerges from the pandemic, workforce issues are top priority. Morale is low, inflation is high, and Nebraska is recording the lowest unemployment rate in the county. This is impacting the NDHHS and the Division of Public Health. MCH EPI has enjoyed growth and is building capacity but has not been immune to staff turnover. Over the coming years MCH EPI will recruit a number of student interns each year in an effort to maintain a good pipeline of potential candidates for Nebraska's MCH workforce.

- *Health Equity and Social Determinants of Health (SDoH)*

The pandemic brought Health Equity and Social Determinants of Health (SDoH) to the forefront, renewing efforts to better integrate and achieve results. This has already affected MCH EPI as it investigates new and innovative ways to bring community, and individuals with lived experiences, into the data collection and interpretation (recommendation) spaces. As the pandemic brought to the surface and illuminated gaps in state-local service systems, we see the emergence of community-based organizations as key partners in addressing priorities, reducing disparities, and addressing root causes.

Changes in Title V Program Capacity

There have been a number of changes in Nebraska that have increased the capacity of Title V. The Office of MCH Epidemiology added a Master's level Epidemiologist (December 2021) through the CDC Foundation, as well as a Health Surveillance Specialist and Community Health Educator (January 2022). These positions primarily staff SET-NET which was moved under the Office of MCH EPI in the fall of 2021.

Title V Partnerships and Collaborations

Nebraska's MCH Epidemiology staff utilize a number of partnerships and collaborations to monitor the needs of the MCH population in NE, and to build relationships that allow for effective coordination. Continued relationships include the Divisions of Behavioral Health, Children and Family Services, and Medicaid and Long-Term Care as well as multiple Division of Public Health programs within DHHS. External partners are UNMC's/Nebraska Perinatal Quality Improvement Collaborative, Nebraska's Department of Education, Nebraska's Children and Families Foundation, local health departments (particularly Douglas County FIMR project), the four designated tribes (Omaha, Ponca, Santee, and Winnebago), the Great Plains Tribal Epi Center, Munroe Meyer Institute, PTI Nebraska, the PRAMS steering committee, the Child and Maternal Death Review Teams' expert volunteers, the Title V steering committee and stakeholders.

Operationalize the Needs Assessment Process and Findings

Nebraska's Needs Assessment findings are fully operationalized. NDHHS Title V is committed to honoring the involvement of stakeholders by ensuring that Needs Assessment priorities guide the majority of Title V work and remain visible to both internal and external partners on our website. Not only does each annual Action Plan have strategies that correspond to one of the 10 priorities identified, but ongoing monitoring of MCH populations is aligned as well, often referring back to Issue Briefs developed by stakeholders during the Needs Assessment process that both describe the issue and identify what success might look like after 5 years of effort.

The process of the Needs Assessment is also operationalized. Nebraska Title V staff utilize a wide range of data sources to monitor the health needs of Nebraska's MCH and CYSHCN populations, including those related to NPMs, SPMs, and EPMs. In addition to the Title V framework, there are a number of agency level assessments which support ongoing monitoring of maternal and child (including those with special health care needs) health, such as the MIECHV Needs Assessment, the State Health Improvement Plan (SHIP), and the Division of Public Health Strategic Plan. This ongoing monitoring ensures that the MCH EPI staff, and Title V, are well suited to initiate annual updates, as well as prepare for the next five-year Needs Assessment.

As part of the continued monitoring and readiness effort, the Office of MCH EPI has been working on a number of data capacity projects that will ultimately improve access to and quality of the data for MCH assessment and programmatic activities. Most notably a PRAMS annual report, an inaugural report of the Maternal Mortality Review Committee, data linkage projects with the blood lead program and Hospital Discharge Data, and an analysis of

Nebraska's Immunization Registry as it relates to the MCH population.

Building team capacity as we integrate new staff has been a priority. At the end of 2020/early 2021 MCH EPI underwent a strategic planning process which resulted in a shared team vision: Generate high quality data to improve the health of families through partnerships. In addition, the following three goals were identified: develop and implement a streamlined process for data requests and products, improve office communication and participation with internal and external partners, and team development to build effective and efficient working relationships based on strengths and competencies. To further refine efforts to improve office communication, team development, and efficient working relationships, MCH EPI initiated a monthly review process to debrief on project and process looking for areas to improve or innovate.

Changes in Organizational Structure/Leadership

During 2021-2022 Nebraska Title V experienced turnover with key staff, but no organizational or leadership changes. Rayma Delaney, Federal Aid Administrator III, who served with DHHS for 24 years retired on July 8. Her successor, Jonathan Newcomb, started in his role on July 6 bringing internal audit experience and significant financial management skills which will serve him well in his new role. Rayma's contributions to Title V grant management in Nebraska cannot be understated, nor her ready assistance to colleagues across the Agency.

Kathy Karsting, DHHS Program Manager II, also resigned with DHHS as of June 10. Her successor, Jessica Seberger, began her new role on August 1, bringing a wealth of experience in maternal and child health issues as the previous manager of PRAMS. Kathy also made significant contributions to the field of Maternal and Child Health in Nebraska, which culminated with a 2021 Title V Lifetime Achievement Award from HRSA MCHB.

Andrea Riley, School Health Program Manager, resigned to take a new position helping the NE Department of Education revitalize its approach to school health issues, in partnership with Children's Hospital. A successor for this position has yet to be identified, as this period of transition will mean changes in how Title V approaches school health.

These are many and significant changes in the core staff of Nebraska Title V. Transitions of course mean changes and often confusion, however for Title V, it is also an important opportunity to focus priorities and determine the right resource mix for ongoing efforts. Additionally, it allows for fresh perspective and original ideas from the new teammates who are joining Title V. The strong foundation in NE as well as the continued commitment of existing staff mean that Nebraska is well-situated to weather this transitional period and emerge as a different, but cohesive MCH team.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,000,000	$3,427,223	$4,000,000	$3,422,256
State Funds	$3,000,000	$2,869,302	$3,000,000	$2,902,472
Local Funds	$200,000	$279,964	$0	$356,152
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$7,200,000	$6,576,489	$7,000,000	$6,680,880
Other Federal Funds	$203,990,666	$147,933,647	$199,706,050	$144,204,751
Total	$211,190,666	$154,510,136	$206,706,050	$150,885,631

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,000,000	$3,709,999	$4,000,000	
State Funds	$3,000,000	$3,002,378	$3,000,000	
Local Funds	$350,000	$207,955	$350,000	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$7,350,000	$6,920,332	$7,350,000	
Other Federal Funds	$212,241,927	$145,345,649	$214,347,896	
Total	$219,591,927	$152,265,981	$221,697,896	

	2023	
	Budgeted	**Expended**
Federal Allocation	$4,000,000	
State Funds	$3,000,000	
Local Funds	$318,934	
Other Funds	$0	
Program Funds	$0	
SubTotal	$7,318,934	
Other Federal Funds	$228,192,347	
Total	$235,511,281	

III.D.1. Expenditures

At the time of the August 2022 submission, obligations of the 2021 grant are not fully liquidated. Expenditures and unliquidated obligations for performance ending September 30, 2022 are reported in the financial forms and narrative. Obligations will be paid in the 90-day liquidation period and reported in the Final Federal Report (FFR) due January 30, 2023.

Three overarching points

1) Each annual federal allotment has a two-year period of availability, permitting two grants to overlap by 12 months. For example, at the time of the August 2022 report submission, the 2021 and 2022 grant funds are available for obligation and expenditure. The 2023 funds in this Application will be initially available in the 2nd year of the 2022 grant period. Nebraska regularly exercises the two-year spending authority given to states to obligate the annual allotment of Title V Maternal Child Health Block Grant in the succeeding fiscal year of the allotment.

2) Title V statutory expenditure requirements are based on the allotment, not the expenditures in a 12-month fiscal year period. The overlap does provide greater flexibility than some grants, yet also requires careful grants management to ensure full compliance with statutes and regulations.

3) Non-federal match for this report is predominately state funds expended in the FFY 2021 period, i.e. October 1, 2020 through September 30, 2021. Subrecipient Tribal MCH programs and community-based projects contribute third-party and non-federal cash expenditures aligned with the subaward period (April 1 through March 31), neither FFY nor state fiscal year (SFY) July 1 through June 30.

Impact of the Lingering Pandemic

During the hopeful months following initial vaccine administration and some relief from COVID-19, planning was underway for eight stakeholder-engaged projects in communities across Nebraska. Six of the eight projects are led by local health departments, so when COVID-19 again surged, the response took priority. Several entities agreed in early 2022 to de-obligate a portion of the 2021 subaward due to circumstances beyond their control that would limit full implementation of some work plan activities. Those 2021 funds, originally budgeted for child-focused priorities, pivoted to other NDHHS-led activities for the population of children (ages 1 through 22).

NDHHS-led activities also experienced a few interruptions that altered the 2021 budget. Grant manager's regular ongoing, careful monitoring budget-to-expense permits course corrections, all described more fully in IIID.2. Budget Narrative in the "build a better budget" process. The grant manager determined in May 2022 if the main cost driver (state-level payroll) was extended four pay periods beyond the original 2021 budget, then the 30%-30% expenditure requirement (of the total grant expense) could be met in conjunction with the remaining unliquidated obligations. NDHHS payroll allocable to Title V is a small percentage attributable to children, however. As a result, the 2021 federal allocation will not be entirely expended, keeping a reasonable margin of variance in the event remaining obligations liquidate below the projection of final expense for the population children ages 1 through 22 years. NDHHS maintains it is better to under expend the federal allotment than to risk non-compliance.

Circumstances challenge alignment of requirements

Two disclaimers are intended to explain any misalignments between financial, program, and performance measures in this annual report.

First, is the need to fit the two-year spending authority of the federal block grant in an annual reporting framework. In a 12-month fiscal year period there are two open grants, i.e. the succeeding year of 2021 funding availability overlaps with the initial year of the 2022 allotment. Overlapping grants could each arguably be credited to the performance demonstrated in the State Action Plan narrative, and the program forms. While all expenditures are

clearly attributable to a specific grant allotment, outcomes during the same period are not so clearly aligned to specific funding.

Second, Nebraska's state fiscal year (SFY) is July 1 through June 30. State appropriations and spending authority do not align with the FFY. For purposes of this report, state expenditures are reported based on payments in the FFY period October 1 through September 30. Adjusting for fiscal period helps explain any variance between the budget and expense greater than 10% in financial forms. Despite these challenges, NDHHS has sound financial and administrative controls in place, and supporting documentation is maintained to demonstrate fiscal compliance.

The narrative is organized to emphasize performance generally about financial resources of the 2021 grant, state expenditures in the FFY 2021 period, and local match associated with subawards of the 2021 grant. Expenditures, including the level of detail needed to demonstrate compliance with 30-30 statutory requirements and the 10% administrative cap are reported in the annual report.

Programs & special projects

With the 2021 federal allotment, NDHHS supported a wide variety of maternal and child health (MCH) activities in 11 state-level public health programs through an internal allocation, all administered within NDHHS. Individual program budgets are often in conjunction with state support and/or other federal awards. A number of subaward agreements with community-based organizations and the four federally-recognized Tribal governments headquartered in Nebraska further extend a statewide impact.

1. **An Aerial View: Federal–State Partnership and Other Federal Funds (Form 2)**

Title V includes the block grant (BG) and state funds (SF), the focus of this narrative. A variety of contracts (procurement of goods and services) are sourced with the federal block grant and state funds are overseen by NDHHS program managers.

The multi-faceted programs of the **Maternal, Child, Adolescent, & School Health (MCASH) team** comprise much of the content of the State Action Plan, which is described elsewhere in this report. MCASH program managers are an integral part of the Title V State Action Plan group, leading a variety of initiatives and coordinating state-level activities with other programs/units to address many of Nebraska MCH priorities and activities across population domains. It is an example of ongoing performance that rolls across reporting periods. The final MCASH expenditures are projected $729,284 of the 2021 Block Grant.

MCH Epidemiology successfully recruited a CDC MCH Epidemiology Assignee who arrived in Nebraska September 2020. The Child and Maternal Death Review team (CMDRT) continued to implement the reorganized Maternal Mortality Review Committee under the CMDRT, by training a MCH Epidemiology Coordinator. The first MMRC report (deaths that covered years 2014 – 2018) is complete and pending final approval. In addition, the team created a fillable electronic SUID Death Scene investigation form and related web-based training. Other activities include continuing with second investment into National Survey of Children's Health oversample, supporting the N-MIECHV data and performance management system, and continued analysis and production of an internal report on the Medicaid-Birth linkage. ($164,768 BG) Title V funds also provided additional support ($123,424 BG) beyond the CDC award to the Pregnancy Risk Assessment Monitoring System (PRAMS).

Nebraska Reproductive Health ($324,423 BG) supports education and preventative health practices that improve reproductive health outcomes, such as decreasing STDs/STIs, preventing unintended pregnancies, promoting appropriate birth spacing, and encouraging a healthy lifestyle. Subawards with six community-based organizations

focused on engaging adolescents through outreach and education events, to increase their utilization of reproductive health services to make informed decisions, decrease STD/STI rates among youth, and decrease unintended pregnancies.

Women's Health Initiatives (WHI) ($37,856 BG) provided support to the Women's Health Advisory Council. In addition, WHI either led or participated in a variety of other external and internal collaborations regarding MCH initiatives; **Birth Defects Registry** ($73,564 BG) provide training to hospitals to use the state electronic birth defect reporting system, perform data quality checks to assure the birth defect data are accurate and complete, and engage with MCH programs to provide accurate, complete, and timely information about children with birth defects.

The **Newborn Screening Program** ($308,036 BG; $272,431 SF) staff conduct continuous monitoring, tracking, and follow-up activities to ensure all Nebraska newborns receive a valid screen for all required conditions. This work includes tracking activities for all approximately 25,000 births and for drawn early, unsatisfactory, post-transfusion, inconclusive, and presumptive positive screening results. Beyond the CDC and HRSA awards for **Early Hearing Detection and Intervention (EHDI)**, additional support from Title V ($42,928 BG) included a subaward to the University of Nebraska-Lincoln (UNL) for HearU Nebraska, providing hearing aids to children ages 0-18 with priority to newly identified children ages 0-3. EHDI was also able to temporarily employ a part-time UNL audiology student.

Most internal allocations are within the Division of Public Health, while one, the **Medically Handicapped Children's Program (MHCP)** is organizationally within the Division of Children & Family Services ($1,191,516 BG; $915,709 SF). MHCP and its partners are essential to the CYSHCN domain. MHCP field staff statewide provide ongoing family-centered case management services to program participants. MHCP continues use of Parent Resource Coordinators (PRC). The program partners with the University of Nebraska Medical Center (UNMC)'s Munroe Meyer Institute (MMI) to conduct Specialty Clinics, neonatal intensive care follow-up through TIPS (Tracking Infant Progress Statewide) program, and the Teratogen Project provides accurate and timely information on exposures to potentially damaging agents during pregnancy and lactation.

Subawards to Tribal governments and local communities ($454,660 BG; $207,955 local/non-federal cash & third-party/in-kind) help ensure Public Health Services and Systems and provide enabling services (and some direct services in Tribal programs) in communities across Nebraska. The 2021 federal award provided assistance to six local health departments, two community-based organizations, plus four subawards with federally recognized Tribes headquartered in Nebraska (Omaha, Ponca, Santee Sioux, and Winnebago). Local and Tribal activities are enhanced and more likely sustained by subrecipients contributing local resources to the total costs (Form 2, line 5). The additional resources are a good indicator of genuine partnerships, steadfast commitment, and appreciation for community-specific solutions to Nebraska's MCH priorities.

Other federal funds (Form 2, Line 9) under the control of the Title V administration is defined by Nebraska as the broad oversight by the MCH Director and the CYSHCN Director. Many other program managers supervised by the MCH Director and CYSHCN Director of Title V are more directly responsible for the administration of the other federal awards. Those expenditures do not perfectly align with this report because of the varying fiscal years and report dates which do not correspond with the Title V MCH Block Grant. Not all prior awards are fully expended because of varying periods of spending authority.

2. **MOE, Match, and 30-30-10 Compliance (Form 2)**

The total state match (Form 2, line 7) is a combination of state funds ($3,002,378) plus local funds and in-kind support ($207,955). The total value of matching resources, including local match, is 86.5% ($3,210,333) or 80.9%

state funds alone of the 2021 federal Title V expended/unliquidated obligations reported ($3,709,999). This exceeds the 3:4 match minimum, and the Maintenance of Effort ($2,626,360, Form 2, line 7A).

Nebraska is compliant with the statutory requirement to expend at least 30% of the federal allotment for Children 1 through 21 years (Form 2, line 1A), plus at least 30% CYSHCN (Form 2, line 1B). NDHHS uses accounting codes by MCH populations to track payments by federal allotment and to identify compliance with the 30%-30% requirement.

Administrative costs (Form 2, 1C.) are $102,026 (2.8%), far below the 10% statutory cap. These costs are primarily attributable to the salary, benefits and indirect costs of the Federal Aid Administrator III position, allocable to performing grants management of the 2021 Title V Block Grant. Additional costs attributable to administrative costs include the annual membership dues to the Association of Maternal Child Health Programs (AMCHP), travel, training and other direct costs to administer the 2021 federal allotment.

3. **Expense by Types of Individuals and Health Coverage (Form 3a) aligned to #s of individuals (Form 5a) who received Direct and Enabling services**

The 2021 allotment of Title V federal funds to Nebraska is $3,896,216. At the time of the August 2022 report submission, the total expenditures/remaining obligations across the five types of individuals served (Form 3a, IA) is $3,607,973, 97.2% of the projected final expense. A total 68,341 persons received an individually-delivered Direct or Enabling Service at a cost of $4,323,537 ($1,495,696 BG; $2,827,842 SF).

	Federal	State	Federal-State		
	Form 3a	Form 3a	Form 3a	Form 5a	Form 5b
Pregnant Women	$ 369,454	$ 381,019	$ 750,473	812	100%
Infants <365 days	$ 469,694	$ 595,896	$1,065,590	553	100%
Children age 1 through 21 years of age	$1,249,511	$ 509,892	$1,759,403	26,022	95%
Children With Special Health Care Needs 0 through 21 years of age	$1,317,591	$ 966,154	$2,283,745	1,615	100%
Others	$ 201,723	$ 757,372	$ 959,095	40,954	4%
subtotal	$3,607,973	$3,210,333	$6,818,306	68,341	
administrative costs	$ 102,026		$6,920,332		
Grand Total	$3,709,999				

4. **Expense by Types of Services (Form 3b) to the #s receiving individually-delivered services (Form 5a) and the total percentage of the population served by Title V Federal-State Partnership (Form 5b)**

Nebraska expenditures of the Federal-State Partnership were 62.5% ($4,323,537) for Direct and Enabling Services (Form 3b) for individually-delivered services to 68,341 persons (Form 5a). Expenditures for Public Health Services and Systems (Form 3b) comprise the other 37.5% ($2,596,794), reaching an average 80% of the MCH population (Form 5b).

	Federal	State	Federal-State		
	Form 3b	Form 3b	Form 3b	Form 5a	Form 5b
Direct Services & Enabling Services	$1,495,695	$2,827,842	$4,323,537	68,341	
Public Health Services and Systems	$2,214,304	$ 382,490	$2,596,794		80% (average all populations)
Total	$3,709,999	$3,210,332	$6,920,331		

III.D.2. Budget

The broad-based category budget (Forms 2, 3a, and 3b) is presented on a presumed 2023 allotment (grant) similar to the level of recent awards. A precise 2023 budget will be finalized and approved within NDHHS during the first year of spending authority.

Three overarching points

These points are intended to give foundation to the remainder of the narrative.

1) Each annual allotment has a two-year period of availability that permits two grants to overlap by 12 months. For example, at the time of the August 2022 submission of the 2023 application, the 2021 and 2022 grant funds are available for obligation and performance. The 2023 funds will be available in the 2nd year of the 2022 grant period.

2) The statutory "30-30-10" requirements are based on the allotment, not the expenditures in a 12-month fiscal year period. The overlap does provide greater flexibility than some grants, yet also requires careful grants management to ensure full compliance with statutes and regulations. Meeting statutory requirements by allotment is carefully balanced with the timing and amount of the next allotment.

3) The State of Nebraska operates in a state fiscal year (SFY) period different than the federal fiscal year (FFY). In more recent Title V applications, NDHHS determined it better to budget state MCH funds based on historical expenditures year-to-year in the FFY period, and not on the state appropriation. For the Title V application, the state MCH match budget is an estimate of the payments anticipated will be transacted in the FFY period. This minimizes a variance budget-to-expenditure for Title V purposes, though with less exactness than the internal budget process based on the state appropriations.

The value of two-year authority

Because Nebraska exercises the two-year spending authority, there is a sufficient level of 2022 federal block grant unobligated at the time of the August 2022 submission requesting 2023 funds. Nebraska Title V can continue operations well into the FFY 2023 period that begins October 1, 2022. The two-year authority is a safety net to ensure continuing operations, chiefly payroll which is the largest percentage of the budget. Seamless, ongoing activities performed by the Title V workforce and subsequent outcomes transcend fiscal year periods, and one significant benefit of states' ability to obligate the block grant funds in the year following the award.

Management strategies ensure compliance

A carefully developed budget precedes expense, and compliance requirements are based on expenditure. Two open block grants in a 12-month period presents grants management complexities. In recent years, several process improvements led by the Federal Aid Administrator III (responsible for the block grant administration) have gradually improved accuracy to administratively manage the separate grants. Two primary strategies, initiated separately and implemented with continuous quality improvements over three grant cycles, are described below.

1) The first strategy began the shift to a minimum three-to-six-month offset into the FFY period to obligate subawards and contracts. That same time offset includes a delay to begin incurring state-level workforce costs, the major cost driver. The offset permits receipt of one or two Notices of Award authorizing sufficient funds to obligate and incur major costs. It also allows sufficient time for performance and reporting to coincide with the July submission of the report. For example, a dozen 2021 subawards that ended March 31, 2022, are liquidated; actual expense and counts are included in the August 2022 submission. While the April through March period is the ideal, it has not been feasible for all agreements to fit within that period.

2) A second strategy began with the 2018 block grant to pilot a process to identify within separate internal program budgets any authorized, unobligated funds available for obligation in the succeeding year. The pilot created an opportunity for continuous quality improvement to "build a better budget" process. Spreadsheet tools developed

for internal allocations identify if the authorized funds are on track to be expended as budgeted. Linked cells share information across multiple worksheets within the individual allocation workbooks. Earlier versions of the worksheets included **Step 1** (by population) and **Step 2** (line items). Those worksheets were enhanced and co-located in a workbook to improve links and functionality. Step 2 (line-item budget) links to **Step 3** (monitoring) worksheet used to routinely reconcile expense to the general ledger, calculating unliquidated obligations and any authorized, unobligated funds. The three-step process is a logical progression to track budget-to-expense and stay on track to meet statutory expenditure requirements on two populations (30-30 earmarks).

Step 1 budget by population

The worksheet seeks high-level information from individual NDHSS program managers, briefly describing planned expense – who, what, when, and projected expense by percentage of each population. If personnel costs are included, program manager provides staff name, position, FTE for individual staff (detailed calculations are done in Step 2). Additionally, Step 1 helps identify a preliminary budget of the subsequent award, dependent on variables if the performance and planned expense aligns with 2022 $ and/or 2023 $. Program managers each submit a Step 1 to the block grant administrator. Later with budget approval, program managers can refer to the program's Step 1 worksheet to assist with coding payment requests by MCH population. Subsidiary accounting codes delineate actual expense by MCH population.

Step 2 line-item budget

From Step 1, the grant administrator uses the information to create **Step 2** for separate allocation workbooks, adding detailed calculations for individual personnel. Using Excel formulas, personnel line items calculate the FTE allocable to the grant for wage and benefits for each staff, multiplied by a projected number of total pay periods, the same number for all staff in all programs. Payroll conversion from one grant to the next is for all staff performing work of the grant. The block grant administrator schedules a one-on-one with each program manager to review the Step 2 worksheet, editing as needed. With mutual agreement between the block grant administrator and each NDHHS program manager, the grant administrator aggregates **Step 1** worksheets. Links connect results from certain cells into the new "roll-up" workbook the grant administrator uses to identify if total projected expense is at least 30% for each of the two "earmarked" populations (the 30-30 statutory expenditure requirements). Though subawards use a different budget-to-expense workbook, total subaward obligations by populations also link to the aggregated "roll-up" workbook. Block grant administrator presents the refined grant budget to Title V co-directors, i.e., the MCH Director and the CSHCN Director, with the final outcome to approve the 2022 budget towards the end of the initial year of spending authority, which timing coincides with the 4th Quarter Notice of Award that informs of the total, final 2022 allotment. That same process will take place for a precise 2023 budget that will be finalized and approved within NDHHS during the first year of spending authority.

Step 3 monitoring

The grant administrator performs budget-to-expense reconciliation periodically using the Step 3 "monitoring" worksheet, noting any unexpected variance from budget. Step 3 provides foundation for a periodic check-in with the individual program managers to stay current and connected regarding obligations and expense, allowing for course corrections that may be needed for the grant. The "roll-up" workbook updates from separate allocation workbooks' monitoring worksheets to aid the grant administrator's role to oversee the separate block grants overlap within a 12-month period, each with compliance requirements.
A query of accounting transactions by business units (aligned to internal programs and subawards) and subsidiary codes assists block grant administrator with routine compliance checks for two open, separate block grants. If monitoring detects that the projected date for payroll conversion needs to change, budgets are easily updated by the value for the number of pay periods.

Non-competitive MCH Tribal Setaside

NDHHS prioritizes its longstanding commitment to the MCH Tribal setaside, a non-competitive process established in 2003 in recognition of Tribal sovereignty and respect for our special government-to-government relationship with the four federally recognized Tribal governments headquartered in Nebraska. The 2023 Tribal setaside is expected to be at a similar funding level ($200,000) as with recent years. The current Tribal subawards of 2022 block grant are for the period April 1, 2022 through March 31, 2023.

Competitive Request for Applications (RFA)

NDHHS periodically conducts a competitive subaward process, releasing a Request for Applications (RFA) to offer a significant level of financial support for community projects. Similar to the prior 2019 RFA, a 2021 RFA offered 2021 grant funds initially, and subsequently subawards existing 2022 funds, and anticipates the 2023 grant. The RFA seeks stakeholder-engaged projects in unique community-based activities to respond to one or more of four state-level, child-focused priorities identified in the 2020 Title V Needs Assessment. The Evaluation Committee members independently review and score Concept Papers based on the “fit” to the RFA. Successful applicants consult with DHHS to develop work plans based on Concept Paper approval. A separate RFA process was simultaneously conducted by the NDHHS Reproductive Health program with the exclusive focus on Sexually Transmitted Disease Among Youth, another priority resulting from the 2020 Needs Assessment. Successful applicants in the two RFA processes performed 2021 work plans October 1, 2021 through March 31, 2022, an initial period of performance will be less than a 12-month period to better align with the 2021 grant. The 2022 subawards began April 1, 2022 and will continue through March 31, 2023. A subsequent renewal (2023 subawards) will be for the period April 1, 2023 through March 31, 2024.

Federal–State Partnership and Other Federal Funds (Form 2)

The phrase ‘Federal-State partnership’ (Form 2, line 8) may be intended as finances alone, though the partnership truly includes all types of resources, e.g. research, expertise and sharing experiences across states through our common federal partner. The Federal-State partnership is an example of building an alliance to tackle state priorities unique to Nebraska, yet often shared with or like those experienced by other states in the nation.

Nebraskans have a proud heritage lending a helping hand to neighbors in tough times. Like physically lending a hand, the same spirit is shown by Nebraska statutes and state funds that protect and support MCH and CYSHCN. The state side of the Federal-State partnership is a significant part of the requested budget (Form 2, line 3). Without the federal support of Title V block grant, however, it would be infeasible to achieve the same level of performance across state priorities in the State Action Plan. The other federal funds (Form 2, line 9) that fall within the administrative oversight of the Title V co-directors, i.e., the MCH Director and the CSHCN Director, signify the additional surrounding supports to Nebraska families.

MOE, Match, and 30-30-10 Compliance (Forms 2 and 3a)

The total state match (Form 2, line 7) is budgeted as a combination of state funds plus local funds and in-kind support. The total value of matching resources is budgeted to meet the 3:4 match minimum, and the Maintenance of Effort (Form 2, line 7A).

Nebraska will be compliant with the statutory requirement to expend at least 30% of the federal allotment for Children 1 through 21 years (Form 2, line 1A), plus at least 30% CSHCN (Form 2, line 1B). NDHSS uses accounting codes by MCH populations to track payments by federal allotment and to identify compliance with the 30%-30% requirement.

Administrative costs below the 10% cap (Forms 2 and 3b)

Administrative costs (Form 2, 1C.) are budgeted at $110,000, which presumably will again be far below the 10% statutory cap depending on the 2023 final authorization. These costs will be primarily attributable to the salary, benefits and indirect costs of the Federal Aid Administrator III position, allocable to performing grants management of the 2023 Title V Block Grant. Grants management is chiefly the time associated with a variety of functions that include: financial resource management generally and specifically based on allowable costs; assistance in linking finances to the State Action Plan and ancillary state-level MCH work; ensuring transparency and accountability in collaboration with NDHHS colleagues on program budgets, allowable costs, and expense tied to performance; oversight directly or assisting others with oversight in pre- and post-award processes of subawards; technical assistance to subrecipients; monitoring subawards and ensuring other compliance requirements of the federal award are planned for and met; and planning for audit-readiness and responding to auditor requests. Additional planned expense attributable to administrative costs include the annual membership dues to the Association of Maternal Child Health Programs (AMCHP), travel, training and other direct costs to administer the 2023 allotment.

Forecasting the preliminary 2023 line-item budget

A three-step process described in preceding paragraphs was used for the 2021 grant budget development and monitoring budget-to-expense to prepare the 2021 expense report submitted in August 2022. It forecasts a similar fine-tuning process for the subsequent 2023 budget presented in this Application. When additional information is known about the federal 2023 allotment, increased accuracy and completeness will go into the internal NDHHS budget process. This is expected to begin in November or December for an approximate 12-month period within the two-year authority. The internal budget process will continue to be detailed and precise, carefully considering statutory requirements, the State Action Plan, and the overlapping 12-month period of the 2022 and 2023 federal allotments.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Nebraska

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

State Title V Program Purpose and Design

Vision for Maternal and Child Health in Nebraska

Nebraska Title V approaches all its work with the life course vision of helping mothers and children live healthier lives and is committed to conducting that work in a way that is aligned with public health principles and quality improvement.

Core Values

In addition to utilizing a strong public health framework, NE Title V approaches all aspects of MCH programming – planning, implementation, and assessment/evaluation - with certain core values in place. Threaded throughout all activities for Title V is a focus on health equity, prevention/wellness, evidence based activity, and workforce development. Data is critical to accurately assessing the state of all populations in Nebraska, and must fully represent all populations. Analyzing health and social determinants data to determine where health disparities exist, and thus specifically targeting resources to remove barriers or lift up disparate populations is key to successful Title V work in Nebraska that will ultimately help to achieve equity. In addition to preventing morbidity and mortality, Nebraska Title V is interested in strategies that allow individuals the opportunity to be wholly well, rather than just "not sick". To this end there is a focus on working upstream as much as possible as well as identifying non-traditional partners that can assist with those social determinants of health that have such an impact on a person's well-being.

Another core value of Nebraska Title V is to engage in evidence based work that is data driven. Epidemiology capacity that is solely focused on maternal and child related data sets (health, social, and economic) offers the ability to fully understand the needs of Nebraska's maternal and child population and to assist MCH programming across the state. These staff not only utilize the national data available to states, but are also well situated to work with internal data sets such as PRAMS, WIC, Child and Maternal Death Review, Immunization, and MIECHV among others. This strong foundation provides the support needed to not only address traditional MCH needs identified in the Needs Assessment, but also any emerging issues that arise – such as a beleaguered public health workforce.

Finally, workforce development at both the state and local level is needed to broaden the impact of MCH strategies and ensure sustainability. Title V is committed to enhancing the MCH workforce by offering technical assistance, continuing education, and funding opportunities; as well as by supporting the work to explore and implement system-level changes that create actual job opportunities for MCH workers such as community health workers. In addition to these core activities, Title V is well-situated to assist with more timely work to improve morale, encourage engagement, and offer supportive services to a workforce that is experiencing the effects of trauma.

Guiding Principles

Nebraska Title V approaches this work using guiding principles that are represented throughout the overall agency. A robust commitment to collaboration is evident in all of the strategies that Title V leads, and is furthered by intentional inclusion of families and consumers at all levels of programming. Opportunities for engagement are offered frequently, and supported with compensation as much as possible to reimburse partners for their time and expertise when activities are not part of their regular work. Additionally, Title V intentionally expands funding opportunities to local, community based organizations who are strongly connected to target populations – such as cultural centers, faith-based organizations, etc. Though these organizations may not be considered traditional partners in public health, their position within communities often means they are ideally situated to reach individuals in a trusted and culturally appropriate way. These collaborations with other internal programs, external organizations,

and family members or consumers are the substance of Title V's role as convener, collaborator, and partner, and indeed are a key strategy for success for a team that is small but mighty. Maintaining relationships is key to ongoing partnerships that improve health outcomes, improve access to quality care, and develop a culturally competent workforce.

Nebraska takes a strategic approach to align the priorities of the state agency with those identified by stakeholders as it implements Title V activities. This alignment ensures that broader influences on Title V activities are in line with the five year Needs Assessment and existing strengths, knowledge, and resources of Title V staff and staff in other program areas. Priorities of the state agency include the NDHHS Business Plan, the NE State Health Improvement Plan (SHIP), and the Division of Public Health Strategic Plan. These plans serve as a cornerstone for the state Title V program – and indeed, a reflection of the above priorities can clearly be seen in the strategies and objectives that govern the past and future work of the Title V MCH Block Grant.

Collaborations and alignment are necessary for a team that is lean, cross-Divisional, and experienced. Staff housed within DHHS and tasked with implementing Title V activities not only fill the role of convener, but conduct programmatic work themselves. Nebraska has been fortunate to retain dedicated professional staff who are subject matter experts for the fields in which they work, including a public health nursing staff; staff trained in adolescent and early childhood needs and interventions – including those with special health care needs; and staff proficient in addressing newborn metabolic disease and hearing screening and follow up.

While some turnover is unavoidable, Title V administrative leads provide a culture of continuous learning and support to ensure staff retention and development, recognizing that this expertise is the backbone of successful programming and the foundation for a system of quality maternal and child healthcare in Nebraska.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

MCH WORKFORCE DEVELOPMENT

Nebraska Title V has put in place a variety of activities to develop a workforce in the state competent to carry out essential public health services and benefit the MCH population. State-level staff supporting Nebraska's Title V activities are listed below, with title and portion of FTE supported by Title V funds included:

NAME	TITLE	% FTE Title V
Sara Morgan	Lifespan Health Services Unit Administrator II/Title V MCH Director	0
Shannon Grotrian	Economic Assistance Policy Administrator II/Title V CYSHCN Director	0
Jonathan Newcomb	Federal Aid Administrator III	100
Melissa Greedy	MHCP Program Coordinator	57
Kristen Smith	Disabled Persons Program Administrator	0
Jennifer Severe-Oforah	Office of MCH Epidemiology Administrator	0
Happiness Kingi	Health Surveillance Specialist	25
Celeste Illian	Epidemiology Surveillance Coordinator	100
Jessica Seberger	Maternal Child Health (MCH) Program Manager II	75
Jackie Moline, RN, BSN, CLC	Maternal Infant Health Program Coordinator	100
vacant	Child and School Health Program Manager	100
Michaela Jennings	Adolescent/Reproductive Health Program Manager II	70
Jennifer Auman	Nebraska Maternal Infant Early Childhood Home Visiting (N-MIECHV) Program Manager	15
Edin Salkanovic	MCSH Administrative Assistant I	100
Emily Rivera	Community Health Educator, Sr.	50
TBD	Program Specialist	50
Krystal Baumert	Newborn Screening Inherited Diseases Clinical Specialist	100
Sarah Ward	Newborn Screening Inherited Diseases Clinical Specialist	100
Vacant	MHCP Social Service Worker	57
Barb Arens	MHCP Social Service Worker	57
Jean Nolte,	MHCP Social Service Worker	57
Kathy Schweitzer	MHCP Social Service Worker	57
Briana Anderson	MHCP Payment Reviewer	57

*Both Title V Co-Directors oversee larger units within the DHHS organization, of which the Title V MCH Block Grant is only a part. Their salaries are paid from a “pooled cost” account which is funded from a portion of the funds from programs under their purview.

During the early parts of 2022, Title V has experienced turnover within its core team. Anytime there is turnover of experienced, long-serving staff a period of transition exists, which can bring some uncertainty and confusion, but also opportunity. Rayma Delaney, Federal Aid Administrator III, who served with DHHS for 24 years retired on July 8. Her successor, Jonathan Newcomb, started in his role on July 6 bringing internal audit experience and significant financial management skills which will serve him well in his new role. Ramya’s contributions to Title V grant management in Nebraska cannot be understated, nor her ready assistance to colleagues across the Agency.

Kathy Karsting, DHHS Program Manager II, also resigned with DHHS as of June 10. Her successor, Jessica Seberger, started in her role on August 1 bringing experience overseeing the Pregnancy Risk Assessment Monitoring System (PRAMS) program and Reproductive Health programming which will allow her to quickly step into the role of MCH team lead. Kathy's significant contributions to the field of Maternal and Child Health in Nebraska have been recently recognized with a 2021 Title V Lifetime Achievement Award from HRSA MCHB.

Both Rayma and Kathy will be sorely missed and leave behind a gap in the Nebraska Title V Team that will be hard to fill. Though new hires will have big shoes to fill, there is a strong foundation for a fresh start. These openings are opportunities for refreshed vision, approaches, and energy to move Title V work forward, and the team is ready to integrate and welcome new members into the work.

Several other state-level staff support Nebraska's Title V activities in a partial but valuable capacity, as listed below:

- Vacant, PRAMS Program Manager
- Jeri Weberg-Bryce, Immunization Program Manager
- Jillian Chance, Newborn Screening Program Manager
- Shirley Pickens-White, Women's Health Initiatives
- Amanda Adams, Newborn Hearing Screening Manager
- Melissa Leypoldt, Women's and Men's Health Program Manager
- Erika Fuchs, Ph.D., MCH EPI Contractor

External to the Department, the MCH and CYSHCN workforce is varied and employed in a wide range of agencies and organizations, including local and Tribal health departments, Federally Qualified Health Centers (FQHC), schools, and various non-profit organizations such as family planning and WIC clinics. Nebraska has a de-centralized public health system, meaning that regional health departments cover the state's 93 counties independent of the state health department. While not all health departments receive funding through the Title V Block Grant, all of them have identified MCH issues as priorities through a local needs assessment process, and thus maintain the staff to work on and address them. Agencies such as Community Action Partnerships, FQHC, and the Nebraska Children and Families Foundation are among the important partners providing MCH services at the local level. This workforce also extends to schools, community hospitals, family planning agencies, WIC clinics, and Tribal/IHS clinics. Importantly, there is an extensive network of private clinics and facilities offering direct care services to Nebraskans daily.

To help support the broader, statewide maternal and child health workforce, Title V has extensive activities that include provision of training, continuing education, and financial support. While training participants are frequently licensed health professionals, particularly nurses, and often include continuing education credits; training opportunities also are delivered to youth-serving professionals and home visitors. In 2019, the MCSH team began developing MCH-specific training for Community Health Workers (CHW), as well as partnering with stakeholders to host in-person regional events for CHW for learning and networking within this diverse and emerging workforce. The role of CHW is promoted as valued and respected members of effective integrated health care teams in clinical and community settings, helping to achieve population level outcomes for maternal and child health.

Additionally, Title V participates in developing new roles for MCH workers, such as home visitors, parent resource coordinators, and the TOP ® educators working in positive youth development. Title V staff supports development and proficiency of the school nurse workforce as well as providers in birthing hospitals and clinics.

Recent training and growth opportunities for Title V program staff and family leaders include the following:

Title V:

Great Plains Public Health Leadership Institute

State Government Leadership Certificate program

National conference participation including: the National Association of School Nurses ; Association of Maternal Child Health Programs ; Association of Public Health Nurses ; the Pediatric Mental Health Care Access program all-grantees meeting ; Maternal Infant Early Childhood Home Visiting all-grantees meeting.

Title V provides capacity building training for evidence-based practice, specifically including Teen Outreach

Program and Healthy Families America.

Family leaders:

- Family leader participation in Title V Steering Committee
- Support for Parent Resource Coordinators at MMI
- Support for CHW workforce development
- Family leader participation on a cross-sector advisory committee and a Technical Workgroup as part of the NE Pediatric Mental Health Care Access grant.

Innovations in staff structures and workforce financing

Staff Structures

To allow local health departments, FQHC, and other partners in the NE public health system the opportunity for a somewhat stable funding stream, NDHHS has encouraged subrecipients to think about funding projects rather than personnel. While salaries and benefits are still allowable costs, this change in perception gives local organizations the flexibility to shift their work as state level priorities shift. Having staff that are broadly trained in multiple MCH issues encourages subject matter expertise while being able to shift work from breastfeeding to premature birth, for example, as the state Needs Assessment or community level analysis highlights some priorities over others.

Nebraska Title V also continues work to ensure that the CHW workforce is sustainably funded and supported. NDHHS has a relatively long history with the CHW workforce, for a decade having offered MCH specific training through the Office of Women's and Men's Health to assist in outreach and navigation particularly for chronic health conditions. In fact, a variety of employers and systems offer training for CHW in Nebraska, however there is no broad mechanism for statewide consensus and coordination of developments in the workforce nor of preparing employers, health professionals, and teams for integration of the CHW. Community Health Workers are employed in public health, community service, and clinical settings.
Fee-for-service funding mechanisms continue to exist alongside value-added financing mechanisms, and more collaboration with insurance is needed to make a final push towards a truly integrated finance model. Title V has long worked constructively with many CHW stakeholders and allies, and has continued to engage with CHW as consultants and trainers, to center CHW leadership and self-determination as navigation towards a sustainable future continues.

III.E.2.b.ii. Family Partnership

One key to comprehensive, family centered care is meaningful involvement of patients, families, and their representatives at all levels of the health care system. True partnerships between families and health professionals and other system providers enhance efforts to achieve quality care, reduce disparities, and bring intentionality to the practice of helping families.

Nebraska Title V regularly creates opportunities to partner with family members/consumers, and supports these partnerships with compensation as much as possible to reimburse individuals for their time and expertise when activities are not part of their regular work. Additionally, Title V intentionally expands funding opportunities to local, community-based organizations who are strongly connected to target populations – such as cultural centers, faith-based organizations, etc. Though these organizations may not be considered traditional partners in public health work, their position within communities often means they are ideally situated to reach individuals in a trusted and culturally appropriate way. This intentional inclusion is key to Title V's vision of meaningful involvement at all levels, and is a guiding principle throughout this work.

Many of the opportunities for family engagement are through participation on advisory committees, materials development, and training/workforce development. As a convener with the strength of extensive partner networks, Title V has a key role in facilitating this type of inclusion. Strong and continuous communication channels bridge family experiences to Title V programs and leadership.

<u>Woman/Maternal Health</u>
A key partner for activities in this domain is the NDHHS Women's Health Initiatives (WHI) program, created in 2000 by legislation that also created the Women's Health Advisory Council. WHI serves as a conduit and liaison between Title V and the Council, which has female consumers serving in various capacities. In addition, staff from WHI are co-leading a project to partner with community cultural organizations to enhance local navigation and health services. This project is expected to build relationships with non-traditional public health partner organizations that may have a direct connection with the target population (i.e. faith-based organizations, sororities, cultural centers, etc).

