Maternal and Child Health Services Title V Block Grant

Nebraska

FY 2025 Application/ FY 2023 Annual Report

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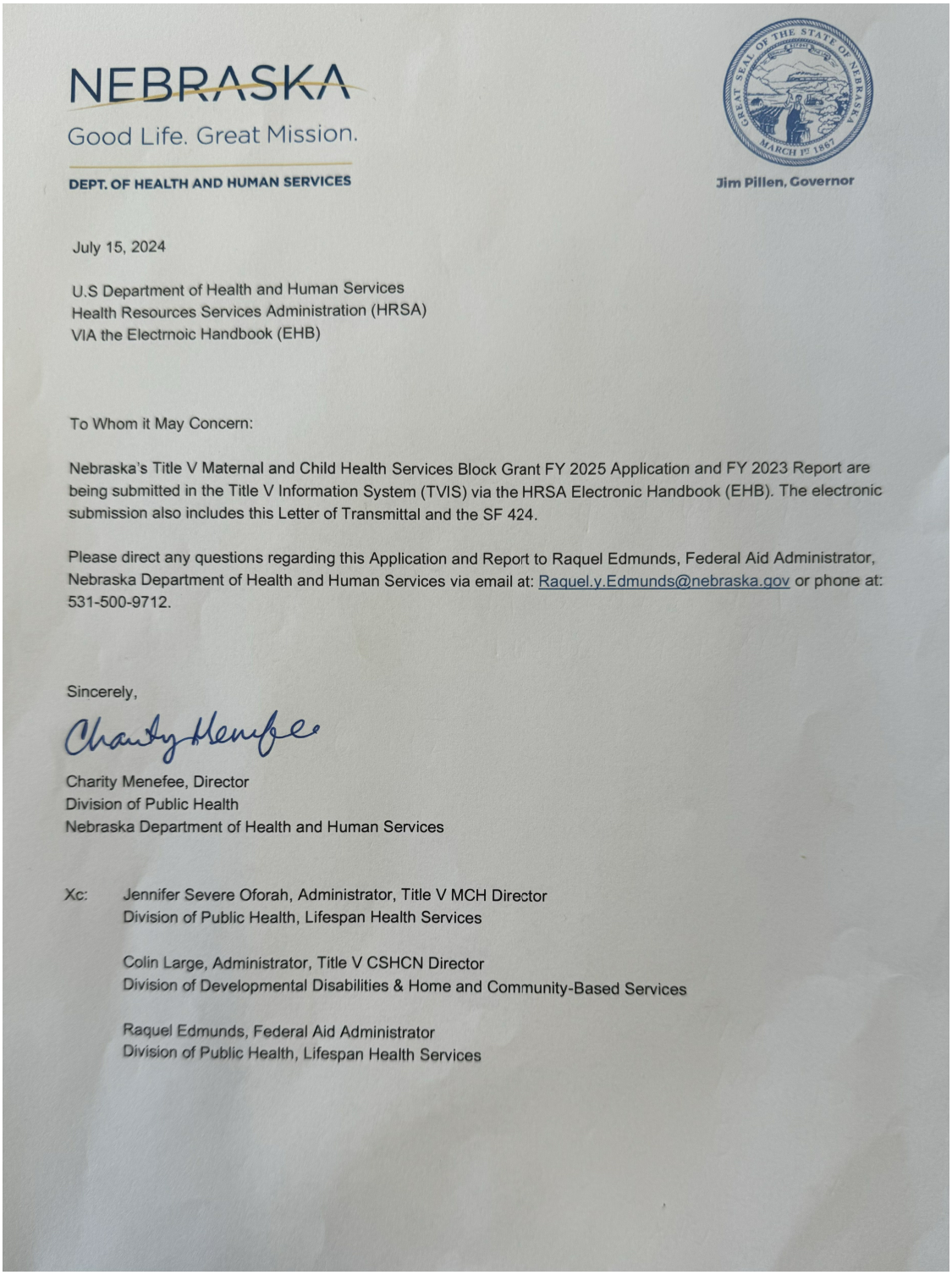
I. General Requirements

I.A. Letter of Transmittal



NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

July 15, 2024

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

To Whom it May Concern:

Nebraska's Title V Maternal and Child Health Services Block Grant FY 2025 Application and FY 2023 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.

Please direct any questions regarding this Application and Report to Raquel Edmunds, Federal Aid Administrator, Nebraska Department of Health and Human Services via email at: Raquel.y.Edmunds@nebraska.gov or phone at: 531-500-9712.

Sincerely,

Charity Menefee

Charity Menefee, Director
Division of Public Health
Nebraska Department of Health and Human Services

Xc: Jennifer Severe Oforah, Administrator, Title V MCH Director
Division of Public Health, Lifespan Health Services

Colin Large, Administrator, Title V CSHCN Director
Division of Developmental Disabilities & Home and Community-Based Services

Raquel Edmunds, Federal Aid Administrator
Division of Public Health, Lifespan Health Services

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 2 of the 2026 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 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. 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 Developmental Disabilities (DD). Core leadership, or the Title V Team, is comprised of six NDHHS 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 five-year cycle. The assessment 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) reported 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 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 are persistent, after many professionals experiencing burnout left the field, recruitment issues delay onboarding of new staff, and training and integrating new public health professionals takes sustained effort overtime. Staffing and workforce capacity remain a significant issue. Recently, syphilis rates have drastically increased and emerged as a significant issue in Nebraska and surrounding states, this includes cases of congenital syphilis which is a serious concern. The State Epidemiologist has taken the lead on the response and Title V has collaborated by accessing the need, collaborating with state and regional leaders, and by providing funds to improve testing.

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 Nebraska 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

A federal-state partnership is evident in Nebraska Title V. The block grant dollars and technical resources available to the state complements, leverages, and 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, local 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 51% (Public Health Services and Systems), 41% (Enabling Services), and 8% (Direct Services). Non-federal dollars are allocated differently, averaging over the same period 14% (Public Health Services and Systems), 69% (Enabling Services), and 17% (Direct Services). The importance of consistent, complementary roles is illustrated with data from Title V reports (2020-2023) 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 consistently over time, as illustrated in the following table:

Federal-State Partnership: expense comparison 2020-2023

by Types of Individuals served (TVIS Form 3a)

Types of Individuals	2020 federal / non-federal		2021 federal / non-federal		2022 federal / non-federal		2023 federal / non-federal	
Pregnant Women	7.9%	11.5%	9.7%	11.9%	8.1%	12.7%	8.8%	8.9%
Infants < 1 year of age	10.7%	15.7%	12.2%	18.6%	15.6%	25.1%	10.0%	13.7%
Children 1 to 22 years of age	37.9%	21.7%	36.6%	12.4%	39.4%	12.4%	41.6%	18.8%
Children and Special Health Care Needs	36.5%	27.5%	36.6%	38.9%	33.1%	38.9%	35.2%	38.0%
Others	7.0%	23.6%	5.0%	10.9%	3.8%	10.9%	4.3%	20.7%

*The 2023 grant is not fully liquidated at the time of the 2024 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

Nebraska Early Dental Health Starter Kit Educational Program

In 2016, NDHHS Office of Oral Health and Dentistry (OOHD) began the Nebraska Early Dental Health Starter Kit Educational program aimed at teaching parents and caregivers of newborns how to establish sound daily oral hygiene habits at a very early age. Since that time the request for the Starter Kits only continues to grow.

Early on the NE Early Dental Health Starter Kits were distributed through a few select local health departments and early childhood clinics and services. Currently, the distribution has grown to include almost all local health departments, WIC Clinics, Early Head Start/Head Start programs, home visiting programs, seven Federally Qualified Health Centers, Children's Physicians network within Children's Nebraska, Nebraska Hospital Association, Ponca Tribe of Nebraska Health Services, early childhood programs including daycares and preschools, and other medical providers across the State. Between May 1, 2023, and June 30, 2024, a total of 30,576 Nebraska Early Dental Health Starter Kits were distributed. The Nebraska Early Dental Health Starter Kits are now being replicated by State Oral Health programs in Illinois and Missouri.

The Early Dental Health Starter Kit includes age-appropriate dental cleaning items, an educational card that tells the care giver how to use them, and a two-minute timer with a message to "brush 2 minutes 2 times a day." Starter Kits also include information to educate parents of the importance of establishing a dental home for their child by age one and a listing of where reduced-cost dental care can be found in Nebraska. On one of the educational items included in the Starter Kits is a QR code that will take caregivers to a video that talks about the importance in starting proper oral hygiene habits from day one and demonstrates how to use each of the age-appropriate items. The video can be found at this link: https://www.unmc.edu/dentistry/outreach/starter-kits.html.

The NDHHS Office of Oral Health and Dentistry partners with Nebraska MCH/Title V, University of Nebraska Medical Center College of Dentistry, and the Nebraska Community Foundation to make the Nebraska Early Dental Health Educational Program a reality. Volunteers from these organizations and others come together to assemble the Starter Kits for distribution. The Nebraska Title V funding makes it possible to purchase items that go into each Starter Kit, supports staff time to implement the program, and aids in distribution of the Starter Kits.

III.B. Overview of the State

Nebraska is a state that covers a large geographic area, but in comparison has a small population base, much of which resides in the eastern half of the state. Measuring 387 miles across with a total area of approximately 77,000 square miles, Nebraska is approximately 20% larger than New England. Much of the land is used for agricultural purposes. Over half (58.9%) of the state's population resides in one of Nebraska's three Metropolitan Statistical Areas (MSA) with populations larger than 50,000 population centers (Grand Island, Lincoln, and Omaha). In contrast, 55.5% of all square miles in Nebraska are frontier and remote, 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.

According to the U.S. Census, Nebraska has experienced shifts in its demographic composition between 2010 to 2020. The primary shifts include 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 of Nebraska's 93 counties, and over 25% in 26 of those (60) counties. In terms of increased diversity, Nebraska has seen its non-white population grow 82% from 2010 to 2020, which now 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.

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 tribes. Though many Native Americans live on reservations, the majority do not. Omaha, Thurston, and Lancaster counties have the largest Native American populations in Nebraska. In northeastern Nebraska, Thurston County is home to the Winnebago and Omaha Tribes. 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 NDHHS Office of Health Disparities and Health Equity's 2021 "Socioeconomic and Health Disparities Report Card" identified disparity ratios of 2.0 or greater that require intervention, as well as disparity ratios over 2.5 that were labeled unacceptable and required immediate intervention. Several issues relevant to maternal and child health had reported ratios over 2.0 such as: 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 ratio reported as 3.1 times higher, Hispanic 2.6 times higher, and African American 2.3 times higher than the White teen birth rates.

In addition, disparities in sexually transmitted diseases by race/ethnicity are large. African Americans rates were 12 times higher while American Indian rates were 5.3 times higher than White rates of sexually transmitted disease. Mental health disparities exist as well. From 2016-2020, the age-adjusted suicide rate per 100,000 people was 16.4 for American Indians and 14.9 for Whites. These populations have higher rates than African American (9.4), Asian (7.2), and Hispanic (7.3) populations. 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 health care remains a challenge for Nebraska. Rural areas have difficulty recruiting and retaining providers and health care professionals, 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 of 93 counties were Family Practice shortage areas. The entirety of 76 counties along with portions of counties surrounding Lancaster and Douglas counties were designated OB/GYN shortage areas. A similar situation exists for the Psychiatry and Mental Health disciplines, with most 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), nine 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.

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 NDHHS 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.

The Newborn Screening Program is an additional component of the CYSHCN health care system providing lifesaving and lifechanging screening for metabolic diseases and hearing. 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, it is important to call out the tele-audiology framework that was initiated by the Nebraska 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 CYSHCN Director. The Administrator for the Lifespan Health Services Unit within the Division of Public Health is designated as the Title V MCH Director. As of January 2024, the CYSHCN Director role is designated as the Policy Administrator within the Division of Developmental Disabilities (DD). 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 statewide programs including the 1915(c) Medicaid Home and Community Based Waivers (HCBS) for individuals with developmental disabilities, physical disabilities, traumatic brain injuries, and the aged, as well as the Lifespan Respite and the Medically Handicapped Children's Program (MHCP). Additional key staff in both Public Health and Developmental Disabilities lead the Title V MCH Block Grant and partner with stakeholders statewide. They are the Maternal Child Health (MCH) team, the MCH Epidemiology team, a Federal Grants Administrator, and the Special Healthcare Needs Program Coordinator.

Another part of the administrative framework for Nebraska Title V are the statutes and regulations that grant broad authority to carry out maternal and child health services in the state, generally 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 Culturally and Linguistically Appropriate Services 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 2025 Application/FY 2023 Annual Report 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. 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 year to year.

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, utilized this process for four cycles (2005, 2010, 2015, and 2020), and is currently utilizing the process for the 2025 needs assessment. During the reporting period, MCH EPI began developing a timeline for completing the 2025 needs assessment, assigning tasks to staff, and creating templates for data analysis and presentation.

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 35.0% for women over 18 years of age and a combined overweight obesity rate of 65.1% for 2021. Further, BRFSS reports that 28.9% of women have been told they have high blood pressure, and 9.2% 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.

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 (NPQIC) review and recommendation process. In 2021 the preterm birth rate among Nebraska resident, occurrent births was 10.6%; the rate increased to 11.3% in 2022.

A long-term approach should be implemented to address pre-pregnancy chronic disease to improve maternal health and reduce risk of preterm birth. In 2022, MCH EPI partnered with Tobacco Free Nebraska to present "Prematurity and Tobacco Cessation" at NPQIC's Annual Summit, and continues to monitor preterm birth trends, especially as they relate to the priority area of tobacco use.

Infant Safe Sleep

Data from the Nebraska PRAMS indicates that Nebraska parents have received the "back to sleep" message; in 2021 87.6% of respondents were placing infants in the supine position for sleep, this remains stable 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 21.6% of respondents indicating sleep surface sharing in 2021 as compared to 23.7% in 2017.

In 2022, Nebraska PRAMS wrote a 2020 annual report; the report was published on the public website in early 2023 (https://dhhs.ne.gov/PRAMS%20Documents/2020%20PRAMS%20Annual%20Report_Approved.pdf). In December 2023, an updated version of the report utilizing 2021 data was published (https://dhhs.ne.gov/PRAMS%20Documents/2021%20PRAMS%20Annual%20Report%20-%20Dec%202023.pdf).

Child Health Domain

Access to Preventive Oral Healthcare

The NDHHS's Office of Oral Health and Dentistry (OOHD) reported in the 2021-2022 Nebraska Oral Health Survey that 58% of 3rd grade children had decay experience and 24% of 3rd grade children had untreated caries. These are significant reductions since the 2015-2016 survey, and state third grade decay experience is now below the national average of 60%. While the prevalence of dental disease remains higher in rural counties compared to urban counties, dental disease disparities between these groups has also been reduced.

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 1,471 Nebraska children (aged 1-9 years) experienced substantiated abuse and/or neglect during 2023, a rate of 6.3/1,000. 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, comprising 58% of all unintentional injury fatalities for the age group in 2022. 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 2020:

- 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 2022, the reported rate of chlamydia infections per 100,000 Nebraska youth aged 15 to 19 years was 1,782. 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 and the rate increase is of concern. Nebraska began tracking maternal and infant syphilis cases longitudinally in FY 2022 and continues working with the syphilis program to provide additional epidemiologic assistance and MCH subject matter expertise.

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 2021 the rate of youth (aged 10 through 19 years) suicide deaths was 7.8 per 100,000 and 8.2 per 100,000 in 2022; the national rate for 2021 was 6.8 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.

The Child Death Review Team (CDRT) report published in late 2023 included a suicide focus (https://dhhs.ne.gov/MCH%20Epidemiology/Child%20Death%20Review%20Team%20Annual%20Report%202023-12.pdf). Nebraska's CDRT has four recommendations to prevent suicide among youth, including 1) ensure access to confidential, professional mental health services and crisis care for all young people across the state, 2) train all clinical and non-clinical staff to identify individuals at risk and respond appropriately, 3) encourage mental health providers to develop a safety plan for children and parents if the child has expressed suicidal ideation/thoughts, and 4) reduce access to lethal means.

The Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) focuses on achieving health equity related to racial, ethnic, and geographic disparities in access to behavioral health care, especially in rural and other underserved areas. NEP-MAP provides training, technical assistance, and care coordination support services to pediatric primary care and other providers to enable them to conduct early identification, diagnosis, and treatment of behavioral health conditions.

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.

Nebraska's Advancing Wellness and Resiliency in Education (AWARE) program implemented by the Nebraska Department of Education and Nebraska Department of Health and Human Services - Division of Behavioral Health in collaboration with six Local Education Agencies aims to improve school-based mental health services. The program addresses high level mental and behavioral health needs of school-aged children in rural schools, including depression, anxiety, suicidal ideation, and trauma.

Cross-cutting 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 continues to impact the NDHHS and the Division of Public Health. MCH EPI has enjoyed growth and continues building capacity but has not been immune to staff turnover. The group is fully staffed but was required to refill positions within the reporting period. MCH EPI additionally recruits bachelor and master's level student interns each year to maintain a pipeline of potential candidates for Nebraska's MCH workforce and has secured a CSTE (Council of State and Territorial Epidemiologists) Applied Epidemiology Fellow for two years.

Health Equity and Social Determinants of Health (SDoH)

Health Equity and Social Determinants of Health (SDoH) continues to remain at the forefront of all work, with 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. Community-based organizations remain key partners in addressing priorities, reducing disparities, and addressing root causes.

As part of the continued monitoring and readiness effort, the Office of MCH EPI has been working on numerous 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; a report of the Maternal Mortality Review Committee; a Child Death Review Team report; data linkage projects with the blood lead program, WIC and SNAP data, and Hospital Discharge Data; an analysis of Nebraska's Immunization Registry as it relates to the MCH population; acquisition of Nebraska's Birth Defects Registry; and participation in learning collaboratives related to health equity, MCH preparedness efforts, and data linkage.

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.

Nebraska's MCH Epidemiology staff utilize several 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, Developmental Disabilities, Children and Family Services, and Medicaid and Long-Term Care as well as multiple Division of Public Health programs within NDHHS. External partners are UNMC/Nebraska Perinatal Quality Improvement Collaborative, Nebraska's Department of Education, Nebraska's Children and Families Foundation, local health departments, the four designated tribes (Omaha, Ponca, Santee, and Winnebago), the Great Plains Tribal Epidemiology Center, Munroe Meyer Institute, Parent Training and Information Center (PTI) Nebraska, the PRAMS steering committee, the Child and Maternal Death Review Teams' expert volunteers, and the Title V steering committee and stakeholders.

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 Title V work and remain visible to both internal and external partners on our public 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 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, NOMs, SPMs, and EPMs. In addition to the Title V framework, there are several agency level assessments which support ongoing monitoring of maternal and child (including those with special health care needs) health, such as the MIECH-V 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.

There have been several changes in Nebraska that have increased the capacity of Title V.

Title V continues to experience turnover and staffing changes within its core team. In late 2023 Jennifer Severe-Oforah, a long-term Title V core team member, took on the role of Lifespan Health Services Unit Administrator II/Title V MCH Director after serving as the Administrator of the Office of MCH Epidemiology. In mid-2023 Celeste Illian joined the core team when she became the Administrator of the Office of MCH Epidemiology (SSDI Director). Within the Office of MCH EPI, Nebraska's Birth Defects Registry was added to the Office of MCH EPI in late 2022, a full-time abstractor and a health surveillance coordinator were added to the office in 2023, and MCH EPI secured a CSTE Applied Epidemiology Fellow at the end of 2023.

In January of 2024, the CYSHCN team members within the Division of Children and Family Services broke off to become the Office of Economic Assistance. This resulted in several smaller organizational/programmatic shifts within NDHHS, Title V CYSHCN and the Medically Handicapped Children's Program (MHCP) moved to the Division of Developmental Disabilities under Policy Administrator Colin Large. Finally, the Federal Aid Administrator resigned in February of 2024; Raquel Edmunds, the newest member of the team, joined in May 2024 as the new Federal Aid Administrator. These changes follow turnover in two core team members in 2022 (Federal Aid Administrator III, and Maternal Child Health (MCH) Program Manager II, and MCH Director).

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

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,000,000	$3,709,999	$4,000,000	$3,837,413
State Funds	$3,000,000	$3,002,378	$3,000,000	$2,900,000
Local Funds	$350,000	$207,955	$350,000	$330,199
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$7,350,000	$6,920,332	$7,350,000	$7,067,612
Other Federal Funds	$212,241,927	$145,345,649	$214,347,896	$154,518,258
Total	$219,591,927	$152,265,981	$221,697,896	$161,585,870

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,000,000	$3,775,140	$4,000,000	
State Funds	$3,000,000	$3,236,272	$3,000,000	
Local Funds	$318,934	$325,257	$350,000	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$7,318,934	$7,336,669	$7,350,000	
Other Federal Funds	$228,192,347	$192,618,635	$253,175,211	
Total	$235,511,281	$199,955,304	$260,525,211	

	2025	
	Budgeted	Expended
Federal Allocation	$4,000,000	
State Funds	$3,000,000	
Local Funds	$350,000	
Other Funds	$0	
Program Funds	$0	
SubTotal	$7,350,000	
Other Federal Funds	$45,104,857	
Total	$52,454,857	

III.D.1. Expenditures

At the time of the July 2024 submission, obligations of the 2023 grant are not fully liquidated. Expenditures and unliquidated obligations for performance ending September 30, 2024, 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, 2025.

The narrative is organized to emphasize performance generally about financial resources of the 2023 grant, state expenditures in the FFY 2023 period, and local match associated with subawards of the 2023 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.

Notes on Expenditures

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 July 2024 report submission, the 2023 and 2024 grant funds are available for obligation and expenditure. The 2025 funds in this Application will be initially available in the 2nd year of the 2024 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 2023 period, i.e., October 1, 2022, through September 30, 2023. Subrecipient Tribal MCH programs and community-based projects contribute third-party and non-federal cash expenditures aligned with a subaward period (April 1 through March 31) and not aligned with the FFY or state fiscal year (SFY) July 1 through June 30.

Circumstances challenge alignment of requirements

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

1) Title V needs 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 2023 funding availability overlaps with the initial year of the 2024 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.

2) 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.

Programs & special projects

With the 2023 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 Health (MCH) team** ($409,995 BG) comprise much of the content of the State Action Plan, which is described elsewhere in this report. MCH program staff are an integral part of the Title V State Action Plan group and led a variety of initiatives and coordinated state-level activities with other programs/units to address many of Nebraska MCH priorities and activities across population domains.

The Office of MCH Epidemiology ($72,302 BG; Title V funds also provided additional support ($135,358 BG) beyond the CDC award to the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Birth Defects Registry ($42,368 BG).) successfully maintain a CDC MCH Epidemiology Assignee since September 2020. The Child Death Review Team (CDRT) and the Maternal Mortality Review Committee meet quarterly. The annual Child Death Report (2020 deaths), and the MMRC report (deaths that covered years 2017 – 2021) were published. Other activities of the Office included continuing with the investment into National Survey of Children's Health oversample, supporting the N-MIECHV data and performance management system. In 2023 the Birth Defects Registry joined the MCH EPI Team, the registry provided training to hospitals to use the state electronic birth defect reporting system, performed data quality checks to assure the birth defect data are accurate and complete, and engaged with MCH programs to provide accurate, complete, and timely information about children with birth defects.

The Adolescent & Reproductive Health Programs ($525,145 BG) supported 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) ($47,245 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.

The **Newborn Screening Program** ($397,869 BG; $696,227 SF) staff conducted continuous monitoring, tracking, and follow-up activities to ensure all Nebraska newborns receive a valid screen for all required conditions. This work included 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)** ($36,533 BG), additional support from Title V 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)** ($1,054,912 BG; $869,154 SF) was organizationally within the Division of Children & Family Services in FY23 but re-organized to Division of Developmental Disabilities in 2024. MHCP and its partners are essential to the CYSHCN domain. MHCP field staff statewide provide ongoing family-centered case management services to program participants. During the 2023 Block Grant period MHCP continued use of Parent Resource Coordinators (PRC). The program partnered 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, which provided accurate and timely information on exposures to potentially damaging agents during pregnancy and lactation. Finally, they added the Nebraska Connecting Families subawards to address the behavioral and mental health needs of CYSHCN in schools, a Nebraska priority.

Subawards to Tribal governments and local communities ($816,583 BG; $325,257 local/non-federal cash & third-party/in-kind) helped ensure Public Health Services and Systems and provided enabling services (and some direct services in Tribal programs) in communities across Nebraska. The 2023 federal award provided assistance to six local health departments, two community-based organizations, and 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 are 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 have been 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 ($3,561,272) plus local funds and in-kind support ($325,257). The total value of matching resources, including local match, is 94% ($3,561,529) or 86% state funds alone of the 2023 federal Title V expended/unliquidated obligations reported ($3,775,140). 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 $69,385 (1.9%), 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 2023 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 2023 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 2023 allotment of Title V federal funds to Nebraska is $3,955,957. At the time of the July 2024 report submission, the total expenditures/remaining obligations across the five types of individuals served (Form 3a, IA) is $3,775,140, 95.4% of the projected final expense. A total 90,103 persons received an individually delivered Direct or Enabling Service at a cost of $4,411,037 ($2,043,190 BG; $2,367,847 SF).

	Federal	State	Federal-State		
	Form 3a	Form 3a	Form 3a	Form 5a	Form 5b
Pregnant Women	$ 326,016	$ 315,454	$ 691,470	829	100%
Infants <365 days	$ 372,329	$ 486,682	$859,011	423	100%
Children (1 through 21 years of Age)	$ 1,541,194	$668,662	$2,209,856	33,329	100%
Children With Special Health Care Needs (0 through 21 years of age)	$ 1,306,274	$ 1,352,541	$ 2,209,856	1,608	100%
Others	$ 159,942	$ 738,189	$ 898,131	55,212	5%
Subtotal	$ 3,705,755	$ 3,561,528	$7,267,283	89,793	
Administrative Costs	$ 69,385				
Grand Total	$ 3,775,140		$ 7,336,668		

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 71.3% ($5,229,370) for Direct and Enabling Services (Form 3b) for individually delivered services to 90,130 persons (Form 5a). Expenditures for Public Health Services and Systems (Form 3b) comprise the other 28.7% ($2,107,298), reaching an average 90% of the MCH population (Form 5b).

	Federal	State	Federal-State		
	Form 3b	Form 3b	Form 3b	Form 5a	Form 5b
Direct Services & Enabling Services	$ 2,078,622	$ 3,150,749	$ 5,229,370	89792	
Public Health Services and Systems	$ 1,696,518	$ 410,780	$ 2,107,298		90.1% (average all populations)
Total	$ 3,775,140	$ 3,561,529	$7,336,168		

III.D.2. Budget

The broad-based category budget (Forms 2, 3a, and 3b) is presented on a presumed 2025 allotment (grant) like the level of recent awards. A precise 2025 budget will be finalized and approved within NDHHS during the first year of spending authority.

Notes on the budget

These three overarching 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 July 2024 submission of the 2025 application, the 2023 and 2024 grant funds are available for obligation and performance. The 2024 funds will be available in the 2nd year of the 2024 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 2024 federal block grant unobligated at the time of the July 2024 submission requesting 2025 funds. Nebraska Title V can continue operations well into the FFY 2025 period that begins October 1, 2024, with the FY 2024 funds. 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 is 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 grant 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 2023 subawards that ended March 31, 2024, are mostly liquidated; actual expense and counts are included in the July 2024 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 2024 funds and/or 2025 funds. 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 completed 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. The block grant administrator presents the refined grant budget to Title V co-directors, i.e., the MCH Director and the CYSHCN Director, with the outcome to approve the 2024 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 2024 allotment. That same process will take place for a precise 2025 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 a 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 Set-aside

NDHHS prioritizes its longstanding commitment to the MCH Tribal set-aside, 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 2025 Tribal set-aside is expected to be at a similar funding level ($215,000) as with recent years. The current Tribal subawards of 2024 block grant are for the period April 1, 2023, through March 31, 2024.

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. Like the prior 2021 RFA, a 2024 RFA offered 2024 grant funds initial, and subsequent awards with 2025 funds, and anticipates another RFA for the 2026 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.

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 submitted work plans for April 1, 2024, through March 31, 2025. A subsequent renewal (2025 subawards) for the April 1, 2025, through March 31, 2026, period has been executed for each agreement.

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.

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 CYSHCN 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% CYSHCN (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 $110,552, which presumably will again be far below the 10% statutory cap depending on the 2025 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 2024 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 grant.

Forecasting the preliminary 2025 line-item budget

A three-step process described in preceding paragraphs was used for the 2023 grant budget development and monitoring budget-to-expense to prepare the 2023 expense report submitted in July 2024. It forecasts a similar fine-tuning process for the subsequent 2025 budget presented in this Application. When additional information is known about the federal 2025 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 2024 and 2025 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

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, Nebraska's Title V program approaches all aspects of programming (planning, implementation, and assessment/evaluation) guided by core values. These values are focused on being data-driven, utilizing evidence-based approaches, convening, and collaborating with community and family partners, and working toward health equity. Nebraska has used its limited Title V funds to build and maintain a solid public health infrastructure to monitor and assess the health of the MCH/CYSCHN populations and determine the impact of/need for public health programing and intervention. Title V is often called to provide leadership and resources in emergent needs often gap filling and supporting communities in their efforts as public health infrastructure/systems are built, maintained, or modified.

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. 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 small core team. Relationships are 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 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 and cross-Divisional. Staff housed within NDHHS 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.

As Nebraska's team begins the fifth and final year of the current phase, they are actively engaged with planning and preparing the 2025 Needs Assessment. The assessment is the foundation that supports and guides the team and the state through the next five years. The assessment is also the opportunity to begin anew, and to recommit to the core values and guiding principles as a staff and as a community. The Title V team utilizes the stakeholder produced issue briefs as guiding documents, to keep the action plan, and the strategies true to the prioritized needs of Nebraska.

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

III.E.2.b.i. 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
Jennifer Severe-Oforah	Lifespan Health Services Unit Administrator II/Title V MCH Director	0
Colin Large	Policy Administrator II/Title V CYSHCN Director	0
Raquel Edmunds	Federal Aid Administrator III	100
Jessica Seberger	Maternal Child Health (MCH) Program Manager II	75
Jackie Moline	Maternal Infant Health Specialist, RN	100
Gabriella Hernandez	Children's Health Program Specialist	100
Jennifer Auman	Maternal Infant Early Childhood Home Visiting Program Manager	15
Jayce Gapp	MCH Administrative Assistant I	100
Celeste Illian	Office of MCH Epidemiology Administrator/SSDI Director	0
Anna Burbach	Health Surveillance Specialist	35
Hailey Li	Epidemiology Surveillance Coordinator	25
Derek Ross	Birth Defects Registry Health Data Coordinator	100
Masoomeh Hajizadeh Oghaz	PRAMS Program Manager	100
Tyler Faulkner	Community Health Educator	100
Michaela Jennings	Adolescent/Reproductive Health Program Manager II	70
Emily Rivera	Community Health Educator, Sr.	50
Gabrielle James	Program Specialist	50
Yousef Ibrahim	Newborn Screening Inherited Diseases Clinical Specialist	100
Sarah Ward	Newborn Screening Inherited Diseases Clinical Specialist	100
Hanna Quiring	MHCP Program Coordinator	57
JoAnn Hendrickson	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 Mood	MHCP Payment Reviewer	57

*Both Title V Co-directors oversee larger units within the NDHHS organization, of which the Title V MCH Block Grant is only

a part. Their salaries are paid from an administration account which is funded from a portion of the funds from programs under their purview.

Title V continues to experience turnover and staffing changes within its core team. In late 2023 Jennifer Severe-Oforah, a long-term Title V core team member, took on the role of Lifespan Health Services Unit Administrator II/Title V MCH Director after serving as the Administrator of the Office of MCH Epidemiology. In mid-2023 Celeste Illian joined the core team when she became the Administrator of the Office of MCH Epidemiology (SSDI Director). In January of 2024, the CYSCHN team members within the Division of Children and Family Services broke off to become the Office of Economic Assistance. This resulted in several smaller organizational/programmatic shifts within NDHHS, Title V CYSCHN and the Medically Handicapped Children's Program (MHCP) moved to the Division of Developmental Disabilities under Policy Administrator Colin Large. Finally, the Federal Aid Administrator resigned in February of 2024; Raquel Edmunds, the newest member of the team, joined in May 2024 as the new Federal Aid Administrator. These changes follow turnover in two core team members in 2022 (Federal Aid Administrator III, and Maternal Child Health (MCH) Program Manager II, and MCH Director).

