



## State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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## I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

### 1.4 Overview of the State

Nebraska, in general, has been considered a very healthy state in which the well-being of its citizens is among the best in the nation. However, certain variables are slowly changing that status over time. For example, Nebraska's ranking for child well-being from the Annie E Casey Foundations Kids Count Data Book has dropped from fourth to eleventh from 1998 to 1999, based in part on an increase in infant mortality in 1996.

In other comparisons with the nation as a whole, Nebraskans enjoy above average health status. A 1998 report by *ReliaStar* ranked Nebraska twelfth among all states in health status. This ranking was based on the analyses of 17 primary indicators. Compared to other states, Nebraska had a very low unemployment rate, a high high-school graduation rate, a low level of infectious diseases, and a low number of premature deaths. In contrast, the state had relatively high rankings and was worse off for motor vehicle deaths, occupational fatalities, more limited activity days, and a high infant mortality rate.

Because Nebraska ranked seventh highest in the nation in 1996 for infant mortality, Governor Johann's created a Blue Ribbon Panel to examine the issue. This panel, representing a wide range of expertise from all parts of the state, has focused on determining the correctable and preventable causes of Nebraska's infant mortality. The panel spent the first six months collecting data, and is progressing to a recommendations stage. Title V has provided staff and financial support for this panel.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 32 out of 93 counties as frontier counties (6 or fewer persons per square mile). In contrast, approximately 50% of the state's citizens reside in the population centers of Lincoln and Omaha, which are situated within 60 miles of each other in the eastern part of the state. The urbanization of Douglas and Sarpy County (Omaha), and Lancaster County (Lincoln) is represented by an average population increase of over 10% between 1990 and 1998.

Nebraska's demographic trends indicate that although the state's total population has grown considerably during the 1990's, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long term care services.

Another significant trend is the aging of the state's population. In 1990, the percentage of the population aged 65 and older was 14.1%, compared to the national average of 12.5%. As of 1997, the number of persons aged 65 and over in Nebraska increased by 4,861. However, the percentage of persons 65 and older in Nebraska showed a slight decline to 13.7%, while the percentage at the national level showed a marginal increase to 12.7%. Most of the increase during the seven-year period in Nebraska can be attributed to the growth in the number of persons 85 and over.

In rural counties (those with populations of less than 20,000 people) about 18% of the population is 65 and over and in 37 counties the number of persons over age 65 exceeds 20%. This trend has important implications for the delivery of health and medical services because an older population needs more services. However, a shrinking total population base reduces the number of people in the service area. The net result is that fewer health and medical services are available to meet the needs of the population. These inadequate services are further compounded by the lack of public transportation services in most rural areas of the state. As Nebraska struggles to maintain health care delivery in rural areas, services for women, children, and children with special health care needs becomes increasingly fragmented and challenging.

Another major demographic trend is the substantial growth of racial/ethnic minority populations. During the decade of the 1980s, the racial/ethnic minority population rose by 23% while there was a minor 0.5% decrease in the White population. This implies a substantial growth of minorities in our state. Since 1990, the racial/ethnic minority population expanded by 39% while the White population increased by 4%. In general, the minority population tends to be younger, have lower incomes, higher poverty, and less insurance coverage. They are also more likely to be employed in high-risk occupations such as meat packing plants and farm labor. As a result, these population groups often experience difficulty gaining timely access to health and medical services. Even when services are available, language and cultural barriers prevent effective utilization of these services. There is a need to optimize these services for minority populations using culturally sensitive tools.

Due to welfare reform, TANF has replaced Aid to Dependent Children (ADC) in several aspects. ACD remains the Nebraska reference for cash assistance, however, TANF focuses on teaching individuals self-sufficiency limiting their need and receipt of cash assistance. Nebraska implemented the Employment First program to guide and assist parents in obtaining and maintaining self-sufficiency within 48 months, utilizing cash assistance for 24 of the 48 months. Employment First provides extended Medicaid coverage, child care services and supplements, and job support.

In 1998, ADC provided benefits for 13,392 families with 25,580 children on an average monthly basis. Of the families receiving ADC, 9,500 also received food stamps. In 1998, ADC benefits totaled over \$52 million with an average monthly payment per family of \$327.34 and \$119.05 per individual. The maximum ADC payment amounted to approximately 32% of poverty.

Nebraska Health and Human Services supplies Food Stamps to families that are at or below 130% of poverty. Throughout 1998, the monthly average of 38,880 household received Food Stamps with the value of the coupons totaling over \$69 million, an average of \$149.28 per household and \$61.87 per person per month. In Nebraska, a total of 93,819 received Food Stamps monthly and approximately half of the recipients were children. There were 47,190 children aged 0-17 found eligible for Food Stamps, however participation rates are lower.

Women who are at or below 185% of poverty and are pregnant, breastfeeding, and postpartum are provided surplus commodity foods through the Commodity Supplemental Foods Program (CSFP). Seniors age 60 and older can receive food if they are at or below 130% of poverty. An average of 1,633 women, infants, and children were served by CSFP per month totaling 19,593 total food packages for FY 1998. Seniors received 141,339 food packages averaging 11,778 seniors served per month in 1998. CSFP currently has 43 sites serving all 93 counties.

The Special Supplemental Nutrition Program for Women Infants and Children began in 1974 and serves at risk, pregnant, breastfeeding and postpartum women, infants, and children up to the age of five. As of April 30, 1998, 54% of the 57,561 income eligible persons participated in WIC. Recently, there has been a drop in WIC participation in Nebraska. In 1996, there were 35,376 WIC participants, 32,351 participated in 1997, while 31,107 participated in 1998.

Children with special health care needs (CSHCN) have been a challenge to health care delivery in Nebraska as well. As in most states, it is difficult to identify and characterize CSHCN in Nebraska. The most significant number includes children with chronic illnesses, such as asthma and diabetes, while a large number also have significant mental health problems, developmental delays, and physical disabilities. All these conditions result in a wide spectrum of services needed to adequately serve children with special health care needs. Identification of the Nebraska's CSHCN population is difficult. Past experience indicates that Nebraska's numbers and conditions are reflective of national averages, except in the area of sickle cell disease.

Nebraska has a lower prevalence of this genetic disease, possibly due at least in part to the smaller proportion of African Americans in Nebraska's population.

Nebraska has not decided on a single definition of CSHCN. One issue that must be clarified before a definition can be established is the spectrum of conditions included that will require an equally diverse range of services to the CSHCN population. The impact of managed care and the new State Children's Health Insurance Program, SCHIP, on CSHCN is uncertain at this point in time. Therefore, the CSHCN program remains uncertain of the range of services it will be required to provide. In addition to involvement with SCHIP, the Title V/CSHCN program is a primary gap-filling program for CSHCN. While most children participating in the program have some type of health care coverage, Title V/CSHCN often helps pay the high deductible. Instead of placing primary emphasis on payment for service, however, Title V/CSHCN has shifted to a role of service coordination for participants with physical disabilities.

However, for purposes of the Title V/CSHCN program, the definition of CSHCN can include traumatic brain injury and autism, in addition to genetic and acquired physical disabilities, and chronic health care needs. These issues will continue to be discussed and will evolve as Nebraska fully appreciates the impact of managed care and SCHIP.

Kids Connection, Nebraska's State Children's Health Insurance Program, is a Medicaid expansion anticipated to cover approximately 24,000 previously ineligible children. The program is administered by the Nebraska Health and Human Services Department of Finance and Support. Effective July 1, 1998, the State expanded Medicaid for children aged 15-18 living in families with income up to 100% FPL. Effective September 1, 1998, the State further expanded Medicaid up to 185% FPL for all children through the age of 18.

Because Kids Connection is a Medicaid expansion, services are delivered through the existing Medicaid delivery system. Managed care is available in Douglas, Sarpy, and Lancaster counties, and the rest of the state is served through a fee-for-service delivery system. Children eligible for Kids Connection receive the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit package. Families are not asked to pay any cost-sharing to participate in the program. Through September, 1999, 5,983 uninsured children were enrolled in the SCHIP program. The total number of uninsured children enrolled in the Medicaid Program in September 1999 was 84,609. Of the 108,102 enrolled children in September 1999, 17,510 had health coverage in addition to Kids Connection.

The number of residents in Nebraska who have enrolled in managed care plans have increased substantially in the past five years. For example, most large employers in Nebraska now offer only managed care plans. In Nebraska's metropolitan areas, about 50% of the Medicaid population belong to a managed care plan. The number of the state's Medicare beneficiaries currently enrolled in managed is low, but the number is likely to increase over the next five years.

The shift to managed care offers many opportunities for maternal and child health agencies at the state and local levels. At the local level, outreach services in the home or schools can be provided. Also, local agencies can work with managed care organizations in monitoring the health of their enrolled population. Managed care organizations also have stronger incentives to offer cost-effective preventive services to their enrolled population, and they should also be very supportive of efforts by maternal and child health agencies to implement community-wide preventive programs (e.g., tobacco control and prevention of injuries).

At the state level, there are similar opportunities to work with managed care organizations on monitoring and statewide prevention programs. States can also develop statewide registries to track immunization levels in both public and private clinics.

Finally, states can be involved in developing performance standards and monitoring the quality of care for the Medicaid population.

The number of uninsured in Nebraska has increased from about five percent in 1985 to almost 10.6% in 1997. In 1997, there were 181,000 people without insurance coverage. Rural residents compared to their urban counterparts were somewhat more likely to be uninsured. It is also estimated that in 1997 a little less than 30% of the uninsured were children. This number is expected to drop in half when the Kids Connection program is fully implemented.

Significant disparities exist in the percentages of uninsured between the White population and racial/ethnic minorities. Data from the 1995-1997 Nebraska Behavioral Risk Factor Survey (NBRFS) indicated that the overall level of uninsured for the total population was 10%. In contrast, the correspondent rates for Native Americans, and Hispanic Americans were 24% and 19%. The rate for African Americans was above the state average at 12%, while the rate for Asian Americans was below the state average at 9%.

Poverty in Nebraska decreased slightly from 11.1% in 1989 to 9.9% in 1997. The national rate in 1993 was 13.6%. In 1989, the only year in which census data are available by age reveals that of the 170,616 persons below the poverty level, 57,026 or 33% were under age 18 and 20,466 or 12% were under age five.

Poverty rates also vary by geographic area. In general, the north central and northwestern counties experienced the greatest poverty rates in 1993, with some pockets along the southern tier of counties. The counties with the highest poverty rates in 1993 were Thurston (25%), Sheridan (18%), and Dawes (17%). These rates are much higher than the national average.

Nebraska's racial and ethnic minority groups are greatly over-represented in the lower income categories. According to the 1990 U.S. Census, the proportion of minority residents living in households with incomes below 100% of the federally-designated poverty level ranged from a low 20.1% for Asian Americans to nearly half (46.2%) for Native Americans living in the state. In comparison, only 9.9% of White Nebraskans lived in poverty. In addition, the proportion of the population with incomes below the poverty level has increased for every racial/ethnic minority group since the 1980 census. Disparity in economic status across the races still remains a challenge for our state.

Differences in poverty rates between Whites and racial/ethnic minority residents of Nebraska were particularly striking for households with children. For children under five years of age, the proportion living in households with incomes below 100% of poverty level ranged from about 25% for Asian Americans to about 65% for Native Americans, compared to 13% of White children in this age group. Rates for minority children in this age group ranged from 14.5% for Asian Americans to more than 50% for Native Americans.

Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the Census Bureau, the state's minority population grew by 25% between 1980 and 1990, and racial/ethnic minorities were found in every Nebraska county. From 1990 to 1997, the minority population rose by 39% and now constitutes 10% of the total population.

In terms of health status, significant disparities exist between racial/ethnic minorities and the White population. For example, during the period 1993-1997, African Americans had twice as many potential years of life lost as the White population. African American infants have three times the mortality rate of White infants. Native Americans experience by far the highest rate of diabetes-related deaths of any racial/ethnic group, and these rates are over four times those for White Nebraskans. Teen birth rates among teens aged 15 to 17 for Hispanics/Latinos are twice as high as for White teens. There are also several access

barriers to health services for racial/ethnic minorities. Some of these barriers include language and cultural differences, lack of health insurance and access to transportation.

The high number of premature deaths for racial/ethnic minorities compared to the White population can be largely attributed to risk factor prevalence and barriers that limit access to care. In 1993, for example, only 19% of all adult Nebraskans who were surveyed indicated that they smoked cigarettes. In contrast, the corresponding percentages for African Americans, Native Americans, Asian Americans, and Hispanic Americans were 2%, 49%, 22% and 24%. Native Americans and Hispanic Americans were also significantly overweight compared to the total population and all racial/ethnic minority groups were less likely to be physically active. Asian Americans were considerably below the state average for cholesterol checks, mammogram screenings, and Pap smear tests. These low percentages could be partially attributed to language/cultural barriers and lack of language/culturally-sensitive programs.

In addition to the risk factor prevalence, racial/ethnic minorities face serious barriers in accessing health care services. One of the major access barriers is the lack of health insurance coverage. A 1993-1994 survey found that 9% of Nebraskans were without any type of health insurance coverage. However, 21% of African Americans, 30% of Asian Americans, and 37% of Hispanic Americans were uninsured. Racial/ethnic minorities were also less likely to see a physician due to the high cost.

Language was a significant barrier for Asian Americans where 30% of the respondents indicated they had a problem. The lack of transportation was also cited as a barrier. For example, 23% of Native Americans said the lack of transportation was a major problem in gaining access to health care services.

Race/ethnicity was identified as a barrier to receiving care. Forty-eight percent of African Americans agreed or strongly agreed that race or ethnic origin is a barrier to the receipt of health care services. The respective percentages for Native Americans, Hispanic Americans, and Asian Americans were 40%, 39%, and 30%.

Nebraska's vision of healthy individuals, families, and communities remains illusive to the growing racial/ethnic minority populations. To bridge the gap between the wide disparities in the health status of racial/ethnic minorities and White population, it is essential to address the high risk factor prevalence, the major barriers that limit access to health care services, and the lack of local public health services across the state.

Nebraska Title V planning activities include an ongoing consideration of these various demographic, socio-economic, and programmatic factors. A more detailed description of recent needs assessment activities is found in Section 3.1.1, but prior to and in conjunction with those activities has been a connection with various Nebraska Health and Human Services System initiatives to respond to the complex and competing factors which impact on the environment of health services delivery in the state. For instance, Nebraska Title V staff were actively involved in the development of a public health improvement plan as part of the Turning Point project. Much of the developmental work which the Nebraska Title V Program will be pursuing related to infrastructure will reflect the priorities and recommended strategies outlined in that plan.

Nebraska's executive and legislative leadership play additional key roles in considering and prioritizing the multiple factors that impact the health and wellbeing of the state's citizens, including the MCH/CSHCN populations. Described in greater detail elsewhere in the application are descriptions of major initiatives, such as the Blue Ribbon Panel on Infant Mortality, the Every Child Wanted, Nurtured and Supported Initiative, and the Children, Youth and Families Services Integration team, and new legislation such as the Women's Health Initiative and Newborn Hearing Screening, which have significant implications for prioritizing and addressing major MCH/CSHCN issues.

Finally, Nebraska Title V has continually used the State Systems Development Initiative grant (SSDI) as an opportunity to address and respond to health system issues. For instance, Years 4 through 6 of Nebraska's SSDI project specifically evaluated the impact of Medicaid managed care on CSHCN. In Year 7, the SSDI funds have been devoted to building the state's capacity to carry out effective planning activities, including needs assessments and development and tracking of performance measures.

## **1.5 The State Title V Agency**

### **1.5.1 State Agency Capacity**

#### **1.5.1.1 Organizational Structure**

The Nebraska Department of Health and Human Services is the State Title V agency. The Department is one of three agencies that form the Health and Human Services System. The other two agencies are the Department of Regulation and Licensure and the Department of Finance and Support.

Within the Department of Health and Human Services, the Division of Family Health provides the principle oversight for administration of the Title V/MCH Block Grant. During FY 2000, organizational changes were made to streamline this administrative function. A MCH Planning and Support Unit was formed, which reports to the Administrator for the Division of Family Health who is also the Title V/MCH Director. This unit is comprised of the MCH Grant Administrator, Program Analyst-Lead, and Administrative Assistant. Other programs and units within the Division of Family Health include: Commodity Supplemental Food Program, Immunizations, Newborn Screening and Genetics, Perinatal, Child and Adolescent Health (including school health and PRAMS), Reproductive Health, and WIC.

The MCH Planning and Support Unit is responsible for organizing and leading the development of the annual plan and report, including the needs assessment. In addition, the unit administers subgrants to communities, monitors allocations to other HHSS units and programs, and coordinates Title V funded activities with other public health programs within the Division and agency.

Also within the Department of Health and Human Services is Special Services for Children and Adults. The administrator for this unit is the Title V/CSHCN Director and the unit manages the Medically Handicapped Children's Program, the primary Title V/CSHCN activity. Other programs housed within this unit include: Aged and Disabled Waiver, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Adult Protective Services, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and the Early Intervention and Medicaid in public Schools Programs, which are co-administered with the Nebraska Department of Education.

Title V – both MCH and CSHCN – maintains a very collaborative relationship with the Medicaid program and Vital Statistics Management Unit, of which are located in the Finance and Support department, as well as the Data Management Unit in the Regulation and Licensure department. In addition, Title V works with a number of programs throughout NDHHS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, minority health, disease prevention, health promotion and education, and rural health. These programs do not receive federal Title V dollars, but through collaboration, are more able to use their funds efficiently to meet the needs of women and children.

An organizational chart displaying the agencies and units is found within the following pages.

Programs funded by the Federal-State Block Grant Partnership budget include allocations within the Health and Human Services System (HHSS) and twenty-two subgrants to community-based agencies. HHSS programs include these within the Department of Health and Human Services: Newborn Screening and Genetics, Immunizations, Reproductive Health, Perinatal, Child and Adolescent Health including school health and PRAMS, MCH Planning and Support, Division of Family Health Administrator, and the Medically Handicapped Children's Program. Department initiatives which have time limited financial support from the Title V/MCH Block Grant include the Blue Ribbon Panel on Infant Mortality and the Every Child Wanted, Nurtured and Supported Initiative. Within the Department of Regulation and Licensure, Title V/MCH Block Grant funds are allocated to the Birth Defects Registry and the Communicable Disease program.

Nebraska's Title V program has twenty-two subgrantees. These funded projects were selected through a competitive process completed in FY 1999. These projects were approved for a two-year period, July 1, 1999 through June 30, 2001.

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Department of Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71- 524. The Medically Handicapped Children's program is found in 71-1401, et seq. Finally, CSFP is found at 71-2226 and WIC at 71-2227.

A number of key pieces of legislation was passed in the 2000 legislative session. Nebraska now has a newborn hearing screening program. This becomes effective in July, 2000. Another important piece of legislation was the Office of Women's Health. The purpose of this Initiative is to improve the health of women in Nebraska by fostering the development of a comprehensive system of coordinated services, policy development, advocacy, and education.

### **1.5.1.2 Program Capacity**

Community level agencies will provide a number of services that encompass all levels of the public health pyramid. Primarily, MCH services include home visitation, assistance with prenatal care, and other support services to at-risk pregnant women (particularly teens) and families with infants and children, "safety net" primary and preventive care services to children, needs assessment activities for minority and newly arrived ethnic populations, and data linkage services to provide better assessment of health status. Preventive and primary care services for pregnant women, mothers, infants, and children are provided through these agencies, which have a long-standing relationship with Title V in Nebraska to provide high quality and effective services. These grantees will receive funding for a two-year period (FY00 and FY01).

State level programs receiving Title V/MCH funds that assure preventive and primary care services to pregnant women, mothers, infants, and children include the state's Perinatal, Child, and Adolescent Health Unit including school health and PRAMS, Newborn Screening and Genetics, Dental Health, Reproductive Health, STD, along with funding for the Birth Defects Registry. PRAMS has completed its pilot stage and has commenced in the formal CDC protocol. Data will begin to be available in fall of 2001.

Also at the state level, one program provides the majority of Title V-funded services to CSHCN – the Medically Handicapped Children's Program (MHCP). MHCP provides or pays for specialty and sub-specialty services through agency and contracted staff from a number of hospitals and private practitioners throughout the state. Many of these professionals participate in community-based multi-disciplinary team diagnostic and treatment planning clinic sessions, and they also offer

medical care and follow-up medical services. Community-based medical home family physicians and pediatricians also provide follow-up services and care coordination throughout Nebraska.

In addition, MHCP operates the SSI-Disabled Children's Program (DCP) for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). Services provided through the Nebraska SSI-Disabled Children's Program include transportation to enable children to obtain diagnostic and/or treatment services, sibling care, attendant care, respite care, meals and lodging while traveling to obtain medical care, personal care needs, utilities related to special high electrical use support equipment (e.g., nebulizers, oxygen concentrators, etc.), architectural modifications including wheelchair ramps, and specific items of equipment to maintain or improve functioning.

Nebraska has decided to adapt Utah's Maternal and Child Health Information Internet-Query Module (MatCHIIM). This system will provide the foundation for MCH data capacity within NHHSS, combining issues of policy, research, and standardized data management, all using applications of Internet technology. This significant enhancement of our data capacity is funded through SSDI.

### **1.5.1.3 Other Capacity**

As described in Section 1.5.1.1, the MCH Planning and Support Unit within the Division of Family Health has primary responsibility for the ongoing administration of the Title V/MCH Block grant. This unit also has primary responsibility for managing and implementing the SSDI project.

Programmatic activities are carried out by various staff within the Division of Family Health. The Perinatal, Child and Adolescent Health Unit within Family Health is responsible for: PRAMS, school health, adolescent health including abstinence education, child health, Healthy Mothers, Healthy Babies toll-free line, perinatal issues such as perinatal guidelines, management of the Substance Free for a Health Start Nebraska grant project and the MCH Providers Partnership project. This unit is staffed by 4.25 full time staff and a contract employee.

The Newborn Screening and Genetics Program staff is responsible for the oversight of Nebraska's newborn metabolic screening activities, genetics planning and development, and planning and implementation of newborn hearing screening. In addition, this program has lead NHHSS' activities related to neural tube defect prevention, and it is staffed by 3.75 employees.

In addition to administering the Title X grant, the Reproductive Health Program carries out a wide range of activities related to women's and adolescent health. This program leads the Nebraska Adolescent Pregnancy Network initiative, and is staffed by 4.0 employees.

The Division Administrator is the Project Director for the CISS Health Systems Development in Child Care Project, and participates in a wide range of collaborative activities and initiatives described elsewhere. She is supported by a 0.2 FTE staff assistant.

Paula Eurek, BS, RD, Title V/MCH Director, has been an employee of the Nebraska Department of Health and Human Services for 16 years. Her maternal and child health experience includes two years of community-level experience as a WIC nutritionist and over 10 years as a state-level WIC nutritionist and administrator. Ms. Eurek assumed the roles of Administrator for the Division of Family Health and Title V/MCH Director in December, 1995. She had prior experience as the interim MCH Division administrator in 1988-1989. Ms. Eurek has been actively involved in a number of efforts particularly focused on early

childhood issues, including the Good Beginnings Management Team, the Nebraska Interagency Coordinating Council, and the Nebraska Head Start State Collaboration Team, and has a special interest in the interfaces and integration opportunities between health and human services for children and families.

Mary Jo Iwan, BA, Title V/CSHCN Director, has been an employee of the Nebraska Department of Health and Human Services for 26 years. She has extensive experience working in programs to serve persons with disabilities, as well as broader based programs such as the Social Services Block Grant. Ms. Iwan assumed the role of Title V/CSHCN Director in 1991. She is actively involved in a number of Governor-appointed organizations, including the Developmental Disabilities Council, the Nebraska Interagency Coordinating Council, and the Governor's Task Force on Alzheimer's Disease and Related Disorders. She is also involved in activities at the national level, including membership on the Health Care Financing Administration (HCFA) Non-Institutional Long-Term Care Technical Assistance Group and HCFA Home and Community Quality Work Group.

### **1.5.2 State Agency Coordination**

In 1997, the State of Nebraska merged five distinct agencies: Nebraska Department of Health, Nebraska Department of Social Services, Department on Aging, Department of Public Institutions, and the Office of Juvenile Services. The new agency is called Nebraska Health and Human Services System. This reorganization has provided a multitude of opportunities for coordination among programs that previously did not work together.

Other state agencies are finding it easier to bring together groups from NHHSS to address issues as well. Examples specific to Title V/CSHCN include MHCP working with the Vocational Rehabilitation and Special Education Programs in Nebraska Department of Education to set up a model medical transition project for CSHCN attempting to adjust to the adult health care environment. Vocational Rehabilitation and MHCP also make referrals to each other for participants 13 years and older. MHCP is also working with Vocational Rehabilitation and the Mental Health program in NDHHS to establish a Traumatic Brain Injury care system for children in Nebraska.

Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral palsy, the Disabled Persons and Family Support Program, and other private non-profit programs all participated in coordinated funding meetings to assure that individuals receive services for which they are eligible. For over fifteen years, this group of providers and advocates has met to discuss individual care plans and find solutions which make the most efficient use of program resources.

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a letter to the family describing possible services they may receive and how to apply. The DDU and MHCP also worked together last year to compile a list of those impacted by the federal change in the definition of "disability" for SSI. All such persons were sent notices from MHCP and DDU which provided the toll-free telephone number of the Parent Training Center in Omaha, a private non-profit agency. This agency made families aware of their potential denial of SSI and the process to appeal the denial.

Described in additional detail in this application are a number of inter-program and inter-agency activities that are illustrative of the coordination that has emerged through the formation of the Health and Human Services System. Among these include the Children, Youth and Families Services Integration Team, which is designing integrated delivery systems for children

and families served by HHSS. Both the Title V MCH and CSHCN Directors are members of this team, as are directors of programs in the areas of child welfare, juvenile services, behavioral health, developmental disabilities, Medicaid, health promotion, and economic assistance. The newly formed Every Child Wanted, Nurtured and Supported Initiative will address teen pregnancy and unintended pregnancy issues from a broad systems perspective, and is staffed by representatives of TANF and Medicaid, as well as Family Health/Title V.

The Substance Free for a Healthy Start Nebraska Project represents a major coordination activity with the Department's substance abuse prevention programs. The establishment of a new state tobacco prevention program (\$21 million over 3 years, funded via the state's tobacco settlement) will create new resources for tobacco use prevention for youth and tobacco cessation programs. Title V/MCH staff will be actively involved in planning and implementing strategies associated with this new program.

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, a public health nurse with the Douglas County Health Department was a member of Nebraska's three-member team that attended child care health consultant training in North Carolina, as part of the CISS Health Child Care Nebraska project. Nebraska Title V has also worked closely with the Douglas County Health Department (DCHD) in support of Omaha Healthy Start, and DCHD is a collaborator in the Substance Free for a Healthy Start Nebraska Project. A staff person with the Lincoln/Lancaster County Health Department (LLCHD) teamed with the Title V/MCH Director in recent participation in the American Public Health Association's MCH Community Leadership Institute. Staff from both urban health departments participated as members of the needs assessment advisory committee and each has representatives on the Blue Ribbon Panel on Infant Mortality.

Nebraska Title V also works with smaller local health departments and other community health agencies, both as a funder and a collaborator. The Turning Point project will continue to provide new opportunities to further these working relationships.

Nebraska Title V works with a wide range of community health providers including its federally qualified health centers. For instance, the Charles Drew Health Center (CDHC) and Indian Chicano Health Center are part of Omaha's Child Health Clinics collaborative, a Title V funded project. In addition, CDHC also administers Omaha Healthy Start, and staff of CDHC are members of the Blue Ribbon Panel on Infant Mortality, the Every Child Wanted, Nurtured and Supported steering committee, and the needs assessment advisory committee. Panhandle Community Services (PCS), the federally qualified health center in western Nebraska, has been the site of one of two Combined Services Projects. Combined Services is a Nebraska model for integrated grant management and service delivery, including MCH services. PCS has carried out this model over the past five years. A three-year evaluation of the model was completed late in 1999, funded through a WIC Special Project grant. PCS's participation in this project and the subsequent evaluation has been invaluable to Nebraska Title V in better understanding integrated service delivery.

Nebraska Title V continues its working relationship with the Primary Care Office. A notable activity over the past year was the planning and implementation of the MCH Provider Partnership's future search conference. This conference focused on rural perinatal health issues.

Nebraska Title V works closely with a number of programs and departments within the University of Nebraska Medical Center (UNMC). The Munroe-Meyer Institute is a close collaborator on a number of CSHCN projects, and is the primary contractor for the Substance Free for a Health Start Project. Staff from the Institute participate as members of the Blue Ribbon Panel on Infant Mortality, the Map to Inclusive Child Care core team, and the needs assessment advisory committee. The Department of Pediatrics and CityMatCH staff have worked closely with Nebraska Title V in the area of data use and data training. They have provided guidance and technical assistance to the needs assessment process, and have provided consultation to the Blue Ribbon Panel on Infant Mortality. Nebraska Title V will be working closely with both staff and faculty at UNMC and the Boy's Town Institute in implementing newborn hearing screening. Many other working relationships exist with various faculty and staff throughout Nebraska's university systems, including the evaluation component of the Abstinence Education program and development and support of internet-based services for families of CSHCN and for school nurses.

Nebraska is looking forward to the possibility of a Masters in Public Health Program. This degree program is being proposed jointly by UNMC and the University of Nebraska – Omaha. Should this program become a reality, it will be a significant step forward in developing public health capacity in the state, including MCH and CSHCN capacity.

**Note: Pgs 15, 16, 17 and 18 are placeholders for organizational charts.**

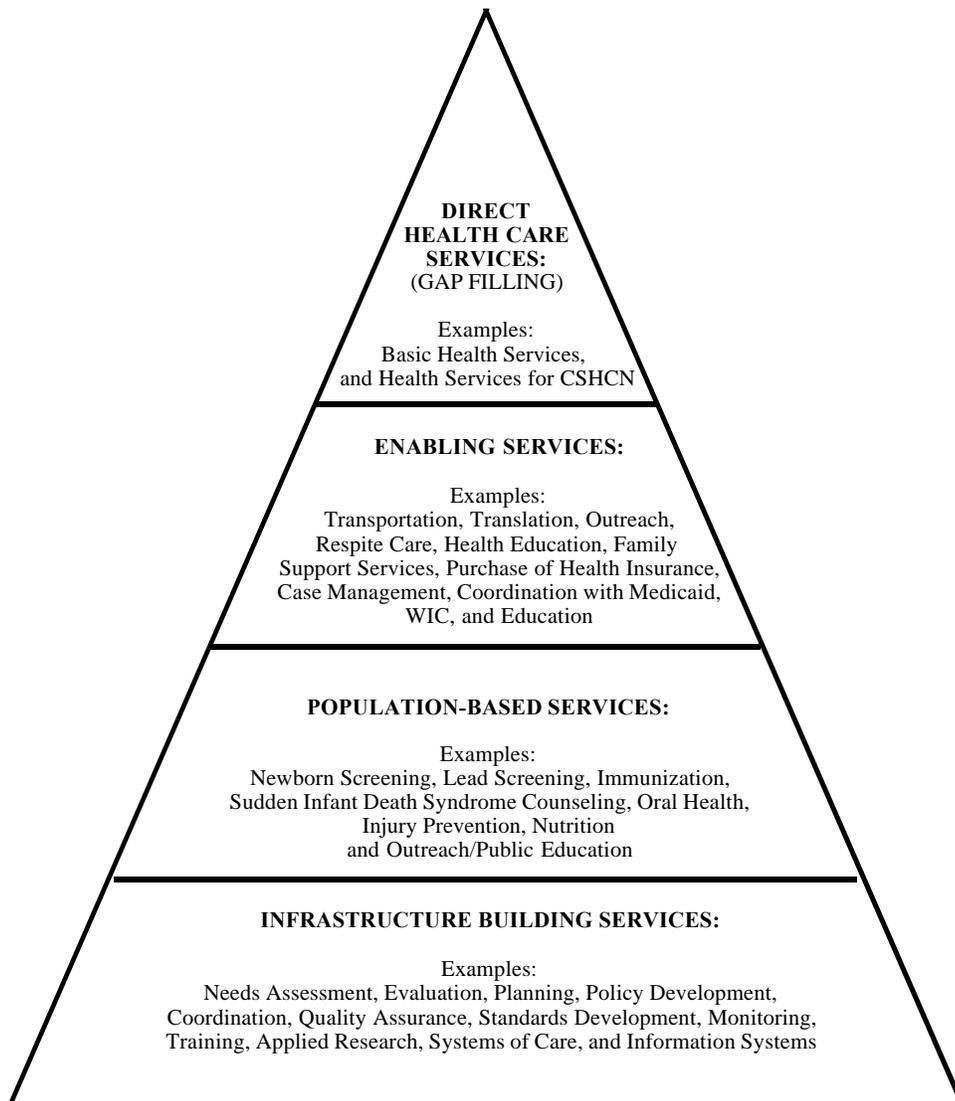






Figure 2

## CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



## II. REQUIREMENTS FOR THE ANNUAL REPORT

### 2.1 Annual Expenditures

See Form 3, Form 4, and Form 5, all of which are included under Section 5.8.

#### **Form 3:**

There has been a change in interpretation of the meaning of "Unobligated Balance" over the years since FY96. Although Nebraska reported an unobligated balance in FY96, since that time Nebraska has obligated the entire Federal Allocation of Title V funds, and as a result, reports a zero balance for this line. NHHSS staff within the Financial Services Division of the Finance and Support agency who have worked with Title V and a number of other federal public health program funds for many years assist Title V staff in budgeting and awarding funds each year. Because these accounting staff have worked with Title V funds for a number of years, they are quite familiar with the requirement for spending the previous year's dollars in the two-year funding cycle prior to spending the current fiscal year allocation. Accounting methods used reflect constant monitoring of these funds, with each year's allocation being given a different accounting code to help assure that "oldest" dollars are spent first. The FY99 expenditures of the federal allocation (\$4,927,698) exceed the budget (\$4,131,363), due to \$709,4442 from the FY98 federal allocation that was obligated in FY98, although actually expended in FY99.

Looking at the state and local contribution to the Federal-State Partnership, expenditures in the categories of "Total State Funds" and "Local MCH Funds" are reported separately for FY99, and are derived from different sources, i.e. expenditure of state general funds is an internal NHHS accounting function, while the reports of local subgrantees' match expenditures are reported by the community agency to the Title V Grant Administrator, and are not a function of the NHHS accounting unit. Beginning with the FY00 budget, the amounts for the categories "Total State Funds" and "Local MCH Funds" are actually totaled and reported together as "Total State Funds" to eliminate the warning message in ERP that the state match requirement is not met. These limitations in ERP contribute to some confusion regarding reporting expenditures in FY99 because prior years were budgeted with a breakdown of "Total State Funds" and a third category entitled "Other Funds". For FY99, the combined expenditures of "Total State Funds" and "Local MCH Funds" are state general funds (\$1,830,959) and local subgrantee's match (\$1,740,170), respectively, totalling \$3,571,129.

Although budget will be addressed in Section 3.3, the combined "Total State Funds" that Nebraska is budgeting for FY01 is \$3,885,843, which meets the match requirement. The actual State general funds budgeted for FY2001 are \$1,788,613. Local funds are derived from the match provided by the local Title V subgrantees, which actual amount for the FY2001 budget is \$2,097,230.

The reporting categories in Form 3, coupled with the limitations of the Electronic Reporting Package (ERP), create complexities which do not allow a clear view of reality, especially when making a year-to-year comparison of budget and expenditures between years where there were different reporting practices.

#### **Form 4:**

Variations between budget and expenditures for FY 1999 are due in large part to obligated funds from the previous fiscal year expended in FY 1999 after budgeting was completed. This is a particularly logical explanation for instances where expenditures exceed budgeted amounts. Conversely, when expenditures were less than budgeted amounts, the reason is likely due to unforeseen changes at the community-level, e.g. staff turnovers and qualified personnel shortages causing delays in hiring or rehiring, which in either case can reduce expenditures dramatically. Since expenditures reported on this form reflect a combination of federal grant allocation, state general funds, and local match, it is of importance to note that the state-level agency is unable to direct community-level agencies in the source and subsequently the designation of match. In fact, the designation of local match is often dictated by what sources of match are available to the community-level agencies and subsequently where their administration determines the matched funds should be categorized. In FY 1999, the local match funds were separated from the state funds in Form 3, and from there it can be observed that the expenditures exceeded the budget, i.e. more match was obtained than what had been anticipated. A possible explanation, particularly as it relates to the budget-to-expenditure variance for pregnant women, children 1-22, and children with special health care needs, is that the additional local match was directed towards these types of individuals in FY 1999, with less local match support than expected for infants and women of reproductive age and/or postpartum.

The budgets of community-based agencies who receive Title V funds contribute a point of reference in the budgeting process for the state's Title V Block Grant Application. The variance in several lines between budgeted and expended columns in FY99 is further likely due to several additional considerations as it relates to limited resources in community-level agencies. First, the budgeting process in smaller, community-based agencies is likely a time- and labor-intensive effort where there are already scarce resources, which activity itself further tugs at those resources. Local agencies' prioritization of resources is directed at program and service provision, rather than administration. At the state level, there will continue to be attention given to providing technical assistance to local subgrantees to achieve greater predictability in budgeting by line item. Nebraska allows line item budget revisions throughout the grant period, which can further contribute to the variation between budget and expenditures. Further contributing to these variations, budgeting and reporting expenditures by types of individuals is already an inexact science, applied to fluctuating line item budgets.

**Form 5:**

As with the variances in Form 4, variances between budget and expenditures for FY 1999 are due in large part to obligated funds from the previous fiscal year expended in FY 1999 after budgeting was completed. This is a particularly logical explanation for instances where expenditures exceeded budgeted amounts. Conversely, when expenditures were less than budgeted amounts, the reason is likely due to unforeseen changes at the community-level, e.g. staff turnovers and qualified personnel shortages causing delays in hiring or rehiring, which in either case can reduce expenditures dramatically.

Building infrastructure services in Nebraska is of great importance, which is reflected in the budget and expenditures for this type of service. Shifting Title V funds away from direct health care services towards building infrastructure services is indicated in both budgeted and expended funds since FY96. In FY99, each community-level grantee was further encouraged and supported in building infrastructure, with \$7,000 included in their awards to be used specifically for network development. However, the variation between budgeted and expended funds for infrastructure building in FY99 is more a reflection of where Nebraska is going, although has not yet arrived at the goal. A possible explanation, particularly as it relates to the budget-to-expenditure variance for infrastructure building, is that more local match was supported in areas of direct services and population-based services than what was directed towards infrastructure building services in FY 1999. As with budgeting and reporting expenditures by types of individuals, the process of budgeting and reporting expenditures by types of services will continue to be addressed at the state level through technical assistance to local subgrantees to achieve greater predictability.

## **2.2 Annual Number of Individuals Served**

See Form 6, Form 7, Form 8, and Form 9, all of which are included under Section 5.4.

### **Form 6:**

The Nebraska Newborn Screening Program (NNSP) screened for biotinidase deficiency, congenital primary hypothyroidism, galactosemia, hemoglobinopathies, and phenylketonuria (PKU) in 1999. A total of 23,932 infants were screened for all of these disorders in 1999. There were 78 home births screened in 1999 and the NNSP continued community collaborations in order to facilitate obtaining the screening of these births. Infants diagnosed as positive for the following disorders were detected and facilitated into treatment through newborn screening: two infants with biotinidase deficiency, thirteen infants with congenital primary hypothyroidism; three infants with sickle cell disease, and one infant with phenylketonuria.

During 1999, The Nebraska Newborn Screening Technical Advisory Committee was very active in assisting the NNSP in applying quality assurance measures and responding to emerging issues in the newborn screening field. The committee met in January, May, October and December of 1999. Efforts to expand the consumer representation on the committee resulted in adding two parents in 1999. The committee addressed the emerging issue of screening using Tandem Mass Spectrometry (TMS) technology. The NNSP collected a great deal of information about TMS and the conditions detected by this instrument to share with the committee in their deliberations. By December 1999 the Newborn Screening Technical Advisory Committee had made the following recommendations to the NNSP: 1. Finding that Medium chain acyl-coA dehydrogenase deficiency (MCAD) meets the written criteria for adding this disease to the newborn screening panel, the Newborn Screening Technical Advisory Committee (NBSTAC) advises the Nebraska Newborn Screening program to add MCAD to the newborn screening panel; 2. Finding that the only acceptable screening method currently available to screen for MCAD is tandem mass spectrometry; and finding it unethical to suppress or not report results obtained using this method; the Newborn Screening Technical Advisory Committee advises the Nebraska newborn Screening Program to draft regulations that would require tandem mass spectrometry to screen for all the diseases for which this methodology is capable. More discussions on how to best structure and manage a newborn screening system that might incorporate screening for MCAD by tandem mass spectrometry are scheduled for Year 2000.

