Maternal and Child Health Services Title V Block Grant

Nevada

FY 2022 Application/ FY 2020 Annual Report

Created on 8/27/2021 at 11:43 AM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Helping people. It's who we are and what we do.

Lisa Sherych
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

July 15, 2021

Christopher Dykton, MA
Acting Director
Division of State and Community Health (DSCH)
Maternal Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
U.S. Department of Health and Human Services (DHHS)
5600 Fishers Lane, Room 18N31
Rockville, MD 20857

RE: Maternal and Child Health Block Grant Submission. FFY 2022 Application and FFY 2020 Annual Report

Dear Mr. Dykton:

The Nevada State Division of Public and Behavioral Health, which administers the Title V Maternal and Child Health Block Grant, respectfully submits the Nevada Federal Fiscal Year (FFY) 2022 Application and FFY 2020 Annual Report to the Health Resources and Services Administration.

It is a pleasure to work with federal, state, and local partners to improve and protect the health of families in Nevada.

Sincerely,

Karissa Loper

Karissa Loper, MPH
Health Bureau Chief
Bureau of Child, Family, and Community Wellness

4150 Technology Way, Suite 300 ● Carson City, Nevada 89706
775-684-4200 ● Fax 775-687-7570 ● dpbh.nv.gov

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Program Overview

Nevada's Title V Maternal and Child Health (MCH) Program is dedicated to working with diverse public and private partners statewide to improve the health of families. Funded partners implement activities serving women of childbearing age, pregnant persons, infants, adolescents, and children, including children and youth with special health care needs (CYSHCN). Nevada utilizes Title V MCH funding to collaborate with partners and strengthen community engagement and activities ensuring all MCH populations can access quality health education and preventive services.

Nevada's Title V MCH Program is housed in the Maternal, Child and Adolescent Health (MCAH) Section; Bureau of Child, Family and Community Wellness (CFCW); Division of Public and Behavioral Health (DPBH); Nevada Department of Health and Human Services (DHHS). The Nevada Title V MCH Program website can be accessed at: http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. The Title V MCH Program is committed to funding evidence-based or informed activities and programming to improve the health and wellbeing of the MCH population in Nevada.

Accomplishments and Priorities by Population Domain

Domain: Women/Maternal Health

According to 2019 Behavioral Risk Factor Surveillance System (BRFSS) data, 65.6% of Nevada women ages 18-44 years received a preventive visit in the past year compared to 72.8% of women nationally. Furthermore, according to 2019 National Vital Statistics System (NVSS) data, 75.4% of pregnant women in Nevada received prenatal care beginning in the first trimester, compared to 77.6% in the US during the same year. This percentage is lower for uninsured women in Nevada, with only 60.8% receiving early prenatal care. The Title V MCH Program partners with statewide and regional MCH coalitions, community-based programs, and public and private partners to increase insurance coverage rates and receipt of timely prenatal care among this population.

Nevada's Title V MCH Program collaborates with partners to identify and reduce modifiable risk factors for improving birth outcomes, including racial and ethnic health disparities. Participation continued in the Association of Maternal Child Health Programs (AMCHP) "Infant Mortality Collaborative Improvement and Innovation Network (IM-CoIIN) 2.0." Partners include Local Health Authorities (LHAs), March of Dimes, Division of Health Care Financing and Policy (DHCFP or NV Medicaid), DPBH Office of Public Health Investigations and Epidemiology (OPHIE), Nevada Healthy Start, Washoe County Fetal Infant Mortality Review (FIMR) Committee, Nevada Maternal Mortality Review Committee (MMRC), and the Nevada Home Visiting (NHV) Program. The Nevada IM-CoIIN team convened monthly to address preterm births and Social Determinants of Health (SDOH) related to Pre/Interconception Care. The IM-CoIIN ended August 2020, and team members participated in an exit interview with recommendations to implement anti-racist strategies to intentionally address the roots of racial injustice in maternal and infant health. Twelve partner organizations in eight counties provide critical screenings to women of childbearing age, especially women living in rural and frontier areas and people who live with increased risk. Screenings include those for postpartum depression; Screening, Brief Intervention, and Referral to Treatment (SBIRT); One Key Question campaign; and others. Collaboration with NHV promotes relevant maternal and infant screenings to MCH populations with higher risk. MCAH staff led state-funded statewide reproductive health efforts through the state's Account for Family Planning (AFP) legislation and funding.

Title V MCH staff have facilitated a COVID-19 and MCH data presentation in collaboration with the DHHS Office of Analytics during Maternal and Child Health Advisory Board (MCHAB) meetings since August 2020. MCAH staff have also discussed Nevada Office of Minority Health and Equity (NOMHE)-planned equity and COVID-19 toolkit distribution opportunities and shared materials from NOMHE and other quality organizations about racism and public health, health equity, health disparities and racism, and racism and pregnancy outcomes.

Title V MCH Program staff post MCH-specific COVID-19 resources on the program website and are engaged in COVID-in-pregnancy surveillance monitoring discussions with CDC as part of an OPHIE-led team. Staff also monitor multisystem inflammatory syndrome in children (MIS-C) associated with COVID-19, share COVID-19 resources to partners to support rapid information sharing, and have reached out to partners and subawardees to understand how COVID-19 is affecting their efforts and activities.

Domain: Perinatal/Infant Health

According to the National Immunization Survey, Nevada's rate for ever breastfeeding increased from 2010-15. In 2016, Nevada's rate decreased slightly but remained in line with the national average (79% and 83.8%, respectively). Nevada's rate increased in 2017 to 81.8%, and the national average remained similar at 84.1%. Nevada's 2016 rate for exclusive breastfeeding at six months was 21.7%, slightly below the national average (25.6%).

Nevada's Title V MCH Program partners with the Nevada Women, Infants, and Children (WIC) Program, MCH coalitions, breastfeeding coalitions, community-based programs, LHAs, the public, and private partners to increase breastfeeding rates by improving access to breastfeeding supports for new mothers.

Nevada WIC breastfeeding campaigns are designed to increase awareness, promote WIC breastfeeding services, and normalize breastfeeding in public locations. Eighty-nine Nevada businesses have signed the pledge to provide welcoming environments to those who breastfeed. Nevada Healthy Start, co-funded by the Nevada Title V MCH Program, promoted breastfeeding to increase breastfeeding initiation among participants using an equity lens. Nevada Healthy Start conducted eight outreach activities between October 2018 and March 2019. Washoe County FIMR reviewed 49 cases in FFY2019. Nevada Title V MCH Safe Sleep efforts include funding a statewide Cribs for Kids Program, statewide English and Spanish radio and television media campaigns, and statewide distribution of children's books with safe sleep messages. Cribs for Kids distributed 810 Safe Sleep Survival Kits, a 7.9% increase from FFY2018. The NHV Program also promotes breastfeeding and safe sleep to participants.

Nevada Title V MCH activities related to decreasing substance use in pregnancy and participation in the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI), Nevada Comprehensive Addiction and Recovery Act (CARA), and IM-CoIIN efforts support this domain. The Nevada Title V MCH Program continues Safe Sleep and Injury Prevention education with Indian Health Service clinics. Trainings provided include Infant Safe Sleep, car seat installation, Ages and Stages Questionnaires (ASQs), and Shaken Baby Syndrome and Abusive Head Trauma. Pregnancy Risk Assessment Monitoring System (PRAMS) data informs improving this domain.

Domain: Child Health

According to the 2018-19 National Survey of Children's Health (NSCH), Nevada (30.6%) is below the national average (36.4%) for children ages nine through 35 months who received a developmental screening using a parent-completed screening tool in the past year. This percentage increased for Nevada from 27.9% in 2017-18. Nevada's Title V MCH Program collaborates with public and private partners to improve the rate of children receiving timely developmental screening and increase the number of applicable entities trained on developmental screening. The

Title V MCH Program implemented the ASQ: Social Emotional 2nd Edition (ASQ-SE2) parent training and screenings statewide, including distributing the CDC Milestone Moments bilingual booklets and a Training of Trainers session.

Nevada's Title V MCH CYSHCN Program promotes the Medical Home Portal (MHP), which improves access to healthcare by assisting and supporting professionals and families using the Medical Home model to care and advocate for CYSHCN and non-CYSHCN. From FFY 2019-20, there was a 416% increase in MHP website views, from 12,437 to 64,132 and the number of unique users increased from 5,961 to 28,657.

The Title V MCH-funded Kindergarten Health Survey conducted annually by the Nevada Institute of Children's Research and Policy (NICRP) shows an increase in overweight children and a decrease in obese children entering kindergarten. The 2019-20 survey showed 11.1% of kindergartners were overweight and 21.3% were obese, increases from 2018-19 (at 10.7% and 20.9% respectively). The Title V MCH Program funded two obesity prevention/physical activity promotion seasonal social media campaigns in FFY 2020 to help address this issue. Child health is also supported via Bullying and Suicide Prevention efforts in partnership with the Nevada Department of Education (NDE) and with the DPBH Office of Suicide Prevention (OSP).

Domain: Adolescent Health

According to 2019 Youth Risk Behavior Surveillance System (YRBSS) data, 21.7% of Nevada adolescents in grades 9 through 12 were physically active at least 60 minutes per day, a slight decrease from 24.9% in 2017, and slightly less than the 2019 national average of 23.2%. Efforts to increase physical activity include continuing support for trauma-informed yoga (a Nevada Innovation Station promising practice), a social media campaign for adolescents promoting physical activity, and initiating a project with the Family Voices state representative agency to increase movement among CYSHCN.

One in five births to a teen (15-19 y.o.) in Nevada is a repeat teen birth, it is important to decrease this, with emphasis on identifying and addressing health disparities. To improve teen birth measures, the Nevada Title V MCH Program partners with state and local teen pregnancy prevention programs, NHV, MCH Coalitions, LHAs, community- programs, and private partners to increase access to educational materials, including funding LHAs and rural/frontier Community Health Nurses (CHNs) to provide education and promote Medicaid coverage of Long Acting Reversable Contraceptives (LARCs) post-partum. The National Governor's Association Learning Network to Improve Insurance Enrollment and Access to Health Care for Adolescents ages 15-18 y.o. continues with efforts initially focusing on Clark County and expanding statewide.

Domain: Children and Youth with Special Health Care Needs

CYSHCN should have access to a medical home, according to the 2018-19 NSCH, only 30.3% of CYSHCN in Nevada have a medical home, well below the national average of 42.3%, but an increase from 2017-18 (26.3%). Comparatively, 41.8% of children without special health care needs in Nevada have a medical home, much closer to the national average of 49%. Nevada's CYSHCN Program provides resources and support to community agencies serving children ages birth to 21 years. The CYSHCN Program funds a variety of community programs to better serve children and families through a network of federal, state, Family Voices affiliate, University, and local community and family-based partners. The CYSHCN Program participates in community and family-led coalitions and committees, including the Nevada Governor's Council on Developmental Disabilities (NGCDD), Newborn Screening Program Advisory Board, and the Nevada Early Intervention Interagency Coordinating Council.

Nevada's CYSHCN Program continues promotion of the MHP, a virtual resource which provides reliable and useful information about medical conditions, care, and knowledge of valuable local and national services and resources,

improving care coordination among children with and without special health care needs. The CYSHCN Program partners with a Family Voices entity which helps to increase MHP promotion, access to health care resources, referrals to adequate insurance coverage, care coordination services, and the CYSHCN toll-free hotline. A recent program accomplishment is the collaboration with the Rape Prevention and Education (RPE) Program and partners to create a resource on sexual assault prevention for those with developmental disabilities.

Nevada's CYSHCN Program also manages the Critical Congenital Heart Disease (CCHD) Registry, ensuring Nevada-born infants are screened for CCHD. The CYSHCN and Adolescent Health and Wellness Program (AHWP) are collaborating with the Nevada Center for Excellence in Disabilities (NCED) to expand resources on health care transition and health literacy.

Domain: Cross-Cutting/Life Course

Nevada's Title V MCH Program collaborates across systems with PRAMS to collect data on women who smoke or use substances during pregnancy and secondhand smoke. Survey questions asked about substance use during the respondent's most recent pregnancy. For 2019 births, when asked about prescription pain medication use during pregnancy, 2.68% said yes, which is a decrease from the 5.4% who said yes in 2018. When asked about methadone use during pregnancy in 2019, 0.85% said yes, compared to 1% in 2018. In 2017, Heroin, amphetamines, methamphetamines, cocaine, tranquilizers, hallucinogens, LSD, sniffing gas, and glue or huffing use were all under 1% each. However, in 2018, reported amphetamine and cocaine use were both greater than 1%, at 1.13% and 1.17% respectively. In 2019, this trend was reversed, and none of the substances were above 1%.

*For 2017 and 2018 weighted data, PRAMS had a response rate of 40.6% and 39.4%, respectively, both under the CDC threshold of 55%. 2019 data had a response rate of 42%, which was below the CDC threshold of 50% for that year. Therefore, all data should be interpreted with caution.

To gain more data about opioid use during pregnancy, Nevada PRAMS staff applied for supplemental opioid funding in 2017 and were awarded funds in September 2018. Thirteen additional questions pertaining to opioid use during pregnancy were included in the 2019 survey. Data from the thirteen opioid use questions for 2019 births showed the most reported over-the-counter pain medication used during pregnancy was acetaminophen, with 55.2% of respondents reporting use. Other over-the-counter pain medications were used less frequently, such as Ibuprofen (13.4%), Aspirin (6.6%), and Naproxen (1.7%). For prescription pain medications, the most reported were Codeine (1.5%), Oxycodone (1.1%), and Hydrocodone (1.1%). Other prescription pain medications like Tramadol, Hydromorphone, Oxymorphone, Morphine, and Fentanyl all were under 1% each.

Of those reporting prescription pain medication use, the most reported ways of obtaining the pain relievers were from a doctor in the Emergency Room (27.1%), their Primary Care or Family Care Doctor (24.5%), OB-GYN, midwife, or prenatal care provider (22.9%), or a friend or family member (20.9%). Of note, 13.7% responded they received the pain relievers without a prescription in some other way.

In response to Nevada's legalization of medical and recreational marijuana, informational resources on pregnancy and marijuana use continue to be disseminated. Nevada's Title V MCH Program partnered with the Department of Taxation to distribute Child Injury Prevention and Pregnancy and Marijuana prevention materials to all marijuana dispensaries in Nevada. According to Nevada PRAMS, when asked about marijuana use during pregnancy in 2018, 11.6% of women said yes; this is a 95% increase from the percentage responding yes in 2017. Title V MCH Program efforts focused on reducing substance use in pregnancy and interconception for women of childbearing age continue to include promotion of the SoberMomsHealthyBabies.org website and associated media campaigns, marijuana prevention education materials, the Substance Use during Pregnancy Provider Toolkit, and ASTHO OMNI activities on reduction of substance exposed infants and neonatal abstinence syndrome (NAS). Nevada's Title V MCH Program participation in CARA Infant Plan of Safe Care substance exposed infant workgroups, IM-CoIIN, home visiting, and perinatal quality efforts all support progress in this domain.

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

How Title V Funds Support State MCH Efforts

The Nevada Title V MCH Program is led by MCH and CYSHCN Director Vickie Ives, MA. The MCH Program and MCAH Section are led by Health Bureau Chief Karissa Loper, MPH. Title V MCH Program Units include: AHWP, CYSHCN, Maternal and Infant Health, RPE, and MCH Epidemiology. MCH also supports and complements NHV, Nevada PRAMS, and the MCHAB. The State Systems Development Initiative (SSDI) Manager is co-funded with Title V MCH funds and participates in all MCH Unit meetings and activities and monitors specific subawards

Title V MCH-funded partners provide interventions and support to reach diverse populations, and include, but are not limited to:

- Nevada 211
- 3 Local Health Authorities
- Dignity Health, St. Rose Dominican Hospitals
- Nevada Statewide MCH Coalitions
- Family TIES of Nevada
- Washoe County FIMR
- Immunize Nevada
- Nevada System of Higher Education
    - University of Nevada, Reno
    - University of Nevada, Las Vegas
- Children's Cabinet Technical Assistance Center on Social Emotional Intervention
- Urban Lotus

Programs funded by the Nevada Title V MCH Program recognize the importance of respecting cultural pluralism. Whether at the state, county, or community level, MCH coalitions and funded MCH partners are expected to provide bilingual resources to meet Culturally and Linguistically Appropriate Services (CLAS) standards and increase cultural competence. Program partners are also encouraged to utilize inclusive language in reports, brochures, social media, and presentations.

III.A.3. MCH Success Story

Nevada 211 Success Story

A Nevada 211 Call Specialist received a call from a single young woman in her first trimester of pregnancy:

"Her voice was soft, and she seemed scared. She described herself as a runaway, but at the age of twenty she could leave her parents' home without their permission. However, she left her home without parental approval, and she felt as if she had run away. She went on to describe the home she left as abusive. She added she felt guilty about leaving her mother and brother. She said she reported her father to Child Protective Services. She claimed he was manipulative, knowledgeable about child abuse, and he skillfully managed to slide by the authorities. She stated she was glad to be away from him, but she didn't know what to do now or where to go. I was able to refer her to a maternity home and youth shelter as well as give resources for Medicaid applications and prenatal care. I explained what happened was not her fault. I told her these people would help her through her crisis. She is very scared and afraid of her father. I informed her she would be given protection there and nobody would give out her information."

Title V MCH funded agencies provided MCH trainings to and promote Nevada 211 by providing information to staff and clientele about the value of the service and how to access its resources. Carson City Health and Human Services (CCHHS), a local health authority in Northern Nevada, promoted Nevada 211 through clinic digital signage and social media. Facebook posts reached 6,486 individuals. All DHHS staff include information in their email closings to find help 24 hours a day by dialing 211; texting 898-211; or visiting https://www.nevada211.org/. Title V MCH awarded partners are also required to register and update program information with Nevada 211.

Success Story

Shared by a participant who works with a youth-serving agency:

"Thank you so much for the training and making it feel comfortable and secure. I just wanted to share with you that the same evening after the training, my daughter was having a complete breakdown. I suspect substance use, but she is not disclosing, but she was saying things like she just doesn't want to be here anymore and things of that nature. I just wanted you to know that your training immediately kicked in, and I was able to immediately address the situation and ask if she was suicidal. I would normally not know what to say, but I had the tools and was able to talk through it so much easier than we would normally try to dance around these things. We were able to openly discuss it, and she stated she has felt suicidal her whole life but really did not want to kill herself and did not have a plan. I just wanted to share that your training had a direct and ironically immediate impact in my life, so thank you for sharing and doing what you do."

III.B. Overview of the State

State Overview

1. Geography

Nevada is the most mountainous state in the U.S. with over 150 named ranges and several mountain peaks exceeding 11,000 feet. The state has a unique topography, with vast distances separating frontier, rural, and urban communities. With a land mass of approximately 110,000 square miles, Nevada is the 7th largest state by land mass in the U.S. The State Demographer indicates Nevada has three urban counties (Carson City, Clark, and Washoe), three rural counties (Douglas, Lyon, and Storey), and eleven counties designated as frontier (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine). The three rural counties (Douglas, Lyon, and Storey) also meet “micropolitan” classification due to their proximity to the urban (metropolitan) counties (Carson City and Washoe).

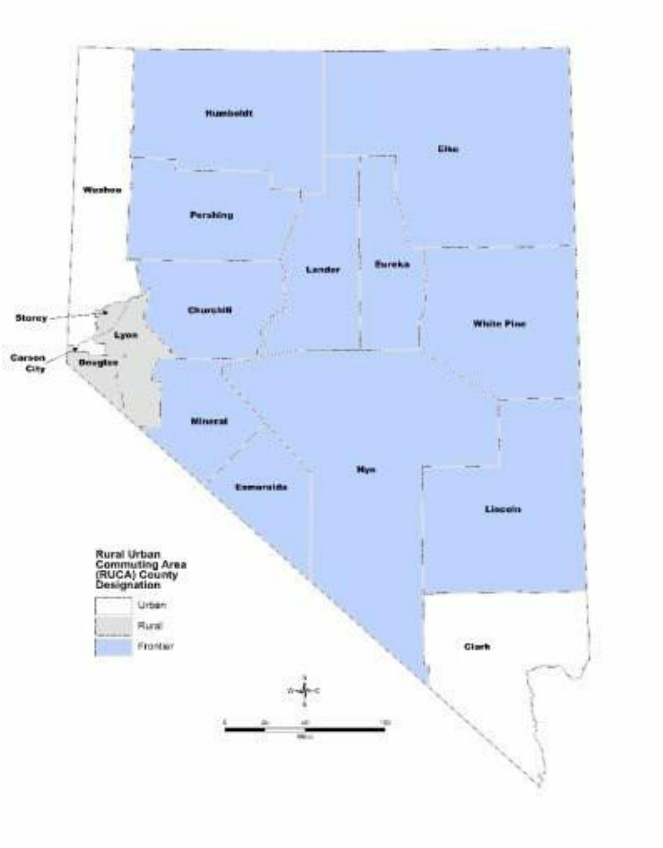


Figure 1. Map of Nevada with Counties

The distance between Washoe and Clark counties is 448 miles (approximately 7.5 hours by car); between Washoe and Elko counties is 290 miles (approximately 4.5 hours); and between Elko and Clark counties is 433 miles (approximately 7.5 hours by car). Residents in the rural and frontier counties are spread across 95,421 square miles or 86.9% of the state’s land mass. Population density ranges from 396 people per square mile in Carson City to 0.27 people per square mile in Esmeralda County. Approximately 90% of Nevada land is publicly owned and administered by federal, state, and Tribal entities, with the remaining 10% privately owned.

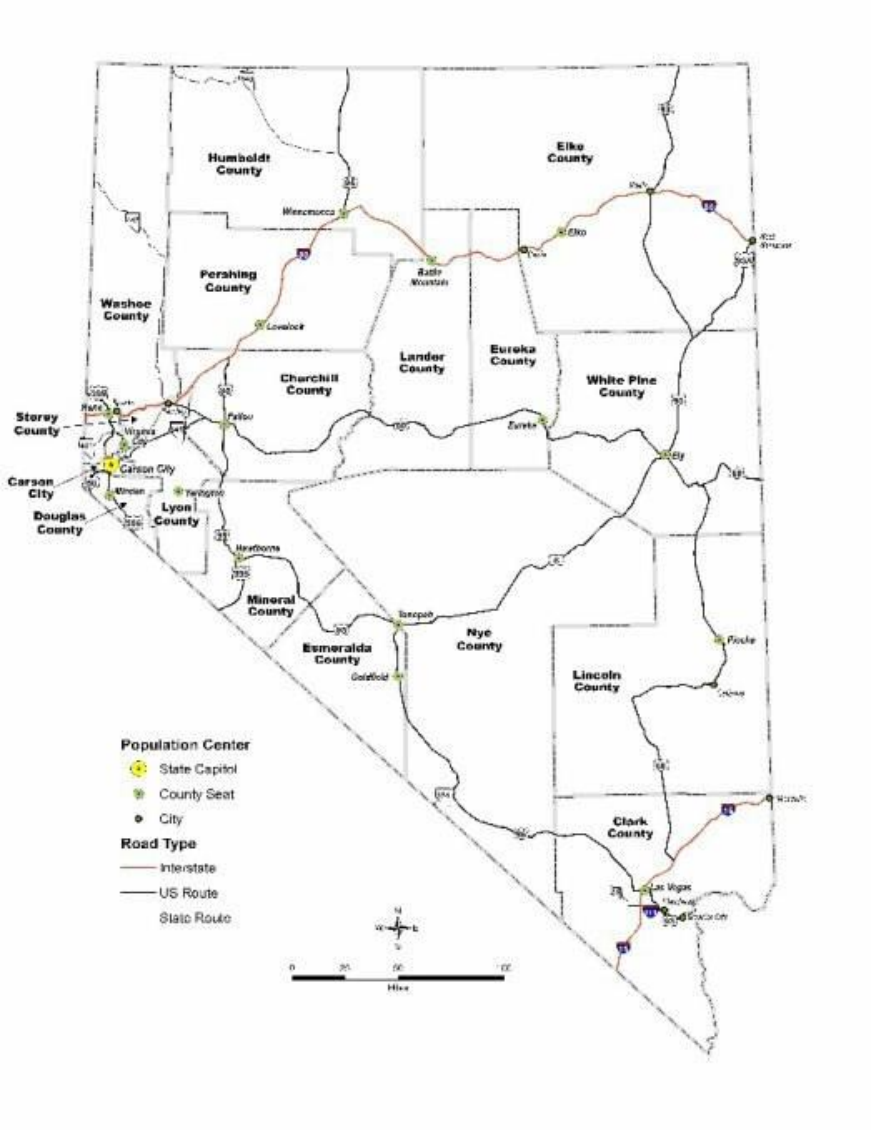


Figure 2. Map of Nevada with Cities

2. Population

In 2020, the Nevada State Demographer's Office and the U.S. Census Bureau estimated Nevada's population at 3,145,184. Between 2010 and 2019, Nevada had the sixth-highest percentage growth in the nation (14.1%, U.S. Census Bureau). While Nevada's population continues to grow, some rural and frontier counties lose population annually. The most densely populated area in the state is Clark County, home to 73.8% (2,320,107 persons) of all Nevada residents (tax.nv.gov). The population in the rural and frontier counties ranges from approximately 982 (Esmeralda County) to 55,116 residents (Elko County). In 2019, the child population (Nevadans under 18 years) made up 22.9% of the population, similar to the proportion across the U.S. (22.4%).

The U.S. Census Bureau also indicates Nevada is an ethnically diverse state, with over 29% of the state's population in 2019 documented as Hispanic Origin of Any Race. In comparison, Nevada's population is 73.9% White alone, 10.3% Black alone, 8.7% Asian alone, 1.7% Native American or Alaskan alone, 0.8% Hawai'ian and Other Pacific Islander alone, and 4.6% two or more races https://www.census.gov/quickfacts/NV.

According to the most recent Kid's Count Data Center (2019) approximately 36% of Nevada's children are from non-

U.S. national families or reside with at least one foreign-born parent, and of these children, 70% are from Latin America. These numbers have been holding steady over the last five years. Health concerns for Nevada's diverse MCAH population include physical, reproductive, behavioral, mental, psychosocial, chronic disease concerns, health disparities, and care of CYSHCN. Language barriers, cultural differences, equitable access to insurance and service availability can influence the use of clinics, hospitals, doctors, and other health care and ancillary services. Nevada Title V MCH-funded partners provide bilingual referrals and resources to community events. Along with providing printed materials, staff link diverse populations to programs providing culturally informed services.

3. Public Health System/Organizational Structure

Governor Steve Sisolak is Nevada's Governor, currently serving the third year of a four-year term. Nevada DHHS is the largest of the State's departments and the Director is appointed by and reports directly to the Governor. The current DHHS Director is Richard Whitley, MS. DHHS is comprised of five divisions, with multiple stand-alone programs falling under the DHHS Director. Divisions include: Division of Public and Behavioral Health, Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy, and the Division of Welfare and Supportive Services (DWSS).

Nevada's three urban counties have their own health authority: Carson City Health and Human Services (Carson City), Washoe County Health District (Washoe County), and Southern Nevada Health District (Clark County). The rural and frontier counties: Humboldt, Elko, Pershing, Lander, Eureka, White Pine, Churchill, Mineral, Esmeralda, Nye, and Lincoln counties do not have their own health authority; therefore, DPBH OPHIE and the DHHS Chief Medical Officer serve as the health authority for those counties. Additionally, some of the rural and frontier counties have or are forming their own boards of health. Nevada Community Health Services (CHS) has community health nursing clinics and behavioral health clinics in various rural and frontier counties to provide family planning services, related preventive health services, public health, and infectious disease services.

DHHS programs helping to promote Title V MCH priorities in Nevada include: Nevada 211, Office of Consumer Health Assistance, NGCDD, the Office of Health Information Technology (HIT), Individuals with Disabilities Education Act (IDEA) Part C Office, Nevada Early Intervention Services (NEIS), the Nevada Office of Minority Health and Equity (NOMHE), Tribal Liaisons (DHHS and DBPH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties and relationships with Tribal Governments), Primary Care Office (addresses access to health care and identifies workforce shortage areas), Oral Health, CHS/CHNs, DPBH OPHIE, Office of Analytics, Substance Abuse Prevention Treatment Agency (SAPTA), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), DCFS, Nevada Medicaid, CDPHP Section, Nevada WIC, and the Nevada State Immunization Program (IZ).

Nevada Revised Statute (NRS) Chapter 442 (http://www.leg.state.nv.us/NRS/NRS-442.html) details the Title V MCH public health authority of DPBH. The DPBH Administrator is Lisa Sherych. The Community Services Branch of DPBH is led by Julia Peek, MHA, CPM. The Bureau of Child, Family and Community Wellness (CFCW) within the Community Services Branch is led by Bureau Chief Karissa Loper, MPH. Ms. Loper oversees WIC, IZ, CDPHP and MCAH. The MCAH Section is led by Title V MCH and CYSHCN Director, Vickie Ives, MA. MCAH programs include: Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Personal Responsibility Education Program (PREP); RPE; Sexual Risk Avoidance Education Program (SRAE); Nevada PRAMS; Early Hearing Detection and Intervention (EHDI); SSDI; and the Title V MCH Program. The MCAH Section also administers the Maternal and Child Health Advisory Board (MCHAB), Nevada Maternal Mortality Review Committee (MMRC), Alliance for Innovation on Maternal Health (AIM) and Account for Family Planning (AFP). The MCAH Section addresses health and social issues among the populations served by coordinating efforts with Nevada DHHS programs, LHAs, public and private partners, universities, MCH Coalitions, Community Coalitions, Family Resource Centers, Federally Qualified Health Centers (FQHCs), regional hospitals, and a variety of other traditional and non-traditional partners.

The MCAH Section includes the Title V MCH Program, led by Mitch DeValliere, DC, MCH Manager. Title V MCH Program fiscal staff include two partially funded Management Analyst II positions and a part time Accounting Assistant III. The SSDI Manager is Tami Conn who leads all MCH and PRAMS data efforts. Nevada Title V MCH Program staff and topic units include:

- The CYSHCN Program Coordinator administers and promotes the MHP, serves family and self-advocates for CYSHCN, provides services and supports for CYSHCN, provides and coordinates health education for CYSHCN and their families, administers the CCHD Registry, and provides trainings for families and health professionals. Partners working with the CYSHCN Coordinator include the University of Nevada, Reno (UNR) Craniofacial Clinic, Children's Cabinet TACSEI, Family TIES of Nevada, partners providing transition activities for older CYSHCN, NGCDD, and NCED.
- The Title V MCH Epidemiologist is responsible for MCH data needs for annual reporting and the five-year needs assessment. Additionally, the MCH Epidemiologist analyzes data and writes reports for federal, state, and local use, including for the Nevada PRAMS and other MCAH programs. Funding for this position is provided through the Title V MCH Block Grant (0.7 FTE) and CDC PRAMS (0.3 FTE).
- The RPE Coordinator collaborates with statewide partners to prevent sexual violence and intimate partner violence among youth and young adults ages 12 to 24 years. Funding for the RPE Coordinator position and related prevention activities is provided through the Title V MCH Block Grant (0.25 FTE), Preventive Health and Health Services Block Grant (PHHSBG) set-aside, and CDC (0.75 FTE).
- The Adolescent Health and Wellness Program Coordinator collaborates with community partners on improving access to health insurance, increasing utilization of adolescent well visits and general health and wellness services, including trauma informed yoga, increasing daily physical activity by adolescents, and administering school-based health center Medicaid certification and related technical assistance.
- The Maternal and Infant Health Program Coordinator collaborates with diverse community partners on a variety of perinatal and interconception care initiatives, including substance use prevention, breastfeeding promotion, injury prevention, IM CoIIN 2.0 lead, perinatal mood and anxiety disorders, safe sleep, and FIMR.

Nevada's Title V MCH activities occur at the local, regional, and statewide levels and MCH cooperates with programs and sections within DPBH supporting women of childbearing age, infants, children, CYSHCN, adolescents, and their families. Examples of Title V MCH-funded partners administering programs congruent with the priorities indicated in the five-year plan, include:

- Children's Cabinet TACSEI provides technical assistance and facilitates parent involvement in social emotional Pyramid Model activities.
- Family TIES of Nevada serves CYSHCN and supports families and health professionals who work on their behalf. They provide advocacy, education, training, and other supports including a toll-free hotline.
- Washoe County FIMR evaluates elements impacting the health in pregnancy and perinatal outcomes, as well as fetal and infant birth outcomes to reduce fetal and infant mortality.
- Money Management/Nevada 211 provides information and referral via https://www.nevada211.org, a toll-free phone number, text support, as well as hosting the Title V MCH toll-free line, supporting the MHP resource sections, and educating on the priority status of pregnant persons at SAPTA-funded treatment centers.

- Immunize Nevada supports training/workforce development, including the coordination of the statewide Nevada Health Conference with trainings to build topical MCH knowledge; they also conduct a variety of other trainings and public media campaigns which support MCH population health and immunization needs. The Nevada Health conference is traditionally held in the fall and was delayed due to COVID. However, the conference occurred virtually in March 2021.

- Nevada Broadcasters Association provides airtime and support for the Sober Moms Healthy Babies (SMHB), PRAMS, and Safe Sleep campaigns. DP Video supports adolescent wellness, transition to adult care, tobacco quit line, and Medical Home Portal social media campaigns. KPS3 updated the Nevada Breastfeeds website.

- Nevada PRAMS' partner is UNR's Center for Surveys, Evaluation and Statistics in the School of Community Health Sciences.

- The Statewide MCH Coalition supports website maintenance, disseminates communications, advocates for MCH populations across public and private health entities in Nevada, conducts or refers to maternal mental health trainings, and supports planning with statewide partners for meeting the community needs of diverse populations.

- UNR NCED provides training on leadership, advocacy, transition education, and the medical home model for parents of CYSHCN.

- Urban Lotus provides trauma-informed yoga to youth who are experience disparities.

Program management and fiscal staff meet weekly to discuss and coordinate all Title V MCH activities across Nevada, while program personnel meet weekly to discuss the status of funded program activities and outcomes. Program and fiscal goals, potential barriers, training needs, and technical assistance are all topics for discussion and action. New activities are considered as funding allows. Nevada Title V MCH Program staff work with community partners to determine the scope of work and budget needed for community-level activities annually. This includes monthly check-in calls and annual site visits to monitor subawardee program deliverables and fiscal processes.

Culturally and Linguistically Appropriate Services (CLAS) Standards

Nevada Title V MCH-funded programs provide outreach and culturally-informed services and ensure funded products are ADA-compliant. Cultural humility Tribal trainings are a valuable component to the success of the Title V MCH Program and are offered to case managers, nurses, and other professionals. Licensed personnel provide CLAS trainings and CHWs, Home Visitors, and various support staff access CLAS and related trainings.

Nevada's Title V MCH Program works with partners in remote areas to increase the number of sufficiently trained staff in the rural/frontier areas of Nevada. The Title V MCH Program staff, including funded partners, work with diverse communities across Nevada, including other partners who have greater understanding of the communities in which they live. Partners offer language and translation assistance, either through local community organizations or over the phone. Several partners have personnel with language skills who can provide language assistance and translation. Title V MCH provides bilingual information and media to serve Spanish language speakers. Nevada State Purchasing provides additional assistance with the capacity to work with diverse entities who provide translation assistance and can aid with translation of documents. Family TIES of Nevada, a Title V MCH-funded Family Voices partner, provides interpretation and translation services at the UNR Craniofacial Clinic. Title V MCH also funds a bilingual CHW in Elko County. Information and materials disseminated by these partners are required to be culturally appropriate. Internal translation support is provided by bilingual MCAH and CFCW staff.

MCAH staff and partners received training related to equity, disparity reduction, and diversity and participated in webinars and trainings related to health equity, diversity, CLAS, intergenerational trauma, minority health and wellness, Tribal partnerships, social determinants of health, race and disparity, and health literacy. The SDOH IM CoIIN 2.0 included surveys related to implicit biases and readiness for change in support of enhancing capacity to address biases and disparities. Nevada's Title V MCH Program works with community members to expand the MCH presence across populations to address gaps and expand service scope to engage all state MCH communities. The Title V MCH Program collects accurate statewide and regionalized demographic information and shares information and trends across all funded community partners.

4. Healthcare

The Patient Protection and Affordable Care Act (ACA) and Medicaid expansion continue to have a positive effect in Nevada. The percent of children ages 0 to 17 years without health insurance from 2012-2019 was 16.6%, 13.9%, 9.7%, 7.6%, 6.1%, 7.1%, 7.9%, and 7.6%. From 2018 to 2019, the proportion of uninsured children in Nevada decreased by 3.8%. Nevada will continue to monitor insurance enrollment data for MCH populations. The Title V MCH Program will also review related Nevada PRAMS data.

Nevada Medicaid is administered by DHCFP with enrollment administered by DWSS for Medicaid and Nevada Check-Up, Nevada's Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Program. Both Fee for Service (FFS) and Managed Care Organizations (MCOs) operate in Nevada. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by contracted MCO providers.

As of September 2020, according to Medicaid and Nevada Check-Up enrollment (Medicaid.gov) an estimated 722,616 individuals were enrolled in Medicaid and Nevada Check-Up. This total has increased from December 2019, when an estimated 626,078 individuals were enrolled. Furthermore, in September 2013 only 332,560 individuals were enrolled. Open enrollment for the Affordable Care Act began in October 2013. These numbers demonstrate continued growth in enrollment, a net increase of 117.3% in Nevada's Medicaid population over the past seven years. (https://www.medicaid.gov/medicaid/by-state/stateprofile.html?state=nevada).

Nevada continues to promote the utilization of EPSDT screenings among Medicaid-eligible children under the age of 21 years. Healthy Kids, the Nevada EPSDT Program, reimburses providers for well-child visits for all children enrolled in Nevada Medicaid and Nevada Check-Up. Outreach to providers and families to encourage EPSDT screenings is a continuing effort for the DHCFP and Title V MCH Program. Continued collaboration between DHCFP and Title V MCH includes education and outreach to promote available preventive benefits and EPSDT screenings, particularly as they relate to maternal, child, and infant health (http://dhcfp.nv.gov/Pgms/CPT/EPSDT/), CoIIN participation, SBHC certification, and well-visit increases for young adult initiatives.

Nevada's Title V MCH Program is instrumental in advancing the Healthy Kids Program by funding parent education materials which encourage Bright Futures recommended preventive health services for infants, children, and adolescents and provide information on enrollment in Nevada Medicaid or Nevada Check-Up. The Title V MCH Program has also developed a growth chart based on Bright Futures recommended preventive pediatric health care visits. The growth chart includes important milestones, as outlined by Bright Futures guidelines. Title V MCH partners receive these materials to disseminate to their clients. In addition, a one-page version of the growth chart is included in the Protect and Immunize Nevada's Kids "PINK" packets; across the state, hospitals distribute these materials to all new parents after the birth of a child. Title V MCH also funds other Bright Futures materials, including the Bright Futures tool and resource kit, and health care professional pocket guide, which are provided to partners statewide. The Title V MCH Program provides data related to MCH quality measures to DHCFP annually.

Nevadans who are uninsured continue to have difficulty with access to providers; however, *Access to Healthcare Network* (AHN) offers a medical discount program for members, who pay a membership fee to access the

discounted provider network and case management services. Participating network providers agree to receive reduced payments to serve members. People in Nevada unable to pay for their health care needs can access limited financial assistance. The Mexican Consulate in Las Vegas provides information relating to health insurance for non-U.S. nationals. FQHCs in Nevada provide sliding scale fees for health care to all prospective patients, irrespective of citizenship status.

No-cost health care is provided in Northern Nevada through the University of Nevada, Reno, School of Medicine (UNSOM) *Student Outreach Clinic* operated by medical students. The clinic is operated in cooperation with the Family Medicine Center and UNSOM and made possible by faculty and community physicians who donate their time. Services include general and acute medical care, gynecological exams, immunizations, and discounted laboratory services. Currently, the Student Outreach Center operates four separate clinics (General and Pediatric; Geriatric and Dermatology; Rural Outreach; and Women's) https://med.unr.edu/university-health/student-outreach-clinic/upcoming-clinics. An obstetrics and gynecology (OB/GYN) Department at UNSOM provides specific education for medical students.

Volunteers in Medicine of Southern Nevada (VMSN) provides no-cost medical care in southern Nevada. The University of Nevada Las Vegas (UNLV) School of Medicine clinical practice provides Southern Nevadans with access to a full range of academic medicine faculty physicians delivering clinical patient-focused and collaborative services. The UNLV clinics are open to the public. Further, Rural Access Network (RAN) events provide oral health, immunizations, and other needed medical services at no cost to people who are medically underserved in Nevada. The Title V MCH Program staff support efforts related to CHS/CHNs and routinely share information with the Nevada Hospital Association, Nevada Rural Hospital Partnership, the Nevada Primary Care Association, and the Nevada Rural Health Network.

5. Employment

According to the Bureau of Labor Statistics, there were approximately 1.5 million Nevadans in the work force as of February 2020. Nevada ranked 32nd in the nation for unemployment in February 2020, with an unemployment rate of 3.6% compared to the national average of 3.5% (https://www.bls.gov/web/laus/laumstrk.htm). The COVID-19 pandemic and subsequent response resulted in a dramatic increase in unemployment for Nevada. The average unemployment rate for Nevada in 2020 was 12.8% compared to the national average of 8.1%. Nevada ranked 51st in the nation for unemployment during 2020. Nevada's unemployment rate has recovered from the highest point of 29.5% in April 2020 to 13.0% in September 2020, and the number of Nevadans in the work force increased from 1.05 million in April to 1.3 million in September.

Nevada's traditional industries include tourism, gaming, and hospitality; logistics and operations; and agriculture. Other industries including manufacturing; information technology; aerospace and defense; energy; and health care have all historically experienced growth and helped stimulate the economy according to the Nevada Governor's Office of Economic Development (GOED). However, according to GOED from July 2019 to July 2020, Nevada job loss was over 138,000 jobs and 56,000 were in the leisure and hospitality industry.(https://goed.nv.gov/wp-content/uploads/2021/01/Nevada-Recovery-and-Resiliency-Plan-FINAL.pdf).

The Kids Count Data Center data for 2019 reports the statewide median income of households with children was $69,300, an increase from $65,400 in 2018. For 2019, U.S. Census Bureau data indicate there were approximately 23,000 children who had at least one parent unemployed, and 89,642 children ages 6 to 12 years old with at least one parent not in the labor force during the year.

6. Housing

Market forces continue to decrease the availability of affordable rental housing, increasing rates of rent burden for

lower income households. According to the National Low-Income Housing Coalition, the 2020 Fair Market Rent (FMR) in Nevada for a two-bedroom apartment was $1,065. For a household to afford this level of rent without paying more than 30% of their income on housing, the household must earn at least $3,549 monthly or $42,592 annually. The estimated hourly mean renter wage in Nevada is $17.42, at which workers could realistically afford a rent charge of only $906.
(https://reports.nlihc.org/sites/default/files/oor/files/reports/state/NV-2020-OOR.pdf).

7. Income

Economic distress indicators such as poverty rate, housing vacancy rate, and percent of adults not working are compared across communities to create the Distressed Communities Index (DCI). According to the Economic Innovation Group 2020 DCI, 16.2% of Nevadans reside in distressed zip codes. Compared to 2018, when four Nevada counties were considered “prosperous” (Douglas, Eureka, Storey, and Washoe), only two met this tier in 2020 (Douglas and Washoe). Furthermore, between 2018 and 2020, two counties considered to be at higher risk became distressed (Esmerelda and Pershing), joining Mineral County for this tier level. Three counties are considered to be at higher risk in 2020 (Lander, Lincoln, and White Pine). Eig.org/dci/interactive-map?path=state/NV&view=county

Nevada faced no recent budget shortfalls in the reporting FFY but is in the process of reckoning with statewide budget shortfalls in light of COVID-19.

The median annual household income for Nevada increased from $58,646 in 2018 to $63,276 in 2019, according to the American Community Survey (ACS). Between 2018-19, the U.S. median annual household income increased from $61,937 to $65,712. According to County Health Rankings and Roadmaps, “Income inequality helps measure gaps in household earnings.” Income inequality is measured as the ratio of household income at the 80th percentile to income at the 20th percentile. In Nevada, the ratio is 4.3 overall and ranges from 3.2 (Lincoln County) to 8.3 (Eureka County) The two largest counties, Clark County and Washoe County, have a ratio of 4.3 (Income inequality in Nevada | County Health Rankings & Roadmaps).

