

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **NE**

APPLICATION YEAR: **2005**

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and Certifications, signed by Director, Nebraska Health and Human Services, are maintained in the administrative files for Nebraska Title V/MCH Block Grant located in the Office of Family Health, MCH Planning & Support. The documents may be inspected by contacting the Title V/MCH Grant Administrator, (402) 471-0197 during regular business hours Monday-Friday, 8:00 a.m.-5:00 p.m. Central Standard Time, or sending a written request to Nebraska Health and Human Services, Office of Family Health, P.O. Box 95044, Lincoln, Nebraska 68509-5044.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

This is updated in its entirety.

***/2005/ Public Input on Nebraska's Title V/MCH Block Grant Application for FY2005 funds was solicited through a: 1) A public notice was printed on June 6, 2004 in the "Omaha World Herald" newspaper, the daily newspaper with statewide coverage and the largest circulation of any Nebraska newspaper, which read:***

***The Nebraska Department of Health and Human Services is seeking public input on its application to the federal government for Title V/Maternal and Child Health Block Grant funds for the period of October 1, 2004 -- September 30, 2005. This application addresses statewide health needs of women, infants, children, adolescents, and their families, including children with special health care needs. Persons wishing to provide such input should do so on or before June 25, 2004, by mailing to Nebraska Health and Human Services, Office of Family Health, Attn: MCH Planning & Support, P.O. Box 95044, Lincoln, NE 68509, or faxing to 402-471-7049, or sending an e-mail to [family.health@hhs.state.ne.us](mailto:family.health@hhs.state.ne.us). Guidelines for input, including an outline of the application, may be found on the internet at [www.hhs.state.ne.us/fah/blockgrant.htm](http://www.hhs.state.ne.us/fah/blockgrant.htm).***

***2) Information regarding Nebraska's MCH Block Grant Annual Plan was available on the Office of Family Health website, and can still be accessed for grant reviewers' information.***

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### III. STATE OVERVIEW

#### A. OVERVIEW

//2003/ This section has been revised in its entirety.//2003//

//2004/ This section has been revised by removing illustrations and charts, and references to same. It has also been edited to remove non-critical information in order to stay within page/character limits. Substantive changes noted when appropriate. //2004//

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

##### a. Large geographic area

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

Nebraska's large land expanse creates unique health service delivery issues. In rural counties, 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

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

##### b. Urban and rural

The total population of NE is projected to grow 11% by 2020. Although Nebraska's total population has grown considerably during the 1990s, many small rural counties that are not near a regional economic or health center continue to decrease in size. Most of the decrease in these counties resulted from out-migration of the younger population (18 to 45 years). Smaller population bases make it more difficult to recruit and retain physicians and other health care professionals. A small population base also makes it more difficult to operate institutional services, such as hospitals, and finance other types of services such as mental health, public health, emergency medical services, and long-term care services.

Nebraska's geography shows the state to be a primarily rural and sparsely populated state by national standards, with 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 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.

##### c. Increasing diversity

***//2005/Another source of change is Nebraska's rapidly increasing diversity in a state previously regarded as homogeneous. Nebraska currently has its highest percentage of foreign-born residents since the 1870's. Minority populations are growing rapidly in both urban and rural parts of Nebraska. According to the US Census, the state's minority population grew by 23% between 1980 and 1990, and racial/ethnic minorities were found in every Nebraska county. From 1990 to 2000, the minority population rose by 83.5% (from 118,162 to 216,769) and now constitutes 12.7% of the total population while the white population increased by 2.2%. Most of this increase in minorities is of Hispanics, whose numbers increased 255%, 40% of the ste's***

**overall population increase. However, they are not alone. Nebraska may have one of the largest Sudanese communities in the country. Numbers of Sudanese, Somalian, Bosian and Vietnamese residents have jumped over the past decade.//2005//**

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

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

#### (1) Immigration

##### (a) Hispanic origin

The largest minority group in the state is the Hispanic American population which experienced the most dramatic increase by more than doubling from 37,200 in 1990 to 94,425 in 2000 (a 153% increase) according to the U.S. Census. Hispanic Americans now comprise 5.5% of the state's population. In 1999, Nebraska ranks fifth in the nation for percentage change of Hispanic population from 1990-1999. In 1999, NE ranks 22nd in the country for the overall percent (4.6%) of the population that is Hispanic. Douglas County, in 1999, had a Hispanic population of 24,529 people. Not surprisingly, these are the highest numbers in the state. Douglas County also experienced the largest "net international migration" from 1990-1999 of 4,449 people.

The Hispanic American population is expected to increase considerably by 2025. It is estimated that the number of Hispanic Americans in the state will reach 145,000 by 2025, nearly double (+99%) the current population. With the availability of employment, the Hispanic population in the central and western part of Nebraska has increased considerably. According to the U.S. Census, Dakota, Dawson, Colfax, Scotts Bluff, Hall, and Morrill counties have a Hispanic population greater than ten percent.

##### (b) Asian and Pacific Islander

NE also ranks fifth in the nation for percentage change (+78.7%) of Asian and Pacific Islander (API) population from 1990-1999, from an API population in 1990 of 12,629 to 22,574 in 1999, according to the U.S. Census Bureau. NE ranks 30th in the country for the overall percent (1.4%) of the population that is API. The Asian/Pacific Islander population is expected to increase considerably by 2025. The Census Bureau estimates that this population will reach 40,000 people, an increase of 90%.

#### (2) Native American

The Native American population in Nebraska grew by 15.7%, from 12,874 in 1990 to 14,896 in 2000, according to the U.S. Census. Native Americans currently comprise 0.9% of Nebraska's total population. Thurston County, home of the Omaha and Winnebago Tribes, ranks number 26 in the U.S. for percentage Native American. Almost half of the county's population is Native American (48%). Four federally recognized Native American tribes are headquartered in Nebraska, the Santee Sioux, Omaha, Winnebago, and Ponca. Three additional tribes, the Oglala Sioux (Pine Ridge Reservation), Iowa, and the Sac and Fox have reservation land located in Nebraska. The Native American population is expected to increase considerably by 2025. Nebraska's Native American population will increase to 25,000 people, an increase of 67%.

Though many of Nebraska's Native Americans live on reservations, the majority does not. The urban areas of Omaha and Lincoln accounted for more than 37% of the state's Native American population, although they make up only a small proportion of these counties' total populations. A sizable group

also exists in the northwestern part of NE adjoining the Pine Ridge Reservation in South Dakota. Among the state's reservations, the Winnebago and Omaha reservations in Thurston County account for 22% of Nebraska's Native American population. An additional 3% reside at the Santee Sioux Indian Reservation in Knox County. The Iowa and the Sac and Fox Indian Reservations on the Nebraska-Kansas border account for about 1% of Nebraska's Native American's total population.

### (3) African American

***//2005/African Americans make up 4.0% of the Nebraska population. This population grew from 58,047 in 1990 to 68,541 in 2000, an 18.1% increase. The African American population is expected to increase considerably by 2025, with growth projected at 63% (to 109,000 people). Almost 90% of Nebraska's African American population are located in the most populous counties (Douglas, Sarpy and Lancaster). This growth is fueled by a large number of African immigrants, particularly from Sudan and Somalia; Nebraska may have one of largest Sudanese communities in the country.//2005//***

### (4) Minority Health Professionals

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

While Nebraska has become an increasingly diverse state, its medical practitioners have not. In 1999, only about one percent of Nebraska physicians was African American, although this group makes up 4% of the state's population. This is less than the U.S. average; approximately 4% of all US physicians are African American. Only eight Native American physicians practice in NE (0.3% of all physicians) yet this minority group makes up 0.9% of the population.

People of Hispanic origin comprise 4.4% of the state's population and are the fastest growing population group, but account for only 1.2% of Nebraska physicians. This represents a drop of almost one half percent in the proportion of physicians in the state who reported Hispanic ethnicity in 1994. Asian Americans are well represented in the physician population. This group makes up only 1.3% of the population of the state, but accounts for 4.8% of physicians.

Additional barriers of receipt of health care were identified for racial and ethnic minority women in Nebraska. One-third of Asian American women (34%) and 12% of Hispanic women reported that language "always," "nearly always," or "sometimes" kept them from getting needed health care, according to a Nebraska Minority Behavioral Risk Factor Survey (NMBRFS).

Respondents to the NMBRFS were asked whether or not they felt racial or ethnic origin is a barrier to receiving health care services in their county. Nearly half of African American women (45%), 40% of Native American and 38% of Hispanic women "strongly agreed" or "agreed" that race or ethnic origin is a barrier. More than one-fourth (28%) of Asian American women expressed agreement with this statement.

### (5) Racial and ethnic health disparities

As in other states, Nebraska's minority population has many health disparities. For example, according to an April 2001 report from the NHHSS Office of Minority Health, life expectancy for a Nebraska woman who is white is almost eight years longer than for a Nebraska woman who is African American and more than eight years longer for a Nebraska woman who is Native American. African Americans have the highest rates of low-weight births and infant deaths in Nebraska. Native Americans in the state are four times more likely to die of diabetes-related causes than white persons.

The CDC's "Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality" showed that Nebraska has one of the highest heart disease death rates in the country for African American and Native American women.

#### d. Aging population

Another significant trend is the aging of the state's population. In 2000, the percentage of the population aged 65 and older was 13.6%, compared to the national average of 12.4%. The total number of Nebraskans over age 65 increased by 4.1%, or by 9,127 individuals, from 1990 to 2000. Nebraska ranks 11th in the nation for percentage of population 65 years and over, however NE ranks only 44th in the nation for percentage change from 1990 to 2000. The population over 65 is projected to grow 48% by 2020. Nebraska ranks 6th in the nation for percentage of the population aged 85 years and over at 2.0%. This is a slight increase from 1990 (1.9%). The total number of people aged 85 and over increased by 4,751 individuals, or by 16.3%. NE ranks 50th in the nation for percentage change from 1990 to 2000.

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%. Hooker County, Nebraska, ranks 2nd of all U.S. counties for percentage of population over 85 years of age at 6.3%. Nebraska has 17 counties (18%) of its counties in the top 100 of all U.S. counties for percentage of population over 85 years of age. The median age of Nebraskans increased from 33.0 in 1990 to 35.3 in 2000.

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

#### e. Special populations

##### (1) Incarcerated

In Nebraska the number of women incarcerated has grown 265% from 1985 to 1998. Using national estimates, 63% of incarcerated women have at least one minor child, and approximately 40% have more than one child under age 18. Nationally, 2.1% of the nation's children had a parent in State or Federal prison. African American children were nearly 9 times more likely to have a parent in prison than white children. Hispanic children were 3 times as likely as white children to have an inmate parent. The number of children with a mother in prison nearly doubled since 1991, while the number of children with a father in prison grew by 58% during this period.

##### (2) Homeless

/2004/ Subsection deleted due to inadequate time to research and present updated, relevant data at the time of this application. //2004//

***/2005/The Nebraska Homeless Assistance Program (NHAP) makes funds available to nonprofit organizations through grant awards in order to serve the needs of people who are homeless and near homeless in the state. According to NHAP data, 13,282 people were homeless in Nebraska during the grant year July 2002 to June 2003 and 31,979 people were near homeless during this same time period. The data is limited to numbers provided by monthly NHAP Reports received from NHAP grantees.//2005//***

##### f. Rural poverty

/2004/ Seven of the nation's 12 poorest counties in 2001 were in Nebraska (US Dept. of Commerce). For the 2nd year in a row, Loup County ranked as the nation's poorest (per-capita income of \$6,235 vs. national per-capita income of \$30,413.//2004//

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

***/2005/ This Subsection 2 of the Overview has been revised in its entirety.***

***Two major initiatives unfolded during FY 2004 that have and will continue to dominate the agenda for Nebraska's Health and Human Services System: Child Protection Reform and Mental Health Reform. Both have potential to significantly impact the work of the Office of Family Health and Title V supported projects.***

***Child Protection Reform came as a response to public reaction to a reported increase in violent child deaths that occurred in recent years. Twenty-one violent deaths occurring since 1998 were highly publicized and a Governor's Children's Task Force was formed to examine these deaths and make recommendations. The 36-member task force called upon the Nebraska Child Death Review Team (CDRT) to assist with the examination of these deaths. The CDRT, administratively housed within the Office of Family Health, identified an additional 9 violent deaths during the period of 1998 - 2003 and thus reviewed the circumstances surrounding a total of 30 deaths, and reported its findings to the Task Force in November 2003.***

***The Governor's Task Force made its report to the Governor in December 2003 and the Governor responded with his priorities in January 2004. His priorities fell into 3 major areas: prevention, accountability, and investigation and prosecution collaboration. Working with the State Legislature, these priorities were translated into LB 1089, a funding bill that was signed into law in April 2003. This bill specifically allocates \$5.5 million to fund 120 new protection and safety workers in the Department, and another \$350,000 for case coordinators at six existing Child Advocacy Centers and a 7th site to be established. Funds were also allocated to support enhancements of the Criminal Justice Information System, development of a public education campaign, training for law enforcement and medical professionals, and related recommendations.***

***Implications of child protection reform for the Office of Family Health were immediate, with involvement of the Child Death Review Team assisting with the analysis of violent child deaths. The Child Death Review Team is also about to issue a report of all child deaths for the period of 1996 through 2001, and will include additional recommendations regarding the prevention of violent deaths and deaths associated with caregiver neglect.***

***The recommendations of the Governor's Task Force and the resultant priorities established by the Governor are informing a number of planning activities within the Office of Family Health, such as Together for Kids and Families, Nebraska's State Early Childhood Comprehensive Systems (SECCS) project. The issues of child protection have the most significant relevance to the family support and parent education components of the SECCS project. It must be noted that the vast majority of the recent violent deaths in Nebraska were among young children, and were often associated with adult caregivers responding inappropriately to normal behaviors of infants and toddlers (crying, toilet training issues, etc.).***

***This initiative has given further momentum to Office of Family Health partnerships with others interested in violence prevention. For instance, staff have participated in preparing a grant application to CDC for a childhood violence prevention planning grant. Other similar opportunities will be explored in the future. Eventually, a more clearly defined role will be established for the Office and its Title V/MCH funded programs in carrying out prevention activities on issues such as Shaken Baby Syndrome.***

***The next major initiative to recently emerge for the Nebraska Health and Human Services System is mental health reform. Led by the Governor and the Chair of the Legislature's Health and Human Services Committee, the planning for this reform was carried out during 2003, with the enabling legislation introduced and then signed into law in 2004. LB 1083 establishes the blue print for reforming behavioral health in Nebraska. This law establishes the Behavioral Health Division within HHS and creates a State Behavioral Health Council. The focus of this system reform effort is to ensure statewide access to behavioral health services; ensure high***

**quality behavioral health services; ensure cost-effective services; and ensure public safety and the health and safety of persons with behavioral health disorders.**

**This reform initiative has as an immediate goal the movement of behavioral health from institutional care to community-based services for persons with chronic and severe mental health disorders. Over time, opportunities exist for building greater community capacity for prevention and early intervention services for behavioral health needs of special concern among the MCH population, such as perinatal depression and early childhood socio-emotional development issues. The Offices of Family Health and Aging and Disability Services will need to be involved in regional and community based planning to assure that these needs are met in the newly designed system.**

**In addition to the two major initiatives described above, one other major project has had significant impact on the NE HHSS. LB 692, signed into law in 2001, has resulted in the creation of local health districts statewide. All 93 Nebraska counties are served by a local health department, compared to just 22 counties in 2001. This tremendous growth in public health infrastructure has given MCH focused programs new avenues for building capacity within communities.**

**To build that capacity, a component was added to the method for allocating funds for community based projects, starting with FFY2003 awards. The new component was a specific set-aside for local health departments meeting the requirements of LB 692, with the funds to be used specifically for infrastructure building. These new local health districts have become partners in a number of MCH activities, including the Comprehensive Integrated Women's Health in State MCH Programs project.**

**Though issued in 2000, the report of the Governor's Blue Ribbon Panel on Infant Mortality continues to provide broad guidance to the Office of Family Health in planning and evaluating activities. Several projects underway or soon to be started are relevant to the Panel's findings and recommendations. Examples include SIDS risk reduction and breastfeeding promotion, activities that are described in more detail in other sections of this application.**

**Looking forward, an emerging priority for the NE HHSS is the issue of obesity/overweight. There has been a gradual intensification of attention to this growing problem among both children and adults. The Nebraska WIC Program has been incorporating physical activity into healthy nutrition for children educational efforts. Nebraska's breast and cervical cancer screening program (Every Woman Matters) has added the Wise Woman component, which includes a focus on physical activity/healthy weights. The Women's Health Council has established physical activity and cardiovascular health as a priority and has supported a number of promotional activities.**

**Most recently, and of true significance, were two collaborative projects related to overweight among Nebraska's children. First was the recent issuance of a report titled "Overweight Among Nebraska Youth." This report, using height/weight data converted to BMI for over 40,000 Nebraska school children shows that a third of Nebraska's school age children are overweight or at risk of being overweight. Released in June 2004, this data is serving as a call to action for the public health community. The report was prepared by the Department's Cardiovascular Program, with assistance in obtaining the data provided by the Office of Family Health's School and Child Health Nurse Coordinator. Then, the Office of Family Health assisted with the planning, promotion and coordination of a VERB conference targeting pre-teen girls and their mothers, coaches, club leaders or other involved adult. The one-day event held June 26, 2004 at Northstar High School in Lincoln, drew over 400 girls and adults. Action-packed activities were offered for the girls, such as basketball, clogging, baton twirling and softball. Adult sessions focused on family activities and ways to support healthy development for their daughters. The conference was supported with funding from the CDC and Region VII Office of Women's Health, through grants to the Office of Women's Health.**

//2005//

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

/2004/This section has been revised in its entirety.

During 2001 a consultant assisted the Department in determining strategies for investment of Title V/MCH Block Grant Funds. This consultation was an important step in developing the framework for external allocation of Block Grant funds for the period beginning FFY 2003. This framework considered a variety of factors, including the availability of tobacco settlement funds to support local health departments and a concurrent need to support Tribal MCH efforts as part of a government-to-government relationship.

Subsequent to this allocation process and the award of funds in support of 31 projects, the State faced a number of financial challenges. The Nebraska Legislature made many difficult decisions to balance the state budget. The elimination of state general funds and tobacco settlement funds for tobacco prevention activities is but one example of reductions in funding for health related programs. In addition, significant changes have been made in Medicaid eligibility and childcare subsidy. The NE Health Care Cash Fund, which supported community-based public health activities through the use of interest earned on tobacco settlement funds, is to be eliminated.