Although the following activity occurred during FY98, the implications have had a long-term affect on improving the efforts of the Nebraska Newborn Screening Program (NNSP). In FY 98, NNSP staff and the NHHSS Medical Advisor met with representatives of the three newborn screening laboratories to discuss laboratory variation in written and phone-in reporting in an

attempt to gain greater consistency among them, as well as their variations in testing methodology and CDC proficiency testing results. A set of quality assurance measures for the labs was developed by NNSP and initiated in May of 1998 when regulation revisions were implemented. Additionally, the program developed alternative strategies to ensure all infants were screened by working directly with parents or with community-based social service and home health agencies when the family was otherwise unable to have their infant screened or simply refused. A contract was developed with a home health agency in Nebraska's largest metropolitan area to assist with obtaining screening and confirmation specimens for certain cases referred by the program.

**Form 7:**

According to Form 7, a total of 55,077 individuals (pregnant women, infants, and children, children with special health care needs, and others) were served by Title V in Nebraska in 1999. These numbers were served primarily by fourteen community-based programs, NHHSS Medically Handicapped Children's Program, and Family Planning. Most of the other state-level programs funded through Title V offer more population-based or infrastructure building services. It is important to note that those services that are population-based are not included in this table, since health care coverage is unknown for participants in these programs. Of those participants included in the table, it appears that the majority of pregnant women and infants served by Title V in Nebraska were covered by Medicaid. In FY99 there was an increase in the percentage served in the category "children age 1 to 22" without health care coverage. While this could be alarming especially with respect to the September 1998 initiation of Kids Connection, Nebraska's SCHIP, on closer scrutiny, however, this increase is in percentage, not in actual numbers served, suggesting that Title V funds are becoming more reserved for those children who might otherwise fall between Medicaid and private insurance coverage. The percentage covered by private insurance/other, however, in 1999 also dropped, perhaps implying that health care coverage under Kids Connection was sought rather than through private insurance. The majority of children with special health care needs continue to be covered primarily by Medicaid.

Of particular importance to note regarding Form 7, individuals receiving Family Planning services are included in "Children 1 to 22" and "Other Individuals" categories. Because of the tracking methods required by Title X, Family Planning recipients in the "Children 1 to 22" category only include "children 1 through 19." Both of these categories may include pregnant women, postpartum and deliveries; however, program data is not collected in a manner which allows for identification by this category.

In addition to the Family Planning numbers shown in the table, Family Planning Community Education sessions were provided to an estimated 11,998 adolescents (6,804 females and 5,194 males) and 5,357 adults (3,403 females and 1,954 males). No information on insurance is available for attendees of these sessions.

Of the count given in the table, in the Children with Special Health Care Needs (CSHCN) category, actually 3,198 children were served through MHCP in FY99, while 1,297 were served through other Title V grantees, for a total of 4,495.

Additional individuals not included in the table, but served by Title V within public health efforts and population-based services, include the following:

- 1) Newborn Screening: A total of 23,932 children born in Nebraska were screened in 1999 (all but nine live births).
- 2) School Health: An estimated 240,000 students, which is approximately 75% of total public school enrollment, and 56% of total non-public school enrollment, were served in 1999 through school nursing surveillance.
- 3) Dental Health: The school-based fluoride mouthrinse program served 30,663 school children in 1999.

Because health insurance coverage cannot be determined, or even estimated for these groups, they are not included in the table.

**Form 8:**

Nebraska's vital records reporting has been delayed for CY99 due to the conversion from ICD-9 to ICD-10 codes and adding electronic certificates to their system capability. As a result, data for total deliveries and total infants will be delayed past September 2000. Actual data collected for FY99 was not truly reflective of the new reporting categories introduced in FY00 for race. Efforts will be made to correct the data collection for FY01 to comply with the new reporting categories.

**Form 9:**

The Perinatal, Child and Adolescent Health Program continues to contract with the Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's Title V toll-free telephone line. The HM/HB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, Title V and Title XIX provider information, and referrals. Efforts continue to improve the quality and increase the usage of the line. Recent additional uses of the line include newborn screening disorder-specific health and referral information, Kids Connection information, folic acid supplementation information and referral information related to perinatal substance use/abuse for Douglas County (with plans of expanding this to statewide service within the next three years). Monthly call report data are tracked and analyzed in order to guide publicity efforts. These data also show that publicity efforts continue to pay off. When the line first began in 1992, calls averaged at 7 per month. In FY 1999, the average was 64 per month. A substantial portion of referrals have gone to medical services, including Title XIX services and related social services. The HM/HB Helpline staff have received training on Kids Connection. The state-level contact person for the helpline has changed as a result of a staff change and subsequent reconfiguration in the Family Health Division's organizational structure, although the responsibilities of the position remain largely the same as prior to the reconfiguration and staff change.

**2.3 State Summary Profile**

See Form 10, which is included under Section 5.8.

## 2.4 Progress on Annual Performance Measures

The references to priority needs found in the following pages are to those priority needs as were identified for the FY 1999 Application. New priority needs have been identified for the upcoming year, as a result of the comprehensive needs assessment.

### **PM #1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure will clearly related to Priority Need #1: To improve access to specialty care for CSHCN." More SSI beneficiaries less than 16 years old receiving rehabilitative serves from Nebraska's CSHCN program is one indication of improved access to specialty care services.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Direct Health Care	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

#### **Capacity/Resource Capability:**

The Medically Handicapped Children's Program (MHCP), Nebraska's Title V/CSHCN Program, operates the SSI-Disabled Children's Program for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by Nebraska's Medicaid Program.

#### **Program Activities:**

- Continued to operate the SSI-Disabled Children's Program through MHCP.
- Continued to provide outreach to hose families who are referred by the Sate Disabilities Determination Section as eligible to receive SSI benefits and are under age 16.
- Continuation of marketing of the SSI-Disabled Children's Program.

#### **Progress Toward Performance Measure:**

Most recent statistics reported in "Children Receiving SSI: June 1999", indicate that 3152 children in NE under age 16 receive SSI. This is approximately 35.6% of NE SSI beneficiaries less than 16 years old who are receiving rehabilitative services from the NE CSHCN program.

**PM #2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure clearly related to Priority Need #1: To improve access to specialty care for CSHCN.” The ability of Nebraska’s CSHCN Program to provide or pay for specialty and subspecialty services not otherwise accessible or affordable to its clients is the cornerstone of activities necessary to improve access to specialty care for CSHCN.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Direct Health Care	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children’s Program (MHCP), Nebraska’s Title V/CSHCN Program coordinates with the University of Nebraska Medical Center (UNMC), Creighton University Medical School, and appropriate community-based specialists and sub-specialists statewide to provide specialty and subspecialty care to CSHCN. Multidisciplinary teams, which includes a MHCP service coordinator, are located in many larger communities. Since appropriate specialists and sub-specialists are not always available in the local communities, personnel from UNMC’s Munroe-Meyer Institute (MMI) are contracted to provide the personnel to complete the multidisciplinary team composition. Other teams made up of UNMC and private specialists and sub-specialists travel to rural communities to conduct specialty care clinics (e.g., craniofacial and cystic fibrosis clinics), develop care plans, and coordinate with the local medical community to assure a medical home.

Title V funds also support the Statewide Genetics Clinics program at MMI, which travels throughout the state to offer genetic counseling and other services through team-based clinics. The Genetics Clinics and MHCP collaborate to utilize the same specialists for MCHP Cerebral Palsy Clinics and Genetics Clinics on subsequent days in order to lower travel costs and build a continuity of specialty and subspecialty care.

**Program Activities:**

- Continued to provide MHCP multidisciplinary team clinics throughout Nebraska.
- Through MHCP’s Clinic Quality Assurance initiative, emphasized services coordination and the provision of assistance to families, when needed, in connection with appropriate specialty and subspecialty care.
- Continued to provide service coordination at the local level through collaboration with other appropriate services for which persons are found to be eligible, in order to assure access to all appropriate care.
- Continued to provide payment for specialty and subspecialty services not otherwise provided through MHCP to participants in the program.
- Continued to fund the Statewide Genetics Clinics at MMI, which travels statewide and collaborates with MHCP for continuity and efficiency.

**Progress Toward Performance Measure:**

In FY99, Nebraska continued to meet all requirements for this measure. With a maximum optional indicator of 9, indicating that Nebraska provided or paid for all possible specialty and subspecialty services through MHCP, the performance objective was consistently met again in FY99. For specific listing of specialty and subspecialty services, see the checklist behind the detail page for PM #2.

**PM #3: The percent of children with special health care needs (CSHCN) in the State who have a “medical/health home”.**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure will clearly related to Priority Need #1: To improve access to specialty care for CSHCN” as well as Priority Need #2: “To identify the gaps in adequate health care for adolescents with special health care needs as they transition from childhood to adult service.” If more CSHCN have a medical home, then more will have access to specialty care, and fewer gaps in care will exist as those who are adolescents transition from childhood to adult services.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Enabling Service	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children’s Program (MHCP), Nebraska’s Title V/CSHCN Program is involved in a number of projects aimed at, among other things, increasing the number of CSHCN who have a medical home. It is believed that working with families, other advocates and the medical community to determine a local medical home for CSHCN has and will continue to shift the responsibility of care and coordination from the state to the local level. This work is achieved through a variety of collaborations with UNMC, Creighton University, Boys Town National Institute, Vocational Rehabilitation, Department of Education Special Education, NHHSS programs including Medicaid and Developmental Disabilities, families, advocates, and local medical and education professionals throughout the state.

**Program Activities:**

- Continued to engage local medical professionals in MHCP multidisciplinary team clinics throughout Nebraska as primary contacts for CSHCN assisted through the program.
- Addressed the issue of transitioning CSHCN from pediatric specialty and subspecialty providers to the adult health care environment.
- Continued to provide a comprehensive system of multidisciplinary clinical services specifically around genetic disorders, congenital anomalies, and neurodevelopmental disabilities throughout the state, as well as outreach and training to families and medical professionals on genetic issues (carried out through UNMC Munroe-Meyer Institute).
- A presentation of the formal medical home concept (with emphasis on the substitution of a family practice physician for a pediatrician as an acceptable option) as outlined by the American Academy of Pediatrics to all Title V, CSHCN staff in the field was developed.
- Quality Assurance Outcomes and Process have been developed and implemented in conjunction with CSHCN multidisciplinary teams throughout Nebraska.

**Progress Toward Performance Measure:**

According to synthetic\* estimates, Nebraska has 78% of the CSHCN population with medical homes.

\*based on 1994 NHIS data and on 1996 CPS data.

**PM #4: The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g., the sickle cell disease) (combined)].**

<b>Relationship to priority need:</b> The priority needs were developed in direct correlation with the State Negotiated Performance Measures, therefore this National Core Performance Measure did not relate specifically to any of the Priority needs. Newborn screening activities prevent, in extreme cases, infant death.	
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

By state statute, the Nebraska Newborn Screening Program (NNSP), which is funded primarily through Title V funds, has the responsibility to assure a system for screening all newborns and that all infants identified with a positive screening result are tracked. Nebraska does not have a centralized screening system, but instead established standards for and is currently working with two labs to maintain quality and consistency.

**Program Activities:**

- NNSP continued efforts to assure all newborns were screened for PKU, hypothyroidism, biotinidase deficiency, hemoglobinopathies, and galactosemia, and that all infants identified with a positive screening result were tracked.
- Continued NNSP policy of notifying parents of all abnormal hemoglobinopathies.
- Continued to advocate for a centralized newborn screening system in an effort to improve quality and effectiveness.

**Progress Toward Performance Measure:**

Using provisional NE 1999 birth data, 99.6% of newborns received at least one screen for each PKU, hypothyroidism, galactosemia, and hemoglobinopathies.

**PM #5: Percent of children through age two who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, haemophilus influenza, and hepatitis B.**

<b>Relationship to priority need:</b> The priority needs were developed in direct correlation with the State Negotiated Performance Measures, therefore this National Core Performance Measure did not relate specifically to any of the Priority needs. This measure has a relationship to Priority Need #6: "To promote safe environments and behaviors for all children and their caretakers." Vaccines are a very effective method of preventing certain illnesses, and can help assure a strong foundation for good health in the first two years of life. Parents who follow through on the recommended schedule of immunizations will, most likely, encourage other safe behaviors in their children throughout their lifetime.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Nebraska Immunization Program provides vaccine to immunization clinics throughout the state, and coordinates outreach services, such as transportation and translation. Nebraska's Title V funds support outreach services within several community-based agencies as part of comprehensive child health services offered by the agencies.

**Program Activities:**

- The Nebraska Immunization Program continued to provide vaccine to residents of Nebraska through a network of public immunization clinics and a school-based clinic.
- Through collaborative efforts between Title V and the Nebraska Immunization Program, coordinated outreach services allowed families to access services more easily.
- Continued to fund several community-based programs that address child health issues through one-on-one outreach with families, which includes education on the importance of immunizations and assistance (e.g., transportation, translation serves) in assuring that children receive immunizations.
- Worked closely with the Medicaid program to assure access to vaccines for Medicaid and SCHIP enrolled children.

**Progress Toward Performance Measure:**

From July, 1998 to June 1999, Nebraska's immunization rate for the 4-3-1-3-3 series was 78.4%, according to CDC's National Immunization Survey. 1999 is the first year that Nebraska has used the 4-3-1-3-3 series for reporting purposes. In the past, the 4-3-1-3 series was reported.

**PM #6: The rate of births (per 1,000) for teenagers aged 15 through 17 years**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #4: “To promote healthy lifestyles in women of child-bearing age,” as well as Priority Need #7: “To promote healthy lifestyles among youth.” If the teen birth rate can be lowered, though this is not necessarily indicative of a decreased teen pregnancy rate, it is possible that more teens—particularly young women—are engaging in fewer risky behaviors. Such a trend would relate directly to the number of youth and women of child-bearing age who engage in healthy lifestyles.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Title V funds support teen pregnancy prevention activities in Nebraska through a number of venues. The School and Child Health Nurse Consultant offers training and materials to school nurses on a variety of strategies to address teen pregnancy prevention. The Adolescent Health Coordinator oversees Title V Abstinence Education activities throughout the state. The Reproductive Health Program provides education, materials, and birth control methods through community-based clinics in the state, and several community-based Title V-funded programs offer teen pregnancy prevention activities as part or all of their curriculum.

**Program Activities:**

- Continued to fund several community-based programs through Title V that address teen pregnancy issues as part or all of their curriculum
- Reproductive health sub-grantees used Title V money for individual education or community education presentations including abstinence and post-poning sexual activity focussed on teen pregnancy prevention.
- Continued to support education and educational materials.
- Continued to support the School and Adolescent Health Program’s ability to provide training and materials to school nurses on teen pregnancy issues.
- Coordinated activities with the MCHB Abstinence Education Program in Nebraska.
- Collaborated with other state and local program staff to develop the Nebraska Adolescent Pregnancy Network (NAPN).

**Progress Made on Performance Measure:**

Provisional 1999 birth data provided by the National Vital Statistics Reports (V. 48, No. 14, August 8, 2000) indicated that NE had 10.5% of live births to mothers under 20 years old.

**PM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #8: "To improve access to needed health services for children in Nebraska's schools," as well as Priority Need #9: "To improve access to dentistry services for Medicaid-eligible children." Since sealants might be considered a substitute indicator of dental access, and since the surveillance of this measure typically occurs through school systems, increasing the percent of third grade children with protective sealants would also indicate improved access to health services for children in schools, as well as improved access to dentistry services for Medicaid-eligible children.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The NHHSS Dental Health Division, is working to train school nurses on oral health screening services. School nurses currently provide fluoride mouth rinse to students, and will also use this opportunity to screen for dental sealants. In the past, no surveillance of this measure was available.

**Program Activities:**

- The NHHSS Dental Health Division offered training to school nurses on dental screening, and specifically on surveillance of dental sealants.
- The NHHSS Dental Health Division continued to provide materials to schools that can be shared with parents throughout the state on the importance of oral health.

**Progress Made on Performance Measure:**

1999 data is currently unavailable. 1998 is the most current available. In 1997 and 1998 NE used a proxy measure of Medicaid eligible children because statewide surveillance of this issue does not occur. In 1998, 10.4% of third grade children received protective sealants.

**PM #8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #6: "To promote safe environments and behaviors for all children and their caretakers," as well as Priority Need #7: "To promote healthy lifestyles among youth." Strategies taken to reduce the rate of death among children due to motor vehicle crashes are part of promoting safe environments and behaviors for those children and promoting healthy lifestyles among them.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Nebraska Office of Highway Safety provided a staff person to NDHHS to coordinate Nebraska's Safe Communities, an adolescent motor vehicle crash prevention program. In addition, their efforts include education and materials, surveillance, and a great deal of collaboration with already existing public health programs, including those funded by Title V. Emergency Medical Services for Children (EMSC) activities increased state capacity to appropriately respond to pediatric emergencies, including motor vehicle crashes. Finally, Nebraska's Child Death Review Team provides valuable information to plan future strategies to reduce fatality rates.

**Program Activities:**

- Through staff provided by the Nebraska Office of Highway Safety, continued to provide education and materials to the general public, particularly focused on school-aged children, on the importance of motor vehicle safety.
- More than 20 communities have Nebraska Safe Communities coalitions to address adolescent motor vehicle safety.
- Continued collaboration with and support of EMSC activities.
- Continued participation in and utilization of Child Death Review Team Report.

**Progress Made on Performance Measure:**

1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had a rate of 6.5 deaths per 100,000 children due to motor vehicle crashes. This is a slight increase from 1997 (5.9).

## PM #9: Percentage of mothers who breastfeed their infants at hospital discharge

<b>Relationship to priority need:</b> The priority needs were developed in direct correlation with the State Negotiated Performance Measures, therefore this National Core Performance Measure did not closely relate to any of the Priority Needs. It is possible that this measure had some relationship to Priority Need #6: "To promote safe environments and behaviors for all children and their caretakers." Since breastfeeding is known to have immunological, nutritional, and psychological benefits for the baby, increasing the percentage of mothers who initiate and continue to breastfeed would also promote a more healthful environment for the baby.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Several community-based Title V-funded programs offered education and assistance to mothers, and all who serve pregnant and parenting women give particular attention to breastfeeding. Three of these programs had at least one lactation consultant, and all had a protocol to follow in dealing with problems in breastfeeding. The WIC Program focuses on breastfeeding as one of its primary goals, with a breastfeeding educator on staff at the state level as well as in all local agencies. Title V and WIC collaborate closely to provide one-on-one education and support, as well as public awareness activities.

### Program Activities:

- Continued to fund community-based programs through Title V that offer education and assistance regarding breastfeeding
- Continued collaborating with WIC to provide one-on-one education and support and conduct public awareness activities on breastfeeding
- Worked with local breastfeeding coalition to promote World Breastfeeding Week

### Progress Made on Performance Measure:

According to the Ross Laboratories Mothers Survey, the prevalence of mothers reported initiating breastfeeding while in the hospital in Nebraska has increased from 60.3% in 1990 to 68.1% in 1998. The prevalence of mothers still breastfeeding after six months has also increased from 1990 to 1998, from 20.7% to 30.8%. Breastfeeding rates among WIC mothers, while still less than overall Nebraska mothers, has increased from 45.7% in 1990 to 56.6% in 1998. The prevalence of mothers still breastfeeding after six months has increased from 9.5% to 24.1%. 1998 numbers are the most recent available.

**PM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #1: "To improve access to specialty care for children with special health care needs." If a higher percentage of newborns are screened for hearing impairment before hospital discharge, more of those with an impairment will be diagnosed, receive timely follow-up, and engage in specialty care.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

The 2000 Nebraska Legislature passed a bill encouraging universal newborn hearing screening (UNHS). If by 12/1/03 >95% of newborns are screened, regulations are to be passed to "require" UNHS. Technical assistance provided by Nebraska's Newborn Screening Program representatives contributed to changes in the draft bill that recognized the significance of a centralized surveillance and tracking system in assuring a successful comprehensive screening system. The legislation included funding for a full-time employee to coordinate activities to implement the screening system (to be hired in 200). At this time 8 hospitals in the state are conducting some level of screening (targeted high risk, or universal), and the number of hospitals is expected to increase each year, however, there is little consistency in the protocol of those conducting screening. The programs coordinator to be hired will facilitate development of standardized guidelines and protocols.

**Program Activities:**

- Through eight hospitals, mostly in Omaha and Lincoln, newborn hearing screening prior to hospital discharge occurred.
- Technical assistance was provided for the draft bill to include mechanisms for a tracking and surveillance system.

**Progress Made on Performance Measure:**

In CY 1999, the percentage of newborns screened was 28.4%\* which more than doubled the percentage screened before discharge from CY98. \*Percentage is based on 6791 newborns screened of 23,907 live births as reported by the National Vital Statistics Reports (V. 48, No. 14, August 8, 2000).

**PM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #1: "To improve access to specialty care for children with special health care needs." If a higher percentage of CSHCN in Nebraska's CSHCN program have a source of insurance, their ability to access specialty care services will also increase.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children's Program is involved in a number of activities that intend to increase the number of children with special health care needs who are covered by some type of health care insurance. MHCP service coordinators work with participating families to pursue any avenue that might lead to enhanced services for their children, including health care coverage. MHCP administrators, in collaborating on projects such as quality assurance for Medicaid Managed Care or better transition from childhood to adult health care, also work to address health care coverage.

**Program Activities:**

- Continued to provide service coordination activities through MHCP, including health care coverage
- Continued to work with the Boys Town National Research Center to examine the effects of Medicaid Managed Care on children with special health care needs, including the training of services coordinators and managed care plan care coordinators on accessing necessary care
- Advocated for children with special health care needs in the development of Kids Connection (SCHIP), with particular regard for marketing of the Medicaid program, entry into/eligibility for Medicaid, and health care and enabling services provided by Medicaid for children with special health care needs
- Worked to address issues of transition of children with special health care needs from pediatric specialty and subspecialty providers to the adult health care environment as a portion of the IEP
- Through Title V-supported program at UNMC's Munroe-Meyer Institute, continued providing a comprehensive system of multidisciplinary clinical services around genetic disorders, which includes assistance with health care coverage
- Through the School and Adolescent Health Program, continued to train and assist school nurses in accessing a multitude of services for children with special health care needs, and in assisting families in garnering health care coverage

**Progress Made on Performance Measure:**

According to the Medically Handicapped Children's Program, 94% of Nebraska's CSHCN were covered either by private insurance or Medicaid (3006/3198) in 1999.

**PM #12: Percent of children without health insurance**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #1: “To improve access to specialty care for children with special health care needs.” If more children have health insurance, then more children with special health care needs have access to specialty care. In addition, there was some relationship to Priority Need #6: “To promote safe environments and behaviors for all children and their caretakers.” Insurance coverage helps assure access to routine primary care and thus anticipatory guidance on preventive measures.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Title V state-level staff have been involved in addressing lack of insurance for children through the development and implementation of Kids Connection – Nebraska’s State Children’s Health Insurance Program (SCHIP). Several hallmarks of Kids Connection is that enrollment establishes twelve months continuous eligibility. As a Medicaid expansion rather than a separate program, utilization of services is through existing Medicaid-enrolled providers. Title V state-level staff participated in the first year activities of a statewide coalition directly related to Medicaid. The coalition stems from the Covering Kids Initiative. This three-year initiative, sponsored by Robert Wood Johnson, seeks to enroll eligible uninsured children across the state in Kids Connection. The coalition is charged with providing input to the lead agency, Voices for Children, to conduct outreach and enrollment for Kids Connection. Local efforts are provided through pilot programs in three agencies with MCH programs funded by Title V. Title V staff intend to remain involved in monitoring three progress of this program over time. Collaboration between these state divisions minimizes Title V funds being used where Medicaid reimbursement for covered services is feasible.

Staff have also worked to develop an agreement between the Family Health Division and Medicaid to allow Title V overmatch to draw down Medicaid administrative match funds that will be set aside for Title V grantees to use for EPSDT outreach activities. The interagency agreement was formalized for a one-year period, which mirrored State FY99 and renewed annually thereafter. The overmatch agreement was not implemented and has expired. Several factors contributed to this shortcoming from the original plan: 1) the absence of anticipated overmatch for Title V, in part due to no minimum requirement from the local subgrantees at that time, and 2) change in administrative priorities for the Medicaid Program.

**Program Activities:**

- Continued involvement with Kids Connection in Nebraska particularly through a statewide coalition.
- Provided training and technical assistance to Title V grantees and other health-related programs to foster their understanding of this new insurance coverage for families

**Progress Made on Performance Measure:**

Prior to the implementation of Nebraska’s SCHIP program in 1998, there were an estimated 24,000 uninsured children at 185% of the federal poverty level. Through September, 1999, 5,983 uninsured children were enrolled in the SCHIP program. The total number of uninsured children enrolled in the Medicaid Program in September, 1999, was 84,609. Of the 108,102 enrolled children in September, 1999, 17,510 had health coverage in addition to SCHIP.

**PM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #7: “To promote healthy lifestyles among youth,” as well as Priority Need #9: “To improve access to dentistry services for Medicaid-eligible children.” If more potentially Medicaid eligible children receive some type of health service through Medicaid, particularly preventive health services, healthy lifestyle behaviors will be encouraged. If more are receiving a service through Medicaid, the use of (and thus, access to) Medicaid purchased dentistry services will also increase.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building	<b>Type of Service:</b> Process
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Because Title V funds are proportionately 1% of federal Medicaid funds used in Nebraska annually, it continues to be a high priority to assure that Medicaid pays for all appropriate services for eligible persons. Ten Title V-funded community-based programs also provide Medicaid-funded services, and these programs allocate resources appropriately to the pursuit of Medicaid reimbursement. State level Title V staff continually work with Medicaid to assure that Title V grantees are utilizing Medicaid reimbursement for services whenever possible.

**Program Activities:**

- Continued to work with the Medicaid program and Title V-funded community-based grantees to assure that these grantees are utilizing Medicaid reimbursement for services whenever possible
- Continued working with other state-level programs, such as School and Adolescent Health Program, Dental Health Division, and Reproductive Health Program, to assure use of Medicaid whenever appropriate

**Progress Made on Performance Measure:**

The percent of potentially Medicaid eligible children who received at least one service paid by the Medicaid program is 92.7%.

**PM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #1: “To improve access to specialty care for children with special health care needs,” as well as Priority Need #2: “To identify the gaps in adequate health care for adolescents with special health care needs as they transition from childhood to adult services.” If more families participate in program and policy activities in MHCP, the unique quality of their involvement will help improve access to specialty care and lead to better information (and the ability of the program to address) on the problems of transitioning from childhood to adult health care services.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement</b> Infrastructure Building Services	<b>Type of Service:</b> Process
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Early Intervention (EI) Program, an entitlement in Nebraska, and Part H of the Individuals with Disabilities Education Act are co-administered by the Nebraska Department of Education, Special Education Branch and the NDHHS Special Services for Children and Adults Division. This locates EI, Part H, and MHCP—the Title V/CSHCN program, under the direction of the Title V/CSHCN Director. EI/Part H employs a Family Partner, a parent of a child with a disability, full-time on its staff. This person advises and participates in policy decisions, planning, and implementation of changes in MHCP. The Family Partner has been involved in Title V Block Grant review activities in Region V, and attends national CSHCN meetings.

**Program Activities:**

- Continued to utilize the EI/Part H Family Partner in an advisory role for MHCP
- Continued to engage additional family participation in program and policy activities for MHCP

**Progress Made on Performance Measure:**

Nebraska is re-evaluating methodology to provide greater input by families at this time. Families have participated in the recent needs assessment process, however, it becomes difficult to bring families into meetings in a central place and even in community-based areas. We remain at level 12.

**PM #15: Percent of very low birth weight live births**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #4: “To promote healthy lifestyles in women of child-bearing age.” Based on the information we have about risk factors related to low birth weight babies, there is an inverse relationship between very low birth weight live births and healthy lifestyles among women of child-bearing age. Ideally, we will see the percent of very low birth weight live births decrease as the promotion of healthy lifestyles in women of child-bearing age increases.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Prenatal care has been a critical focus for state- and local-level Title V-funded activities, in particular as it relates to birth outcomes such as low birth weight. In FY99, an additional stride was taken to identify the link between behaviors and experiences to birth outcomes. The Pregnancy Risk Assessment Monitoring System (PRAMS) was initiated in Nebraska with all of its program funds coming from Title V in its start-up year.

**Program Activities:**

- Continued to support several community-based programs that address very low birth weight births through support and education on topics such as early and continuous prenatal care, smoking and substance abuse, and teenage pregnancy prevention with some programs using a case management model, offering services in multiple languages, and led by culturally-competent staff.
- Continued participation in Omaha’s Healthy Start program and the Public Health Advisory Committee for this program, working to increase awareness of the importance of prenatal care among women of child-bearing age in North Omaha.
- With grant support through MCHB, improve screening for perinatal substance abuse.
- Continued to develop the Perinatal Care Quality Improvement Committee (PNCC) which was established to determine the current status of perinatal care provision in the era of managed care and to come to consensus in establishing guidelines for perinatal care. The committee has continued reviewing existing standards and guidelines for the provision of perinatal care, incorporating finds from data gathered, and drafting state-specific guidelines. The organizations, and consumers, has approved the format for the guidelines and continues the process of reviewing, editing and revising content. When content revision is complete, distribution, follow-up education and support by the group will follow in an effort to insure the product is appropriate for providers across the state and well utilized.
- Initiated PRAMS (Pregnancy Risk Assessment Monitoring System).

**Progress Made on Performance Measure:**

1999 data is unavailable. 1998 data is the most recent available. In 1998, 1.3% of live births were very low birth weight. This is a slight increase from 1.29% in 1997.

**PM #16: The rate (per 100,000) of suicide deaths among youths aged 15-19**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure had a direct relationship to Priority Need #6: "To promote safe environments and behaviors for all children and their caretakers," as well as Priority Need #7: "To promote healthy lifestyles among youth." A reduction in the rate of suicide deaths among teens will require the promotion of safe environments and behaviors, as well as healthy lifestyles.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Child Death Review Team provides useful information on the circumstances surrounding youth suicide deaths, which can be used in the development of prevention strategies. The School and Adolescent Health Program had provided information to school personnel on strategies to prevent suicide deaths, including recognition of youth at risk. The Health Promotion and Education Division of NDHHS expanded its capacity to address intentional injuries, including suicides. Title V program staff consequently works closely with this division to coordinate activities.

**Program Activities:**

- Continued participation in and utilization of Child Death Review Team Report
- Continued support to school systems through School and Adolescent Health Program and other community based Title V programs

**Progress Made on Performance Measure:**

1999 data is unavailable. 1998 is the most current data available. In 1998 NE had a rate of 11.8 per 100,000 youths. This is a slight increase from 9.9 in 1997.

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

<b>Relationship to priority need:</b> The priority needs were developed in direct correlation with the State Negotiated Performance Measures, therefore this National Core Performance Measure did not relate specifically to any of the Priority Needs. Very low birth weight is often linked to prematurity, which is the leading cause of infant deaths.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Although Nebraska does not have a formal system of perinatal regionalization, in the past, both MHCP and MCH Division staff collaborated on Neonatal Intensive Care Unit (NICU) site visits across the state. There is discussion currently about reinstating those collaborative NICU visits. These visits allow state and national experts to provide education and support to those hospital nurseries providing care to the infant with intensive and intermediate care needs, and reinforced appropriate guidelines for transfer of the neonate.

**Program Activities:**

- Continued the Perinatal Care Quality Improvement Committee. This committee is developing practitioner guidelines to assure that those newborns needing a higher level of care are transferred appropriately.

**Progress Made on Performance Measure:**

1999 data is unavailable. 1998 is the most current data available. In 1998 78.9% of very low birth weight infants were born at high-risk delivery facilities. This is a slight decrease from 1997 (81.7%).

**PM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester**

<b>Relationship to priority need:</b> Though the priority needs were developed in direct correlation with the State Negotiated Performance Measures, this National Core Performance Measure related to Priority Need #3: "To further reduce infant deaths in Nebraska due to SIDS," as well as Priority Need #4: "To promote healthy lifestyles in women of child-bearing age," and Priority Need #5: "To reduce the prevalence of neural tube defects." Early entry into prenatal care can help improve pregnancy outcomes, which lowers the risk factors associated with SIDS. Early entry into prenatal care also helps women become aware earlier in their pregnancy about the importance of folic acid intake, which helps reduce the risk of neural tube defects. Early entry also helps assure that women with complex problems or chronic illness or other risks are seen by specialists.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Several Title V community-based grantees provide home visitation or case management services to pregnant women and provide education in schools and communities at large on the importance of early prenatal care as part of their activities.

**Program Activities:**

- Continued to fund several Title V grantees who provide prenatal support services and education to communities on the importance of early prenatal care, many of whom are Medicaid presumptive eligibility providers
- Continued to collaborate with the Northern Plains Healthy Start program, which focuses on risk factors associated with pregnancies to Native American women
- Continued participation in Omaha's Healthy Start program and the Public Health Advisory Committee for this program
- Continued the Perinatal Care Quality Improvement Committee with the development of practitioner and consumer guidelines that will enhance early entry into prenatal care.

**Progress Made on Performance Measure:**

1999 data is provided by the National Vital Statistics Report (V. 48, No. 14, August 8, 2000). According to this report 84.4% of infants born to pregnant women began receiving prenatal care during the first trimester. This is slight increase from 83.6% in 1998.

**SP #1: Percent of children with special health care needs who receive assistive technology and/or home modification services**

<b>Relationship to priority need:</b> This measure related to Priority Need #1: “To improve access to specialty care for children with special health care needs.” Increasing the percentage of children with special health care needs who receive assistive technology or home modification services, which are specialty services, will also improve access to specialty care for this population.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Direct Health Care Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

In and of itself, the SSI-Disabled Children’s Program provides special medical equipment and supplies not usually covered by Medicaid or private insurance, as well as home modification services. In collaboration with the Nebraska Assistive Technology Project, a professional assessment, architectural consultation, plans, and project monitoring was added to enhance the quality of services provided. This project effects children eligible for SSI-Disabled Children’s Program, the Home and Community Based Medicaid Waiver, and the Disabled Persons and Family Support Programs.

**Program Activities:**

- Continued providing special equipment, supplies, and home modification services through SSI Disabled Children’s Program.
- Continued coordination of funding for Assistive Technology when one funding source is not sufficient to provide needed service.
- Continued collaboration as a part of the Assistive Technology Partnership including the Medicaid Home and Community Based Waivers, Medicaid, Public Assistance Programs Special Needs, Disabled Persons and Family Support Program, Vocational Rehabilitation and Assistive Technology.

**Progress Made on Performance Measure:**

In 1999, CSHCN received 186 requests, of these 179 were granted for a percentage of 96.2%.

**SP #2: Percent of CSHCN in state CSHCN Program that have transition plans that address health care, including insurance, by age 18**

<b>Relationship to priority need:</b> This measure related to Priority Need #2: "To identify gaps in adequate health care for adolescents with special health care needs as they transition from childhood to adult services." A percentage increase in children with special health care needs that have transition plans would be a good indicator of whether or not gaps in such transition services are adequately being identified and addressed. <b>This measure has been retired.</b>	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Enabling Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

This state performance measure has been retired.

**Program Activities:**

- This state performance measure has been retired.

**Progress Made on Performance Measure:**

This state performance measure has been retired.

**SP #3: Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants**

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #3: "To further reduce infant deaths in Nebraska due to SIDS." African American and Native American infants are two racial groups that, in comparison with other Nebraska infants, have a higher rate of SIDS. By lowering the incidence of SIDS among these two groups, the incidence of SIDS among all infants is also affected.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Through Title V in Nebraska, a number of activities toward the reduction of SIDS are occurring. A number of funded community-based programs provide prenatal and parenting education that includes information on SIDS. State-level staff are involved in a number of initiatives (as listed below) to increase awareness of SIDS, particularly among African American and Native American persons.

**Program Activities:**

- Continued participation in Omaha’s Healthy Start program, which focuses on reducing infant mortality, including SIDS rates among African American, and the Public Health Advisory Committee for this program.
- Continued collaboration with the Northern Plains Healthy Start program, which focuses on reducing infant mortality, including SIDS rates among Native Americans.
- Continued to fund several community-based programs (in counties where more than 60% of all African American and Native American births occur annually) that provide prenatal and parenting education, including information on risk factors for infant mortality and incidence of SIDS. As part of their activities, these programs targeted African American and Native American families with this information.
- Continued collaboration with the Nebraska SIDS Foundation to raise awareness on the importance of infant sleep position and other ways to reduce the risk of SIDS.
- Continued to work with WIC to provide both population-based and program specific education and materials on breastfeeding, which has been linked to a decrease in incidence of SIDS.

**Progress Made on Performance Measure:**

1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had a rate of 3.3 per 1,000 live births. This is a decrease from 1997 (4.0).

## SP #4: Percent of women of child-bearing age who report smoking in the last 30 days

<b>Relationship to priority need:</b> This measure directly related to Priority Need #4: “To promote healthy lifestyles in women of child-bearing age.” Healthy living among women of child-bearing age increases the chances of healthy birth outcomes, as well as the quality of life in women and their children. Abstinence from smoking and alcohol use, as well as a healthy diet and exercise, all contribute to a healthy lifestyle. Said another way, a decrease in the percentage of women who report smoking is one measure of healthy lifestyles in women of child-bearing age.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Title V supports many community-based programs that deal with perinatal substance abuse issues as part of their activities. At the state level, Title V collaborates with a number of other related programs to carry out activities such as the distribution of practitioner guidelines for perinatal substance abuse.

### Program Activities:

- Continued to fund several community-based programs that provide prenatal and parenting education, including information on risk factors for infant mortality such as substance abuse.
- Continued to fund and collaborate with Douglas County Health Department’s MCH Leadership Initiative in the development of practitioner guidelines for perinatal substance use assessment, including discussion on legal and ethical implications, and a resource list for perinatal substance abuse services.
- Collaborated with Tobacco Free Nebraska to promote awareness of the hazards of smoking among all women of child-bearing age and youth.
- Continued to participate in Omaha’s Healthy Start program, which focuses on reducing infant mortality, including reducing the incidence of smoking among African American women of child-bearing age, and the Public Health Advisory Committee for this program.
- Continued to collaborate with the Northern Plains Healthy Start program, which focuses on reducing infant mortality, including reducing the incidence of smoking among Native American women of child-bearing age.

### Progress Made on Performance Measure:

According to the 1999 Behavioral Risk Factor Survey, 26.4% of the women surveyed reported that they were regular smokers. This is a slight increase from 1998 when 25.1% of women of child-bearing age reported smoking within the last 30 days.

## SP #5: Incidence of neural tube defects (per 10,000 live births)

<b>Relationship to priority need:</b> This measure was directly and specifically related to Priority Need #5: "To reduce the prevalence of neural tube defects." Neural tube defects are among the most common birth defects contributing to significant infant morbidity and mortality in the U.S. One-half to two-thirds can be prevented by the daily use of folic acid in women of child-bearing age. Preventing NTDs is a major opportunity to reduce mortality and morbidity in babies and children. Blood folates may be an additional means for determining whether a population of women of child-bearing age are consuming adequate amounts of folic acid.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Though Nebraska's rate is significantly higher than the national Healthy People 2000 objective, Title V staff and other collaborative partners are engaged in a number of activities that will attempt to reduce the incidence of neural tube defects. Most notable is a folic acid public awareness campaign that was in the development phase during 1999.

### Program Activities:

- In collaboration with other partners (Nebraska Developmental Disabilities Council, March of Dimes, UNMC, Nebraska Pharmacists Association, Nebraska Medical Association, Nebraska Dietetic Association, Planned Parenthood, and Nebraska Retail Grocers Association), began planning a folic acid public awareness campaign.
- Continued funding several community-based programs that provide prenatal education and materials to participants, including information on folic acid and neural tube defects.
- Continued funding UNMC's Statewide Genetics Clinics, including the teratogen toll-free line, which strives to reduce birth defects through information dissemination to health care professionals.

### Progress Made on Performance Measure:

1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had a rate of 4.25 per 10,000 live births. This is a decrease from 6.0 in 1997.