Nevada’s urban areas struggle with an unusually high cost of living relative to low wages and insecure work associated with service industry tourism economies. The poverty level in rural and urban areas is comparable; however, accessing medical and health care services is severely limited in rural and frontier counties due to geographic access barriers, as well as difficulties in recruiting and retaining providers. This translates into low rates of routine preventive health services being delivered to these regions, such as recommended EPSDT screening and childhood immunizations, and decreased access to preconception health services, including the screening and management of chronic conditions, counseling to achieve a healthy weight, and smoking cessation.

Overall, Nevada’s relatively strong economy has not offset other measures of state performance that rank poorly compared to other states, as evidenced by Nevada’s rankings in the 2021 Camelot Index. The Camelot Index ranks states on six quality of life measures: economy, health, crime, education, society, and state government. Nevada ranks 29th for economy, which considers poverty rates, incomes, and tax bases. Nevada experienced a double-digit loss in ranking from 2020, dropping 10 spots. Nevada ranks 26th for prudent state government fiscal measures, the same as in 2020. The state is in the bottom half for all other measures. Nevada ranks 38th for health of the state’s population; this measure encompasses age-adjusted death rates, infant mortality rates, and health insurance coverage rates. When comparing crime rates across states, Nevada ranks 40th, and for measures of a healthy society, such as home ownership rates and food security, Nevada ranks 45th. Finally, when comparing measures for education such as high school graduation rate, standardized testing scores, and pupil to teacher ratio, Nevada ranks 46th in the nation. Notably, Nevada is the bottom-ranked state for pupil-teacher ratio. These rankings are useful to know to help inform where Nevada can leverage its strengths to improve these and related measures in the future.

8. Policy/Legislature

The 80th Nevada Legislative Session ended June 3, 2019, and a key piece of legislation passed was Assembly Bill (AB) 169 which established a Maternal Mortality Review Committee and protections for the Committee. MCAH staff support the MMRC programmatically and administratively. Nevada's Title V MCH Program shared information relating to MCH populations from legislation passed in the session with partners statewide, particularly in relation to any changes to the Nevada Check-Up and Medicaid programs which broaden allowable billing codes or reimbursement and creation of a Diapering Committee and Family Planning account, as well as on newborn screening fee change and panel addition pathways. A bill was passed funding a study on home visiting which includes MCAH participation and the passage of the Account for Family Planning created opportunities to improve reproductive health statewide.

NRS Chapter 442 codifies statutes related to Title V MCH. NRS 442.133 provides the membership and terms of the MCHAB. The MCHAB is comprised of nine members appointed to two-year terms by the State Board of Health, with two legislators appointed by the Legislative Counsel. MCHAB is staffed by the Title V MCH Program Manager and an Administrative Assistant III. MCHAB advises the DBPH Administrator on objectives related to primary care, infant mortality, preventing fetal alcohol syndrome and substance use by pregnant persons, and increasing immunizations. The MCHAB meets at least quarterly.

The CYSHCN Director served on the Association of Maternal and Child Health Programs (AMCHP) Policy Committee with a two-year term ending January 2020. Chapter changes under review by Medicaid relevant to MCH populations are shared widely with MCH partners and coalitions, and DHCFP has worked with the Title V MCH Program on provider draft chapter changes related to preterm birth.

The MCAH Section and Title V MCH Program worked in close partnership with DCFS and SAPTA to support efforts to align and implement federal and state legislative changes to the Infant Plan of Safe Care and are active in Infant Plan of Care efforts as a key partner. Title V MCH Program staff function as core members of the Nevada ASTHO OMNI team on substance use in pregnancy and NAS reduction efforts.

9. State Title V Emerging Issues

COVID-19

The Nevada Health Response Center, Nevada DPBH, and the CDC are closely monitoring the outbreak of the respiratory illness caused by the 2019 novel coronavirus (COVID-19). DPBH is encouraging healthcare providers to refer to the CDC's Health Alert Network (HAN) and DPBH Technical Bulletins and DHHS efforts inform the state COVID-19 information hub at https://nvhealthresponse.nv.gov/. The latest Nevada COVID-19 statistics and response efforts are also located at the website and kept updated through the efforts of the DHHS Office of Analytics and DPBH OPHIE office. Local health authorities, including Southern Nevada Health District (SNHD), Washoe County Health District (WCHD), and Carson City Health and Human Services (CCHHS) are also key responders monitoring and providing information related to COVID-19.

In addition to the DHHS and DPBH efforts, Title V MCH Program staff posts MCH-specific COVID-19 resources on the program website; are engaged in COVID-in-pregnancy surveillance monitoring discussions with CDC as part of an OPHIE-led team; MIS-C efforts; share COVID-19 resources and technical bulletins to partners to support rapid information sharing; and have reached out to partners and subawardees to see how COVID-19 is affecting their efforts/activities and to assist with any technical assistance and/or adaptations or fiscal redirects as needed. MCH funded statewide clear face mask purchases for school districts and EHDI partners and supported a CHS immunization need, MCH and NHV staff were awarded pass through HRSA funds via AMCHP for a COID-19 related telehealth project for CYSHCN and prenatal care. Fortunately, most MCH-funded partners have been able to function

well and adapt to the challenges of using virtual platforms. MCH staff have adapted administrative and organizational processes to support program implementation while telecommuting. Title V MCH staff continue to facilitate a COVID-19 and MCH data presentation in concert with the Office of Analytics during the MCHAB meetings since August 2020. MCAH staff have also discussed NOMHE-planned equity and COVID-19 toolkit distribution opportunities and shared materials from NOHME and other quality organizations about racism and public health, health equity, health disparities and racism, and racism and pregnancy outcomes.

Congenital Syphilis

In 2018, Nevada was the top ranked state for primary and secondary syphilis rates and ranked second for congenital syphilis (CS) rates. In 2019, Nevada remained the top ranked state for primary and secondary syphilis rates, while falling to fourth for CS rates. Primary and secondary syphilis rates have been increasing in Nevada since 2012. According to the CDC, Nevada's rate of primary and secondary syphilis per 100,000 persons, from 2012-2019 are as follows: 4.1, 7.3, 11.0, 11.7, 15.3, 19.7, 22.7, and 26.6. With this increase of syphilis cases comes a rise in congenital syphilis. According to CDC, CS rates in Nevada have been rising since 2012. Nevada's CS rates per 100,000 persons from 2012-2019 are as follows: 2.9, 5.7, 13.9, 22.0, 33.1, 57.9, 85.5, and 114.7; this represents a 34.2% increase from 2018 to 2019, and a 3855.2% increase over an eight-year span. MCAH staff are members of the CS Workgroup for Nevada and have been instrumental in CS prevention informational campaign development and resource distribution.

Teen Suicide

Teen suicide is an emerging issue in Nevada. Data from the National Vital Statistics System (NVSS) shows the adolescent suicide rate for those ages 15-19 years per 100,000 adolescents in Nevada was 15.6 for the reporting period of 2017-19; this represents an increase of 2.6% from the 2016-18 rate. Nevada's 2017-19 teen suicide rate is higher than the U.S. rate of 11.2 suicides per 100,000 adolescents during the same reporting period. When stratifying adolescent suicide rates for those ages 15-19 years by urban/rural residence, the 2015-19 rate was 20.0 in non-metro (rural) areas compared to 14.4 and 13.1 in small/medium and large metro areas, respectively. Title V MCH will continue to be an active participant in the Healthy Tomorrows Grant with the Nevada Primary Care Association. The Healthy Tomorrows project is focused on creating adolescent-friendly spaces in FQHCs to increase repeat visits and a develop a patient-centered medical home for Nevada's adolescents. Title V MCH Program funding also helped support the Nevada OSP with teen suicide prevention and systems-building projects, such as Youth Mental Health First Aid and Project AWARE, via funding for the OSP Manager and the crisis call line. Title V MCH staff also participate on the HRSA Mental Health Evaluation Committee and attend Statewide Children's Mental Health Consortia meetings. Title V MCH Program staff also wrote a letter of support for The Foundation for Positively Kids in their application to the Healthy Tomorrows Program grant.

Substance Use During Pregnancy and Substance Exposed Infants

Close monitoring of substance use during pregnancy and substance exposed infants will continue to be a priority for DPBH and Nevada's Title V MCH Program. According to data from NVSS, the percent of women who smoked during pregnancy was 3.5% in 2019; a decrease from 5.4% in 2010, or a change of 35.2%. NVSS data also reflects a modest decline in the use of substances during pregnancy, as the percentage of women who reported smoking, alcohol use, and/or drug use decreased from 5.5% in 2016 to 5.3% in 2019. MCAH will continue to work on state efforts regarding Comprehensive Addiction Recovery Act (CARA) and the Infant Plan of Safe Care including education, training, OMNI work group participation, and increasing awareness. Nevada PRAMS staff make inquiries about substance use before, during, and after pregnancy and provide self-reported data in addition to vital statistics

and hospital inpatient data to inform Title V MCH efforts/activities. To enhance other substance use prevention efforts, PRAMS data will be presented to both the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) and Promoting Innovation in State/Territorial Maternal and Child Health Policymaking (PRISM) learning communities.

Title V MCH Program staff are also core members of the Nevada ASTHO OMNI NAS-related efforts in Nevada and also participate in the AMCHP PRISM efforts. MCH funds will support Infant Plan of Care material translation and distribution and the MCH Director will present on CARA referral pathways at a Project ECHO webinar in August and co presented at the Nevada Health Conference on Infant Plans of Care.

Maternal Mortality Review Committee (MMRC) and Alliance for Innovation on Maternal Health (AIM) Efforts

Governor Steve Sisolak signed Assembly Bill (AB) 169 of the 80th Nevada Legislative Session into law in June 2020, establishing a Nevada MMRC. AB169 was codified in NRS 442.751 through 442.774, inclusive, and reflected the work of a wide vary of supporters and advocates. The MMRC is required to: 1) review incidents of maternal mortality and severe maternal morbidity (SMM) in Nevada; 2) disseminate findings and recommendations concerning maternal mortality and SMM to providers of health care, medical facilities, other interested persons and the public; 3) publish timely reports consisting of data relating to maternal mortality and SMM, descriptions of incidents reviewed by the Committee, and recommendations to reduce maternal mortality and SMM in Nevada.

Nevada established the state's first MMRC and convened the first meeting in February 2020 and convened a total of four times that year. This MMRC will continue to meet at least twice annually to review all incidences of maternal mortality in Nevada. The Title V MCH Program will be involved in supporting MMRC-related meeting travel and ancillary costs for members, and in considering possible opportunities for implementing MMRC recommendations in MCH programmatic efforts for prevention, increased awareness of the existence and recommendations of the MMRC among the public, clinicians, and policy makers, and supporting dissemination of required reports and data-driven MMRC recommendations (e.g., evidence-based practices, screenings, and patient and provider education). The 2021 legislative session added a partnership between the MMRC and the NOHME Advisory Board in relation to recommendations of the MMRC in the biennial report to the legislature.

Reporting produced by the MMRC support staff is included in Nevada's Title V MCH Block Grant reporting, and health equity in birth outcomes and maternal domain population health maximization will be key areas of topical intersect in priorities of the MMRC, MCAH Section, SSDI Program, and Title V MCH Program. Title V MCH Program staff will look for opportunities to create sustained funding for the MMRC as it was passed into law without dedicated funding. SSDI funds help support MMRC administrative support staff. The Title V MCH Program is in discussions with the Nevada Rural Hospital Partnership to launch Advanced Life Support in Obstetrics (ALSO), American College of Obstetricians and Gynecologists (ACOG) efforts to reduce rural maternal mortality by working with critical access hospitals. Nevada is now an Alliance for Innovation on Maternal Health (AIM) State, which will help staff support activities reducing preventable maternal mortality and severe maternal morbidity (SMM), beginning with the hypertension patient safety bundle with the Nevada AIM launch June 24, 2021.

Early Childhood Continuum

Strengthening the early childhood education continuum to include public health is an emerging issue the Nevada Title V MCH Program will help address. The Title V MCH Program will continue and expand efforts to achieve the goal of NPM 6: To increase the percent of children, ages 9 to 35 months, who received a developmental screening using a parent completed screening tool. According to data from NSCH, Nevada has experienced an increase in the percent of children screened, from 27.9% during 2017-2018 to 30.6% during 2018-2019. Systems-level interventions are needed to address all components of child development. Title V MCH Program staff will continue to work with the

Early Childhood Advisory Council, Pritzker initiatives, Nevada Early Intervention Services (NEIS), and NHV to engage diverse partners and leverage existing efforts to address the early childhood continuum. The MCH Director and NHV staff have been core participants in Pritzker efforts in Nevada also related to strengthening the early care continuum. Title V MCH funding replaced out of date audiological equipment. The new audiological equipment will serve all NEIS children statewide.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Needs assessment update

Title V MCH utilizes national and state data to update the needs of Nevada's MCH populations. Federal data sources include:

- National Vital Statistics System (NVSS)
- National Survey on Children's Health (NSCH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- American Community Survey (ACS)
- Youth Risk Behavioral Survey (YRBS)
- National Survey on Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Early Hearing Detection and Intervention (EHDI)

State data sources include the Division of Health Care Financing and Policy Medicaid data, the Office of Analytics, the Office of Vital Records, hospital inpatient data, and the Nevada Report Card published by Nevada Department of Education (NDE) and the Nevada Rural and Frontier Data Book published by the University of Nevada, Reno, School of Medicine. Federally Available Data (FAD) and MIECHV federal data are also integrated into ongoing needs assessment activities.

The Title V MCH Program and State Systems Development Initiative (SSDI) managers met weekly to discuss the Title V Block Grant report and application. Discussions included updates to the 5-Year Needs Assessment and staff review of current priorities and performance measures and comparing them to the needs indicated by Needs Assessment and to state and federal data indicators.

The MCH Epidemiologist created a Power BI Data Dashboard which publicly displays Title V FAD https://dpbh.nv.gov/Programs/TitleV/MCAH-Data-and-Publications/. The dashboard includes Nevada trends, comparisons to national benchmarks, and breakouts by indicators such as race and ethnicity and urban-rural residence for all Title V MCH NPMs and NOMs. The dashboard is updated annually in April to coincide with the publication of the updated FAD and is shared with partners to keep them engaged with MCH state performance.

The Nevada Critical Congenital Heart Disease (CCHD) Registry is maintained by the CYSHCN coordinator, and reports are published annually to monitor state performance https://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/TitleV/CCHD%20Report%202019.pdf.

A survey is sent to statewide partners and is open to the public to assess the ongoing needs or changes in priorities from a community engagement perspective. CYSHCN partners serving families are engaged in this process. Feedback is also received through the quarterly MCHAB meetings where updates on Title V MCH activities are widely shared and discussed in a public context. Ongoing performance monitoring and evaluating activities occurs in monthly check in calls and quarterly reports from each Subawardee of Title V MCH funds. The results of this statewide public input survey are noted within each population domain.

COVID-19 impacted the state's MCH population in many ways, and the overall changes in the health status and needs of the Nevada MCH population compared to the identified needs for the Title V MCH Block Grant are shown below:

Women/Maternal Health

- More than one (1) in six (6) women in Nevada (17.7%), ages 19-44 years, are uninsured (higher than the United States at 15%), according to the 2019 ACS.
- Across all MCH populations, a higher percentage of Hispanic women and children are uninsured compared

to other race/ethnicity groups, according to the 2019 ACS.

- Single parents experience the highest poverty rates, at more than twice the rate of two-parent households, according to the 2019 ACS.
- Single parents of children younger than five (5) years are most likely to be economically marginalized.
- The percent of people in Nevada who receive prenatal care beginning in the first trimester has increased by 14.4% (from 65.9% to 75.4%) during the time period of 2010 to 2019, according to NVSS data. The most variation is seen when looking at prenatal care by educational attainment, with college graduates and those with some college being more likely to receive prenatal care than high school graduates and those with less than high school education.
- In the public input survey, the top three most important health problems/health issues for women of reproductive age in the community where they live are: mental health (76%), illicit substance use (38%) and domestic or intimate partner violence (37%).
- In the public input survey, the top three most important health problems/health issues for pregnant and post-partum women in the community where they live are: mental health (70%), postnatal care (32%), and prenatal care (26%).

Perinatal/Infant Health

- Nevada's rate of sleep-related sudden unexpected infant death (SUID) reached a high in 2018 of 142.9 deaths per 100,000 live births, a 53.5% increase over the time period of 2009 to 2018. Rates disproportionately affect Black or African American infants with 258.3 deaths per 100,000 live births. White infants had a rate of 117.0 per 100,000, and Hispanic infants had the lowest rate at 60.2 deaths per 100,000 live births according to NVSS 2016-2018 data.
- Nevada's infant mortality rate has shown slight increases since 2009, increasing from 5.8 deaths per 1,000 live births to a rate of 6.1 deaths per 1,000 live births in 2018. Black infants and American Indian/Alaska Native have disproportionately higher rates, with 9.7 and 9.4 deaths per 1,000 live births, respectively. White and Hispanic infants had the lowest rates, at 5.3 and 5.0 deaths per 1,000 live births respectively, according to NVSS 2016-2018 data.
- The Health Care Cost and Utilization Project-State Inpatient Database indicates the rate of infants born in Nevada with neonatal abstinence syndrome (NAS) has increased 375% from 2008 to 2018, from 1.6 per 1,000 birth hospitalizations to 7.6 per 1,000 birth hospitalizations. The rate is highest amongst White infants (10.8), with the lowest rates among Hispanic infants (3.7) in 2018.
- In the public input survey, the top three most important health problems/health issues for newborns and infants in the community where they live are: maternal substance use during or after pregnancy (49%), child abuse and neglect (40%), and not receiving developmental screenings (39%).

Child Health

- According to the 2018-2019 NSCH, while insurance rates are generally high among children, access to consistent and adequate health insurance coverage is lower in Nevada (62.4%) compared to the United States (66.8%).
- The State of Nevada, Division of Child and Family Services 2017 Statewide Child Death Report indicates there is a racial and ethnic disparity among statewide child deaths of all causes, as Black or African American child deaths (ages 0 to 17 years) are disproportionately higher at 22.7 percent versus their population distribution in Nevada (10%) .
- More children in Nevada (19.5%), compared to children nationwide (18.2%), have ever experienced two (2) or more Adverse Childhood Experiences (ACEs) according to the 2018 NSCH.

- In the public input survey, the top three most important health problems/health issues for young children (one to five years old) in the community where they live are: access to affordable childcare and/or pre-school (74%), caregiver substance use or mother/father substance use (32%), and child abuse/neglect (23%).
- In the public input survey, the top three most important health problems/health issues for children (six to 11 years old) in the community where they live are: overuse of technology/excessive screen time (65%), mental health (38%), and physical activity (37%).

Adolescent Health

- Lesbian, Gay, and Bisexual (LGB) youth experience high levels of bullying and violence, homelessness, fear, and mental health issues compared to their heterosexual peers, according to the 2019 Nevada Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.
- Nevada ranks 34th among states for 2019 teen birth rate according to the NVSS. Nevada's teen birth rate has decreased by 57% since 2009. Black or African American teens continue to experience the highest teen birth rates in Nevada, at 32.2 per 1,000 girls ages 15 to 19 years.
- Data from the NVSS shows the adolescent suicide rate in Nevada (15.6 per 100,000) is significantly higher than the national average (11.2 per 100,000) for 2017-2019. Nevada's rate has increased by 140% since 2007.
- In the public input survey, the top three most important health problems/health issues for adolescents (12 to 21 years old) in the community where they live are: mental health (79%), lack of skills needed during adolescence and to transition into adulthood (63%), and excessive use/inappropriate use of social media (26%).

Children and Youth with Special Health Care Needs

- Access to a medical home (i.e., patient-centered comprehensive coordinated care) occurs for less than half of Nevada's children (44%), according to data from the NSCH. Among CYSHCN, this is less than one-third (32%), lower than the United States average.
- According to data from the NSCH, 3% of children in Nevada ages 3 through 17 were diagnosed with an autism spectrum disorder in 2018-2019, compared to 2.9% nationally.
- Data from the NSCH shows 39% of children in Nevada ages 3 through 17 with a mental or behavioral condition received treatment or counseling in 2018-2019, a 14% increase from 2016. This is below the national average of 53%.
- In the public input survey, the top three most important health problems/health issues for children and youth with special healthcare needs (birth to 21 years old) in the community where they live are: lack of adequate access to specialty medical care (60%), navigation of the system of care for CYSHCN (50%), and inadequate respite care (29%).

Cross-Cutting

- Language and insurance status (i.e., uninsured or Medicaid) are shared risk factors across MCH population groups regarding access to services and are reported to be a common reason why people report experiencing unequal treatment in receiving services.
- Substance use was a concern among adolescents, pregnant, and one-year postpartum people.
- Alcohol and marijuana were the most reported substances used during pregnancy among Nevada birthing people, with marijuana surpassing alcohol use in 2015 (5.3 and 5.0, respectively, per 1,000 live births) and sharply increasing in 2018 (13.7 and 4.2 per 1,000 live births, respectively) according to the 2019 Nevada Substance Abuse Prevention Treatment Agency (SAPTA) Epidemiologic profile.

Access to Services

Access to services is a significant barrier to health and wellbeing, with community members reporting lack of providers, needed services offered by a local provider, and physical access to providers as key barriers. Community members, MCH professionals, and service providers identified the same set of resources needing improvement (or those services not available, accessible, affordable, and/or high quality) in their community to benefit MCH population groups: mental health services, childcare options, housing, health care options, and good paying jobs with livable wages.

The barriers are particularly prevalent in rural and frontier communities in Nevada. Only 5.3% of health care and social assistance employees in Nevada live in rural and frontier counties (despite 9.5% of Nevada's population living in these areas). Overall, more than two-thirds of Nevada's population live in a federally designated primary medical care health professional shortage area (HPSA). The proportion of populations who reside in dental and mental health care HPSAs is even larger with almost 100% of the population in all rural and frontier counties living in a mental health HPSA.

Protective factors for adverse health outcomes for MCH population groups are less prevalent in Nevada. For example:

- Nevada ranks 28th nationwide for percent of children who live in a home where the family demonstrates qualities of resilience during difficult times, using data from the 2019 NSCH.
- Using data from the ACS, one (1) in ten (10) youth (ages 16 to 19 years) are disconnected in Nevada (defined by neither working nor in school), putting them at greater risk of increased violent behavior, smoking, alcohol consumption and marijuana use, and emotional and cognitive deficits than their peers who are working and/or in school.
- The percent of parents who report feeling their child definitely lived in a safe neighborhood was lower in Nevada (46.7%) compared to parents across the United States (63.9%), according to the 2019 NSCH. The percent reporting their child is definitely safe at school was also lower (52.9% vs 70.1%).
- 2019 KidsCount data shows more children in Nevada ages three (3) to four (4) years are not enrolled in school (62%), including preschool or pre-kindergarten, than in the United States (52% not enrolled); this is most prevalent among children who are low-income (70%) and children who are Hispanic (72%).

Funding for public health is an indicator of the resources available to improve population health. Nevada is identified as the least healthy state when considering the amount of public health funding available relative to other states, including both a combination of state dollars dedicated to public health and federal dollars directed to states by the CDC and HRSA. Per-capita public health funding amounts to $46 in Nevada, lower than the United States per-capita average of $87, according to Trust for America's Health.

The Nevada Title V MCH Program will continue collaborations with public and private partners to improve the health of the Nevada MCH populations in areas of need identified by state data, FAD, and Needs Assessment feedback. The 5-Year Needs Assessment and state and federal data informed the state priorities, objectives, and strategies for the State Action Plan.

Noted Changes to Title V Program Capacity

Nevada Maternal, Child and Adolescent Health (MCAH) Section has experienced changes in the MCH Program Unit. The CYSHCN Coordinator position has been vacant since December of 2020. The position is currently a contract position, but the most recent legislative session reviewed the request to make the position a state line employee. Other staff members maintained the program and the CYSHCN Director continued to address all

CYSHCN constituent calls and ensured all activities of the CYSHCN Coordinator were maintained. The MCH Epidemiologist updated the Medical Home Portal and CCHD database. The Adolescent Health and Wellness Program Coordinator followed up with subawards and work orders associated with the CYSHCN Program and the Title V MCH Program Manager administered fiscal responsibilities. The CYSHCN Director embedded CYSHCN populations in the HRSA funded AMCHP Telehealth grant received by MCAH to help support access to care. Sickle cell focused immunization supports and materials, sexual assault prevention among children with developmental and intellectual disabilities, and access to accessible parks statewide all came from novel CYSHCN-focused partnerships.

Title V Program Partnerships, Collaboration and Coordination

The Title V MCH Program collaborates with a network of partners, collaborators, and agencies to support a systems-based model of delivering public health and enabling services to Nevada's MCH populations. Partnerships include the local Family Voices affiliate, Family TIES, state agencies, Local Health Authorities (LHAs), the Nevada System of Higher Education (NSHE), non-profit organizations, MCH Coalitions, community partners, and advocacy groups.

DHHS formed an Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross training and data analytics support. Title V MCH continues to fund a MCH Biostatistician and Health Resource Analyst (HRA) within this group and MCAH has two HRA positions located in the Office of Analytics working with Early Hearing Detection (EHDI) and Nevada Home Visiting data (NHV/MIECHV). These positions are crucial members of the MCAH team in increasing MCH data support and analytics capacity, accessing primary data and generating analyses and reports on behalf of MCAH and Title V MCH, in addition to the work of the MCH Epidemiologist and SSDI Manager. Title V MCH continues to integrate with SSDI; MCAH created a PRAMS, SSDI, MCH Epidemiology organizational unit to foster cross-training and data supports. The MCAH Section Manager and Office of Analytics Manager meet regularly with staff in relation to MCAH data needs.

SSDI enhances Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming. The MCH Program plans to improve evaluation activities around NPMs. MCAH PRAMS, MMRC and AIM efforts and a pending MCAH data dashboard development project support enhanced surveillance capabilities which will benefit the MCH Program.

Other programs who partner to promote Title V MCH priorities in Nevada include: the Office of Analytics, Nevada Home Visiting, EHDI, TPP, Nevada Governor's Council on Developmental Disabilities, Individuals with Disabilities Education Act (IDEA) Part C Office, Nevada Early Intervention Services (NEIS), the Nevada Office of Minority Health and Equity (NOMHE), Primary Care Office (PCO), Oral Health, Community Health Services, Account for Family Planning, Office of Vital Records, Aging and Disability Services Division (ADSD), PCO, OSP, Office of Public Health Investigations and Epidemiology (OPHIE), SAPTA, the Division of Child and Family Services (DCFS), Chronic Disease Prevention and Health Promotion (CDPHP), Women, Infants, and Children (WIC) and the Immunization Program (IZ). Oral Health and ADSD MOUs with MCH will also support MCH goals.

The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate- income children. Nevada Medicaid is administered through the Division of Health Care Financing and Policy (DHCFP), with enrollment administered by the Division of Welfare and Supportive Services (DWSS) for Nevada Check Up, Nevada's Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Program and Medicaid. Both Fee for Service (FFS) and Managed Care Organizations (MCOs) operate in the state. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by contracted MCO providers. Tribal members can choose FFS or MCOs in urban or rural areas.

The Nevada Department of Education (NDE) and DPBH collaborate through an interlocal contract to support a

statewide School Wellness Coordinator. The School Wellness Coordinator, funded by MCH, supports strengthening collaborations between MCAH and NDE, as well as those of the Nutrition Unit, Immunization and CDPHP sections.

DHHS and DBPH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties with Tribal Governments. The Regional Emergency Medical Services Authority (REMSA), a Title V MCH partner, is funded by MCH to distribute car seats and provides safe sleep education and injury prevention information as part of the MCH injury prevention pilot developed with key staff at participating Tribal Nations.

Title V MCH partners with WIC, MCH statewide coalitions, breastfeeding coalitions, community-based programs, LHAs, the public, and private partners to increase breastfeeding rates by improved access to breastfeeding supports for new mothers. Breastfeeding campaigns and a MCH-administered website are designed to increase awareness, promote breastfeeding services, and normalize breastfeeding in public locations in partnership with WIC staff.

Title V MCH funds the Nevada Institute for Children's Research and Policy (NICRP) to conduct an annual health survey of children entering kindergarten, in partnership with all school districts.

Other state and local public and private organizations serving MCH populations funded by MCH include Children's Cabinet, Washoe County Health District Fetal Infant Mortality Review (FIMR), University of Utah Medical Home Portal, Nevada 211, REMSA, Immunize Nevada, Nevada Broadcasters Association, Urban Lotus, and Statewide MCH Coalitions. Family TIES, a Title V MCH-funded Family Voices partner, provides interpretation and translation at the University of Nevada, Reno, Craniofacial Clinic. Title V MCH also funds a bilingual CHW in Elko County. Information and materials disseminated by these partners are required to be culturally appropriate. Internal translation support is provided by MCAH staff members. Children's Cabinet TACSEI provides technical assistance and facilitates parent involvement in social emotional Pyramid Model activities.

Money Management/Nevada 211 provides information and referral via www.nv211.org, a toll-free phone number, text support, as well as hosting the Title V MCH toll free line, supporting the MHP resource sections, and educating people on the priority status of pregnant persons at SAPTA funded treatment centers. Urban Lotus provides trauma-informed yoga to disproportionately affected youth. REMSA, in addition to distributing car seats, provides safe sleep media outreach, and distributes Infant Safe Sleep Survival Kits to families experiencing disadvantage statewide via partners.

Immunize Nevada supports training/workforce development, including the statewide Nevada Health Conference with trainings to build topical MCH knowledge. Nevada Broadcasters Association is funded to promote Safe Sleep, PRAMS, and Sober Moms Healthy Babies PSAs. DP Video is funded to promote adolescent physical activity, transition to adult health care and the Medical Home Portal social media campaigns. The Statewide MCH Coalition is funded by MCH to support website maintenance, communication, maternal mental health and other MCH trainings, promote Go Before You Show campaign, and plan conferences for meeting community needs of diverse populations and focusing on specific MCH NPMs.

Efforts to Operationalize the Five-Year Needs Assessment

Efforts to operationalize the Nevada 5-Year Needs Assessment include the addition of NPM 5 and NPM 12. NPM 5 includes three parts: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding. PRAMS data is used for ESM 5.1 to monitor safe sleep efforts. The needs assessment and FAD indicated safe sleep as a priority. Title V MCH efforts to increase the percentages of infants placed in a safe sleep environment include the Cribs for Kids Program through the Regional Emergency Medical Services Authority (REMSA),

statewide PSAs on radio and television, all coalitions and funded partners being required to promote safe sleep as a condition of funding, active participation in social media awareness of safe sleep in partnership with DCFS on DHHS platforms, FIMR support and MCH staff service in reviews and data to action efforts, joint efforts with the Executive Committee of the Statewide Child Fatality Review, and social media efforts with partners on safe sleep.

NPM 12, Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care, was added due to the needs assessment. Efforts to increase the percentages include partnering with the Nevada Center for Excellence in Disabilities (NCED) for transition activities.

Ongoing activities with partners supported NPMs being retained due to the most recent needs assessment. Special attention to areas of disconnect between provider rankings and those of the public and CBOs is an area of particular interest with the 5-year needs assessment results. Promoting use of the needs assessment by partners and to help secure other funding has helped inform numerous grant applications. The needs assessment was made publicly available and shared with numerous partners statewide as a resource.

Nevada has implemented several innovative projects to build childhood resiliency and reduce suicide rates. State agencies, including the Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH), Division of Child and Family Services (DCFS), and Nevada Department of Education (NDE) have taken leadership roles in ensuring Nevada's children are equipped with necessary skills. Furthermore, school districts have bolstered messaging in their local communities, informing schoolchildren and their families how to access resources for assistance.

Organizational Structure

DPBH is led by Administrator Lisa Sherych and organized into four (4) branches: Administrative Services; Clinical Services; Community Services; and Regulatory and Planning Services. Within Community Services, led by Deputy Administrator Julia Peek, MHA, CPM, is the Bureau of Child, Family, and Community Wellness (CFCW), led by Bureau Chief Karissa Loper, MPH. The MCAH Section is led by the MCH Director and CYSHCN Director, Vickie Ives, MA. The MCAH mission is to improve the health and wellbeing of Nevada's pregnant persons, women of childbearing age, infants, children, and youth, including CYSHCN, and their families to protect and advance health, safety, and quality of life through the development of partnerships, education, health promotion, and disease and injury prevention. MCAH staff understand active engagement of families, caregivers, and communities are integral to positively impacting the health of MCH populations.

Title V MCH staff collaborate with other sections and programs within DPBH, other state agencies within DHHS, NDE, ADSD, DHCFP, DCFS, and the Department of Taxation.

Emerging Public Health Issues

COVID-19

The Nevada Health Response Center, Nevada DPBH, and the CDC are closely monitoring the outbreak of the respiratory illness caused by the 2019 novel coronavirus (COVID-19). DPBH is encouraging healthcare providers to refer to the CDC's Health Alert Network (HAN) and DPBH Technical Bulletins and DHHS efforts inform the state COVID-19 information hub at https://nvhealthresponse.nv.gov/ and MCH is posting MCH resources on the program website. The latest Nevada COVID-19 statistics and response efforts are also located at the website and kept updated through the efforts of the DHHS Office of Analytics and DPBH OPHIE office. LHAs, including Southern Nevada Health District (SNHD), Washoe County Health District (WCHD), and Carson City Health and Human

Services (CCHHS) are key responders monitoring and providing information related to COVID-19. Clear masks were provided by MCH to schools statewide to support those who are living with deafness or hard of hearing and the Nevada Telehealth Project was done in response to COVID-19 related needs, as were numerous CARES related funding enabled projects in the MCAH Section.

Congenital Syphilis

In 2018, Nevada was the top ranked state for primary and secondary syphilis rates and ranked second for congenital syphilis (CS) rates. In 2019, Nevada remained the top ranked state for primary and secondary syphilis rates, while falling to fourth for CS rates. According to the CDC, Nevada's primary and secondary syphilis rates have been increasing since 2012, from 4.1 to 26.6 per 100,000 persons in 2019. With this increase of syphilis cases comes a rise in congenital syphilis. According to CDC, CS rates in Nevada have been rising since 2012, from 2.9 to 114.7 per 100,000 in 2019, a 3855% increase. MCAH staff are key members of the CS Workgroup for Nevada and have been instrumental in CS prevention informational campaign development and resource distribution including specialized training and resources for all home visiting LIAs.

Substance Use During Pregnancy and Substance Exposed Infants

Close monitoring of substance use during pregnancy and substance exposed infants is a continuing priority for DPBH and Nevada's Title V MCH Program. According to NVSS, the percent of women who smoked during pregnancy was 3.5% in 2019; a decrease from 5.4% in 2010, or a change of 35.2%. NVSS data also shows the percentage of women who reported smoking, alcohol use, and/or drug use modestly decreased from 5.5% in 2016 to 5.3% in 2019. MCAH will continue to work on state efforts regarding Comprehensive Addiction Recovery Act (CARA) and the Infant Plan of Safe Care including education, training, OMNI work group participation, and increasing awareness. Nevada PRAMS collects data on substance use before, during, and after pregnancy in addition to vital statistics to inform Title V MCH efforts/activities. To enhance other substance use prevention efforts, PRAMS data will be presented to both the Opioid Use Disorder, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) and Promoting Innovation in State/Territorial Maternal and Child Health Policymaking (PRISM) learning communities.

Title V MCH Program staff are also core members of the Nevada ASTHO OMNI NAS-related efforts in Nevada and participate in the AMCHP PRISM efforts.

Maternal Mortality Review Committee (MMRC) and Alliance for Innovation on Maternal Health (AIM) Efforts

Reporting produced by MMRC support staff is included in Nevada's Title V MCH Block Grant reporting, and health equity in birth outcomes and maternal domain population health maximization are key areas of topical intersect in priorities of the MMRC, MCAH Section, SSDI Program, and Title V MCH Program. SSDI funds help support MMRC administrative support staff and CDC funds will be available in the Fall. The Title V MCH Program is in discussion with the Nevada Rural Hospital Partnership to launch Advanced Life Support in Obstetrics (ALSO), American College of Obstetricians and Gynecologists (ACOG) efforts to reduce rural maternal mortality by working with critical access hospitals. Nevada is an Alliance for Innovation on Maternal Health (AIM) State, which will help staff support activities reducing preventable maternal mortality and severe maternal morbidity, beginning with the hypertension patient safety bundle with the Nevada AIM launch June 24, 2021.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Process Description

Goals for the Title V MCH Program Five-Year Needs Assessment included surveying the community partners serving MCH populations to help guide the priority needs for the Title V MCH Program, reviewing Federally Available Data (FAD) for Nevada and other state-specific MCH data, linking National Performance Measures (NPMs), Evidence-based or -informed Strategy Measures (ESMs) and State Performance Measures (SPMs) to the state priorities, and identifying the best use of Health Resources and Services Administration (HRSA) Title V MCH Block Grant resources to improve health outcomes in each of the Title V MCH domains.

The Maternal, Child and Adolescent Health (MCAH) Section houses the Title V MCH and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs. Title V MCH and MIECHV collaborated on the HRSA needs assessments required by each grant, discussed goals for each program, and agreed upon a selection process for State Master Service Agreement agencies qualified to coordinate and complete a Five-Year Needs Assessment. After the selection process, Title V MCH and MIECHV staff chose Health Management Association (HMA) to complete the Five-Year Needs Assessment. HMA implemented a mixed method research design to inform the Needs Assessment, including multiple strategies to gather stakeholder and public input from across the state. MCAH staff presented to the Intertribal Council and Tribal Health Director's meetings, the Nevada Governor's Council on Developmental Disabilities, the Maternal and Child Health Advisory Board, and many other venues to heighten awareness of the Needs Assessment and engage collaboration on survey engagement.

HMA worked with Title V MCH and MIECHV program staff to identify and interview key stakeholders working in Title V MCH and MIECHV-funded programs or working with targeted population groups. Key stakeholders identified additional stakeholders for interviews or focus groups through the interview process, which allowed HMA to access a large and diverse number of stakeholders for information gathering. HMA then hosted an online community survey dispersed via Title V MCH and MIECHV staff, partner organizations, and social media channels and a series of focus groups were conducted across the state. Finally, HMA conducted secondary analyses of publicly available population health and surveillance data.

Key Informant Interviews

Twenty (20) semi-structured, in-depth interviews were conducted with a total of 33 key leaders working in maternal, child and adolescent health and wellness from Carson City, Churchill, Humboldt, Storey, Washoe, Mineral, Lyon, Clark, Elko, Eureka, and Nye counties (11 of 17 total counties). Interviews were designed to gather information about the most pressing health issues facing MCH population groups and what is most needed to effectively address these health issues. Leaders included those from organizations associated with special needs transportation, rural/frontier families, undocumented populations, foster care representation, child/abuse neglect, family resource centers, etc. Interviewees were also asked about gaps and barriers in services and programming in Nevada for MCH population groups. Finally, key informant interviews sought to gather information about disparities related to geography, race and ethnicity, and other identified socio-cultural differences.

The list of key informant interviews was finalized in collaboration with Title V MCH and MIECHV program staff and included providers of physical and mental health services, county and city officials, tribal representatives, academic institutions, and leaders at key social service organizations, including family resource centers, juvenile probation offices, Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning (LGBTQ) centers, and county coalitions. Informant selection methodology ensured diversity across expertise area and geography.

Notes from each key informant interview were reviewed using NVivo for health topic themes such as access to care, mental health, or oral health. The guide acted as the starting place for coding notes, and when possible, each set of codes were grouped into themes by MCH population group and geography.

Community Survey

In October 2019, HMA developed an online community survey in collaboration with Title V MCH and MIECHV program staff to

seek feedback from communities regarding the most important health needs for each MCH population group. Survey respondents were asked about health needs and issues in their community and what resources exist to address those health needs and issues. They were also asked about inequities within the MCH populations and where respondents think MCH population groups turn for information and resources. Finally, for each MCH population group, respondents were provided a list of health topics and asked to select the top three (3) health needs for each group.

The survey was posted online from November 21, 2019 to December 16, 2019 and a link to the survey was posted on the Division of Public and Behavioral Health (DPBH) homepage. Internal and external partners, stakeholders, and program subawardees were sent the survey link via email, along with information on survey purpose. Information about the survey, as well as the survey link, was posted on DPBH social media accounts. In total, 339 individuals responded to the online survey, of whom 46 percent (n=157) identified as a "community member," 46 percent (n=157) as a "service provider/partner or public health professional in maternal and child health services," and seven (7) percent (n=25) as a "service provider/partner or public health professional in a Maternal, Infant and Early Childhood Home Visiting Program." Among service providers, 30 percent were health care professionals and approximately 26 percent identified as community service providers. Public health professionals identified as 16 percent of providers, with just six (6) percent identifying as an educator and one (1) percent as a school nurse. Throughout the report, all service providers/partners and public health professionals who responded to the survey are noted as "MCH professionals and service providers."

Descriptive analysis was conducted for each of the survey questions, including a description of the number of people who included a given topic as a top three (3) issue, per MCH population group. Cross tabulations were conducted to understand whether variation existed in responses between respondent type (i.e., service provider or community member). Broad themes for any open-ended responses were determined through manual review.

Focus Groups

Between August 2019 and January 2020, HMA held 14 focus groups at different locations across Nevada. All focus groups took place in one (1) of the following Nevada counties: Carson City, Washoe, Clark, Storey, and Nye.

Participants were asked about:

1. Health needs of different MCH populations in Nevada;
2. Health needs of friends/family members;
3. Where clients receive health information;
4. What problems/barriers clients experience when trying to access services;
5. Services needed but not accessible, available, and/or affordable;
6. What are homes, schools, and communities doing to improve health and safety; and
7. What is Nevada doing well or what areas need improvement to address the health of MCH population groups across the state.

Specific focus groups were convened to better understand the perspective of populations including at-risk youth; parents engaged in home visiting; Spanish speakers; mothers in recovery from substance use; community members who identify as LGBTQ; families with children and youth with special health care needs (CYSHCN); and participants from frontier or rural communities. To support free flow of information, a list of open-ended questions was used to explore participant's insights. Analysis of focus group notes was conducted similarly to key informant notes using NVivo to note the health topic themes, such as access to care, mental health, or oral health, for example.

Data Sources Utilized

Along with the key informant interviews, surveys, and focus groups, HMA used a variety of national data sources including the National Vital Statistics System (NVSS), National Survey on Children's Health (NSCH), Behavioral Risk Factor Surveillance System (BRFSS), American Community Survey (ACS), Youth Risk Behavioral Survey (YRBS), National Survey on Drug Use and Health (NSDUH), Pregnancy Risk Assessment Monitoring System (PRAMS), as well as state data sources including the Nevada Report Card published by Nevada Department of Education (NDE) and the Nevada Rural and Frontier Data Book published by the University of Nevada, Reno, School of Medicine. FAD and MIECHV federal data were also integrated into the assessment.

The Title V MCH Program and MIECHV staff, led by the State Systems Development Initiative (SSDI) Manager met weekly to discuss the findings of the Five-Year Needs Assessment. In the meetings, staff reviewed current priorities and performance measures and compared them to the needs indicated by Needs Assessment survey respondents and to state and federal data indicators. Common needs appeared throughout the assessment drafts and Title V MCH Program staff and the SSDI Manager created the Title V MCH Program logic model (see attachment). The logic models helped focus the priorities and performance measures.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

MCH Population Health Status

Data suggest Nevada improved on several indicators relevant to MCH population groups compared to the United States as a whole since 2015. This assessment goes beyond key performance measures to understand root causes or drivers of MCH health and wellness outcomes, including both strengths and opportunities for improvement in Nevada.

The Needs Assessment identified strengths among MCH population groups, specifically:

- The community survey revealed respondents felt their communities were good places to raise children, including satisfaction with local schools and recreational facilities.
- Stakeholders felt a sense of commitment and urgency for improving the health and well-being of MCH population groups.
- Many communities engaged partners and leaders who were willing to work on solutions to improve MCH outcomes statewide.
- Nevada was ranked 11th in decline of teen pregnancy rate compared to the United States over the past decade.