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

- Jason Kilker, Immunization Program Manager
- Jillian Chance, Newborn Screening Program Manager
- Angel Sumpter, Newborn Hearing Screening Manager
- Melissa Leypoldt, Women's and Men's Health Program Manager
- Erika Fuchs, CDC MCH EPI Assignee

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's Hospital 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 MCH team developed MCH-specific training for Community Health Workers (CHW) and partnered with stakeholders to host in-person and virtual regional events for CHW for learning and networking. Community Health Workers are valued and respected members of effective integrated health care teams in clinical and community settings and they are part of a care team that improves 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 Association of Maternal Child Health Programs; CityMatCH MCH

Leadership Conference, Association of Women's Health, Obstetric and Neonatal Nurses.

- Title V provides capacity building training for evidence-based practice, specifically including Teen Outreach Program and Healthy Families America.

Family leaders:

- Support for Parent Resource Coordinators at MMI
- Support for CHW workforce development
- Family leader participation on a cross-sector advisory committee as part of the NE Pediatric Mental Health Care Access grant.
- Family leader participation in Title V Steering Committee
- Family Leadership Advisory Committee will start in Fall 2024

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 supports CHW workforce sustainability. Community Health Workers are employed in public health, community service, and clinical settings. NDHHS offered MCH specific training through the Office of Women's and Men's Health for over a decade. The content trained CHWs to assist in outreach and navigation particularly for chronic health conditions. In Fall 2022, two CHW training programs received 3-year grants from HRSA to support CHW training. The Nebraska Association of Local Health Directors received a separate 3-year grant from HRSA to build local health department capacity to support dental health services with CHWs. With the influx of support for CHW trainings, NDHHS paused administration of its training.

While there are now well-funded training programs in the state, the future of CHW sustainability is in question. CHWs are often employed through organizations with grant funds, and if CHWs could be reimbursed for services through Medicaid, their employment could be more permanent. The NDHHS' Division of Medicaid and Long-Term Care is generally supportive of Medicaid reimbursement but needs a certification or credentialing standard to identify scope of practice and training requirements for CHWs. Because state and community stakeholders are interested in Medicaid reimbursement for CHW services, those partners will need to develop consensus for training and scope of practice requirements. This is work in progress.

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 CHWs 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

To promote comprehensive family centered care, Title V supports 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 center respect in the practice of helping families.

Title V provides funding opportunities to local, community-based organizations who are strongly connected to target populations – such as nonprofit organizations, tribal and local health departments, faith-based organizations, etc. 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.

Nebraska Title V creates opportunities to partner with families and supports these partnerships with compensation, when possible, to reimburse individuals for their time and expertise when activities are not part of their regular work.

Nebraska Title V is developing a Family Leadership Advisory Committee to create a shared vision, provide feedback on state level objectives and strategies, and develop an action plan to support committee growth and impact. This committee will have its first meeting in Fall 2024. Family leaders will be invited to participate through local organizations that they interact with. Title V plans to share the recruitment flyer with tribal and local health departments, home visiting programs, WIC clinics, organizations that participate in the Vaccines for Children program, community health workers, and Title V Steering Committee members.

To support participation, Title V will compensate attendees for participation at every meeting, offer mileage reimbursement, and have childcare on-site as needed. The committee will meet in-person four times a year for 3-5 hours each meeting. The meeting location will depend on the makeup of the committee and will aim to be centrally located for most members. Nebraska aims to have 8-10 family leaders in the committee in the first year and grow by 6-8 for the next two years. Ideally, family leaders would participate in the committee for three years, in a staggered format. This would lead to a new group of family leaders in the committee every four years.

Title V proposes to have the action plan include activities to

- Support each family leader’s growth individually,
- Ensure the committee is inclusive and supportive of each leader,
- Provide feedback for Title V about family needs and suggested strategies to improve health,
- Promote growth in diversity of the committee, and
- Draft evaluation measures for effectiveness and efficiency based on the committee’s interests.

In 2024-2025, the Family Leadership Advisory Committee will have one meeting that focuses on the Title V Needs Assessment process and each member will be invited to participate in the needs assessment (in addition to the advisory committee). If they do participate in the needs assessment, in addition to the Family Leadership Advisory Committee, they will be offered compensation for both activities.

Woman/Maternal Health

The NDHHS Women and Men’s Health program, in partnership with the NDHHS Women’s Health Initiatives (WHI) program, are co-leading a project to partner with community cultural organizations to enhance local navigation and health services. This project depends on relationships with non-traditional public health partner organizations that have a direct connection with the target population (i.e. faith-based organizations, sororities, cultural centers, etc).

The health of women is further supported through Community Health Worker trainings provided by Nebraska’s Community Health Worker / Promotores (CHW/P) Collaborative. In recent years, NDHHS included maternal and child health modules in its internal CHW training, but that training has been paused because other state level partners have received HRSA funding to train CHWs. The CHW/P Collaborative trainings are promoted to CHWs across Nebraska to promote families accessing available services. Recent CHW/P Collaborative trainings have focused on domestic violence, assisting immigrants with benefits in Nebraska, serving the refugee population in Nebraska, and Nebraska’s Medicaid redetermination efforts. Title V

provides training and support to CHWs because they are community members embedded in organizations whose job duties include bridging the potential gap between medical advice and social experience to address needs and improve health.

Perinatal/Infant Health

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.

The NDHHS WIC program has a network of part-time, paid 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. WIC parents who are champions of breastfeeding are often encouraged by WIC staff to become BFPCs.

Child Health

The Nebraska Maternal, Infant, Early Childhood Home Visiting (N-MIECHV) program is very close with families – offering programming in family's homes. 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.

Partnership with NDHHS Injury Prevention program supports families across the state. Nebraska has approximately eight Safe Kids programs 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 (CYSHCN)

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 across the state offer support 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, client/family satisfaction surveys are conducted on an on-going basis to hear from and adjust services based on participant family feedback. In the past few years, UNMC MMI has also started a "Connecting Families" Steering Committee. The goal of the committee is to create a space where stakeholders 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 to enhance the services and supports available for youth in schools who need mental and behavioral health supports across the state of Nebraska. Family involvement and voice is a key requirement of this committee.

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 connection emboldens parents to be further involved in system

improvements. In addition, the EHDI program connects 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.

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 CYSHCN domain, but they also bring the voice of disabilities inclusion into other domains as well.

Adolescent Health

The Adolescent & Reproductive 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. Local community-based organizations are encouraged to include youth-voice from their community in the design of work to make reproductive health clinics “youth-friendly.” Additionally, programs working on suicide prevention have engaged youth in schools to help design and administer programming that is relevant to their peers.

Title V has put a priority on expanding the reach of Teens in the Driver Seat program, a peer-to-peer motor vehicle 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. Participation 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 in Pediatrics), 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 sub work groups. 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 staff are mindful of the role of families in addressing the priority, as well as considering how severely and disproportionately affected by discipline practices some families are, as well as barriers to opportunity and services. This work is directly tied to the work of the Connecting Families Steering Committee, mentioned above. Families benefit from support services and information and knowledge regarding their rights and responsibilities. Title V considers the benefit of partnership to families as Title V supports engagement. 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 24 years.

The workforce and capacity have grown over time. The Office of MCH EPI currently has nine full time equivalents (FTE), two contracted FTE, and one long-term assigned Fellow. MCH EPI consists of the State Systems Development Initiative (SSDI), Title V Needs Assessment and support, The Child Death Review Team (CDRT), ERASE Maternal Mortality (ERASE MM), Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), Nebraska's Maternal Infant and Early Childhood Home Visiting (MIECHV) performance management and data system, Nebraska Birth Defects Registry, and general MCH EPI subject matter expertise for the unit and division. The following section describes the staff, their roles, and funding.

Current Staff

Celeste Illian, MPH, Office of MCH EPI Administrator
Erika Fuchs, PhD, MPH, CDC MCH Epidemiologist Assignee
Haley Li, MPH, MCH Epidemiologist
Anna Burbach, BS, Health Surveillance Specialist
Kayla McKain, MSN, RN, Program Specialist- RN
Ama Bikoko, MHA, MPH CDC Foundation Epidemiologist
Tyler Faulkner, BS, Community Health Educator
Masoomeh Hajizadeh Oghaz, PhD, Program Coordinator
Sally Mertens, BS, Administrative Technician
Vacant, Office Specialist
Derek Ross, BS, Health Data Coordinator
Jobert Tiendrebeogo, MPH, CSTE Applied Epidemiology Fellow

Roles and Responsibilities

The MCH EPI Administrator joined MCH EPI in January 2020, originally as an MPH-level epidemiologist and took on the role of Administrator in early 2023. The previous long-term Administrator was promoted internally at the end of 2022 but continues to be involved at a higher level with the work of MCH EPI. 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 previous Administrator invested 3 years to reorganize and build Nebraska's Maternal Mortality Review Committee so that staff could coordinate, and then shifted focus on reorganizing the birth defects registry 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, NDHHS, 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. 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 works with

students and interns on an ongoing basis. Finally, the Assignee is responsible for maintaining the PRAMS Institution Review Board (IRB) clearance.

The MCH Epidemiologist was joined MCH EPI in April 2024. The position's primary role is analyzing data for the Maternal Mortality Review Committee (MMRC) and supporting the CDRT. 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 supports the Birth Defects Registry. The MCH Epidemiologist position is funded by ERASE MM and Title V.

The Health Surveillance Specialist is responsible for data collection and management of the CDRT, 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 CMDRT provides oversight to the Douglas County Fetal and Infant Mortality Review committee, so the Specialist is a member of their review team. 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 Program Specialist- RN first joined the team in a temporary assignment in April 2023, and was hired on in a full time, permanent capacity in April 2024 and serves as the MMRC nurse abstractor. Funded by ERASE MM, the nurse abstractor is tasked with obtaining all records pertaining to each maternal death in Nebraska, developing a summary abstract for each case, managing the review process, and aggregating the data into several databases once the reviews are complete. The Program Specialist also works to engage community partners, local health departments, and MMRC committee members in programming aimed to reduce poor maternal health outcomes.

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 Administrative Technician has a significant role ensuring that operations run efficiently and without error. While the Administrative Technician primarily focuses on gathering and managing all aspects of the data collection process, there is also an element of quality improvement. The Administrative Technician monitors timeliness and accuracy of data, often working with the coordinator to address issues with CDC or the surveyors as appropriate. Over the past year, the Administrative Technician moved into a part time role, and MCH EPI sourced a Temporary, part-time Administrative Technician to assist the PRAMS team. Finally, the Office Specialist, 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 overall.

Finally, the Birth Defects Registry was transferred to MCH EPI in the Fall in 2022. A long-term employee retired in January 2024, and the position was reclassified to better support the registry moving forward. The Health Data Coordinator is set to begin work in July 2024. They are responsible for managing the data collection and management, in addition to training and quality assurance of hospital clerks who submit most of the cases. Over the next few years, the registry will undergo several incremental changes related to modernization; the registry is currently working with Nebraska Newborn Screening Program to develop a new data system.

Impact or Organizational Changes on Future Development

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).

The Director has primary responsibility for supporting Nebraska’s Title V program’s data needs including coordinating the MCH Needs Assessment; identifying priority needs; selecting National Performance Measures (NPMs) and developing State Performance Measures (SPMs)/ Evidence Base Strategy Measures (ESMs) for the Title V Action Plan; as well as reporting and monitoring progress. Nebraska will successfully submit the 2023 annual report and 2025 application in this funding year.

In addition, SSDI provides leadership and technical support for projects to link various data systems: 1) Pregnancy Risk Assessment Monitoring System (PRAMS) data linkage with hospital discharge data, 2) linkage between WIC and SNAP data, 3) an Early Childhood Integrated Data System (ECIDS; partnership with the Nebraska Department of Education), and 4) a DPH Data Query System that would include DPH’s major databases.

Nebraska’s SSDI program continues to grow the state’s data capacity for informed decision making and resource allocation in programming for women, infants, children, and youth, including children and youth with special health care needs. The following narrative describes the program’s goals and objectives, and details progress for the reporting period (12/1/2023-present).

SSDI has been active in building and supporting timely and linked MCH data systems 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 several 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 Epidemiology 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.

The SSDI Director collaborated with the Vital Records Unit to develop division-wide Approved Researcher protocol and documentation to streamline requests from researchers to receive and utilize health data. The protocol was put in place in January 2024, and have been successful in releasing PRAMS, Cancer Registry, and Birth Defects Registry data at this point.

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. The dataset was previously 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 secured a Hospital Discharge dataset with identifiers for data linkage.

Over the past funding cycle, SSDI successfully participated in a project linking PRAMS survey data with Nebraska hospital discharge data to understand more completely Severe Maternal Morbidity in Nebraska. This work is ongoing; however, it is a step toward the identified need to link the Hospital Discharge dataset to improve demographic completeness. The results from the project were presented at several national level webinars/trainings, and in an oral presentation at the Council for State and Territorial Epidemiologists (CSTE) meeting in June 2024. Also in FY2024, MCH EPI staff continued utilizing HDD for linkage with birth certificate data to examine SMM further and submitted a drafted Nebraska SMM report for internal approval.

Documentation of standard operating procedures, protocols, and job tools have been drafted for all MCH EPI program areas and continue to be refined and updated as needed. MCH EPI continued supporting Maternal Mortality Review Committee, Child Death Review Team, Birth Defects Registry, PRAMS, Maternal, Infant, and Early Childhood Home Visiting, and other programs with data collection, implementation, and analysis.

The SSDI Director has primary responsibility for enabling Nebraska's Title V program assessment, monitoring, and reporting. 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.

Nebraska's Title V program core team of internal staff, and the external steering committee, have met quarterly over the past year. These two committees monitor progress on the current action plan, while planning for future activities.

MCH EPI led participation in the Association of Maternal and Child Health Programs (AMCHP) Emergency Preparedness and Response Action Learning Collaborative (EPR ALC) which utilizes the "Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health" to improve readiness/preparedness for emergent response. They developed an access and functional needs tabletop exercise that was delivered at the Nebraska Preparedness Seminar about POD sites and clinic dispensing and included a scenario with MCH-related content. The CDC MCH epidemiology assignee to Nebraska also delivered a talk at the Nebraska Preparedness Seminar about the importance of considering the needs of infants, children, and women of reproductive age in planning for emergencies.

In the coordination and implementation of the Title V Needs Assessment activities there were several key program activities, products, and materials 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.

The SSDI Director developed an action plan timeline for data analysis for the 2025 needs assessment process, and MCH EPI staff have collected and analyzed data relating to over 200 indicators across all five domains. The analyzed data are being reviewed by a designated scientific team, and fact sheets are being developed using the finalized data.

III.E.2.b.iii.c. 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. MCH EPI was able to expand upon the maternal mortality work done in previous years by securing Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) funding through CDC in 2022. The work with the Division of Public Health's data visualization project called Atlas continues working toward cause of death and birth dashboards 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.

MCH EPI engaged in several training and leadership development opportunities as well. The team participated in two Association of State and Territorial Health Officials (ASTHO) projects called "Using Data to Address Racial Inequities in Maternal and Child Health Learning Community," and "Linking PRAMS and Clinical Outcomes Data Multi-Jurisdictional Learning Community Cohort 2". Key staff attended the American Public Health Association, Association of Maternal and Child Health Programs, MMRIA Users Meeting, Council of State and Territorial Epidemiologists, National Fatality Review Meeting and PrevCon, and local/state conference. Finally, MCH EPI hosted a Master's level Epidemiology Program summer intern and one AMCHP Graduate Student Epidemiology Program (GSEP) intern in 2023.

As MCH EPI looks to the next 12 months with intention to build additional capacity, staff will build capacity related to existing datasets, attend relevant national maternal and child health and epidemiology related conferences, and host at least two additional interns.

There are several potential challenges that MCH EPI faces in their capacity building efforts. First, several new key team members were added in the last year. Recruiting and onboarding new staff is time and resource intensive and changes the team dynamics and historical knowledge available. Additionally, 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.

Finally, NDHHS 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, for both public records requests as well as approved researcher requests; these processes continue to affect how MCH EPI does business with its external partners. MCH EPI spearheaded a division-level effort to develop a standardized approved researcher process and documentation, which has been implemented successfully. 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

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 NDHHS 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 NDHHS 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 Mpox response, particularly around vaccine distribution but also targeted outreach and education. In 2023, Title V leadership and MCH epidemiologists were requested to assist with surveillance of syphilis, including congenital syphilis, due to an alarming increase in cases.

Nebraska's Office of Maternal and Child Health Epidemiology participated in the 2023 cohort of the Association of Maternal and Child Health Program's (AMCHP) Emergency Preparedness and Response in Maternal and Child Health Action Learning Collaborative. A multidisciplinary team of members from the Division of Public Health, including maternal and child health epidemiology, WIC, the Office of Health Disparities and Health Equity, Public Health Emergency Preparedness, vaccine preventable diseases, and the Title V director participated in a 6 month long series of interactive workshops to

review, assess, document findings, and make recommendations utilizing the AMCHP “Public Health Emergency Preparedness and Response Checklist for Maternal and Infant Health”. The checklist yielded thoughtful considerations and several actionable recommendations to improve on preparedness. The team prioritized items on the checklist for Nebraska’s needs and began and completed some sub strategies. Recent progress and successes include: WIC staff working on an after action report and new preparedness plans for events like the recent formula shortage; MCH reviewed newborn screening’s plan for emergencies and working with newborn screening to improve their overall data capacity; a public health emergency response team member gave a presentation on MCH preparedness at the annual Nebraska emergency preparedness meeting; the lead MCH epidemiologist on the team estimated the number of pregnant women in the state and by county; the PRAMS team discussed potentially adding preparedness items to PRAMS if there are appropriate questions for future use; and the MCH epidemiology team has worked with the general epidemiology unit to discuss data needs along with facilitators and barriers to timely data.

Additionally, five members of the Nebraska team were able to attend the Tabletop Exercise for the Inclusion of MCH Populations in Emergency Preparedness and Response held by the National Association of County and City Health Officials (NACCHO) at the Preparedness Summit in Atlanta in April 2023. This exercise required working together with other professionals providing leadership and subject matter expertise for MCH while addressing their public health needs during an emergency scenario. In addition to optimizing the State’s readiness to respond to public health emergencies, including data, programming, partnerships, and communications, participation in the tabletop exercise assessed the team’s knowledge of the State’s EPR plans and the gaps within the team’s knowledge and plans.

In late 2023, the Nebraska PER team, in collaboration with the MCH epidemiologist who leads the MCH EPR workgroup, developed an access and functional needs tabletop exercise that was delivered at the Nebraska Preparedness Seminar about POD sites and clinic dispensing, and included a scenario with MCH-related content. This scenario tested participants’ knowledge and preparedness to serve a mother with a 3-week-old infant and other children who had a potential exposure to anthrax and a need for safe infant formula, breastfeeding information, and clean supplies. The CDC MCH epidemiology assignee to Nebraska also delivered a talk at the Nebraska Preparedness Seminar about the importance of considering the needs of infants, children, and women of reproductive age in planning for emergencies. The talk, entitled “Integrating Maternal and Child Health into State Emergency Preparedness and Response Plans” had approximately 60 attendees from state (Nebraska and Indiana) and local public health, hospital staff, health care coalition members, academics, and a region 7 emergency management specialist within the Office of the Assistant Secretary for Preparedness and Response in the US Department of Health and Human Services.

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

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

Title V maintains a robust commitment to collaboration with a variety of other stakeholders, including other NDHHS 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; Pediatric Mental Health Access 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; Aid to the Aged, Blind and Disabled; Social Services to the Aged and Disabled; as well as the State Disability Program and Nebraska Lifespan Respite Network and the University Center for Excellence in Developmental Disabilities. 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.

The new CYSHCN Director is the Director of Home and Community-Based Services Programs, and provides executive leadership and oversight of statewide programs, including the 1915(c) Medicaid waivers for individuals with developmental disabilities, physical disabilities, traumatic brain injuries, and the aged, as well as the Lifespan Respite and Medically Handicapped Children's Programs and serves as the project lead for the Nebraska Olmstead Plan. He coordinates closely with state agencies and external stakeholders to monitor and evaluate current initiatives and identify future initiatives which will support Nebraskans, regardless of disability, to live full and meaningful lives within their communities. The work of integrating the new CYSHCN team members from the Division of Developmental Disabilities into the Title V work offers rich new opportunities to strengthen and build partnerships.

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, and 2024 will include dental. 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. Beginning January 2024, Medicaid coverage post-partum care was extended to 12 months.

External partners are perhaps some of the most important in ensuring quality health care with an integrated delivery system. Partners such as the Nebraska 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.

Title V leverages networks developed through collaboration. The NDHHS Division of Children and Family Services (DCFS) has invested in the Bring Up Nebraska statewide network of Community Collaborative organizations to promote child abuse prevention efforts. Because of the growth and support of the Community Collaboratives from DCFS, Title V received three RFA applications from Community Collaboratives when Title V released an RFA in 2024.

Title V has built effective collaborative partnerships with tribal and local health departments but struggles to successfully partner with some small community-based organizations because of federal fiscal management requirements. Recent revisions to the Uniform Guidance, 2 CFR 200 (effective October 1, 2024) should support NDHHS in streamlining grant administration and enhancing transparency throughout the grant process.

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.

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) is important to the health of the MCH/CYSHCN populations. The Nebraska Department of Health and Human Services, encompasses both Title V and MLTC. Title V is implemented by the Division of Public Health and as of January 2024, the Division of Developmental Disabilities (DD). The reorganization that resulted in the CYSHCN programing moving to DD should strengthen the relationship between Title V and MLTC and provide additional impetus to update the Interagency Agreement (IAA).

The IAA was last revised in 2015. Title V has attempted to update the IAA several times, however multiple challenges and disruptions including organizational restructuring, leadership changes, staff turnover, as well as the COVID-19 pandemic have limited the programs' ability to complete the task. Further, Nebraska's IAA involves three Divisions within a single agency and can be seen as a redundancy for programs and Divisions who already work together to achieve a common mission.

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 expansion of Medicaid eligibility in 2020. MLTC began the Medicaid redetermination (an end to continuous enrollment), in March 2023, and concluded April 30, 2024. Finally, MLTC is currently implementing the extension of coverage for 12 months post-partum, which will affect roughly 10,000 women annually,

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. Title V most recently revisited the IAA in the fall of 2023, when staff meet with MLTC leadership to inform, dialogue, and vision a new agreement. The outcome was promising as there was initial agreement to add data and information sharing to the current agreement. However, soon after the MLTC Director resigned, and the reorganization was announced. Title V will resume efforts on the IAA in the fall of 2024.

There have been several mutually beneficial projects or collaborations between Title V and MLTC, including partnering on the redetermination process. 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 were particularly inclusive during this time, beginning with exploratory meetings hosted by MLTC where staff from other Divisions described 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.

As the new Title V core team's relationships develop and strengthen so will the relationship with MLTC. The new CYSHCN team members with the Division of Developmental Disabilities plan, implement, and evaluate the MLTC waivers and state plan amendments that directly influence health care delivery for the MCH population, particularly CYSHCN. The two divisions meet monthly and quarterly to coordinate and manage the work, resulting in joint policy level decision making on issues related to MCH services delivery and coverage, particularly for CYSHCN. This coordination led to the announcement in March 2024 of the elimination of the wait list for DD services by October 2025.

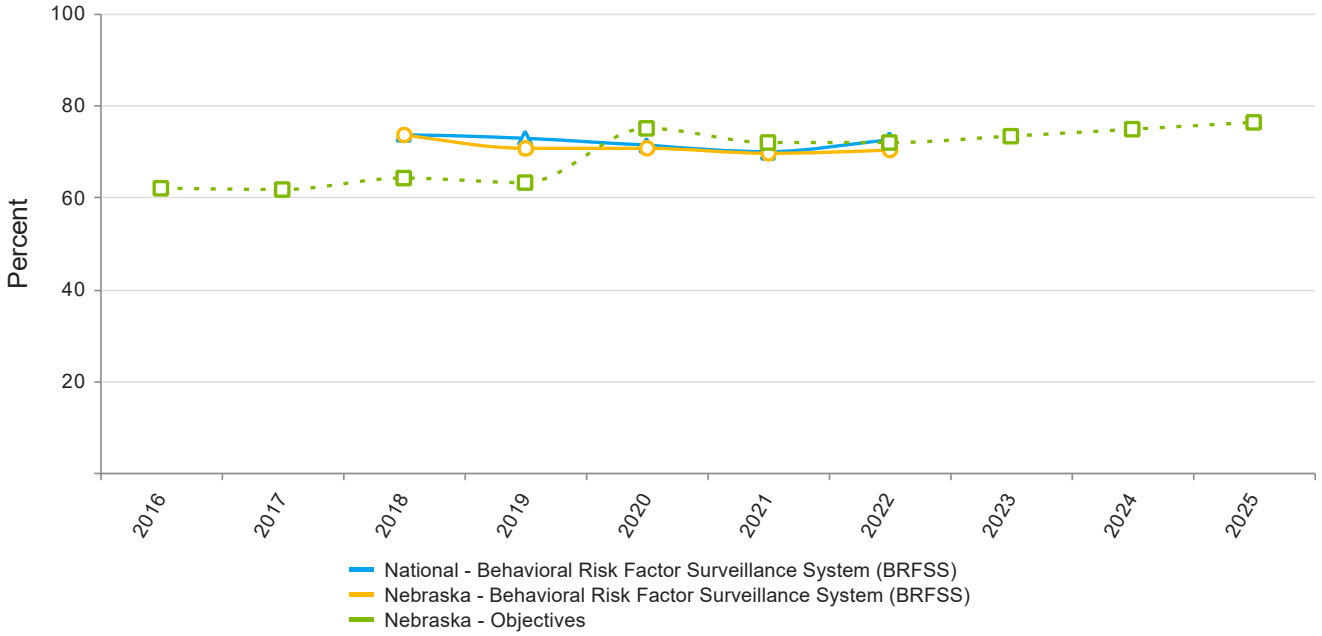
Finally, in recent years Title V has supported statewide efforts to seek Medicaid reimbursement for community health workers (CHWs). At the same time, statewide interest in Medicaid reimbursement for doulas has grown. In 2023-2024, the Title V team had internal conversations about the scope of practice and required training for CHWs and doulas. After internal discussion and conversation with external stakeholders like the Malone Center in Lincoln, NE and I Be Black Girl in Omaha, NE (two organizations that have doula training programs), Nebraska Title V is framing doulas as a type of community health worker with a specialized scope of work. As Title V supports Medicaid reimbursement for CHWs, it will also be promoting Medicaid reimbursement for doulas MLTC leadership have been present and involved in all levels of the conversations and will continue to partner as the work progresses.

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

Women/Maternal Health

National Performance Measures

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		74.9	71.8	71.8	73.2
Annual Indicator	73.5	70.4	70.5	69.5	70.1
Numerator	244,199	234,784	234,343	235,133	238,027
Denominator	332,326	333,478	332,326	338,515	339,443
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	74.7	76.2

Evidence-Based or –Informed Strategy Measures

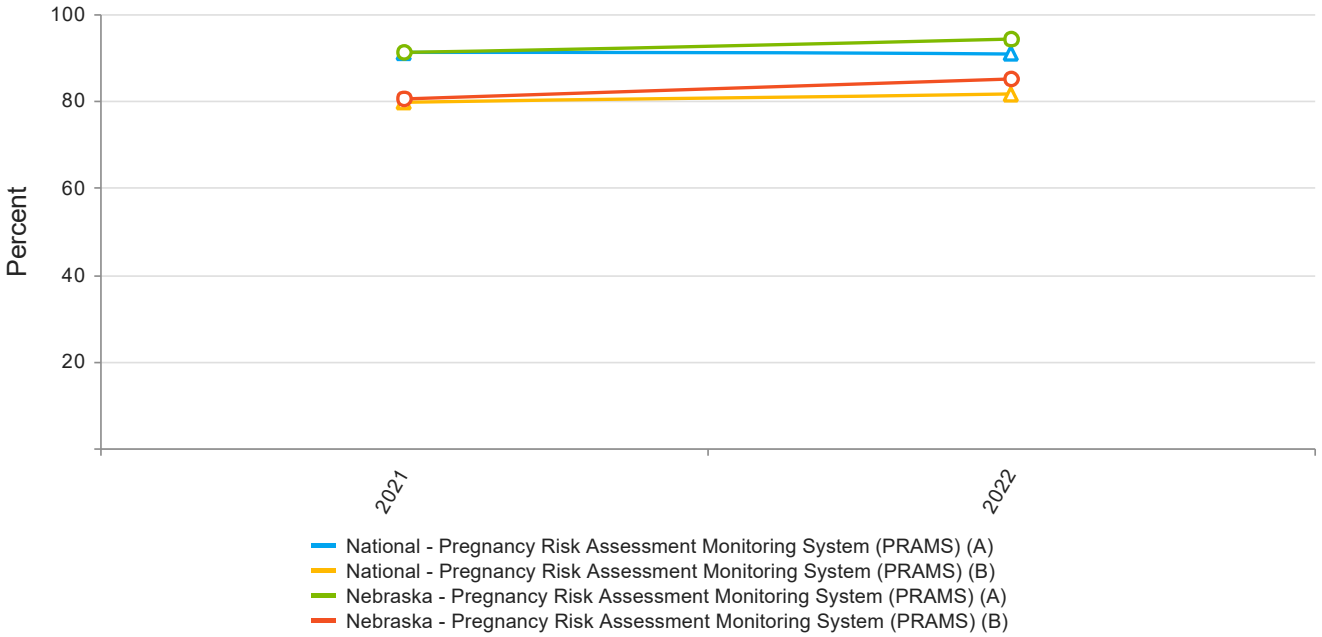
ESM WWV.2 - Percent of women participating in Women's Community Health Initiative who have had a well check according to the US Preventive Services Task Force (USPSTF) guidelines based on age and history.

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			75
Annual Indicator		100	38.5
Numerator		10	5
Denominator		10	13
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	93.9
Numerator	22,016
Denominator	23,454
Data Source	PRAMS
Data Source Year	2022

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	85.0
Numerator	18,650
Denominator	21,929
Data Source	PRAMS
Data Source Year	2022

Evidence-Based or –Informed Strategy Measures

None

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 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	
Five-Year Objectives	
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 age 18 to 44 years.	
Strategies	
WM1a (1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska Medicaid Expansion) enrollment and benefits and promote Medicaid redetermination efforts following the end of the continuous coverage requirement.	
WM1a (2): The Women's and Men's Health Program will implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUM) project in collaboration with a community organization.	
WM 1a (3): Title V will collaborate with the Chronic Disease Prevention and Control Program and the Office of Health Disparities within the Division of Public Health to align efforts and leverage existing strategies.	
ESMs	Status
ESM WWV.1 - Participation in the Women's Community Health Initiative for Preventing Cardio Vascular Disease.	Inactive
ESM WWV.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 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

State Action Plan Table (Nebraska) - Women/Maternal Health - Entry 2

Priority Need

Cardiovascular Disease including Diabetes, Obesity, and Hypertension

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

WM1b: By 2025, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth.

Strategies

WM1b (1): Promote Nebraska's newly extended Medicaid postpartum coverage by educating providers and the general public about the change in coverage.

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

Women/Maternal Health - Annual Report

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, 2022 to September 30, 2023. This represents the third 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 2022-2023, with NPM, SPM, and ESM statements for the period 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 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.

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 maternal and women's health for women of childbearing age. Within NDHHS, Title V is the connecting link between the Women and Men's Health Programs, the Adolescent & Reproductive Health Program, STD prevention program, Women's Health Initiatives, the Maternal & Child Health Program, the Office of Rural Health, the Nebraska Maternal Infant Early Childhood Home Visiting program (N-MIECHV) and the Office of Health Disparities. 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, I Be Black Girl, The Malone Center, local and tribal public health departments, and health systems growing their community health footprint in the state.