With this erosion in financial resources, Nebraska's Title V/MCH Block Grant funds will play a critical role in sustaining key activities. The goal for FY 2004 and FY 2005 is to honor the 3-year commitments made to support external projects begun in FY 2003. Stability of these projects will be crucial as other resources are diminished.

In addition to these external projects, Nebraska Title V/MCH Block Grant funds support a wide array of programs and activities within the HHSS. Many of these programs are part of the basic public health infrastructure and depend on the Block Grant as a primary funding source. These programs, such as newborn metabolic screening, birth defects registry, and child death reviews, will be a higher priority for continued funding. Other projects are being funded on a year to year basis, such as the fatherhood initiative. These will need to be carefully evaluated annually and will be lower priority when rationing the block grant funds.

In conclusion, stability of infrastructure and maintenance of current efforts will be the primary determinants of how Title V/MCH Block Grant funds will be invested in the upcoming fiscal year. The downside of this approach is that there will be little flexibility to address emerging issues. As a remedy, the Office of Family Health and its collaborators have and will continue to be more aggressive in seeking competitive funds from a wide array of sources.//2004// ***/2005/ Examples of grant opportunities pursued this current year include submittal of an application for a perinatal depression grant and collaboration with other units of the HHS System for a violence prevention grant and a healthy weights for women grant.***

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

***/2004/ This section has been revised in its entirety.***

***Details are provided above regarding a wide range of issues, including large geographic area, urban and rural differences, increasing diversity, racial and ethnic health disparities, an aging population, and special populations. In addition, the realities of diminishing state resources were described. Taken together, these are the primary challenges to the delivery of Title V services, but not the only challenges.***

***As previously stated, Medicaid eligibility changes have been made in response to state budget shortfalls. As a consequence, thousands of low income children and parents no longer have Medicaid coverage. These reductions in coverage have and will continue to stress Block Grant funded services, particularly the Medically Handicapped Children's Program, which has long been a gap filler for those children not eligible under Medicaid.***

**Health professional shortages have been a longstanding challenge for delivering MCH services across the state. Thirty-four of 93 counties are considered all or partially included in a Health Professional Shortage Area. The number of Federally Qualified Health Centers (FQHCs) has grown to 9, but these centers do not begin to address the vast distances some families have to travel to receive care.**

**At the operational level, MCH and CSHCN staff have needed to respond to issues such as HIPAA privacy standards and a new state accounting system. Though neither is directly impacting delivery of services, both require diversion of manpower resources to training, revision of procedures, and/or technical assistance to communities. These activities detract from planning, program development, quality assurance and other MCH/CSHCN activities.**

**Though difficult to quantify, September 11, 2001 and resulting home land security efforts have had an impact on MCH services. In the long run, infusion of bioterrorism funds will help build infrastructure and capacity of the public health system in Nebraska. In the short run, some of these efforts have diverted resources. For instance, the newly formed local health districts had to quickly give attention to bioterrorism assessments and small pox vaccinations.**

**Historically, Nebraska has been challenged in meeting match requirements for the Title V/MCH Block Grant at the state level, resulting in a significant dependence on local match sources. This situation will likely become more acute over time, as state general funds become scarcer and tobacco settlement funds are further diverted to other uses. At the same time, local match has usually included considerable amounts of Medicaid reimbursement as match. With fewer children now eligible for the program, that income will be reduced and thus negatively impacting local match (as well as the obvious disadvantage to children at risk). These compounding factors, though not a crisis this year, may become so in the future.**

**In summary, Nebraska's greatest challenges in providing MCH/CSHCN services are: widely and unevenly dispersed populations; increasingly diverse populations; significant health disparities among racial/ethnic minorities; shortages of health professionals primarily in rural areas; diminished financial resources; and increased demands on existing infrastructure.//2004//**

## **B. AGENCY CAPACITY**

Community level agencies provide a number of services that encompass all levels of the public health pyramid. Primarily, MCH services include: home visitation; assistance with prenatal care; 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.

/2004/ During FY 2002, a set-aside was created to support MCH infrastructure development within existing and newly formed local public health departments. This set-aside strengthened Nebraska's long-standing emphasis on this level of the pyramid.//2004//

Preventive and primary care services for pregnant women, mothers, infants, and children are provided through these agencies, several of which have a long-standing relationship with Title V in Nebraska. These grantees will receive funding through September 30, 2002.

/2004/ The current grant cycle runs through September 2005 for most projects. Two projects are being funded on a year-to-year basis, depending on the availability of funds.//2004//

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, MCH Epidemiology Unit(which includes the Child Death Review)

and PRAMS; Newborn Screening and Genetics; Office Minority Health; Office of Women's Health; Dental Health; Reproductive Health; STD's; along with funding for the Birth Defects Registry. /2004/ Also funded within HHSS effective October 1, 2002 is the Office of Economic Assistance for its fatherhood initiative. //2004//

Also at the state level, one program provides the majority of Title V-funded services to CSHCN -- the Medically Handicapped Children's Program (MHCP). Located in the Office of Aging and Disability Services, 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.

/2004/ The Disabled Children's Program (DCP), which is a component of MHCP, provides funding to help families care for their children with disabilities at home. A family focused assessment process determines the need for services. Some of the funded services include: respite care; mileage, meals and lodging for long-distance medical trips; special equipment and home/architectural modifications; and care of siblings while care is received by the child with a disability/special need. The Disabled Children's Program (DCP) was designed to serve children who have a special health care need, receive monthly Supplemental Service Income (SSI) checks, are 15 years of age or younger, and live at home with their families. //2004//

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. PHINE (Public Health Information for Nebraska) is currently available on NHHSS' intranet system. /2004/ PHINE is just one example of the numerous data projects that have been developed and/or supported through Nebraska's State Systems Development Initiative (SSDI) grant. More recently, SSDI funds have been allocated to help support a wide range of data projects throughout HHSS, including the YRBS, BRFSS tobacco questions, the Adult and Youth Tobacco Surveys, and injury prevention data analysis. //2004//

***/2005/ PHINE is no longer an active project, due to difficulties with software and other logistics. //2005//***

In Nebraska, statutes pertaining to maternal and child health are found in Chapter 71, sections 2201-2208. The duties concerning the responsibility of the Nebraska Health and Human Services as to the federal early intervention program are found in 43-2509. Statutes requiring the birth defects registry are found in 71-645 through 648. Metabolic screening and associated responsibilities are found in 71-519 through 71-524. The Medically Handicapped Children's program was addressed in 71-1401, et seq. Finally, CSFP is found at 71-2226 and WIC at 71-2227. /2004/ NRS 71-1401 et seq has been repealed. //2004//

A number of key pieces of legislation was passed in the 2000 legislative session including the newborn hearing screening program. More information is found in section 1.4. Another important

piece of legislation was appointment of a Women's Health Advisory Council and the creation of 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. Additional information about the Office of Women's Health is found in section 1.4. A 2001 key piece of legislation was LB 692 which appropriated money to minority health and public health. This legislation was discussed more fully in Section 1.4. Finally, a relevant piece of legislation passed in 2002 is LB235. This legislation enhanced Nebraska's newborn metabolic screening program. This is best described in section 1.4.

//2004/ All references to section 1.4 should now read Section IIIA.//2004//

***//2005/ In 2003, LB 407 was signed into law which allocated \$1,620,000 in tobacco settlement funds to the Lifespan Respite Services program for the biennium from July 1, 2003 through June 30, 2005. Use of this source of funds for respite care has allowed expansion of this service and has resulted in more MHCP funds being devoted to medical and rehabilitative services.//2005//***

## C. 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 Office 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 Office of Family Health who is also the Title V/MCH Director. This unit is comprised of the MCH Grant Administrator, Epidemiology Surveillance Coordinator, Community Health Nurse and Administrative Assistant. The MCH Planning and Support Unit is staffed by a total of 4.0 FTE. ***//2005/ Early in FFY 2004, the MCH Planning and Support Unit was modified, and now includes only the Federal Aid Administrator and an Administrative Assistant, for a total of 2.0 FTE. Data functions previously a part of this unit were moved to a newly created MCH Epidemiology Unit. //2005//***

Other programs and units within the Office of Family Health include: Commodity Supplemental Food Program; WIC; Immunizations; Newborn Screening and Genetics; Perinatal, Child and Adolescent Health (including school health, MCH Evaluation and Assessment, and PRAMS); and Reproductive Health. ***//2005/ MCH Evaluation and Assessment functions are now a part of the newly formed MCH Epidemiology Unit. This new unit includes PRAMS, Child Death Review, and SSDI-supported activities.//2005//***

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 sub-grants to communities, monitors allocations to other HHSS units and programs, and coordinates Title V funded activities with other public health programs within the Office and agency.

In January 2002, the Director of the Department of Health and Human Services announced a reorganization. Special Services for Children and Adults became a part of the Office of Aging and Disability Services. The Title V/CSHCN Director, who is also the co-director for Part C of the Individuals With Disabilities Education Act, was named the Assistant Administrator for this office. The Special Services for Children and Adults houses the following programs: Medically Handicapped Children's Program (MHCP), Home and Community-Based Medicaid Waiver for Aging and Disabilities, 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 Early Intervention and

Medicaid in Public Schools Programs.

Early Intervention is co-administered with the Nebraska Department of Education.

Title V -- both MCH Planning and Support and MHCP -- maintain 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 NHHSS including: child care, juvenile services, mental health and substance abuse, developmental disabilities, minority health, health promotion and disease prevention, women's health, communicable diseases, dental health and rural health. Of these areas outside of Family Health and Aging and Disability Services, only minority health, data management, dental health, communicable diseases and women's health receive federal Title V funds. An organizational chart displaying the agencies and units is found within the following pages.

/2004/ Effective October 1, 2003, the Office of Economic Assistance also received Title V funds.//2004//

Programs funded by the Federal-State Block Grant Partnership budget include allocations within the Health and Human Services System (HHSS) and twenty-two sub-grants 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, MCH Evaluation and Assessment, and PRAMS); MCH Planning and Support; Office of Family Health Administrator; Medically Handicapped Children's Program; Office of Women's Health; and Office of Minority Health.

/2004/ Effective October 1, 2002, twenty-nine community-based agencies are receiving subgrants to support thirty-one projects. The Office of Economic Assistance within the Department of Health and Human Services is also receiving an internal allocation of Title V funds.//2004//

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. The Dental Health Division, which reports to the Chief Medical Officer, is also allocated Title V funds.

Nebraska's Title V program currently has twenty-two sub-grantees. These funded projects were selected through a competitive process completed in FY 1999. These projects were approved through September 30, 2002. New MCH allocation process was explained in section 1.4.

/2004/ There are currently twenty-nine subgrantees, 27 of which have three-year awards and two have one-year awards. The allocation process is now described in Section IIIA2j.//2004//

***/2005/ During FFY 2004, administrative changes at the Department head level have an impact on the Office of Family Health. In January 2004, the Governor appointed the Department's Director, Ron Ross, to be the State's new Treasurer, filling a vacancy created through a resignation. A new Department Director was chosen, Nancy Montanez. Ms. Montanez, assuming leadership in a time of major reforms chose to assign line authority for the Health Services branch of the Department to the Chief Medical Officer, Dr. Richard Raymond. This assignment, executed through a Memorandum of Understanding, gives Dr. Raymond full authority and responsibility for programs and activities carried out in this branch, which includes the Office of Family Health and administration of the Title V/MCH Block Grant. Consequently, Dr. Raymond is the authority for signing all documents associated with this annual application and report.//2005//***

## D. OTHER MCH CAPACITY

As described earlier, the MCH Planning and Support Unit within the Office 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 Office 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, MCH Evaluation and Assessment (including the Child Death Review) and the MCH Providers Partnership project. This unit is staffed by 5.5 full time staff and a contract employee. **//2005/ The MCH Epidemiology Unit was created in FFY 2004, and includes PRAMS, Child Death Review, and SSDI activities. It is staffed by 3.5 FTE and a contract employee. The Perinatal, Child and Adolescent Health Unit is staffed by 5.0 FTE.//2005//** 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. It is staffed by 4.0 full-time 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 4.1 full-time staff.

*//2004/*In regards to the MHCP, it partially funds the Answers4Families website which includes comprehensive information for families of children with special needs, school nurses, foster and adoptive families, and families, agencies and others concerned with children's mental health. The website also hosts discussion listservs (discussion groups for these populations). The website also includes information and internet listservs for other populations with special needs. This website also hosts the Nebraska Resource Referral System (NRRS) which includes over 8,000 social services type resources including child care, respite coordinator information, medical/health and public health information, food pantries, etc. Addresses: <http://www.answers4families.org> and <http://www.answers4families.org/nrrs/>.

Since Nebraska's Department of Health and Human Services, Office of Aging and Disability Services is a Co-Lead for Part C of the Individuals with Disabilities Education Act along with the Nebraska Department of Education, Special Populations, the Family Partner full time position represents families for both the Early Development Network programs and the CSHCN programs. The Family Partner attends CSHCN training for CSHCN staff, national MCH/CSHCN meetings and is a member of advisory groups to the CSHCN Program. The CSHCN Nurse Consultant staff member has been a family member of a CSHCN in the past but this currently is not the situation. *//2004//*

The Office Administrator 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 Nebraska Health and Human Services for 18 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 Office 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 Early Childhood Interagency Team, Fatherhood Initiative Issue Strategy Group, and has special interest in the interfaces and integration opportunities between health and human services for children and families.

*//2004/* Ms. Eurek has been an employee of the Nebraska Health and Human Services for almost 20 years. She is currently the Project Director for Nebraska's Integrated Comprehensive Women's Health Services in MCH Programs grant project, and should it be funded, will be the Project Director for the State MCH Early Childhood Comprehensive Systems Grant Program. *//2004//*

Mary Jo Iwan, BA, Title V/CSHCN Director, has been an employee of Nebraska Health and Human Services for 31 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 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.

## **E. 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 grouping of three agencies 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 and mental health 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 seventeen 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 notice to the family describing possible services they may receive and how to apply. The DDU and MHCP also worked together 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 Early Childhood Interagency Team, which is designing integrated delivery systems for young children served by HHSS and the Department of Education. Both the Title V MCH and CSHCN Directors are members of this team.

*//2004/ The Early Childhood Interagency Team is no longer active.//2004//*

*//2004/ With the administration of Nebraska's Title V/MCH Block Grant located within the Office of Family Health, abundant opportunities exist to coordinate Block Grant investments with a wide range of MCH programs and activities funded through other sources, including WIC, CSFP, Immunizations, and Reproductive Health. Then, with the Office of Family Health being in the same division of HHS with the Offices of Rural Health, Minority Health, Women's Health, Public Health, and Disease Prevention & Health Promotion, another and even more significant level of collaboration opportunities exist. References to these collaborative efforts are found throughout this application.//2004//*

Nebraska Title V has a long-standing working relationship with the state's urban health departments. Both the Douglas County Health Department and the Lincoln/Lancaster County Health Department currently receive Title V funds for specific activities, but each have been partners in a wide range of initiatives. For instance, a public health nurse with the Douglas County Health Department was a member of Nebraska's three-member team that attended childcare 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.

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, as will the new funding allocation and LB692. /2004/ Nebraska Title V has expanded its involvement with and support of local health departments through the creation of an infrastructure set-aside. Since October 1, 2002, 12 local health departments are receiving Title V funds for infrastructure and/or service delivery projects.//2004//

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 and the Every Child Welcomed, Nurtured and Supported steering 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.

/2004/ The Blue Ribbon Panel on Infant Mortality is currently not active, and the Every Child Welcomed, Nurtured and Supported steering committee has completed its work. The Indian Chicano Health Center is now the One World Health Center. Nebraska currently has nine Federally Qualified Health Centers, 5 of which are receiving Title V funds either as subgrants or as contractors of subgrantees.//2004//

Nebraska Title V continues its working relationship with the Primary Care Office by sharing data and information.

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. Staff from the Institute participate as members of the Blue Ribbon Panel on Infant Mortality. The Department of Pediatrics and CityMatCH staff have worked closely with Nebraska Title V in the area of data use and data training. In the past, 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 works closely with both staff and faculty at UNMC and the Boy's Town Institute to implement 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 has a fledgling Masters in Public Health Degree program, a combination degree program sponsored by the University of Nebraska Medical Center and the University of Nebraska at Omaha. The MPH program finished its first semester in operation in May, 2002.