Despite these strengths, for many MCH indicators, racially and ethnically diverse and low-income families in Nevada are disproportionately negatively impacted. The assessment identified significant age, gender, geographic, and racial and ethnic disparities.

The Needs Assessment identified opportunities for improvement among MCH population groups, specifically:

Women/Maternal Health

- Nearly one (1) in five (5) women in Nevada (19.6%), ages 19-44 years, are uninsured (higher than the United States at 15.2%), according to the 2017 American Community Survey.
- Across all MCH populations, a higher percentage of Hispanic women and children are uninsured compared to other race/ethnicity groups, according to the 2017 American Community Survey.
- Single mothers experience the highest poverty rates, at more than twice the rate of two-parent households, according to the 2017 American Community Survey. Single mothers of children younger than five (5) years are most vulnerable to poverty.
- Mental health was a predominant issue noted across all MCH population groups, according to Nevada survey respondents.
- Violence, including both violence to women (23%) as well as child abuse and neglect (26%), ranked high as health problems/issues for women of reproductive age and children birth to five (5) years according to Nevada survey respondents.

Perinatal/Infant Health

- Nevada's rate of sleep-related sudden unexpected infant death (SUID) reached a nine (9) year high in 2016 of 124.1 deaths per 100,000 live births but decreased in 2017 to 81.1 deaths per 100,000 live births. Rates

disproportionately affect Black or African American infants with 233.8 deaths per 100,000 live births, while white infants and Hispanic infants had the lowest rates at 90.3 and 57.8 deaths per 100,000 live births respectively according to National Vital Statistics System 2017 data.

- Nevada's infant mortality rate has remained stable since 2009, with a rate of 5.8 deaths per 1,000 live births in 2017. Black or African American infants have disproportionately higher rates, with 9.9 deaths per 1,000 live births. White and Hispanic infants had the lowest rates, at 4.7 and 4.9 deaths per 1,000 live births respectively, according to National Vital Statistics System 2016 data.
- The Health Care Cost and Utilization Project-State Inpatient Databases indicates the highest rate of infants born in Nevada with neonatal abstinence syndrome (NAS) per 1,000 birth hospitalizations was amongst White infants (13.7), with the lowest rates among Hispanic infants (2.7) in 2017.

Child Health

- According to the 2018 National Children's Health Survey, while insurance rates are generally high among children, access to consistent and adequate health insurance coverage is lower in Nevada (63.4%) compared to the United States (67.5%).
- The State of Nevada, Division of Child and Family Services 2016 Statewide Child Death Report indicates there is a racial and ethnic disparity among statewide child deaths, as Black or African American child deaths (ages 0 to 17 years) are disproportionately higher at 23.6 percent versus their population distribution in Nevada (10%) .
- More children in Nevada (22%), compared to children nationwide (18.6%), have ever experienced two (2) or more Adverse Childhood Experiences (ACEs), particularly parental separation or divorce, living with someone with substance use problems, and having a parent who served time in jail, according to the 2018 National Children's Health Survey.

Adolescent Health

- Lesbian, Gay, and Bisexual (LGB) youth experience high levels of bullying and violence, homelessness, fear, and mental health issues compared to their heterosexual peers, according to the 2017 Nevada Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report.
- Nevada ranks 41st among states in the 2017 teen pregnancy rate; however, Nevada is ranked 11th nationwide in decrease of the teen pregnancy rate across all racial and ethnic groups. Black or African American teens continue to experience the highest teen birth rates in Nevada, at 38.4 per 1,000 girls ages 15 to 19 years.
- Data from the Centers for Disease Control and Prevention (CDC) shows the number of deaths among all female adolescents in Nevada due to intentional self-harm is one of the highest in the nation, at 11 deaths per 100,000 population, compared to the US average of 6.2 deaths per 100,000 population.

Children and Youth with Special Health Care Needs

- Access to a medical home (i.e., patient-centered comprehensive coordinated care) occurs for less than half of Nevada's children, according to data from the National Survey of Children's Health. Among CYSHCN, this is less than one-third, lower than the United States average. Access to a medical home is lowest among CYSHCN, ages 0-5 years (16.3%), compared to the same age group of children without special needs (40.8%).

Cross-Cutting

- The difference between families experiencing poverty in rural and frontier communities who are also connected to benefits, such as food stamps/SNAP benefits, is greatest in Nye (10.4%), White Pine (10%), and Mineral (9.9%) counties, according to the 2017 American Community Survey. For Nevada as a whole, 16.1% of families live below the poverty level, while only 12.3% are connected to food stamp/SNAP benefits.
- Language and insurance status (i.e., uninsured or Medicaid) are shared risk factors across MCH population groups regarding access to services and are reported to be a common reason why people report experiencing unequal treatment in receiving services.

- Data from the 2018 Nevada Substance Abuse Prevention and Treatment Agency (SAPTA) Epidemiologic profile shows overall self-reported tobacco use among mothers during pregnancy decreased since 2010 from 66.8 to 48.2 per 1,000 live births in 2017; however, the rate among mothers living in rural communities increased to an eight (8) year high at 132.5 per 1,000 live births in 2017.
- Substance use was a concern among adolescents, pregnant, and one-year postpartum women.
- Alcohol and marijuana were the most reported substances used during pregnancy among Nevada mothers, with marijuana surpassing alcohol use in 2015 (5.3 and 5.0, respectively, per 1,000 live births) and increasing in 2017 (8.5 and 5.6 per 1,000 live births) according to the Nevada SAPTA Epidemiologic profile.

Access to Services

Access to services is a significant barrier to health and wellbeing, with community members reporting lack of providers, needed services offered by a local provider, and physical access to providers as key barriers. Both community members, MCH professionals, and service providers identified the same set of resources needing improvement (or those services not available, accessible, affordable, and/or high quality) in their community to benefit MCH population groups: mental health services, childcare options, housing, health care options, and good paying jobs with livable wages.

The barriers are particularly prevalent in rural or frontier communities in Nevada. Only 5.3% of health care and social assistance employees in Nevada live in rural and frontier counties (despite 9.5% of Nevada's population living in these areas). Overall, more than two-thirds of Nevada's population live in a federally designated primary medical care health professional shortage area (HPSA). The proportion of populations who reside in dental and mental health care HPSAs is even larger with almost 100% of the population in all rural and frontier counties living in a mental health HPSA.

Protective factors for adverse health outcomes for MCH population groups are less prevalent in Nevada. For example:

- Nevada ranks 47th nationwide in the percent of children who experience protective family routines and habits using data from the 2018 National Children's Health Survey
- Using data from the American Community Health Survey, one (1) in ten (10) youth (ages 16 to 19 years) are disconnected in Nevada (defined by neither working nor in school), putting them at greater risk of increased violent behavior, smoking, alcohol consumption and marijuana use, and emotional and cognitive deficits than their peers who are working and/or in school.
- The percentage of parents who report feeling their child lived in a safe neighborhood and was safe at school was lower in Nevada (59.6%) compared to parents across the United States (65.3%), according to the 2018 National Children's Health Survey.
- 2018 KidsCount data shows more children in Nevada ages three (3) to four (4) years are not enrolled in school (62%), including preschool or pre-kindergarten, than in the United States (52% not enrolled); this is most prevalent among children who are low-income (82%) and children who are Hispanic (72%).

Funding for public health is, in part, an indicator of the resources available to improve population health. Nevada is identified as the least healthy state when considering the amount of public health funding available relative to other states, including both a combination of state dollars dedicated to public health and federal dollars directed to states by the CDC and HRSA. Per-capita public health funding amounts to $46 in Nevada, lower than the United States per-capita average of $87, according to Trust for America's Health.

The Nevada Title V MCH Program will continue collaborations with public and private partners to improve the health of the Nevada MCH populations in areas of need identified by state data, FAD, and Needs Assessment feedback. The Five-Year Needs Assessment and state and federal data informed the state priorities, objectives, and strategies for the current State Action Plan.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Organizational Structure

The Governor of Nevada and the Cabinet and elected constitutional officers make up the Executive Branch. The Governor is the chief magistrate, the head of the executive department of the state's government and the commander-in-chief of the Nevada military forces. Steve Sisolak was elected Governor of Nevada on November 2, 2018.

The Department of Health and Human Services (DHHS) is the largest department in the Nevada Executive Branch. DHHS is comprised of five (5) Divisions along with additional programs and offices overseen by the DHHS Director's Office. Richard Whitley, MS, is the DHHS Director and was appointed by Governor Brian Sandoval in June 2015. The Divisions under DHHS include: the Division of Public and Behavioral Health (DPBH), Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy (DHCFP, aka Nevada Medicaid), and Division of Welfare and Supportive Services (DWSS).

DPBH is led by Administrator Lisa Sherych and organized into four (4) branches: Administrative Services; Clinical Services; Community Services; and Regulatory and Planning Services. Within Community Services, led by Deputy Administrator Julia Peek, MHA, CPM, is the Bureau of Child, Family, and Community Wellness (CFCW), led by MCH Director and Bureau Chief Candice McDaniel, MS. The MCAH Section is led by the CYSHCN Director, Vickie Ives, MA, and is within CFCW. The MCAH mission is to improve the health and wellbeing of Nevada's pregnant women, women of childbearing age, infants, children and youth, including CYSHCN, and their families to protect and advance health, safety, and quality of life through development of partnerships, education, health promotion, and disease and injury prevention. MCAH understands active engagement of families, caregivers, and communities is integral to positively impacting the health of MCH populations.

The Title V MCH Program is in the MCAH Section and is organized into the Maternal and Infant Health Program (MIP), Adolescent Health and Wellness Program (AHWP), CYSHCN Program, and MCH Epidemiology/Evaluation. The Health Program Manager I, Brian (Mitch) DeValliere, DC, leads the Title V MCH Program and collaborates closely with the Health Program Specialist II, SSDI Manager position, Tami Conn, and the DHHS Office of Analytics to ensure MCH data needs are supported.

Nevada's Title V MCH Program supports and is advised by a Maternal and Child Health Advisory Board (MCHAB). The Nevada MCHAB was established via executive order in 1989 and established by law in 1991 in Nevada Revised Statute 442.133 and meets quarterly. MCHAB is comprised of nine (9) individuals appointed to two (2) year terms by the State Board of Health from a list provided by the DPBH Administrator and two (2) legislators appointed by the Legislative Counsel. Members of MCHAB make MCH-related recommendations to the DPBH Administrator.

Title V MCH staff collaborate with other sections and programs within DPBH, as well as with other state agencies within DHHS. Title V MCH staff also collaborate with NDE and the Department of Taxation.

III.C.2.b.ii.b. Agency Capacity

Agency Capacity

The Title V MCH Program functions as a unit within the MCAH Section of CFCW, DPBH and takes a coordinated, systems-based approach to improving MCH health and wellbeing. Title V MCH Program Coordinators work to improve the function of each program unit within Title V MCH. For example, the AHWP Coordinator and CYSHCN Coordinator collaborate to improve transition from adolescent to adult health. The MCAH Rape Prevention and Education Coordinator collaborates with the AHWP and CYSHCN Coordinators to prevent intimate partner violence and promote shared protective factors. The MCH Epidemiologist coordinates data requirements with each Title V MCH program unit to enhance reports for internal/external partners and the MCHAB and links MCH to SSDI and PRAMS efforts as part of MCH data efforts led by the SSDI Manager.

The Title V MCH Program also coordinates efforts with other sections/programs within DPBH through Memoranda of Understanding (MOU). MOUs support the DPBH Office of Public Health Investigations and Epidemiology (OPHIE) and the DHHS Office of Analytics provides data for Title V MCH Block Grant narratives and reports, as well as for special reports requested by leadership, stakeholders, and the public. DPBH Community Health Services (CHS) promotes well visits for

women of childbearing age, adolescent preventive medical visits, and health care transition from pediatric to adult care for adolescents and CYSHCN. The DPBH Primary Care Office improves health care outcomes through its efforts to coordinate the federal shortage designation process, the J-1 Physician Visa Waiver Program, and other healthcare worker recruitment and retention programs. The CFCW Chronic Disease Prevention and Health Promotion Section provides resources for the SSDI Manager. The CFCW Immunization (IZ) Program co-funds a fiscal position and promotes Title V MCH population-related immunizations, including maternal and adolescent vaccines and provides reports on activities for MCHAB quarterly meetings.

The MCH Director is the CFCW Bureau Chief and is supported by the Deputy Bureau Chief, Karissa Loper, MPH, who leads IZ and MCAH efforts. The CYSHCN Director is the MCAH Section Manager. The CYSHCN Coordinator works with the CYSHCN Director and Title V MCH Program Manager to ensure CYSHCN and their families and/or caregivers receive the resources needed to support access to appropriate referrals and health care. In addition, the CYSHCN Program coordinates efforts to increase the number of children who have a Medical Home, leads the critical congenital heart disease (CCHD) registry, and supports transition from pediatric/adolescent to adult health care.

Nevada DHHS Tribal Liaisons and Title V MCH staff collaborate to share resources to address the needs of MCH populations in Nevada Tribal Nations and support targeted an injury prevention efforts. DHHS has MOUs with all 27 federally recognized Tribes of Nevada. These MOUs extend to the five (5) Divisions, including DPBH which houses the Title V MCH Program. DCFS has an additional MOU with Nevada Tribes for the Indian Child Welfare Act (ICWA) Program. A Tribal Consultation process is established at DHHS to guide the work and interactions with federally recognized Tribes in Nevada and must meet federal regulations. All topics and issues related to the health and wellbeing of Nevada Tribal members is important to discuss at Tribal Consultations which are held quarterly by DHHS.

The most important pieces of Tribal Consultation consist of the following: open and ongoing information exchange prior to implementing any proposed policies affecting Tribal Nations, including informal discussions and information sharing which leads to informed decision-making; creating the opportunity for DHHS to be responsive to the issues and concerns expressed by the Tribal Nations; continuation of trust, transparency and collaboration with the Tribal Nations; the commitment to work together to improve the quality, availability and accessibility to public health, human services and behavioral health care for Tribal communities in Nevada. DHHS agencies collaborate to present on the Divisions' current topics of importance and topics requested by the Tribal Nations at Consultation.

To support the ongoing communication and trust between Tribal Nations and DHHS, the Tribal Liaisons have traveled to all the Tribal Health Clinics to meet face-to-face with the Health Directors, Tribal Council Members, and other tribal organization staff (i.e., Social Service Program Directors). Additionally, to support Tribal partners, the DHHS Tribal Liaisons attend all meetings hosted at the Inter-Tribal Council of Nevada (ITCN) and meetings related to Tribal matters, as applicable. Also, with the partnership of other DHHS agencies, many community events are attended. MCAH staff presented on the MCAH Programs and Five-Year Needs Assessment at ITCN and Tribal Health Directors meetings and provided MCAH resource packets to the Tribal Liaisons for their visits as guests of the Tribal Health Clinics.

III.C.2.b.ii.c. MCH Workforce Capacity

MCH Workforce Capacity

The Title V MCH Program supports 11 full-time equivalent (FTE) positions located in Nevada's capital city, Carson City. FTE positions include a MIP Coordinator, an AHWP Coordinator, a Health Program Manager 1 (HPM 1), a MCH Epidemiologist, a Rape Prevention and Education (RPE) Coordinator, as well as 6 employees in various roles and capacities including the MCH Director and Bureau Chief (supported by a Deputy Bureau Chief with MCAH and IZ oversight), CYSHCN Director and Section Manager, two (2) Management Analysts, and two (2) Administrative Assistants in the Bureau of CFCW. The SSDI Manager and a part time Accounting Assistant III are funded through internal MOUs.

The MCH Director and CFCW Bureau Chief provides oversight of MCAH and across diverse programs and sections and is supported by the Deputy Bureau Chief, who leads IZ and MCAH efforts and programming, and Bureau Office Manager McKenna Bacon. The CYSHCN Director and MCAH Section Manager manages the Title V MCH Program and other MCAH

programs and projects. The Title V MCH Program Manager oversees the Nevada Title V MCH Program and is responsible for Title V MCH Block Grant, MCH staff support, budget development and oversight, and grant fiscal administration.

The MIP Coordinator position is currently vacant. Eileen Hough, MPH, is the AHWP Coordinator; Kagan Griffin, MPH, RD, is the MCH Epidemiologist and PRAMS Lead Coordinator; Larissa White, MPH, CPH is the CYSHCN Program Coordinator; Yesenia Pacheco is the RPE Coordinator; Lisa Light is the Accounting Assistant III (0.5 FTE); and Desiree Wenzel is the MCAH Office Manager.

The Nevada SSDI Manager, Tami Conn, leads MCH data efforts, supervises the MCH Epidemiologist and PRAMS Program and supports evaluation activities regarding NPMs, contributing to building the evidence base for the Title V MCH Block Grant; the SSDI Manager also supports the Nevada Maternal Mortality Review Committee (MMRC) and Alliance for Innovation on Maternal Health (AIM) efforts.

Misty Allen, MA, the Office of Suicide Prevention (OSP) Manager, coordinates suicide prevention efforts and provides Suicide Hotline data for Title V MCH reporting. Jie Zhang, MS, supports all MCAH data needs as the MCH Biostatistician II in the DHHS Office of Analytics and works closely with the MCAH and MCH teams. Further, eleven (11) Community Health Nurses (CHNs) provide services for MCH populations in rural communities and are partially funded by MCH, as well as a Primary Care Office (PCO) position, and a School Wellness Coordinator & Liaison at NDE.

Workforce challenges include recruiting and maintaining qualified and experienced public health professionals, the time needed to fill vacant positions due to state human resource processes, as well as needing to use contracted employees for key positions. The financial consequences to Nevada as a result of COVID-19 have culminated in a hiring freeze and furloughs of one (1) day per month for six (6) months from January 2021 – July 2021, impacting the state's ability to recruit staff for vacant positions and to renew contracted staff.

Serving the diverse MCH population in Nevada, addressing health disparities, increasing engagement with MCH leaders with lived experience, and family and adolescent engagement are important goals of the Title V MCH Program. Attending Culturally and Linguistically Appropriate Services (CLAS) Standards trainings, racism and health outcomes trainings, family and adolescent engagement trainings, and implicit bias trainings are key to staff development and improving MCH staff understanding of root causes of disparity and pathways to authentic engagement and partnership so activities can be designed and implemented to move data to action in collaboration with funded partners, MCH stakeholders, family members, and those with lived experience who are served by Title V MCH programs.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Title V Program Partnerships, Collaboration and Coordination

The Nevada Title V MCH Program collaborates with a network of partners, stakeholders, and agencies to support a systems-based model of delivering public health and enabling services to Nevada's MCH populations. Partnerships include the local Family Voices affiliate, Family TIES of Nevada led by Mary Meeker, state agencies, Local Health Authorities (LHAs), the Nevada System of Higher Education (NSHE), non-profit organizations, MCH Coalitions, community partners, and advocacy groups.

DHHS formed an Office of Analytics under the DHHS Director's Office to consolidate data capacity and facilitate cross training and data analytics support. Title V MCH funds the MCH Biostatistician and a Health Resource Analyst (HRA) position within this group. The MCAH Section also staffs two (2) HRA positions in the DHHS Office of Analytics to work with Nevada Early Hearing Detection and Intervention (EHDI) Program and Nevada Home Visiting (NHV/MIECHV) data. These positions are crucial members of the MCAH team and increase MCH data support and analytics capacity, accessing primary data and generating analyses and reports on behalf of MCAH and Title V MCH, in addition to the work of the MCH Epidemiologist and SSDI Manager.

Title V MCH continues to integrate with SSDI; MCAH created an organizational unit which includes PRAMS, SSDI, and MCH Epidemiology to foster cross-training and to meet program data needs. The MCAH Section Manager and Office of Analytics

Manager meet regularly with staff regarding MCAH data needs. SSDI enhances Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming. The Title V MCH Program plans to improve NPM evaluation activities using PRAMS, MMRC, and AIM efforts, as well as a pending MCAH data dashboard project to support enhanced surveillance capabilities to drive data-informed decision-making.

Other programs partnering to promote Title V MCH priorities in Nevada include: the DHHS Office of Analytics, NHV/MIECHV, EHDI, Teen Pregnancy Prevention (TPP), the Nevada Governor's Council on Developmental Disabilities, the Individuals with Disabilities Education Act (IDEA) Part C Office, Nevada Early Intervention Services (NEIS), the Nevada Office of Minority Health and Equity (NOMHE), the PCO (addresses access to health care and identifies workforce shortage areas), the Oral Health Program, CHNs, the Office of Public Health Investigations and Epidemiology (OPHIE), the Substance Abuse Prevention and Treatment Agency (SAPTA), the Division of Child and Family Services (DCFS), the Chronic Disease Prevention and Health Promotion (CDPHP) Section, the Nevada Women, Infants, and Children (WIC) Program and the Nevada State Immunization Program (IZ).

Nevada's Children's Health Insurance Program (CHIP), Nevada Check-Up, provides coverage to low- and moderate-income children. Nevada Medicaid and NV Check-Up are administered through the Division of Health Care Financing and Policy (DHCFP), with enrollment administered by the Division of Welfare and Supportive Services (DWSS) for NV Check-Up and Medicaid. Both Fee for Service (FFS) providers and Managed Care Organizations (MCOs) operate in Nevada. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by contracted MCO providers.

NDE and DPBH collaborate through an interlocal contract to support a statewide School Wellness Coordinator. The School Wellness Coordinator, funded by Title V MCH, will support strengthening collaborations between MCAH and NDE, as well as with the Nutrition Unit, Immunization, and CDPHP Sections; contracts/MOUs with the Oral Health Program and ADSD also support MCH goals.

DHHS and DPBH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties and relationships with Tribal Governments. The Regional Emergency Medical Services Authority (REMSA), a Title V MCH partner, distributes car seats and provides safe sleep education and injury prevention information as part of the MCH injury prevention pilot developed with key staff at participating Tribal Nations.

The Title V MCH Program partners with Nevada WIC, MCH statewide coalitions, breastfeeding coalitions, community-based programs, LHAs, and public and private stakeholders to increase breastfeeding rates by improving access to breastfeeding supports for new mothers. Breastfeeding campaigns and a MCH-administered website are designed to increase awareness, promote breastfeeding services, and normalize breastfeeding in public locations in partnership with WIC staff.

Title V MCH funds the Nevada Institute for Children's Research and Policy (NICRP) to conduct an annual health survey of children entering kindergarten, in partnership with all school districts. Other state and local public and private organizations serving MCH populations funded by MCH include: Family TIES, which also hosts the CYSHCN toll-free help line; Children's Cabinet; Washoe County Health District Fetal Infant Mortality Review (FIMR) Committee; University Center for Autism and Neurodevelopment (UCAN); University of Utah Medical Home Portal; Nevada 211; REMSA; Immunize Nevada; Nevada Broadcasters Association; Urban Lotus; and the Statewide MCH Coalitions. Family TIES of Nevada, a Title V MCH-funded Family Voices partner, provides interpretation and translation services at the University of Nevada, Reno, Craniofacial Clinic. Nevada Title V MCH also funds a bilingual Community Health Worker (CHW) in Elko County. Partners disseminate information and materials which are culturally appropriate. Internal translation support for written educational materials is provided by MCAH and CFCW staff when needed. Nevada's Children's Cabinet Technical Assistance Center on Social Emotional Intervention (TACSEI) provides technical assistance and facilitates parent involvement in social emotional Pyramid Model activities.

Money Management/Nevada 211 provides information and referrals via www.nv211.org, a toll-free phone number, text support, as well as hosting the Title V MCH toll-free phone line, supporting the MIP resource sections, and educating women on the priority status of pregnant women at SAPTA-funded treatment centers. Urban Lotus provides trauma-informed yoga to at-risk youth. REMSA, in addition to distributing car seats, provides safe sleep media outreach and distributes Infant Safe Sleep Survival Kits to at-risk families via statewide partners.

Immunize Nevada supports staff training and workforce development, including planning and hosting the statewide Nevada Health Conference with trainings to build topical MCAH knowledge in cross-cutting health topic areas, including CDPHP, IZ, etc. Nevada Broadcasters Association is funded to promote Safe Sleep, PRAMS, and Sober Moms Healthy Babies (SMHB) PSAs. DP Video is funded to promote adolescent physical activity, tobacco quit-line, transition to adult, and SMHB social media campaigns. The Statewide MCH Coalition is funded to support website maintenance, communication, maternal mental health and other MCH trainings, promote the Go Before You Show campaign, and plan conferences with partners for meeting the community needs of diverse MCH populations.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

The Title V MCH Program staff and SSDI Manager met weekly to discuss the results of the Five-Year Needs Assessment. Staff reviewed Nevada's current Performance Measures and compared them to the needs indicated by the state data, FAD, and the needs assessment focus groups, interviews, and surveys. Common themes appeared throughout the Needs Assessment and the Title V MCH Program staff created a logic model for each program unit, as well as an overarching Title V MCH Program Logic Model containing eight (8) National Performance Measures (NPMs):

- NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year
- NPM 4 A: Percent of infants who are ever breastfed and B: Percent of infants breastfed exclusively through 6 months
- NPM 5 A: Percent of infants placed to sleep on their backs, B: Percent of infants placed to sleep on a separate approved sleep surface, and C: Percent of infants placed to sleep without soft objects or loose bedding
- NPM 6: Percent of children, ages 9 through 35 months, who received a development screening using a parent-completed screening tool in the past year
- NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
- NPM 14: Percent of women who smoke during pregnancy

The Logic model also describes an outline for Evidence-Based or -Informed Strategy Measures (ESMs). After selecting the NPMs, weekly Title V Block Grant meetings focused on the selection of ESMs and State Performance Measures (SPMs). HRSA guidance and researching measures from other state programs led to the team to choose measures consistent with the selected NPMs and the priorities identified in the Needs Assessment. The final measures were incorporated into the State Action Plan and include:

- ESM 1.1: Percent of pregnant women who received prenatal care beginning in the first trimester
- ESM 4.1: Percent of PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends
- ESM 5.1: Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and/or environment
- ESM 6.1: Percent of Medicaid enrolled children, ages 9 to 35 months, who received a developmental screening using a standardized tool
- ESM 10.1: Percent of adolescents, ages 12 through 17, who received Medicaid and/or Nevada Check-Up covered preventive well visits
- ESM 11.1: Number of Nevada Medical Home Portal website views
- ESM 12.1: Percent of health transition training participants who reported a change in knowledge, practice, or policy
- ESM 14.1.1: Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits
- SPM 1: Percent of mothers who reported late or no prenatal care
- SPM 2: Percent of women who used substances during pregnancy
- SPM 3: Repeat teen birth rate
- SPM 4: Teenage pregnancy rate

Emerging issues and some frequently cited needs were not selected as specific priorities for Nevada's Title V MCH Program because of existing collaborative efforts with other agencies dedicated to these needs. Further, the Nevada Title V MCH Program continues to engage in and report on many issues related to MCH health even though they are not selected NPMs for the Block Grant.

Mental health was considered a top three (3) health problem in qualitative responses in three (3) domains: women and maternal health, adolescent health, and CYSHCN. MCAH and the Title V MCH Program collaborate with other statewide agencies and stakeholders to advance mental health treatment and awareness. Title V MCH efforts include those to address perinatal mood and anxiety disorders (PMAD), a Suicide Prevention Hotline, NHV efforts to address infant mental health, MCH Coalition efforts, Mental Health First Aid, Urban Lotus Project's efforts to provide Yoga classes to young people undergoing substance use and mental health treatment, participation in the HRSA Pediatric Mental Health Evaluation group and Systems of Care efforts, and the FIMR Case Review Team recommendation to develop a Spanish-speaking support group to address the need in Washoe County's Latina population.

Domestic or intimate partner violence was considered a top health problem for women of reproductive age and was also listed as a concern for pregnant and post-partum women. Title V MCH includes the RPE Program and integrates associated efforts to provide education and prevention support to partners who work with these populations. TPP efforts related to providing information and education about human and sexual trafficking includes MCH participation.

Promoting healthy weight was listed as a top concern for children ages 6-11 years. Efforts related to increasing physical activity for children and adolescents are led by NDE and the Nutrition Unit within CFCW; the AHWP Coordinator participates in these efforts. Increasing adequate insurance coverage is addressed via existing statewide partnerships and program participation in efforts in place under other state agencies. The addition of safe sleep and increasing transition of care for adolescents and CYSHCN NPMs build on existing efforts and partner networks.

Some priority needs from the previous reporting cycle remain because the Title V MCH Program efforts are showing improvement or there is a need to make additional improvements. For example, improving preconception and interconception health among women of childbearing age, promoting breastfeeding, and reducing substance use during pregnancy are ongoing priority concerns and show some improvement as the Nevada and national statistics become closer to the same level. However, there is much room for improvement, particularly in relation to key perinatal outcomes. Increasing developmental screenings and improving care coordination efforts remain priorities; it is important to Nevada to improve these measures to meet or exceed the national-level outcomes and improve the lives of Nevadans. Promoting safe sleep, promoting a medical home for every Nevada child, and increasing transition of care for adolescents and CYSHCN were chosen as needs based on data indicating a gap in state data compared to national data on these measures.

From MIECHV collaboration, to evaluating available data and Needs Assessment results, to selecting the priority needs and associated performance measures using logic models, the Nevada Title V MCH Program staff collaborated on a set of measures and priorities to guide implementation of efforts to improve the health of Nevada MCH populations over the next five-year period. This work synthesized community, family, stakeholder, and provider voices and feedback with key data on MCH needs and gaps. By addressing existing state priorities and recognizing and adding new priorities and performance measures, Nevada's Title V MCH Program is in a strong position to facilitate the enabling and public health services necessary to address the State Action Plan and improve outcomes using data to action interventions.

The Five-Year Needs Assessment can be found as an attachment as well as on the Division of Public and Behavioral Health website.
http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/TitleV/dta/Publications/Needs%20Assessment%20Final(2).pdf

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,085,007	$1,846,079	$2,091,381	$1,900,965
State Funds	$1,563,756	$1,562,785	$1,578,536	$1,504,548
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$3,648,763	$3,408,864	$3,669,917	$3,405,513
Other Federal Funds	$59,515,762	$60,203,912	$63,696,900	$56,788,244
Total	$63,164,525	$63,612,776	$67,366,817	$60,193,757

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,236,205	$2,002,924	$2,236,205	
State Funds	$1,677,154	$1,516,837	$1,677,154	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$3,913,359	$3,519,761	$3,913,359	
Other Federal Funds	$68,182,911	$82,532,152	$64,444,026	
Total	$72,096,270	$86,051,913	$68,357,385	

	2022	
	Budgeted	**Expended**
Federal Allocation	$2,236,205	
State Funds	$1,677,154	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$3,913,359	
Other Federal Funds	$111,476,910	
Total	$115,390,269	

III.D.1 Expenditures

Federal Fiscal Year 2022 Application - Expenditure Narrative

In FFY 2020, the Nevada Title V MCH Program expended $2,2002,924 in federal funds and $1,516,837 in state match funds for a total of $3,519,761. The state match funds are comprised of $1,016,837 from the State General Fund and in in-kind contributions from the Nevada Broadcaster's Association. FFY 2020 state match funds expended meet Nevada's maintenance of effort amount of $853,034.

Budgeted vs. Expended by Types of Individuals Served:

The $2,002,924 award received for FFY 2020 was 10.43% lower than the budget of $2,236,205 submitted for FFY 2020.

Pregnant Women:

Budget: $476,196
Expended: $506,393
Variance: Expenditures are 6.34% more than budgeted

The variance is higher than expected. This may be because the original budget did not consider the full amount of funding available in state match funds.

Infants <1 year old:

Budget: $499,058
Expended: $507,311
Variance: Expenditures are 1.65% more than budgeted

The variance is higher than expected. This may be because the original budget did not consider the full amount of funding available in state match funds.

Children 1 to 22 years old:

Budget: $860,481
Expended: $1,009,543
Variance: Expenditures are 17.32% more than budgeted

Children with Special Healthcare Needs:

Budget: $1,068,761
Expended: $1,109,498
Variance: Expenditures are 3.81% more than budgeted

Others:

Budget: $146,836
Expended: $178,266
Variance: Expenditures are 21.40% more than budgeted

Administration:

Budget: $223,619
Expended: $128,446
Variance: Expenditures are 42.56% less than budgeted

Budgeted vs. Expended by Types of Services:

Direct Health Care Services:

Direct services include preventive and primary care services for all pregnant women, mothers, and infants up to age 1, preventive and primary care services for children and services for CYSHCN. Nevada Title V MCH does not support direct services with HRSA funds.

Budget: $0
Expended: $0
Variance: No variance

Enabling Services:

Enabling services are defined as non-clinical services that aim to increase access to health care and improve health outcomes.

Budget: $1,056,607
Expended: $570,221
Variance: Expenditures are 46.03% less than budgeted

The variance is higher than expected. This may be because the COVID-19 pandemic caused shifts in spending.

Public Health Services and Systems:

Budget: $2,856,752
Expended: $2,949,540
Variance: Expenditures are 3.25% more than budgeted

III.D.2 Budget

Federal Fiscal Year 2022 Application – Budget Narrative

The total estimated Federal Fiscal Year FFY 2022 Title V MCH budget is $3,913,359. As required, the state of Nevada's FFY 2022 application budget adheres to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget purposes, at $2,236,205. State matching funds are budgeted at $1,677,154 and are comprised of State General Funds and in-kind contributions from Nevada State Broadcasters Association. The amount of state funds to be used to support Maternal and Child Health programs in FFY 2022 is shown in the budget documentation of the state application. We assure that the $853,034 maintenance of effort requirement (FFY89 level of state funding) will be satisfied.

For FFY 2022, $670,862, 30% of the federal Title V allocation, is budgeted for Preventive and Primary care of Children and Adolescents. The same amount, $670,862, 30% of the federal Title V allocation, is budgeted for Children and Youth with Special Health Care Needs. Administrative costs for Federal Fiscal Year 2022 are budgeted at $223,619, 10% of the MCH allotment. Administrative expenditures will not exceed this amount. The remaining FFY 2022 Federal Title V award is directed towards services for pregnant women, postpartum women, and infants up to age one year as well as other activities supporting MCH populations throughout the state.

Services are provided through contracts with local agencies, including health districts and community-based nonprofit agencies.

Other Federal Funds

Nevada's Title V Program is housed in the Bureau of Child, Family, and Community Wellness. The Bureau also administers the following federal grant programs/funding streams totaling $111,476,910 in FFY22. All federally funded programs referenced below provide services to the populations served by the Maternal and Child Health Block Grant Program.

Administration for Children and Families

Sexual Risk Avoidance Education Program (SRAE)
Personal Responsibility Education Program (PREP)

Centers for Disease Control and Prevention

Early Hearing Detection and Intervention (EHDI)
Pregnancy Risk Assessment Monitoring System (PRAMS)
Rape Prevention and Education
Preventive Health and Health Services
Colorectal Cancer Control Program (CRCCP)
National Comprehensive Cancer Control Program (NCCCP)
Tobacco Control Program
Vaccines for Children/Immunizations
National Breast and Cervical Cancer Early Detection (NBCCEDP)
Diabetes Prevention
Heart and Stroke Prevention (1815)
Heart and Stroke Prevention (1817)
Tobacco Control Quitline Capacity

Health Resources and Services Administration

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)
Universal Newborn Hearing Screening

United Department of Agriculture

Women, Infants and Children (WIC)
Summer EBT
FMN Program
Healthy Hungry Free Kids Act
WIC BFBC

Budget by Types of Individuals Served

In FFY 2022, the Nevada Title V MCH program is budgeting the following federal and state match funds towards the individuals served requirements:
Pregnant Women - $524,051
Infants < 1 year old - $602,318
Children 1 to 22 years old - $1,174,009
Children and Youth with Special Healthcare Needs - $1,174,008
All Others – $215,354

Total Budgeted by types of individuals served is $3,689,740 because the administrative costs of $223,619 are excluded in this calculation.

Budget by Types of Services

Nevada no longer allocates funds to direct health care (DHC) services and only budgets for Enabling Services and Public Health Services and Systems. In FFY 2022, the Nevada MCH program plans to allocate federal and state match funds as follows:

Direct Health Care Services - $0
Enabling Services - $978,339
Public Health Services and Systems - $2,935,020

III.E. Five-Year State Action Plan

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

State: Nevada

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

State Title V Program Purpose Design

The Nevada Department of Health and Human Services (DHHS) oversees five Divisions, including Child and Family Services (DCFS), Health Care Financing and Policy (DHCFP/NV Medicaid), Aging and Disability Services (ADSD), Welfare and Supportive Services (DWSS), and Public and Behavioral Health (DPBH). The Nevada Title V MCH Program is part of the Maternal, Child and Adolescent Health (MCAH) Section of the Bureau of Child, Family, and Community Wellness within DPBH. The mission statement of DPBH, "It is the mission of the Division of Public and Behavioral Health to protect, promote and improve the physical and behavioral health of the people of Nevada," is the guiding directive for the Nevada Title V MCH Program.

Title V MCH staff are dedicated to improving Nevada families' health, emphasizing women, birthing people, infants, and children, including children and youth with special health care needs (CYSHCN). Title V funding from the Health Resources and Services Administration (HRSA) supports:

- health education and prevention activities,
- increasing access to health care services,
- developing, and leveraging key partnerships and collaborations, and
- planning and implementing program components reaching specific populations in collaboration with community-level partners, coalitions, non-profit organizations, and other state agencies.

National Performance Measures (NPM), Evidence-Based or- Informed Strategy Measures (ESM), and State Performance Measures influence Nevada Title V MCH priorities. Nevada's Title V MCH 2020 Needs Assessment demonstrated the need to focus on the following priorities.

- Improve preconception and interconception health among individuals of childbearing age
- Reduce substance use during pregnancy
- Promote breastfeeding
- Promote Safe-Sleep
- Increase developmental screening
- Provide a Medical Home
- Improve care coordination among adolescents
- Increase transition care for adolescents and CYSHCN

Nevada Title V MCH Program staff meet weekly to discuss programmatic updates and address the needs of partners, collaborators, and subawardees. Nevada Title V MCH also remains flexible to adapt to the changing health outcomes for Nevadans. Emerging issues require Nevada Title V MCH staff to stay abreast of evolving MCH healthcare needs. Nevada Title V MCH priorities currently address the following key issues:

COVID-19

The Nevada Health Response Center, Nevada DPBH, and the CDC are closely monitoring the outbreak of the respiratory illness caused by the 2019 novel coronavirus (COVID-19). DPBH is encouraging healthcare providers to refer to the CDC's Health Alert Network (HAN) and DPBH Technical Bulletins and DHHS efforts inform the state COVID-19 information hub at https://nvhealthresponse.nv.gov/. The latest Nevada COVID-19 statistics and response efforts are also located at the website and kept updated through the efforts of the DHHS Office of Analytics and DPBH OPHIE office. Local health authorities, including Southern Nevada Health District (SNHD), Washoe County Health District (WCHD), and Carson City Health and Human Services (CCHHS) are also key responders monitoring

and providing information related to COVID-19.

In addition to the DHHS and DPBH efforts, Title V MCH Program staff posts MCH-specific COVID-19 resources on the program website; are engaged in COVID-in-pregnancy surveillance monitoring discussions with CDC as part of an OPHIE-led team; MIS-C efforts; share COVID-19 resources and technical bulletins to partners to support rapid information sharing; and have reached out to partners and subawardees to see how COVID-19 is affecting their efforts/activities and to assist with any technical assistance and/or adaptations or fiscal redirects as needed. MCH funded statewide clear face mask purchases for school districts and EHDI partners and supported a CHS immunization need, MCH and NHV staff were awarded pass through HRSA funds via AMCHP for a COID-19 related telehealth project for CYSHCN and prenatal care. Fortunately, most MCH-funded partners have been able to function well and adapt to the challenges of using virtual platforms. MCH staff have adapted administrative and organizational processes to support program implementation while telecommuting. Title V MCH staff continue to facilitate a COVID-19 and MCH data presentation in concert with the Office of Analytics during the MCHAB meetings since August 2020. MCAH staff have also discussed NOMHE-planned equity and COVID-19 toolkit distribution opportunities and shared materials from NOMHE and other quality organizations about racism and public health, health equity, health disparities and racism, and racism and pregnancy outcomes.

Congenital Syphilis

In 2018, Nevada was the top ranked state for primary and secondary syphilis rates and ranked second for congenital syphilis (CS) rates. In 2019, Nevada remained the top ranked state for primary and secondary syphilis rates, while falling to fourth for CS rates. Primary and secondary syphilis rates have been increasing in Nevada since 2012. According to the CDC, Nevada's rate of primary and secondary syphilis per 100,000 persons, from 2012-2019 are as follows: 4.1, 7.3, 11.0, 11.7, 15.3, 19.7, 22.7, and 26.6. With this increase of syphilis cases comes a rise in CS. According to CDC, CS rates in Nevada have been rising since 2012. Nevada's CS rates per 100,000 persons from 2012-2019 are as follows: 2.9, 5.7, 13.9, 22.0, 33.1, 57.9, 85.5, and 114.7; this represents a 34.2% increase from 2018 to 2019, and a 3855.2% increase over an eight-year span. MCAH staff are members of the CS Workgroup for Nevada and have been instrumental in CS prevention informational campaign development and resource distribution.

Teen Suicide

Teen suicide is an emerging issue in Nevada. Data from NVSS shows the adolescent suicide rate for those ages 15-19 years per 100,000 adolescents in Nevada was 15.6 for the reporting period of 2017-19; this represents an increase of 2.6% from the 2016-18 rate. Nevada's 2017-19 teen suicide rate is higher than the U.S. rate of 11.2 suicides per 100,000 adolescents during the same reporting period. When stratifying adolescent suicide rates for those ages 15-19 years by urban/rural residence, the 2015-19 rate was 20.0 in non-metro (rural) areas compared to 14.4 and 13.1 in small/medium and large metro areas, respectively. Title V MCH will continue to be an active participant in the Healthy Tomorrows Grant with the NVPCA. The Healthy Tomorrows project is focused on creating adolescent-friendly spaces in FQHCs to increase repeat visits and a develop a patient-centered medical home for Nevada's adolescents. Title V MCH Program funding also helped support the Nevada OSP with teen suicide prevention and systems-building projects, such as Youth Mental Health First Aid and Project AWARE, via funding for the OSP Manager and the crisis call line. Title V MCH staff also participate on the HRSA Mental Health Evaluation Committee and attend Statewide Children's Mental Health Consortia meetings. Title V MCH Program staff also wrote a letter of support for The Foundation for Positively Kids in their application to the Healthy Tomorrows Program grant.

Substance Use During Pregnancy and Substance Exposed Infants

Close monitoring of substance use during pregnancy and substance exposed infants will continue to be a priority for DPBH and Nevada's Title V MCH Program. According to data from NVSS, the percent of women who smoked during pregnancy was 3.5% in 2019; a decrease from 5.4% in 2010, or a change of 35.2%. NVSS data also reflects a modest decline in the use of substances during pregnancy, as the percentage of women who reported smoking, alcohol use, and/or drug use decreased from 5.5% in 2016 to 5.3% in 2019. MCAH will continue to work on state efforts regarding CARA and the Infant Plan of Safe Care including education, training, OMNI work group participation, and increasing awareness. Nevada PRAMS staff make inquiries about substance use before, during, and after pregnancy and provide self-reported data in addition to vital statistics and hospital inpatient data to inform Title V MCH efforts/activities. To enhance other substance use prevention efforts, PRAMS data will be presented to both the OMNI and PRISM learning communities.

Title V MCH Program staff are also core members of the Nevada ASTHO OMNI NAS-related efforts in Nevada and also participate in the AMCHP PRISM efforts. MCH funds will support Infant Plan of Care material translation and distribution and the MCH Director will present on CARA referral pathways at a Project ECHO webinar in August and co presented at the Nevada Health Conference on Infant Plans of Care.

Maternal Mortality Review Committee (MMRC) and Alliance for Innovation on Maternal Health (AIM) Efforts

Governor Steve Sisolak signed Assembly Bill (AB) 169 of the 80th Nevada Legislative Session into law in June 2020, establishing a Nevada MMRC. AB169 was codified in NRS 442.751 through 442.774, inclusive, and reflected the work of a wide vary of supporters and advocates. The MMRC is required to: 1) review incidents of maternal mortality and severe maternal morbidity (SMM) in Nevada; 2) disseminate findings and recommendations concerning maternal mortality and SMM to providers of health care, medical facilities, other interested persons and the public; 3) publish timely reports consisting of data relating to maternal mortality and SMM, descriptions of incidents reviewed by the Committee, and recommendations to reduce maternal mortality and SMM in Nevada.