Another key activity is the Community Health Worker (CHW) training provided by Title V staff. Maternal and child health modules have been incorporated as part of the online Health Navigation course which is designed for individuals working in communities who can connect people to health services, such as CHW, Health Navigators, social workers, nurses, advocates, survivors, and individuals interested in helping their communities. Previous modules have included breastfeeding, infant mortality, and screening and testing/treatment of sexually transmitted disease. CHW also represent a key avenue to spread word about Nebraska's Medicaid Expansion, called Heritage Health Adult.

<u>Perinatal/Infant Health</u>
Engaging families in developing programs and activities related to the potentially vulnerable and stressful perinatal or infant life stages is especially important. NDHHS has a long history of passionate engagement of family members on both the Newborn Metabolic Screening and Early Hearing Detection and Intervention (EHDI) Advisory Committees. Both groups enjoy the input of family members on a range of issues from state regulation changes, screening requirements/guidance, development of guidance documents, program planning, and more.

Title V also works to ensure that parents and families are involved with materials development. Prior to launch of the

Abusive Head Trauma portion of the NE Safe Babies Campaign, NDHHS partnered with Safe Kids organizations across the state to pilot the Crying Plan. New parents had the opportunity to read the Plan and answer a short survey about its usefulness and effectiveness.

Breastfeeding is another topic area that enjoys robust family involvement. The NDHHS WIC program has a network of breastfeeding peer counselors (BFPC) who work with WIC clients across the state. While not Certified Lactation Counselors (CLC), these peer counselors help new moms as they navigate breastfeeding initiation by offering support and resources. In the five years of the previous MCH needs assessment cycle, 2015-2020, Title V hosted the LEARN project, Lactation Education Across Rural Nebraska, with a specific goal of training and supporting minority women to improve breastfeeding disparities.

Child Health

A key programmatic partnership that brings Title V close to the lives of families is through the Nebraska Maternal, Infant, Early Childhood Home Visiting (N-MIECHV) program. This program distributes both federal and state funds to Local Implementing Agencies (LIAs) throughout the state, who seek to provide quality home visiting services with fidelity to an evidence-based model. While many families are enrolled during the prenatal period, N-MIECHV can be an important influence on the early childhood years. Each of the N-MIECHV LIAs have an advisory committee that includes current or former parent participants. Recommendations on decisions about planning, design, implementation, and evaluation of activities all come from the advisory groups, and parent participants are afforded significant weight in the discussions.

Another vital component of the Title V work in the Child Health domain is the partnership with NDHHS Injury Prevention program. Nebraska has approximately eight Safe Kids programs across the state which are made up of local families, community members, and local organizations. They are completely responsible for planning and hosting the various events which offer education and services to families.

Children and Youth with Special Health Care Needs

For families with children with special health care needs, being an empowered decision-maker and advocate is extremely important. One way that Title V has facilitated this is through a very successful partnership between the Medically Handicapped Children's Program (MHCP) and the University of Nebraska Medical Center (UNMC) Munroe Meyer Institute (MMI). Through this partnership clinics are offered across the state for eligible patients, where direct care services and care coordination are available. Patients have access to a Parent Resource Coordinator (PRC), family members who have adult children with special health care needs who have experienced the system, but who have also completed a curriculum to train them on Nebraska services. In addition, a client/family satisfaction survey was conducted so the program can hear from participant families themselves.

In addition to the Advisory Committee mentioned above, the NDHHS EHDI program has a strong partnership with Hands and Voices/Guide By Your Side (GBYS), an external group that recruits parent guides who have a child that is deaf or hard of hearing and are trained to work with families to help them with their journey. EHDI connects parents of infants who have failed a hearing test with a GBYS parent guide to help them understand and navigate their next steps. This also has proven to be an exciting mechanism for parents to be further involved in system improvements. DHHS facilitated a learning community made of families, their representatives, and other stakeholders to discuss how results of hearing screening are communicated by hospital staff. This effort to gather parent perspectives has resulted in a script as part of a training video distributed to hospital staff involved with the hearing screening process. This script was developed to ensure that hospital staff knew parents' priorities, including not minimizing results of hearing screens, providing risk factor information, and providing accurate information to motivate parents to follow-up in a timely manner without causing stress or concern. In addition, the EHDI program has begun implementing a new program to connect families of children who are deaf or hard of hearing (D/HH) with a D/HH

Role Model or Mentor by the time their child is 9 months of age. Program implementation is occurring according to parent input received via a survey asking about needs and wants as well as from organizational meetings held with parents, individuals who are D/HH, advocates of individuals who are D/HH, deaf educators, early intervention specialists, family support professionals, and audiologists.

In the 2020 Needs Assessment, family representatives were present in several domains, most strongly in the CYSHCN workgroup. Not only do advocates for children and families with special needs bring their voices to the CYCHCN domain, they also bring the voice of disabilities inclusion into other domains as well.

Adolescent Health

The adolescent/young adult time period is an important time to engage families. Youth are forming their own opinions, becoming independent, and learning to navigate the health care system on their own. As potential future health care consumers or parents, it is very important to include adolescents and young adults in a variety of program activities. The Title V Adolescent Health program has fully adopted a Positive Youth Development philosophy and practice, assuring young people are viewed as assets and for their potential, rather than being regarded as problems to be fixed. Engagement of youth in development of a strategic plan was achieved through a combination of incentives and meeting youth where they are comfortable and empowered.

Additionally, Title V has put a priority on increasing the spread of Teens in the Driver Seat program, a peer-to-peer safety program where teens help to shape the program and are responsible for implementation and education. This program is of high value not only due to the shown impact it has had on driver safety, but also due to the highly inclusive and empowering nature of the model. Participating in schools across the state has been rising, and Title V will continue to support this program in the future.

Cross-cutting/Systems-building

As the lead agency for Nebraska's Pediatric Mental Health Care Access program, called NEP-MAP (Nebraska Partnership for Mental Healthcare Access), Title V has been able to ensure that the commitment to family inclusion and family empowerment is clear in the NEP-MAP work structure of Advisory Committee and Technical Workgroups. Family members are treated with equal respect and regard as professional members. Family members receive compensation as expert consultants for their participation in NEP-MAP activities. Advisory committee meetings often open with a family story and group discussion about the family experience.

As Title V continues to develop work on Behavioral and Mental Health in Schools, the strategies are mindful of the role of families in addressing the priority, as well as considering the fact that some families are severely and disproportionately affected by discipline practices, as well as barriers to opportunity and services. Family members require not only support services, but also information and knowledge regarding their rights and responsibilities. Title V is well-positioned to bring families to the table, helping to improve school-family partnerships in addition to reaching overall goals.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH Epidemiology Workforce

The Office of MCH Epidemiology (MCH EPI) is responsible for epidemiology, data analysis, and MCH data systems within the Division of Public Health (DPH). The office is embedded within Lifespan Health Services Unit, alongside the MCH programs, and has been developed to support Nebraska's Title V programs and stakeholders over the past 22 years.

The workforce and capacity have grown over time and is currently in a capacity building phase. The Office of MCH EPI has eight full time equivalents (FTE), and two contracted FTE. MCH EPI consists of the State Systems Development Initiative (SSDI), Title V Needs Assessment and support, The Child and Maternal Death Review Teams (CMDRT), Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), Nebraska's Maternal Infant and Early Childhood Home Visiting (MIECHV) performance management and data system, and the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET). The following section describes the staff, their roles, and funding.

Current Staff

Jennifer Severe-Oforah, MCRP, Office of MCH EPI Administrator

Erika Fuchs, PhD, MPH, CDC MCH Epidemiologist Assignee

Celeste Illian, MPH, MCH Epidemiologist (CMDRT, PRAMS, and SET-NET)

Happiness Kingi, MPH, Health Surveillance Specialist (MIECHV and CMDRT)

Ama Bikoko, MHA, MPH CDC Foundation Epidemiologist (SET-NET)

Mamie Lush, MA, Health Surveillance Specialist (SET-NET)

Tyler Faulkner, BS, Community Health Educator (SET-NET)

Jessica Seberger, MA, PRAMS Coordinator

Gina Saitta, BA, PRAMS Data Manager

Sally Mertens, BS, Office of MCH EPI Staff Assistant

Roles and Responsibilities

The MCH EPI Administrator is a long-term employee who has led and developed the DHHS MCH EPI effort in Nebraska since 2002. The Administrator is responsible for oversight, development, and management of the MCH EPI projects and workforce. This position is assigned as a core member of the Title V team, is responsible for coordinating the MCH Needs Assessment, and is primarily funded by the SSDI grant. A significant portion of effort is on program development, for example the Administrator invested 3 years to reorganize and build Nebraska's Maternal Mortality Review Committee so that staff could coordinate, and now the Administrator can focus on building the SET-NET program. The Administrator has played a lead development role in all projects and staff within the office. The Administrator is responsible for assuring that staff have access to the data and resources they need to perform their work, as well as leading and supporting staff in personal development and achievement of operational/performance goals. Finally, the Administrator serves as a resource to partners within the Division of Public Health, DHHS, external state agencies, and MCH collaborators in the development and implementation of MCH projects/programs.

The CDC MCH Epidemiologist Assignee joined the Office of MCH EPI in September 2020 and is supported with Title V funding. The Assignee fills the role of lead scientist in the office, a position that was vacant for nearly three years when a long-term contractor relocated (October 2017). Core responsibilities are to build MCH EPI data and workforce capacity, as well as assure compliance with ethical standards in research and public health practice. To build data capacity the Assignee currently works to support the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to gain access to, and enhance the utilization of, their data. In addition, the assignee is currently the lead on the SET-NET project. Beyond providing technical support to MCH EPI and other staff within the Division of Public Health, the Assignee is dedicated to helping to build the future Public Health Workforce. As an Adjunct Professor at the College of Public Health within the University of Nebraska Medical Center, the Assignee will work with students and interns on an on-going basis. Finally, the Assignee is responsible for maintaining the PRAMS Institution Review Board (IRB) clearance.

The MCH Epidemiologist was recruited to join MCH EPI in January of 2020 with the primary role of coordinating the Maternal Mortality Review Committee (MMRC) and supporting the CMDRT. The CMDRT provides oversight to the Douglas County Fetal and Infant Mortality Review committee, so the MCH Epidemiologist is a member of their review team. In addition, the Epidemiologist provides informal support to the Nebraska Perinatal Quality Improvement Collaborative as they work on shared interests, such as preterm birth and severe maternal morbidity. Finally, the MCH Epidemiologist provides analytical support to PRAMS, and in the future will also support SET-NET projects. This position is funded by Title V.

The office currently has two Health Surveillance Specialists. One Specialist is responsible for data collection and management of the CMDRT, a role that includes obtaining all records pertaining to each death of a child aged 0 through 17 years in Nebraska, managing the review process, and aggregating the data into several databases once the reviews are complete. In addition, the Specialist tracks status of population-level indicators to inform the CMDRT, the legislature, and stakeholders as appropriate. The Specialist also serves as data support for the MIECHV program which includes preparing quarterly performance reports on the state and local level and annual reporting to HRSA of benchmarks/constructs and demographics. This position is funded with both Title V and MIECHV funds. The second Specialist is responsible for managing the data collection of the SET-NET program which currently includes follow-up on all laboratory-confirmed SARS-CoV-2 RNA pregnancies and infants in 2020 and a random sample for 2021. Nebraska's SET-NET will expand to include syphilis and Hepatitis C in 2022. The SET-NET data collection is supported by a Community Health Educator who abstracts and enters data. Finally, the CDC Foundation located an MPH Epidemiologist in the Office to help build out the SET-NET program. This assignment is scheduled to end in the Fall of 2022; MCH EPI has secured funds and is seeking to extend the assignment.

The PRAMS program has been collecting data since 1999 in partnership with the CDC and Title V and is a model of high-quality public health programming. PRAMS is the cornerstone from which the Office of MCH EPI was built. The Coordinator is responsible for managing the grant, conducting research, and promoting the utilization of PRAMS data to stakeholders and partners. In addition, the Coordinator provides opportunities for stakeholders to be involved in PRAMS work, including participation on the Steering Committee as well as on various workgroups producing data-to-action products. The Coordinator is a supervisor and shares responsibilities with the Office Administrator to ensure staff are working as an efficient and effective team. The PRAMS Data Manager has a significant role ensuring that operations run efficiently and without error. While the Data Manager primarily focuses on gathering and managing all aspects of the data collection process, there is also an element of quality improvement. The Data Manager monitors timeliness and accuracy of data, often working with the Coordinator to address issues with CDC or the surveyors as appropriate. Finally, the MCH EPI Staff Assistant, plays a significant role in the PRAMS survey with inventory, and processing of mail, and data entry, in addition to supporting the MCH EPI team.

Impact or Organizational Changes on Future Development

While the pandemic continues to have an impact on the workforce, it has had a minimal impact on the functioning of MCH EPI, as the office continues to grow and develop. However, despite this ability to maintain, MCH EPI staff are aware that COVID effects on Nebraska's women and children will require new, robust data analysis in the future. The full impacts from individuals delaying care or screening, experiencing increased stress/anxiety, or dealing with financial/social vulnerability will be affecting the population well into the future. Certainly, there is a role for MCH EPI in improving health equity in data collection, and analysis.

As the Office of MCH EPI continues to build capacity and support staff development, there are areas where growth is expected to occur in the future. Data linkages, access to and quality of MCH data, workforce development, and increasing reporting/publications are all emerging issues. The Office is well positioned at this juncture to address these areas of focus

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

In Nebraska, the State Systems Development Initiative (SSDI) provides for the leadership and administration of the Office of MCH Epidemiology (MCH EPI). The foundation of MCH EPI has been the work with the Title V MCH Block Grant, particularly the planning and implementation of the MCH Needs Assessment and managing the Block Grant data. Thus, the SSDI investment in Nebraska has been to provide coordination of the MCH Needs Assessment, a highly structured data-driven process, as well as provide funding for the MCH EPI staff who provide support and access to timely data.

Nebraska has adopted the needs assessment process as described in the Family Health Outcomes Project (FHOP) product "Developing an Effective Planning Process: A Guide for Local MCH Programs": https://fhop.ucsf.edu/planning-guide. Nebraska has utilized this process for four cycles (2005, 2010, 2015, and 2020).

Nebraska's SSDI is also involved in a number of efforts with agency and statewide programs to improve data quality and their capacity to expand datasets and manage new ones. Most recently this has involved, among other initiatives, partnering with the Division of Public Health (DPH) Strategic Plan, Nebraska's Public Health Atlas (a web-based data visualization for DPH data), and the Early Childhood Integrated Data System (ECIDS) Core team, a joint venture of DHHS and the Department of Education.

In the current funding cycle, SSDI has been providing leadership and technical support for projects to link various data systems: 1) the annual linkage of birth certificate data with Medicaid pregnancy-related eligibility and claims files, 2) an Early Childhood Integrated Data System (ECIDS; partnership with the Nebraska Department of Education), and 3) a DPH Data Query System that would include DPH's major databases.

In addition, SSDI has successfully restructured the Maternal Mortality Review Committee (MMRC) within the Child and Maternal Death Review Team (CMDRT). This process started in 2018 and is in the last year of transition. The inaugural report of the MMRC "Maternal Morbidity and Mortality in Nebraska, 2014-2018" was published in September, 2021.

SSDI efforts in building and supporting timely and linked MCH data systems

SSDI has been active in growing MCH data capacity for more than two decades. Over that time access to and timeliness of data sets and data utilization has improved. SSDI has been involved in a number of quality improvements, development of new data sources, data linkages, and has been invaluable in the establishment and now growth of the Office of MCH Epidemiology.

The Office of MCH Epi staff are considered superusers and have direct access the Vital Records System, which includes Birth, Death, Fetal Death, Newborn Screening, and the Birth Defects Registry. Nebraska WIC and MCH EPI are located within the same unit (Lifespan Health Services) and have a long history of working together, most recently the programs achieved a long-term shared goal of dedicated MCH epidemiological support. In addition, WIC has been an active partner in the PRAMS research. MCH EPI has conducted PRAMS in Nebraska since 1999.

Over the past funding cycle, SSDI has successfully negotiated an MOU with Medicaid data and performed a successful linkage. A technical methods report was produced, and key indicators were reported. Staff changes within the Office of MCH EPI and organizational changes within Division of Medicaid and Long-Term Care, as well as a loss of agency capacity due to COVID-19 have stalled future linkages, but these are not permanent barriers.

The Hospital Discharge annual dataset has been accessible to MCH Epi for many years, but due to quality issues of coverage and missing demographics, has historically been underutilized. Most recently, the dataset was utilized to perform a Severe Maternal Morbidity analysis for inclusion in the MMRC report. This analysis underscored the utility of the dataset and the need to link with the Vital Records and/or participate in quality improvement efforts with the Nebraska Hospital Association. In 2022, The Office of MCH EPI has been able to secure a Hospital Discharge dataset with identifiers for data linkage.

Role SSDI plays in enabling ongoing Title V assessment, monitoring, and reporting

The SSDI Director has primary responsibility for supporting Nebraska's Title V program and responding to data needs specified in the Title V MCH Services Block Grant Application and Annual Report Guidance. These

responsibilities include coordinating the 5-year Needs Assessment; providing assistance in identifying priority needs; selecting National Performance Measures (NPM) and developing State Performance Measures (SPM)/ Evidence Base Strategy Measures (ESM) for the Title V Action Plan; reporting results; and monitoring progress. The SSDI Director is responsible for supporting the ongoing assessment, monitoring, and reporting, and does so by monitoring national and state data sets in between Needs Assessments and participating on the Title V Steering Committee to inform stakeholders about overall progress.

Key SSDI program activities, products, or materials developed in support of Title V

In the coordination and implementation of the Title V Needs Assessment activities there are a number of key products developed in service to Title V. The first is the prioritization process, a template criteria development tool and scoring matrix that is customized by stakeholder decision making. The second is a compressive list of well sourced MCH Indicators that include but are not limited to the core/minimum data set. In the most recent 2020 Needs Assessment Nebraska utilized over 200 indicators over the five population and the cross-cutting domains that cover mortality, morbidity, health determinants, and demographics. The third product is a factsheet data visualization template with statistical analysis tools. Each factsheet covers a minimum of one indicator, visualizations, and data for the past five-years, as well as statistical analysis on trend, disparities, and comparisons to the national rate/benchmarks. The final product is the Issue Brief. The brief is a template that is customized to the stakeholder defined criteria, and document when a need is proposed for prioritization. A brief is created for each issue, which are then utilized by stakeholders to score the needs and prioritize the final 10 issues which make up the Priorities for the next 5-year period. They are also used by Title V staff to write the action plan, select performance measures, develop strategies, and monitor progress over the next five years.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Other MCH Data Capacity Efforts

There are several activities and projects that MCH EPI are leading or involved in that are not funded by Title V, but supported by staff. As previously mentioned SET-NET, a new activity, is solely funded by CDC. The work with the Division of Public Health's data visualization project called Atlas is finalizing a cause of death dashboard and launching a birth dashboard in partnership with MCH EPI is funded through CDC. In addition, work on the Early Childhood Integrated System (ECIDS) which is currently funded through the Preschool Development Grant (PDG), continues with technical assistance from the Statewide Longitudinal Data Systems (SLDS) Grant Program.

As MCH EPI looks to the next 12 months with intention to build additional capacity, the Immunization registry (NESIIS) and Hospital Discharge Data are two datasets that the office will be working with to increase data quality and add to staff competencies. In addition, MCH EPI will engage in a number of training and leadership development opportunities such as participating in two Association of State and Territorial Health Officials (ASTHO) projects the first "Using Data to Address Racial Inequities in Maternal and Child Health Learning Community," and the second "Linking PRAMS and Clinical Outcomes Data Multi-Jurisdictional Learning Community Cohort 2". Key staff will be attending the CityMatCH Leadership and MCH Epidemiology Conference, as well as American Public Health Association, and Council of State and Territorial Epidemiologist Conferences. Finally, MCH EPI prepare to host at minimum one Graduate Student Epidemiology Program (or similar) summer intern in 2023.

There are several potential challenges that MCH EPI faces in their capacity building efforts. First, many of the examples listed above are not fully funded long-term programs but rather efforts that rely on collaboration and participation of a multitude of partners and external agencies. Other efforts rely on the work of MCH EPI to make a case or produce findings that spur additional interest and/or investment. In addition, while the Office of MCH EPI has been able to demonstrate a need and make a case for additional staff and resources, there is a limit on available resources and how much growth can be sustained. It is already known that one mid-level staff member will relocate in 2023 and finding a replacement in the current job market will be challenging. This dip in staffing will impact the office, but will hopefully be temporary.

Finally, the Nebraska Department of Health and Human Services has embarked on several projects that have, and will impact the work of MCH EPI. First, are the overall efforts to streamline external data sharing processes, as of July 2021, all requests for data are required to go through the Public Records Request Policy, this process has affected how MCH EPI does business with its external partners. Second, is in answer to lessons learned during the COVID response regarding the public health data infrastructure and the inability for datasets and systems to provide timely integrated data needed to make necessary decisions. The result is an effort to build a public health data warehouse called Data Nexus. This has been a long-term vison of many public health and epidemiological professionals, including MCH EPI and SSDI for some time now, and has the potential to vastly streamline data linkages, analysis, and reporting. This work will be foundational to the public health modernization efforts the Division of Public Health will embark on over the next five years.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

MCH Emergency Planning and Preparedness

Nebraska Department of Health and Human Services has a Public Health Preparedness and Emergency Response (PER) section that is dedicated to ensuring a level of readiness at both the state and local levels. PER is responsible for providing coordination and support of state public health resources during an event, as well as maintaining and updating the Public Health and Medical Services Annex (Emergency Services Function #8) of the overall State Emergency Operations Plan. The Nebraska Emergency Management Agency coordinates ESF8 with other state ESF.

ESF8 broadly includes content specific to a coordinated state response and support of state resources during an event. Events in the plan can be natural or manmade, but for Nebraska the most probable and historic threats to public health include tornadoes, major floods, or major snow/ice event. The plan provides supplemental assistance to state, tribal, county, and local governments in the following core functional areas:

- Assessment of public health/medical needs
- Health surveillance
- Medical care personnel
- Health/medical equipment and supplies
- Patient evacuation
- Patient care
- Safety and security of drugs, biologics, and medical devices
- Blood and tissues
- Food safety and security
- Agriculture safety and security
- All-hazard public health and medical consultation, technical assistance, and support
- Behavioral healthcare
- Public health and medical information
- Vector control
- Potable water/wastewater and solid waste disposal
- Mass fatality management, victim identification, and decontaminating remains
- Veterinary medical support

Specific program elements are not directly addressed or specifically called out in ESF8, as the plan is broad in nature, however the roles assigned to Nebraska DHHS as the lead agency for coordination and support speak to many areas where Title V expertise can be drawn upon. These include providing subject matter experts regarding public health issues; coordinating with Local Health Departments during an event; and implementing state level plans, policies, and procedures as needed. In addition, the ESF8 threat matrix which identifies common threats to the state and its residents addresses multiple consequences of various events which could affect the maternal and child population in Nebraska. These include a degraded/overwhelmed healthcare system, morbidity/mortality rate increase, absenteeism at schools, behavioral health issues, and disruption of services. MCH expertise is also identified in the plan's specified actions to address these consequences, including coordination with the local health departments and the healthcare system, coordination with public information officers for public health messaging, and coordination with other DHHS Divisions, such as the Division of Behavioral Health. In practice, Title V leadership was called to the Incident Command Structure for COVID19 response to oversee the vaccine distribution effort from planning to evaluation. In 2022 Title V leadership was also called to participate in the Monkeypox

response, particularly around vaccine distribution but also targeted outreach and education.

Nebraska' s Office of Maternal and Child Health Epidemiology will review, assess, document findings, and make recommendations utilizing the Association of Maternal and Child Health Programs (AMCHP) "Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health" in FY 2023. The team will produce data and visualizations to aid in decision making, in an emergent situation, for the MCH populations in NE. The checklist should yield thoughtful considerations and several actionable recommendations to improve on preparedness.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Public and Private Partnerships

Title V maintains a robust commitment to collaboration with a variety of other stakeholders, including other DHHS programs, external organizations, and family members or consumers. These partners bring not only expertise, but their own networks of participants, partners, and contacts who are vital to informing and performing Title V work.

To increase reach, Title V partners with other HRSA MCHB programs that have similar goals and objectives, including the Newborn Metabolic Screening and Early Hearing, Detection, and Intervention Programs; the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; Healthy Start; and PTI Nebraska (Family-to-Family Health Information Center and Family Voices affiliate). Other federally funded program partners include WIC; Immunization; WiseWoman; Adolescent Health; Child and Maternal Death Review; Childcare Development Fund; Lifespan Respite; Aid to the Aged, Blind and Disabled; Social Services to the Aged and Disabled; and the State Disability Program. Connections across a variety of federally funded programs ensure that resources are leveraged to the greatest extent possible, and there is no redundancy as a variety of programs work towards similar goals.

External partners are perhaps some of the most important in ensuring quality health care with an integrated delivery system. Partners such as the NE Perinatal Quality Improvement Collaborative (NPQIC) and the University of Nebraska Medical Center Munroe-Meyer Institute provide a direct link to clinical care systems for many of Title V's strategies and help to assess the effectiveness and quality of health care in birthing hospitals and clinic settings. NPQIC was founded on quality improvement and has led projects addressing health outcomes such as depression screening, prevention of first cesarean, breastfeeding initiation, and maternal hypertension. MMI has been a significant partner in integrating care – first by including Parent Resource Coordinators in clinics across the state and then by connecting primary care provides with behavioral health expert consultants in the NEP-MAP project. In addition, Title V staff have relationships with birthing hospitals and clinics across the state which have proven fruitful in addressing perinatal/infant goals and objectives.

Medicaid is an important partner in ensuring quality health care, efficient delivery, and integrated services. Beginning in 2017, Medicaid offered enrollees a single plan combining physical health, behavioral health, and pharmacy benefits in an integrated health care program – a practice that has continued throughout recent changes to the overall program. Medicaid expansion, called Heritage Health Adult (HHA), was implemented in 2020 and has seen successful inclusion of many Nebraskans who can now receive health care benefits.

Other examples of health systems innovation and change in Nebraska include Accountable Care Organization models, some with rural adaptations; urban systems building stronger networks into the rural areas; and the formation of an Accountable Health Community approach in Douglas County, to drive population health outcomes. As noted elsewhere in this application, Community Health Workers are an additional aspect of health system and workforce change.

These affiliations are vital in planning, evaluation, and implementation strategies. Title V provides multiple opportunities for involvement including participating in the five-year Needs Assessment, serving on the Title V Steering Committee, and providing feedback on initiatives such as sub award opportunities, public input, and family engagement strategies. Additionally, Title V staff serve on partner-led initiatives, such as the NPQIC Board and NE Children and Family foundation workgroups.

While Title V has a proven track record in building effective collaborative partnerships to undertake various activities,

in 2021 Title V began considering the merits of non-traditional partners, those who may be more representative or closer to directly serving the disparate and disadvantaged populations Title V seeks to impact. Building on the success of previous initiatives such as the Infant Toddler Pantry project and Community Health Worker consultants, Title V has sought to invest resources directly with the community level social support organizations women of color turn to for aid during pregnancy and early family life. While establishing these relationships will take time and trust, it is important to intentionally seek partnerships with organizations that meet women of childbearing age where they live, work, worship, and seek support.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Nebraska relationship between Title V programming and Medicaid Long Term Care (MLTC) needs to be discussed, redefined, and updated. The Interagency Agreement (IAA) was last revised in 2015, however multiple changes and disruptions have prevented meaningful efforts to address the issue, including organizational restructuring, leadership changes, and staff turnover as well as the COVID-19 pandemic. The fact that Nebraska's IAA involves three Divisions within the large DHHS agency - Children and Family Services (CFS), Public Health (PH), and Medicaid Long Term Care (MLTC) – only increases the complexity and difficulty in getting the right people to the table.

In addition to the changes in workforce and organizational structure, there have been significant alterations to the Medicaid program since 2015. MLTC accomplished an integration of medical and behavioral health services, a shift from fee-for-service towards value-added services, and more recently an expansion of Medicaid eligibility. Finally, MLTC is preparing for the upcoming "Medicaid unwind" with the end of the Public Health Emergency (PHE) declared by the federal government in 2020. This will mean a return to requirements that MLTC resume determination of eligibility on a regular basis for Medicaid clients. This will have a significant impact on clients, with some determined to be ineligible due to changes in circumstance and others potentially determined ineligible determination due to a failure to provide information. These changes underscore the need to update the IAA in a meaningful way to encompass the ways the Divisions can work together to mitigate or enhance these impacts.

This is not to say that there have been no mutually beneficial projects or collaborations between Title V and MLTC. Separate agreements that formalize workflows for certain parts of the relationship with MLTC have been achieved in the time since the current IAA was signed, and projects around data linkage and outreach regarding Medicaid expansion have furthered MCH goals and objectives. Additionally, MLTC staff have been ready participants in a variety of workgroups and Advisory Councils, such as health equity, a CMS Affinity Group project on offering Medicaid services in school settings, the NEP-MAP Advisory Board, and the Council on Developmental Disabilities to name a few.

The work around Medicaid expansion has been impactful in areas of outreach, enrollment, and changes to the state plan. MLTC staff have been particularly inclusive during this time, beginning with exploratory meetings hosted by MLTC where staff from other Divisions had the opportunity to describe how existing programs or networks could be utilized to identify potential new clients and encourage them to apply for benefits as well as share information. MLTC staff have also reached out while planning for the unwinding, offering partner Divisions the opportunity to comment and collaborate in the effort.

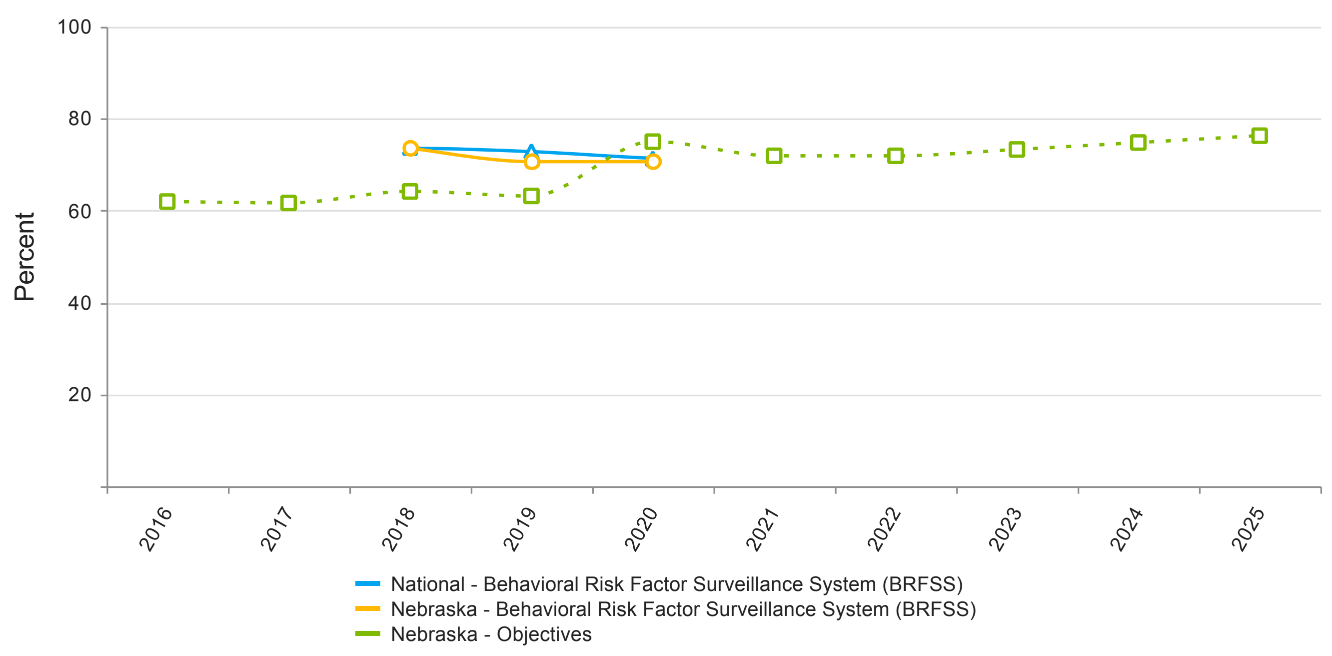
Title V intends to revisit the IAA in 2023 to educate, dialogue, and reach agreement with new partners within the three Divisions. To that end, it is anticipated that there are DHHS leaders who are unfamiliar with Title V and the statutory relationship between the Divisions. Technical assistance is again sought for facilitated conversations between the Divisions of CFS, PH, and MLTC. That third-party assistance will be invaluable to describe how these programs work together, to answer questions, and guide the discussion towards agreement.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year Indicators and Annual Objectives



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2017	2018	2019	2020	2021
Annual Objective				74.9	71.8
Annual Indicator			73.5	70.4	70.5
Numerator			244,199	234,784	234,343
Denominator			332,326	333,478	332,326
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.8	73.2	74.7	76.2

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			20
Annual Indicator		0	0
Numerator		0	0
Denominator		1	1
Data Source		Program Data	Program Data
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

ESM 1.2 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	75.0	80.0	85.0

State Action Plan Table

State Action Plan Table (Nebraska) - Women/Maternal Health - Entry 1

Priority Need

Cardiovascular Disease including Diabetes, Obesity, and Hypertension

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

WM1a: By 2025, increase access to preventive health care and address health disparities in order to reduce rates of obesity, diagnosed diabetes, and diagnosed hypertension in women age 18 to 44 years.

WM1b: By 2025, develop and implement an innovative project design to address maternal and birth disparities, specifically those impacting Black mothers.

Strategies

WM1a (1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska Medicaid Expansion) to promote enrollment and benefits, particularly for disparate and disadvantaged women of childbearing age and other parents/caregivers.

WM1a (2): The DHHS Women's Health Initiatives Program will implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUM) project in collaboration with a community cultural organization.

WM1b(1): Led by the Women's Health Program Manager, a planning team will develop project design and implementation plans.

ESMs	Status
ESM 1.1 - Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.	Inactive
ESM 1.2 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

WOMEN'S AND MATERNAL HEALTH DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Women's/Maternal Health Domain** for the period October 1 2020 to September 30 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the Women's and Maternal Health Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Cardiovascular Disease including Diabetes, Obesity, and Hypertension**
  NPM: Percent of women, ages 18-44 years, with a preventive medical visit in the past year
  ESM: Participation in the Women's Community Health Initiative for Preventing Cardiovascular Disease

1. Context: The State of the Women's and Maternal Population Domain

In the 2020 Needs Assessment, stakeholders developing the Issue Brief entitled "Cardiovascular Disease Including Diabetes, Obesity, and Hypertension," focused on obesity and women, and the racial disparities seen in disease rates of obesity related co-morbidities such as diabetes and hypertension. Racial disparities such as these can lead to elevated rates of death, earlier onset of illness, and greater severity of disease for minority populations.

For the 2020-2025 Needs Assessment, Title V worked with the Nebraska Association of Local Health Directors to bring forward a summary of current priorities identified through the Community Health Needs Assessment and Community Health Improvement Plans that local public health departments regularly undertake in their respective jurisdictions. This summary allowed stakeholders to consider degree of alignment with local and regional priorities when determining the final selection of priorities for the upcoming five year period. Six local public health departments identify obesity as a priority issue in their regions. Eight local health departments identify heart disease prevention as a priority, while four name diabetes prevention. Three health departments have a priority statement related to healthy lifestyles and wellbeing.

Title V in Nebraska draws on a collaborative infrastructure for activities in the area of maternal and women's health for women of childbearing age. Within DHHS, Title V is the connecting link between the Office of Reproductive Health, the Women's Health Initiative, STD prevention program, the Maternal Child Adolescent School Health Program, the Office of Rural Health, the Nebraska Maternal Infant Early Childhood Home Visiting program (N-MIECHV) and the Office of Health Disparities and Health Equity. Additionally, Title V works to leverage the expertise of external partners, such as the Nebraska Perinatal Quality Improvement Collaborative, the Women's Fund of Omaha, local public health departments, and health systems growing their community health footprint in the state.

By the close of the 2020-2021 Title V year, some developments stand out as notably impactful on the state's population of women of childbearing age, primarily the COVID pandemic and Medicaid Expansion in Nebraska.

Impact of COVID on Women of Childbearing Age in Nebraska

Real-time observations indicate that women of childbearing age have been affected by the pandemic in numerous ways. More women than men dropped out of the work force to care for children when schools and child care providers closed. Women dominate many service sector jobs, and as a result were more at risk of job loss and economic hardship during the pandemic. Women experiencing birth during the pandemic may have been denied the presence and support of their birth partners and families due to hospital restrictions. Women of childbearing age have been subjected to rumors and misinformation about the effects of COVID vaccine on fertility and fetal development. Due to closure of clinic services for non-essential care, access to STD and contraceptive services diminished during the COVID pandemic.

In addition, the pandemic has taken a toll on mental wellbeing of women, with early data showing higher rates of depression and anxiety among women, compared with pre-pandemic levels. Particularly for women already vulnerable due to socioeconomic stress, alarmingly high rates of new or worsening mental health problems have been seen. This has been complicated further by raising awareness of structural racism in systems such as law enforcement, health care, housing, and other sectors. This has further compounded the stress women may feel about pregnancy, childbirth, and parenting.

The COVID pandemic notably altered access to care for all Nebraskans, prompting many people to defer or delay non-essential care. This affected women of childbearing age seeking prenatal care, contraception, routine screenings, and other aspects of non-urgent health care.

Medicaid Expansion in Nebraska

Medicaid Expansion was passed by a ballot initiative in Nebraska in 2018. Enrollment opened in August 2020, and benefits became effective October 2020. The significance of Medicaid expansion for women of childbearing age cannot be

overstated, as it creates the opportunity for eligible women, to receive preconception and interconception health care. Typically, Nebraska's Medicaid coverage for pregnancy ends at 30 days postpartum, removing opportunities for continuous health care coverage following and between births.

New Perspectives on Maternal Disparities
With protests occurring in numerous areas of the country, women's voices have grown stronger about experiences of disrespectful treatment and unfair treatment they encounter in health systems and other sectors. These disruptions combine to set the stage for new strategies and approaches to directing resources and affording leadership to those most affected by disproportionate outcomes.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension
2020-2021 Objectives and Strategies

Objective WM1a: By 2025, increase access to preventive health care and address health disparities in order to reduce rates of obesity, diagnosed diabetes, and diagnosed hypertension in women ages 18-44 years

Summary of Programmatic Efforts
Planned strategies related to this objective included promoting Medicaid Expansion by conducting outreach and education about the benefits of health insurance and how to apply, with a focus on disparate and disadvantaged women of childbearing age. The Women's Health Initiative (WHI) program set out to develop a pilot project to enhance local navigation and access to health services. WHI also collaborated with partners to identify needs for updates to and translations of existing educational materials for women on cardiovascular disease, as well as reviewed use of social media to assure cultural relevance and inclusion of disparate audiences.

Regarding Medicaid Expansion, during the 2020-2021 period, education and outreach activities were provided by WHI, the Office of Women's and Men's Health, and the Maternal Child Adolescent School Health Program. Promotional materials in several languages were routed to school nurses statewide for passing along to parents of students. WHI disseminated information through a presentation at the Women's Health Advisory Council. During a rapid-cycle pandemic response project launched by Title V in Spring 2021 to fund local community infant-toddler pantries, Medicaid Expansion materials were distributed to every recipient of pantry supplies. The Title V Community Health Worker continuing education project delivered, and recorded for on-demand reply, a live online session on Medicaid delivered by CHW and Medicaid co-presenters.

During 2020-2021, WHI developed a framework for the proposed navigation project including goals, prospective partners, a logic model, and an evaluation process. In September 2021 the request for applications was released, though unfortunately no responses were received and in 2021-2022 the team began working on a new invitation to apply. The call for applicants prioritizes faith-based organizations and community cultural centers to diversify the partner base and work with local groups who are more directly connected to the population of interest.

For the translation project, the Women's Health Initiative met with the DHHS Chronic Disease Prevention and Control Program and the Office of Women's and Men's Health Programs to review materials. Since programs have moved away from printing materials and instead post links from nationally recognized agencies and programs on web pages, links were checked and fixed where needed to assure access to educational materials.

Use of Evidence-based or Evidence-informed Approaches in this Priority
In May 2020, HRSA released *MCH Evidence Resources for Nebraska*, which included an ESM Development Guide, and an Agency-specific ESM brief. In this document, readers are pointed to strategies which have proven effective in addressing NPM 1: Percent of women ages 18-44 years with a preventive medical visit in the past year. Evidence-linked and promising practices are described.

The Centers for Disease Control and Prevention, Division of Nutrition and Physical Activity and Obesity are a source for reliable evidence-based intervention strategies in this priority area. CDC is also noted as being a source for programs that are culturally appropriate in REACH (Radical and Ethnic Approaches to Community Health https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/index.htm). During the childbearing years, breastfeeding as a prevention behavior improves health and nutrition outcomes for both mother and child.

The Nebraska ESM: participation in the Women's Community Health Initiative for Preventing Cardiovascular Disease, measures a quantity of individual participants in a pilot project.

3. Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension
NPM: Percent of women, ages 18-44 years, with a preventive medical visit in the past year
ESM: Participation in the Women's Community Health Initiative for Preventing Cardiovascular Disease

Alignment: Prevention of cardiovascular disease and co-morbidities such as diabetes, obesity, and hypertension, is not accomplished through the delivery of health services alone, in fact by some estimates access to health care may account for only 20% of overall population health. The NPM does not encompass the social, cultural, environmental, and economic aspects of prevention and well-being that are fundamental to reducing the toll of cardiovascular disease in the United States. The ESM statement measures a quantity unrelated to impact or significance of the project when implemented.

4. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures in an effort to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA has specifically highlighted inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Cardiovascular Disease including Diabetes, Obesity, and Hypertension		
	Proposed for 2020-2021	*Achieved 2020-2021*
How much did we do?	How many Heritage Health training activities and/or resources for community providers were promoted by Title V	4 (Women's Health Advisory; MCH Infant Toddler Pantry Project; CHW education session; OWMH survey)
How well did we do it?	How many Title V staff promoted at least one Heritage Health Adult Activity or distributed messages about HHA? How many Community Health Workers received information about HHA? How many CHW indicated they would help people enroll in HHA?	Estimated 6 45 65%
Is anyone better off?	What information is available from Medicaid on gender, race, and geographic area of newly enrolled persons? Does any group seem left out?	38,824 Ethnicity: 24% minority, 67% white, 9% not reported Location: 21% rural, 79% urban

Discussion – Other Programmatic Impacts
Title V's involvement in Community Health Worker workforce development continues with strong engagement and purpose. Promoting Medicaid Expansion, or Heritage Health Adult, is a common theme in population domains involving adults or adults-as-caregivers. Community Health Worker workforce development is discussed in more detail in the Cross-cutting/Systems-building Domain.

By April 2021, nearly 39,000 new enrollees were part of Heritage Health Adult. Nearly 25% were members of minority groups, indicating strong diverse reach.

5. Challenges and Emerging Issues

Mobilizing Community Partners for Subawards.
As with many lean state agencies, and primary methodology for work and impact is through funding subrecipient entities in the community with capacity and reach to undertake public health action. Such a methodology only works if local entities perceive the application and procurement processes offered by the state as accessible, fair, and rewarding. During the initial period of project development by the Women's Health Initiative, a Request for Applications received no responses.

Various anecdotal reasons for this include: lack of awareness of opportunity; perception that the application is too burdensome for size of award; and/or local agencies are understaffed and lacking capacity for new project development. The challenge of locating community partners willing to enter into procurement processes and state requirements is compounded when program developers wish particularly to partner with local organizations led by and embedded in hard to reach communities and groups.