## SP #6: Hospitalizations for injuries (per 100,000), birth to 14 (intentional and unintentional)

<b>Relationship to priority need:</b> This measure directly related to Priority Need #6: "To promote safe environments and behaviors for all children and their caretakers." A decrease in hospitalizations for injuries most likely means a decrease in injuries, which may indicate an increase in the incidence of safe behaviors by children. Awareness and action to prevent the occurrence and severity of injuries—or the promotion of safe environments and behaviors—must occur for this measure to decrease.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

### Capacity/Resource Capability:

Title V funds a number of community-based projects that conduct home visitation with new parents, providing education on the importance of injury prevention and abuse issues, among other things. The NDHHS Protection and Safety Division supports activities in communities to prevent intentional childhood injury, and is also participating in strategic planning to incorporate intentional injury prevention into the other, more traditional enforcement activities conducted by the division. A number of communities throughout the state have formed their own unintentional injury prevention coalitions, including Lincoln, Omaha, Hastings, Grand Island, and Kearney. Most activities are focused on traffic related injuries.

### Program Activities:

- Through NDHHS Protection and Safety Division, continued to support community-level activities and state-level public awareness activities focused on intentional childhood injury prevention
- Continued to fund a number of community-based projects that conduct home visitation with new parents, providing education about injury prevention and abuse issues.
- Through community efforts, participated in coalitions across the state that work to create public awareness of unintentional injury prevention.

### Progress Made on Performance Measure:

Due to a contract that the State of Nebraska has with the Hospital Association, 1999 hospital discharge data will not be available until 2001. 1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had 6289.1 hospitalizations for injuries per 100,000 children. This is a slight decrease from 6345.4 in 1997.

## SP #7: Percent of teens who report use of alcohol in last 30 days

<b>Relationship to priority need:</b> This measure was directly related to Priority Need #7: "To promote healthy lifestyles among youth." Alcohol increases the likelihood of sexual activity, exposing youth to STDs and HIV while under the influence of alcohol. Proper use of contraceptives is less likely, increasing the risk of pregnancy as well. Alcohol is responsible for a high percentage of teen motor vehicle accidents, and has a strong influence on morbidity and mortality. A decrease in the percentage of teens who report use of alcohol in the last 30 days would indicate an increase in those who engage in healthy lifestyles.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

### Capacity/Resource Capability:

Through the School and Adolescent Health Program, Title V funds supported school nurses through training and materials on issues of alcohol and substance abuse among teens. Also through the School and Adolescent Health Program, six communities were and continue to be engaged in Abstinence Education programs that include education on the relationships between decreased inhibitions and risks encountered for sexual behavior, including alcohol and drug use. Three Title V community-based grantees provided education on the dangers of alcohol and drug use to youth as part of self-efficacy and self-esteem improvement strategies toward teenage pregnancy prevention.

### Program Activities:

- Through School and Adolescent Health Program, continued to support school nurses with materials and training on talking with teens and parents about alcohol and substance use, signs of substance abuse, and referral and treatment of substance abuse.
- Continued to support three Title V-funded community-based teen pregnancy prevention programs that include education on dangers of alcohol and drug use for youth.

### Progress Made on Performance Measure:

This measure is based on YRBS data, with its limitations. In Nebraska, this survey is conducted every other year, and data is available for FY99. Comparison data from FY95 to FY97 shows an increase in teens who report use of alcohol in the last 30 days, from 55% to 56%. 1999 data indicates a slight decrease to 55.8% of teens who report use of alcohol in the last 30 days. The survey (of more than 2000 students) is also unrepresentative, as the largest school district in the state prohibits access to its students. The survey data shown for this measure on Form 11 is not adjusted to reflect the whole population.

**SP #8: Percent of public school districts where students have access to registered school nursing services**

<b>Relationship to priority need:</b> This measure was directly related to Priority Need #8: "To improve access to needed health services for children in Nebraska's schools." Documentation of school districts with an employed or contracted school nurse shows more appropriate referrals to health providers, a healthier school population, less absenteeism, and healthier staff members. If a higher percentage of public school students have access to school nursing services, their access to needed health services is most likely increased as well.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Title V funds the School and Adolescent Health Program, now a part of Perinatal, Child and Adolescent Health, which offers consultation, training, and support to school nurses throughout Nebraska. This program also worked to educate school districts, communities, and legislators on the value of school nursing services. The interest from Nebraska's tobacco settlement money was designated by the Unicameral to create the Excellence in Health Care Trust Fund (since renamed Nebraska Health Care Cash Fund). Among other things, one focus of grants funded through the Cash Fund would support the hiring of school nurses by educational service units, school districts, public health entities, or partnerships between schools and public health entities in order to identify children for Medicaid eligibility and to provide immunizations and other public health services. The RFP was announced in FY00. Currently, many school districts' nursing staffs are being reduced as their overall state support has been "capped".

**Program Activities:**

- Through the School and Adolescent Health Program, continued to educate school districts, communities, and legislators on the importance of school nursing services and the associated outcomes.
- The School and Child Health Nursing Coordinator provided orientation and in-service training to school health nurses several times throughout the year.
- The School and Child Health Nursing Coordinator is involved in a variety of initiatives at the state- and community-level which present rich opportunities for collaboration with a variety of professional disciplines and groups.
- Through the School and Adolescent Health Program, continued to provide consultation to Nebraska's first school-based health center in Grand Island.

**Progress Made on Performance Measure:**

This measure has remained constant from SY96 to SY98, with 18.9% school districts offering school nursing services to students through some mechanism. In 1999, Nebraska had 571 operational school districts- the most in the nation. Of these school districts, 121 had at least one school nurse (21%). State-wide, Nebraska has invested 192.09 full-time equivalency positions for school nurses. While only 121 districts had a school nurse, it represents 509 schools. Grand Island has the only school-based clinic in Nebraska.

**SP #9: Percent of Medicaid-participating dentists who see 25 or more Medicaid patients each month**

<b>Relationship to priority need:</b> This measure directly related to Priority Need #9: “To improve access to dentistry services for Medicaid-eligible children.” The more Medicaid patients that Medicaid-participating dentists see on a regular basis, the more improvement made by the Medicaid program in offering access to dentistry services for persons eligible for their program.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Child death rate per 100,000	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The NHHSS Dental Health Division works closely with Nebraska’s Medicaid program to determine and implement strategies to increase the number of dentists who participate with Medicaid, as well to make it easier for those dentists who do participate with Medicaid to see larger numbers of eligible patients.

**Program Activities:**

- Through NHHSS Dental Health Division, trained school nurses on oral health screenings for students and educational opportunities with families on the importance of oral health.
- Continued collaboration with the Medicaid program, especially Kids Connection (SCHIP), which has increased the number of children in Nebraska eligible for Medicaid services, including dental care.
- Continued Title V funding to seven community-based programs that offer home visitation to families with infants and young children, including education and referral to health and dental services.

**Progress Made on Performance Measure:**

1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had 13.3% of Medicaid participating dentists see 25 or more Medicaid patients per month.

**SP #10: Percent of CSHCN seen at CSHCN multidisciplinary team clinics who receive recommended nutritional follow-up services**

<b>Relationship to priority need:</b> This measure directly related to Priority Need #10: "To identify CSHCN requiring nutritional services and assure their provision of such services."	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Enabling Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

Nutrition for children with special health care needs has been one of the priorities of MHCP for a number of years. Steps taken to address this issue include the addition of a nutritional consultant to MHCP multidisciplinary teams, now named Specialty Clinics for Children and Youth, for cerebral palsy, midline neurological defects, juvenile rheumatoid arthritis, and craniofacial. The Aged and Disabled Medicaid Home and Community-Based Services Waiver includes nutritional services in their array of services and provides for in-home assessment and follow-up. In addition, Medicaid has revised regulations for EPSDT to allow easier billing for nutritional services.

**Program Activities:**

- Continued to provide nutritional consultation through MHCP Specialty Clinics for Children and Youth multidisciplinary teams for cerebral palsy, midline neurological defects, juvenile rheumatoid arthritis, and craniofacial.
- Continued to provide nutritional services, in-home assessment, and follow-up through the Aged and Disabled Medicaid Home and Community-Based Services Waiver.

**Progress Made on Performance Measure:**

No measuring tool was in effect for 1999. Data will be available for 2000 in 2001.

## **2.5 Progress on Outcome Measures**

All of the outcome measures rely on vital statistics (birth, death and neonatal deaths). Progress cannot be reported for CY 1999 at this time due to difficulties in NHHSS Vital Statistics offices. Nebraska is switching to ICD-10 from ICD-9 coding, extended waits for receiving other state information, in addition to adding electronic certificates and software problems. Data are expected in October, 2000.

### **III. REQUIREMENTS FOR THE APPLICATION (Section 505)**

#### **3.1 Needs Assessment of the Maternal and Child Health Population**

##### **3.1.1 Needs Assessment Process**

Nebraska's needs assessment process began in 1998 when a contract was negotiated with the University of Nebraska Medical Center and CityMatCH for consultation and training on developing a comprehensive planning cycle, developing a working model for managing an ongoing planning cycle, and developing skills and strategies for assisting communities with planning activities, including needs assessments and use of performance measures. The recommended model provided the framework for subsequent work.

The application for the State Systems development Initiative (SSDI) was the next major step. The first goal of the project was to develop and sustain a comprehensive planning cycle for maternal and child health, including children with special health care needs. Objectives included: completing the five-year Title V needs assessment, developing and establishing an ongoing state-level process which included routine and periodic needs assessment, development and implementation of strategies, and evaluation; and finally development and adaptation of tools and methods that supported effective MCH planning at the community level.

The second goal of this grant was to create and maintain capacity to collect and analyze high quality, reliable maternal and child health data needed to assure accurate measurement of performance and achievement of desired health outcomes. Objectives included: development of data management methodologies which permitted ongoing collection and analysis of data required for the 18 National "Core" Performance Measures, reviewed, refined and developed new State Performance Measures which reflected current state priority needs and desired health outcomes as established by the needs assessment, and finally, adapted methodology which allowed communities and other stakeholders to access current and accurate maternal and child health data.

Nebraska's SSDI project has built the state's capacity to carry out comprehensive planning for the maternal and child health population, including children with special health care needs. A project coordinator has expanded the human resources available to carry out data and planning related activities. A contract was also entered into with a local health education consultant to support the needs assessment process by facilitating meetings of the needs assessment advisory committee, assisting the MCH/CSHCN management team in gathering and organizing data, and conducting some of the data analysis. The needs assessment process adopted included community level input, nomination and prioritization of needs through a group process. The needs assessment advisory committee had 43 members, including families of CSHCN. Over the course of four meetings, the needs assessment advisory group discussed and analyzed data, deliberated priority health needs, and brainstormed policy recommendations. This group chose six priority needs: asthma, CSHCN, intentional injuries, substance abuse, oral health and obesity (nutrition).

The Governor of Nebraska, Mike Johanns, in September of 1999 appointed an Infant Mortality Blue Ribbon Panel to address Nebraska's stagnant infant mortality rate, and increasing neonatal mortality rate. The Panel members represent a wide range of expertise from all parts of the state: neonatologists, epidemiologists, obstetricians, nurses, children's advocates, and consumers, as well as other individuals with expert knowledge. The group, acknowledging that infant mortality was the result of multi-faceted problems, chose to break into sub-committees to collect and analyze data, and develop recommendations. The

sub-committees address the issues of: birth defects, racial and ethnic health disparities, SIDS, trauma, health care access, and prematurity. Currently the group is done with the data collection and analysis and is working on recommendations for policy changes. The Panel has provided the Title V needs assessment with an abundance of data in relation to infant mortality.

Input from the advisory committee and the Blue Ribbon Panel, as well as staff analysis of relevant data, was compiled into a list of 18 potential priority needs. This list was mailed to over 600 stakeholders and was posted on NHHSS' internet website. Comments and rankings were received from over 100 respondents.

The next piece of the needs assessment process included targeted input from the Nebraska Minority Public Health Association. Both individual members and the Executive Board of the Nebraska Minority Public Health Association submitted their priority needs. The Executive Board ascertained that infant mortality and adolescent pregnancy were the two priority needs in the minority community. Individual members (including public health and health care professionals, consumers, and advocates of Nebraska's minority communities) agreed to those two priorities but also included: homicide, suicide, access to health care (especially transportation), domestic violence, obesity, diabetes, mental health, access to mental health services, adult uninsured (regardless of race/ethnicity), asthma, SIDS, and community-level capacity to ascertain and address health needs.

The final piece of the needs assessment process was to review the primary and secondary data collected, review community input, identify health needs and gaps in service, set priorities for health needs, develop new state performance measures, and develop a plan for intervention.

The assessment process yielded a number of general conclusions. Among these is the fact that Nebraska lacks population-based data on CSHCN. Programmatic data is available in fragmented forms. Furthermore, the lack of definition in Nebraska for a child with special health care needs hampered communication. One result of the needs assessment process was to determine that a separate and more specific needs assessment would be beneficial for this population. This will ensure that a definition of the population is secured, and a thorough assessment can proceed.

Another finding was the lack of data around oral health care, asthma, and obesity in Nebraska. These health topics also overlap into CSHCN. Oral health care, asthma, and obesity have only recently been considered health priorities in Nebraska, and system development is in its infancy. Another interesting conclusion reached was the lack of infrastructure surrounding childhood immunization. Nebraska has one county using a separate immunization registry for its public sector. The registry used in the rest of the state does not include the private sector. Furthermore, because Nebraska relies on the National Immunization Survey by the CDC for its immunization percentages, minority and geographic information is unavailable.

Title V staff have also concluded that another, more intense level of needs assessment must begin almost immediately after the submission of this application. Though priority health needs were determined, priority strategies to address those needs were not identified. A participatory process to select key strategies will be initiated early in FY 2001.

In section 3.2.1 "Priority Needs" of this document is the new list of state priority needs for Nebraska based on the needs assessment performed over the last year. Section 3.4.2.1 "Development of State Performance Measures" lists Nebraska's new state performance measures based on the priority needs assessed.

### 3.1.2 Needs Assessment Content

#### 3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Although Nebraska generally fared better than the nation in most areas of maternal and child health, progress toward some of the state's Year 2000 objectives has been slow. Nebraska, in general, has been considered a very healthy state in which the well-being of its citizens is among the best in the nation. However, certain variables are slowly changing that status over time. For example, Nebraska's ranking for child well-being from the Annie E. Casey Foundations Kids Count Data Book has dropped from fourth to eleventh from 1998 to 1999, based in part on an increase in infant mortality in 1996.

In other comparisons with the nation as a whole, Nebraskans enjoy above average health status. A 1998 report by *ReliaStar* ranked Nebraska twelfth among all states in health status. This ranking was based on the analyses of 17 primary indicators. Compared to other states, Nebraska had a very low unemployment rate, a high school graduation rate, a low level of infectious diseases, and a low number of premature deaths. In contrast, the state had relatively high rankings and was worse off for motor vehicle deaths, occupational fatalities, more limited activity days, and a high infant mortality rate.

Because Nebraska ranked seventh highest in the nation in 1996 for infant mortality, Governor Johann's created a Blue Ribbon Panel to examine the issue. This panel, representing a wide range of expertise from all parts of the state, has focussed on determining the correctable and preventable causes of Nebraska's infant mortality. The panel spent the first six months collecting data, and is progressing to a recommendations stage. Title V provides staff and financial support for this panel.

Nebraska's MCH population has a number of key health status indicators and risk factors that warrant focused attention. Through the needs assessment process the following is a list of Nebraska's more significant health status problems: unintended/out-of-wedlock/adolescent pregnancy, domestic violence, racial and ethnic disparities, unintentional injuries, birth defects, low birth weight, substance abuse, immunization, cigarette smoking, homicide and suicide, asthma, oral health care (including for CSHCN), obesity, breastfeeding, lead screening, nutrition consultation for CSHCN, CSHCN secondary complications, and medical homes for CSHCN.

Nebraska's geography and demographics provides some unique system strengths and weaknesses. Because most of Nebraska's population lives on the eastern part of the state, most health care services and public health infrastructure is located there as well. This leaves access as a major issue in central and western Nebraska. Particularly vulnerable is Nebraska's CSHCN population. Nebraska's public health infrastructure is small in workforce, underfunded (Nebraska ranks 49<sup>th</sup> in state funding for public health), and Nebraska does not have a formal public health school to provide additional in-state advanced training. Only 22 out of Nebraska's 93 counties have any type of local public health organizational capacity. While entities such as community action agencies and hospitals are providing some public health services, many key public health activities are not being provided in most parts of the state.

Because Nebraska has limited resources, its commitment to intra-governmental, inter-governmental, and interagency cooperation is excellent. Many of the state's small local public health department/community health systems lack the necessary resources to provide MCH activities. Communities have considerable latitude in determining their priorities through their community planning process. However, when major needs or gaps are identified in an area, it is expected that the state agency will work with and encourage the community to address these needs. In essence, improving the health status of Nebraska's MCH populations requires true collaboration between governments, communities, organizations, and individuals.

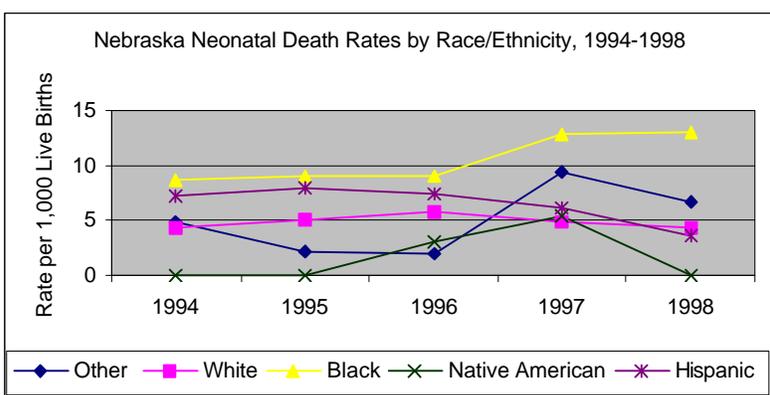
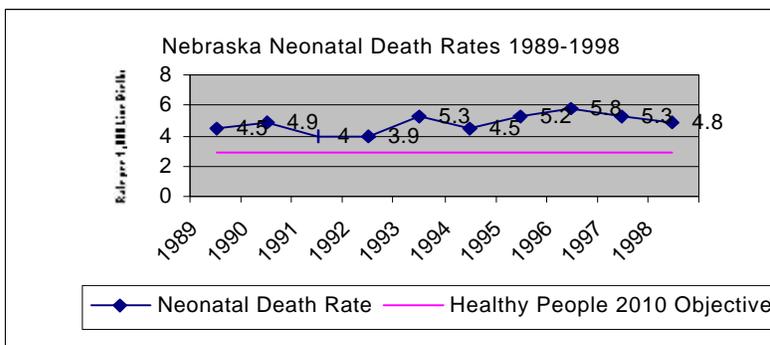
The following is a problem-oriented overview of Nebraska's major morbidity, mortality, risk factors, and disparities of the Title V population.

**Births.** In 1998, the number of resident live births in Nebraska marginally increased from the number registered in 1997, from 23,313 to 23,533. The 1998 birth rate of 14.3 per 1,000 estimated population matches the lowest figure ever recorded in the state's history, which was posted last year. However, the 1998 rate is just slightly lower than the 1998 U.S. provisional national birth rate of 14.6. 1998 marks the thirteenth consecutive year in which Nebraska's birth rate was lower than the U.S. birth rate. Ninety percent of all births in 1998 were to white mothers for a birth rate of 13.7 per 1,000 white residents. The birth rate for African Americans is 18.4 per 1,000 African American residents; for Native Americans it is 27.3 and among persons of Hispanic origin, the 1998 birth rate is 23.9.

Birth rates observed through Nebraska in 1998 varied considerably from county to county. Dakota County had the highest birth rate of the state's 93 counties, with a rate of 20.6 live births per 1,000 residents, while Sioux County, with just six resident live births in 1998, had the lowest (4.0). Among Nebraska communities with a population of at least 2,500, South Sioux City recorded the highest birth rate in 1998 (25.8), while Fairbury recorded the lowest (7.5).

**Fetal Deaths.** There were 131 fetal deaths reported in Nebraska in 1998, resulting in a fetal death ratio of 5.6 per 1,000 live births. Ratios are higher among African Americans (9.7), Native Americans (9.9) and people of Hispanic origin (7.7) than among Whites (5.3). The ten-year trend in fetal death ratios shows a gradual decrease. If this trend continues, the projected rate will be higher than the year 2010 objective of 4.1 fetal deaths per 1,000 live births. Fetal death rates were higher than the national rate among mothers younger than 15 (14.2 and 29.4 respectively\*), and slightly higher for mothers older than 35 years old (8.9 and 9.1 respectively). The number one cause of fetal death is complications of the placenta, cord and membranes (29%) followed by other and ill defined conditions (25%), and birth defects (13%).

**Neonatal Deaths.** In 1998, there were 114 neonatal deaths (deaths among infants less than one month old) resulting in a mortality rate of 4.8 deaths per 1,000 live births. This equals the national rate. Nebraska consistently has a higher rate of neonatal death than the Healthy People 2010 Goal of 2.9, and over a ten year period of time (1989-1998) had a mean rate of 4.82. For the past five years, neonatal deaths account for 74.9% of all infant deaths in Nebraska. While Nebraska's overall neonatal death rate has remained stable, the rate for African American neonates has steadily risen, and for 1998 is 13.0. This number is three times the rate than for White neonates and the overall



population. The national neonatal death rate for African Americans is 9.4.

Post-Neonatal Deaths. There were 58 post-neonatal (28 to 364 days) deaths in Nebraska in 1998, resulting in a mortality rate of 2.5 deaths per 1,000 live births. This equals the national rate. However, it is much higher than the Healthy People 2010 objective of 1.5 post-neonatal deaths per 1,000 live births. Post-neonatal mortality rates are higher for Nebraska's minority populations. African Americans experience over two times the relative risk for post-neonatal mortality than Whites. Native Americans have a relative risk rate of 2.4.

Infant Deaths. A total of 172 infant deaths occurred among Nebraska residents in 1998. Infant mortality rates in Nebraska declined from 9.0 infant deaths per 1,000 live births in 1985-1989 to 7.3 per 1,000 in 1998. This rate is the lowest ever recorded in the state's history, just slightly better than the previous record of 7.33 posted in 1992. The Nebraska rate is slightly higher than the national rate of 7.2, and it is unlikely that it will decrease enough to achieve the Year 2010 objective of 4.5.

By age group, mortality rates in Nebraska were highest for infants born to adolescent mothers. In Nebraska, the infant mortality rate for infants born to mothers 17 years of age or younger was 13.2 per 1,000 live births for the five year period 1993-1997. Infants born to mothers aged 18-19 were less likely to die within the first year of life at a rate of 10.7. However, this rate is still slightly higher than for infants born to older mothers and higher than the national rate.

The infant mortality rate for African Americans in Nebraska (19.5) was more than three times the rate for white infants (6.7) in 1998, over the last five years (1994-1998) has been double (15.68) the white rate (7.26), and the highest rate since 1993 (26.2). The national infant mortality rate for African Americans is 13.7. For the past five years (1994-1998) the leading causes of infant mortality for African Americans have been: 1) SIDS, 2) prematurity, 3) "all other causes", 4) birth defects, and 5) maternal complications.

The 1998 infant mortality rate for Hispanic infants was 5.5 per 1,000 live births. However from 1994-1998, the mortality rates for people of Hispanic ancestry was 9.36, higher than the overall rate. The national rate is 6.0. For the past five years (1994-1998) the leading causes of infant mortality for people of Hispanic ancestry have been: 1) birth defects, 2) prematurity and SIDS (tied), 3) "other perinatal conditions", 4) maternal complications, other respiratory conditions and "all other conditions" (tied).

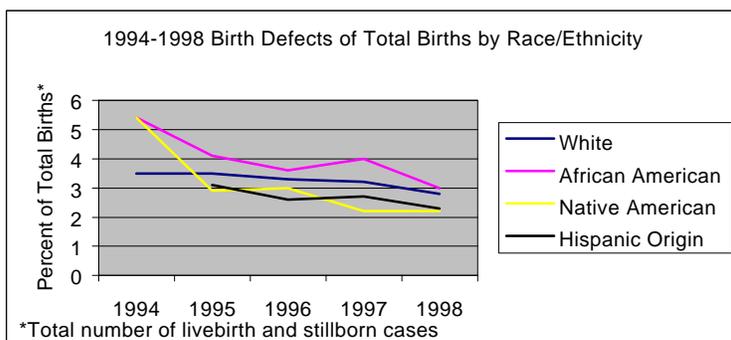
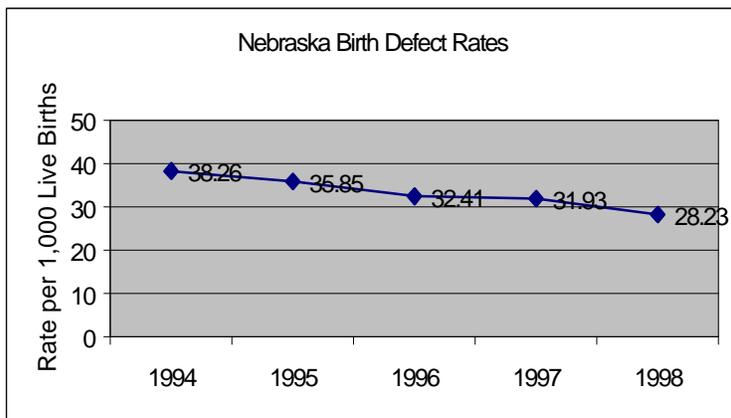
Rates for Native Americans have substantially decreased over the last five years, however still remain high at 8.42 for the time period of 1994-1998. Overall, the Native American infant mortality rate has been decreasing since 1994 and in 1998 was 2.5. The national rate is 8.7. For the past five years (1994-1998) the leading causes of infant mortality for Native Americans have been: 1) SIDS and accidents (tied), 2) "all other conditions" and "other perinatal conditions" (tied).

**Table 1: Infant Mortality Rates and Relative Risk for Nebraska Racial and Ethnic Minority Populations**

	1983-1987		1988-1992		1993-1997	
	Rate per 1,000 Live Births	Relative Risk	Rate per 1,000 Live Births	Relative Risk	Rate per 1,000 Live Births	Relative Risk
White	8.9		7.1		7.6	
African American	19.0	2.1	20.2	2.8	17.1	2.3
Native American	21.9	2.5	18.2	2.6	9.0	1.2
Asian American	NA	NA	6.2	0.9	5.2	0.7
Hispanic American	7.4	0.8	10.1	1.4	9.3	1.2

As in recent years, the two leading causes of infant deaths in Nebraska in 1998 were birth defects and Sudden Infant Death Syndrome (SIDS), which resulted in 46 and 23 infant deaths, respectively. In addition, low birth weight (<2500 grams) babies were disproportionately represented among infant deaths. In 1998, low birth weight babies accounted for 110 (64%) of Nebraska's infant deaths, with 70 of these children falling into the very low birth weight (<1500 grams) category. Neonates (infants less than 28 days old) accounted for about two-thirds of Nebraska's 1998 infant deaths, with a count of 114, while post-neo-nates (infants between 28 days and one year of age) accounted for the remaining 58.

**Birth Defects.** A total of 1,226 birth defects were diagnosed among 668 children born to Nebraska women in 1998. The latter figure translates into a rate of 28.23 cases per 1,000 resident live births, a decrease from the 1997 rate of 31.9. Following a long-established pattern, defects of the circulatory system were the most frequently diagnosed conditions in 1998, accounting for 349 (26.4%) of all defects reported. The 1998 data also show that birth defects were reported more than twice as frequently among low birth weight (less than 2500 grams) babies than among those of normal weight. Birth defects rates are declining at a rate of approximately 2.5% per year, mostly attributable to a declining rate of spina bifida. Despite the overall declining rate, Nebraska follows the national trend of increasing trisomy, congenital heart disease, and anencephaly types of birth defects.

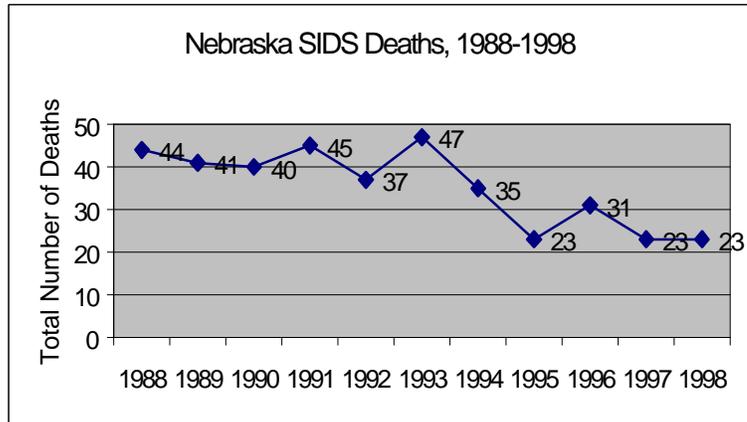


Over the past five years, African Americans experienced a higher percentage of total births effected by birth defects than any other racial or ethnic group.

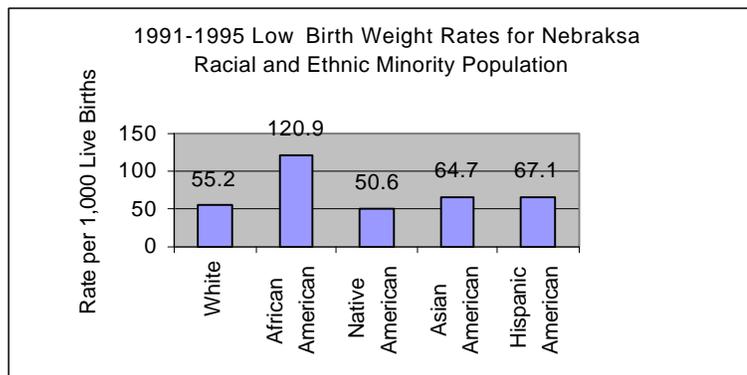
The number of infants born and diagnosed with fetal alcohol syndrome has remained constant over the last five years, averaging 1.6 per year. Nebraska's birth defect registry lists birth defects diagnosed in the first year of life. Fetal Alcohol Syndrome frequently isn't diagnosed until the child reaches his toddler years. Every year for the past five years, an average of 11.2% of pregnant women report using alcohol during their pregnancies.

Birth defects accounted for 13% (17) of total fetal deaths (131), and 27% (46) of infant deaths (172) in Nebraska in 1998. It was the third leading cause of fetal death and the number one leading cause of infant death.

SIDS. Twenty-three infants died from SIDS in 1998. This accounts for 13% of the infant deaths in Nebraska. In Nebraska, SIDS deaths have decreased approximately 50% in ten years. Nationally SIDS deaths have declined by approximately 40%. In Nebraska SIDS still remained the leading cause of infant death of African Americans from 1994-1998 (23%) and Native Americans (tied at 27%).



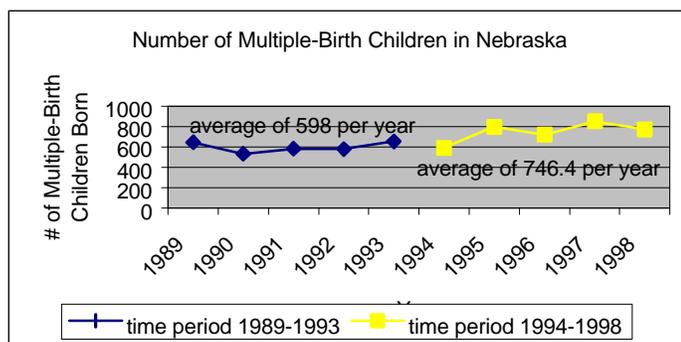
Low Birth Weight. Low birth weight (LBW) rates have increased steadily in Nebraska, reflecting the national trend. In Nebraska, the proportion of low-weight births has risen from 55.3 low weight births per 1,000 live births in 1985-1989 to 65.4 in 1998, a decrease from the 1997 figure of 70.3. Prior to 1998, the state's low birth weight rate had increased for five of the last seven years, after reaching an all time low of 52.8 in 1990. Long-term trends show that the low



weight birth rates declined substantially in Nebraska during the 1970s and, to a lesser extent, the 1980s. This trend is similar to that observed throughout the United States during the same period.

Although the nationwide low birth weight rate is higher (73.0), it has increased more slowly than the Nebraska rate. Since it has been moving away from the target, it is unlikely the LBW rate in Nebraska will meet the state's Year 2000 objective of no more than 50 low-weight births per 1,000 live births. Low birth weights were nearly twice as likely among African American infants (120.9 per 1,000 live births) as among white infants (55.2) in Nebraska for the latest five-year period.

The state rate for very low weight births (i.e. babies weighing less than 1500 grams) in 1998 was 13.0 per 1,000 live births, the same as the 1997 figure and the highest ever recorded in Nebraska history. Until the late 1980s, the state's very low birth weight rate showed no consistent trend in any direction, but since then it has been rising steadily. As with low-weight births, the Nebraska trend for very low weight births is similar to the national trend. In Nebraska, although LBW babies comprised only 6.6% of live births, these infants accounted for 75% of all infant deaths. The mortality rate among LBW infants was 10.45.



Multiple Births. Nationally the number and rate of twin and triplet and other higher order multiple births have climbed at an unprecedented

pace over the last two decades. The extraordinary risk in the incidence of multiple pregnancies is a public health concern

because of the heightened risk to the mother and child; infants born in multiple deliveries are born earlier and smaller than singletons, are less likely to survive the first year of life, and are more likely to suffer life-long disability when they do survive. Accordingly, multiple births are exerting growing influence over important indicators of infant health such as low birthright and preterm birth rates. National statistics indicate that rates of low birth weight, very low birth weight, and infant mortality were 4 to 33 times higher for twins and triplet / + compared with singleton births. Multiple births born to women of any age are high-risk births, however: twins are 4 times; triplets, 10 times; quadruplets, 13 times; and quintuplets, 30 times more likely than singletons to die within the first month of life. Nationally, between 1980 and 1997, the overall LBW rate rose 10%; singleton LBW rose a comparatively modest 2%.

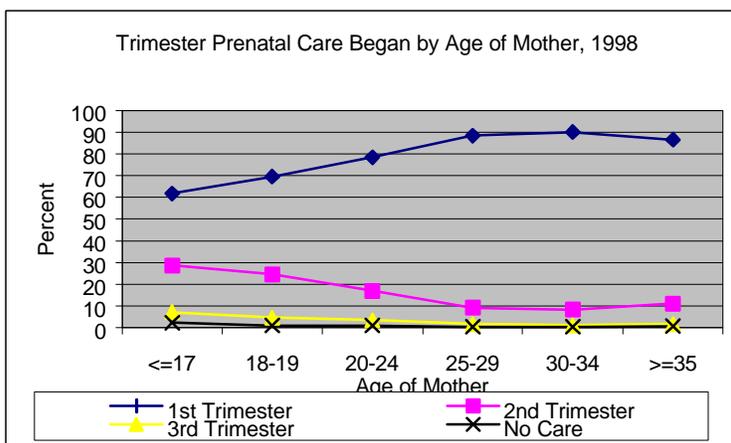
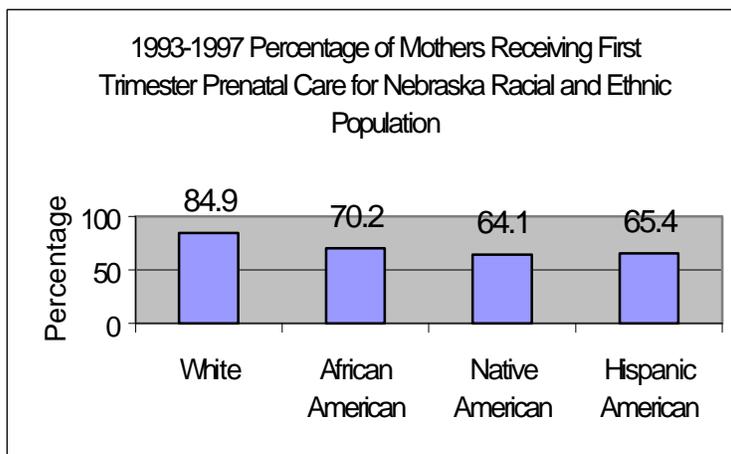
Nebraska leads the country for triplet / + birth rates with a rate of 323.6 per 100,000 births. This is twice the U.S. level (151.2). Nebraska ranks number three for twin birth rate per 100,000 with a rate of 30.3. The U.S. rate is 25.8.

Nationally, the steep climb in multiple births coincides with two overlapping and related trends: older age at childbearing and the increasing use of fertility enhancing therapies (e.g., fertility drugs such as Clomid and Pergonal and assisted reproductive technologies such as in-vitro fertilization) which more often result in a plural pregnancy. In the U.S. an estimated one-third of the increase in multiple births since the late 1970's and early 1980's has been attributed to the shift in the maternal age distribution; the remainder is likely the result of these therapies. If this estimate is reliable, it translates to more than 225,000 multiple births in the U.S. associated with fertility therapy from 1980-1997. Nebraska's growth in multiple births may be correlated to the two assisted reproductive technology sites located in Omaha.

Prenatal Care. Only slight progress has been made in Nebraska in improving the proportion of mothers who begin receiving prenatal care in the first three months (first trimester) of pregnancy. In 1998, 83.6 percent received first trimester care, compared to 81.3 percent nationwide in 1995. Nebraska's 1998 rate is slightly less than the 1997 rate of 83.7%. Rates will not meet the state's Year 2000 target of at least

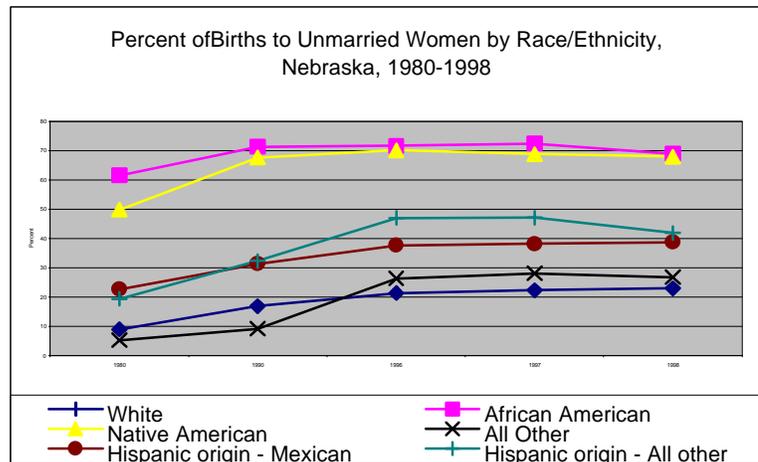
95% receiving first trimester prenatal care. Among racial and ethnic minorities in the state, first trimester care rates were generally much lower than the rate for White mothers (84.9%) in 1993-1997, averaging 70.2% for African American mothers, 64.1% for Native Americans, and 65.4% for people of Hispanic ancestry.

Women in the youngest age groups are the most likely to delay prenatal care until



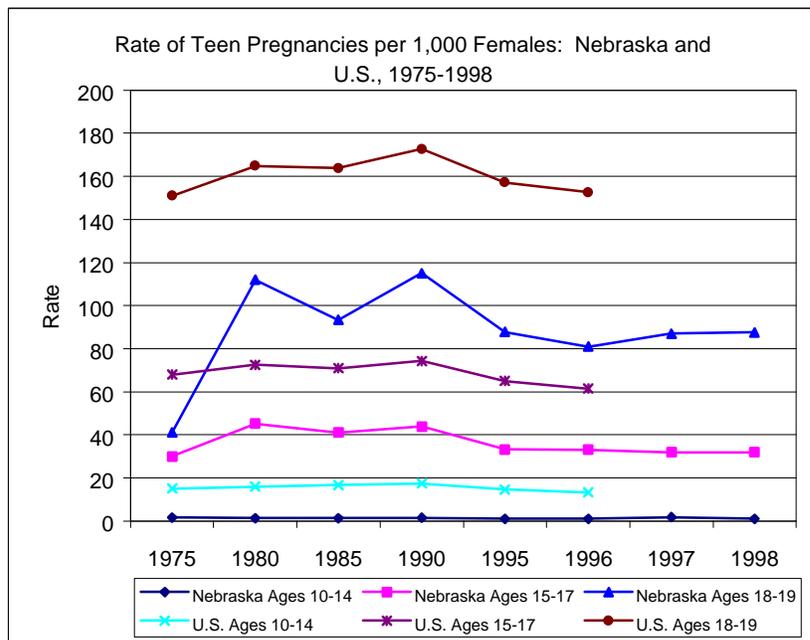
the second or third trimester, or to receive no prenatal care at all. In fact, about one-third (33.2%) of Nebraska's 1998 teenaged mothers did not begin prenatal care until after the first trimester of pregnancy, or did not receive any prenatal care, compared to 14.1% for mothers 20 years of age and older. However, as an indicator of the adequacy of prenatal care, the Kessner Index provides a better measure, by combining information from the birth certificate concerning the trimester during which prenatal care began, the number of state's 1998 live births occurred among women who did not receive adequate prenatal care. This rate is identical to the figure tabulated in 1997.