Nevada established the state's first MMRC and convened the first meeting in February 2020 and convened a total of four times that year. This MMRC will continue to meet at least twice annually to review all incidences of maternal mortality in Nevada. The Title V MCH Program will be involved in supporting MMRC-related meeting travel and ancillary costs for members, and in considering possible opportunities for implementing MMRC recommendations in MCH programmatic efforts for prevention, increased awareness of the existence and recommendations of the MMRC among the public, clinicians, and policy makers, and supporting dissemination of required reports and data-driven MMRC recommendations (e.g., evidence-based practices, screenings, and patient and provider education). The 2021 legislative session added a partnership between the MMRC and the NOMHE Advisory Board in relation to recommendations of the MMRC in the biennial report to the legislature.

Reporting produced by the MMRC support staff is included in Nevada's Title V MCH Block Grant reporting, and health equity in birth outcomes and maternal domain population health maximization will be key areas of topical intersect in priorities of the MMRC, MCAH Section, SSDI Program, and Title V MCH Program. Title V MCH Program staff will look for opportunities to create sustained funding for the MMRC as it was passed into law without dedicated funding. SSDI funds help support MMRC administrative support staff. The Title V MCH Program is in discussions with the Nevada Rural Hospital Partnership to launch Advanced Life Support in Obstetrics (ALSO), American College of Obstetricians and Gynecologists (ACOG) efforts to reduce rural maternal mortality by working with critical

access hospitals. Nevada is now an AIM State, which will help staff support activities reducing preventable maternal mortality and severe maternal morbidity (SMM), beginning with the hypertension patient safety bundle with the Nevada AIM launch June 24, 2021.

Early Childhood Continuum

Strengthening the early childhood education continuum to include public health is an emerging issue the Nevada Title V MCH Program will help address. The Title V MCH Program will continue and expand efforts to achieve the goal of NPM 6: To increase the percent of children, ages 9 to 35 months, who received a developmental screening using a parent completed screening tool. According to data from NSCH, Nevada has experienced an increase in the percent of children screened, from 27.9% during 2017-2018 to 30.6% during 2018-2019. Systems-level interventions are needed to address all components of child development. Title V MCH Program staff will continue to work with the Early Childhood Advisory Council, Pritzker initiatives, Nevada Early Intervention Services (NEIS), and NHV to engage diverse partners and leverage existing efforts to address the early childhood continuum. The MCH Director and NHV staff have been core participants in Pritzker efforts in Nevada also related to strengthening the early care continuum. Title V MCH funding replaced out of date audiological equipment. The new audiological equipment will serve all NEIS children statewide.

State Title V Program Purpose Design Conclusion

The Nevada Title V MCH Program is a small, enthusiastic, and well-organized unit within the MCAH Section. It works in conjunction with MCAH programs, including NHV, SSDI, PRAMS, PREP, the SRAE Program, EHDI, AIM, MMRC, AFP, RPE, and OSP. The Nevada Title V MCH Program aims to address many key health needs of Nevada's MCH population using evidence-based approaches, highlighting SDOH, and prioritizing the importance of partner collaboration. Nevada Title V MCH takes a systems-based approach to achieve the mission of DPBH and embraces intra- and inter-agency braided efforts. In addition to Title V MCH Block Grant priorities, program staff support the Governor's priorities and those of DHHS to maximize MCH population health outcomes and improve Nevada families' health and well-being.

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

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

MCH Workforce Development

Nevada Title V MCH supports 11 Full-Time Equivalent (FTE) staff members and eight employees in various roles and capacities in the Bureau of Child, Family, and Community Wellness (CFCW). Candice McDaniel, MS, CFCW Bureau Chief, served as the Nevada Title V MCH Director during the reporting period and provided oversight across diverse programs and sections, including MCAH. Ms. McDaniel accepted another position within the state. Karissa Loper, MPH, served as the Deputy Bureau Chief and was recently promoted to Health Bureau Chief. Vickie Ives, MA, serves as the MCH and CYSHCN Director and MCAH Section Manager. Mitch DeValliere, DC, serves as the Title V MCH Program Manager for the MCH Unit. The MCH Unit includes Eileen Hough, MPH, AHWP Coordinator; Kagan Griffin, RD, MPH; MCH Epidemiologist and PRAMS Lead Coordinator; and Amber Hise, RD, Maternal and Infant Program Coordinator. Tami Conn is the SSDI Manager and works closely with the MCH Unit and leads data efforts. Larissa White, MPH, PhD, served as the CYSHCN Coordinator, and Yesenia Pacheco served as the RPE Coordinator during the reporting period; however, both positions are currently vacant. Desiree Wenzel serves as the MCAH Section Office Manager.

Non-MCH funded key partners within the MCAH Section, CFCW, and other areas of DPBH collaborating on MCH-related activities include:

- PREP 1.0 FTE Coordinator, SRAE Program 1.0 FTE Coordinator, 1.0 FTE Administrative Assistant (AA) II, and 0.4 FTE Grants and Project Analyst (GPA) I;
- EHDI 1.0 FTE Coordinator, EHDI 1.0 FTE Data Analyst, EHDI 1.0 FTE AA II, and 0.5 FTE Audiologist;
- AFP, Health Program Specialist 1,1.0 FTE Coordinator;
- Division of Child and Family Services staff;
- Nevada WIC Program and Immunization Program staff; and
- Substance Abuse Prevention and Treatment Agency program staff.

Partially or fully funded MCH key state partners include:

- RPE Program 0.25 FTE Coordinator through leveraged Preventive Health and Health Services Block Grant and CDC grant funds
- Community Health Nurses who provide health promotion and prevention services, care coordination, health education, and outreach to support public health in Nevada's rural and frontier counties
- NHV Program - two sites co-funded
- Nevada Immunization Program 0.5 FTE Accounting Assistant supports MCH fiscal efforts
- DHHS Office of Analytics 1.0 FTE Biostatistician and 1.0 FTE Health Resource Analyst II who provides data support across MCAH programs
- 1.0 FTE SSDI Manager
- 1.0 FTE Office of Suicide Prevention Manager
- Primary Care Office 0.5 FTE Health Resource Analyst
- MMRC 0.5 FTE Nurse Abstractor (Ancillary costs only)

State and Division Staff Training

Nevada continues to maintain its Online Professional Development Center (https://nvelearn.nv.gov) and provide in-person classes to employees. The Development Center contains various trainings, including developing and

applying logic models for planning, implementing, and evaluating programs, effective techniques for presenting data, and practical methods for making decisions. DPBH employees meet annual HIPAA and information security training requirements using the Development Center and can use it to further job-related skills. Employees value the continuing education offered by MCH trainings to stay current on topical MCH developments in priority areas. Additional trainings taken by MCH staff were limited during the COVID-19 pandemic, but virtual trainings were attended. Other workforce development opportunities are provided to staff by various state programs, federal agencies, academic institutions, and professional organizations such as the AMCHP, Immunize Nevada, HRSA/AMCHP Technical Assistance and Regional meetings, the Nevada Public Health Association (NPHA), and through an assortment of coalition conferences. Title V MCH staff attend the Statewide MCH Coalition and Breastfeeding Coalition sponsored trainings and Project ECHO, the local Area Health Education Center (AHEC), and UNR trainings.

MCAH Staff Training

In the reporting year, MCAH Section staff participated in various workforce development opportunities. However, with statewide travel restrictions in place due to COVID-19, MCAH staff training opportunities were limited to virtual settings. Trainings provided to MCAH staff Include:

- The MCH Director attended numerous development opportunities and trainings in support of MCH, WIC, CDPHP, and Immunization as the Chief of these Sections. She continues to be a key participant in statewide systems building initiatives such as the Nevada Pritzker Foundation efforts, Medicaid MCH workgroups, and early childhood initiatives.

- The CYSHCN Director attended trainings and conferences during the reporting period, including the Technical Assistance HRSA Title V MCH meeting and AMCHP Policy Committee meetings, Association of State and Territorial Health Officials (ASTHO)-Opioid Disorder, Maternal Outcome, OMNI Core and Advisory Team meetings, the ASTHO Expansion meeting, HRSA Title V MCH Reverse Site Visit, Prevent Child Abuse Nevada, Community Engagement meetings on Access to Reproductive Health, NOMHE training and Advisory Board meetings, AIM and ERASE MM meetings, Tennessee Perinatal Quality Collaborative meeting, PREP and SRAE All-Grantee Meeting, Nevada Pritzker meetings, NGCDD meetings, CARA meetings, NDE Health Standards Meetings, Protecting our Adolescents Round Table Discussion, Western Genetics meeting, and many local reoccurring meetings, including the Statewide Executive Committee to Review Child Fatality, FIMR, SETNET, MCH Emergency Preparedness and Response Learning Community (EPR-LC), IM-CoIIN SDOH meetings, Nevada March of Dimes Conference, Pediatric Mental Health Evaluation, MHP Advisory Committee, Certified Contract Manager training and certification, Naloxone administration training, Nevada Health Conference, MCH Research Quarterly Meetings, and Nevada Newborn Screening Advisory Committee. Numerous webinars and trainings were attended on MCH topics with a focus on health equity, maternal mortality, and MCH and COVID-19 topics.

- The Title V MCH Program Manager attended local reoccurring meetings including for the MHP Advisory Committee, AMCHP Policy All State meetings and the AMCHP 2020 annual conference, and IM-CoIIN SDOH meetings. The Title V MCH Program Manager also attended the Nevada Certified Contract Management (NVCCM) and Nevada Health Conference (NHC).

- The Maternal and Infant Program Coordinator was vacant during the majority of the reporting period, but relevant topical trainings were attended by the MCH Manager and CYSHCN Director.

- The RPE Program Coordinator attended the Nevada RPE Technical Assistance Training in Las Vegas, Nevada, CDC-required trainings related to RPE administration, the Sexual Violence Coalition Conference, and standing meetings with cross agency state partners led by the Office of the Attorney General..

- The AHWP Coordinator attended several webinars and online training courses including: Cultural Competence: What it Means for Person-Centered Thinking, Planning, and Practice, Emergency Preparedness & Response: Online Training Course, AMCHP Collaboration Lab: From Data to Action: Using and Translating Needs Assessment Data, Focus on engaging specific subpopulations in Title V programs/activities, Preventing and Responding to Child Trafficking During COVID, School-Based Health Centers in the Time of COVID19, the Association of Public Health Nutritionists annual conference, the AMCHP 2020 annual conference, and The Motivational Interviewing (MI) Training.

- The CYSHCN Program Coordinator continued to receive training on the MHP and Medical Home Model from various sources. The CYSHCN Program Coordinator attended the AMCHP 2020 annual conference, Interagency Coordinating Council, EPR-ALC, and Nevada Domestic and Sexual Violence Coalition Conference.

- NHV agencies received training on 'serve and return,' a child friendly method of teaching children; Parents as Teachers; Mind in the Making; use of Nevada 211; Strengths-based Practice, home visitor safety; Trauma-Informed Care; Reflective Practice; Adverse Childhood Experiences (ACEs); recognizing and reporting child abuse; choosing your caregiver or partner carefully; family engagement; Bright by Text; Reading Aloud; library tools and resources; Welfare and Supportive Services; Liberty Dental (Medicaid); and Job Connect/Department of Employment, Training, and Rehabilitation (DETR) programs.

- The PREP Coordinator attended the Gender Identity & Sexual Orientation Minority (GSM) Conference: LGBTQ+ Health, Topical Training: Understanding and Responding to Human Trafficking and Promoting Healthy Relationships among Youth, A Provider's Introduction to Substance Use Disorder Treatment for LGBT Individuals, APP Grantee Virtual Conference, *Creating a 20*/20 Vision: Healthy Youth, Healthy Futures, and Nevada Public Health Association (NPHA) 2020 Virtual Annual Conference.

- The MCH Data Research Group meets twice a year providing training and collaboration opportunities, and the MCH Data Workgroup meets monthly to discuss data efforts and needs. The MCH Data Workgroup also attends PCO data sharing meetings quarterly. All MCAH staff also attend quarterly MCHAB meetings.

- The MCH Epidemiologist attended Power Bi training to produce the data dashboard. She also attended Grant Writing USA, a 2-day virtual grant writing and management course.

Pediatricians, Family and General Practitioners, and Obstetricians and Gynecologists

According to the May 2020 Bureau of Labor Statistics (BLS) Occupational Employment Statistics Query System, the number of Obstetricians and Gynecologists (OBGYN) per 1,000 persons in the U.S. is 0.136. For 2020, Nevada data is unavailable, but in 2018 the Nevada rate was 0.09. An absence of a full-time OBGYN exists in 10 of 17 Nevada counties: Storey, Mineral, Esmeralda, Lincoln, Eureka, Lyon, Humboldt, Nye, White Pine, and Pershing (March of Dimes, Nowhere to Go: Maternity Care Deserts 2020 Report).

There is evidence to suggest along with absence of full-time OBGYNs, shortages in providers appear in other counties. The Doximity September 2019 OBGYN Workforce Study developed a composite index score to assess

the severity of the risk of OBGYN shortages in different metropolitan areas. Las Vegas, the largest metropolitan area in Nevada, was found to be at the highest risk for shortages in the U.S. This index considered the average age of the workforce and the average workload, based on the number of births per OBGYN per year.

The 2020 U.S. rate for Family Medicine physicians is 0.709 per 1,000 persons and 0.364 per 1,000 persons for General Internal Medicine physicians. For Nevada, the rates are 0.507 and 0.269, respectively.

The 2020 U.S. rate for Pediatricians is 0.198 per 1,000 persons, and for Nevada, the rate is 0.104 per 1,000 persons.

The Nevada Health Workforce Research Center is in the Office of Statewide Initiatives at the UNR SOM. According to the 2020 Nevada Health Workforce Research Center's Physician Workforce in Nevada: A Chartbook Report, Nevada has the lowest number of providers per 100,000 population of any state. Nevada needs additional 244 pediatricians to meet the national average. In 2020, the number of active primary care providers, including general practice, family practice, OBGYN, pediatrics, geriatrics, internal medicine, physician assistants, and nurse practitioners in Nevada is 182.8 providers per 100,000 population compared to 241.9 providers per 100,000 persons nationally. Nevada has the lowest number of providers per 100,000 population of any state. An estimated 2,026,181 Nevadans, or 67.3% of the state's population, reside in a federally designated primary care health professional shortage area. Three counties, Esmeralda, Eureka and Storey, have no licensed physicians.

Family Partnership

Nevada Title V MCH staff collaborate with agencies, programs, and organizations at the local and state level to meet the needs of the state's MCH populations and the priorities in the 5-year plan. Nevada Title V MCH can reach families and consumers through these collaborations to receive input and recommendations on developing and implementing the programs provided to Nevada MCH populations. Using the Family Voices four domains of family engagement (commitment, transparency, representation, and impact), this section describes how the Nevada Title V MCH Program engaged families in programmatic initiatives.

A commitment was demonstrated in the activities of funded partners, including, but not limited to, Nevada's family partnership champion, Family TIES of Nevada (FTON), and the Nevada Statewide MCH Coalition. Through presentations to the MCHAB, NGCDD, and other agency partners, the Nevada Title V MCH Program acknowledged the contributions these organizations made to meet the needs of Nevadan families. Nevada Title V MCH staff participated in the NGCDD and Interagency Coordinating Council, including persons living with intellectual and developmental disabilities and family representatives. Staff also participated in Nevada Leadership Education in Neurodevelopmental and Related Disabilities (NvLEND) and Learn the Signs Act Early (NvLTSAE) training activities, which offered opportunities to engage CYSHCN in transition and their families. To improve commitment in the application year, Nevada Title V MCH plans to explore options for a written policy relating to family engagement in systems-level initiatives and identify funding for family leaders' time and other costs they may incur in the course of engagement efforts.

Transparency was displayed through Title V MCH Program activities meant to understand the issues children and families face in Nevada. Title V MCH solicited feedback from the public on MCH-related matters via a survey link (English and Spanish) posted on the DPBH and Statewide MCH Coalition websites. Consumers could also provide information directly to the MCH Coalition by telephone or email. During the quarterly MCHAB meetings, members of the public provided feedback and other information related to MCH populations. Furthermore, the NICRP in partnership with all Nevada School Districts and DPBH conducted an annual health survey of children entering kindergarten. By completing the survey, parents and families provided a voice on the status of Nevada kindergartners. Survey information informed local efforts to improve future programming and the health of Nevadan communities. Nevada's Title V MCH Program funded the survey, partnering with NICRP.

Every Nevada Title V MCH staff member had the support and information they needed to participate in family engagement discussions and webinars to improve workforce development. Nevada Title V MCH staff and funded partners also had the support necessary to understand their family partnership role in programmatic activities and a clear understanding of how these activities increase family engagement statewide. Through training provided by HRSA, Family Voices, and other family-centered organizations, Nevada's Title V MCH Program staff and funded partners received evidence-based toolkits and information on assessing and increasing family engagement.

Representation was achieved by focusing efforts on diverse groups, including racial/ethnic, linguistic, socioeconomic, rural/frontier geographical, and rare or complex disease populations. FTON staffs a bilingual (Spanish) hotline for CYSHCN and their families. Furthermore, FTON provided translation services to families receiving care through agencies like the Northern Nevada Cleft Palate Clinic. The Children's Cabinet-Technical Assistance Center on Social Emotional Intervention (TACSEI) has a Family Engagement Coordinator on staff to facilitate parent involvement, especially for those living in rural areas, in completing developmental screenings for their children. Nevada Title V MCH staff also participated in the Mountain States Regional Genetics Network, where families with lived experience contribute to expanding genetics services in Nevada. To improve representation in the application year, Nevada Title V MCH will explore the possibility of reaching diverse families and organizations in rural and frontier areas by supporting telehealth strategies.

Program impact has been measured by assessing current ESMs, listening to partner feedback concerning programmatic activities, working with funded partners to implement strategies to improve family partnership as outlined above, and evaluating how partners contributed to meeting NPMs. Evaluation occurred through a review of quarterly reporting, weekly Title V MCH team discussions, MCH Navigator training, and biweekly or monthly partner check-ins. To improve impact in the application year, Nevada Title V MCH will explore opportunities to engage family leaders in choosing ESMs. MCH will also collaborate with family leaders to evaluate these ESMs and utilize family leaders' input to improve programmatic activities and goals.

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

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

MCH Epidemiology Workforce

Nevada Title V MCH supports one Full-Time Equivalent (FTE) MCH Epidemiologist, one FTE Biostatistician, one FTE Health Resource Analyst (HRA) specializing in Geographic Information System (GIS) activities, and the SSDI Manager. Title V MCH funds 100% of the HRA and Biostatistician, while the MCH Epidemiologist is funded 70% through Title V MCH and 30% through the PRAMS grant. The SSDI Manager is funded 42% by Title V MCH and 58% by the SSDI grant.

The Office of Analytics, housed within Nevada DHHS provides additional epidemiological support for Title V MCH efforts. One Biostatistician and a GIS specialist assist with complex Title V MCH data asks utilizing advanced SAS skills and map requests.

The (SSDI) Manager works closely with the Title V MCH Unit and assists with data efforts. The MCH Epidemiologist is responsible for managing, organizing, analyzing, and displaying MCH data. The current MCH Epidemiologist, Kagan Griffin, MPH, RD, received training in Microsoft Power BI, Excel, and introductory SAS. The SSDI Manager performs higher-level data management, PRAMS Management, and systems functions, such as database management. Tami Conn is the current SSDI manager and previously held the MCH Epidemiologist role. The SSDI Manager also received Power BI, Excel, and introductory SAS training.

Previously, OPHIE housed the SSDI Manager and SSDI grant. Having the grant and manager in a different office from Title V MCH made workflow difficult. After Ms. Conn started as the SSDI Manager in September of 2019, MCAH requested the grant and position move to the MCAH section. Nevada's legislature meets every other year in odd years. Leadership submitted the request to move the position to the MCAH section in the 2021 legislative session and was approved, taking effect July 1, 2021. Transferring the funds and position into MCAH will enhance impact and coordination.

Improving epidemiological training for both the MCH Epidemiologist and SSDI Manager roles is a priority, and both positions have applied for the 2021 CityMatCH Training Course in Epidemiology. Furthermore, with data dashboards becoming more prevalent, the MCH Epidemiologist utilizes Power BI to display Federally Available Data to the public. Gaining more advanced Power BI and dashboarding skills is a priority for the MCH Epidemiologist. Future individuals in this role will also need to be trained in Power BI to update the dashboard with the annual data release.

A planned area of change for the epidemiology workforce is to train the MCH Epidemiologist in more advanced SAS skills to complete more data analysis within the MCH unit. SAS skills training will help streamline data requests and analyze data in a timelier fashion.

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

State Systems Development Initiative and Other Title V MCH Data Capacity Efforts

The purpose of Nevada SSDI is to develop, enhance, and expand Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming. This project also aims to expand on the linkage of MCH data sets. Nevada SSDI aims to support evaluation activities around NPMs contributing to building the evidence base for the Title V MCH Block Grant. Nevada seeks to enhance surveillance capabilities related to MCH.

Nevada DHHS formed an Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross-training and data analytics support. Nevada Title V MCH continues to fund a Biostatistician and Health Resource Analyst (HRA) within this group. MCAH funds two additional HRA positions in the Office of Analytics, working with EHDI and NHV. These positions are crucial members of the MCAH team in increasing MCH data support and analytics capacity, accessing primary data, and generating analyses and reports on behalf of MCAH and MCH, in addition to the work of the MCH Epidemiologist and SSDI coordinator. Nevada Title V MCH continued to integrate SSDI and MCH staff, creating a PRAMS, SSDI, MCH Epidemiology organizational unit to foster cross-training and data supports.

This integration of SSDI and MCAH staff has been ongoing since late 2019. Nevada's SSDI grant and coordinator position has historically resided in OPHIE. Having SSDI under OPHIE instead of under MCAH caused challenges with keeping the position filled and spending the funds appropriately. The SSDI program submitted a request to move both the position and grant into the MCAH budget in 2019. Nevada's Legislature meets every other year, and the SSDI Program submitted the request to the Legislature again in 2021. The request was approved, and the change will go into effect July 1, 2021.

Title V MCH has three goals to help maximize SSDI funding:

1. To build and expand MCAH data capacity to support Nevada Title V MCH Program efforts and contribute to data-driven decision-making in MCAH programs. Specific areas in which the SSDI program assists include:

    1. Data support in conducting ongoing MCAH needs assessment, including the Five-Year Needs Assessment for the Title V MCH Program and the NHV and SRAE needs assessment.

    2. Support of yearly submission of the Title V MCH Block Grant Application and Annual Report.

    3. Identification of additional structural and process measures to address Nevada MCH NPMs

    4. Continued development of State Performance Measures (SPMs) to address the identified MCH Program priority needs.

2. Advance the development and utilization of linked information systems between key MCH-related datasets in Nevada.
3. Support surveillance systems development to address data needs related to emerging MCAH and Title V MCH issues.

Other MCH Data Capacity Efforts

Nevada DHHS formed an Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross-training and data analytics support. Nevada Title V MCH continues to fund a Biostatistician II and a Health Resource Analyst (HRA) within this group. MCAH funds two additional HRA positions in the Office of Analytics, working with EHDI and NHV. These positions are crucial members of the MCAH team in increasing MCH data support and analytics capacity, accessing primary data, and generating analyses and reports on behalf of MCAH and MCH, in addition to the work of the MCH Epidemiologist and SSDI coordinator. Nevada Title V MCH continued to integrate SSDI and MCH staff, creating a PRAMS, SSDI, MCH Epidemiology organizational unit to foster cross-training and data supports.

Nevada established PRAMS surveillance in 2017 to collect state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. Title V MCH provides funding to PRAMS to assist in promotional efforts to help increase response rates to the survey and has provided funding in the past for supplemental survey questions. Data has been collected since September 2017, and supplemental questionnaires have been conducted on opioid, disability, and COVID-19 information.

Data from PRAMS has been presented to outside partners, most notably at the January 2021 Nevada Public Health Cannabis and Vaping Summit. PRAMS data is also utilized for Nevada performance measure reporting on safe sleep and directs Title V programmatic efforts. Title V MCH also provides funding for BRFSS questions. Data from BRFSS includes information to guide programmatic efforts.

The MCH Epidemiologist and SSDI Manger played vital roles in the 2020 5-year needs assessment. The MIECHV data analyst also worked on the 5-year needs assessment since Nevada did a combined MCH/MIECHV needs assessment. Additionally, the SSDI Manager and CYSHCN Director work as support staff for the newly formed MMRC using the Maternal Mortality Review Information Application (MMRIA) data collection system and the MCH Epidemiologist joins them in AIM efforts and leads AIM data collections and systems design.

The MCH Epidemiologist created and maintains a Power BI Data Dashboard, publicly displaying Title V Federally Available Data (FAD). The dashboard includes Nevada trends, comparisons to national benchmarks, and breakouts by indicators such as race and ethnicity and urban-rural residence for all Title V MCH national performance measures and national outcome measures. The dashboard is updated annually in April to coincide with the publication of the updated FAD.

The CYSHCN Coordinator is responsible for maintaining the Nevada CCHD Registry. The purpose of the Nevada CCHD Registry is to ensure all children born in Nevada are screened for CCHD at birth and those identified with CCHD receive timely and appropriate medical intervention. The CYSHCN Coordinator receives monthly CCHD reports from hospitals, compiles them in a database, and then uses that data for annual reports.

Title V MCH faces a few challenges in improving the use of MCH data. Staffing turnover presents issues with keeping staff members trained on data sources. Still, recent efforts have been made to create redundancy in training on the use and implementation of data systems. Building capacity in qualitative data capacity and data evaluation is of interest to continue to grow skill sets.

MCH Emergency Planning and Preparedness

Nevada Title V program staff were selected to attend cohort two of the AMCHP Emergency Preparedness Response Learning Collaborative (EPR-LC) on a team including the CYSHCN Program Coordinator and Director, Public Health Preparedness (PHP) state and LHA staff, and EMS representation. The EPR-LC fostered relationships and discussion and resulted in MCH participation in full scale exercises, tabletop exercise planning, Pediatric Surge Plan PHP development and drafting, and co-presentations to the EPR-LC Cohort 3 with MCH and PHP staff. Additional Incident Command System (ICS) trainings 300 and 400 were completed by the CYSHCN Director to enhance PHP skill sets beyond the required 100, 200, 700 and 800 ISC courses which all MCH Unit members have completed. The Nevada Title V program is proactive in emergency preparedness planning and coordination with partners at the state and local levels to help center the needs of the MCH population. MCH staff will be sharing training with NHV PHP efforts. MCH staff are active in pediatric planning with PHP staff. Awareness of resources gained in working with EPR-LC were applied in the early days of the COVID-19 pandemic and critical supports for WIC families were facilitated by the CYSHCN Director due to resource awareness gained by participating in the Cohort 2 efforts which was shared with WIC and engaged to deliver food to WIC families who could not access it without volunteer agency support.

Key points in relation to Nevada PHP collaboration efforts include:
(a) The state has a written EOP, and it is reviewed regularly.
(b) The state's EOP specifically consider the needs of the MCH population in the Pediatric Surge Plan and explicitly includes medically affected women, infants, and children.
(c) Title V MCH program staff were involved and consulted in the planning and development of the State's Pediatric Surge Plan
(d) Title V leadership (MCH and CYSHCN Director) is included in the State's emergency preparedness planning with the DPBH PHP Section before a disaster since the EPR-LC Team began and this is ongoing as needed.
(e) Title V leadership is not yet part of the Incident Management Structure (IMS) other than as part of the Pediatric Surge Plan.
(f) The Nevada Title V MCH Program needs assessment did not identify PHP as a priority, but lessons learned from Zika MCH communications and family linkage to resources efforts, COVID-19 MCH gaps in relation to agile processes on referral to care and early intervention services and the need for a bidirectional referral system are some of the lessons learned from previous emergency responses. Wildfire and air quality, heat advisory, and flood or earthquake threats as they relate to environmental exposures and planning for MCH issues for pregnant persons, infants and children, including CYSHCN are areas in need of development going forward
for future disaster or public health emergency planning.
(g) The Nevada Title V MCH Program staff participated in the development of pediatric emergency preparedness and response tabletop exercise planning, pediatric plan development, communication plan MCH points of contact identification and were key in introducing CYSHCN, sexual assault prevention, breastfeeding and contraception access needs into discussions of tools and strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population in partnership with DPBH PHP staff leads on PHP plan development. It is important to note close relationships between WIC, NSIP, and DPBH PHP.
(h) Nevada Title V MCH Program staff have participated in the pediatric surge plans and have emphasized continuity and planning needs for public health programs such as CCHD and EHDI newborn screening, CYSHCN beyond durable medical equipment needs and energy continuity with grid disruption, and home visiting needs (training on PHP planned for next Federal Fiscal Year), to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.

Nevada Title V MCH Program annually assesses PHP opportunities to collaborate and continues to grow MCH integration in EOP efforts; evaluating what is needed in responding to an emerging public health threat or disaster impacting the MCH population will be ongoing. Partnerships developed in the EPR-LC identified many future goals for greater MCH integration, data sharing (for example, CDC pregnancy estimator tool utilization), MCH staff training in ISO and PHP emergency response basics; these will continue to be active areas of development

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

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

Public and Private Partnerships

The Title V MCH Program collaborates with a network of partners, collaborators, and agencies to support a systems-based model of delivering public health and enabling services to Nevada's MCH populations. Partnerships include the local Family Voices affiliate, Family TIES, state agencies, LHAs, the Nevada System of Higher Education (NSHE), non-profit organizations, MCH Coalitions, community partners, and advocacy groups.

DHHS formed an Office of Analytics under the Director's Office to consolidate data capacity and facilitate cross-training and data analytics support. Title V MCH continues to fund a Biostatistician and Health Resource Analyst (HRA), and MCAH has two HRA positions located in the Office of Analytics working with EHDI and NHV/MIECHV data. These positions are crucial members of the MCAH team in increasing MCH data support and analytics capacity, accessing primary data, and generating analyses and reports on behalf of MCAH and Title V MCH, in addition to the work of the MCH Epidemiologist and SSDI Manager. Title V MCH continues to integrate with SSDI; MCAH created a PRAMS, SSDI, MCH Epidemiology organizational unit to foster cross-training and data supports. The MCAH Section Manager and Office of Analytics Manager meet regularly with staff concerning MCAH data needs.

SSDI enhances Nevada Title V MCH data capacity to allow for informed decision making and resource allocation supporting effective, efficient, and quality programming. The MCH Program plans to improve evaluation activities around NPMs. MCAH PRAMS, MMRC, AIM efforts, and a MCAH data dashboard development project support enhanced surveillance capabilities which will benefit the MCH Program.

Other programs partnering to promote Title V MCH priorities in Nevada include:

- The Office of Analytics,
- Nevada Home Visiting,
- Early Hearing Detection and Intervention,
- Teen Pregnancy Prevention,
- Nevada Governor's Council on Developmental Disabilities,
- IDEA Part C Office,
- Nevada Early Intervention Services,
- The Nevada Office of Minority Health and Equity,
- Primary Care Office (addresses access to health care and identifies workforce shortage areas),
- Oral Health,
- Community Health Nurses,
- Nevada OPHIE,
- Substance Abuse Prevention Treatment Agency,
- The Division of Child and Family Services,
- Chronic Disease Prevention and Health Promotion,
- Women, Infants, and Children and
- Immunization Program.

The Children's Health Insurance Program (CHIP) provides coverage to low- and moderate-income children. Nevada Medicaid is administered through DHCFP with enrollment administered by DWSS for Nevada Check Up, Nevada's CHIPRA Program, and Medicaid. Both FFS and MCOs providers operate in the state. FFS providers serve rural areas, and the urban areas of Clark and Washoe counties are served by contracted MCO providers. MCAH staff

meet quarterly with two different DHCFP workgroups and partner frequently on MCH efforts.

NDE and DPBH collaborate through an MOU to support a statewide School Wellness Coordinator. The School Wellness Coordinator, funded by MCH, supports strengthening collaborations between MCAH and NDE and those of the Nutrition Unit, Immunization, and CDPHP sections. Oral Health and ADSD MOUs with MCH will also support MCH goals.

DHHS and DBPH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties and relationships with Tribal Governments. The Regional Emergency Medical Services Authority (REMSA), a Title V MCH partner, distributes car seats and provides safe sleep education and injury prevention information as part of the MCH injury prevention pilot developed with key staff at participating Tribal Nations.

The Title V MCH Program partners with WIC, MCH statewide coalitions, breastfeeding coalitions, community-based programs, LHAs, the public, and private partners to increase breastfeeding rates by improved access to breastfeeding supports for new mothers. Breastfeeding campaigns and a MCH-administered website are designed to increase awareness, promote breastfeeding services, and normalize breastfeeding in public locations in partnership with WIC staff.

Title V MCH funds the NICRP to conduct an annual health survey of children entering kindergarten, in partnership with all school districts.

Other state and local public and private organizations serving MCH populations funded by MCH include:

- Family TIES, who also host the CYSCHN toll-free help line,
- Children's Cabinet,
- Washoe County Health District FIMR,
- UCAN,
- University of Utah Medical Home Portal,
- Money Management International / Nevada 211,
- Immunize Nevada,
- Nevada Broadcasters Association,
- Urban Lotus, and
- Statewide MCH Coalitions.

Family TIES, a Title V MCH-funded Family Voices partner, provides interpretation and translation at the UNR Craniofacial Clinic. Title V MCH also funds a bilingual CHW in Elko County. Information and materials disseminated by these partners are required to be culturally appropriate. MCAH staff members provide internal translation support. Children's Cabinet TACSEI offers technical assistance and facilitates parent involvement in social-emotional Pyramid Model activities.

Money Management / Nevada 211 provides information and referral via www.nv211.org. They also offer a toll-free phone number, text support and host the Title V MCH toll-free line. Nevada 211 supports the MHP resource sections and educates women on the priority status of pregnant persons at SAPTA funded treatment centers. Urban Lotus provides trauma-informed yoga to disproportionately affected youth. In addition to distributing car seats, REMSA provides safe sleep media outreach and distributes Infant Safe Sleep Survival Kits to families statewide via partners.

Immunize Nevada supports training/workforce development, including the statewide Nevada Health Conference with trainings to build topical MCH knowledge. Nevada Broadcasters Association is funded to promote Safe Sleep,

PRAMS, and SMHB PSAs. DP Video is funded to promote adolescent physical activity, tobacco quit-line, transition and SMHB social media campaigns. Title V MCH funds the Statewide MCH Coalition to support website maintenance, communication, maternal mental health, and other MCH training. The Coalition also promotes the Go Before You Show campaign and plans conferences with partners to meet community needs of diverse populations and focus on specific MCH NPMs.

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

Title V MCH – Title XIX Inter-Agency Agreement (IAA)

Division of Health Care Finance and Policy (DHCFP) is the state Medicaid agency and collaborates with the Title V MCH program to meet the needs of Nevada's MCH populations. As part of overall Nevada DHHS efforts to build systems of care, DHCFP and Title V MCH hold regular meetings to discuss ways to synchronize program initiatives and avoid duplication of effort. The communication between DHCFP and Title V MCH encourages technical assistance to local health agencies, care coordination, and policy-making efforts. Future coordination efforts will include consistent messaging to improve program outreach and enrollment information and MCO quality improvement meetings.

Title V MCH coordinates efforts with partners to increase the percentage of adequately insured Nevadans, especially CYSHCN. DHCFP collaborates with partners to identify Medicaid reimbursable services and promotes early identification of referrals of individuals to appropriate services who may be eligible for Medicaid benefits. Each agency has proved a willingness to provide timely information on administrative or fiscal changes impacting children and families.

DHCFP and Title V MCH implemented a process allowing for Medicaid and other public health data sharing. The data-sharing agreement streamlines critical data acquisition to populate the Title V MCH application and report. Title V and DHCFP partnered with the National Academy for State Health Policy (NASHP) on a learning network regarding medically complex children and Maternal and Infant Health Initiative (MIHI) efforts.

The Title V MCH staff presented information to DHCFP to broaden the focus during pregnancy to total parental health healthy babies. The staff highlighted current MMRC efforts and policy efforts to improve maternal health. MMRC information included a review of maternal mortality (MM) and severe maternal morbidity (SMM) incidents and efforts to reduce these incidents in conjunction with a Perinatal Quality Collaborative (PQC). Policy efforts include expanding Medicaid coverage, doula and midwife coverage by Medicaid, expanding home visiting Medicaid coverage, and provider training, including Advanced Life Support in Obstetrics (ALSO) multidisciplinary training.

The Silver State Health Insurance Exchange (SSHIX), also known as Nevada Health Link www.nevadahealthlink.com, is the state agency overseeing and operating the health insurance marketplace in Nevada. The marketplace is governed by seven board members and 22 staff members. Three MCOs offer plans on Nevada Health Link: Health Plan of Nevada, Silver Summit Health Plan, and Anthem. Carriers are allowed to use telemedicine to meet accessibility requirements. Once enrolled in an MCO, participants are enrolled in the Dental Benefit Administration (DBA), which LIBERTY Dental Plan provides.

Nevada is a Medicaid expansion state and allows more low-income adults to access health insurance. The Open Enrollment Period occurs every year and began on November 1, 2020 and ended on December 15, 2020. A Special Enrollment Period (SEP) started February 15, 2021 and runs through August 15, 2021. The 2020 coverage period had 77,410 enrollments, down 7.24% from the 2019 coverage period in which 83,449 people signed up for Medicaid coverage.

Nevada Health Link projected an initial goal of 118,000 enrollees before the first open enrollment period in 2013.

According to a Kaiser Family Foundation report (Uninsured Rates for the Nonelderly by Age | KFF), there were still 342,000 uninsured nonelderly residents in Nevada in 2019. Nevada Health Link will continue with outreach efforts targeted at specific uninsured populations and continue to offer certified assisters, licensed brokers, and navigators to provide in-person assistance for people enrolling in the SSHIX. Nevada Title V MCH partners and collaborators will continue to conduct various activities to inform consumers of the benefits of signing up for health insurance and help consumers enroll for health insurance if needed.

All Nevada Title V MCH funded agencies refer uninsured families to Nevada 211 to obtain health insurance benefits information and distribute brochures outlining steps to access insurance to families of adolescents.

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

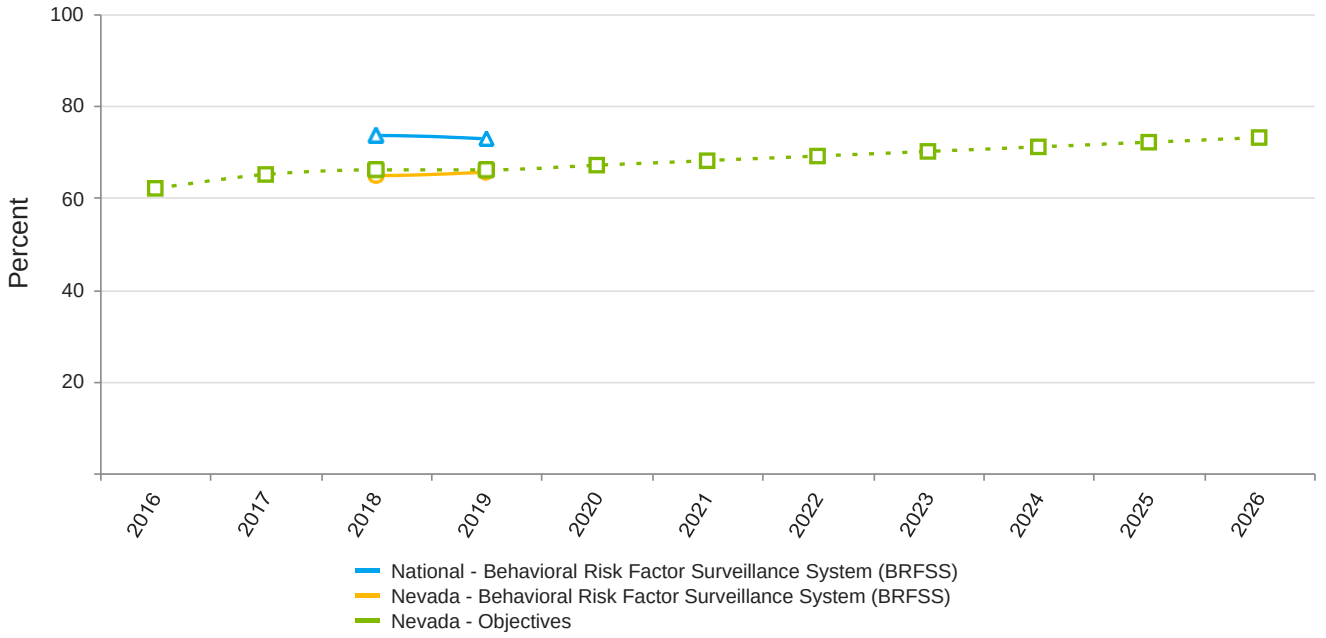
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	65.2	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	14.5	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	8.8 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	10.7 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.2 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.9	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.1	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.6	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.5	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	148.5	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	142.9	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS	Data Not Available or Not Reportable	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	7.6	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	18.9	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS	Data Not Available or Not Reportable	NPM 1

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					67
Annual Indicator				64.6	65.6
Numerator				346,488	350,884
Denominator				536,239	534,782
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

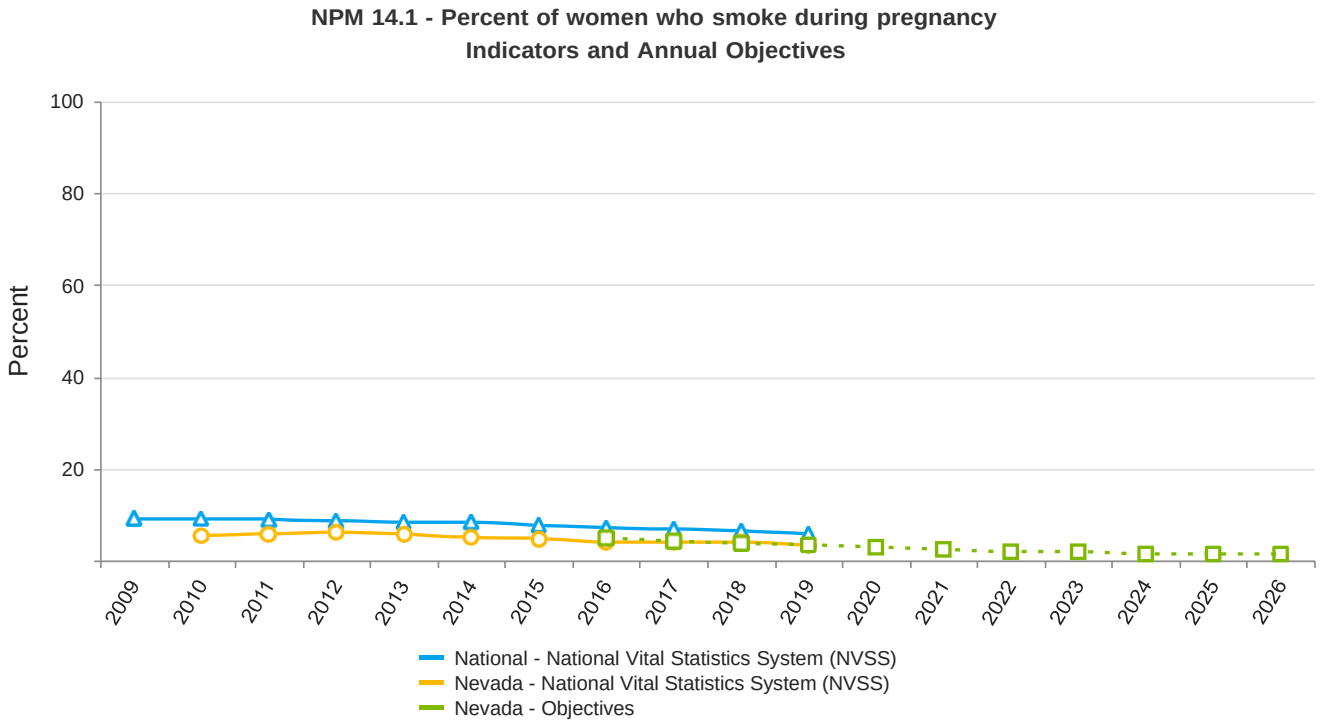
Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of pregnant women who received prenatal care beginning in the first trimester

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			76
Annual Indicator	74	74.6	75.4
Numerator	24,893	25,805	24,800
Denominator	33,651	34,573	32,897
Data Source	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	77.0	78.0	79.0	80.0	81.0	82.0



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	5	4.3	3.8	3.5	3
Annual Indicator	4.8	4.0	4.2	4.2	3.5
Numerator	1,726	1,440	1,491	1,492	1,217
Denominator	35,965	35,964	35,462	35,400	34,682
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.5	2.0	2.0	1.5	1.5	1.5

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	88.8	91.9
Numerator	732	30,895
Denominator	824	33,607
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

State Performance Measures

SPM 1 - Percent of mothers who reported late or no prenatal care

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		7	4.5	4	4
Annual Indicator	7.9	4.6	4.7	4.9	3.3
Numerator	2,805	1,601	1,634	1,680	1,109
Denominator	35,378	34,838	34,577	34,357	33,261
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.5	3.5	3.0	3.0	2.5	2.5

SPM 2 - Percent of women who used substances during pregnancy

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		5	4.5	4	5
Annual Indicator	5.5	5.5	6	5.3	5.8
Numerator	1,950	1,924	2,060	1,817	1,932
Denominator	35,378	34,838	34,577	34,357	33,261
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	4.5	4.5	4.0	4.0	3.5	3.5

State Action Plan Table

State Action Plan Table (Nevada) Women/Maternal Health Entry 1	
Priority Need	
Improve preconception and interconception health among women of childbearing age	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
Increase the percent of women, ages 18 through 44, receiving a preventive medical visit in the past year to 70% by 2025	
Increase the percent of women receiving prenatal care in first trimester to 80% by 2025	
Strategies	
Collaborate with public and private partners to provide women, ages 18 through 44, with information on the benefits available to link them to appropriate health care coverage options	
Collaborate with public and private partners to engage (through outreach) and educate (e.g. website, materials, etc.) women, ages 18 through 44, communities, and health care professionals, regarding women's health, including early prenatal care and screenings	
Collaborate with public and private partners to conduct training focused on rape and sexual assault prevention	
Partner to conduct and/or fund survey activities that ask questions regarding pre and interconception care	
Collaborate with MCH Coalition and other partners to improve health literacy, including health promotion campaigns and dissemination of health information (including translation/interpretation)	
Collaborate with public and private partners to conduct data collection, surveying, and other activities to improve maternal health and birth outcomes	
Collaborate with public and private partners to provide women, ages 18 through 44, communities and health care professionals with information to reduce disparity in perinatal outcomes	
ESMs	**Status**
ESM 1.1 - Percent of pregnant women who received prenatal care beginning in the first trimester	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State Action Plan Table (Nevada) Women/Maternal Health Entry 2	
Priority Need	
Reduce substance use during pregnancy	
NPM	
NPM 14.1 - Percent of women who smoke during pregnancy	
Objectives	
Reduce the number of women who smoke during pregnancy to 1.5% by 2025	
Reduce the percent of children ages 0-17 who live in households where someone smokes to 13% by 2025	
Increase the percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits to 97% by 2025	
Reduce the percent of women using substances during pregnancy to 3.5% by 2025	
Strategies	
Collaborate with public and private partners such as The Tobacco Control Program (TCP) and Medicaid to promote smoking cessation programs.	
Disseminate educational materials to partners for statewide distribution and engage partners through outreach to encourage promotion of smoking cessation resources	
Collaborate with public and private partners to improve outcomes related to substance use	
Collaborate with public and private partners to conduct data collection, surveying, and other activities to improve maternal health and birth outcomes, including continuation of Nevada PRAMS	
ESMs	**Status**
ESM 14.1.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

State Action Plan Table (Nevada) Women/Maternal Health Entry 3

Priority Need

Improve preconception and interconception health among women of childbearing age

SPM

SPM 1 - Percent of mothers who reported late or no prenatal care

Objectives

Increase the percent of pregnant women/new mothers receiving prenatal care in first trimester to 76%.