Maternal Mental Health
As noted above in discussion about impacts of COVID on women of childbearing age, the strain on mental health is evident to many providers and systems of care in Nebraska. The pandemic has taken a toll on the mental wellbeing of women, with early data showing higher rates of depression and anxiety among women, compared with pre-pandemic levels. Particularly for women already vulnerable due to socioeconomic stress, alarmingly high rates of new or worsening mental health problems have been seen. This has been complicated further by raising awareness of structural racism in systems such as law enforcement, health care, housing, and other sectors. This has further compounded the stress women may feel about pregnancy, childbirth, and parenting. From a life course perspective, the significance of this on infants and children as well as mothers, cannot be overstated.

Maternal Mortality Review
In the period 2020-2022, Nebraska Title V, specifically MCH Epidemiology, included Maternal Mortality Review in the Women's and Maternal Health population domain. Initially, the MMRC discussion was included in the Women's and Maternal domain out of the expectation that the MMRC would over time be able to develop data-to-action opportunities to improve women's health entering and following childbirth. Later, for the 2022-2023 application, the Title V team determined the better placement for relevant discussion is in the Perinatal/Infant Domain.

The review of all maternal deaths in Nebraska began in 2014 after being added to the Child Death Review Team's scope in 2013. The review of deaths that occurred in 2014-2016 was conducted by the Nebraska Medical Association, through a contract agreement with DHHS. In 2018, the Child and Maternal Death Review Team (CMDRT) utilized new guidance and best practice tools from CDC to reorganize how maternal death reviews were conducted in NE. This resulted in the formation of a sub-committee within the CMDRT: the Nebraska Maternal Mortality Review Committee (MMRC). The MMRC became operational in 2019, and has been undertaking a review of five years of maternal deaths (sufficient sample size to release data in a report) in order to comprehensively understand maternal mortality in Nebraska. In 2020-2021, the MMRC began working toward a committee membership representative of the diversity of the state of Nebraska.

6. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

Title V's participation in promoting Heritage Health Adult has resulted in more families with parents and caregivers, as well as women of childbearing age, receiving information about opportunities and eligibility for health insurance. In Nebraska, prior to the onset of the COVID pandemic, an estimated 80,000 adult individuals would be newly eligible for health insurance coverage as a result of the ballot initiative in 2018.

Alignment between Title V workforce development activities for CHW, and Title V population health priorities has become a reliable way to amplify and reinforce virtually all of the Title V population health priorities, especially as relate to more effectively addressing disparities.

A quality improvement approach to improve the extent to which Title V can effectively engage with diverse subrecipients in order to achieve objectives is needed. The poor response to an initial RFP release was disappointing, and points to the need to better understand what changes are necessary to effectively work with non-traditional community partners.

WOMEN'S AND MATERNAL HEALTH DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **Women's/Maternal Health Domain** for the period October 1, 2022 to September 30, 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the Women's and Maternal Health Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension**
  NPM: Percent of women ages 18-44 years with a preventive medical visit in the past year.
  ESM: Percent of women participating in the Women's Health Community Initiative who have a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history (new)

1. Description of Planned Activities

OVERVIEW OF THE WOMEN'S AND MATERNAL HEALTH DOMAIN
The Women's Health Initiative
Nebraska stakeholders in the 2020 Title V Needs Assessment were concerned with the overall health and well-being of women of childbearing age, and the risks they bear for chronic disease conditions particularly if not receiving preventive and interconception care. In undertaking work in this priority area, Title V leverages the capacity of the Women's Health Initiative Program, which monitors the status of women's health in Nebraska and serves as a clearinghouse for women's health information, including maternal and child health, breast and cervical cancers, heart disease, chronic disease, behavioral health, substance abuse, intimate partner violence and health disparities.

The Women's Health Initiative (WHI) was established in 2000 by the Nebraska Legislature. At the same time, the Women's Health Advisory Council (WHAC) was also created. The purpose of the Council is to advise and serve as a resource for the Women's Health Initiatives in carrying out its duties as enacted by the Nebraska Legislature. The Women's Health Initiative Program provides administrative support to the Council.

Maternal Infant Health Program
The Maternal Infant Health program within Nebraska Title V collaborates with the Women's Health Initiative in work related to maternal health – particularly those activities which can lead to improved birth outcomes and better health during the postpartum period. This partnership has resulted in collaborative efforts such as supporting doula training and certification, and providing information to providers, pregnant and postpartum people.

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension
2022-2023 Objectives and Proposed Strategies

Objective WM1a: By 2025, increase access to preventive health care and address health disparities to reduce rates of obesity, diagnosed diabetes, and diagnosed hypertension in women aged 18 to 44 years.

Strategy WM 1a (1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska's Medicaid Expansion) to promote enrollment and benefits, particularly for disparate and disadvantaged women of childbearing age and other parents/caregivers.

Strategy WM 1a (2): The DHHS Women's Health Initiatives Program will implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN) project in collaboration with a community organization.

Discussion of Activities for this Objective – Relevance to Identified Priority
Promoting Heritage Health Adult, Nebraska's Medicaid Expansion effort, is infused in numerous domains and priorities of this application. It is explicitly named as a strategy in this priority because of the opportunity represented by Medicaid Expansion for adult women of childbearing age to receive postpartum and interconception care. While the expansion effort has been well underway for some time now, this work is still needed to assist individuals with the education needed to help them get enrolled. It is particularly important in 2022-2023 as the Division of Medicaid Long-Term Care (MLTC) prepares for the upcoming "Medicaid unwind" with the end of the Public Health Emergency (PHE) declared by the federal government in 2020. The end of the PHE means a return to requirements that MLTC resume determination of eligibility on a regular basis for Medicaid clients. With the expectation that some current participants will be determined to be ineligible, it is important to ensure that clients are aware of the effort so they can respond to requests for information or submit new information proactively to avoid an ineligible determination due to a failure to provide information.

WHI has been collaborating with the Office of Women's and Men's Health on a project with community partners to address obesity and the need for healthcare access in underserved neighborhoods in the northwest quadrant of Lincoln NE. Project attendees will participate in 12 different Walk and Talk sessions. Each week will focus on a different healthy lifestyle behavior e.g. preventive screening, increasing fruits and vegetables, tracking and monitoring steps/minutes of exercise, stress management, etc. Data tools will be used to track changes in weight and blood pressure. This will begin as a pilot project, with the potential of statewide spread. A Request for Proposals was released in the 2021 period, and one community partner was identified to work with. The slow progress to receive applications and execute an agreement has highlighted how state/federal processes are difficult for many local, small organizations to navigate. Additional technical assistance has been necessary to help the applicant reach success in the various steps of a complicated, bureaucratic process. WHI and OWMH hope to have an executed agreement in place and work beginning in the 2022 grant year, as well as another community partner identified to join the project.

Though the stakeholders in the 2020 Needs Assessment process clearly identified disparities between different race/ethnicity groups as a problem, a responder in the public input process cautioned against being too narrow in scope as Title V seeks to address the problem:

> "The strategies…appear to be geared only towards those eligible for Medicaid and those in "underserved neighborhoods." That is a small subset of all of the women in Nebraska aged 18-44 years old. Therefore, I do not think that priority area will be very well addressed when the strategies are focused on such a narrow population. Additionally, the 18-44 year old focus area seems very narrow to concentrate on when looking at CVD."

In the 2019-2020 Annual Report, the Maternal Mortality Review Committee was identified as an emerging priority for Nebraska. In the period 2020-2021, the MCH Epidemiology Office began developing the methods and procedures involved in establishing an MMRC, including training of a staff team by Centers for Disease Control and Prevention. This important work continues in Nebraska, and continues to be supported by Title V, however ongoing strategies for the Maternal Mortality Review Committee have shifted to the Perinatal/Infant Health domain for the 2022-2023 year. This shift recognizes that the objective within the Women/Maternal health domain is more aligned with people becoming healthy before they become pregnant, as well as being narrowly focused on cardiovascular disease, making the MMRC work more appropriately aligned in a different domain.

2. Alignment of planned activities with annual needs assessment updates

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension

In describing expectations for working on this priority, stakeholders indicated "large systemic efforts at all socioeconomic levels" would be needed. They pointed to a plethora of evidence-based interventions to improve nutrition and physical activity; life course interventions designed to promote healthy habits from early childhood onward; and the availability of culturally- and linguistically appropriate activities to improve the health status of women of childbearing age.

The activities proposed on the part of the Women's Health Initiative are aligned with the findings of the Needs Assessment in 2020. There are no new findings to update the needs assessment in this priority area.

3. Emerging new priorities taking precedence over the established priority needs

Mental and Behavioral Needs of Women

As discussed in other areas of this application, Title V, along with stakeholders and advocates statewide, are acutely aware of the many ways mental health issues are manifest in all MCH populations in Nebraska. The combination of social and health vulnerabilities existing prior to the onset of the pandemic with continued stressors felt by not only pandemic-related effects but additional challenges such as rising inflation have meant little relief for Nebraska families.

Title V MCH sees there is a role for the block grant to be a committed and invested asset for the state to meet these needs particularly focusing on the most disadvantaged and disproportionately affected families. This work does not displace the established priority needs however, are noted as they will involve Title V MCH in the Women/Maternal Health Domain in the coming year.

4. Relevance of ESM to selected NPM, changes in ESM

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension.
NPM: Percent of women ages 18-44 years with a preventive medical visit in the past year.
ESM: Percent of women participating in the Women's Health Community Initiative who have a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history (new)

In April 2021, Nebraska was provided with the ESM Report from MCH Evidence Center for the state. The MCH Evidence Center assesses ESMs aligned to NPMs for the degree to which they are supported by evidence, and through the lens of Results-based Accountability. For the Women's and Maternal Health Domain, the report concludes there is no similar strategy found in the established evidence for the NPM, although there is moderate evidence supporting the use of community-based group education and patient navigation. The ESM of participation in the Women's Health Initiative is considered an effective measure of reach, which could be strengthened by measuring levels of engagement.

In addition to assigning ESM to at least one Priority in each Population Domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measures. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlights inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension.		
	Proposed for 2022-2023	*Proposed for 2023-2023*
How much did we do?	How many Heritage Health training activities and/or resources for community providers were promoted by Title V? How many Title V staff promoted at least one Heritage Health Adult activity or distributed messages/materials about Heritage Health Adult?	How many community partners participated? Can we capture number of individuals served?
How well did we do it?	How many women received information about Heritage Health through this project?	Did the partners in this project represent the target population? Do they expand the reach of our efforts to serve the target population? Were the women participating in the MSHIUN project members of the target population?
Is anyone better off?	How did overall Medicaid enrollment numbers change related to both expansion and the unwind?	Was positive change seen in health measures of participants of the MSHIUN project?

5. Are changes needed in the established SPMs and SOMs, if applicable

Not applicable for this domain.

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plan for this domain is shown in the table below.

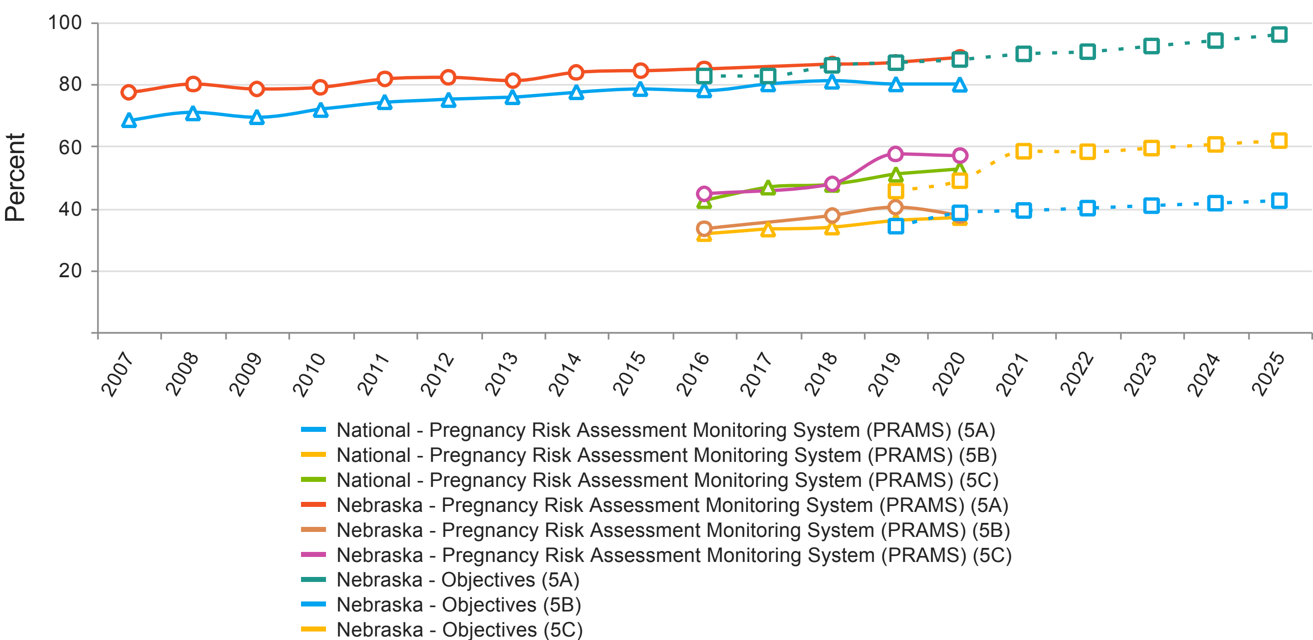
Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2021**
Year 1 20-21	• Begin review of educational materials for CLAS and literacy. • Form relationship with community cultural organization to undertake collaborative project. • Promote Heritage Health Adult • Provide relevant PRAMS educational materials	• Delay to Y2 • Ongoing • Ongoing • Completed
Year 2 21-22	• Implement collaborative project • Promote Heritage Health Adult • Provide relevant PRAMS educational materials • New: Maternal Mortality Review Committee	• Ready • Interrupted due to policy changes • Ready • Begun
Year 3	• Implement collaborative project • Promote Heritage Health Adult • Provide relevant PRAMS educational materials	• Ongoing • Ongoing • Done
Year 4	• Implementation • Evaluation • Sustainability Planning	
Year 5	• Determination on replication/sustainability • Determination of Return on Investment	

The strategy to provide relevant PRAMS materials was removed since it was completed. The strategy to update Maternal Mortality Review Committee membership, procedures, and recommendations was shifted to the Perinatal/Infant Health domain for the 2022-2023 year. This shift recognizes that the objective within the Women/Maternal health domain is more aligned with people becoming healthy before they become pregnant, as well as being narrowly focused on cardiovascular disease, making the strategy more appropriately aligned in a different domain.

Perinatal/Infant Health

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	2018	2019	2020	2021
Annual Objective	82.5	85.9	86.8	87.8	89.6
Annual Indicator	84.2	85.1	86.1	86.8	88.5
Numerator	21,305	21,558	20,652	20,367	20,471
Denominator	25,319	25,347	23,975	23,464	23,130
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019	2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.3	92.1	93.9	95.8

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		34.2	38.5	39.2
Annual Indicator	33.5	37.7	40.3	37.8
Numerator	8,129	8,832	8,976	8,403
Denominator	24,265	23,403	22,266	22,224
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.0	40.8	41.6	42.4

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		45.5	48.8	58.3
Annual Indicator	44.6	47.9	57.2	57.0
Numerator	10,890	11,176	12,710	12,719
Denominator	24,418	23,326	22,219	22,326
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	58.1	59.3	60.5	61.7

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:	**Inactive - Replaced**				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			45	58	100
Annual Indicator			53	88	95
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2021
Provisional or Final ?			Final	Final	Final

ESM 5.2 - The percent of clinics receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:	**Active**		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.0	65.0	75.0

State Performance Measures

SPM 1 - The percent of preterm births.

Measure Status:	Active

State Provided Data

	2019	2020	2021
Annual Objective			10.3
Annual Indicator	10.5	10.5	10.9
Numerator	2,597	2,551	2,654
Denominator	24,758	24,293	24,293
Data Source	NE Vital Records	NE Vital Records	NE Vital Records
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional

Annual Objectives

	2022	2023	2024	2025
Annual Objective	10.7	10.5	10.2	10.0

State Action Plan Table

State Action Plan Table (Nebraska) - Perinatal/Infant Health - Entry 1

Priority Need

Infant Safe Sleep

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

PIN3a: By 2025, decrease Sudden Unexplained Infant Death rate by: promoting safe sleep practices particularly separate sleep surface; racial disparities; and protective factors such as breastfeeding.

Strategies

PIN3a(1): The DHHS Maternal Infant Health Program will continue expansion of NE Safe Babies campaign to include family practice, pediatric, and OB-GYN clinics across Nebraska.

PIN3a(2): The DHHS Maternal Infant Health Program and MCH Epidemiology Office will undertake next steps in development of the Sudden Infant Death Investigation Form education, by reviewing user evaluations, and considering marketing and promotion activities.

PIN3a(3): The DHHS Maternal Infant Health Program will continue to develop collaborations with Omaha Healthy Start and rural health clinics.

ESMs	Status
ESM 5.1 - The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".	Inactive
ESM 5.2 - The percent of clinics receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".	Active

NOMs

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Nebraska) - Perinatal/Infant Health - Entry 2

Priority Need

Premature Birth

SPM

SPM 1 - The percent of preterm births.

Objectives

PIN2a: By 2025, decrease preterm birth by addressing disparities among women of childbearing age, increasing access to care, and providing education.

PIN2b: By 2025, continue implementation of the Nebraska Maternal Mortality Review Committee.

Strategies

PIN2a (1): Title V staff will participate in a cross-sector multidisciplinary group led by NPQIC to identify and make recommendations to Title V on action to prevent premature birth.

PIN2a(2): The DHHS Maternal-Infant Health Program will continue to develop collaborations with Omaha Healthy Start and rural health clinics to reduce risk for premature birth.

PIN2b (1): The Nebraska Maternal Mortality Review Committee will implement a process for developing actionable recommendations.

PIN2b(2): The Maternal Mortality Review Committee will incorporate Child Death Review data to inform prematurity prevention.

PERINATAL-INFANT HEALTH DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Perinatal-Infant Health Domain** for the period October 1 2020 to September 30 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the Perinatal Infant Health Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Infant Safe Sleep**
  NPM: Percent of infants placed to sleep on their backs; placed on a separate sleep surface; placed to sleep without soft objects or loose bedding
  ESM: The number of birthing hospitals and pediatric clinics that become Champions of the Nebraska Safe Babies Campaign

- **Premature Birth**
  SPM: The percent of preterm births
  ESM: None

1. Context: The State of the Perinatal-Infant Population Domain

In the priority area of Preterm Birth, stakeholders identified prematurity in the population as a problem both on the increase and characterized by significant disparities among income and racial/ethnic groups. Stakeholders emphasized the influence of social determinants of health (SDOH) on prematurity and encouraged Title V to consider opportunities to address SDOH in addition to interventions in clinical settings, such as clinical decision-making tools for providers to identify risk for prematurity. Stakeholders pointed to national best practices from March of Dimes, Centers for Disease Control, and other credible and invested organizations for effective strategies to address prematurity. An intervention addressing SDOH and improving pregnancy outcomes in California was described as a promising example of a project in local health jurisdictions. In addition, stakeholders note that improving access to health care overall in the population, particularly for women of child-bearing age without health insurance, is another viable strategy to improving pregnancy outcomes.

In the priority area of Infant Safe Sleep, stakeholders continue their focus on a topic that has been carried forward from the 2015-2020 period and characterized by several innovations and effective activities in the Nebraska Safe Babies campaign. The Nebraska Safe Babies campaign was launched in March 2017, with a focus on safe sleep practices. In July 2018, the phase of Abusive Head Trauma prevention was added to the campaign. In 2019 outreach was expanded from birthing hospitals to include pediatric and family practice clinics. Data obtained by the Office of MCH Epidemiology show 16 SUID/SIDS deaths in Nebraska for 2018, compared to 27 SUID/SIDS deaths in 2017 and 18 in 2019. In 2020, the Association for Maternal and Child Health Programs (AMCHP) showcased the Nebraska Safe Babies campaign in the Implementation toolkit for National Performance Measure 5 on safe sleep.

In the Issue Brief created on the topic of safe sleep, stakeholders point to a pattern of data showing improvements in safe sleep practices and advocated for the work to continue. Additionally, while breastfeeding was not selected as a priority on its own, stakeholders identified how much of a protective factor it is and encouraged Title V to identify nuanced messaging around safe sleep practices that emphasize the importance of both breastfeeding and a safe sleep surface for babies. For effective interventions, stakeholders recommend continuing the Nebraska Safe Babies campaign, now (2019-2020) entering expansion to include pediatric, family practice, and OB-GYN clinics as well as birthing hospitals as pledged and champion organizations.

For the 2020-2025 Needs Assessment, Title V worked with the Nebraska Association of Local Health Directors to bring forward a summary of current priorities identified through the Community Health Needs Assessment and Community Health Improvement Plans that local public health departments regularly undertake in their respective jurisdictions. This summary allowed stakeholders to consider degree of alignment with local priorities when determining which issues should be included in Title V's final list of priorities for the upcoming five-year period.

While some local public health departments in Nebraska identified low birth weight as a priority, none have explicitly identified prematurity or reducing infant death through Community Health Needs Assessment or Improvement Plans. However, multiple national and state level organizations have identified both premature birth prevention and safe sleep as priorities, providing a strong network for NE Title V to align with.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Infant Safe Sleep
2020-2021 Objectives and Strategies

Objective PIN1a: By 2025, decrease Sudden Unexplained Infant Death rate by promoting safe sleep practices and protective factors such as breastfeeding, and addressing racial disparities

Summary of Programmatic Efforts
Planned strategies in this objective for the period 2020-2021 included continuing the expansion of NE Safe Babies campaign to include family practice, pediatric, and OB-GYN clinics across Nebraska, as well as a review of available data to identify actionable educational or policy recommendations. In a student activity with the University of Nebraska Medical Center College of Nursing, the MCASH Program would undertake a literature review of evidence regarding the impact of racial bias and other structural determinants of health and equity influence on how women are presented with educational information and resources regarding safe sleep. This review was to further allow for identification and recommendation of change strategies where actionable. Finally, the DHHS Maternal Infant Health Program worked with students to undertake a review of available consumer education products regarding safe sleep and identify needs for health literate, culturally diverse and inclusive, translated versions.

During this period, two new clinics became Clinic Champions in the NE Safe Babies campaign. Low uptake was attributed to several factors, limiting the time and staff availability in the clinic setting for continuing education for staff to implement the campaign, as well as the lingering effects of the COVID19 pandemic.

In the arena of collaboration to improve Fetal Infant Mortality Review, a web-based training activity and new fillable documentation form were developed because of the data review and prepared for implementation in the 2021-2022 period.

Use of Evidence-based or Evidence-informed Approaches in this Priority
In May 2020, HRSA released *MCH Evidence Resources for Nebraska*, which included an ESM Development Guide, and an Agency-specific ESM brief. In this document, readers are pointed to strategies which have proven effective in addressing NPM 5A-C: Percent of infants placed to sleep on their backs, percent of infants placed to sleep on a separate approved sleep surface, and percent of infants placed to sleep without soft objects or loose bedding. Evidence-linked and promising practices are described.

The Nebraska ESM in the Perinatal-Infant Health domain: the number of birthing hospitals and pediatric clinics that become Champions of the Nebraska Safe Babies Campaign, aligns with an emerging evidence-linked strategy, caregiver, and parent education by home visitors. MCH Evidence, in the ESM Review & Resources Agency Brief, identifies the ESM of the NE Safe Babies Hospital Campaign as Measuring Quantity of Effort.

Priority: Premature Birth
2020-2021 Objectives and Strategies

Objective PIN2a: By 2025, decrease preterm birth by addressing disparities among women of childbearing age, increasing access to care, and providing education

Summary of Programmatic Efforts
Planned strategies related to this objective included the Maternal-Infant Health Program convening and sustaining a cross-sector multidisciplinary group to identify and make recommendations to Title V on actions to take to prevent premature birth and birth disparities. This strategy transformed early on to a subrecipient activity lead by the Nebraska Perinatal Quality Improvement Collaborative (NPQIC), a longtime Title V partner. In addition, the Maternal-Infant Health Program initiated a collaborative activity with Omaha Healthy Start on prematurity prevention, while the Nebraska PRAMS program developed, implemented, and evaluated a Data-To-Action project related to prematurity during the period.

In the 2020-2021 period, the NPQIC Prematurity Group met a total of seven times. The charge of the group included: analyses of and resources to identify gaps, frame population- and systems-level strategies amenable to Title V influence and partner reach to prevent premature birth and address birth disparities; and make recommendations to Title V based on this work. The group agreed that provider training must be included and consider needs for culturally- and linguistically appropriate services. Title V also requested recommendations from NPQIC on evaluation approaches. Toward these

objectives, the group collected and analyzed data and selected Tobacco Use and Obesity as areas of focus. In May 2021, the Maternal Infant Health program and Tobacco Free Nebraska partnered on outreach to obstetric and family practice providers regarding tobacco use during pregnancy, and available smoking cessation resources.

Collaboration between Title V and Omaha Healthy Start has not progressed as smoothly as hoped due to staff and leadership changes at Omaha Healthy Start, though communication between the programs is ongoing. Though unable to partner with Omaha Healthy Start as originally planned, the Maternal Infant Health Program developed a Warning Signs to Know During and After Pregnancy fact sheet, geared towards empowering birthing people with critical information to advocate for their own health and birth outcomes. Title V partnered with birthing hospitals, Obstetric and Family Practice clinics throughout the state to get this information to targeted individuals.

Lastly, the PRAMS program completed a data-to-action report on prematurity. The data-to-action report detailed efforts spearheaded by Nebraska DHHS between 2018 and 2020. During that time, multiple groups used PRAMS data, Vital Records data, and other sources to develop products (like a fact sheet, statewide birth improvement plan, and issue brief) describing premature birth in Nebraska. The data-to-action report described how the products were used by stakeholders to advocate for resources to reduce preterm births.

Use of Evidence-based or Evidence-informed Approaches in this Priority

3. Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Infant Safe Sleep

NPM: Percent of infants placed to sleep on their backs; placed on a separate sleep surface; placed to sleep without soft objects or loose bedding
ESM: The number of birthing hospitals and pediatric clinics that become Champions of the Nebraska Safe Babies Campaign

Alignment:
The Priority and NPM are aligned, with the NPM measuring the Priority. The ESM does not measure individual family practices directly, but as a measure of the number of clinics adopting the NE Safe Babies campaign standards addresses upstream change such as the necessary policies, practices, and education that systematically must be in place to routinely educate new parents.

Priority: Premature Birth

SPM: The percent of preterm births
ESM: None

Alignment:
The SPM is aligned with, and directly measures, the priority. There is no ESM assigned to this priority.

4. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA has specifically highlighted inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures **Infant Safe Sleep**		
	Proposed for 2020-2021	*Achieved 2020-2021*
How much did we do?	How many clinics have pledged, or become Champions during the period?	2
How well did we do it?	Have actionable priorities and strategies been identified because of the FIMR review? If so, to what extent is progress being made during the period?	Improve training for individuals completing death scene review
Is anyone better off?	In what ways is Title V approaching the role of racial bias in understanding and addressing safe sleep practices across cultures and groups?	Student activities reviewed literature regarding racial bias in maternal education, and review of materials with Omaha Healthy Start.

Discussion – Other Programmatic Impacts
Safe Sleep, and Nebraska Safe Babies, continue to provide the foundation for many partnerships and credibility for Title V in Nebraska. All birthing hospitals are in regular communication with Maternal Infant Health Program staff. Safe Sleep is a cross-divisional, cross-sector interest, resulting in Safe Sleep being named as one of Nebraska's priorities in the Perinatal Infant Domain for the 2020-2025 period.

Results Based Accountability (RBA) measures **Preterm Birth**		
	Proposed for 2020-2021	*Achieved 2020-2021*
How much did we do?	How many cross-sector meetings on reducing preterm birth occurred during the period?	7
How well did we do it?	Has a collaborative activity with Omaha Healthy Start been developed?	No
Is anyone better off?	Have the performance parameters for the Omaha Healthy Start project been met?	N/A

Discussion – Other Programmatic Impacts

5. Challenges and Emerging Issues

Nationwide, in the summer of 2020, the country experienced significant unrest, which led to national discussions about the quality of maternity care and treatment of Black and minority mothers. This national conversation resulted in federal attention on maternal morbidity and mortality, infant mortality, and existing disparities, specifically the heavy burden placed on women in minority populations. In addition, several national organizations, including the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) and the American Public Health Association (APHA) participated in bringing forward speakers and data on these topics, to support states in their own efforts.

In 2021, Nebraska began working with partners to better center Black and other minority women in population- and systems-level efforts to improve birthing outcomes, shifting focus from data points describing the "average" (i.e., white-predominant) status towards data that describes the most disadvantaged groups. This naming of desired outcomes for disparate populations elevates the intent to address the most vulnerable among us to the highest level of Title V planning.

6. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

In early 2021, one hospital became a NE Safe Babies Safe Sleep Champion to make a total of 53 Safe Sleep Champion Hospitals with four hospitals pledged to complete the steps. To further the campaign spread, DHHS shifted from a focus on the hospitals to the Family Practice, Obstetric, and Pediatric Clinics throughout Nebraska. Two new clinics completed the five steps and became NE Safe Babies Clinic Champions. During this time activities included creating a mailing and email list of OB/GYN, Family Practice and Pediatric clinics, emailing close to 1300 (1290) designated physicians' information on

the Clinic Campaign and a physical mailing of a packet of Clinic Campaign information and materials to 395 clinics across the state.

Under the direction of the Maternal Infant Health Program, UNMC College of Nursing Students completed the review of consumer education products and presented their information to Omaha Healthy Start. Information was well received and Omaha Healthy Start provided feedback to the students. Omaha Healthy Start reviewed their program materials and incorporated the NE Safe Babies materials into their programing.

Nebraska Title V has been actively involved with the NPQIC multidisciplinary group working on premature birth, including attending all 7 meetings and evaluating the data on prematurity. This work has resulted in excellent collaboration as well as recommendations to Title V on where to focus efforts in future years.

PERINATAL INFANT HEALTH DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **Perinatal Infant Health Domain** for the period October 1, 2022 to September 30, 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the Perinatal Infant Health Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Premature Birth**
  SPM: The percent of preterm births
  ESM: None

- **Priority: Infant Safe Sleep**
  NPM: A) the percent of infants placed to sleep on their back; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding
  ESM: The percentage of rural clinics receiving outreach that become champions within one year (new)

1. Description of Planned Activities

OVERVIEW OF THE PERINATAL INFANT DOMAIN
Nebraska Safe Babies Campaign
As a result of sustained efforts in the Title V Maternal Infant Health Program, the Nebraska Safe Babies campaign has emerged as Nebraska Title V's signature effort to address safe sleep and abusive head trauma. The campaign draws many stakeholders who are prepared to commit time and resources as Champion hospitals and clinics. Initiation of the Nebraska Safe Babies campaign was based on quality improvement activities engaging many stakeholders and champions. A key internal partner for Title V in this effort has been the Nebraska Maternal Infant Early Childhood home visiting program, N-MIECHV.

NPQIC
Another key Title V affiliate in the Perinatal Infant domain is the Nebraska Perinatal Quality Improvement Collaborative (NPQIC). Title V has been involved with NPQIC since its creation in 2014, participating on the initial board of directors; overseeing the allocation of state general fund dollars in support of NPQIC; and as participant in numerous quality improvement activities, from Breastfeeding and Count the Kicks to the Prematurity Steering Committee.

Medicaid Managed Care Organizations
Also instrumental in the delivery of prenatal care to women in Nebraska is the role of Managed Care Organizations in Medicaid. MCOs can construct their own value-added services and implement unique activities in support of statewide Medicaid-directed performance measures. Examples include vaccination of pregnant women, maternal depression screening, and safe sleep.

Priority: Premature Birth
2022-2023 Objectives and Proposed Strategies

Objective PIN2a: By 2025, decrease preterm birth by addressing disparities among women of childbearing age, increasing access to care, and providing education

Strategy PIN 2a (1): Title V staff will continue to participate in a cross-sector multidisciplinary group led by NPQIC to identify and make recommendations on action to prevent premature birth

Strategy PIN 2a (2): Title V staff will release a funding opportunity to improve birth outcomes in Native American communities directed towards local organizations

Discussion of Activities for this Objective – Relevance to Identified Priority
In the first instance, the activities planned by Title V focus on continuing the Prematurity Steering Committee, established by Title V as a deliverable in the subaward to the NPQIC. In addition to the funding relationship, Title V staff, including the Maternal Infant Health Nurse and an MCH Epidemiologist, participate on the Prematurity Steering Committee. The 2021-2022 program year will signify Year 2 of the Prematurity Steering Committee. Year 1 was invested in data review, during which the Prematurity Steering Committee selected smoking in pregnancy as their primary focus. Of note in this area is that participants in the Title V public input process mainly felt that the strategy would address the priority, however one respondent questioned how recommendations would be delivered. The respondent said:

> "I have found that when working with various cultures than my own, recommendations are implemented through investing time to build relationships. What is the plan for how to deliver the recommendations?"

Exercising its powerful impact as a funder, Title V will provide opportunities to organizations more directly connected to at-risk populations and offer resources to help them improve birth outcomes in their communities. This continues a project began in 2020-2021 focused on disparities in premature birth and access to premature care experienced by women of color. The proposed project was intentional in assuring that the voices and experiences of minority women were centered in the work from the very start and began with a small focus group of Black mothers and others to discuss and vet the emerging proposal. Also key to project implementation is the principle that Title V investments in implementation projects should be placed with organizations connected to, serving, and/or led by community members, particularly women of color that are of child-bearing age. Title V's initial idea is to seek partnerships in faith communities, sororities, social and cultural organizations, and other local organizations with a direct connection to the target population.

In addition, Title V plans to continue work begun in 2022 which involved partnering with local organizations to distribute educational materials, identify gaps in services, and support training. The Malone Community Center located in Lincoln has a great support system for parents, involving doulas and breastfeeding educators. In addition, they are interested in beginning a certification process for doulas – providing education for current doulas to get certified and/or for those who want to become a doula to take the certification class. Title V is working on exploring ways to support these efforts, including the possibility of scholarships to offset the costs of the doula certification/training.

The Partnership for a Healthy Lincoln has also been active in access to prenatal care issues. Title V staff will join a committee working with MCO's and providers through the state looking at the gaps in coverage and getting pregnant women into prenatal care as early as possible. This effort will be supported by an online dashboard of maps better describing services and outcomes across the state.

Objective PIN2b: By 2025, continue implementation of the Nebraska Maternal Mortality Review Committee

Strategy PIN2b (1): The Nebraska Maternal Mortality Review Committee will implement a process for developing actionable recommendations

Strategy PIN2b (2): The Maternal Mortality Review Committee and Child Death Review Team will utilize results from PRAMS and Hospital Discharge Data linkage analyzing outcomes related to prematurity

Discussion of Activities for this Objective – Relevance to Identified Priority
The Nebraska Maternal Mortality Review Committee (MMRC) offered over one hundred recommendations in case reviews for data years 2014 to 2019. The recommendations, evaluated by MMRC staff, were determined to be wide ranging and comprehensive. However, the recommendations need to be prioritized to move data to action and make progress on the MMRC's goal of reducing preventable maternal mortality.

In early 2022, MMRC staff collaborated with a facilitator to plan a recommendation prioritization process for the full committee. At the April 2022 quarterly MMRC meeting the committee participated in the facilitated conversation, which resulted in identification of seven priority recommendation topic areas: closed loop social support, non-discriminatory practices, behavioral health access, healthcare best practice adoption, domestic violence safety plan development, care continuity, and medical care access. These seven priority recommendation areas will be further defined through actionable implementation strategies developed by committee members. The actionable implementation strategies developed by the MMRC will include what entity or entities should take what action at what time and will be used to draw in partner organizations and the broader community to move MMRC recommendations into action.

For the strategy to utilize data linkage results, the teams involved have been working on a project which has resulted in two primary improvements to the teams understanding of prematurity. Linking the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Hospital Discharge Dataset (HDD) yielded insights into data quality and comprehensiveness. The HDD lacks completeness in race and ethnicity variables, which has a significant impact on development of recommendations, since maternal outcomes vary greatly by race and ethnicity, with Black women and other women of color experiencing much higher rates of maternal morbidity and mortality than White women. As stated in NDHHS Office of Health Disparities and Health Equity's mission, the promotion of health equity in Nebraska can be addressed, in part, using the linked dataset. Race and ethnicity data is missing for over 90% of observations in Nebraska HDD. While work is currently underway by the Nebraska Hospital Association (NHA) to reduce instances of missing data, linkage with PRAMS (which oversamples some racial and ethnic groups) would allow for more immediate analysis by race and ethnicity to tailor public health recommendations and messaging to improve maternal health.

The linkage of PRAMS and HDD would also center maternal perceptions of the perinatal period. There are multiple PRAMS questions that would add patient voices to prematurity analysis including questions related to pre-pregnancy health care visits, pre-pregnancy chronic disease burden, barriers to receiving prenatal care, satisfaction with prenatal care, pregnancy-induced disease burden, smoking and alcohol use, stressful life events, abuse, and infant and maternal postpartum visit status. Analyzing these data will improve knowledge about maternal experiences related to the outcomes of interest,

through patient-centered outcomes research to further refine efforts to reduce prematurity.

Priority: Infant Safe Sleep
2022-2023 Objectives and Proposed Strategies

Objective PIN3a: By 2025, decrease Sudden Unexplained Infant Death rate by promoting safe sleep practices particularly separate sleep surface; racial disparities; and protective factors such as breastfeeding

Strategy PIN3a (1): The Title V Maternal Infant Health Program will partner with the Office of Rural health on continued expansion of NE Safe Babies campaign in rural family practice, pediatric, and OB-GYN clinics across Nebraska

Strategy PIN3a (2): The DHHS Maternal Infant Health Program and MCH Epidemiology Office will develop strategies to increase use of the new Sudden Unexplained Infant Death Investigation Form and training opportunities, targeting specific user groups such as law enforcement, first responders, county attorneys, etc.

Strategy PIN2a (3): The DHHS Maternal Infant Health Program will continue to develop collaborations with community partners and rural health clinics

Discussion of Activities for this Objective – Relevance to Identified Priority
Nebraska Safe Babies
The NE Safe Babies Campaign continues to focus on infant safe sleep education to providers throughout the State of Nebraska. The Safe Sleep Campaign started in the hospital setting to educate and review safe sleep practices with providers. Beginning in the fall of 2019 the NE Safe Babies Campaign spread to the clinic setting, providing education on Safe Sleep, Abusive Head Trauma Prevention, and the CRYing Plan to pregnant people prior to birth, and then follow up providing the same information at the well-baby visits through-out their first year of life. For the upcoming year, the focus will be on rural practices, partnering with the Office of Rural Health to utilize Calm Baby Gently and Sleep Baby, Safe and Snug book incentives for clinics that become champions by Dec 31, 2022; encouraging Local Health Departments, Tribal Health Departments, and Community partners to become Clinic Champions; and investigating a collaboration with WIC programs to provide education and programming to clients.

Previous work in this priority identified Omaha Healthy Start (OHS) as an important partner. Unfortunately, the activities planned for collaboration with OHS have been interrupted by changes in Healthy Start leadership. While Title V anticipates forming a relationship with new leadership, and establishing collaborative projects, in the meantime Title V plans to shift focus towards working with other community partners to distribute educational materials, identify gaps in services, and support training. The Omaha Better Birth Project provides support for low-income and teen families in the Omaha area and hosted a baby shower for approximately 50 families on June 18th, 2022. In partnership with Title V, they distributed the ABCs of Safe Sleep, 1-2-3 Don't Shake Me, The CRYing Plan, Breastfeeding brochure, and the Warning Signs to Know During and After Pregnancy fact sheet to all 50 families that attended the baby shower. Omaha Better Birth Project has a baby shower once or twice per year, so this partnership is expected to continue.

Sudden Unexplained Infant Death Investigation
Responding to recommendations from stakeholders, the Office of MCH EPI created a fillable form for use during investigations of sudden unexplained infant death, with an accompanying self-directed, web-based training in 2021. The recommendation was spurred in part by a recognition that the data collected on-scene during investigation is critical to effective evaluation of the death by Child Death Review Teams later, and tools were needed to support investigators in their work. The next step to move this forward is to further encourage use of the form and training tools. The Office of MCH EPI will work with communications and interns to develop strategies to increase use of these tools and build in ways to track usage and success.

2. Alignment of planned activities with annual needs assessment updates

Priority: Preterm Birth

Alignment: Planned activities focus on partnerships with expert organizations (NPQIC, community groups, and MMRC). These activities are closely aligned with recommendations of stakeholders in the 2020 Needs Assessment, which were to utilize a multi-disciplinary group to examine data more closely, particularly around social determinants of health; as well as to make recommendations for implementation, educate providers, and communicate with mothers.

Priority: Safe Sleep

Alignment: In the 2020 Needs Assessment, stakeholders recommended as promising strategies the continuation of the Nebraska Safe Babies Campaign, and the continuation of the Child Death Review Team effort to take a data-driven approach to prioritizing prevention efforts. Proposed activities for 2022-2023 are aligned with the needs assessment in these two respects.

There are no new findings to update the needs assessment in the priority area of Safe Sleep.

3. Emerging new priorities taking precedence over the established priority needs

The established priority needs remain in place. While emerging priorities can be observed in this domain; primarily around continuing needs of pregnant people and new parents related to the ongoing pandemic, these emerging issues are not taking precedence of the established priority needs.

4. Relevance of ESM to selected NPM, changes in ESM

Priority: Infant Safe Sleep
NPM: A) the percent of infants placed to sleep on their back; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding
ESM: The percentage of rural clinics receiving outreach that become champions within one year

In April 2021, Nebraska was provided with the ESM Report from MCH Evidence Center for the state. The MCH Evidence Center assesses ESMs aligned to NPMs for the degree to which they are supported by evidence, and through the lens of Results-based Accountability. For the Perinatal Infant Health Domain, the report finds that, at the level of Expert Opinion, the ESM aligns with the MCH Best Practice strategy of "Building on Campaigns with Conversations." The ESM of birthing hospital participation is a measure of reach, which could be strengthened by using a denominator (total # of relevant group addressed) to show a percentage.

In addition to assigning ESM to at least one Priority in each Population Domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measures. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlights inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Priority: Premature Birth			
	Proposed for 2022-2023	*Proposed for 2022-2023*	*Proposed for 2022-2023*
How much did we do?	Was the funding opportunity for community organizations to improve birth outcomes released? How many agreements were executed?	How many Prematurity Steering Committee meetings have Title V staff attended?	Did the MMRC create actionable recommendations using the new priority areas? How many?
How well did we do it?	Did funds for local projects go to organizations who are directly connected to the target population?	In what ways have consumers/women been involved in the Prematurity Steering Committee?	Were the recommendations sufficiently targeted to include who should take specific action when? Do those identified partners represent target populations?
Is anyone better off?	How many women were directly impacted by services offered through this funding opportunity? Were their lives improved?	Did the Steering Committee make actionable recommendations?	Did any partners agree to work on these recommendations?

Results Based Accountability (RBA) measures Priority: Infant Safe Sleep		
	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How many professionals initiated and completed the SUID Death Scene Investigation training during the period?	How many rural clinics have pledged, or become Champions during the period? How many collaborative projects have we initiated with partners?
How well did we do it?	What are evaluation results from users completing the training? Have these results been used to update the training curriculum and/or form?	How many new mothers do these partnerships impact each year? Do they belong in targeted groups?
Is anyone better off?	Did the form improve knowledge surrounding the circumstances of the death?	Has any behavior change occurred from these partnerships?