Unmarried Births. The frequency of births to unmarried women in Nebraska increased in 1998 to the highest ever recorded in Nebraska history. A total of 6,172 live births were recorded among unmarried women in 1998, up from the 6,018 recorded in 1997. The 1998 figure represents over one-quarter (26.2%) of the state's 1998 resident live births; the comparable figure for 1997 was 25.8%. Thirty-three percent of the unmarried births were to women under 20 years old. In 1998, 2,485 females aged 10-19 became mothers, of which 83% were unmarried. According to the 1990 census, nearly 40% of the 33,611 Nebraska families headed by single woman with children under 18 lived in poverty.



In 1993, 37% of the infants born to Omaha residents were to unmarried women. This is an increase from 35% in 1991, and a substantial increase from 25% in 1980, and 14% in 1970. Nationally, 31% of all births are to unmarried women, placing Omaha's 37% well above the national average.

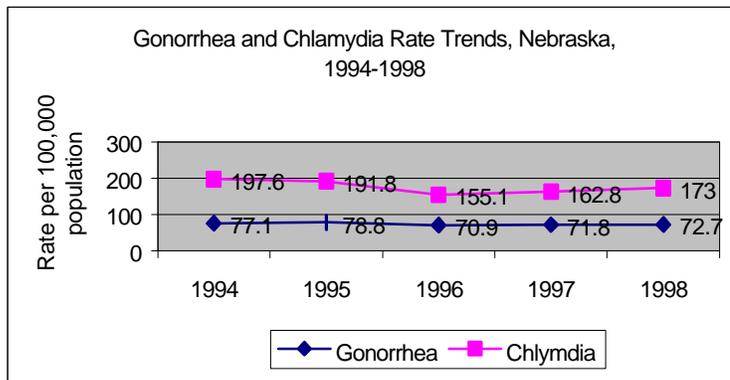
Adolescent Pregnancy and Births. In Nebraska, the teen pregnancy rate has decreased substantially from 42 pregnancies per 1,000 girls (aged 15 to 17) in 1989 to 29.5 in 1997. The rate in Nebraska is much lower than the rate nationwide (76 in 1994) and meets the state's Year 2000 objective of no more than 30 teen pregnancies per 1,000. Currently, 10.6% of the overall births in Nebraska are to adolescent mothers. This number has been steady for the last five years ranging from low in 1995 of 10% to a high of 11% in 1994.



In 1997, 3,562 women aged 12-20 gave birth. Teen births as a percentage of total births have increased from 12% in 1987 to 14.9% of all births in 1997. In 1997, almost 25% of teen births had a history of a previous birth. Among teens who gave birth in 1997 23.9% aged 15-17 had a partner at least five years older than themselves, and 25.3% aged 18-19 had a partner at least five years older than themselves.

Sexually Transmitted Disease.

Nebraska had 3,887 cases of gonorrhea and chlamydia reported in 1997 and 4,085 cases in 1998. Most (97%) of the number of cases reported were to Nebraskans between the age group of 15-44. In 1997 and 1998, 73% and 75% (respectively) of the cases are from the age group of 15-24. Rates of both gonorrhea and chlamydia declined through 1996 and in 1997, however, rates increased in 1998.



**Nebraska Chlamydia and Gonorrhea Incidence by Race/Ethnicity for 1996 and 1998**

	Chlamydia		Gonorrhea	
	1996	1998	1996	1998
<b>White</b>	51%	51.30%	20%	24.90%
<b>African American</b>	25%	27.40%	60%	55.50%
<b>Native American</b>	3%	3.60%	2%	1.40%
<b>Hispanic American</b>	9%	10.50%	3%	4.30%
<b>Other</b>	12%	7.20%	15%	13.90%

In Nebraska, sexually transmitted diseases disproportionately effect minorities. The relative risk for sexually transmitted disease incidence is almost 17 times greater for African Americans than for Whites. Native Americans experience a relative risk rate of 5.4, and people of Hispanic ancestry experience a relative risk rate of 2.5.

HIV and AIDS. In 1997, there were 91 cases of HIV/AIDS reported in Nebraska with an incidence rate of 5.5 per 100,000 persons per year. It is somewhat reassuring to note that this rate is about one-fourth as high as the national rate (22.3). As is true nationwide, racial and ethnic minority groups are over-represented among Nebraskans who have HIV/AIDS. African Americans made up 23% of all persons diagnosed with HIV/AIDS in 1995-1997, but they comprise only 3.8% of the estimated population of the state. The relative risk for African Americans is over six times higher for HIV/AIDS incidence. Hispanic Americans and Native Americans are also over-represented among persons with HIV/AIDS, compared to their share of the population. Native Americans and Hispanic Americans, respectively, have relative risk rates of 1.8 and 2.4. Reported AIDS cases decreased by 21% in 1997.

In 1997, there were 30 deaths due to AIDS in Nebraska. The number of deaths from this cause have declined substantially since a high of 82 in 1994, due primarily to new advances in treatment that may extend survival among those who are HIV-infected.

The 1995-1996 Nebraska Behavioral Risk Factor Surveillance System Report surveyed Nebraskans about several HIV/AIDS related attitudes. The report concluded that:

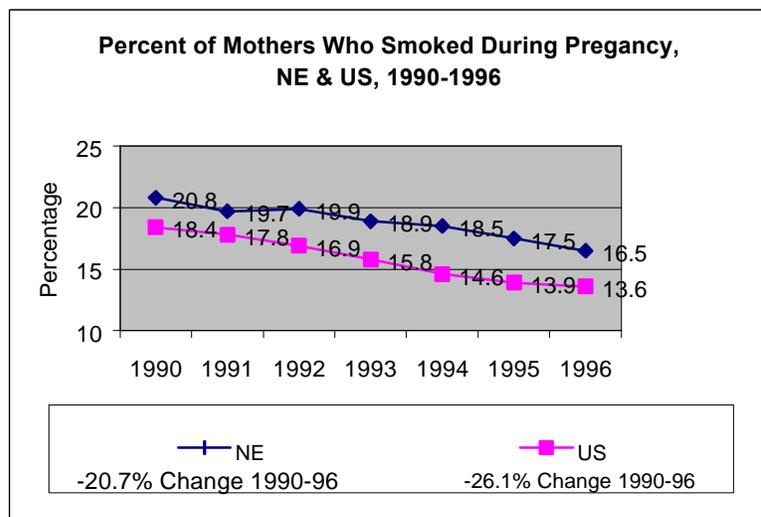
- Nine out of ten adults aged 18 to 64 years (89%) indicated that, if they had a sexually active teenager, they would encourage him or her to use a condom.
- One-third (34%) thought a properly used condom would be very effective in preventing transmission of HIV.
- Nine percent of Nebraskans in this age group perceive themselves to be at “high” or “medium” risk of contracting HIV/AIDS.
- One-third of those surveyed (33%) reported they had at some time had their blood tested for HIV infection, not counting the times when they had donated blood.

**Breastfeeding.** According to the Ross Laboratories Mothers Survey, the prevalence of mothers reported initiating breastfeeding while in the hospital in Nebraska has increased from 60.3% in 1990 to 68.1% in 1998. The prevalence of mothers still breastfeeding after six months has also increased from 1990 to 1998, from 20.7% to 30.8%.

Breastfeeding rates among WIC mothers, while still less than overall Nebraska mothers, has increased from 45.7% in 1990 to 56.6% in 1998. The prevalence of mothers still breastfeeding after six months has increased from 9.5% to 24.1%.

**Pregnancy and Tobacco.**

Nationally, the percentage of women who smoked during pregnancy declined every year from 1990 through 1996. The rate of smoking during pregnancy was 18.4% in 1990 and has declined by 26% to a rate of 13.6 in 1996. In Nebraska, the percentage of maternal smoking declined every year except 1992, during years 1990 through 1996. The rate of smoking during pregnancy was 20.8% in 1990 and has declined by 20% to a rate of 16.5 in 1996. This indicates that Nebraska still has more maternal smoking than the national rate, and has decreased more slowly than the national rate for the past seven years.

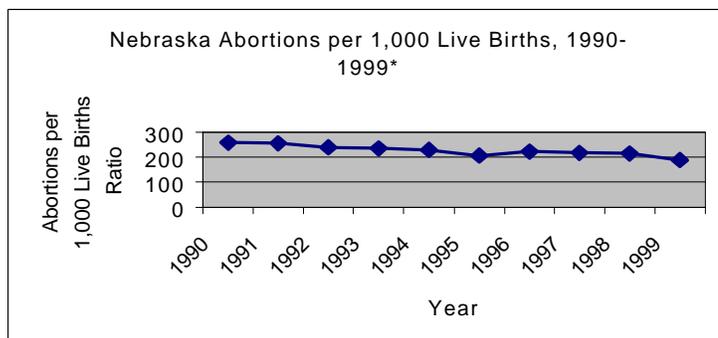


Nationally, declines in smoking during pregnancy were reported for all race and Hispanic origin groups between 1990 and 1996. Of all race and ethnic groups, American Indian women have the highest rate of smoking during pregnancy (21.3 in 1996); they also reported the smallest decline between 1990 and 1996 (5%). In Nebraska, Native American were by far more likely to smoke than any other racial or ethnic group. In 1994, Native Americans had a maternal smoking rate of 31.8%. The rate has increased over 10%, and in 1998 was at 35.6%.

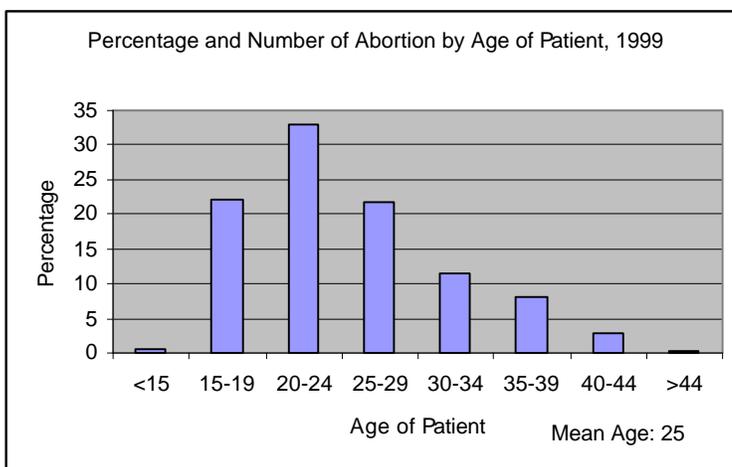
In the U.S. smoking rates were also high for non-Hispanic white mothers, 16.9% in 1996, a decline of 20% from 1990. In Nebraska, white women have experienced a decline of 14.2% from 1994 through 1998. Nebraska’s Hispanic mothers experienced a decline of 37.5% to 5.1% in 1998. The decline was higher than the national decrease of 36%, but Nebraska still has more Hispanic mothers smoking while pregnant than the U.S. rate (4.3% vs. 5.1%) Nationally, non-Hispanic Black mothers had a decline of 35% to 10.3% in 1996. In Nebraska, maternal smoking rates remain higher than the national rate at 16.7% in 1998. Black women in Nebraska only experienced a 10.2% decrease from 1994-1998. Like the national trend, Nebraska women with less education than a high school diploma were also more likely to smoke during pregnancy.

Nationally white pregnant women consume more cigarettes on average per day than Black pregnant women. In Nebraska, Native American women were found to be the heaviest smokers. Hispanic and Asian were the lightest smokers. Black and white women again had very similar consumption habits.

Abortion. A total of 5,140 abortions were reported to the Nebraska Department of Health and Human Services during 1998. Nebraska had a ratio of 215 abortions per 1,000 live births in 1998. The number of abortions performed on Nebraska residents in Nebraska during 1998 was 3,998. Women from 25 other states accounted for the remainder. Almost one quarter of the abortions performed in Nebraska are for residents of other states. Nebraska had a ratio of 169.9 abortions (for Nebraska residents) per 1,000 resident live births.



The current Nebraska Department of Health and Human Services system for collecting abortion data is limited in that abortion data is not collected by race or county, therefore, pregnancy rates cannot be calculated by race, county, or areas of the state. The abortion data collected is further limited by the fact that Nebraska Department of Health and Human Services does not have reciprocal agreements with surrounding states to collect abortion data for the women of Nebraska who seek abortions in other states.



In 1996, the report for collecting abortion data was revised and approved for use in 1997. The report was revised in an attempt to collect additional data by count of residence, race, ancestry, marital status, and highest level of education completed by the woman. Since the completion of the new data is optional, it is questionable if the data collected will be useful for statistical purposes. Over 99% did not report the additional data requested.

The mean age of a woman having an abortion performed was 25. The number one reason women sought an abortion was "socio-economic", followed by "no contraception used" and "contraceptive failure". Almost 34% of the women having abortions had had a previous abortion. Approximately 54% had previous parity, and approximately 66% had previous gravidity. Abortion complications were rare, 99.8% of abortions had no complications.

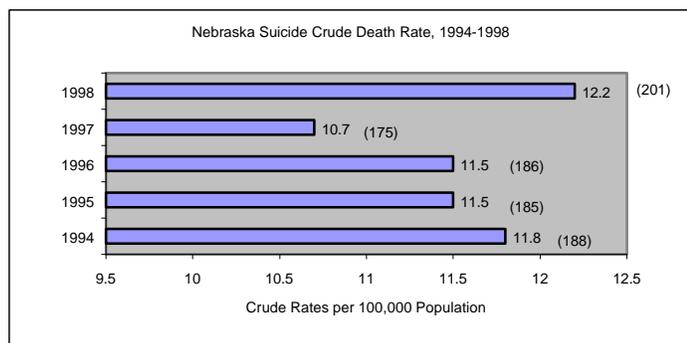
Childhood Immunizations. The national goal set by the U.S. Centers for Disease Control and Prevention (CDC) is that 90% of all children be immunized with four diphtheria-tetanus-pertussis (DTP) shots, three polio shots, and one measles-mumps-rubella (MMR) shot by the age of two. According to the National Immunization Survey covering the time period from July, 1998 to June 1999, 78.4% of children aged 19-35 months in Nebraska had been appropriately immunized. The national estimate for immunization is 73% for the same time period. The National Immunization Survey is a phone survey of approximately 400

Nebraska families over a one year's period of time. However, data are limited due to the small number of minority families sampled, so immunization rates for Nebraska's people of color and geographic location are unavailable.

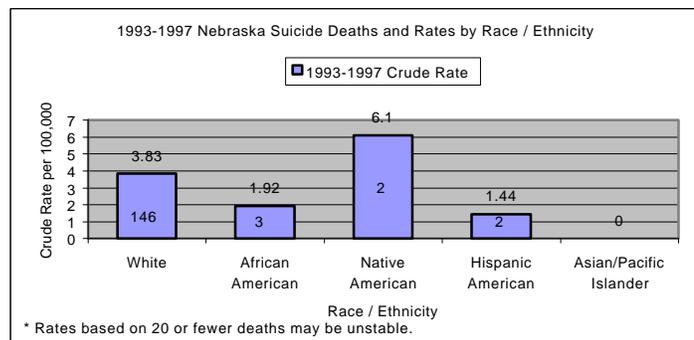
There were 24 reported cases of pertussis (whooping cough) in Nebraska in 1998. This is a noticeable increase from the last five years where the numbers hovered around 14 or 15. There have been a total of 110 cases from 1992 to 1998. The disease does not have a strong effect on older children or adults however, it can be easily passed to young children who may end up hospitalized or worse. Although there have been no deaths in recent years, pertussis is a potentially deadly disease for young children.

In 1999 there were 90 cases of confirmed rubella in NE. The last confirmed case of rubella was in 1990. A minimum of four cases occurred among pregnant women; two were in the first trimester. Approximately 83% of the total number of cases occurred among Hispanics born outside the U.S. To date, one infant has been born with congenital rubella syndrome.

Suicide. Suicide was the tenth leading cause of death in Nebraska in 1998 with 201 deaths. It was the fourth leading cause of death among women aged 15-29, the fourth leading cause of death among women aged 30-44, and the ninth leading cause of death among women aged 45-59. In 1998, 17 children aged 1 to 19 died due to suicide. Both the 1998 number of 201 and rate of 12.2 is an



increase from 1997. From 1993-1997, the relative risk (comparison to the White population) of suicide for Native Americans was 1.6. Nationally, as in Nebraska, Native American adolescents have the highest rates of suicide.



Similar to the national trend, Nebraska adolescent and young adult males have a consistently higher suicide rate than their female peers, averaging more than four times the rate of adolescent and young adult females. Like the national trend, in Nebraska older adolescents are more likely to commit suicide than younger adolescents. Nationally, suicide rates have fallen sharply for most adolescents. Nebraska's rates have stayed consistent.

While adolescent males have a much higher rates of death due to suicide, adolescent females are much more likely to exhibit non-lethal suicidal behavior. In 1999, 13.5% of youth surveyed in grades 9-12 reported having made plans to attempt suicide in the last twelve months. More females (15.4%) than males (11.5%) said they had made plans to attempt suicide. Almost six percent of youth surveyed in grades 9-12 reported having actually attempted suicide. Two and a half percent reported they tried more than once. Again, more females (7.5%) reported having attempted suicide than males (3.3%).

Homicide. Although the homicide rate in Nebraska is less than half the national rate, homicides in the state have increased over the past ten years. The rate and number of homicides in Nebraska has stayed consistent over the last five years. However adolescent males, especially African American males, are disproportionately represented.

Homicides were the fourth leading cause of death for African Americans in Nebraska in 1991-1995, up from fifth in the previous five-year period. This cause accounted for 102 deaths over the last five years and resulted in a rate of 34.7 per 100,000 population. From 1993-1997, the relative risk (comparison to the White population) of homicide for African Americans was 11.5, and for Hispanics 3.4 (1). The disparity between rates is even greater for African American males, where homicide rates are 17.9 times as high as the rate for white males. Among African American males, the homicide rate averaged 57.3 over the latest five-year period. Since homicide victims are frequently young, the number of years of potential life lost due to this cause are considerable. Among racial and ethnic minority residents of Nebraska, there was an average of 1,270 years of life lost each year from 1991-1995. African Americans accounted for nearly three-fourths of the total. The number of years of potential life lost (YPLL) per person was more than 12 times as high for African Americans as for Whites in the state. Native Americans averaged six times as many YPLL per person, while Hispanic Nebraskans lost more than three times as many YPLL.

Domestic Violence / Child abuse. In 1998, 2,800 children (66%) of the children involved in substantiated cases of abuse and neglect were neglected. Twenty-nine percent, or 1,231, of the children were abused and 11% (481) children were sexually abused. Nebraska has a network of 22 domestic violence/sexual assault programs. These programs provided 13,706 adults and 7,995 adolescents and children with emergency shelter, information, and support from July 1, 1997 – June 30, 1998. During the same time period, 6,008 (79%) of the 7,658 children in violent homes witnessed violence. Eleven percent (836) were physically harmed and 352 (5%) were suspected of being sexually abused. Female children were more likely to be victims of abuse and neglect than male children.

Youth Violence. According to the 1997 NE Youth Risk Behavior Survey, 31% of the students surveyed were involved in physical fights during the past year and the percent of students who reported carrying a weapon during the past 12 months is declining slightly from 20% in 1995 to 17% in 1997.

Intentional and Unintentional injuries. The leading cause of death of Nebraskans aged 1 to 34 is unintentional injuries. In 1996, 48 children aged 14 and under were killed in Nebraska due to unintentional injuries and over 19,900 children were treated for injuries in Nebraska hospitals. In Nebraska, ambulance runs totaled 4,884 for trauma to children aged 14 and under. Children aged 1-4 had the highest age specific rate of injury, in 1996, with 6,640 per 100,000 population, followed closely by children aged 10-14 with an age specific rate of 6,164 per 100,000 population. The lowest age specific rate is seen in the less than one age group with 286 per 100,000. Combining all age groups, more males (57.9%) were injured than females (42.1%). Males in the 1 to 4 age group had a higher rate of hospital discharge than any other group. There is a definite increase in discharges in the summer months leading into the start of the school year. The source for this information is the 1996 Nebraska Safe Kids Injury Report. This report used three data sources: emergency room, hospital inpatient discharge, and hospital outpatient discharge. This results in inflated rates. In 2000, the reporting will change.

Falls were the leading cause of hospital discharge for children 1 to 9 and struck by object the leading cause of hospital discharge for children 10 to 14.

Overall in Nebraska, unintentional injuries are the fifth leading cause of death, but because injury victims tend to be much younger than people dying from heart disease or cancer, the number of years of potential life lost (YPLL) due to injuries is higher than for any other cause of death.

The unintentional injury rate in Nebraska declined from 33.0 deaths per 100,000 in 1988 to 30.8 in 1997, but has not quite reached the objective for 2000 (29.3 deaths per 100,000). Progress in Nebraska nearly matches the improvement in unintentional injury deaths nationwide.

The death rate due to motor vehicle crashes is down in Nebraska compared to the 1988 baseline. However, rates have shown an upturn since 1995. A similar trend is evident in the rate of alcohol-related motor vehicle deaths.

The proportion of adult Nebraskans who report “always” or “nearly always” using their automobile safety belts has increased dramatically from 49% in 1988 to 77% in 1997. Most of the improvement can be attributed to a state law that went into effect in January 1993 that requires use of safety belts in motor vehicles.

<b>Ranking of Discharges by Cause of Injury to Children Age 14 and Under, 1996, NE</b>		
Cause of Injury	# of children injured	%
Falls	6,064	30.4%
Struck by/against object	4,309	20.2%
Other specified & classifiable	1,475	7.3%
Cutting/piercing	1,445	7.2%
Overexertion	1,063	5.3%
Pedal cyclist	839	4.2%
Motor vehicle - Traffic	763	3.8%
Natural/environmental	760	3.8%
Poisoning	622	3.1%
Fire/Burns	345	1.7%
Top 10 Total	17,685	87%
Other	2,261	13%
Total cause of injury	19,946	100%

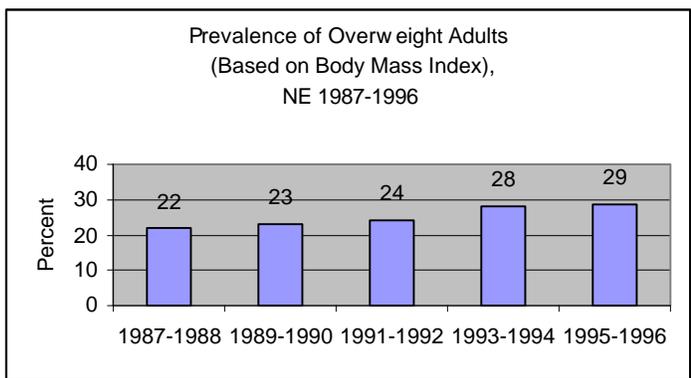
Obesity/ Nutrition. Nationally there has been an increasing prevalence of overweight and obesity among children. CDC’s National Pediatric Nutrition Surveillance System (PedNSS) shows that the prevalence of overweight among children aged to less than 5 years has steadily increased, from 7.0% in 1989 to 8.6% in 1997. During the same period of time, overweight among infants under age 2 increased from 10.8% to 11.3%. In 1997, PedNSS reported 10.3% of children nationally as being overweight. In Nebraska, 9.4% of children were reported by PedNSS as being overweight. Comprehensive data on obesity in children in Nebraska is unavailable.

Nationally, among children 4 to 5 years old, the proportion of children considered at risk of overweight demonstrated a relative increase of 23.2% while children considered overweight showed a relative increase of 29.2% during the years 1983-1995. The prevalence of at risk for overweight and overweight among 0-5 year old girls is consistently higher than among boys. The prevalence of overweight among boys does not surpass that of girls until age 12 years and older. Overweight continues to be a health problem that disproportionately affects poor youth and minority children and carries with it many social and economic consequences. A major concern over the increasing prevalence of childhood overweight is the range of medical and psychosocial complications associated with it, including hypertension, dyslipidemia, insulin resistance, type 2 diabetes mellitus, sleep apnea and other orthopedic problems, body image disturbances, and lowered self-esteem. As many as 30% of overweight children 5-11 years old have elevated blood pressure. Type 2 diabetes is becoming more commonly diagnosed among overweight children.

Overweight-related conditions are the second leading cause of death in the U.S., resulting in about 300,000 lives lost each year. Diabetes, coronary heart disease and some types of cancer are all associated with overweight. High blood pressure is also much more common among overweight persons. The prevalence of overweight has increased at a record pace in the U.S. since 1980. As a result, it is estimated that 58 million adult Americans are currently overweight.

Nebraska conducted a Behavior Risk Factor Surveillance survey in 1995-1996. The following information is reported in this report prepared in April, 1998. It is the most current available report.

More than one-fourth (29%) of adult Nebraskans reported heights and weights that placed them in the overweight category, based on the body mass index. The proportion of adults who are at risk due to overweight has increased over the years. Prevalence of overweight was slightly higher for men (30%) than for women (28%). In general, prevalence of overweight increased with increasing age of respondent through age 64. The proportion of



overweight respondents ranged from a low of 12% for 18-24 years olds to 39% for persons aged 55 to 64. Prevalence dropped off among respondents aged 65 to 74, but 34% were still classified as overweight. Only 23% of respondents aged 75 and older were in the overweight category.

**Nebraska Respondents Who are Overweight by Education Level and Income Level**

Education	Percent
Less than high school	33%
High school graduate / GED	33%
Some college / tech	27%
College grad	25%
<b>Income</b>	
< \$20,000	31%
\$20,000-\$34,999	29%
\$35,000 or more	28%

Both rural and urban residents were about equally likely to be overweight (29%). Nebraskans with more education are less likely to be overweight, as are residents with household incomes over \$35,000 annually.

The prevalence of overweight in Nebraska equaled the national median of 29%.

Oral Health. Nationally, five to 10 percent of young children have early childhood caries; in addition, 20% of children from low income families and 43% of Native American children have early childhood caries. In Nebraska, communities report limited access to oral health services, particularly in rural areas. Approximately 14% of Nebraska parents of children with special health care needs responding to a survey indicate difficulty in accessing oral health services for their children. Nationally, more than half of all children aged 6-8 and two-thirds of all 15 –year-old adolescents experience dental decay. Sixty percent of adolescents have gum disease. Limited data exists on the oral health of Nebraskan children.

According to the 1995-1996 BRFSS report, more than two-thirds (69%) of the adults surveyed said they had visited the dentist within the past year. For 11%, it had been one to two years since their last visit. Twelve percent of respondents stated it had been five years or more since they had been to the dentist.

Men were less likely (66%) than women (71%) to have visited the dentist in the last year. Compared to younger respondents (73%), a smaller proportion of persons aged 55 and older had visited the dentist within the past twelve months (62%). Rural Nebraskans (66%) were somewhat less likely than residents of urban counties (74%) to report a dental visit in the past year.

The proportion of persons who had visited a dentist in the last twelve months increased with increasing educational level. A similar trend is evident by household income of respondents.

Respondents were asked how many of their permanent teeth have been removed because of tooth decay or gum disease. About half (52%) reported that they had lost not teeth due to these dental problems. The proportion of women who reported losing six or more teeth (22%) was slightly greater than the proportion of men (18%). Prevalence of tooth loss increased with age of the respondents. Rural residents (25%) were about twice as likely as urban respondents (12%) to say they had six or more of their permanent teeth removed. Almost sixty percent of respondents with less than a high school education reported losing six or more teeth compared to only six percent of college graduates.

Persons without dental insurance (32%) were about three times as likely as persons with routine care dental insurance (10%) to report losing six or more permanent teeth.

Diabetes. Approximately 135,000 Nebraskans currently have diabetes, although only about one-half of them have been diagnosed and are aware they have the disease. Five percent of adult Nebraskans surveyed for the 1995-1996 BRFSS said they have been told by a doctor that they have diabetes. The prevalence of diabetes among the adult population has remained fairly constant since 1987, according to the BRFSS, ranging from 4 to 6% in Nebraska. Prevalence of undiagnosed diabetes was slightly higher among females (6%) than among males (5%). Females in Nebraska are 40% more likely to have diabetes than males. This sex difference appears in all adult age groups and all racial/ethnic groups.

Two percent of all Nebraska births for 1990-1995 were to mothers with diabetes. A 15% increase in the maternal diabetes rate during that period may reflect improved reporting of that risk on birth certificates, following new guidelines implemented in 1989.

Persons aged 45 and older were much more likely than younger Nebraskans to report that they have diabetes (6-11%). Only 2% of respondents aged 18 to 44 had ever been told they have diabetes.

The proportion of respondents to the Nebraska BRFSS who had ever been told by a doctor that they have diabetes (5%) was slightly higher than the national median of 4%. The national range was from 3 to 7%. The majority of adults in the 1995-1996 BRFSS reported being diagnosed with diabetes as adults. Three-fourths of the adults with diabetes in this survey

were age 40 or older (74%) when they were told they have the disease. Only 8% said they had been diagnosed as children or adolescents (under age 20). In 1998, diabetes was the seventh leading cause of death in Nebraska accounting for 335 deaths. This is an increase both in number and rate.

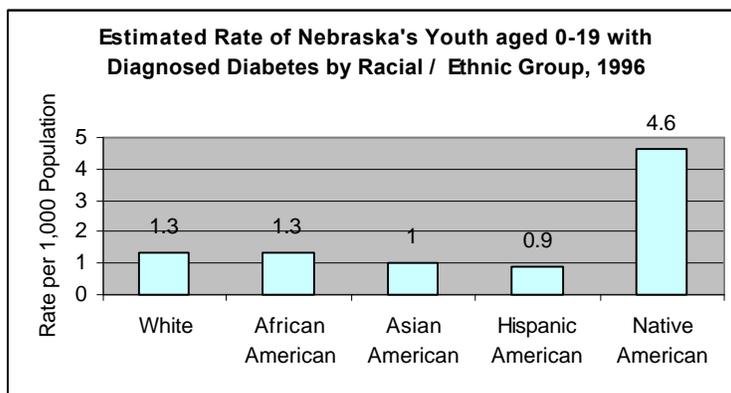
**Diabetes Deaths in Nebraska, 1994-1998\***

	1994	1995	1996	1997	1998
Number of deaths	282	284	333	313	335
Rate**	12.1	11.8	13.6	12.9	14.1

\*\*Age-adjusted rates per 100,000 population

Among Nebraskan women, diabetes was the seventh leading cause of death in 1998 with 185 women dying. In women aged 45-59, diabetes was the fourth leading cause of death; 22 women died in this age group. Diabetes is more prevalent among most of Nebraska's minority populations.

For adults age 45 and over, Native Americans have diabetes rates four times as high as non-Hispanic Whites, while Hispanic Americans and African Americans have rates twice as high as Whites. One third of Native Americans in Nebraska age 45 and over are estimated to have diagnosed diabetes. African that of the White population. Hispanic Americans are slightly more like than Whites



to die from diabetes than Whites, however, the risk is increasing (1.2 in 1983-1987 to 1.6 in 1993-1997).

According to the CDC, in 1997 (the most current information available) 28,221 men and 30,539 women in Nebraska have been diagnosed with diabetes (total = 58,760) . Thirteen percent (3,977) of African American Nebraskans have diabetes, compared to 4.7% of White Nebraskans (52,776). Numerous diabetes-related complications were reported including 100 new cases of blindness. The number of lower extremity amputations increased from 241 in 1996 to 471 in 1997. Another common diabetes-related complication is end-stage renal disease; 163 new cases of end-stage renal disease were diagnosed in 1997. This is an increase from 156 in 1996. The end-stage renal disease incident rate from diabetes more than tripled between 1985 and 1995 in Nebraska.

In 1997, there were 22,819 diabetes-related hospitalizations. This is an increase from 1996 (21,483). When surveyed, 30% of persons with diabetes had at least one day of poor health in which they couldn't perform their usual activities. The cost of diabetes in Nebraska (including direct cost and indirect cost) totaled about \$769.0 million in 1997.

In 1996, the CDC provided youth diabetes information. The number of Nebraska youth (0-19) with diagnosed diabetes in 1996 was 668. Diabetes is found in Native American youth almost three times more often than in Whites.

Cancer. The Nebraska Cancer Registry recorded 8,548 diagnoses of cancer among Nebraskans in 1997. The 1997 data show a very slight increase from 1996, when 8,521 diagnoses were reported. Nebraska's 1997 cancer diagnoses translate into an annual incidence rate of 384.9 cases per 100,000 population. The four most frequently mentioned sites (breast, prostate,

lung, and colorectal) accounted for more than half (56.4%) of all invasive cancer diagnoses among Nebraskans in 1997. Comparison of Nebraska and U.S. rates shows that, for all sites combined and for most individual sites, the incidence of cancer among Nebraskans is about equal to or lower than that experienced by Americans as a whole. In Nebraska, women had less incidence of cancer than men for the time period of 1993-1997. Men had a rate of 454.6, women had a rate of 329.5, and the overall rate was 381.9. The national rate for women is 346.3.

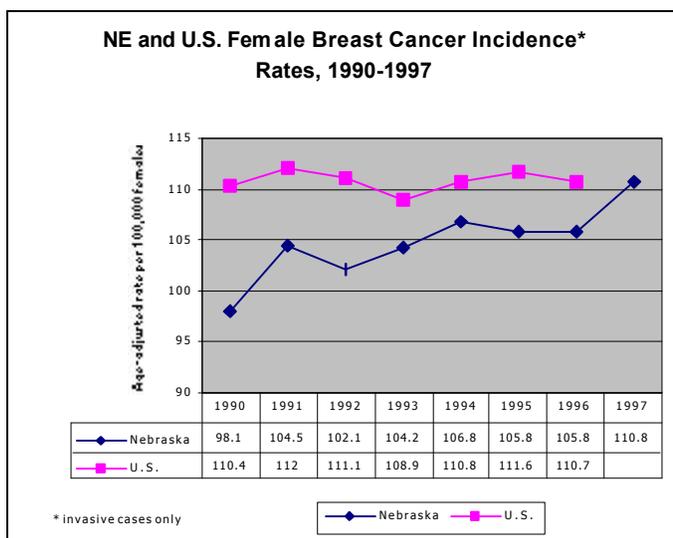
Nebraska recorded 3,234 cancer deaths among Nebraskans in 1997. This figure represents a slight decrease from Nebraska's 1996 tally of 3,313 cancer deaths. Nebraska's 1997 cancer death count translates into a statewide cancer death rate of 148.1 per 100,000 population. The four most frequently mentioned sites (lung, colorectal, breast, and prostate) accounted for slightly more than half (53.7%) of all cancer deaths among Nebraskans in 1997. Taken together, all deaths attributed to cancer comprised over one of every five (21.1%) Nebraska deaths in 1997. Comparison of Nebraska and U.S. rates shows that, for most specific sites and for all sites combined, cancer mortality is about equal or lower for Nebraskans than for Americans in general. In Nebraska, women were less likely to die from cancer than men for the time period of 1993-1997. Men had a cancer mortality rate of 191.3, women had a rate of 125.1, and the overall rate was 152.7. The national rate for women is 140.8.

Although lung cancer was only the third most frequently diagnosed cancer among Nebraskans in 1997, it was the year's leading cause of cancer mortality, accounting for more than 25% of the state's cancer deaths. Long the leading cause of cancer deaths among Nebraska men, lung cancer overtook breast cancer in 1993 to become the leading cause of cancer deaths among Nebraska women as well. In recent years, lung cancer has averaged about 1,000 diagnoses and more than 850 deaths per year among Nebraskans.

Cancer of the breast is by far the most common malignancy diagnosed among women and the second most frequent cause of female cancer deaths. In Nebraska, the disease accounted for nearly 6,000 cases (both invasive and in situ) between 1993 and 1997. Nearly one of every three cancers diagnosed among women during these years involved breast as the primary site. Among Nebraska women, fewer than one of every five breast cancers are detected among women under 50, and more than half are diagnosed among women 65 and older.

The relative risk of prostate cancer death for African Americans is more than two times higher than it is for the white population, the relative risk for cervical cancer death is one and a half times higher, and lung cancer is 1.6 times higher. Native American males have a relative risk for lung cancer deaths 1.5 times higher than the White population.

Radon. In Nebraska, a random survey of over 2,000 homes during the heating season of 1989-1990 found more than half had radon screening tests above the EPA "action level". Although many Nebraska homes are "slightly high," few Nebraska readings have been in the "very high" category. This represents the third highest percent of homes in the U.S. The statewide



average screening level of 5.5 pCi/l represents the fourth highest average in the U.S. Eastern Nebraska, especially Northeastern counties, is where the highest indoor radon concentrations are found.

Asthma. From 1990-1994, asthma was the recorded cause of death for 51 Nebraskans aged 5-14 and 15-34. This is an age-adjusted death rate of 1.9/100,000 – a rate higher than the US death rate of 1.4/100,000. Nebraska has an estimated 5,728 children with asthma in public schools; 4,186 use inhalers, 517 receive nebulizer treatments. Asthma accounts for approximately 11.6% of hospital stays for children aged 1-4, 15.54% of hospital stays for children aged 5-14, and 17.19% for Nebraskans aged 15-34. Nebraska has insufficient data to accurately determine incidence and prevalence of asthma among children. In the U.S., overall, the number of people with asthma increased by 75% between 1980 and 1994. It's estimated that more than 14 million people in the U.S. suffer from asthma. Among children under four years old, it increased by 160%. The next largest increase was among children aged 5-14 at 74%. Between 1974 and 1995, the estimated annual number of office visits for asthma nearly doubled. In 1995 alone, asthma caused 1.8 million emergency room visits and 10 million missed school days, making it the number one reason for school absenteeism. Hospitalizations for the 15-year period ending in 1994 increased by 20% to 466,000 (from 386,000 in 1979).

Deaths due to asthma nationally continue to rise. Asthma causes more than 5,000 deaths per year. In all age groups, death rates for African Americans are higher than for Whites or other groups. In 1990, asthma's cost to the U.S. was \$6.2 billion (direct and indirect costs). Currently it is \$11 billion. Medicaid and Medicare absorb \$1 billion of that cost.

Nationally, the burden of asthma is more substantial for those who are below the poverty level, however, the rate of asthma prevalence is rising in all population groups at about the rate of increase. The health disparities that exist between those above and below the poverty line have been constant over time. The greater burden of asthma on those below the poverty level is probably attributable to risk factors that are present to a greater extent in lower income groups such as poor indoor air quality, outdoor air pollution, early and more frequent respiratory infections in children and other factors, including poorer nutrition and less breastfeeding.

Tuberculosis. While Nebraska enjoys a low rate of tuberculosis at 1.5 for the five year period of 1995-1999, it is still slightly above the Year 2010 Objective of 1.0 new case per 100,000 population. The number of deaths per year in Nebraska from tuberculosis hasn't exceeded four since 1985, and Nebraska's age-adjusted death rate of tuberculosis has been consistently between zero and 0.2 per 100,000 population. While Nebraska's current numbers are low, the overwhelming number of new cases diagnosed each year are to foreign-born individuals.

Substance abuse. The prevalence of binge drinking has remained steady since 1989, with 16% of Nebraska adults reporting this behavior in 1997. The Nebraska Healthy People 2000 target rate is 13%. Among high school students prevalence is much higher with 42% stating they had participated in binge drinking in the past month, 44% of males, 40% of females. The Nebraska Healthy People 2000 target rate is 25%. Nationally, 25% of ninth graders have participated in binge drinking in the past month. Of the ninth graders surveyed in Nebraska, the percentage of binge drinking participants is 35%. Nationally, 12<sup>th</sup> graders increase the percentage of those who have participated in binge drinking in the past month to 39% while Nebraska's high school seniors report an increase to 65%. Nebraska is ranked second in the country for binge drinking by youth. According to Nebraska's Youth Risk Behavior Survey, alcohol is the preferred drug for teens: 80% of those surveyed reported having had at least one drink in their lifetimes.

The proportion of adults who say they drink and drive has remained stable at about 4% since 1988. The Nebraska Healthy People 2000 target rate is 2%. The number of alcohol-related motor vehicle deaths per 100,000 population is 5.7. The Nebraska Healthy People 2000 target rate is 5.0. According to the 1997 Youth Risk Behavior Survey 50% of males and 46% of females surveyed reported that they rode in a car in the past 30 days with someone who had been drinking alcohol. Twenty-five percent of 10<sup>th</sup> graders, 26% of 11<sup>th</sup> graders and 47% of 12<sup>th</sup> graders drove after drinking alcohol.

For the past five years, the average percentage of women reporting they consumed alcohol during their pregnancy is just over eleven percent.

Of surveyed Nebraska youth in grades 9-12, 31.2% reported trying marijuana at least once. Surveyed Nebraska youth reported that they were most likely to try marijuana for the first time by age 13 or 14. Almost seven percent of surveyed Nebraska youth reported that they had tried a form of cocaine (including powder, crack or freebase), almost 13% reported that they had sniffed glue, or breathed the contents of aerosol spray cans, or inhaled paints to get high. Approximately two percent of surveyed Nebraska youth reported that they had used a form of heroin and almost eight percent of surveyed Nebraska youth reported that they had used methamphetamines.