/2004/Three admission cycles have been completed and there are currently 45 students active in the program. One student has graduated. The Program is currently pursuing national accreditation.//2004//

***/2005/ The Masters in Public Health Degree program is now accredited.***

***Expanded collaborations during FFY 2004 can be attributed to a number of activities, such as Together for Kids and Families, Nebraska's State Early Childhood Comprehensive Systems project. In addition, Office of Family Health are actively working with Medicaid Managed Care staff on a prenatal care quality improvement project, and are in the early stages of discussion regarding building MCH epidemiology capacity within Tribal Health programs in the Aberdeen area.***

***An ongoing project that has depended on a close partnership with the Nebraska Department of Education is implementation of the READY Act. This act, passed by the Legislature in 2002, requires that materials be provided to the parents of all infants born in Nebraska that promote early learning opportunities and healthy, safe child development. The Title V/MCH Director was the lead HHSS contact for this project, and helped coordinate the health and safety content of the materials and planned for the distribution. The Department of Education took the lead in the overall design and production. A Title V/MCH funded project field tested the materials with young parents. The booklet, "First Connections with Families" was completed late in 2003, and distribution started in January 2004. The Perinatal, Child and Adolescent Health Unit is responsible for ongoing distribution. Participating hospitals distribute to new parents, while other parents receive via the mail 3-4 months after birth.***

***These new examples are but a sample of the ever changing array of partnerships that form and emerge over time.//2005//***

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

***/2005/***

***#01HSCI The rate of children hospitalized for asthma (10,000 children less than five years of age).***

***Due to Nebraska's contract with the Nebraska Hospital Association for hospital discharge data, 2003 data is unavailable at this time.***

***Nebraska's rate of children (age 0-5) has changed little in the past four years, from 15.3 in 1999 to 15.9 per 10,000 children in 2002.***

***Details of Nebraska's activities surrounding asthma are found under "State Priorities", and listed as "Childhood morbidity and mortality due to asthma need to be reduced".***

***#02HSCI The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.***

***Nebraska has historically done well on this indicator, from a rate of about 75% in 1997 to almost 90% in 2000. However, with recent legislative cuts to Medicaid/SCHIP this indicator is posed to decrease in future years. Specific changes to Medicaid and SCHIP that effect #02HSCI and #03HSCI are: reduced the period of guaranteed continuous Medicaid/SCHIP eligibility for children from 12 months to 6 months from the date of initial eligibility and monthly eligibility determinations will be made thereafter; required that the family's total***

**income be used in determining each family member's eligibility for Medicaid/SCHIP (new budgetary methodology); changed the income disregard for work-related expenses from 20% of gross income to a \$100 deduction from gross monthly earned income; reduced transitional Medicaid for families losing eligibility for cash assistance (welfare to work program) from 24 months to the federal requirement of 12 months; and medical coverage for children eligible under presumptive eligibility guidelines is eliminated.**

**An estimated 12,600 children and 12,750 adults previously eligible lost Medicaid/SCHIP coverage.**

**#03HSCI The percent of SCHIP enrollees whose age is less than one year whose age is less than one year who received at least one initial periodic screen.**

**Nebraska has achieved 100% for this indicator historically. However, cuts to Medicaid including SCHIP could undermine this indicator in the future. See #02HSCI for additional details.**

**#04HSCI The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.**

**Nebraska has experienced a decline in this indicator since 1997. Details of Nebraska's activities surrounding prenatal care are found under "National Performance Measure 18".**

**Approximately one-third of Nebraska's deliveries are paid for by the state's Medicaid program. Because so many pregnancies are covered by Medicaid, recent changes to the state's Medicaid program may further decrease this indicator. These changes, some of which are directly related to coverage of pregnant women and some are not, include: Medicaid coverage to caretaker relatives with family incomes equal to or less than 50% of the federal poverty level ended June 30, 2003; reduced transitional Medicaid for families losing eligibility for cash assistance (welfare to work program) from 24 months to the federal requirement of 12 months; required that the family's total income be used in determining each family member's eligibility for Medicaid/SCHIP (new budgetary methodology); changed the income disregard for work-related expenses from 20% of gross income to a \$100 deduction from gross monthly earned income; medical coverage for nineteen and twenty-year olds eligible under the "Ribicoff" provision of the federal Social Security Act is eliminated; and medical coverage for children eligible under presumptive eligibility guidelines is eliminated.**

**As a result of these changes, some adults previously eligible for Medicaid may no longer be eligible. An estimated 12,600 children and 12,750 adults previously eligible lost Medicaid/SCHIP coverage.**

**#05HSCI Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.**

**The Office of Family Health is currently working with Medicaid to complete the linkage for this indicator. The linkage will be complete during July, 2004. In 2005, Nebraska will switch over to a check-off box. However, linkage reports for 1999-2004 will be forthcoming.**

**Additionally, early work has begun on collaborative planning with Medicaid Managed Care to develop a prenatal care quality assurance initiative.**

**#06HSCI The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.**

**Changes in Medicaid were made by the Nebraska Legislature, however these changes did not directly include eligibility based on percentage of poverty level. Infants (age 0 to 1) are qualified for Medicaid up to 150% of FPL, and SCHIP to 185% of FPL. Children age 1 to 5 are**

**qualified for Medicaid up to 133% of FPL, and SCHIP to 185%. Pregnant women are eligible for Medicaid up to 185% of FPL.**

**#07HSCI The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.**

**This indicator has mixed success in Nebraska. However, with changes in Medicaid/SCHIP eligibility, the overall number of EPSDT eligible children will decrease. Furthermore, children's orthodontics coverage has been limited through legislative cuts to Medicaid to cases involving craniofacial birth defects affecting the occlusion and mutilated and severe occlusion cases only. Nebraska continues to have trouble recruiting and retaining Medicaid dental providers.**

**The Office of Family Health in partnership with the Dental Division, are working with UNMC's Department of Pediatric Dentistry and the Association of State and Territorial Dental Directors (ASTDD) to implement Nebraska's first-ever open-mouth oral health survey. The screenings will be held in Fall, 2004. Results are expected for the Title V Block Grant Application/Report in July, 2005. Funding is provided by the State Systems Development Initiative (SSDI) Grant.**

**#08HSCI The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN program.**

**Denominator of 3100 taken from table 7 produced by SSA, SSI Record, 10 percent sample of December 2002 of number of children in Nebraska receiving federally administered SSI payments of children under the age of 16 years. Numerator taken from the CONNECT computer system and number choosing to obtain Respite services from the Lifespan Respite Subsidy Program instead of the CSHCN funding source totals a numerator of 912. This equals 29.4%. This is a percentage somewhat lower than expected. It is noted however, that all SSI eligible children referrals received from the Nebraska Department of Education, Disability Determinations Section (a) are not counted/entered into the computer system by MHCP (CSHCN) (b) until the family has decided to seek benefits from one of the MHCP programs and that (c) MHCP may not provide benefits some families require. These factors and the presence of SCHIP benefits (Kids Connection in NE) serving more children have acted to lower CSHCN counts.**

**This trend is reversing due to the lessening of the SCHIP programs benefits to children and Nebraska's infrastructure building/mutual referral for services contract with the Federation of Families for Children's Mental Health.**

**#09(A)HSCI The ability of States to assure that the MCH program and Title V agency have access to policy and program relevant information and data. Nebraska continues to struggle with the annual linkage of birth certificates and Medicaid eligibility or Paid Claims Files and a linkage with WIC files. The Office of Family Health is currently working with Medicaid to complete the linkage for this indicator. The linkage will be complete during July, 2004. In 2005, Nebraska will switch over to a check-off box. However, linkage reports for 1999-2004 will be forthcoming. Upon completion of the Medicaid linkage, a WIC linkage protocol will be established."**

**For many years, Nebraska has used a linked birth and infant death file, and a linkage of birth and newborn screening files.**

**Nebraska has a contract with the Nebraska Hospital Association for hospital discharge data. Due to the nature of the contract, 2003 data is unavailable at this time. Discussion is on-going at this time to enable NHHSS to obtain limited identifiers from this dataset for the purpose of linkage with other datasets.**

**Nebraska has had a birth defects registry system since the early 1970's. It recently received a**

**grade of "B". NHHSS was unsuccessful in a bid for grant monies in 2003 to enhance the system, but continues to seek funding that would enable the system to move from a reactive system, to a proactive system.**

**Nebraska has an excellent PRAMS project that has received national attention for its high completion rates. Begun in 1999, the project has published one data report, with a second report in progress. Nebraska PRAMS is conducted yearly.**

**In June 2004, the Title V/MCH Director helped initiate a HHSS cross-cutting team to look at public health data issues, including quality of data and data analyses, access to data, better utilization of data, and related issues. This team will look at ways to improve the HHS System's capacity to support both internal and external users of public health data.**

**See #09(B)HSCI for details of YRBSS. Nebraska engages in all three of these data sources. Funding is provided by the State Systems Development Initiative (SSDI) Grant, in partnership with Tobacco Free Nebraska, for a number of youth-related surveys and reports:**

**2003 Youth Risk Behavior Survey" (publish date July, 2004)  
Data and Trends on Tobacco Use in Nebraska" (publish date May, 2004),  
Social Climate Survey"  
2002 Middle School Youth Tobacco Survey.**

**SSDI will continue to support the YRBS. An electronic database will be available in 2005 for the first time, enabling Nebraska to perform further analysis. YRBS continues to be hampered by lack of participation from Nebraska's largest school district, Omaha Public Schools (OPS). Despite repeated attempts to collaborate with the OPS School Board, OPS will not be included through the 2005 YRBS. Negotiations will continue again for 2007 at that time. Without OPS participation, YRBS results are not truly representative of a statewide population and no racial/ethnic data is available. YRBS is performed every other year in Nebraska.**

**The Adolescent Health Program in the Office of Family Health is in the process of developing a series of 10 fact sheets highlighting the 2002 School Health Education Profile (SHEP) data and 2003 YRBS data. These fact sheets describe the behaviors of Nebraska students (YRBS) and then from the SHEP data describe what schools are doing in terms of their instructional programs, their policies, and their in-service activities. Topics covered on the fact sheets include: tobacco, nutrition, physical activity, violence/safety, sexual activity/STDs, alcohol and coordinated school health model. MCH/Title V funds support this project.**

**The Office of Family Health was part of a team headed by the Nebraska Injury Prevention Project (Office of Health Promotion and Disease Prevention) that will publish two reports during the Summer of 2004: Safe Kids and Pediatric Falls. Primary funding for these projects is through CDC's Injury program, however, supplemental funding is from the State Systems Development Initiative (SSDI) Grant.**

**Finally, the Office of Family houses the Child Death Review Team (CDRT) coordinator. In the past year, six years of child deaths were reviewed, and an aggregate report will be published in July, 2004. Funding for the CDRT is mostly provided by the Title V/MCH Block Grant Application/Report, with supplemental funding from the State Systems Development Initiative (SSDI) Grant. CDRT was also instrumental in providing data for a Governor's Children's Task Force. This Task Force was charged with assessing and developing recommendations for improvements aimed at preventing future violent child deaths. Their work resulted in the publication of "A Roadmap to Safety for Nebraska's Children" late in 2003.**

**#09(C)HSCI The ability of States to determine the percent of children who are obese or overweight.**

**In 2004 Office of Family Health was part of a team headed by the Nebraska Cardiovascular**

**Health Program (Office of Health Promotion and Disease Prevention) that published the "Overweight Among Nebraska Youth 2002/2003 Academic School Year". //2005//  
//2005//**

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

/2004/ This section is new in its entirety.

The investment of Title V funds in Nebraska is driven by a number of key factors. The first set of factors is the MCH/CSHCN priorities identified through the needs assessment completed in 2000. These priorities have guided a number of funding decisions. A second important factor was the technical assistance consultation provided by Donna Petersen in 2001. This consultation provided recommendations for how to balance investments in infrastructure and local services. Next, Nebraska's emerging local health districts, supported through tobacco settlement funds, offered a unique opportunity for building MCH capacity. Finally, Nebraska has, like many other states, entered into a period of revenue shortfalls. The scarcity of resources has touched just about every major health and human services program and activity.

As a result, decisions on the allocation of Title V funds has been a balance between meeting the needs of the MCH/CSHCN populations, capitalizing on opportunities to build infrastructure, and sustaining basic, ongoing services in a time of fiscal difficulties. The format for this application does not permit a clear, concise description of how these factors have played out. Rather, it forces a fragmented description of activities based primarily on federal parameters. A preferred format would have been a description of need, followed by description of funded activities to meet those needs, and then how progress in meeting those needs will be measured (a combination of national and state performance measures).

It must also be pointed out that the term Title V Program is a misnomer. The Title V/MCH Block Grant is a funding stream used to finance a wide array of programs within the statutory limitations of the grant. The reader will note that throughout the following sections within Part IV, the term Title V program is not used. In addition, the accomplishments and activities described are often not funded or are only partially funded by the Title V/MCH Block Grant. The block grant, in comparison to other funding streams and policy arenas, has a limited impact on several of the identified national performance measures and a number of the state measures.//2004//

### **B. STATE PRIORITIES**

/2004/ This section is new in its entirety.

***//2005/ Updated throughout to reflect current activities and data.//2005//***

Nebraska's last comprehensive needs assessment was completed in 2000. At that time, ten priority needs were identified, with one subsequently amended. Below is a description of each priority need, NE's capacity and resource capability to address each, and relationships to national and state performance measures. Nebraska is currently in the process of completing another needs assessment in 2005.

1. Childhood morbidity and mortality due to asthma need to be reduced. NE HHS is the recipient of a 3-year asthma capacity-building grant from CDC. Currently in Year 3, this grant project focuses on building a statewide asthma coalition and developing a 5-year strategic plan. This project is supporting local coalitions and physician training. Project staff provides technical assistance to the Office of Family Health, particularly around school asthma protocols. The Office's School & Child Health Nursing Coordinator (a Title V funded position) then works with schools across the state in developing and implementing protocols.

Three Title V-funded community-based projects focus all or in part on asthma-related services.

None of the NPMs directly relate to this priority need. Thus Nebraska selected SPM#11 -- Rates of hospitalization for asthma among children ages 5-17.

2. Reduce incidence and prevalence of nutrition-related health problems among children, including CSHCN. A large part of NE HHS capacity to address this need is in its WIC Program. This program currently serves over 9500 children ages 1 -- 4. The other major nutrition program within the Office of Family Health is the Commodity Supplemental Food Program.

Steps have been made to expand nutrition capacity over the past year. The breastfeeding support help-line continues to be funded through the Title V Block Grant. In addition, 6 other Title V-funded community projects have nutrition components dealing with obesity/diabetes prevention and/or breastfeeding support.

For CSHCN, the MHCP has long provided nutritional consultation through its multidisciplinary teams for cerebral palsy, midline neurological defects, and craniofacial disorders. In addition MHCP provides nutritional services, in-home assessment, and follow-up through the Aged and Disable Medicaid Home & Community Based Services Waiver. The pediatric feeding & swallowing clinic offered by Great Plains Medical Center in rural western Nebraska is a community-based project which continues to be funded in 2004.

Title V funds have thus been recently re-directed to enhance nutrition-related services for children, including CSHCN. To address remaining gaps, the Family Health and Aging and Disability Services participated in an HHSS inter-program strategic planning process for nutrition and physical activity. Family Health staff continue participate in the NE Action for Healthy Kids State Team. Action for Health Kids is a nationwide initiative dedicated to creating health-promoting schools that support sound nutrition and physical activity

NPM#11 measures in part progress being made to address this need (% of mothers who breastfeed their infants at hospital discharge). In addition, Nebraska chose SPM#10 - % of CSHCN seen at MHCP multi-disciplinary team clinics that receive recommended nutritional follow-up services.

3. Increase access to quality oral health care for MCH/CSHCN population. Title V has long been a funding source for Nebraska's dental program. This program has focused on broad population-based efforts, including education/technical assistance for communities. The program has worked to promote fluoridation of public water supplies. Its school fluoride mouth rinse program is being phased out, with a greater focus on promoting dental sealant programs. Nebraska's dental program works closely with the NE Dental Association to increase access to dental care.

An open-mouth survey of 3rd grade school children will soon be conducted in Nebraska looking at their dental needs. The collaboration between the UNMC College of Dentistry and the Dental Health Division plans to examine 2000 children in approximately 80 schools across the state during the 2004-2005 school year. CDC will provide a calibration training session in August for the team of dentists who will conduct the exams across the state. SSDI funds are helping support this project.

Three Title V-funded community projects have an oral health component. Additional local efforts have been provided by Head Start programs. Even taken together, these efforts are not adequately addressing the problem of a dwindling supply of dentists serving the MCH/CSHCN population.

NPM#9 directly relates to this priority need, but Nebraska has been unable to gather accurate, reliable data for this measure. Added SPM#9- % of Medicaid-participating dentists who see 25 or more Medicaid patients each month.

4. Decrease rates of adolescent, non-marital, and unintended pregnancies. The NE HHS has been the Title X Family Planning grantee for 30+ years. This program serves over 35,000 women & men each year. In addition to Title X funds, the program is supported with a modest amount of Title V funds and state general funds for STD screening/treatment and cervical cancer screening/diagnosis. The resource capability of this program is continually challenged, particularly with increasing costs for contraceptives. The NE HHS is also the grantee for the Abstinence Education grant. Through this program, community-based efforts have been developed and promoted, a statewide coalition

supported, and training and public awareness efforts offered statewide.

Eight new community-based projects began in 2003, implementing a wide-range of abstinence-based education related activities. They are funded through the Abstinence Education grant.

Three additional community-based projects are funded through Title V and have a youth development or other teen pregnancy prevention related component.

These 2 programs, along with local efforts, provide NE's primary capacity to address this need. The Every Child Welcomed, Nurtured & Supported steering committee provided recommendations for additional and/or enhanced activities, but budgetary problems resulted in postponed implementation.

This need is directly related to NPM#8 -- birth rate for teenagers aged 15 through 17. Nebraska also chose SPM#12 -- rates of minority adolescent births.

5. Reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities. Work continues on the SIDS risk reduction tee shirt campaign. Nebraska has two Healthy Start projects (Omaha Healthy Start and Aberdeen Area Healthy Start). The Title V/MCH Director has been participating in the development of a State Minority Public Health Plan which will include recommendations regarding access to prenatal care. Title V funds have been allocated to nine community-based projects that address in some way infant mortality reduction (home visitation, prenatal care, case management, outreach, smoking cessation, etc.) The Office of Family Health continues to be active in supporting the work of Baby Blossoms as they move forward to implement a blueprint for action for the prevention of infant mortality. Partnerships continue with Medicaid Managed Care in developing a quality assurance initiative.

These efforts do not adequately address the needs of all geographic areas and population groups. Racial/ethnic disparities in infant mortality rates continue to be unacceptable. Quality of and access to care still need to be fully assessed and addressed.

Three NPMs relate to various aspects of this need (NPM#15 - % of VLBW infants among all live births; NPM#17 - % of VLBW infants delivered at facilities for high-risk deliveries and neonates; and NPM#18 - % of infants born to pregnant women receiving prenatal care beginning in the first trimester). NPM#17 is of marginal utility for Nebraska, because levels of perinatal care are not formally established/monitored except for Medicaid reimbursement purposes. Nebraska has thus included two SPMs to better gauge progress in addressing disparities in infant mortality: SPM#3 -- incidence of confirmed SIDS cases among African American and Native American infants; and SPM#14 - % of African American women beginning prenatal care during the first trimester.

6. Reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age. The perinatal media/information campaign materials were produced and the campaign was implemented which included a box of promotional materials which were sent to primary care providers. A tobacco cessation quit-line was promoted, until its discontinuance when funds were no longer available. Four community-based projects funded through Title V have a tobacco cessation component. Four additional community projects, with the support of tobacco settlement funds, continued in this fiscal year. As stated in previous sections of this application, tobacco settlement funds will no longer be available to support a comprehensive prenatal/perinatal tobacco cessation program, so the program has been scaled down.

Two Office of Family staff continue to be involved in SICA work groups. There is an opportunity for potential collaboration in the future with the Office of Mental Health, Substance Abuse and Addiction Services, Behavioral Health Division of NHHS as they apply for a Strategic Prevention Framework State Incentive Grant from SAMHSA.