5. Are changes needed in the established SPMs and SOMs, if applicable?

Priority: Premature Birth
SPM: The percent of preterm births

The State Performance Measure is not specific to disparities, although there are many that exist and are of concern to stakeholders. In Nebraska, the rate for white mothers is 9.8%, compared to 14.8% for Black women in Nebraska, and 13.8% for American Indian women. Most public health providers and allies have no difficulty imagining that the solutions to prematurity risk for Black mothers will not be the same as for American Indian mothers, which will be different from those for white mothers. Similarly, the state of public health science indicates the solutions needed are not limited to behavior change among women affected but MUST consider the social and economic circumstances in which women live and give birth, as well as cultural preferences and belief systems. In addition to the racial disparities mentioned above, Nebraska sees income, educational attainment, and age group disparities. Women with less than a high school education, are 35 years of age and older, and those with incomes lower than 194% of the Federal Poverty Level all experience higher rates of premature birth. Given the complexity of the issue and the need for flexibility in annual strategies, the 5-year objective is written in such a way to focus annual strategies on addressing disparities while the SPM stays at an all-encompassing target. This approach is reflected in the language of the Issue Brief, which expresses progress in this area as a reduction in the rate of preterm birth AND decreasing disparities between different demographic groups.

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plans for this domain is shown in the table below.

Priority: Premature Birth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Convene a group to select prevention priorities and strategies • PRAMS Data to Action • Explore racial bias in perinatal care	• Convened • Done • Planning
Year 2	• Prematurity Screening Committee (NPQIC) • PRAMS Data to Action • New: Improve Birth Outcomes Project	• Meeting • Done • Planned
Year 3	• Prematurity Screening Committee (NPQIC) • Improve Birth Outcomes Project • New: MMRC recommendations	• Meeting • Planned • Ready
Year 4	• Prematurity Screening Committee (NPQIC) • Improve Birth Outcomes Project • MMRC recommendations	
Year 5	• Evaluate Impact of Prematurity Screening Committee (NPQIC) • Evaluate Birth Outcomes Project • Evaluate MMRC recommendations	

In the instance of Premature Birth, a strategy for the Maternal Infant Health Program to convene and lead a group to identify

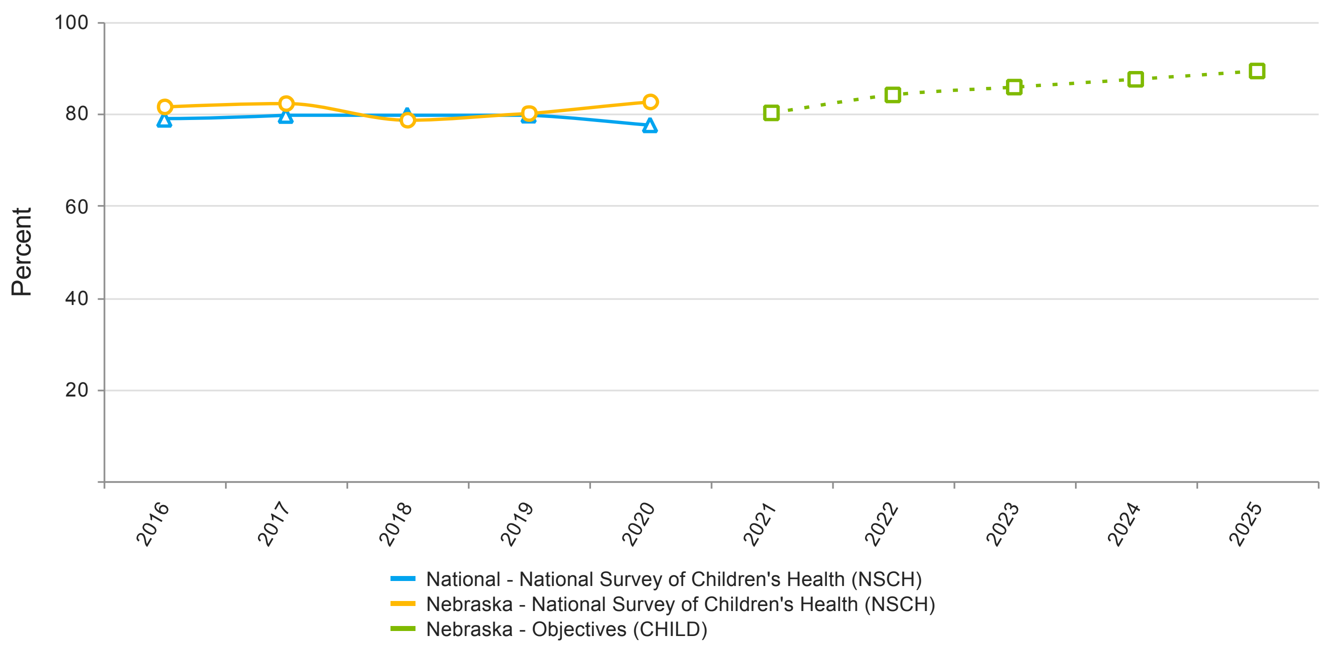
and make recommendations on actions to prevent premature birth and birth disparities, was modified in the 2021-2022 action plan to indicate the Maternal Infant Health Program and MCH Epi are participating in a Prematurity Steering Committee led (as a deliverable in a funding agreement from Title V) by the Nebraska Perinatal Quality Improvement Collaborative. The purpose of the steering committee is to make recommendations to prevent premature birth. Also, in the strategies for Premature Birth, the strategy regarding a PRAMS data-to-action project on prematurity is removed as it was completed in 2020-2021. Newly added this year is the work to implement new recommendations from the MMRC.

Priority: Infant Safe Sleep 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Develop a plan to expand NE Safe Babies Campaign to include clinics • Omaha Healthy Start Collaboration • Omaha FIMR Data to Action • Update PRAMS Materials	• Convened • Interrupted • No action on FIMR
Year 2	• NE Safe Babies Campaign • Omaha Healthy Start Collaboration • Disseminate New Materials	• Adaptations • Interrupted • Done
Year 3	• NE Safe Babies Campaign • Community Collaboration • New: Increase use of Sudden Unexplained Infant Death form and training	• Ongoing • Planned • Planned
Year 4	• NE Safe Babies Campaign • Community Collaboration • Evaluate use of Sudden Unexplained Infant Death form and Training	
Year 5	• Evaluate Impact of NE Safe Babies Campaign • Evaluate Community Collaboration • Evaluate Sudden Unexplained Infant Death training and forms	

In the area of Safe Sleep, changes to strategies have reflected changes in partnerships. The strategy to collaborate with Omaha Healthy Start has been broadened to allow for more opportunity with other community partners, and the previous discussion around Fetal Infant Mortality Review has shifted to working more with law enforcement, first responders, and other investigators involved in sudden infant death cases. Updates to reflect progress, challenges, and changes in the work environment keep Title V staff and partners focused on long-term goals while still effecting short term change.

Child Health

National Performance Measures



NPM 13.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2019	**2020**	**2021**
Annual Objective			80.1
Annual Indicator	78.5	80.1	82.4
Numerator	345,091	363,265	370,833
Denominator	439,399	453,443	450,251
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.0	85.7	87.4	89.2

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			25
Annual Indicator		18	33
Numerator			
Denominator			
Data Source		Program Data	Program Data
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

ESM 13.2.2 - The percentage of children participating in the Open Mouth Survey from rural and underserved communities

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	50.0	50.0	50.0

State Performance Measures

SPM 2 - The rate of substantiated reports of child abuse and neglect per 1,000 children (1-9).

Measure Status:	Active

State Provided Data

	2019	2020	2021
Annual Objective			9.8
Annual Indicator	7.2	10	7.4
Numerator	1,718	2,369	1,765
Denominator	237,985	236,820	237,146
Data Source	NE Family Online Client User System, Census	NE Family Online Client User System, Census	NE Family Online Client User System, Census
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2022	2023	2024	2025
Annual Objective	7.3	7.1	6.9	6.8

State Action Plan Table

State Action Plan Table (Nebraska) - Child Health - Entry 1

Priority Need

Access to Preventive Oral Health Care Services

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

CH5a: By 2025, increase the percent of children ages 1 to 17 years who receive preventive oral health care services.

Strategies

CH5a(1): The DHHS Office of Oral Health will identify needs for translation of existing health literate oral health education materials.

CH5a(2): The Office of Oral Health will distribute dental health starter kits in the population and report evaluation measures of the project.

CH5a(3): The DHHS School Health Program and the Office of MCH Epidemiology will participate in the planning and implementation of the statewide Oral Health Survey.

ESMs	Status
ESM 13.2.1 - The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.	Inactive
ESM 13.2.2 - The percentage of children participating in the Open Mouth Survey from rural and underserved communities	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Nebraska) - Child Health - Entry 2

Priority Need

Child Abuse Prevention

SPM

SPM 2 - The rate of substantiated reports of child abuse and neglect per 1,000 children (1-9).

Objectives

CH4a: By 2025, reduce rate of substantiated child abuse or neglect by: supporting prevention, early identification, and early intervention strategies; and investigating disproportionality of children and families involved with the Child Welfare Agency.

Strategies

CH4a (1): The Nebraska MIECHV program will expand evidence-based home visiting services Nebraska families at-risk for child abuse and neglect in a collaboration with DHHS Division of Children and Family Services.

CH4a (2): Title V staff will continue collaboration with the Division of Children and Family Services in the Thriving Families, Safer Children workgroup, and Bringing Up Nebraska initiatives.

CHILD HEALTH DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Child Health Domain** for the period October 1 2020 to September 30 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the Child Health Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Child Abuse Prevention**
  SPM: The rate of substantiated reports of child abuse and neglect per 1,000 children ages 1-9 years.
  ESM: None.

- **Access to Preventive Oral Health Care Services**
  NPM: Percent of children ages 1 – 17 years who had a preventive dental visit in the past year.
  ESM: The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.

1. Context: The State of the Child Population Domain

Title V work in the child health domain is complemented by participation in numerous vibrant networks of stakeholders and partners. Nebraska Title V partners with several significant systems-level and capacity building activities in the state, benefitting child health and life course outcomes. These include the Preschool Development Grant (PDG); Rooted in Relationships, a child well-being initiative and enhancement of early childhood mental health comprehensive systems work within the Nebraska Children and Families Foundation; First Five Nebraska, which was awarded a Pritzker Children's Initiative Prenatal-to-Age 3 planning grant; and Help Me Grow, currently in development, but with plans to sustain and grow to all of Nebraska. Title V is making investments in Help Me Grow at the local level through a local subaward. Within DHHS, the Division of Children and Family Services (CFS), the Injury Prevention Program, the Oral Health Program, and the Child Lead Prevention Program have long been partners with Title V. Important collaborations with the child welfare sector, through the Prevention Administrator at CFS, have both improved child safety and well-being at the population level and provided early intervention/prevention services to stressed families at-risk for involvement in the child welfare system. Title V is a partner in multiple child abuse prevention activities led by CFS, including the Child Abuse Prevention Fund Board, Plan to Prevent Child Maltreatment Deaths, and the Bring Up Nebraska and Thriving Families initiatives.

Title V is also closely linked with, and shares priorities and objectives with, Nebraska's Maternal Infant Early Childhood Home Visiting program. Title V serves as lead agency for the state's Pediatric Mental Health Care Access Program, providing additional resources and stakeholders with shared interests in improving screening in primary care and increasing access to a spectrum of pediatric mental health care services. Title V participates in Nebraska's Learn the Signs, Act Early autism awareness and identification project.

Children's Hospital, based in Omaha, has expanded their footprint in Nebraska, with clinical service locations, clinics, and referral networks as well as community-based and school health services, providing child psychiatry and consultation services via telehealth statewide. In 2021-2022, the Nebraska Department of Education began strategic planning to expand and embrace comprehensive and coordinated school health programs and entered into an agreement with Children's Hospital to provide additional expertise and staff support to the Nebraska Department of Education in this area.

Impact of COVID on Children in Nebraska
The realities of the pandemic experience nationwide have also affected Nebraska children. Stakeholders are concerned about lagging school performance scores as well as assorted mental and behavioral health issues, including suicide, among Nebraska children and youth. Attention to both measuring and responding to the effects of the prolonged pandemic and related disruptions to daily routine as well as impacts on the economy and services, will need to continue. This attention must address the disparities and inequities that continue to exist within systems.

National Survey of Children's Health Oversample
Considering discussion about the state of Child Health in Nebraska, it is relevant to discuss an investment by Title V to increase population sampling in Nebraska by the National Survey of Children's Health. Nebraska originally planned to oversample by 1,500 addresses with a goal of adding 272 interviews, expecting a total of 780 interviews. Nebraska's response rate was 15% higher than anticipated, with nearly 1,100 interviews completed. As a result, in 2022 Nebraska has access to a richer data set about Nebraska children, including preventive dental visits and other key measures of access to care.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Child abuse prevention
2020-2021 Objectives and Strategies

Objective CH4a: By 2025, reduce rate of substantiated child abuse or neglect by supporting prevention, early identification, and early intervention strategies, and investigating disproportionality of children and families involved with the Child Welfare Agency

Summary of Programmatic Efforts
Planned strategies in this objective include expanding the reach of Nebraska's Maternal Infant Early Childhood Home Visiting program (N-MIECHV, an evidence-based approach to child abuse prevention) through a funding collaboration with the Division of Children and Family Services (CFS) Temporary Assistance to Needy Families (TANF) program. As a result, six existing sites were able to expand their programs, and one new site was added, to take referrals specifically under the enhanced program activities and serve an additional capacity of 300 more families.

In a second strategy launched in 2020-2021, the MCH Epidemiology program at DHHS was to begin assessing available data and describe existing disparities among Child Welfare involved families. Due to Nebraska's inclusion in the Thriving Families, Safer Children national partnership as one of four states selected to continue work on community well-being; this analysis was shifted to that project. Title V will work with CFS as a partner in this project, participating in workgroups and providing expertise. During the period of this report, efforts were largely in communications, collaboration, and planning relevant to this strategy.

Use of Evidence-based or Evidence-informed Approaches in this Priority
N-MIECHV implements Healthy Families America, which has proven effectiveness in reducing risk of abuse and neglect among participating families.

The Child Welfare data assessment project proceeds with the expectation that disparities that are not recognized, measured, or identified, cannot be addressed. An initial assessment of 2020 Nebraska data conducted by Casey Family Programs showed that certain minority children have a rate of screened in reports of child abuse and neglect which is at least twice that of White children. Additionally, examination of data on families engaging with prevention systems such as Community Response and Alternative Response showed that White families are most represented. Further analysis is necessary to identify root causes and gaps in available services at the community level, as well as how Nebraska can ensure supports and services available for all families to reduce system involvement for children.

Nebraska DHHS participates in the Family First Prevention Services Act (FFPSA) of 2018, which calls for a greater emphasis on States providing child maltreatment prevention services that are rooted in promising, supported, or well-supported practices. While the web site https://www.mchevidence.org is silent on evidence based interventions to prevent child abuse, the field is well-studied and evidence guides are readily available. The web site https://www.childwelfare.gov/topics/preventing/evidence/ provides extensive access to evidence registries, including https://homvee.acf.hhs.gov/ the evidence-base for home visiting. At the child welfare site, Nebraska's Bringing Up Nebraska project is highlighted.

Priority: Access to Preventive Oral Health Care Services
2020-2021 Objectives and Strategies

Objective CH5a: By 2025, increase the percent of children ages 1- 17 years who had a previous dental visit in the past year

Summary of Programmatic Efforts
Planned strategies included Title V partnering with the DHHS Office of Oral Health to translate dental health promotion materials into more languages as needed, and to assist in the distribution of Dental Health Starter Kits to children and families. These activities remain current and in process, though slowed by the pandemic and related closures limiting client and family contacts. N-MIECHV participated by distributing 20 cases of 200 kits each in English, and 12 cases in Spanish. In addition to these efforts, Title V through the School Health Program and MCH Epidemiology has partnered with the Oral Health Program to launch a statewide assessment of children's oral health by screening children in selected schools and Head Start programs. In 2020-2021, the Oral Health Survey was largely in planning phase conducting the selection of schools, setting protocols, and planning logistics. The Oral Health Survey itself will be completed in 2021-2022 and operationalized with technical assistance from the Association of State and Territorial Dental Directors. University of Nebraska Medical Center College of Dentistry Pediatric Residents will be enlisted as examiners in several counties, while registered dental hygienists with public health authorization will serve as examiners in other areas.

In the Oral Health Program, capacity grew with the addition of a Community Health Educator to assist with program activities. The position is jointly supported by Title V and preventive health services block grant funds. No decisions were

made about translation of materials.

Use of Evidence-based or Evidence-informed Approaches in this Priority
The web site, https://mchevidence.org reviews evidence to promote the preventive dental visit in childhood. Key findings include:

- School/preschool interventions appear to be effective.
- Public insurance coverage appears to be effective.
- Medicaid reforms appear to be effective.

3. Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Child Abuse Prevention
SPM: The rate of substantiated reports of child abuse and neglect per 1,000 children ages 1-9 years
ESM: None

Alignment: Nebraska stakeholders in the 2020 Needs Assessment, as in other years, expressed grave concerns about child abuse and neglect – and the possible disparities and disproportionate burdens occurring with some groups and communities. The SPM assigned to this priority is well-aligned with associated strategies addressing the exploration and identification of disparities, though not called out in the SPM. No ESM has been assigned to this priority in Nebraska.

Priority: Access to Preventive Oral Health Care Services
NPM: Percent of children ages 1 – 17 years who had a preventive dental visit in the past year
ESM: The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program

Alignment: The NPM of measuring preventive dental visits in the past year is well-aligned with the priority of improving access to dental care. However, the operative means for providing increased access to care has not been with a dentist or dental home per se, but rather the incorporation of dental health promotion materials into school-based services provided by public health dental hygienists, or into home visits. The ESM is a measure of quantity of sites participating in the dental health promotion project, not children, so the unit of measure between NPM and ESM is slightly mismatched and not indicative of results or impact.

4. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures in most domains in an effort to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA has specifically highlighted inclusion and equity-focused efforts that have been transforming Title V work in Nebraska.

Results Based Accountability (RBA) measures Child Abuse Prevention		
	Proposed for 2020-2021	*Achieved 2020-2021*
How much did we do?	How many new sites and families were added to N-MIECHV during the period?	6 sites expanded and one new site was added. Additional capacity to serve 300 was gained. Pandemic disruptions continued to impact outreach and enrollment.
How well did we do it?	Have points of disproportionality been identified through the CFS-MCH Epi collaboration?	Points of disproportionality have been identified, though not through a collaboration between CFS and MCH Epi. Data analysis conducted by Casey Family Programs found disproportionate rates for screened in reports and for participation in prevention programs, as discussed above.
Is anyone better off?	Do families enrolled through N-MIECHV expansion project have the same rate of achievement on benchmarks compared with other N-MIECHV families?	"*Anecdotal data indicates that families referred from child welfare providers have a more difficult time with initial engagement, but once they do engage, their success on benchmark measures is similar to families not involved with the child welfare system*."

Discussion – Other Programmatic Impacts
Work towards expanding evidence-based home visiting through braided, cross-divisional, state and federal funding sources at DHHS, in order to serve more families in collaboration with child welfare services, has been groundbreaking for service delivery. Title V leadership and alignment has been instrumental in guiding the process. In addition to expanding capacity for families across Nebraska, the efforts have created new organizational processes, networks for communication and collaboration, and enhanced the visibility and credibility of DHHS as a provider of preventive services for families. Additionally, Nebraska's inclusion as one of four states in the Thriving Families, Safe Children Initiative has far-reaching implications for strengthening the community well-being system in the state. Assistance from the Casey Family Programs, support from the First Lady of Nebraska, and strong engagement by local partners has set the stage for a successful expansion of critical services and supports for all families in Nebraska.

Results Based Accountability (RBA) measures Access to preventive oral health care services for children		
	Proposed for 2020-2021	*Achieved 2020-2021*
How much did we do?	How many dental health starter kits were distributed by the Office of Oral Health during the period?	212 cases of dental kits to N-MIECHV
	How many materials were newly translated?	None
	How many schools participated in the Oral Health Survey?	The survey will occur in 2021-2022
How well did we do it?	How many schools participated in the Oral Health Survey? Are diverse children and underserved areas represented in the Oral Health Survey?	The selection of schools for invitation to participate in the survey was an intentional representative sample, which provided urban and rural diversity as well as racial and ethnic diversity.

Discussion - Other Programmatic Impacts

5. Challenges and Emerging Issues

COVID Response

As the pandemic extended into 2020-2021, Title V MCH began to identify the effects of program operations on subrecipients and on families. The 2020 Needs Assessment was conducted primarily using virtual platforms. Many participants were engaged in response activities within their programs, while others were primarily affected by shutdowns and disrupted operations. Some were dealing firsthand with illness and loss. By the close of the 2020 program period for Title V, it was becoming clear the consequences of the pandemic could potentially be impacting life course trajectories for MCH populations for some time, especially those already vulnerable and experiencing social needs. By 2021, Title V MCH was responding with partners and approaches to help families with diapers and other critical supplies.

Equitable access to pediatric mental health care

In 2018, Title V MCH became the lead agency for Nebraska's HRSA-funded Pediatric Mental Health Care Access program, called NEP-MAP (Nebraska Partnership for Mental Health Access in Pediatrics). In doing so, stakeholders, partners, and Title V staff, were recognizing the rising tide of mental health issues in the population, so Title V leadership in this federal area was a natural fit. In 2021 NEP-MAP published the results of a family survey, with intentional oversampling of rural areas to represent all regions of the state. Findings underscore the extent to which families identify ways they see their children's mental and emotional well-being affected during the COVID pandemic. In addition, as needs and screening increase, with increasing referrals to mental and behavioral health care, waiting times are increasing for families to access care.

Medicaid Expansion in Nebraska: Heritage Health Adult

In October of 2020, Nebraska opened enrollment for Heritage Health Adult, enacting Nebraska's Medicaid Expansion program. Throughout this Annual Report, as well as the 2023 Application, Nebraska touches on the benefits of Medicaid Expansion to MCH populations, particularly women of childbearing age and their domestic partners. Medicaid Expansion means access to physical, dental, mental, and behavioral health services as well as medications for an estimated 80,000 adults between 19 and 64 years of age in Nebraska. Adults who care for their own preventive health needs are more likely to care for the needs of their children.

6. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

The COVID pandemic continues to have an impact on outreach and disrupt the usual means of connecting at the community level. Where feasible, alternative methods such as telecommunications are in place and working as well as can be expected. Pandemic response has also contributed to a growing sense of flexibility and agility about maintaining communications by effective means. The Oral Health Survey, by nature a high contact undertaking by examiners, was only in planning phase during this period.

In terms of strategic directions, it is important to make the connection between the pandemic, family stress, and risk of child abuse and neglect. All parties have proceeded with expanding home visiting as well as other supports and resources, with patience, compassion, and persistence.

CHILD HEALTH DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **Child Health Domain** for the period October 1, 2022 to September 30, 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the Child Health Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Child Abuse Prevention**
  SPM: The rate of substantiated reports of child abuse and neglect per 1,000 children ages 1-9 years
  ESM: None

- **Priority: Access to Preventive Oral Health Care Services**
  NPM: Percent of children ages 1-17 years with a preventive dental visit in the past year
  ESM: The percentage of children in the Open Mouth survey from rural and underserved communities (new)

1. Description of Planned Activities

OVERVIEW OF THE CHILD HEALTH DOMAIN
Systems Partners
Nebraskans care about child wellbeing, and there are several strong systems-level efforts led by state organizations and foundations to improve child and family services and outcomes. First Five Nebraska, the Nebraska Children and Families Foundation (NCFF), and the Buffett Early Childhood Institute at the University of Nebraska-Lincoln all bring strong infrastructure and policy-building assets to helping Nebraska families succeed. Title V MCH has collaborative relationships with all, and partners with NCFF on a variety of activities. NCFF is the lead agency for the Bring Up Nebraska effort, which in turn heavily supports the infrastructure of community collaboratives across the state. In addition to these well-established organizations, Nebraska participates in a Preschool Development Grant, and First Five Nebraska leads a Pritzger Prenatal to Three project. Title V and N-MIECHV have both actively participated in the development of the state plan under the Families First Prevention Act which includes home visiting services for families at-risk of involvement in the child welfare system. Additionally, Title V participates on the Child Abuse Prevention Fund Board, on workgroups focused on Preventing Child Maltreatment Deaths, and ensures Child Welfare representation on the Child Maternal Death Review Team. This is an example of the Nebraska DHHS approach to integrated service delivery in health and human services that has grown collaborative opportunities for Title V and related programs to participate in discussion and planning for alternative interventions for families and children at risk of involvement in the child welfare system.

Title V School Health Program
In addition to systems- and state-level collaborations to build a comprehensive system of child and family supports and services, Title V MCH invests in the ongoing operations and services of the School Health Program, located within the Maternal Child Adolescent School Health (MCASH) Team. The program has been in existence for nearly three decades and has included the role of designated State School Nurse Consultant filled by the Program Manager.

During 2022, the School Health Program Manager resigned to take a new position helping the NE Department of Education revitalize its approach to school health issues, in partnership with Children's Hospital. While this transition necessarily means changes in how Title V approaches school health, it is an exciting and significant development for Nebraska, offering the opportunity to strengthen and refresh health issues for children in the school setting. Much is still to be determined; however, it is known that the role of state School Nurse Consultant and likely much of the support to school nurses across the state will move out of DHHS. For Title V, this is an important opportunity to focus priorities and determine the right resource mix for ongoing efforts. Title V will move forward with refilling this vacant position, and the new staff person will have an opportunity to participate in development of this role during the transitory period.

Priority: Child Abuse Prevention
2022-2023 Objectives and Proposed Strategies

Objective CH4a: By 2025, reduce rate of substantiated child abuse or neglect by: supporting prevention, early identification, and early intervention strategies; and investigating disproportionality of children and families involved with the Child Welfare Agency

Strategy CH4a (1): The Nebraska MIECHV program will expand evidence-based home visiting services targeted to Nebraska families at-risk for child abuse and neglect in a collaboration with DHHS Division of Children and Family Services

Strategy CH4a (2): Title V staff will continue collaboration with the Division of Children and Family Services in the Thriving Families, Safer Children workgroup, and Bringing Up Nebraska initiatives

Discussion of Activities for this Objective – Relevance to Identified Priority
N-MIECHV Expansion
For the past few years, the N-MIECHV program housed in the Division of Public Health has worked in a formal collaborative partnership with the Division of Children & Family Services (DCFS) to implement Family First Prevention Services Act (FFPSA) services, primarily through the Child Welfare Protocol of Healthy Families America model of home visiting. Additionally, starting in 2020, DCFS allocated funds from the Temporary Assistance for Needy Families (TANF) program for the expansion of HFA evidence-based home visiting programs across the state – representing the support of executive leadership for this work. Written into the NDHHS 5-year Business Plan, the partnership allocated $500,000 the first year, with an increase of $500,000 each year through 2024. First the existing HFA programs expanded capacity to serve more families, then one small, previously privately funded program in the southeastern corner of the state was brought onto the N-MIECHV network and expanded as the first "new" program for the Business Plan.

N-MIECHV conducted an updated needs assessment in 2020 to identify the counties in Nebraska whose community data shows most "at risk" for child maltreatment due to factors such as the rates of poverty, teen pregnancy, and/or exposure to violence or substance abuse, among others. Utilizing TANF funding over the next four years, between four and six new HFA programs will be implemented in identified priority counties that do not have existing services. N-MIECHV uses a community planning approach where local early childhood stakeholders decide whether there are system gaps for needed services in their community, and whether an HFA program might help close those gaps. Once a local implementing agency is identified, N-MIECHV will issue awards to the community to serve vulnerable pregnant and parenting families. Already two community meetings have occurred, with excellent turnout at each, and additional meetings are planned.

Expanding Home Visiting services was well received by the respondents of our public input process, with the below comment as an example:

> "Communities need access to programs that support parenting skills, nutrition, and whole-body wellness. Schools should not be the primary source for teaching about parenting, health, and wellness."

Although one commenter indicated that connection of services needs to be a focus as well:

> "home visiting needs to be coordinated across home visiting programs and coordinated with other services"

Child Welfare Disparities
The Child Abuse and Neglect Issue Brief created because of the Title V Needs Assessment process clearly identified disparities between racial groups in NE when looking at alleged and substantiated child abuse and neglect rates. As a result, the Division of Children and Family Services committed to analyzing data to further describe existing disparities. DCFS found that in certain locations across NE, Native and multi-racial children have a rate of screened in reports at least twice that of White children. Despite this, one encouraging finding is that American Indian/Alaska Native families were represented in the Community Response population at a significantly higher percentage as compared to the Alternative Response population (10.3% vs 2%), with the same situation existing for Black families, though showing less difference between the programs (12% vs 8.6%). Community Response is the local system of supports and services for vulnerable families intended to prevent unnecessary entry into the child welfare system, while Alternative Response is a program offered to lower risk families that have already entered the child welfare system. Additionally, evaluation of the child well-being collaboratives has shown that people participating in Community Response made significant improvements in the areas of Concrete Supports and Resilience in particular, but generally improved Protective Factors in most measured areas. The DCFS has used this data to support an application for Family Support through Primary Prevention funds from the federal Children's Bureau, which if awarded will provide the opportunity to further evaluate the prevention model and spread successful interventions statewide.

Priority: Access to Preventive Oral Health Care Services
2022-2023 Objectives and Proposed Strategies

Objective CH5a: By 2025, increase the percent of children ages 1 to 17 years who receive preventive oral health care services

Strategy CH5a(1): The DHHS Office of Oral Health will identify needs for translation of existing health literate oral health education materials

Strategy CH5a (2): The Office of Oral Health will distribute dental health starter kits in the population and report evaluation measures of the project

Strategy CH5a (3): The DHHS Office of Oral Health and Dentistry (OOHD) will analyze data collected during the statewide Oral Health Survey

Discussion of Activities for this Objective – Relevance to Identified Priority
During 2021, the DHHS Office of Oral Health and Dentistry (OOHD) conducted a scan of translation needs including identifying languages to translate educational materials to and identifying which oral health educational materials to translate. Increasing the number of languages oral health materials are available in will increase the knowledge of families in Nebraska about the importance of oral health and the need to get preventive oral health services for their children. For the upcoming year, OOHD will reach out to community partners to determine needs around quantity, etc. and move towards translating and distributing materials.

Distributing Nebraska Early Dental Health Starter Kits to families of children birth to age five helps to educate these families not only about the importance of daily oral hygiene, but also provides examples of age-appropriate oral hygiene tools to use. Increased understanding of the need for preventive oral health care leads to guardians taking their children in for routine dental care and the establishment of a dental home. In addition, the Nebraska Early Dental Health Starter Kits contain a listing of Dental Public Health Clinics in Nebraska where families can access lower cost oral health care services. Title V will continue supporting this activity in the upcoming year.

During 2022, the OOHD conducted a basic screening survey of Head Start and third graders across Nebraska to obtain updated surveillance data. With the state survey completed, the Office of Oral Health and Dentistry will look at trends for the two age populations related to the number of children with caries experience, those who have received previous dental treatment, the urgency on needed dental treatment, and numbers of third grade children with sealants. Additionally, OOHD will report out results in a document drafted and disseminated to stakeholders and the public. This information allows the OOHD to monitor where preventive services are provided across Nebraska and identify where adjustments to program activities need to be made. OOHD also uses this data when applying for additional funding to help support program activities.

One continuing challenge for Nebraska in this area is the shortage of dental health professionals across the state. This is not a new problem, and there has been significant effort to expand the available dental health workforce in rural areas, primarily using public health hygienists. Nebraska is unique in that a Public Health Authorization allows hygienists to offer preventive services without requiring a dentist on-site. Title V has supported the NDHHS Office of Oral Health and Dentistry in efforts to grow the capacity for public health hygienists across the state and will continue this support into the 2022-2023 year. This aligns with what stakeholders would like to see, as shown by these comments received during the public input process:

> "I think a better use of funding for priorities would be to fund dental health professionals especially those who work in public health and can provide services along with oral health education to populations who need this care."

> "…the oral health objectives fall…short. Public health dental hygienist are actively doing many of these things already. We are taking time to educate parents and children and offering preventive services that are making a difference. Consider funding support of these PH dental hygienists that are in the trenches working already!!"

Though the supportive role of Title V is not be as readily visible to stakeholders (i.e. not a specific strategy in the action plan), this is good confirmation that Title V is moving the direction that stakeholders feel is important.

2. Alignment of planned activities with annual needs assessment updates

Priority: Child Abuse Prevention
Stakeholders in the 2020 Needs Assessment recognized not only the problem of child abuse, but the opportunities for prevention services embodied in the Families First Prevention Act, the collaborative Bring Up Nebraska effort, and evidence-based home visiting such as the Healthy Families America programs funded by N-MIECHV. Stakeholders advocated for universal home visiting services for all families, and in general increased family supports help children.

Alignment: Planned activities for 2022-2023 are aligned with the needs assessment findings and recommendations of stakeholders. Title V will continue collaborative relations with state and systems-level partners to support infrastructure development for expanding home visiting services statewide through N-MIECHV. The considerable interest among child advocates in the state as to data showing disparities (by race/ethnicity, gender, and/or geographic status) in child welfare involvement of families has been leveraged for a grant application that, if funded, could enhance prevention work, and continue efforts to reduce rates of child abuse/neglect.

There are no new findings to update the needs assessment in this priority area.

Priority: Access to Preventive Oral Health Care Services
When stakeholders selected this priority in 2020, they were well-aware that dental health issues are among the most chronic health problems for children. The Office of Oral Health at DHHS is an active partner with Title V in needs

assessment activities. Stakeholders particularly pointed to the preservation, if not expansion, of public health dental services, particularly those available to children at school, and to low-income families, pointing to existing disparity between urban and rural access to dental services for children.

Alignment: Activities proposed for 2022-2023 are consistent with findings and recommendations of the Needs Assessment. The Office of Oral Health indicated a need for additional translated materials to reach all families in Nebraska with prevention information. The distribution of dental kits is a measure of reach in the population.

There are no new findings to update the needs assessment in this priority area.

3. Emerging new priorities taking precedence over the established priority needs

Mental and Behavioral Needs of Families and Children, with and without special health care needs
As discussed in other areas of this application, Title V, along with stakeholders and advocates statewide, are acutely aware of the many ways mental health issues are manifest in all MCH populations in Nebraska. The combination of social and health vulnerabilities existing prior to the onset of the pandemic with continued stressors felt by not only pandemic-related effects but additional challenges such as rising inflation have meant little relief for Nebraska families. Of note, during the public input process, this view was echoed by a Nebraska respondent, saying, "Child abuse prevention and support should be a priority with the stress families are under related to Covid. Mental health programs and suicide prevention needs to be a priority due to increasing numbers and stress due to social isolation and Covid."

Title V MCH sees there is a role for the block grant to be a committed and invested asset for the state to meet these needs particularly focusing on the most disadvantaged and disproportionately affected families. This work does not displace the established priority needs, however, are noted as they will involve Title V MCH in the Child Health Domain in the coming year.

4. Relevance of ESM to selected NPM, changes in ESM

Priority: Access to Preventive Oral Health Care Services
NPM: Percent of children ages 1-17 years with a preventive dental visit in the past year.
ESM: The percentage of children in the Open Mouth survey from rural and underserved communities (new)

In April 2021, Nebraska was provided with the ESM Report from MCH Evidence Center for the state. The MCH Evidence Center assesses ESMs aligned to NPMs for the degree to which they are supported by evidence, and through the lens of Results-based Accountability. For the Child Health Domain, the number of sites participating in the dental kit project aligns with the Emerging MCH Best Practice strategy of Caregiver/Parent Education/Counseling. The ESM is an effective measure of reach, which could be strengthened by using a denominator (total # of relevant group addressed) to show percentage.

In addition to assigning ESM to at least one Priority in each Population Domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measures. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlights inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Priority: Child Abuse Prevention		
	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How did Title V support analysis of disparities among families involved in child welfare?	How much did N-MIECHV programs expand?
How well did we do it?	Are there actionable findings identified through data?	How did communities with new N-MIECHV programs provide additional support for prevention and early identification/intervention strategies?
Is anyone better off?	Did recommendations get implemented?	How many new families received Home Visiting services because of expansion?

Results Based Accountability (RBA) measures Priority: Access to Preventive Oral Health Care Services		
	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How many Dental Kits were distributed? How many materials were translated?	How many children participated in the Oral Health survey?
How well did we do it?	Who received the dental kits and translated materials? Did we reach the families who need it the most?	What findings came out of the Oral Health survey data analysis?
Is anyone better off?	Can we measure an improvement in dental care – either in at-home practices or in accessing care from a professional?	How do the findings of the Oral Health survey compare with the results of the previous study?

5. Are changes needed in the established SPMs and SOMs, if applicable

Priority: Child Abuse Prevention
SPM: The rate of substantiated reports of child abuse and neglect per 1,000 children ages 1-9 years
ESM: None

The SPM is aligned with the Priority, and further is copied almost exactly from the Issue Brief drafted by stakeholders during the Title V Needs Assessment. Stakeholders also expressed concern with perceived disproportionality reflected in child welfare cases, with minority families suspected to be disproportionately reported, and investigated, by child welfare authorities. Additional strategies in this area should include an equity lens to comprehensively address Child Abuse Prevention.

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plans for this domain is shown in the tables below.

Priority: Child Abuse Prevention 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Expand N-MIECHV Home Visiting • Learn more about disparities in child welfare	• Started • Started
Year 2	• Expand N-MIECHV Home Visiting • Learn more about disparities in child welfare	• Sustain • Done
Year 3	• Expand N-MIECHV Home Visiting. • New: Title V staff will work with the Division of Children and Family Services to further evaluate Nebraska's Community Well-Being prevention model and its ability to address social determinants of health and increase protective and promotive factors within families and communities	• Sustain • Ready
Year 4	• Expand N-MIECHV Home Visiting. • Data to Action on disparities in child welfare	
Year 5	• Evaluate N-MIECHV Home Visiting Expansion • Evaluate Action on disparities in child welfare	

In the priority area of Child Abuse Prevention, with the data review complete the new strategy is to further evaluate the preventive model in NE and its ability to support vulnerable families. This work will be significantly enhanced if the submitted grant application is funded.

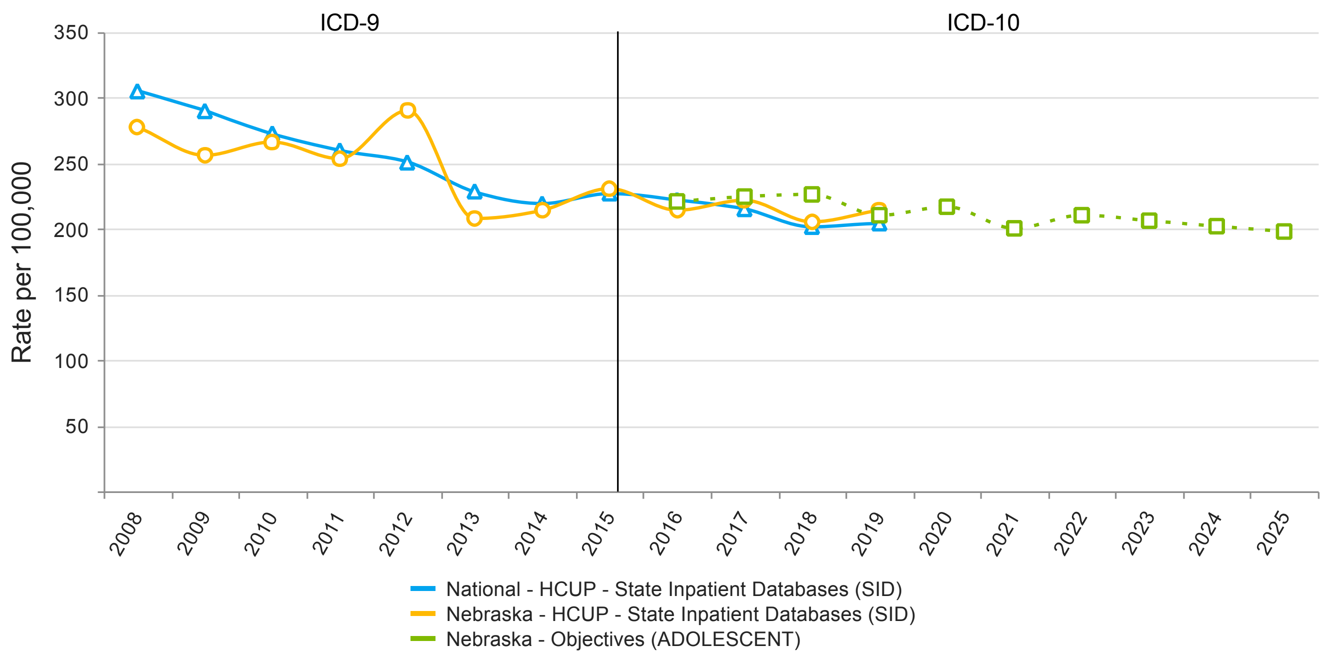
Priority: Access to Preventive Oral Health Care Services 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Oral Health Program Review materials • Oral Health Program distribute dental kits • Plan statewide oral health survey	• Started • Interrupted
Year 2	• Oral Health program Update/Translate Materials • Oral Health Program distribute dental kits • Plan statewide oral health survey	• Ready • Ongoing • Ready
Year 3	• Oral Health Program distribute dental kits • Conduct statewide oral health survey	• Ongoing • Ongoing
Year 4	• Oral Health Program distribute dental kits • Data analysis statewide oral health survey	
Year 5	• Evaluate Oral Health Program outreach with dental kits • Disseminate statewide oral health survey	

In the priority area of Access to Preventive Oral Health Care Services, there are no changes proposed for the action plan in 2022-2023.

Adolescent Health

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	224.4	226.1	210.2	216.7	200.3
Annual Indicator	230.7	214.5	221.2	204.9	214.6
Numerator	447	559	582	543	572
Denominator	193,724	260,644	263,114	265,061	266,584
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	210.3	206.1	201.9	197.9

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - The number of schools participating in the "Teens in the Driver Seat" program.

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			38	38	38
Annual Indicator			33	33	22
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	27.0	32.0	37.0	42.0

State Performance Measures

SPM 3 - The rate of chlamydia infections reported per 100,000 youth (age 15-19).

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1,883.9
Annual Indicator	1,922.4	1,776	1,805.1
Numerator	2,550	2,361	2,500
Denominator	132,645	132,940	138,497
Data Source	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1,768.9	1,733.5	1,698.8	1,664.9

SPM 4 - The death rate due to suicide per 100,000 youth (age 10-19).

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			7.4
Annual Indicator	8.8	7.5	7.8
Numerator	70	60	63
Denominator	794,759	798,225	810,807
Data Source	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census
Data Source Year	2017-2019	2018-2020	2019-2021
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.6	7.5	7.3	7.2

State Action Plan Table

State Action Plan Table (Nebraska) - Adolescent Health - Entry 1

Priority Need

Motor Vehicle Crashes among Youth

NPM

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objectives

AD6a: By 2025 reduce the number of crashes among adolescent drivers age 14 to 19 years to prevent injury and death by addressing disparities in minority and rural populations.

Strategies

AD6a(1): The DHHS Office of Injury Prevention will expand the scope of the Teens in the Drivers Seat survey to include non-participating schools, in order to enlarge the data and understanding of Nebraska youth driving behaviors.

AD6a(2): The DHHS Office of Injury Prevention will expand its distribution plan for safe driving materials including Graduated Drivers Licensing to community cultural centers other non-school settings.

AD6a(3): The DHHS Office of Injury Prevention will incorporate a health equity lens in Teens in the Drivers Seat expansion by using a Health Equity Planner in data collection and assessment to identify inequalities and social determinants of health.

ESMs	Status
ESM 7.2.1 - The number of schools participating in the "Teens in the Driver Seat" program.	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Nebraska) - Adolescent Health - Entry 2

Priority Need

Sexually Transmitted Diseases among Youth

SPM

SPM 3 - The rate of chlamydia infections reported per 100,000 youth (age 15-19).

Objectives

AD7a: by 2025, decrease the rates of chlamydia and gonorrhea among youth in Nebraska by addressing disparities among racial/ethnic and urban/rural groups.