Medicaid Expansion and Redetermination in Nebraska

By the close of the 2022-2023 Title V year, Medicaid redetermination efforts in Nebraska had a notable impact on the state's population of women of childbearing age. Medicaid Expansion was passed by a ballot initiative in Nebraska in 2018. Enrollment opened in August 2020, and benefits became effective October 2020. According to the Nebraska Medicaid Annual Report for State Fiscal Year 2023, since October 2020 over 75,000 Nebraskans have enrolled in Medicaid Expansion, representing a significant opportunity for some of the most vulnerable Nebraskans to access health insurance. Medicaid expansion created the opportunity for eligible women to receive preconception and inter-conception health care. Historically, Nebraska's Medicaid coverage for pregnancy ends at 60 days postpartum, removing opportunities for continuous health care coverage following and between births.

The end of the COVID-19 related Public Health Emergency (PHE) ended the period of continuous enrollment on March 31, 2023, and required that all Medicaid enrollees have their eligibility redetermined annually after April 1, 2023.

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**

2022-2023 Objectives and 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 WM1a(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 WM1a(2): The NDHHS Women's Health Initiatives Program will implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN) project in collaboration with a community organization.

Summary of Programmatic Efforts

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 inter-conception care.

The end of the COVID-19 related Public Health Emergency (PHE) ended the period of continuous enrollment on March 31, 2023, and required that all Medicaid enrollees must have their eligibility redetermined annually after April 1, 2023. 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. Title V supported outreach and education on Heritage Health Adult through the Community Health Worker Collaborative's Medicaid Redetermination webinars hosted in May and June 2023. The webinar was held three times and a total of 150 people attended.

The Women and Men's Health Programs provide all enrollees of the Every Woman Matters program with information about Medicaid and how to enroll in it. All materials are available in English and Spanish. During this period, 661 women received information about Medicaid eligibility and enrollment.

Beginning in January 2023, staff from the Women's Health Initiative Program attended quarterly meetings sponsored by ASTHO and CDC about the "Power of Partnerships: Health Equity, Minority Health, and Women's Health Capacity Building Assistance." Collaboration driven by these meetings is intended to co-create a health equity network to meet the needs of practitioners from women's health, minority health, and health equity and community-based organizations around a shared mission to stand ready to address future emergency and non-emergency events by developing strong partnerships and collective effort to advance equity and resiliency. The Women's Health Initiatives staff invited colleagues from the Office of Health Disparities and the Women and Men's Health Programs to participate in the quarterly meetings. To date, the relationships built and discussions inspired by the meetings are the deliverable from the collaboration.

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 and Men's Health Programs and Women's Health Initiative are aligned with the findings of the Needs Assessment in 2020.

Collaboratively, the Women and Men's Health Programs and Women's Health Initiatives executed a subaward with a community-based organization to address obesity and the need for healthcare access in underserved neighborhoods. The Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN) project was an 8-week program to increase participant's awareness about healthy behaviors and ways to make lifestyle changes. MSHIUN participants attended 8 Walk and Talk sessions with a weekly focus on healthy lifestyle behaviors (e.g. preventive screening, increasing fruits and vegetables, tracking and monitoring steps/minutes of exercise, stress management, etc). The framework for the project included goals, partners, a logic model, and an evaluation process. The project tracked changes in weight and blood pressure, but the short-term nature of it led to limited change. For more discussion about this project, see the Challenges

and Emerging Issues section below.

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 (Racial 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.

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: 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.

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. Acknowledging limitations in measurement, the ESM statement measures project-level participation in clinical services.

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 for 2022-2023 Cardiovascular Disease including Diabetes, Obesity, and Hypertension	
How much did we do?	Q: How many Heritage Health training activities and/or resources for community providers were promoted by Title V? A: The CHW Collaborative hosted Medicaid Redetermination hosted in May and June 2023. The webinar was held three times and a total of 150 people attended. Q: How many Title V staff promoted at least one Heritage Health Adult activity or distributed messages/materials about Heritage Health Adult? A: 15 staff + 8 CHW Collaborative members Q: How many community partners participated (MSHIUN)? Can we capture number of individuals served? A: One; Yes - 32 people participated, including 13 females age 18-44.
How well did we do it?	Q: How many women received information about Heritage Health through this project? A: 150 via webinar and 661 via Every Woman Matters Q: Did the partners in the MSHIUN project represent the target population? Do they expand the reach of our efforts to serve the target population? A: Yes, Yes Q: Were the women participating in the MSHIUN project members of the target population? A: Yes – participants were women from Lincoln, NE age 18-44
Is anyone better off?	Q: How did overall Medicaid enrollment numbers change related to both expansion and the unwind? A: Not sure, unable to measure this Q: Was positive change seen in health measures of participants of the MSHIUN project? A: Project measured health but participants did not have to report their data to NDHHS; short term change wasn't long enough to measure change in cholesterol.

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. Title V's support of Medicaid Redetermination efforts support utilization of Heritage Health Adult. Community Health Worker workforce development is discussed in more detail in the Cross-cutting/Systems-building Domain. By December 2023, over 75,000 new enrollees were part of Heritage Health Adult.

5. Challenges and Emerging Issues

Mobilizing Community Partners for Subawards

As with many lean state agencies, a 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 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. Recent revisions to the Uniform Guidance, 2 CFR 200 (effective October 1, 2024) should support NDHHS in streamlining grant administration and enhancing transparency throughout the grant process.

Maternal Mortality Review

In the period 2020-2022, Nebraska Title V included the Maternal Mortality Review Committee in the Women/Maternal Health population domain. Initially, the MMRC discussion was included in the Women/Maternal Health 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. This shift recognizes that the 2020-2025 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.

Maternal Health Innovation Grant

In late 2023, I Be Black Girl (IBBG) received for a HRSA State Maternal Health Innovation Grant to improve maternal health. They seek to transform outcomes through systemic change that will support Black women and people with capacity for pregnancy. Title V staff will support IBBG's activities for this grant.

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. 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 the Title V population health priorities.

A quality improvement approach to improve the extent to which Title V can effectively engage with diverse subrecipients to achieve objectives is needed. The poor response to an initial RFP release was disappointing and attempts to attract additional community-based organizations have been met with limited interest. These roadblocks to project-implementation point to the need to better understand what changes are necessary to effectively work with non-traditional community partners.

Women/Maternal Health - Application Year

In this section, Nebraska MCH Title V describes planned activities in the **Women's/Maternal Health Domain** for the period October 1, 2024 to September 30, 2025. This represents the fifth 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 2024-2025 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

NPM: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components (new)

ESM: None

1. **Description of Planned Activities**

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension

2024-2025 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 WM1a(1): Title V will conduct outreach and education on Heritage Health Adult (Nebraska's Medicaid Expansion) enrollment and benefits and promote Medicaid redetermination efforts following the end of the continuous coverage requirement.

Strategy WM1a(2): The Women's and Men's Health Program will implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN) project in collaboration with a community organization.

Strategy WM1a(3): Title V will collaborate with the Chronic Disease Prevention and Control Program and the Office of Health Disparities within the Division of Public Health to align efforts and leverage existing strategies.

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 inter-conception 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. Title V remains committed to increasing awareness of Medicaid eligibility requirements (including presumptive eligibility for pregnant people) as the Division of Medicaid Long-Term Care (MLTC) has resumed determination of eligibility on a regular basis for Medicaid clients.

Effective in January 2024, Nebraska's Medicaid program increased postpartum coverage for enrollees from 60 days to 12 months. This change has major potential to improve health outcomes for women, especially for those women with chronic conditions, needs for contraception to support desired birth spacing, and to support/improve inter-conception care.

The Women's and Men's Health Program provides preventive screening programs and services, education, and information to Nebraska women on breast and cervical cancer, cardiovascular (heart) disease and diabetes. Education and information is also provided to Nebraska men and women on colon cancer. Women's and Men's Health provides health and wellness information for living a healthy life. In recent restructuring, the work of the Women's Health Initiative's (WHI) Program has

been absorbed by other programs within the Lifespan Health Services Unit (within which Title V is housed). The Unit is responsible for providing best practices, recommendations, education and expertise to the Nebraska Department of Health and Human Services. This work is now mainly completed by the Women and Men's Health Program and the Maternal Infant Health program.

In the 2024-2025 period, Title V will partner with the Community Health Worker Consultant-Trainer Cadre and Women's and Men's Health Program to disseminate information about Medicaid expansion and redetermination. Outreach and education will focus on disparate and disadvantaged women of childbearing age and other parents/caregivers. The Maternal Infant Health program will distribute a postcard to providers about the postpartum coverage expansion and provide postcards with a similar message for people who are impacted by the postpartum coverage expansion.

After minor restructuring within the Lifespan Health Services Unit, the Women's and Men's Health Program will provide coordination of the Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN) project. This community-based project addresses obesity and the need for healthcare access in underserved neighborhoods by incorporating walk-and-talk sessions with healthy lifestyle behaviors (e.g. preventive screening, increasing fruits and vegetables, tracking and monitoring steps/minutes of exercise, stress management, etc.) to improve health metrics like weight and blood pressure.

Community based organizations have expressed little interest in this project across Nebraska. In 2020-2021, the project was developed, with support from the Chronic Disease Prevention and Control (CDPC) Program, to be small-scale and community-based, but there have been fewer than 5 active projects since 2020. Interest may be restricted by the requirements of state/federal processes for subawards with small organizations.

The Women's and Men's Health Programs are currently planning for a new phase of MSHIUN implementation with a faith-based organization and a community center. Relationships between the Women and Men's Health Programs and the Office of Health Disparities have grown through participation in the ASTHO and CDC's collaborative quarterly meeting: "Power of Partnerships: Health Equity, Minority Health, and Women's Health Capacity Building Assistance." The Women's and Men's Health Program staff and Office of Health Disparities staff will meet with CDPC Program staff again in late 2024 to inform 2024-2025 activities and document their "lessons learned" over time.

Responses from the 2024 Title V Public Input Survey echo questions Title V has about the best way to support this priority need going forward. The national Title V shift to encourage focus on the postpartum visit will likely narrow the priority need for Women for the 2025-2030 period.

- "The Chronic Disease Prevention and Control program has grants for CVD reduction strategies, Diabetes Prevention Program, and the Diabetes Self-Management and Education programs that could also leverage out/partner on this strategy."
- "Chronic conditions are a difficult and time-consuming issue to address. I am wondering if a new initiative (MSHIUN) is necessary or if there are current successful initiative happening that can be supported and expanded. Partners are essential for success with this strategy (UNL extension, state chronic disease program, local health departments, workplace wellness groups, etc.).
- "I think this one is a 'toughie' as it not only incorporates access to health foods and modes of exercise, but also overall lifestyle change which can be hard to adopt (speaking from years of experience as an exercise professional in YMCA world). Ideas sound solid, but implementation and adoption by participants is a whole other challenge."

Where possible, Title V will promote efforts to prevent chronic disease for women in other work groups, like ALIGN Nebraska (discussed in the Perinatal/Infant Health domain), the State Maternal Health Innovation Task Force, and through the MMRC.

Priority: Cardiovascular Disease including Diabetes, Obesity, and Hypertension

2024-2025 Objectives and Proposed Strategies

Objective WM1b: By 2025, increase the percent of women who attended a postpartum checkup within 12 weeks after giving birth.

Strategy WM1b(1): Promote Nebraska's newly extended Medicaid postpartum coverage by educating providers and the

general public about the change in coverage.

In 2024-2025, the Maternal Infant Health (MIH) Program will develop education materials about Nebraska's newly extended Medicaid postpartum coverage and will share it with all licensed obstetrician/gynecologists, family practice providers, and pediatricians in Nebraska. The MIH Program will develop a companion piece for the public and share that with the licensed providers. Providers will be sent extra materials to share with their clients.

The Maternal Infant Health program collaborates with the Women's and Men's Health Program and Maternal Mortality Review Committee in work related to maternal health – particularly those activities which can lead to improved birth outcomes and better health during the postpartum period. These partnerships have resulted in collaborative efforts such as supporting doula training and certification, working on care coordination subawards with local community organizations, and providing educational information to providers, pregnant, and postpartum people. The MIH Program will use the partnerships it has developed to widely share education about Medicaid postpartum coverage.

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 community-based activities currently in progress by Title V 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

Maternal Mortality Review Committee Recommendations

In 2022, Nebraska's MMRC drafted actionable recommendations intended to reduce maternal mortality in Nebraska. The priority areas include:

1. Closed loop social support
2. Non-discriminatory practices
3. Behavioral health access
4. Healthcare best practice adoption
5. Domestic violence safety plan development
6. Care continuity
7. Medical care access

Title V is reviewing the recommendations, identifying what recommendations are actionable and related to the current Title V priority need for Women, and drafting action strategies for the actionable recommendations. In 2024-2025, Title V will implement action strategies connected to any actionable recommendations that would 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.

State Maternal Health Innovation Task Force

At the end of the 2022-2023 reporting period, I Be Black Girl received a State Maternal Health Innovation Grant from HRSA. They seek to transform outcomes through systemic level change that will support Black women and people with capacity for pregnancy. By centering the needs of Black birthing people who have historically been pushed to the margins, I Be Black Girl aims to create a Maternal and Child Health (MCH) ecosystem that will transform systems for the health and well-being of all.

Through this investment, IBBG aims to (1) establish the Nebraska Maternal Health Task Force (MHTF), (2) improve state level maternal health data and surveillance, and (3) promote and execute innovation in maternal health service delivery.

IBBG will establish a MHTF which will strengthen the state's MCH ecosystem. In convening the Nebraska MHTF, IBBG seeks to improve state level MCH data and surveillance in service of shifting statewide health systems and policies which meaningfully invest in Black maternal health. IBBG will strengthen and scale its Doula Passage Program (DPP), laying the foundation to explore additional strategies that support Black MCH."

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

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.

NPM: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components (new)

ESM: None

New in this application, the newly required NPM aims to measure the percent of women who attended a postpartum checkup within 12 weeks after giving birth and (separately) the percent of women who attended a postpartum checkup within 12 weeks after giving birth received recommended care components. Nebraska Title V will examine best practices and available data to develop an appropriate ESM by July 2025.

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 2023-2024
How much did we do?	Strategy WM1a(1): How many Medicaid / Heritage Health educational activities and/or resources for community providers were promoted by Title V? Strategy WM1a(2): How many organizations has Title V approached to implement Making Sustainable Health Impacts in Underserved Neighborhoods (MSHIUN)? Strategy WM1a(2): How many community partners participated in MSHIUN?
How well did we do it?	Strategy WM1a(1): How many women received information about Medicaid/Heritage Health through Title V efforts? Strategy WM1a(2): Did the partners in the MSHIUN represent the target population? Strategy WM1a(2): Were the women participating in MSHIUN part of the target population?
Is anyone better off?	Strategy WM1a(1): How did overall Medicaid enrollment numbers change related to both expansion and the redetermination? Strategy WM1a(2): Was positive change seen in health measures of participants of MSHIUN?

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 7/2024**
Year 1	• Begin review of educational materials for CLAS and literacy. • Form relationship with community cultural organization to undertake collaborative project (MSHIUN). • Promote Heritage Health Adult • Provide relevant PRAMS educational materials	• Delay to Y2 • Ongoing • Ongoing • Completed
Year 2	• Implement collaborative project (MSHIUN) • Promote Heritage Health Adult • Provide relevant PRAMS educational materials • New: Maternal Mortality Review Committee	• Ongoing • Ongoing • Completed • Ongoing
Year 3	• Recruit and continue collaborative project (MSHIUN) • Initiate the Improving Birth Outcomes project • Promote Heritage Health Adult • MMRC build internal capacity with CDC funding • Identify relevant MMRC recommendations	• Ongoing • Ongoing • Ongoing • Ongoing • Ongoing
Year 4	• Develop modified curriculum and best practices for community engagement for the collaborative project (MSHIUN) • Promote Heritage Health Adult Expansion and Redetermination • Draft strategies on relevant MMRC recommendations in partnership with Women's Health Advisory Council	• Ongoing • Ongoing • Ongoing
Year 5	• Promote Heritage Health (including Expansion for all women and specifically postpartum care expansion and Eligibility Redetermination efforts) • Summarize lessons learned about community engagement from MSHIUN • Explore strategies that can improve CVD and address health equity through partnership with CDPC Program and Office of Health Disparities • Implement strategies on relevant MMRC recommendations	

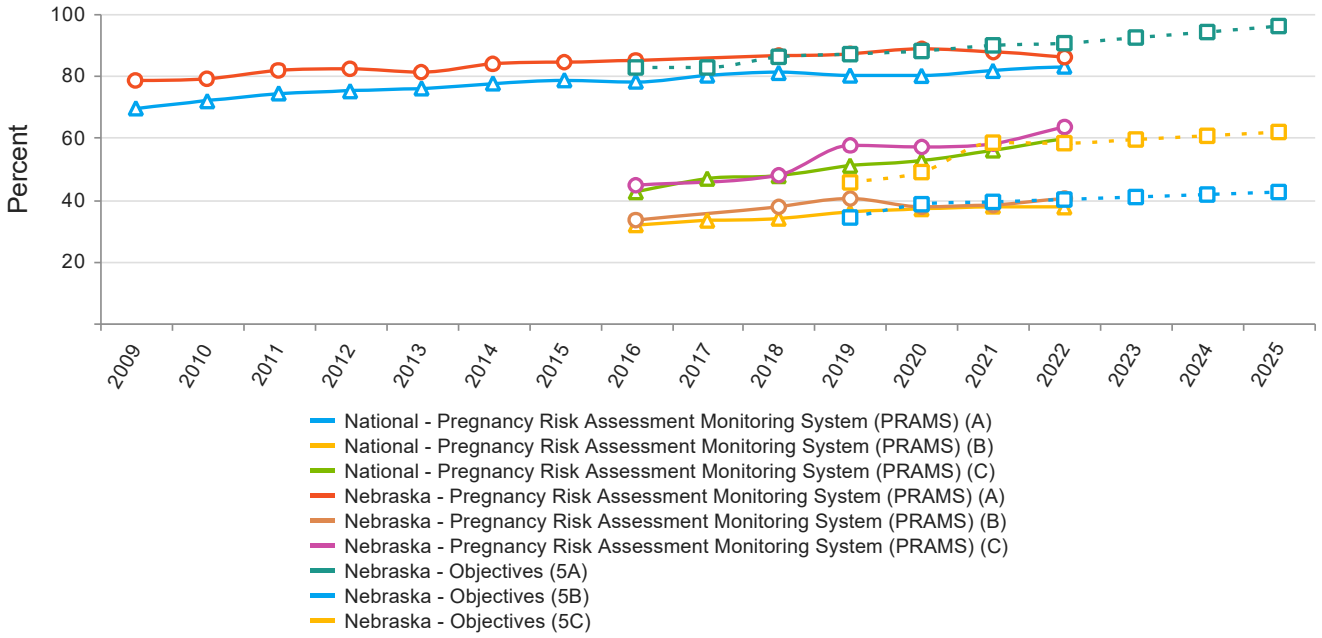
The strategy to provide relevant PRAMS materials was removed since it was completed. A strategy was added to support partnership with the Chronic Disease Prevention and Control Program and the Office of Health Disparities.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	86.8	87.8	89.6	90.3	92.1
Annual Indicator	86.1	86.8	88.5	87.6	85.9
Numerator	20,652	20,367	20,471	20,548	19,696
Denominator	23,975	23,464	23,130	23,460	22,938
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	93.9	95.8

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	34.2	38.5	39.2	40	40.8
Annual Indicator	37.7	40.3	37.8	38.4	40.3
Numerator	8,832	8,976	8,403	8,711	8,894
Denominator	23,403	22,266	22,224	22,698	22,062
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	41.6	42.4

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.5	48.8	58.3	58.1	59.3
Annual Indicator	47.9	57.2	57	57.9	63.3
Numerator	11,176	12,710	12,719	13,202	14,030
Denominator	23,326	22,219	22,326	22,793	22,167
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	60.5	61.7

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

ESM SS.2 - The percent of organizations receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			10
Annual Indicator		0.3	5.9
Numerator		1	23
Denominator		388	388
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	25.0

State Performance Measures

SPM 1 - The percent of preterm births.

Measure Status:	Active				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10.3	10.7	11.1
Annual Indicator	10.5	10.5	10.6	11.3	11.5
Numerator	2,597	2,551	2,514	2,651	2,790
Denominator	24,758	24,293	23,646	23,357	24,193
Data Source	NE Vital Records	NE Vital Records	NE Vital Records	NE Vital Records	NE Vital Records
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	11.3	11.1

State Action Plan Table

State Action Plan Table (Nebraska) - Perinatal/Infant Health - Entry 1	
Priority Need	
Infant Safe Sleep	
NPM	
NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	
Five-Year Objectives	
PIN3a: By 2025, decrease Sudden Unexplained Infant Death (SUID) rate by promoting safe sleep practices particularly separate sleep surface; racial disparities; and protective factors such as breastfeeding.	
Strategies	
PIN3a(1): Title V will evaluate the impact of the Nebraska Safe Babies Campaign and share lessons learned to ensure sustainability of safe sleep education/programming.	
PIN3a(2): Support partnerships with community-based organizations (like Omaha Healthy Start and MilkWorks) and rural health clinics by offering safe sleep materials and training.	
PIN3a(3): Provide American Indian and Alaskan Native (AI/AN) communities with SIDS/SUIDS prevention that builds on community cultural strengths and values.	
ESMs	**Status**
ESM SS.1 - The number of birthing hospitals and pediatric clinics that become Champions of the "Nebraska Safe Babies Campaign".	Inactive
ESM SS.2 - The percent of organizations receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

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

Priority Need

Premature Birth

SPM

SPM 1 - The percent of preterm births.

Five-Year 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): Support partnerships with community-based organizations (like ALIGN Nebraska and the State Maternal Health Task Force) and rural health clinics.

PIN2a(2): Provide guidance and support for community implementation of prenatal plans of safe care for substance using pregnant people.

PIN2b (1): Review the Nebraska Maternal Mortality Review Committee recommendations and identify appropriate Title V actions to inform prematurity prevention.

PIN2b(2): Review the Child Death Review Team recommendations and identify appropriate Title V actions to inform prematurity prevention.

Perinatal/Infant Health - Annual Report

In this section, Nebraska MCH Title V reports on the accomplishments and 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 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 2022-2023, with NPM, SPM, and ESM statements for the period 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 clinics receiving outreach that become Champions of the "Nebraska Safe Babies Campaign"

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 that is increasing 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.

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, Abusive Head Trauma prevention was added to the campaign. In 2019, outreach was expanded from birthing hospitals to include OB/GYN pediatric and family practice clinics.

In the Issue Brief created on the topic of safe sleep, stakeholders pointed 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 recommended continuing the Nebraska Safe Babies campaign with 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.

Key actors for this domain include the Title V Maternal Infant Health Program and the Nebraska Perinatal Quality Improvement Collaborative (NPQIC). The Maternal Infant Health Program launched and executed the Nebraska Safe Babies

campaign, which has emerged as Nebraska Title V's signature effort to address safe sleep and abusive head trauma. NPQIC has partnered with the University of Nebraska Medical Center and the Partnership for a Healthy Nebraska to form "ALIGN Nebraska." This group advocates for early and adequate prenatal care for all Nebraskans and is developing a public education campaign to educate Nebraskans on the importance of early and adequate prenatal care.

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

Priority: Premature Birth

2022-2023 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.

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.

Summary of Programmatic Efforts

In 2022-2023, Title V staff participated in the ALIGN Nebraska work group led by the Partnership for a Healthy Nebraska. In February 2023, ALIGN Nebraska released the "ALIGN Nebraska Prenatal Care and Infant Mortality Policy Brief" that included policy recommendations to promote early and adequate prenatal care. Title V staff also participated in a committee working with Nebraska's Managed Care Organizations and providers through the state looking at the gaps in coverage and getting pregnant women into prenatal care as early as possible.

Collaborative efforts to promote prematurity prevention included meetings with the Office of Rural Health, Nebraska Tribal partners, and Medicaid Managed Care Organizations. At meetings with each of these partners, the Maternal-Infant Health Program Manager shared materials for prematurity prevention, including the Nebraska-developed "Warning Signs to Know During and After Pregnancy" fact sheet. The "Warning Signs to Know During and After Pregnancy" fact sheet is geared towards empowering birthing people with critical information to advocate for their own health and birth outcomes.

During this period, two community-based organizations that primarily serve Black families expanded access to culturally relevant and trusted providers, community-based care, and various kinds of birth workers by developing doula training programs. Title V championed their work, while also reflecting on how doula services fit into the perinatal landscape and how NDHHS could promote their work. Title V considered the possibility of Medicaid reimbursement for doula services, wondering if doula services equated to those of a community health worker, or if doulas services were distinct enough to require their own scope of work and certification/credentialing process. NDHHS supports Medicaid reimbursement for community health workers, noting that doula services require additional specialized training. At the end of this period, there was no immediate direct path to doula service reimbursement through NDHHS.

Strategy PIN 2a (2) was incorporated into existing subawards with the tribes. Each year, Title V sets aside roughly $200,000 to support the four federally recognized Tribes in Nebraska. In the 2022-2023 period the Tribes used a portion of the funds to support prenatal care, vaccination during the perinatal period, education about infant safe sleep, breastfeeding, the importance of prenatal appointments, and infant care. Title V staff review the tribal work plans each year and offer suggestions and supports to strengthen the offerings and ensure activities align with federal requirements of the funding. Title V staff provided technical assistance to the Santee Sioux Tribe of Nebraska and the Omaha Tribe of Nebraska to develop their work plans and identify relevant actions and performance measures to meet their goals and objectives.

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.

Summary of Programmatic Efforts

In the 2021 Maternal Death Review Team Report, the Nebraska Maternal Mortality Review Committee (MMRC) offered 21 recommendations from 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.

During the current reporting period, the MMRC completed an informal landscape analysis to see what partners are already engaged in this work. MMRC is prioritizing care continuity and medical care access and developing a pilot project to turn these recommendations into action.

To further understand outcomes in the pregnancy, birth, and postpartum periods for Nebraskan birthing mothers, the Office of MCH Epidemiology, through the support of the Association of State and Territorial Health Officials, linked Pregnancy Risk Assessment Monitoring System (PRAMS) data to statewide Hospital Discharge Data (HDD) sourced from the Nebraska Hospital Association. These data were analyzed to gain a better understanding of the burden of severe maternal morbidity (SMM) in Nebraska and to refine efforts to reduce SMM. Upon completing the linkage, the datasets underwent an internal validation process. The purpose of the process was to ensure that the estimates produced using the linked data were credible. To achieve this, weighted population estimates derived from the linked datasets were compared to actual population-level data. The project continued throughout the 2022-2023 reporting period.

The linkage of PRAMS and HDD centered maternal perceptions of the perinatal period to identify ways to reduce preterm birth. There are multiple PRAMS questions that 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 improves knowledge about maternal experiences related to the outcomes of interest, through patient-centered outcomes research to further refine efforts to reduce prematurity. These results will be made available to the Maternal Mortality Review Committee and Child Death Review Team.

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

Priority: Infant Safe Sleep

2022-2023 Objectives and 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 NDHHS 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 NDHHS Maternal Infant Health Program will continue to develop collaborations with community partners and rural health clinics.

Summary of Programmatic Efforts

During this reporting period, the Safe Babies Campaign continued 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 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 the same information at the well-baby visits through-out their first year of life. The Maternal Infant Health Program collaborated with the Office of Rural Health to promote the Nebraska Safe Babies Clinic Campaign to rural providers. During this period, one new clinic became a Clinic Champion. Low uptake was attributed to several factors, including market saturation.

Responding to recommendations from stakeholders, the Office of MCH Epidemiology 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 Team later, and tools were needed to support investigators in their work. The Office of MCH Epidemiology encouraged members of the Child Death Review Team to advocate for the form when working with partners across the state.

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 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.

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

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.

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 percentage of clinics receiving outreach 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.

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 for 2022-2023 **Preterm Birth**	
How much did we do?	Q: Was the funding opportunity for community organizations to improve birth outcomes released? How many agreements were executed? A: Yes, two subawards were provided to tribal organizations in Nebraska. Q: How many Prematurity Steering Committee meetings have Title V staff attended? A: All – but the Prematurity Steering Committee ended before the 2022-2023 period. Q: Did the MMRC create actionable recommendations using the new priority areas? How many? A: The MMRC reviewed existing activities by doing an informal landscape analysis. The MMRC did not create actionable recommendations.
How well did we do it?	Q: Did funds for local projects go to organizations who are directly connected to the target population? A: Yes Q: In what ways have consumers/women been involved in the Prematurity Steering Committee? A: N/A – committee ended Q: Were the recommendations sufficiently targeted to include who should take specific action when? Do those identified partners represent target populations? A: N/A – actionable recommendations were not created
Is anyone better off?	Q: How many women were directly impacted by services offered through this funding opportunity? Were their lives improved? A: Data is not available for this, life improvement was not measured Q: Did the Steering Committee make actionable recommendations? A: N/A Q: Did any partners agree to work on these recommendations? A: N/A

Discussion – Other Programmatic Impacts

Collaborations with new partners have allowed Title V staff to reach new audiences to promote prematurity prevention. Title V staff were able to reach rural hospitals, utilizing the reach of the Medicaid Managed Care Organizations in Nebraska, and support for tribal initiatives.

Results Based Accountability (RBA) measures for 2022-2023 Infant Safe Sleep	
How much did we do?	Q: How many professionals initiated and completed the SUID Death Scene Investigation training during the period? A: 10 Q: How many rural clinics have pledged, or become Champions during the period? A: One clinic that has 14 locations. Q: How many collaborative projects have we initiated with partners? A: One
How well did we do it?	Q: What are evaluation results from users completing the training? Have these results been used to update the training curriculum and/or form? A: These have not been evaluated by Title V. Q: How many new mothers do these partnerships impact each year? Do they belong in targeted groups? A: Not sure because the activities are combined with funds the tribes are already receiving.
Is anyone better off?	Q: Did the form improve knowledge surrounding the circumstances of the death? A: This is not something we can measure yet because the deaths for this time have not been reviewed. Q: Has any behavior change occurred from these partnerships? A: Not able to measure change this year.

Discussion – Other Programmatic Impacts

Safe Sleep, and Nebraska Safe Babies, continue to provide the foundation for many partnerships for Title V in Nebraska. All birthing hospitals are in regular communication with Maternal Infant Health Program staff.

5. Challenges and Emerging Issues

Beginning in the summer of 2020, the country experienced significant unrest, which led to national discussions about the quality of maternity care and treatment of mothers who are Black, Indigenous, or people of color (BIPOC). In 2021, Nebraska began working with partners to better center BIPOC women in population- and systems-level efforts to improve birthing outcomes, shifting focus from data points describing the average status towards data that describes the most disadvantaged groups. This work continues with a focus on supporting work initiated by the four federally recognized Tribes of Nebraska.

In the area of Safe Sleep, changes to strategies have reflected changes in partnerships. A previous 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 Unexplained 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. As Title V plans for the 2024-2025 application, it will turn to evaluation of success and needs for safe sleep sustainability after this five-year period ends.

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

As of September 30, 2023, there were 54 Safe Sleep Champion Hospitals with one hospital pledged to complete the steps.

To further the campaign spread, NDHHS shifted from a focus on the hospitals to the Family Practice, Obstetric, and Pediatric Clinics throughout Nebraska. Six clinics are NE Safe Babies Clinic Champions. As few clinics have become Safe Sleep Champion Clinics, Title V activities have shifted towards collaboration to promote the Nebraska Safe Babies Campaign.

The NPQIC Prematurity Steering Committee responded to the question of how to prevent prematurity in Nebraska by promoting tobacco cessation to medical providers in Nebraska. After reviewing data and trends in both prematurity and risk factors for prematurity, the group identified tobacco cessation as a strategy that could reduce risk for all pregnant people. The promotion of tobacco cessation increased registrations for Nebraska Tobacco Quitline Online Provider Trainings. While this doesn't measure use of tobacco cessation resources or a reduction in prematurity, it does suggest that providers found and were interested in the resources to improve patient health.