### **3.1.2.2 Direct Health Care Services and 3.1.2.3 Enabling Services.**

Nebraska's direct health care services for the MCH population is hindered by demographics and geography. Most of the population is located on the eastern portion of the state, where most of the services are also located. Most of Nebraska has been federally-designated as health professional shortage areas (HPSAs), Medically Underserved Areas (MUAs), an Medically Underserved Populations (MUPs). In 1999, over half (50/93) of Nebraska's counties have been designated, either in full or in part, as primary care HPSAs. These shortage areas potentially affect more than 25% of Nebraska's population. Based on 1998 Census estimates, more than 12% of the state's population lives directly within a HPSA. In addition, 73% of Nebraska's 93 counties have been designated, in full or in part, as containing MUAs or MUPs. Over 22% of the state's population live within the designated areas and are potentially affected by a shortage of health services. In addition to federally-designated HPSA, Nebraska has state-designated HPSAs. Within state-designated HPSAs, a high degree of shortage exists in each of the defined health specialization, including those directly related to MCH populations, including CSHCN. Two-thirds of Nebraska's counties currently have a shortage of family practice physicians (62/93), 78% have a shortage of general surgeons (73/93), 92% have a shortage of internal medicine physicians (86/93), 94% have a shortage of psychiatrists (88/93), 95% have a shortage of pediatricians (89/93) and 91% have a shortage of OB/GYNs (85/93).

Nebraska also had federally-designated dental HPSAs. In 1999, populations within 17 counties in Nebraska were affected, to some extent, by a shortage of dental health care in their areas. One-third of the state's population live in counties containing a designated dental health HPSA. Affected populations include central Nebraska, southwest Nebraska, and Northeast Nebraska, including the Winnebago and Omaha Native American populations.

In 1999, the majority of Nebraska's counties (66/93) were designated as Mental Health Care HPSAs. Two facilities, the Douglas County Hospital in Omaha and the Norfolk Regional Center, have also been included. Based on 1998 census estimates, the population represented within these shortage areas exceeds 48% of the state's total population.

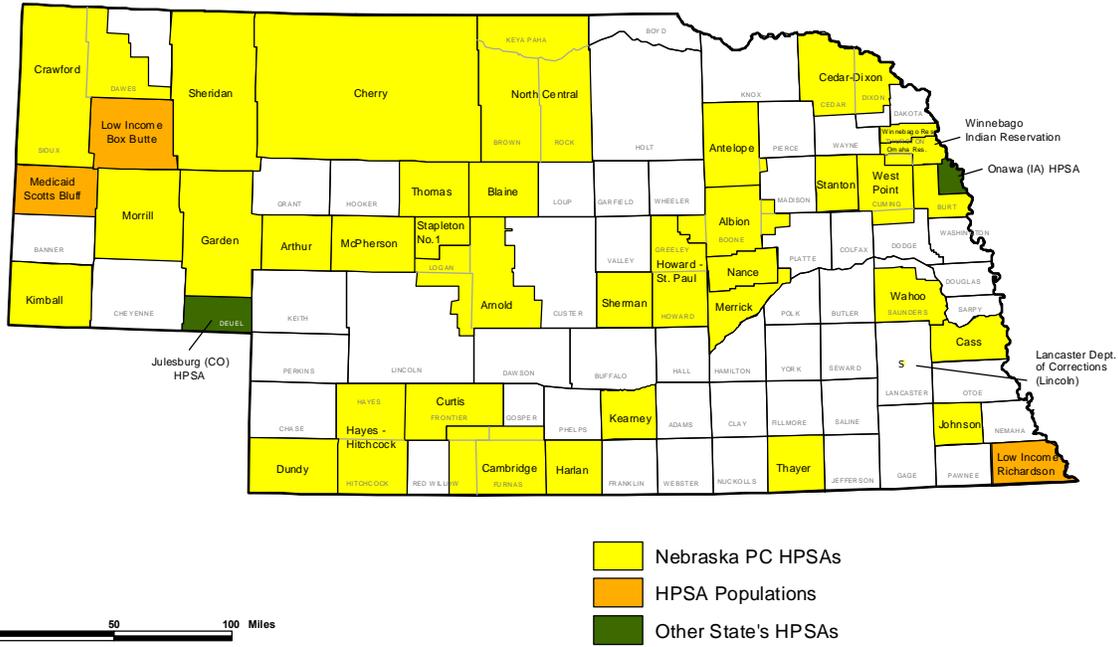
Nebraska's CSHCN population receives sub-specialty care through the Title V funded Medically Handicapped Children's Program (MHCP) that recruits health care professionals to form sub-specialty clinics to travel in teams to rural areas of

Nebraska. These teams include nutritionists, physical therapists, medical social workers, sub-specialty physicians and nurses. In addition, Nebraska's educational system has divided Nebraska into Educational Service Units (ESU). Each ESU has a number of trained speech pathologists, school nurses, audiologists, physical therapists, and psychologists.

Of the 36 pediatric specialists (representing 11 different specialty areas) in Nebraska, all but five were located in Douglas County. All but one pediatric specialist practiced in the Eastern part of the state (one pediatric hematology-oncologist is located in Lincoln county). In addition to the 36 pediatric specialists, Nebraska has 202 pediatricians (total 238) located in 18 counties.

# Federally Designated Primary Care Health Professional Shortage Areas

Nebraska - 2000

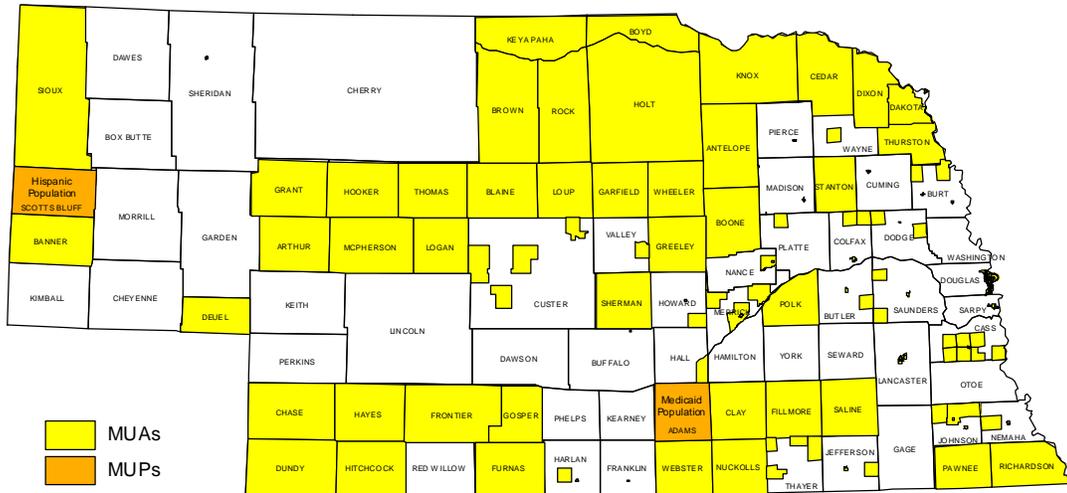


Data Source: Bureau of Primary Health Care (BRHC), Division of Shortage Designation, March 5, 2000.  
<http://www.bphc.hrsa.dhhs.gov/databases/hpsa/hpsa.cfm>  
 Nebraska Health and Human Services System, Office of Rural Health, 2000

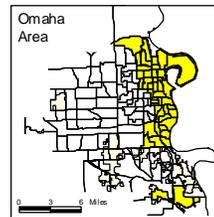
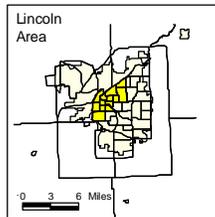
Cartography: Russ Wetzel  
 Nebraska Center for Rural Health Research

# Federally Designated Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)

Nebraska - 2000



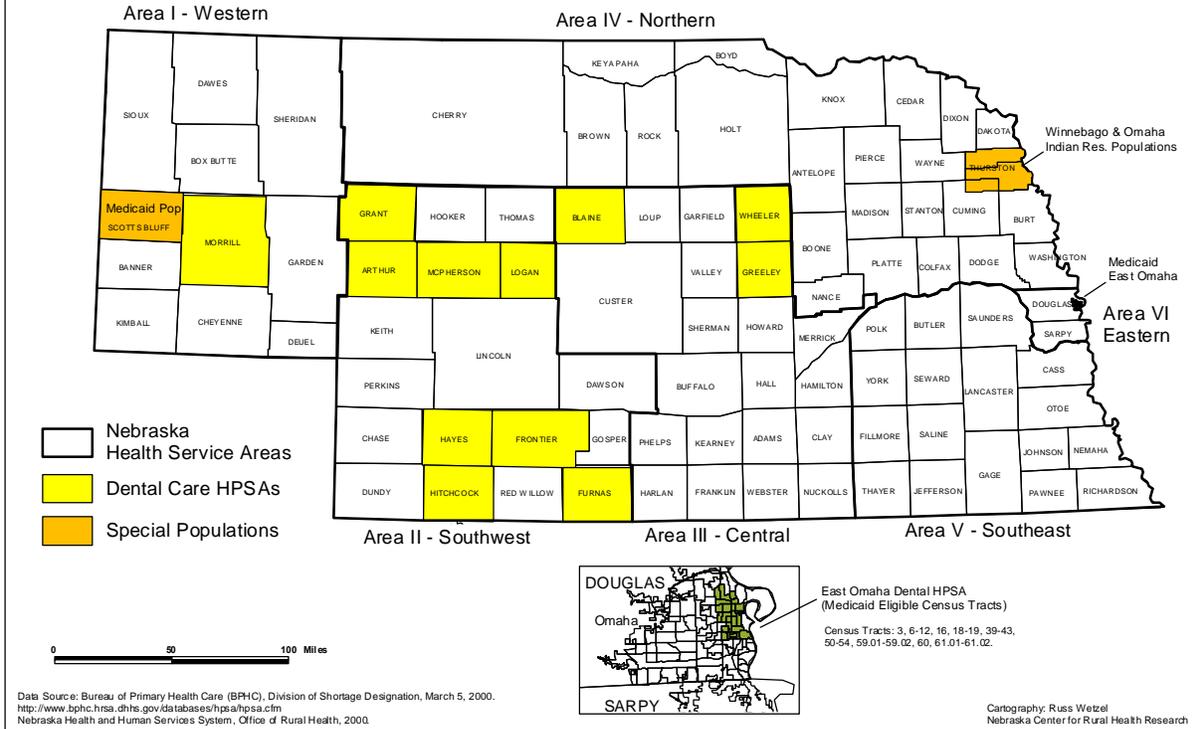
Data Source: Bureau of Primary Health Care (BPHC), Division of Shortage Designation, March 5  
<http://www.bphc.hrsa.dhhs.gov/databases/hpsa/hpsa.cfm>  
 Nebraska Health and Human Services System, Office of Rural Health, 2000



Cartography: Russ Wetzel  
 Nebraska Center for Rural Health Research

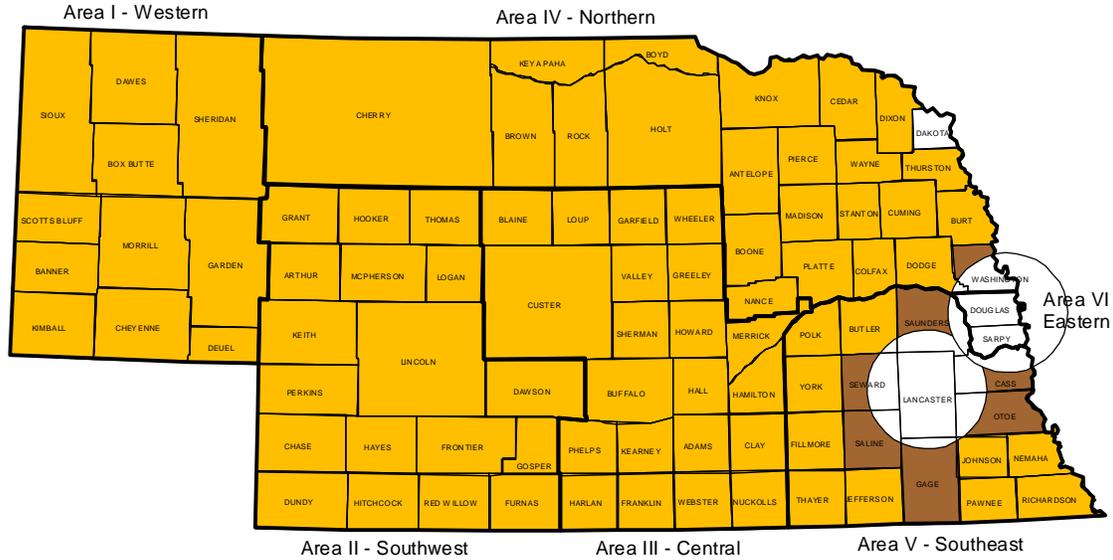
# Federally Designated Dental Care Health Professional Shortage Areas

Nebraska - 2000





# State Designated Pediatric Care Shortage Areas - Nebraska, 1999



Data Source: Nebraska Health and Human Services System, Office of Rural Health, May 5, 1999.

Cartography: Russ Wetzel  
Nebraska Center for Rural Health Research

In Nebraska there are significant geographic and financial barriers to health care. Many rural areas have an inadequate supply of primary care physicians and other health care professionals. Approximately 11% of Nebraskans are uninsured and many more are underinsured. The percentage of uninsured is considerably higher for racial/ethnic minorities and cultural barriers are often formidable.

Prior to implementation of Nebraska's SCHIP program in 1998, there were an estimated 24,000 uninsured children at 185% of the federal poverty level. Through September, 1999, 5,983 uninsured children were enrolled in the SCHIP program. The total number of uninsured children enrolled in the Medicaid Program in September, 1999, was 84,609. Of the 108,102 enrolled children in September, 1999, 17,510 had health coverage in addition to SCHIP.

Kids Connection, Nebraska's State Children's Health Insurance Program, is a Medicaid expansion anticipated to cover approximately 24,000 previously ineligible children. The program is administered by the Nebraska Department of Health and Human Service's (DHHS) Department of Finance and Support. Effective July 1, 1998, the State expanded Medicaid for children aged 15-18 living in families with income up to 100% FPL. Effective September 1, 1998, the State further expanded Medicaid up to 185% FPL for all children through the age of 18.

Because Kids Connection is a Medicaid expansion, services are delivered through the existing Medicaid delivery system. Managed care is available in Douglas, Sarpy, and Lancaster counties, and the rest of the state is serviced through a fee-for-service delivery system. Children eligible for Kids Connection receive the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit package. Families are not asked to pay any cost-sharing to participate in the program. In terms of access, Title V sometimes provides critical health services such as immunizations, obstetric, and well child care, and screening for early intervention. Some Title V sub-grantees also use funds for transportation.

Details regarding managed care, TANF, food stamps, CSFP, WIC and CSHCN services relevant to Direct Health Care Services and Enabling Services may be found in **1.4 Overview of the State**. That section also describes significant demographic trends, including the increases in Nebraska's racial/ethnic minority population.

Additional issues that impact Direct Health Care Services and Enabling Services are the challenges faced by Nebraska's hospitals. In dealing with the financial pressures of operating in rural areas, 31 Nebraska hospitals have been designated as critical access hospitals, and 41 total have applied for this status. It is expected that over 50 hospitals will be designated as critical access by the end of the year. Over the years, rural hospitals have taken on new roles in providing community based health services, including those for the MCH/CSHCN population. Long range, the network of critical access hospitals will have implications for emergency care for MCH/CSHCN, as well as perinatal care and preventive population-based services.

Challenges faced by urban communities include an influx of new immigrants from various parts of the world. These immigrants bring with them a multitude of cultural and language needs and in some cases no health care coverage. A particular challenge in delivering health care services in Douglas County has been the arrival of Sudanese immigrants. Identifying and engaging translators has taxed community-based health care providers.

Though Title V in Nebraska has long been moving towards an emphasis on population based and infrastructure building services, gap filling direct patient care is still a need because of access issues, particularly in urban areas. With health disparities a major concern and a large percentage of Nebraska's racial/ethnic minorities residing in urban areas, there will continue to be a role for Title V as a provider of direct health care for immigrant and other low-income uninsured populations.

During FY2001, Nebraska Title V will invest additional time and resources to more clearly identify service delivery gaps and evaluate current strategies to fill those gaps.

### 3.1.2.4 Population-Based Services.

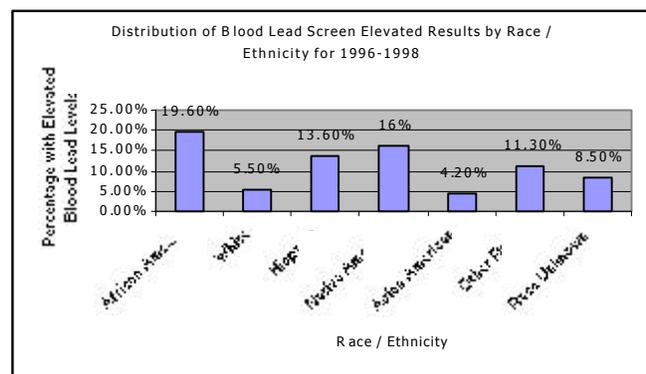
Newborn Screening. Title V funds in Nebraska support the Newborn Screening System that identifies genetic and metabolic disorders. In 1998 in Nebraska one infant was born with biotinidase deficiency. Biotinidase deficiency left untreated can result in nerve and brain damage, and mental retardation. Other problems, including metabolic decompensation resulting in coma and death, may occur. Six infants with congenital primary hypothyroidism (CPH) were born. CPH left untreated can result in mental retardation, various degrees of growth failure, deafness and neurologic abnormalities. Two infants were born with phenylketonuria (PKU). Infants born with undiagnosed or untreated PKU have progressive developmental delay in the first year of life, severe mental retardation, seizures, and autistic-like behavior. One infant was born with sickle cell disease and one infant with sickle cell-hemoglobin C disease. The sickling hemoglobinopathies cause lifelong hemolytic anemia with acute and chronic tissue damage secondary to the blockage of blood flow produced by the abnormally shaped red blood cells. Clinical manifestations include painful crises, sepsis, infections, splenic sequestration, and in some cases, stroke. In 1998, there were 23,862 births in the state of Nebraska (including out-of-state-residents who give birth in Nebraska). Of these, 23,858 were screened. A total of 4 births were not screened. Two were home births.

Title V funds also provided funding to the PKU Clinic at the University of Nebraska Medical center (UNMC) to support the purchase and distribution of metabolic formula and to provide nutritional counseling services for infants, children and women of childbearing age affected by phenylketonuria (PKU). Nebraska resident adult males were also served, although not with Title V funds. Through this program some 41 individuals with PKU were served in 1998.

As of July 1, 2000, a new state law will take effect that will encourage universal newborn hearing screening. In 1998, eight hospitals were participating in newborn hearing screening. From 1997 to 1998 the percentage of newborns screened for hearing impairment before hospital discharge increased from 4.1% to 12.4%. This increase is due primarily to two more hospitals providing screening during 1998. The new law will require screening if by 2003 voluntary screening does not reach 95% of infants.

Lead screening. In 1998, fewer than one in twenty Nebraska children under the age of six were screened for elevated blood lead levels. Lead can have significant detrimental physical, behavioral, and cognitive development effects on young children. Young children living in homes built prior to 1950 are at significantly greater risk of exposure to lead. Homes built before 1950 almost always contain lead-based paint and 38% of the homes in Nebraska were built prior to 1950. Homes built prior to 1978 may also present a risk for lead exposure. Seventeen percent of Nebraskan children under age five live in poverty. A major risk factor for lead poisoning in children is child poverty.

In Nebraska, 8,391 children were reported having been screened for elevated blood lead levels in 1998. This number reflects an increase of 2,000 children from the number tested in 1997. In 1998, 612 (7.3%) of children



screened had blood lead levels above the threshold of 10µg/dL. Nationally, 4.4% of children screened had high blood lead levels. Douglas County Health Department screened 9,280 children under the age of 6 from 1991-98, 24.2% had blood lead levels greater than 10µg/dL.

During the years 1996, 1997, and 1998, 21,979 children were screened for elevated blood lead levels. Of those screened, 28 children were considered seriously lead poisoned and qualified for hospitalization. During this same period 1,859 Nebraska children had blood lead levels in the range where the detrimental psychological and psychological health effects have been clearly demonstrated. Overall, 8.6% of children screen had elevated blood lead levels.

Elevated blood lead levels are disproportionately found in Nebraska's minority children. Approximately 20% of children screened with elevated blood lead levels were African American. Native American children made up 16%, Hispanic American children 13.6%, other race 11.3%, race unknown 8.5%. White children made up 5.5% of children screened with elevated blood lead levels.

Nutrition Services. A survey of children with special health care needs in Nebraska currently participating in CSHCN multi-disciplinary clinics indicated that almost 50% (approx. 240-300) require follow-up nutritional services. Few licensed medical nutritional therapists (LMNTs) provide nutritional services to CSHCN. LMNTs indicated that they require additional training and education to provide services to CSHCN.

Most nutrition services for MCH population are categorical in nature, with no comprehensive state plan cutting across funding streams.

Immunizations. Nebraska has 55 public immunization sites serving 84 of Nebraska's 93 counties. The Nebraska Immunization Program provides vaccines to the sites. It should be noted that many of Nebraska's public immunization clinics make extensive use of community volunteers in order to deliver needed services to local children.

Because of fragmented and incomplete immunization records, immunization providers find it hard to determine whether children are up-to-date on their immunizations. Children often visit more than one immunization clinic or private physician to receive vaccinations. In addition, the ability to use data to measure immunization levels, identify who never started their vaccinations on time, who started and has fallen behind, and where to allocate funds in order to impact on the largest number of children with the greatest need is critically important. Currently one Nebraska county uses a different computer program to track public immunizations. This program is incompatible with the statewide public sector registry. Plans to expand to the private sector have been postponed.

When the CDC decreased state funding of immunization programs in 1998, Title V provided programmatic funding to Nebraska's Immunization Program to ensure its efficacy sustainability.

Injury Prevention. The Nebraska Office of Highway Safety provides a staff person to NDHHS to coordinate Nebraska's Safe Communities, an adolescent motor vehicle crash prevention program. In addition, their efforts include education and materials, surveillance, and a great deal of collaboration with already existing public health programs, including those funded by Title V. More than 20 communities have Nebraska Safe Communities coalitions. Emergency Medical Services for Children (EMSC) activities increases state capacity to appropriately respond to pediatric emergencies, including motor vehicle crashes. Nebraska also has a Child Death Review Team that provides information to plan future strategies to reduce fatality rates.

Title V collaborates with the state's only poison control center located in Children's Hospital in Omaha to reduce the number of poisonings.

Title V, through the School and Adolescent Health Program, provides information to school personnel (and other community members) on strategies to prevent suicide and violence. Information is also available on youth at risk. The Health Promotion and Education Division of NDHHS has expanded its capacity to address intentional injuries. Title V program staff consequently works closely with this division to coordinate activities. Like nutrition services, injury prevention lacks a comprehensive statewide plan in Nebraska. Programmatic activities are tied to funding streams.

Outreach/Public Education. Title V funds the Healthy Babies Helpline, a tollfree hotline for parents to call about services for their children. Specifics about this program are found later in this document. Title V also funds a neural tube defect prevention campaign, in addition, UNMC's Munroe-Meyer Institute receives funding for their teratogen services.

One of the gaps in services provided is around SIDS. While the nationwide Back to Sleep campaign has reduced the number of SIDS cases nationally by 40%, Nebraska continues to have SIDS as a leading cause of infant mortality. African American and Native American infants disproportionately die from SIDS than White infants. A targeted SIDS campaign is needed to reduce this number.

### **3.1.2.5 Infrastructure Building Services**

As stated earlier under 3.1.2.1 and 3.1.2.2, Nebraska has significant gaps in the availability of primary care providers and local public health agencies. Added to that, state-level public health resources are in large part categorical, with fragmented capacity in the core functions. These issues have historically impacted infrastructure building for the MCH and CSHCN population.

One of the most significant activities to have occurred recently to address public health infrastructure is Nebraska's participation in Turning Point. As a result of that initiative, Nebraska released "Nebraska's Plan to Strengthen and Transform Public Health in Our State" on November 30, 1999. The report outlines strategies in eight areas: building public health infrastructure at the community level; developing new and improved partnerships between communities and the state; improve the health status of racial/ethnic minorities; develop innovative health promotion and disease/risk factor prevention programs; developing and monitoring intervention strategies relating to environmental health hazards; building integrated health and medical system that maintains an adequate safety net and improves access to high quality services; improving accountability by developing and monitoring performance-base standards and measures; and developing and implementing a promotional campaign to increase visibility and understanding of public health.

Title V/MCH staff was actively involved in developing three of the strategies and the entire plan outlines priority infrastructure issues relevant to MCH/CSHCN populations.

Specific infrastructure issues that have been pertinent to Nebraska's Title V programs has been lack of capacity in the core function of assessment. Our current SSDI funded activities are beginning to address these issues through additional human resources, the transfer of an Internet query data system, and additional training and technical assistance for state and community staff. Building this capacity will be an ongoing need in future years. Other efforts to strengthen data capacity has been Title V support of a Minority Behavior Risk Factor Survey (currently in process). The Nebraska Minority Public Health Association is focusing on the capacity of communities of color to assess, identify, and address health needs, including those of the MCH and CSHCN populations.

Organizational changes over the past five years have incrementally impacted infrastructure building capacity. In 1995, the Department of Health reorganized, forming a Division of Family Health. This Division resulted in Title V/MCH activities being organized with several related programs and activities, including WIC, Commodity Supplemental Food Program, Immunizations, Reproductive Health, and School and Adolescent Health, as well as Newborn Screening and Genetics. In 1997, the Department of Health sunset as an agency, as did the Departments of Public Institutions, Social Services and Aging, and the Office of Juvenile Services. In their place, the Health and Human Services System was created, consisting of three departments: Services, Finance and Support, and Regulation and Licensure.

These reorganizations have contributed significantly to collaborative efforts around systems building for the MCH/CSHCN populations. The earlier Department of Health reorganization facilitated work in the area of integration of services. Just this past year, a 3-year evaluation of an integration model was completed. That study revealed that some MCH indicators can be positively impacted through integration of services, including earlier access to preventive services, increased rates of referrals, and enhanced delivery of nutrition and health education. The presence of the School and Child Health Nursing Coordinator within the Division has fostered systems development with school health services. With the support of the SSDI

grant, the Division of Family Health is pursuing better integrated planning activities, including needs assessment and the development and tracking of performance measures.

The new HHSS system resulted in the MCH and CSHCN components being placed in the same agency. The System also includes child care, Medicaid, child welfare, and economic assistance. Specific activities and efforts that have been facilitated by this reorganization include: Title V/MCH and CSHCN participation in the development of Kids Connection (Nebraska's State Children's Health Insurance Program or SCHIP); collaborative development and administration of Healthy Child Care Nebraska, an in-progress effort to integrate children and youth services through the efforts of a Children, Youth and Family Services Integration Team.

Some recent systems building activities include Nebraska's participation in Map to Inclusive Child Care, the APHA/Colgate Palmolive MCH Community Leadership Initiative, and the MCH Provider Partnership. Since 1998, Title V/MCH has collaborated with Medicaid and led an effort to develop perinatal care guidelines. In 1999, Nebraska received Healthy Start funds to initiate "Substance Free for a Healthy Start Nebraska" project. This project focuses on building collaborative systems with health care providers to improve prenatal screening for risk of substance abuse. Major collaborators with this project include the University of Nebraska Medical Center and Douglas County Health Department.

Nebraska is unique in having co-leads for Early Intervention services: the Department of Health and Human Services and the Department of Education. As a result, Nebraska's Title V/CSHCN staff is actively involved in the early intervention delivery system in Nebraska.

Early childhood services have received significant state-level attention over the past year. A Governor appointed business council made a series of recommendations for supporting early childhood care and education. Among the recommendations of the council was the consolidation of advisory bodies. As a consequence, state legislation was passed and effective July 1 three bodies dealing with early childhood issues will be merged into a new advisory body: Nebraska Interagency Coordinating Council (early intervention), the Child Care and Early Childhood Education Coordinating Committee, and the Nebraska Head Start State Collaboration Team. Parallel to the development of a new advisory body, the Lieutenant Governor has convened an interagency task force consisting of representatives from the Department of Health and Human Services and the Department of Education (including both the Title V MCH and CSHCN directors). This task force is addressing a wide range of system issues as they impact young children. Taken together, the new advisory body and the interagency task force will play major roles in addressing systems issues in the area of early childhood, including MCH and CSHCN.

Previous collaborations with the Nebraska Chapters of the AAP and Family Physicians included the development of a joint statement on children's health. Members of these organizations and the Nebraska Medical Association have been active in Nebraska's Blue Ribbon Panel on Infant Mortality. The MCH Provider Partnership effort and the work on perinatal guidelines have also actively involved members of these professional organizations. Nebraska's AAP has also contributed to Healthy Child Care Nebraska, and is taking leadership through its CATCH coordinator to address health disparity issues in partnership with the Primary Care Bureau.

Systems building activities with tertiary care centers and children's hospitals have been less active in recent years. A previous activity of Nebraska's Title V MCH/CSHCN programs was the routine site visits to neonatal intensive care units and routine training and technical assistance to "Level I" birthing hospitals. Organizational changes and limitations on resources in large part ended active involvement in perinatal care system quality assurance. Recent work and observations of the Blue

Ribbon Panel on Infant Mortality will likely result in specific recommendations related to perinatal care delivery systems and the role of the Department in monitoring and improving those systems.

Healthy Child Care Nebraska has begun focusing on systems building in regards to child care health consultation. The upcoming challenge is finding, developing and supporting structures within communities to house and facilitate the work of child care health consultants.

Nebraska's CSHCN population receives sub-specialty care through the Title V funded Medically Handicapped Children's Program (MHCP) that recruits health care professionals to form sub-specialty clinics to travel in teams to rural areas of Nebraska. These teams include nutritionists, physical therapists, medical social workers, sub-specialty physicians and nurses. In addition, Nebraska's educational system has divided Nebraska into Educational Service Units (ESU). Each ESU has a number of trained speech pathologists, school nurses, audiologists, physical therapists, and psychologists.

Within the Department of Health and Human Services is Special Services for Children and Adults. The administrator for this unit is the Title V/CSHCN Director and the unit manages the Medically Handicapped Children's Program, the primary Title V/CSHCN activity. Other programs housed within this unit include: Aged and Disabled Waiver, Katie Beckett Plan Amendment Services Coordination, Social Services Block Grant for the Aged and Disabled (Title XX), Disabled Persons and Family Support, Adult Protective Services, SSI Disabled Children's Program, Nebraska Resource Referrals System, Genetically Handicapped Persons Program, Early Intervention Waiver, and the Early Intervention and Medicaid in public Schools Programs, which are co-administered with the Nebraska Department of Education.

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

In addition, MHCP operates the SSI-Disabled Children's Program (DCP) for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by the Nebraska Medical Assistance Program (Title XIX, Medicaid). Services provided through the Nebraska SSI-Disabled Children's Program include transportation to enable children to obtain diagnostic and/or treatment services, sibling care, attendant care, respite care, meals and lodging while traveling to obtain medical care, personal care needs, utilities related to special high electrical use support equipment (e.g., nebulizers, oxygen concentrators, etc.), architectural modifications including wheelchair ramps, and specific items of equipment to maintain or improve functioning.

Other state agencies are finding it easier to bring together groups from NHHSS to address issues as well. Examples specific to Title V/CSHCN include MHCP working with the Vocational Rehabilitation and Special Education Programs in Nebraska Department of Education to set up a model medical transition project for CSHCN attempting to adjust to the adult health care environment. Vocational Rehabilitation and MHCP also make referrals to each other for participants 13 years and older. MHCP is also working with Vocational Rehabilitation and the Mental Health program in NDHHS to establish a Traumatic Brain Injury care system for children in Nebraska.

Vocational Rehabilitation, MHCP, the Developmental Disabilities Council, League of Human Dignity, Aged and Disabled Medicaid Waiver, Easter Seals Society, United Cerebral palsy, the Disabled Persons and Family Support Program, and other private non-profit programs all participated in coordinated funding meetings to assure that individuals receive services for which they are eligible. For over fifteen years, this group of providers and advocates has met to discuss individual cares and find solutions which make the most efficient use of program resources.

The Disabilities Determination Unit (DDU) for Social Security and SSI is located in the Nebraska Department of Education. The DDU sends notification to MHCP on a regular basis of children determined eligible for SSI, at which time MHCP sends a letter to the family describing possible services they may receive and how to apply. The DDU and MHCP also worked together last year to compile a list of those impacted by the federal change in the definition of "disability" for SSI. All such persons were sent notices from MHCP and DDU which provided the toll-free telephone number of the Parent Training Center in Omaha, a private non-profit agency. This agency made families aware of their potential denial of SSI and the process to appeal the denial.

Data capacity for CSHCN continues to be addressed through Nebraska's SSDI project. Use of hospital discharge data is being explored as a means for gathering more population based data on CSHCN, to supplement programmatic data. The national CSHCN survey will be particularly useful in enhancing data availability.

Individuals and organizations that have been involved in CSHCN assessment activities include parent representatives, staff of Munroe-Meyer Institute at the University of Nebraska Medical Center (Nebraska's LEND project), staff with the Governor's Planning Council for Developmental Disabilities, and Department of Education staff working with transition activities, vocational rehabilitation, and Early Intervention. The CSHCN needs assessment was integrated with the overall needs assessment, though this process had many shortcomings. A more focused approach would be more appropriate to arrive at more conclusive findings.

Overall, the major needs and system weaknesses in the area of infrastructure building services include:

- Perinatal systems of care, particularly quality assurance activities
- Linkages/collaborations with the behavioral health system, addressing all MCH and CSHCN populations
- Comprehensive plan addressing intentional injuries (domestic violence, youth homicide and suicide, child abuse)
- Enhanced state-level data capacity, especially as it relates to CSHCN
- Community capacity to identify and address local MCH and CSHCN needs and the particular needs of racial/ethnic minorities
- Renewed/expanded involvement in quality assurance for MCH/CSHCN populations participating in Medicaid and Medicaid managed care

## 3.2 Health Status Indicators

Some data for the health status indicators is not available and has not been collected. What data has been collected was analyzed and included in the five year needs assessment. The needs assessment process was used to identify Nebraska's priority needs, including the lack of data which was identified as capacity or infrastructure building for the future. See 5.4 through 5.7 for ERP tables. See 3.1 to review the Needs Assessment for additional information.

### 3.2.1 Priority Needs

Most of Nebraska's priority needs, based on Nebraska's five-year needs assessment, are related to health status or health behaviors. One might argue, therefore, that most of these needs cross all levels of the pyramid. For purposes of this application, though, most of the following ten priority needs appear to be most closely related to population-based services, enabling services, and building infrastructure services. Priority needs specifically relating to population-based services are: reducing morbidity and mortality due to asthma; reducing rates of adolescent, non-marital, and unintended pregnancies; reducing rates of infant mortality with an emphasis on eliminating racial/ethnic disparities; reducing use of tobacco, alcohol, and illicit substances among youth and women of childbearing age; and reducing rates of injury, both intentional and unintentional, among the MCH/CSHCN population.

**Asthma:** The rate per 10,000 hospitalizations for asthma in children less than five years old has risen from 11.65 to 15.10 from 1995 to 1997. In Nebraska there was 51 deaths due to asthma from 1990-1994. This is an age-adjusted death rate of 1.9/100,000, higher than the US death rate of 1.4/100,000.

**Adolescent, nonmarital, and unintended pregnancies:** Nebraska has an infant mortality problem. All three of these types of pregnancies, according to research, end in higher rates of infant mortality. Nebraska's teen mothers are less likely to begin first trimester prenatal care, and more likely to not receive prenatal care than any other age group. 1998 brought record numbers of births to unmarried women – for the second year in a row. Families that include adolescent, nonmarital, and unintended pregnancies are more likely to experience economic hardship. In Nebraska, between 25-30% of teen mothers will have more than one pregnancy before they turn 20. This is higher than the national average of 20-22%.

**Infant mortality:** Nebraska's infant mortality rates have been flat since the beginning of the 1990's while the national rates have been decreasing. This health status indicator, a strong measure of a state's overall well-being, indicates a significant racial/ethnic health disparity. African American infants are four times as likely to die before their first birthday than are white infants.

**Tobacco, alcohol, and substance abuse:** In 1999, 65% of surveyed Nebraska youth in grades 9-12 reported having tried cigarette smoking. Approximately 37% reported having at least one cigarette in the last 30 days. Almost 22% of youth reported being regular smokers (at least one cigarette every day for 30 days). The prevalence of binge drinking in Nebraska is higher than the NE Healthy People 2000 objective (16%, 13%). Among high school students prevalence of binge drinking is much higher with 42% stating they had participated in binge drinking in the past month. The NE Healthy People 2000 objective was 25%. For the past five years, the average percentage of women reporting they consumed alcohol during their pregnancy is just over 11%. No change has occurred. Over 31% of surveyed Nebraska youth in grades 9-12 reported trying marijuana at least once. They also reported they were most likely to try marijuana for the first time by age 13 or 14.

**Injuries:** The leading cause of death of Nebraskans aged 1 to 34 is unintentional injuries. Children aged 1-4 had the highest age specific rate of injury, in 1996, with 6640 per 100,000 population, followed closely by children aged 10-14 with an age specific rate of 6164 per 100,000 population. From 1993-1997, the relative risk (comparison to the white population) of homicide for African Americans was 11.5 and for Hispanics 3.4. The overall rate of homicide has increased from 3.3 per 100,000 in 1988 to 4.0 in 1997. In 1997, suicide was the second leading cause of death for Nebraskans aged 15-24.

Enabling services relate strongly to the CSHCN, but are not limited to that population. Two of our priority needs are enabling services: reducing the incidence and prevalence of nutrition-related health problems among children, including CSHCN; and increasing the number of CSHCN who have a medical home and access to pediatric specialists.

**Nutrition-related health problems:** Nationally there has been an increasing prevalence of overweight and obesity among children. The CDC's National Pediatric Nutrition Surveillance System (PedNSS) shows that the prevalence of overweight among children aged to less than 5 years has steadily increased from 7.0% in 1989 to 8.6% in 1997. In Nebraska, 9.4% of children were reported by PedNSS as being overweight. A survey of children with special health care needs who attend current CSHCN multi-disciplinary clinics indicated that almost 50% (approximately 240-300) require follow-up nutritional services.

**CHSCN with a medical home:** A national performance measure as well, this priority need in Nebraska is a result of Nebraska's unique demographics and geography. In 1999, the Office of Rural Health reported that of Nebraska's 93 counties, 89 experienced a shortage of pediatricians. Of the 36 pediatric specialists in Nebraska, all but five were located in Douglas County (Omaha). All but one pediatric specialist was in the eastern part of the state.

Two of our priority needs are infrastructure building services: increase access to quality oral health care for MCH/CSHCN population; and increase the state's capacity for surveillance of immunization status.

**Oral health care:** Nationally, five to ten percent of young children have early childhood caries; in addition, 20% of children from low income families and 43% of Native American children have early childhood caries. In Nebraska, communities report limited access to oral health services, particularly in rural areas. Approximately 14% of Nebraska parents of children with special health care needs responding to a survey indicate difficulty in accessing oral health services for their children. Limited data exists on the oral health of Nebraska's children.

**Immunization status capacity:** According to the CDC's National Immunization Survey, 82.4% of two-year-olds in Nebraska had been appropriately immunized. The national goal is 90%. Nebraska currently lacks the ability to track childhood immunizations and to accurately determine the immunization levels. The National Immunization Survey has a number of limitations. The methodology does not provide for adequate sampling to determine rates for specific populations or geographic areas. There were 24 reported cases of pertussis in Nebraska in 1998. This is a noticeable increase from the last five years where the number hovered around 14 or 15. There have been a total of 82 cases from 1995-1999.

**Racial and Ethnic Health Disparities:** The Nebraska needs assessment indicates that we have significant racial and ethnic health disparities. This is recognized as a top ten priority need. Disparities exist in almost all health indicators including: adolescent pregnancy, nonmarital pregnancy, infant mortality, high blood lead levels, homicide, birth defects, low birth weight infants, diabetes, SIDS, and many others. This need covers all levels of the pyramid, but also has a specific infrastructure-building component because of the need to develop community-level aspects to assess and address local needs.