Strategies

AD7a(1): The DHHS Adolescent Reproductive Health Program will continue the process of testing, refinement, and dissemination of the Conversation Starters project.

AD7a(2): The DHHS Adolescent Reproductive Health Program will facilitate the evaluation of Making a Difference (MAD) pilot implementations and seek to renew, as appropriate.

AD7a(3): The DHHS Adolescent Reproductive Health Program will continue the current Adolescent Health Subawards with assessment/determination of changes to be made following the current period of performance.

State Action Plan Table (Nebraska) - Adolescent Health - Entry 3

Priority Need

Suicide among Youth

SPM

SPM 4 - The death rate due to suicide per 100,000 youth (age 10-19).

Objectives

AD8a: by 2025, reduce suicide rates among youth by: increasing access to early intervention services and education; addressing stigma; promoting protective factors (resilience, asset-building, family engagement) and reducing risk factors.

Strategies

AD8a(1): Title V will participate in key collaborations: the Nebraska Statewide Suicide Prevention Coalition, the Garrett Lee Smith Suicide Prevention project management team, the Nebraska Partnership for Mental Health Care Access in Pediatrics, the Behavioral Health System of Care, and the Society of Care.

ADOLESCENT HEALTH DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Adolescent Health Domain** for the period October 1, 2020 to September 30, 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the Adolescent Health Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Motor Vehicle Crashes among Youth.**
  NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10-19 years.
  ESM: The number of schools participating in the “Teens in the Driver Seat” program.

- **Sexually transmitted disease among Youth.**
  SPM: The rate of chlamydia infections reported per 100,000 youth ages 15-19 years.
  ESM: None.

- **Suicide among Youth.**
  SPM: The death rate due to suicide per 100,000 youth ages 10-19 years.
  ESM: None.

1. Context: The State of the Adolescent Population Domain

The Adolescent Health Domain dominated the Title V 2020 Needs Assessment in the respect that participants and stakeholders selected three population health priorities in this Domain, the most priority statements of any of the population domains. Stakeholders are tuned into both the potential and the risks of this period, and are committed to producing more positive and equitable youth outcomes.

In selecting Motor Vehicle Crashes among Youth as a priority, stakeholders responded to the fact the MVC are the leading cause of death among youth, as well as evidence of existing disparities, with males, rural youth, and American Indian youth most disproportionately affected. Stakeholders also identified that effective intervention strategies exist, including Nebraska’s Graduated Drivers Licensing (GDL) laws; peer-to-peer education such as Teens in the Driver Seat (TDS); and the importance of parental involvement in their teen’s developing driver behaviors. In 2015-2020 a priority in the Adolescent domain has been Injury Prevention, with a focus on motor vehicle crashes.

Sexually Transmitted Diseases among Youth was also a population health priority in the 2015-2020 Needs Assessment cycle in Nebraska, and stakeholders remained concerned about the prevalence, disparities, and life course implications of sexually transmitted diseases on youth and related risk behaviors. The issue brief created by stakeholders on this topic speaks to impacts on both physical and mental well-being of youth affected, particularly Black youth. During the 2015-2020 period, Title V focused primarily on activities and strategies involving improved school referral systems for sexual health issues of youth at school; improved communication between youth and trusted adults on sensitive topics; and youth-friendly clinics. In the 2020 Needs Assessment, stakeholders point to evidence-based teen pregnancy prevention programs that may have the secondary effect of also reducing STDs. Youth-serving organizations working on Positive Youth Development (PYD) strategies, including the Teen Outreach Program (TOP), which is sponsored by the DHHS Adolescent Health Program in several sites, are identified as promising venues in which to engage with youth. Stakeholders also pointed to the role of schools in offering standards-based sexuality education curricula, and the role of effective parent-child communication in mitigating youth risk behaviors.

Suicide among Youth is trending upward and has been a top cause of death in Nebraska for young people. Stakeholders bringing forward the issue brief for this priority expressed concern not only at the preventable loss of life represented by each suicide, but also at the magnitude of impacts secondarily occurring in families, among friends, and impacting schools and communities. At the time of the 2020 needs assessment, stakeholders worked with the most recently available data about youth suicide, compiled by MCH Epidemiology. However, since that time, much more data and anecdotal evidence have emerged regarding escalating mental and behavioral health needs among youth, of which suicidality is only one. The total effects of pandemic-related disruptions and losses on the well-being of MCH populations passing through critical and sensitive periods of the lifespan will not be known fully for some time.

Stakeholders noted the opportunity for Title V to align with and amplify the Nebraska State Suicide Prevention Plan developed collaboratively in the state for the period 2016-2020. There are several funding streams in Nebraska addressing

this critical issue and part of Title V's work is to a) help align and promote mutual reinforcement of efforts statewide and b) advocate for intentional efforts to disrupt disparities in suicide. Stakeholders also urged effective strategies through workforce development, such as training school personnel and enhancing training of mental and behavioral health professionals as well as others including Community Health Workers.

For the 2020-2025 Needs Assessment, Title V worked with the Nebraska Association of Local Health Directors to bring forward a summary of current priorities identified through the Community Health Needs Assessment and Community Health Improvement Plans that local public health departments regularly undertake in their respective jurisdictions. The summary allowed stakeholders to consider degree of alignment with local priorities when determining which issues should be included in the final list of Title V priorities for the upcoming five-year period.

Five of seventeen local health departments have prioritized motor vehicle safety, unintentional death, and injury prevention as priorities. One health department prioritized teen pregnancy prevention.

Noteworthy to the population domain priority of Suicide among Youth is the fact that fifteen of seventeen local health departments in Nebraska have identified Mental Health issues as a priority. Eight local health departments have identified access to preventive care and screenings as a priority as well.

Nebraska Title V addresses adolescent health priorities in the state through the combined capacity of the DHHS Adolescent Health Program, Injury Prevention, Reproductive Health, School Health, and STI/STD programs, all of which partner with a variety of external entities across the state to accomplish their goals.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Motor Vehicle Crashes among Youth.
2020-2021 Objectives and Strategies

Objective AD6a: By 2025 reduce the number of crashes among adolescent drivers ages 14-19 years to prevent injury and death by addressing disparities in minority and rural populations.

Summary of Programmatic Efforts
In 2020, planned strategies for this objective focused on the ongoing work of the Office of Injury Prevention at DHHS, and approaches to expand the reach of the program by expanding the scope of the Teens in the Driver Seat survey to include non-participating schools in order to enlarge the available data set to better understand diversity in driver behaviors and better localize prevention strategies. The Injury Prevention program also agreed to address the need for health-literacy and translations in prevention education materials in order to reach a wider and more diverse audience of families. Third, the Injury Prevention Program planned a campaign to reach out to more community cultural centers and non-school settings, in order to reach a broader and more diverse audience of parents of teen drivers, some of whom might be quite unfamiliar with U.S. driving regulations and practices for adolescents.

In practice, the Injury Prevention Program worked with a total of 16 schools, 12 participating in the Teens in the Driver Seat program, and 4 additional schools agreeing to participate in the survey. An informational card for parents about Nebraska's Graduated Driver's License requirements for teen drivers was translated into Spanish. In April 2021, the Injury Program recognized a total of eleven schools with All Star and Outstanding recognitions. One non-school community program for youth joined Teens in the Driver Seat.

Use of Evidence-based or Evidence-informed Approaches in this Priority

At the website, www.mchevidence.org, the evidence review for injury prevention does not focus on motor vehicle crashes to a useful degree to assess strength of evidence in interventions. In the What Works for Health Directory of County Health Rankings and Roadmaps, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health the topic of Community Safety encompasses safe transportation, within which Graduated Drivers Laws are shown as being supported by scientific evidence of effectiveness. All other evidence-supported interventions are of a policy, not educational, nature.
According to the CDC (https://www.cdc.gov/motorvehiclesafety/seatbelts/facts.html 12/23/2019) for adults and older children (who are big enough for seat belts to fit properly), seat belt use is one of the most effective ways to save lives and reduce injuries in crashes. A total of 23,714 drivers and passengers in passenger vehicles died in motor vehicle crashes in 2016. More than half (range: 53%-62%) of teens (13-19 years) and adults aged 20-44 years who died in crashes in 2016 were not buckled up at the time of the crash.

For Teens in the Driver Seat as an intervention, the TDS website (https://www.t-driver.com/) cites the following: Teens in the Driver Seat® program surveys show risk awareness levels increasing by up to 200 percent. Cell phone use at Teens in the

Driver Seat® program schools has been shown to drop by 30 percent, and seat belt use has gone up by over 14 percent. A rigorous 20-county control group analysis for Texas indicates the program results in an average decrease of 14.6 percent in injury and fatal crashes (total) where the program has been sustained for three or more years.

Priority: Sexually transmitted disease among Youth.
2020-2021 Objectives and Strategies

Objective AD7a: By 2025, decrease the rates of chlamydia and gonorrhea among youth in Nebraska by addressing disparities among racial/ethnic and urban/rural groups.

Summary of Programmatic Efforts
In 2020, a robust slate of strategies was set, involving the DHHS STD Program, the Adolescent Health Program, and the Reproductive Health Program mirroring the robust intent of stakeholders in identifying this priority, especially considering disparities. The STD program would have the opportunity to review materials to enhance cultural and linguistic appropriateness for diverse youth audiences and their caregivers and educators. The Adolescent Health Program, despite pandemic disruptions and interruptions, continued to prepare for collaborative approaches to completing a set of Conversation Starters for youth-serving adults to use with youth around sensitive topics, including racism and bias. Another project from the previous Title V 5-year Needs Assessment was completed and disseminated during the period, the Youth Friendly Clinic Recommendations. Also named as a strategy was the possibility that Title V might contribute funding for additional sites to participate in the evidence-based TOP positive youth development program. Finally, Title V continued to support the process of re-imagining the Reproductive Health Program as a vehicle to support the sexual health and well-being of adolescents, with Title V positioned to make subawards to youth-serving organizations.

Due to participation from several program areas, and particularly the leadership of the Adolescent Health and Reproductive Health programs, progress was made on all but one front. The Conversation Starter project moved forward, and the Youth Friendly Clinic recommendations were finalized, and plans put in place to review/revise annually to ensure medical accuracy. Pandemic-related restrictions on in-person meetings prevented TOP expansion to occur, however the ongoing strategic planning in the Adolescent/Reproductive Health program identified other more flexible evidence-based curriculum which could be implemented as an alternative to TOP in some settings. Subawards were again issued in 2021 for youth-friendly clinic projects through the Reproductive Health Program.

Use of Evidence-based or Evidence-informed Approaches in this Priority
When considering the use of evidence-based practice in the priority area of reducing STDs among adolescents in Nebraska, the resource www.mchevidence.org offers evidence primarily focused on adolescent well-visits for preventive health care, which may or may not be a visit inclusive of, rather than specific for, reproductive and sexual health services. The summary of evidence includes the following:
"The following trends emerged from analysis of peer- reviewed evidence...
- *Expanded insurance coverage appears to be effective.*
- *Patient reminders appear to be somewhat effective.*
- *There is insufficient evidence of the effectiveness for school-based health centers*."

In the evidence review of the County Health Rankings "What Works" feature (https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies?search_api_views_fulltext=sexual%20health&items_per_page=10&page=1) there is strong evidence supporting the following interventions to promote sexual health of adolescents:
- *Comprehensive risk reduction sexual health education (scientifically supported);*
- *School-based health centers (scientifically supported);*
- *Condom availability programs (scientifically supported);*
- *Behavioral interventions to prevent HIV and other STIs (individual, group, and community-level interventions to provide education, support, and training that can affect social norms about HIV and other STIs – scientifically supported);*
- *Extra-curricular activities for social engagement (scientifically supported); and*
- *School-based social and emotional instruction (scientifically supported);*

A review of the scientifically supported interventions above suggest the use of Conversation Starters to promote behavioral interventions would be plausibly related to evidence-based practice. The TOP curriculum as developed and adapted by

Wyman is an evidence-based curriculum, see:https://wymancenter.org/top/

In the Adolescent Reproductive Health Subawards, subrecipients utilize a mix of approaches, some of which may be evidence-based. The Reproductive Health Program issued a total of six awards in 2021, including rural and urban communities, for the purpose of increasing adolescent use of reproductive health services. Subrecipients were specifically asked to test and use the Youth Friendly Clinic resources which were evidence-based.

Priority: Suicide among Youth.
2020-2021 Objectives and Strategies

Objective AD8a: By 2025 reduce suicide rates among youth by increasing access to early intervention services and education, addressing stigma, promoting protective factors, and reducing risk factors.

Summary of Programmatic Efforts
Many Nebraska stakeholders are deeply concerned by youth suicide in the state. The prioritization of youth suicide was underscored with a particular sense of urgency. Strategies included working in the setting of schools, through the School Health Program, building on work begun previously addressing the gaps and assets in screening and referral of students; training of school personnel; needs for health literate and culturally- and linguistically-appropriate materials and communications for diverse consumers; referrals to community resources; school-family partnerships; and trauma-informed/restorative practices.

As noted, Title V does not work alone in this space, but alongside numerous systems partners and resources. Specifically in order to assure that Title V efforts would be mutually-reinforcing and complementary with other system leaders, Title V committed during this period to continuing to be an active and present member of the Nebraska Statewide Suicide Prevention Coalition, as well as taking a new spot as a member of Nebraska's Garrett Lee Smith Suicide Prevention Grant project management team. Through these collaborations alone, Title V has been able to advocate for statewide reach of efforts, as well as a greater equity-focus, including greater outreach to promote training for Community Health Workers in such areas as suicide prevention, mental health first aid, and motivational interviewing.

Aware that American Indian youth suffer significant disparity in this area, Title V also identified an intent to work more closely with the Society of Care in Nebraska. https://societyofcare.org/

The experience of the School Health Program proved fruitful in planning ensuing activities. There are several partners working at the systems level and also at the local school level to reduce risk of suicide and build protective factors. The School Health Program identified that School Nurses were often not included in these projects, yet interact with students with mental and behavioral health needs frequently. The School Health Program launched a number of educational events and communication activities for school nurses to improve knowledge of and communication about suicide prevention resources.

As a footnote, while Title V typically issues subawards to local entities for maternal and child health promotion activities, in addition to resources dedicated to priorities as described here, in 2020-2021 four local subawards named suicide prevention as a priority concern in their workplans. In addition, during this period in early February 2021, the nation's Surgeon General released a Call to Action to Implement the National Strategy for Suicide Prevention.

Use of Evidence-based or Evidence-informed Approaches in this Priority
The website www.mchevidence.org does not provide an evidence framework for mental and behavioral health issues of youth, nor suicide prevention.

Referring to County Health Rankings and Roadmaps, What Works feature, there is a category of strategies around the topic of Family and Social Support that are supported by evidence and pertain to socially and emotionally healthy youth. These include:

- Youth peer mentoring
- Extracurricular activities for social engagement
- Outdoor experiential learning
- Youth leadership programs

At the same resource, Crisis Lines and Mental Health First Aid are also evidence-supported strategies.

Perhaps most significantly the Suicide Prevention Resource Center is an important resource for evidence-based best

practices in suicide prevention. Here, resources at use in Nebraska schools include Kognito online resources, QPR Gatekeeper Training, and SOS (Signs of Suicide). https://www.sprc.org/resources-programs

3. Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Motor Vehicle Crashes among Youth.
NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10-19 years.
ESM: The number of schools participating in the "Teens in the Driver Seat" program.

Alignment:
In this priority, Nebraska makes use of traditional alignment between hospitalization for non-fatal injury by age group and the priority topic of motor vehicle crashes involving youth drivers. For the ESM, Nebraska draws on the evidence-based model Teens in the Driver Seat, by collaborating with the DHHS Injury Prevention Program, and measuring the extent to which Nebraska schools are participating in the program in a given year.

Priority: Sexually transmitted disease among Youth.
SPM: The rate of chlamydia infections reported per 100,000 youth ages 15-19 years.
ESM: None.

Alignment:
Nebraska uses an SPM, or state performance measure, in the priority area of sexually transmitted disease, and measures the incidence of chlamydia infections in a period for an age group of youth, the majority of whom are female. Nebraska's strategies in this priority largely focus on behavioral interventions, rather than looking at youth entering a point of care. There is no ESM associated with this priority.

Priority: Suicide among Youth.
SPM: The death rate due to suicide per 100,000 youth ages 10-19 years.
ESM: None.

Alignment:
Alignment between the priority and SPM in this area is starkly clear. Missing is Nebraska's disparities between racial and ethnic groups in this priority. There is no ESM assigned to this priority.

4. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures in an effort to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA has specifically highlighted inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Motor Vehicle Crashes among Youth		
	Proposed 2020-2021	*Achieved 2020-2021*
How much did we do?	How many schools participated in the 2020-2021 Teens in the Driver Seat survey?	12 high schools and two middle schools, plus two additional non-TDS schools.
How well did we do it?	How many materials were newly translated?	1 – Spanish version of GDL info for parents
Is anyone better off?	Has the Injury Prevention Program formed new relationships with cultural centers as a means to reach diverse parents?	Communication with a program for multicultural youth did not result in TDS enrollment.

Discussion – Other Programmatic Impacts
The Injury Prevention Program carries out activities with Title V as well as CDC funding.

Results Based Accountability (RBA) measures STDs Among Youth		
	Proposed 2020-2021	*Achieved 2020-2021*
How much did we do?	How many STD materials were reviewed and translated?	No reported progress.
How well did we do it?	What was the level of participation in testing/evaluating the Conversation Starters? Was the evaluation of the Youth Friendly Clinic recommendations completed?	There was no convening during the period due to the pandemic. Clinic staff reviewed and approved the recommendations prior to completion. No youth were involved in review.
Is anyone better off?	Were additional TOP clubs initiated with Title V support?	No. Pandemic diminished TOP activity during the period.

Discussion - Other Programmatic Impacts
This activity area seems to have been particularly sensitive to impacts brought about by the COVID pandemic and resulting disruptions, which prevented school and after-school routines, disrupted clinic access, and disrupted the operations of numerous community providers.

Results Based Accountability (RBA) measures Suicide Among Youth.		
	Proposed 2020-2021	*Achieved 2020-2021*
How much did we do?	How frequently was Title V present at Nebraska Suicide Prevention Coalition meetings and Garrett Lee Smith meetings	90%
How well did we do it?	Was Title V able to bring an equity-focus to youth suicide prevention? If so, how?	Yes. Title V Needs Assessment Issue Brief documents disparities for stakeholders. In meetings, Title V speaks to literacy and CLAS aspects of prevention materials (cultural and linguistic appropriate standards).
Is anyone better off?	Has Title V identified a gap we can help fill?	Yes. Advanced suicide prevention training for school health professionals; suicide prevention training for community health workers; statewide scope and reach

Discussion - Other Programmatic Impacts
The urgency of work in this area has escalated as a result of life course disruptions at critical and sensitive periods for many youth, children, and families during the pandemic. Because Title V in Nebraska serves as lead agency for Nebraska's Pediatric Mental Health Care Access Program (2021-2023) there has been opportunity to leverage additional resources and supports for the mental and behavioral well-being of children and families, while sustaining an equity-focus.

5. Challenges and Emerging Issues

Suicide, depression, and anxiety
Numerous sources speak to the impact of the pandemic and subsequent loss of social, educational, and economic supports for many families, on adolescents. One of the sources unique to Nebraska is the NEP-MAP Family Survey. NEP-MAP is the name of Nebraska's Pediatric Mental Health Care Access Program. Families relate their concerns about the

mental state of children during the pandemic. See the report at www.dhhs.ne.gov/NEPMAP

Consequences of limited access to STD and contraceptive services
Similarly, recent anecdotal evidence shows that STDs are on the rise among youth due to disruptions in access to health services, as well as increasing risk behaviors.

6. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

The Youth-friendly clinic environments work has met with a ready and enthusiastic audience in family planning clinics. This activity is deemed to have promising merit and has been built into subrecipient activities by the Reproductive Health Program. However, the scale and scope of the intervention activity with six subawards is small and unlikely to have population impact.

In the case of Nebraska's priority statement of suicide among youth, most advocates agree that saving of one life is a worthy impact, and that working towards zero suicide is the goal. In Nebraska, efforts are continuously occurring at the systems, school, and individual levels.

Adolescent Health - Application Year

ADOLESCENT HEALTH DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **Adolescent Health Domain** for the period October 1, 2022 to September 30, 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the Adolescent Health Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Motor Vehicle Crashes among Youth**
  NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19 years
  ESM: The number of schools participating in the Teens in the Driver Seat program

- **Priority: Sexually Transmitted Diseases among Youth**
  SPM: The rate of chlamydia infections reported per 100,000 youth ages 15-19 years
  ESM: None

- **Priority: Suicide among Youth**
  SPM: The death rate due to suicide per 100,000 youth ages 10-19 years
  ESM: None

1. Description of Planned Activities

OVERVIEW OF THE ADOLESCENT HEALTH DOMAIN
Working in the Adolescent Health domain has always involved a certain amount of programmatic agility, as ideally there will be a progression of youth partners and their allies as years pass. Being adaptable to trends and unexpected developments is part of the joy of adolescence and for those who support them. In Nebraska, Title V works to address population health priorities of the Adolescent population by leveraging the assets of the Nebraska Injury Prevention Program, the Adolescent Health Program, and the Reproductive Health Program.

The Nebraska Injury Prevention Program
The Nebraska Injury Prevention Program is a natural ally for Title V in addressing the priority of Motor Vehicle Crashes among Youth. The Injury Prevention Program deploys the Teens in the Driver Seat program in Nebraska and has a long history of working to promote motor vehicle safety for children and youth, with many relevant partners across NE including the NE Department of Transportation, NE State Patrol, and engaged schools. In the priority of Motor Vehicle Crashes, the Injury Prevention Program takes the lead, and collaborates with the School Health Program.

The Adolescent Health Program
In Nebraska, the Adolescent Health program traces its origins and identity primarily to pregnancy prevention and abstinence training, transforming towards Positive Youth Development programming approximately a decade ago. Today, the Adolescent Health Program is funded jointly by Title V and by funding from the Adolescent Pregnancy Prevention Program, Family and Youth Services Bureau Administration for Children and Families, US Department of Health and Human Services. With Personal Responsibility Education Program (PREP) and Sexual Risk Avoidance Education (SRAE) funding, the Adolescent Health Program implements the Teen Outreach Program® (TOP®), intervention in schools, after-school programs and community-based settings. One significant impact of COVID was school disruption and interruption of after-school services and clubs for youth. In response, the Adolescent Health program staff are exploring other evidence-based curricula that address the Title V priority of Sexually Transmitted Diseases among Youth. One specific curriculum, Making A Difference (MAD), is currently being implemented as a pilot and, if successful, is expected to continue with Title V support. The Nebraska MAD program is a 9 (nine) session program that can be delivered in a variety of timing structures and settings.

The Reproductive Health Program
In some ways like the Adolescent Health Program, the Reproductive Health Program has been undergoing a recent transformation, growing away from a long history of managing Title X Reproductive Health funding in Nebraska (now housed with another grantee agency in the state), and transforming to positive promotion of life course reproductive well-being at a population health level, not focused on pregnancy prevention and direct services in a clinic setting.

In an organizational shift made during 2021, Title V combined the Adolescent and Reproductive Health programs, reflecting the strong focus of Reproductive Health activities during the young adult period. Strong priorities to encourage young people to become healthy before becoming pregnant, to engage in holistic programming discussing healthy relationships as well as individual health, and to support community partners delivering services in a youth-friendly way are now better reflected in

the joint vision and shared work of these two program areas.

Medicaid Expansion for young adults aged 19 and older
In addition to programmatic assets Title V can leverage to address population health priorities of adolescents, it is necessary to repeat here that Nebraska has expanded Medicaid, effective October 1, 2020, and more recently (effective October 1, 2021) collapsed an originally two-tiered system of benefits that included work and community participation requirements for some benefits. Now all enrollees into Medicaid Expansion, called Heritage Health Adult, will have the advantage of a full and uniform package of benefits without imposition of additional requirements.

This will allow young adults aged 19 and older who meet the income guidelines for Medicaid Expansion, to enroll in health insurance. Title V sees this as a major consideration in addressing access barriers and improving opportunity and resources for disadvantaged Nebraskans, including young adults who may have grown up in homes with limited access to medical, dental, and mental health services.

Impacts of COVID on Adolescents and Young Adults
Title V agencies, well-versed in the language of life course development theory may be among the most adept at speaking to the unintended and negative consequences of disrupted development, particularly during critical and sensitive periods of the lifespan, several of which are integral to the passages of adolescence and young adulthood. As a consequence of the COVID pandemic, many adolescents have experienced grief, loss, disruption, and lack of social supports at precisely key periods of emerging personality and competence.

Impacts of COVID are telling on adolescents in disrupted early career and academic paths; increased substance use; increased mental health issues; and loss of supports and opportunities. Having one's dreams dashed in adolescence can be particularly painful and damaging to the developing sense of self.

Priority: Motor Vehicle Crashes among Youth
2022-2023 Objectives and Proposed Strategies

Objective A6a: By 2025, reduce the number of crashes among adolescent drivers ages 14-19 years to prevent injury and death by addressing disparities in minority and rural populations

Strategy AD6a(1): The DHHS Office of Injury Prevention will expand the scope of
the Teens in the Driver Seat survey to include non-participating schools, to enlarge the data and understanding of Nebraska youth driving behaviors

Strategy AD6a(2): The DHHS Office of Injury Prevention will incorporate a health equity lens in Teens in the Driver's Seat Expansion by using a Health Equity Planner in data collection and assessment to identify inequalities and social determinants of health

Discussion of Activities for this Priority – Relevance to Identified Priority
In the 2022-2023 period, the Injury Prevention Program intends to increase the number of schools participating in Teens in the Driver Seat by five. Based on findings of surveys completed by non-TDS schools in 2021-2022, the Injury Prevention Program will increase targeted teen driver/passenger safety education outreach to urban schools and schools in areas with high rates of motor vehicle crashes. These activities show strong relevance to the priority to reduce motor vehicle crashes among youth.

Priority: Sexually Transmitted Disease among Youth
2022-2023 Objectives and Proposed Strategies

Objective AD7a: AD7a: by 2025, decrease the rates of chlamydia and gonorrhea among youth in Nebraska by addressing disparities among racial/ethnic and urban/rural groups

Strategy AD7a (1): The DHHS Adolescent Reproductive Health Program will continue to process of testing, refinement, and dissemination of the Conversation Starters project

Strategy AD7a (2): The DHHS Adolescent Reproductive Health Program will facilitate the evaluation of Making a Difference (MAD) pilot implementation and seek to renew as appropriate

Strategy AD7a (4): The DHHS Reproductive Health Program will identify project opportunities to promote sexual health among underserved, disproportionately affected groups

Discussion of Activities for this Priority – Relevance to Identified Priority
For the Conversation Starters project, the Adolescent Health program conducted two virtual workshops with stakeholders in the winter of 2022 to review and revise the draft starter questions. Once a final product is available, pilot pairs of adults/young people will be sought to test the starters. The team intends to work toward final distribution in early 2023.

For the selection of an evidence-based youth program to address STDs, the Adolescent and Reproductive Health program reviewed evidence-based curricula and selected Making A Difference (MAD), an evidence-based, abstinence approach to STD prevention to pilot in spring and summer of 2022. Program staff will assess the success and scalability of MAD with the intention to continue replication into 2023 through sub awardee relationships.

In 2021-2022, the Reproductive Health Program awarded Title V federal funds to eligible and qualified entities to engage adolescents up to 21 years of age, to increase utilization of reproductive health services. The initial period of performance ended March 31, 2022; renewals were issued for the period April 1, 2022 through March 31, 2023 to continue the work started through the initial awards to increase youth utilization of services.

Approaches geared towards working with community organizations seem to resonate with stakeholders – one respondent in the public input process said:

> "I hope there is commitment from the state (DHHS) to continue to allow MCH to fund organization who provide information to school students on STDs and reproductive health. Without such efforts the ability to meet the Y6 objective I think is not hopeful."

Priority: Suicide among Youth
2022-2023 Objectives and Proposed Strategies

Objective AD8a: by 2025, reduce suicide rates among youth by: increasing access to early intervention services and education; addressing stigma; promoting protective factors (resilience, asset-building, family engagement) and reducing risk factors

Strategy AD8a(1): Title V will participate in key collaborations: the Nebraska Statewide Suicide Prevention Coalition, the Garrett Lee Smith Suicide Prevention project management team, the Nebraska Partnership for Mental Health Care Access in Pediatrics, and the NDHHS Behavioral Health System of Care

Discussion of Activities for this Priority – Relevance to Identified Priority
As Title V entered work in this priority area of Suicide Prevention, it quickly became clear that there are numerous organizations working in this space, and numerous small prevention projects working regionally or with a cluster of school districts. Some partners have statewide interests, while others have regional or local interests. Title V's participation in these collaborative efforts is strongly identified with the priority to decrease rates of suicide as well as to build protective factors.

With the resignation of staff in the School Health program, and more leadership from the NE Department of Education in school health issues, Title V is in a transition period regarding school health work. Title V will retain expertise in child health issues in the school setting, however with the state School Health Nurse Consultant role leaving DHHS to NDE, Title V will no longer lead school health work in the same way that it had in the past. This provides an opportunity to refocus resources towards Title V priorities, particularly in the areas of mental/behavioral health issues – an area particularly relevant in this domain.

2. Alignment of planned activities with annual needs assessment updates

Priority: Motor Vehicle Crashes among Youth

When stakeholders met together in the 2020 Needs Assessment, they understood the effectiveness of Teens in the Driver Seat as peer-to-peer traffic safety education, as well as the significance of parent awareness of and involvement in their teen's safe driver education. The planned activities are aligned with the priority and effective. There is no change in the priority or strategies because of needs assessment updates.

Priority: Sexually Transmitted Diseases among Youth

In the 2020 Needs Assessment, stakeholders identified Title V investment in sexual health education and STD education would be effective in decreasing risk behaviors and infections, particularly when accompanied with policies and practices of youth-serving professionals that are medically accurate, developmentally appropriate, inclusive, and youth-friendly. The planned activities are aligned with the priority and effective. There are no changes in the priority or strategies because of needs assessment updates.

Priority: Suicide among Youth

When stakeholders addressed Suicide as a priority among adolescents in Nebraska, they expected Title V to stimulate statewide, intentional, and collaborative efforts to increase capacity across the state through training, increased prevention services, early interventions, and improved access to care. In 2022, there is evidence that the prevalence and severity of

mental and behavioral health issues in the adolescent population are increasing, further validating the priority. The planned activities are aligned with the priority and expected to be effective. There are no changes in the priority or strategies are a result of needs assessment updates.

3. Emerging new priorities taking precedence over the established priority needs

There are no new priorities taking precedence over the established priority needs in the adolescent health domain. The period of the pandemic has precipitated or exacerbated mental and behavioral health issues of all MCH populations, including youth. The approaches used in suicide prevention also are effective in addressing other issues of mental or behavioral health.

4. Relevance of ESM to selected NPM, changes in ESM

Priority: Motor Vehicle Crashes among Youth
NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19 years
ESM: The number of schools participating in the Teens in the Driver Seat program

In April 2021, Nebraska was provided with the ESM Report from MCH Evidence Center for the state. The MCH Evidence Center assesses ESMs aligned to NPMs for the degree to which they are supported by evidence, and through the lens of Results-based Accountability. For the Adolescent Health Domain, the report concludes there is moderate evidence for effectiveness corresponding to the NPM, considering alignment with the MCH Best Practice Strategy of "School-based Interventions". The ESM of participation in Teens in the Driver Seat is an effective measure of reach, which could be strengthened by using a denominator (total # of relevant group addressed) to show percentage.

In addition to assigning ESM to at least one Priority in each Population Domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measure. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures in an effort to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlight inclusion and equity-focused efforts that have been transforming Title V work.

	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How many schools and how many youth participated in the TDS survey?	Was the health equity planner implemented? What was its reach?
How well did we do it?	Were additional schools reached by TDS that weren't before?	Did the reach to youth expand to target populations?
Is anyone better off?	Did we gain needed insights from new data?	Did the rate of Motor Vehicle crashes decrease?

Results Based Accountability (RBA) measures Priority: Sexually Transmitted Diseases among Youth			
	Proposed for 2022-2023	*Proposed for 2022-2023*	*Proposed for 2022-2023*
How much did we do?	How many partner organizations were funded?	How many partner organizations implemented the new curriculum?	How many stakeholders participated in the development of the Conversation Starters?
How well did we do it?	Did the partner organizations reach youth with their proposed activities?	How many youth were served by the curricula focused on STDs?	How were the Conversation Starters revised based on input from diverse users and consumers?
Is anyone better off?	Was there any measurable change in behavior or outcomes?	Was there any measurable change in behavior or outcomes?	Was there any measurable change in behavior or outcomes?

	Proposed for 2022-2023
How much did we do?	Measure of Title V participation in statewide suicide prevention meetings.
How well did we do it?	What gap area is Title V helping address in statewide suicide prevention?
Is anyone better off?	Did more professionals get trained?

5. Are changes needed in the established SPMs and SOMs, if applicable

Priority: Sexually Transmitted Diseases Among Youth
SPM: The rate of chlamydia infections reported per 100,000 youth ages 15-19 years

Priority: Suicide Among Youth
SPM: The death rate due to suicide per 100,000 youth ages 10-19 years

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plans for this domain is shown in the tables below.

Priority: Motor Vehicle Crashes Among Youth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Collect data from schools that are/are not TDS schools • Distribute materials to schools via school nurses • Evaluate effectiveness of distribution.	• Done • Started
Year 2	• Teens in the Driver Seat outreach • School Health communication channels • Driver safety education materials for minority groups	• Sustain • Ongoing • Interrupted
Year 3	• Teens in Driver Seat • School Health communication channels • Implement Health Equity planner	• Ongoing • Done • Planned
Year 4	• Teens in Driver Seat •	
Year 5	• Teens in Driver Seat •	

In the priority of Motor Vehicle Crashes, there are changes including the removal of a strategy to assess and address the need for translations of health literate educational materials for culturally diverse audiences, and removal of distribution of materials through School Health communication channels. The DHHS Injury Prevention Program considers these strategies completed in calendar year 2021.

Priority: Sexually Transmitted Diseases among Youth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• Update and Translate Prevention Materials as needed • Conversation Starters Project • Youth friendly Clinic recommendations • Expand TOP programming	• Interrupted • Interrupted • Completed • Interrupted
Year 2	• Conversation Starters • Collaboration between Adolescent Health and STD program • Reproductive Health program subawards for adolescent health	• Sustain • Ready • Ready
Year 3	• Distribute Conversation Starters • Implement MAD curriculum • Fund local agencies	• Planned • Redy • Ongoing
Year 4	• Evaluate Conversation Starters • Evaluate MAD curriculum • Continue collaborations with local agencies	
Year 5	• Evaluate Conversation Starters • Evaluate MAD curriculum • Continue collaborations with local agencies	

In the priority of STDs among youth, there are several changes in strategies, compared to 2021-2022:

- The strategy to develop and disseminate Youth Friendly Clinic Environment recommendations was removed in 2021 because it was completed. There is a plan to annually review for medical accuracy and the recommendations are used in the Adolescent Reproductive Health sub awards as a guide for awardees intending to improve their youth-friendliness.
- New to this priority is "the DHHS Adolescent Reproductive Health Program will facilitate the evaluation of Making a Difference (MAD) pilot implementation and seek to renew as appropriate". This represents the natural next step to the previous strategy to select an evidence-based or evidence informed model to address STDs among youth.

Priority: Suicide Among Youth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• School Health program increases activity in mental and behavioral health in schools • Participate in Garrett Lee Smith prevention grant management team • Participate in Nebraska Statewide Suicide Prevention Coalition	• Completed • Completed • Completed
Year 2	• School Health Program: Suicide Prevention and Behavioral Health in Schools • GLS and NSSPC participation	• Ongoing • Ongoing
Year 3	• School Health Program: Suicide Prevention and Behavioral Health in Schools • GLS and NSSPC participation	• Ongoing • Ongoing
Year 4	• School Health Program: Suicide Prevention and Behavioral Health in Schools • GLS and NSSPC participation	
Year 5	• School Health Program: Suicide Prevention and Behavioral Health in Schools • GLS and NSSPC participation	

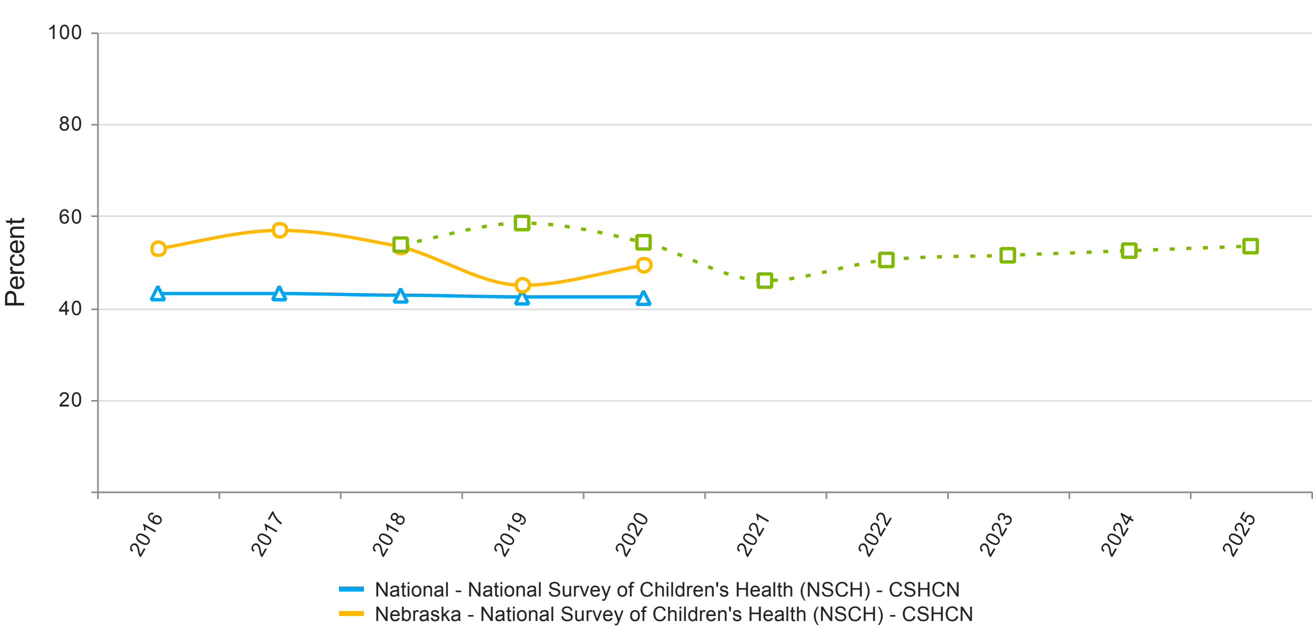
In the priority area of Suicide, the 2022-2023 proposed strategies have changed:

- A strategy for the School Health Program to work collaboratively with others to increase capacity of schools to respond to suicide risk among students has been removed due to changes in the Title V School Health program.
- A strategy that previously specified Title V working with Nebraska Statewide Suicide Prevention Coalition, and Nebraska's Garrett Lee Smith Suicide Prevention Grant project management team has been modified to more generally speak to Title V working with partners to align and amplify suicide prevention efforts for all children, youth, and families.
- A strategy specifying Title V collaboration with the Society of Care has been removed from this priority.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		53.7	58.4	54.2	45.9
Annual Indicator	52.7	57.0	53.1	45.0	49.4
Numerator	41,148	46,782	44,838	39,911	42,610
Denominator	78,126	82,066	84,509	88,648	86,203
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.4	51.4	52.4	53.4

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.

Measure Status:	**Inactive - Replaced**				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			350	1,000	1,500
Annual Indicator			1,506	1,380	1,625
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2020
Provisional or Final ?			Final	Final	Final

ESM 11.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Center

Measure Status:	**Active**		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	80.0	85.0	90.0

State Action Plan Table

State Action Plan Table (Nebraska) - Children with Special Health Care Needs - Entry 1

Priority Need

Behavioral and Mental Health in School

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

CS9a: by 2025, the Medically Handicapped Children's Program (MHCP) will collaborate with stakeholders to implement a formalized, sustainable, statewide support structure to provide a continuum of supports to families with children and youth with special health care needs (CYSHCN).

CS9b: By 2025, Title V will collaborate with partners to increase the capacity of schools for behavioral health access and referrals, and equitable behavior management practices.

Strategies

CS9a(1): MHCP will establish the family collaborative by identifying a contractor, developing operating agreements, and establishing membership.

CS9a(2): MHCP, in collaboration with the Munroe Meyer Institute (MMI) at the University of Nebraska Medical Center, will continue the Parent Resource Coordinator (PRC) project, supporting families with CYSHCN age birth to 21 years. This support includes mentorship with families and medical clinic providers to enhance the coordination between education, medical, and social supports for families.

CS9b(1): Title V will participate in collaborations with networks, programs, and projects working with schools related to mental wellbeing of students.

CS9b(2): Title V will provide continuing education on mental and behavioral health best practices for school health professionals.

CS9b(3): Title V will continue to learn from key informants perspectives and recommendations about Title V strategies to address disparities and promote equitable behavior management practices at school.

ESMs	Status
ESM 11.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.	Inactive
ESM 11.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Center	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Children and Youth with Special Health Care Needs (CYSHCN) Domain** for the period October 1, 2020 to September 30, 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the CYSHCN Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Behavioral health in schools**
  NPM: Percent of children with and without special health care needs, ages 0-17 years, who have a medical home
  ESM: The number of CYSHCN families who have contact with a Parent Resource Coordinator

1. Context: The State of the CYSHCN Population Domain

The Medically Handicapped Children's Program and dedicated CYSHCN funding from Title V is administered by the Division of Children and Family Services. The Medically Handicapped Children's Program (MHCP) provides medical support services to children and youth with special health care needs in low-income families. Eligible families have no insurance or are under-insured creating a hardship and many times resulting in the children not receiving proper health care if the assistance isn't provided. Covered diagnoses include diabetes, cystic fibrosis, severe asthma, seizures, heart conditions, genetic disorders, craniofacial disorders, certain orthopedic conditions, and cerebral palsy, among many others. The program assists in paying for prior authorized specialized medical care for the enrolled child or youth as well as providing case management services for the families.

In 2020-2021, MHCP continued its partnership with the University of Nebraska Medical Center Munroe-Meyer Institute (UNMC MMI) to deliver medical services to CYSHCN throughout western and northern Nebraska. Specialized providers in this geographic area are often scarce. These services are provided through medical clinics by a variety of specialized providers, who travel to rural areas of the state to provide services in a clinical team approach. The team members are part of UNMC MMI or have an agreement with MHCP outside of UNMC MMI. The team's expertise typically consists of a geneticist, pediatrician, registered nurse, phyciatrist, orthopedic surgeon, orthodontist, oral plastic surgeon, physical therapist, psychologist, nutritionist, and others. Clinic teams focus on each child or youth with special health care needs to evaluate/follow up on their care, determine comprehensive treatment plans, and make recommendations. Once dictated, clinic reports are distributed to families, as well as the Primary Care Provider and assigned MHCP Social Services Worker.

The Medically Handicapped Children's Program (MHCP) holds medical clinics in communities across Nebraska. The clinics bring a team of medical specialists to rural Nebraska to address the needs of children and youth with special health care needs. The COVID-19 pandemic impacted the service offered to families in 2020-2021. During the early months of the pandemic, many sites closed and medical clinics had to be placed on hold leaving families without the medical care and socialization they were accustomed to. Fortunately, for the families, the medical teams were able to adapt and provide services via telehealth when appropriate and available. Telehealth options provided a solution for services until the clinic sites were able to fully reopen and COVID-19 restrictions were lifted. UNMC is a state-of-the-art medical institute that was easily able to ensure a smooth transition to telehealth services. The clinics are now offered using a hybrid model with in-person and telehealth service delivery as needed.