Some gaps remain in MCH capacity to address alcohol and substance abuse among women.

No NPMs relate to this priority need. Nebraska therefore has SPM#4 - % of women of childbearing age that report smoking in the last 30 days.

7. Reduce rates of injury, both intentional and unintentional, among MCH/CSHCN.

The lead for injury prevention in the HHSS continues to be the Office of Disease Prevention & Health Promotion. This Office carries out injury prevention activities funded through the PHHS block grant, the National Safe Kids/GM grant, and a CDC injury prevention grant. Family Health programs have a close working relationship with injury prevention staff. One of Nebraska's Title V-funded community based projects has a childhood injury prevention component.

Staff with Family Health and Disease Prevention & Health Promotion see a need to expand prevention efforts. Child passenger safety has been a primary focus over the years, and more work needs to be done related to other unintentional injuries. Intentional injuries (homicide and suicide) have many prevention gaps. Recent assessment and planning efforts around suicide have not focused on NE youth because of relatively small numbers in this age group

NPM#10 (rates of death to children aged 14 years and younger caused by motor vehicle crashes) is directly related to this priority need. Nebraska has also selected SPM#6 -- rates of hospitalizations for injuries among children birth to age 14.

8. Increase the number of CSHCN who have a medical home and access to pediatric specialists. MHCP continues to actively work on infrastructure building for telemedicine as a strategy to address access issues. As stated earlier in this application, a vast geographic area, sparsely populated rural areas, and shortages of primary care providers result in barriers to access, including medical homes and specialists for CSHCN. Though technology will help address geographic issues, changes in Medicaid eligibility and ever more scarce state financial resources will be impediments to addressing this priority need.

NPM#3 is directly related to this priority need (% of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home).

9. Build MCH infrastructure statewide. As previously described, Title V funds were set aside for the purpose of building MCH infrastructure within Nebraska's local health departments. Currently, Title V funds support infrastructure building in eleven of the local health departments. Native American Tribes had the option of using their set-aside for infrastructure building. Through these efforts, Nebraska Title V is seeking to assist local and Tribal governments build their capacity to assess MCH needs and fill gaps.

To keep some momentum going, staff have placed additional emphasis on locating additional financial resources. In addition, Nebraska MCH and CSHCN staff will expand partnerships with other programs and agencies, such as the SAMHSA project described earlier

None of the national performance measures are specific to infrastructure building. Nebraska had chosen SPM#13 -- the state's score on building statewide immunization registry capacity. Due to the limitation placed on the number of SPMs to be included in this application, SPM#13 was retired last year.

10. Eliminate racial and ethnic health disparities. Nebraska has taken some positive steps to begin addressing this need. In 2001, tobacco settlement funds were allocated to support minority health projects and expand the staffing of the Office of Minority Health. These funds are still intact. Nebraska's Comprehensive Integrated Women's Health Services in MCH Programs grant project has placed a special emphasis on addressing the needs of racial/ethnic minority women. The Office of Family Health, through the Perinatal, Child and Adolescent Health unit, has worked on a number of collaboratives addressing culturally competent care for the MCH population. The Title V RFP issued in 2002 included a set-aside for Nebraska's Native American Tribes. Omaha Healthy Start and the Aberdeen Area Healthy Start projects are additional examples of projects specifically targeting health

disparities.

These efforts are just a beginning in addressing health disparities. With an ever more culturally and linguistically diverse population, Nebraska will have the continued challenge of preparing its medical and public health work force for providing appropriate and accessible care. And we have barely begun to assess and address institutional racism and its impact on health outcomes. The Title V/MCH Director has participated in a task force developing a Nebraska Minority Public Health Plan. This plan, to be completed later in 2004, will help bring greater focus on the wide range of public health issues and needs for Nebraska's racial/ethnic minority populations, including MCH.

The NPMs are silent on the issue of racial/ethnic health disparities. Nebraska has chosen these SPMs to gauge progress in narrowing the gaps: SPM#3 -- incidence of confirmed SIDS cases among African American and Native American infants; SPM#12 -- rates of minority adolescent births; and SPM#14-% of African American women beginning prenatal care during the 1st trimester. //2005//

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

The Newborn Screening & Genetics Program managed universal screening for 6 diseases (Biotinidase Deficiency, Congenital Primary Hypothyroidism, Galactosemia, Hemoglobinopathies, MCAD & PKU). From July 20, 2002 till July 1, 2003 specimens were sent to two in-state labs for 5 disorders. A second specimen on each newborn was sent to one of two labs out of state. During this period while greater than 99% of newborns received the mandatory screen, approximately 55 % of newborns received the supplemental screen. Since July 1, 2003 when Nebraska contracted with a single lab to do all of the mandated screening plus supplemental screening, > 99% of newborns receive the mandated screen and approximately 95 % of newborns have benefited from the optional (consent required) supplemental screening panel.

This was a big transition year going from multi-lab to single lab services. For this transition, staff prepared training materials, revised consent/dissent procedures and forms, updated filter paper collection forms, and other related procedures. Eleven regional in-services were provided at 9 sites for nursing and laboratory personnel. In addition, 3 grand rounds were conducted to familiarize physicians with new requirements. Major activities involved revising regulations, conducting a request for proposal for the lab services contract, revising patient education materials and working closely with the laboratory to get set up and begin screening Nebraska's newborns.

In calendar year 2003, 26,008 of 26, 067 (99.77%) newborns were screened for the 6 required disorders listed above (54 expired at <48 hours of age, 5 were home births --two of which expired -- who were not screened).

Newborns identified with screened disorders in the CY 2003 were: 4 infants with biotinidase deficiency (3 partials treated, and 1 profound); 1 with congenital primary hypothyroidism; 2 infants with galactosemia (one classical and one Duarte treated); 5 with sickle cell disease, plus 1 with hemoglobin-C disease and 5 with PKU (2 classical and 3 hyperphenylalaninemia). All newborns with clinically significant screening results received follow-up and referral to appropriate metabolic, endocrine and hematology specialists. All cases had confirmatory testing and either had diagnosis ruled out or were diagnosed and entered into a treatment plan.

Program serves infants (screening), CSHCN (follow-up/referral/treatment), pregnant women & women of child bearing age (formula and pharmaceutically manufactured foods). Activities are

population-based, though direct and enabling services are provided to pregnant women, CSHCN and women of childbearing age. In addition infrastructure-building activities are done in managing the system of newborn screening.

#### b. Current Activities

The Newborn Screening and Genetics Program continues to screen for the 6 disorders, as described for FY 2003. Follow-up, referral and treatment activities also continue, with no major changes in focus or scope.

During the 2003 Legislative Session, LB 119 was passed. This law revises genetic testing legislation passed in 2002, by changing definitions of genetic testing covered under the law and revising requirements for handling blood specimens. Regulation development started in 2002 and was resumed in 2003. Final regulations were adopted in February of 2004 and Informed Consent Manuals were distributed to every medical clinic birthing hospital as well as to the stakeholders that helped develop the regulations and forms.

#### c. Plan for the Coming Year

Screening, referral, and treatment activities will continue as described for FY 2003 and FY 2004. New or renewed focus will be given to quality assurance monitoring, reinstatement of professional education efforts via a regularly published newsletter, and expanding patient education through development of multi-lingual materials. Resources will be sought to support development of educational materials in non-written media.

The newborn screening advisory committee will monitor national recommendations and consider evaluation of congenital adrenal hyperplasia and cystic fibrosis for possible addition to Nebraska's newborn screening panel.

Activities will continue to focus on the same populations and levels of the pyramid as described for FY 2004.

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

#### a. Last Year's Accomplishments

Nebraska's CSHCN Program carried out a number of activities in support of this performance measure during this period, examples include:

A Services Coordinator/Social Services Worker was assigned to help families access services to fit their needs and those of the child with a disability or chronic health care need. Help was provided to identify and access services and assistance in locating payment sources. The worker was also the family's link into the medical team evaluation and treatment planning process through specialty clinics for children and youth.

Specialty clinics for CSHCN are teams which consist of specialty physicians, nutritionists, nurses, occupational therapists, physical therapists, psychologist, dentists, speech and hearing pathologists, and the family. The teams met all at one time and place. Team membership depended upon the particular medical conditions being reviewed. The most important member of the teams was the family. Teams provided diagnosis, a written plan of treatment, and access to all the team members at one time. The family was able to carry a list of written recommendations home from the team clinic. Copies of the completed report/plan were

provided to service providers and school systems as authorized. Family satisfaction survey forms were available at all MHCP clinic sessions to solicit family/client comments regarding clinic participation, experience and outcomes.

The CSHCN Program was cognizant of the need for families to be involved in decision-making. The integrated system of services includes the Family Partner for the Early Development Network (Early Intervention-Part C). Many CSHCN staff members statewide were members of the Regional Planning Teams for the Early Development Network and parent input is provided at that level. Families were included in the needs assessment process for CSHCN as members of committees and teams.

These activities were primarily direct service and enabling, and are targeted to the CSHCN population.

#### b. Current Activities

See FY2003 Activities above. These FY 2004 activities continue to relate to the same levels of the pyramid and population groups as indicated for FY2003.

The State of Nebraska Regulations for the CSHCN Program were re-written over the past FY and approved in FY 2003. These regulations provided some changes related to Services Coordination activities provided by CSHCN Social Services staff members. Many of these changes serve to integrate CSHCN services with those of the Early Development Network and provide additional provide a more comprehensive collaboratively role with other Nebraska Programs for CSHCN and Children with Special Needs. Family, provider and advocate input has resulted in the addition of CSHCN nutritional direct care services for children born at very low birthweights.

Comments provided through family satisfaction survey forms at the Specialty Clinics for Children and Youth held at the University of Nebraska Medical Center, Munroe Meyer Institute in Omaha are partially responsible for changes currently occurring in CSHCN Clinic Team composition, process and procedures.

Very close attention is being paid to CSHCN budgets for direct care and enabling services. The CSHCN Program has experienced a 100% increase in referrals for direct care because of the lowering of income eligibility for Nebraska Medicaid Title XIX and XXI Programs.

#### c. Plan for the Coming Year

See FY2004 Activities above. The planned FY 2005 activities continue to relate to the same levels of the pyramid and population groups as for FY2004.

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

#### a. Last Year's Accomplishments

The Medically Handicapped Children's Program staff, the staff of the Early Development Network (Part C) and the Children's Services Coordination staff for the Home and Community Based Waiver have been trained and are working with families to urge that each child has a medical home physician.

Nebraska has taken a somewhat broader approach to the definition of a Medical Home than that first initiated by the American Academy of Pediatrics. The AAP policy statement of July

2002, which was written more broadly, is more acceptable because it is believed that many Family Physicians may fit into the definition as Medical Home physicians.

Nebraska, along with many other rural states, has many fewer pediatric physicians than needed to provide every child with a pediatric medical home. Primary Care Service Areas for Nebraska (and surrounding areas) taken from the "2000 Physician Supply data and 2000 US Census Data of Self Designated Primary Physicians" show Nebraska to average 2,608 children per pediatrician vs. a national average of 1,769 children per pediatrician. The only areas in NE that follow the national averages are the Lincoln area with 1,797 children per pediatrician and Omaha with 1,451 children per pediatrician. Yankton, SD, which includes a corner of Nebraska as part of their service area, has 1,161 children per pediatrician. The large majority of Primary Care Service Areas in NE are listed as "No Pediatr."

Based on the above it is somewhat surprising that Nebraska ranks somewhat better than the National average on the recent CSHCN National survey (53.8% vs. 52.6%).

Operations of the CSHCN multidisciplinary team evaluations have led to opportunities to discuss the advisability of a medical home for CSHCN. These are ongoing activities.

Medical home training was held on November 8, 2002 at the Crowne Plaza in Omaha for physicians, physician assistants, nurse practitioners, school nurses, services coordinators and families (virtually all who work with children with special needs). Staff attending included all of the above groups including Services Coordinators for the Early Development Network, Home and Community Based Medicaid Waiver and Medically Handicapped Children's Program (MHCP). The conference was titled "Early Childhood Intervention: Role of Healthcare Provider and Educator" and also included information on autism, newborn metabolic screening and newborn hearing screening. A CSHCN telephone consultation was held with Dr. Carl Cooley following this training regarding a Medical Home Initiative for Nebraska.

A Medical Home indicator was added to the integrated computer tracking system for the CSHCN Program, the Home and Community Based Medicaid Waiver for children and the Early Development network. In addition to beginning our own count, this is a way to remind staff to discuss Medical Home with each family.

#### b. Current Activities

During FY 2004, program activities continued which are described in FY 2003. This is with the exception of the medical home training which was not repeated due to budget restraints.

#### c. Plan for the Coming Year

Continuation of the program operations that include continued medical home emphasis. This includes continued collaboration with EDN and Home and Community Based Medicaid Waiver staff. In the future we hope to have valid Medical Home data for a rural state that considers Family Practice Physicians as Pediatric Medical Home providers.

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

#### a. Last Year's Accomplishments

Ongoing activities to increase the numbers of children with special health care needs who have a source of payment for medical services continues to include: continued advocacy with the Medicaid program in urging eligibility for CSHCN for any and all of the Medicaid Title XIX and XXI programs that are available for children; continued referral of families of CSHCN to the Nebraska Medicaid Program (all Medicaid titles and coverage available); continued coverage of CSHCN specialty care payments through the MHCP; continued supplementation of private health insurance benefits where appropriate; continued referral to private medical insurance; continued referral to the CHIP medical insurance program (Nebraska State Comprehensive Health Insurance Program, which provides a State supplemental to the insurance premium for those who are not insurable through any other means); continued funding and support of Genetics/Neurobehavioral clinics through Munroe Meyer Institute at the University of Nebraska Medical Center; and continued funding of and provision of MHCP Specialty Clinics for CSHCN.

During FY 2003, the above ongoing activities were carried out. As previously mentioned, this year the Nebraska Legislature made changes in eligibility in eligibility for Medicaid for children. The length of continuous eligibility for Kids Connection (Nebraska's SCHIP) was shortened from 12 months to 6 months and the income level for SCHIP was lowered. These changes have removed approximately 25,000 children from Nebraska Medicaid roles. At the same time, it was determined that no additional funding would be available to the MHCP Program for the following year or for FY 2004.

#### b. Current Activities

Activities described above in FY 2003 have continued into FY 2004. The numbers of referrals/applications to MHCP continue to increase, and with parallel increases in state general fund expenditures for MHCP.

#### c. Plan for the Coming Year

Budget constraints which have sharply limited the services provided for direct care may be relaxed slightly during FY 2005 due to improved State revenues. No final decisions have been made. Inasmuch as the funds available from the Block Grant do not keep up with the increased costs of services, additional funding from other State sources will be needed for any improvements or expansion of services. Additional resources are uncertain at this time.

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

#### a. Last Year's Accomplishments

CSHCN services are integrated to the extent that services are available regardless of the Program or Service for which the family is eligible.

Application forms are shared between Programs with the MHCP application necessary only when an application requesting help or assistance has not been made for another HHS Program. The MHCP application is also shared, with applicant permission, with a number of other agencies and programs, which may meet the requested, need.

Nebraska's % on the National survey of 79.6% vs the National average of 74.3% can be attributed to efforts to integrate programs/systems to increase the ease of use/availability. This is also the highest % in Region VII.

The Lifespan Respite Subsidy application was placed online through the HHS website. This

has allowed families of CSHCN, caregivers of adults with disabilities and caregivers of the elderly population and their Services Coordinators and advocates easy access to an application for HHS services.

The University of Nebraska Medical Center, Munroe Meyer Institute (MMI) Genetics clinics and the MHCP Specialty Clinics for Children and Youth have been operating by sharing personnel from MMI for a number of years. This usually means that personnel that travel from Omaha often staff a MHCP clinic on one day and staff a Genetics clinic the following day. This not only improves access for families but is also more cost effective.

The MHCP, MMI and the Special Education Branch of the Nebraska Department of Education have been working with Nebraska Medicaid, the Educational Services Unit and Regional West Medical Center in Scottsbluff to begin a telemedicine service for CSHCN to make medical appropriate medical evaluations and other consultation and evaluations more accessible.

#### b. Current Activities

A system of Genetics Outreach Clinics has been operated by the University of Nebraska Medical Center, Munroe Meyer Institute (MMI). Funding for these activities and a birth defects prevention hot line has been a part of the Nebraska MCH grants process and has been funded for a number of years. These projects also include a small amount of Legislative general fund appropriation.

The priorities for MCH process approvals changed in FY2002 with this project no longer meeting priority criteria. Therefore, the MHCP began the process of contracting with MMI for these activities for the 2003-2004 State year and beyond. The contract will include the transfer of the general fund appropriation plus federal MCH funds.

Progress on telemedicine with the western areas of Nebraska has included commitment of funds, placement of equipment and arrangements of Nebraska Medicaid participation and commitment of professional services not allowed by Medicaid.

#### c. Plan for the Coming Year

The transfer of the Genetics Clinics and the birth defects hot line (Teratology hot line) to MHCP will allow the MHCP diagnostic and treatment planning to be marketed together with these services. The MHCP has been mailing approximately 3000 flyers every calendar quarter to provide the dates and times of the Specialty Clinics for Children and Youth. The Genetics clinic schedule will be included in this mailing.

The CSHCN Program, MMI and the Special Education Branch of the Nebraska Department of Education will begin the Telemedicine program from Scottsbluff, NE to MMI in Omaha.

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

#### a. Last Year's Accomplishments

Please see the general CSHCN program description in PM# 2 above.

MHCP and MMI have worked together in setting quality assurance standards for both the MHCP Specialty Clinics for Children and Youth system and Social Services Worker/Services Coordinator file review. These QA standards include the responsibility of each team to

transition CSHCN in each specialty reviewed by the Team. This includes occupational therapy to adult occupational therapy, child psychology to adult psychology, pediatric dentistry to adult dentistry, pediatrician to adult physician, etc.

Nebraska has had an excellent Vocational Rehabilitation system in the Nebraska Department of Education to which all CSHCN known to the MHCP are referred at age 14 if they haven't been referred earlier. The Nebraska Department of Education also has an excellent program for educational to work transition for CSHCN. The MHCP staff are trained to work with the MHCP Specialty Clinics system and individuals regarding transition to adult medical providers.