### **Nebraska's Top Ten Priority Needs:**

1. Childhood morbidity and mortality due to asthma need to be reduced.
2. Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN.
3. Increase access to quality oral health care for MCH/CSHCN population.
4. Decrease rates of adolescent, non-marital, and unintended pregnancies.
5. Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.
6. Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age.
7. Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN.
8. Increase the number of CSHCN who have a medical home and access to pediatric specialists.
9. Increase the state's capacity for surveillance of immunization status.
10. Eliminate racial and ethnic health disparities.

Numbers assigned to these priority needs do not imply relative importance, but serve only to label the needs for reference purposes.

**See Section 8 "Supporting Documents" for Form 14.**

### 3.3 Annual Budget and Budget Justification

#### 3.3.1 Completion of Budget Forms

See Form 2, Form 3, Form 4, and Form 5, all of which are included in Section 5.8.

#### 3.3.2 Other Requirements

#### Budget Justification

##### Forms 1 and 2:

Based on the President's budget proposal, it was anticipated that Nebraska would receive an allocation of \$4,185,740. Because all unspent Title V funds from FY 2000 will be obligated at the beginning of FY 2001, a budgeted unobligated balance of \$0 is reflected.

NHHSS staff within the Financial Services Division of the Finance and Support agency who have worked with Title V and a number of other federal public health program funds for many years assist Title V staff in budgeting and awarding funds each year. Because these accounting staff have worked with Title V funds for a number of years, they are quite familiar with the requirement for spending the previous year's dollars in the two-year funding cycle prior to spending the current fiscal year allocation. Accounting methods used reflect constant monitoring of these funds, with each year's allocation being given a different accounting code to help assure that "oldest" dollars are spent first.

In addition to the Title V funds reflected above, there are two categories of funds applied to the Title V required state match: state general funds and match generated by Title V-funded community-based agencies. The categories of "Total State Funds" and "Local Funding" are totaled and reported together as Total State Funds to eliminate the warning message in ERP that the state match requirement is not met. The combined total that Nebraska is providing is \$3,885,843, which meets the match requirement. The actual State general funds budgeted for FY2001 are \$1,788,613. Local funds are derived from the match provided by the local Title V subgrantees, which actual amount for the FY2001 budget is \$2,097,230. The FY89 Maintenance of Effort amount of state general funds was \$2,626,360; therefore, Nebraska exceeds this requirement for FY 2001 as well. **The total Federal-State Block Grant Partnership Subtotal for Nebraska, then, is \$8,071,583.**

On Form 2, other federal funds reflected include all federal funds under the control of the MCH/Title V Director and the CSHCN/Title V Director. These funds total \$49,899,431.

##### Form 3:

Figures listed on Forms 1 and 2 for FY 2001 are identical to those reflected under FY 2001 Budgeted on Form 3. It is important to note that what had been defined by Nebraska as "Other" or "Local Funding" prior to the development of the guidance for the FY2000 application has since been included as part of "State Funds". Without merging local funds with state funds, an ERP-generated warning occurs, since Nebraska does not contribute enough state general funds to alone meet the 3-to-4 match requirement or the 1989 maintenance of effort requirement. For this reason, budgeted funds for FY 2001 again shows a shift of such funds from "Other" or "Local Funding" to "State Funds".

The budgets of community-based agencies who receive Title V funds contribute a point of reference in the budgeting process for the state's Title V Block Grant Application. Beginning with FY 2000, the state agency has required the community-based organizations to contribute a minimum of 20% of their respective awards as local match. The local match contribution budgeted for FY 2001 (\$2,097,230.00) nearly equals the amount of the federal allocation subgranted to the 22 local agencies (\$2,292,003.00). This 91.5% match budgeted by local agencies for FY 2001 is a substantial increase from the 60% match-to-award budgeted by the local agencies for FY 2000. Further, if history repeats, the local agencies' match expenditures might exceed their budgeted match for FY2001 as was the case for budget-to-expenditures for match in FY 1999. Despite the positiveness of this trend of an increasing percentage of local match contribution relative to award, this creates a discrepancy between the budget and expenditures reported on Form 3 in those years.

Besides the difficulty described above in budgeting for anticipated local agency match, the process of budgeting, and subsequently reporting expenditures, is complicated by several additional factors: 1) federal funds are budgeted, and expended, in a state fiscal year that does not correspond to the federal fiscal year; 2) Title V federal allocation can be drawn down in a two-year period although application and reporting is completed for a one-year period; and, 3) obligated funds from the year immediately prior to the following year in which the funds are expended confuses a comparison of budgeting and reporting expenditures for a fiscal year, especially in years where obligated funds from the previous year cause expenditures to exceed the budget.

**Form 4:**

No significant variations in budgeted amounts for types of individuals appear on Form 4 from FY 2000 to FY 2001. However, it should also be noted that while new state priorities have changed for FY 2001, the local agencies receiving Title V funds in FY2001 requested funds based on the state fiscal year which began prior to the federal fiscal year. As a result, the agencies' work plans focus on the previous state priority needs with the line item budgets from agencies reflecting the support of activities not entirely focused on Nebraska's new MCH priority needs. The state agency as Title V recipient allows subrecipient line item budget revisions throughout the grant period, which may contribute to the variation between budget and expenditures which Nebraska reports. Budgeting by types of individuals is already an inexact science relative to line item budgeting, which is further complicated by the probability of fluctuating line item budgets.

"Administration" has been defined for Nebraska as indirect costs (based on the rate included in the most recent NHHSS Indirect Cost Agreement) associated with all NHHSS Title V-funded programs, and is consistently budgeted at \$200,000.

**Form 5:**

FY 2001 budgeted funds were categorized by type of service for this form by each Title V-funded program's administrative staff. These staff were given training on the definitions of each type of service, which we believe allows them to give more accurate descriptions of how their funds are spent.

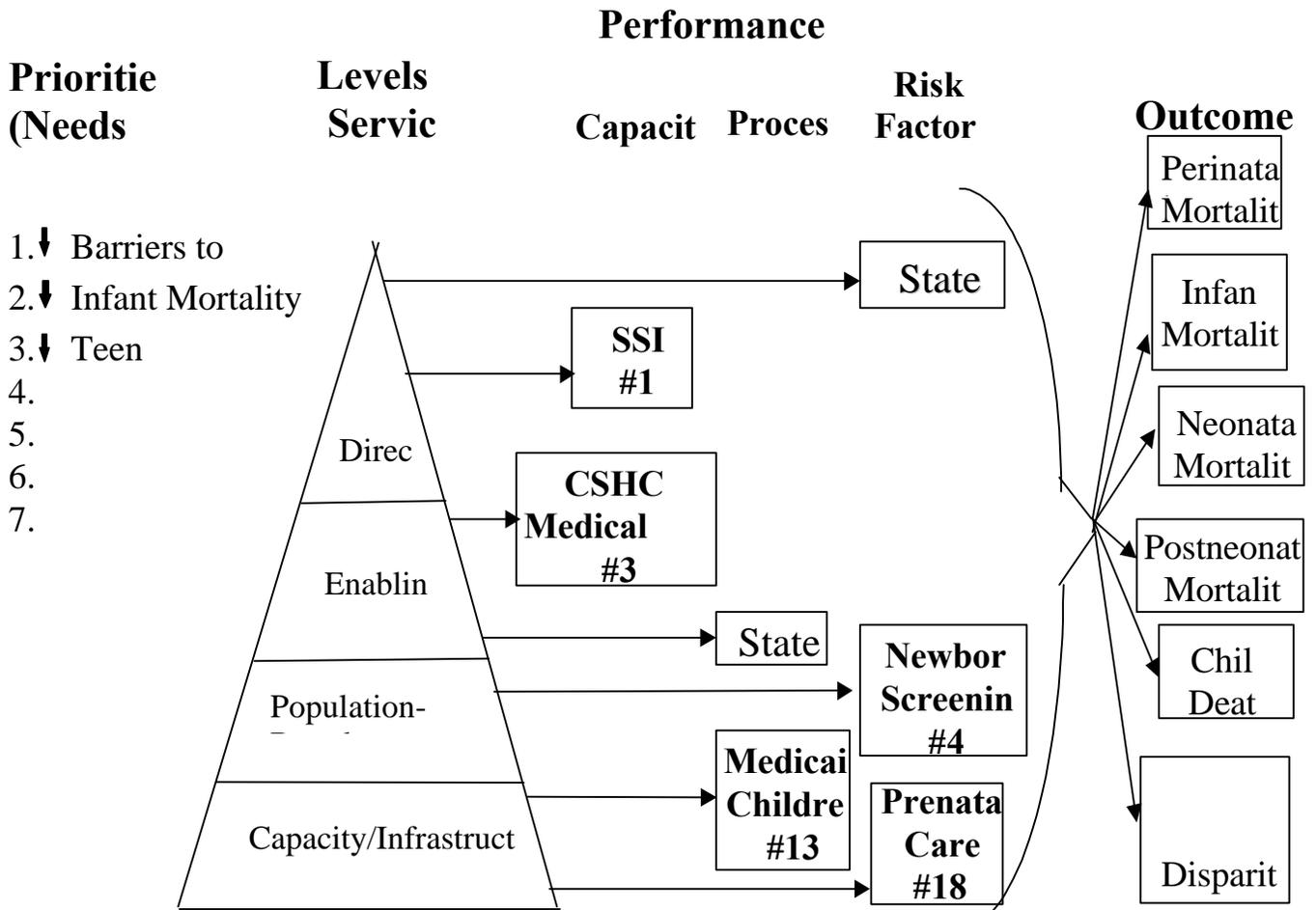
Building infrastructure services in Nebraska is of great importance, which is reflected in the budget for this type of service. Shifting Title V funds away from direct health care services towards building infrastructure services is indicated in budgeted funds since FY96. In FY99, each community-level grantee was further encouraged and supported in building infrastructure, with \$7,000 included in their awards to be used specifically for network development.

As with budgeting and reporting expenditures by types of individuals, the process of budgeting and reporting expenditures by types of services will continue to be addressed at the state level through technical assistance to local subgrantees to achieve greater predictability.

Performance Measures

Figure 3

**Title V Block  
Performance Measurement**



OSCH/MCHB 4/97 \*PERFORMANCE MEASURE

### 3.4.1 National “Core” Five Year Performance Measures

**FIGURE 4  
PERFORMANCE MEASURES SUMMARY SHEET**

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of children with special health care needs who receive assistive technology and/or home modification services -- <b>RETIRED</b>	X				X		
2) Percent of children with special health care needs in the state CSHCN program that have transition plans that address health care, including insurance, by age 18-- <b>RETIRED</b>		X			X		
3) Incidence of confirmed SIDS cases among African American and Native American infants			X				X
4) Percent of women of child-bearing age (18-44 yrs.) who report smoking in the last 30 days			X				X
5) Incidence of neural tube defects -- <b>RETIRED</b>			X				X
6) Hospitalizations for injuries, age birth to 14			X				X
7) Percent of teens who report use of alcohol in the last 30 days			X				X
8) Percent of public school districts where students have access to registered school nursing services-- <b>RETIRED</b>				X	X		
9) Percent of Medicaid-participating dentists who see an average of 25 or more Medicaid patients each month				X	X		
10) Percent of CSHCN seen at CSHCN multidisciplinary team clinics who receive recommended nutritional follow-up services		X			X		
11) Rates of hospitalization due to asthma among children ages 5-17			X				X
12) Rates of minority adolescent births			X				X
13) The state's score on building statewide immunization registry capacity				X	X		
14) The percent of African American women beginning prenatal care during the first trimester			X				X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services  
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

### **3.4.1.1 Five Year Performance Objectives**

See Form 11: Tracking Performance Measures by Service Levels, which is in Section 5.9.

## **3.4.2 State “Negotiated” Five Year Performance Measures**

### **3.4.2.1 Development of State Performance Measures**

See Form 16: State “Negotiated” Performance Measure Detail Sheets, which is in Section 5.10.

See Form 11: Tracking Performance Measures by Service Levels, which is in Section 5.9.

### 3.4.2.2 Discussion of State Performance Measures

Most of Nebraska's priority needs, based on Nebraska's five-year needs assessment, are population-based services, enabling services, and building infrastructure services. The state performance measures were developed as a direct result of the priority needs and needs assessment. Consequently, several of the previous priority needs and state performance measures were retired.

<p><b>State performance measure:</b> SP#1: Percent of children with special health care needs who receive assistive technology and/or home modification services.</p>	<p><b>Relationship to priority need:</b> <b>RETIRED</b></p>
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<p><b>State performance measure:</b> SP#2: Percent of children with special health care needs in the state CSHCN program that have transition plans that address health care, including insurance, by age 18.</p>	<p><b>Relationship to priority need:</b> <b>RETIRED</b></p>
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<p><b>State performance measure:</b> SP#3: Incidence of confirmed SIDS cases among African American and Native American infants.</p>	<p><b>Relationship to priority need:</b> #5: Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities. #10: Eliminate racial and ethnic health disparities.</p>
<p><b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #2: The ratio of the black infant mortality rate to the white infant mortality rate.</p>	
<p><b>Pyramid placement:</b> Population-based services</p>	
<p><b>Reason it was chosen:</b> In 1998, 23 infants dies from SIDS. This accounts for 13% of the infant deaths in Nebraska. SIDS deaths have decreased approximately 50% in ten years. However, SIDS still remained the leading cause of infant death of African Americans from 1994-1998 (23%) and Native Americans (tied at 27%).</p>	

<p><b>State performance measure:</b> SP#4: Percent of women of child-bearing age (18-44 yrs.) who report smoking in the last 30 days.</p>	<p><b>Relationship to priority need:</b> #6: Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age.</p>
<p><b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births.</p>	
<p><b>Pyramid placement:</b> Population-based services</p>	
<p><b>Reason it was chosen:</b> In 1998, 15.96% of pregnant women used tobacco. This is less than the 1990 prevalence of 20.7%. However, Native Americans were more than twice as likely to use tobacco during pregnancy. Tobacco use during pregnancy is correlated with low birth weight (LBW). Low birth weight rates have increased steadily in Nebraska and at a faster rate than the national level.</p>	

<p><b>State performance measure:</b> SP#5: Incidence of neural tube defects</p>	<p><b>Relationship to priority need:</b> <b>RETIRED</b></p>
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<b>State performance measure:</b> SP#6: Hospitalizations for injuries, age birth to 14.	<b>Relationship to priority need:</b> #7: Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN.
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Population-based services	
<b>Reason it was chosen:</b> The leading cause of death of Nebraskans aged 1 to 34 is unintentional injuries. Children aged 1-4 had the highest age specific rate of injury, in 1996, with 6640 per 100,000 population, followed closely by children aged 10-14 with an age specific rate of 6164 per 100,000 population. From 1993-1997, the relative risk (comparison to the white population) of homicide for African Americans was 11.5 and for Hispanics 3.4. The overall rate of homicide has increased from 3.3 per 100,000 in 1988 to 4.0 in 1997. In 1997, suicide was the second leading cause of death for Nebraskans aged 15-24. The method currently used to calculate the rate of hospitalizations for injuries uses 3 data sources: emergency room, hospital inpatient discharge and hospital outpatient discharge. This creates duplication and results in inflated rates. The method to calculate this rate will be changed in 2000 to include only hospital inpatient data and will enable us to compare other states.	

<b>State performance measure:</b> SP#7: Percent of teens who report no use of alcohol in the last 30 days.	<b>Relationship to priority need:</b> #6: Reduce rates of tobacco, alcohol, and illicit substances among youth and women of childbearing age.
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Population-based services	
<b>Reason it was chosen:</b> The prevalence of binge drinking in Nebraska is higher than the NE Healthy People 2000 Objective (16%, 13%). Among high school students prevalence of binge drinking is much higher with 42% stating they had participated in binge drinking in the past month. The NE Healthy People 2000 Objective was 25%.	

<b>State performance measure:</b> SP#8: Percent of public school districts where students have access to registered school nursing services.	<b>Relationship to priority need:</b> <b>RETIRED</b>
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<b>State performance measure:</b> SP#9: Percent of Medicaid-participating dentists who see an average of 25 or more Medicaid patients each month	<b>Relationship to priority need:</b> #3: Increase access to quality oral health care for MCH/CSHCN population.
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure-building services	
<b>Reason it was chosen:</b> Nationally, five to ten percent of young children have early childhood caries; in addition, 20% of children from low income families and 43% of Native American children have early childhood caries. In Nebraska, communities report limited access to oral health services, particularly in rural areas. Approximately 14% of Nebraska parents of children with special health care needs responding to a survey indicate difficulty in accessing oral health services for their children. Limited data exists on the oral health of Nebraska's children.	

<b>State performance measure:</b> SP#10: Percent of CSHCN seen at CSHCN multi-disciplinary team clinics who receive recommended nutritional follow-up services.	<b>Relationship to priority need:</b> #2: Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN.
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Enabling services	
<b>Reason it was chosen:</b> Nationally there has been an increasing prevalence of overweight and obesity among children. The CDC's National Pediatric Nutrition Surveillance System (PedNSS) shows that the prevalence of overweight among children aged to less than 5 years has steadily increased from 7.0% in 1989 to 8.6% in 1997. In Nebraska, 9.4% of children were reported by PedNSS as being overweight. A survey of children with special health care needs who attend current CSHCN multi-disciplinary clinics indicated that almost 50% (approximately 240-300) require follow-up nutritional services.	

<b>State performance measure:</b> SP#11: Rates of hospitalization for asthma among children ages 5-17	<b>Relationship to priority need:</b> #1: Childhood morbidity and mortality due to asthma need to be reduced.
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Population-based services	
<b>Reason it was chosen:</b> The rate per 10,000 hospitalizations for asthma in children less than five years old has risen from 11.65 to 15.10 from 1995 to 1997. In Nebraska there were 51 deaths due to asthma from 1990-1994. This is an age-adjusted death rate of 1.9/100,000, higher than the US death rate of 1.4/100,000.	

<b>State performance measure:</b> SP#12: Rates of minority adolescent births	<b>Relationship to priority need:</b> #4: Decrease rates of adolescent, non-marital, and unintended pregnancies. #5: Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities. #10: Eliminate racial/ethnic health disparities.
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #2: The ratio of the black infant mortality rate to the white infant mortality rate.	
<b>Pyramid placement:</b> Population-based services	
<b>Reason it was chosen:</b> Nebraska has an infant mortality problem. All three of these types of pregnancies, according to research, end in higher rates of infant mortality. Nebraska's teen mothers are less likely to begin first trimester prenatal care, and more likely to not receive prenatal care than any other age group. 1998 brought record numbers of births to unmarried women – for the second year in a row. Families that include adolescent, nonmarital, and unintended pregnancies are more likely to experience economic hardship. In Nebraska, between 25-30% of teen mothers will have more than one pregnancy before they turn 20. This is higher than the national average of 20-22%. The Executive Board of the Nebraska Minority Public Health Association specifically identified adolescent births as one of two priority needs.	

<b>State performance measure:</b> SP#13. The state's score on building statewide immunization registry capacity.	<b>Relationship to priority need:</b> #9: Increase the state's capacity for surveillance of immunization status. #10: Eliminate racial/ethnic health disparities.
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #6: The child death rate per 100,000 children aged 1-14.	
<b>Pyramid placement:</b> Infrastructure-building services	
<b>Reason it was chosen:</b> According to the CDC's National Immunization Survey, 82.4% of two-year-olds in Nebraska had been appropriately immunized. The national goal is 90%. Nebraska currently lacks the ability to track childhood immunizations and to accurately determine the immunization levels. The National Immunization Survey has a number of limitations. The methodology does not provide for adequate sampling to determine rates for specific populations or geographic areas. There were 24 reported cases of pertussis in Nebraska in 1998. This is a noticeable increase from the last five years were the number hovered around 14 or 15. There have been a total of 82 cases from 1995-1999.	

<b>State performance measure:</b> SP#14: Percent of African American women beginning prenatal care during the first trimester.	<b>Relationship to priority need:</b> #5: Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities. #10: Eliminate racial/ethnic health disparities.
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births.	
<b>Pyramid placement:</b> Population-based services	

**Reason it was chosen:** The percentage of African American women beginning prenatal care during the first trimester in 1998 was 70.64%, less than the overall NE rate of 83.6%, and slightly less than the US African American rate of 71.0%. Early entry into prenatal care results in improved birth outcomes.

### **3.4.2.3 Five Year Performance Objectives**

See Section 5.10 for Form 11, National Performance Measure Objectives

Some of the National and State Performance Measures rely on Medicaid and/or Vital Statistics records. Progress cannot be reported due to the lack of 1999 data. Vital Statistics records are expected in October, 2000.

### **3.4.2.4 Review of State Performance Measures**

The review of State Performance Measures will occur during the Application Review Process, to be conducted at the MCHB Region VII Office in Kansas City, Missouri on August 22, 2000.

### **3.4.3 Outcome Measures**

See Section 5.11 for Outcome Measure Detail Sheets.

All of the outcome measures rely on vital statistics (birth, death and neonatal deaths). Progress cannot be reported for CY 1999 at this time due to difficulties in NHHSS Vital Statistics offices. Data are expected in October, 2000.

See Section 5.8 for "Supporting Documents" for Form 12.

#### IV. REQUIREMENTS FOR THE ANNUAL PLAN

##### 4.1 Program Activities Related to Performance Measures

###### **PM #1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program**

<b>Relationship to priority need:</b> This National Core Performance Measure will clearly relate to Priority Need #2: "Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN." And Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." More SSI beneficiaries less than 16 years old receiving rehabilitative services from Nebraska's CSHCN program is expected to reduce the incidence and prevalence of nutrition-related health problems and to increase the number of CSHCN with a medical home and access to pediatric specialists.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Direct Health Care	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

###### **Capacity/Resource Capability:**

The Medically Handicapped Children's Program (MHCP), Nebraska's Title V/CSHCN Program, operates the SSI-Disabled Children's Program for those children eligible for SSI who are under age 16 and require rehabilitative and support services not otherwise provided by Nebraska's Medicaid Program. The following Specialty Clinics for Children and Adults teams are available to CSHCN: cerebral palsy (including neuromuscular), mid line neurological defects and spina bifida, craniofacial (including cleft lip/palate and other facial conditions), rheumatoid arthritis, diabetes, cystic fibrosis, and cardiac conditions.

###### **Program Activities:**

- Continue to operate the SSI-Disabled Children's Program through MHCP
- Continue to provide outreach to those families who are referred by the State Disabilities Determination Section as eligible to receive SSI benefits especially for their children under age 16
- Continuation and improvement of marketing of the SSI-Disabled Children's Program

###### **Anticipated Impact on Performance Measure:**

Based on participation rates for FY96, FY97, and FY98, performance objectives for FY99 and FY00 were set at 38% each year. These targets were set while taking into consideration that: 1) services offered through MHCP and SSI-DCP would most likely not be changing in the next few years; and 2) the change in definition of "disability" for eligibility for SSI has had an adverse impact on the number of SSI beneficiaries in Nebraska during FY97 and FY98. Targets will remain steady at 38.0% for FY01 and FY02, increase to 39.0% in FY03 and FY04, and 40.0% in FY05. Approximately 35.6% of NE SSI beneficiaries less than 16 years old are receiving rehabilitative services from the NE CSHCN program

**PM #2: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients**

<b>Relationship to priority need:</b> This National Core Performance Measure clearly relates to Priority Need #2: “Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN.” Priority Need #3: “Increase access to quality oral health care for MCH/CSHCN population.” And Priority Need #8: “Increase the number of CSHCN who have a medical home and access to pediatric specialists.” The ability of Nebraska’s CSHCN Program to provide or pay for specialty and subspecialty services not otherwise accessible through Kids Connection (Nebraska Medicaid), private health insurance or otherwise affordable to its clients is the cornerstone of activities necessary to improve outcomes of children with special health care needs.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Direct Health Care	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children’s Program (MHCP), Nebraska’s Title V/CSHCN Program, coordinates with the University of Nebraska Medical Center (UNMC), Creighton University Medical School, and appropriate community-based specialists and subspecialists statewide to provide specialty and subspecialty care to children with special health care needs in Nebraska. Specialty Clinics for Children and Youth, MHCP’s multidisciplinary teams, which include an MHCP service coordinator, are located in many larger communities. Since appropriate specialists and subspecialists are not always available in these local communities, personnel from UNMC’s Munroe-Meyer Institute (MMI) are contracted to provide personnel to team composition. Other teams made up of UNMC and private specialists and subspecialists travel to rural communities to conduct specialty care clinics, (e.g., diabetes, craniofacial and cystic fibrosis teams clinics), develop care plans, and coordinate with medical home providers in the local medical community and facilitate the family obtaining medical home providers as needed. The addition in FY00 of a pediatric endocrinologist and a CDE certified diabetic educator, with consultation by a licensed medical nutritional therapist, greatly enhanced the multidisciplinary team clinics across Nebraska.

Title V funds also support the Statewide Genetics Clinics program at MMI, whose staff travels throughout the state to offer genetic counseling and other services through team-based clinics as well. The Genetics Clinics and MHCP collaborate to utilize the same specialists for MHCP Cerebral Palsy Clinics and Genetics Clinics on subsequent days in order to lower travel costs and build a continuity of specialty and subspecialty care.

**Program Activities:**

- Continue to provide MHCP Specialty Clinics for Children and Youth multidisciplinary team clinics throughout Nebraska
- Through MHCP’s Clinic Quality Assurance initiative, continue to emphasize services coordination and the provision of family-centered and culturally competent assistance to families, where needed, in connecting with appropriate specialty and subspecialty care
- Continue to provide service coordination at the local level through collaboration with other appropriate services for which persons are found to be eligible, in order to assure access to all appropriate care
- Continue to provide payment or supplemental payment where insurance coverage is inadequate and Nebraska Medicaid (including Kids Connection) is not available for specialty and subspecialty services to participants in the program
- Continue to fund the Statewide Genetics Clinics at MMI, whose staff travels statewide and collaborates with MHCP for continuity and efficiency.

**Anticipated Impact on Performance Measure:**

As indicated by the checklist attached to the detail (Form 16) for PM#2, Nebraska’s Title V/CSHCN Program currently provides or pays for all nine services listed. No changes in program services have occurred in the past few years nor are likely to occur in the next few years -- except decreased reliance on the Title V/CSHCN Program to pay for services coverable through Kids Connection (SCHIP). Performance objectives will remain at the highest level of 9.0 through FY05.

**PM #3: The percent of children with special health care needs (CSHCN) in the State who have a “medical/health home”**

<b>Relationship to priority need:</b> This National Core Performance Measure will directly relate to Priority Need #1: “Childhood morbidity and mortality due to asthma need to be reduced,” as well as Priority Need #8: “Increase the number of CSHCN who have a medical home and access to pediatric specialists.” If more children with special health care needs have a medical home, then more will have access to specialty care. A medical home will help ensure that follow-up care following treatment plans will reduce the rates of morbidity and mortality for children with asthma.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Enabling Service	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children’s Program is involved in a number of projects aimed at, among other things, increasing the number of children with special health care needs who have a medical home. It is believed that working with families, other advocates, and the medical community to determine a local medical home for children with special health care needs has and will continue to shift the responsibility of care and coordination from the state to the local level. This work is achieved through a variety of collaborations with UNMC, Creighton University, Boys Town National Institute, Vocational Rehabilitation, Department of Education Special Education, NHHSS programs including Medicaid and Developmental Disabilities, families, advocates, and local medical and education professionals throughout the state. Outreach and enrollment resulting from the promotion of Kids Connection (SCHIP), an expansion of Medicaid, with 12 months continuous eligibility, increases the probability that children with special health care needs are establishing a medical home, especially when these children were not previously enrolled in regular Medicaid.

**Program Activities:**

- Continue to engage local medical professionals in MHCP multidisciplinary team clinics throughout Nebraska as the primary contacts for children with special health care needs who are assisted through the program
- Continue to collaboratively address the issue of transitioning children with special health care needs from pediatric specialty and subspecialty providers to the adult health care environment
- Continue to provide a comprehensive system of multidisciplinary clinical services specifically around genetic disorders, congenital anomalies, neurodevelopmental disabilities and diabetes throughout the state, as well as outreach and training to families and medical professionals on genetic issues (as carried out through UNMC Munroe-Meyer Institute)
- Title V and MHCP staff and parent advocates will continue to actively participate in the state coalition to increase outreach and enrollment in Kids Connection supported by Robert Wood Johnson Foundation Covering Kids Initiative.

**Anticipated Impact on Performance Measure:**

No comprehensive data on children with special health care needs can currently be found in Nebraska, so Title V staff worked to extrapolate from secondary data to develop a measure of CSHCN with a medical home. For the development of the FY97 annual report last year, a variety of 1996 resources from the national level were used to develop an estimate of the percentage of low-income uninsured CSHCN with a usual source of care—a category for which it is most crucial that MHCP assist. Having no other objective data to study, this estimate for 1996 (78.3%) was used to help set incremental performance objectives for CY97 (79%), CY98 (80%), CY99 (81%), and CY00 (82%). According to this estimate, NE had 78% of the CSHCN population with medical homes in 1999.

Last year, for the development of the FY98 annual report, a Newacheck estimate of children with special health care needs in Nebraska was extrapolated for the denominator, and an indicator was determined using last year’s percentage as a baseline. The numerator was then calculated by applying the indicator percentage to the denominator. This methodology was used to re-formulate CY96 and CY97 data, with the denominator remaining constant from year to year, and using the original indicator from CY96 that was based on national data. This methodology has produced results comparable to informal counts of children with a community primary care provider (either pediatrics or family physician) by MHCP Workers in the field.

It is hoped that SCHIP will have a positive impact on assisting a larger number of CSHCN to find and use a medical home. The MHCP Medical Director provided a training module on Medical Home to MHCP field staff in the fall of 1999.

Hopefully this has more clearly defined the definition of "medical home" for staff. Attempts to extrapolate a more accurate state-specific indicator for this measure will be continue to be made in the future. Based on the trend, targets are set at 1.0% increments through CY05, i.e. 83.0% for CY01, 84.0% for CY02, 85.0% for CY03, 86.0% for CY04, and 87.0% for CY05.

**PM #4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell disease) (combined)]**

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities." Nebraska has a very high percentage rate for newborn screening and follow up, and will continue to strive for 100%. Early identification with follow up relates to the reduction of infant mortality when, in extreme cases, conditions unidentified and untreated can result in infant death. Also, a strong relationship exists between this measure and Outcome Measure #1: "The infant mortality rate per 1,000 live births," and Outcome Measure #3: "The neonatal mortality rate per 1,000 live births".	
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

By state statute, the Nebraska Newborn Screening Program (NNSP), which is funded primarily through Title V funds, has the responsibility to assure all newborns are screened and that all infants identified with a positive screening result are tracked. Nebraska does not have a centralized screening system, but instead establishes standards for and is currently working with three labs to maintain quality and consistency.

**Program Activities:**

- NNSP will continue to assure all newborns are screened for PKU, hypothyroidism, biotinidase deficiency, hemoglobinopathies, and galactosemia, and that all infants identified with a clinically significant positive screening result are tracked to obtain a confirmatory specimen, diagnosis and treatment
- Implement NNSP policy of notifying parents of all abnormal hemoglobinopathies
- Continue providing additional education and referral of NNSP specialty and genetic services for the population screened positive for hemoglobinopathies through the Title V toll-free line, Healthy Mothers/Healthy Babies Helpline
- Continue to advocate for a fee-based centralized newborn screening system in an effort to improve quality and effectiveness
- Develop and implement long-term tracking system to monitor patient outcomes and to develop a data source on cost-effectiveness which, in turn, will assist efforts to advocate for a fee-based or alternative funding source for newborn screening services
- Continue to assure access to treatment for the PKU affected population of infants, children and women of childbearing age through funding of metabolic formula and dietary consultation

**Anticipated Impact on Performance Measure:**

Performance objectives for CY99, CY00, continuing through CY05 were developed by Nebraska Newborn Screening Program staff, and have been set at 100%. NNSP, by state statute, is required to assure that all newborns are screened and that those identified with a positive screening result be tracked. For CY96, CY97, and CY98, performance indicators were above 99.0%. Using provisional 1999 NE birth data, 99.6% of newborns received at least one screen. Due to some difficulty in tracking and following up on home births, a very small number of infants were not screened in the appropriate amount of time. The goal, however, must be to screen 100% of all newborns.

**PM #5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B**

<b>Relationship to priority need:</b> This National Core Performance Measure indirectly relates to Priority Need #9: "Increase the state's capacity for surveillance of immunization status." Separate surveillance (or assessment) systems exist for the various entities who record immunizations, e.g. private clinics, public clinics, daycare centers, and schools. The current immunization surveillance that covers both public and private clinics relies on the national immunization telephone survey. Unfortunately, the survey method used excludes Nebraskans without telephone service in their homes which suggests the survey misses those presumably of lower economic status and thus at high risk of not being current on the immunization schedule. Further, the measure could have in some instances an indirect relationship to Priority Need #7: "Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN." Vaccines administered on time in the first two years of a child's life are a very effective method of preventing certain illnesses and can help establish a strong foundation for a lifetime of good health. Parents who begin on time and follow through on the recommended schedule of immunizations are likely to encourage other safe behaviors in their children throughout their lifetime.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Nebraska Immunization Program: provides vaccines and supplies to public immunization clinics throughout the state with federal 317 funding, reimburses private clinics for vaccine administration costs with federal Vaccines For Children funds, coordinates outreach services, such as transportation and translation, and collaborates with the state's daycare facilities and nearly 1,000 Nebraska school districts to maintain immunization status records. Vaccines in public clinics are administered largely by volunteers. Due to a decrease in Immunization Action Plan federal funding in FY00 and likely in the coming years, the Nebraska Immunization Program's ability to provide same level of statewide support could be hampered without an internal allocation of Title V funds.

**Program Activities:**

- The Nebraska Immunization Program will continue to provide vaccine and supplies to public immunization clinics throughout the state and reimburse private clinics for vaccine administration. In addition to the 4-3-1 and the 4-3-1-3 series, the 4-3-1-3-3 series was started in FY99.
- Continue funding and technical assistance to Title V-funded, community-based agencies, for outreach, education, enabling services (e.g. transportation and translation), and the administration of vaccines in regions of the state where accessibility, availability, and affordability are barriers to children receiving immunizations
- Plan, strategize and develop enhancements to the present system to get more children immunized on time

**Anticipated Impact on Performance Measure:**

Performance objectives for CY99, CY00, and continuing through CY05 were established with the assistance of the Nebraska Immunization Program. It was decided that, even though outcomes for CY96, CY97, CY98, CY99 were 80%, 75%, 75%, and 78.4% respectively, objectives should be in line with CDC single antigen goals of 90% for the upcoming years. 1999 is the first year that Nebraska has used the 4-3-1-3-3 series for reporting purposes. In the past, the 4-3-1-3 series was reported. Nebraska has adopted the Healthy People 2010 goal: "90% of children through age 2 will be "fully immunized". Although Nebraska has fallen significantly below the performance indicator in recent years, the Nebraska Immunization Program will continue striving to meet the goal of 90%.

**PM #6: The rate of births (per 1,000) for teenagers aged 15 through 17 years**

<b>Relationship to priority need:</b> This National Core Performance Measure directly relates to Priority Need #4: "To reduce rates of adolescent, non-marital, and unintended pregnancies."	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Title V funds support teen pregnancy prevention activities in Nebraska through a number of venues. The Perinatal, Child and Adolescent Program offers training and materials to school nurses on a variety of strategies to address teen pregnancy prevention, and oversees Title V Abstinence Education activities throughout the state. The Reproductive Health Program provides education, materials, and birth control methods through community-based clinics in the state, and MCH Planning and Support Program monitors 17 community-based, Title V-funded programs that offer teen pregnancy prevention activities as part or all of their program. A state-level coalition of programs, including the Perinatal, Child and Adolescent Health Program, continues to address teen pregnancy issues.

**Program Activities:**

- Continue to fund 17 community-based programs through Title V that address teen pregnancy issues as part or all of their programs
- Continue to support the Nebraska Reproductive Health Program by providing funding for educational activities and materials focused on teen pregnancy issues
- Continue to support the Perinatal, Child and Adolescent Health Program's ability to coordinate statewide school nursing activities, provide training and materials to school nurses on teen pregnancy issues, and with funds from the MCHB Abstinence Education Program to continue support of community-based agencies by coordinating activities related to abstinence. Continue participation in the Nebraska Adolescent Pregnancy Network (NAPN), a state-level coalition of programs, to develop Nebraska-specific information on facts and resources that will educate the public and health professionals
- Continue work of Every Child Wanted, Nurtured and Supported Initiative.

**Anticipated Impact on Performance Measure:**

The performance objectives for CY99, CY00, and continuing through CY05 were established with the assistance of the Reproductive Health Program and the School and Adolescent Health Program (now configured as the Perinatal, Child and Adolescent Health Program). The objectives for CY99 and CY00 were set at a rate of 20 births per 1,000 to be in line with the goal of the Reproductive Health Program. Based on three years of progress (CY96 – CY98) and national trend data, Nebraska is likely to meet the Reproductive Health Program goal by CY00, resulting in the targets set through CY05 to incrementally decrease .5% each year. Provisional 1999 birth data provided by the National Vital Statistics Reports (V. 48, No. 14, August 8, 2000) indicated that NE had 10.5% of live births to mothers under 20 years old.

**PM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth**

<b>Relationship to priority need:</b> This National Core Performance Measure will relate to Priority Need #3: "Increase access to quality oral health care for MCH/CSHCN population." Sealants are one indicator of dental access. Surveillance for dental sealants is accomplished, in part, through school systems, however, limitations exist with this method and so any data collected by this means is not currently used towards measuring progress towards this measure. Although Medicaid data is not representative of the Nebraska population, sealants paid by Nebraska Medicaid will provide trend data on the use of sealants for preventative dentistry. Approximately 98% of the state's dentists are enrolled providers for Nebraska Medicaid, although many Medicaid clients are unable to access dental services largely due to limitations of dental practices to accept more clients since most of Nebraska is a dental care shortage area.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The NHHSS Dental Health Division's sole funding has been from Title V since state funding was lost several years ago. Relative to this measure, the Dental Health Division trains school nurses on oral health screening services, and will also use this opportunity to provide guidance to school nurses about the identification of sealants. Because of the resource limitations of the Dental Health Division, there is insufficient training statewide to school nurses on sealant identification to provide for quality assurance. As a result, any sealant data via the annual state nurse survey is not a reliable indicator for this measure. As another preventative service, school nurses provide fluoride mouth rinse to students.

**Program Activities:**

- The NHHSS Dental Health Division will continue to offer training to school nurses on dental screening, and strive to move towards quality assurance to facilitate the surveillance of dental sealants
- The NHHSS Dental Health Division will continue to provide materials to schools that can be shared with parents throughout the state on the importance of oral health
- The NHHSS Dental Health Division will continue to meet with dentists in the Nebraska Dental Association's eight dental districts to reintroduce them to what is involved in participating in Medicaid and discuss preventive care and barriers to care for families

**Anticipated Impact on Performance Measure:**

Dental sealant surveillance data is not currently available on third grade children in Nebraska. In FY99, the NHHSS Dental Health Program began to conduct surveillance activities with the assistance of school nurses who are offered training on oral health screening and surveillance services with increasing progress towards collecting data statewide for dental sealant identification. This data will not be used for Title V reporting purposes, however, because resources for training simply do not allow for quality assurance, and data is collected inconsistently by school nursing staff across the state. Until more sufficient data is collected, it was decided to use Medicaid data to report on this measure, and though we do not anticipate that this data is reflective of the sealant status of all third graders in the state, we believe it does provide some insight on the trend of use (or non-use) of sealants by dentists as a preventive strategy for children. Medicaid data for FY97 shows that 12.1% of Medicaid-eligible children received one or more sealants, which decreased to 10.4% in FY98. Objectives were set at 15% and 17% for FY99 and FY00, respectively. We believe that the implementation of strategies to increase dentists' participation in Medicaid and to bring preventive care to the forefront of the field will have some impact on this measure as it is now measured. However, the target of 17.0% will be maintained through FY05 until improved school nurse surveillance is available.

**PM #8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children**

<b>Relationship to priority need:</b> This National Core Performance Measure directly relates to Priority Need #7: "Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN." This measure has an indirect relationship to Priority Need #6: "To reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age" because of the correlation of motor vehicle crashes to alcohol use.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Nebraska Office of Highway Safety provides a staff person to NDHHS to coordinate prevention activities through public health activities. Their health promotion efforts include education and materials, surveillance, and a great deal of collaboration with already existing public health programs, including those funded by Title V. In addition, Emergency Medical Services for Children (EMSC) activities will increase state capacity to appropriately respond to pediatric emergencies, including motor vehicle crashes. Finally, Nebraska's Child Death Review Team provides valuable information to plan future strategies to reduce fatality rates.