In addition to the services directly provided through the Medically Handicapped Children's Program, the ongoing partnership with UNMC MMI is integral in serving the children and youth with special health care needs across Nebraska. This partnership has allowed Title V to continue the Family Care Enhancement Project. The project employs Parent Resource Coordinators (PRCs) in medical clinics throughout the state to partner with families as they work through the different systems of care to get the needed services for their children with special health care needs. The Parent Resource Coordinators have children of their own with special health care needs and also complete training to best serve the families. Parent Resource Coordinators are part of Nebraska's dynamic workforce of Community Health Workers (CHW). Other areas in which the partnership with UNMC MMI has helped Title V branch out are with medical clinics (as discussed above), Neonatal Intensive Care Follow-up, and the Teratogen Project.

The Disabled Children's Program (DCP), which falls under the Medically Handicapped Children's Program, enrolls children and youth with special health care needs who are birth through 15 years of age and are currently receiving payment through Supplemental Security Income (SSI). If a child is receiving SSI, they are eligible for and receiving Medicaid/Managed Care benefits for their medical needs, therefore DCP offers the supportive services not received through Medicaid/Managed Care or other related sources. In the DCP, many of the children and youth enrolled are receiving services due to eligible diagnoses related to mental and/or behavioral health. DCP offers services such as medical mileage reimbursement, meals/lodging reimbursement, respite care, special equipment, and home/vehicular modifications. The Social Services

Workers offer case management to families enrolled and receiving services. There are specific and significant concerns addressed by DCP to support children and families: appointments to psychiatrists for medication checks, additional visits to medical professionals at further distances due to children with sensory issues from mental health causes, and/or the increased need for respite care due to children with high-risk behavioral needs.

In 2020-2021, services related to CYSHCN were also delivered by the Title V School Health Program. Through a public health workstream, the School Health Program works with schools and school health professionals across the state, and is led by a professional nurse consultant. Through this workstream, Title V is able to complement the work of the Medically Handicapped Children's Program with population-level public health approaches to address the priorities of children and youth with special health care needs as they are served in the school setting, including disparities. Prior to the onset of the pandemic, in late 2019 Voices for Children in Nebraska released the annual Kids Count report. Included in the report were findings from a study of discipline practices in Nebraska schools, including one that describedthe significant disproportionality children and youth with disabilities face regarding disciplinary and exclusionary measures. Nebraska stakeholders have deep concerns about the disparities and barriers faced by these children. This report resonated strongly with stakeholders in the 2020 MCH Needs Assessment, and stakeholders expect Title V to respond.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Behavioral health in schools
2020-2021 Objectives and Strategies

Objective CS9a: By 2025, the Medically Handicapped Children's Program (MHCP) will collaborate with stakeholders to implement a formalized, sustainable, statewide support structure to provide a continuum of support to families with children and youth with special health care needs

Summary of Programmatic Efforts
Planned strategies for this objective include Title V seeking a community partner to develop and implement a Collaborative with stakeholders. The Collaborative establishment will include families, and enhance the availability of knowledge, services, and supports for families of CYSHCN. Included will be a website and information repository, formalized partnerships supported by memoranda of understanding or agreement; medical-community-legal partnerships; training and outreach for families and providers; and data collection and evaluation.

The strategies started with Nebraska Title V completing the planning steps of developing a formal outline of the intention, the purpose, and the hopeful outcomes of the future Collaborative. Title V considered and made decisions on possible community members that had the potential to be a vendor, developed a program budget, researched similar projects in other state Title V programs or other programs, researched Nebraska resources and programming, and initiated the drafting of the competitive procurement tool that will be utilized. The results of the internal research for Nebraska confirmed the need for a Collaborative of stakeholders to provide a continuum of support to families with children and youth with special health care needs that will be a resource of currently collected information and to advocate for the needs of these families and others in the community.

The project has been named the Nebraska Connecting Families Network. The Nebraska Title V staff completed the draft of the competitive procurement documents and recently posted the proposal for community agencies to consider.

Planned strategies for this objective also included Title V partnering with Munroe Meyer Institute and Nebraska's Early Development Network to continue growing the Parent Resource Coordinator program to provide support to families with CYSHCN ages birth to 21 years.

The partnership between the Medically Handicapped Children's Program (MHCP) and the University of Nebraska Medical Center, Munroe-Meyer Institute (MMI) allowed the program to engage and empower families through a peer support model called the Family Care Enhancement Project. The project promotes the principles of family-centered care in a medical care setting and also parent-to-parent mentorship. Parent Resource Coordinators (PRCs), who are family members that have children with special health care needs, are placed in medical clinics throughout the state to help other families that have CYSHCN get connected to early intervention services, and special education services, and other community social and health resources. Parent Resource Coordinators are family members who have CYSHCN and have experienced the systems. Each Parent Resource Coordinator must complete a training curriculum on Nebraska services so they can support other families currently needing services in our statewide systems.

MMI partners with pediatric medical practice sites, as well as outstate clinic sites, in select locations across the state, to provide Parent Resource Coordinator services to families seen in the practice. The project allows Parent Resource Coordinators to provide face-to-face mentorship to families and medical clinic providers to enhance the coordination between educational, medical, and social services programming. Each Parent Resource Coordinator is required to complete online training modules upon their hire, shadow other Parent Resource Coordinators in clinics, and are provided with ongoing technical assistance to address the questions of families. At least two of the Parent Resource Coordinators were bilingual, enriching the consumer experience.

The Family Care Enhancement Project has proven over time the effectiveness of peer support and family-centered models to support the CYSHCN population in decision-making, family engagement, and empowerment. The benefits of a family working through difficult times with another parent that has experienced a similar situation with their CYSHCN cannot be overstated. From October 1, 2019, through September 30, 2020, the Parent Resource Coordinators served 1,380 children and families. Approximately 86 percent of children and families received case management services (intensive support—more than 30 minutes spent with family) and the other 14 percent were classified as information and referral (light touch—less than 30 minutes with family) only. The community resources most requested were related to Family Supports, Educational Supports, and Medical Supports in that order.

The PRCs were vital in referring children with special health care needs to the Early Development Network (EDN) and Early Development Special Education (EDSE). Early intervention and detection must be in place for the best outcomes for CYSHCN. If the CYSHCN were not found eligible for services through EDN or EDSE, the PRCs connected the families to other Early Intervention programs or other community resources.

Use of Evidence-based or Evidence-informed Approaches in this Objective.
The use of Community Health Workers is supported by some evidence of effectiveness in providing education, referral, and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes, according to the site County Health Rankings and Roadmaps, What Works for Health directory at https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

Objective CS9b: The School Health Program will implement a collaborative integrated project with schools and community partners to promote trauma-informed care and restorative discipline practices as approaches to address disparities and exclusion at school

Summary of Programmatic Efforts
When Title V entered into this priority, driven as noted by deep concerns expressed by stakeholders at data showing disparities in ways behavior is managed at school, Title V developed strategies speaking broadly to collaborative work in an area (Behavioral Health in Schools) already populated by several initiatives and activities. The first planned strategy was for the School Health Program to convene a cross-sector project team (or other means of continuous, collaborative communication) to promote the alignment and integration of approaches statewide to improve mental and behavioral well-being of students with and without special health care needs. The second planned strategy laid the groundwork for the identification of opportunities to develop, implement, and evaluate a project activity to promote trauma-informed schools and restorative discipline practices in order to disrupt racial and other disparities in school discipline practices.

In practice, the School Health Program Manager led several very informative convening activities with partners working in the area of mental or behavioral health in schools in Nebraska, and much was gained by the sharing of information. However, in an active field, there seemed little likelihood that Title V's best contribution would be another small project. As an alternative, working in partnership with NEP-MAP, the Nebraska Partnership for Mental Healthcare Access in Pediatrics, Nebraska's HRSA-funded Pediatric Mental Health Care Access Project for which Title V serves as lead, the School Health Program launched the School Nurse Behavioral Health Consultation project, which provided office hours for school nurses to contact a pediatric psychiatric Nurse Practictioner for information and input regarding students with behavioral and mental health issues at school. In addition, with the Nurse Practitioner consultant and other mental health professionals, the School Health Program provided a series of mental health continuing education topics for school health professionals.

From this point, the program returned to the original issue brief, to once again review stakeholder expectations that Title V has something to bring to the table on the topic of disparities in behavior management practices at school, with data demonstrating the most severe disciplinary practices rest disproportionately on minority students, male students, and children and youth with disabilities. By 2021-2022 the School Health Program, while continuing the Consultation service and continuing education, designed and initiated an activity to interview key stakeholders to gain greater insight about the dimensions of the issue.

Use of Evidence-based or Evidence-informed Approaches in this Objective.
The phrase prompt is especially pertinent in this priority area due to the fact that stakeholders identify that evidence-based practices for integrated behavior management at school and home exist. However, stakeholders and key informants report, such practices may not be implemented consistently and with fidelity; teachers may lack support, training, and resources for implementing such practices; or these practices may not be part of a teacher's toolbox for classroom management, leaving the teacher to address disruptive behavior from an emotional or inconsistent foundation.

To assure parents and families are recognized as decision-makers for their children and have access to the support they need, evidence points strongly to the role of family-centered medical home approaches, wherein the *provider* commits to the practices that make families comfortable and confident with care. An external body of accumulated information and resources is only as good as the current accuracy, and the accessibility (through literacy, language, and technology) that places information in the hands of diverse and multicultural users.

3. Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Behavioral health in schools

NPM: Percent of children with and without special health care needs, ages 0-17 years, who have a medical home
ESM: The number of CYSHCN families who have contact with a Parent Resource Coordinator

Alignment:
The language of the priority statement makes alignment with National Performance Measures. No NPM is available that speaks to mental health needs among MCH populations, and the site www.mchevidence.org offers little guidance regarding this priority. The selection of the NPM regarding medical home links to family empowerment, however, is not nuanced sufficiently to target the scenario that most alarmed stakeholders, which is how students are affected by behavior management in schools.

In the What Works for Health directory of County Health Rankings and Roadmaps, there is evidence for logical alignment between the need identified for resources for family empowerment and family engagement, and contact with Parent Resource Coordinators. At https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health evidence supports the effectiveness of the following strategies in increasing quality and coordination of care, and provision of culturally competent care: navigators, cultural competence of providers, skilled interpretation, and medical home.

4. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Objective CS9a: By 2025, the Medically Handicapped Children's Program (MHCP) will collaborate with stakeholders to implement a formalized, sustainable, statewide support structure to provide a continuum of support to families with children and youth with special health care needs

Discussion of Performance Measurement and Other Programmatic Impacts
In the Medically Handicapped Children’s Program, performance targets were met for the first year of development and implementation of the new Nebraska Connecting Families Network project. Nebraska Title V finalized the outline for the future Collaborative, named the project the Nebraska Connecting Families Network, and initiated the drafting of the competitive procurement tools.

Objective CS9b: The School Health Program will implement a collaborative integrated project with schools and community partners to promote trauma-informed care and restorative discipline practices as approaches to address disparities and exclusion at school

Discussion of Performance Measurement and Other Programmatic Impacts: Results-based Accountability Measures
Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures in an effort to make annual impacts and achievements more discernable to front-line staff and stakeholders. In addition, the use of RBA has specifically highlighted inclusion and equity-focused efforts that have been transforming Title V work. The public health focus of this domain, as exemplified by the activities of the School Health program and Title V’s focus on improving mental health access for the pediatric population with and without special needs, is represented by RBA.

Results Based Accountability (RBA) measures Behavioral Health in Schools		
	Proposed 2020-2021	*Achieved 2020-2021*
How much did we do?	How many cross-sector meetings on behavioral health in schools were convened by the School Health Program? How many people participated?	Three,with at least six people at each convening.
How well did we do it?	Did the group consider equity topics in their work? If so, describe.	No entity was identified with an equity focus, cultural competency component, or prioritizing disparities.
Is anyone better off?	Has the School Health Program implemented any program interventions working with School Nurses or other school personnel? If so, what is the measure of impact?	School Nurse Behavioral Consultation Project; Educational events for school nurses by mental health professionals on anxiety, depression, and suicide.

Discussion – Other Programmatic Impacts
This priority represents Title V MCH working in a capacity to address the special needs of children with mental and behavioral needs, in ways that span the boundaries of the CYSHCN and Child Health domains. The presence of Title V MCH in this space has brought many stakeholders to the table to work on equity topics, screening, care coordination, and other strategies to improve access to care and family support.

5. Challenges and Emerging Issues

Disparities in Discipline
In late 2019 Nebraska saw the release by Voices for Children of the annual Kids Count report. Included in the report was a report of findings from a study of discipline practices in Nebraska schools. One of the findings was the significant disproportionality children and youth with disabilities face regarding disciplinary and exclusionary measures. Nebraska stakeholders have deep concerns about the disparities and barriers faced by these children. In 2020, the selected priority for the next five years in the Children and Youth with Special Health Care Needs domain is entitled Behavioral Health in Schools. Inequitable discipline measures are just one aspect of the educational challenges faced disproportionately by children and youth with special needs, as well as children and youth from marginalized groups. Stakeholders interpret the need for greater availability of family support at the school and systems level.

Mental health and behavioral health needs of all children, and the need for public health approaches to serve CYSHCN.
The need for improved access to mental health care services, improved screening practices for all youth, and resources to support the mental well-being of all youth in the population, are great. Health and community systems of care cannot fully meet these needs, especially for disadvantaged and minority youth, with traditional approaches. Tele-behavioral health use escalated during the pandemic, representing one strategy and school-based mental health services, often in partnership with local community provider organizations, are another. Universal screening of children and youth, accompanied by effective referrals, also is embraced by many providers.

6. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

The efforts of Title V to widen the lens of the CYSHCN domain to include the School Health program and address the needs of all children with mental and behavioral health needs is a strategy intended to reduce stigma, include more families, and align more fully with the population level strategies Title V is using to improve mental well-being in the population.

Meanwhile, Title V continues to support the systems-level infrastructure of the Medically-Handicapped Children's Program, with particular emphasis on utilization of Parent Resource Coordinators.

In the 2020 Needs Assessment, Nebraska stakeholders coalesced around a single priority, which arises from the previously-discussed Kids Count report in late 2019, illuminating disparities in disciplinary practices and consequences for students in Nebraska's public schools. The priority is entitled, "Behavioral Health in Schools." Nebraska will continue the dual and intertwined approaches of addressing the priority and the concerns raised by stakeholders particularly in the area of disparities, of responding through workstreams of the Medically Handicapped Children's program, and of the Title V

School Health Program.

CYSCHN DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **CYSHCN Domain** for the period October 1, 2022 to September 30, 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the CYSHCN Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Behavioral and Mental Health in School**
  NPM: Percent of children with and without special health care needs, ages 0-17 years, who have a medical home
  ESM: The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator (new)

1. **Description of Planned Activities**

OVERVIEW OF CYSHCN DOMAIN
Division of Children and Family Services – Medically Handicapped Children's Program
The Medically Handicapped Children's Program (MHCP) will continue to provide medical support services to children and youth with special health care needs in low-income families. Eligible families have no insurance or are under-insured creating a hardship and many times resulting in the children not receiving proper health care if the assistance isn't provided. Covered diagnoses include diabetes, cystic fibrosis, severe asthma, seizures, heart conditions, genetic disorders, craniofacial disorders, certain orthopedic conditions, cerebral palsy, among many others. The program assists in paying for prior authorized specialized medical care for the enrolled child or youth as well as providing case management services for the families.

During 2020-2021, MHCP has continued its partnership with the University of Nebraska Medical Center Munroe-Meyer Institute (UNMC MMI) to deliver direct medical services to CYSHCN throughout western and northern Nebraska. This is a geographic area where specialized providers are sparse. These services are provided through medical clinics by a variety of specialized providers, traveling to rural areas of the state to provide services in a clinical team approach. The team members are part of UNMC MMI or have an agreement with MHCP outside of UNMC MMI. The team's expertise typically consists of geneticist, pediatrician, registered nurse, physiatrist, orthopedic surgeon, orthodontist, oral plastic surgeon, physical therapist, psychologist, nutritionist, and others. Clinic teams focus on each child or youth with special health care needs to evaluate/follow up on their care, determine comprehensive treatment plans, and make recommendations. Once dictated, clinic reports are distributed to families, as well as the Primary Care Provider, and assigned MHCP Social Services Worker.

In addition to the services directly provided through the Medically Handicapped Children's Program, the ongoing partnership with UNMC MMI is integral in serving the children and youth with special health care needs across Nebraska. This partnership has allowed Title V to expand in areas such as the Family Care Enhancement Project. The project employs Parent Resource Coordinators in medical clinics throughout the state to partner with families as they work through the different systems of care to get the needed services for their children with special health care needs. The Parent Resource Coordinators have children of their own with special health care needs and complete training to best serve the families. Other areas in which the partnership with UNMC MMI has helped Title V branch out are medical clinics as discussed above, Neonatal Intensive Care Follow-up, and the Teratogen Project. The Parent Resource Coordinators are active in, and bring a family-centered perspective to, Title V Community Health Worker workforce development. UNMC MMI also delivers the clinical demonstration project activities of a tele behavioral health consultation project for primary care providers, through a subaward with DHHS and the pediatric mental health care access program.

The Disabled Children's Program (DCP), which falls under the Medically Handicapped Children's Program, enrolls children and youth with special health care needs who are birth through 15 years of age and are currently receiving payment through Supplemental Security Income (SSI). If a child is receiving SSI, they are eligible for and receiving Medicaid/Managed Care benefits for their medical needs, therefore DCP offers the supportive services not received through Medicaid/Managed Care or other related sources. In the DCP, many of the children and youth enrolled are receiving services due to eligible diagnoses related to mental and/or behavioral health. DCP offers services such as medical mileage reimbursement, meals/lodging reimbursement, respite care, special equipment, and home/vehicular modifications. The Social Services Workers offer case management to families enrolled and receiving services. There are specific and significant concerns

addressed by DCP: Appointments to psychiatrists for medication checks, additional visits to medical professionals at further distances due to children with sensory issues from mental health causes, and/or the increased need for respite care due to children with high-risk behavioral needs. These, as well as others, are all too common in the Disabled Children's Program.

In 2021, the Medically Handicapped Children's Program has implemented a competitive procurement process for Nebraska's Connecting Families Network. The network will be a community collaborative with partners, organizations, school personnel, students, families, advocacy groups, and/or other stakeholders to address the identified disparities related to lost instruction time for students in school, disproportionate suspension of children with disabilities (especially those who are minorities), and harsher discipline practices which lead to long-standing, inequities.

Division of Public Health
The Title V program year 2021-2022 represented continuing development of looking at and growing public health and population-based approaches to supporting the life course wellbeing and equity of Children and Youth with Special Health Care Needs.

In recent applications and reports, Title V has joined other states in lifting the cascade of mental and behavioral health issues among youth with and without special health care needs, likely accelerated or intensified due to pandemic stressors that continue. Building the capacity of schools and other community organizations to serve students and families well when they have mental and behavioral health issues is a significant public health approach that can better serve children with and without special health care needs.

Changes in the DHHS School Health program will impact how Title V addresses this identified need. During 2022, the School Health Program Manager resigned to take a new position helping the NE Department of Education revitalize its approach to school health issues, in partnership with Children's Hospital. While this transition necessarily means changes in how Title V approaches school health, it is an exciting and significant development for Nebraska, offering the opportunity to strengthen and refresh health issues for children in the school setting. Much is still to be determined; however, it is known that the role of state School Nurse Consultant and likely much of the support to school nurses across the state will move out of DHHS. For Title V, this is an important opportunity to focus priorities and determine the right resource mix for ongoing efforts. Title V will move forward with refilling this vacant position, and the new staff person will have an opportunity to participate in development of this role during the transitory period.

Stakeholders also see the value in a broad approach to community-based services. One respondent in the public input process said:

> "Kids behaviors don't need to be managed, this is why most school interventions don't work. they need to be taught how to identify and express feelings appropriately....using schools only to do this is short sighted, they have a lot to do."

Priority: Behavioral and Mental Health in School
2021-2022 Objectives and Proposed Strategies

Objective CS9a: by 2025, the Medically Handicapped Children's Program (MHCP) will collaborate with stakeholders to implement a formalized, sustainable, statewide support structure to provide a continuum of supports to families with children and youth with special health care needs (CYSHCN)

Strategy CS9a (1): MCHP will establish the family collaborative by identifying a contractor, developing operating agreements, and establishing membership

Strategy CS9a (2): MHCP, in collaboration with the Munroe Meyer Institute (MMI) at the University of Nebraska Medical Center, will continue the Parent Resource Coordinator (PRC) project, supporting families with CYSHCN age birth to 21 years.

Discussion of Activities for this Objective – Relevance to Identified Priority
The continued partnership between the Medically Handicapped Children's Program (MHCP) and the University of Nebraska Medical Center, Munroe-Meyer Institute (MMI) allows the program to engage and empower families through a peer support model called the Family Care Enhancement Project. The project promotes the principles of family-centered care in a medical care setting and parent-to-parent mentorship. Parent Resource Coordinators (PRC), who are family members that have children with special health care needs, are placed in medical clinics throughout the state to help other families that have CYSHCN get connected to early intervention services, special education services, and other community social and health resources. Parent Resource Coordinators are family members who have CYSHCN who have experienced the systems. Each PRC must complete a training curriculum on Nebraska services so they can support other families currently needing services in our statewide systems.

MMI partners with pediatric medical practice sites, as well as outstate clinic sites, in select locations across the state, to provide PRC services to families seen in the practice. The project allows PRC to provide face-to-face mentorship to families and medical clinic providers to enhance the coordination between educational, medical, and social services programming. Each PRC is required to complete online training modules upon hire, shadow other Parent Resource Coordinators in clinics, and are provided with ongoing technical assistance to address the questions of families.

Medically Handicapped Children's Program will continue to proceed in the development of the competitive contractor section process for Nebraska's Connecting Families Network. The Network's agreements will include planned interventions and strategies to enhance the availability of knowledge, services, and supports for families of CYSHCN. Nebraska's Connecting Families Network will create a space where stakeholders can connect to design a framework for sharing and advancing individual knowledge and skills to navigate a continuum of family support and maximize the interaction of family and service providers.

Objective CS9b: By 2025, Title V will collaborate with partners to increase the capacity of schools for behavioral health access and referrals, and equitable behavior management practices.

Strategy CS9b (1): Title V will participate in collaborations with networks, programs, and projects working with schools related to mental well-being of students.

Discussion of Activities for this Objective – Relevance to Identified Priority
Title V, through the School Health Program, has spent time discovering more about the many partners, systems, resources, and actors that have an interest in mental health and well-being of school-aged children and youth in Nebraska. This is by no means to say there is an organized or functioning network or system of services that covers the needs of children and youth in all areas of the state. Some are structural, for example, the Behavioral Health regions in Nebraska, and some are grant-funded, such as the AWARE-SEA project through the Department of Education and funded by the Substance Abuse and Mental Health Services Administration. Emerging regional partners are from the Mental Health Technology Transfer Center Network, and academic, such as the Behavioral Health Education Center of Nebraska at the University of Nebraska Medical Center.

In 2022-2023, DHHS Title V will continue relationship-building and collaboration with these many partners, looking at strategies to improve screening and referral, as well as equity practices in schools. Additionally, Title V will be using this time to evaluate the focus and priorities of school health efforts, in partnership with the NE Department of Education. In the meantime, NEP-MAP (Nebraska Partnership for Mental Health Care Access in Pediatrics) continues to collaborate with Title V to bring the School Nurse Behavioral Health Consultation Service to school nurses, helping address their questions and needs to assist children and youth at school.

2. Alignment of planned activities with annual needs assessment updates

The formal establishment of a family-systems collaborative group, led by an entity identified through a competitive request for proposals process, is aligned with the need to increase family voices, family empowerment, and family resources to meet the needs of children with mental and behavioral health needs, in schools and other systems.

The capacity of schools and other community organizations to respond to student behaviors with fair, just, and reasonable interventions to preserve the student's educational opportunities and make appropriate referrals for screening and management are key to correcting life course disparities that are set in motion when children do not have the opportunity to succeed in school.

The activities of this domain are closely aligned with stakeholder expectations and the 2020 needs assessment. There are no updates to the needs assessment that alter this alignment.

3. Emerging new priorities taking precedence over the established priority needs

No new priorities have emerged in this domain to take precedence over the established priority need. The COVID pandemic has resulted in raised awareness of the increasing intensity of this priority need among all children and youth.

4. Relevance of ESM to selected NPM, changes in ESM

Priority: Behavioral and Mental Health in School

NPM: Percent of children with and without special health care needs, ages 0-17 years, who have a medical home

ESM: The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator (new)

In April 2021, Nebraska was provided with the ESM Report from MCH Evidence Center for the state. The MCH Evidence Center assesses ESMs aligned to NPMs for the degree to which they are supported by evidence, and through the lens of Results-based Accountability. For the CYSHCN Domain, the report concludes there is no similar strategy found in the established evidence for the NPM. The ESM of parents having contact with a Parent Resource Coordinator is considered an effective measure of reach, which could be strengthened by using a denominator (total # of relevant group addressed) to show %. In the coming year, Title V goes further with this ESM to measure family satisfaction with the supports provided by the PRC – getting feedback directly from involved families as a measure of success and necessary improvements.

In addition to assigning ESM to at least one Priority in each Population Domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measure. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlights inclusion and equity-focused efforts that have been transforming Title V work. In the CYSHCN domain, RBA measures pertain only to the public health/school health workstream.

Results Based Accountability (RBA) measures Priority: Behavioral Health in Schools		
	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How many families worked with a PRC?	Was the Family Collaborative opportunity released? Did an agreement get executed?
How well did we do it?	Did families get appropriately matched with a PRC reflecting their cultural background and/or language of choice?	Were stakeholders involved in the design of the Collaborative? How many stakeholders were engaged?
Is anyone better off?	What were the results of the family satisfaction survey?	Did the Collaborative have any measurable impacts? What were they?

5. Are changes needed in the established SPMs and SOMs, if applicable

This section is not applicable in the CYSCHN domain.

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plan for this domain is shown in the table below.

Priority: Behavioral Health in Schools 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1	• (MHCP) Convene a Family-Systems Collaborative • (Public Health) Explore educational/discipline disparities • (Public Health) Increase capacity of schools to respond to mental and behavioral health needs (training, collaborations, resources)	• Planning • Delayed • Begun
Year 2	• (MHCP) Family-Systems Collaborative • (Public Health) Explore educational/discipline disparities • (Public Health) Increase capacity of schools to respond to mental and behavioral health needs (training, collaborations, resources)	• Planned • Ready • Ongoing
Year 3	• (MHCP) Family-Systems Collaborative • (Public Health) Re-envision Title V contributions to school health issues • (Public Health) Increase capacity of schools and other community orgs to respond to mental and behavioral health needs	• Planned • Ready • Ongoing
Year 4	• (MHCP) Family-Systems Collaborative • (Public Health) Title V contributions to school health • (Public Health) Increase capacity of schools and other community orgs to respond to mental and behavioral health needs	
Year 5	• (MHCP) Family-Systems Collaborative is evaluated for impact. • (Public Health) Title V school health efforts evaluated. • (Public Health) Capacity building efforts with schools and other community orgs to respond to mental and behavioral health needs is evaluated.	

In the workstream described for the Medically Handicapped Children's Program in the CYSHCN domain, there are no changes proposed for the action plan in 2022-2023.

In the public health workstream described for the Title V School Health Program in the CYSHCN domain, strategies are modified compared to 2021-2022:

- A strategy for the School Health Program to convene and lead a cross-sector group to achieve alignment and integration of behavioral health activities in schools statewide has been changed to a strategy describing the role of the School Health Program working collaboratively with other partners to increase the capacity of schools and other community-based organizations to respond to mental and behavioral health needs of students with and without special health care needs.
- A strategy in 2021-2022 to work with partners including families to explore root causes of disparities in Nebraska's education system, particularly in areas disciplinary practices disproportionately impacting minority youth and youth with special needs, and identify feasible and appropriate responses for child advocates, including Title V has been removed. The work conducted in 2021-2022 has paved the way for the collaborative effort described above with community-based organizations.

Cross-Cutting/Systems Building

State Performance Measures

SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active

State Provided Data

	2019	2020	2021
Annual Objective			62.5
Annual Indicator	64.1	61.3	63
Numerator			
Denominator			
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives

	2022	2023	2024	2025
Annual Objective	64.3	65.5	66.9	68.2

State Action Plan Table

State Action Plan Table (Nebraska) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Improved Access to and Utilization of Mental Health Care Service
SPM
SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Objectives
XC10a: By 2025, increase awareness and decrease stigma around mental and behavioral health issues by ensuring that training, outreach, and provider tools reflect best practices in health literacy and are culturally- and linguistically-appropriate for underserved populations
XC10b: By 2025, increase screening, referral, and treatment in primary care for mental and behavioral health.
Strategies
XC10a(1): Title V will continue Community Health Worker (CHW) workforce development activities, working with cross-divisional and cross-sector partners to assure all CHW have access to QPR Gatekeeper suicide prevention training, Mental Health First Aid, trauma-informed care, and other mental health topics with the intention of improving referrals to care and reducing stigma about mental and behavioral health issues.
XC10a (2): Title V will continue CHW workforce development activities, including sustainable infrastructure, with CHW center and in the lead, through engagement of the CHW Consultant Trainer Cadre.
XC10b(1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska Medicaid Expansion) to promote enrollment and improve access to care, particularly for disparate and disadvantaged women of childbearing age, and other parents/caregivers.
XC10b(2): Title V will continue as lead agency in Nebraska Pediatric Mental Health Care Access Program, NEP-MAP.

CROSS-CUTTING AND SYSTEMS-BUILDING DOMAIN
Nebraska Annual Report for the 2020-2021 Year

In this section, Nebraska MCH Title V reports on the accomplishments and activities in the **Cross-cutting and Systems-building Domain** for the period October 1 2020 to September 30 2021. This represents the fifth year of activity in the Title V needs assessment cycle. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 42 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

From the 2020 Needs Assessment, the Nebraska Priorities selected in the Cross-Cutting and Systems-Building Domain for 2020-2021, with NPM, SPM, and ESM statements for the period are as follows:

- **Improved access to and utilization of mental health care services by MCH populations**
  SPM: Percent of children ages 0-17 years who are continuously and adequately insured
  ESM: None

1. Context: Cross-cutting and Systems-building Priorities in Nebraska

In 2020, the stakeholder group convening to write the issue brief for the cross-cutting domain was the largest of the assembled domain work groups, representing statewide and cross-sector involvement. The sustained engagement of participants throughout the needs assessment process resulted in two work products, the selected priority and an issue brief focusing specifically on increased mental and behavioral health screening in the population. The stakeholder group was interested in both provider-level and system-level considerations of access to mental and behavioral health, through a lens informed by equity, social determinants of health, and workforce development including Community Health Workers (CHW).

Through the group's work, it became clear that rising and unaddressed mental health issues in the population were of paramount importance. Stakeholders used a risk and protective factor framework for the social and environmental determinants of mental well-being and development of resilience in the population, resulting in two primary strategies: improving primary care practice with health literacy, family-centered medical home and integrated care approaches, universal screening for mental and behavioral health issues using normed and standardized instruments, and a skill set to make behavioral health referrals. The second strategy is also workforce related: build the capacity of Community Health Workers to help people increase access to and utilization of mental health services. Stakeholders envisioned this would involve training, better integration of CHW in primary care teams to receive a warm hand off from providers to help families with social needs and navigating care, CHW educating the public about availability of Heritage Health Adult (Nebraska Medicaid Expansion), and CHW working to decrease stigma about seeking care for mental health.

For the 2020-2025 Needs Assessment, Title V worked with the Nebraska Association of Local Health Directors to bring forward a summary of current priorities identified through the Community Health Needs Assessment and Community Health Improvement Plans that local public health departments regularly undertake in their respective jurisdictions. This summary allowed stakeholders to consider degree of alignment with local priorities when determining the final priorities for Title V for the coming five-year period.

Stakeholders noted in the Issue Brief for this priority that fifteen of Nebraska's local public health departments identify Mental Health as a priority in the Community Health Improvement Plans and/or Community Health Needs Assessments. Eight local public health departments identify Access to Care as a priority as well.

Community Health Workers in Nebraska

Nebraska Title V has been making investments in Community Health Worker workforce development as an equity-focused strategy to improve access to care for approximately seven years. Many stakeholders, allies, and Community Health Workers participate in Title V-led or hosted activities. The 2020-2021 period was highly productive in that several reports on the CHW Workforce and key topics were published on the DHHS CHW webpage, www.dhhs.ne.gov/MCASH-CHW. In collaboration with the University of Nebraska, Title V has published an assessment of the CHW workforce in Nebraska, a review of training opportunities and recommendations for CHW in Nebraska, and (from a local health department collaborator and convener) a discussion of feasible CHW Workforce sustainability strategies for Nebraska. In 2021, Title V convened the CHW Consultant-Trainer Cadre, a group of eleven diverse CHW from across Nebraska dedicated to guiding Title V workforce development activities, demonstrating fidelity to "nothing about us without us."

Medicaid Expansion
As named in other domain reports for this period, Medicaid Expansion figures prominently in any discussion about access to care, whether physical, dental, or mental/behavioral. Critical to improving access to care is the availability of health insurance. Nebraska voters approved Medicaid Expansion in 2018, and enrollment opened in August of 2020, with benefits becoming effective in October 2020. Estimates are that between 80,000 and 90,000 individuals would become newly eligible for Medicaid in Nebraska, representing a significant opportunity for some of the most vulnerable Nebraskans to access health insurance.

The Rising Tide of Mental Health Needs
It is clear stakeholders were concerned about mental and behavioral health issues of MCH populations in the 2015-2020 needs assessment cycle. These concerns have continued to emerge throughout the population at the time of this writing. Mental health topics and considerations are pervasive in every domain group.

2. Summary of Programmatic Efforts and Use of Evidence-based or Evidence-informed Approaches to Address Priority Needs

Priority: Improved access to and utilization of mental health care services by MCH populations
2020-2021 Objectives and Strategies

Objective XC10a: by 2025, increase awareness and decrease stigma around mental and behavioral health issues by ensuring that training, outreach, and provider tools reflect best practices in health literacy and are culturally and linguistically appropriate for underserved populations

Summary of Programmatic Efforts
For the period 2020-2021, Nebraska proposed three significant strategies in this objective area. The Maternal, Child, Adolescent, and School Health (MCASH) staff worked with partners to include mental health topics in continuing education activities for Community Health Workers, as well as continued work to enact recommendations provided by a state-level, state-wide consensus group to identify financing and sustainability strategies for the CHW workforce in Nebraska. Third, as has been seen in other population domains, Title V continued to promote Heritage Health Adult, Nebraska's Medicaid Expansion program, particularly among diverse and disadvantaged parents and caregivers.

During the period, CHW met as a cadre monthly, discussing multiple topics including sustainability and mental/behavioral health, such as "Housing, Behavioral Health, and Culture: The role of the CHW" with a guest speaker and Certified Peer Support Specialists with staff from the Division of Behavioral Health. A subgroup of CHW participated on a continuing education committee, vetting speakers, and topics as well as planning for the logistics of offering CE – examples included offerings on depression, anxiety, and non-suicidal self-injury. Finally, CHW participated in planning for, hosting, and speaking at the Nebraska Conference on Health Equity in April. Agenda items of note included a speaker from the National Association of Community Health Workers and a breakout session for CHW.

Objective XC10b: By 2025, increase capacity of primary care providers to screen, refer, and treat mild-to-moderate mental health issues in children, youth, and women of childbearing age

Summary of Programmatic Efforts
For this objective, Nebraska Title V continued its leadership role in NEP-MAP, the Nebraska Partnership for Mental Healthcare Access in Pediatrics, Nebraska's project in the HRSA-funded Pediatric Mental Health Care Access program. In 2020-2021, Nebraska was in Year 3 of 5 planned years of project operations, primarily continuing the clinical demonstration project (providing consultation services to rural-based primary care providers needing assistance treating or referring patients) and offering other screening/referral tools to encourage more community-based services. Other projects included Reach Out and Read (an early childhood reading program which draws on the relationship between primary care provider and young families to distribute books), the school nurse behavioral health consultant project, continuing to facilitate the Advisory Committee and associated technical workgroups, and initiating a care coordination project with UNMC.

Objective XC10c: By 2025, assess impact of tele-behavioral health on improving access and utilization of mental and behavioral health services by MCH populations in Medicaid

Summary of Programmatic Efforts
The strategy underlying this objective was to be an activity undertaken with Nebraska Medicaid administration to measure tele-behavioral health utilization trends in NE. Both the pandemic and its associated response meant that while tele-behavioral health access was as needed as ever, the project to measure utilization could not occur. National and state level policy measures allowing telehealth during the pandemic relaxed some restrictions, including removing the requirement for a written agreement with a patient's signature and broadening the scope of allowed applications that can be used. These efforts ensured that telehealth was easier to use during the pandemic, though staff were unable to measure any change in usage as planned.

Use of Evidence-based or Evidence-informed Approaches in this Priority
The use of Community Health Workers is supported by some evidence of effectiveness in providing education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes, according to the site County Health Rankings and Roadmaps, What Works for Health directory at https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

Assessment of Alignment of NPMs, ESMs, SPMs, and SOMs with Priority Needs

Priority: Improved access to and utilization of mental health care services by MCH populations
SPM: Percent of children ages 0-17 who are continuously and adequately insured.
ESM: None.

Alignment:
The State Performance Measure of children ages 0-17 years who are continuously and adequately insured does not speak to the central topic of access to mental and behavioral health care services, nor to impacts of the Community Health Worker workforce which are central to the strategies deployed in this area. Likewise, the structure of national performance measures provides no framework for equity-focused work to improve access to care, other than measurement of preventive visits or health insurance coverage.

There is no ESM assigned to this population domain, however Results-based Accountability measures as described in the following section offer some additional insights related to activities.

3. Progress in Achieving Established Performance Measure Targets along with Other Programmatic Impact

Results Based Accountability (RBA) measures Improved access to and utilization of mental health care services by MCH populations		
	Proposed 2020-2021	*Achieved 2020-2021*
How much did we do?	How many training activities aligned with mental health first aid, motivational interviewing, suicide prevention, and trauma-informed care were promoted among CHW during the period?	CHW participated in three cross-sector planning sessions. Mental health topics included in the CHW continuing education project starting in 2022.
How well did we do it?	How many Community Health Workers were involved in the CHW Stakeholder group? What proportion of participants were systems partners, what proportion family advocates or CHW?	No achievement. The stakeholder group to move forward with sustainability and financing strategies did not convene in 2021 as planned.
Is anyone better off?	Does the NEP-MAP data show increases in Primary Care Provider training on mental health topics; increased screening; increased referrals; increased likelihood to treat children/youth with mild to moderate mental health conditions? What are the impacts of equity-focused strategies in Title V and NEP-MAP during this period?	No achievement. The NEP-MAP provider data project closed in late 2021 because of incomplete data submission, perceived data burden on providers.

Other Programmatic Impact
Despite little impact on proposed RBAs for the period, the success of the Title V CHW Consultant-Trainer Cadre is significant. The Cadre has provided space and opportunity for CHW to be visible in leadership and training roles of significance. In the CHW continuing education project, organizers including CHW have been intentional about applying principles of Popular Education in developing and delivering sessions. Each session features CHW Cadre members discussing ways that CHWs encounter the topic of interest in the population, and the significance of the topic in CHW experience. The sessions include polls, chats, and other interactive tools to invite sharing of expertise and perspective

between peers.

Likewise, within the NEP-MAP project there has been significant success regardless of the lack of provider-specific data from enrolled clinics. NEP-MAP has provided training opportunities, clinical consultation services, and a screening resource/referral guide that have laid the foundation to help primary care providers increase their screening and referral practices within their clinics, as well as to treat mild cases if appropriate.

4. Challenges and Emerging Issues

Nebraska has many engaged, ready stakeholders, Community Health Workers, and allies who would like to see the workforce grow and thrive to promote equity and improved population health outcomes. However, Nebraska lacks a single focal point for convening, organizing, and sustaining these workforce development activities. Stepping into this space, Nebraska Title V has made numerous substantial, impactful contributions to workforce development, from formation of the Cadre, to publishing original reports giving life and voice to the diverse CHW workforce, as well as offering continuing education and 2021 Community Health Workers are Heroes recognition awards. However, a more robust internal infrastructure will need to be established in order to sustain or coordinate several small program areas of activity, as well as to move this workforce to the next phase of formal, sustained recognition. The formation of the Cadre has itself resulted in an exponential acceleration in the capacity of Title V to accomplish activities, yet at the same time only one staff member is assigned to support all components of emerging and dynamic activity, along with other existing responsibilities in other program areas. Some areas of anticipated activity, including moving towards a certification model for Nebraska CHW, require sustained and coordinated efforts across systems, partners, and time. Title V will need to evaluate it's own capacity as well as that within the broader agency and in partner organizations in order to offer a solution for this next phase of CHW development.

5. Overall Effectiveness of Strategies and Approaches: Addressing Needs and Promoting CQI

As noted above, the effectiveness of the formation of the CHW Consultant-Trainer Cadre in growing workforce development activities has been considerable, however, this is paired with thoughtful consideration regarding the extent to which Title V staff at DHHS can keep pace with expanded and accelerated growth in activities. The visibility and credibility of Title V leadership in CHW workforce development is well-regarded by many stakeholders statewide, and many express hope Title V investments will continue. In addition, consideration needs to be mad about how to measure the short-term and long-term returns on Title V investments in CHW workforce development.

There is an immediate imperative to work with others to effectively address mental and behavioral health issues in the population and implement strategies to improve mental wellbeing and resilience. Development of the CHW workforce suggests an untapped resource to deploy in response to this need, particularly in a state where the rural nature of many areas means a lack of formally trained and licensed mental/behavioral healthcare providers.

Cross-Cutting/Systems Building - Application Year

CROSS-CUTTING/SYSTEMS-BUILDING DOMAIN
Nebraska Application for the 2022-2023 Year

In this section, Nebraska MCH Title V describes planned activities in the **Cross-cutting/Systems-building Domain** for the period October 1 2022 to September 30 2023. This represents the third year of activity in the Title V five-year needs assessment cycle for 2020-2025. The numerical sequence of headings used to organize the narrative below correspond to the narrative guidance for the Annual Report year as found on page 43 of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report, OMB Number 0915-0172, Expiration Date 1/31/2024*.

The Nebraska Priorities in the Cross-cutting/Systems-building Domain with 2022-2023 NPM, SPM, and ESM statements are as follows:

- **Priority: Improved Access and Utilization of Mental Health Care Services**
  SPM: Percent of children ages 0-17 years who are continuously and adequately insured
  ESM: None

1. **Description of Planned Activities**

OVERVIEW OF THE CROSS-CUTTING/SYSTEMS-BUILDING DOMAIN

Equity Focus

Since 2015, the Cross-cutting/Systems-building Domain has provided a focal point for Nebraska Title V MCH to discuss and develop culture of health activities related to addressing the social determinants of health and equity, engagement, and systems-integration. Title V both leads and partners in several sustained equity-focused systems-level activities, within the Department of Health and Human Services (Health Equity Collective Impact) and outside the Department (NEP-MAP Technical Workgroup #2 for CLAS and Equity). Through these efforts and others, Title V has gained many cross-sector partners deeply committed to changing life course outcomes for the most disadvantaged in the population. In 2019-2020, Title V with stakeholder input began to put forward “equity” as equated with “access,” as in: there is no health equity without access to care. For this reason, the opportunity represented for MCH populations ages 19-64 years in Medicaid Expansion (passed by voters in 2018, opened for enrollment 2020), is of specific significance to Title V and many stakeholders.