Perinatal/Infant Health - Application Year

In this section, Nebraska MCH Title V describes planned activities in the **Perinatal Infant Health Domain** for the period October 1, 2024 to September 30, 2025. This represents the fifth 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 2024-2025 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 organizations receiving outreach that become champions of the “Nebraska Safe Babies Campaign”

1. **Description of Planned Activities**

Priority: Premature Birth

2024-2025 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 PIN2a(1): Support partnerships with community-based organizations (like ALIGN Nebraska and the State Maternal Health Task Force) and rural health clinics.

Strategy PIN2a(2): Provide guidance and support for community implementation of prenatal plans of safe care for substance using pregnant people.

Discussion of Activities for this Objective – Relevance to Identified Priority

In 2024-2025, strategies to support this objective will focus on continuing collaborative relationships and supporting community-based organizations and efforts. Title V will continue to support local organizations by offering educational materials, identifying gaps in services, and supporting training. The Malone Community Center located in Lincoln offers a support system for parents, involving doulas and breastfeeding educators. The Malone Center has begun a certification process for doulas; they will provide education for current doulas to get certified and/or for those who want to become a doula to take their certification class. Other organizations that actively work on prematurity prevention include I Be Black Girl, Partnership for a Healthy Lincoln, and the Nebraska Perinatal Quality Improvement Collaborative. Title V will connect with each organization and offer support for their ongoing initiatives. Title V staff have joined committees working with MCOs and providers throughout the state as they examine gaps in coverage and promote getting pregnant people into prenatal care as early as possible.

A key Title V partner 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, originally 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 are instrumental in the delivery of prenatal care to women in Nebraska. 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.

The responses to the 2024 Title V Public Input Survey suggested multiple partners Title V could collaborate with. These partners included:

- “Partnering with WIC to ensure pregnant people have access to healthy foods could also help as the education provided by WIC addresses tobacco and substance use, mental health, physical activity, and nutrition, which can all help reduce preterm births and improve maternal and infant health.”
- “Participation in ALIGN is a great way to address preterm birth. If we could get community-based organizations and home visitation programs involved with ALIGN, that would be great too and help disseminate the education.”
- “Please make sure to include the early care and education community - mixed delivery system in these efforts. Specifically, collaboration with Early Head Start. Include Early Head Start in all efforts around this priority and strategies.”
- “Should also consider partnerships with Purpose Built Communities.”

A recent strategy for this objective was to support community-based organizations who are more directly connected than NDHHS to at-risk populations and offer resources to help them improve birth outcomes in their communities. Passing Title V funds along to community-based organizations proved more difficult than expected because of State of Nebraska requirements for reporting and fund administration. Title V has since focused efforts to support communities to the federally-recognized tribes in Nebraska. Title V has traditionally set-aside a portion of funding for tribal activities. In 2023-2024, Title V staff will hold biannual technical assistance (TA) calls with each tribal partners to support the use of Title V funds and provide support for performance management and continuous quality improvement. While not all tribes use the funds for prematurity prevention, each call will include a conversation with the Maternal Infant Health Program Specialist-RN about TA for prematurity prevention.

The newly formed State Maternal Health Innovation Task Force led by I Be Black Girl has interest in supporting maternal health by improving health for Black women, which is likely to reduce disparities in preterm birth. The Task Force aims to use partnership and data to promote innovation in maternal health service delivery. While NDHHS has had limited success supporting community-based organizations to impact preterm birth, the Task Force could push for improvements that reduce preterm birth. Title V staff are participating on the Task Force and involved in conversations about data that can help the Task Force drive action.

Strategy PIN 2a (2) was new in the FY24 application. Title V staff will provide guidance and support for community implementation of Prenatal Plans of Safe Care for substance using pregnant people through collaboration with the Division of Children and Family Services and the Nebraska Children and Families Foundation to promote Prenatal Plans of Safe Care. Title V staff will connect community partners to medical clinics and hospitals, as necessary, and advocate for this prevention strategy. The Prenatal Plans of Safe Care activities involve a physical binder to manage systems of care that is tailored to the community to provide support for pregnant people using substances. When a substance-using pregnant person is identified, they are offered a binder that can help them coordinate their care and encouraged to develop a plan of safe care for themselves and their baby during pregnancy and through delivery. There are two communities in Nebraska currently piloting the Prenatal Plans of Safe Care. In 2024-2025, Title V staff will support the expansion of the Prenatal Plans of Safe Care into two other communities.

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

Strategy PIN2b(1): Review the Nebraska Maternal Mortality Review Committee recommendations and identify appropriate Title V actions to inform prematurity prevention.

Strategy PIN2b(2): Review the Child Death Review Team recommendations and identify appropriate Title V actions to inform prematurity prevention.

Discussion of Activities for this Objective – Relevance to Identified Priority

In April 2022, the Nebraska Maternal Mortality Review Committee (MMRC) identified seven priority recommendation topic

areas to reduce maternal mortality in Nebraska. These seven priority recommendation areas were used by the Office of MCH Epidemiology in conversation with community members and community leaders across Nebraska. Listening sessions with community members were hosted in Omaha, Lincoln, Nebraska City, Kearney, and virtually. The listening sessions featured the recommendation topics areas and asked community members if the recommendations from the MMRC were in line with their thoughts on how to prevent maternal mortality.

Three priorities were shared by the MMRC and community participants:

1. Connected social support
2. Inclusive care with human dignity
3. Right care at the right time

In 2024-2025, Title V staff will continue two pilot projects that were started in 2023-2024 and use these projects to drive future action. The current pilot projects focus on piloting pregnant/postpartum care coordination between clinics/hospitals and local health departments as well as community action teams that review MMRC recommendations to identify local action that could reduce maternal mortality / morbidity in their community. In the summer of 2025, Title V will review the results of the pilot projects and the new priority needs that stakeholders have selected in the 2025 Title V MCH Needs Assessment to inform strategies and programming.

The Nebraska Child Death Review team submits reports to the Nebraska Legislature annually. Each time a new report is submitted to the Nebraska Legislature, Title V will review the recommendations and identify strategies that would impact perinatal/infant health that are appropriate for Title V to act on or financially support.

Feedback from the 2024 Public Input survey echoes the sentiments heard in the community listening sessions and the plans of the Office of MCH Epidemiology: “The strategy to support partnerships with CBO is spot on -there needs to be involvement at the local level, particularly with trusted organizations who best connect with target populations. Also, better implementing recommendations from the Death Review Team is a great idea.”

Priority: Infant Safe Sleep

2024-2025 Objectives and Proposed Strategies

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

Strategy PIN3a(1): Title V will evaluate the impact of the Nebraska Safe Babies Campaign and share lessons learned to ensure sustainability of safe sleep education/programming.

Strategy PIN3a(2): Support partnerships with community-based organizations (like Omaha Healthy Start and MilkWorks) and rural health clinics by offering safe sleep materials and training.

Strategy PIN3a(3): Provide American Indian and Alaskan Native (AI/AN) communities with SIDS/SUIDS prevention that builds on community cultural strengths and values.

Discussion of Activities for this Objective – Relevance to Identified Priority

Title V staff have been promoting the Nebraska Safe Babies Campaign since 2017 and has had very few new champions in the past year or two. The overall goal of the Nebraska Safe Babies Campaign is to provide evidence-based education to parents of newborns as well as hospital and clinic staff. Providing a consistent baseline education for all hospital and clinic personnel caring for children under the age of one will provide a consistent, evidence-based message to parents of approximately 25,000 newborns across the State. As the next Title V Needs Assessment is set to launch later this year, Title V plans to spend the last year with safe sleep as a priority by evaluating the impact of the campaign and focusing on sustainability of hospital and clinic gains made between 2015-2025.

To become a Safe Babies Hospital Champion, hospitals had to complete five steps.

1. Take the NE Safe Babies: Safe Sleep Campaign Pledge
2. Develop or update current Safe Sleep Policy

3. Hospital personnel education and education plan
4. Provide patient/client education
5. Complete Internal Audits to ensure staff are well-trained and modeling safe sleep

The steps were similar for Safe Babies Clinic Champions. Sustainability of these practices will be evaluated to identify a standard for how frequently Title V staff should be connecting with Champions to emphasize the commitment they made when they first became Champions. When this work is completed, Title V will share lessons learned and plans for future safe sleep promotion with interested stakeholders.

The 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.

Title V will continue partnerships with the Medicaid Managed Care Organizations in 2024-2025. Each managed care organization has services to support the perinatal period and infant health. Title V will offer the following items for distribution: 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.

Strategy PIN 3a (3) has been created to address disparities in safe sleep by race/ethnicity. In 2024-2025, Title V staff will focus safe sleep prevention in communities with American Indian and Alaskan Native families. These efforts will use materials developed with the Nebraska Safe Babies Campaign and adapt them, when necessary, to build on community cultural strengths and values. This will be done in partnership with the four federally recognized Tribes of Nebraska and health departments that serve other American Indian and Alaskan Native families in Nebraska. Efforts will build upon traditional infant sleep practices (e.g. cradleboard use), emphasizing political and cultural sovereignty, self-determination, spirituality, cultural connectedness, cultural resiliency, connection to land and place, and strengthening social connections. This work will be done in tandem with efforts to support Tribal prematurity prevention.

Like in 2023, feedback from the 2024 Public Input survey identified cultural sensitivity as a necessary component of safe sleep promotion. One respondent said, “I think it is additionally important, with the racial disparities to make the campaign material with representation from all communities. Also training staff in those communities who those individuals are already working with to provide this education to the parents.” Another respondent had a similar comment, “This strategy is not designed to understand or honor the cultural beliefs of many BIPOC families that practice safe co-sleeping and could further perpetuate the shame and stigma families face when practicing safe co-sleeping. La Leche Leagues has a great educational handout regarding safe co-sleeping strategies.” Title V must address the role of culture in order to connect to families that practice unsafe sleep.

2. Alignment of planned activities with annual needs assessment updates

Priority: Preterm Birth

Alignment: Planned activities focus on partnerships with expert organizations (NPQIC, ALIGN Nebraska, community-based organizations, 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 2024-2025 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, these emerging issues are not taking precedence of the established priority needs.

Of note, but not taking precedence over preterm birth and safe sleep efforts, is interest in supporting doulas across the state. In the 2024 Nebraska Legislative session there was a legislative bill introduced (LB1278) to provide reimbursement for doula and full spectrum doula services. The proposed bill was sent to the Health and Human Services Committee, had a hearing, but failed to be voted out of committee. The conversation and interest has grown from recent efforts to support birth workers by community-based organizations in Lincoln and Omaha. The two community-based organizations with vocal support for doula services serve primarily Black families and have identified doula services as a potential disrupter to systemic racism that has perpetuated infant mortality disparities in Nebraska.

Efforts to improve access to doulas crosses over into the Women's Health domain as doula access impacts the mother-infant dyad at a critical time for both parties. Title V encourages and supports conversation about doulas and community health workers. Title V is learning how to best support doulas in Nebraska through conversations with other states and MCH professionals.

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 2024-2025
How much did we do?	Strategy PIN2a(1): How many ALIGN Nebraska or State Maternal Health Innovation Task Force meetings did Title V staff participate in? Strategy PIN2a(2): How many communities that were developing prenatal plans of safe care for substance using pregnant people did Title V staff support? Strategy PIN2b(1) and (2): What percent of relevant MMRC and CDRT recommendations were acted on?
How well did we do it?	Strategy PIN2a(1): Has Title V identified the gap area it is addressing in prematurity prevention? Strategy PIN2a(2): How many communities launched prenatal plans of safe care programs? Strategy PIN2b(1) and (2): Has Title V worked with partners to move the recommendations to action?
Is anyone better off?	Strategy PIN2a(2): Are people connected to systems of support during pregnancy? Strategy PIN2b(1) and (2): Did Title V or any partners agree to work on prioritized recommendations from the MMRC? Did that partnership impact care that people received in Nebraska?

Results Based Accountability (RBA) measures Priority: Infant Safe Sleep	
	Proposed for 2024-2025
How much did we do?	Strategy PIN3a(1): How many organizations have maintained practices that earned them designation as “Safe Sleep Champions”? Strategy PIN3a(2): How many partners has Title V worked with to promote safe sleep? Strategy PIN3a(3): How many Tribes and community organizations did Title V offer culturally appropriate safe sleep resources and trainings?
How well did we do it?	Strategy PIN3a(2): Did Title V share its Safe Sleep work and tips for sustainability with partners across Nebraska? Strategy PIN3a(3): How did partners in American Indian and Alaskan Native communities utilize the provided resources and trainings?
Is anyone better off?	Strategy PIN3a(1) and (2): Is the number of sleep related deaths decreasing overall? Are sleep related deaths decreasing for both urban and rural infants?

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. 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. The State Maternal Health Innovation Task Force has potential to identify and advocate for changes across domains that will improve maternal health and will likely have impacts on infant health.

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 7/2024**
Year 1	• Convene a group to select prevention priorities and strategies • PRAMS Data to Action • Explore racial bias in perinatal care	• Convened • Completed • Completed
Year 2	• Prematurity Screening Committee (NPQIC) • PRAMS Data to Action • New: Improve Birth Outcomes Project	• Completed • Completed • Completed
Year 3	• Improve Birth Outcomes Project • Identify relevant MMRC and CDRT recommendations • Support prematurity efforts statewide through collaboration	• Completed • Ongoing • Ongoing
Year 4	• Support prematurity efforts statewide through collaboration • Incorporate “Improve Birth Outcomes Project” into Tribal Set-Aside Funding • Evaluate and act on relevant MMRC and CDRT recommendations	• Ongoing • Ongoing • Ongoing
Year 5	• Support prematurity efforts statewide through collaboration • Act on relevant MMRC and CDRT recommendations	

Early strategies for the Maternal Infant Health Program have concluded, requiring adjustment to the 5-year action plan for

Premature Birth. The strategy for participation in the cross-sector multidisciplinary group led by NPQIC to identify and make recommendations on action to prevent premature birth has concluded. The group developed a call to action for tobacco use screening for all women of reproductive age, released in July 2022.

Title V will review recommendations from the MMRC and Child Death Review Team, identify actionable recommendations, and work to act on the recommendations in 2024-2025.

The 2022-2023 application for Perinatal / Infant Health identified a strategy to improve birth outcomes in Native American communities. This work will continue in 2024-202 by being incorporated into existing, broad tribal set aside funding for tribes. The set aside funding is available for work on any tribal priorities within the maternal and child health domains and is not tethered to priority areas. Technical assistance for prematurity prevention will be provided to each tribal partner throughout 2024-2025.

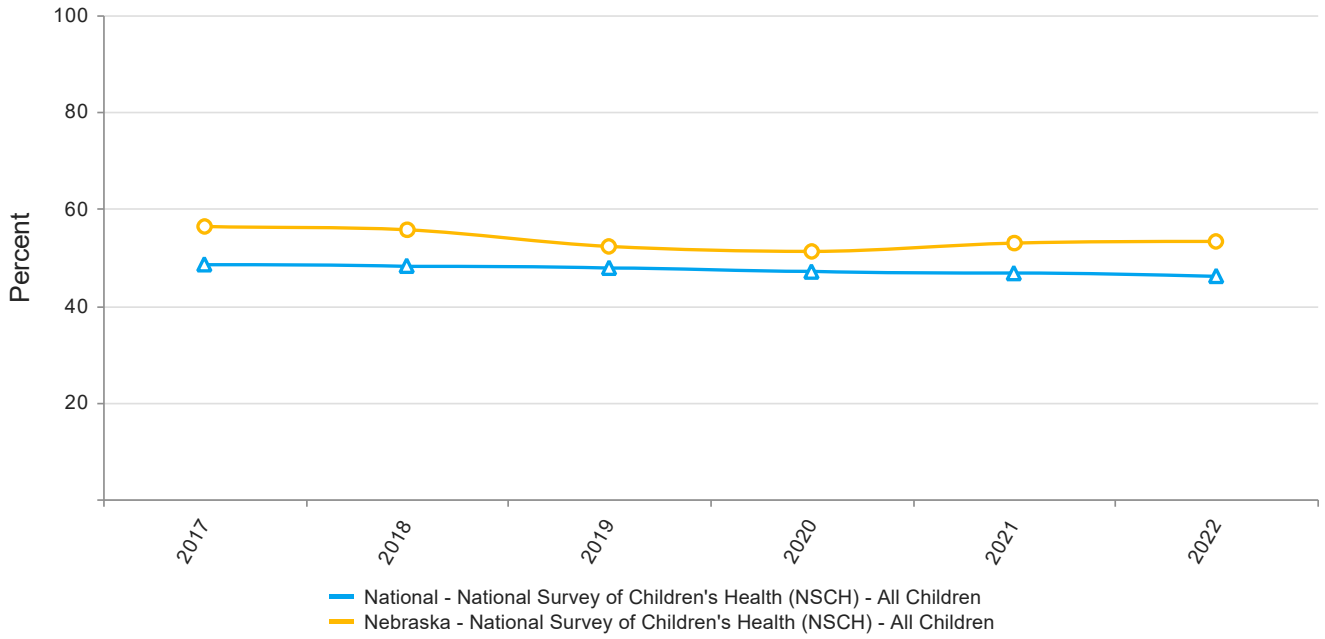
Priority: Infant Safe Sleep **5-year Action Plan, 2020-2025**		
Period	**Summary activities of the period**	**Status 7/2024**
Year 1	• Develop a plan to expand NE Safe Babies Campaign to include clinics • Omaha Healthy Start Collaboration • Omaha FIMR Data to Action • Update PRAMS Materials	• Convened • Interrupted • No action on FIMR • Completed
Year 2	• NE Safe Babies Campaign • Omaha Healthy Start Collaboration • Disseminate New Materials	• Ongoing • Interrupted • Completed
Year 3	• NE Safe Babies Campaign • Community Collaboration • Evaluate NE Safe Babies Clinic Campaign (Urban/Rural Comparison) • New: Increase use of Sudden Unexplained Infant Death form and training	• Ongoing • Ongoing • Planned • Done
Year 4	• Expand NE Safe Babies Campaign • Community Collaboration • Collaborate with Tribal partners and organizations that serve AI/AN people to promote safe sleep	• Ongoing • Ongoing • Ongoing
Year 5	• Evaluate Impact of NE Safe Babies Campaign / Share recommendations for sustainability • Evaluate Community Collaboration • Collaborate with Tribal partners and organizations that serve AI/AN people to promote safe sleep	

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. A focus on Fetal Infant Mortality Review, law enforcement, first responders, and other investigators completed in 2021-2022. Safe sleep activities for 2024-2025 will focus on evaluating the impact of efforts from 2015-2024 and considering sustainable activities for 2025 and beyond.

Child Health

National Performance Measures

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



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.3
Numerator	254,081
Denominator	476,545
Data Source	NSCH-All Children
Data Source Year	2021_2022

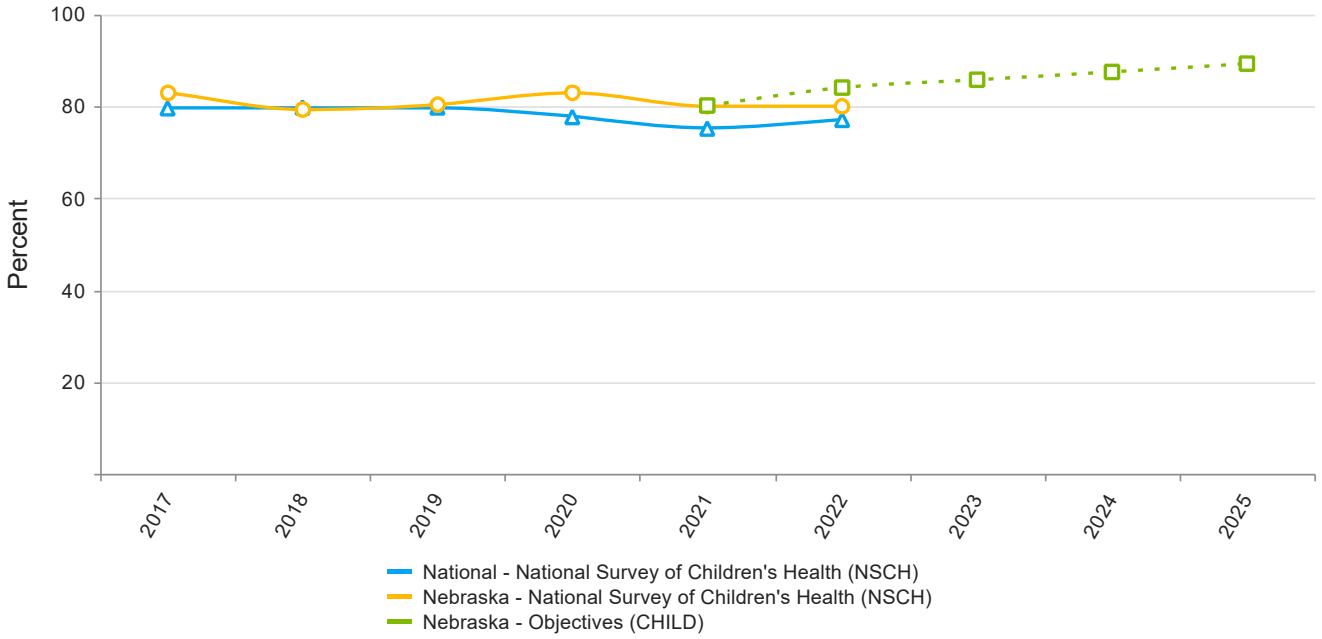
Evidence-Based or –Informed Strategy Measures

ESM MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator

Measure Status:			Active
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			90
Annual Indicator		88.5	90.5
Numerator		85	86
Denominator		96	95
Data Source		Parent Resource Center Family Satisfaction Survey	Parent Resource Center Family Satisfaction Survey
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	95.0	95.0

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			80.1	84	85.7
Annual Indicator	78.5	80.1	82.4	79.3	79.8
Numerator	345,091	363,265	370,833	346,905	353,942
Denominator	439,399	453,443	450,251	437,597	443,513
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	87.4	89.2

Evidence-Based or –Informed Strategy Measures

ESM PDV-Child.2 - The percentage of children participating in the Open Mouth Survey from underserved communities

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			50
Annual Indicator		53.1	53.1
Numerator		2,233	2,233
Denominator		4,208	4,208
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2022
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	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:	Inactive - Replaced				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			9.8	7.3	7.1
Annual Indicator	7.2	7.1	7.5	6.6	6.3
Numerator	1,718	1,687	1,765	1,536	1,471
Denominator	237,985	236,569	234,730	232,972	232,972
Data Source	NE Family Online Client User System, Census	NE Family Online Client User System, Census	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	2022/21	2023/22
Provisional or Final ?	Final	Final	Final	Final	Final

State Action Plan Table

State Action Plan Table (Nebraska) - Child Health - Entry 1	
Priority Need	
Child Abuse Prevention	
NPM	
NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year 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 build capacity within existing agencies to provide evidence-based home visiting services targeted to Nebraska families at-risk for child abuse and neglect in collaboration with NDHHS Division of Children and Family Services.	
CH4a (2): Title V staff will continue collaboration with the Division of Children and Family Services (DCFS), Child Abuse Prevention Fund Board, Plan to Prevent Child Maltreatment Deaths workgroup, Prenatal Plans of Safe Care, and Bring Up Nebraska initiatives co-led by DCFS and Nebraska Children and Families Foundation.	
ESMs	**Status**
ESM MH.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.	Inactive
ESM MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator	Active

NOMs

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

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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

Priority Need

Access to Preventive Oral Health Care Services

NPM

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Five-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 NDHHS Office of Oral Health & Dentistry (OOHD) will distribute dental health starter kits in the population and report evaluation measures of the project.

CH5a(2): The OOHD and Title V will fund and support community-based oral health care service delivery through subaward agreements.

ESMs	Status
ESM PDV-Child.1 - The number of sites participating in the Nebraska Early Dental Health Starter Kits Educational program.	Inactive
ESM PDV-Child.2 - The percentage of children participating in the Open Mouth Survey from underserved communities	Active

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

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

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Child Health - Annual Report

In this section, Nebraska MCH Title V reports on the accomplishments and 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 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 2022-2023, with NPM, SPM, and ESM statements for the period 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 participating in the Open Mouth survey from rural and underserved communities.

1. Context: The State of the Child Population Domain

Systems Partners

NDHHS' approach to integrated service delivery in health and human services 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.

Within Nebraska there are several strong systems-level efforts led by state level 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, supports the referral network Help Me Grow Nebraska, and First Five Nebraska leads a Prenatal to Three project. Title V and Nebraska Maternal, Infant, and Early Childhood Home Visiting (N-MIECHV) Programs have both actively participated in the development of the state plan under the Families First Prevention Services Act which includes home visiting services for families at-risk of involvement in the child welfare system. N-MIECHV has active data sharing MOUs in place with the Division of Child and Family Services. Local implementing agencies who administer local MIECHV programs have partnerships in place that include local MOUs with local Child and Family Services staff. 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. Within NDHHS, Title V has long partnered with the Injury Prevention Program, the Oral Health Program, and the Child Lead Prevention Program.

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 invests in ongoing operations and services supporting school health. In 2022-2023, the Nebraska's Children's Hospital & Medical Center partnered with the Nebraska Department of Education to expand and embrace comprehensive and coordinated school health programs to provide additional expertise and staff support in response to needs identified during the COVID-19 pandemic. The School Health Nurse Consultant position moved from NDHHS to Children's Hospital & Medical Center. This transition changed how Title V approached school health and stressed the importance of partnerships. NDHHS reclassified the remaining position to broaden its scope to support children's initiatives.

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

Priority: Child Abuse Prevention

2022-2023 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.

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 NDHHS Division of Children and Family Services (DCFS).

Strategy CH4a(2): Title V staff in partnership with DCFS staff will collaborate to support the Thriving Families, Safer Children workgroup and larger Bringing Up Nebraska initiatives.

Summary of Programmatic Efforts

In recent years, N-MIECHV has worked in a formal collaborative partnership with the Division of Children & Family Services (DCFS) to implement Family First Prevention Services Act (FFPSA), 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 with support of executive leadership. N-MIECHV offers training materials for CFS employees about MIECHV and promotes referral from DCFS into home visiting programs.

During 2022-2023, N-MIECHV used a community planning approach to evaluate system gaps for needed services in the community, and discussed whether an HFA program might help close those gaps. Once a local implementing agency (LIA) expressed interest with support from the community, N-MIECHV began a grant process to fund the new program and N-MIECHV guided the new LIA through the start-up process.

During the 2022-2023 period, N-MIECHV added six new sites with new local implementing agencies. When the sites are fully staffed and trained they will have capacity for about 300 families. Expansion was targeted in priority counties, based on the 2020 N-MIECHV Needs Assessment. The Needs Assessment identified 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.

Since August 2021, the Thriving Families, Safer Children initiative and the Prenatal to Three Coalition (led by First Five Nebraska) have worked together to establish shared goals, strategies, and data. Collaboration between DCFS and the Division of Public Health has supported the expansion of home visiting in the state, as discussed above.

Within the Thriving Families, Safer Children initiative, the project developed an Action Team Network to address racial disparities in reported and substantiated reports of child abuse and neglect. During this reporting period, the Action Team Network evaluated local data disparities, training needs, and staffing to address regional disparities. To leverage the wide range of community culture within Nebraska (from small towns centered around farming and ranching to medium sized towns whose economy is driven by a college or meat-packing companies to urban cities with many industries and communities), the Action Team Network is tailoring their action to specific community need.

Nebraska Children and Families Foundation (NCFF) is the lead agency for the Bring Up Nebraska effort, which heavily supports the infrastructure of Community Collaboratives across the state. In 2022-2023, NCFF provided funding and technical assistance to more than 23 developed or developing Community Collaboratives across Nebraska, including three Tribal nations as well as tribal affiliated families throughout western Nebraska. Overall, between July 1, 2022, and June 30, 2023, Bring Up Nebraska efforts served 13,228 participants and 9,711 children.

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.

NDHHS participates in the Family First Prevention Services Act (FFPSA), which calls for a greater emphasis on States providing child maltreatment prevention services that are rooted in promising, supported, or well-supported practices. Title V and N-MIECHV actively participate in the development of the state plan under the Families First Prevention Services Act, which includes home visiting services for families at-risk of involvement in the child welfare system. 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

2022-2023 Objectives and 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 NDHHS Office of Oral Health and Dentistry (OOHD) will identify needs for translation of existing health literate oral health education materials.

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

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

Summary of Programmatic Efforts

During this reporting period, the OOHD reviewed needs for dental health promotion materials translation using a temporary Community Health Educator. The Community Health Educator determined that there was not a significant need for translation services beyond English and Spanish. Thus, this strategy is complete.

The OOHD distributed Dental Health Starter Kits to 15,494 children and families. The kits were distributed to more than twice as many children and families as during the prior year. For more information about these efforts, see the MCH Success Story within this application and annual report. Partners for distribution included the University of Nebraska Medical Center College of Dentistry, Local Health Departments, Childcare Providers, Preschools and Elementary Schools, Federally Qualified Health Centers, Children's Hospital & Medical Center Pediatrician Offices and Children's Hospital & Medical Center Emergency Department.

In addition to these efforts, the Office of MCH Epidemiology supported the OOHD in completing a statewide assessment of children's oral health by screening children in selected schools and Head Start programs. In 2022-2023, the Oral Health Survey was administered and completed with technical assistance from the Association of State and Territorial Dental Directors. University of Nebraska Medical Center College of Dentistry Pediatric Residents supported the survey as examiners in several counties, in partnership with dental hygienists with public health authorization. They began analyzing the data in FY23 and this continued past September 30, 2023.

During this period, Title V and the OOHD funded local health departments and community-based organizations to address the shortage of dental health professionals across the state. These partnerships supported community outreach events and dental clinics in schools. At the dental clinics in schools, public health hygienists provided accessible preventative oral health services (screening, fluoride varnish and sealants) and incorporated a robust educational element and referral services for those who need additional dental evaluation and treatment if an area of concern was indicated. Partnerships between local health departments and community organizations help the health department reach families they have not previously served and encourage the establishment of a dental home at which to receive regular dental care.

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 Open Mouth Survey from rural and underserved communities.

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 rural and underserved community participation in the Open Mouth Survey, 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-based Accountability (RBA) measures in most domains 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 for 2022-2023 Child Abuse Prevention	
How much did we do?	Q: How did Title V support analysis of disparities among families involved in child welfare? A: DCFS completed this work, Title V connected DCFS to related initiatives Q: How much did N-MIECHV programs expand? A: 6 new programs, adding over 300 spots
How well did we do it?	Q: Are there actionable findings identified through data? A: Data shows Black and Native American families enter CFS at a higher rate; action to address disparities will be taken at the local level Q: How did communities with new N-MIECHV programs provide additional support for prevention and early identification/intervention strategies? A: Six communities did community planning prior to identifying new local implementing agencies to run home visiting programs
Is anyone better off?	Q: Did recommendations get implemented? A: An action team network was created to look into abuse and neglect reporting and substantiation at the local level. Q: How many new families received Home Visiting services because of expansion? A: LIAs were not established, staffed, and trained to provide home visiting services during this period

Discussion – Other Programmatic Impacts

Expanding evidence-based home visiting through braided, cross-divisional, state and federal funding sources at NDHHS has been groundbreaking for service delivery. Title V leadership and alignment has been instrumental in guiding the process. This expansion allows N-MIECHV to serve more families in collaboration with child welfare services. 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 NDHHS 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 and strong engagement by local partners set the stage for a successful expansion of critical services and supports for all families in Nebraska.

Results Based Accountability (RBA) measures for 2022-2023 Access to preventive oral health care services for children	
How much did we do?	Q: How many Dental Kits were distributed? How many materials were translated? A: 15,494 total: 12,874 English kits and 2,620 Spanish kits Q: How many children participated in the Oral Health survey? A: 909 students within 32 Head Start sites, 3,299 3rd graders within 73 schools Statewide, 1,434 3rd graders within 22 schools in Lancaster County
How well did we do it?	Q: Who received the dental kits and translated materials? Did we reach the families who need it the most? A: 20 organizations / networks of care, Yes Q: What findings came out of the Oral Health survey data analysis? A: Urban / rural disparity; full report can be found here.
Is anyone better off?	Q: Can we measure an improvement in dental care – either in at-home practices or in accessing care from a professional? A: Not yet, hope to see change in 5 years Q: How do the findings of the Oral Health survey compare with the results of the previous study? A: In 2015-2016 there were wide geographic disparities in decay experience and untreated decay. Results of the 2022-2023 survey had much smaller geographic disparities for decay experience and untreated decay.