During FY 2002, the State of Nebraska Regulations/Policies for CSHCN were written to include additional emphasis on transition for MHCP staff. These regulations received official approval in March, 2003 and have been utilized since that date.

Quality assurance processes with rural Nebraska Specialty Clinics for Children and Youth are carried out by the Pediatric Nurse Consultant on the MHCP/Home and Community Based Medicaid Waiver staff (shared position) and the MHCP Medical Director. Quality assurance activities are also monitored for MHCP Services Coordination staff by the MHCP Program Specialist and the MHCP/Waiver Pediatric Nurse Consultant.

#### b. Current Activities

Quality assurance activities described for FY 2003 continued in FY 2004.

#### c. Plan for the Coming Year

Quality assurance activities described for FY 2004 will continue into FY 2005. The CONNECT computer system will be used to assure transition through the appropriate services programs and systems.

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

#### a. Last Year's Accomplishments

The Nebraska Immunization Program is located within the Office of Family Health. Primarily funded through the National Immunization Program (NIP) at the CDC, this program administers the 317 and Vaccine for Children (VFC) funds, as well as a Perinatal Hepatitis B project. In FY 2003, the program supported 85 counties with public clinics across the state, 85 counties with public VFC providers, and 207 VFC private providers. The Program also administered, through a subgrant, an immunization registry that includes all public immunization clinics except those in Lancaster County. Nebraska participates in the Hallmark Card program (a card signed by the Governor and First Lady and sent to the parents of all newborns with an immunization message).

Three community-based projects received Title V funds to address various immunization-related activities.

These activities are most directly related to infants and children, and are population-based services.

#### b. Current Activities

The Nebraska Immunization Program continues to support 85 counties with public immunization clinics and 207 private VFC providers. Over the past several months, staff has been involved at various levels with bioterrorism projects, including small pox immunization efforts and national stockpile activities. The immunization registry continues to be in place, with current efforts focused on keeping it stable and updated, and looking ahead to how to support/maintain the registry in the future. A modest allocation of Title V funds has been made this year to the Immunization Program, as partial support for the registry.

Currently, three community-based projects funded through Title V have an immunization component. One is funded on a year-to-year basis depending on the availability of carry-over of Block Grant funds.

Again, these activities are primarily targeted to infants and children, and are population-based services. Planning efforts around the registry may be better considered as infrastructure building.

### c. Plan for the Coming Year

New rules and regulations regarding required immunizations for children enrolled in school and licensed early childhood programs (preschool, HeadStart and daycare) will be instituted. Varicella (chickenpox) will be required for kindergartners, 7th graders, and all out-of-state transfer students; varicella and hepatitis B will be required for all children enrolled in licensed early childhood programs. Continuation of efforts to address the future of the immunization registry since the CDC consultation. Normal immunization-related activities will continue.

Of the three local projects that utilize Title V fund for immunization projects, one is funded on a year-to-year basis. Its continuation will be dependent on the availability of carry-over of FY 2004 Block Grant funds.

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

### a. Last Year's Accomplishments

The Nebraska Reproductive Health Program had 38,560 unduplicated users for its FY 2003, 23% of which were adolescents age 10-19. Through the program's public education component, 1,274 education sessions were provided by local family planning agencies. Participants included 3,934 adolescent males and 5,191 adolescent females. These local family planning agencies are also involved in numerous community-level partnerships addressing teen pregnancy prevention, and sponsor various projects, including "Wise Guys" and Girl Power. State-level program staff are actively involved in Nebraska's teen pregnancy prevention coalition, assisting with various public awareness efforts. Primarily funded through Title X/Family Planning, the Program also receives modest ongoing support through Title V (\$150,000 per year).

The Nebraska Abstinence Education Program administered the Title V Section 510 grant. Eight new community-based projects began October 1, 2003 as a result of an RFP issued in August 2003. Each community began implementing a wide range of abstinence-education related activities. The Program also facilitated W.A.I. T. (Why Am I Tempted Abstinence Education) training to interested communities and Unmasking Sexual Con Games (Abstinence Education) Training to staff at HHSS youth treatment and rehabilitation centers. A new community awareness tool, Motivational Productions -- Multi-Media video was implemented in 5 communities across the state following a Governor's proclamation signing and program kick-off event in September 2003.

Three community-based projects received Title V funds to support youth development and other teen-pregnancy prevention related activities.

These activities directly reach adolescents, a subset of the child population. Activities range from direct services (clinical care through family planning clinics) to enabling services (health education for youth) to population-based (public education).

#### b. Current Activities

The Nebraska Reproductive Health Program continues its focus to provide quality, accessible preventive health services and education for adolescents. The Nebraska Abstinence Education program offered training and support to eight new community-based sub recipients culminating with a grantee symposium in June 2004. These eight new communities are expected to continue with their individual programs through the FY 05 grant year. These projects are to target high-risk teens and have a focus on cultural awareness, sensitivity, and broad-based community support.

Three community-based projects funded through Title V have a youth-development or other teen-pregnancy prevention related component. Two of these projects specifically target racial/ethnic minority youth with youth-development activities based on cultural traditions.

All activities continue to focus on adolescents, and are direct, enabling or population-based services.

#### c. Plan for the Coming Year

No major changes are planned for FY 2005.

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

#### a. Last Year's Accomplishments

NE's Dental Health Division, funded solely by Title V, promotes access to oral health care for children. During FY 2003 program activities focused on infrastructure building activities, with an emphasis on supporting communities. In particular, the Division assisted local communities to increase prevention services especially in dental shortage areas. Division staff assisted newly forming local health departments develop local oral health efforts to increase access to care and eliminate racial and ethnic health disparities. In addition, the Division provided assistance to community health centers throughout the state in the development of local dental sealant programs.

The Division continued its efforts to work with the Medicaid program to decrease barriers to care and recognize the outstanding dedication of providers.

Three community-based projects funded through Title V had an oral health component: 1 conducting oral health screenings (population-based service); 1 providing acute dental care (direct service); and 1 leading community collaborative planning (infrastructure building). Most activities were focused on children.

#### b. Current Activities

The Nebraska Dental Health Division is currently working with MCH staff, CDC and the

University of Nebraska Medical Center Pediatric Dental Residency program in conducting a mouth survey of 3rd grade school children in Nebraska and their dental needs. They plan to examine 2000 children in approximately 80 schools across the state during the 2004-2005 school year. CDC will provide a calibration training session in August for the team of dentists who will conduct the exams across the state.

The Dental Health Division also recently conducted Nebraska's first-ever state-wide Oral Health Forum and the Title V Project Director served on the planning committee. More than 225 participants were involved in the 2 day training conference which included training on everything from sealant programs and hospital dental programs to how to open a public health dental clinic. The training was geared toward the new Health District dentists who are sitting on the local boards of health providing oral health expertise.

A big part of staff time is devoted to providing support for those at the local level as they begin to conduct needs assessment and strategic planning relative to oral health. The web page has been updated ([www.hhs.state.ne.us/dental](http://www.hhs.state.ne.us/dental)) to include downloadable materials and sessions from the Nebraska State Oral Health Forum.

The three-community based projects described for FY 2003 continue to provide similar services.

Populations served and levels of the pyramid are also as described for FY 2003.

#### c. Plan for the Coming Year

Continue work with local health departments/communities. Complete the mouth survey.

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

#### a. Last Year's Accomplishments

As described in the earlier section on State Priorities, the Office of Disease Prevention and Health Promotion provides leadership for the agency in injury prevention, including child motor vehicle safety. Through its Safe Kids program, staff worked extensively with local coalitions to promote proper use of child passenger restraints (training of technicians, sponsoring car seat/booster seat check events, etc.). Child restraint use increased from 76% (2002) to 86% (2003). The Office of Family Health worked collaboratively with injury prevention staff, particularly through the participation of the School and Child Health Nurse Consultant in the development of the statewide injury prevention plan.

Also in FY 2003, the Child Death Review Team continued to meet to better understand motor vehicle deaths among children and identify appropriate prevention activities. The work of the team is supported with Title V funds.

Title V funds supported one community-based project with a child passenger safety component.

Target populations for activities are infants and children, and are primarily population-based services. The development of a statewide injury prevention plan is infrastructure building.

#### b. Current Activities

The Office of Family Health continues its collaboration with the Office of Disease Prevention

and Health Promotion, including implementation of the statewide injury prevention plan. The statewide injury plan was released this year. The Nebraska Child Passenger Safety Board has developed a child-safety curriculum for use in child care settings, and is working with the School and Child Health Nurse Coordinator (and HCCN project director) in implementation.

One community based project continues to promote child passenger safety utilizing Title V funds.

Populations served and levels of the pyramid are as described for FY 2003.

### c. Plan for the Coming Year

The Office of Health Promotion and Disease Prevention will continue its major activities, utilizing General Motors funding. Collaborative efforts will continue with Office of Family Health staff, particularly around curricula for child care providers. The one community-based project is being funded on a year-to-year basis, and its continuation into FY 2005 will be dependent on the availability of funds.

The possible reasons for an increase in rates for this indicator (from 4.7 per 100,000 children in 2002 to 6.6/100,000 in 2003) will be explored as part of the Child Death Review Team's work in this upcoming year.

## Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

### a. Last Year's Accomplishments

The pilot breast pump-lending program was implemented at one local agency. Multi-user and single-user electric pumps were provided to clients that need help in establishing/maintaining breastfeeding. A unit on breastfeeding was developed and implemented as part of the "Learning About WIC" training provided to all new WIC local agency employees. This unit reinforces the idea that all WIC staff members play a role in breastfeeding promotion and support.

### b. Current Activities

A nationwide media campaign is underway to promote exclusive breastfeeding for 6 months. The Nebraska WIC Program will promote this media campaign in conjunction with August Breastfeeding Month. Clients are being referred to the Breastfeeding Assistance Line which is supported with Title V funds. State WIC Program staff participated in training offered by USDA on the implementation and management of a breastfeeding peer counselor program. Manual breast pumps are provided to all WIC local agencies and are given clients that need help managing short-term breastfeeding concerns.

Two Title V funded community-based projects address breastfeeding. One of these projects is the toll-free breast-feeding assistance line referenced above.

### c. Plan for the Coming Year

The Nebraska WIC Program goals for FY2005 include: Piloting a breastfeeding peer counselor program in at least one WIC local agency; training WIC clerical staff using the breastfeeding peer counselor curriculum; monitoring pump lending program to determine if the provision of an electric pump has an effect on breastfeeding duration; developing a client-centered protocol for breastfeeding education for pregnant and breastfeeding women; redesign the breastfeeding

survey to identify barriers to breastfeeding duration.

A collaborative initiative lead by the Perinatal, Child and Adolescent Health Unit and the WIC Program is planned for 2005. This initiative will have as its primary purpose the development of consensus and shared expectations for the promotion of breastfeeding in Nebraska. Key stakeholders to be involved will be lactation consultants, WIC nurses and nutritionists, primary care providers (OB/GYNs, family physicians, pediatricians, PAs, nurse practioners), local public health departments, Tribal health programs, hospitals, employers, and child care providers. This initiative will be coordinated with another project underway addressing safe sleep environments, in order to resolve differing views on bed sharing

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

#### a. Last Year's Accomplishments

Nebraska Revised Statute SS71-4739 provided for voluntary newborn hearing screening in Nebraska. This statute established a goal of 95% of newborns screened for hearing before hospital discharge by December 31, 2003. If that goal was not met, the Department was to establish regulations requiring screening.

During calendar year 2003, hospitals reported screening the hearing of 97% of newborns during their birth admission. This compares to 89% in 2002. Activities that helped contribute to this increase included utilizing Nebraska Health Care Cash Funds to provide financial assistance to fourteen additional hospitals. The funds were used for the purchase of newborn hearing screening equipment and program development. By the end of 2003, the number of hospitals that provided newborn hearing screening had increased to 67 (100% of birthing hospitals). Program staff worked with local providers and Early Intervention staff to improve referrals for diagnosis, treatment and other support. Work continued in the area of parent education and refinement of screening methods and referral protocols.

These activities are a mixture of infrastructure-building (data base development, work with hospitals and referral networks) and population-based (screening and tracking activities). The target population is infants.

#### b. Current Activities

The Nebraska Newborn Hearing Screening Program continues to work with health care providers, parents, and hospitals to maintain and exceed the goal of 95% of all newborns screened before hospital discharge. Work has begun on development of a newborn hearing screening tracking and follow-up module that is integrated with the State of Nebraska's electronic vital statistics reporting system. A mini-grant from the American Academy of Pediatrics provided funds to gather input from physicians and hospital personnel for the electronic data system. Nebraska has been selected for the Hearing Head Start pilot project, beginning in September 2004. Training and technical assistance will be provided to at least five Early Head Start, migrant, and American Indian grantees.

#### c. Plan for the Coming Year

With the goal of 95% of all newborns screened before hospital discharge having been met, program activities will focus on carrying-out the ongoing mandates of Nebraska Revised Statute SS71-4739: maintain a tracking system, collect required data, apply for available federal funding, and provide consumer education. Work will continue on development and

implementation of the electronic data reporting system and implementation of the Hearing Head Start pilot project. Work will also continue on improving and enhancing screening, testing, and referral activities.

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

#### a. Last Year's Accomplishments

FY 2003 saw further erosion in the State's revenue projections. Additional steps were taken to curb spending. These steps included the elimination of presumptive eligibility for children under Kids Connection, Nebraska's State Children's Health Insurance Program (a Medicaid expansion). In addition, 12-month continuous eligibility under this program was reduced to 6 months. The Ribicoff Program was eliminated, thus impacting Medicaid coverage for a group of older adolescents.

As stated earlier in this application, a conscious decision was made to invest more Title V funds in infrastructure building. As a consequence, less funds supported direct care. Four community-based projects support direct care. A new CSHCN service provider was added (Great Plains Medical Center's pediatric feeding and swallowing team).

Nebraska has five federally qualified health centers and five Indian Health Services Facilities. The newly established local health departments are gradually building their capacity to assess MCH needs locally, and will assuredly play a role in addressing the needs of the uninsured population over time.

The Medically Handicapped Children's Program has long been the payer of last resort for CSHCN without health insurance. In addition, Title V funds supported clinical consultation through multidisciplinary clinics sponsored by the University of Nebraska Medical Center's Munroe Meyer Institute.

Target populations for the Title V funded direct services were: pregnant women, infants, children, and children with special health care needs.

#### b. Current Activities

During FY 2004, the activities described have continued. In addition, the Office of Public Health received funding for the Nebraska State Planning Grant in October 2003 to address the problem of the uninsured in the state. The Governor appointed members to the Nebraska Health Insurance Policy Coalition to provide guidance and oversight to the project. To date the program has conducted a household survey to identify characteristics of the uninsured, the barriers to insurance, and the estimated number of under-insured. Employers were also surveyed because of their role in providing health insurance. Focus groups were also conducted to identify barriers to obtaining health insurance beyond cost, to better understand how decisions are made concerning the purchase of health insurance, and to identify participants' perceptions on a few strategies for expanding health insurance coverage in the state. Preliminary reports will be available later this year and a strategy is in the development stage as well. This project should provide valuable insight on the uninsured in addressing the MCH population.

#### c. Plan for the Coming Year

Nebraska Title V will make every effort to hold the course and sustain services currently available, including direct health care for the uninsured MCH/CSHCN populations.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

**a. Last Year's Accomplishments**

During FY 2003, Nebraska saw further reduction of eligibility standards to the Medicaid population. These are described under NPM #13.

Rural Nebraska continues to present real challenges regarding access to care for all populations, including MCH and CSHCN eligible for Medicaid. Medicaid managed care is only in place in 3 urban counties (Douglas, Sarpy, and Lancaster). The PHONE project, financed with Medicaid administrative funds (75%) and local match (25%), plays an important role in assuring access to Medicaid benefits for families living in rural Nebraska.

The Public Health Outreach Nursing and Education program (PHONE) is a contracted service with Nebraska HHSS. It provides community outreach and education to Medicaid and Kids Connection eligible families. Through PHONE, public health nurses are available statewide (90 rural counties) to assist health care providers with: missed or late appointments; failure to present Medicaid/Kids Connection cards at appointments; failure to comply or follow-up with recommended medical, dental or vision care; inappropriate use of the emergency room; transportation barriers; or lack of coverage. The PHONE nurses assist eligible or potentially eligible Medicaid/Kids Connection families by: helping to find medical, dental or vision homes, assisting with the application process; providing education on accessing appropriate levels of care; identifying barriers; and offering information on community resources and assisting with referrals.

Seven of the 9 PHONE contractors/subcontractors are now also Title V-funded projects, expanding the opportunities for coordination and integration. Significant levels of coordination and integration occurred between PHONE and Title V-funded activities.

The referrals and presumptive eligibility determinations carried out by the Title V/MCH and CSHCN providers and the PHONE nurses are enabling services and the target populations are infants, children, and CSHCN.

**b. Current Activities**

See Current Activities for NPM #13, which also relate to this performance measure. The PHONE project continues, as described above and recently expanded to 18 contracts. The PHONE contractors are primarily located in newly formed Health Departments. Rural Medicaid eligible families benefit from this expanded service because nurses will be available in more areas in the state and not have to cover such large geographic regions.

**c. Plan for the Coming Year**

Title V funded community-based projects will continue to refer children to Medicaid as appropriate and maintain the close working relationship with the PHONE project.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

**a. Last Year's Accomplishments**

No specific new activities were initiated specifically to address rates of very low birth weight

births during this period. Omaha Healthy Start, the Aberdeen Area Healthy Start, and CRIB projects continued to address infant mortality risks, including VLBW.

Within HHS, the Title V-funded Perinatal, Child and Adolescent Health Unit carried out a number of projects with potential impact on this measure. Prenatal tobacco cessation activities were carried out with tobacco settlement funds for the second and final year. The media/information campaign materials were finalized and were in production.

Four community-based projects funded through Title V have a tobacco cessation component. Seven of the community-projects funded with tobacco settlement funds in the first year continued into this fiscal year, and four additional projects were funded during FY 2003. These several projects taken together are building local capacity to promote tobacco cessation among Nebraska women. To reinforce/support this local work, a training session was held in April 2003 to bring local projects together to share successful strategies and gain additional insight into how to build local capacity in this area.