As has been mentioned repeatedly throughout this submission, the pandemic continues to exact a toll on Nebraskans, with early data showing higher rates of depression and anxiety in certain groups as compared to pre-pandemic levels. For many people, this is complicated by racial unrest that has swept the country, raising awareness of structural racism in law enforcement, health care, housing, and other systems to new levels. For change to be effective, it must be led by those most affected, and be strongly connected to the community level.

Community Health Workers

Title V has been participating and investing in Community Health Worker workforce development activities in Nebraska since 2017, along with many other stakeholders and allies. Initial objectives aligned with equity work, and the role of CHW in reaching and assisting to care groups and individuals experiencing differential consequences because of ill-health is increasingly valued. Title V began to frame objectives specifically around CHW as agents for MCH equity. In the current Title V MCH five-year cycle, CHW are centered in and leading in workforce development activities.

Mental Health Needs in the Population

In the 2020 Needs Assessment, the Cross-cutting/Systems-building Domain workgroup was the largest subgroup of participants working together to identify domain priorities for consideration by the larger group convened for the purpose of identifying priorities for the 2020-2025. The themes of equity and Community Health Workers resonated for the group throughout consideration of data indicative of numerous MCH population health concerns of life course significance. When the time came for the domain workgroup to formulate a priority phrase or statement and develop an issue brief, the group settled on Mental Health issues in the population, stating both access and utilization of services to encompass threads of:

- Reaching the most disadvantaged and diminish stigma through CHW
- Promoting Medicaid Expansion
- Promoting screening in community and clinical settings for all populations and age groups
- Using tele-behavioral health to improve access to care and understand COVID-driven changes.

Priority: Improved Access and Utilization of Mental Health Care Services
2022-2023 Objectives and Proposed Strategies

Objective XC10a: By 2025, increase awareness and decrease stigma around mental and behavioral health issues by ensuring that training, outreach, and provider tools reflect best practices in health literacy and are culturally and linguistically appropriate for underserved populations

Strategy XC10a(1): Title V will continue CHW workforce development activities, working with cross-divisional and cross-sector partners to assure all CHW have access to training such as QPR Suicide Prevention, Mental Health First Aid, and Trauma-informed care training, with the objectives of improving referrals, and reducing stigma about mental and behavioral health issues

Strategy XC10a(2): Title V will continue CHW workforce development activities, including sustainable infrastructure, with CHW centered and leading, through engagement of the CHW Consultant Trainer Cadre

Discussion of Activities for this Objective – Relevance to Identified Priority
The rise of mental health issues in Title V populations locally, statewide, and nationally seen initially when participating in the 2020 Needs Assessment continues to be alarming. And it's not just the increase in amount; the sheer breadth of these needs is intimidating. Maternal depression and substance use, postpartum depression, youth suicide, early childhood behavior issues so challenging to childcare providers that children are expelled from childcare, and mental health issues disproportionately experienced by children and youth with special health care needs (CYSHCN), are all described as increasing challenges. For Title V, it has become clear that as a supporting partner to stakeholders leading efforts in this field (i.e., the NDHHS Division of Behavioral Health, the Society of Care, Region partners, and more) addressing stigma is a unique and culturally nuanced aspect of addressing mental health needs in the populations that Title V supports. Strategies accompanying this objective include building training opportunities for CHW statewide to become equipped with skills appropriate to CHW competencies, including raising awareness, addressing stigma, and making effective referrals - anywhere in the state. In 2020-2021, the initiative began by Title V to assure CHW can access QPR Suicide Prevention training, Mental Health First Aid, Trauma-informed care, and Motivational Interviewing trainings regularly in each of six Behavioral Health regions in the state. This initiative has grown to encompass cross-systems partners interested in the training initiative for child welfare workers, school personnel, juvenile justice, and child probation workers, in addition to CHW. In 2021-2022, Title V continued the effort with CHW and other partners throughout the state to both build and promote a training calendar of offerings delivered by prevention coordinators and trainers in each behavioral health region. 2022-2023 will see more of this effort to provide continuing education opportunities for CHW assisting their efforts to connect with individuals in the community and make referrals as necessary, helping to decrease stigma in a culturally appropriate way.

In 2020-2021, Nebraska Title V MCH intentionally shifted from "engaging" CHW in this work to fully "centering" CHW and making space for CHW to lead systems-building work for the CHW workforce, with CHW, stakeholders, employers, trainers, and other allies. This has been accomplished through individual consulting services contracts with CHW who, constitute the CHW Consultant-Trainer cadre. Contracts with CHW will again be executed in the 2022-2023 year, providing the mechanism to reimburse individuals for their time and expertise as they continue to develop this important workforce.

These activities are all strongly relevant to the priority and backed by the participation of CHW and many other stakeholders, as evidenced by the following comment from a respondent in the public input process:

> "The Focus to develop Community Health Workers is very wise as this is a growing initiative across the country."

Objective XC10b: By 2020, increase capacity of primary care providers to screen, refer, and treat mild to moderate mental and behavioral health issues in children, youth, and women of childbearing age

Strategy XC10b(1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska Medicaid Expansion) to promote enrollment and improve access to care, particularly for disparate and disadvantaged women of childbearing age, and other parents/caregivers

Strategy XC10b(2) :Title V will continue as lead agency in Nebraska's Pediatric Mental Health Care Access Program (NEP-MAP)

Discussion of Activities for this Objective – Relevance to Identified Priority
The strategy in this Objective around Medicaid Expansion addresses the activities of Title V and many other partners in promoting enrollment among all eligible persons, but particularly women of childbearing age, parents, and caregivers of children, in Heritage Health Adult, Nebraska's Medicaid Expansion. While the expansion effort has been well underway for some time now, this work is still needed to assist individuals with the education needed to help them get enrolled. It is particularly important in 2022-2023 as the Division of Medicaid Long-Term Care (MLTC) prepares for the upcoming "Medicaid unwind" with the expected end of the Public Health Emergency (PHE) declared by the federal government in 2020. The end of the PHE means a return to requirements that MLTC resume determination of eligibility on a regular basis for Medicaid clients. With the expectation that some current participants will be determined to be ineligible, it is important to ensure that clients are aware of the effort so they can respond to requests for information or submit new information proactively to avoid an ineligible determination due to a failure to provide information. Community Health Workers will be invaluable in assisting with this effort, based on their close connection to members of their community. In 2020-2021, the CHW Consultant-Trainers provided numerous unexpected and actionable insights into barriers to Medicaid enrollment and the messaging that will help address misconceptions and concerns with certain populations.

Stakeholders appreciate the focus on Medicaid Expansion and using CHW in that project, particularly with populations that may need additional help such as translation. One respondent said:

> "Promoting Medicaid Expansion and addressing stigma with CHWs could help with access for some populations. What about those populations that speak languages other than English?"

The second strategy in this objective describes Nebraska Title V's continued role of lead agency for Nebraska's pediatric mental health care access program, called NEP-MAP. This project involves broad systems-level work that has resulted in cross-systems improvements in mental health access. In the 2022-2023 program year, NEP-MAP enters Year 5 of an expected total of five years of funding. Sustainability planning for NEP-MAP has included identifying return-on-investment formulations for the various components of NEP-MAP which include:

- A cross-systems advisory committee of approximately 70 members including strong family representation
- Provider-to-provider behavioral health consultation services using telehealth
- A training project for family-centered care coordination
- A workgroup for CLAS and Equity
- Reach Out and Read, an early literacy project
- NEP-MAP evaluation services.

In addition to maintaining grant activities in Year 5 of the NEP-MAP, Title V will be working with current partners and stakeholders to determine feasibility of applying for a subsequent grant award should another notice of funding opportunity be released.

2. Alignment of planned activities with annual needs assessment updates

Priority: Improved Access and Utilization of Mental Health Care Services

Planned activities included in the 2022-2023 Application for this domain are strongly aligned with the recommendations of the 2020 Needs Assessment. There are no new findings to update the needs assessment in this priority area.

3. Emerging new priorities taking precedence over the established priority needs

There are no emerging new priorities in this domain to identify currently.

4. Relevance of ESM to selected NPM, changes in ESM

While this priority area encompasses several significant areas of activity for Title V in Nebraska, including Equity, Mental Wellbeing of MCH Populations, Adequate Health Insurance, and Access to Care, no NPM or ESM has been assigned in this priority area for the 2020-2025 cycle.

In addition to assigning ESM to at least one Priority in each population domain, corresponding to a selected NPM, Nebraska Title V uses Results-based Accountability Measures. Since 2015, Nebraska Title V has been writing and utilizing Results-base Accountability (RBA) measures to make annual impacts and achievements more discernable to front line staff and stakeholders. In addition, use of RBA often highlights inclusion and equity-focused efforts that have been transforming Title V work.

Results Based Accountability (RBA) measures Priority: Improved Access and Utilization of Mental Health Care Services		
	Proposed for 2022-2023	*Proposed for 2022-2023*
How much did we do?	How many training activities aligned with mental health first aid, motivational interviewing, suicide prevention, and trauma-informed care were promoted among CHW during the period?	How many CHW are active in the CHW Consultant Trainer Cadre?
How well did we do it?	Were offered training activities utilized by CHW? Did individuals or groups utilizing training represent target populations?	What is the distribution of participation in the Cadre by Behavioral Health region? (Is statewide reach successful?)
Is anyone better off?	What were evaluation results of training – was any improvement indicated?	What were evaluation results of training – was any improvement indicated or action taken?

5. Are changes needed in the established SPMs and SOMs, if applicable

Priority: Improved Access and Utilization of Mental Health Care Services
SPM: Percent of children ages 0-17 years who are continuously and adequately insured.
ESM: None

The SPM identifies the measure of insurance coverage for children, while Title V is also intentionally attentive to Medicaid Expansion enrollment and the impact of the Medicaid "unwind" effort in the coming year. This is relevant for adults, particularly women of childbearing age in the interconception period, and adults who are parents and caregivers of children and youth. This SPM also addresses the disparities and disproportionality that can be seen in mental/behavioral health issues. All are strongly aligned with the Priority and need no changes.

6. Updates or changes to the Five-Year Action Plan Table

The effort to describe a five-year trajectory of planned and proposed activities is a new approach for Nebraska. The goal is to provide stakeholders regular information on the efforts of Title V in relation to Priority Statements, Objectives, and Strategies that is readily accessible and even engaging. A synopsis of the five-year action plan for this domain is shown in the table below.

Priority: Improved Access and Utilization of Mental Health Care Services 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2022**
Year 1 20-21	• CHW education to increase reach of prevention to all communities and groups. Address stigma. • Leverage NEP-MAP to improve primary care screening, referral, and treatment for mental health issues. • Advance equity practices in health care and public health • Promote Heritage Health Adult and child health Insurance	• Training project started • Ongoing • Ongoing • Ongoing
Year 2 21-22	• CHW education to increase reach of prevention to all communities and groups. Address stigma. • Leverage NEP-MAP to improve primary care screening, referral, and treatment for mental health issues. • Advance equity practices in health care and public health • Promote Heritage Health Adult and child health Insurance	• Ongoing • Ongoing • Ongoing • Ongoing
Year 3	• Continue CHW training project; evaluate results • Determine sustainable NEP-MAP activities • Continue equity work in all domains and priorities • Promote Heritage Health Adult and child health Insurance	• Ongoing • Ongoing • Ongoing • Ongoing
Year 4	• Evaluate CHW workforce development activities for sustainability and effectiveness • Evaluate trends in mental health needs of the MCH population • Promote Heritage Health Adult and child health Insurance	
Year 5	• Determination on replication/sustainability • Determination of Return on Investment	

III.F. Public Input

"Grass roots" – at the very foundation or source - describes the intent of Nebraska's public input process. It is right to involve persons who will be impacted by policies and practices, empowering them to have a say beginning in the development stage and beyond.

The importance of public engagement is demonstrated multiple ways in Nebraska Title V. It begins with stakeholders actively engaged in the five-year Needs Assessment and the selection of priorities that shape the State Action Plan and continues with their help to draft the Action Plan itself.

In addition to the state-level focus of the Action Plan, a stakeholder-engaged process is the backbone of local community-level projects in response to the Request for Applications (RFA) in 2021. Nebraska Title V currently helps support eight community-level projects led by local organizations that meaningfully involve stakeholders to address certain priorities identified in the 2020 Needs Assessment. Project integrity is achieved with contributions of time and experience of local community members in the separate eight projects, each uniquely designed by and for the respective eight communities. Projects will continue with grant support through early 2023.

The importance of public input is also shown by adding a separate, permanent public input webpage to provide a route and convey the message that anyone, at any time, may ask questions and provide comment on Nebraska's Title V MCH Block Grant. The intent goes well beyond meeting the statutory requirement to seek public input on the annual Application itself. During the period October 1, 2020 – June 2, 2022, there were 429 visits to the public input webpage, 307 unique. A good day is receiving a comment or question from someone wanting to know more about Title V MCH Block Grant.

Nebraska's Application / Annual Report is routinely made available to the public for comment or questions during its development and after its transmittal. An annual announcement within a 60-day window of the submission to HRSA kicks off the new season for comment on the proposed Application. After its development and submission, the combined 2023 Application / 2021 Report will be available by hyperlink to the Title V Information System (TVIS) where the most current information is available.

Joining the Title V Steering Committee is another option for stakeholder input. Membership cycles can be either long or short-term resulting in continual opportunity for new perspectives yet keeping a solid base of experience and knowledge. Quarterly gatherings provide the opportunity for the Title V Core Team to present updates and seek input from members of the Steering Committee. These check-ins help gauge if the wide array of supported activities is on track to meet objectives directed at Nebraska's priorities. Despite the negatives of a pandemic, it ushered the advent of virtual meetings now fairly commonplace, in turn reducing demands on travel costs and time to further encourage Steering Committee participation.

Increasingly, public input methods involve technology to reach a large audience quickly and cost effectively. Despite the benefits of technology, messages and relationships ideally are developed in person through community activities, services, workgroups, conferences, and other venues that bring Nebraska families and professionals together.

The announcement for input on the 2023 Application was disseminated using a combination of delivery methods. This multi-method approach has proven beneficial over a number of years to extend the message geographically throughout the state and to reach a greater number of Nebraskans than would be possible otherwise. The State Action Plan is the centerpiece for the structured public input prior to the annual submission, inviting input on it rather than directing the public to an intimidating and large amount of complex information in the Application. Focusing on

the State Action Plan framework is not without its downside, as it inherently means limitations to showcase the full degree of efforts planned for the 2023 grant.

Messaging and functionality remain a focus of inviting input on the proposed 2023 State Action Plan. It began with a brief, themed approach to appeal to multiple audiences. The announcement emphasized how the considerable process leading up to the invitation for input also involved the public in identifying priorities and subsequently creating the State Action Plan. The announcement used the opportunity to briefly describe why and how the objectives and strategies are selected to address measures that align to the priorities. Adding this - and limiting the survey questions to exclusively the State Action Plan - is not intended to squelch the number of responses, rather to stay focused on the already-established priorities resulting from the stakeholder-engaged process in the 2020 Needs Assessment.

Within the 24-day comment period, 22 responses were received to a three-item survey. In the demographic item, respondents identified their role(s) with Nebraska's MCH population, with the ability to select all roles that apply. Over half (59%) of the respondents (13) identified as a public health professional, while less than half as a parent or other caregiver (9), as a concerned citizen (9) and advocate (6). Respondents also included provider of health/human services (4), representatives of civic organizations (3) and a faith community (2), teachers (2), behavioral health practitioners (2), youth (1), and school nurse (1). Five respondents indicated the "other" demographic and specified home visitor, registered nurse, public health dental hygienist, private non-profit employee, and an employee of a public entity. None of the respondents identified as a school administrator, medical practitioner, or representative of business.

One survey question was directed exclusively on the State Action Plan. The following table summarizes how respondents reacted in one of four ways on whether the proposed strategies will adequately address the associated priority. The reference code, e.g. B-1 and C-3, preceding a priority is explained following a summary of the survey results.

	Yes	No	No Comment	Skipped
B-1 Premature Birth	14	1	4	3
B-2 Infant Safe Sleep	13	3	3	3
C-3 Child Abuse Prevention	14	4	2	2
C-4 Access to Preventative Oral Health Care Services	12	6	2	2
Y-5 Motor Vehicle Crashes Among Youth	10	2	6	4
Y-6 Sexually Transmitted Disease Among Youth	13	2	4	3
Y-7 Suicide Among Youth	14	1	5	2
CSHCN-8 Behavioral & Mental Health in School	15	1	4	2
WM-9 Cardiovascular Disease including Diabetes, Obesity, and Hypertension	13	2	2	5
CCSB-10 Improved Access to Utilization of Mental Health Care Services	14	4	2	2

"Yes" responses - In all but one of the 10 priorities, the majority of respondents believe the strategies in the State Action Plan will address the priority, ranging from 15 voting yes on Behavioral & Mental Health in School, 14 voting yes on Premature Birth, Child Abuse Prevention, Suicide Among Youth strategies, and Improved Access to

Utilization of Mental Health Care Services. All other priorities had 12 or 13 who responded yes.

"No" responses - All priorities received at least 1 no vote (Premature Birth, Suicide Among Youth, and Behavioral & Mental Health in School). Other priorities ranged from 2 to 6 respondents voting no. The priority Motor Vehicle Crashes Among Youth tallied 2 no votes, less than half (10) voted yes, and 6 no comment. Six respondents on the priority Access to Preventative Oral Health Care Services were not confident the strategies will address the priority.

"No comment" - All 10 priorities tallied from 2 to 6 respondents who expressed no comment.

Skipped - Respondents could skip priorities that were not of interest to them. Among the 10 priorities, a range of 2-5 respondents skipped reacting to whether the strategies would address a priority.

Scores and comments were carefully reviewed and considered for inclusion in the 2023 State Action Plan. A reasonable expectation of responders to the survey, especially persons who offered comments, is to know their voice was heard. Will they be able to identify it in the submitted Application, or more specifically the State Action Plan? Not necessarily, but that does not mean the input was unimportant. It is possible that comments and suggestions, though thoughtful and insightful, are impractical to incorporate into the State Action Plan framework. Fitting the input received into the required framework continues to evolve and improve with more family engagement and other interactions between the Title V team and fellow Nebraskans.

The results will continue to be contemplated beyond the annual Application itself. Responses are valuable in one way or another, utilized in ways that may not be reflected in the State Action Plan. For example, the Nebraska Title V MCH Block Grant webpage underwent edits based on prior public input. Improved online information was in response to common questions and comments received in recent years.

The remainder of this section describes the process of inviting public input on the 2023 Application. References to Supporting Documents offers a quick glimpse at the content. The annual announcement was delivered using two methods, i.e., email relay and a system-generated notice to webpage subscribers (**Supporting Document 1**). Messaging sought to connect process and content with a timely, appealing theme to most Nebraskans. The overriding 'gardening' theme is also used in the email and the announcement (**Supporting Document 2**) to point out the similarity between designing and seeking input on the State Action Plan to that of gardening tools and inviting green thumbs to grow healthy Nebraska families. A theme is used to interest readers, and then transition to the opportunity to review content of the proposed State Action Plan (**Supporting Document 3**) using the interactive functionality of hyperlinks. Finally, a survey method (**Supporting Document 4**) enhances ease to react to the proposed plan and to share opinions about what helps grow healthy families.

In May 2022 the email opener was sent to 41 key contacts whose email addresses are easily confirmed to be current and ready to accept communication. In addition, the key contacts are also selected because they have their own contact group(s). In several cases this means access to a sizable listserv. Similar to several prior years which proved to be an effective method of delivery, asking key contacts to forward the email to expand the notification is similar to a relay. A few examples of key contacts, and significant partners, include the MCH Director as the facilitator of the Nebraska Title V Steering Committee, the state coordinator for the Planning Council on Developmental Disabilities, the overseer of the State Health Improvement Plan, the state WIC Director, and managers in charge of the School Health Nurse listserv and the Office of Health Disparities and Health Equity listserv. The total number of deliveries through the initial 41 key contacts is unknown though a good estimate is likely 500-800 through email relay alone. Most likely there are duplicate recipients through the multiple method delivery approach, but perhaps only a minor annoyance to receive it more than once.

The email notifying 4,930 subscribers to the Nebraska Title V MCH Block Grant webpage that an update was posted

resulted in 459 visits, with 341 unique. The public input announcement resulted in 60 visits to the public input webpage, with 52 unique.

The webpage featuring the announcement was removed after the requested response date, as was the survey itself. For a partial experience of the interactive functionality of these methods, readers can visit “the lattice” (Supporting Document 3), i.e., Nebraska’s proposed State Action Plan at the time of public input notification. Interactive functionality allows responders to more easily choose from the priorities of interest to them. From the overview of “the lattice”, three-way linkages route to a priority need, the proposed objectives and strategies, and returns to the “the lattice” for additional selections.

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III.G. Technical Assistance

III.G Technical Assistance

Facilitated conversations between the Divisions of CFS, PH, and MLTC to update the Interagency Agreement
Nebraska's Interagency Agreement between Divisions within DHHS - Children and Family Services (CFS), Public Health (PH), and Medicaid Long Term Care (MLTC) – is in need of an update. Multiple changes have occurred since the agreement was last signed, including organizational restructuring, leadership changes, staff changes, and significant alterations to the Medicaid program (integration of medical and behavioral health services, a shift from fee-for-service towards value-added services, and most recently, expansion). While other agreements have been entered into that formalize workflows for certain parts of the relationships, the overall agreement should be updated. In the expectation that other Division staff will not be familiar with Title V or the statutory relationship between the Divisions, facilitated conversations to assist in describing how these programs work together would be beneficial.

Improving family/consumer engagement and other forms of public input
Title V has made strides in ensuring families and consumers have representation, including on Advisory Boards, as valued consultants offering feedback on messaging and education products, and on various workgroups. Additionally, Nebraska has seen a marked increase in the amount of public input received when asking for feedback on the block grant and associated action plan. However, there is always room for improvement, and Nebraska has not yet been successful in getting family/consumer engagement at all of the planning levels of Title V or related programs. Nebraska needs technical assistance to help determine the best way to engage families in the complicated Title V framework and ensure that they are given the tools for successful, meaningful interactions with professionals.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Intra-Agency Protocol-Nebraska.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 1-Public Input delivery methods-Nebraska.pdf

Supporting Document #02 - 2-Public Input announcement-Nebraska.pdf

Supporting Document #03 - 3-Public Input-the lattice-Nebraska.pdf

Supporting Document #04 - 4-Public Input Survey-Nebraska.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org chart Title V MCH Block Grant 071422.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nebraska

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,000,000	
A. Preventive and Primary Care for Children	$ 1,347,182	(33.6%)
B. Children with Special Health Care Needs	$ 1,420,584	(35.5%)
C. Title V Administrative Costs	$ 110,001	(2.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 2,877,767	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,000,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 318,934	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 3,318,934	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,626,360		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 7,318,934	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 228,192,347	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 235,511,281	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)	$ 58,530,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Services Block Grant (CSBG)	$ 5,178,192
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Home Energy Assistance Program (LIHEAP)	$ 29,213,636
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	$ 1,700,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 9,380,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 286,977
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 326,542
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 57,000,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,900,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 3,254,124
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 600,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,260,897
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 625,482

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Emergency Food Assistance Program (TEFAP)	$ 350,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	$ 970,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Supplemental Nutrition Assistance Program (SNAP)	$ 20,180,000
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 35,088,485
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 158,012
US Department of Housing and Urban Development (HUD) > Community Planning and Development > Nebraska Homeless Assistance Program	$ 1,000,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,000,000 (FY 21 Federal Award: $ 3,896,216)		$ 3,709,999	
A. Preventive and Primary Care for Children	$ 1,250,000	(31.3%)	$ 1,249,511	(33.6%)
B. Children with Special Health Care Needs	$ 1,250,000	(31.3%)	$ 1,317,591	(35.5%)
C. Title V Administrative Costs	$ 125,000	(3.1%)	$ 102,026	(2.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 2,625,000		$ 2,669,128	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,000,000		$ 3,002,378	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 350,000		$ 207,955	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 3,350,000		$ 3,210,333	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,626,360				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 7,350,000		$ 6,920,332	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 212,241,927		$ 145,345,649	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 219,591,927		$ 152,265,981	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)	$ 50,400,000	$ 30,075,471
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Services Block Grant (CSBG)	$ 5,076,126	$ 4,801,785
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Home Energy Assistance Program (LIHEAP)	$ 29,985,724	$ 27,620,132
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	$ 1,400,000	$ 1,679,737
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 9,340,000	$ 9,397,671
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 269,147	$ 202,802
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 324,411	$ 216,415
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 57,000,000	$ 14,799,633
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 110,650
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,525,000	$ 1,122,682
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 171,323	$ 172,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 3,817,361	$ 5,153,636

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 600,000	$ 298,194
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 1,309,215	$ 1,317,276
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 281,211
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 204,773
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 637,311	$ 598,506
US Department of Agriculture (USDA) > Food and Nutrition Services > Emergency Food Assistance Program (TEFAP)	$ 350,000	$ 341,541
US Department of Agriculture (USDA) > Food and Nutrition Services > Supplemental Nutrition Assistance Program (SNAP)	$ 16,400,000	$ 20,179,095
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 30,266,309	$ 25,629,182
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	$ 450,000	$ 291,301
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
US Department of Housing and Urban Development (HUD) > Community Planning and Development > Nebraska Homeless Assistance Program	$ 980,000	$ 751,456

Form Notes for Form 2:

The 2021 award is $3,896,216, with spending authority through September 30, 2022. At the time of the August 12, 2022 reporting due date, the total final expenditure on obligations is projected will be $3,709,999 at the conclusion of the liquidation period following grant end.

Any variances budget-to-expenditure result from: 1) preparation of an annual budget estimate and exercising two-year spending authority; 2) state appropriations by SFY expended in FFY; and 3) budget estimates for anticipated local funds transacted within subaward periods of performance.

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The 2021 grant will be slightly under expended due to COVID-19 pandemic disruptions and adjustments, the result of constant change and uncertainty. One of the primary triggers was how to proceed with obligations to 8 stakeholder-engaged projects that had originally been developed in a "hopeful pause" of the pandemic. Projects experienced yet another surge during the period October 2021 through March 2022. Alternatives to the usual in-person activities were accommodated, however, local communities and especially local health departments that led six of the 8 projects continued to be nearly consumed in pandemic response and vaccine administration. As a result, completing all planned activities of some of the projects with the 2021 grant funds obligated was infeasible. All projects address children-focused priorities, and without the actual expense in that population, continuing to expend the 2021 grant in other population categories within NDHHS, e.g. personnel costs, would jeopardize compliance with the statutory 30% expenditure for children.

2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget of administrative costs for the 2021 grant was an estimate of the anticipated allotment at the time of submission September 2020.

3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
At the time of 2021 budget submission, it was unknown what amount local partners would contribute because subawards resulting from a Request for Applications had not been finalized. NDHHS does not rely on local support to meet the statutory requirement. Local support was contributed to total project costs, both non-federal cash and in-kind, and is subsequently reported.

4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Services Block Grant (CSBG)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is the current award for the period of 10/01/2022 thru 09/30/2023.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Home Energy Assistance Program (LIHEAP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is the current award for the period of 10/01/2022 thru 09/30/2023.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	

9.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: FY21 SRAE award is for the period 10/1/21-09/30/22.	
10.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: FY20 PREP award is for the period 10/1/21-09/30/22.	
11.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
12.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The current award is for the period 7/1/22 - 6/30/23.	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
The FY23 Breast and Cervical Cancer Award Period is 6/30/22 to 6/29/23. This is a new grant cycle with expected budget amount of $1,900,000.

14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
This is for the grant period 7/1/22 - 6/30/23.

15.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
The FY23 WISEWOMAN Award period is 9/30/22 to 9/29/23. Award Total is $600,000.

16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
The award for the period 9/30/21 - 9/29/23 is $1,260,897.

17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

Field Note:
The application for 2023 (Year 5) will be for the period 9/30/22 - 9/29/23 in the amount of $445,000.

18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2023**

	Column Name:	**Application Budgeted**
	Field Note: The current award is for the period 4/1/22 - 3/31/23.	
19.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is the FFY2022 award for the period 10/1/21 - 9/30/22.	
20.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Emergency Food Assistance Program (TEFAP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
21.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
22.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Supplemental Nutrition Assistance Program (SNAP)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
23.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

	Field Note: Funds allocated for FFY22, as of 6/2/22 is $250,000. Breastfeeding Peer Counseling (BFPC) grant was reduced so NE could spend all of prior year funds. BFPC grants are for 3 yrs.	
24.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Funds allocated for FFY22, as of 6/2/2022 for WIC Nutritional Services and Administration (NSA) ($11,921,465) and Food ($23,167,020). CVB values were increased by Congress for FFY22. Food grants will pay for the increase with no additional appropriations.	
25.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: SSDI FY23 (5/2022-4/2023)	
26.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: $158,012 is for the period 5/2022-05/2023.	
27.	**Field Name:**	**Other Federal Funds, US Department of Housing and Urban Development (HUD) > Community Planning and Development > Nebraska Homeless Assistance Program**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: This is a projected award for the period of 10/01/2022 thru 09/30/2023. Subject to change.	
28.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)**
	Fiscal Year:	**2021**

	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $58,535,092. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $58,535,092 at that time. Expenditures are as of 06/02/2022.

29.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Services Block Grant (CSBG)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $ 5,162,169. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $ 5,162,169 at that time. Expenditures are as of 06/02/2022.

30.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Home Energy Assistance Program (LIHEAP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $28,934,737. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $28,934,737 at that time. Expenditures are as of 06/02/2022.

31.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $1,763,461. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $1,763,461 at that time. Expenditures are as of 06/02/2022.

32.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $9,400,475. DHHS still has spending authority through September 30, 2022 and anticipates expended amounts to be $9,400,475 at that time. Expenditures are as of 06/02/2022.

33.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Final expenditure on FY20 SRAE (10/1/2020-09/30/2021).

34.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Final expenditures on FY19 PREP (10/1/2020-09/30/2021).

35.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $ 56,627,234. DHHS still has spending authority on this grant. Expenditures are as of 06/02/2022.

36.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate. The authorized amount was $160,000 for the period 7/1/2020 - 6/30/2021. The expended is actual; the program was unable to expend the total award due to restrictions on how the funding could be spent.

37.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The FY21 Breast and Cervical Cancer award period was 6/30/20 to 6/29/21. Expenditures of that award are $1,122,682.28.

38.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
$172,500 was expended for 05/2020-04/2021.

39.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Grant period 7/1/20 - 6/30/21.

40.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The FY21 WISEWOMAN award period was 9/30/20 to 9/29/21. Expenditures of that award are $298,194.54.

41.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate for the award ($1,317,276) for the period 9/30/2019-9/29/2021; award was fully expended.

42.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
$281,211 was expended of the 2021 award (Year 3) for the period 9/30/20 - 9/29/21.

43.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate. The authorized amount is $235,000 for the period 4/1/21 - 3/31/2022. Expended is actual; program was unable to expend the total award due to restrictions on how the funding could be spent.

44.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Received $620,062 for FY21. Two subrecipients did not expend entire subawards.

45.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Emergency Food Assistance Program (TEFAP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $341,541. Full amount has been expended. Expenditures are as of 06/02/2022.

46.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Supplemental Nutrition Assistance Program (SNAP)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount for FY21 is $20,179,095. DHHS still has spending authority through September 30, 2022. Full amount expended. Expenditures are as of 06/02/2022.

47.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Closeout Expenditures for FFY21 WIC awards:
NSA: $10,521,574
Food: $13,185,050
ARPA/CVB: $1,572,163
BFPC: $350,395

Notes: 1) ARPA funds were appropriated to WIC separately and tracked separately for the expanded value of the fruit/veggie cash value benefit (CVB); 2) NE implemented a new infant formula rebate contract in 1/2021 which provided a higher rebate which in turn reduced food grant expenditures.

48.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
The budget was an estimate; the authorized amount is $965,967. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $965,967 at that time. Expenditures are as of 06/02/2022.

49.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
SSDI 12/1/20 - 11/30/21 fully expended.

50.	**Field Name:**	**Other Federal Funds, US Department of Housing and Urban Development (HUD) > Community Planning and Development > Nebraska Homeless Assistance Program**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:

The budget was an estimate; the authorized amount for FY21 is $1,006,505. DHHS still has spending authority through September 30, 2022 and anticipates expended amount to be $1,006,505 at that time. Expenditures are as of 06/02/2022.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Nebraska

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 398,333	$ 369,454
2. Infants < 1 year	$ 506,408	$ 469,694
3. Children 1 through 21 Years	$ 1,347,182	$ 1,249,511
4. CSHCN	$ 1,420,584	$ 1,317,591
5. All Others	$ 217,492	$ 201,723
Federal Total of Individuals Served	$ 3,889,999	$ 3,607,973

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 393,908	$ 381,019
2. Infants < 1 year	$ 616,054	$ 595,896
3. Children 1 through 21 Years	$ 527,141	$ 509,892
4. CSHCN	$ 998,838	$ 966,154
5. All Others	$ 782,993	$ 757,372
Non-Federal Total of Individuals Served	$ 3,318,934	$ 3,210,333
Federal State MCH Block Grant Partnership Total	$ 7,208,933	$ 6,818,306

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Nebraska

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 144,672	$ 134,183
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 23,348	$ 21,655
B. Preventive and Primary Care Services for Children	$ 44,808	$ 41,559
C. Services for CSHCN	$ 76,516	$ 70,969
2. Enabling Services	$ 1,467,938	$ 1,361,512
3. Public Health Services and Systems	$ 2,387,390	$ 2,214,304
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 5,544
Physician/Office Services		$ 27,176
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 30,201
Dental Care (Does Not Include Orthodontic Services)		$ 39,218
Durable Medical Equipment and Supplies		$ 27,618
Laboratory Services		$ 1,391
Other		
STD tests		$ 3,035
Direct Services Line 4 Expended Total		$ 134,183
Federal Total	$ 4,000,000	$ 3,709,999

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 308,706	$ 298,604
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 7,002	$ 6,773
B. Preventive and Primary Care Services for Children	$ 146,810	$ 142,006
C. Services for CSHCN	$ 154,894	$ 149,825
2. Enabling Services	$ 2,614,799	$ 2,529,238
3. Public Health Services and Systems	$ 395,429	$ 382,491
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 22,042
Physician/Office Services		$ 106,929
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 44,366
Dental Care (Does Not Include Orthodontic Services)		$ 20,150
Durable Medical Equipment and Supplies		$ 75,671
Laboratory Services		$ 29,433
Other		
unknown other direct service of nominal amount		$ 13
Direct Services Line 4 Expended Total		$ 298,604
Non-Federal Total	$ 3,318,934	$ 3,210,333

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Nebraska

Total Births by Occurrence: 24,802 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	24,761 (99.8%)	271	62	62 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Nebraska Early Hearing Detection and Intervention (EHDI)	24,645 (99.4%)	1,398	55	53 (96.4%)
Congenital Critical Heart Disease (CCHD) – Confirmed Cases	0 (0.0%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

There is long term follow-up management / treatment done for cystic fibrosis through the Nebraska Cystic Fibrosis Center in Omaha, NE for infants / children who are seen in Nebraska. Some babies born in Nebraska receive long-term care at the Colorado Cystic Fibrosis Center in Denver, CO since the distance to CO may be closer for some families. All pertinent medical history and information is obtained and evaluations are conducted.

There is long term follow-up management / treatment conducted for metabolic diseases through the Nebraska Metabolic Center in Omaha, NE for infants / children who are seen in Nebraska. Some babies born in Nebraska receive long-term care at the Colorado Metabolic Center in Denver, CO since the distance to CO may be closer for some families. All pertinent medical history and information is obtained and evaluations are conducted.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2021**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 24,802 births occurred in Nebraska. Of those 24,761 were screened in accordance with Nebraska State Law. There were 41 births not screened as they expired prior to 48 hours of life.	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: In 2021, 41 of the 24,802 births expired prior to 48 hours of life. Therefore, those 41 births were not screened.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: There were an additional 381 inconclusive screens for amino acids and acylcarnitines (MS/MS) requiring a repeat newborn screen. These did not require confirmatory testing, therefore, these cases were not counted in the number of presumptive positive screens.	
4.	**Field Name:**	**Nebraska Early Hearing Detection and Intervention (EHDI) - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: There were 24,645 births that received at least one screen for hearing loss. Newborn hearing screening in Nebraska is not a mandatory law.	
5.	**Field Name:**	**Nebraska Early Hearing Detection and Intervention (EHDI) - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

Field Note:
Referrals are made to the Early Development Network (EDN). Parents can refuse a referral.

The number referred for treatment is less than the confirmed cases. In one case, parent(s) are not interested in services due to the infant having mild hearing loss. In the second case the infant has transient hearing.

6.	**Field Name:**	**Congenital Critical Heart Disease (CCHD) – Confirmed Cases - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

Field Note:
Nebraska hospitals are required under state law to screen newborns for CCHD. However, the State of Nebraska does not have authority to collect the data.

7.	**Field Name:**	**Congenital Critical Heart Disease (CCHD) – Confirmed Cases - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

Field Note:
Nebraska hospitals are required under state law to screen newborns for CCHD. However, the State of Nebraska does not have authority to collect the data.

8.	**Field Name:**	**Congenital Critical Heart Disease (CCHD) – Confirmed Cases - Total Number Confirmed Cases**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

Field Note:
Nebraska hospitals are required under state law to screen newborns for CCHD. However, the State of Nebraska does not have authority to collect the data.

9.	**Field Name:**	**Congenital Critical Heart Disease (CCHD) – Confirmed Cases - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**

Field Note:
Nebraska hospitals are required under state law to screen newborns for CCHD. However, the State of Nebraska does not have authority to collect the data.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Nebraska

Annual Report Year 2021

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	**(A) Title V Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private / Other %**	**(E) None %**	**(F) Unknown %**
1. Pregnant Women	812	45.5	0.0	46.5	8.0	0.0
2. Infants < 1 Year of Age	553	60.9	0.0	22.0	17.1	0.0
3. Children 1 through 21 Years of Age	26,022	18.9	4.8	65.9	10.4	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,615	55.5	14.2	8.1	22.2	0.0
4. Others	40,954	16.6	0.0	65.9	17.5	0.0
Total	68,341					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	24,291	Yes	24,291	100.0	24,291	812
2. Infants < 1 Year of Age	24,654	Yes	24,654	100.0	24,654	553
3. Children 1 through 21 Years of Age	559,644	Yes	559,644	95.0	531,662	26,022
3a. Children with Special Health Care Needs 0 through 21 years of age^	106,398	Yes	106,398	100.0	106,398	1,615
4. Others	1,352,947	Yes	1,352,947	4.0	54,118	40,954

^Represents a subset of all infants and children.

Form Notes for Form 5:

As instructed in the Guidance & Forms, Nebraska is reporting based on the expenditures reported on Form 2, line 8 (the Federal-State Partnership).

Individuals with unknown insurance coverage in each population (except CSHCN which had available data) are calculated using HRSA-provided reference data for Nebraska. The total number of persons provided direct and enabling services (Form 5a) and reached through public health services & systems (Form 5b) decreased from the prior reporting period. The reduction in numbers is related to several conditions: 1) a shorter performance period for local communities with subawards of 2021 grant to end March 31, 2022. Going forward this will be a full one-year period April – March to better align with the July 15 reporting requirement. 2) The Injury Prevention Program did not require the financial support of the 2021 grant as the prior report and subsequent numbers; and 3) fewer numbers are also the result of a non-MCH focus with the Nebraska Native American Public Health Act state funds.

The numerator data source is program data of NDHHS and local partners for all types of individuals served. The denominator data sources are reference data for Nebraska provided by HRSA for Form 5a and Form 5b.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**

Field Note:
Nebraska reports 812 Pregnant Women (through 60 days postpartum) received direct and enabling services through NDHHS programs and local partners:
- Newborn Screening provided direct services to 3 pregnant women to ensure access to special foods and formula for metabolic conditions;
- N-MIECHV (the state-funded support of evidence-based programs in 7 counties) provided case management home visiting services to 138 pregnant women;
- Reproductive Health program subawards provided enabling services to 8 pregnant women;
- Oral health subaward provided direct services that included 5 pregnant women;
- STD testing of 249 pregnant women;
- Tribal subawards provided both direct and enabling services to 145 pregnant women through health screenings, early prenatal care and education, breastfeeding promotion, and injury prevention;
- WIC Farmers Market Nutrition Program subaward to Douglas County WIC distributed coupons for redemption of locally-grown produce with nutrition education to 264 pregnant woman.

Numerator data source: program data of NDHHS and local partners.
The number of Pregnant Women with unknown insurance coverage were calculated for Form 5a using reference data for Nebraska.

Denominator data source: National Vital Statistics System – Pregnant Women, 2020

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**

Field Note:
Nebraska reports 553 Infants (less than 1 year) received direct and enabling services by Title V though NDHHS programs and local partners:
- Newborn Screening of 79 infants screening positive whose parents received a consultation to determine the lab result was a false positive;
- Tribal subawards' health programs supported 225 infants through breastfeeding, injury prevention, and immunization enabling services;
- N-MIECHV (the state-funded support of evidence-based programs in 7 counties) provided case management home visiting services to 179 infants;
- Nebraska Elemental Formula Reimbursement Program provided enabling service to 70 infants with certain medical conditions that require medically necessary amino acid-based elemental formulas.

Numerator data source: program data of NDHHS and local partners.
The number of Infants with unknown insurance coverage were calculated for Form 5a using reference data for Nebraska.

Denominator data source: National Vital Statistics System – Infants, 2020

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Nebraska reports 20,407 Children (ages 1 through 21) received enabling services by NDHHS programs and local partners; adding CSHCN (0 through age 21) as a subset of children brings the total served to 26,022.
- Reproductive Health program through subawards for adolescent reproductive health (engagement of adolescents to increase their utilization of reproductive health services) provided enabling services to 8,873 adolescents.
- N-MIECHV (the state-funded support of evidence-based programs in 7 counties) provided case management home visiting services to 147 Children;
- Tribal subawards provided a variety of enabling services to 1,338 Children (public health programs promoted injury prevention, immunizations, healthy lifestyle choices, and cultural traditions in various formats e.g. nutrition demonstrations and events);
- STD testing of 10,773 adolescents as enabling service;
- WIC Farmers Market Nutrition Program subaward to Douglas County WIC distributed coupons for redemption of locally-grown produce with nutrition education, serving 2,469 Children.

Numerator data source: program data of NDHHS and local partners.
The number of Children with unknown insurance coverage were calculated for Form 5a using reference data for Nebraska.

Denominator data source: American Community Survey – Children 1-21, 2019

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Of the 26,022 total Children, 1,615 CSHCN (0 through age 21) received direct or enabling services by NDHHS programs and local partners.
- The Medically Handicapped Children's Program (MHCP) served 1,529. MHCP reported insurance coverage for 1,174, with 355 uninsured. MHCP field staff statewide provided ongoing family-centered case management services to program participants. MHCP continues use of Parent Resource Coordinators (PRC). The program partners with the University of Nebraska Medical Center (UNMC)'s Munroe Meyer Institute (MMI) to conduct Specialty Clinics, neonatal intensive care follow-up through TIPS (Tracking Infant Progress Statewide) program, and the Teratogen Project provided accurate and timely information on exposures to potentially damaging agents during pregnancy and lactation.
- Newborn Screening provided access to special feeds and formula to patients identified through newborn screening with metabolic conditions. Insurance coverage is reported for all 65 CSHCN (0 through age 21) receiving this direct service, reducing the cost to Title V.
- Tribal subaward reports an enabling service to 21 CSHCN (0 through age 21).

Numerator data source: program data of NDHHS and local partners.
The number of CSHCN with unknown insurance coverage were calculated for Form 5a using reference data for Nebraska.