5. Challenges and Emerging Issues

COVID-19 Response

As the United States pushed to resume activities that many had paused or lessened during the COVID-19 pandemic, in 2022-2023 Title V MCH could see the effects of program operations on subrecipients and on families. The 2020 Needs Assessment was concluded 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. Inflation in the economy further stressed American families and may impact life course trajectories for MCH populations for some time, especially those already vulnerable and experiencing social needs.

Equitable access to pediatric mental health care

Since 2018, Title V MCH has been 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 recognized the rising tide of mental health issues in the population.

During this reporting period, NEP-MAP activities continued. NEP-MAP continued the clinical demonstration project (providing consultation services to rural-based primary care providers needing assistance treating or referring patients) and offered screening/referral tools to encourage community-based service utilization. NEP-MAP expanded its access promotion to reach schools through partnership with the University of Nebraska Public Policy Center. NEP-MAP engaged its Advisory Committee and built deeper collaborative relationships with the Nebraska Department of Education and Nebraska's Children's Hospital. All NEP-MAP projects aim to increase the capacity of healthcare providers to screen, refer, and treat mild to moderate mental and behavioral health issues in children and youth.

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 2025 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

In terms of strategic directions, Title V connected the pandemic, family stress, and risk of child abuse and neglect. In the wake of the COVID-19 pandemic all parties have proceeded with expanding home visiting as well as other supports and resources, with patience, compassion, and persistence.

Child Health - Application Year

In this section, Nebraska MCH Title V describes planned activities in the **Child Health Domain** for the period October 1, 2024 to September 30, 2025. This represents the fifth 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 2024-2025 NPM, SPM, and ESM statements are as follows:

Priority: Child Abuse Prevention

NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (new)

ESM: The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator (new)

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 participating in the Open Mouth survey from rural and underserved communities

1. Description of Planned Activities

Priority: Child Abuse Prevention

2024-2025 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 build capacity with existing agencies to provide evidence-based home visiting services targeted to Nebraska families at-risk for child abuse and neglect in collaboration with NDHHS Division of Children and Family Services

Strategy CH4a(2): Title V staff will continue collaboration with the Division of Children and Family Services (DCFS), Child Abuse Prevention Fund Board, Plan to Prevent Child Maltreatment Deaths workgroup, Prenatal Plans of Safe Care, and Bring Up Nebraska initiatives co-led by DCFS and Nebraska Children and Families Foundation.

Discussion of Activities for this Objective – Relevance to Identified Priority

Nebraskans care about child well-being, 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 local Community Collaboratives), 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.

NDHHS approaches integrated service delivery in health and human services collaboratively. Title V, N-MIECHV, and related programs participate in discussion and planning for alternative interventions for families and children at risk of involvement in the child welfare system.

For the past few years, the N-MIECHV program, housed in the Division of Public Health, has worked in a formal collaborative partnership with DCFS to implement Family First Prevention Services Act (FFPSA), 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.

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. After community planning to identify appropriate organizations to provide home visiting services in each community, N-MIECHV used braided funding to expand services across Nebraska via subawards. In 2024-2025, HFA will build capacity in new and existing sites, increasing the number of families each site can serve. By the end of 2025, funding support and technical assistance will increase N-MIECHV capacity statewide from 711 families to 883 families – 172 new families.

Child Welfare Disparities

The Child Abuse and Neglect Issue Brief created through 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, DCFS committed to analyzing data to further describe existing disparities.

DCFS found that in certain locations across NE, American Indian/Alaska Native and multi-racial children have a rate of screened in reports at least twice that of White children. NCFF is leading programs intended to reduce unnecessary entry into the child welfare system, and they are reaching the populations most at risk of child abuse and neglect. Nebraska’s Community Response model is the backbone support element of a community-based prevention system and encompasses all individual-level strategies implemented across the life span. Community Response coordinates existing resources within a community to help children, young adults, and families address immediate needs, and increase promotive and protective factors long-term. Community Response is intended to prevent unnecessary entry into the child welfare system. A similar program, Alternative Response, is offered to lower risk families that have already entered the child welfare system. In general, DCFS is working to use federal dollars to support prevention efforts before families enter the child welfare system.

During the 2024-2025 reporting period, the Action Team Network will focus on lifting and advocating for the voices of individuals with lived expertise. The Action Team Network does this via community forums, parent advisory committees, and feedback sessions. The information and input garnered through these convenings from Lived Experts will be shared with NDHHS, community partners, and stakeholders. This work is led by the Lived Experts across the state and the National Thriving Families, Safer Children Action Network.

Nebraska recently worked with an outside partner, The Stephen Group, and completed a comprehensive, bottom up, and strategic approach to child welfare. This child welfare approach included the development of recommended practice and finance models for Nebraska. The products of this approach were developed after input was gathered from multiple interviews, community forums, focus groups held across the state, intersectoral finance subcommittees, stakeholder input, surveys and builds upon previous work to improve the Nebraska child welfare system.

A key focus of these recommendations is to move Nebraska toward an integrated model to support child welfare. Presently, children and families regularly pass through several systems of care that often are not coordinated. This is a case where each entity is focusing on delivering the services it provides instead of focusing on the overall welfare of that child or family. This re-designed system involves quickly identifying potentially at-risk youth, and making sure there is capacity to access the right services at the right time to keep children safe and develop future well-being. It involves strengthening relationships across court system, probation, executive branch agencies, state department of education, and community partners to support integration across agencies, as well as data collection and outcome monitoring.

As a result of this comprehensive review, DCFS has concluded the work of the Thriving Families, Safer Children workgroup and focus efforts on community involvement, intersectoral engagement, integration across agencies, and data collection and monitoring. In 2024-2025, Title V and DCFS staff will support systems change by engaging in this transformative work as a partner and by supporting prevention efforts through the Community Collaboratives.

Results of the 2024 Public Input Survey support the work described for this priority. One respondent commented, “The Bring Up Nebraska efforts are building momentum and are best placed to connect the dots in communities working to get families services before a crisis. Integrating these efforts with thoughtful poverty-alleviation initiatives that expand the workforce and upskill individuals can help break the poverty cycle and reduce abuse and neglect.” A second comment illustrates the need for this systems-overhaul, “Families all over the state need intensive help with parenting. Our current system is desperately underserving all of our communities. The privatization of the child welfare system has been disastrous. Nothing short of

drastic changes to our system as a whole is going to make much of a difference in the prevention, identification and intervention process." Nebraska's leaders for the child welfare system agree and are working to make preventive change.

A final response from the 2024 Public Input survey suggests that if Nebraska addresses mental health (as Title V aims to do in three other priorities), then child abuse will be reduced. The respondent wrote, "I agree and commend the collaboration with Bring Up Nebraska. However, the strategies do not visibly address greater access to mental health supports. Mental health needs are huge contributors to poverty, substance abuse, and domestic violence and changing a person's mental health trajectory could positively impact the rest of the factors."

Priority: Access to Preventive Oral Health Care Services

2024-2025 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 NDHHS Office of Oral Health & Dentistry (OOHD) will distribute dental health starter kits in the population and report evaluation measures of the project.

Strategy CH5a(2): The OOHD and Title V will fund and support community-based oral health care service delivery through subaward agreements.

Discussion of Activities for this Objective – Relevance to Identified Priority

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. Kits are distributed by local partners, including but not limited to local and tribal health departments, Children's Hospital & Medical Center, and the University of Nebraska Medical Center's College of Dentistry. Title V will continue supporting this activity in the upcoming year.

In 2023, funded by Title V, the OOHD hired a part-time temporary Community Health Educator to help with the distribution of the dental health starter kits. The OOHD has another full-time temporary Community Health Educator to support oral health workforce development. This recent growth has doubled the capacity of the team.

The OOHD recently completed a basic dental screening survey of Head Start and third graders across Nebraska and released a report and fact sheet describing the surveillance data. With the state survey completed, the Office of Oral Health and Dentistry evaluated 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. The OOHD shared results with stakeholders and the public. OOHD monitors where preventive services are provided across Nebraska and identifies 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 2024-2025 year. Since 2021, Title V has subawarded funds to Local Health Departments and community-based organizations for Child and Adolescent related Title V priorities. In 2024-2025, there will be two organizations engaged in oral health care service delivery through a Title V subaward. The OOHD will fund ten organizations to provide oral health care service delivery. Title V will monitor progress in each community to assess if there are interventions that could be effectively scaled up for expanded reach.

Responses received from the 2024 Public Input Survey support community-based solutions (as currently provided through

Title V subawards), and stress that the absence of dentists statewide that take Medicaid is impacting the care families can access. This comment captures sentiments that multiple respondents shared, “We need more dentists to take Medicaid-especially in rural areas. Families don't understand WHY they need to go to the dentist every six months. The education needs to be there…” Another common comment highlights reimbursement rates, “Medicaid needs to pay more for these services, so that more dentists will participate in the Medicaid program. I hear far to often from people who cannot get service, or are on a ridiculously long waiting list because of how few providers will take Medicaid.” The Division of Medicaid and Long-Term Care is listening, in 2024, Nebraska’s Medicaid program increased their reimbursement rates for dental services by 12.5%.

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 Family First Prevention Services 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 2024-2025 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 continued 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 & Dentistry at NDHHS 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 2024-2025 are consistent with findings and recommendations of the Needs Assessment. 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, 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.

In 2021-2022, the Children’s Nebraska, formerly Children’s Hospital & Medical Center partnered with the Nebraska Department of Education to expand and embrace comprehensive and coordinated school health programs to provide additional expertise and staff support. The School Health Nurse Consultant position moved from the Nebraska Department of Health & Human Services Maternal & Child Health (MCH) Program to Children’s Hospital & Medical Center. The MCH Program and Title V maintain robust connections and collaborations with the staff who are supporting Nebraska school health services. Children’s Nebraska is leveraging their School Social Work Coordinator to address mental health needs in schools across Nebraska.

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: Child Abuse Prevention

NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (new)

ESM: The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator (new)

New in this application, the newly required NPM aims to measure the percent of children with and without special health care needs, ages 0 through 17, who have a medical home. In this application the ESM for the Child with Special Health Care Needs domain defaulted as an ESM for the Child Domain. Nebraska Title V will examine best practices and available data to develop an appropriate ESM by July 2025.

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 participating in the Open Mouth survey from rural and underserved communities

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. The ESM is a measure of quantity of rural and underserved community participation in the Open Mouth Survey, so the unit of measure between NPM and ESM is slightly mismatched and not indicative of results or impact.

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 2024-2025
How much did we do?	Strategy CH4a(1): How many new N-MIECHV families could local implementing agencies serve by Sept 2025 compared to Sept 2024? Strategy CH4a(2): How many communities have Community Collaboratives supporting Community Response? How many families were served by Community Response and Alternative Response?
How well did we do it?	Strategy CH4a(1): How did communities with new N-MIECHV programs provide additional support for prevention and early identification/intervention strategies? Strategy CH4a(2): Has DCFS developed strategies to reduce racial disparities in alleged and substantiated child abuse reports? If yes, what are they?
Is anyone better off?	Strategy CH4a(1): How many N-MIECHV families were served by local implementing agencies by Sept 2025? Strategy CH4a(2): How many families were served by Community Response and Alternative Response?

Results Based Accountability (RBA) measures Priority: Access to Preventive Oral Health Care Services	
	Proposed for 2024-2025
How much did we do?	Strategy CH5a(1): How many dental kits were distributed? Strategy CH5a(1): How many organizations are participating in distribution activities? Strategy CH5a(2): How many families received dental services supported by Title V and the Office of Oral Health & Dentistry?
How well did we do it?	Strategy CH5a(1): Who received the dental kits? Did we partner with organizations that can reach the families who need it the most?
Is anyone better off?	Strategy CH5a(2): Did Title V and/or the OOHD add or adjust the communities they partner with to provide dental health care services based on the results of the statewide oral health survey?

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

New in this application, the SPM has been replaced by the newly required NPM. The new NPM aims to measure the percent of children with and without special health care needs, ages 0 through 17, who have a medical home. Nebraska Title V will examine best practices and available data to develop an appropriate ESM by July 2025.

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.

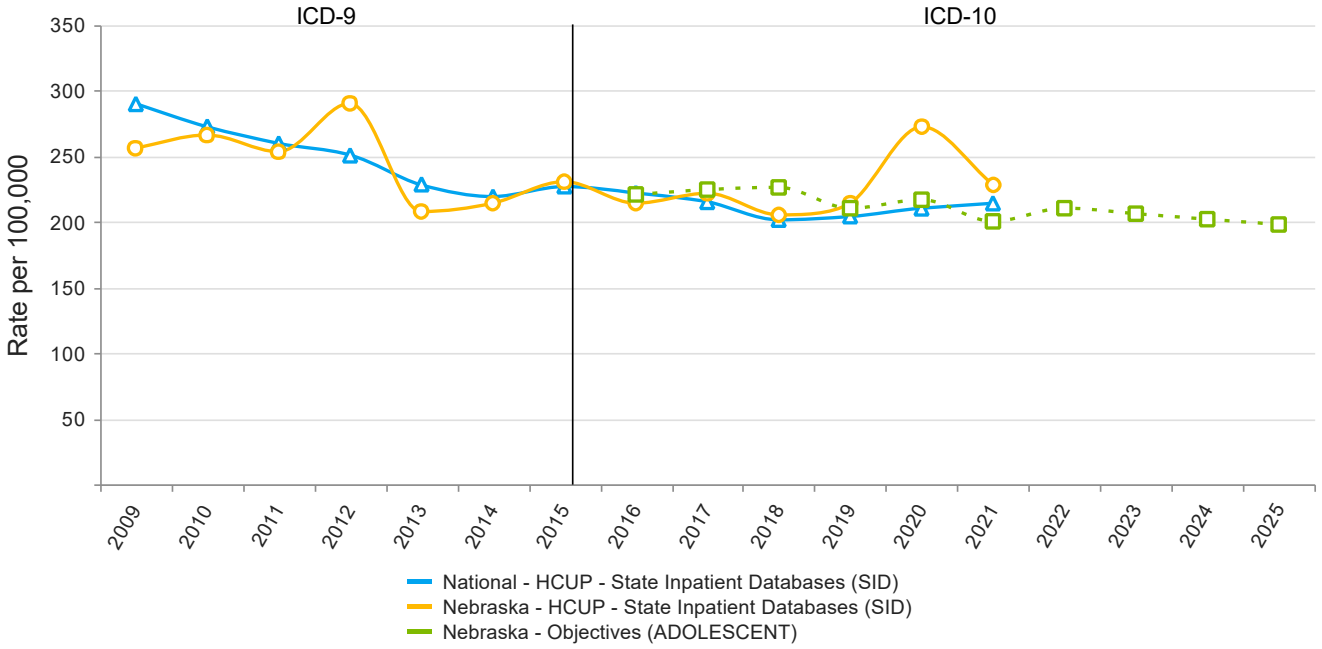
Priority: Child Abuse Prevention **5-year Action Plan, 2020-2025**		
Period	**Summary activities of the period**	**Status 7/2024**
Year 1	• Expand N-MIECHV Home Visiting • Learn more about disparities in child welfare	• Started • Started
Year 2	• Expand N-MIECHV Home Visiting • Learn more about disparities in child welfare	• Sustain • Done
Year 3	• Expand N-MIECHV Home Visiting. • 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 • Ongoing
Year 4	• Expand N-MIECHV Home Visiting. • Title V and DCFS will evaluate Nebraska's Community Well-Being prevention model • Title V and DCFS will assess programming impact on disparities in child welfare • Review framework for the practice and financing of the child welfare system	• Ongoing • Ongoing • Ongoing • Ongoing
Year 5	• Monitor and support N-MIECHV Home Visiting Expansion • Evaluate action on disparities in child welfare • Support new child welfare framework for prevention	

Priority: Access to Preventive Oral Health Care Services 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2024**
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 • Completed conducting the statewide oral health survey • Data analysis of statewide oral health survey	• Ongoing • Ongoing • Ongoing
Year 4	• Oral Health Program distribute dental kits • Develop evaluation component for distribution of dental health kits • Disseminate statewide oral health survey report	• Ongoing • Ongoing • Complete
Year 5	• Evaluate Oral Health Program outreach with dental kits • Fund dental health care service providers through OOHD and Title V	

Adolescent Health

National Performance Measures

NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent
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)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	210.2	216.7	200.3	210.3	206.1
Annual Indicator	221.2	204.9	214.6	272.7	228.0
Numerator	582	543	572	727	633
Denominator	263,114	265,061	266,584	266,580	277,643
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives		
	2024	2025
Annual Objective	201.9	197.9

Evidence-Based or –Informed Strategy Measures

ESM IH-Adolescent.1 - The number of schools participating in the "Teens in the Driver Seat" program.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	38	38	38	27	26
Annual Indicator	33	33	22	22	23
Numerator					
Denominator					
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	29.0	33.0

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**	**2022**	**2023**
Annual Objective			1,883.9	1,768.9	1,733.5
Annual Indicator	1,922.4	1,776	1,800	1,787.5	1,787.5
Numerator	2,550	2,361	2,493	2,457	2,457
Denominator	132,645	132,940	138,497	137,456	137,456
Data Source	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census	Unavailable, Census
Data Source Year	2019	2020	2021	2022	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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	2022	2023
Annual Objective			7.4	7.6	8
Annual Indicator	8.8	7.2	7.4	8.2	8.8
Numerator	70	58	61	68	73
Denominator	794,759	809,241	821,764	833,143	825,575
Data Source	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census
Data Source Year	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	8.5	8.2

State Action Plan Table

State Action Plan Table (Nebraska) - Adolescent Health - Entry 1	
Priority Need	
Motor Vehicle Crashes among Youth	
NPM	
NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent	
Five-Year 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 under resourced and rural populations.	
Strategies	
AD6a(1): The Office of Injury Prevention will incorporate an access lens in Teens in the Driver's Seat expansion and other teen driver safety initiatives by using a health equity planner and in data collection and assessment to identify inequalities and social determinants of health.	
AD6a(2): The Office of Injury Prevention will target teen driver safety programming efforts in high crash rate counties.	
AD6a(3): Title V will fund and support community-based motor vehicle crash prevention through subaward agreements.	
ESMs	**Status**
ESM IH-Adolescent.1 - The number of schools participating in the "Teens in the Driver Seat" program.	Active
NOMs	
NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM	
NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM	
NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle	
NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide	

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).

Five-Year 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 Adolescent & Reproductive Health (ARH) Program will test, refine, and disseminate “Conversation Starters” (named the Chatterbox Chats) for teen and parent communication.

AD7a(2): The Adolescent & Reproductive Health Program will implement the Making a Difference (MAD) curriculum.

AD7a (3): The Adolescent & Reproductive Health Program will support projects to promote sexual health among underserved and disproportionately affected groups.

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).

Five-Year 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 with the Nebraska Statewide Suicide Prevention Coalition, Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP), Nebraska Department of Education Office of Coordinated Student Support Services, and Society of Care.

AD8a(2): Title V will promote utilization of the 988 suicide and crisis lifeline.

AD8a(3): Title V will fund and support community-based suicide prevention efforts through subaward agreements.

Adolescent Health - Annual Report

In this section, Nebraska MCH Title V reports on the accomplishments and 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 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 2022-2023, with NPM, SPM, and ESM statements for the period 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 disease 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. Context: The State of the Adolescent Population Domain

The Adolescent Health Domain dominated the Title V 2020 Needs Assessment in that participants and stakeholders selected three population health priorities in this domain and had the majority of 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 (MVC) among youth as a priority, stakeholders responded to the fact that MVC are the leading cause of death among youth and there are disparities between urban/rural youth. Stakeholders recognized that effective intervention strategies exist including Nebraska’s Graduated Drivers Licensing (GDL) laws; drivers’ education, peer-to-peer education such as Teens in the Driver Seat (TDS); and parental involvement in enforcing and understand GDL laws.

The Nebraska Injury Prevention Program (IPP) 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 across the state and has a long history of motor vehicle safety work for children and youth. The IPP partners with the Nebraska Department of Transportation Highway Safety Office, Nebraska State Patrol, Mothers Against Drunk Driving Nebraska, Department of Education Family, Career, and Community Leaders of America, local health departments, Nebraska Community Collective, and engaged schools. The Injury Prevention Program takes the lead and collaborates with the Children’s Health Program Specialist to address the priority of motor vehicle crashes.

Sexually transmitted diseases among youth has been a population health priority since 2015. Stakeholders remain 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 of sexually transmitted diseases on both physical and mental well-being of youth affected, particularly Black youth. Between 2015-2020, Title V worked to improve school referral systems for sexual health issues of youth at school, improve communication between youth and trusted adults on sensitive topics, and supported youth-friendly clinics.

In the 2020 Needs Assessment, stakeholders pointed 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 strategies were identified as promising venues to engage 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. In recent years, some Nebraskans have loudly opposed school-based sexuality education curricula, and in response, Title V leaned more toward strategies that would strengthen parent-child communication as a risk behavior mitigator.

In Nebraska, suicide among youth has been trending upward since 2010 and has been a top cause of death in Nebraska for young people. In the 2020 Title V Needs Assessment, stakeholders were 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. In recent years, available data and anecdotal evidence have stressed escalating mental and behavioral health needs among youth, of which suicidality is only one. 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. Because 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. The impacts of the COVID-19 pandemic on adolescents can be seen in disrupted early career and academic paths; increased substance use; increased mental health issues; and loss of supports and opportunities.

Stakeholder alignment

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 and updated most recently in 2022. Funding for this work is increasing in Nebraska, allowing Title V to support this work by a) helping align and promote mutual reinforcement of efforts statewide and b) advocating for intentional efforts to disrupt disparities in suicide. Stakeholders encouraged Title V to support effective strategies through workforce development, such as training school personnel and enhancing training of mental and behavioral health professionals.

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 NDHHS Adolescent & Reproductive Health Program, Injury Prevention, Children's Health, and STI/STD programs, all partner with 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.

2022-2023 Objectives and 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 NDHHS 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 NDHHS 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.

Summary of Programmatic Efforts

To improve the Teens in the Driver Seat (TDS) program, the Injury Prevention Program surveyed 9 long standing TDS school programs to get feedback along with getting their perspective on why they continue to do the program. The top three reasons for initially doing the program were wanting to keep students safe, leadership opportunities, and valuable resources that fit well into their student organization. The top reasons for continuing TDS are the free resource kit, cash reward program, and student buy-in. This feedback helped to guide continued programming and communication/outreach. There were 23 active TDS schools, with a total of 22,962 teens reached in the 2022-2023 school year. By the end of the school year, 12 schools were recognized in the TDS All Star program for all the activities they did. Also, three teachers were awarded the TDS SponStar Award.

A draft teen driver safety infographic for Box Butte County was created to bring awareness to the community on the high rates of crashes as determined by Crash Outcomes Data Evaluation System data from the Nebraska Teen Motor Vehicle Safety Surveillance Report. The fact sheet compares county crash rates to state rates, seasonal crashes, seat belt use, and driver education uptake. It also contains evidence-based solutions for communities to pick from to implement. Partners in creating the fact sheet included Mothers Against Drunk Driving Nebraska, Four Corners Health Department, Nebraska's Department of Education Family, Career, and Community Leaders of America and Panhandle Public Health District. The infographic was tested with community members for understanding and ease of reading prior to full spread of the information. Due to the information provided, the Panhandle Public Health District chose to put efforts towards increasing driver education in their coverage area. Plans will continue forward using the fact sheet to work with local health departments and partners to bring awareness to the problem of high crash rates in some districts.

TDS and the Injury Prevention staff promoted the Driving the Message Contest to all Nebraska schools. The deadline for the Driving the Message Contest was January 28, 2023. 3 posters and 1 video were submitted for the 2023 Driving the Message Contest

- One video was submitted by a student from Norfolk Senior High School, Norfolk NE
- Two posters was submitted by a student from Malcolm Jr./Sr. High School, Malcolm, NE

The Norfolk submitted video placed first in the country and the school was awarded $1,000.

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

The following are best practice countermeasures to improve teen driver safety, recommended by the Governor's Highway Safety Association (Source: GHSA Spotlight Report 2023):

- **Strengthen the Education of Graduated Driver License (GDL) laws.** Every state has a GDL program, which phases in driving privileges for teens and imposes restrictions, such as banning nighttime driving or limiting the number of peers in the vehicle. Nebraska's law is secondary enforcement and does not meet the primary enforcement evidence-based recommendation.
- **Bolster parent/guardian and other adult involvement.** Parents and guardians play a key role in their child's experience of learning to drive and should understand and enforce their state's GDL provisions. The report recommends building a parent education element into state licensing requirements, among other changes.
- **Make driver training available to all.** Driver education and training should be available to everyone – regardless of race, income, gender, language, age or other characteristics. States should assess their driver education standards and ensure they are accessible and relatable to all, both culturally and financially. This is critical, as all young driver safety programs should be viewed through an equity lens.
- **Invest in impactful peer-to-peer education programs.** Peer-to-peer education programs are an important way to

reach young drivers, but they're not all created equally and must be part of a broader effort. Effective youth programs should be teen-led, inclusive of all cultures, sustainable, positive and have measurable objectives.

- **Leverage driver assistance technology and apps.** Technology advancements have made vehicles safer than they've ever been for drivers and passengers of all ages. Features such as lane-departure warning, blind spot monitoring and automatic emergency braking can help prevent crashes involving young drivers, but both young drivers and their parents need to be familiar with how these features work and their limitations. There are also a range of in-vehicle and cell phone apps to either incentivize teens to drive safely or to help parents monitor their child's driving.
- **Incorporate technology and driver responsibility into education.** As vehicle technology continues to evolve, ensuring that our youngest and riskiest drivers understand it and use it correctly is critical. GHSA recommends that more information on vehicle safety features be incorporated into driver education programs, along with guidance on driving electric vehicles. These education efforts should also focus on the safety of people walking, biking or scooting, so that novice drivers understand their role in protecting everyone on the road.

In 2020, the National Center for Education in Maternal and Child Health released an evidence review of NPM 7.2: Injury Hospitalization – Ages 10 through 19. The goal of this NPM is to decrease the rate of hospital admissions for non-fatal injury among adolescents and youth ages 10 through 19. Within this review there is a section on preventing motor vehicle-related injuries for teen drivers and passengers. The review identifies graduated drivers licensing systems and risk awareness and injury prevention educational programs as having "emerging evidence" for their effectiveness at injury prevention. These are main strategies that Title V supports for motor vehicle crash prevention. There is "mixed evidence" for the effectiveness of computerized driving simulation programs.

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 and "In-vehicle monitoring & feedback for teen drivers and families" has some evidence of effectiveness.

According to the National Highway Traffic Safety Administration (https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812683) seat belt use is one of the most effective ways to save lives and reduce injuries in crashes for adults and older children (who are big enough for seat belts to fit properly). Nationally, 2,514 people were killed in crashes involving a teen driver (15-18 years old) in 2022. 50% of teen passenger vehicle drivers who died in 2022 were unbuckled (https://www.nhtsa.gov/road-safety/teen-driving).

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 34%, and seat belt use has gone up by 17%.

Priority: Sexually transmitted disease among Youth.

2022-2023 Objectives and 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 NDHHS Adolescent & Reproductive Health Program will continue to process of testing, refinement, and dissemination of the Conversation Starters project.

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

Strategy AD7a(3): The NDHHS Adolescent & Reproductive Health Program will identify project opportunities to promote sexual health among underserved, disproportionately affected groups.

Summary of Programmatic Efforts

The Adolescent & Reproductive Health (ARH) Program spent the 2022-2023 period working towards final approval for their Conversation Starter Project. The ARH Program developed a name for the project, Chatterbox Chats. The Chatterbox is a fortune teller printable that can be folded and manipulated by two hands. The ARH Program developed questions to go with the Chatterbox using the socio-economic model. Questions were grouped by topics like “Getting to Know Your Young Person” and “Relationships.” The Chatterbox Chats include instructions, tips, and a glossary. The focus of the project is building trust and connection between youth and their parents, caregivers, and trusted adults. As such, some of the questions in the Chatterbox are on sensitive topics that can be difficult for trusted adults to navigate without prompts, including sexual health, racism, and bias. The project was developed during the 2022-2023 period, but its public release was delayed because the sensitive nature of the project required additional internal review before release. Final development for release continued past the end of the reporting period.

The ARH program continued funding the Making A Difference (MAD) curriculum during the 2022-2023 period. MAD is an evidence-based curriculum that includes nine modules that provide young people with the opportunity to learn about abstinence, puberty, sexually transmitted infections and HIV, pregnancy, healthy relationships, peer pressure, and refusal/negotiation skills. This program is well-suited to communities in Nebraska because it is a short-term commitment for program staff and youth, is inclusive, and fits the political context of Nebraska. During the 2022-2023 period, the ARH Program funded two subrecipients to implement the MAD curriculum, serving a total of 35 youth. MAD participants responded that they were more likely to “resist or say no to negative peer pressure” (86%), that “the most effective way to prevent STD/STIs is to not have sex” (97%), and that they were “confident in my ability to access accurate information about STDs/STIs” (86%).

During the 2022-2023 period of performance the ARH Program explored reproductive health outcomes by demographics, with a focus on reducing disparities. Individuals with intellectual and developmental disabilities (ID/DD) experience poorer reproductive health outcomes, such as a higher likelihood of experiencing sexual assault and rape as well as being more vulnerable to sexual exploitation and manipulation. Young people with ID/DD are often not allow to participate in programming or courses that cover important sexual and reproductive health information. If they are allowed, it may not be adapted to fit their learning needs. Harmful societal myths, such as the myth that people with ID/DD are asexual or hypersexual, also impacts this population’s access to sexual and reproductive health information. The ARH Program spent part of the 2022-2023 period beginning an environmental scan of how best to provide sexual education for this population. This scan continued into the 2023-2024 period. In addition to this scan, the ARH Program is developing expertise in this area. The Community Health Educator, Sr. completed a Certificate Program in Sexuality Education and Disability: Understanding Neurodiversity, Intellectual Disabilities, and Sexual Health offered by Certifi by Marcy University in September 2023. The program consisted of twelve hours of synchronous and twelve hours of asynchronous lectures.

Title V continued to support the ARH 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. Subaward projects were available for local organizations to increase adolescent use of reproductive health services through outreach and education, youth-friendly clinic updates, and professional development for staff. During this period of performance, the ARH Program continued agreements with six eligible and qualified entities to engage adolescents up to 21 years of age; one-year periods of funding began April 1, 2021 and were renewed annually through March 31, 2024.

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:

- 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);
- Comprehensive clinic-based programs for pregnant & parenting teens (scientifically supported);
- Comprehensive risk reduction sexual health education (scientifically supported);
- Condom availability programs (scientifically supported);
- Digital interventions to prevent HIV and other STIs (scientifically supported);
- Expedited partner therapy for treatable STIs (scientifically supported); and
- HIV/STI partner notification by providers (scientifically supported).

A review of the scientifically supported interventions above suggests the use of Conversation Starters to promote behavioral interventions would be plausibly related to evidence-based practice.

In the Adolescent Reproductive Health Subawards, subrecipients utilize a mix of approaches, some of which may be evidence-based. As mentioned above, the ARH Program issued a total of six awards in 2023, including rural and urban communities, for the purpose of increasing adolescent use of reproductive health services. Subrecipients were specifically asked to focus on outreach and education, youth-friendly clinic updates, and professional development for staff.

Priority: Suicide among Youth.

2022-2023 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 (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 (NEP-MAP), and the NDHHS Behavioral Health System of Care.

Summary of Programmatic Efforts

There are numerous organizations working in to prevent suicide in Nebraska. Partners work on prevention projects regionally, with a cluster of school districts, and statewide. 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. In a shift of Strategy AD8a(1), Title V worked broadly with partners to align and amplify suicide prevention efforts for all children, youth, and families. Specifically, Title V was an active and present member of the Nebraska Statewide Suicide Prevention Coalition and leads the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP). Title V was not active in the work of the Garrett Lee Smith Suicide Prevention project because the project focused on one behavioral health region in Nebraska and the Nebraska Department of Education. During the 2022-2023 reporting period, the NDHHS Behavioral Health System of Care was not active and was in transition after federal funding for the System of Care ended.