The array of community-projects funded through Title V changed for FY 2003 and thirteen prenatal care projects were funded. Projects include: Blue Valley Community Action (perinatal case management, prenatal education and tobacco cessation for pregnant women), Central Nebraska Community Services, Inc. (home visits for high-risk pregnant mothers and children), Lancaster County Health Department (tobacco cessation for pregnant women), Lincoln Medical Education Foundation, Inc. (screening, assessment, and intervention for pregnant women identified at risk for substance abuse), NAF Multicultural Human Development Corporation (direct care and outreach to Hispanic women and children), Omaha Tribe (direct health care for Native Americans), Panhandle Partnership for Health and Human Services (prenatal case management), Ponca Tribe (direct care), Sarpy/Cass Department of Health and Wellness (prenatal and postpartum smoking cessation), South Heartland District Health Department (develop resources on prenatal/perinatal and infant health), University of Nebraska Medical Center (direct care, prevention and education activities) and Winnebago Tribe of Nebraska (prenatal education).

#### b. Current Activities

At the state-level, the perinatal tobacco cessation media campaign was finalized and materials were produced. The new tobacco prevention campaign targeting women of childbearing age was launched. Physicians and health care providers were sent a display box of promotional materials to help inform women about the hazards of using tobacco.

Four community-based projects were funded to support system and infrastructure building around prenatal tobacco cessation. The thirteen Titles V funded prenatal care projects continued.

During this period, the Perinatal, Child and Adolescent Health Unit is re-assessing approaches to improving pregnancy outcomes. Partnerships with key stakeholders are being strengthened or formed.

#### c. Plan for the Coming Year

At the state level, perinatal tobacco cessation activities will be scaled down due to the discontinuation of tobacco settlement funding. Funds will no longer be available for community-based projects. The media and informational materials will be distributed as long as supplies last, and training in brief intervention techniques would be offered only if alternate funding sources can be identified. The thirteen Title V funded prenatal care projects will continue.

The Office of Family Health and the Perinatal, Child and Adolescent Health Unit will be initiating renewed efforts to address pregnancy outcome, including VLBW. The Office and Unit is partnering with Baby Blossoms (formerly Omaha Area Perinatal Collaborative) and Medicaid Managed Care to do planning and quality assurance projects. Focus of the collaboration projects will be preconception care and prenatal care quality assurance, respectively.

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

**a. Last Year's Accomplishments**

In Section IV. B., gaps in injury prevention activities are described, including youth suicide prevention. Office of Family Health staff participated in the development of a statewide injury prevention plan, but again, this planning process did not focus on suicide among youth.

With organizational and administrative changes made in the Child Death Review Team (CDRT) late in FY 2002, suicide among Nebraska children and adolescents will receive renewed attention in terms of better understanding the circumstances associated with these events.

Activities related to this performance measure have thus been infrastructure building.

**b. Current Activities**

The statewide injury prevention plan has recently been released. The Child Death Review Team continues its work; its report on 1996-2001 deaths is currently in press. In its work to date, the team has identified suicide deaths that had not been reported as such on death certificates. Under reporting may be masking the full scope of youth suicide in Nebraska. The modest decline in the rate of suicide deaths is thus difficult to assess.

Again, work continues to be infrastructure building.

**c. Plan for the Coming Year**

With the completion of the state-wide injury prevention plan and the issuance of the Child Death Review Team report for 1996-2001, Nebraska Title V/MCH will have a better framework for developing and/or collaborating on suicide prevention activities. In developing the CDRT report, several connections were made with new statewide organizations involved in teen suicide prevention. We expect to become more involved with their activities.

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

**a. Last Year's Accomplishments**

In Section IV.B. State Priorities, it was pointed out that Nebraska does not have a formal system of perinatal regionalization. Nebraska Title V/MCH has not focused on issues related to maternal transport in recent years. These facts reflect the policy environment, including the absence of statutory provisions related to perinatal regionalization.

Local efforts assessed circumstances surrounding perinatal systems and care provided to VLBW infants. The Omaha Area Perinatal Collaborative (now Baby Blossoms) examined these issues. The Collaborative includes the University of Nebraska Medical Center and the Douglas

County Health Department, both funded in part through the Title V/MCH Block Grant. In addition, the MCH Evaluation and Assessment Coordinator within the Office of Family Health (a Title V funded position and primary staff for the Child Death Review Team) is actively involved in the Collaborative. Though the Collaborative's work is focused on Omaha births and not state-wide births, the fact that births in Omaha are a significant portion of all Nebraska births makes this a project potentially significant one for the state as a whole. This is especially so since the facilities for high-risk deliveries that are located in Omaha are part of networks with more rural hospitals.

#### b. Current Activities

No changes have occurred in terms of policy positions related to perinatal regionalization. The reviews being done of all neonatal deaths by the Nebraska Medical Association may identify trends related to maternal transport.

Based on the Perinatal Periods of Risk Approach (PPOR), the Omaha Area Perinatal Collaborative identified the "periods of risk" found to have the greatest excess deaths and disparities for their population. The group is now moving forward to implement a blueprint for action for the prevention of infant mortality. The Office of Family Health continues to be active in supporting this work. Early work has begun on collaborative planning with Medicaid Managed Care to develop a prenatal care quality assurance initiative. This quality assurance project may address maternal transport issues.

These activities would be best described as infrastructure building.

#### c. Plan for the Coming Year

Baby Blossoms will continue its work into FY 2005, as will the neonatal death reviews being conducted by the Nebraska Medical Association. The work of these two groups will be considered together in making decisions related to perinatal systems. In addition, partnerships will continue with Medicaid Managed Care in developing a quality assurance initiative. Models for cooperative quality assurance with rural hospitals and providers will be explored.

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

#### a. Last Year's Accomplishments

See FY 2003 Accomplishments for NPM #15 for a description of Title V accomplishments related to prenatal care.

#### b. Current Activities

See Current Activities for NPM #15 for description of Title V activities related to prenatal care. In addition, the work of Baby Blossoms, described under NPM #17, is addressing prenatal care issues through various efforts, including use of the Perinatal Periods of Risk construct.

#### c. Plan for the Coming Year

A number of quality and access to care issues that were to be examined during 2004 will be carried over into 2005. The Perinatal, Child and Adolescent Health Unit Manager position was vacant from July 2003 until January 2004. The new manager has been familiarizing herself with the issues, needs, barriers and opportunities related to prenatal care. During 2005, she will be

actively pursuing collaborations with health insurance plans, health provider associations, and the public health community. //2005//

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**  
List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Screen, refer, track, & facilitate treatment for 6 disorders as per Neb. Rev. Stat. 71-519 to 524	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue quality assurance activities with hospitals, contracted laboratory, and referral networks.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Implement new regulations developed in response to LB 119.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Reinstigate professional education activities, including a routine newsletter.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Expand patient education materials including mult-lingual and non-written media.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Continue to provide multi-disciplinary specialty clinics, with families as members of these team.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Specialty team provides written recommendations to family and copies provided to service providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue integrated model of delivering MCHP and Early Intervention Services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Utilize satisfaction survey responses for evaluating and improving services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. MHCP staff will continue to work with families in identifying a medical home.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Utilize a medical home indicator as part of the computer tracking system for CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue to provide training to staff and work with stakeholders in promoting medical home concept.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate w/ Early Development Network & Community Based Medicaid Waiver staff in making referrals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Advocate with Medicaid for eligibility of CSHCN for all available services.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide services through MCHP.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Refer to private and public insurance programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Fund Genetics/Neuro Behavioral Clinic through UNMC.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Integrate services for CSHCN, using CONNECT system for tracking.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Share application forms between programs as permitted by families.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Maintain Life Span Respite Subsidy application online.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue to implement telemedicine option in cooperation with Medicaid, NDE, and UNMC.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Integrate genetics outreach clinics with specialty clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Maintain QA standards for transition referrals for CSHCN served by speciality clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue collaboration with Vocational Rehabilitation program for referrals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Administer public immunization clinics in 85 counties and support 207 private VFC providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Maintain current immunization registry for all public clinics (except in				

Lancaster Co.)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue participation in Hallmark Card Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Provide Title V funds to 3 community projects with immunization components.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Study and develop plan for expanded or enhanced immunization registry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Implement Varicella rules and regulations for children enrolled in school and licensed early childhood programs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Continue to administer Title X Family Planning and Abstinence Education programs.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide Title V funding to 3 community projects with teen pregnancy prevention components.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue collaborations with teen pregnancy prevention and asset building coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Continue to provide statewide system development efforts through NE Dental Health Division.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue work with providers and Medicaid to increase access to oral health services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide Title V funds to 3 community projects with oral health components.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continue to conduct the mouth survey of 3rd grade school children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Collaborate with NE Safe Kids Program in promoting child passenger safety.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate in the implementation of the state injury prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Administer Child Death Reiew Team activities and use findings in planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Incorporate injury prevention into childcare provider curricula.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provide Title V funds to 1 community project with a child motor vehicle safety component.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Provide comprehensive breastfeeding support and promotion through NE WIC Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Monitor the WIC program's breast pump loan program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Participate/coordinate the nationwide media campaign to promote exclusive breastfeeding for 6 months.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continue Title V support of state wide breastfeeding helpline.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide Title V support for 2 additional community projects supporting breastfeeding.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Establish a breastfeeding stakeholder group to develop a statewide promotion plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Pilot a breastfeeding peer counselor program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. NE Newborn Hearing Screening Program continues work with NE hospitals in promoting screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Maintain tracking system and provide consumer education.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Maintain QA system for screening, referral, diagnosis, and treatment services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop and implement an electronic data reporting system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement the Hearing Head Start pilot project.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Refer children to the degree possible to Medicaid program.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Continue to advocate for Medicaid coverage for the largest possible number of children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with FQHC's and provide Title V funds for other community clinic services.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Continue to provide Title V funds to 7 out of the 9 Medicaid PHONE projects.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to provide referrals to Medicaid at all applicable Title V funded clinics.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

15) The percent of very low birth weight infants among all live births.				
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1. Provide Title V funds to 13 community projects that provide direct/enabling services to pregnant wom	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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2. Support population-based prenatal tobacco cessation campaign in cooperation with Tobacco Free NE.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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3. Re-assess approaches to improving pregnancy outcomes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
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1. Collaborate in the implementation of the statewide injury prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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2. Provide administrative support to Child Death Review Team and use findings for planning activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
----	--------------------------	--------------------------	--------------------------	--------------------------

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
----	--------------------------	--------------------------	--------------------------	--------------------------

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
----	--------------------------	--------------------------	--------------------------	--------------------------

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
----	--------------------------	--------------------------	--------------------------	--------------------------

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
----	--------------------------	--------------------------	--------------------------	--------------------------

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
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1. Support the work of Baby Blossums for the prevention of infant mortality.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
2. Continue contract with Nebraska Medicaid Association for reviews of neonatal deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3. Collaborate with Medicaid Managed Care to develop a prenatal care quality assurance initiative.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>NATIONAL PERFORMANCE MEASURE</b>				<b>Pyramid Level of Service</b>			
				<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.							
1. Provide Title V funds to 13 community projects providing direct/enabling services to pregnant women.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Coordinate activities with Baby Blossums around access issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3. Coordinate activities with Omaha Healthy Start and Aberdeen Area Healthy Start.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

**D. STATE PERFORMANCE MEASURES**

**State Performance Measure 1: SPM#3 - Incidence of confirmed SIDS cases/1000 live births among African American and Native American infants**

**a. Last Year's Accomplishments**

This state performance measure was chosen to address the following priority needs: "reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities" and "eliminate racial and ethnic health disparities." While the incidence of SIDS in Nebraska has decreased by over 50% since the inception of the "Back To Sleep" campaign in 1994, the rate of SIDS death among African American and Native American infants has been as much as three times higher than that for white infants.

The SIDS risk reduction tee shirt campaign continued into 2003. The partnership supporting this effort expanded and included previous and new partners: the Douglas County Health

Department, Omaha Healthy Start, Community Resources for Infants and Babies (CRIB), the Nebraska SIDS Foundation, the Nebraska Hospital Association, the Junior League of Omaha, the NHHSS Office of Minority Health, the Doral Group, and the Nebraska Minority Public Health Association. Once again, 100% of Nebraska's birthing hospitals participated.

The prenatal tobacco cessation activities were scaled down, as previously described, due to the reductions in tobacco settlement and state general funding for all prevention/cessation efforts. The Office of Family Health continued to promote the media campaign/educational materials component to the degree possible with other resources, including Title V funds.

One community project (Omaha Tribe) targeted Native Americans in SIDS/infant mortality prevention.

Both local and statewide activities could be considered population-based services, and the target population being postpartum women and other caregivers of infants.

#### b. Current Activities

One community project continues to provide population-based SIDS/infant mortality prevention to Native Americans. Currently, an evaluation is being completed on the tee shirt campaign. The perinatal tobacco cessation project continued into 2004, and it has been described in more detail in earlier sections of this application.

Current research on safe-sleep practices is being reviewed to determine best educational approaches to issues such as bed sharing. The program manager for Perinatal, Child and Adolescent Health attended a Safe Sleep Symposium which addressed risk factors, best practices, a medical examiner's perspective and front line efforts. Yet this year, a joint planning process that focuses on safe-sleep and breastfeeding promotion will be initiated.

#### c. Plan for the Coming Year

The partners described above will continue to work with the Office of Family Health in refining and enhancing approaches to SIDS prevention. Options currently being explored will be implemented to the degree determined feasible with available resources. Special attention will be given to safe-sleep practices, and designing educational approaches that reflect current research and that respond to cultural issues.

### State Performance Measure 2: *SPM#4 - Percent of women of childbearing age who report smoking in the last 30 days*

#### a. Last Year's Accomplishments

This performance measure was chosen as a way to track progress in addressing Priority Need # 6 -- reduce use of tobacco, alcohol, and illicit substances among youth and women of childbearing age. It also provides some measure of a significant risk factor associated with another priority need, Priority Need # 5 -- reduce rates of infant mortality with an emphasis on eliminating racial/ethnic disparities.

Staff within the Office of Family Health carried out a number of key activities related to this measure, many of which have been referenced else where in this application. Perinatal tobacco cessation activities being carried out with tobacco settlement funds were in the second and final year. The media/information campaign materials were finalized and produced.

Four community-based projects were funded through Title V have a tobacco cessation component. Seven of the community-projects funded with tobacco settlement funds in the first year continued into this fiscal year, and four additional projects were funded during FY 2003. These projects taken together built local capacity to promote tobacco cessation among Nebraska women. To reinforce/support this local work, a training session was held in April 2003 to bring local projects together to share successful strategies and gain additional insight into how to build local capacity in this area.

These efforts are population-based and infrastructure building services, and the target populations are pregnant women and women of childbearing age.

#### b. Current Activities

The Perinatal media/information campaign materials were produced after a public relations firm tested attitudes and knowledge of Nebraska women of child-bearing age as it related to tobacco cessation messages. The campaign was implemented this year and includes a box of promotional materials (patient brochures, posters, chart stickers, health care provider lapel buttons, pocket guides, etc.). These boxed sets were sent to primary care providers as a direct mailing, and are available to other providers upon request.

A tobacco cessation quit-line was promoted, until its discontinuance in May 2004 when funds were no longer available for the line.

As stated earlier in the section on State Priorities, four community-based projects funded through Title V have a tobacco cessation component. Four additional community projects, with the support of tobacco settlement funds, continued in this fiscal year. These projects are building local capacity to promote tobacco cessation among Nebraska women.

#### c. Plan for the Coming Year

As stated in previous sections of this application, tobacco settlement funds will no longer be available to support a comprehensive prenatal/perinatal tobacco cessation program. The Office of Family Health will continue the media/information campaign as long as materials remain in stock. To the degree possible, training/technical assistance for local efforts will continue in collaboration with a scaled-down Tobacco Free Nebraska Program. Title V support of currently funded community-based projects will continue.

### State Performance Measure 3: *SPM#5 - Incidence of neural tube defects per 10,000 live births*

#### a. Last Year's Accomplishments

This measure relates to Priority Need #5- reduce infant mortality with an emphasis on racial/ethnic disparities. Neural tube defects are among the most common birth defects contributing to infant mortality and morbidity, and one-half to two-thirds can be prevented through the daily use of folic acid among women of childbearing age.

The Office of Family Health had previously coordinated folic-acid promotion/neural tube defect prevention activities, but due to competing needs/issues staff had limited time to sustain the collaborative efforts started in earlier years. When a small March of Dimes grant became available to support these efforts, the Office of Women's Health was approached to take over the lead role in folic-acid promotion. That Office did accept the challenge and was awarded the March of Dimes grant and began planning/organizational efforts to reinvigorate the campaign.

Through the March of Dimes project, focus groups were held regarding knowledge and attitudes about folic acid. Results indicated that women prefer to eat fortified foods to taking a multivitamin; and that women who had babies with birth defects were the most effective teachers for other women. Additionally, focus group participants recommended using guest speakers in Health, Child Development, and Sex Education classes to teach teenagers about the importance of folic acid.

Family planning clinics were also contacted through the project regarding their knowledge of and provision of folic acid information to clients. All clinics provide some folic acid information in initial packets given to clients, and all are interested in increasing their efforts.

The Nebraska Grocer's Association was contacted about adding a folic acid message to grocery bags throughout the state, but it was determined that such a project would have to occur at the national level. The March of Dimes and the Centers for Disease Control and Prevention were suggested as organizations that could lead such a project.

The Nebraska Pharmacy Association was contacted about assisting with promoting folic acid use. The group is interested in participating, and offered to add a flyer about folic acid to all birth control prescriptions, and include information on the campaign in their monthly journal.

A webpage was developed to convey information on folic acid. It is part of the Office of Women's Health website, and can be found at [www.hhs.state.ne.us/hew.owh](http://www.hhs.state.ne.us/hew.owh).

Activities are primarily population based, with women of childbearing age being the target population.

#### b. Current Activities

The Office of Women's Health continues to take the lead in the Department's efforts to promote folic acid use by women of childbearing age. Through contractual arrangements, that office completed the focus groups with women of child bearing age to assess knowledge of and barriers to using folic acid. In addition, these contractors are working with both family planning agencies and the parish nurse network to incorporate folic acid counseling into their respective settings. Work is also being done with the pharmacy and grocery associations to follow-up on work done the previous year.

#### c. Plan for the Coming Year

The Office of Women's Health will continue with projects described for the current year, and utilize focus group findings for refining approaches.