Strategies

Collaborate with public and private partners to engage (outreach) and educate (e.g. website, materials, etc.) women, ages 18 through 44, communities, and health care professionals, regarding women's health, including early prenatal care and screenings.

State Action Plan Table (Nevada) Women/Maternal Health Entry 4

Priority Need

Reduce substance use during pregnancy

SPM

SPM 2 - Percent of women who used substances during pregnancy

Objectives

Reduce the percent of women who used substances during pregnancy to 3.5% by 2025.

Strategies

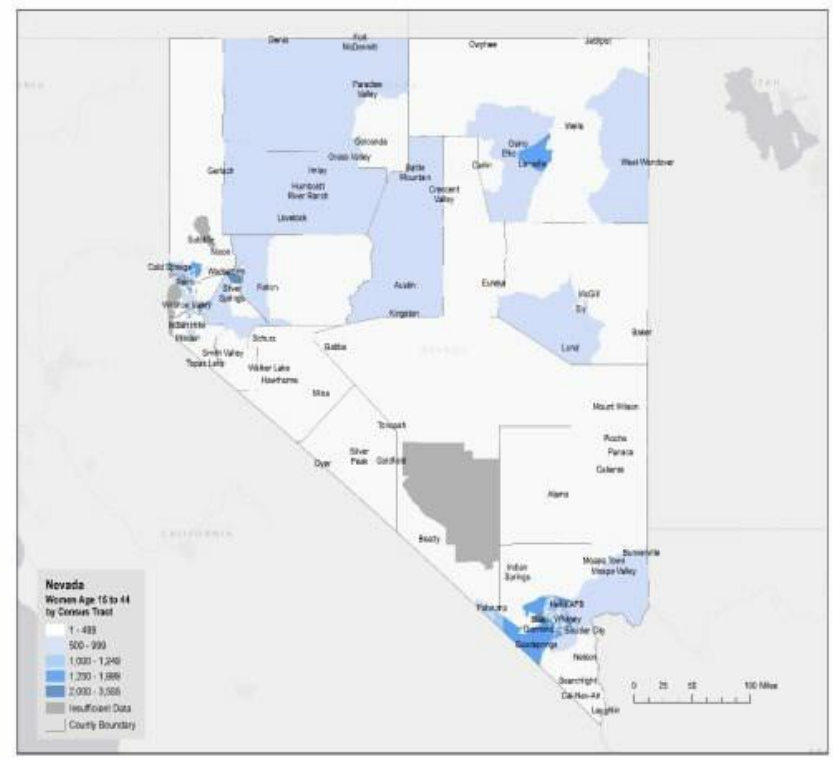
Collaborate with public and private partners to promote use of the State's Tobacco Quitline for pregnant women and new mothers.

Disseminate educational materials to partners for statewide distribution.

Collaborate with public and private partners to improve outcomes related to substance use

Women/Maternal Health Report

As part of the Title V MCH Program, Maternal and Infant Health Program (MIP) staff provide technical assistance, resources and support to private and public agencies serving women, ages 18 through 44. The MIP Coordinator works closely with these agencies, as well as the Title V MCH Program Manager and MCH Director to improve the health outcomes of women of childbearing age. The Women/Maternal Health report demonstrates how collaboration between agencies, leadership and MIP staff are working to accomplish the state priority to improve the health of Nevada women. The population of women, ages 18 through 44 is demonstrated by Census tract in the map below.



The Title V MCH Program staff chose NPM 1 and NPM 14 to improve women and maternal health outcomes. Improving preconception and interconception health among women of childbearing age is a priority need in Nevada. Title V MCH partners with public and private partners to enhance efforts to meet this priority by increasing the percent of women, ages 18 through 44, with a preventive medical visit in the past year (NPM 1). Reducing substance use in women of childbearing age is another ongoing priority in Nevada. Public and private partners assist with these efforts to reduce the percent of women who smoke during pregnancy (NPM 14). All subawardees share information about the Nevada Tobacco Quitline as part of their scope of work. Program activities and successes related to these efforts are included in the body of the report.

Nevada Home Visiting Report

Title V MCH collaborates with the Nevada Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program co-funding activities for the Sunrise Children's Foundation expanded Home Instruction for Parents of Preschool Youngsters (HIPPY) program in Pahrump and the Children's Cabinet developmental Parents as Teachers home visiting program in Elko. The design and delivery of the MIECHV-funded programs are to provide comprehensive,

coordinated health and social service fostering continuous access to care for people who are pregnant or who have young children. The Nevada Home Visiting (NHV) Program focuses on many of the MCH priorities, including improving preconception and interconception health, breastfeeding promotion, increasing developmental screenings, reducing teen pregnancy, reducing substance use during pregnancy, and increasing adequate insurance coverage for families.

HIPPY programs (serving families with children aged three, four, and five) help parents engage with their children in daily learning activities to help promote literacy and school readiness. The program fosters language development, problem-solving, logical thinking, and perceptual skills in children. Parents as Teachers serves expectant mothers and families with children up to kindergarten entry providing child development education, health education, activities to build cognitive and motor skills in children, and parent-child interaction coaching. Both programs provide:

- Developmental and social development screening.
- Birth spacing education.
- Screening for insurance coverage.
- Depression screening (both post-partum and general).
- Screening for domestic violence.
- Screening for necessary needs (housing, food, clothing, and utilities).
- Substance misuse screening.

Referrals are provided for any screening showing need. Referrals are followed up, and assistance is given in making any appointments or any application follow through.

Agencies implementing home visiting programs for NHV pursue Continuous Quality Improvement (CQI) and conduct Plan Do Study Act (PDSA) cycles to test small changes to improve processes and outcomes. Significant improvements have been made to the Early Learning and Literacy benchmark through CQI. Benchmark data from MIECHV are shared with the Title V MCH Epidemiologist and other staff.

NHV staff and all implementing agencies are participating in a core competency certification program including self-paced courses as follows: ASQ-3, Basics of Home Visiting, Building Engaging Relationships, Challenges: Substance Abuse, Domestic Violence, Infant Mental Health, Pregnancy, Supervising Home Visitors, Trauma for Home Visitors, and Trauma for Supervisors. In addition to the self-paced courses, the certification also requires the following live webinars: Domestic Violence: Safety Planning, Exploring Values and Beliefs, Home Visiting Boundaries, Home Visiting Safety, Implementing Tools, Home Visiting Boundaries for Supervisors. Matching Resources, Partnering for Change, Motivational Interviewing, Reflective Supervision, Impact of Domestic Violence, Trauma in Communities, and Understanding Substance Abuse. Technical Assistance has been provided to agencies for data entry, CQI processes, and family engagement.

All home visiting models provide information to encourage well child and adult well visits, immunizations on schedule, child development topics, and safe home information. In addition to these topics, agencies serving expectant mothers and infants all have a certified lactation educator to provide breastfeeding education and support. NHV has provided each of those agencies with commercial grade and loaner breast pumps to encourage longer breastfeeding as mothers return to work.

NHV provides bilingual materials and agencies serving populations with bilingual home visitors who have bilingual staff. Families are also provided with Spanish language books for children to keep, and agencies maintain a resource library for check-out in Spanish and English. In addition, families are administered Spanish language screenings and learning materials. A total of 118 MIECHV families reported Spanish as their primary language in FFY2019.

- 519 households were served by the Nevada Home Visiting Program in FFY2019.
- 620 children were served by the Nevada Home Visiting Program in FFY2019.
- 21 parents less than 17 years of age were served in FY2019
- 149 pregnant persons were served
- 64 enrollees were pregnant and less than 21 years of age

All home visiting agencies transitioned to virtual visits in March 2020. Family retention and services remained steady in spite of the change in service delivery. AMCHP provided funding via the CARES act to provide laptops and hotspots with data plans for families needing those items to carry out virtual home visits, medical visits, mental health visits, and other critical needs.

The Nevada Statewide Maternal and Child Health (MCH) Coalition Report

Title V MCH fully funds the Statewide MCH Coalition. The Nevada Statewide MCH Coalition had a presence at the American Academy of Pediatrics (AAP) conference and hosted the 2020Mom Annual Forum statewide during the Spring. With the pandemic of COVID-19 in 2020, the Coalition opted for participation in many virtual webinars and web conferences to attend to respect safety measures across the community. This included the PMAD coordinators' annual attendance of the Post-partum International conference, which moved to a virtual platform. The Nevada Chapter of the American Academy of Pediatrics hosted their yearly conference online for the first time. Monthly coalition meetings in the North and South also moved on to online platforms such as Zoom and WebEx. Despite the different platforms and adjustments needed, the Coalition continued its involvement in the community and events. The Coalition demonstrated support for breastfeeding, pre-conception and inter-conception health, developmental screenings, anxiety and depression, safe sleep, marijuana use during pregnancy education, and other statewide resources. Coalition social Media outlets continued to grow, with Facebook totaling 417 "Likes" and Instagram totaling 291 "Followers." Social posts included awareness and support for the following programs: SMHB, Nevada 211, the MHP, Nevada Tobacco Quitline, Go Before You Show, breastfeeding, safe sleep facts, and lead poisoning information. Partner organizations and agencies in Nevada shared additional postings and daily "stories." The MCH website, Facebook and Instagram saw continued growth throughout the year.

The MCH website saw continued growth in total visitors throughout the year, as well as Facebook and Instagram, see chart below:

Statewide Maternal and Child Health Coalition Social Media – 2019-2020

October 2019-September 2020	Facebook Following	Instagram Following	Website Total Visitors
October	357	166	215
November	358	170	216
December	360	173	221
January	362	187	300
February	365	200	297
March	371	216	243
April	375	226	439
May	384	232	208
June	386	241	235
July	395	257	242
August	402	271	388
September	417	291	405
Total for Grant Year	**417**	**291**	**3409**

In February of 2020, the NV Statewide MCH Coalition hosted a live webcast of the 2020Mom Forum, “We Can Do More – in Maternal and Mental Health Care.” The 2020 focus of the Forum was to address and discuss pathways to transform systems of care and access to the right care at the right time at the right price. This included discussions about technology, employer strategies, and regulatory levers. The coalition hosted locations in Nevada: Carson City, Reno, and Las Vegas. The 75 participants that attended this Forum included nurses, therapists, and statewide community organizations.

The PMAD Coordinator attended nine (9) online or in-person PMAD related trainings through Maternal Mental Health NOW, Nevada Suicide Prevention Coalition, and 2020Mom. The Coordinator also conducted outreach to

organizations that included OBGYN offices, therapists, doulas, Health Districts, WIC offices, and other local programs. Collaboration continues with HealthPlan of Nevada's Behavioral Health Options in assisting PMAD families with available resources statewide in navigating care. Additionally, in partnership with UNLV School of Medicine, trainings were given to current and active pediatricians in Nevada. The PMAD coordinator attended the Postpartum Support International conference (300+ attendees).

Nevada MCH staff worked with statewide partnerships including SNHD, WCHD, CCHHS, Safe Kids, Southern and Northern NV Breastfeeding Coalition, Immunize Nevada, UNLV, UNR, Children's Advocacy Alliance, Healthy Living Institute University Medical Center, Nevada 211, the Nevada State Oral Health Program, NICRP, and other statewide partners to continue the goal of building the capacity of the MCH Coalition partners. This effort helped promote statewide MCH messaging for improving the health of expectant parents, women of childbearing age, infants, children, CYSHCN, and their families.

Due to the stay-at-home orders in Nevada, the NV Statewide MCH Coalition did not hold its annual Fall Symposium to minimize a large gathering. Funding for the symposium was redirected for a media campaign for the Go Before You Show Campaign (GBYS). The campaign message of Go Before You Show is to help create public education effort for women and families to obtain prenatal care early on in their pregnancies. In Northern Nevada, the GBYS campaign included electronic billboards, vinyl billboards, and smart device impressions to redirect users back to the coalition website. In Southern Nevada, the GBYS campaign included bus shelters in areas that higher impacts of COVID19. The campaign ran for approximately four weeks in both the North and South.

The MCH Coalition Steering Committee is comprised of volunteer leadership members from both the Northern Nevada MCH Coalition and the Southern Nevada MCH Coalition and Title V MCH staff. Four (4) meetings are held each year to discuss proposed and current activities.

Title V MCH staff contributed ongoing content to the statewide MCH Coalition e-newsletter and encouraged membership growth, new partner linkages, and outreach to youth-serving agencies. Topics shared included MCH COVID information, state resources, CYSHCN-relevant information and trainings, child, medical, reproductive health, perinatal and infant resources, webinars, conferences, Project ECHO, teen health week, adolescent physical activity, adolescent-centered care, information briefs for parents, and materials to promote campaigns for suicide prevention, childhood obesity awareness, Sexual Assault Nurse Examiner regional training opportunities, and physical fitness and sports. Numerous Title V MCH funded partners participated in the MCH Coalitions; for example, Urban Lotus Project, serving youth in northern Nevada attended meetings to share the value of trauma-informed yoga no-cost courses to help young people cope with daily life stressors and the MCH-funded Washoe County FIMR uses the Northern Nevada MCH Coalition meeting to present recommendations as they function as the FIMR's Community Action Team.

Women's Health and Wellness Outcomes

Title V MCH staff will continue to participate in efforts to promote reproductive health, planning, and access. MCH staff work with AFP and Teen Pregnancy Prevention PREP and SRAE programs, and other key partners to promote informed reproductive choices and education to support reproductive life planning. Association of State and Territorial Health Officials (ASTHO) OMNI efforts and quality improvement of Infant Plan of Safe Care processes continued, as did efforts to create robust wrap around care and referrals for people who are pregnant and use substances. Efforts continue to try and get significant utilization of the Tobacco Quitline among pregnant people. PRAMS data to action exploration, pregnancy surveillance efforts, and programming based on surveillance resulted in initial PRAMS data use.

Nevada Alliance for Maternal Innovation (AIM) launched and MCAH staff worked on Nevada MMRC establishment pathways and data reporting working with the Office of Analytics to reduce preventable maternal mortality and severe

maternal morbidity. Exploration of perinatal quality improvement efforts more broadly continued as a possible space to leverage efforts of substance use, LARC, and perinatal mortality review committees. Development of more robust maternal and perinatal data evaluation and applying for a CDC-MCH Assignee was completed and is pending in an effort to present timely key indicators of MCH health. Continuing to look for opportunities to expand NHV capacity to serve more families through additional funding streams and continued participation of MCH staff in early childhood support and systems building initiatives continue and focus on referral pathway supports and data integration.

Maternal-focused PSAs, websites, social media and print campaigns, and sponsoring conferences for information sharing and collaboration are ongoing. Staff training on equity, and programmatic efforts focused on disparity reduction are key areas of focus and include the IM-CoIIN and current partnerships with NOMHE, The Center, NGCDD, and the NCEDSV efforts to prevent sexual assault among CYSHCN with developmental disabilities.

Title V MCH provided funding for an Oral Health pilot which included focused education to expectant parents and children living in rural Nevada and Clark County. Mobile dental services provided in partnership between SNHD and the UNLV School of Dental Medicine, Nevada Oral Health Program afforded the opportunity to promote the importance of dental care during pregnancy and the connection between oral health and perinatal outcomes.

Title V MCH funded thirteen public health clinics to improve maternal and women's health among those aged 18-44 years old (y.o.). These entities encompassed CCHHS, a LHA in Northern Nevada and 12 nursing clinics within DPBH CHS providing services in Nevada's rural and frontier areas. Clinic assessments, education, reproductive education, and resources were based on nationally accepted standards of practice. Clients were screened for use of alcohol, tobacco/nicotine/vaping, recreational drugs, suicidal thoughts, and other risky behaviors utilizing a SBIRT approach. Education and referrals for care were provided for individuals in need of services. General preventive health education such as weight and nutrition, exercise, and preconception counseling were incorporated in the comprehensive patient teaching model.

All clinicians were mandatory reporters and educated in the recognition of patients at risk for human trafficking, neglect, and abuse. Staff were additionally trained in the delivery of culturally competent care. Age-appropriate education and counseling were conducted along with referrals, as needed. Education provided to avoid sexually transmitted infections and communicable diseases and treatment protocols followed CDC guidelines.

Through 13,070 clinic visits, CHS educated women of childbearing age (ages 18-44 y.o.) on wellness and the value of yearly visits. Reporting criteria to MCH varied. For CCHHS, of the 1,946 well-visits, education and referrals were made to 1,115 people using alcohol, 403 people using substances, 38 affected by intimate partner violence, and 281 experiencing depression. CCHHS reported race and ethnicity; however, 48% of the clientele declined to specify. Of those reporting, 46% identified as White and 49% identified as Hispanic. CHS provided 1,146 well care visits, 1,709 nutrition and weight management counseling sessions, and 14 referrals were made for women experiencing depression. CHS activities resulted in 719 identified sexually transmitted infections and 2,017 contraceptive visits (27 intrauterine and 16 implantable devices). CHS provided immunizations in clinic settings and through outreach events. 824 adult vaccinations were given to 714 individuals (ages 22 – 44 y.o.) in the clinic and at community point of dispensing sites during which Title V MCH funded education, resources, and referrals were provided. COVID-19 did not impact the number of individuals being referred for emotional and behavioral health concerns.

Clinic staff distributed diverse women's health-related materials. Topics covered included the value of no-cost yearly checkups, reproductive health (including long-acting reversible contraception), sexually transmitted infections, healthy pregnancy outcomes, immunizations, depression, and intimate partner violence prevention. Resources provided by the MCH Program included information about *Go Before You Show,* Nevada Tobacco Quitline, sobermomshealthybabies.com, PRAMS, Text4Baby, Nevada 211, and the MHP.

CCHHS promoted the US Preventive Task Force Recommendations for women's health annual checkups through community events, social media, and the clinic digital signage. CCHHS reached 2,254 individuals during outreach activities at three locations. Two Facebook posts promoting annual well women exams reached 6,608 users, and messages were displayed outside the clinic on the digital signage.

Partners Allied for Community Excellence (PACE) Coalition, an entity within the Nevada Statewide MCH Coalition, was awarded Title V MCH funding to employ a Community Health Worker (CHW) to participate in MCH activities in Elko County and nearby rural communities. The PACE Coalition ensures CHW collaborations with other community partners on key MCH objectives/priorities to improve health outcomes in women. The CHW distributed information on topics such as child health, pregnancy, diabetes, intimate partner violence assistance, tobacco/nicotine/vaping cessation, and suicide prevention. The staff participated in 17 community collaboration meetings promoting PACE's programs to improve health among MCH populations. Additionally, the CHW taught one Mental Health First Aid (MHFA) class empowering community members to avert suicide attempts. During the pandemic, staff placed information on maternal and child coping tips into the agency website and sent content to their listserv. The intended award emphasis was to provide care coordination and increasing connections to resources and services for Hispanic and underserved populations; when bilingual staff were no longer hired by PACE Title V MCH staff discontinued funding.

COVID-19 Efforts

MCAH staff added COVID-19 MCH population-related content into the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. Materials contained Nevada's response to the pandemic, as well as information and resources for women of childbearing age, in addition to all other populations served by the award. Identified links sent viewers to the CDC COVID-19 resources in American Sign Language via YouTube and Spanish language content. The CDC materials and placement of the links were shared widely with funded partners. The statewide MCH Coalition and PCO disseminated the materials through listservs. Clear mask were provided by MCH to teachers and children in schools statewide to support those who are living with deafness or hear of hearing and the Nevada Telehealth Project was done in response to COVID-19 related needs, as were numerous CARES related funding enabled projects in the MCAH Section.

In FFY 21, all Title V MCH funded partners promoted the Nevada Resilience Project helping families and individuals experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, through text and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Additionally, state staff shared the Nevada 211 mobile app launch to help Nevadans connect with needed resources in response to the pandemic.

Sober Moms Healthy Babies Annual Report

Title V MCH continued to work with the list of SAPTA-funded treatment providers to update the *SoberMomsHealthyBabies.org* website to prevent substance use in pregnant people, as well as provide information to women of childbearing age, providers, and concerned family and friends. The website provides the substance use help line number, Nevada 211, Crisis Call Center, the Nevada Tobacco Quitline, and other resources. The website specifies the treatment priority status for pregnant people at SAPTA-funded agencies and the importance of people identifying they are pregnant. SAPTA-funded treatment centers must not deny treatment to persons unable to pay. All treatment centers listed on the website are SAPTA-funded.

The website had 2,878 sessions and 2,604 users. New users represented 90.1% of the total number of users and 9.9% were returning visitors. A total of 4,706-page views occurred. Most of these sessions were accessed from Las

Vegas, Reno, Carson City, with Sparks and Elko rounding out the top five.

The public awareness campaign uses radio and television public service announcements in English and Spanish throughout the state to promote the www.SoberMomsHealthyBabies.org website, in addition to the distribution of window clings and referral cards. The collaboration ensures substance use in pregnancy materials and resources will reach the intended audience. The 2020 media campaign had a total of 10,742 total spots aired (9,118 radio advertisements and 1,624 television advertisements), promoting the *SoberMomsHealthyBabies.org* website and the importance of pregnant persons receiving treatment and preventing substance use in persons of childbearing age. All LHAs and MCH subgrantees promoted the *SoberMomsHealthyBabies.org* website and shared SMHB referral cards; OMNI partners also widely shared the site URL.

To raise awareness on the priority admission of pregnant people at state-funded treatment centers, Title V MCH continued to disseminate removable wall stickers promoting the *SoberMomsHealthyBabies.org* website. Title V MCH is in contact with state agencies and LHAs that have agreed to help with distribution and promotion. Partnerships with the Department of Taxation, Division of Health Care Finance and Policy (DHCFP), SAPTA, local hospitals and providers, March of Dimes, faith based and MCH Coalitions, and other DPBH programs continue.

All three LHAs participated in sharing substance use in pregnancy resource distribution. CCHHS used Title V MCH funds to endorse pregnant and postpartum persons being substance-free through their clinic digital signage and social media. Facebook messages with information about the sobermomshealthybabies.com website reached 5,814 families.

Title V staff participate in CARA and NAS focused efforts and serve as a core team member on the ASTHO OMNI and PRISM Nevada Team and on numerous subcommittees focused on reduction of substance use in pregnancy and building systems of referral for families with substance exposed infants. LARC and Community Reproductive Engagement Committee MCH staff involvement intersects with substance use prevention efforts, as does engagement on possible Title V Families First efforts.

Marijuana Efforts Annual Report

The Nevada Title V MCH Program has continued to disseminate Spanish and English marijuana awareness materials to partners statewide. These materials were developed in the last funding year in response to Nevada's legalization of medical and recreational marijuana, and informational resources on pregnancy, breastfeeding and marijuana were developed by the Title V MCH program. The Title V MCH Program developed posters displayed in all dispensaries related to use in pregnancy and injury prevention and marijuana for children. Efforts to reduce substance misuse in pregnancy and improve inter-conception care are funded by the Title V MCH program and include promoting the SoberMomsHealthyBabies.org website and associated media campaigns and focusing perinatal activities on reduction of NAS. Title V MCH funded partners promote SoberMomsHealthyBabies.org through social media and print materials developed by Title V MCH, in addition to the CARA and OMNI resources, marijuana use and pregnancy information and posters, and marijuana and childhood injury prevention warnings; informational sheets are distributed widely through FIMR and the LHAs.

Tobacco Cessation Report

All Title V MCH funded programs promoted the Nevada Tobacco Quitline to pregnant persons and women of childbearing age. CCHHS and CHS clinics provided people who smoke tobacco education and counseling. Referrals to the Nevada Tobacco Quitline were supplied to 7,159 individuals of all ages. CCHHS promoted the Nevada Tobacco Quitline through paid and earned media that reached over 14,500 individuals. CCHHS collaborated with health care providers working in behavioral health settings and substance use treatment facilities to educate them on Nevada Tobacco Quitline. These collaborations are intended to help a disparate population (with behavioral health conditions and/or substance use issues) be connected to a Tobacco Quitline resource.

The Tobacco Control Program Annual Report

The CDPHP Tobacco Control Program (TCP) disseminates Nevada Tobacco Quitline (NTQ) promotional material to Nevada providers, WIC clinics, early childhood educators, and Nevada Head Start sites. The promotional materials are given to pregnant and postpartum women who use tobacco. The NTQ continues to provide callers 13 years and older with up to five scheduled personalized, culturally competent coaching sessions, unlimited inbound calls, web and text support, and Nicotine Replacement Therapies (NRTs) free of charge to callers ages 18 and older, upon availability. The Pregnancy/Postpartum Program (PPP) offered mothers in Nevada a designated trained coach throughout each session along with incentivized gift cards for each completed counseling call. According to the guidelines of the PPP program, each pregnant caller was enrolled before giving birth to ensure eligibility for both programs. PPP provides five (5) coaching sessions during pregnancy and four (4) coaching sessions postpartum, and the same coach administers each session. This allows the parent to focus on their health and the baby, creating longevity for both through cessation. Comprehensive printed educational materials on the benefits of quitting smoking during pregnancy and harmful effects on babies were provided upon each enrollment process.

The NTQ enrolled 1,828 callers during the program period, which included five (5) pregnant people. The NTQ offers a free program specializing in helping pregnant people quit smoking. The tailored treatment plan meets their needs by providing intensive behavioral support, including an increased number of coaching calls compared to the general population. As an incentive, reward gift cards for $5 and $10 are given after scheduled and completed counseling calls. For pregnant and new parents who have quit, additional postpartum support is available to prevent relapse. NTQ uses evidence-based treatment practices to help pregnant smokers quit and remain tobacco-free. Although the call volume was limited, outreach was expanded to CHWs, women's health care providers, WIC clinics, and events in the community. MCH opportunities to heighten NTQ awareness are being implemented, including promotion by all Title V MCH funded partners and the Chronic Disease Coalition monthly newsletters.

Partnerships continued to expand with the NTQ as listed: Medicaid MCOs, Division of Welfare and Social Services, the MCAH Section, local Tribal health departments, University Medical Center, Nevada Health Centers, Carson Tahoe Hospital, Lyon County Medical Center, Northern Nevada Health Centers, AHN, and mental health clinics and behavioral health facilities. Established relationships with providers created an opportunity for a health system change through an NTQ e-Referral process specific to patients interested in cessation.

Nevada Health Conference Report

The 2019 theme of the MCH partially funded Nevada Health Conference, October 14-15, 2019, "Creating a Healthier Nevada through Community Collaboration and Change" highlighted the importance of collaboration with other healthcare disciplines, addressed the health disparities, barriers, and challenges across the lifespan through an array of healthcare-related fields. Title V MCH provided significant funding to the conference, sponsoring scholarships and travel, sponsoring materials, and serving on the conference planning committee.

A panel discussion included, Julia Peek, MHA, CPM, Deputy Administrator, DPBH, and other healthcare and legislative leaders to discuss current trends and topic relevant to the Silver State. The first day of the conference was concluded by Dr. Kenneth Hempstead from the Permanente Medical Group. His keynote topic was "Effective Communication without Confrontation." Day two opened with Dr. Joel Amundson, Board Certified Pediatrician and Fellow of the American Academy of Pediatrics and President of Dr. Joel's Clinic in Portland, Oregon, and President emeritus at Boost Oregon. Dr. Amundson spoke on Vaccine Hesitancy. The lunchtime program included Jamie Schanbaum who shared her emotional and empowering journey as Meningitis survivor and now Paralympic Cyclist. The conference also included a networking reception that encouraged students and professionals to exchange ideas and connect with the exhibitors.

Testimonials from some of the 215 attendees included:

“By far the best in-state health conference available to Nevada healthcare providers and public health and social services professionals. Thank you Immunize Nevada for coordinating and thank you to all the continuing sponsors.”

“Great experience! I came out with a whole new prospective on things. Great information provided and loved all the workshops I went to.”

“I find this conference to be one of the most valuable tools in continuing education.”

Continuing education credits were issued through the University of Nevada for multiple healthcare related fields included:

- Certified Health Education Specialists (CHES)
- Certified Public Health
- Nursing
- Pharmacists
- Physicians (plus 1 hour of ethics/addiction care)
- Social Work

Each year the Nevada Health Conference awards scholarships to individuals who wish to attend the conference but may not otherwise be able to attend due to cost. MCH funds scholarships via Immunize Nevada, in addition to the Nevada Public Health Training Center, and the Nevada DPBH.

- Total number of Applicants: 43
- Total number of Applicants Awarded: 39
- Total number of Recipients (people who accepted and/or didn’t cancel): 38 (local scholarships: 6; traveling scholarships 32)
- No-show(s): 1

Reality Works Report

Title V MCH provided partners with Reality Works figures (substance exposed, abusive head trauma, and fetal alcohol spectrum disorder infant sized figures) including the Nevada Public Health Foundation (NPHF) for their Supporting Teens Achieving Real-Life Success (STARS) workshop aimed at improving life skills and supporting pregnant and parenting teens and providing tools for self-sufficiency. Reality Works figures provided by Title V MCH were used to help reinforce the importance of abstaining from substances and alcohol use while pregnant. Other focus areas of the classes include reducing a repeat teen pregnancy with information on birth control, birth spacing, and continuing education. The overall goal was to support the pregnant and parenting teens and give them tools to reach their highest level of self-sufficiency. Items provided by the Title V MCH program included an infant oral health kit with tooth paste and toothbrushes, baby bath thermometers, text4baby water bottles and lunch bags, and informational handouts on various topics such as safe sleep, marijuana, WIC, and developmental screenings.

Rape Prevention and Education Program

Nevada’s RPE Program is part of a national effort launched by the CDC in response to the Violence Against Women Act of 1994. The RPE Program focuses on preventing first-time perpetration and victimization of sexual violence by reducing modifiable risk factors and increasing protective health and environmental factors associated with sexual violence. The RPE Program Coordinator is co-funded through Title V MCH Block Grant and CDC to create a full-time position dedicated to supporting sexual assault and violence prevention. Federally approved strategies reflected the expansion of previous RPE Program work preventing sexual violence through approaches impacting

agency professionals, advocates, college campuses, and Las Vegas/Reno casino and bar personnel. The Nevada RPE Program, in coordination with grant subrecipients, has worked to implement community prevention strategies. Through these efforts, the RPE program builds and strengthens internal state capacity through programs aimed at risk and protective factors related to violence prevention.

RPE funded activities to support Active Bystander Intervention Training to increase participation in active bystander behavior through education and intervention techniques. Safe Embrace in Northern Nevada and The Rape Crisis Center (RCC) in Southern Nevada, collaborated with the Las Vegas Metropolitan Police Department to educate staff from 108 Reno and Las Vegas bars and clubs. The topics focused on the signs of predatory behavior and the dangers of drugs and alcohol in sexual violence. RCC assisted casino and club management in creating policies to avert potentially dangerous situations for staff and patrons.

In collaboration with UNLV, the Jean Nidetch Women's Center, a CARE Peer Program 45-hour empowerment-based training curriculum was conducted virtually with students due to COVID-19. The interactive modules focused on increasing awareness of community and societal factors leading to sexual violence and harassment and increasing social norms that protect against violence. Following leadership preparation, new peer advocates delivered virtual trainings via Canvas, UNLV's student portal, to the student body and self-identified campus groups. An Interpersonal Violence Collaborative Interest Group, consisting of administrative and educational faculty, convened quarterly to build campus infrastructure to establish best practices and evidence-based strategies for policy reform in response to interpersonal violence and harassment on the campus.

The NCEDSV hosted an Economic Justice Series as a part of their annual conference to support domestic and sexual violence statewide prevention efforts. NCEDSV held five virtual forums focusing on economic justice as a tool for sexual violence prevention in Nevada, hosting 185 individuals statewide. Each forum explored a specific economic justice priority, including and featured panelists with expertise in these areas. MCAH Program staff from SRAE, PREP, and RPE programs attended the conference to increase strategies for linking adolescent health to risks and protective factors related to sexual assault and intimate partner violence. NCEDSV continues to hold regional trainings to support domestic and sexual violence statewide prevention efforts.

Trauma-Informed Yoga Report

Title V MCH funding supported Urban Lotus Project yoga and mindfulness instruction to help adolescents ages 12-17 y.o. cope with stress. The program also served young adults. Young adults were served at five facilities with 87 yoga classes taught to 84 individuals comprised of pregnant and parenting young persons, and young people undergoing substance use and mental health treatment. Most students attended multiple yoga classes resulting in 452 pupil exposures. COVID-19 significantly impacted the ability for in-person courses and only one facility held on-site classes during this six-month period.

The collaboration with ULP and MCH resulted in two products inside the *AMCHP Innovation Hub* in hopes of replicating the success of this effort elsewhere, allowing women of childbearing age to reap the benefits of specialized yoga and mindfulness instruction. The promising practice is housed inside *AMCHP's MCH Innovations Database* and showcased as one of the NPM 8 adolescent physical activity implementation toolkits. https://create.piktochart.com/output/44298021-npm-8-disseminating-tools-and-resources.

Nevada Maternal Mortality Review Committee

Nevada MMRC statute are codified in NRS 442.751 through 442.774, inclusive, and the Committee is required to: (1) review incidents of maternal mortality and severe maternal morbidity (SMM) in Nevada; (2) disseminate findings

and recommendations concerning maternal mortality and SMM to providers of health care, medical facilities, other interested persons and the public; (3) publish timely reports consisting of data relating to maternal mortality and SMM, descriptions of incidents reviewed by the Committee, and recommendations to reduce maternal mortality and SMM in Nevada. Nevada's MMRC convened for their first meeting in February 2020. This committee will continue to meet multiple times a year to review all incidences of maternal mortality in Nevada and address health disparities and to end preventable MM and SMM.

The Title V MCH Director and MCAH staff have worked with CDC for a number of years in efforts to bring a MMRC to Nevada and are involved in supporting the MMRC and in considering opportunities for implementing MMRC recommendations in MCH programmatic efforts for prevention, increased awareness of the existence and recommendations of the MMRC among the public, clinicians, and policy makers, and supporting dissemination of required reports and data-driven MMRC recommendations (e.g., evidence-based practices, screenings, and patient and provider education). Reporting produced by the MMRC support staff will be included in the Title V MCH Block Grant reporting, and health equity in birth outcomes and maternal domain population health maximization will be key areas of topical intersect in priorities of the MMRC, AIM, MCAH Section, SSDI Program, and Title V MCH Program.

Two contributing factors to maternal mortality at the systems level which could have a large impact in preventing maternal mortality were identified by MMRC members. First, the Committee identified the need to provide adequate drug treatment options to pregnant women. The Committee recommends educating providers on Nevada's substance use disorder treatment options which already exist for pregnant women and removing barriers to care. The second relates to substance use in pregnancy and the identified need as a society to address SDOH for all populations. At the provider level, the utility of recommending the use of a suicide screen in addition to the antepartum and postpartum depression screen was discussed. Finally, a recommendation for outreach promoting the importance of prenatal care and preventing delays in prenatal care was identified.

SSDI funds help to support MMRC case abstraction staff. MCAH staff have facilitated maternal mortality and severe maternal morbidity presentations to the MCHAB in concert with the Nevada DHHS Office of Analytics and the efforts of the Title V MCH-funded Biostatistician in the Office of Analytics.

Advanced Life Support in Obstetrics

In an effort to prevent maternal mortality and severe maternal morbidity, the Title V MCH Program initiated plans to fund Advanced Life Support in Obstetrics (ALSO) training for rural and frontier critical access hospital staff. ALSO is an evidence-based, interprofessional, and multidisciplinary training program that equips the entire maternity care team with skills to effectively manage obstetric emergencies. However, due to COVID-19, Title V MCH staff postponed the training.

Women/Maternal Domain Accomplishments

Despite challenges posed by the pandemic, funded partners could dedicate efforts to help women of childbearing age with education, resources, and referrals to improve their health outcomes. MCAH staff added COVID-19 MCH population-related content into the DPBH website and shared pandemic information and resources with partners pertinent to women of childbearing age and their families.

Highlights of maternal and women's health efforts include robust substance use in pregnancy prevention efforts and internal and external stakeholder engagement, successful partnerships with NHV to improve dyad outcomes and reproductive health, strong relationships with the LHAs, support of statewide MCH Coalition networks, MMRC groundwork, funding statewide and local conferences for information sharing and workforce development, and

support of novel trainings for sexual assault prevention with non-traditional partners in the bar and casino industries.

Women/Maternal Health Data

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

According to BRFSS, the percent of women, ages 18 through 44, with a preventive medical visit in the past year in Nevada increased from 64.6% in 2018 to 65.6% in 2019. Nevada is significantly below the US national average of 72.8% for this metric and ranks 48th out of the 50 states and the District of Columbia (D.C.). Most women in Nevada with a preventive medical visit in 2019 were aged 35-44 years old (y.o.) (67.5%), followed by 25-34 y.o. (66.8%) and 18-24 y.o. (60.4%). When stratifying by race and ethnicity, Non-Hispanic Black women had the most preventive medical visits (68%), followed by Hispanic women (65.2%), and finally Non-Hispanic White women (59.7%).

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data from NVSS show a steady, significant increase for Nevada's percent of pregnant women receiving prenatal care in the first trimester from 2015 to 2019 (72.6% to 75.4%). Nevada did not meet the Healthy People 2020 goal of 77.9%. For 2019 Nevada remains below the national average of 77.6%, and ranks 37th out of the 50 states and D.C. There are racial/ethnic disparities for timely prenatal care in Nevada. In 2019, non-Hispanic White (79.5%) women had the highest prenatal care coverage, followed by non-Hispanic Asian (79.0%), non-Hispanic Multiple Race (76.9%), Hispanic (72.7%) and Non-Hispanic Black (72.0%). Non-Hispanic Native Hawaiian/Other Pacific Islander (60.7%) and Non-Hispanic American Indian/Alaska Native (51.1%) had the lowest percent.

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

According to the HCUP - State Inpatient Databases (SID), the rate of severe maternal morbidity per 10,000 delivery hospitalizations in Nevada decreased from 73.1 in 2015 Q1-Q3 to 65.2 in 2018. Nevada is significantly below the 2018 national average of 77.5 per 10,000 delivery hospitalizations. Women aged greater than or equal to 35 y.o. had the highest rate (120.5) in 2018, while women aged 20-24 y.o had the lowest rate (24.7). By race/ethnicity, Non-Hispanic Black persons (102.9) had the highest rate, followed by Other (73.6), non-Hispanic Asian/Pacific Islander (62.2), Non-Hispanic White (58.3), and Hispanic (58.1).

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

The 2015-2019 five-year estimates from NVSS indicate Nevada's maternal mortality rate per 100,000 live births (14.5) is less than the national rate (17.8). This represents an increase from the 2014-2018 estimate of 9.5 per 100,000 live births for Nevada. Even with the five-year estimates, the data should be interpreted with caution, and no stratified data exists for Nevada.

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

Data from NVSS indicates the percent of low birth weight deliveries in Nevada remained in the 8% to 8.5% range from 2009 to 2016. There was an increase in 2017 to 9.1%, but it declined to 8.7 and 8.8% in 2018 and 2019 respectively. Nevada is above the US national average for this measure, as the US percent of low birth weight deliveries has remained in the 8.0% to 8.3% range since 2009 with a low of 7.99% (2012) and a high of 8.3% (2017, 2018, and 2019). Nevada ranks 36th out of 50 states and D.C. for percent of low birth weight deliveries. Racial/ethnic disparities are apparent. In 2019, Non-Hispanic Black (14%) women had the highest percent of low birth weight deliveries followed by Non-Hispanic Asian women (10.8%), Non-Hispanic Multiple Race (9.1%), and Non-Hispanic Native Hawaiian/Other Pacific Islander (8.9%). Hispanic (7.7%), Non-Hispanic White (7.6%), and Non-Hispanic American Indian/Alaskan Native (6.1%) women were below the Nevada average of 8.8%.