In 2022-2023, Title V continued four subawards to local organizations for suicide prevention with adolescents. These organizations served the Omaha metro area and two local health department regions centered around towns with between 8,000-25,000 residents. The local organizations developed projects with a local/regional focus. Highlights from these projects include:

- The Wellbeing Partners developed a mental health literacy curriculum for all Omaha Public Schools middle schools. This curriculum, "Look, Listen, Link", has a reach of 10,000 students. The curriculum includes materials for students

in the 6th, 7th, and 8th grades and the adults who care for them (teachers, parents, after-school providers, and mentors).

- Collaborative efforts by Children's Nebraska included teaming with the following local, state and national organizations: Nebraska Department of Education, School Social Work Association of NE, Nebraska School Counselor Association, Nebraska School Psychologists Association, Omaha Public Schools, ESU 10, Bellevue Public Schools, Winnebago Public Schools, Project Harmony, Neurosequential Network, Center for Safe and Supportive Schools and Workplaces, Northeast Public Health Department, Nebraska Native Youth Coalition, NDHHS, and other Nebraska schools and educational organizations. These collaborative efforts aimed to expand mental health training, support, and resources, ensuring a whole-child approach to addressing youth mental wellness and suicide prevention.
- Four Corners Health Department (FCHD) engaged stakeholders in a four-county region to assess, plan, and implement youth suicide prevention work. The Steering Committee meets monthly and participates in trainings, to build internal awareness and skills. FCHD developed a comprehensive media campaign and community education initiative to increase awareness and engagement around suicide in youth. The media campaign materials were developed in the 2022-2023 period of performance and were launched in the next year. The community education initiative included trainings like Mental Health First Aid training, Wellness Recovery Action Plan (WRAP) workshop, and Question, Persuade, and Refer (QPR) training.
- South Heartland District Health Department (SHDHD) convened local stakeholders to identify key steps to improve schools' ability to assess their youth's suicide risks and act to build their capacity. SHDHD distributed over 400 Mental Wellness Kits to 10 schools in the district. SHDHD also worked with two clinics to promote screenings for suicide risk within their clinics.

As an on-going project, the NDHHS Adolescent Health Program sponsors the Teen Outreach Program (TOP). TOP is a nationally-recognized, evidence-based program that empowers teens with the tools and opportunities to build social-emotional skills, strengthen relationships, and avoid risky behaviors. TOP clubs provide social-emotional learning and peer connection. NDHHS subawarded funds that supported 19 clubs during the 2022-2023 period.

Through these collaborations, 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.

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.

The County Health Rankings and Roadmaps' What Works feature has 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:

- Extracurricular activities for social engagement
- Group-based parenting programs
- Outdoor experiential learning
- Youth leadership programs
- Crisis lines
- Cross-age youth peer mentoring
- Father involvement programs
- Intergenerational mentoring and activities

- Social service integration

The Suicide Prevention Resource Center is an important resource for evidence-based best practices in suicide prevention. 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 NDHHS Office of Injury Prevention, and measuring the extent to which Nebraska schools are participating in the program each year.

The effectiveness of Teens in the Driver Seat can be attributed to its peer-to-peer traffic safety education and 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 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. 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-based 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 for 2022-2023 Motor Vehicle Crashes among Youth	
How much did we do?	Q: How many schools and how many youth participated in the TDS survey? A: 11 schools high schools, 5 middle schools, 1,777 youth participated Q: Was the health equity planner implemented? What was its reach? A: Yes, the health equity planner was implemented. Information from the planner guided the program to address equity issues in driver education in rural areas and partners needed to address it.
How well did we do it?	Q: Were additional schools reached by TDS that weren't before? A: 4 schools in the Three River Public Health District were newly reached by TDS Q: Did the outreach to youth expand to target populations? A: Yes, the Three River Public Health District serves the target population.
Is anyone better off?	Q: Did we gain needed insights from new data? A: Yes, identified high crash rate counties and efforts that can be implemented. Q: Did the rate of motor vehicle crashes decrease? A: Have not ran the data to compare or determine that.

Discussion – Other Programmatic Impacts

The Office of Injury Prevention carries out activities with Title V as well as CDC funding.

Results Based Accountability (RBA) measures for 2022-2023 STDs Among Youth	
How much did we do?	Q: How many stakeholders participated in the development of the Conversation Starters? A: 27 – 12 adults and 15 young people Q: How many partner organizations implemented the new curriculum? A: Two Q: How many partner organizations were funded? A: Two
How well did we do it?	Q: How were the Conversation Starters revised based on input from diverse users and consumers? A: The pilot only included one chatterbox that had "a small sample of questions", but adults were given the complete list of drafted questions for their feedback. Feedback from the pilot pairs lead to: • The creation of a glossary to help parents know definitions of terms that came up in the conversations.

	• Changes to language and sentence structure (shortening phrasing). Notably, none of the pairs gave feedback to take out any of the questions. Some feedback asked for the addition of questions on topics that will be covered by later releases (hopefully) such as financial information and more specific openers for talks about sexual activity. The pilot only included a small sample of questions. Q: How many youth were served by the curricula focused on STDs? A: There were two cohorts during this period. A total of 47 youth were served across the two cohorts; 18 youth were served November 1, 2022 - March 31, 2023 and 29 youth were served April 1, 2023 - September 30, 2023 Q: Did the partner organizations reach youth with their proposed activities? A: Yes
Is anyone better off?	Q: Was there any measurable change in behavior or outcomes? A: After participation in the MAD program, more than 80% of participants said they were more likely to… • Resist or say no to negative peer pressure • Think about consequences before making a decision • Better understand what makes a relationship healthy Almost all participants (97%) agreed that the most effective say to prevent STD/STIs is to not have sex. After participation in the program, most (86%) participants are confident in their ability to access accurate information about STDs/STIs and 66% are confident in their ability to access STD/STI services in their community.

Discussion - Other Programmatic Impacts

The ARH 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 ARH Program implements the Teen Outreach Program® (TOP®), intervention in schools, after-school programs and community-based settings. Title V funds support the Making A Difference (MAD) curriculum that is offered for schools, after-school programs, and community-based settings.

Results Based Accountability (RBA) measures for 2022-2023 Suicide Among Youth.	
How much did we do?	Q: Measure of Title V participation in statewide suicide prevention meetings. A: Staff attended quarterly meetings for the NE Suicide Prevention Coalition; subawardees led and participated in regional meetings.
How well did we do it?	Q: What gap area is Title V helping address in statewide suicide prevention? A: Title V is building staff capacity statewide through trainings like QPR, Mental Health First Aid, Look, Listen, Link, and Wellness Recovery Action Plans. Title V supports school and community-based suicide prevention advisory groups, including Hope Squads.
Is anyone better off?	Q: Did more professionals get trained? A: Yes! At a regional level, each local organization Title V funded did provide training as part of their work. Children's Nebraska used a portion of their funds to offer mental health scholarships to trainings for staff across Nebraska.

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 Healthcare Access Program (NEP-MAP), 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 remained challenging issues during this reporting period. The pandemic impacted social, educational, and economic supports for many families. Title V investments in local organizations fostered the development of multiple promising practices, but this work remained too new to expand during 2022-2023.

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. There is an ongoing need for health education in under-resourced regions, among youth that are a part of historically and culturally underrepresented and underserved groups, and particularly vulnerable youth that have experienced foster care, adjudication systems, and/or homelessness.

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

Ensuring clinics are youth-friendly has promising merit and has been built into subrecipient activities by the Adolescent & Reproductive Health Program. 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

In this section, Nebraska MCH Title V describes planned activities in the **Adolescent Health Domain** for the period October 1, 2024, to September 30, 2025. This represents the fifth 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 2024-2025 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

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.

Priority: Motor Vehicle Crashes among Youth

2024-2025 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 under resourced and rural populations

Strategy AD6a(1): The Office of Injury Prevention will incorporate an access lens in Teens in the Driver's Seat expansion and other teen driver safety initiatives by using a health equity planner and in data collection and assessment to identify inequalities and social determinants of health

Strategy AD6a(2): The Office of Injury Prevention will target teen driver safety programming efforts in high crash rate counties.

Strategy AD6a(3): Title V will fund and support community-based motor vehicle crash prevention through subaward agreements.

Discussion of Activities for this Priority – Relevance to Identified Priority

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.

In the 2024-2025 period, the Office of Injury Prevention (OIP) intends to promote the Teens in the Driver Seat program with the hopes of increasing the number of schools participating in the program. Using data from the Teen Motor Vehicle Safety Surveillance Report, the Office of Injury Prevention will increase targeted teen driver/passenger safety education outreach in

counties with high rates of motor vehicle crashes. Programming activities will utilize the Child Safety Learning Collaborative guidance tool to ensure an access lens is woven through all initiatives. These activities show strong relevance to the priority to reduce motor vehicle crashes among youth.

Responses to the 2024 Public Input survey support this initiative and highlight other risks relevant to this population:

- “Again, supporting work at the local level via CBO is a great way to approach these outcomes. Teens in the Driver Seat is a wonderful program with good results - incorporating a health equity lens will be interesting to see.”
- “I appreciate the equity lens here and a focus on the areas of the state with the highest crash rates”
- “Long standing issue with a population that makes impulsive/ poor decisions when driving. Poor social issues related to alcohol / drug use.”
- “Need to find a way to reduce phone usage while driving”

The Office of Injury Prevention (OIP) recommends that parents complete a Parent-Teen Driving Agreement to keep teen drivers safer behind the wheel. The OIP also suggests parents increase their understanding of Graduated Driver Licensing provisions, support enforcement of these laws to increase compliance, and role model safe driving behaviors such as wearing a seat belt and obeying traffic laws. During the 2024-2025 period, the OIP will also promote driver’s education programs and “Parents Drive the Message” – messaging for teens from parents about the importance of safe driving.

Since 2021, Title V has awarded funds to local health departments and community-based organizations for child and adolescent related Title V priorities. In 2024-2025 there will be one community-based organization engaged in motor vehicle crash prevention through a Title V subaward.

Priority: Sexually Transmitted Disease among Youth

2024-2025 Objectives and Proposed 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

Strategy AD7a(1): The Adolescent & Reproductive Health (ARH) Program will test, refine, and disseminate “Conversation Starters” (named the Chatterbox Chats) for teen and parent communication.

Strategy AD7a(2): The Adolescent & Reproductive Health Program will implement the Making a Difference (MAD) curriculum.

Strategy AD7a(3): The Adolescent & Reproductive Health program will support projects to promote sexual health among underserved and disproportionately affected groups.

Discussion of Activities for this Priority – Relevance to Identified Priority

The Adolescent Health and Reproductive Health program’s blend of focus on adolescents and reproductive health reflects the strong focus on reproductive health activities during the young adult period. The merger of the two programs, finalized in 2021, has unified Title V’s approach to encouraging young people to become healthy before becoming pregnant, engaging in holistic programming discussing healthy relationships as well as individual health, and supporting community partners delivering services in a youth-friendly way.

In the past five years, reproductive health efforts have undergone a 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.

The Adolescent Health and Reproductive Health program provides Positive Youth Development programming and is supported by funding from Title V, the Adolescent Pregnancy Prevention Program, Family and Youth Services Bureau Administration for Children and Families, and 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.

The ARH Program has released its initial Conversation Starters pack, named the Chatterbox Chats. The ARH Program has plans to release new expansion packs periodically. The Conversations Starters is digitized and available for download on the ARH Program website.

Two responses to the 2024 Public Input survey highlight the need for family-based content to support conversation about topics like sex and STDs. The first respondent says, in response to all three of the strategies, “Is this realistic since many families fight sex ed in the schools? I would also say starting early education is important as we are seeing more youth under 13 being sexually active.” The second respondent seems to build on this sentiment, “But good luck getting many schools to allow the curriculum to be taught. Many schools will only promote abstinence an bury their heads in the sand.” The ARH Program hopes that by promoting family-based content, their materials can facilitate meaningful conversations between adults and young people. Parent-child communication is an effective strategy to delay sexual initiation, increase condom use, and decrease sexual risk behaviors (Family & Youth Services Bureau, 2016; Kitchen & Huberman, 2011).

Related to this, the ARH Program plans to explore best practices for providing programming for individuals with intellectual and developmental disabilities (IDD). In this funding period, the ARH Program will provide a training/education for youth serving professionals with information on how to best serve this population. The ARH Program has considered developing an expansion pack for the Conversation Starters / Chatterbox Chats geared towards people with intellectual and developmental disabilities.

In 2021-2022, the Adolescent and Reproductive Health program staff explored evidence-based curricula abstinence approach to STD prevention. One specific curriculum, Making A Difference (MAD), was piloted and well-received by youth and the ARH program will continue offering it into 2024-2025 with Title V support. The Nebraska MAD program is a 9 (nine) module program that can be delivered in a variety of timing structures and settings.

In 2024, 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. These awards will be continued through 2024-2025. Awardees are encouraged to develop youth advisory committees to incorporate youth voice into their projects. Responses to the 2024 Public Input survey highlighted syphilis as a missing STD in this priority need. The ARH Program is supporting the awardees to develop capacity to provide education about syphilis to youth and young adults. NDHHS is partnering with the Office of the Assistant Secretary for Health and Centers for Disease Control and Prevention to increase awareness and availability of at-home testing for syphilis.

The ARH Program will work collaboratively with partners like the Nebraska Department of Education, Children’s Nebraska, and community-based-organizations to promote youth engagement and health equity among the adolescent population across Nebraska. Future action planning of the Adolescent and Reproductive Health program will draw from the Reproductive Well-Being National Blueprint for Action.

Priority: Suicide among Youth

2024-2025 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 with the Nebraska Statewide Suicide Prevention Coalition, Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP), Nebraska Department of Education Office of Coordinated Student Support Services, and Society of Care.

Strategy AD8a(2): Title V will promote utilization of the 988 suicide and crisis lifeline.

Strategy AD8a(3): Title V will fund and support community-based suicide prevention efforts through subaward agreements.

Discussion of Activities for this Priority – Relevance to Identified Priority

There are numerous organizations working on suicide prevention in Nebraska, 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.

Responses from the 2024 Public Input survey highlight the breadth and depth of factors that impact suicide in youth. Title V's strategies for this need are multi-pronged to address the complexity of suicide prevention.

- "Having more focus on the protective factors and positives would be a great angle. When we start talking about suicide prevention sometimes kids have already been low and depressed for a long time."
- "Educating the parents how important it is to see the good in your kid and let them know they are loved. First the parents need training but sadly we have so many children being raised by children. The cycle repeats itself. Also the schools are responsible in putting a stop to bullying."
- "This needs to be addressed better by all community organizations, leaders and groups with more than just lip service. We say wonderful things but it is very rarely integrated into society and this is displayed by employers who fire employees for taking leave for mental illness and more."
- "Good ideas will help some but when the waitlists are SOOO long for kids to get in and see a counselor, to connect with someone, you are putting a band aid on the problem with the emergency hot lines."

The COVID-19 pandemic required collaborative effort to address a real and wide-reaching crisis. Collaboration in Nebraska has improved as partners have had to work together to maximize their impact and align services. To address the mental health needs of Nebraskans, partners are prioritizing collaboration and expanding reach. In 2024-2025, Title V will leverage the Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP) to guide collaboration with partners working on suicide prevention. Statewide, Title V will attend quarterly meetings for the Nebraska Statewide Suicide Prevention Coalition and offer support and funding as it is needed. Nebraska Title V works with the Nebraska Department of Education Office of Coordinated Student Support Services in multiple collaborative projects, including through NEP-MAP, through Bring Up Nebraska (see the Child Health domain), and through the Connecting Families Network (see the Children with Special Health Care Needs domain).

Opportunities for collaboration are vast and Title V plans to promote utilization of Nebraska's 988 suicide and crisis lifeline in 2024-2025. In 2020, Congress designated the new 988 dialing code to operate through the existing National Suicide Prevention Lifeline. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the lead federal agency, in partnership with the Federal Communications Commission and the Department of Veterans Affairs and Vibrant Health. In Nebraska, most calls are fielded in-state and support is available via text and chat. Title V will work with community health workers to promote the lifeline.

Since 2021, Title V has awarded funds to community-based organizations for child and adolescent related Title V priorities. In 2024-2025, Title V will fund five community-based organizations to support suicide prevention. As wait lists to see providers are long and travel is often necessary, investment in community level supports may help prevent some treatment needs and increase social support for everyone. Title V will monitor progress in each community to assess if there are interventions that could be effectively scaled up for expanded reach.

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.

The recent increase in syphilis rates requires action. Nebraska is providing Adolescent and Reproductive Health program awardees with support to provide education about syphilis to youth and young adults. NDHHS is partnering with the Office of the Assistant Secretary for Health and Centers for Disease Control and Prevention to increase awareness and availability of at-home testing for syphilis.

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. The new strategy to promote utilization of the 988 suicide and crisis lifeline is a response to the increased need for this priority.

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

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

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 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: Motor Vehicle Crashes among Youth	
	Proposed for 2024-2025
How much did we do?	Strategy AD6a(2) and AD6a(3): How many students were reached through the TDS program? Strategy AD6a(2): What outreach was provided for counties with high risk for motor vehicle crashes?
How well did we do it?	Strategy AD6a(2): How many additional schools started TDS? Strategy AD6a(2): How many schools in high risk counties started TDS? Strategy AD6a(2): Did the OIP raise awareness that the county was high risk?
Is anyone better off?	Strategy AD6a(2): Is the county taking action to reduce risk?

Results Based Accountability (RBA) measures Priority: Sexually Transmitted Diseases among Youth	
	Proposed for 2024-2025
How much did we do?	Strategy AD7a(1): How many releases and updates of the Conversation Starters / Chatterbox Chats were shared? Strategy AD7a(2): How many cohorts of MAD have been implemented? Strategy AD7a(3): How many partner organizations and underserved/ disproportionately affected groups were engaged by ARH?
How well did we do it?	Strategy AD7a(1): How many people reported using the Conversation Starters / Chatterbox Chats via QR code survey? Strategy AD7a(2): How many youth were served by the MAD curricula focused on STDs? Strategy AD7a(2): What percent of youth who completed the MAD curriculum correctly identifying that the most effective way to prevent STDs/STIs is to not have sex? Strategy AD7a(3): Did the partner organizations/groups reach youth or youth serving professionals with their proposed activities?
Is anyone better off?	Strategy AD7a(2): Did MAD participants felt like the discussions and activities helped them learn program modules? Strategy AD7a(3): How many adolescents utilized reproductive health services after receiving referral?

Results Based Accountability (RBA) measures Priority: Suicide among Youth	
	Proposed for 2024-2025
How much did we do?	Strategy AD8a(1): How many statewide suicide prevention meetings did Title V staff participate in? Strategy AD8a(2): How did Title V promote use of the 988 suicide and crisis lifeline? Strategy AD8a(3): How many counties do the Title V subawards reach for suicide prevention efforts?
How well did we do it?	Strategy AD8a(1): What gap area is Title V helping address in statewide suicide prevention?
Is anyone better off?	Are Title V staff and partners aware of and promoting the 988 suicide and crisis lifeline? Is the 988 suicide and crisis lifeline use increasing over time?

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 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 7/2024**
Year 1	• Collect data from schools that are/are not TDS schools • Distribute materials to schools via school nurses • Evaluate effectiveness of distribution.	• Completed • Completed • Completed
Year 2	• Teens in the Driver Seat outreach • School Health communication channels • Driver safety education materials for minority groups	• Completed • Completed • Interrupted
Year 3	• Teens in Driver Seat • Promote TDS through partners • Implement Health Equity planner • Target teen driver safety programming efforts on high crash rate counties (with epi support)	• Ongoing • Ongoing • Planned • Ongoing
Year 4	• Implement Teens in Driver Seat programming • Use planning tool to guide TDS expansion • Promote TDS through partners • Target TDS programming efforts in high crash rate counties	• Ongoing • Planned • Ongoing • Planned
Year 5	• Teens in Driver Seat • Target TDS programming efforts in high crash rate counties	

In the priority of Motor Vehicle Crashes, there are changes to the strategies including the addition of a strategy to target teen driver safety programming efforts in counties with high teen crash rates and the inclusion of on-going community-based work on motor vehicle crash prevention through subaward agreements. The strategy for general expansion of the TDS program was revised to be more targeted. These strategies build on work done in 2020-2023.

Priority: Sexually Transmitted Diseases among Youth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2024**
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 • Cancelled • Completed
Year 3	• Finalize & Distribute Conversation Starters • Implement MAD curriculum • Fund local agencies (ARH)	• Ongoing • Ongoing • Ongoing
Year 4	• Implement Conversation Starters with CQI • Explore IDD and develop training/programming • Implement MAD curriculum • Continue collaborations with state & local agencies • Fund local agencies (YYA (formerly ARH)) and assess plans for future funding	• Ongoing • Planned • Ongoing • Ongoing • Ongoing
Year 5	• Implement Conversation Starters/ Chatterbox Chats with CQI • Implement MAD curriculum • Continue collaborations with local agencies	

In the priority of STDs among youth, Title V broadened the third strategy from a focus on subawards to broadly supporting projects to promote sexual health among underserved and disproportionately affected groups.

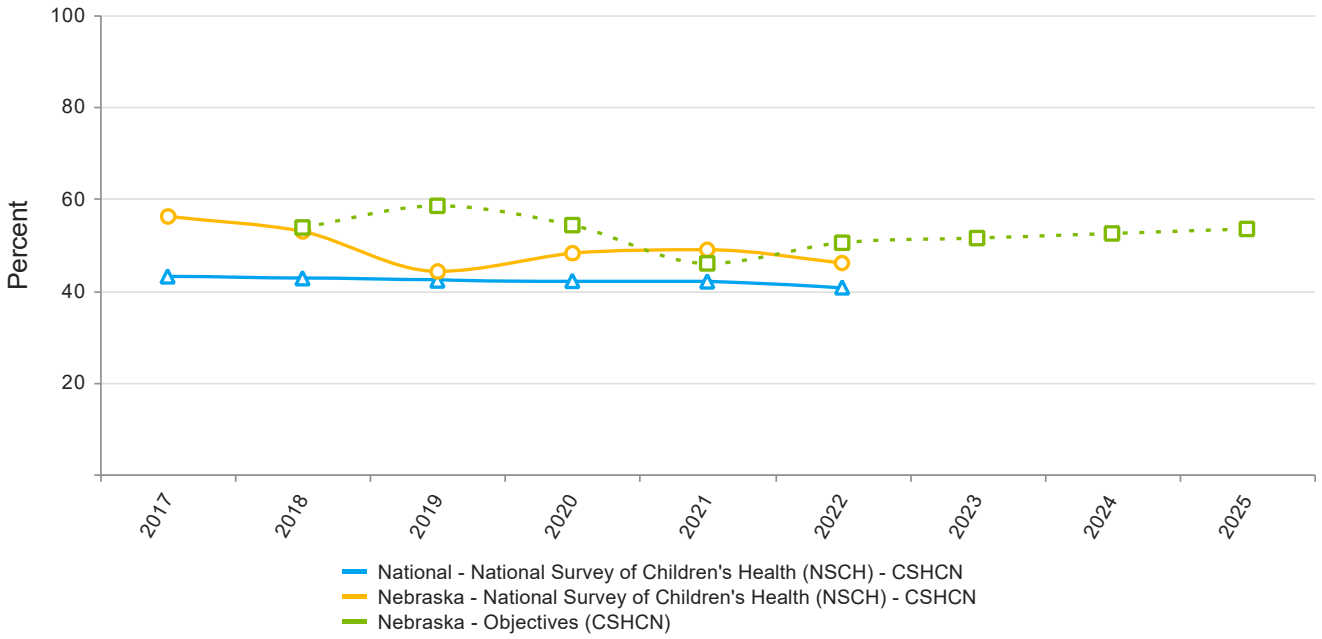
Priority: Suicide Among Youth 5-year Action Plan, 2020-2025		
Period	**Summary activities of the period**	**Status 7/2024**
Year 1	• School Health program increases activity in mental and behavioral health in schools • Participate in Garrett Lee Smith prevention grant management team • Participate in 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	• Suicide Prevention and Behavioral Health in Schools • GLS and NSSPC participation • Promote 988 suicide and crisis lifeline • Community-based suicide prevention subawards	• Ongoing • Ongoing • Planned • Ongoing
Year 5	• Partner to support suicide prevention and behavioral health in schools • Nebraska Statewide Suicide Prevention Coalition participation • Promote 988 suicide and crisis lifeline • Community-based suicide prevention subawards	

There are no changes in strategies compared to 2023-2024. Additional activities will support the strategies and these are discussed above.

Children with Special Health Care Needs

National Performance Measures

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



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	58.4	54.2	45.9	50.4	51.4
Annual Indicator	53.1	45.0	49.4	50.1	46.0
Numerator	44,838	39,911	42,610	38,765	38,965
Denominator	84,509	88,648	86,203	77,381	84,678
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	52.4	53.4

Evidence-Based or –Informed Strategy Measures

ESM MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator

Measure Status:			Active
State Provided Data			
	2021	**2022**	**2023**
Annual Objective			90
Annual Indicator		88.5	90.5
Numerator		85	86
Denominator		96	95
Data Source		Parent Resource Center Family Satisfaction Survey	Parent Resource Center Family Satisfaction Survey
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	95.0	95.0

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 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year 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 work with University of Nebraska Medical Center's Munroe Meyer Institute (UNMC MMI) to maintain the family collaborative and convene statewide stakeholders to identify a continuum of needed family supports.	
CS9a(2): MHCP will work with UNMC MMI to continue the Parent Resource Coordinator (PRC) project, supporting families with CYSHCN age birth to 21 years.	
CS9b(1): Participate in collaborations with partners, networks, programs, and projects working with schools to address disparities and promote equitable access and engagement with mental/behavioral health resources.	
CS9b(2): Partner with Children's Nebraska (formerly the Children's Hospital and Medical Foundation) and Nebraska Department of Education to provide continuing education on mental and behavioral health best practices for school health professionals.	
ESMs	**Status**
ESM MH.1 - The number of CYSCHN families who have contact with a Parent Resource Coordinator.	Inactive
ESM MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator	Active

NOMs

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

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Children with Special Health Care Needs - Annual Report

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, 2022 to September 30, 2023. This represents the third 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 2022-2023, with NPM, SPM, and ESM statements for the period are as follows:

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 percentage of families who are satisfied with supports provided by the Parent Resource Center

1. Context: The State of the CYSHCN Population Domain

Through 2023, the Medically Handicapped Children's Program and dedicated CYSHCN funding from Title V was administered by the Division of Children and Family Services until January 2024 when it transitioned to the Division of Developmental Disabilities. 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 2022-2023, 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 clinics are offered in-person and via telehealth services 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 CYSHCN. 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. 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 CYSHCN 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.

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. In 2022-2023, services to support CYSHCN were also delivered by Nebraska's school health nurse consultant. Through this workstream, Title V complemented 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 served in the school setting, including disparities.

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

Priority: Behavioral Health in Schools

2022-2023 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 supports to families with 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.

Summary of Programmatic Efforts

In 2023, the University of Nebraska Medical Center, Munroe-Meyer Institute (UNMC MMI) developed the Connecting Families Network in response to an RFA that sought applicants to convene 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.

During this period, UNMC MMI hired a project manager and a project assistant. The project manager assists with planning, coordination, and organization of meetings, resources, and project personnel. They are responsible for the day-to-day work of the project including supervising the project assistant(s), communication with steering committee members, planning logistics for an annual conference, compiling, and summarizing information, coordinating with the program evaluators conducting survey and focus groups, and assisting the project director and co-director with any additional needed tasks.

UNMC MMI recruited and onboarded a Steering Committee of community stakeholders and leaders in school-based mental health. The Steering Committee includes two parent representatives, a coordinator of Nebraska MTSS/PBIS from the NE Dept of Education, a parent/special education lawyer, two members with ties to Nebraska's Native American communities throughout the state, and mental health expertise, Kim Foundation Executive Director, representative from Disability Rights NE, representative from PTI Family2Family Health Information Center, representative from NE Title V programs, UNO School Psychology faculty member, School Social Work Coordinator with Children's Hospital, director of Independence Rising Independent Living Center, representative from NE Division of Behavioral Health, and a director of special education in a western NE rural school district.

The NCF Steering Committee had its first meeting on June 30, 2023. This meeting reviewed and discussed the

goals/objectives of the NCF project and determined the initial steps. The second meeting was August 25, 2023. The Steering Committee meets quarterly. Three subcommittees of Steering Committee members were formed: Mental/Behavioral Health Resources Identification/Dissemination, Family Assessment, and Collaboration Summit planning. The subcommittees also include members of the NCF MMI team who participate in the committees and support the work of the Steering Committee members. The NCF MMI team meets every three weeks to review the progress of the subcommittees, discuss and remediate any issues or concerns, and plan the next steps. The NCF leadership team (2 Co-directors, project manager, project assistant) meets every two weeks to review progress and discuss and remediate any issues or concerns, and plan the next steps.

Additionally, MMI partnered 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. Parent Resource Coordinators provided 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 are 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. From October 1, 2022, through September 30, 2023, the Parent Resource Coordinators served 2,947 children and families. Most children and families received case management services (intensive support—more than 30 minutes spent with family) while fewer received information and referral (light touch—less than 30 minutes with family) only. The community resources most requested were related to care coordination, family 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). The PRCs were vital in referring children with special health care needs to the Early Development Network (EDN) and Early Development Special Education (EDSE). Between October 1, 2022 and September 30, 2023 PRCs referred 520 families for EDN/EDSE referral. 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: 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.

Summary of Programmatic Efforts

The 2022-2023 period was a year of growth and capacity building for the Title V team because the staff tasked with supporting collaboration within the NDHHS Division of Public Health had turnover in 2022 and 2023.The MCH Program Manager / Title V Coordinator started in the position in August 2022 and the team hired a Children's Health Program Specialist in April 2023. Much of this reporting year was spent learning about past and on-going activities with school health, the Nebraska Partnership for Mental Health Care Access in Pediatrics (NEP-MAP), and the Nebraska Department of Education.

Of note, staff learned about communities that had received grant-funding from the Substance Abuse and Mental Health Services Administration (for Project AWARE). The Nebraska Department of Education (NDE) passed Project AWARE funding on to three communities for a five-year period starting in 2018. In 2021, NDE received additional funding to support

three more communities. The purpose of the funding was to build or expand the capacity of state educational agencies, in partnership with state mental health agencies overseeing school-aged youth and with three local education agencies, to:

1. Increase awareness of mental health issues among school-aged youth;
2. Provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues; and
3. Connect school-aged youth, who may have behavioral health issues (including serious emotional disturbance or serious mental illness), and their families to needed services.

As the first five-year period neared completion, the three communities who received initial funding have shared "lessons learned" with other communities and educational service units (ESUs). Nebraska's Partnership for Mental Health Care Access in Pediatrics (NEP-MAP) has been interested in the ways the communities have been able to address mental health needs within schools.

Title V staff participated in NDE's School Mental Health Advisory Committee. Responding to state legislation, the Advisory Committee defined what a "behavioral health point of contact" is for each school building, identified the Nebraska Resource and Referral System as a registry of state and local behavioral health resources available to work with students and families by geographic area, and established a mental health first aid training program for teachers and other personnel employed by a school district or an educational service unit receiving funds from a specific NDE grant.

Title V has increased 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 through partnership with Children's Nebraska. In 2022, the School Health Nurse Consultant position moved from NDHHS to Children's Nebraska with funding support from NDE. Children's Nebraska developed a school health focus that included a School Social Work Coordinator. With Title V support, this team oversees Nebraska's school nurse listserv and forum, sharing communication, upcoming events, and providing a space for school nurses to talk to other nurses from across Nebraska.

Use of Evidence-based or Evidence-informed Approaches in this Objective.