The webpage will continue, and will be updated as necessary. Through a partnership with the Olson Center for Women's Health, bookmarks with a folic acid message will be created and distributed to libraries across the state. Folic acid information remains part of the Office of Women's Health display at conferences, health fairs, and

State Performance Measure 4: *SPM#6 - Hospitalizations for injuries (per 100,000), bith to 14 (intentional and unintentional)*

#### a. Last Year's Accomplishments

This measure was chosen as a means for assessing progress in addressing Priority Need #7 -

-reduce rates of injury, both intentional and unintentional, among MCH/CSHCN.

As described under State Priorities and NPM#10 and NPM#16, the Office of Disease Prevention and Health Promotion provides leadership for the agency in the area of injury prevention. See these earlier sections for details.

#### b. Current Activities

Related information is provided in NMPs #10 and #16. In addition, a collaboration between the Nebraska SAFE KIDS Program and the Office of Family Health's SSDI Project resulted in the preparation of "The Report on Unintentional Fall Related Injuries, 2001 Data." This report identified falls as the leading cause of injury-related hospitalizations for Nebraska children, and provides insight into risk factors associated with this major cause of injury.

The Annual Performance Objective for this measure has been revised for 2003.

#### c. Plan for the Coming Year

See NPMs #10 and #16 for related information. And as stated for Current Activities, "The Report on Unintentional Fall Related Injuries, 2001 Data" provides insight into the nature of fall related injuries among Nebraska children. The report goes on to offer recommendations for prevention efforts. The Office of Family Health will collaborate with Nebraska SAFE KIDS in implementing those strategies feasible within resource constraints.

### State Performance Measure 5: *SPM#7 - Percent of teens who report use of alcohol in the last 30 days*

#### a. Last Year's Accomplishments

This measure was also chosen to gauge progress in addressing Priority Need #6 -- reduce use of tobacco, alcohol, and illicit drugs among youth and women of child-bearing age.

Title V state-level infrastructure contributed to the State Incentive Cooperative Agreement (SICA), a state/federal partnership to reduce substance abuse among youth ages 12 to 17. Two staff of the Office of Family Health actively participated in work groups that were instrumental in designing strategies to deliver \$7.5 million dollars in federal funds (SAMSHA) over a three-year period to community partnerships throughout Nebraska.

Title V also supported several community-based organizations' direct care and population-based services directed towards pregnant women at risk of substance abuse. In addition, an urban Native American organization using a youth development model enhanced protective factors insulating youth from the risks of alcohol, tobacco, and drug use.

#### b. Current Activities

The SICA-sponsored Nebraska Risk and Protective Factor Student Survey implemented in conjunction with Nebraska schools and communities, is identifying baseline data on risk and protective factors within communities across the state. Governor Johanns announced June 1st that 14 community coalitions will be awarded \$2.7 million in first-year SICA funding to implement culturally and locally appropriate substance abuse prevention policies, practices, and programs directed towards youth ages 12 to 17. Five additional local health departments received MCH-specific infrastructure funding in FY2004, with three departments to assess,

plan, and collaborate with partners around general issues related to MCH population including substance use. Two local health department assessments completed in the previous year detected substance abuse needs in the county and/or district.

c. Plan for the Coming Year

Community-based projects will continue to be supported with Title V funding. Title V capacity invested in SICA state-level work groups is expected to lead to continued collaboration to address child and adolescent health through violence prevention planning, with the common thread between these activities being risk and protective factors.

State Performance Measure 6: *SPM#9 - Percent of Medicaid-participating dentists who see 25 or more Medicaid patients each month*

a. Last Year's Accomplishments

Because Nebraska has limited capacity to collect data for NPM #9, this state performance measure was chosen as an alternative for tracking progress in assessing Priority Need # 3 -- increase access to quality oral health care for MCH/CSHCN population.

See NPM #9 for related activities.

b. Current Activities

See NPM #9 for related activities.

c. Plan for the Coming Year

See NPM #9 for related activities planned for FY 2005.

State Performance Measure 7: *SPM#10 - Percent of CSHCN seen at CSHCN multidisciplinary team clinics that receive recommended nutritional follow-up services*

a. Last Year's Accomplishments

Nutrition for children with special health care needs is an ongoing priority of MHCP. This priority is addressed by a nutritional consultant (Licensed Nutritional Medical Therapist, LMNT) on all Specialty Services for Children and Youth multidisciplinary teams with input regarding the number who receive/have received nutritional counseling, those referred for nutritional counseling and numbers who receive nutritional counseling.

Every effort has been made to assure the LMNT is trained and experienced in working with children with special health care needs through review of their resume of training and experience before contracting for Team membership. CSHCN, Medicaid and Home and Community Based Medicaid Waiver staff participated in a special task force with the Nebraska Dietetic Association, University of Nebraska System licensed LMNT's, and representatives of programs to increase nutritional awareness and services to persons with special needs to draft policies and procedures for providing LMNT services to these programs. As a result of these meetings Medicaid, Home and Community Based Medicaid Waiver and MHCP policies and regulations have changed to make it easier for these populations to receive paid LMNT

services.

The MHCP and Waiver Services Programs encourage LMNT home visits by allowing special rates. Policy for MHCP includes in-home LMNT assessments and follow-up consultation for those families and children who are not seen by an MHCP multidisciplinary Team upon request of the family or the MHCP Services Coordinator.

**b. Current Activities**

Continued activities as above and system and policy changes as needed to meet the purposes of this priority.

**c. Plan for the Coming Year**

Continue activities as above and system and policy changes as needed to meet the purposes of this priority. Our goals for these nutritional activities are to improve financial support for LMNT services, improve the health/nutrition of children with special health care needs and to assist in educating the services system and families of new nutritional knowledge as it becomes available.

**State Performance Measure 8: *SPM#11 - Rates of hospitalization due to asthma among children ages 5-14***

**a. Last Year's Accomplishments**

This performance measure was chosen as a means to monitor progress in addressing Priority Need # 1 -- childhood morbidity and mortality due to asthma needs to be reduced.

As described in the earlier section on State Priorities, the Office of Disease Prevention and Health Promotion has been administering a CDC asthma grant. During FY 2003, staff funded through this grant continued planning and collaborative work. The School and Child Health Nurse Coordinator coordinated efforts with this project, linking them to school nursing and Healthy Child Care Nebraska activities.

Attack on Asthma Nebraska continued its pilot project with selected Nebraska schools. Based on the results of this pilot, the Nebraska Board of Education voted in May 2003 to make the protocol mandatory by May 2004.

These activities have been primarily infrastructure building, with some population-based services starting late in the period. The target population is children with special health care needs.

**b. Current Activities**

Three community-based projects are receiving funds for asthma related activities. Coordination continues with the CDC-funded asthma project in the Office of Disease Prevention and Health Promotion.

**c. Plan for the Coming Year**

Community-based projects will continue into the second year of 3-year project periods. The School and Adolescent Health Nurse Coordinator will continue to work with the Office of Disease Prevention and Health Promotion on asthma protocols and education for schools and

child care, and with Attack on Asthma Nebraska in its efforts to assist Nebraska school districts in complying with the new Board of Education mandate.

### State Performance Measure 9: *SPM#12 - Rates of minority adolescent births*

#### a. Last Year's Accomplishments

This performance measure was chosen as a means to monitor progress in addressing both Priority Need # 4 -- decrease rates of adolescent, non-marital, and unintended pregnancies and Priority Need #10 -- eliminate racial and ethnic health disparities.

Two community-based projects receiving Title V funds during FY 2003 specifically addressed teen pregnancy prevention and/or reduction of other related behavioral risks among racial/ethnic minority adolescents. In addition, Omaha Healthy Start had a teen pregnancy prevention component, and the Nebraska Abstinence Education Program continued to enhance its outreach to racial/ethnic minority youth.

The Nebraska Reproductive Health Program, funded through Title X and Title V, continued its targeting of racial/ethnic minority populations through special projects sponsored by community-based organizations serving primarily racial/ethnic minority women and adolescents. Numerous pieces of educational materials were translated into Spanish. During 2003, Program users with Hispanic origins increased to 18% from 17% in 2001.

Activities are a combination of population-based services and direct care, with the target population being children (adolescents).

#### b. Current Activities

The two community-based projects continue to be funded through Title V. Both are Tribal programs and one is a health center program in a Salvation Army facility.

The Nebraska Abstinence Education Program released an RFP in August 2003. As a result, eight new communities were funded through the grant beginning September 2003. Two of these communities, Columbus and Lexington, each serve large Hispanic populations, with abstinence education now being delivered within these communities. Additional funds were also awarded on a one-time basis to the Winnebago tribal area for the purpose of initiating abstinence education among tribal youth. Both funding opportunities support the grant's first goal to decrease the disparity of abstinence education opportunities among racial and ethnic minority populations.

#### c. Plan for the Coming Year

Community-based projects will be continued, as will efforts through the Reproductive Health Program. New Abstinence Education community projects will be initiated.

### State Performance Measure 10: *SPM#14 - Percent of African American women beginning prenatal care during the first trimester*

#### a. Last Year's Accomplishments

This state performance measure was selected to provide additional information on progress being made in addressing Priority Need #5 -- reduce rates of infant mortality with an emphasis

on eliminating racial/ethnic disparities.

Under NPM #15, community-based projects related to prenatal care are described. Of these, two have African American women as a significant portion of their target population. In addition, Omaha Healthy Start received direct federal funding and addressed the need to improve access to prenatal care for African American women.

The local projects were both direct care and enabling services, and state-level efforts were infrastructure building.

**b. Current Activities**

The Perinatal, Child and Adolescent Health Program Manager attended a regional Healthy Start conference this year with the Omaha Healthy Start Director and three consumers of the program. This conference fostered collaboration and relationship building between Healthy Start and Title V. In addition, the program manager continues to be involved with the work of Baby Blossoms. Involvement with both of these organizations is the first step in renewed collaborations to address this issue/need.

During this current year, the Title V/MCH Director has been participating in the development of a State Minority Public Health Plan. She is chairing a workgroup that is drafting a MCH section, which will include recommendations regarding access to prenatal care.

**c. Plan for the Coming Year**

The Office of Family Health will continue its renewed collaborations with key stakeholders, including Baby Blossoms, Omaha Healthy Start, and Medicaid Managed Care to develop and implement strategies to improve access to prenatal care. The Minority Public Health Plan will provide an important public policy platform from which to launch renewed efforts.//2005//

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) SPM#3 - Incidence of confirmed SIDS cases/1000 live births among African American and Native American infants				
1. Continue SIDS risk reduction tee-shirt campaign at all Nebraska birthing hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Expand SIDS risk reduction collaboration to more organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Support prenatal and post-partum tobacco cessation through media and information campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Assess current SIDS risk reduction efforts and expand to better address safe sleep environments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) SPM#4 - Percent of women of childbearing age who report smoking in the last 30 days				
1. Promote prenatal tobacco cessation media information campaign materials.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide Title V funds to 4 community projects with a tobacco prevention component.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) SPM#5 - Incidence of neural tube defects per 10,000 live births				
1. Office of Women's Health works with family planning and parish nurses in promoting folic acid.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) SPM#6 - Hospitalizations for injuries (per 100,000), birth to 14 (intentional and unintentional)				
1. Coordinate with Office of Disease Prevention & Health Promotion in developing injury prevention plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Support Child Death Review Team and use findings in planning injury prevention activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Implement injury prevention curricula for child care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) SPM#7 - Percent of teens who report use of alcohol in the last 30 days				
1. Provide Title funds to community/Tribal projects addressing youth risk reduction.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Collaborate w/ SAMSHA/SICA project in developing State plan for youth substance abuse prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) SPM#9 - Percent of Medicaid-participating dentists who see 25 or more Medicaid patients each month				
1. Support NE Dental Health Division's work w/ Medicaid and providers regarding access issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide Title V funding to 3 community projects with Oral Health components	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) SPM#10 - Percent of CSHCN seen at CSHCN multidisciplinary team clinics that receive recommended nutritional follow-up services				
1. Continue to include nutritional consultant on all speciality service multidisciplinary teams	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Promote home visits of nutritional consultant by allowing special rates.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) SPM#11 - Rates of hospitalization due to asthma among children ages 5-14				
1. Provide Title V funds to 3 community projects with asthma related activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. School & Child Health Nurse Coordinator works with schools and childcare on asthma protocols.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Coordinate planning activities with CDC - funded asthma grant project staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) SPM#12 - Rates of minority adolescent births				
1. Provide Title V funds to 6 community/Tribal programs addressing risk reduction among teens	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue to administer Title X Family Planning and Abstinence Education Grants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Continue collaborations with Omaha Healthy Start and Aberdeen area Healthy Start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STATE PERFORMANCE MEASURE		Pyramid Level of Service			
		DHC	ES	PBS	IB
10) SPM#14 - Percent of African American women beginning prenatal care during the first trimester					
1. Provide Title V funds to 4 community projects with African American women as a target population		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue cooperative efforts with Omaha Healthy Start and Omaha Area Perinatal Collaboratives		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Use findings from Nebraska Medical Association Neonatal Death Reviews in assessing barriers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct mid-course review of Blue Ribbon Panel's recommendations and progress in implementing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

The Perinatal, Child and Adolescent Health (PCAH) Program, within the Office of Family Health, continues to contract with Nebraska Methodist Hospital to provide the Healthy Mothers/Healthy Babies Helpline, Nebraska's toll-free telephone line, as required by statute. The PCAH Program Manager is the state-level contact person for the helpline. The HM/HB Helpline provides 24-hour nurse-operator service to the MCH population statewide regarding health care questions, and information and referral for the following: Title V and Title XIX providers, Kids Connection, newborn screening disorder-specific information, folic acid supplementation, and perinatal substance use/abuse for Douglas County (with plans of expanding this to statewide service within the next few years). In FY2000, perinatal substance abuse resource/referral services for consumers and health care providers were added to the contract for the HM/HB Helpline. The new Tobacco Cessation Quitline is promoted to HM/HB callers. /2004/ The Helpline will serve as the contact number for ordering materials related to the statewide Perinatal Smoking Cessation Media Campaign, scheduled to be launched in Summer or Fall 2003. //2004// In FY 2001, the average was 65 per month for a total of 784 calls for the year. /2004/ In FY 2002, the monthly average of 54 calls, for a total of 645 calls, represents a 17.7% decrease from the previous year. Year-to-date in FY 2003, the monthly average is 45 calls. /2005/In FY 2003, the average was 44 per month for a total of 522 for the year. Year-to-date in FY 2004, the monthly average is 22 calls. Staffs of PCAH and MCH Planning & Support are identifying the reasons for the downward trend in usage and will take measures to increase

***use of the helpline. //2005//***

/2004/ Title V funds have supported a variety of public health infrastructure development for some time, due to limited public health state funds and previously the absence of statewide local health departments. Beginning in FY 2003, a portion of Title V funds are specifically awarded for "MCH Community Infrastructure." There are 10 qualified local health departments awarded the first year. Overall, half of internal Title V allocations are infrastructure investments, and nearly a third of external awards support infrastructure building.

Title V infrastructure investments are often multiplied, as shown in these examples of cross-cutting community & state efforts. Staff of PCAH, MCH Planning & Support and the Office of Minority Health recently shared ideas for offering cultural competency and CLAS training to health care providers, many of whom are community-level providers supported by Title V funds and other funds administered by the Office of Family Health. Initially, the Office of Minority Health is training in 3 locations to 150 participants. The State Dental Director provides assistance in planning for, and delivering services at, the school-based dental sealant program supported by Title V funds in metro Omaha (see PM). Several Title V-funded providers are members of the MCH Collaborative in Omaha, which is facilitated by the Douglas County Health Department (DCHP). A subrecipient of MCH Community Infrastructure funds DCHD is a veteran MCH capacity-building leader in its own right, and also extends the opportunity to providers through the collaborative.

A small investment of Healthy Child Care funds is being multiplied through a contract with the University of Nebraska Public Policy Center to explore a "MCH virtual institute" concept. The Center is a member of the Nebraska Educational Alliance for Public Health Impact (NEAPHI). NEAPHI, established in 2000, is an informal association of academic and practice organizations concerned with the state of Nebraska's public health workforce. NEAPHI's long-term goal is to build and sustain capacity in Nebraska to improve the public's health, a natural fit with MCH capacity building.

In May 2003, a two-day training was provided to a small group of the Nebraska's public health workforce, supported by funding by the State Systems Development Initiative (SSDI). Richard A. Krueger, Ph.D., Professor and Evaluation Leader, University of Minnesota, trained 24 State-level public health leaders to design and conduct focus group interviews. SSDI funds also supported the Program Development and Granting Writing training. In 2002, 230 participants attended the two-day training provided to state- and community-level public health workforce in 5 locations throughout the state.

Monitoring subrecipients, as required and described in the OMB Circulars, is a primary role of the pass-through entity. Due to limited FTE of internal Grants and Cost Management staff to conduct on-site financial reviews, part of the responsibility of monitoring Federal funds relies on a contractor paid with Title V funds to conduct these reviews. Another contract resulted from audit findings on earmarking for FY 2000 and FY 2001. NHHS sought technical assistance from MCHB regarding grants and financial management. The MCHB offer did not meet the needs as identified in the audit corrective action plan. Title V funds were expended for a contractor to identify and clarify the issue, and recommend strategies to resolve it. Many hours of state staff time have also been invested towards resolving this audit finding. The investment of staff time and consultation with a nationally-recognized expert will have long-term administrative benefit, e.g. enhanced understanding of the OMB Circulars and paperwork reduction clearance process. The most immediate need to achieve audit resolution, however, has not been accomplished. //2004//

***//2005/ During 2004, the MCH Planning and Support Unit provided leadership in the organization and presentation of a series of grants management audioconferences for HHSS staff and staff of subgrantees and potential subgrantees. This training was provided for all federally funded programs within the HHSS and was supported with each agency's pooled funds.//2005//***

## F. TECHNICAL ASSISTANCE

As previously described, the Office of Family Health invited a consultant, under the auspices of the United States Department of Health and Human Services Region VII Office, to visit Nebraska in 2001 to determine needs and recommendations regarding Nebraska's Title V Funds Allocation System. To reiterate, this consultant, Donna J. Petersen, MHS, ScD identified various needs, including: integrated data systems; attention to the needs created by the growth of diverse racial/ethnic minority populations; development of infrastructure and integrated systems to support families regardless of their economic circumstances; more targeted technical assistance and consultation to external agencies and communities; more precise and relevant quality assurance systems; an information dissemination strategy targeting local public health entities, partners, and the general public; and the support of enabling services that facilitate access to direct service provided by others, such as interpreter services, transportation, respite care, and outreach. The consultant noted that a relatively small investment in critical functions can leverage much greater investment outside the agency by supporting the development of systems that respond to needs appropriately and that work in partnership to secure desired outcomes.