Denominator data source: National Survey of Children's Health - CSHCN, 2019-2020

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Nebraska reports 40,954 Others received a direct or enabling service by Title V through NDHHS programs and local partners. NDHHS includes in this category: childbearing women over age 21; parents; and adult males served in family-centered care through the following programs:
- Health Mothers Health Babies helpline / Nebraska 211 provided enabling services to 14,993 callers;
- Newborn Screening ensured access to special foods and formula to 11 persons with metabolic conditions categorized as Others;
- Evidence-based home visiting provided case management home visiting services to 190 persons categorized as Others;
- Breast and Cervical Cancer program provides cervical cancer screening and prevention; office visits in which a pap smear, breast exam, or STD test was done, and laboratory costs for pap smears were provided to 589 persons categorized as Others;
- STD testing of 21,913 persons categorized as Others;
- Tribal subawards' health clinics provided services for well-woman care to 2,617 persons categorized as Others;
- WIC Farmers Market Nutrition Program subaward to Douglas County WIC distributed coupons for redemption of locally-grown produce with nutrition education to 641 persons categorized as Others.

Numerator data source: program data of NDHHS and local partners.
The number of Others with unknown insurance coverage were calculated for Form 5a using reference data for Nebraska.

Denominator data source: American Community Survey – Others 22+, 2019

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**

	Fiscal Year:	**2021**

Field Note:
At all service levels, Nebraska Title V estimates reaching 24,291 Pregnant Women (or 100% of the population), through NDHHS programs and local partners. In addition to the programs listed for Form 5a for direct and enabling services, the following includes the population-based activities (Public Health Services and Systems) of NDHHS and its major program partnerships:
- Maternal Mortality Review Committee (MMRC) under the Child Maternal Death Review Team (CMDRT) review of 11 maternal cases;
- NDHHS agreement with the University of Nebraska Medical Center for the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) impacted an estimated 24,291 pregnant women;
- Pregnancy Risk Assessment Monitoring System (PRAMS) selected 2,313 Nebraska mothers for participation in the survey;
- The Women's Health Initiative reached an estimated 250 pregnant women through a variety of systems-level work;
- Tribal subawards impacted 130 pregnant women.

Numerator data source: program data of NDHHS and local partners

Denominator data source: National Vital Statistics System – Resident Live Births, 2020

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
At all service levels, Nebraska Title V estimates reaching 25,314 Infants (or 100% of the population), through NDHHS programs and local partners. In addition to the programs listed for Form 5a for direct and enabling services, the following includes the population-based activities (Public Health Services and Systems) of NDHHS and its major program partnerships:
- Newborn Screening Program screened 24,761 babies born in Nebraska for metabolic conditions. Births not screened, expired prior to 48 hours of life;
- Pregnancy Risk Assessment Monitoring System (PRAMS) selected 2,313 Nebraska mothers (with infants) for participation in the survey.
- Maternal Child Adolescent School Health (MCASH)'s Maternal - Infant Health Program's Nebraska Safe Babies Campaign impacted an estimated number of infants, citing 24,761 births in Nebraska;
- Child Maternal Death Review Team (CMDRT) review of 133 cases of Infants;
- Tribal subawards reached 206 infants with a population-based service.

Numerator data source: program data of NDHHS and local partners

Denominator data source: Infants < 1 Year of Age: National Vital Statistics System – Occurrent Live Births, 2020

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
At all service levels, Nebraska Title V estimates reaching 497,221 Children (or 89% of the population), through NDHHS programs and local partners. In addition to the programs listed for Form 5a for direct and enabling services, population-based activities (Public Health Services and Systems) include:
- Reproductive Health Program educated providers, increased assess to STD/HIV testing and education; and partnered with other programs to leverage resources to impact an estimated 1,950 adolescents;
- Maternal Child Adolescent School Health (MCASH)'s School Health Program and Adolescent Health Program through continuing education for health professions and Community Health Worker training support, and partnering with school health nurses statewide reached an estimated 324,176 Children;
- Child Maternal Death Review Team (CMDRT) review of 108 cases of Children;
- Office of Oral Health is working on the 2021-2022 Nebraska Oral Health Survey of Young Children that includes Head Start and 3rd grade sites with 2,950 Children screened to-date;
- Subaward with Panhandle Public Health District implementing a stakeholder-based process piloted with the Place Matters toolkit, and the resulting project to reduce blood lead levels impacted 6 Children;
- Subawards directed at four child-focused priorities identified in the 2020 Needs Assessment estimate impacting 32.504 Children through stakeholder-engaged projects.

Numerator data source: program data of NDHHS and local partners

Denominator data source: US Census Bureau Population Estimates, 2020

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
At all service levels, Nebraska Title V estimates reaching 110,047 CSHCN (or 100% of the population), through NDHHS programs and local partners. In addition to the programs listed for Form 5a for direct and enabling services, the following includes the population-based activities (Public Health Services and Systems) of NDHHS and its major program partnerships:
- Maternal Child Adolescent School Health (MCASH)'s School Health Program estimates impacting 53,960 CSHCN in Nebraska public schools;
- Birth Defects Registry reports 3,918 birth defect cases;
- Early Hearing Detection & Intervention (EHDI) reports 55 infants and 19 Children over age 1 with a confirmatory audiologic evaluation of DHH (deaf or hard-of-hearing), a total 62 CSHCN;
- Biomedical Research through agreement with Creighton University Boys Town Research Hospital reached an estimated 53,199 CSHCN;
- Tribal subawards reached 13 CSHCN with a population-based service
- Panhandle Public Health District implementing a stakeholder-based process piloted with the Place Matters toolkit, and the resulting project to reduce blood lead levels impacted 10 CSHCN with a population-based service.

Numerator data source: program data of NDHHS and local partners

Denominator data source: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2019-2020) multiplied by US Census Bureau Population Estimates 0-21, 2020

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:

At all service levels, Nebraska Title V estimates reaching 47,504 persons categorized as Others, or 4% of the population. For the numerator, NDHHS includes in this category: childbearing women over age 21; parents of teens (age 13-17); and adult males served in family-centered care. In addition to the programs listed for Form 5a for direct and enabling services, the following includes the population-based activities (Public Health Services and Systems) of NDHHS and its major program partnerships:

- Reproductive Health Program educated providers, increased assess to STD/HIV testing and education; and partnered with other programs to leverage resources to impact an estimated 3,050 persons categorized as Others;
- Among a variety of activities reaching this population through systems work, the Women's Health Initiative led collaborative work on a priority from the 2020 Title V Needs Assessment impacting an estimated 2,000 persons categorized as Others.

Numerator data source: program data of NDHHS and local partners.

Denominator data source: US Census Bureau Population Estimates, 2020

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Nebraska

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	24,767	17,113	1,746	4,257	374	979	32	219	47
Title V Served	257	3	0	0	254	0	0	0	0
Eligible for Title XIX	9,614	4,140	1,129	2,018	213	334	24	292	1,464
2. Total Infants in State	23,444	15,030	1,471	4,996	244	672	16	1,015	0
Title V Served	455	65	3	9	306	1	0	1	70
Eligible for Title XIX	12,184	4,692	1,337	2,845	246	384	32	689	1,959

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Nebraska

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(866) 813-1731	(866) 813-1731
2. State MCH Toll-Free "Hotline" Name	Nebraska 2-1-1	Nebraska 2-1-1
3. Name of Contact Person for State MCH "Hotline"	Jackie Moline	Jackie Moline
4. Contact Person's Telephone Number	(402) 471-0165	(402) 471-0165
5. Number of Calls Received on the State MCH "Hotline"		14,993

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	Nebraska Family Helpline	Nebraska Family Helpline
2. Number of Calls on Other Toll-Free "Hotlines"		11,624
3. State Title V Program Website Address	https://dhhs.ne.gov/Pages/Title-V.aspx	https://dhhs.ne.gov/Pages/Title-V.aspx
4. Number of Hits to the State Title V Program Website		4,647
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

Nebraska Department of Health and Human Services partners with Nebraska 2-1-1 to provide and capture the information regarding referral to services for moms and babies throughout the State of Nebraska. Nebraska 2-1-1, answered by United Way of the Midlands, is a free, comprehensive information and referral system linking Nebraska residents to health and human service programs, community services, disaster services and governmental programs. 2-1-1 assistance is available in multiple languages, and services are accessible to people with disabilities. Nebraska 2-1-1 is available by phone, text (text zip code to 898211), or online www15496.ne211.org.

Another support, the Nebraska Family Helpline (888) 866-8660, provides a single point of access to children's behavioral health services. Parents with kids of all ages can call with any type of question regarding their child's behavior. It is also a resource for professionals. Operated by Boys Town, this service is private, anonymous and free of charge. The Helpline employs trained crisis counselors to offer research-based support and advice 24-hours a day, 365 days a year. The Helpline received 11,624 inbound calls and made 3,333 outbound calls. The total number of unique families served was 7,883. For more information, visit https://dhhs.ne.gov/Pages/Nebraska-Family-Helpline.aspx.

There were 4,647 visits to two primary webpages. Of the total, 1,778 visits were to Lifespan Health Services https://dhhs.ne.gov/Pages/Lifespan-Health-Services.aspx plus 2,869 visits to the Medically Handicapped Children’s Program https://dhhs.ne.gov/Pages/Medically-Handicapped-Children.aspx.

Form 8
State MCH and CSHCN Directors Contact Information

State: Nebraska

1. Title V Maternal and Child Health (MCH) Director	
Name	Sara Morgan
Title	Interim Deputy Director
Address 1	301 Centennial Mall South
Address 2	PO Box 95026
City/State/Zip	Lincoln / NE / 68509
Telephone	4024506683
Extension	
Email	Sara.Morgan@nebraska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Shannon Grotrian
Title	Economic Assistance Policy Administrator
Address 1	301 Centennial Mall South
Address 2	PO Box 95026
City/State/Zip	Lincoln / NE / 68509
Telephone	14024712738
Extension	
Email	Shannon.Grotrian@nebraska.gov

3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Nebraska

Application Year 2023

No.	Priority Need
1.	Cardiovascular Disease including Diabetes, Obesity, and Hypertension
2.	Premature Birth
3.	Infant Safe Sleep
4.	Access to Preventive Oral Health Care Services
5.	Child Abuse Prevention
6.	Motor Vehicle Crashes among Youth
7.	Sexually Transmitted Diseases among Youth
8.	Suicide among Youth
9.	Behavioral and Mental Health in School
10.	Improved Access to and Utilization of Mental Health Care Service

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Cardiovascular Disease including Diabetes, Obesity, and Hypertension	New
2.	Premature Birth	New
3.	Infant Safe Sleep	New
4.	Access to Preventive Oral Health Care Services	New
5.	Child Abuse Prevention	New
6.	Motor Vehicle Crashes among Youth	New
7.	Sexually Transmitted Diseases among Youth	New
8.	Suicide among Youth	New
9.	Behavioral and Mental Health in School	New
10.	Improved Access to and Utilization of Mental Health Care Service	New

Form 10
National Outcome Measures (NOMs)

State: Nebraska

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	79.7 %	0.3 %	18,997	23,830
2019	79.4 %	0.3 %	19,136	24,098
2018	78.8 %	0.3 %	19,504	24,753
2017	77.2 %	0.3 %	19,452	25,213
2016	78.1 %	0.3 %	20,381	26,105
2015	77.0 %	0.3 %	20,130	26,132
2014	75.4 %	0.3 %	19,761	26,200
2013	73.6 %	0.3 %	18,950	25,758
2012	74.9 %	0.3 %	19,180	25,606
2011	75.2 %	0.3 %	19,077	25,377
2010	75.1 %	0.3 %	19,002	25,308
2009	74.3 %	0.3 %	19,465	26,209

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	65.2	5.3	154	23,635
2018	52.6	4.7	127	24,151
2017	52.4	4.6	130	24,817
2016	50.2	4.5	124	24,707
2015	57.3	5.5	110	19,203
2014	52.9	4.6	136	25,696
2013	45.6	4.3	114	24,989
2012	47.1	4.4	114	24,223
2011	37.0	3.9	91	24,627
2010	53.7	4.7	134	24,973
2009	47.0	4.3	121	25,759
2008	42.6	4.2	103	24,186

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	23.6	4.3	30	126,944
2015_2019	19.3	3.9	25	129,332
2014_2018	19.8	3.9	26	131,371

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.4 %	0.2 %	1,793	24,283
2019	7.6 %	0.2 %	1,872	24,750
2018	7.6 %	0.2 %	1,927	25,478
2017	7.5 %	0.2 %	1,930	25,817
2016	7.0 %	0.2 %	1,869	26,583
2015	7.1 %	0.2 %	1,893	26,673
2014	6.6 %	0.2 %	1,775	26,786
2013	6.4 %	0.2 %	1,682	26,086
2012	6.7 %	0.2 %	1,734	25,939
2011	6.6 %	0.2 %	1,702	25,716
2010	7.1 %	0.2 %	1,839	25,914
2009	7.1 %	0.2 %	1,922	26,935

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	10.5 %	0.2 %	2,546	24,276
2019	10.5 %	0.2 %	2,596	24,746
2018	10.5 %	0.2 %	2,664	25,483
2017	9.9 %	0.2 %	2,556	25,806
2016	9.6 %	0.2 %	2,554	26,574
2015	9.9 %	0.2 %	2,629	26,660
2014	9.1 %	0.2 %	2,439	26,775
2013	8.7 %	0.2 %	2,274	26,063
2012	9.3 %	0.2 %	2,417	25,907
2011	9.1 %	0.2 %	2,327	25,692
2010	9.8 %	0.2 %	2,547	25,905
2009	9.7 %	0.2 %	2,597	26,898

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	27.6 %	0.3 %	6,694	24,276
2019	26.9 %	0.3 %	6,664	24,746
2018	25.4 %	0.3 %	6,470	25,483
2017	25.0 %	0.3 %	6,462	25,806
2016	24.6 %	0.3 %	6,542	26,574
2015	24.2 %	0.3 %	6,453	26,660
2014	23.7 %	0.3 %	6,355	26,775
2013	23.2 %	0.3 %	6,053	26,063
2012	23.8 %	0.3 %	6,165	25,907
2011	24.8 %	0.3 %	6,360	25,692
2010	25.4 %	0.3 %	6,578	25,905
2009	25.0 %	0.3 %	6,728	26,898

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	1.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	3.0 %			
2015/Q3-2016/Q2	3.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	5.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	4.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.8	0.4	119	24,816
2018	4.9	0.4	125	25,538
2017	5.9	0.5	152	25,904
2016	6.3	0.5	168	26,676
2015	6.2	0.5	167	26,758
2014	5.8	0.5	155	26,867
2013	5.4	0.5	140	26,156
2012	5.8	0.5	152	26,027
2011	5.5	0.5	143	25,782
2010	5.9	0.5	153	25,991
2009	5.9	0.5	160	27,023

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.9	0.5	122	24,755
2018	5.8	0.5	147	25,488
2017	5.5	0.5	143	25,821
2016	6.1	0.5	161	26,589
2015	5.7	0.5	152	26,679
2014	5.1	0.4	136	26,794
2013	5.2	0.5	136	26,095
2012	4.7	0.4	121	25,942
2011	5.6	0.5	144	25,720
2010	5.2	0.5	136	25,918
2009	5.4	0.5	145	26,936

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.2	0.4	78	24,755
2018	3.8	0.4	98	25,488
2017	3.5	0.4	90	25,821
2016	3.8	0.4	101	26,589
2015	4.0	0.4	107	26,679
2014	3.6	0.4	97	26,794
2013	3.7	0.4	96	26,095
2012	3.1	0.4	80	25,942
2011	3.7	0.4	96	25,720
2010	3.7	0.4	96	25,918
2009	3.3	0.4	88	26,936

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	1.8	0.3	44	24,755
2018	1.9	0.3	49	25,488
2017	2.1	0.3	53	25,821
2016	2.3	0.3	60	26,589
2015	1.7	0.3	45	26,679
2014	1.5	0.2	39	26,794
2013	1.5	0.2	40	26,095
2012	1.6	0.3	41	25,942
2011	1.9	0.3	48	25,720
2010	1.5	0.2	40	25,918
2009	2.1	0.3	57	26,936

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	137.3	23.6	34	24,755
2018	204.0	28.3	52	25,488
2017	147.2	23.9	38	25,821
2016	199.3	27.4	53	26,589
2015	134.9	22.5	36	26,679
2014	164.2	24.8	44	26,794
2013	183.9	26.6	48	26,095
2012	142.6	23.5	37	25,942
2011	140.0	23.3	36	25,720
2010	189.1	27.0	49	25,918
2009	144.8	23.2	39	26,936

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	72.7 ϟ	17.1 ϟ	18 ϟ	24,755 ϟ
2018	62.8 ϟ	15.7 ϟ	16 ϟ	25,488 ϟ
2017	104.6	20.1	27	25,821
2016	109.1	20.3	29	26,589
2015	97.5	19.1	26	26,679
2014	89.6	18.3	24	26,794
2013	61.3 ϟ	15.3 ϟ	16 ϟ	26,095 ϟ
2012	84.8	18.1	22	25,942
2011	85.5	18.2	22	25,720
2010	57.9 ϟ	15.0 ϟ	15 ϟ	25,918 ϟ
2009	85.4	17.8	23	26,936

Legends:

Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.4 %	1.2 %	2,699	23,666
2019	8.4 %	0.9 %	1,995	23,852
2018	11.2 %	1.3 %	2,734	24,333
2016	9.3 %	1.0 %	2,388	25,644
2015	7.0 %	0.9 %	1,809	25,705
2014	6.9 %	0.9 %	1,807	26,036
2013	5.2 %	0.7 %	1,312	25,418
2012	6.5 %	0.9 %	1,626	24,938
2011	6.0 %	0.7 %	1,494	25,002
2010	5.1 %	0.6 %	1,267	25,021
2009	4.4 %	0.6 %	1,153	25,998
2008	6.1 %	0.8 %	1,514	24,900
2007	6.2 %	0.8 %	1,536	24,797

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	1.9	0.3	44	22,697
2018	1.5	0.3	35	23,395
2017	1.3	0.2	33	24,918
2016	2.0	0.3	50	24,875
2015	1.4	0.3	26	19,180
2014	2.3	0.3	58	25,773
2013	1.8	0.3	46	25,263
2012	1.4	0.2	35	24,595
2011	0.9	0.2	21	24,697
2010	1.0	0.2	25	25,268
2009	0.6 ϟ	0.2 ϟ	16 ϟ	26,228 ϟ
2008	NR ⚑	NR ⚑	NR ⚑	NR ⚑

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	7.0 %	0.9 %	31,602	448,677
2018_2019	10.1 %	1.3 %	45,591	450,926
2017_2018	11.9 %	1.7 %	52,204	437,159
2016_2017	9.6 %	1.4 %	41,452	433,956
2016	8.3 %	1.2 %	36,387	437,091

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	16.9	2.7	40	236,820
2019	16.0	2.6	38	237,985
2018	18.8	2.8	45	239,499
2017	15.9	2.6	38	239,406
2016	18.0	2.7	43	239,000
2015	21.9	3.0	52	237,846
2014	19.0	2.8	45	237,239
2013	13.9	2.4	33	237,379
2012	18.1	2.8	43	237,734
2011	17.8	2.8	42	235,374
2010	20.0	2.9	47	234,754
2009	17.3	2.7	40	231,449

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	34.5	3.6	92	266,580
2019	32.3	3.5	86	266,584
2018	32.1	3.5	85	265,061
2017	37.6	3.8	99	263,114
2016	27.6	3.3	72	260,644
2015	28.9	3.3	75	259,258
2014	31.9	3.5	82	256,719
2013	37.7	3.8	96	254,911
2012	39.4	3.9	100	253,527
2011	25.5	3.2	65	254,481
2010	33.0	3.6	83	251,636
2009	32.1	3.6	81	252,712

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	15.4	2.0	61	397,164
2017_2019	17.7	2.1	70	394,769
2016_2018	16.1	2.0	63	391,807
2015_2017	16.4	2.1	64	389,247
2014_2016	15.8	2.0	61	386,435
2013_2015	19.0	2.2	73	384,250
2012_2014	20.1	2.3	77	383,352
2011_2013	18.1	2.2	70	386,062
2010_2012	16.0	2.0	62	387,494
2009_2011	17.2	2.1	67	389,569
2008_2010	21.5	2.4	84	390,349
2007_2009	26.9	2.6	106	393,438

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	12.1	1.7	48	397,164
2017_2019	14.7	1.9	58	394,769
2016_2018	14.3	1.9	56	391,807
2015_2017	14.1	1.9	55	389,247
2014_2016	11.6	1.7	45	386,435
2013_2015	12.0	1.8	46	384,250
2012_2014	11.5	1.7	44	383,352
2011_2013	10.1	1.6	39	386,062
2010_2012	8.3	1.5	32	387,494
2009_2011	6.2	1.3	24	389,569
2008_2010	7.9	1.4	31	390,349
2007_2009	9.7	1.6	38	393,438

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	18.2 %	1.4 %	86,203	472,785
2018_2019	18.8 %	1.5 %	88,648	472,106
2017_2018	17.9 %	1.7 %	84,509	472,109
2016_2017	17.5 %	1.6 %	82,066	470,087
2016	16.7 %	1.5 %	78,126	468,031

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	12.5 %	1.9 %	10,799	86,203
2018_2019	15.6 %	3.0 %	13,817	88,648
2017_2018	21.2 %	4.3 %	17,917	84,509
2016_2017	19.8 %	3.9 %	16,226	82,066
2016	17.6 %	4.1 %	13,734	78,126

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.7 %	0.7 %	10,441	390,069
2018_2019	2.5 %	0.7 %	9,753	384,992
2017_2018	2.6 % ϟ	1.0 % ϟ	9,711 ϟ	378,478 ϟ
2016_2017	2.7 % ϟ	1.0 % ϟ	10,367 ϟ	384,535 ϟ
2016	2.0 % ϟ	0.6 % ϟ	7,575 ϟ	387,590 ϟ

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	7.5 %	1.0 %	29,194	389,724
2018_2019	7.0 %	1.1 %	26,562	379,910
2017_2018	7.2 %	1.4 %	26,682	372,990
2016_2017	6.6 %	1.3 %	25,323	383,990
2016	5.8 %	1.0 %	22,444	386,957

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	64.9 %	4.8 %	33,448	51,542
2018_2019	61.6 % ϟ	5.6 % ϟ	29,394 ϟ	47,690 ϟ
2017_2018	59.1 % ϟ	8.0 % ϟ	25,597 ϟ	43,323 ϟ
2016_2017	57.6 % ϟ	7.6 % ϟ	25,670 ϟ	44,543 ϟ
2016	52.8 % ϟ	7.0 % ϟ	20,652 ϟ	39,080 ϟ

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	91.6 %	1.2 %	432,898	472,398
2018_2019	90.1 %	1.4 %	423,940	470,773
2017_2018	89.6 %	1.8 %	421,968	470,980
2016_2017	88.6 %	1.7 %	415,675	469,393
2016	88.6 %	1.5 %	413,490	466,642

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.7 %	0.3 %	1,884	12,828
2016	15.2 %	0.3 %	2,092	13,807
2014	16.9 %	0.3 %	2,324	13,726
2012	17.2 %	0.3 %	3,020	17,514
2010	14.4 %	0.3 %	2,245	15,622
2008	14.8 %	0.3 %	2,450	16,603

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	13.3 %	1.3 %	12,364	93,213
2017	14.6 %	1.2 %	13,089	89,849
2015	13.0 %	1.0 %	11,297	86,722
2013	12.7 %	1.0 %	10,878	85,518
2011	11.6 %	0.6 %	9,225	79,744
2005	10.9 %	0.6 %	9,655	88,471

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	12.6 %	1.7 %	26,011	206,686
2018_2019	11.5 %	1.8 %	23,612	206,039
2017_2018	12.0 %	2.3 %	23,173	192,637
2016_2017	15.5 %	2.4 %	28,943	186,368
2016	16.7 %	2.5 %	32,082	191,615

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.2 %	0.7 %	24,787	473,990
2018	6.2 %	0.6 %	29,463	473,595
2017	5.6 %	0.8 %	26,493	475,064
2016	5.5 %	0.6 %	25,706	471,820
2015	4.7 %	0.6 %	21,842	469,996
2014	5.0 %	0.6 %	23,395	468,566
2013	5.9 %	0.6 %	27,316	464,212
2012	5.4 %	0.6 %	25,213	465,331
2011	7.3 %	0.7 %	33,722	459,193
2010	5.2 %	0.6 %	23,723	457,767
2009	6.3 %	0.8 %	28,174	447,403

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

 Created on 8/16/2022 at 2:20 PM

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	80.8 %	2.8 %	21,000	26,000
2016	77.4 %	3.8 %	21,000	27,000
2015	78.0 %	3.2 %	21,000	27,000
2014	71.4 %	3.8 %	19,000	27,000
2013	79.6 %	3.2 %	21,000	27,000
2012	68.6 %	4.0 %	18,000	26,000
2011	77.8 %	3.6 %	20,000	26,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	71.4 %	1.9 %	321,438	450,193
2019_2020	68.0 %	1.8 %	306,592	450,870
2018_2019	69.2 %	2.1 %	307,064	443,862
2017_2018	62.9 %	2.1 %	276,804	440,041
2016_2017	63.4 %	1.9 %	277,036	436,896
2015_2016	62.4 %	2.0 %	270,843	434,392
2014_2015	63.0 %	2.2 %	270,668	429,905
2013_2014	62.7 %	2.0 %	271,156	432,321
2012_2013	60.0 %	2.4 %	259,816	432,952
2011_2012	50.7 %	2.7 %	214,947	424,012
2010_2011	50.0 %	3.3 %	211,537	423,074
2009_2010	44.5 %	2.9 %	204,002	458,431

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	82.6 %	2.4 %	110,469	133,705
2019	73.9 %	3.4 %	98,120	132,699
2018	75.6 %	3.2 %	99,943	132,155
2017	71.0 %	3.0 %	92,323	130,068
2016	63.7 %	3.2 %	81,644	128,088
2015	60.6 %	2.9 %	76,589	126,296

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	91.3 %	1.7 %	122,057	133,705
2019	91.2 %	2.3 %	120,975	132,699
2018	89.0 %	2.4 %	117,664	132,155
2017	92.3 %	2.0 %	120,110	130,068
2016	86.8 %	2.4 %	111,206	128,088
2015	87.7 %	2.1 %	110,706	126,296
2014	82.2 %	2.7 %	102,396	124,549
2013	86.1 %	2.4 %	106,198	123,339
2012	81.4 %	3.0 %	99,453	122,250
2011	81.8 %	2.6 %	100,197	122,542
2010	70.3 %	3.0 %	86,793	123,466
2009	51.6 %	3.3 %	63,417	123,014

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	87.3 %	2.2 %	116,747	133,705
2019	86.3 %	2.8 %	114,543	132,699
2018	84.0 %	2.7 %	111,001	132,155
2017	84.8 %	2.5 %	110,344	130,068
2016	80.2 %	2.6 %	102,717	128,088
2015	78.1 %	2.4 %	98,643	126,296
2014	74.1 %	3.0 %	92,319	124,549
2013	77.5 %	2.7 %	95,629	123,339
2012	75.5 %	3.1 %	92,300	122,250
2011	76.0 %	2.9 %	93,109	122,542
2010	65.7 %	3.2 %	81,105	123,466
2009	53.2 %	3.3 %	65,470	123,014

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.1	0.5	984	65,082
2019	15.3	0.5	993	64,915
2018	16.7	0.5	1,073	64,349
2017	18.1	0.5	1,158	63,964
2016	19.1	0.6	1,213	63,529
2015	22.1	0.6	1,388	62,860
2014	22.3	0.6	1,390	62,432
2013	24.8	0.6	1,552	62,491
2012	26.6	0.7	1,671	62,826
2011	27.4	0.7	1,731	63,289
2010	31.0	0.7	1,958	63,093
2009	34.8	0.7	2,209	63,547

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.1 %	1.1 %	2,865	23,656
2019	12.3 %	1.1 %	2,903	23,663
2018	12.1 %	1.3 %	2,928	24,253
2016	10.2 %	1.0 %	2,613	25,542
2015	11.9 %	1.1 %	3,034	25,506
2014	9.4 %	0.9 %	2,429	25,735
2013	10.7 %	0.9 %	2,703	25,206
2012	11.2 %	1.1 %	2,782	24,956

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	1.5 %	0.4 %	6,950	471,153
2018_2019	2.0 % ϟ	0.6 % ϟ	9,434 ϟ	470,197 ϟ
2017_2018	3.0 % ϟ	1.1 % ϟ	13,945 ϟ	470,382 ϟ
2016_2017	2.9 % ϟ	1.0 % ϟ	13,739 ϟ	469,140 ϟ
2016	2.5 %	0.6 %	11,456	466,908

Legends:

Indicator has an unweighted denominator <30 and is not reportable

ϟ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Nebraska

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	2018	2019	2020	2021
Annual Objective				74.9	71.8
Annual Indicator			73.5	70.4	70.5
Numerator			244,199	234,784	234,343
Denominator			332,326	333,478	332,326
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.8	73.2	74.7	76.2

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2017	2018	2019	2020	2021
Annual Objective	82.5	85.9	86.8	87.8	89.6
Annual Indicator	84.2	85.1	86.1	86.8	88.5
Numerator	21,305	21,558	20,652	20,367	20,471
Denominator	25,319	25,347	23,975	23,464	23,130
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2016	2018	2019	2020

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.3	92.1	93.9	95.8

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		34.2	38.5	39.2
Annual Indicator	33.5	37.7	40.3	37.8
Numerator	8,129	8,832	8,976	8,403
Denominator	24,265	23,403	22,266	22,224
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.0	40.8	41.6	42.4

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Nebraska PRAMS began asking this question in 2016, Phase 8 of the questionnaire.
Nebraska should receive the 2016 data by the end of the summer.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2018	**2019**	**2020**	**2021**
Annual Objective		45.5	48.8	58.3
Annual Indicator	44.6	47.9	57.2	57.0
Numerator	10,890	11,176	12,710	12,719
Denominator	24,418	23,326	22,219	22,326
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2016	2018	2019	2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	58.1	59.3	60.5	61.7

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2017**

   Column Name: **State Provided Data**

   Field Note:
   Nebraska PRAMS began asking this question in 2016, Phase 8 of the questionnaire.
   Nebraska should receive the 2016 data by the end of the summer.

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	224.4	226.1	210.2	216.7	200.3
Annual Indicator	230.7	214.5	221.2	204.9	214.6
Numerator	447	559	582	543	572
Denominator	193,724	260,644	263,114	265,061	266,584
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	210.3	206.1	201.9	197.9

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		53.7	58.4	54.2	45.9
Annual Indicator	52.7	57.0	53.1	45.0	49.4
Numerator	41,148	46,782	44,838	39,911	42,610
Denominator	78,126	82,066	84,509	88,648	86,203
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	50.4	51.4	52.4	53.4

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2019	**2020**	**2021**
Annual Objective			80.1
Annual Indicator	78.5	80.1	82.4
Numerator	345,091	363,265	370,833
Denominator	439,399	453,443	450,251
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	84.0	85.7	87.4	89.2

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Nebraska

SPM 1 - The percent of preterm births.

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			10.3
Annual Indicator	10.5	10.5	10.9
Numerator	2,597	2,551	2,654
Denominator	24,758	24,293	24,293
Data Source	NE Vital Records	NE Vital Records	NE Vital Records
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	10.7	10.5	10.2	10.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - The rate of substantiated reports of child abuse and neglect per 1,000 children (1-9).

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			9.8
Annual Indicator	7.2	10	7.4
Numerator	1,718	2,369	1,765
Denominator	237,985	236,820	237,146
Data Source	NE Family Online Client User System, Census	NE Family Online Client User System, Census	NE Family Online Client User System, Census
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.3	7.1	6.9	6.8

Field Level Notes for Form 10 SPMs:

None

SPM 3 - The rate of chlamydia infections reported per 100,000 youth (age 15-19).

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			1,883.9
Annual Indicator	1,922.4	1,776	1,805.1
Numerator	2,550	2,361	2,500
Denominator	132,645	132,940	138,497
Data Source	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1,768.9	1,733.5	1,698.8	1,664.9

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2020**

   Column Name: **State Provided Data**

   Field Note:
   The decrease is an affect of the pandemic. The testing sites were closed for a portion of 2020. I will not adjust the annual objectives.

SPM 4 - The death rate due to suicide per 100,000 youth (age 10-19).

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			7.4
Annual Indicator	8.8	7.5	7.8
Numerator	70	60	63
Denominator	794,759	798,225	810,807
Data Source	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census
Data Source Year	2017-2019	2018-2020	2019-2021
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	7.6	7.5	7.3	7.2

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			62.5
Annual Indicator	64.1	61.3	63
Numerator			
Denominator			
Data Source	NSCH	NSCH	NSCH
Data Source Year	2017-2018	2018-2019	2019-2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	64.3	65.5	66.9	68.2

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Nebraska

ESM 1.1 - Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.

Measure Status:	Inactive - Replaced

State Provided Data

	2019	2020	2021
Annual Objective			20
Annual Indicator		0	0
Numerator		0	0
Denominator		1	1
Data Source		Program Data	Program Data
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
In the pilot year, one community has been identified, but a site has not been selected.

ESM 1.2 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	75.0	80.0	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:	Inactive - Replaced

State Provided Data

	2017	2018	2019	2020	2021
Annual Objective			45	58	100
Annual Indicator			53	88	95
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2021
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2020**

Column Name: **State Provided Data**

Field Note:
52 Safe Sleep Champion Hospitals
34 AHT/SBS Prevention Champion Hospitals
2 Clinic Champions.

ESM 5.2 - The percent of clinics receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:			Active
Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	65.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.1 - The number of schools participating in the "Teens in the Driver Seat" program.

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective			38	38	38
Annual Indicator			33	33	22
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	27.0	32.0	37.0	42.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 18,891 teens reached.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 59,481 teens reached	

ESM 11.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.

Measure Status:	Inactive - Replaced

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			350	1,000	1,500
Annual Indicator			1,506	1,380	1,625
Numerator					
Denominator					
Data Source			Program Data	Program Data	Program Data
Data Source Year			FY 2019	FY 2020	FY 2020
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Center

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	80.0	85.0	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.

Measure Status:	**Inactive - Replaced**		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			25
Annual Indicator		18	33
Numerator			
Denominator			
Data Source		Program Data	Program Data
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: calendar year	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 17,600 kits.	

ESM 13.2.2 - The percentage of children participating in the Open Mouth Survey from rural and underserved communities

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Nebraska

SPM 1 - The percent of preterm births.
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To decrease preterm birth rate by addressing disparities, increasing access to care, and providing education.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of infants born less than 37 weeks gestation in a calendar year. **Denominator:** The number of live births in a calendar year
Data Sources and Data Issues:	Nebraska Vital Records, Birth Certificate File
Significance:	When looking at preterm birth in Nebraska, significant demographic disparities exist between racial/ethnic, income, and educational attainment groups. Babies born preterm (in 2018 made up 10% of all births) are at high risk for mortality and morbidity such as cerebral palsy, chronic lung disease, hearing loss, and intellectual disabilities. Women who experience one preterm birth are at risk for subsequent preterm births. Educating women about their risk; encouraging women to become healthy prior to becoming pregnant (i.e controlling chronic disease, achieving a healthy weight, and refraining from substance use); and educating women about spacing births appropriately. Additionally, increasing access to care and screening women of reproductive age for social determinants of health.

SPM 2 - The rate of substantiated reports of child abuse and neglect per 1,000 children (1-9).
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To reduce rate of substantiated child abuse or neglect, by supporting implementation of prevention, early identification, and intervention strategies and addressing the disparity between races when comparing rates of alleged and substantiated cases.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** The number of substantiated reports of child abuse and neglect among children, age 1-9, in a calendar year. **Denominator:** The estimate number of children age 1-9.
Data Sources and Data Issues:	The numerator is Nebraska's Statewide Automated Child Welfare Information System (SACWIS) also known as N-FOCUS (Nebraska Family Online Client User System). The denominator is the US Census Estimates.
Significance:	Adverse childhood experiences such as child maltreatment have significant life long consequences. Impacts include disruption to growth and development, depression, higher incidence of illness and chronic diseases, as well as a shortened lifespan. Infants are the most vulnerable to abuse and neglect.

SPM 3 - The rate of chlamydia infections reported per 100,000 youth (age 15-19).
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the rates of sexually transmitted disease among youth in Nebraska.
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** The number of chlamydia infections reported for youth (15-19) in a calendar year. **Denominator:** The estimate number of youth (15-19).
Data Sources and Data Issues:	The numerator is the Nebraska Sexually Transmitted Infections Program. The denominator is US Census Estimates.
Significance:	Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States STDs cause many harmful, often irreversible, and costly clinical complications. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women.

SPM 4 - The death rate due to suicide per 100,000 youth (age 10-19).
Population Domain(s) – Adolescent Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase access to services, education, and early intervention. To decrease stigma in order to reduce rates of suicide among adolescents (ages 15 through 19). ToIncrease protective factors, resilience, strengths building, and family engagement.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Rate</td></tr>
<tr><td>Unit Number:</td><td>100,000</td></tr>
<tr><td>Numerator:</td><td>The number of deaths due to sucide for youth (10-19) for the last three calendar years.</td></tr>
<tr><td>Denominator:</td><td>They number of deaths to youth (10-19) for the the last three calendar years.</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Nebraska Vital Records, Death File</td></tr>
<tr><td>Significance:</td><td>Mental health is essential to a person’s well-being, healthy family and interpersonal relationships, and the ability to live a full and productive life. People, including children and adolescents, with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide.</td></tr>
</table>

SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase access to care for the maternal and child health population</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children, ages 0 through 17 years, who were reported by a parent to not able to obtain needed health care in the last year</td></tr>
<tr><td>Denominator:</td><td>Number of children, ages 0 through 17 years</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH)</td></tr>
<tr><td>Significance:</td><td>Improving access to quality health services is essential for optimal health in both preventing and treating health conditions. When needed care is not received, health may suffer and conditions may not be prevented or may grow in severity. Common barriers to care include cost, language, logistical, and structural factors, such as not having transportation or scheduling difficulties. Adequate insurance and access to a patient-centered medical home can reduce unmet needs for health care.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Nebraska

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Nebraska

ESM 1.1 - Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Replaced
Goal:	Increase the number of women accessing preventive healthcare for cardio vascular disease,
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of sites participating in the initiative **Denominator:** The number of potential sites identified
Data Sources and Data Issues:	Program Data, Women's Health Initiatives.
Significance:	In Nebraska, African American, American Indian, and Hispanic women were more likely to be obese compared to white women. Racial disparities also exist in diagnoses of diabetes and hypertension, with higher rates for African American, American Indian, and Hispanic women than their white counterparts in Nebraska. According to the CDC, various cardiovascular diseases rank among the leading causes of death in women of all races.

ESM 1.2 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of women who access preventive healthcare for cardio vascular disease.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of participants who have had a well check according to the USPSTF guidelines based on age and history. **Denominator:** The number of female participants.
Data Sources and Data Issues:	Program Data, Women's Health Initiatives.
Evidence-based/informed strategy:	There is evidence that community-based/faith-based organizations are effective at providing cardiovascular prevention programs for high-risk women. These community health programs could be equally effective in promoting to well-women care to participants.
Significance:	In Nebraska, African American, American Indian, and Hispanic women were more likely to be obese compared to white women. Racial disparities also exist in diagnoses of diabetes and hypertension. According to the CDC, various cardiovascular diseases rank among the leading causes of death in all women.

ESM 5.1 - The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Inactive - Replaced
Goal:	The overall goal of the Nebraska Safe Babies Campaign is to provide evidence-based education to parents of newborns as well as birthing hospital and pediatric clinical staff.
Definition:	**Unit Type:** Count **Unit Number:** 500 **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Program data
Significance:	A survey of all birthing hospitals in Nebraska revealed that hospitals are not providing consistent preventative education messages on Infant Safe Sleep and Abusive Head Trauma/Shaken Baby Syndrome Prevention Education (AHT/SBS). Providing a consistent baseline education for all hospital personnel caring for children under the age of one will provide a consistent, evidence-based message to parents of more than 26,000 newborns across the State.

ESM 5.2 - The percent of clinics receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>The overall goal of the Nebraska Safe Babies Campaign is to provide evidence-based education to parents of newborns as well as birthing hospital and pediatric clinical staff.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of new campions in the fiscal year.</td></tr>
<tr><td>Denominator:</td><td>The number of clinics receiving outreach to participate in the program.</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program data</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Aligns with MCH best strategy "Building on Campaigns and Conversations".</td></tr>
<tr><td>Significance:</td><td>A survey of all birthing hospitals in Nebraska revealed that hospitals are not providing consistent preventative education messages on Infant Safe Sleep and Abusive Head Trauma/Shaken Baby Syndrome Prevention Education (AHT/SBS). Providing a consistent baseline education for all hospital personnel caring for children under the age of one will provide a consistent, evidence-based message to parents of more than 24,000 newborns across the State.</td></tr>
</table>

ESM 7.2.1 - The number of schools participating in the "Teens in the Driver Seat" program.
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Increase the number of schools participating in an evidence-based teen driver safety program.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Program Data, Nebraska Injury Prevention.
Significance:	Motor vehicle crashes are the leading cause of death for teens. Teens in the Driver Seat® is a teen driven peer-to-peer educational program that focuses solely on traffic safety and addresses all major driving risks for this age group. Teens, along with a sponsor, help shape the program and are responsible for implementing it.

ESM 11.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Inactive - Replaced
Goal:	Increase the number of families served by the program.
Definition:	**Unit Type:** Count **Unit Number:** 3,000 **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Administrative data from the Family Care Enhancement Project
Significance:	Parent Resource Coordination aims to increase access to, and the provision of Medical Homes, through improvements in patient and family centered care.

ESM 11.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Center
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of families served by the program who are satisfied with the support provided by the community health workers.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of parents reporting satisfaction with the support they receive. **Denominator:** The number of parents who responded to the customer satisfaction survey.
Data Sources and Data Issues:	Program survey data; Family Care Enhancement Project.
Evidence-based/informed strategy:	xxx
Significance:	Parent Resource Coordination aims to increase access to, and the provision of Medical Homes, through improvements in patient and family centered care.

ESM 13.2.1 - The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Inactive - Replaced
Goal:	To increase the percent of children (ages 1 through 17) receive preventive oral health care services.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Program Data, the Office of Oral Health and Dentistry
Significance:	A significant percentage of Nebraska's population lives in rural locations, including approximately 125,000 children ages 1-9 and many low-income children and youth eligible for Medicaid benefits do not receive mandated preventive dental services. More than half of Nebraska is considered a state designated general dentist shortage area.

ESM 13.2.2 - The percentage of children participating in the Open Mouth Survey from rural and underserved communities
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	Children 6 through 11, All Children 0 through 17
Goal:	To increase the percent of children (ages 1 through 17) receive preventive oral health care services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of children participating in the Open Mouth Survey from rural and underserved communities. **Denominator:** The number of children participating in the Open Mouth Survey.
Data Sources and Data Issues:	Open Mouth Survey, the Office of Oral Health and Dentistry
Evidence-based/informed strategy:	Aligns with Caregiver/Parent Education/Counseling.
Significance:	A significant percentage of Nebraska's population lives in rural locations, including approximately 125,000 children ages 1-9 and many low-income children and youth eligible for Medicaid benefits do not receive mandated preventive dental services. More than half of Nebraska is considered a state designated general dentist shortage area.

Form 11
Other State Data

State: Nebraska

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Nebraska

Annual Report Year 2021

	Access				Linkages	
Data Sources	**(A) State Title V Program has Consistent Annual Access to Data Source**	**(B) State Title V Program has Access to an Electronic Data Source**	**(C) Describe Periodicity**	**(D) Indicate Lag Length for Most Timely Data Available in Number of Months**	**(E) Data Source is Linked to Vital Records Birth**	**(F) Data Source is Linked to Another Data Source**
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	No	No	Less Often than Annually	16	Yes	
4) WIC	Yes	Yes	Daily	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Daily	18	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None