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 percentage of families who are satisfied with supports provided by the Parent Resource Center

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

Discussion of Performance Measurement and Other Programmatic Impacts: Results-based Accountability Measures

Since 2015, Nebraska Title V has been writing and utilizing Results-based Accountability (RBA) measures in an effort to make annual impacts and achievements more discernable to front-line staff and stakeholders. 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 for 2022-2023 **Behavioral Health in Schools**	
How much did we do?	Q: How many families worked with a PRC? A: 2,947 families Q: Was the Family Collaborative opportunity released? Did an agreement get executed? A: Yes, yes!
How well did we do it?	Q: Did families get appropriately matched with a PRC reflecting their cultural background and/or language of choice? A: Yes – if their language of choice was English or Spanish Q: Were stakeholders involved in the design of the Collaborative? How many stakeholders were engaged? A: Yes, between 20-30 stakeholders were engaged in the Connecting Families Network
Is anyone better off?	Q: What were the results of the family satisfaction survey? A: 99% of respondents felt comfortable working with their PRC and that their PRC was knowledgeable. Q: Did the Collaborative have any measurable impacts? What were they? A: Not yet, the collaborative work began in Summer 2023.

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

Nebraska needs 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. Health and community systems of care cannot fully meet these needs, especially for disadvantaged and minority youth, with traditional approaches. Nebraska's Partnership for Mental Healthcare Access in Pediatrics supports the following strategies to address this need:

- Tele-behavioral health use

- School-based mental health services, often in partnership with local community provider organizations
- Universal screening of children and youth, accompanied by effective referrals

Title V is working with partners like Children's Nebraska and the Nebraska Department of Education to support these strategies.

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

Title V aims to widen the lens of the CYSHCN domain to include the Maternal and Child Health program and address the needs of all children with mental and behavioral health needs. By widening the lens to include mental and behavioral health, Title V hopes to reduce stigma, include more families, and align more fully with the population level strategies.

Children with Special Health Care Needs - Application Year

In this section, Nebraska MCH Title V describes planned activities in the **Children and Youth with Special Health Care Needs (CYSHCN) Domain** for the period October 1, 2024, to September 30, 2025. This represents the fifth 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 2024-2025 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

1. **Description of Planned Activities**

Priority: Behavioral and Mental Health in School

2024-2025 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): MHCP will work with University of Nebraska Medical Center's Munroe Meyer Institute (UNMC MMI) to maintain the family collaborative and convene statewide stakeholders to identify a continuum of needed family supports

Strategy CS9a(2): MHCP will work with UNMC MMI to 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 Medically Handicapped Children's Program (MHCP) was recently moved from the Division of Child and Family Services (DCFS) to the Division of Developmental Disabilities (DD). The MCHP provides medical support services to children and youth with special health care needs in low-income families. The move from DCFS to DD reflects an effort by NDHHS to align service support around life-course needs. 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.

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 addition to the services directly provided through the Medically Handicapped Children's Program, MHCP's 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 systems of care to get the services for their children. The Parent Resource Coordinators have children of their own with special health care needs and complete training to serve the families. Parent Resource Coordinators (PRC), who are CYSHCN family members, are placed in medical clinics throughout the state to help other CYSHCN families get connected to early intervention services, special education services, and other community social and health resources because they have experience with relevant systems of care. PRC support includes mentorship with families and medical clinic providers to enhance the coordination between education, medical, and social supports for families.

UNMC MMI also coordinates the Clinical Demonstration Project, including training and tele-behavioral health consultation for primary care providers, through Nebraska's pediatric mental health care access program, Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP).

Starting in 2023, UNMC MMI created a network to connect CYSHCN families to each other and existing services. This network, the Connecting Families Network has become a community collaborative with partners, organizations, school personnel, students, families, advocacy groups, and/or other. The goal is to create a space where stakeholders 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 to enhance the services and supports available for youth in schools who need mental and behavioral health supports across the state of Nebraska.

As described above, in partnership with the MHCP, UNMC MMI will continue the Connecting Families Network through 2025. Activities that the Network will work on in 2024-2025 include:

- Hosting an annual conference to convene stakeholders
- Understanding mental and behavioral health resources available to students and families and recommending ways to improve access and utilization of resources
- Administering focus groups to understand what families think and say about their attempts to find and utilize mental and behavioral health services for their children.
- Developing a white paper to summarize their work and recommendations for Title V

The group will develop a white paper that summarizes steps Title V and Nebraska systems can take to improve access to and engagement with existing resources which lead to disparities related to lost instruction time for students in school with mental and behavioral health needs, disproportionate suspension of children with disabilities (especially those who are minorities), and harsher discipline practices time for students with mental and behavioral health needs which lead to long-standing, inequities.

During 2024-2025, MHCP will continue its partnership with the University of Nebraska Medical Center Munroe-Meyer Institute (UNMC MMI) to deliver direct medical services to CYSHCN throughout Nebraska through the Family Care Enhancement Project. The project promotes the principles of family-centered care in a medical care setting and parent-to-parent mentorship. 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 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.

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): Participate in collaborations with partners, networks, programs, and projects working with schools to address disparities and promote equitable access and engagement with mental/behavioral health resources.

Strategy CS9b(2): Partner with Children's Nebraska (formerly the Children's Hospital and Medical Foundation) and Nebraska Department of Education to provide continuing education on mental and behavioral health best practices for school health professionals.

Discussion of Activities for this Objective – Relevance to Identified Priority

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 societal stressors. Staff changes within the Maternal Child Health (MCH) program have impacted how Title V addresses this identified need. For the past 10+ years, the MCH program has had a school health program staffed by a School Nurse Consultant. In April 2022, this position moved to Children's Nebraska (formerly Children's Hospital and Medical Center) with funding support from the Nebraska Department of Education. To add capacity and partnership reach to Title V, the MCH program broadened the remaining position to focus on children's health instead of narrowly focusing on school health. Title V aims to build the capacity of schools and other community organizations to serve students and families well when they have mental and behavioral health issues.

In 2024-2025, Title V will collaborate with partners, systems, resources, and actors that have an interest in mental health and well-being of school-aged children and youth in Nebraska. As a coordinated response to recent legislation the Nebraska Department of Education developed a School Mental Health Advisory Committee. Title V is active in this committee. In 2023 the Committee responded to new state legislation that required each school district to designate one or more behavioral health points of contact for each school building or other division as determined by the school district. The legislation also required the Nebraska Department of Education (NDE) and the NDHHS Division of Behavioral Health (DBH) to develop a registry of state and local behavioral health resources available to work with students and families by geographic area. After thorough conversation and exploration of existing resources in Nebraska, NDE and DBH chose to promote the existing Nebraska Resource and Referral System. In 2024-2025, Title V staff will continue to support the efforts of NDE, Children's Nebraska, and DBH to support mental health in schools and promote trainings that reach both the behavioral points of contact at schools and (when they are different) school health nurses in schools. As part of these efforts, the partnership will utilize the network developed through the 2024-2025 "Enhancing School-based Health and Mental Health Services through Training, Education, Assistance, Mentorship, and Support (TEAMS)" Cohort with the American Academy of Pediatrics (AAP).

A response from the 2024 Public Input survey highlights the growth opportunities for Title V for this priority need, "Please include preschools/childcare centers in this area, we are seeing many behavioral issues at a very young age that if we can get help for while the brain is still developing, we can potentially stop the upper grades in the school from having issues." Title V is committed to expanding partnership to reach new partners in 2024-2025.

Across the state, the need for mental and behavioral health access and referrals has resulted in increased funding and programming. On-going projects that Title V will support include

- Project AWARE through the Department of Education (funded by the Substance Abuse and Mental Health Services Administration) through 2026
- An Intellectual and Development Disabilities Toolkit to Support Connections in Schools from The Arc of Nebraska
- Healthy Schools Program through NDE
- Regional trainings offered by the Mental Health Technology Transfer Center Network
- Trainings from the Behavioral Health Education Center of Nebraska at the University of Nebraska Medical Center

A suggestion from the 2024 Public Input survey prompted the Title V team to consider restorative justice in schools as a topic for training for 2024-2025. The respondent wrote, "There is very little conversation in rural Nebraska for restorative practices with discipline issues in school. This is one of the most-widely proven effective strategies to enhance school culture and make more meaningful impacts in individuals. When I bring this up to school administrators it is like they are hearing it for the first time. Their first question is always around capacity as well, so building strategies that uses the already-existing models of restorative practices that are out there (and not hard to learn) can help a school build a coordinated plan that comes out when needed." This will be explored more with partners like NDE, DBH, and Children's Nebraska.

In 2024-2025, NDHHS 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. NEP-MAP (Nebraska Partnership for Mental Health Care Access in Pediatrics) is aligning efforts with NDE, Children's Nebraska, and Title V to support mental health services offered in schools. NEP-MAP is conducting interviews with school mental health staff to identify best practices to provide sustainable mental health services. In 2024-2025, NEP-MAP will promote these best practices and

work with partners to provide technical assistance and funding support (when possible) to increase adoption of these best practices.

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

In April 2021, Nebraska received 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 concluded 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 percent. In 2024-2025, 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 2024-2025
How much did we do?	Strategy CS9a(2): How many families worked with a PRC? Strategy CS9b(1) and (2): How many statewide projects did Title V staff collaborate on related to this priority?
How well did we do it?	Strategy CS9a(1): How many stakeholder groups were involved in the Nebraska's Connecting Families Network? Strategy CS9a(2): Did families get appropriately matched with a PRC reflecting their cultural background and/or language of choice? Strategy CS9b(2): Did the Title V collaborations result in increased capacity of schools for behavioral health access and referrals? For equitable behavior management practices?
Is anyone better off?	Strategy CS9a(2): Did most families that work with PRCs have positive family satisfaction survey results? Strategy CS9a(1): Did the Collaborative have any measurable impacts? What were they? Strategy CS9b(2): Did people who received training and outreach about behavioral health resources think it would improve their utilization of school and referral resources?

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

This section is not applicable in the CYSHCN 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 7/2024**
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) Support development of Connecting Families Network (renamed from Family-Systems Collaborative) • (Public Health) Collaborate with school health partners • (Public Health) Increase capacity of schools and other community orgs to respond to mental and behavioral health needs	• Ongoing • Ongoing • Ongoing
Year 5	• (MHCP) Connecting Families Network completes resource mapping and identify needs • (Public Health) Evaluate built capacity with schools and other community orgs to respond to mental and behavioral health needs.	

There are no changes proposed for the action plan compared to 2023-2024. Additional activities will support the strategies, and these are discussed above.

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	2022	2023
Annual Objective			62.5	64.3	64.9
Annual Indicator	64.1	61.3	63	63.6	61.9
Numerator					292,971
Denominator					473,344
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	66.2	67.5

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
Five-Year 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): Support Community Health Worker (CHW) workforce development activities, working with cross-divisional and cross-sector partners to promote access to training such as QPR Suicide Prevention, Mental Health First Aid, and trauma-informed care training, with the objectives of improving referrals to care, and reducing stigma about mental and behavioral health issues.
XC10a(2): Coordinate CHW workforce development activities with the CHW Collaborative, including development of a sustainable infrastructure led by CHWs that supports connection with other CHWs.
XC10b(1): Conduct outreach and education on Medicaid redetermination efforts to promote enrollment and improve access to care, particularly for disparate and disadvantaged women of childbearing age, and other parents/caregivers.
XC10b(2): Promote screening, referral, and treatment in primary care by leading activities in Nebraska’s Pediatric Mental Health Care Access Program, Nebraska Partnership for Mental Health Care Access in Pediatrics (NEP-MAP).

Cross-Cutting/Systems Building - Annual Report

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, 2022, to September 30, 2023. This represents the third 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 2022-2023, with NPM, SPM, and ESM statements for the period are as follows:

Priority: 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:

1. 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.

2. 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 since 2017. Many stakeholders, allies, and community health workers participate in Title V-led or hosted activities. In the 2022-2023 period, one report on the CHW Workforce was published on the NDHHS CHW webpage, www.dhhs.ne.gov/MCASH-CHW. In collaboration with the University of Nebraska, Title V published "An Assessment of the Community Health Worker Workforce in Nebraska during COVID-19." In 2022-2023, Title V continued

supporting the CHW Consultant-Trainer Cadre, a group of eight CHWs from across Nebraska. The Cadre guides Title V workforce development activities, demonstrating fidelity to “nothing about us without us.”

During the 2022-2023 period, the University of Nebraska Medical Center, Creighton University, and the Nebraska Association of Local Health Directors applied for and received funding from the Health Resources and Services Administration to develop training programs for CHWs in Nebraska. In 2023, each funded organization launched trainings for CHWs across Nebraska.

Medicaid Expansion / Redetermination

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. According to the Nebraska Medicaid Annual Report for State Fiscal Year 2023, over 75,000 Nebraskans enrolled in Medicaid Expansion. This represents a significant opportunity for some of the most vulnerable Nebraskans to access health insurance. The end of the COVID-19 related Public Health Emergency (PHE) ended the period of continuous enrollment on March 31, 2023, and required that all Medicaid enrollees must have their eligibility redetermined annually after April 1, 2023.

The Rising Tide of Mental Health Needs

Stakeholders were concerned about mental and behavioral health issues of MCH populations in the 2015-2020 needs assessment cycle. These concerns continued to emerge throughout the population as the 2020 needs assessment was completed. Mental health topics and considerations were pervasive in every domain group and coalesced in the Cross-Cutting Domain. Mental health needs were also prioritized in the Adolescent and Children with Special Healthcare Needs Domains.

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

2022-2023 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.

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.

Summary of Programmatic Efforts

During the period, the CHW Cadre met monthly to discuss CHW sustainability and training.

Throughout the 2022-2023 period, the Cadre was re-engaged after a brief pause because of staff changes in the MCH Program Manager position in summer 2022. Due to this pause and increased statewide capacity for CHW trainings, the Cadre focused most of its 2023 efforts on supporting CHW sustainability and building a CHW Facebook Page (viewable by anyone) and Group (viewable by people who ask to join and can be verified as being CHW-adjacent and in/around Nebraska). The Cadre envisioned the Facebook Page and Facebook Group as a venue for CHWs to connect and hear about upcoming trainings and statewide efforts to support CHW sustainability. The page was launched in July 2023.

The CHW Cadre hosted two trainings in the 2022-2023 period. The Cadre promoted Medicaid redetermination efforts by hosting a webinar on Medicaid Redetermination to encourage healthcare staff to talk to their clients and communities about

the changes in Medicaid eligibility determination. The webinar was held three times, in May and June 2023, and about 50 people attended each training. The Cadre hosted a webinar about the Impact of Intimate Partner Violence in August 2023 and 30 people attended.

As mentioned in the Context section above, during the 2022-2023 period the University of Nebraska Medical Center, Creighton University, and the Nebraska Association of Local Health Directors received funding from the HRSA to develop training programs for CHWs in Nebraska. Title V was eager to hear about the awards and convened partners in early 2023 to discuss ways to align efforts and curriculum of the new programs. The newly funded programs are building CHW knowledge and capacity and organizational capacity to use CHWs. With a focus on sustainability, the conversation with CHW stakeholders turned to sustainability. Nebraska's Medicaid and Long-Term Care division attended the early 2023 meeting and discussed Medicaid reimbursement options for CHWs. The staff outlined the process to work towards reimbursement and stakeholders present expressed interest in this work. Throughout the 2023 year, the MCH program facilitated conversations between stakeholders to explore the requirements for a State Plan Amendment, one of which was a certification process to standardize who could provide CHW services. This work continued into the next reporting period.

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).

Summary of Programmatic Efforts

Title V supported outreach and education on Heritage Health Adult through the CHW Cadre's Medicaid Redetermination webinars hosted in May and June 2023. The webinar was held three times and a total of 150 people attended.

The NDHHS Women and Men's Health Programs also promoted outreach and education on Heritage Health Adult by discussing Medicaid with every woman who utilized their program services. During this period, 661 women received information about Medicaid eligibility and enrollment.

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 (PMHCA) program. In 2022-2023, Nebraska was in Year 5 of 5 planned years of project operations. In June 2023, NEP-MAP applied for continued PMHCA funding after conversation with all NEP-MAP partners about interest and capacity for future work. Gratefully, Nebraska received continued PMHCA funding for 2023-2026.

During this reporting period, NEP-MAP continued the clinical demonstration project (providing consultation services to rural-based primary care providers needing assistance treating or referring patients) and offered screening/referral tools to encourage community-based service utilization. NEP-MAP supported Reach Out and Read (an early childhood reading program which draws on the relationship between primary care provider and young families to distribute books), developed and piloted a Person- and Family-Centered Care Coordination training with UNMC, and expanded its access promotion to reach schools through partnership with the University of Nebraska Public Policy Center. NEP-MAP engaged its Advisory Committee and built deeper collaborative relationships with the Nebraska Department of Education and Nebraska's Children's Hospital. All NEP-MAP projects aim to increase the capacity of healthcare providers to screen, refer, and treat mild to moderate mental and behavioral health issues in children and youth.

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

3. 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. 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.

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

Results Based Accountability (RBA) measures for 2022-2023 **Improved access to and utilization of mental health care services by MCH populations**	
How much did we do?	Q: 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? A: Zero, largely due to staff turnover and increased statewide capacity for CHW training Q: How many CHW are active in the CHW Consultant Trainer Cadre? A: 8
How well did we do it?	Q: Were offered training activities utilized by CHW? Did individuals or groups utilizing training represent target populations? A: Yes, 150 CHWs from across Nebraska attended CHW Cadre trainings. Q: What is the distribution of participation in the Cadre by Behavioral Health region? (Is statewide reach successful?) A: The Cadre has membership from 4/6 behavioral health regions in Nebraska.
Is anyone better off?	Q: What were evaluation results of training – was any improvement indicated? A: Evaluations for the Medicaid Redetermination were solicited and few attendees completed the evaluation. Q: What were evaluation results of training – was any improvement indicated or action taken? A: Only four of 150 participants completed the evaluation and thus Title V did not use the evaluations to make improvements.

Other Programmatic Impact

Despite a small 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 CHWs 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. Additionally, the new Facebook Page and Group for CHWs help spread training messages to CHWs across Nebraska.

Similarly, 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.

5. Challenges and Emerging Issues

Nebraska has many engaged stakeholders who would like to see the CHW workforce grow and thrive to promote equity and improved population health outcomes. 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 annual recognition awards.

Progress towards sustainability is driven by committed partners, however, Title V can support only one staff member for all components of emerging and dynamic activity, along with other existing responsibilities in other program areas. Future work for CHW sustainability includes moving towards a certification model for Nebraska CHW and supporting efforts towards Medicaid reimbursement. Title V must continuously evaluate its own capacity, as well as that within the broader agency and in partner organizations, to offer a solution for this next phase of CHW development.

6. 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 NDHHS can keep pace with expanded and accelerated growth in activities. In addition, consideration needs to be made 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

In this section, Nebraska MCH Title V describes planned activities in the **Cross-cutting/Systems-building Domain** for the period October 1, 2024 to September 30, 2025. This represents the fifth 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 2024-2025 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.

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. Through this work, Title V has developed many cross-sector partnerships with deep commitment 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 in Medicaid Expansion (passed by voters in 2018, opened for enrollment 2020), is of specific significance to Title V and many stakeholders.

Title V has participated and invested in Community Health Worker workforce development activities in Nebraska since 2017, along with other statewide 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.

1. Description of Planned Activities

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): Support Community Health Worker (CHW) workforce development activities, working with cross-divisional and cross-sector partners to promote access to training such as QPR Suicide Prevention, Mental Health First Aid, and trauma-informed care training, with the objectives of improving referrals to care, and reducing stigma about mental and behavioral health issues.

Strategy XC10a(2): Coordinate CHW workforce development activities with the CHW Collaborative, including development of a sustainable infrastructure led by CHWs that supports connection with other CHWs.

Discussion of Activities for this Objective – Relevance to Identified Priority

Recent years have seen a rise of mental health issues in Title V populations locally, statewide, and nationally. 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 Title V must be a vocal supporting partner to stakeholders leading efforts in this field (i.e., the NDHHS Division of Behavioral Health, the Society of Care, regional 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.

To “center” rather than “engage” CHWs in workforce development, Title V developed the CHW Consultant-Trainer Cadre by contracting with individual CHWs and forming a leadership collaborative. In 2024, the Cadre renamed themselves the CHW Collaborative to broaden their potential reach in supporting CHW workforce development in Nebraska. Contracts with CHW will be continued into the 2024-2025 year, providing the mechanism to reimburse individuals for their time and expertise as they continue to develop this workforce.

In 2020-2021, Title V began an initiative to assure CHWs 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. Since 2020, Title V has continued to build and promote a training calendar of offerings delivered by prevention coordinators and trainers across Nebraska.

The CHW Collaborative has identified specific workforce development initiatives to support sustainability of CHWs across Nebraska. Workforce development topics identified by the CHW Cadre include:

- Develop evidence-based trainings
- Promote workforce training efforts for CHWs across Nebraska
- Engage CHWs in Nebraska (via Facebook page and group for CHWs)
- Promote outstanding service in Nebraska with CHW Awards
- Participate in the NEP-MAP Advisory Committee
- Develop an action plan supporting advocacy and sustainability

In 2024-2025, the CHW Collaborative will promote continuing education opportunities for CHW, assist CHW efforts to connect with individuals in the community using the Facebook page, trainings, and via email, and try to reduce stigma using a culturally appropriate lens. In 2024-2025, Title V staff will encourage the Collaborative to discuss sustainability of the CHW Collaborative as the Title V funding is a short-term support.

Objective XC10b: By 2025, increase screening, referral, and treatment in primary care for mental and behavioral health.

Strategy XC10b(1): Conduct outreach and education on Medicaid redetermination efforts to promote enrollment and improve access to care, particularly for disparate and disadvantaged women of childbearing age, and other parents/caregivers.

Strategy XC10b(2): Promote screening, referral, and treatment in primary care by leading activities in Nebraska’s Pediatric Mental Health Care Access Program: Nebraska Partnership for Mental Health Care Access in Pediatrics (NEP-MAP).

Discussion of Activities for this Objective – Relevance to Identified Priority

Title V shifted the strategy in this objective from purely Medicaid Expansion to focus on Medicaid redetermination efforts in 2023-2024 because the Public Health Emergency declared by the federal government ended in 2023. With the expectation that some current participants will be determined to be ineligible, it is important to ensure that clients are aware of the return to determination of eligibility 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. In 2024-2025, the Community Health Worker Collaborative will promote Medicaid eligibility requirements and share general information about how CHWs can support people who qualify for Medicaid (including support in maintaining Medicaid coverage).

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 2024-2025 program year, NEP-MAP plans to:

- Maintain a cross-systems advisory committee that includes strong family representation

- Maintain a provider-to-provider behavioral health consultation services and promote utilization of the consultation services
- Offer mental and behavioral health trainings for care coordination staff, school staff, and primary care provider
- Identify paths to sustainability for NEP-MAP activities.

Public input survey responses for this domain highlighted the need for Title V to broadly consider mental health providers, especially statewide access to providers. This can be seen in the following responses:

- “Access to screening is challenged by limited providers, especially in rural areas.”
- “The biggest barrier here is lack of providers. Maybe incentives for providers in rural areas or scholarships for providers that come back and give several years to rural communities.”
- “There are not enough mental health services available. It is also very costly and insurance companies do not want to cover it very well and deductibles are so high to meet before they do parents are tending to not seek the help their children need.”
- “You have to find a way to attract more mental health providers to rural Nebraska first before you can do any of these other things. There are already wait lists to see some providers in more urban areas. People would like to see someone locally vs driving for a few hours or doing telehealth.”

Feedback for this domain highlighted the need to expand the reach of the efforts beyond community health workers. NEP-MAP aims to build primary care provider capacity for mental health service delivery through training and consultation. In 2024-2024, NEP-MAP is exploring ways to engage providers across the state through local partners. Additionally, NEP-MAP is interested in building up statewide capacity for care coordination between clinics, hospitals, and local health departments. Together, the groups will also support strategy XC10a(1).

2. Alignment of planned activities with annual needs assessment updates.

Priority: Improved Access and Utilization of Mental Health Care Services

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 group highlighted the themes of equity and impact of community health workers through the MCH population health data across the life course. 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.

Planned activities included in the 2024-2025 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.

With 2023’s end of the Public Health Emergency that halted Medicaid redetermination efforts in 2020, Nebraska has shifted strategy XC10b(1) to focus on Medicaid redetermination instead of enrollment in Nebraska’s Medicaid Expansion, Heritage Health Adult. There are no new updates for 2024-2025.

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 2024-2025
How much did we do?	Strategy XC10a(1) and XC10b(1): How many of the CHW Collaborative training activities/promotions included Medicaid redetermination, QPR suicide prevention training, mental health first aid, motivational interviewing, and/or trauma-informed care? Strategy XC10a(2): How many paid CHWs are active in the CHW Collaborative? How many CHWs are in the CHW Collaborative network?
How well did we do it?	Strategy XC10a(1) and XC10b(1): Were CHW Collaborative offered training activities attended by 25 or more people? Did individuals or groups utilizing training represent target populations? Strategy XC10a(2): How many of the six statewide Behavioral Health regions are represented by CHW Collaborative members? (Is statewide reach successful?)
Is anyone better off?	Strategy XC10a(1) and XC10b(1): Did CHW Collaborative training evaluation results indicate an increased awareness/understanding of training material? Do attendees report being better equipped to provide culturally and linguistically appropriate services after attending CHW Collaborative trainings?

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. Title V is also intentionally attentive to Medicaid Expansion enrollment and the impact of Medicaid redetermination effort in the coming year. This is relevant for adults, particularly women of childbearing age in the inter-conception 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 7/2024**
Year 1	• 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 • Completed • Completed • Completed
Year 2	• 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	• Completed • Completed • Completed • Completed
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	• Completed • Completed • Completed • Completed
Year 4	• Continue CHW training project; evaluate results • Leverage NEP-MAP to improve primary care screening, referral, and treatment for mental health issues. • Evaluate CHW workforce development activities for sustainability and effectiveness • Promote Medicaid redetermination efforts	• Ongoing • Ongoing • Ongoing • Ongoing
Year 5	• Continue CHW training project; evaluate results • Evaluate CHW workforce development activities for sustainability and effectiveness • Promote Medicaid redetermination efforts	

III.F. Public Input

Nebraska's public input process seeks to involve people who will be impacted by Title V policies and practices, empowering them to contribute to the creation of strategies from the beginning and annually as they are revised. Ongoing public input for the Title V programs takes a variety of forms and allows stakeholders to provide contributions to Title V program's evolution.

Community partners, family leaders, and other stakeholders are actively engaged in the five-year Needs Assessment and 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 drives local community-level projects awarded in response to the Request for Applications (RFA) in 2021 and again in 2024. Nebraska Title V helped support eight community-level projects led by local organizations from 2021-2024 and will support 11 from 2024-2026. These projects 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 each of the separate projects, uniquely designed by and for the respective communities.

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, 2022 – May 31, 2024, there were 340 visits to the public input webpage, 254 unique visitors.

Nebraska begins the new season for comment on the proposed application with an annual announcement that is released within a 90-day window of the submission to HRSA. After its development and submission, the combined 2025 Application / 2023 Report will be available by hyperlink to the Title V Information System (TVIS) where the most current information is available. Public input generally is "always open" and available on the department's website.

When soliciting public input from Nebraskans, the State Action Plan framework is shared for review. The State Action Plan framework provides highlights of the State Action Plan rather than providing the public with complex information held within the application. This allows stakeholders to decipher the state action plan quicker and provide meaningful feedback that can be implemented into the state action plan. This year there were some respondents who wanted to know more about the specifics of the plan than was provided. Staff followed up with these respondents on a case-by-case basis.

In 2024, the annual announcement for public input was disseminated using a combination of delivery methods. This multi-method approach has proven beneficial in past years to extend the message geographically through-out the state and reach a variety of Nebraskans. The announcement was sent via email to Title V stakeholders and requested they send it to their contacts before responding to the State Action Plan framework via survey. NDHHS created social media posts to promote the survey via Facebook and LinkedIn. The social media posts were shared five times between May 22, 2024 and June 5, 2024. The webpage featuring the announcement was removed after the requested response date, as was the survey itself.

Within the 23-day comment period, 87 participants provided feedback to a three-item survey. In 2024, more than twice as many participants as in 2023 provided feedback via the survey. In the demographic item, respondents could identify their role(s) with Nebraska's MCH population, with the ability to select all roles that apply. While most respondents did not identify their role, 33/87 respondents identified as a parent or other caregiver, 23/87 respondents identified themselves as advocates, 23/87 respondents identified themselves as public health professionals, 15/87 respondents said they were a provider of health/human services, 14/87 said they were concerned citizens. The remaining respondents who selected their identity said they had roles like school nurse, teacher, representative of civic organization, home visiting staff, or childcare provider.

The second survey question requested feedback on the strategies in the State Action Plan. The following table summarizes if respondents thought the strategies in the plan would address the priorities. The last column in the table denotes how many comments were left about whether the proposed strategies will adequately address the associated priority.

Title V Priority	Yes	No	No Opinion	Skipped	Number of Comments Provided
Premature Birth	65	11	11	0	25
Infant Safe Sleep	70	11	6	0	21
Child Abuse Prevention	68	12	7	0	31
Access to Preventative Oral Health Care Services	67	10	10	0	30
Motor Vehicle Crashes Among Youth	65	9	11	2	16
Sexually Transmitted Disease Among Youth	59	12	15	1	22
Suicide Among Youth	69	12	5	1	24
Behavioral & Mental Health in School	68	13	6	0	25
Cardiovascular Disease including Diabetes, Obesity, and Hypertension	62	8	17	0	14
Improved Access to Utilization of Mental Health Care Services	68	9	9	1	27

“Yes” responses – In all priorities, most respondents believe the strategies in the State Action Plan will address the priority need. There was most confidence in the strategies for Suicide Among Youth (80% thought the strategies would address the priority need) and least confidence in the strategies for Sexually Transmitted Disease Among Youth (69% thought the strategies would address the priority need).

“No” response – Between 8-13 respondents per priority indicated that they did not think the proposed strategy would address the priority need.

“No Opinion” – Between 5-17 respondents per priority indicated that they had no opinion about if the strategies proposed would address the priority need.

The last question on the survey asked respondents to provide their contact information if they wanted follow-up communication on their responses from the Title V staff.

The total scores and comments were reviewed and considered for inclusion in the 2025 State Action Plan. Having their voice heard is a reasonable expectation of responders to the survey, especially persons who offered comments. Respondents may not be able to identify their input in the Application or State Action Plan, but the Title V team reviewed each comment provided. It is possible that comments and suggestions were insightful but not practical to incorporate into the State Action Plan framework. Nebraska Title V's work of fitting the input received into the required framework continues to evolve and will improve with more family engagement and other interactions between the Title V team and fellow Nebraskans.

The results are also considered and responded to beyond in 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 was edited based on prior public input. Improved online information was provided 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 2025 Application. Supporting Documents

offer a glimpse at the content of the public input request. The annual announcement was delivered using two methods, i.e., email relay and social media (**Supporting Documents 1 and 2**). This year, Title V sought to streamline the communication about the process, and provided an overview online that was very similar to what was sent out via email (**Supporting Document 3**). The proposed State Action Plan was provided in PowerPoint format (**Supporting Document 4**). Finally, a survey method to provide feedback (**Supporting Document 5**) provides structure to share opinions about what helps grow healthy families.

In May 2024, the email opener was sent to over 115 key contacts whose email addresses are easily confirmed to be current and ready to accept communication. In addition, the key contacts were also selected because they had their own contact group(s). In several cases this meant access to a sizable listserv. The email asked key contacts to forward the email to expand the notification like 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 WIC Director, and staff in charge of the School Health Nurse listserv and the Office of Health Disparities email contacts. The total number of deliveries through the initial 50 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.

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 NDHHS (Developmental Disabilities (DD), Public Health (PH), and Medicaid Long Term Care (MLTC)) needs 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.

Targeted Universalism

As Title V embarks on the 2025 Needs Assessment, to advance health equity, we would like to consider incorporating a Targeted Universalism framework into the criteria, findings of the assessment as well as, the objectives and strategies of the 2025 Action Plan. Nebraska is interested in dialoging and learning from subject matter experts and other states who have implemented this framework in policy and practice.