**Program Activities:**

- Through staff provided by the Nebraska Office of Highway Safety, continue to provide education and materials to the general public, particularly focused on school-aged children, on the importance of motor vehicle safety
- Continue collaboration with and support of EMSC activities
- Update motor vehicle safety information and activities into CISS Health Systems Development in Child Care project
- Continue participation in the development of and utilization of Child Death Review Team Report

**Anticipated Impact on Performance Measure:**

The performance objectives for CY97, CY98, CY99, and CY00 were established based on the CY96 indicator of 6.5 deaths per 100,000 children age 1-14. The CY00 target was set for minimal improvement. Because few new activities are anticipated in the next few years, maintaining the objective at 5.0 deaths per 100,000 will be continued through CY05. 1999 data is unavailable at this time. 1998 is the most current available. In 1998 NE had a rate of 6.5 deaths per 100,000 children. This is a slight increase from 1997 (5.9).

## PM #9: Percentage of mothers who breastfeed their infants at hospital discharge

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #2: “Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN.” Since breastfeeding is known to have nutritional benefits, among other benefits, for the baby, increasing the percentage of mothers who initiate and continue to breastfeed would also likely guard against nutrition-related health problems in infancy, childhood, adolescence, and later adulthood.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Fourteen community-based Title V-funded programs offer education and assistance to mothers, and all give particular attention to breastfeeding. Three of these programs have at least one lactation consultant, and all have a protocol to follow in dealing with problems in breastfeeding. The WIC Program focuses on breastfeeding as one of its primary goals, with a breastfeeding consultant on staff at the state level as well as in all local clinics. Title V and WIC collaborate closely to provide one-on-one education and support, as well as public awareness activities. Nebraska Prenatal Risk Assessment Monitoring System (PRAMS), funded in part with Title V funds, monitors breastfeeding data, among other things.

### Program Activities:

- Continue to fund fourteen community-based programs through Title V that offer education and assistance regarding breastfeeding
- Continue collaborating with WIC to provide one-on-one education and support and conduct public awareness activities on breastfeeding
- Continue the coordination of a state-level committee to address disparities in prenatal care standards among providers and insurers in Nebraska, which will include breastfeeding education and support
- Continue to support PRAMS in Nebraska to monitor risk factors and pregnancy outcomes, including breastfeeding data
- Contribute to the Governor-appointed Blue Ribbon Panel headed by the state’s Chief Medical Officer directed to examine the steady high infant mortality

### Anticipated Impact on Performance Measure:

Performance objectives for CY98, CY99, and CY00 were established with assistance from the Nebraska WIC Program. Based on data for CY96 and CY97, which shows 64.2% and 68.1% of mothers breastfeeding at hospital discharge (according to the Ross Laboratories Mothers Survey) respectively—a fairly significant increase in that 2-year period, objectives were set at 70% in CY98, 73% in CY99, and 75% in CY00 to reach the Healthy People 2000 objective on schedule. The target will remain at 75% through CY05, which is the 2010 objective.

Because Ross survey data was not available for CY98, a proxy measure from the WIC Pediatric Nutrition Surveillance System was used to complete the indicator for that year. Although the indicator was much lower than the objective, trend data justifies not lowering the objectives for CY00 through CY05. According to the Ross Laboratories Mothers Survey, the prevalence of mothers reported initiating breastfeeding while in the hospital in Nebraska has increased from 60.3% in 1990 to 68.1% in 1998. The anticipated impact of a number of new public awareness activities is hoped to continue increasing the numbers of women breastfeeding, as trend data suggests. The prevalence of mothers still breastfeeding after six months has also increased from 1990 to 1998, from 20.7% to 30.8%.

Breastfeeding rates among WIC mothers, while still less than overall Nebraska mothers, has increased from 45.7% in 1990 to 56.6% in 1998. The prevalence of WIC mothers still breastfeeding after six months has increased from 9.5% to 24.1%.

**PM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge**

<b>Relationship to priority need:</b> This National Core Performance Measure will relate to Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." If a higher percentage of newborns are screened for hearing impairment before hospital discharge, more of those with an impairment will be diagnosed, receive timely follow-up, and engage in specialty care.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

The Nebraska Legislature just passed a bill for voluntary, universal newborn hearing screening with a goal of 95% of infants screened by December 1, 2003. If hospital participation does not reach this level, newborn hearing screening will become mandatory. The Department will collect data, track, and monitor findings, and provide training. A number of hospitals in the state were already conducting some level of screening prior to the legislation, however, there has been little consistency in the protocol of those conducting screening. Without reporting requirements, subsequently no tracking currently exists.

**Program Activities:**

- Although voluntary at least until December 2003, newborn hearing screening will likely occur in more hospitals prior to discharge as a result of a new Nebraska law
- Through the Nebraska Newborn Screening Program, continue to identify those hospitals throughout the state already conducting newborn hearing screening
- Develop protocol for hospital screening and reporting, and the state's training, data collection and database, and follow up

**Anticipated Impact on Performance Measure:**

Performance objectives for CY99, CY00, and continuing through CY05 were developed with assistance from the Nebraska Newborn Screening Program and the MHCP Medical Director. Data used for performance indicators for CY96, CY97, and CY98 were primarily based on estimates given those hospitals engaged in newborn hearing screening, and are not seen as particularly reliable, since there has not been a consistent protocol for screening or data collection among them. Objectives, then, were established with caution, but because we anticipated that momentum around this issue would continue to increase in the next few years, improvement in the measure for CY99 and CY00 had been changed from 10% and 20%, respectively, to 15% and 25%. The dramatic jump in the indicators beginning in CY01 and continuing through CY05 (50% in CY01, 75% in CY02, and 95% in CY03, CY04, and CY05) reflects the new legislation encouraging hospitals to begin newborn hearing screening to reach 95% by December 2003. If this level is not reached voluntarily, hospital participation will become mandatory after that time. In CY99, the percentage of newborns screened was 28.4%\* which more than doubled the percentage screened in CY98.

\*Percentage based on 6791 newborns screened of 23,907 live births as reported by the National Vital Statistics Reports (Vol. 48, No. 14, August 8, 2000).

**PM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care**

<b>Relationship to priority need:</b> This National Core Performance Measure will relate to several Priority Needs. Priority Need #1: "Childhood morbidity and mortality due to asthma need to be reduced." Priority Need #3: "Increase access to quality oral health care for MCH/CSHCN population." Priority need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities." Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." Numerous health outcomes, as denoted in the Priority Needs addressed in this measure, would be improved with the increase in the percentage of CSHCN who have a means to pay for primary and specialty care, resulting from accessibility due to affordability.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Medically Handicapped Children's Program is involved in a number of activities that intend to increase the number of children with special health care needs who are covered by some type of health care insurance. MHCP service coordinators work with participating families to pursue any avenue that might lead to enhanced services for their children, including health care coverage. MHCP administrators, in collaborating on projects such as quality assurance for Medicaid Managed Care or better transition from childhood to adult health care, also work to address health care coverage.

**Program Activities:**

- Continue to provide service coordination activities through MHCP, including health care coverage
- A project was funded through MHC SSDI grants (State System Development Initiative) with the Father Flanagan's Boys Town to examine the effects of Medicaid Managed Care on children with special health care needs and to discover new methods of families and Services
- Coordinators access to health care. We currently are awaiting the results of a study regarding missed appointments for medical care and barriers to receiving medical care as a result of this grant.
- Continue advocating for children with special health care needs in the development and implementation of Kids Connection (SCHIP), with particular regard for marketing of the Medicaid program, entry into/eligibility for Medicaid, and health care and enabling services provided by Medicaid for children with special health care needs
- Continue referring children who are over income for SCHIP to the State of Nebraska health insurance plan for persons who cannot otherwise purchase health insurance since they have been found to be "uninsurable". (Nebraska Comprehensive Health Insurance Pool - CHIP)
- Continue working to address issues of transition of children with special health care needs from pediatric specialty and subspecialty providers to the adult health care environment
- Through Title V-supported program at UNMC's Munroe-Meyer Institute, continue providing a comprehensive system of multidisciplinary clinical services around genetic disorders, which includes assistance with health care coverage
- Through the Perinatal, Child, and Adolescent Health Program, continue to train and assist school nurses in accessing a multitude of services for children with special health care needs, and in assisting families in garnering health care coverage

**Anticipated Impact on Performance Measure:**

Performance objectives were established by Title V/CSHCN staff based on indicator data for FY96, FY97, and FY98. A number of pertinent new activities were initiated by MHCP in FY97, which is reflected in the increased percentage of CSHCN with a source of insurance from 86% in FY96 to 93% in FY97. This increase was followed in FY98 by a slight increase of 94%. Beginning in FY 99, Kids Connection (SCHIP) has been highly successful in outreach and enrollment. It was anticipated that this Medicaid expansion would further increase the number of CSHCN served by MHCP who have some type of insurance. For these reasons, targets for FY99 and FY00 were set at 93% and 95% respectively. Enrollment in Kids Connection is expected to level off for CSHCN, thus the target is not expected to continue to increase. As a result, the objective of 95% will be maintained for FY01 through FY05. According to the NE Medically Handicapped Children's Program, 94% of NE CSHCN were covered either by private insurance or Medicaid (3006/3198) in 1999.

## PM #12: Percent of children without health insurance

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #1: "Childhood morbidity and mortality due to asthma need to be reduced." Aspects of reducing the risks of asthma include access to health care and enhanced management of the disease. When the number of uninsured children decreases, a reduction in morbidity and mortality due to asthma will likely occur. This measure is also related to Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." Although this priority need is directed at CSHCN, as the number of children with health insurance increases, it is more likely that children with special health care needs establish a medical home and have access to specialty care. In addition, there is some relationship to Priority Need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities." Health insurance coverage alone will not assure a reduction in the mortality rate of infants in the racial/ethnic populations, although infants at high risk include those whose families are economically deprived which often is drawn along racial/ethnic lines.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children	

### Capacity/Resource Capability:

Title V administrative staff have been integrally involved in the development of Kids Connection (SCHIP), and the Title V-funded community-based agencies that conduct presumptive eligibility for pregnant women into Medicaid are also being trained to do so for children into Kids Connection. Four of these Title V subgrantees contract with Nebraska's Medicaid program to conduct public health nursing activities (including outreach to families and providers to increase access to care) which complements and maximizes their Title V-funded activities. MCH Planning and Support staff participate in a statewide coalition centered on Kids Connection/Medicaid. In the second year of a three-year grant, funded by Robert Wood Johnson Covering Kids Initiative, the goal is to further expand the outreach efforts and children enrolled in Kids Connection.

### Program Activities:

- Continue involvement in the enhancement and progress monitoring of Kids Connection, an expansion of Medicaid that offers coverage for children whose families are up to 185% of the federal poverty level for 12-month continuous eligibility
- Continue coordinating with Medicaid and community-based agencies regarding Title V funded activities and the public health nursing contracts across the state
- Continue coordinating with Medicaid and Title V funded, community-based agencies for the enrollment and training of presumptive eligibility providers
- Through Perinatal, Child, and Adolescent Health Program, WIC Program, Reproductive Health Program, Dental Health Division, and Immunization Program, educate and train other community-based providers regarding Kids Connection

### Anticipated Impact on Performance Measure:

The U.S. Census Data and American Academy of Pediatrics estimates for percentage of uninsured in Nebraska in 1996 (9%) were used initially to establish the performance objective. Knowing that implementation of Kids Connection (Nebraska's SCHIP through an expansion of Medicaid) would occur late in CY98, coupled with the estimated 24,000 uninsured Nebraska children at 185% of the federal poverty level, targets for CY99 and CY00 were set at 8.0% and 7.5%, respectively. After a full year of Kids Connection data (CY99), the rate of uninsured children was expected to show a change. Through September, 1999, 5,983 uninsured children were enrolled in the SCHIP program, for a total of 84,609 otherwise uninsured children enrolled in Kids Connection. Of the 108,102 enrolled children in Kids Connection in September, 1999, excluding those eligible under SCHIP, 17,510 had additional health coverage. Targets are set for at 7.0% for CY01, 6.5% for CY02, 6.0% for CY03, 5.5% for CY04, and 5.0% for CY05.

**PM #13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program**

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #1: "Childhood morbidity and mortality due to asthma need to be reduced." If more Medicaid-eligible and potentially-eligible children receive a Medicaid-covered service, supply or pharmaceutical product related to managing asthma, the greater reduction in the effects of asthma. This measure is also related to Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." As the number of Medicaid-eligible children receiving a service paid by Medicaid increases, the more likely that children with special health care needs establish a medical home and have access to specialty care. In addition, there is some relationship to Priority Need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities." This measure alone will not assure a reduction in the mortality rate of infants in the racial/ethnic populations, although infants at high risk include those whose families are economically deprived which often is drawn along racial/ethnic lines.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building	<b>Type of Service:</b> Process
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Because Title V funds are roughly a slim 1% of federal Medicaid funds to Nebraska annually, it continues to be a high priority to MCH Planning and Support to assure that Nebraska Medicaid pays for all Medicaid-covered services for Medicaid-eligible persons when medically necessary. Ten Title V-funded community-based programs are Medicaid-enrolled providers for a variety of coverable services. A number of Title V grantees have contracts with Medicaid to conduct public health nursing and outreach services that enroll more eligible children and families for Medicaid. Some of the same community-based agencies are further enrolled and trained to determine presumptive eligibility for Medicaid. MCH Planning and Support staff work with Medicaid staff to assure that Title V grantees are utilizing Medicaid reimbursement for services whenever possible.

**Program Activities:**

- Continue to work with the Medicaid program and Title V-funded community-based grantees to assure that these grantees are utilizing Medicaid reimbursement for services whenever possible
- Continue working with other state-level programs, such as Perinatal, Child, and Adolescent Health Program, Dental Health Division, and Reproductive Health Program, to assure use of Medicaid whenever appropriate
- Investigate the feasibility of renewing an interagency agreement between the Family Health Division and Medicaid Division to utilize any Title V overmatch to draw down federal funds for Medicaid to support outreach activities, thus, increasing the number of Medicaid-eligible children who receive a service paid by Medicaid

**Anticipated Impact on Performance Measure:**

Performance objectives were set by Title V staff with assistance from the Medicaid Research Division. Nebraska's utilization rate for Medicaid is already quite high, (93.95% for FY96, 93.91% for FY97, 94.56% for FY98 and 92.7% for FY99), although the utilization rate is skewed by capitation payments for statewide coverage for mental health through a managed care plan and Nebraska's 12-month eligibility for Kids Connection. With the passage of Title XXI (SCHIP), an expansion of Medicaid called Kids Connection was implemented in Nebraska on September 1, 1998. As of April 2000, the marketing and outreach campaigns and public health nursing contracts have enrolled 25,446 more children into Medicaid, most of whom were eligible under Title XIX (Medicaid) eligibility, but not previously enrolled. Disenrollment, for a variety of reasons, was 493 of SCIP-eligible kids which represents only 7.2% of the total enrolled under SCIP eligibility since the start of Kids Connection. It has determined that utilization of Medicaid by Medicaid-eligible children will "max out" at around 95%. Subsequently, targets were set for this measure at 95% beginning in FY98 and subsequently are expected to be maintained at 95% through FY05.

**PM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program**

<b>Relationship to priority need:</b>	
<ul style="list-style-type: none"> <li>- Priority Need #1: "Childhood morbidity and mortality due to asthma need to be reduced."</li> <li>- Priority Need #2: "Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN."</li> <li>- Priority Need #3: "Increase access to quality oral health care for MCH/CSHCN population."</li> <li>- Priority Need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities."</li> <li>- Priority Need #7: "Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN."</li> <li>- Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists."</li> <li>- Priority Need #10: "Eliminate racial/ethnic health disparities."</li> </ul>	
<p>If more families participate in program and policy activities in MHCP, the unique quality of their involvement will help address the many related Priority Needs as identified above. In a reciprocal way, the empowerment many parents experience as a result of participation, will enable them to be the best possible advocate for their child with a special health care need, or even broader to include their community, especially communities with ethnic/racial diversity. This grassroots energy is a significant factor in the strides already accomplished in MHCP. Further development of parent/family involvement can be redefined to include community-level participation in program and policy activities.</p>	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement</b> Infrastructure Building Services	<b>Type of Service:</b> Process
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The Early Intervention (EI) Program, an entitlement in Nebraska, and Part H of the Individuals with Disabilities Education Act are co-administered by the Nebraska Department of Education, Special Education Branch and the NDHHS Special Services for Children and Adults Division. This locates EI, Part H, and MHCP—the Title V/CSHCN program, under the direction of the Title V/CSHCN Director. EI/Part H employs a Family Partner, a parent of a child with a disability, full-time on its staff. This person advises and participates in policy decisions, planning, and implementation of changes in MHCP. The Family Partner has been involved in Title V Block Grant review activities in Region V, and attends national CSHCN meetings.

**Program Activities:**

- Continue to utilize the EI/Part H Family Partner in an advisory role for MHCP, which has included participation in the five-year Title V needs assessment process.
- Investigate the duties and role of paid family members in other states with the purpose of designing a role(s) for paid family members at MHCP multidisciplinary team clinics
- Eventual implementation of a program which includes a paid family partner as a member of the team at MHCP clinics (possibly not until FY00)
- A survey was completed in FY99-2000 (first part of the FY00) of families who attend the MHCP multidisciplinary team clinics, including questions regarding how parents might be more interested or willing to participate in program and planning activities. Survey results are now being distributed and analyzed. From data captured by the survey, it is likely that a role with families at Special Clinics for Children and Youth clinics will be developed.

**Anticipated Impact on Performance Measure:**

The investigation and future implementation of a program that has a paid family partner as a member of the multidisciplinary team at MHCP clinics is expected to increase the ranking of this performance measure. Since this activity is in its early stages, we had not previously expected to immediately increase the ranking dramatically until FY00. Therefore, we projected an annual performance objective of 13 in FY99, and 14 in FY00. Actual work on this ranking will be completed prior to the submission of this application to federal MCH staff. However, we do not expect to see a dramatic increase in the performance ranking over that obtained in FY 1998 due to the length of time required to develop additional family roles with the MHCP Program. The target of 14.0 will be maintained for FY01, increased to 15.0 for FY02 and FY03, and at 16.0 for FY04 and FY05.

## PM #15: Percent of very low birth weight live births

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #4: “Decrease rates of adolescent, non-marital, and unintended pregnancies.” Particularly among adolescents due to age and pregnancies which were unintended, there is a greater risk of very low birth weight. This measure is also related to Priority Need #5: “Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities,” as well as Priority Need #6: “Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age.” A decrease in very low birth weight live births will help to decrease infant mortality. Further, based on the information regarding risk factors related to low birth weight babies, there is an inverse relationship between very low birth weight live births and use of tobacco, alcohol, and illicit substance use.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Prenatal care is an important focus for Title V, and collaboration with other programs and agencies allow us to take our message of its importance even further. Nineteen community-based programs are funded through Title V that include education on such related topics as early and continuous prenatal care, smoking and substance abuse, and teenage pregnancy prevention as strategies to reduce very low birth weight births. The development of a state-level adolescent pregnancy prevention coalition has been an additional way Title V administration is involved in lowering the number of very low birth weight live births.

### Program Activities:

- Continue to support nineteen community-based programs that address very low birth weight births through education on topics such as early and continuous prenatal care, smoking and substance abuse, and teenage pregnancy prevention
- Continue the Substance Free for a Healthy Start, Nebraska project to motivate providers to universally screen pregnant women for substance use and to enhance the system of care available for referral and treatment of pregnant women
- Participate in the Nebraska Adolescent Pregnancy Network, to provide public and professional awareness on issues of adolescent pregnancy, including the significance of low birth weight births, and collaboration between state agency programs
- Support the Nebraska PRAMS project and disseminate resulting data regarding identifiable risk factors to premature birth, as well as data on use of fertility drugs that may be connected to an increase in premature birth and low birth weight
- Continue to participate in Omaha’s Healthy Start program and the Public Health Advisory Committee for this program, working to increase awareness of the importance of prenatal care among women of child-bearing age in North Omaha
- In conjunction with Douglas County Health Department, distribute perinatal substance abuse practitioner guidelines in Omaha, and eventually throughout the state
- The MCH Providers Partnership Project, a grant through the American College of Nurse Midwives and MCHB, led to the ‘Future Search’ conference focused on identifying issues in rural perinatal care. The identification of issues will lead into focused discussions in the coming year regarding how to proceed. One issue which surfaced was cultural competency. Ultimately, measures taken through this project will improve birth outcomes for patients of those providers, including birth weight
- Contribute to the Governor-appointed Blue Ribbon Panel headed by the state’s Chief Medical Officer directed to examine the steady high infant mortality.

### Anticipated Impact on Performance Measure:

Performance objectives were set by Title V staff, using trend information that included CY96 through CY98 data. Though the percentage actually increased slightly over those three years, very gradual incremental improvement had been anticipated for CY99 and CY00 with targets set at 1.10% and 1.0%, respectively, for these two years. Trends currently being monitored are the number of multiple births (twins, triplets, etc.). These numbers have been increasing, reflecting a national trend, and are likely contributing to the small increases in very low birth weight births. However, with the myriad of program activities, it is anticipated the percent of very low birth weight live births will begin to decline and subsequently targets are set at 1.0% for CY01 and CY02, .95% for CY03 and CY04, and .90% for CY05.

**PM #16: The rate (per 100,000) of suicide deaths among youths aged 15-19**

<b>Relationship to priority need</b> This National Core Performance Measure has a direct relationship to Priority Need #7: "Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN," which for this measure is focused on intentional, self-inflicted injury which can result in death. This measure may also have an indirect relationship to Priority Need #6: "Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age," since use of these substances may contribute to suicide deaths.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,000 children aged 1-14	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The Child Death Review Team provides useful information on the circumstances surrounding youth suicide deaths, which can be used in the development of prevention strategies. The Perinatal, Child, and Adolescent Health Program--via the School and Child Health Nursing Coordinator--will continue to provide information to school personnel on strategies to prevent suicide deaths, including recognition of youth at risk. The Health Promotion and Education Division recognizes the need to expand its capacity in addressing intentional injuries, including suicides. Title V program staff will consequently work closely with this division as it does so. Finally, NHHSS, through its redesign process, offers opportunities to more closely integrate behavioral health, juvenile services and child welfare, with public health activities to address youth suicide prevention.

**Program Activities:**

- In collaboration with Health Promotion and Education staff, begin to work to build expertise and capacity around suicide prevention among youth
- Continue participation in and utilization of Child Death Review Team Report
- Continue support to school systems through Perinatal, Child, and Adolescent Health Program which includes the school nursing component and Title V awards
- Pursue opportunities to design integrated strategies in collaboration with child welfare, juvenile services, behavioral health, and public health programs within NHHSS

**Anticipated Impact on Performance Measure:**

While it is realized that partnering activities with other programs may not have a significant, immediate impact on this performance measure, we will attempt to work toward the Healthy People 2010 objective of 6.0. With that in mind, and knowing that the CY96, CY97, and CY98 rates were 14.8, 9.9, and 11.8 deaths per 100,000, respectively, we attempted to establish realistic annual objectives of 11.0 for CY99, 10.0 for CY00, 9.5 for CY01, 9.0 for CY02, 8.5 for CY03, 8.0 for CY04, and 7.5 for CY05.

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

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #5: “Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.” A strong relationship exists between this measure and Outcome Measure #1: “The infant mortality rate per 1,000 live births,” as well as Outcome Measure #3: “The neonatal mortality rate per 1,000 live births.” Very low birth weight is often linked to prematurity, which is the leading cause of infant deaths.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Although Nebraska does not have a formal system of perinatal regionalization, in the past, both MHCP and MCH Division staff collaborated on Neonatal Intensive Care Unit (NICU) site visits across the state. There is discussion currently about reinstating those collaborative NICU visits, with the team consisting of staff of MHCP and Medicaid Managed Care. These visits would allow state and national experts to provide education and support to those hospital nurseries providing care to the infant with intensive and intermediate care needs. Additionally, PRAMS will provide a population-based perspective into the utilization of services, including those for delivery, and assist us in better understanding usage patterns.

**Program Activities:**

- Through NHHSS Medical Advisor, attempt to recruit public health intern to analyze vital records regarding very low birth weight births to reveal and understand patterns among localities of birthing facilities at which these infants are born
- The Prenatal Care Quality Improvement Committee has approved the format for guidelines to assure quality prenatal care for all Nebraskans, and will proceed with reviewing, editing, and revising content in the coming year
- Continue support of the PRAMS project and from the analysis of data the flow of information will eventually provide an educational experience for prenatal care providers, as birth outcomes are related to various risk factors, including immediate hospital care for the newborn
- Implementation of Critical Care Access Hospitals in Nebraska

**Anticipated Impact on Performance Measure:**

The standards previously used during NICU site visits were the ACOG/AAP Guidelines for Perinatal Care, and although terminology has changed in the last few years, the definition for Tertiary Care (or Level III, Subspecialty Care) is taken from this resource for the purpose of reporting on this measure. Based on these data for CY96 (78.9%), CY97 (81.7%), and CY98 (78.9%), targets were set for CY00 and continuing through CY05 knowing that every attempt will be made to meet the HP 2000 and 2010 objective of 90% of pregnant women and infants receiving risk appropriate care.

**PM #18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**

<b>Relationship to priority need:</b> This National Core Performance Measure relates to Priority Need #5: “Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.” Early entry into prenatal care can help improve pregnancy outcomes and help to reduce the risk of infant mortality. Early entry also helps assure that women with complex problems or chronic illness or other risks are seen by specialists. This measure is also related to Priority Need #10: “Eliminate racial/ethnic health disparities.” More women in racial/ethnic populations are likely to seek care in the first trimester with sufficient attention to a variety of health care delivery issues at the community level, e.g. cultural competency of the prenatal care providers.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

**Capacity/Resource Capability:**

Title V at the state and local levels is heavily involved in activities to help increase early entry into prenatal care. State Title V staff are involved in a number of initiatives, including the Governor-appointed Blue Ribbon Panel (to examine Nebraska’s steady high infant mortality rate), PRAMS project, the Prenatal Care Quality Improvement Committee (PNCC), and the Every Child Wanted, Nurtured and Supported Initiative, to name a few. Eighteen Title V community-based grantees provide home visitation or case management services to pregnant women and provide education in schools and communities at large on the importance of early prenatal care as part of their activities.

**Program Activities:**

- Continue to fund eighteen Title V grantees who provide prenatal support services and education to communities on the importance of early prenatal care, eleven of whom are Medicaid presumptive eligibility providers
- Continue to collaborate with the Northern Plains Healthy Start program, which focuses on risk factors associated with pregnancies to Native American women
- Participate in the Nebraska Adolescent Pregnancy Network, to provide public and professional awareness on issues of adolescent pregnancy, including strategies to help teens understand the importance of early prenatal care
- Continue to support the Prenatal Care Quality Improvement Committee (PNCC), involving prenatal care providers, public health professionals, health care coverage plans, and consumers to assure quality prenatal care for all Nebraska women, including early and continuous care
- Continue to work with all of the Healthy Start projects in the state, and to participate in Omaha’s Healthy Start Public Health Advisory Committee for this program
- Focus discussions on issues which emerged from the ‘Future Search’ conference, which is one product from the Providers Partnership, a group of prenatal care providers coming together to ultimately improve collaborative practice and access to care, and resulting from grant support through the American College of Nurse Midwives and MCHB

**Anticipated Impact on Performance Measure:**

Performance objectives were established by Title V staff, using trend data that shows 84.3% of infants in CY96 were born to pregnant women receiving prenatal care beginning in the first trimester, 83.7% in CY97, and 83.6% in CY98. 1999 data is provided by the National Vital Statistics Report (V. 48, No. 14, August 8, 2000). According to this report 84.4% of infants born to pregnant women began receiving prenatal care during the first trimester. This is slight increase from 83.6% in 1998.

Though additional activities will be under way in the near future, they are not expected to have a significant impact on this rate in the immediate future, but possibly sometime after this five-year period is completed. For that reason, targets for FY00 and continuing through FY05 were set at 90% each year.

**SP #1: Percent of children with special health care needs who receive assistive technology and/or home modification services**

<b>Relationship to priority need:</b> State Performance Measure #1 is being retired beginning FY01, because it does not relate to the new Priority Needs as a result of the most recent five-year needs assessment conducted as part of this application.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Direct Health Care Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**SP #2: Percent of CSHCN in state CSHCN Program that have transition plans that address health care, including insurance, by age 18**

<b>Relationship to priority need:</b> This measure has been retired.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Enabling Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

### SP #3: Incidence of confirmed SIDS cases (per 1,000 live births) among African American and Native American infants

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #5: “To reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.” African American and Native American infants are two racial groups that, in comparison with other Nebraska infants, have a higher rate of SIDS. This measure also relates to Priority Need #10: “Eliminate racial/ethnic health disparities.” Although cultural health beliefs and practices may influence the higher incidence of SIDS in the African American and Native American populations, more women in racial/ethnic populations are likely to use the recommended sleep positions when health care providers are culturally competent, for example.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

#### Capacity/Resource Capability:

Through Title V in Nebraska, a number of activities toward the reduction of SIDS are occurring. Eighteen community-based programs provide prenatal and parenting education—particularly the Healthy Start projects, which includes information on SIDS. State-level staff are involved in a number of initiatives (as listed below) to increase awareness of SIDS, particularly among African American and Native American persons.

#### Program Activities:

- Remain involved with all the Healthy Start projects in Nebraska, that focus on reducing infant mortality, including SIDS rates, and continue to participate in Omaha’s Healthy Start’s Public Health Advisory Committee
- Continue to collaborate with and partially fund Nebraska sites within the Northern Plains Healthy Start program, which focuses on reducing infant mortality, including SIDS rates among Native American women
- In conjunction with Douglas County Health Department, distribute perinatal substance abuse practitioner guidelines in Omaha, and eventually throughout the state
- Continue to fund six community-based programs (in counties where more than 60% of all African American and Native American births occur annually) that provide prenatal and parenting education, including information on risk factors for infant mortality and incidence of SIDS. As part of their activities, these programs will target African American and Native American families with this information.
- Continue to collaborate with the Nebraska SIDS Foundation to raise awareness on the importance of infant sleep position and other ways to reduce the risk of SIDS
- Continue to supply funds to and remain involved in PRAMS program in Nebraska, which will provide population-based data on risk factors associated with pregnancy, including risk factors for SIDS
- Continue to work with WIC to provide both population-based and program specific education and materials on breastfeeding, which has been linked to a decrease in incidence of SIDS
- Continue to participate in the Nebraska Adolescent Pregnancy Network, to provide public and professional awareness on issues of adolescent pregnancy, including incidence of SIDS among infants born to adolescents and strategies to reduce associated risk factors
- Continue to support the Prenatal Care Quality Improvement Committee (PNCC), involving prenatal care providers, public health professionals, health care coverage plans, and consumers to assure quality prenatal care for all Nebraska women, including early and continuous care
- Through Healthy Child Care Nebraska (CISS Health Systems Development in Child Care Grant), continue appropriate state-level partnerships that promote smoke-free environments for infants in child care as well as appropriate infant sleep position.
- Continue the Substance Free for a Healthy Start, Nebraska project to motivate providers to universally screen pregnant women for substance abuse and to enhance the system of care available for referral and treatment of pregnant women.
- Contribute to the Governor-appointed Blue Ribbon Panel headed by the state’s Chief Medical Officer directed to examine the steady high infant mortality.

**Anticipated Impact on Performance Measure:**

Performance objectives for this measure were established by Title V staff with assistance from the NHHSS Medical Advisor, and are based on indicator data for CY96—which is a 5-year average of 1992-1996—that shows a total of 37 deaths caused by SIDS among 8,054 total births among African American and Native American infants. This translates into a rate of 4.6 confirmed SIDS cases per 1,000 live births for Native American and African American infants combined. For the same 5-year period, incidence of SIDS among white infants was 1.3 confirmed cases per 1,000 live births, among Hispanic infants the rate was 1.2 confirmed cases, and among Asian infants the rate was 0 confirmed cases. Even with a 5-year average, the numbers among minority populations are very small, but there is clearly cause for specific concern for the well-being of Native American and African American infants.

Performance objectives for CY99 and CY00 were set at 3.2 and 3.0, respectively. Targets of 2.9 for CY01, 2.8 for CY02, 2.7 for CY03, 2.6 for CY04, and 2.5 for CY05 are established. Based on trends and with the activities outlined above that are intended to focus SIDS education efforts on Native American and African American populations specifically, it is believed that these targets will be met.

## SP #4: Percent of women of child-bearing age who report smoking in the last 30 days

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #6: "Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age." Tobacco is a substance associated with both lifelong health consequences, as well as perinatal outcomes.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

### Capacity/Resource Capability:

Title V supports nineteen community-based programs that deal with perinatal substance abuse issues as part of their activities. At the state level, Title V collaborates with a number of other related programs to carry out activities such as the distribution of practitioner guidelines for perinatal substance abuse, continued support of the Nebraska PRAMS project, and remaining involved in the Prenatal Care Quality Improvement Committee (PNCC).

### Program Activities:

- Continue to fund nineteen community-based programs that provide prenatal and parenting education, including information on risk factors for infant mortality such as substance abuse
- Continue to fund and collaborate with Douglas County Health Department's MCH Leadership Initiative in the distribution of practitioner guidelines for perinatal substance use assessment, discussion on legal and ethical implications, and a resource list for perinatal substance abuse services
- Continue supporting a PRAMS program in Nebraska, which will provide population-based data on risk factors associated with pregnancy, including use of alcohol and tobacco
- Participate in the Nebraska Adolescent Pregnancy Network, to provide public and professional awareness on issues of adolescent pregnancy, including substance use among adolescents and strategies to reduce this use
- Continue to support the Prenatal Care Quality Improvement Committee (PNCC), involving prenatal care providers, public health professionals, health care coverage plans, and consumers to assure quality prenatal care for all Nebraska women, including early and continuous care.
- Collaborate with Tobacco Free Nebraska to promote awareness of the hazards of smoking among all women of child-bearing age and youth
- Collaborate with Tobacco Prevention and Control Program within the Health Promotion and Education Division on prevention of substance use among pregnant women, including the provision of training and materials to Title V-funded prenatal care programs and home visitation providers
- Continue to participate in Omaha's Healthy Start program, which focuses on reducing infant mortality, including reducing the incidence of smoking among African American women of child-bearing age, and the Public Health Advisory Committee for this program
- Continue to collaborate with the Northern Plains Healthy Start program, which focuses on reducing infant mortality, including reducing the incidence of smoking among Native American women of child-bearing age
- Continue the Substance Free for a Healthy Start, Nebraska project to motivate providers to universally screen pregnant women for substance use and to enhance the system of care available for referral and treatment of pregnant women
- Participate in the review of the state plan for the comprehensive tobacco prevention and control program, resulting from legislative creation to use \$7 million annually for three years from the principal of the Nebraska Tobacco Settlement funds.

### Anticipated Impact on Performance Measure:

Performance objectives were established by Title V staff with assistance from the NHHSS Medical Advisor, and were based on data for CY96 which shows that 22.7% of women of child-bearing age reported smoking in the last 30 days on the Behavioral Risk Factor Survey (BRFS). The BRFS is weighted by age, sex, race, and number of phone lines accessible in a household. Data from the CY97 and CY98 BRFS show indicators of 25.7% and 25.1% respectively. Despite an actual increase during this time, objectives for CY99 and CY00 were set at 22% and 21% respectively. Although data from the CY99 BRFS shows indicator of 26.4%, optimism prevails with the new legislative creation to use \$7 million from the principal of Nebraska Tobacco Settlement funds for the Tobacco Prevention and Control Plan. The objectives for CY00, CY01 and CY02 are 21%, and CY03, CY04, and CY05 at 20% to reach the Healthy People 2010 objective.

**SP #5: Incidence of neural tube defects (per 10,000 live births)**

<b>Relationship to priority need:</b> State Performance Measure #5 is being retired beginning FY01. Though it relates to Priority Need #5: "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities," other measures competed for the maximum allowable number of state performance measures.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Infant mortality rate per 1,000 live births	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants	

## SP #6: Hospitalizations for injuries (per 100,000), birth to 14 (intentional and unintentional)

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #7: "Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN." A decrease in hospitalizations for injuries most likely means a decrease in injuries or perhaps less severe injuries, which may indicate an increase in the incidence of safe behaviors by children. Awareness and action to prevent the occurrence and severity of injuries—and the promotion of safe environments and behaviors—must occur for this measure to decrease.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

### Capacity/Resource Capability:

Title V funds 22 community-based projects, many of which conduct home visitation with new parents to provide education on the importance of injury prevention and abuse issues, among other things. The NDHHS Protection and Safety Division supports activities in communities to prevent intentional childhood injury, and is also participating in strategic planning to incorporate injury prevention into more traditional enforcement activities conducted by the division. A number of communities throughout the state have formed their own unintentional injury prevention coalitions, including Lincoln, Omaha, Hastings, Grand Island, and Kearney. Most activities are focused on traffic-related injuries. Nebraska's CISS Health Systems Development in Child Care grant is focused on building a network of child care health consultants and other methods to better link child care providers and families to preventive health care within their communities, as well as to increase the availability of inclusive child care for CSHCN in Nebraska. The goals of inclusion do not directly relate to reducing intentional and unintentional injuries, although inclusion raises a special concern with safety for CSHCN.

### Program Activities:

- Through NDHHS Protection and Safety Division, support community-level activities and state-level public awareness activities focused on intentional childhood injury prevention
- Continue to fund community-based projects that conduct home visitation with new parents to provide education about injury prevention and abuse issues
- Through community efforts, participate in coalitions across the state that work to create public awareness of unintentional injury prevention
- MHCP's Specialty Clinics for Children and Youth teams and MHCP Services Coordinators are expected to note and report any possible evidence of abuse and neglect to appropriate authorities as a part of MHCP quality assurance processes
- Through CISS Health Systems Development in Child Care Project, promote safe environments for children in out-of-home care through collaborative efforts with the Nebraska Department of Education and its Early Childhood Training Center through the Nebraska Safe Kids Program
- Also, through the CISS grant, activities related to CSHCN will be closely connected to another initiative, Map to Inclusive Child Care, to increase the availability of inclusive child care in Nebraska

### Anticipated Impact on Performance Measure:

Changes were made in State Negotiated Performance Measure #6. Previously, the Measure used hospital discharge data from three sources (emergency room, inpatient, and ambulatory surgery) to calculate the hospitalization rate of injuries to children 0-14. However, this calculation resulted in substantial duplication and the resulting rate was in the 5000 range when normally this number is in the 100's. We have changed the calculation procedures so only inpatient data is used to figure the hospitalization rate of injuries to children 0-14. Objectives for the future were changed accordingly. The recalculated data for SP #6 is:

	<u>CY1996</u>	<u>CY1997</u>	<u>CY1998</u>
Annual Performance Objective	180	170	160
Annual Performance Indicator	183.0	163.6	157.7
Numerator	665	595	573
Denominator	363,221.0	363,633.0	363,439.0

Performance objectives are 150 and 140 for CY99 and CY00.

**SP #7: Percent of teens who reported no use of alcohol in last 30 days**

<b>Relationship to priority need:</b> This measure is directly related to Priority Need #6: "Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age." Alcohol use during adolescence is associated with a wide range of other unhealthy behaviors and subsequent negative outcomes.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Population Based Services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

Through the School and Child Health component of the Perinatal, Child and Adolescent Health Program, Title V funds support school nurses through training and materials on issues of alcohol and substance abuse among teens. Through the Abstinence Education Project funded by MCHB and within the Perinatal, Child, and Adolescent Health Program, six communities are engaged in Abstinence Education programs that include education on the relationships between decreased inhibitions and risks encountered for sexual behavior, including alcohol and drug use. Eleven Title V community-based grantees provide education on the dangers of alcohol and drug use to youth as part of self-efficacy and self-esteem improvement strategies toward teenage pregnancy prevention.

**Program Activities:**

- Through School and Child Health component, continue to support school nurses with materials and training on talking with teens and parents about alcohol and substance use, signs of substance abuse, and referral and treatment of substance abuse
- Through School and Child Health component, continue to support six communities that provide Abstinence Education programs which include education on alcohol and drug use as risk factors to teen pregnancy
- Continue to support eleven Title V-funded community-based teen pregnancy prevention programs that include education on dangers of alcohol and drug use for youth
- Implement the Substance Free for a Healthy Start, Nebraska project to motivate providers to universally screen pregnant women for substance abuse and to enhance the system of care available for referral and treatment of pregnant women
- Continue support of the PRAMS project in Nebraska, which will provide population-based data on risk factors associated with pregnancy, including alcohol use

**Anticipated Impact on Performance Measure:**

Performance objectives were established by Title V staff with assistance from the Perinatal, Child, and Adolescent Health Program. The source for indicator data is the Youth Risk Behavioral Survey, which is conducted every two years in Nebraska. Indicators in CY95, CY97, and CY99 were 55%, 56%, and 55.8%, respectively. Although activities have not changed significantly, beginning with CY01 the performance measure is being reworded to be reflective of the Healthy People 2010 objective, i.e. stated in a positive perspective of not using alcohol, rather than the percent who reported using alcohol. As a result, the objective is 45% for CY01, 46% for CY02, 47% for CY03, 48% for CY04, and 50% for CY05, although indicator data will be available every odd-numbered year from the YRBS. This progress will keep the state in line to meet the Healthy People 2010 objective of 80%.