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

According to NVSS, the percent of preterm births has remained around 10% from 2009 to 2019 with a high of 10.9% (2010) and a low of 9.8% (2013). At the same time, the US percent of preterm births has remained lower with a high of 10.2% (2019) and lows of 9.6% (2013, 2014, and 2015). Nevada ranked 36th out of 50 states and D.C. for this metric in 2019. Racial/ethnic disparities are apparent. In 2019, Non-Hispanic Native Hawaiian/Other Pacific Islander (14.5%) had the highest percent of preterm births, followed by Non-Hispanic Black (14%), Non-Hispanic Multiple Race (11.5%), and Non-Hispanic Asian (11.3), and Non-Hispanic American Indian/Alaskan Native (11.2%). Hispanic (10.2%) and Non-Hispanic White (9.5%) women were below the 2019 Nevada average of 10.7%.

Women/Maternal Health Plan for the Application Year

Nevada Home Visiting Plan

The NHV Program will continue to partner with Title V MCH staff on numerous efforts. Title V MCH collaborates with the Nevada MIECHV Program co-funding activities for the Sunrise Children's Foundation expanded Home Instruction for Parents of Preschool Youngsters (HIPPY) program in Pahrump and a developmental Parents as Teachers program in Washoe County.

NHV will provide training specific to positions as needed. Program staff will attend model training for Home Instruction for Parents of Preschool Youngsters (HIPPY) and Parents as Teachers (PAT) programs.

NHV will connect with diverse populations. Culturally appropriate support will be provided to Tribal communities. Support to English language learners with language-appropriate materials and bilingual home visitors will continue. Insurance eligibility assistance will be provided to at least 90% of the families who are uninsured or underinsured. Programs will continue to disseminate educational information on safe sleep, breastfeeding, marijuana use, domestic violence awareness, immunizations, tobacco cessation, nutrition, and fitness. Information and referrals will be provided to at least 90% of enrollees reporting need or screening positive. At least 90% of enrollees will be screened for depression, intimate partner violence, developmental concerns, and parent-child interaction. Other areas of need will be addressed, including substance use, housing, food security, and medical needs.

NHV will continue to implement additional data collection through Visit Tracker, a web-based database. In addition to the annual and quarterly reports submitted to the Health Resources and Services Administration (HRSA), the program will monitor model fidelity using data submitted, site visits, and annual model reports. NHV will also provide quarterly data reports to each agency. NHV will implement a Continuous Quality Improvement (CQI) plan approved by HRSA, embracing the Plan Do Study Act (PDSA) cycles as a method to improve systems, processes, and outcomes. Participating local implementing agencies (LIAs) will create monthly, data driven PDSAs to enhance program quality, focusing on model fidelity and family literacy. The most successful changes will be adapted and spread throughout the Home Visiting agencies. LIAs will submit monthly progress reports on CQI activities. Title V MCH co-funded NHV LIAs will be included in these activities. NHV will provide quarterly reports to MCH for distribution at MCHAB meetings and meet MCH deliverables. Start Early: The Essentials of Home visiting (previously known as Achieve On Demand), continues to provide professional development opportunities through live webinars and self-paced courses.

The collaborative Title V MCH and MIECHV Needs Assessment has informed program development in home visiting and will be used as a tool to drive program improvements in areas experiencing higher risk factors.

The Nevada Statewide Maternal and Child Health Coalition Plan

Plans for the upcoming year include MCH staff as the primary support for the state breastfeeding website updates and maintenance after the redesign and launch in April 2021. MCH staff will continue to promote the Breastfeeding Welcome Here Campaign. Dignity Health will collaborate with the Breastfeeding Coalitions and other Title V partners to help enroll Nevada businesses as breastfeeding-friendly establishments. The Statewide Coalition will continue to support critical NPMs related to Title V, and MCH staff will continue to attend coalition meetings and leadership calls. Additionally, the Statewide MCH Coalition website and e-newsletters will continue. They will look to community groups to expand outreach and participation, promoting text4baby, Nevada Tobacco Quitline, Nevada 211, and the MHP. Other Title V MCH partners will continue to fund and promote resources using the website, social media outlets, educational materials, health fairs, and other organizations and coalitions. Northern and Southern Nevada MCH Coalition meetings and quarterly MCH Steering Committee meetings will continue to be supported. Coalition

listservs and local meetings will continue to disseminate COVID-19 and MCH resources to other partners. The northern MCH coalition will continue to serve as the Community Action Team for the Title V MCH funded Washoe County FIMR.

Women's Health and Wellness Plan

In partnership with PREP, SRAE, and the AFP, MCH staff will continue to promote informed reproductive choices and education to support reproductive life planning. MCH staff will continue in core team roles for:

- CARA and ASTHO OMNI/PRISM statewide members' efforts and quality improvement of Infant Plan of Safe Care processes
- SBIRT policy change and implementation
- Family resource and provider resource development
- Stigma reduction
- MAT utilization, and
- Dyad-centered care.

These efforts will continue, as will efforts to create robust wrap around care and referrals for women who are pregnant and use substances. Obtaining significant utilization of the Tobacco Quitline among pregnant people is also a priority.

COVID-19 and pregnancy surveillance efforts and programming based on that surveillance continue to be an area of focus. Title V MCH will increase the use of PRAMS data. Title V MCH will continue to promote the importance of keeping prenatal care and women's and adolescent well visits during COVID-19 via social media campaigns. Close and frequent communication with Title V MCH funded partners related to COVID-19 impacts on scopes of work and emerging MCH population needs will continue for all population domains.

As part of the AIM efforts, the hypertension patient safety bundle launched. Nevada MMRC efforts, including data collection, case review, reporting, recommendations, and development of data to action interventions to reduce preventable maternal mortality and SMM are ongoing. Perinatal quality improvement efforts will continue as a possible space to leverage efforts of the Promoting Innovation in State & Territorial MCH Policy Making (PRISM) and perinatal mortality review committees. Title V MCH will investigate more robust maternal and perinatal data evaluation across all MCH populations to present timely key maternal and child health indicators. Title V MCH will continue to promote the data dashboard to partners statewide. Continuing to look for opportunities to expand NHV capacity to serve more families through broader funding streams and continued participation of MCH staff in early childhood support and systems building initiatives will continue and focus on referral pathway supports and data integration.

Funding PSAs, websites, social media and print campaigns, and sponsoring conferences for information sharing and collaboration will be ongoing. Staff training on equity, systemic racism as a public health issue, and programmatic efforts focused on disparity identification, and reduction will be core focus areas. Current partnerships with NOMHE, The Center, the NGCDD, and the NCEDSV efforts continue to prevent sexual assault among women and CYSHCN with developmental disabilities are ongoing.

Efforts will continue to promote reproductive health in partnership with AFP staff who are now co-located with MCH in the MCAH Section. The Nevada Legislature awarded biennial funding totaling six million dollars to the Nevada DHHS to support reproductive health access statewide through the AFP. Continuation and competitive requests for proposal funds were awarded to the LHAs, county health and social service entities, FQHCs, and community-based organizations. MCH staff will continue to work with the AFP Program to share data, leverage efforts, and evaluate

the impact of the funding.

Title V MCH will continue to award funds to CCHHS and DPBH CHS to promote women/maternal health in Carson City and rural counties. Priorities will focus on improving women's health (ages 18 – 44 y.o.) by enabling services and educational materials on women's health. Examples include the value of no-cost yearly checkups, reproductive health and long-acting reversible contraception, sexually transmitted infections, and healthy pregnancy outcomes. Educational material also includes *Go Before You Show,* Nevada Tobacco Quitline, sobermomshealthybabies.org, PRAMS, immunizations, depression, and intimate partner violence prevention. CCHHS will make education, counseling, and referrals to women affected by alcohol and substance use, intimate partner violence, and depression. Staff will distribute health-related brochures provided by the Title V MCH Program through clinic visits and community outreach events and promote routine well-visits through Facebook and digital signage.

Sober Moms Healthy Babies Plan

Title V MCH will continue to fund the *SoberMomsHealthyBabies.org* website to prevent substance use among pregnant people. The public awareness campaign will also continue to promote the website and the distribution of referral cards and removable wall stickers. Collaboration with LHAs, PRISM members, and DPBH SAPTA will ensure substance use in pregnancy materials and resources will be promoted.

All LHAs and MCH subgrantees will continue to promote the *SoberMomsHealthyBabies.org* website and share SMHB referral cards. CCHHS will use Title V MCH funds to promote the website through their clinic digital signage and social media posts.

ASTHO OMNI produced final provider and family resources will be added to the website and the previous resources developed and posted and content will be kept up to date with new resources and a dedicated CARA page.

Title V staff will participate in CARA focused efforts and serve as a core team member on the PRISM Nevada Team and on numerous subcommittees focused on reduction of substance use in pregnancy and building systems of referral for families with substance-exposed infants as efforts continue to create a robust continuum of care for families.

Marijuana Efforts Plan

Title V MCH will continue to disseminate marijuana awareness materials to partners statewide. Title V MCH staff will work with Nevada WIC to ensure marijuana materials are administered to WIC clinic statewide and continue the SoberMomsHealthyBabies.org website promotion through public service announcements (PSAs) in English and Spanish on radio and television stations statewide.

The Tobacco Prevention and Control Program Plan

All Title V MCH funded agencies will promote the Nevada Tobacco Quitline (NTQ). Sharing information regarding the Quitline with women of childbearing age is explicitly articulated within the scope of work for each funded program serving this population. MCH staff will work with NTQ staff and Nevada 211 to improve data collection to track utilization by women of childbearing age. CHS and CCHHS, and other MCH funded partners will provide tobacco cessation counseling, educational materials, and referrals to pregnant persons and women of childbearing age.

Increasing collaboration between the NTQ and MCH will help promote tobacco cessation for pregnant/postpartum mothers. The CDPHP TCP will establish discussions with providers to assess tobacco use with their patients and develop

a mechanism for appropriate data collection. They will continue to disseminate targeted NTQ promotional material for pregnant and postpartum women who use tobacco to increase uptake and utilization.

Nevada Health Conference Plan

Immunize Nevada hosted the Nevada Health Conference in March 2021 and will likely hold the next conference in March 2022. The Title V MCH program will again provide funding, planning, and support. The Title V MCH program will also be a key partner and sponsor and continue to provide funds for scholarships to individuals unable to attend due to cost-related issues. Title V MCH Program will provide resources to participants along with conference materials, including crucial information on perinatal information and a pamphlet promoting the value of adolescent well visits and educating on how to sign up for health insurance, substance use during pregnancy awareness materials, and PRAMS. Title V MCH staff are members of the planning committee, and staff often present and facilitate at the conference.

Reality Works Plan

Title V MCH will continue to provide partners with Reality Works figures showing outcomes of infants exposed to substances, alcohol, and experiencing abusive head trauma. Nevada Public Health Foundation will use the figures for the Supporting Teens Achieving Real-Life Success workshop aimed at improving life skills and supporting pregnant and parenting teens and providing tools for self-sufficiency.

Rape Prevention and Education Program Plan

The RPE Program will look for areas to align five-year project activities with the Title V MCH State Action Plan, mainly designing safer environments and fostering economic growth for adolescents and young women. RPE will address shared risk and protective factors through collaborative partnerships within the MCAH Section and other DPBH programs and external agencies working with populations of interest. Goals for the coming year will focus on increasing the number of community strategies implemented, creating protective environments to protect against violence, providing opportunities to empower and support young women, and continuing efforts related to CYSHCN and sexual assault prevention in partnership with the Title V MCH CYSHCN Coordinator and Director.

Trauma-Informed Yoga Plan

Title V MCH will continue to support Urban Lotus Project (ULP) yoga and mindful awareness instruction to help adolescents with and without special healthcare needs cope with stress and promote trauma-informed care to agencies serving young adults. The Title V MCH funded Innovation Station project will focus on adolescents ages 12-17y.o.; however, ULP will continue serving young persons and provide Title V MCH with data about young adults helped.

Advanced Life Support in Obstetrics Plan

In response to state priorities regarding maternal mortality and morbidity prevention, the Title V MCH Program, in conjunction with NRHP, hopes to fund Advanced Life Support in Obstetrics (ALSO) training for rural and frontier critical access hospital staff. ALSO is an evidence-based, interprofessional, and multidisciplinary training program equipping the entire maternity care team with skills to effectively manage obstetric emergencies. This comprehensive training encourages a standardized team-based approach amongst physicians, residents, nurse midwives, registered nurses, and other members of the maternity care team to improve patient safety and positively impact maternal outcomes.

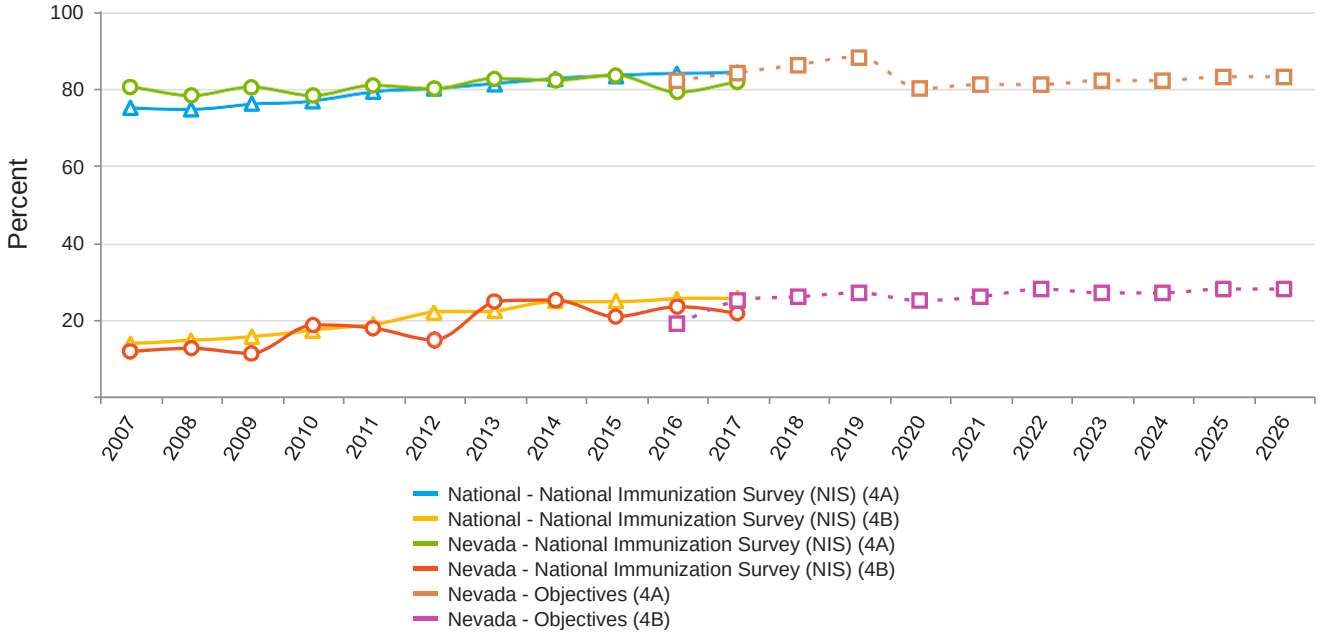
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	6.1	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.5	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	142.9	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	82	84	86	88	80
Annual Indicator	82.6	82.3	83.5	79.0	81.8
Numerator	26,908	25,695	29,014	27,212	26,457
Denominator	32,591	31,207	34,751	34,427	32,331
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	81.0	81.0	82.0	82.0	83.0	83.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	19	25	26	27	25
Annual Indicator	24.9	25.0	20.8	23.6	21.7
Numerator	7,990	7,700	7,086	7,914	6,799
Denominator	32,061	30,787	34,093	33,557	31,379
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	27.0	27.0	28.0	28.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	1.8	1.9
Numerator	6	6
Denominator	328	320
Data Source	Nevada PRAMS	Nevada PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.5	1.3	1.0	0.8	0.5	0.4

NPM 5A - Percent of infants placed to sleep on their backs
Indicators and Annual Objectives

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	77.6	76.8
Numerator	25,230	25,805
Denominator	32,492	33,607
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	35	34.1
Numerator	11,072	10,334
Denominator	31,599	30,290
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	43.1	39.7
Numerator	13,539	12,275
Denominator	31,413	30,901
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	44.0	45.0	46.0	47.0	48.0	49.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	73.2	74.6
Numerator	25,078	25,082
Denominator	34,250	33,607
Data Source	Nevada PRAMS	Nevada PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	70.0	68.0	65.0	63.0	61.0

State Action Plan Table

State Action Plan Table (Nevada) Perinatal/Infant Health Entry 1	
Priority Need	
Promote Breastfeeding	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
Increase the percent of children who are ever breastfed to 87% by 2025	
Increase the percent of children who are exclusively breastfed at 6 months to 30% by 2025	
Decrease the percent of PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends to 0.5% by 2025	
Strategies	
Partner with MCH Coalition and MCH stakeholders on activities and website postings to increase awareness, community-wide support and business education of breastfeeding, safe sleep, etc. (includes FIMR)	
Collaborate with public and private partners such as WIC, faith-based and breastfeeding coalitions, community based programs, and local health authorities to improve access to breastfeeding supports for new mothers	
Collaborate with public and private partners to conduct data collection, surveys, and other activities to improve breastfeeding rates	
Collaborate with public and private partners to proved website maintenance and updates to...	
ESMs	**Status**
ESM 4.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

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

Priority Need

Promote Safe-Sleep

NPM

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

Objectives

Increase the percent of infants placed to sleep on their backs to 84% by 2025.

Increase the percent of infants placed to sleep on a separate approved sleep surface to 40% by 2025.

Increase the percent of infants placed to sleep without soft objects or loose bedding to 48% by 2025.

Strategies

Provide staff support and training to home visitors on promotion of safe sleep practices

Collaborate with public and private partners to conduct data collection, surveys, and other activities to understand current safe sleep practices

Collaborate with public and private partners to promote safe sleep resources to the community such as media campaigns

Collaborate with Cribs for Kids (C4K) to support providing educational resources to parents and caregivers on the importance of safe sleep behaviors

ESMs	Status
ESM 5.1 - Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment	Active

NOMs

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

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

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

Perinatal/Infant Health Annual Report

As part of the Title V MCH Program, the Maternal and Infant Health Program (MIP) provides technical assistance, resources and support to private and public partners serving mothers and infants. The MIP Coordinator works closely with these partners, as well as the Title V MCH Program Manager and MCAH Section Manager, to improve the health outcomes of mothers and infants. The Perinatal/Infant Health report demonstrates how collaboration between agencies, leadership and MIP is working to accomplish the state priorities to promote breastfeeding and safe sleep.

Results of the Five-Year Needs Assessment demonstrated the need to continue promoting breastfeeding (NPM4) to improve health outcomes for infants. Promoting breastfeeding is one of a number of priority areas for the MIP. Title V MCH staff partner with public and private community members to enhance efforts to meet this priority by increasing the percent of infants who are ever breastfed (NPM 4A) and who are breastfed exclusively for six months (NPM 4B). Program activities and successes related to these efforts are included in the body of the Perinatal/Infant Health report.

the Five-Year Needs Assessment demonstrated the need to promote safe sleep and reduce preventable infant death and NPM 5 was included as a performance measure. In addition to collaborating with existing partners to promote safe sleep, establishing new partners to increase the percent of infants placed to sleep on their backs (NPM 5A), on a separate approved sleep surface (NPM 5B) and placed to sleep without soft objects or loose bedding (NPM 5C) will continue to be a priority in funded efforts.

Perinatal health and newborn screening are covered in the CYSHCN domain narrative, but in relation to perinatal and infant health, MCAH staff serve on the Newborn Screening Advisory Board and report on CCHD efforts and the CCHD Registry maintained by CYSHCN staff and work in partnership with EHDI staff. The EHDI and Title V MCH programs work closely together and are co-located in the MCAH Section.

Breastfeeding Report

Title V MCH staff continued statewide campaigns to improve infant feeding practices in maternity hospitals and increase community and business support for those choosing to breastfeed. Nevada WIC supported WIC participants by providing free professional lactation services, breast pumps, and an enhanced food package to those breastfeeding.

Nevada WIC and Title V MCH staff continued to promote and support breastfeeding through the use of an existing (previously CDC-funded) campaign to model Baby Steps to Breastfeeding Success (BS to BS) with funding and support from Title V MCH: http://azdhs.gov/prevention/nutrition-physical-activity/breastfeeding/index.php#hospitals-baby-steps. New maternity hospitals were given the opportunity to participate, and past hospital participants were offered refresher training. BS to BS educates maternity hospitals on how they may implement five evidence-based low or no-cost practices to support breastfeeding:

1. Initiate breastfeeding in the hour after birth,
2. Promote 24-hour rooming-in,
3. Avoid giving infants any food or liquid other than breast milk unless medically indicated,
4. Avoid artificial nipples for healthy term infants,
5. Give mothers a breastfeeding resource to help with breastfeeding questions after discharge.

Two breastfeeding campaigns in Nevada are designed to increase awareness, promote WIC breastfeeding services, and normalize breastfeeding in public locations. For the Breastfeeding Welcomed Here (BFWH)

campaign, Nevada businesses were asked to pledge their commitment to provide welcoming environments to breastfeeding mothers. This campaign included statewide print and social media posts. PACE Coalition, a Title V MCH funded agency serving Elko and nearby rural communities, sent out materials marketing the BFWH campaign to their listserv and Chamber of Commerce members. As of September 30, 2020, 115 Nevada businesses have signed this pledge. The WIC Breastfeeding Peer Counseling (BFPC) program is used to help WIC participants expand their breastfeeding journey by offering one on one culturally appropriate breastfeeding support. WIC peer-to-peer support and breastfeeding services were promoted in Washoe and Clark Counties where BFPC services are offered.

Title V MCH and Nevada WIC were invited to participate in the Association of State Public Health Nutritionists' (ASPHN) Children's Healthy Weight Collaborative Improvement and Innovation Networks' (CHW CoIIN) Breastfeeding Stream at the Intensive Learning Level. Nevada's project focuses on promoting breastfeeding support to partners of WIC mothers through education and outreach with the intent of increasing breastfeeding rates.

Title V MCH funds CCHHS to provide businesses with supplies for a designated breastfeeding area for employees. CCHHS sent 155 emails, 15 letters, made 77 telephone calls, and five in-person visits to local businesses to identify interest in establishing breastfeeding-friendly workplaces. Additionally, staff reached out to local maternal child health and immunization coalitions to determine interest in establishing breastfeeding-friendly workplaces. Six businesses created a designated breastfeeding area for employees and were provided supplies such as privacy screens, refrigerators, or reclining chairs. CCHHS provided each agency a placard for the recliners mentioning the gracious donation of the chairs through Title V MCH funds. Businesses proudly sent photos to CCHHS of the newly created spaces to confirm the space was established.

Two Title V MCH funded partners, CCHHS and PACE Coalition, promoted the Breastfeeding Welcome Here (BFWH) Campaign by informing businesses about Nevada breastfeeding laws; the awareness of the law was widely promoted by Title V MCH staff and resources were developed for distribution and posting on the MCAH website. Businesses can receive placards informing patrons breastfeeding is welcomed at the agency and be listed on the Nevadabreastfeeds.org website as a breastfeeding-friendly business. PACE Coalition placed content about the BFWH Campaign on the agency website, conducted a Facebook campaign endorsing the project, sent information to 230 members on the agency listserv, and provided content to businesses registered with the Chamber of Commerce. As a result of the promotion, PACE Coalition used Title V MCH funds to provide three businesses with privacy screens allowing women to breastfeed in a comfortable space. Each agency confirmed space was set up, as intended, by sending photos of the screens to PACE Coalition.

Title V MCH ordered an updated Breastfeeding Awareness Month banner to hang in Carson City, Nevada, during a week of National Breastfeeding Month, August 2020.

Breastfeeding Success Story

> 'The screens provided by PACE are utilized by Mothers who are breastfeeding and have visits with their child/ren while in our facility. The screens allow the mother to interact with their child/ren, who may be older while feeding the younger child comfortably. The younger child being breastfed does not have to be covered for privacy allowing the mother to engage the child while feeding.'

DCFS/Child Protective Services – Elko NV

Pregnancy Risk Assessment Monitoring System Report

PRAMS is part of a national effort to reduce infant mortality and adverse birth outcomes. The PRAMS questions cover the period before, during, and shortly after pregnancy. The PRAMS questionnaire packets include a cover

letter, a question brochure, and a consent document. If a mother does not respond after three questionnaires are sent, an attempt is made to reach her by telephone. Mothers who complete the survey by mail or telephone are offered a $20 Walmart gift card (funded by PRAMS). PRAMS data will be used to monitor the progress of national and state pregnancy and birth-related health measures. PRAMS data will also be used to identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants. Nevada PRAMS started collecting data in September 2017. For 2018 and 2019 births, Nevada PRAMS completed full years of data collection of 12 batches each. The weighted data from the 2018 births had a response rate of 39.4%, and 2019 births weighted data had a response rate of 42% which falls below the CDC-required threshold of 55% for 2018 and 50% for 2019. Due to this response rate, the data are to be interpreted with caution. PRAMS entered its fourth year of funding in May 2019. Title V MCH provided funds to cover the costs of printing and distribution of PRAMS survey covers, informational brochures, and posters. Title V MCH has supported efforts to increase the survey response rate through funding a Nevada Broadcasters Association and DP Video Productions media campaign airing of PRAMS television, radio, and social media advertisements in both English and Spanish. The most recent social media campaign through DP Video Productions ran in August and September of 2020. Boosted PRAMS posts for the campaign reached 180,866 people on Facebook and Instagram, and advertisements reached 127,791 people on the same platforms. Twitter posts and advertisements made 493,450 impressions. Nevada Broadcasters Association aired radio advertisements for PRAMS from August 2019 until July 2020.

All Title V MCH subrecipients have language in the contracts to educate pregnant persons about PRAMS. Promotional materials are disseminated to appropriate agencies educating about PRAMS, such as posters, brochures, water bottles, ice packs, pens, and tote bags. CCHHS promoted awareness of the PRAMS survey through digital clinic signage, and two Facebook social media campaigns reached 8,023 individuals. Title V MCH staff sit on the PRAMS Steering Committee.

Fetal Infant Mortality Review Report

WCHD's FIMR is fully funded by the Title V MCH Program and MCAH. With funding from the Block Grant and Nevada State General Funds, Public Health Nurses (PHNs) in the Maternal Child Health Program examined individual cases of fetal and infant deaths. The FIMR coordinators presented cases to the Case Review Team (CRT) and evaluated aggregate data to determine trends that are public health concerns in need of intervention efforts.

The FIMR team continued data abstraction from July 1, 2019-June 30, 2020 from the local hospitals, local healthcare providers, Medical Examiner, and Vital Statistics. Data were abstracted on 81 fetal and infant deaths that occurred in Washoe County and were received between May 2019 and May 2020. Of the 81 cases, 64 (79%) were Washoe County residents, and 17 (21%) were not. Most obtained all or part of their prenatal care in Washoe County. Washoe County FIMR cases have decreased from 91 fetal and infant deaths in FY2019 to 81 in FY2020. FIMR staff participate in the Northern Nevada Maternal Child Health Coalition (NNMCHC) which acts as the Community Action Team (CAT). The CRT reviewed 37 cases during nine FY2020 meetings.

MCAH staff attend FIMR and led efforts to implement the new Case Reporting System developed by the National Center for Fatality Review and Prevention (NCFRP). to improve their reporting quality and completeness.

. NNMCHC meetings are generally held every other month. Strategies for implementing recommended activities in the community are discussed at the NNMCHC meetings. The NNMCHC continued to promote the GBYS campaign. There were concerns that women did not know where to go or what to do because of COVID-19 restrictions and misinformation on social media. The NNMCHC provided in-services from local medical experts about COVID-19 in pregnancy and in children to help providers educate and advocate for their patients during this unprecedented time. A CRT member followed up on recommendations to include pregnancy-specific resources for patients and was able to get a special button added on the DPBH website to help direct women to pregnancy-related information about

COVID-19 and their risks.

Syphilis also continues to be a significant concern, as the number of infectious cases continue to rise. Ongoing education regarding the importance of testing in the first and early third trimesters of pregnancy, as well as other syphilis prevention and case identification, continue to be disseminated and FIMR members remain involved in statewide efforts to address the increase in syphilis and CS.

Increased access to LARC during the postnatal period is an area of interest for FIMR. FIMR staff participate in Pregnancy and Infant Loss Support Organization of the Sierras (PILSOS) monthly meetings and attended the PILSOS Day of Remembrance event at Idlewild Park on October 13, 2019. Staff attended the Fetal and Infant Mortality Review Technical Assistance Meeting on January 23, 2020, in Fresno, CA provided by the NCFRP.

FIMR brochures and various educational materials continue to be disseminated at the WCHD and local hospitals. These materials include information provided by Title V MCH on the Nevada Tobacco Quitline, soberomshealthybabies.org, the MHP, and Nevada PRAMS. The FIMR Program is prepared to serve diverse populations with interpreter services and sympathy cards and educational materials are available in both English and Spanish and are sent to all reported cases within Washoe County.

FIMR Success Story

The CRT, CAT, and NNMCHC continued to collaborate across diverse teams, committed to improving the health of women, infants, and children in northern Nevada. Together with the WCHD FIMR team, recommendations continue to be made for policy and system changes to reduce the impact of fetal and infant mortality. Fetal and infant losses at greater than 37 weeks gestation increased from 19.9% of the 91 WC FIMR cases in FY19 to 22.2% of the 81 WC FIMR cases in FY20. More information is being gathered to understand this increase. The FIMR CRT is starting to explore a simple campaign called "Count the Kicks" to raise awareness of fetal movement and what to do if there are concerns. "Count the Kicks" has been successful in other communities. In Iowa, where the program was developed, they have seen a 32% reduction in stillborn rates. The program aims to empower women to be aware of their baby's movement patterns

Cribs for Kids/Safe Sleep Report

The Regional Emergency Medical Services Authority (REMSA), funded through the Title V MCH Block Grant, operates as the lead agency for the Cribs for Kids (C4K) Program in Nevada. C4K provides educational resources to parents and caregivers on the importance of practicing safe sleep behaviors with infants to prevent mortality. Partner agencies participate in train the trainer sessions, including evidence-based, best practice Safe Sleep Education endorsed by the American Academy of Pediatrics (AAP). Safe Sleep Survival Kits for infants are provided to families who cannot afford to purchase a crib for their infant. Safe Sleep Survival Kits include a Pack and Play Crib, a crib sheet with the safe sleep message, a Halo SleepSack, Safe Sleep ABC photo magnet, Philips Soothie Pacifier, Safe Sleep educational materials (brochure, door hanger, and flyer), a Safe Sleep DVD, and a *"Sleep Baby Safe and Snug"* children's book funded by the Title V MCH Program. Materials are available in English and Spanish.

In 2019-2020, the C4K Coordinator conducted 16 Train the Trainer safe sleep educational trainings. Eight trainings were held in Washoe County, five in Clark County, and the rest in rural Nevada.

A total of 69 professionals and staff received safe sleep training materials from the C4K program. When the pandemic hit, the C4K program made a shift to an online platform, making it possible to continue working with partners to train employees. During community events and the train-the-trainer sessions, the C4K Program shared additional internal MCH agency materials with the public, including Nevada 211, sobermomshealthybabies.org, the Nevada Tobacco Quitline, and the MHP.

Eighteen new and existing agencies actively participated in the C4K Program by assisting with the distribution of 845 Safe Sleep Survival Kits and 548 families were entered into the REDCap database. Ongoing communication efforts are prioritized to ensure Safe Sleep education and materials are widely distributed and participation in C4K activities continue to increase.

For the 2019-2020 cycle, C4K usually works with Immunize Nevada to distribute Safe Sleep brochures in the PINK packets. They typically request 1-2 times a year, but this year had enough left over from last year. Other safe sleep materials distributed statewide included 70 binders, 265 posters, 13,545 brochures, nine flip charts, and 548 Sudden Unexplained Infant Death (SUID) intake questionnaires. Also, 232 three-(3) month follow-ups and 77 twelve-(12) month follow-up surveys were conducted to identify knowledge gaps related to infant safe sleep practices. The survey showed 94% of parents laid their infant on their back at 3 months, and 88% laid their infant on their back at 12 months. At 3 months, 76% of parents answered yes to the question “Do you keep blankets, stuffed animals, and pillows out of the crib when baby is sleeping?” and 78% at 12 months answered yes to the same question.

In October 2016, the American Academy of Pediatrics (AAP) published new safe sleep recommendations. Cribs for Kids (C4K) current curriculum was updated to reflect these changes, and information was presented to partners. The most recent CDC statistics, which includes data up to 2017, were added to the curriculum. The statistics will be updated to reflect any new changes. The curriculum is also available online through a shared drive for C4K partners to access the most recent changes or forms. The curriculum continues to include a section on how to set up a REDCap account and enter data.

C4K staff also attended bi-monthly Washoe County Child Death Review meetings, Statewide Executive Committee Child Fatality Review meetings and Northern Nevada MCH Coalition meetings.

This group aimed to ensure evidence based, standardized statewide safe sleep messaging to raise public awareness on the importance of following Safe Sleep Guidelines and reducing infant deaths. Similar efforts continue in the ongoing SUID prevention efforts of the Statewide Executive Committee to Review Child Fatalities of which one MCH staff member is an appointee.

The C4K Program staff also distributes infant, convertible and booster car seats statewide. This grant cycle, 83 seats were distributed, all were disseminated on rural Tribal reservations. Owyhee Community Health Facility distributed 41 car seats, South Bands Health Center distributed 19 car seats, Walker River Paiute Tribe distributed 13 car seats, and Washoe Tribe distributed 10 car seats. A Tribal pilot in concert with interested Tribal Nations, C4K, IHS staff, NICRP and MCH was funded via Title V MCH to prevent injury.

Title V MCH funded the PACE Coalition to enhance perinatal/infant health in Elko County and nearby rural communities. The CHW taught two safe sleep courses serving four expectant mothers. All class participants were provided materials to enhance health outcomes, including information about safe sleep, Nevada Tobacco Quitline, sobermomshealthybabies.org, PRAMS, Text4Baby, Nevada 211, and the MHP.

Safe Sleep Media Campaign Report

The Safe Sleep Media Campaign ran from October 1, 2019 through September 30, 2020 with English and Spanish radio and television public service announcements statewide. For this funded period, the Safe Sleep media campaign had a total of 15,555 total spots aired (14,081 radio advertisements and 1,474 television advertisements). The average return on investment for airtime was 24 to 1.

All LHAs promote Safe Sleep messaging. The Title V MCH Program works closely with partners across the state The Statewide Executive Committee to Review Child Fatalities membership includes the MCH Director, working closely with other members to leverage statewide efforts to end preventable infant and child mortality statewide, including SUID.

Perinatal/Infant Health and Wellness Report

ASTHO OMNI participation by Title V MCH staff was focused on systems building to provide referrals and interventions for substance exposed infants, and state interest in formalizing a statewide perinatal quality collaborative was explored as part of the OMNI Action Plan. The MCH Director and Title V MCH MIP Coordinator and other MCH staff actively participated in numerous infant and perinatal focused workgroups, conferences, webinars, taskforces, committees, community meetings, provider outreach, hospital presentations, MCH data meetings, and breastfeeding and MCH coalitions. The CYSHCN Director served on the AMCHP Policy Committee where perinatal and infant health policy was a key area of emphasis, and all key Title V MCH staff participated in AMCHP efforts.

Fourteen public health clinics were awarded Title V MCH funding to improve perinatal and infant health: CCHHS, WCHD, and 12 nursing clinics within DPBH CHS serving Nevada's rural and frontier areas. Clinic staff provided information about securing a medical home, being adequately insured, postpartum and infant visits, safe sleep, developmental screens, breastfeeding, and nutrition, Text4Baby, SMHB website, as well as immunizations schedules for women and family members (flu and Tdap cocooning) and infant/toddlers. All clinic staff distributed perinatal/infant health-related materials provided by the Title V MCH Program. Materials covered safe sleep, Text4Baby, substance use in pregnancy (including marijuana), PRAMS, Nevada 211, and the MHP. Furthermore, staff discussed reproductive health and promoted Medicaid coverage for long-acting reversible contraceptives immediately postpartum.

CHS conducted perinatal and infant health and wellness activities in clinic settings and through outreach events. One hundred fifty-four vaccinations were administered to 31 infants during which Title V MCH funded education, resources, and referrals were provided. Three community events promoted oral health for pregnant persons, infant safe sleep, and child abuse and neglect prevention. COVID-19 impacted staff's ability to perform additional planned activities in Nevada's rural and frontier regions.

CCHHS provided counseling and education to 54 pregnant persons about establishing an obstetrician, breastfeeding, PRAMS, immunizations, and WIC support services. Women who tested positive or were considering pregnancy were given bags, with materials provided by MCH, to promote healthy pregnancy outcomes endorsing Text4Baby, *Go Before You Show,* Nevada Tobacco Quitline, Cribs for Kids, being alcohol and substance-free, as well as other pertinent information. Additional activities endorsed infant immunizations, Text4Baby, and sobermomshealthybabies.com through the clinic's digital signage and social media campaigns. Facebook messages containing information about infant vaccinations reached 4,478 families with 709 engaged users. TheText4Baby Facebook campaign reached 1,988 individuals. Sobermomshealthybabies.com Facebook posts about substance use treatment resources during pregnancy reached 5,814.

Title V MCH funded the PACE Coalition to enhance perinatal/infant health in Elko County and nearby communities in rural areas. The CHW provided clients with information about safe infant sleep, substance use in pregnancy, tobacco cessation, Nevada 211, PRAMS, breastfeeding and nutrition, local WIC offices, immunization schedules, and baby growth charts. Additionally, the staff created and disseminated several perinatal/infant health brochures. The content focused on Perinatal Mood and Anxiety Disorder (PMAD), general prenatal health, nutrition for nursing women, and infant nutrition. The infant feeding pamphlet contained a comic/coloring section providing a fun place for siblings to be creative. COVID-19 shifted all client contact to telephone calls. In the three rural counties served by the award, many women did not have internet access, so the CHW offered to send materials through the mail. The pandemic necessitated PACE Coalition to update the agency website allowing for perinatal and infant health resources. Title V MCH funding provided for new parents to obtain infant car seats. The CHW provided four families with car seats and referred three women for car seat installations.

Multiple perinatal related presentations were made to the MCHAB for which Title V MCH staff serve as support staff.

Staff facilitated recommendations from the MCHAB being passed on to the Administrator of DPBH in relation to the prior Legislative Session from key statewide subject matter experts in MCH. Also, MCH staff provided packets of brochures and MCH information to the Tribal Liaison to share with Tribal partners statewide.

COVID-19 Efforts

Title V MCH staff added COVID-19 MCH population-related content into the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/.

CDC content on pregnancy and COVID-19 were inserted into the MIP Program webpage http://dpbh.nv.gov/Programs/MIP/dta/Links/links/. The CDC materials and placement of the links were shared widely with funded partners and community members. The statewide MCH Coalition and PCO disseminated the materials through listservs.

In FFY 21, all Title V MCH funded partners were requested to promote the DPBH awarded Nevada Resilience Project, helping families and individuals experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, through text and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Additionally, state staff shared the launch of Nevada 211 mobile apps to help Nevadans connect with needed resources in response to the pandemic. MCAH staff have also discussed NOMHE-planned equity and COVID-19 toolkit distribution opportunities and shared materials from NOMHE and other quality organizations about racism and public health, health equity, health disparities and racism, and racism and pregnancy outcomes.

Social Media Promoting Prenatal Care During COVID-19

Title V MCH awarded funds to DP Video for a month-long social media campaign. The campaign displayed videos and messages reminding pregnant persons to keep scheduled prenatal visits and increase telehealth awareness Pregnant persons were provided a link to the COVID-19 and pregnancy information from CDC inside the DPBH website http://dpbh.nv.gov/Programs/MIP/dta/Links/links/ and in the main MCH COVID resource page. Four video ads (2 English/2 Spanish) were displayed on Facebook/Instagram. The messages reached 50,067 people in the specified demographics, with 25,274 video views, 285,994 media impressions and 1,064 clicks on the links for additional resources. Four video ads (2 English/2 Spanish) were displayed on Twitter, resulting in 194,693 media impressions.

Perinatal Immunizations Report

Title V MCH funding supported a 0.5 FTE position for NSIP to improve health among women of childbearing age, linking immunization to interconception and preconception care, as well as supporting Tdap cocooning efforts. In immunization compliance visits with obstetricians, an informational packet, furnished by the MCH Program, was dropped off for distribution to expectant parents. The materials related to improving maternal and infant health outcomes, such as the PRAMS survey and substance use in pregnancy (sobermomshealthybabies.org). Obstetricians promoted the benefits of Tdap vaccines early in the third trimester, as well as flu shots at any time during pregnancy. One new practitioner was enrolled in the Tdap Cocooning Program. The Coordinator in this position attended MCHAB meetings and prepared quarterly updates on their work to share with MCHAB members. Title V MCH also co-funded at 0.5FTE an Accounting Assistant III with NSIP, supporting Title V MCH fiscal efforts.

NSIP created a new partnership with WIC to assess the vaccine status of pregnant people served and provided referrals to immunizing practitioners. WIC staff received training to access NV WebIZ (the statewide immunization

information system) and view the immunization status of WIC recipients. An electronic toolkit was developed and distributed to WIC staff offering resources on how to discuss vaccines and where clients can receive needed immunizations. The NSIP/WIC partnership was shared as an innovative practice during a presentation at the Nevada Health Conference, hosted by Immunize Nevada, supported by Title V MCH funds.

The HRSA MIECHV and Title V MCH funded NHV Program also provided education and referral supports promoting timely vaccination for NHV families and numerous evidence-based screenings and supports to promote healthy pregnancy and infancy for NHV families.

Infant Mortality Collaborative Improvement and Innovation Network (IM-CoIIN) Report

To address issues relating to birth outcomes and SDOH, Nevada Title V MCH is involved in several statewide initiatives as part of the IM-CoIIN 2.0 in partnership with AMCHP. Nevada CoIIN partners included: Title V MCH, NHV, Nevada Healthy Start Program, SNHD, WCHD, Nevada Medicaid, and March of Dimes (Nevada Chapter). The aim of the IM-CoIIN 2.0 is to build state and local capacity and test innovative strategies to shift the impact of SDOH and increase equity in birth outcomes by developing evidence-based policies, programs, and place-based strategies.

Messaging on the importance of 17-alpha-hydroxyprogesterone caproate (17P) and LARCs were embedded in Nevada IM-CoIIN efforts. The Nevada IM-CoIIN efforts have led to further distribution of Go Before You Show campaign materials, March of Dimes preterm birth resources and information distribution, and drafting of two policy changes to 17P verbiage for consideration for inclusion in the Medicaid Service Manual (MSM) after a public hearing process. The IM-CoIIN team partnered with the UNRSOM Project ECHO (http://med.unr.edu/echo) to host a provider-focused webinar on 17P with continuing medical education units. 17-P efforts are currently on hold pending the outcome of a FDA review reassessing the expedited approval given to 17P.

Perinatal/Infant Domain Accomplishments

MCAH staff added COVID-19 MCH population-related content into the DPBH website and shared pandemic information and resources with partners pertinent to pregnant persons. The Title V MCH Program conducted a month-long social media campaign to remind pregnant persons to keep scheduled prenatal visits and learn whether the provider needs to see them in person or if the visit can be done by phone or video. MCAH staff participated in the Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) and will continue to do so in the next reporting period

Perinatal infant health highlights include the production of data to action reporting related to PRAMS promotion efforts and substance use in pregnancy. Extensive outreach activities and partnerships of MCH staff supported varied messaging, and funded efforts to improve birth outcomes, CME development and provision to prevent preterm birth and widespread safe sleep messaging and perinatal mortality prevention efforts.

Perinatal/Infant Domain Data

NPM 4A - Percent of infants who are ever breastfed

According to the National Immunization Survey (NIS), the percent of infants who are ever breastfed in Nevada has fluctuated from 2007 to 2017, reaching a high of 83.5% in 2015 but then falling to 79% in 2016. In 2017, Nevada rose slightly to 81.8%. which is below the 2017 national average of 84.1% and below the Healthy People (HP) 2020 objective of 81.9%. Nevada ranks 34th out of 50 states and D.C. for this measure.

NPM 4B - Percent of infants breastfed exclusively through 6 months

The percent of infants breastfed exclusively through 6 months in Nevada reached a high of 25% in 2014 but decreased slightly to 21.7% in 2017 (NIS). Nevada is below the 2017 national average of 25.6%, and below the Healthy People 2020 objective of 25.5%. Nevada ranks 44th out of 50 states and D.C. for this measure.