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 - Title V Public Input_SupportingDoc1.pdf

Supporting Document #02 - Title V Public Input_SupportingDoc2.pdf

Supporting Document #03 - Title V Public Input_SupportingDoc3.pdf

Supporting Document #04 - Title V Public Input_SupportingDoc4.pdf

Supporting Document #05 - Title V Public Input_SupportingDoc5.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Org Chart Title V 9.5.24 - Final.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nebraska

	FY 25 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	$ 1,550,000	(38.7%)
B. Children with Special Health Care Needs	$ 1,450,000	(36.2%)
C. Title V Administrative Costs	$ 110,000	(2.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,110,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,000,000	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 350,000	
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)	$ 3,350,000	
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	
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)	$ 45,104,857	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 52,454,857	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 308,810
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 166,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,000,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines for Children/Immunizations	$ 3,613,548
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 625,000
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	$ 681,025
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 > The Loving Support Peer Counseling Program (Breastfeeding)	$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 35,868,541
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)	$ 172,804
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 247,385
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ERASE Maternal Mortality	$ 331,847
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > NBS PROPEL	$ 244,000

	FY 23 Annual Report Budgeted		FY 23 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 23 Federal Award: $ 4,122,683)		$ 3,775,140	
A. Preventive and Primary Care for Children	$ 1,347,182	(33.7%)	$ 1,541,194	(40.8%)
B. Children with Special Health Care Needs	$ 1,420,584	(35.5%)	$ 1,306,274	(34.6%)
C. Title V Administrative Costs	$ 110,001	(2.8%)	$ 69,385	(1.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 2,877,767		$ 2,916,853	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,000,000		$ 3,236,272	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 318,934		$ 325,257	
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)	$ 3,318,934		$ 3,561,529	
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		$ 7,336,669	
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		$ 192,618,635	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 235,511,281		$ 199,955,304	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Child Care and Development Block Grant (CCDBG)	$ 58,530,000	$ 41,364,446
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Community Services Block Grant (CSBG)	$ 5,178,192	$ 4,885,793
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Low Income Home Energy Assistance Program (LIHEAP)	$ 29,213,636	$ 30,165,332
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Refugee Resettlement	$ 1,700,000	$ 13,969,332
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Social Services Block Grant (SSBG)	$ 9,380,000	$ 9,412,739
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 286,977	$ 242,948
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 326,542	$ 303,092
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 57,000,000	$ 27,671,102
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 157,415
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	$ 1,467,084
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 3,254,124	$ 2,831,137
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 600,000	$ 751,816

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
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	$ 1,249,959
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 428,533
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 263,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 625,482	$ 601,515
US Department of Agriculture (USDA) > Food and Nutrition Services > Emergency Food Assistance Program (TEFAP)	$ 350,000	$ 2,075,796
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	$ 970,000	$ 599,301
US Department of Agriculture (USDA) > Food and Nutrition Services > Supplemental Nutrition Assistance Program (SNAP)	$ 20,180,000	$ 23,707,624
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 250,000	$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 35,088,485	$ 28,959,551
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 158,012	$ 158,012
US Department of Housing and Urban Development (HUD) > Community Planning and Development > Nebraska Homeless Assistance Program	$ 1,000,000	$ 1,003,108

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: FY23 NOA totaled 3,955,957.00	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: The program acknowledges the data alert that here is more than 10% difference between what was budgeted and what was expended to date. This is a result of staff changes in years 2022, 2023, and 2024.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: The program acknowledges the data alert that here is more than 10% difference between what was budgeted and what was expended to date. This is a result of staff changes in years 2022, 2023, and 2024.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: The program acknowledges the data alert that here is more than 10% difference between what was budgeted and what was expended to date. This is a result of staff changes in years 2022, 2023, and 2024.	

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 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 300,000	$ 326,016
2. Infants < 1 year	$ 500,000	$ 372,329
3. Children 1 through 21 Years	$ 1,550,000	$ 1,541,194
4. CSHCN	$ 1,450,000	$ 1,306,274
5. All Others	$ 90,000	$ 159,942
Federal Total of Individuals Served	$ 3,890,000	$ 3,705,755

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 225,000	$ 315,454
2. Infants < 1 year	$ 375,000	$ 486,682
3. Children 1 through 21 Years	$ 1,162,500	$ 668,662
4. CSHCN	$ 1,087,500	$ 1,352,541
5. All Others	$ 150,000	$ 738,189
Non-Federal Total of Individuals Served	$ 3,000,000	$ 3,561,528
Federal State MCH Block Grant Partnership Total	$ 6,890,000	$ 7,267,283

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 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 500,000	$ 399,449
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 40,000	$ 27,031
B. Preventive and Primary Care Services for Children	$ 250,000	$ 216,605
C. Services for CSHCN	$ 210,000	$ 155,813
2. Enabling Services	$ 1,750,000	$ 1,679,173
3. Public Health Services and Systems	$ 1,750,000	$ 1,696,518
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		$ 8,231
Physician/Office Services		$ 27,614
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 5,110
Dental Care (Does Not Include Orthodontic Services)		$ 149,663
Durable Medical Equipment and Supplies		$ 144,254
Laboratory Services		$ 2,809
Other		
other		$ 61,768
Direct Services Line 4 Expended Total		$ 399,449
Federal Total	$ 4,000,000	$ 3,775,140

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 700,000	$ 686,428
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 140,000	$ 115,599
B. Preventive and Primary Care Services for Children	$ 35,000	$ 32,785
C. Services for CSHCN	$ 525,000	$ 538,044
2. Enabling Services	$ 2,500,000	$ 2,464,321
3. Public Health Services and Systems	$ 350,000	$ 410,780
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		$ 8,222
Physician/Office Services		$ 95,840
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 14,909
Dental Care (Does Not Include Orthodontic Services)		$ 40,731
Durable Medical Equipment and Supplies		$ 526,269
Laboratory Services		$ 457
Direct Services Line 4 Expended Total		$ 686,428
Non-Federal Total	$ 3,550,000	$ 3,561,529

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: 24,349 **Data Source Year: 2023**

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	24,301 (99.8%)	563	52	52 (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 I (MPS I)	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)	22,561 (92.7%)	72	25	25 (100.0%)
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 a 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 a 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:	**2023**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: 24,349 births occurred in Nebraska. Of those 24,301 were screened in accordance with Nebraska State Law. There were 48 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:	**2023**
	Column Name:	**Core RUSP Conditions**
	Field Note: In 2023, 48 of the 24,439 births expired prior to 48 hours of life. Therefore, those 48 births were not screened.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2023**
	Column Name:	**Core RUSP Conditions**
	Field Note: There were 563 total number of out-of-range results. (140 were presumptive positive requiring confirmatory testing, 64 were inconclusive screens for disorders requiring a repeat newborn screen, and 359 were inconclusive screens for amino acids and acylcarnitine's (MS/MS) requiring a repeat newborn screen.	
4.	**Field Name:**	**Nebraska Early Hearing Detection and Intervention (EHDI) - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2023**
	Column Name:	**Other Newborn**
	Field Note: There were 22,561 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:	**2023**
	Column Name:	**Other Newborn**

	Field Note: Referrals are made to the Early Development Network (EDN). Parents can refuse a referral.	
6.	**Field Name:**	**Congenital Critical Heart Disease (CCHD) - Confirmed cases - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2023**
	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:	**2023**
	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:	**2023**
	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:	**2023**
	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 2023

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	829	38.0	10.7	42.0	9.3	0.0
2. Infants < 1 Year of Age	423	54.3	15.4	15.6	14.7	0.0
3. Children 1 through 21 Years of Age	33,329	22.1	6.2	62.8	8.9	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,608	54.1	15.2	17.6	13.1	0.0
4. Others	55,212	28.5	8.0	49.6	13.9	0.0
Total	89,793					

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	24,345	Yes	24,345	100.0	24,345	829
2. Infants < 1 Year of Age	24,533	Yes	24,533	100.0	24,533	423
3. Children 1 through 21 Years of Age	566,135	Yes	566,135	100.0	566,135	33,329
3a. Children with Special Health Care Needs 0 through 21 years of age^	104,515	Yes	104,515	100.0	104,515	1,608
4. Others	1,377,441	Yes	1,377,441	5.0	68,872	55,212

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**

Field Note:
Nebraska reports 829 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 216 pregnant women;
- STD testing of 465 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;
-

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.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**

Field Note:
Nebraska reports 423 Infants (less than 1 year) received direct and enabling services by Title V though NDHHS programs and local partners:
- Newborn Screening of 61 infants screening positive whose parents received a consultation to determine the lab result was a false positive;
- Tribal subawards' health programs supported 121 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 205 infants;
- Nebraska Elemental Formula Reimbursement Program provided enabling service to 36 infants with certain medical conditions that require medically necessary amino acid-based elemental formulas.

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.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**

Field Note:
Nebraska reports 31,721 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 33,329.
- Reproductive Health program through subawards for adolescent reproductive health (engagement of adolescents to increase their utilization of reproductive health services) provided enabling services to 8,398 adolescents.
- N-MIECHV (the state-funded support of evidence-based programs in 7 counties) provided case management home visiting services to 336 Children;
- Community and Tribal subawards provided a variety of enabling services to 13,402 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 9,585 adolescents as enabling service;

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.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**

Field Note:
Of the 33,329 total Children, 1,608 CSHCN (0 through age 21) received direct or enabling services by NDHHS programs and local partners.
- The Medically Handicapped Children's Program (MHCP) served 1,275. MHCP reported insurance coverage for 1,068, with 207 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 307 CSHCN (0 through age 21) receiving this direct service, reducing the cost to Title V.
- Tribal subaward reports an enabling service to 26 CSHCN (0 through age 21).

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.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**

Field Note:
Nebraska reports 55,212 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 24,945 callers;
- Newborn Screening ensured access to special foods and formula to 81 persons with metabolic conditions categorized as Others;
- Evidence-based home visiting provided case management home visiting services to 343 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 1,536 persons categorized as Others;
- STD testing of 26,010 persons categorized as Others;
- Tribal subawards' health clinics provided services for well-woman care to 2,297 persons categorized as Others;

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.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**

Field Note:
At all service levels, Nebraska Title V estimates reaching 26,843 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:
- NDHHS agreement with the University of Nebraska Medical Center for the Nebraska Perinatal Quality Improvement Collaborative (NPQIC) impacted an estimated 24,108 pregnant women;
- Tribal subawards impacted 137 pregnant women;
- The Maternal Mortality Review Committee (MMRC) under the Child Maternal Death Review Team (CMDRT) and the Pregnancy Risk Assessment Monitoring System (PRAMS) are key infrastructure supporting the grant, the public health system and all perinatal women in Nebraska.

Numerator data source: program data of NDHHS and local partners

Denominator data source: National Vital Statistics System – Resident Live Births, 2022

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**

	Field Note: At all service levels, Nebraska Title V estimates reaching 37,144 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 24,301 babies born in Nebraska for metabolic conditions. Births not screened, expired prior to 48 hours of life; Office of Oral Health provided 10,000 Early Dental Health Starter Kits to birthing hospitals via the Nebraska Hospital Association; - Tribal subawards reached 122 infants with a population-based service; -Child Maternal Death Review Team (CMDRT) and the Pregnancy Risk Assessment Monitoring System (PRAMS)are key infrastructure supporting the grant, the public health system and all infants in Nebraska. 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, 2022	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: At all service levels, Nebraska Title V estimates reaching 508,835 Children (or 90% 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: - Adolescent and Reproductive Health Program educated providers, provided evidence-based youth development training, increased assess to STD/HIV testing and education; and partnered with other programs to leverage resources to impact an estimated 8,451 adolescents; - Maternal Child Health Program through continuing education for health professions and Community Health Worker training support, and partnering with school health nurses statewide reached an estimated 328,772 Children; - Office of Oral Health distributed 20,576 Early Dental Health Starter Kits; - Subawards directed at four child-focused priorities identified in the 2020 Needs Assessment estimate impacting 117,670 Children through stakeholder-engaged projects- Child Maternal Death Review Team (CMDRT)are key infrastructure supporting the grant, the public health system and all children in Nebraska. Numerator data source: program data of NDHHS and local partners Denominator data source: US Census Bureau Population Estimates, 2022 *There is no way to know if there is duplication across any of the program counts.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**

Field Note:

At all service levels, Nebraska Title V estimates reaching 129,676 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 Health (Program estimates impacting 54,075 CSHCN in Nebraska public schools;
- Birth Defects Registry reports 5,305 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 82 CSHCN;
- Biomedical Research through agreement with Creighton University Boys Town Research Hospital reached an estimated 53,199 CSHCN;
- local and Tribal subawards reached 17,015 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 (2021-2022) multiplied by US Census Bureau Population Estimates 0-21, 2022
*There is no way to know if there is duplication across any of the program counts.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**

Field Note:
At all service levels, Nebraska Title V estimates reaching 62,656 persons categorized as Others, or 5% 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 94 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 5,000 persons categorized as Others.
-local and Tribal subawards reached 2,350 others with a population-based service

Numerator data source: program data of NDHHS and local partners.

Denominator data source: US Census Bureau Population Estimates, 2022

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Nebraska

Annual Report Year 2023

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	25,239	16,407	1,498	5,118	343	818	52	785	218
Title V Served	260	77	31	112	4	4	0	28	4
Eligible for Title XIX	9,615	3,661	1,100	2,234	229	365	0	332	1,694
2. Total Infants in State	24,180	15,941	1,421	4,783	220	812	39	759	205
Title V Served	264	88	29	115	3	7	0	17	5
Eligible for Title XIX	11,609	3,897	1,166	2,784	208	341	33	473	2,707

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Nebraska

Reporting on Form 7 in the 2025 Application/2023 Annual Report is optional. The state has opted-out of providing Form 7 data. Reporting on Form 7 is mandatory for 2026 Application/2024 Annual Report.

Form Notes for Form 7:

None

Field Level Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Nebraska

1. Title V Maternal and Child Health (MCH) Director	
Name	Jennifer Severe-Oforah
Title	DHHS Administrator II
Address 1	301 Centennial Mall South
Address 2	P.O. Box 95026
City/State/Zip	Lincoln / NE / 68508
Telephone	(402) 471-2091
Extension	
Email	jennifer.severeoforah@nebraska.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Colin Large
Title	DHHS Administrator II
Address 1	301 Centennial Mall South
Address 2	P.O. Box 95026
City/State/Zip	Lincoln / NE / 68508
Telephone	(402) 853-1452
Extension	
Email	Colin.large@nebraska.gov

3. State Family Leader (Optional)	
Name	Sarah Swanson
Title	Assistant Professor/Director Family Care Enhancement Project
Address 1	6902 Pine St.
Address 2	
City/State/Zip	Omaha / NE / 68106
Telephone	(402) 559-4573
Extension	
Email	Sarah.Swanson@unmc.edu

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Celeste Illian
Title	DHHS Administrator I
Address 1	301 Centennial Mall South
Address 2	P.O. Box 95026
City/State/Zip	Lincoln / NE / 68508
Telephone	(402) 471-0805
Extension	
Email	celeste.Illian@nebraska.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(866) 813-1731

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Nebraska

Application Year 2025

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 - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	80.4 %	0.3 %	19,203	23,871
2021	80.5 %	0.3 %	19,538	24,271
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 PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	60.1	5.2	135	22,460
2020	63.0	5.3	141	22,375
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 SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	25.1	4.5	31	123,488
2017_2021	22.4	4.2	28	124,964
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 MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.9 %	0.2 %	1,918	24,338
2021	7.6 %	0.2 %	1,880	24,601
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 LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	11.3 %	0.2 %	2,759	24,335
2021	10.8 %	0.2 %	2,653	24,598
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 PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	29.6 %	0.3 %	7,200	24,335
2021	28.8 %	0.3 %	7,091	24,598
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 ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	2.0 %			
2021/Q4-2022/Q3	2.0 %			
2021/Q3-2022/Q2	2.0 %			
2021/Q2-2022/Q1	2.0 %			
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	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 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.7	0.4	117	24,657
2020	4.8	0.4	116	24,347
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 PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	5.5	0.5	135	24,609
2020	5.7	0.5	138	24,291
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 IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	3.5	0.4	85	24,609
2020	3.1	0.4	76	24,291
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 IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.0	0.3	50	24,609
2020	2.6	0.3	62	24,291
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 IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	166.6	26.0	41	24,609
2020	148.2	24.7	36	24,291
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 IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	97.5	19.9	24	24,609
2020	111.2	21.4	27	24,291
2019	72.7	17.1	18	24,755
2018	62.8	15.7	16	25,488
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	15.3	16	26,095
2012	84.8	18.1	22	25,942
2011	85.5	18.2	22	25,720
2010	57.9	15.0	15	25,918
2009	85.4	17.8	23	26,936

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	10.0 %	1.2 %	2,345	23,462
2021	9.7 %	1.1 %	2,316	23,923
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 DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	1.7	0.3	37	21,652
2020	1.8	0.3	41	22,620
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	0.2	16	26,228
2008	NR	NR	NR	NR

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - 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) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	10.1 %	0.9 %	45,150	445,513
2020_2021	8.4 %	0.8 %	36,983	441,065
2019_2020	7.2 %	0.9 %	32,466	448,564
2018_2019	10.3 %	1.3 %	46,576	450,870
2017_2018	12.3 %	1.6 %	54,010	440,492
2016_2017	9.7 %	1.3 %	42,529	437,404

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 TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	15.5	2.6	36	232,972
2021	19.8	2.9	47	237,146
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 CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	39.5	3.8	108	273,475
2021	35.3	3.6	98	277,643
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 AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	14.4	1.9	59	408,893
2019_2021	14.8	1.9	60	404,082
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 AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	8.8	1.0	72	817,698
2019_2021	7.8	1.0	63	810,807
2018_2020	7.4	1.0	59	798,225
2017_2019	8.7	1.1	69	794,759
2016_2018	9.0	1.1	71	788,819
2015_2017	8.6	1.1	67	783,016
2014_2016	7.2	1.0	56	776,621
2013_2015	6.7	0.9	52	770,888
2012_2014	6.9	1.0	53	765,157
2011_2013	5.9	0.9	45	762,919
2010_2012	5.0	0.8	38	759,644
2009_2011	3.6	0.7	27	758,829

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	17.7 %	1.0 %	84,678	477,497
2020_2021	16.6 %	1.0 %	78,644	473,807
2019_2020	18.3 %	1.3 %	86,472	472,566
2018_2019	17.5 %	1.4 %	82,834	472,020
2017_2018	16.9 %	1.6 %	79,708	472,138
2016_2017	17.7 %	1.5 %	83,062	469,829

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 CSHCN - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	13.7 %	1.8 %	11,580	84,678
2020_2021	14.6 %	2.0 %	11,462	78,644
2019_2020	13.3 %	2.0 %	11,505	86,472
2018_2019	15.8 %	2.8 %	13,056	82,834
2017_2018	22.3 %	4.3 %	17,789	79,708
2016_2017	20.7 %	4.0 %	17,185	83,062

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 SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	1.8 %	0.3 %	7,180	396,571
2020_2021	1.9 %	0.5 %	7,313	390,043
2019_2020	2.6 %	0.7 %	10,335	390,139
2018_2019	2.4 %	0.7 %	9,080	386,033
2017_2018	2.2 %	0.9 %	8,503	383,374
2016_2017	2.5 %	0.9 %	9,849	389,189

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 ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	8.4 %	0.8 %	33,217	395,853
2020_2021	7.9 %	0.8 %	30,681	389,635
2019_2020	7.4 %	0.9 %	29,046	390,800
2018_2019	6.5 %	1.0 %	24,920	381,461
2017_2018	6.7 %	1.3 %	25,433	376,818
2016_2017	6.7 %	1.2 %	26,067	387,798

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 ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	53.4 %	4.0 %	29,221	54,704
2020_2021	61.3 %	4.1 %	30,823	50,260
2019_2020	64.0 %	4.8 %	33,191	51,843
2018_2019	60.0 %	5.7 %	27,714	46,224
2017_2018	58.8 %	7.8 %	24,377	41,462
2016_2017	58.1 %	7.2 %	25,792	44,361

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 MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	93.0 %	0.8 %	442,426	475,819
2020_2021	93.5 %	0.7 %	442,362	473,029
2019_2020	91.8 %	1.1 %	433,363	472,181
2018_2019	90.5 %	1.4 %	426,191	470,980
2017_2018	90.0 %	1.7 %	424,357	471,294
2016_2017	88.7 %	1.6 %	416,122	469,038

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 CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	14.6 %	0.4 %	1,074	7,376
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 <20 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
2021	19.2 %	1.5 %	17,477	91,023
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
2021_2022	15.0 %	1.4 %	45,121	300,700
2020_2021	14.8 %	1.3 %	43,305	293,359
2019_2020	14.5 %	1.5 %	43,137	298,447
2018_2019	13.9 %	1.6 %	40,920	294,328
2017_2018	15.5 %	2.0 %	44,521	287,632
2016_2017	17.1 %	1.9 %	49,285	288,146

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 OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	4.9 %	0.6 %	23,252	473,852
2021	5.3 %	0.8 %	25,597	481,100
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 UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	73.7 %	3.3 %	19,000	25,000
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 VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	62.3 %	2.1 %	282,605	453,620
2021_2022	62.5 %	2.0 %	281,826	450,780
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 VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	81.1 %	3.1 %	114,333	140,984
2021	82.7 %	2.7 %	110,010	133,046
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 VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	90.1 %	2.2 %	126,990	140,984
2021	92.3 %	1.8 %	122,789	133,046
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 VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	88.3 %	2.5 %	124,506	140,984
2021	89.7 %	2.1 %	119,306	133,046
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 VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	14.1	0.5	937	66,690
2021	14.0	0.5	944	67,606
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 TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	12.8 %	1.4 %	2,998	23,373
2021	12.0 %	1.2 %	2,833	23,664
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 PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	2.8 %	0.5 %	13,197	473,458
2020_2021	2.1 %	0.4 %	9,675	470,205
2019_2020	1.6 %	0.4 %	7,680	470,784
2018_2019	2.2 %	0.7 %	10,194	470,452
2017_2018	2.8 %	0.9 %	13,139	470,561
2016_2017	2.8 %	0.8 %	13,117	469,070

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 FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Nebraska

NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective		74.9	71.8	71.8	73.2
Annual Indicator	73.5	70.4	70.5	69.5	70.1
Numerator	244,199	234,784	234,343	235,133	238,027
Denominator	332,326	333,478	332,326	338,515	339,443
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	74.7	76.2

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	86.8	87.8	89.6	90.3	92.1
Annual Indicator	86.1	86.8	88.5	87.6	85.9
Numerator	20,652	20,367	20,471	20,548	19,696
Denominator	23,975	23,464	23,130	23,460	22,938
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	93.9	95.8

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	34.2	38.5	39.2	40	40.8
Annual Indicator	37.7	40.3	37.8	38.4	40.3
Numerator	8,832	8,976	8,403	8,711	8,894
Denominator	23,403	22,266	22,224	22,698	22,062
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	41.6	42.4

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	45.5	48.8	58.3	58.1	59.3
Annual Indicator	47.9	57.2	57	57.9	63.3
Numerator	11,176	12,710	12,719	13,202	14,030
Denominator	23,326	22,219	22,326	22,793	22,167
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	60.5	61.7

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	210.2	216.7	200.3	210.3	206.1
Annual Indicator	221.2	204.9	214.6	272.7	228.0
Numerator	582	543	572	727	633
Denominator	263,114	265,061	266,584	266,580	277,643
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives		
	2024	**2025**
Annual Objective	201.9	197.9

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	58.4	54.2	45.9	50.4	51.4
Annual Indicator	53.1	45.0	49.4	50.1	46.0
Numerator	44,838	39,911	42,610	38,765	38,965
Denominator	84,509	88,648	86,203	77,381	84,678
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	52.4	53.4

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.3
Numerator	254,081
Denominator	476,545
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			80.1	84	85.7
Annual Indicator	78.5	80.1	82.4	79.3	79.8
Numerator	345,091	363,265	370,833	346,905	353,942
Denominator	439,399	453,443	450,251	437,597	443,513
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	87.4	89.2

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	93.9
Numerator	22,016
Denominator	23,454
Data Source	PRAMS
Data Source Year	2022

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	85.0
Numerator	18,650
Denominator	21,929
Data Source	PRAMS
Data Source Year	2022

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**	**2022**	**2023**
Annual Objective			10.3	10.7	11.1
Annual Indicator	10.5	10.5	10.6	11.3	11.5
Numerator	2,597	2,551	2,514	2,651	2,790
Denominator	24,758	24,293	23,646	23,357	24,193
Data Source	NE Vital Records	NE Vital Records	NE Vital Records	NE Vital Records	NE Vital Records
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	11.3	11.1

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Starting with 2021 data, Nebraska is reporting only resident, occurrent births. As of reporting, 2021 data are still provisional.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Starting with 2021 data, Nebraska is reporting only resident, occurrent births. As of reporting, 2022 data are still provisional.	

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

Measure Status:	Inactive - Replaced				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			9.8	7.3	7.1
Annual Indicator	7.2	7.1	7.5	6.6	6.3
Numerator	1,718	1,687	1,765	1,536	1,471
Denominator	237,985	236,569	234,730	232,972	232,972
Data Source	NE Family Online Client User System, Census	NE Family Online Client User System, Census	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	2022/21	2023/22
Provisional or Final ?	Final	Final	Final	Final	Final

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**	**2022**	**2023**
Annual Objective			1,883.9	1,768.9	1,733.5
Annual Indicator	1,922.4	1,776	1,800	1,787.5	1,787.5
Numerator	2,550	2,361	2,493	2,457	2,457
Denominator	132,645	132,940	138,497	137,456	137,456
Data Source	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census	NE STI Program, Census	Unavailable, Census
Data Source Year	2019	2020	2021	2022	2022
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	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 effect of the pandemic. The testing sites were closed for a portion of 2020. I will not adjust the annual objectives.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 2023 data were not available at the time of reporting. 2022 is the most recent year of data available.	

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			7.4	7.6	8
Annual Indicator	8.8	7.2	7.4	8.2	8.8
Numerator	70	58	61	68	73
Denominator	794,759	809,241	821,764	833,143	825,575
Data Source	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census	NE Vital Records, Census
Data Source Year	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Annual Objectives		
	2024	2025
Annual Objective	8.5	8.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Beginning with 2020 data reporting, Nebraska data includes only resident, occurrent deaths.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Beginning with 2020 data reporting, Nebraska data includes only resident, occurrent deaths. 2021 data are provisional at time of reporting.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Beginning with 2020 data reporting, Nebraska data includes only resident, occurrent deaths. 2021 and 2022 data are provisional at time of reporting.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Beginning with 2020 data reporting, Nebraska data includes only resident, occurrent deaths. 2021 through 2023 data are provisional at time of reporting.	

SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			62.5	64.3	64.9
Annual Indicator	64.1	61.3	63	63.6	61.9
Numerator					292,971
Denominator					473,344
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	66.2	67.5

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Nebraska

ESM WWV.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

State Provided Data			
	2021	2022	2023
Annual Objective			75
Annual Indicator		100	38.5
Numerator		10	5
Denominator		10	13
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	85.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
This project was completed in April 2023, and will not be applicable moving forward. Data reflects January through April 2023

ESM SS.2 - The percent of organizations receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			10
Annual Indicator		0.3	5.9
Numerator		1	23
Denominator		388	388
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	25.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
• 2 new Abusive Head Trauma/Shaken Baby Syndrome Prevention Champions
• 1 new Safe Sleep Hospital Champion
• 1 new Clinic Campaign Champion
• 18 new LEARN Campaign (breastfeeding) Champions

Currently there are 45 birthing hospitals in NE and numerous clinics that see OB, Pediatric, or Family Practice patients caring for the maternal / child population. Quite a few have closed or no longer see pregnant women.

ESM IH-Adolescent.1 - The number of schools participating in the "Teens in the Driver Seat" program.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	38	38	38	27	26
Annual Indicator	33	33	22	22	23
Numerator					
Denominator					
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	29.0	33.0

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	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 24,825 teens reached in fall semester 2022.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: There were 23 active Teens in the Driver Seat (TDS) schools, with a total of 22,962 teens reached in the 2022-2023 school year. By the end of the school year, 12 schools were recognized in the TDS All Star program for all the activities they did. Also, three teachers were awarded the TDS Spon-star Award.	

ESM MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			90
Annual Indicator		88.5	90.5
Numerator		85	86
Denominator		96	95
Data Source		Parent Resource Center Family Satisfaction Survey	Parent Resource Center Family Satisfaction Survey
Data Source Year		2022	2023
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	95.0	95.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Family Satisfaction Survey has a number of questions aligned with this measure, in this case "Working with my PRC has helped me get connected to community resources" was chosen.

ESM PDV-Child.2 - The percentage of children participating in the Open Mouth Survey from underserved communities

Measure Status:	Active

State Provided Data			
	2021	2022	2023
Annual Objective			50
Annual Indicator		53.1	53.1
Numerator		2,233	2,233
Denominator		4,208	4,208
Data Source		Program Administrative Data	Program Administrative Data
Data Source Year		2022	2022
Provisional or Final ?		Final	Final

Annual Objectives		
	2024	2025
Annual Objective	50.0	50.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: In addition, 1,678 (40%) of children who were screened were from rural communities.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: No new survey was conducted to report on.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Nebraska

SPM 1 - The percent of preterm births.
Population Domain(s) – Perinatal/Infant Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To decrease preterm birth rate by addressing disparities, increasing access to care, and providing education.</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 infants born less than 37 weeks gestation in a calendar year.</td></tr>
<tr><td>Denominator:</td><td>The number of live births in a calendar year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Nebraska Vital Records, Birth Certificate File</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	Inactive - Replaced
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

Measure Status:	Active
Goal:	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). TolncreaseTo increase protective factors, resilience, strengths building, and family engagement.
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** The number of deaths due to sucide for youth (10-19) for the last three calendar years. **Denominator:** The population of youth (10-19) for the the last three calendar years.
Data Sources and Data Issues:	Nebraska Vital Records, Death File, Census
Significance:	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.

SPM 5 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To increase access to care for the maternal and child health population
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children, ages 0 through 17 years, who were reported by a parent to 1) have continuous insurance in the past 12 months, and 2) have current insurance which is adequate for the child's healthcare needs. NPM 15 **Denominator:** Number of children, ages 0 through 17 years
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	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.

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 WWV.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 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of women who access preventive healthcare for cardio vascular disease.</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 participants who have had a well check according to the USPSTF guidelines based on age and history.</td></tr>
<tr><td>Denominator:</td><td>The number of female participants.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Program Data, Women's Health Initiatives.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM SS.2 - The percent of organizations receiving outreach that become Champions of the "Nebraska Safe Babies Campaign".
NPM – 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 D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

Measure Status:	Active
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:	<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>
Data Sources and Data Issues:	Program data
Evidence-based/informed strategy:	Aligns with MCH best strategy "Building on Campaigns and Conversations".
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 24,000 newborns across the State.

ESM IH-Adolescent.1 - The number of schools participating in the "Teens in the Driver Seat" program.
NPM – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - Adolescent, Formerly NPM 7.2) - IH-Adolescent

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 MH.2 - The percentage of families who are satisfied with supports provided by the Parent Resource Coordinator
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Measure Status:	Active
Goal:	Increase the number of families served by the program who are satisfied with the support provided by the community health workers.
Definition:	<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 parents reporting satisfaction with the support they receive.</td></tr><tr><td>**Denominator:**</td><td>The number of parents who responded to the customer satisfaction survey.</td></tr></table>
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 PDV-Child.2 - The percentage of children participating in the Open Mouth Survey from underserved communities
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	To increase the percent of children (ages 1 through 17) receive preventive oral health care services.
Definition:	<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 children participating in the Open Mouth Survey from rural and underserved communities.</td></tr><tr><td>**Denominator:**</td><td>The number of children participating in the Open Mouth Survey.</td></tr></table>
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
Part 1 – MCH Data Access and Linkages

State: Nebraska

Annual Report Year 2023

	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	Monthly	0		
2) Vital Records Death	Yes	Yes	Monthly	0	Yes	
3) Medicaid	No	No	Less Often than Annually	16	No	
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	

Other Data Source(s) (Optional)

	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
9) Birth Defects Registry	Yes	Yes	Daily	0	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Nebraska

Annual Report Year 2023

Products and Publications information has not been provided by the State.