**SP #8: Percent of public school districts where students have access to registered school nursing services**

<b>Relationship to priority need:</b> State Performance Measure #8 is being retired beginning FY01, because it does not directly relate to the new Priority Needs as a result of the most recent five-year needs assessment conducted as part of this application.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children	

**SP #9: Percent of Medicaid-participating dentists who see 25 or more Medicaid patients each month**

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #3: "Increase access to quality oral health care for MCH/CSHCN population." Most of Nebraska is in a dental care shortage area, creating access concerns for the entire MCH/CSHCN population, not just those Medicaid-eligible. This measure was chosen based on the availability of data and as a way to monitor an at-risk group particularly vulnerable to access barriers.	
<b>Relationship to outcome measure:</b> Outcome measure #1: Child death rate per 100,000	
<b>Pyramid placement:</b> Infrastructure Building Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs	

**Capacity/Resource Capability:**

The NHHSS Dental Health Division, which now receives its sole funding from Title V, works closely with Nebraska's Medicaid program to determine and implement strategies to increase the number of dentists who participate with Medicaid, as well to make it easier for those dentists who do participate with Medicaid to see larger numbers of eligible patients. A change in Nebraska's Medicaid program to increase the rate reimbursed to participating dentists has had a positive impact. The Dental Health Division Administrator will continue to meet with dentists in the Nebraska Dental Association's eight dental districts to reintroduce and familiarize them to what is involved in participating in Medicaid and discuss preventive care and barriers to care for families.

**Program Activities:**

- Through NHHSS Dental Health Division, train school nurses on oral health screenings for students and educational opportunities with families on the importance of oral health
- Through NHHSS Medicaid program, evaluate the impact that the increased rates of reimbursement to Medicaid-participating dentists have had on the Medicaid dental program, particularly for preventive dental care, and consider other possible revisions to Medicaid-covered dental services
- Through NHHSS Dental Health Division, meet with dentists in the Nebraska Dental Association's eight dental districts to reintroduce them to what is involved in participating in Medicaid and discuss barriers to care for families
- Continue to fund fourteen community-based programs through Title V that offer home visitation services to families with infants and young children, including outreach and education regarding health services such as dental health services
- Ongoing work through the Perinatal Care Quality Improvement Committee will focus on the importance of oral health during pregnancy and result in including it in the Nebraska Perinatal Guidelines under development. This is especially important in light of the growing literature regarding periodontal disease and premature labor.

**Anticipated Impact on Performance Measure:**

This measure was changed with the development of the FY98 annual report. The change was from the percent of Medicaid-participating dentists who see 25 or more Medicaid patients every month to the percent who see an average of 25 or more Medicaid patients per month based on total yearly visits. In retrospect, the measure used previously was seen as too rigid. Therefore, the measure was modified and the previous data was omitted. With the new methodology, only FY98 data was available last year. Original objectives for FY99 and FY00 were cautiously set at 15.0% and 17.0% based on this one year of data. Targets for FY01 will remain at 17.0%, increase to 18.0% for FY02 and FY03, and 19.0% for FY04 and FY05.

**SP #10: Percent of CSHCN seen at CSHCN multidisciplinary team clinics who receive recommended nutritional follow-up services**

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #2: "Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN." If we are able to increase the options of financial support for nutritional services and inform the medical community and families of the importance of nutritional services, access to nutritional services for children, especially those at risk, should increase.	
<b>Relationship to outcome measure:</b> Outcome measure #6: Child death rate per 100,000	
<b>Pyramid placement:</b> Enabling Services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

**Capacity/Resource Capability:**

Nutrition for children with special health care needs has been one of the ongoing priorities of MHCP. Steps taken to address this issue include the addition of a nutritional consultant to MHCP multidisciplinary teams for cerebral palsy, midline neurological defects, juvenile rheumatoid arthritis, and craniofacial. The Aged and Disabled Medicaid Home and Community-Based Services Waiver includes nutritional services in their array of services and provides for in-home assessment and follow-up. Medicaid has drafted revisions to the regulations to allow licensed nutritional medical therapists (LNMT) to enroll as Medicaid providers and bill Medicaid directly for their services rather than going through a physician's office or outpatient hospital. If these revised regulations are adopted, it will allow for easier billing for the services of LNMTs.

**Program Activities:**

- Continue to provide nutritional consultation through MHCP multidisciplinary teams for cerebral palsy, midline neurological defects, juvenile rheumatoid arthritis, and craniofacial
- Continue to provide nutritional services, in-home assessment, and follow-up through the Aged and Disabled Medicaid Home and Community-Based Services Waiver
- Continue to work with the Medicaid program regarding regulatory changes for the billing of nutritional services.
- Specialty Clinics for Children and Youth Nutritional Consultants/team members are reporting on the number of children seen by the teams who have previously received nutritional services and who are in need of nutritional services.

**Anticipated Impact on Performance Measure:**

Because this is a new measure last year, data began with FY98 was based on expert anecdotal information. Based on that data and an anticipated increase in services coordination and services provision in the area of nutrition to CSHCN, objectives for FY99 and FY00 were both set at 75%, a significant increase from the 50% indicator shown for FY98. Targets for CY01 and continuing through CY05 are being maintained at 75%. No measuring tool was in effect for 1999. Data will be available for year 2000 in 2001.

## SP #11: Rates of hospitalization due to asthma among children ages 5-14.

<b>Relationship to priority need:</b> This new measure for FY01 directly relates to Priority Need #1: "Childhood morbidity and mortality due to asthma need to be reduced," as well as Priority Need #8: "Increase the number of CSHCN who have a medical home and access to pediatric specialists." This measure will identify progress towards reducing childhood morbidity and mortality the result of asthma, which is likely to be reflective of the establishment of a medical home and access to pediatric specialists, particularly for children with special health care needs.	
<b>Relationship to outcome measure:</b> Outcome measure #6: The child death rate per 100,00 children aged 1-14	
<b>Pyramid placement:</b> Population-based services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children with Special Health Care Needs	

### Capacity/Resource Capability:

The Perinatal, Child, and Adolescent Health Program addresses asthma, particularly via the School and Child Health Nursing Coordinator in this program who participates on the Asthma Team. The Asthma Team has multidisciplinary representation to look at developing infrastructure and proposes to eventually hire an Asthma Program Manager, to form a statewide Asthma Coalition and Data Advisory Team, develop and maintain an asthma surveillance system, evaluate current and future asthma activities, and find consensus on the selection of asthma treatment guidelines. The annual School Nurse Survey instrument and methodology will continue to be fine tuned for enhanced reliability and validity, increased response rate, and utilization of data with a variety of initiatives.

### Program Activities:

- Continue participation on the Asthma Team, multidisciplinary group to address various asthma-related concerns
- Continue to enhance the instrument and methodology to conduct the annual School Nurse Survey, devising strategies to increase the response rate and data utilization
- Convey information to school nurses statewide, particularly as new data emerges, providing education/training and consultation regarding intervention strategies for implementation at school and in the home

### Anticipated Impact on Performance Measure:

Few resources currently exist to address asthma in a comprehensive, statewide approach. As a new measure, the program activities are expected to build significantly in the next year. The rates of hospitalization are not expected to change significantly in the first year, but the success of the activities will be more apparent beginning in FY02 and beyond. The objectives for CY01 and continuing through CY05 are set at 8.0.

## SP #12: Rates of minority adolescent births

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #4: “Decrease rates of adolescent, non-marital, and unintended pregnancies,” and to Priority Need #5: “Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities,” as well as Priority Need #10: “Eliminate racial/ethnic health disparities.” Adolescent pregnancy is associated with a number of poor health outcomes for all populations, including racial/ethnic minorities. This measure was chosen to address current trends and is in response to public input to the needs assessment process.	
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #2: The ratio of the black infant mortality rate to the white infant mortality rate.	
<b>Pyramid placement:</b> Population-based services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant women, mothers and infants	

### Capacity/Resource Capability:

Title V funds support teen pregnancy prevention activities in Nebraska through a number of venues. The Perinatal, Child and Adolescent Program offers training and materials to school nurses on a variety of strategies to address teen pregnancy prevention, and oversees Title V Abstinence Education activities throughout the state. The Reproductive Health Program provides education, materials, and birth control methods through community-based clinics in the state, and MCH Planning and Support Program monitors 17 community-based, Title V-funded programs that offer teen pregnancy prevention activities as part or all of their curriculum. A state-level coalition of programs, including the Perinatal, Child and Adolescent Health Program, continues to address teen pregnancy issues. Resources and capacity to address adolescent births are present, and specifically address adolescent births among minorities.

### Program Activities:

- Continue to fund 17 community-based programs through Title V that address teen pregnancy issues as part or all of their program
- Continue to support the Nebraska Reproductive Health Program by providing funding for educational activities and materials focused on teen pregnancy issues
- Continue to support the Perinatal, Child and Adolescent Health Program’s ability to coordinate statewide school nursing activities, provide training and materials to school nurses on teen pregnancy issues, and with funds from the MCHB Abstinence Education Program to continue support of community-based agencies by coordinating activities related to abstinence. Continue participation in the Nebraska Adolescent Pregnancy Network (NAPN), a state-level coalition of programs, to develop Nebraska-specific information on facts and resources that will educate the public and health professionals
- Attention on minority adolescents is inclusive in the above-listed activities.

### Anticipated Impact on Performance Measure:

As a new measure, the performance objective for minority adolescent births was established with the assistance of the Reproductive Health Program and the School and Adolescent Health Program (now configured as the Perinatal, Child and Adolescent Health Program). This measure relates to national performance measure #6 to reduce the rate of births for teenagers aged 15 through 17 years. Nebraska’s emphasis on eliminating racial disparities will aid in reducing the rates of minority adolescent births gauged by this new state performance measure. The objective for CY01 was set at a rate of 20 births per 1,000, 19.5 in CY02, 19.0 in CY03, 18.5 in CY04, and 18.0 in CY05.

**SP #13: The state’s score on building statewide immunization registry capacity.**

<b>Relationship to priority needs:</b>	
This measure directly relates to Priority Need #9: “Increase the state’s capacity for surveillance of immunization status,” as well as Priority Need #10: “Eliminate racial/ethnic health disparities.” Even well-meaning, diligent parents/guardians who take their children for immunizations on time can be only as thorough as memory and manual recordkeeping allows. If an immunization record goes with the child to each immunization site or the child is seen consistently at the same site where records are maintained for the child, a centralized system is not as critical. However, memories fail and manual, hardcopy recordkeeping is reliable only if the record is accessible every time a vaccine is administered. With an increasingly mobile society, it is more likely that a child will not receive their immunizations consistently at the same clinic site, especially if the family moves to another location in the state. While immunization record maintenance is obviously critical for the health of individual children, a universal system would further allow a better method of monitoring immunization status for school entrance and a year-to-year comparison of the Nebraska population. The state’s current immunization surveillance that covers both public and private clinics relies on the national immunization telephone survey. Telephone survey excludes Nebraskans without telephones who, presumably due to lower economic status, are at high risk of not being current on the immunization schedule.	
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #6: The child death rate per 100,000 children aged 1-14.	
<b>Pyramid placement:</b> Infrastructure-building services	<b>Type of Service:</b> Capacity
<b>Category of Persons Served:</b> Children	

**Capacity/Resource Capability:**

The present capacity for 55 public immunization clinics in Nebraska to downlink electronic immunization records into a central system in Omaha, Douglas County is not connected to the electronic registry system used in Lincoln, Lancaster County. The public clinics with access to a statewide registry are located throughout the state, however, do not capture all the immunized children in Nebraska. Reliance remains on a written, hardcopy immunization record maintained by parents and taken to the immunization clinic(s) where vaccines are administered. The public immunization clinics follow up in writing to the physician when the child has a medical home, although this is not a reciprocal process when the vaccine is administered at the physician’s office and there is a public immunization clinic in the vicinity.

**Program Activities:**

- Facilitate a task force to do strategic planning to encompass the development of the existing plan for statewide public registry and operationalize of the plan
- Continue maintenance of effort within Nebraska’s current immunization system
- Enhance the communication process between the public and private sectors where public immunization clinics and a child’s medical home intersect, especially focused on developing a two-way communication flow of information

**Anticipated Impact on Performance Measure:**

The performance objectives set for this new measure were established in conjunction with the Nebraska Immunization Program using the following scale:

- Stage One (1.0): Use CDC’s National Immunization Survey Data
- Stage Two (2.0): Develop plan for statewide public registry
- Stage Three (3.0): Operational statewide public registry
- Stage Four (4.0): Develop plan for statewide private registry
- Stage Five (5.0): Fully implemented statewide public and private registry

The targets are 3.0 for CY01, 4.0 for CY02, and reaching the maximum scale of 5.0 in CY03 which will be maintained at the highest level indefinitely.

**SP #14: The percent of African American women beginning prenatal care during the first trimester.**

<b>Relationship to priority need:</b> This measure directly relates to Priority Need #5 "Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities" as well as Priority Need #10: "Eliminate racial/ethnic health disparities." An increase in the percent of African American women beginning prenatal care during the first trimester will contribute to a reduction in the rate of African American infant mortality. As the percent of African American women who begin prenatal care during the first trimester increases, Nebraska's priority to eliminate racial/ethnic health disparities will be positively impacted.	
<b>Relationship to outcome measure:</b> Outcome measure #1: The infant mortality rate per 1,000 live births. Outcome measure #2: The ratio of the black infant mortality rate to the white infant mortality rate.	
<b>Pyramid placement:</b> Population-based services	<b>Type of Service:</b> Risk Factor
<b>Category of Persons Served:</b> Pregnant women, mothers and infants	

**Capacity/Resource Capability:**

Title V funds support community-based agencies addressing health disparities. Home visiting and case management facilitate a family-level approach to assure culturally-appropriate services. Enabling and population-based services and activities to build infrastructure are keenly focused on racial/ethnic disparities to facilitate a cross-cutting approach to address health disparities. State- and community-level activities involve such groups as the Nebraska Minority Public Health Association and the Nebraska Minority Health Office to identify, implement, and evaluate practices specific to the needs of the various subpopulations often found in pockets of a racially- and culturally-diverse state with great geographic expanse.

**Program Activities:**

- Contribute to the Governor-appointed Blue Ribbon Panel headed by the state's Chief Medical Officer directed to examine infant mortality
- Continue to support the Prenatal Care Quality Improvement Committee (PNCC), involving prenatal care providers, public health professionals, health care coverage plans, and consumers to assure quality prenatal care for all Nebraska women, including early and continuous care
- Continue the Substance Free for a Healthy Start, Nebraska project to motivate providers to universally screen pregnant women for substance abuse and to enhance the system of care available for referral and treatment of pregnant women
- Develop targeted initiatives specific to the needs of the African American community.

**Anticipated Impact on Performance Measure:**

Pending the findings and recommendations of the Governor's Blue Ribbon Panel, it is too preliminary to suggest what activities will be undertaken to pinpoint the reduction of Nebraska's stagnant overall infant mortality rate and the increasing rate among African Americans. Whatever the recommendations will be, having a specific focus on certain aspects of prenatal care and infant care is expected to have a significant impact on the rates of infant mortality generally, and for the African American population specifically for purposes of this measure. Although the baseline indicator is 70.6% for FY98, the performance objectives are set at 90% beginning in CY01 and continuing through CY05.

## 4.2 Other Program Activities

### Medicaid/Kids Connection (SCHIP)

Title V coordinates with Medicaid in a number of ways. Current MCH Planning and Support staff is familiar with the Medicaid system sufficient enough to offer information to Title V subgrantees about regulations, programs areas, coverage issues, eligible provider types and enrollment, billing and the claims processing and payment system as it pertains to their MCH program. Where MCH Planning and Support staff is not sufficiently qualified to advise, staff is familiar with the delineation of Medicaid staff responsibilities to refer Title V subgrantees to the appropriate Medicaid staff person. Collaboration between these state divisions minimizes Title V funds being used where Medicaid reimbursement for covered services is feasible.

With the passage of Title XXI (SCHIP), an expansion of Medicaid called "Kids Connection" was implemented in Nebraska on September 1, 1998. Kids Connection efforts at outreach and eliminating barriers have been highly successful in enrolling uninsured Nebraska children, aided by marketing campaigns and public health nursing contracts. As of April 2000, 25,446 more children have been enrolled into Medicaid, most of whom were eligible under Title XIX (Medicaid) eligibility, but not previously enrolled. This further suggests the successfulness of the Kids Connection campaign, i.e. reaching kids who otherwise were Medicaid eligible but for reasons like stigma were not receiving Medicaid coverage. Disenrollment, for a variety of reasons, was 493 of SCIP-eligible kids which represents only 7.2% of the total enrolled under SCIP eligibility since the start of Kids Connection. One hallmark of the success of Kids Connection is 12-month continuous eligibility, stretching beyond Medicaid's one-month eligibility. This extended eligibility period aids continuity of care and increases opportunity to establish and utilize a medical home. By continuing to coordinate a public health presence at a variety of meetings throughout the year, Title V staff hopes to keep the medical home issue at the forefront of discussions about Kids Connection and Medicaid in general. Medicaid has contracts with seven regional community-based organizations in Nebraska to conduct public health nursing case management and outreach services. These services are intended to increase the number of eligible persons, particularly children, who enroll in Medicaid, as well as teach and promote preventive health care strategies and use of a medical home. Four of these seven contracted agencies which provide public health nursing case management services also receive Title V funds. This overlap further reinforces the need for Medicaid and Title V to be the strongest complementary counterparts as possible.

Eleven Title V grantees are Medicaid presumptive eligibility (PE) providers for pregnant women, and for children through Kids Connection. Representatives of Title V and Medicaid jointly strive to ensure these providers are informed and involved in caring for pregnant women and children. Presumptive eligibility determination for children originated with current PE providers for pregnant women and now has expanded to include new PE providers, e.g. hospitals. Staff in the Primary Care Unit of Medicaid have trained all eleven Title V grantees on the PE process for children and increased the number of PE providers by training hospital staffs as well.

MCH Planning and Support staff participate in a statewide coalition directly related to Medicaid and SCHIP. The coalition stems from the Covering Kids Initiative. This three-year initiative, sponsored by Robert Wood Johnson, seeks to enroll eligible, uninsured children across the state in Kids Connection. The coalition is charged with providing input to the lead agency, Voices for Children, to conduct outreach and enrollment for Kids Connection. Local efforts are provided through pilot programs in three agencies which have MCH programs funded by Title V. The second year of Nebraska's Covering Kids Initiative began in April 2000. Title V staff intend to remain involved in monitoring the progress of this program over time.

Nebraska Health and Human Services staff are in the preliminary stages with consultant group Health Systems Research, Inc. (HSR) regarding the CompCare Initiative to identify, plan, and implement technical assistance to support state efforts to strengthen quality systems of healthcare for children and adolescents. State-level partners include Title V representatives from the Family Health Division and Special Services for Children and Adults, as well as Medicaid staff including Kids Connection which is Nebraska's SCHIP and an extension of Medicaid, Medicaid EPSDT, public health nursing, and presumptive eligibility programs, and Medicaid staff who work with managed care and quality assurance. The group is being coordinated by the Medical Advisor for NHHS. The goals are to coordinate multiple quality assurance activities and strengthen these activities for improvement in child health status in Nebraska. Three target areas for enhancing quality assurance are CSHCN, dental services for children, and EPSDT services.

There is an interagency agreement between the divisions of Family Health, which division includes the administration of the Maternal and Child Health Block Grant/Title V, and Medicaid. The original agreement was developed in 1998 and effective for the period of July 1, 1998 through June 30, 1999, and renewed annually thereafter. The agreement addresses maximizing federal funds by using Title V overmatch to draw down Medicaid administrative federal dollars. The additional funds were designated to support a number of EPSDT outreach activities throughout the state, particularly to enhance activities already conducted by Title V programs. Since the original agreement, significant administrative changes occurred in both the Medicaid and Family Health Divisions and the Finance and Support agency of Nebraska Health and Human Services. New staff are familiarized with the interagency agreement to keep it a working document.

#### **Grant-Supported Special Projects**

The Division of Family Health, through a WIC Special Project Grant, completed a three-year evaluation of the Combined Services model as implemented at Panhandle Community Services. This model represents an organized effort to better coordinate grant funded activities, including prenatal and parenting support through Title V, immunizations, WIC, CSFP, and reproductive health services. Data from this evaluation will enhance future administrative decisions on how to organize and support integrated delivery systems at the local level. The five-year commitment to the two Panhandle agencies that have combined services plans will conclude at the end of FY2001. During the coming year, state-level staff for the various programs involved will begin the process to determine the approach for FY2002.

To address the issue of access to care and to assure medical homes, a partnership continues with Title V staff and the NHHSS Primary Care Office. The great number of federally-designated medically-underserved geographic areas and health professional shortage areas in the state make this collaboration imperative. In a related strategy, the PCAH Unit recently applied for and was awarded a small grant through the Maternal and Child Health Bureau and the American College of Nurse Midwives. The award supported a Maternal and Child Health 'Future Search' conference focused on identifying issues in rural perinatal care. The Providers Partnership Project is designed to improve collaborative prenatal practice in the state. In order to raise providers' awareness of the issue of access and the importance of collaborative care with full utilization of all primary care providers, continued collaboration between PCAH and the NHHSS Primary Care Office will be vital.

The Nebraska Title V/MCH Director continues as the Project Director for Nebraska's CISS Health Systems Development in Child Care grant. This project, now called Healthy Child Care Nebraska, is focusing on building a network of child care health consultants, and other methods to better link child care providers and families to preventive health care within their communities. The project will also be specifically addressing quality assurance through a review of current licensing

requirements and outreach for SCHIP. Project activities are carried out in part through an agreement with the Nebraska Department of Education and its Early Childhood Training Center.

Activities associated with this CISS grant as they relate to CSHCN will be closely connected to another initiative, Map to Inclusive Child Care. Nebraska is one of the Year Three states participating in this Child Care Bureau activity. The Title V/CSHCN Director is a member of the initiative's core team, and the Title V/MCH Director and School and Child Health Nurse Coordinator are part of the advisory panel. The core team and advisory panel recently conducted a strategic planning retreat, identifying priorities and key activities to increase the availability of inclusive child care in Nebraska.

The Nebraska Health Care Cash Fund is currently open for competitive applications, with awards to be made early fall 2000. This fund, financed through interest from Nebraska's tobacco settlement money, is providing an opportunity for communities to apply for maternal and child health related activities. Title V/MCH staff will be involved in preliminary reviews of these applications.

The Title V/MCH Director is a member of Nebraska's Public Health Team. This team is addressing cross-agency public health issues within the Nebraska Health and Human Services system. Among these issues is building adequate capacity to carry out the core public health functions. The Title V/MCH Director is specifically addressing Nebraska's public health statutes as a member of a subcommittee. This long-term project will help address some of the issues relating to enabling legislation and the impact on public health services, including those for the MCH population.

The Nebraska Public Health Improvement Plan, developed with support from the Turning Point grant from Robert Wood Johnson Foundation, is a blueprint to strengthen and transform public health in the state over the next several years. Eight strategies for change include building public health infrastructure at the community level, developing new and improved state-local partnerships, and creating a culturally sensitive and linguistically appropriate public health system to improve the health status of Nebraska's growing racial/ethnic minority populations. The latter strategies will be in conjunction with the work of the Minority Health Office.

#### **Initiatives/Work Groups with Title V Involvement**

The Governor-appointed Blue Ribbon Panel headed by the state's Chief Medical Officer is examining infant mortality rates in Nebraska. Subcommittees have been examining various issues related to infant mortality, including: access to quality care, SIDS, trauma, birth defects, prematurity, and racial ethnic disparities. The Panel is scheduled to release its first report late in 2000, but preliminary observations were considered in the needs assessment. Title V MCH staff have been actively involved in supporting the work of the Panel.

The Chief Medical Officer recently announced the intent to start a state Office of Public Health. Although the specifics of the development of this new entity are not yet available, the potential key responsibilities of the Office of Public Health will be: to coordinate the implementation of the Turning Point Plan for Public Health, coordinate strategies across the three state agencies in the Health and Human Service System, staff the teams for Public Health and Public Health Law, serve as a liaison to local public health departments and other community-based public health agencies, and coordinate the development of applications to the Nebraska Health Care Cash Fund Grant Program. This is a first step towards enhanced support of public health at the state level. However, the Office of Public Health is not mandated, nor does it have state appropriated dollars to support the structure or the activities of the office. Initially at least, the Office of Public Health is likely to be directed by

reassigned Department staff already in the midst of many of the activities now being attempted in separate units throughout the Department of Health and Human Services.

Quite new is the Every Child Wanted, Nurtured and Supported initiative. The steering committee will advise the Department of Health and Human Services on the design and implementation of methods to address teen pregnancies, unintended pregnancies, and non-marital births with the anticipated impact of improving the health and well-being of children and families. The Title V/MCH Director is the Project Leader for the initiative, and steering committee members include staff from three Title V community programs, Omaha Healthy Start, and an Abstinence Education community project. The steering committee is scheduled to make recommendations in the Fall of 2000.

The Nebraska Perinatal Care Quality Improvement Committee (PNCC) was established a few years ago to determine the current status of perinatal care provision in the era of managed care and to come to consensus in establishing guidelines for perinatal care. Over the past year, the committee has continued reviewing existing standards and guidelines for the provision of perinatal care, incorporating findings from data gathered, and drafting state-specific guidelines. The committee, consisting of practitioners, payers, advocacy groups, government agencies, community-based organizations, and consumers, has approved the format for the guidelines and continues the process of reviewing, editing and revising content. When content revision is complete, distribution, follow-up education and support by the group will follow in an effort to insure the product is appropriate for and well utilized by providers statewide.

Staff of the Family Health Division work with all of the Healthy Start projects in the state as they strive to reduce the disparity of infant mortality among minority populations. The state's Native American population has been served by the Northern Plains Healthy Start program over the past several years, while Douglas County's high infant mortality rate among the African American population is being addressed through the Omaha Healthy Start project.

### **New Legislation**

The Nebraska Unicameral passed and/or overrode Governor's veto of several bills this session that will have an impact on maternal child health. A bill requiring the creation of an Office of Women's Health passed the legislative body, but was vetoed by the Governor. The Legislature overrode the veto of the bill creating the office, but did not override the veto of the associated appropriation bill. This new office has been placed within Preventive and Community Health. The Title V/MCH Director is a member of its advisory committee, as required by the enabling statute.

Newborn hearing screening will be voluntary, universal screening with a goal of 95% of infants screened by December 1, 2003. If hospital participation does not reach this level, newborn hearing screening will become mandatory. The Newborn Screening Program's role will be to collect data, track, and monitor findings, and provide training.

Telehealth will be a health care delivery option for Medicaid-eligible clients beginning July 1, 2000. This results from a legislative bill passed a year ago which mandates Medicaid to develop a system and procedures for telehealth to increase service to Medicaid clients. Telehealth may reduce Medicaid costs. Telehealth is particularly appropriate for a sparsely-populated state with great geographic expanse. The anticipated impact for the state's women, infants and children including CSHCN and their families is service access, where the service is feasible via this technology, resulting in enhanced individual and public health. More information about Nebraska Medicaid's telehealth regulations is available on the Internet at [www.nol.org/home/sos/rules/hearings.htm](http://www.nol.org/home/sos/rules/hearings.htm).

### **Children With Special Health Care Needs**

The Medicaid/MHCP contract will continue next year with the programs supporting each other through referrals of children that can benefit from MHCP multidisciplinary teams found through Medicaid EPSDT examinations, as well as referrals to Medicaid from MHCP of children appearing to meet eligibility guidelines. The contract will also continue the practice of MHCP billing Medicaid for those Medicaid-eligible children seen at MHCP diagnostic and treatment planning multidisciplinary team clinics.

The MHCP Nurse Consultant and the Aged and Disabled Waiver Manager will continue to be members of the Medicaid Managed Care quality assurance efforts, and the MHCP Medical Director will continue as a member of the NHHSS quality assurance committee, which monitors the quality of programs system wide.

The Boys Town National Research Center, funded through SSDI funds, brought together MHCP, Early Intervention, Aged and Disabled Waiver, managed care plans, and other service/care coordinators together for joint training on accessing care. These sessions were designed to assure familiarity with each others' systems and processes to facilitate children with special health care needs and other persons with disabilities or chronic care needs access to medical care. The training executive committee included families of children with special health care needs, managed care plan personnel, and two MHCP service coordinators. Products as a result of this grant include: 1) "Medicaid Managed Care and Children with Special Health Care Needs: Access to Health Care Services," a report on year-one activities (March 1998); 2) a care coordination matrix for children with special health care needs, by a Medicaid Managed Care Work Group on Training (Summer 1999); 3) "Care Coordination for Children with special Health Care Needs, a multidisciplinary training (Summer 1999); and, 4) video tapes of the training and of Medicaid Managed Care Plans/HHS Services Coordinators. The primary video is a summary of the training and conversations with the Medicaid Managed Care Quality Assurance Administrator.

MHCP staff is also working with a new MCH planning grant for the planning of a Traumatic Brain Injury System. The Administrator is a member of the Advisory Board. The MCH grant was obtained by the Nebraska Department of Education in concert with the Nebraska Brain Injury Association. Other agencies represented on the Board and members of the technical advisory panel include: Vocational Rehabilitation, and providers of rehabilitative and support services to develop a Traumatic Brain Injury Network in Nebraska. Planning for such a system will range from acute care to long-term supportive and rehabilitative services. Factors such as facilities, outpatient care, and living within the community with supportive services will be included in this network, which hopes to address the inadequacy of any continuum of appropriate services for survivors of brain injury.

In the MHCP program, planning has begun to include greater involvement of families receiving services through the program. The Family Partner member of the state's Early Intervention Program planning and administration is a full-time employee of the Nebraska Parent Center in Omaha. She is a parent of a child with special health care needs, is active in numerous Early Intervention organizations, and is active on advisory committees and planning for all children with special health care needs, including those served by MHCP. She has attended the AMCHP conference in 1998 and 1999, and was a member of a Regional Title V/MCH Block Grant review team for the FY 1999 applications. Her role in regard to planning for this program will continue to increase. She is a member of the MCH Needs Assessment Team (as are other parents of CSHCN) and reviews change in policy and services for CSHCN. She currently is the Children With Special Health Care Needs listserv monitor on the Family portion of the Nebraska Network for Children and Families website, (<http://www.nncf.unl.edu>) (NNCF). There are

currently over 100 families of children with special health care needs members of this listserv. Her leadership abilities to get others involved has contributed to the growth of this listserv and has assisted MHCP in gaining greater family involvement. During the past year, families, multidisciplinary team members, services coordinators (of all programs for children) were asked to suggest another name for the multidisciplinary team clinics held for CSHCN instead of using the terms for Cerebral Palsy, Craniofacial, Mid-Line Neurological Birth Defects and Juvenile Rheumatoid Arthritis. Families were included in this through the listserv at NNCF and contributed to the final selection. The Survey results of 150 families that attend the CSHCN multidisciplinary team clinics during the 2000 fiscal year are under review. However, they did indicate an involvement of families helping families related to these clinics. This will be considered as input on survey results are obtained and planning continues.

In addition to working closely with Medicaid, both the MCH and CSHCN programs work collaboratively with a number of other agencies and programs in Nebraska to address health issues for the maternal and child population, including children with special health care needs, most often through systems development. Several examples follow: 1) An example of this is a quality assurance system for diabetic care to assure the same quality of service to the rural and minority populations as the urban and non-minority populations and a system for the ongoing assessment of newborn graduates of the Neonatal Intensive Care System in Nebraska. 2) The Nebraska March of Dimes has been a lead partner in the five-year needs assessment process. March of Dimes is also involved in various initiatives at the state level, including the Governor's Blue Ribbon Panel to identify the contributing factors to Nebraska's stagnant infant mortality rate. 3) The Nebraska Pregnancy Risk Assessment and Monitoring System (PRAMS) is coordinated by an experienced, doctoral-level MCH epidemiologist, employed by the University of Nebraska Medical Center and officed in the Family Health Division. In its second year, Nebraska PRAMS is building capacity to collect state-specific information, analyze it, and apply data to plan, evaluate, and improve public health programs, systems of primary care, and influence public policy. In addition to Title V funds, Nebraska PRAMS has received funding and technical assistance from the Centers for Disease Control (CDC) this year to more fully support the work, especially in the complex process of weighting data for analysis. A minimum 70% survey response rate is needed for validity to strengthen the generalization of the sample results to the entire population of Nebraska women whose pregnancies resulted in a live birth.

During the past year, several state-level initiatives have begun which address a wide range of maternal and child health issues. The Title V/MCH Director and Title V/CSHCN Director are both members of the Children, Youth and Families Services Integration Team. This team is seeking ways to better coordinate and integrate the wide range of services provided by the Department of Health and Human Services, including child welfare, economic assistance, developmental disabilities services, Medicaid, juvenile services, public health services, and behavioral health. A separate initiative, lead by the Lieutenant Governor, is specifically addressing integration as it relates to early childhood care and education. This collaborative effort includes both Health and Human Services and the Department of Education. Again, both the Title V/MCH and CSHCN Directors are participants in this activity. This initiative was stimulated in part by a new law merging three advisory bodies dealing with early childhood issues: the Nebraska Interagency Coordinating Council, the Child Care and Early Childhood Education Coordinating Council, and the Head Start State Collaboration Team.

### **Title V Subgranting Process**

Title V funds were subgranted to community-based programs for FY 2000 through a competitive application process. The last competitive process prior to FY2000 was FY 1996, so a significant number of new programs were hoping to receive an award. Over \$6 million in applications were received, while only approximately half of Nebraska's allocation, or \$2.2 million, was

available for subgranting to community-based programs. (The remainder of the allocation supports state-level, population-based programs.) Since Title V funds are the major source with which Nebraska currently addresses maternal and child health issues, many programs were not funded, while others previously funded had the award level reduced. The reductions allowed an opportunity to broaden the base by funding new initiatives or agencies that more equitably represent the geographic expanse of the state. Twenty out of forty-four applicants were awarded. Two additional programs received funds as part of a previously established five-year commitment through combined services plans, where the agency strives to integrate a range of services in the sparsely-populated Panhandle region of Nebraska, in conjunction with state-level administrative oversight of multiple funding streams. Funds for FY 2001 (Year 2) were offered non-competitively and only the group of subgrantees funded in FY 2000 (Year 1) were eligible to apply. Agencies were required to update their work plans and budgets, with the expectation that the programs would not dramatically change. These continuation requests are currently under review.

The first-time Title V-funded programs beginning in FY 2000 include three tribal-based programs that address infant mortality or prenatal care issues. Two of the three are previous Healthy Start projects, and the third had opened last year a health clinic in south Omaha to serve all Native Americans in the area and will use Title V funds to support the addition of prenatal care services in this location.

Each of the 14 subgrantees in non-competitive FY 1999 received an award of \$7,000 in addition to their project funding. This additional award was intended to support activities that would create a role specifically for maternal and child health programs within health and human service networks that were being developed regionally throughout the state. Results of this emphasis on building infrastructure will be reflected in the reporting forms in Nebraska's Annual Report for FY 1999 contained in the document herein. Creative strategies were implemented all around Nebraska, and in particular, the Omaha grantees engaged in a process that has the potential to streamline MCH services, reduce competition among agencies, and help the community fill in the gaps of missing services. Through a collaborative effort of the four Title V grantees in Douglas County, plus the North Omaha Healthy Start project, a contract was negotiated with the Nebraska Children and Families Foundation to establish and lead the Douglas County Services Coordination and Integration Committee. The committee, representing diverse interests within the communities, worked to identify strong concerns of providers and consumers and determined the focus of the project to be "Access to a well managed unified system of care." Working with Dr. Catherine Alter from Denver University, data were then collected on county referral patterns which were analyzed to reflect the way the current system works, and to determine implications for future "systems integration" work.

#### **Toll-free Hotline.**

The Perinatal, Child and Adolescent Health Program continues to contract with the Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's Title V toll-free telephone line. The HM/HB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, Title V and Title XIX provider information, and referrals. Efforts continue to improve the quality and increase the usage of the line. Recent additional uses of the line include newborn screening disorder-specific health and referral information, Kids Connection information, folic acid supplementation information and referral information related to perinatal substance use/abuse for Douglas County (with plans of expanding this to statewide service within the next three years). Monthly call report data are tracked and analyzed in order to guide publicity efforts. These data also show that publicity efforts continue to pay off. When the line first began in 1992, calls averaged at 7 per month. In FY 1999, the average was 64 per month. A substantial portion of referrals have gone to medical

services, including Title XIX services and related social services. The HM/HB Helpline staff have received training on Kids Connection. The state-level contact person for the helpline has changed as a result of a staff change and subsequent reconfiguration in the Family Health Division's organizational structure, although the responsibilities of the position remain largely the same as prior to the reconfiguration and staff change.

The Perinatal, Child and Adolescent Health (PCAH) unit manager continues to serve as the National Healthy Mothers/Healthy Babies Coalition's Region VII Coordinator, although recently a collaborative effort was initiated in a sharing of the responsibility with the March of Dimes, Nebraska Chapter, Director of Program Services. Because the Regional Coordinator position is designed to improve the national-level organization's ability to communicate with and support states, it is anticipated that this increased capacity will better serve the states in the region, facilitating use of the National HMHB Coalition's support and expertise in work with mothers and children.

### **4.3 Public Input**

Nebraska's Title V/MCH Block Grant Application for FY2001 funds was first released for public review and comment in April, 2000 beginning with the preliminary list of priority health needs which resulted from the five-year needs assessment conducted this year. Copies of the list of preliminary priority health needs were mailed directly to an "interested persons list" of approximately 800 persons and agencies involved in issues related to the MCH population throughout Nebraska. Responses helped to develop Nebraska's updated MCH priority needs upon which the Application was built. The mailing also announced the website where the list could be accessed on the Internet. Approximately 100 requests to review the application were received. A public notice was also placed in Nebraska newspapers. A variety of comments and recommendations were received and incorporated in this process. The final version of this Application incorporated recommendations received from the public.

### **4.4 Technical Assistance**

The one technical assistance need Nebraska requested for FY 2000 was not accomplished, i.e. regarding oral health for children with special health care needs. Families of children with special health care needs often do not access oral health services, as they have so many other more immediate health concerns to address. As a result, something which might be a precursor to other health problems is not prevented, and ensuing problems arise. The survey conducted in FY 2000 of families participating in the Medically Handicapped Children's Program multidisciplinary clinics did not yield the information necessary to assess the reason that families underutilized oral health services, although the survey identified that 86% of the respondents indicated that their child with special health care needs has a dentist. The need for this technical assistance continues, so the request is carried over for FY 2001.

The higher priority for technical assistance for FY 2001, however, is the need to address grant allocation methodologies to develop strategies to best address Nebraska's maternal and child health priorities. Specifically, this includes a look at the pros and cons of competitive versus non-competitive subgranting, including formula funding.

With both technical assistance requests for FY 2001, Nebraska seeks recommendations from MCHB for qualified individuals to provide training to the relevant Nebraska representatives with respect to each request.

## V. SUPPORTING DOCUMENTS

### 5.1 GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [Title V Sec. 501(b)(3)]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. [Title V Sec. 501(b)(4)]

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (For planning and systems development) Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

#### 1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

#### 2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and

training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

### 3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

### 4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19\_\_." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the Federal Title V Block Grant allocation, the Applicant's funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the State funds (the total matching funds for the Title V allocation - match and overmatch), Local funds (total of MCH dedicated funds from local jurisdictions within the State), Other Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and Program Income (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

## 5.2 Assurances and Certifications

### ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace,
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
    - (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight  
Office of Management and Acquisition  
Department of Health and Human Services  
Room 517-D  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant

organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

**5.3 Other Supporting Documents**  
(No Documents Included)

## 5.4 Core Health Status Indicator Forms

## 5.5 Core Health Status Indicator Detail Sheets

## 5.6 Developmental Health Status Indicator Forms

## 5.7 Developmental Health Status Indicator Detail Sheets

## 5.8 All Other Forms

## 5.9 National “Core” Performance Measure Detail Sheets

**5.10 State “Negotiated” Performance Measure Detail Sheets**

**5.11 Outcome Measure Detail Sheets**