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

NVSS data indicate the percent of preterm births (<37 weeks) in Nevada has not significantly changed from 2009-2019. In 2019, Nevada's preterm birth rate was 10.7% compared to 10.2% nationally. Nevada has not met the HP 2020 objective of 9.4%, and ranks 36th out of 50 states and D.C. When stratifying by race and ethnicity, Non-Hispanic Native Hawaiian/other Pacific Islander (14.5%), Non-Hispanic Black (14.0%), Non-Hispanic Multiple Race (11.5%), Non-Hispanic Asian (11.3%), and Non-Hispanic American Indian/Alaska Native (11.2 %) have percent of preterm births higher than the average for Nevada. Hispanics (10.2%) and Non-Hispanic White (9.5%) have the lowest preterm birth rates.

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

According to NVSS, Nevada's infant mortality rate per 1,000 live births in 2018 was 6.1, marking the first time since 2009 that Nevada has been above the national average, which was 5.7 for 2018. Nevada ranks 30th out of 50 states and D.C. Racial and ethnic disparities exist in infant mortality in Nevada. Three-year estimates for 2016-2018 indicate Nevada's Non-Hispanic Black (9.7) and Non-Hispanic American Indian/Alaska Native infant mortality rate (9.4) was almost twice that of non-Hispanic White (5.3) and Hispanic (5.0) rates. Three-year infant mortality rates among women with less than high school education (7.4) were the highest, followed by high school graduates (6.9) and women with some college (4.6). Infant mortality rates were lowest in women who were college graduates (3.7).

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

According to the NVSS, the sleep-related SUID rate per 100,000 live births in Nevada increased sharply from 81.1 in 2017 to 142.9 in 2018. From 2009 to 2018, Nevada has experienced similar increases and decreases in the rate. For example, in 2009 the rate was 93.1 and in 2010 the rate dropped to 58.4, and in 2016 the rate was 124.1 before dropping to 81.1 in 2017. Nevada's rate in 2018 of 142.9 is significantly higher than the 2018 national average of 90.6. A maternal age of less than 20 years old had the highest rate (274.2), compared to 153.1, 134.2, and 75.2 for the 20-24, 25-29, and 30-34 age groups, respectively. Non-Hispanic Black women had the highest rate among any race or ethnicity (258.3) and was lowest for Hispanic women (60.2). Non-Hispanic White women had a rate of 117.

Perinatal/Infant Health Plan for Application Year

Results of the Five-Year Needs Assessment demonstrated the need to continue promoting safe sleep as well as breastfeeding; therefore, Title V MCH included NPM 5 as a performance measure. In addition to collaborating with existing partners to promote breastfeeding and safe sleep, establishing new partners to increase the percent of infants placed to sleep on their backs (NPM 5A), on a separate approved sleep surface (NPM 5B) and placed to sleep without soft objects or loose bedding (NPM 5C) will be a priority in future funded efforts.

COVID-19 resources for all MCH populations will continue to be posted, updated and widely promoted on the Title V MCH website and staff will continue to be involved with information sharing, data related to MCH populations and COVID-19, and monitoring and technical assistance support to funded partners on adaptations and needs due to COVID-19 impacts. MCH staff will continue to partner with NOMHE on efforts including COVID-19 data related to disparity and equity and distribution of an equity toolkit during COVID-19 under production by NOMHE. A COVID-19 Nevada MCH population data report will be presented to the MCHAB in partnership with the Office of Analytics, and MCAH staff will continue to participate in the CDC Pregnancy Surveillance Module in partnership with the lead entity, the Office of Public Health Informatics and Epidemiology.

MCAH staff will be involved in Newborn Screening Advisory Board and newborn screening and diapering account regulation development. The EHDI and Title V MCH programs work closely together and are co-located in the MCAH Section and will explore possible funded efforts in relation to CCHD and EHDI data collection and capacity development in concert with SSDI staff and the Office of Vital Records.

Breastfeeding Plan

The Title V MCH Program will reach out to all birthing hospitals in Nevada to further assess if there is a continued need of the BS-to-BS Program, which will be re-evaluated based on hospital response.

Efforts will continue to encourage Nevada businesses to sign the *Breastfeeding Welcomed Here* pledge. Title V MCH is managing and promoting the nevadabreastfeeds.org website statewide and in the Breastfeeding Welcome Here Campaign and working on getting more businesses engaged in the campaign. The nevadabreastfeeds.org website was redesigned, and content updated and refreshed to ensure relevant and timely information is provided for breastfeeding families and interested collaborators, including information for CYSHCN. NHV will continue breastfeeding efforts resulting in their above average uptake of breastfeeding as compared to the Nevada population.

Title V MCH will award funds to CCHHS in Northern Nevada to promote the Breastfeeding Welcome Here (BFWH) Campaign. Staff will inform local businesses about Nevada breastfeeding laws, the opportunity to receive placards advising patrons breastfeeding is welcomed at the agency, and the ability to be listed on the Nevadabreastfeeds.org website as a breastfeeding-friendly business.

The Title V MCH Maternal and Infant Health Coordinator will attend Breastfeeding Coalition meetings, as possible and support DHHS postings related to Breastfeeding Week.

Nevada Pregnancy Assessment Monitoring System (PRAMS) Plan

Data collected by PRAMS will be used to monitor the progress of national and state pregnancy and birth-related health measures. PRAMS efforts will also identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants. Nevada PRAMS

was awarded COVID, Opioid and Disability supplemental funding to add questions. Nevada PRAMS staff purchased promotional items such as hot/cold packs, reusable water bottles, pens, tote bags, posters and flyers which will be provided to OBGYN, pediatricians, vital records, and WIC Clinics across Nevada. PRAMS staff will continue to attend Title V MCH Unit and Block Grant meetings, and the programs will continue closely linked efforts. MCH staff serve on the PRAMS Steering Committee.

All Title V MCH subrecipients will continue to have language in their contracts to educate expectant parents about PRAMS. Promotional materials will be disseminated to suitable agencies educating about PRAMS.

Fetal Infant Mortality Review Plan

The Title V MCH Program will continue to fund and MCH staff will continue to serve on the CRT of the FIMR Program to reduce fetal and infant mortality in Washoe County by examining contributing factors of fetal, neonatal, and postnatal deaths including identification of disparately impacted populations and recommendations to improve outcomes and promote equity. FIMR staff will facilitate 8-10 CRT meetings where at least forty cases will be reviewed annually each FFY. Community Action Team updates will continue to be provided at the NNMCH Coalition meetings. The CAT will consider implementing objectives and evaluation components for interventions of policy, systems or community norm changes needed to reduce fetal, neonatal, and postnatal deaths based on case findings, CRT recommendations and community input.

The CRT will also be actively involved in the implementation of activities such as birth spacing initiatives and will continue to promote the Go Before you Show Campaign in Nevada. The CRT will continue to evaluate mortality reduction strategies, maternal substance use challenges, prevention of premature births, disparities, maternal obesity, identification of cases directly or indirectly linked to COVID-19, and other emerging issues.

FIMR staff will continue to participate in Local NNMCH Coalition meetings and events, CDR meetings, Western Regional FIMR, and additional community program activities.

Cribs for Kids/Safe Sleep Plan

The Title V MCH funded Cribs for Kids (C4K) Program will continue activities throughout the state. Train the trainer sessions will continue to be offered statewide with a focus on providing survival kits to rural areas and Tribal Nations across the state. Additional trainings will be provided as requested by partners. Technical assistance will be provided as needed, along with ongoing support to ensure agencies are collecting and entering mandatory data on three and twelve-month follow-up surveys.

Safe Sleep Survival Kits will continue to be distributed through partner agencies statewide. Safe Sleep Survival Kits include a Pack and Play Crib, a crib sheet with the safe sleep message, a Halo Sleep Sack, Safe Sleep ABC photo magnet, Philips Soothie Pacifier, Safe Sleep educational materials (brochure, door hanger, and flyer), a Safe Sleep DVD, and a *"Sleep Baby Safe and Snug"* children's book. Materials will be provided in English and Spanish. Additional funds next Federal Fiscal Year will focus on zip codes of highest risk.

The Title V MCH Program will continue Safe Sleep and Injury Prevention education with Tribal Nations via Indian Health Service clinics and provide funds to support Safe Sleep Survival Kits and car seats in injury prevention efforts. Clinics participate in trainings including Infant Safe Sleep, car seat installation, ASQs, and Abusive Head Trauma. Additional resources will include drowning prevention, tobacco cessation, substance use in pregnancy, car safety, and other Title V MCH resources. All class participants are provided materials to enhance healthy outcomes including safe sleep brochures, Nevada Tobacco Quitline, sobermomshealthybabies.org, PRAMS, Text4Baby, Nevada 211, and the MHP.

The Safe Sleep Media Campaign will continue radio and television public service announcements statewide to promote Safe Sleep for infants. The Title V MCH Director will continue to attend meetings of the Statewide Executive Committee to Review Child Fatalities and will work closely with community partners, the three LHAs, and DCFS to leverage efforts to end preventable infant and child mortality statewide, including SUID.

Perinatal/Infant Health and Wellness Plan

The ASTHO OMNI participation will be replaced by the PRISM efforts to equitably address substance use and addiction and mental health for women, children, and families within the context of the COVID-19 pandemic. State interest in formalizing a statewide perinatal quality collaborative will continue to be explored by Title V MCH staff. PRAMS Data to Action reports will include perinatal outcome areas of interest. Epi360 and CS efforts will continue, as will MCAH participation in pregnancy and COVID and MIS-C efforts led by OPHIE. Perinatal concerns will be addressed in relation to PHP and pediatric planning.

Title V MCH will award funds to CCHHS and DPBH CHS to promote perinatal and infant health in Carson City and rural counties. Staff will educate parents of infants on the value of securing a medical home and being adequately insured, immunizations, safe sleep, breastfeeding and nutrition, well-child checkups, reproductive health, and promotion of Medicaid coverage for long-acting reversible contraceptives immediately postpartum, as well as monitor for symptoms of perinatal and mood anxiety disorder. Clinic personnel will distribute various health-related brochures provided by the Title V MCH Program. Additionally, CCHHS will use digital clinic signage and Facebook social media posts to promote PRAMS, Nevada 211, the MHP, infant immunizations, and Text4Baby.

Child Health

Linked National Outcome Measures

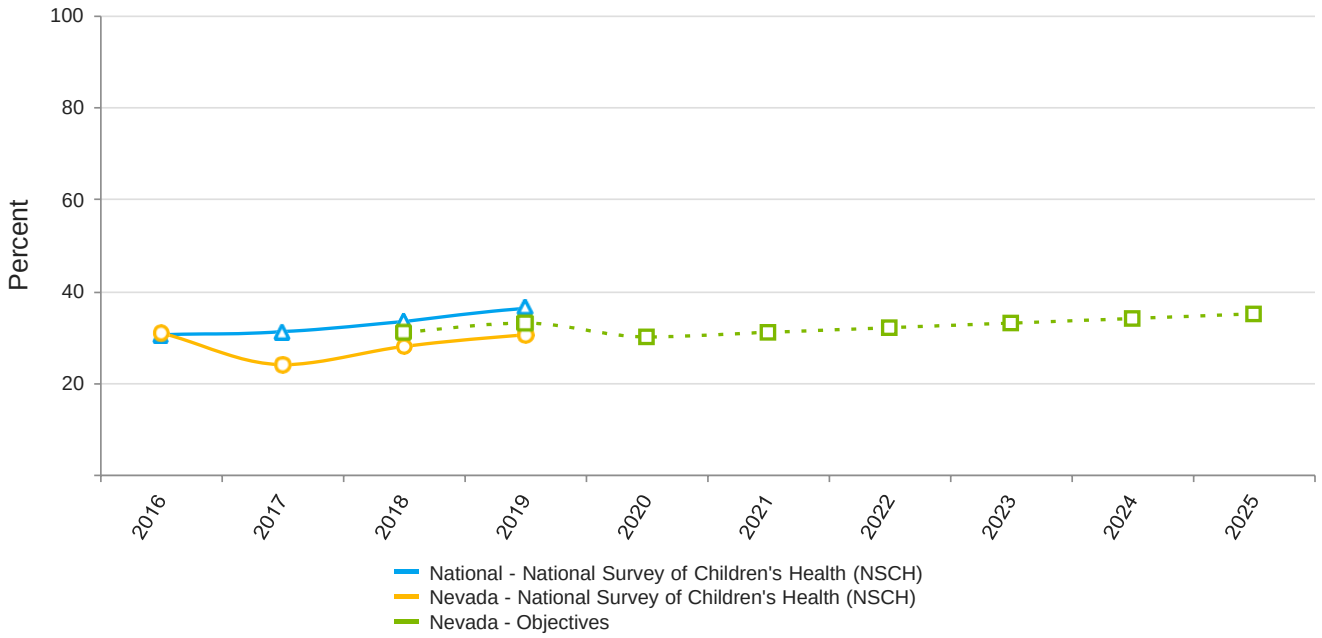
National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	8.5 %	NPM 11 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	39.2 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 6 NPM 8.1 NPM 11 NPM 15
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	12.9 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	11.7 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	12.3 %	NPM 8.1
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	NIS-2016	63.8 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	52.0 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	68.9 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.0 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	87.0 %	NPM 15

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.9 %	NPM 11 NPM 15

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children s Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			31	33	30
Annual Indicator		30.9	24.1	27.9	30.6
Numerator		23,385	19,924	26,239	25,096
Denominator		75,745	82,645	94,028	82,133
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.

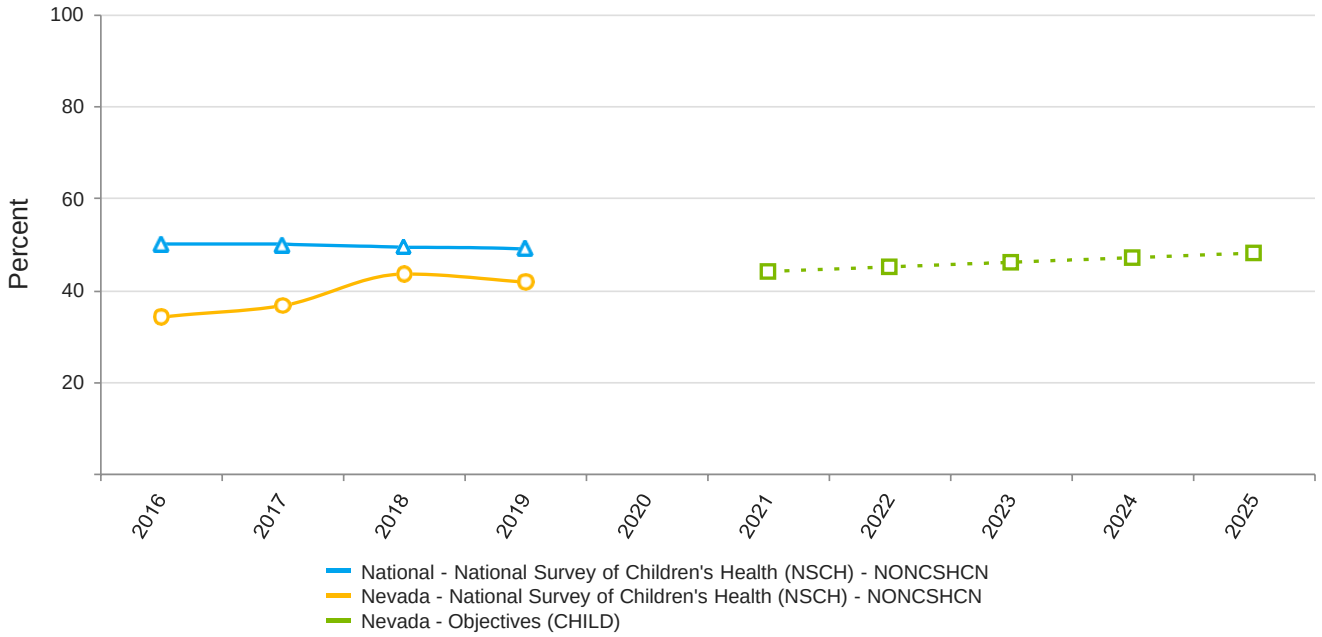
Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			7
Annual Indicator	6.4	7.5	7.5
Numerator	3,358	3,903	3,687
Denominator	52,790	51,977	49,222
Data Source	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	9.0	10.0	11.0	12.0	13.0

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

Indicators and Annual Objectives



NPM 11 - Child Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	43.4	41.8
Numerator	248,300	240,683
Denominator	572,498	576,398
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	45.0	46.0	47.0	48.0	49.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of Nevada Medical Home Portal website views.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			17,000
Annual Indicator	4,838	12,390	64,132
Numerator			
Denominator			
Data Source	Medical Home Portal	Medical Home Portal	Medical Home Portal
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65,000.0	66,000.0	68,000.0	70,000.0	72,000.0	75,000.0

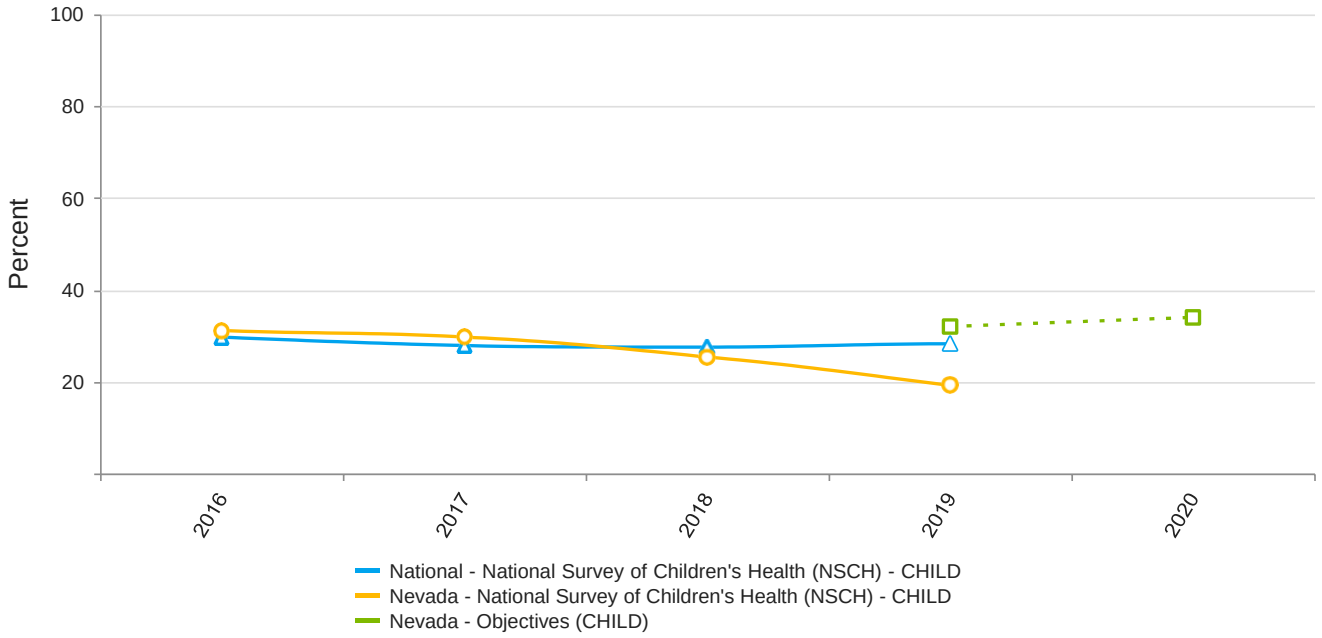
State Action Plan Table

State Action Plan Table (Nevada) Child Health Entry 1	
Priority Need	
Increase developmental screening	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
Increase the percent of children, ages 9 through 35 months, who receive a developmental screening using a parent-completed screening tool to 35% by 2025	
Strategies	
Collaborate with public and private partners to communicate the importance of developmental screenings, including referral to appropriate health professionals	
Collaborate with Title V MCH public and private partners, families of CYSHCN, and providers to conduct outreach to educate individuals, families and communities regarding the benefits of the medical home portal for CYSHCN	
Collaborate with Title V MCH partners to train providers on the parent-completed screening tool	
Collaborate with public and private partners on community events, trainings and other events/activities which include information about the importance of developmental screenings	
Collaborate with Title V MCH partners to promote use of the Medical Home Portal to provide resources for families and health care providers	
ESMs	Status
ESM 6.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

State Action Plan Table (Nevada) Child Health Entry 2	
Priority Need	
Promote a Medical Home	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percent of children with special health care needs with a medical home in the past year to 53.3% by 2020	
Increase the percent of children without special health care needs with a medical home in the past year to 54.8% by 2020	
Increase the number of WIC, Home Visiting, and other program participants that received information on the benefits of a medical home by 20% by 2025	
Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025	
Strategies	
Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc.	
Partner to identify and conduct outreach to CYSHCN groups, including families to promote the availability and benefits of Medical Home Portal	
ESMs	Status
ESM 11.1 - Number of Nevada Medical Home Portal website views.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

2016-2020: National Performance Measures

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



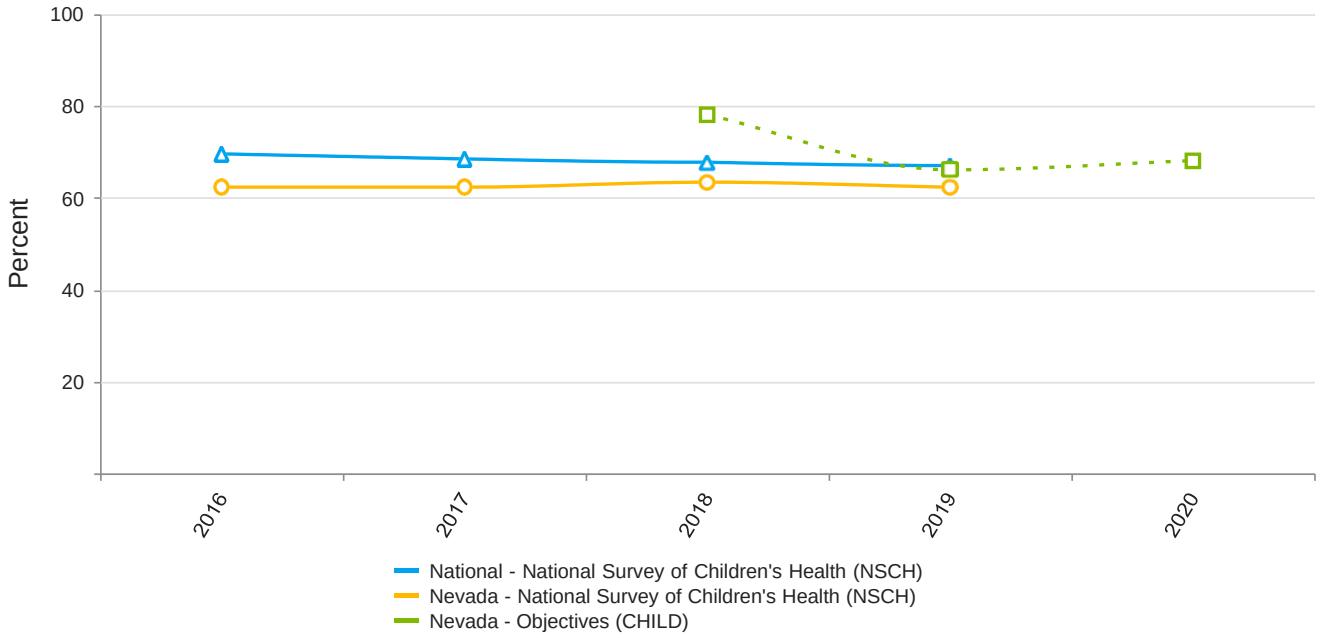
Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2017	**2018**	**2019**	**2020**
Annual Objective			32	34
Annual Indicator	31.0	29.8	25.5	19.4
Numerator	73,747	66,162	54,124	45,602
Denominator	237,722	221,688	212,017	235,095
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 8.1.2 - Number of sites conducting training and technical assistance to early care and education centers to reduce childhood obesity.

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			260
Annual Indicator	266		0
Numerator			
Denominator			
Data Source	State Obesity Prevention and Control Program		NA
Data Source Year	2018		NA
Provisional or Final ?	Final		Final

2016-2020: NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Indicators and Annual Objectives



2016-2020: NPM 15 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	80	68
Annual Indicator		62.2	62.2	63.4	62.4
Numerator		415,085	417,372	429,828	423,713
Denominator		667,147	670,675	678,451	679,500
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

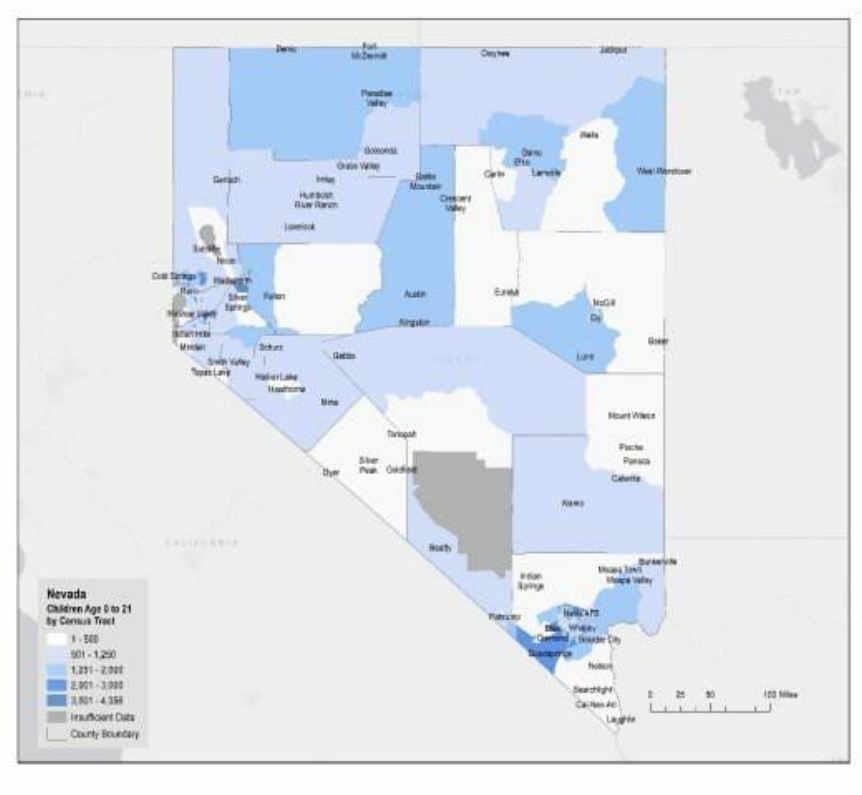
2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 15.2 - Percent of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up.

Measure Status:		**Active**	
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			70
Annual Indicator		40.3	41.2
Numerator		293,607	302,489
Denominator		728,298	734,488
Data Source		Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year		CY 2019	CY 2020
Provisional or Final ?		Final	Provisional

Child Health Annual Report

The Title V MCH Program staff are dedicated to improving child health outcomes by partnering with families and agencies to help children reach optimal growth, psychological development, and overall health. Child wellness was promoted through developmental screens, school-based health center activities, information about the benefits of a medical home and value of adequate insurance, immunization schedules, Bright Futures resources, oral health screenings, physical activity, and weight management. The population distribution by Census tract for children, ages 0 to 21, is indicated in the map below.



To enhance child health outcomes, Title V MCH Program staff selected NPM 6, and NPM 15 to increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (NPM 6) and to increase the percent of children, ages 0-17 y.o. who are adequately insured (NPM 15). Health outcomes are anticipated to improve when developmental screens are conducted and adequate insurance increases consistent medical visits. Additional efforts to improve child health involved medical screenings, collection of survey data about five-year old's for improving early childhood health planning, and referrals made through Nevada 211 and the MHP. Program activities and successes on these efforts are highlighted in the report.

Developmental Screening

The Title V MCH Program sought to increase the percentage of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (NPM 6). According to the NSCH 2018-2019 report, 30.6% of Nevadan children ages 9 through 35 months received a developmental screening using a parent-completed screening tool in the past year compared to 36.4% nationwide.

To improve developmental screening, Title V MCH Program partners provided over 500 community, parent, and

provider education courses statewide concerning developmental milestones and the importance of screening using the Pyramid Model framework. The Pyramid Model is a tiered prevention and intervention framework to avert and address challenging behavior through evidence-based practices. The Pyramid Model consists of four layers:

(1) the foundation, where systems and policies are developed to ensure an effective workforce can adopt and sustain evidence-based practices;

(2) tier one, where universal supports for all children occur through nurturing and response relationships and high-quality supportive environments (behavioral needs of about 80% of children met here) ;

(3) tier two, where prevention through targeted social-emotional strategies is used to prevent problem behaviors (behavioral needs of about 15% of children addressed here); and

(4) tier three, where individualized, intensive interventions comprise the top of the pyramid (required for about 5% of children).

The Children's Cabinet completed over 1,000 and Stages Questionnaire: Social Emotional 2nd Edition (ASQ-SE2) and ASQ 3rd Edition (ASQ-3) developmental screenings. For all participating school district classrooms, a set of materials was provided to support social and emotional skills using the Pyramid Model framework, with most materials provided in English and Spanish. Fact sheets were provided for each family, and some families received additional materials to support their abilities further to teach and support social and emotional skills at home.

The Title V MCH Program also participated in the WIC Developmental Monitoring Project, a joint project between U.S. DHHS, CDC, and the Association of State Public Health Nutritionists (ASPHN), which improves developmental screening in low-income families. The WIC Developmental Monitoring Project helps WIC staff respond to concerns from parents about their child's development, provides an easy way to monitor a child's early development using CDC *Learn the Signs. Act Early* (LTSAE) milestone checklists, help parents set goals related to their child's growth and development, offer parent education about a child's developmental milestones, and provide WIC staff with resources to refer a child when indicated. Title V MCH partners with the NHV Program to help support two local implementing agencies. NHV provides ASQ and ASQ-SE screenings to the families they serve and facilitates resources and referrals to care related to developmental delays. NHV shares Milestone Moments and LTSAE resources with all families they serve in addition to the screenings home visitors provide.

The Title V MCH Program purchased Milestone Moments booklets as part of a multi-agency effort to ensure the University Center of Autism and Neurodevelopment (UCAN) located at UNR can continue statewide screening and distribution of the *Learn the Signs. Act Early* parental screening tool Milestone Moments to increase the percent of children between the ages of 9 to 35 months who received a developmental screening statewide.

Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) 2020 Report • The Children's Cabinet

The Title V MCH Program provides funding to the Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) for Young Children in partnership with The Children's Cabinet. TACSEI is a statewide, collaborative initiative to enhance the ability of early care and education personnel and families to address the social, emotional, and behavioral needs of all young children birth to five years. Using the Pyramid Model, a tiered prevention and intervention framework to prevent and address challenging behavior through evidence-based practices, Nevada TACSEI provides training and technical assistance (TA) to support social emotional competence and address challenging behaviors in young children at-risk for or those with identified developmental delays.

The Title V MCH Program funds three TACSEI staff positions, including the Regional Coordinator (RC), Data and Evaluation Coordinator (D&EC), and Family Engagement Coordinator (FEC). The RC provides leadership, TA, and training to local and regional TACSEI implementation sites and connects with diverse partners to expand potential sites. The D&EC handles data collection and summarization for the ASQ-SE2 and TACSEI evaluation activities. The

FEC is a contractual position in collaboration with the statewide non-profit organization Nevada Parents Encouraging Parents, Parents Educating Professionals, and Professionals Empowering Parents (Nevada PEP).

In addition to MCH funding, The Children's Cabinet has continually strived to expand Pyramid Model implementation and training through new Child Care and Development Fund (CCDF) funding. CCDF now supports three statewide specialists to focus on Pyramid Model entry-level skills and training. The specialists will help to reduce the number of children, particularly children on the childcare subsidy program, being asked to leave their programs either temporarily (suspension) or permanently (expulsion). This additional funding has allowed MCH-funded coordinators to focus on the implementation and demonstration sites and provide statewide coordination and consistency of training and outreach to sites and not the high demand for entry-level training for the larger early childhood community. In addition, CCDF now funds a .5 FTE coach in northeastern Nevada (Wells Family Resource Center), and the statewide TACSEI Coordinator, Janice Lee (located at UNR). The Children's Cabinet is the fiscal agent for these partner positions.

Highlights of The Children's Cabinet and TACSEI

The Northern Nevada Coordinator supported building internal capacity within each site to sustain implementation of Pyramid Model practices to fidelity, conducting developmental screenings and/or assessments for all children in their program, and providing leadership team meeting coordination and direct coaching support. Coordinators worked with ten implementation and eight demonstration sites to conduct developmental screening and/or assessments for all children in their program, including a social emotional screening tool. Due to COVID-19, all sites shut down for several months, and most coaching has been virtual.

The Southern Nevada Coordinator has worked on bringing onboard a new Implementation Site, Cornerstone Christian Academy and Tykes Preschool in Clark County. This center has their Leadership Team in place with community members and parents. The Leadership Team will guide and monitor the implementation of the Pyramid Model in the program.

Coordinators attended 20 site-level leadership team meetings and spent 215 hours of coaching time with implementation and demonstration sites. Coordinators provided most of their coaching focus to Tier 1 (universal) and Tier 2 (prevention) support with 370 hours. Coordinators spent their main coaching hours in these top five categories: leadership team meetings, Teaching Pyramid Observation Tool for Pre-School Classrooms (TPOT) and Teaching Pyramid Infant-Toddler Observation Scale (TPITOS) assessments, data collection, problem-solving discussions, and data review. Coordinators spent their secondary coaching hours in these top five categories: reflective conversation, problem-solving discussion, data review, modeling, and goal setting and action planning.

Nevada TACSEI sites administered over 1,000 ASQ-SE2 and ASQ-3 screens. Statewide, staff provided Pyramid Model training to 480 participants who attended 35 sessions. For Implementation/Demonstration sites, 42 participants attended 5 trainings.

The Children's Cabinet Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) Success Stories

In Southern Nevada, TACSEI collaborates with community partners to provide ongoing support to the Quality Rating and Improvement System (QRIS) sites, coaches, and FEC. They achieve this by promoting practices for all children at the base of the pyramid, for children who need targeted social-emotional supports, individualized behavior support practices at the center levels, and practices for children with significant social skill deficits or persistent challenging behavior at the top of the pyramid.

TACSEI was able to work closely with Sunrise Early Head Start Program in Clark County. All of the centers' directors trained with the E-Pyramid Model and received 18 hours of Nevada Registry approved training. After taking the training, Sunrise received social emotional kits for every classroom. A specialist developed a training on how to use these social emotional kits, and a majority of Sunrise staff took the training. The TACSEI team continues to support Sunrise through sharing resources such as the Children's Cabinet training catalog, National Center for Pyramid Model Innovations (NCPMI) articles and tip sheets, and other applicable other sources. They continue to collaborate with their staff's teaching practices promoting young children's healthy social and emotional development with the Pyramid Model.

Challenging behaviors in early childhood remained persistent and had rising cases during the 2020 COVID-19 pandemic; however, the northern quality specialist was able to continue assisting sites upon request using a variety of ways to connect with sites such as Zoom, phone, email, text and in person support. Raynee Clark was able to support: Summit Ridge Christian Preschool, Roots and Wings, Caughlin Club Kids, One World Children's Academy, Early Learning Center 2, and Kids R Kool, in which each program struggled with multiple challenging behaviors of various levels. Using Pyramid Model tools, she reduced suspensions and expulsions throughout the programs and made the proper referrals to outside resources such as Early Childhood Mental Health.

Professionals are becoming Nevada Registry approved trainers for Pyramid Model in the Northeast region, which is critical to sustainability and immersing knowledge and skills into practice. There are now two staff at Great Basin College, three staff at Head Start of Northeastern Nevada, two staff at NEIS, one staff from The Children's Cabinet, one staff from the Nevada Behavior and Autism Center, and one staff from the Wells Family Resource Center. One additional trainer from Little Peoples Head Start is in the Nevada Registry Trainer application process. In 2020, a TACSEI Day was added to the ECE August Pre-Service. TACSEI began the practice of offering Module 3a for returning staff and Module for new staff (56 participants total) and they will begin the cycle again in February to train any additional new staff and substitute teachers in the Region. There are also three members of the Northeastern implementation sites that have attained degrees in higher education in 2020.

Demonstration and Implementation Sites

Despite all the challenges COVID-19 has brought to the implementation and demonstration sites, they have shown how resilient they can be. Teachers are overcoming obstacles of virtual learning and finding amazing ways to support their families and parents with Pyramid Model tools. Sites utilize resources from NCPMI to do this to continue social and emotional supports while learning from home.

Developmental Screening: Clinical Settings

Title V MCH awarded funding to 13 public health clinics to improve child health. These entities encompassed CCHHS in Northern Nevada and 12 nursing clinics within DPBH CHS providing services in Nevada’s rural and frontier areas. Developmental screens were only conducted as part of well-child visits for uninsured clients. Of the eight screens, seven young children were connected to specialty care through referrals for developmental hearing or vision screenings with findings outside of age-based norms. Families were provided with CDC Milestone Moments booklets or given information on how to access the CDC mobile app tracker to monitor their child’s development.

Children’s Health and Wellness Clinic and Agency Outcomes

Clinic staff from 13 Title V MCH funded clinics (CCHHS and CHS) provided information about the value of adequate insurance, developmental screens, overall child wellness, immunization schedules, oral health, and weight management. The public health clinics refer families with private insurance and Medicaid to primary care providers to establish a medical home with local pediatricians. A CCHHS-created infographic was disseminated at the local WIC office promoting the importance of a medical home. The flier was distributed to 1,322 people presenting for WIC services,

allowing for discussion about the value of a medical home. During the pandemic, WIC staff discontinued in-person visits, and materials were sent through email. CCHHS sent out 366 vaccination reminder cards for children aged four months through 35-months old. Childhood immunizations were endorsed through outreach events and health promotion marketing campaigns, including clinic digital signage. CHS served children within clinic settings and through community outreach events. 3,924 vaccines were administered to 1,853 children and youth ages 0-21 y.o. During outreach events, education, Title V MCH provided resources, and referrals were provided. Prior to COVID-19, fluoride varnish was applied on 168 children.

Title V MCH funded Partners Allied for Community Excellence (PACE) Coalition, to employ a Community Health Worker (CHW) to participate in MCH activities in Elko County and nearby communities to assist underserved populations. Through community events, the CHW distributed educational information provided by the Title V MCH Program, including ways to access resources and/or how to work with local health care professionals to improve child health. Developmental screenings, vaccinations, nutrition, obesity prevention, and well-child visits were promoted, and the CHW helped families enroll their children into Nevada Medicaid/Nevada Check-Up. During the pandemic, staff placed information on the agency Facebook page about child safety and content about child coping tips was inserted into the agency website and sent to their listserv.

School-Based Health Centers

The Title V MCH AHWP Coordinator provided technical assistance to school-based health care facilities intending to support comprehensive services such as primary care, preventive health, vison screens, oral health, screening and lab services, pharmacy, mental/behavioral health, and social services for children and adolescents. Advancements to grow Nevada school-based health services will be realized by the newly approved State Plan Amendment by the Centers for Medicare and Medicaid Services (CMS). This created expanded pathways for Medicaid reimbursement under the existing Provider Type 60 for services provided at public schools for physical, dental, and behavioral/mental health. Nevada Medicaid reimbursements were formerly only available to students with an identified disability receiving specialized school instruction and related services through Individualized Educational Plans (IEP). Nevada has several school-based mental health centers whose clients will greatly benefit from the Medicaid reimbursement expansion.

The AHWP Coordinator participated in bi-monthly calls with other states working to improve School-Based Health Center (SBHC) policies and practices. The special interest group, comprised of adolescent health coordinators managing or working closely with SBHCs, explored how the field is transforming into a new health care delivery model. Staff shared challenges and solutions and successes to highlight what works well in their states. During the pandemic, discussions focused on reaching students and staff clinics, especially in rural and low-income areas, as well as implementing telehealth services and enhanced partnerships with Medicaid for reimbursement.

Collaboration with Child Serving Agencies

MCH staff attended child/adolescent emotional and behavioral health meetings of the Nevada Children's Behavioral Health Consortium and the Adolescent Health Task Force, which decided to join efforts with the Washoe County Children's Mental Health Consortium. Due to COVID-19, the meetings focused on support systems to build childhood resiliency. Topics included providing schools with resources for mental health services and crisis assistance. Other topics included student support apps, ensuring families whose children were living with disabilities receive needed educational and emotional supports and discussions about the advantages and challenges posed by telehealth services.

The AHWP Coordinator serves as the Title V MCH representative on Nevada's state team of the National Comprehensive School Mental Health CoIIN. The state CoIIN efforts led by NDE held an initial two-day meeting at the

end of the reporting period. The partially funded HRSA MCHAB project will focus on supports and services promoting a positive school climate, social-emotional learning, and mental health and well-being while reducing the prevalence and severity of mental illness. The group will assess and address the social and environmental factors impacting physical and mental health. In FFY21, NDE was awarded a school-based mental health grant to increase the number of qualified mental health service providers in school districts with the highest demonstrated need to conduct school-based mental health services.

MCAH staff participated in implementation and evaluation meetings for the Nevada Pediatric Psychiatry Solutions (NVPeds) project. The program led by DCFS offers direct psychiatric care to children and youth. NVPeds aims to integrate emotional and behavioral health care into pediatric primary care settings using telehealth technologies. The project serves pediatric primary care clinicians by providing teleconsultation, care coordination, and training and education to increase capacity to provide emotional and behavioral health care to children and youth.

Nevada Institute for Children's Research and Policy Kindergarten Heath Survey

Title V MCH funded NICRP to conduct an annual health survey of children entering kindergarten in partnership with all school districts. Survey data provides estimates for monitoring MCH indicators and reporting to local, state, and federal entities and informs local efforts on how to improve future programming and child health. The *Health Status of Children Entering Kindergarten in Nevada* annual report (2019-2020 results) was posted on NICRP's website and the agency distributed the report statewide to partners. Title V MCH staff shared the reports with awarded partners, the MCH Coalition and PCO e-newsletters for mass distribution.

NICRP circulated questionnaires to all public elementary schools in the state. NICRP received a total of 7,965 surveys (28.6% response rate) from parents in all 17 school districts. There was a decrease in the response rate compared to the previous year (34.3%), although the same methods for data dissemination were utilized. Distribution in Clark County, the largest Nevada county, was a bit delayed which may have accounted for the decrease. All completed surveys were returned prior to the COVID-19 outbreak resulting in-person school closures. Data were weighted by district to increase state representativeness.

When compared to last year, behaviors in the health status category remain relatively steady with only slight fluctuations. There was a slight increase in reporting of obese children (31.6% to 32.4%), resulting in the second cumulative year increase in rates reporting obesity among children. A slight increase was reported in children drinking non-diet soda once a day or more (6.8% to 7.0%). The percentage of respondents reporting exclusive breastfeeding increased this year compared to last year, especially at 12 months (13.9% to 17.6%), This was the second consecutive year rates improved for infants being exclusively breastfed for both six and 12 months. More respondents reported experiencing no barriers to accessing healthcare compared to last year.

Furthermore, fewer respondents reported transportation, insurance, medical providers, and financial resources as barriers to accessing healthcare. Rates slightly increased for children who had a routine check-up (89.3% to 90.6%) and those who had been to the dentist (77.8% to 79.3%) in the 12 months prior to the survey. More respondents reported trying to access mental health care as compared to last year (6.5% to 7.1%) and 40% of these individuals reported having trouble obtaining the services which was a slight decrease from last year (40% to 40.2%).

Nevada 211

Nevada 211, a program of Money Management International, was awarded Title V MCH funds to provide access to health and social service information and resources for maternal and child health populations and their families. Title

V MCH supports a portion of personnel costs to manage the website and operate the telephone call center connecting people with needed services. Nevada 211 is a special telephone number to provide information and referrals to health and social service organizations. Resources include but are not limited to places to find food, housing, emergency shelter locations, children's services, adoption and foster care, mental health and counseling services, support for seniors, safety for those affected by intimate partner violence, and individuals living with disabilities. Specific services for children include breastfeeding support, diaper programs, childcare and assistance with related expenses, clothing, family support, and respite care.