The consultant recognized the opportunity that MCH programs and other state programs will have with the development of a new local health infrastructure. She recommended that State Title V/MCH and Medically Handicapped Children's Programs develop the capacity to support this emerging local health network by participation in the development of comprehensive integrated databases; development of guidelines for local agencies, tools for assessment and planning, and performance standards; development and implementation of quality assurance standards; support for inter- and intra-agency partnerships to shape systems of services; and provision of technical assistance and consultation to state agencies, private entities, and local communities.

The Office of Family Health and its MCH Planning and Support Unit has utilized Dr. Petersen's recommendations in a number of ways. One very significant outcome of her consultation was the development of a request for proposal (RFP) process during the Spring of 2002. One of the new features seeks to more equitably distribute funds into all areas of Nebraska. The state's 93 counties have been grouped into four regions to accomplish a statewide distribution of MCH funds. The levels of funding for part of these funds are now based on a geographic formula using a relative risk assessment. A second new feature, also based on a geographical formula, is the MCH capacity-building activities. While infrastructure has previously been important, it is now paired with the development of local public health departments statewide. Passage of LB692 in the NE Unicameral in 2001 provided incentive to establish local public departments. This RFP provided for MCH infrastructure-building funds specifically for those local health departments qualifying for the County Public Health Aid Program as detailed in LB692.

Another new feature of the RFP was that community-based services and projects with statewide impact are set apart from those activities on a smaller scale. Statewide is defined as activities that take place in or have an impact on at least 2/3rds (62) of Nebraska's 93 counties. The final new feature of the RFP was a set-aside of funds for Native American MCH services and infrastructure. Because the four federally recognized Tribes of Nebraska have unique government-to-government relationship with the State of Nebraska and in recognition of their sovereignty, this separate set-aside-funding component was established. Proposals were due July 1, 2002, and 29 agencies were awarded funds to support 31 projects beginning October 1, 2002.

For FY 2004, the Office of Family Health is requesting technical assistance in assessing the RFP process and its outcomes, particularly, was the RFP successful in translating Dr. Petersen's recommendations into action and was it effective in making sound investments of Title V funds to address State needs. In addition, with changing fiscal and policy environments, this assessment would look at the current relevance of the 2001 recommendations and our responses to those recommendations.

We see this requested consultation as being part of the 5-year comprehensive MCH/CSHCN needs assessment. Investment strategies need to be investigated as much as health status and system capacity issues are.

In addition to an evaluation of this RFP process, the Office of Family Health is seeking assistance in designing a methodology for evaluating the needs assessment process currently underway and to be completed in 2005. Finally, the Office is also seeking a contractor to develop a methodology for determining priorities and identifying strategies as the final part of the needs assessment. Therefore we have a 3-part request related to the needs assessment process.

MCH Planning and Support staff are currently researching possible contractors for all three components of this project, and believe that the Family Health Outcome Project with the University of California-San Francisco may be an appropriate choice for any or all components.

***//2005/ This Office of Family Health staff has been exploring these technical assistance options with FHOP and intends to formalize these requests during the remainder of FY 2004. Should arrangements not be completed prior to September 30, 2004, the request will be carried over into FY 2005. //2005//***

A second and separate technical assistance request is help in identifying an appropriate tool for assessing the quality, comprehensiveness and continuity of services for CSHCN delivered through Nebraska's Medicaid Managed Care program. Many survey tools and other instruments have been developed in other states and regions, and Nebraska is seeking assistance in selecting and adapting a tool. A possible contractor for this selection process is the Institute for Child Health Policy.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

/2004/ This is updated in its entirety.

/2005/

***This section is mostly unchanged. References to FY have been updated, as relevant to the present. Nebraska expended the FY 2003 allotment prior to September 30, 2004.***

***Nebraska has longstanding concerns with the budget and expenditure forms and instructions. Our concerns stem from incongruent requirements of an annual report for a grant with a two-year period of availability of funds. Despite our best efforts to clarify and communicate concerns over time, to-date we believe these attempts have failed to be understood. We submitted written comments and recommended changes to Federal entities involved in the review, revisions, and re-approval of the Guidance and Forms in May 2003, although no significant revisions were made to the financial portion of the Guidance and Forms. As a result, this narrative attempts to re-clarify the limitations of the financial forms, as much to justify expenditures of Nebraska's Title V funds for FY 2003.***

***Our longstanding concerns were heightened for FY 2000 and FY 2001. Audits of those years resulted in Federal findings that Nebraska was not in compliance with the statutory earmarking requirements. The corrective action plan to resolve the finding was an extensive commitment of Title V administrative staff time, in consultation with a respected authority on federal policies affecting acquisition, administration and audit of Federal grants. We continue to strive for audit resolution for Nebraska, and we believe ultimately to improve the utility of the information while minimizing the reporting burden to all states.***

***The period of availability of the Federal MCH allotment allows expenditures in the fiscal year or the succeeding one, i.e. a two-year period (42 U.S.C. 703(b)). For example, the FY 2003 report should include expenditures of the allotment that can occur during the period October 1, 2002 - through September 30, 2004, although that is 21/2 months past the FY 2003 report due date of July 15. At best, expenditures of the FY 2003 allotment can only be reasonably reported through May 2004 as it takes time to post and internally report accounting activity and then to compile the required annual reporting forms.***

***The instructions for the annual report's financial forms are vague and contradictory. Form 3 instructions state: "columns labeled \*expended\* are to contain the actual amounts expended for the \*applicable year\*." (Emphasis added). \*Applicable year\* is not defined in the Glossary. Form 3 feeds into sequentially numbered forms, even further confusing the instructions for Form 4 and Form 5, stated: "enter the budgeted and expended amounts for the appropriate \*fiscal year\*." (Emphasis added). \*Fiscal Year\* is not defined either, although is generally understood to mean a 12-month period for accounting purposes, with a caveat that \*Fiscal Year\* is a 24-month period for an allotment with a two-year period of availability of funds. Without clear guidance, Nebraska opted to report expenditures "during" FY 2003 (October 1, 2002 - September 30, 2003), a combination of the FY 2002 and FY 2003 allotments. The attached table depicts the overlap of the two-year period of availability of funds with the fiscal year period, relative to the reporting due date. The shaded cells show the context of the expenditures submitted with this report.***

***Section 506(a)(1) of Title V, Social Security Act [42 U.S.C. 706] states generally the requirement for submitting an annual report. Section 506(a)(3)(E)(b)(1) states that expenditures from amounts received under Title V are to be audited not less than once every two years. The two-year audit period may have been intended to coincide with the period of availability of funds for the Federal allotment. Financial forms re-approved in May 2003 for the Block Grant Guidance & Forms, as part of the required annual report, are not designed for an audit of the***

**two-year period in which an allotment can be expended. This audit limitation is especially critical for the earmarking requirement established in statute. To further confuse the requirement, the terms "payment" and "allotment" are used interchangeably in statute. [Section 705(a)]. Taken together, the provisions for earmarking and the period of availability of funds make a convincing case that the earmark must be met over the period for availability of funds, not over the single fiscal year in which funds are expended.**

**There is one especially bothersome aspect of the audit finding, and so the reason for our persistent approach to make clear the problems with the financial forms. The audit finding proposed questioned costs of \$96,000 for the FY 2000 audit because the auditor was unable to determine if the State met the expenditure requirement for at least 30% for preventive and primary care services for children. In our response to the proposed finding, we successfully argued that the questioned costs were unknown because the annual report did not require reporting expenditures of the allotment. A year later, without audit resolution, the auditors expanded the finding to include all the earmarks (30-30-10) through a scope limitation. (Note: Nebraska's audit findings are the result of the auditors' inability to test records, not due to our withholding information or preventing testing.) To-date we have not been required to pay back funds, however, until there is resolution, the finding remains.**

**Financial reporting in the FY 2003 Report, as in prior years, conforms to the required annual report format showing funds expended in a fiscal year. If audited for FY 2003, it is probable that another finding for earmarking would result. It is not determinable if we could continue to avoid repayment of questioned costs. The table attached illustrates the incongruent requirements, causing the Federal audit finding for earmarking for two consecutive years.**

**One possible solution is to maintain two separate record keeping systems, one for the required annual report based on fiscal year payments and another by expenditures of the allotment. Separate record keeping would be unnecessary if the annual reporting forms were revised to reflect the two-year expenditure of an allotment by subcategories of "Types of Individuals" and "Types of Services". Presently, accounting staff assigns codes to distinguish individual expenditures by allotment within a fiscal year. Additional coding could identify earmarked expenditures of an allotment across the two-year period of availability of funds. Pairing allotment with earmark coding would eliminate the need to keep two separate systems to be compliant with auditing and to continue submitting annual reports in the format prescribed by MCHB.**

**The local community subrecipients (32) are monitored by line items budgets and expenditures to achieve the detail and accuracy to monitor Federal funds. Since subrecipient monitoring is also a compliance requirement, it is not an option to minimize reporting by scaling down the 32 local subrecipients to report only the earmarked, subcategory expenditures. A change in the reporting system for subrecipients of Title V funds would affect 48 subrecipients, especially the 31 reporting by line item. With each report, subrecipients would need to identify expenditures by line items, in addition to reporting for at least the 2 subcategories within the category of "Types of Individuals", i.e. the earmark for "Children" and "CSHCN." For MCH Planning & Support, this would mean a minimum 3 subcategories to include administrative costs. Although somewhat cumbersome to have subrecipients report both by line item and by category expenditures, this still appears to be more feasible than to report one way to MCHB and to maintain another method to achieve audit compliance. We have urged that these data elements be reduced to the absolute minimum needed to allow for compliance with the statute authorizing the MCH Block Grant, i.e. the earmarked 30-30-10. Further, we have suggested that the fiscal data required by Section 706(a)(2)(iv) be combined with the requirement and timing for submission of the reporting required under 45 C.F.R. 96.30(b), i.e. OMB Standard Form 269A "Financial Status Report" (FSR). This would enhance the ability of all states to reconcile periodic financial reports submitted to the Federal government with their annual financial statements audited pursuant to OMB Circular A-133. Further, it would create the ability to demonstrate states' current carry-over authority available under Section 703(b) of the statute.**

***Without the additional accounting records of expenditures by allotment and earmarking, the auditors relied on the annual report (Form 4) to test if the earmarking requirement was met. Form 4 has two limitations to use it for auditing compliance: 1) expenditures are based on the fiscal year (not the expenditures of an allotment); and, 2) the expenditure column of Form 4 "Types of Individuals" combines the Federal expenditures with expenditures of State match ("Federal-State Partnership"), although earmarking is based on the Federal allocation only. 42 U.S.C. 706(a)(2)(iv). (See also, Legislative Briefing Title V Law Legal Compendium, New MCH State Leaders' Orientation Manual, October 2000, pg. 19). In other words, Form 4 does not identify earmarking expenditures because it is a combination of Federal and State funds, nor does it make the necessary distinction between expenditure of an allotment and expenditures in a fiscal year.***

***The FSR reflects the obligations and expenditures for the period of availability of funds, although the format does not incorporate the requirement to categorize expenditures by "Types of Individuals" (Form 4), nor "Types of Services" (Form 5), as required by U.S.C. 706(a)(2)(iv). The non-final FSR (due 15 months into and 9 months prior to the conclusion of the period of availability of funds) seeks obligation of unexpended funds for carry-over authority. The FSR is critical to the Form 2 budget and subsequently the remainder of the financial forms driven by it.***

***Budget-to-expenditure variations (Forms 3, 4, and 5) cannot be explained without discussing Form 2, albeit a budget form in a section to explain expenditures. Specifically, Line 2, Form 2 "Unobligated Balance" is problematic due to misinterpretation of several lines of the FSR, i.e. "Unobligated Balance" and "Unliquidated Obligations," which are similar phrases, but with a distinct difference for budgeting. The FSR seeks the "Unliquidated Obligations," i.e. obligated funds not yet expended. In a non-final FSR, Nebraska calculates "Unliquidated Obligations" as allotment minus outlay. In the final FSR, the same line must be zero. As stated on page 57 of the Block Grant Guidance & Forms, the MCHB instruction overrides the standard instruction for Standard Form 424, Line 15b. ("Applicant") by instructing applicants to report the "Unobligated Balance." That figure feeds Line 2, Form 2. If Form 2 sought the "Unliquidated Obligations" (obligated, unexpended funds) rather than the "Unobligated Balance", the budget would accurately reflect the new allotment plus the carryover from the previous allotment. Accordingly, the definition for "carryover" in the glossary should be revised. Since Nebraska reports zero "Unobligated Balance", our budget reflects only the new allotment. The difference is typically six figures. Nebraska exercises carry-over authority, although is unable to budget carry-over using the present form and instructions, so its grant expenditures exceed budget. A wide variance between FY 2003 budget and expenditures (approximately \$338,627), as with previous years, is explained primarily by the incompatible budget and expenditure reporting formats originating with the misinterpretation of the FSR, which feeds Form 2, Form 3, Form 4, and Form 5.***

***Form 4 requires that administrative costs be reported along with categories of "Types of Individuals". The staff responsible for the administration of Nebraska's MCH Block Grant do not provide services, although administrative costs must be reported among "Types of Individuals Served." Including administrative costs with expenditures for services detracts from the percentage for 30-30 earmarked expenditures, and could contribute to auditing irregularities. Administrative costs would be more logically and accurately reported on Form 5 as part of the subcategory "Infrastructure." Administrative functions contribute to state-level MCH infrastructure by needs assessment, planning, policy development, monitoring, building information systems, etc.***

***//2005//***

## B. BUDGET

/2004/ This is updated in its entirety.

/2005/

***This section remains mostly unchanged. References to FY have been updated, as relevant to the present.***

***Much of what is requested for budget narrative has already been described in the Expenditure narrative, although in it budget features are addressed and clarified as they relate to expenditures. Our determination to make a shift in the context is due to the inextricable relationship of budget and expenditure, and our interpretation that statutory "maintenance of effort" and "earmarking" requirements are based on expenditures. The guidance and forms mistakenly connects these to budget. The Guidance for Section V. "Budget Narrative" confuses these distinctions by instructing the expenditure narrative to precede budget narrative. Logically, expenditures are "subsequent to" budget. Heading Section V. "Financial Narrative" would be more descriptive of the section content as it would be inclusive of budget and expenditures.***

***Budget and expenditures are necessarily intertwined. Understanding the particular function of budget and expenditure are important for accountability, as the use of funds is based in statutory requirements. It is not the intent to minimize the purpose of budgeting, although we believe it is responsible to emphasize our understanding that accountability is entirely related to expenditures. Expenditures, of course, are legitimized by a realistic budget.***

***An introductory statement in the budget Form 2 instruction states: "This form provides details of the State's MCH budget and \*the fulfillment of certain spending requirements\* under Title V for a given year." (Emphasis added.) Contrast budget as a plan for expenditures with actuality being the expenditure of funds. The fulfillment of spending requirements, i.e. "earmarking" and "maintenance of effort", comes with expenditure; it is not a direct result of budget alone. If compliance of earmarking and maintenance of effort were based in budget, although they are not, Form 2 would be further misleading. Due to its limitation to budget carryover (see Expenditure narrative for detail), the earmarkings are percentages of the budgeted allotment, rather than the allotment plus carryover.***

***Amount, source, and time period are critical components in budget and expenditure. Form 2 seeks a budget overview of funds, including "Other Federal Funds" under the control of the person responsible for the administration of Title V. The format does not allow for subsequent report of actual expenditures of the budget amount of "Other Federal Funds." Further, some of these other Federal funds do not mirror the Title V fiscal year period of October 1-September 30, making it difficult to accurately understand the financial relationships between the various sources and amounts of funds to Title V. The sources of Nebraska's other Federal funds are self-explanatory on Form 2. There is an increase for FY 2004 for "Other Federal Funds" under the control of CSHCN Director. State Early Childhood is a new line.***

***Federal Title V support clearly complements Nebraska's effort. Nebraska's budgeted "maintenance of effort", based on FY 1989 State support, has consistently been surpassed. The source of non-Federal funds is a combination of State Comprehensive Systems and local funds and in-kind support to meet both maintenance of effort and the 3:4 match requirement. The largest single source of State support comes thru the Medically Handicapped Children's Program (MHCP), with \$1,458,567 budgeted for FY 2005. Other sources of State funds that complement Title V funding include support to the following programs: the Immunization Program for vaccine purchase, Newborn Metabolic Screening Program which also includes a cash fund from screening fees, Reproductive Health Program, Birth Defects Prevention legislation to support genetic clinics at the University of Nebraska Medical Center, and tobacco settlement funds used for several MCH activities. Altogether State funds budgeted for state-***

**level programs and activities total \$2,615,918. Another \$940,000 is budgeted for match from the 32 subawards expected for FY 2005.**

**The inadequacies of the financial forms to produce meaningful and accountable information is further demonstrated between Form 2, Form 3 and Form 4. Compliance with the 30-30-10% earmarkings is suggested on Form 2 budget, although we interpret the statutory earmarking requirements as the expenditure of allotment. The expenditure of the Federal allocation (Form 3) is shown separate from the earmarked categories of expenditures on Form 4, which are a combination of Federal and State funds. Form 4 cannot be used to determine earmarking compliance, as that is based on the Federal allotment alone. Form 5 is also plagued with the same problems as Form 4, although not in the same statutory compliance since the Form 5 categories are not earmarked. (See Expenditure narrative regarding Form 5 relative to administrative cost and infrastructure.) If administrative costs were incorporated on Form 5, as suggested, Form 5 would need to identify the distinction between budget for Federal and State funds relative to the 10% earmark. We have previously asked on multiple occasions to have a clearer definition of "administrative costs," now more important due to the audit finding of the 10% administrative earmark. None of these requests for clarification have been satisfied.**

**Any significant year-to-year budget variations are difficult to discern, and subsequently to explain, in the present format and instruction limitations to these financial forms.**

**//2005//**

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.