Nevada 211 call specialists answered 574 calls from individuals inquiring about maternal and child health resources and services. Ninety four percent of the callers were pregnant. Most were insured through Medicaid (72%) with the largest needs being housing, utility, and food assistance. Pregnant people and new parents were provided with information to help improve maternal and infant health outcomes. At the beginning of the pandemic, call specialist staff were overwhelmed by the number of individuals needing access to food and basic supplies such as toilet paper and diapers.

MCH SPECIFIC REFERRALS	COUNTS
Pregnancy Risk Assessment Monitoring System	68
Sobermomshealthybabies.org	4
Text4Baby referrals	40
Perinatal Mood and Anxiety Disorder helpline	5
Nevada Tobacco Quitline referrals	4
Medical Home Portal	35

Title V MCH staff arranged trainings for Nevada 211 call specialists to expand and update their knowledge base of MCH programs. The sessions served as refresher courses for most staff with topics covering information to assist families of children and youth with and without special health care needs. Topic included the Infant Plan of Safe Care for Nevada Plan of Care (CARA), PMAD, Safe Sleep, Text4baby, PRAMS, SMHB website, the MHP, and Nevada Tobacco Quitline.

Nevada 211 provided the University of Utah, Department of Pediatrics with a quarterly export of Nevada 211 agency-level information to be placed into the database supporting Nevada's MHP webpages. A key offering of the MHP is information about local community and professional services to assist families of CYSHCN.

Nevada 211 Success Story

Nevada 211 Call Specialist received a call from single young woman in her first trimester of pregnancy:

> *"Her voice was soft, and she seemed scared. She described herself as a runaway, but at the age of twenty she could leave her parents' home without their permission. However, she left her home without parental approval, and she felt as if she had runaway. She went on to describe the home she left as abusive. She added she felt guilty about leaving her mother and brother. She said she reported her father to Child Protective Services. She claimed he was manipulative, knowledgeable about child abuse, and he skillfully managed to slide by the authorities. She stated she was glad to be away from him, but she didn't know what to do now or where to go. I was able to refer her to a maternity home and youth shelter as well as give resources for Medicaid applications and prenatal care. I explained what happened was not her fault. I told her these people would help her through her crisis. She is very scared and afraid of her father. I informed her she would be given protection there and nobody would give out her information.*

This young lady has many issues she will have to work through. I feel she made a major step in her life and that we helped her with that first, life-changing step."

Title V MCH funded agencies promoted Nevada 211 by providing information to staff and clientele about the value of the service and how to access its resources. CCHHS promoted Nevada 211 through clinic digital signage and social media. Facebook posts reached 6,486 individuals. All DHHS staff include information in their email closings to find help 24 hours a day by dialing 211; texting 898-211; or visiting https://www.nevada211.org/. Title V MCH awarded partners are also required to register and update program information with Nevada 211.

Physical Activity and Nutrition

To enhance child health outcomes, Title V MCH Program staff selected NPM 8 to increase physical activity among children ages 6-11 y.o. The NSCH *2017-2018 Report* revealed 25.5% of Nevadans ages 6-11- y.o. were physically active every day at least 60 minutes per day compared to 27.7% nationally. The percentage of physically active Nevadans decreased to 19.4% in the 2018-2019 report, while the national average increased to 28.3%. Movement and play activities are needed to manage childhood obesity, as well as enhance mental and physical health conditions to prevent chronic diseases. The 2019 Nevada Middle School Youth Behavior Health Survey reported 59.6% of students watched TV, played video or computer games, or used a computer for three or more hours per day showing the need for youth to be more active.

Children's Healthy Weight Collaborative Improvement and Innovation Network (CoIIN)

The Title V MCH Program received technical assistance through the Children's Healthy Weight CoIIN. The learning collaborative, overseen by the Association of State Public Health Nutritionists (ASPHN), supports Title V MCH programs to promote physical activity, breastfeeding, and nutrition through quality improvement practices. The innovative nutrition integration component was the final phase of the CoIIN. Title V MCH staff selected to partner with DPBH programs working on childhood nutrition included WIC, the Obesity Prevention and Control Program (OPCP), and the Office of Food Security and Wellness (OFS). Consequently, Title V MCH staff created a collaborative relationship with the Nevada Supplemental Nutrition Assistance Program – Education (SNAP-Ed) and their network of partners and implementing agencies through the Nevada Nutrition Assistance Consortium. Title V MCH staff partnered with OPCP and OFS to conduct a social media campaign supporting enrollment into the Child and Adult Care Food Program (CACFP) among Early Care and Education (ECE) providers. The campaign to be conducted in FFY21 will address common enrollment barriers as identified in the *CACFP ECE Gap Analysis (2018)*. In Nevada, the CACFP helps childcare settings improve childhood nutrition, prevent obesity, and address food insecurity. CACFP provides reimbursement for healthier meals and snacks served in licensed childcare settings. Nevada has the lowest CACFP enrollment rates in the country despite these benefits. The social media messages will target ECEs providing care to children who are under resourced ages birth to eight years old. Bilingual and culturally relevant messaging will be available for ECE center staff.

Trauma-Informed Yoga

Title V MCH funding supported Urban Lotus Project yoga and mindfulness instruction to help adolescents ages 12-17 y.o. cope with stress. The program also served elementary school-aged children. Urban Lotus Project reports non-Title V MCH funded activities for ages 5-11 y.o. Prior to COVID-19, children were served at four facilities with 168 yoga classes taught to 438 individuals in elementary schools, those residing in a temporary shelter for children who have survived abuse, or mental health treatment facilities. Most students attended multiple yoga classes resulting in 2,412 pupil exposures. COVID-19 significantly impacted the ability to provide yoga instruction and none

of the facilities were able to offer the classes to children after mid-March.

The collaboration with ULP and MCH resulted in two products inside the *AMCHP Innovation Hub* in hopes of replicating the success of this effort elsewhere, allowing adolescents to reap the benefits of the specialized yoga and mindfulness instruction. The promising practice is housed inside *AMCHP's MCH Innovations Database* and showcased as one of the NPM 8 adolescent physical activity implementation toolkits. https://create.piktochart.com/output/44298021-npm-8-disseminating-tools-and-resources. Furthermore, ULP became a Champion of the National Youth Sports Strategy (NYSS), promoting youth sports participation. NYSS is organized by the US Department of Health and Human Services through the Office of Disease Prevention and Health Promotion's Physical Activity Program.

COVID-19 Efforts

COVID-19 guidelines requiring masks to be worn in public can pose communication barriers for individuals who are deaf and hard of hearing (D/HH). Title V MCH funded the purchase of face masks with a clear window to six school districts and two partners working with children or parents who are D/HH. The transparent section of the mask allows the wearer's lips to be visible, making lip-reading and the speaker's facial expressions possible.

MCAH staff added COVID-19 MCH population related content into the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. Materials contained Nevada's response to the pandemic, as well as information and resources for children with and without special health care needs, in addition to all other populations served by the award. Identified links sent viewers to the CDC COVID-19 resources in American Sign Language via YouTube and Spanish language content. The CDC materials and placement of the links were shared widely with funded partners and collaborators. The statewide MCH Coalition and PCO disseminated the materials through listservs.

In FFY 21, all Title V MCH staff requested all funded partners promote the Nevada Resilience Project, helping individuals and families with children experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, text, and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Additionally, state staff shared the launch of two Nevada 211 mobile apps to help Nevadans connect with needed resources in response to the pandemic. The Nevada 211 Youth app complements the initial one for individuals and families. It specifically helps young people locate services and resources such as health care, crisis support, employment services, food pantry locations, and emergency housing programs.

Child Health Domain Accomplishments

Title V MCH focused on improving the health status of children to reduce negative long-term implications for health, productivity, and longevity. Despite challenges posed by the pandemic, funded partners could dedicate efforts to help children reach optimal physical growth, psychological development, and overall health. MCAH staff added COVID-19 child health and wellness-related content into the DPBH website and shared pandemic information and resources with partners pertinent to children with and without special health care needs. Parents/caregivers, providers, and partners received best practice information about developmental screens, school-based health services, benefits of a medical home and value of being adequately insured, immunization schedules, oral health screenings, and physical activity and weight management.

The Health Status of Children Entering Kindergarten in Nevada annual report revealed increases in exclusive breastfeeding, especially at 12 months. More respondents reported experiencing no barriers to accessing healthcare and trying to access mental health care. MCAH staff created new partnerships with state agencies to build childhood resiliency due to gaps identified in the Title V Five-Year Needs Assessment. Furthermore, COVID-19 necessitated collaboration to

leverage program information and resources.

Child Health Data

NPM 6- Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

According to the 2018-2019 NSCH, 30.6% of Nevadan children ages 9 through 35 months received a developmental screening, which is up from 27.9% in 2017-2018. Nevada is below the 2018-2019 national average of 36,4%, and ranks 33rd out of the 50 states and D.C.

NPM 8.1- Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

The 2018-2019 NSCH shows the percent of Nevadan children who are physically active at least 60 minutes per day is 19.4%. This percentage has been steadily declining since 2016, when it was 31%. Nevada is significantly lower than the 2018-2019 national average of 28.3%, and ranks last out of the 50 states and D.C. While race and ethnicity data are limited for this measure, Non-Hispanic Multiple Race (33.3%) and Non-Hispanic White (21.9%) children are more likely to be physically active than Hispanic children (13.6%).

NPM 15- Percent of children, ages 0 through 17, who are continuously and adequately insured

According to data from the NSCH the percent of children who are continuously and adequately insured has remained stable from 2016 to 2018-2019 at 62.4%. This is significantly lower than the 2018-2019 U.S. national average of 66.8%, and Nevada ranks 43rd lowest out of the 50 states and D.C. Disparities exist in Nevada for this measure, as Non-Hispanic Black children are least likely to be continuously and adequately insured (54.9%). Hispanic children are also slightly below the Nevada average at 61.6%. Non-Hispanic White, Non-Hispanic Asian, and Non-Hispanic Multiple Race are above the Nevada average, at 62.8%, 65.1%, and 70.2% respectively.

Child Health – Plan for Application Year

Developmental Screening

The Children's Cabinet will be awarded Title V MCH funds for developmental screenings using the Pyramid Model framework. The ASQ-SE2 and ASQ 3rd Edition (ASQ-3) developmental screenings will continue statewide, focusing on Nevada's frontier and rural areas. Online implementation of ASQ-SE2 and ASQ-3 screenings will be available, along with promoting the *Learn the Signs. Act Early* campaign. Nevada WIC staff will provide resources to refer a child when indicated. Families will be provided with Milestone Moment booklets in English and Spanish or given information on accessing the CDC mobile app tracker to monitor their child's development. MCH will participate in a statewide co-funded effort led by UNR related to printing and distributing Nevada-customized CDC Milestone Moments booklets.

The Children's Cabinet and Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI)

The Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) will continue to focus on frontier and rural areas of the state. TACSEI will meet with staff at private, religious, charter, public, preschools, and daycares to implement screenings and programs. The Family Engagement Coordinator (FEC) will continue to conduct technical assistance (TA) and training based on the Pyramid Model to personnel within organizations serving CYSHCN 0-5 years of age. The FEC will also continue to facilitate parent involvement in TA development, implementation, and evaluation to support family engagement in early care and education settings. The Regional Coordinator (RC) and fellow TACSEI staff will attend summit and leadership meetings to increase program reach. Online implementation of the ASQ-SE2 screenings and data collection will continue, along with the distribution of Milestone Moment booklets in English and Spanish. Through CCDF funding, The Children's Cabinet contributed $5,000 towards the reprinting of these booklets and our Reno, Elko and Las Vegas offices all serve as statewide distribution locations for these booklets.

Children's Health and Wellness

Title V MCH will award funds to CCHHS in Northern Nevada and DPBH CHS providing care in each rural county to promote child health. Staff will educate parents/caregivers of children on wellness, the value of securing a medical home and being adequately insured, yearly well-child checkups, immunization schedules, and oral health screenings. Clinic personnel will distribute various child health-related brochures provided by the Title V MCH Program. CCHHS will promote Nevada 211, the MHP, and childhood immunizations through clinic digital signage and Facebook social media posts.

The Title V AHWP Coordinator will continue to attend several emotional, behavioral, and mental health collaboration meetings to improve childhood resiliency. Discussions will focus on school and community resources for mental health services and crisis assistance, ensuring families whose children are living with disabilities receive needed educational and emotional supports, and creating linkages between state programs to help best serve those in need. The Title V MCH staff will participate in a project with state agencies to build an interconnected system framework focused on increasing childhood resiliency. The project will develop a system to align state program efforts, identify areas of strengths, and create an action plan to improve child and adolescent emotional well-being.

School-Based Health Centers

The AHWP Coordinator will continue to provide technical assistance on the School-Based Health Center (SBHC) certification process and promote the Nevada SBHC Toolkit. The AHWP Coordinator will also encourage comprehensive services, including primary care, preventive health, vision screens, oral health, screening and lab services, telehealth, pharmacy, emotional and behavioral health, and resources to social service agencies. This staff member will continue to serve as the Title V MCH representative in a learning collaborative led by the Department of Education, to enhance mental health supports and services towards positive school climates, social emotional learning, mental health, and well-being. The AHWP Coordinator will continue to strengthen partnerships with state agencies to build childhood resiliency.

Nevada Institute for Children's Research and Policy

In partnership with all Nevada School Districts, the NICRP will conduct an annual health survey of children entering kindergarten with funding from the Title V MCH Program. The *Health Status of Children Entering Kindergarten in Nevada* annual report will be posted on NICRP's website and distributed to partners statewide.

Nevada 211

Nevada 211 will continue to be Title V MCH funded to provide information on health and human service programs throughout the state, including physical, behavioral, socio-emotional, and mental health resources, and support for families of children with and without special health care needs. Nevada 211 will provide quarterly data exports to the University of Utah, Department of Pediatrics for the MHP. All Title V MCH subrecipients will have language in their contracts to include updating agency information with Nevada 211 resources and promoting Nevada 211 services.

Trauma-Informed Yoga

Title V MCH will continue to support Urban Lotus Project (ULP) yoga and mindful awareness instruction to help adolescents with and without special health care needs to cope with stress and promote trauma-informed care to agencies serving children and youth. The Title V MCH funded Innovation Station project will focus on adolescents ages 12-17y.o.; however, ULP will continue serving elementary school-aged children and provide Title V MCH with data about children served.

Adolescent Health

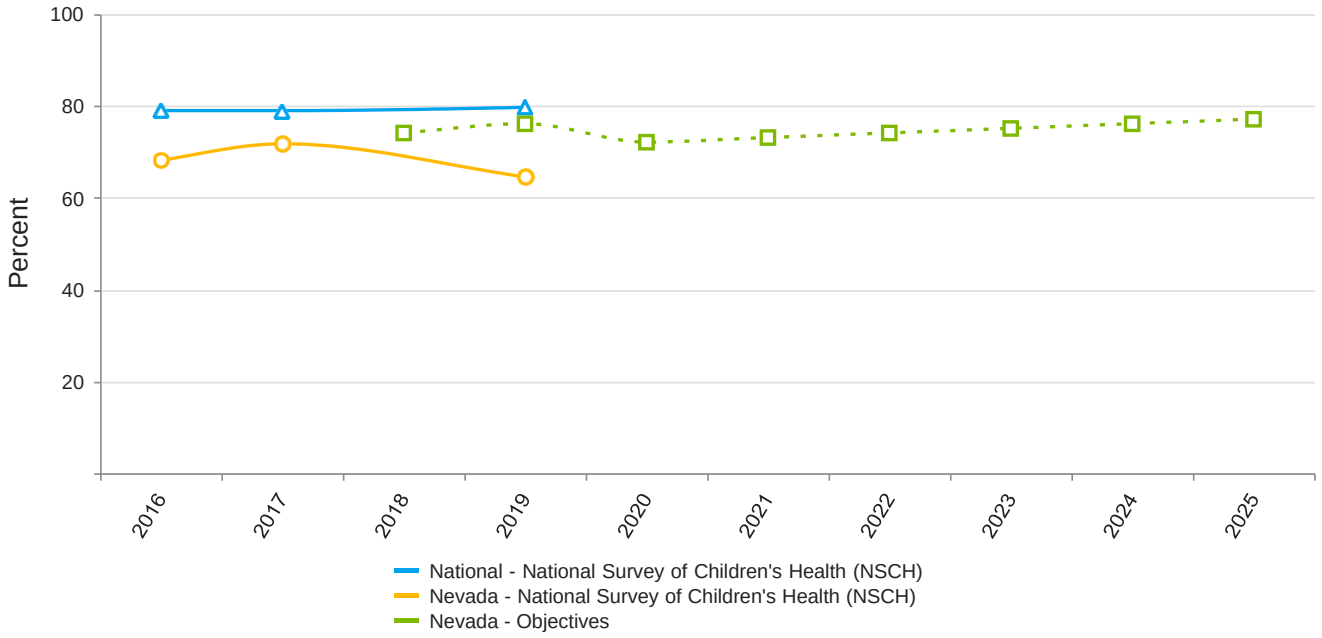
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	29.9	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	9.7	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	15.6	NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	8.5 %	NPM 10 NPM 12 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	39.2 %	NPM 10 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 8.2 NPM 10 NPM 15
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	12.9 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	11.7 %	NPM 8.2 NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	12.3 %	NPM 8.2 NPM 10
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	NIS-2016	63.8 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	52.0 %	NPM 10 NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	68.9 %	NPM 10 NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.0 %	NPM 10 NPM 15

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	87.0 %	NPM 10 NPM 15
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	18.9	NPM 10
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.9 %	NPM 15

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children s Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			74	76	72
Annual Indicator		68.2	71.7	71.7	64.5
Numerator		145,792	164,488	164,488	143,969
Denominator		213,715	229,387	229,387	223,281
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures

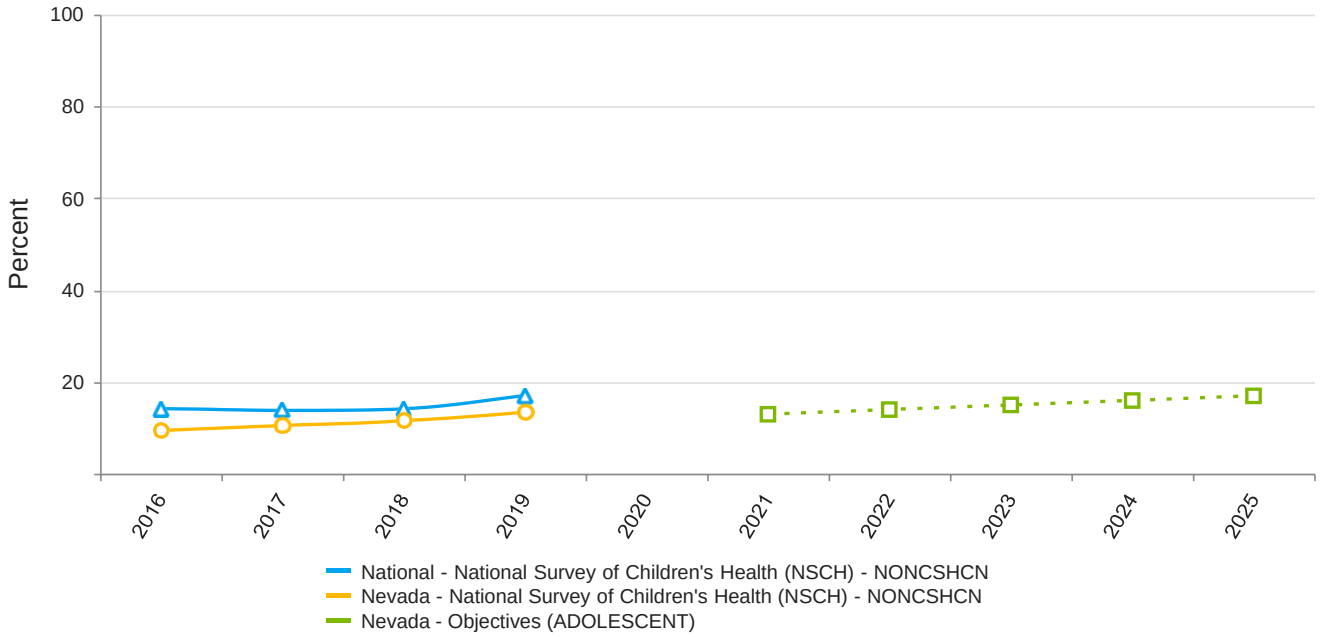
ESM 10.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			26
Annual Indicator	32	24	31
Numerator			
Denominator			
Data Source	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	13.5
Numerator	21,585	23,357
Denominator	186,655	173,474
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	13.0	14.0	15.0	16.0	17.0	18.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	55.0	60.0	65.0	70.0	70.0

ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	50.0	60.0	65.0	70.0

State Performance Measures

SPM 3 - Repeat teen birth rate

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		16	16	15	15
Annual Indicator	16.6	22.9	22.4	16.4	14.3
Numerator	339	436	395	275	221
Denominator	2,040	1,901	1,762	1,679	1,543
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	14.0	14.0	13.0	13.0	12.0	12.0

SPM 4 - Teenage pregnancy rate

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	29	25	24	21
Annual Indicator	25.9	24.4	21.3	16.9
Numerator	2,485	2,377	2,124	1,758
Denominator	96,038	97,485	99,599	104,108
Data Source	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	19.0	18.0	17.0	16.0	15.0

State Action Plan Table

State Action Plan Table (Nevada) Adolescent Health Entry 1	
Priority Need	
Improve care coordination among adolescents	
NPM	
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	
Objectives	
Increase the percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year to 77% by 2025	
Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025	
Reduce repeat birth rate among adolescent females, ages 15 to 19, to 12 repeat births per 1,000 by 2025	
Strategies	
Collaborate with public and private partners to provide adolescents, ages 12 through 17, with information on the benefits available and link them to appropriate health care coverage options	
Collaborate with public and private partners to conduct outreach, education, and eligibility assistance to promote utilization of family planning and link women to appropriate health services, vaccinations, screenings (breast and cervical cancer, substance use/misuse, behavioral/mental health, postpartum depression, etc.), LARC, and use of 1-key question	
Collaborate with public and private partners on activities focused on teen pregnancy prevention, bullying, rape and sexual assault prevention, suicide, and other factors that negatively impact health	
Coordinate with partners and local health authorities to enhance the quality of adolescent clinic environments	
ESMs	**Status**
ESM 10.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen	Active

NOMs

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

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

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

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

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

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

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

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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

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

State Action Plan Table (Nevada) Adolescent Health Entry 2

Priority Need

Increase transition of care for adolescents and CYSHCN

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

Increase percent of children with special health care needs ages 12 through 17, who received services necessary to transition from pediatric to adult health care to 16% by 2025

Increase percent of children without special health care needs ages,12 through 17, who received services necessary to transition from pediatric to adult health care to 17% by 2025

Strategies

Coordinate with partners and local health authorities to improve the messaging of transition care.

Collaborate with public and private partners to provide adolescents, ages 12 through 17, with information on the benefits available and link them to appropriate health care coverage options

Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy.

ESMs	Status
ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition	Active
ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition	Active

NOMs

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

State Action Plan Table (Nevada) Adolescent Health Entry 3

Priority Need

Improve care coordination among adolescents

SPM

SPM 3 - Repeat teen birth rate

Objectives

Reduce repeat birth rate among adolescent females, ages 15 to 19, to 12 repeat births per 1,000 by 2025.

Strategies

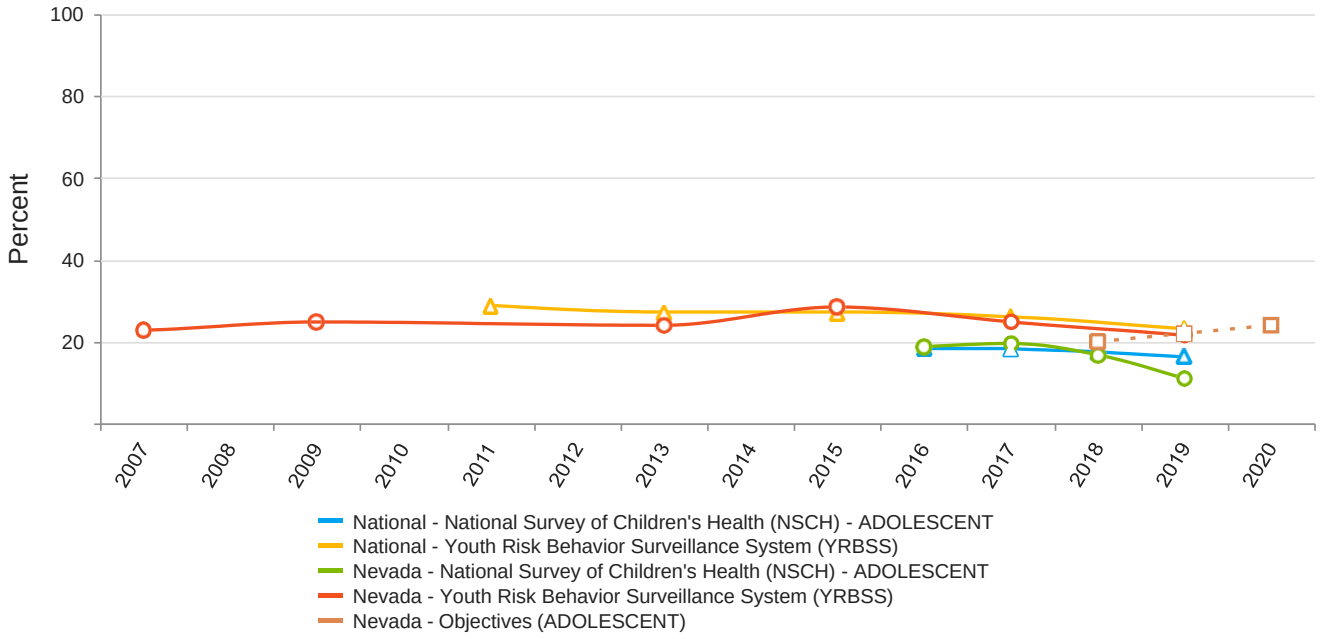
Collaborate with the Sexual Risk Avoidance Education (SRAE) Program and the State Personal Responsibility Education Program (PREP).

Collaborate with community partners on educational campaign focused on decreasing teen pregnancy and repeat pregnancy.

State Action Plan Table (Nevada) Adolescent Health Entry 4
Priority Need
Improve care coordination among adolescents
SPM
SPM 4 - Teenage pregnancy rate
Objectives
Reduce pregnancies among adolescent females, ages 15 to 19, to 16 pregnancies per 1,000 by 2025
Strategies
Collaborate with the State Sexual Risk Avoidance and Education (SRAE) Program and the State Personal Responsibility Education Program (PREP) on positive youth development, Sexually transmitted infection (STI) reduction and teen pregnancy reduction.
Collaborate with community partners on resource sharing related to decreasing teen pregnancy.

2016-2020: National Performance Measures

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	16	18	20	22	24
Annual Indicator	28.6	28.6	24.9	24.9	21.7
Numerator	34,940	34,940	33,324	33,324	27,320
Denominator	122,356	122,356	134,051	134,051	126,074
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			20	22	24
Annual Indicator		18.7	19.6	16.8	11.1
Numerator		39,329	44,325	37,886	23,534
Denominator		210,143	226,517	225,199	212,773
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

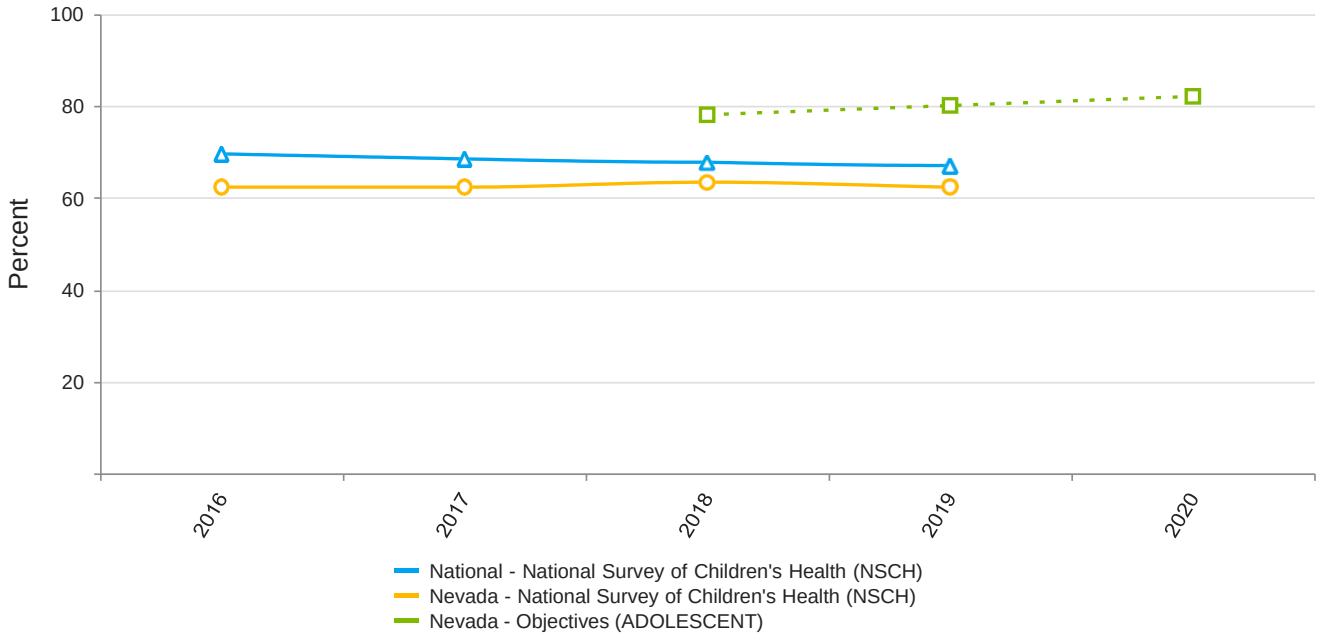
2016-2020: ESM 8.2.1 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			14	16
Annual Indicator	9	13	18	5
Numerator				
Denominator				
Data Source	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program
Data Source Year	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: ESM 8.2.2 - Number of unique visitors to MCH social media including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			105,000	110,000
Annual Indicator	99,000	131,396	117,179	141,486
Numerator				
Denominator				
Data Source	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program
Data Source Year	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Final	Final	Final	Provisional

2016-2020: NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Indicators and Annual Objectives



2016-2020: NPM 15 - Adolescent Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	80	82
Annual Indicator		62.2	62.2	63.4	62.4
Numerator		415,085	417,372	429,828	423,713
Denominator		667,147	670,675	678,451	679,500
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 15.2 - Percent of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up.

Measure Status:		**Active**	
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			70
Annual Indicator		40.3	41.2
Numerator		293,607	302,489
Denominator		728,298	734,488
Data Source		Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year		CY 2019	CY 2020
Provisional or Final ?		Final	Provisional

Adolescent Health Annual Report

Adolescence is a time of remarkable opportunity and growth. Starting at age 10, young people discover, learn from, and adapt to the world around them. They forge a sense of who they are, aspire to be, remember to make decisions, manage emotions, and create deeper connections with peers and others. During this time, adolescents build resilience, develop interests, passions, and meaningful goals shaping their adult lives. Their developing brains are well suited to these tasks, but the systems serving them are often not.

The health status of adolescents is a key determinant for adult health, productivity, and longevity. Adolescence, the transition from childhood to early adulthood between 10 and 19 years old (y.o), is critical in human development. While adolescence may appear to be a relatively healthy period of life, health patterns, behaviors, and lifestyle choices made in adolescence have important implications over time. Habits and behaviors frequently started during adolescence related to healthy weight management, exercise, sexual behavior, nicotine/tobacco/vaping, alcohol, and substance use can impact the risk of unfavorable health outcomes in the short- and long term. Mental health disorders and related conditions often surface during adolescence and are best addressed early to ensure optimum health. MCH staff use the public health approach by addressing risk factors decreasing the likelihood of adverse health outcomes in youth.

Best practice youth-friendly resources were shared to improve adolescent health and wellness outcomes. The materials included unique activities and tips to address health and wellness, health insurance, self-advocacy, and health literacy. The content was shared with the Title V MCH Program CYSHCN Coordinator, Title V funded agencies, community organizations, and health care providers. Additionally, the state SRAE and PREP Programs distributed materials to enhance programming at youth-serving non-medical agencies. Best practice materials disseminated were created by agencies such as Bright Futures, Got Transition, Adolescent Health Initiative, Adolescent and Young Adult Health National Resource Center, and AMCHP. Materials highlighted adolescent well-visits, youth-friendly services, adolescent risk screening, the transition from pediatric to adult health care, COVID-19 impact on youth emotional health and well-being, and other pertinent topics to enhance the provision of adolescent care.

To improve adolescent health outcomes, Title V MCH Program has been working to enhance adolescent health and wellness through NPM 15, NPM 12, NPM 10, and NPM 8. Title V MCH sought to increase the percentage of children, ages 0-17-years old (y.o) who are adequately insured (NPM 15). MCH staff also strived to expand the percent of adolescents with and without special health care needs, ages 12 – 17 y.o, who received services necessary to make transitions to adult health care (NPM 12). Other goals include increasing the percent of adolescents, ages 12-17 y.o. with a preventive medical visit in the past year (NPM 10); and increasing the percent of *adolescents, ages 12 – 17 y.o. who* are physically active at least 60 minutes a day (NPM 8). Health outcomes are anticipated to improve when youth are adequately insured, possess health literacy, receive yearly wellness visits, and are physically active. Program activities and successes on these efforts are highlighted in the report.

Well-Visits

The 2019 NSCH showed 64.5% of Nevadans, ages 12-17- y.o., received a preventive health visit, compared to 79.6% nationwide. Efforts to increase preventive medical visits included partnering with outside agencies to increase the percent of children, ages 0-17 y.o. who are adequately insured (NPM 15). The 2018-2019 NSCH revealed 57.5% of Nevadans ages 12-17- y.o. had adequate and continuous insurance coverage compared to 63.5% nationwide. It is essential to ensure adolescents receive recommended health screenings to address

physical, emotional, cognitive, and social changes which can have a lasting impact on their lives. As of 2013, most insurance plans cover preventive health services for adolescents with no out-of-pocket cost, as mandated by the ACA. These no-cost preventive health visits include alcohol, drug, tobacco/nicotine/vaping use screening; behavioral health and depression assessments; reproductive health and sexually transmitted infection prevention counseling and screening; administration of age-recommended vaccines; and obesity management.

To increase access to care, the AHWP disseminated 17,325 brochures (9,175 English/8,150 Spanish) highlighting the value of yearly adolescent checkups and how to apply for health insurance. Primary distribution partners included DWSS, DCFS, Nevada Health Link (state online Marketplace), Title V MCH funded partners, and community agencies working to enhance the uptake of yearly adolescent well-visits. Due to COVID-19, the distribution count of brochures was 44% less than the previous year since agencies were primarily conducting business online or through telephone. All distribution partners received electronic links to the documents for posting on their websites or dissemination to their listservs.

Title V MCH awarded funding to DP Video to arrange promotional efforts to increase the percentage of yearly adolescent well-visits through video posts on Facebook, Instagram, and Twitter targeting youth and parents/caregivers. Campaign messaging was pilot tested by Nevada youth of various socioeconomic and cultural backgrounds, including those living with special health needs. All English and Spanish messages reached targeted ages, racial and ethnic groups, and met CLAS standards. The messages accommodated individuals with visual impairments via descriptions of images on the video screens. Six video ads (three each in English and Spanish) displayed on Twitter resulted in 493,656 media impressions. Facebook led to 540,946 media impressions, 30,217 video views, and 1,414 engaged users.

Health Care Transition

According to the 2018-2019 NSCH, 8.3% of CYSHCN in Nevada received services necessary to transition to adult health care compared to 22.9% nationwide. This gap between Nevada and the nationwide average has widened from 2017-2018, when the percentages were 10.3% and 18.9%, respectively. Similarly, for non-CYSHCN in Nevada, 13.5% received services necessary to transition to adult health care compared to 16.9% nationwide. Thus, Title V MCH selected *NPM 12: percent of adolescents with and without special health care needs, ages 12 – 17 (y.o), who received services necessary to make transitions to adult health care,* as a new priority measure to align with Title V MCH staff's desire to empower youth with and without special health care needs to engage in their health care as they transition into adulthood.

The AHWP and CYSHCN Programs initiated a new collaborative partnership with the Title V MCH-funded partner DP Video Productions for a social media campaign on health care transition and health literacy. DP Video arranged for the promotional efforts of health care transition video posts on Facebook, Instagram, and Twitter, using the state-operated Nevada Wellness website. DP Video conducted a month-long social media campaign displaying videos and messages promoting the concept of youth learning how to advocate for themselves instead of relying on parents/caregivers to meet all these needs. English and Spanish messages contained video descriptors for the visually impaired. The campaign met the targeted audience of adolescents and families with teens. Six video ads were displayed on Twitter, resulting in 500,633 media impressions. Facebook led to 133,154 views, 275,751 media impressions, and 50,640 engaged users.

Collaboration with Youth-Serving Agencies

The AHWP Coordinator engaged with other state staff through the National Network of State Adolescent Health Coordinators. The AHWP Coordinator also participated in bi-monthly calls with Region IX states and quarterly calls with Regions VIII, IX, and X. The calls focused on how best to serve adolescents, state policies to include youth in

the workforce, challenges and solutions faced by the pandemic, and state program successes. Furthermore, the AHWP Coordinator attended several adolescent-focused conferences and webinars and shared highlights with funded partners and youth-serving agencies across the state.

Several DPBH programs cross over into each other's field of expertise, including prevention and education surrounding sexual and intimate partner violence, teen pregnancy, sexual risk avoidance education, obesity, food security, tobacco/nicotine/vaping, suicide, substance use, and emotional and mental health. The Topical information was shared with Title V MCH funded partners and DPBH adolescent-focused programs about upcoming webinars and training, round-table discussions, community events, new publications, and youth-focused materials. The AHWP Coordinator disseminated adolescent-focused health information through the statewide MCH Coalition and state PCO e-newsletters. Topics included but were not limited to emotional and behavioral health, tips to deal with isolation and uncertainty during the pandemic, adolescent-centered care, and health care transition from pediatric to adult care.

MCAH staff served on the Youth Advisory Council through the NVPCA Healthy Tomorrows Partnership for Children Program (HTPCP) grant. The HTPCP project collaborated with Title V MCH to improve adolescent well-visits rates in FQHCs. The AHWP Coordinator shared social media content for posting on FQHC's Facebook pages. Topics included the value of adolescent well-visits, health care transition awareness, youth engagement in physical activity, and adolescent emotional well-being during COVID-19. This staff member organized a demonstration for several FQHCs on the Rapid Adolescent Prevention Screening (RAAPS) electronic risk assessment tool to promote its use during well-visits. Unfortunately, due to COVID-19, discussions about implementing the screening tool during clinic well-visits were placed on hold.

The AHWP Coordinator serves on Nevada's state team of the National Comprehensive School Mental Health CoIIN. The state CoIIN efforts led by NDE held its initial two-day meeting at the end of the reporting period. The partially funded HRSA MCHAB project will focus on supports and services promoting a positive school climate, social-emotional learning, mental health, and well-being while reducing mental illness prevalence and severity. The group will assess and address the social and environmental factors impacting both physical and mental health. In FFY21, NDE was awarded a school-based mental health grant to increase the number of qualified mental health service providers providing school-based mental health services to students in school districts with demonstrated needs.

Title V MCH funded a School Wellness Coordinator position to strengthen existing collaborations between MCAH and NDE, the state Nutrition Unit, NSIP, and the CDPHP Section. Collaborative efforts occurred within the Nevada Department of Agriculture and school districts to support the Nevada School Wellness Policy and integration of behavioral and mental health through the School Mental Health Partnership. MCAH staff sat on the Department of Education Health Standards development team.

Youth Engagement

The AHWP Coordinator attended webinars and conferences to learn best practices of authentic youth engagement to prepare Nevada for future planning and implementation. The staff member participated in the HRSA teaching series focused on engaging specific populations in Title V MCH funded activities and programs discussing genuine participation and authentic voice and youth advisory councils' use. The AHWP Coordinator took an interactive adolescent-focused motivational interviewing course to further skills in empowering youth. Handouts and PowerPoint presentations from webinars and meetings were shared with Nevada youth-serving agencies, including youth advisory councils such as Healthy Young NV and the Nevada chapter of Youth MOVE.

Pregnant and Parenting Teens

MCAH partners with agencies serving pregnant and parenting teens through work conducted by NHV, the Maternal

and Infant Health Program, Title V MCH, AFP, and PREP. The NHV Program serves young adult families to improve health outcomes, promote breastfeeding, increase developmental screening, and reduce teen pregnancy and substance use.

Clinic Adolescent Health and Wellness Outcomes

Thirteen public health clinics were awarded Title V MCH funding to promote adolescent health and wellness. These entities encompassed CCHHS in Northern Nevada and 12 nursing clinics within DPBH CHS providing services in Nevada's rural and frontier areas. During clinic visits, adolescents were screened for risk behaviors, including nutrition and weight management, depression, intimate partner violence, alcohol, drug, and tobacco/nicotine/vaping use through Bright Futures Brief Risk Assessment tools. Age-appropriate education and counseling were conducted along with referrals, as needed. Education to avoid sexually transmitted infections (STIs) and communicable diseases and treatment protocols followed CDC guidelines. Clinicians were mandatory reporters and educated in recognition of patients at risk for human trafficking, neglect, and abuse and trained in the delivery of culturally competent care, including the provision of services to those in non-traditional relationships. Adolescents were screened for sexual coercion and encouraged to include family engagement in discussions regarding sexual decisions. Services were customized to the individual based on age and SDOH.

Through 2,313 clinic visits, adolescents were educated on wellness and the value of yearly visits. Reporting criteria to Title V MCH varied by the funded agency. CCHHS revealed among the 199 adolescent well-visits, education and referrals were made to 46 who use alcohol, 49 who use substances, nine adolescents affected by intimate partner violence, and 18 experiencing depression. CCHHS reported race and ethnicity; however, 13% of the clientele declined to specify. Of those reporting, 63% identified as White and 38% identified as Hispanic.

Additionally, CCHHS conducted reminder telephone calls for adolescents delayed in age-appropriate vaccinations. CHS provided 262 adolescent well-care visits, 383 nutrition and weight management counseling sessions, and referrals were made to five experiencing depression. Title V MCH activities resulted in 236 identified STIs and delivery of 451 contraceptives. CHS provided flu and adolescent immunizations in clinic settings and at outreach events. During clinical visits, staff distributed diverse adolescent health-related brochures. Title V MCH provided materials covering the benefits of being adequately insured, the value of annual well-visits, health care transition awareness, reproductive health, sexually transmitted infections, depression, intimate partner violence prevention, tobacco/nicotine/vaping cessation, and nutrition.

CCHHS and CHS clinic staff were provided Title V MCH funds to enhance the quality of adolescent clinic visits and grow the number of adolescents and their families receiving health care transition information. Activities were implemented to create adolescent-friendly clinic environments through staff training and quality improvement tools. CCHHS and CHS managers used best practice materials from the Adolescent Health Initiative to train staff using *Starter Guides* (mini toolkits) and *Spark* trainings. Clinic staff handed out one-page information sheets from www.GotTransition.org, educating young people and their parents/caregivers about the steps necessary to navigate the transition from pediatric to adult health care system. Health care transition education engages and empowers adolescents and young adults to advocate for themselves by breaking down health and wellness, insurance coverage, and self-advocacy in a way they can easily understand. In FFY21, staff will learn Got Transitions Six-Core Elements of Health Care Transition through downloadable materials and partake in a six-session interactive Project ECHO webinar series, complete with case-based discussions. The online course series is being offered using Title V MCH funds through an award provided to NCED.

The AHWP Coordinator organized a demonstration of best practice tools to strengthen CCHHS and CHS' presence as adolescent-focused medical homes. The Adolescent-Centered Environment Assessment Process (ACE-AP) quality improvement program is designed to guide clinics through a self-assessment of the environment, policies,

and practices related to youth-friendly services using 12 key areas of adolescent-centered care. The RAAPS electronic risk assessment tool, performed during well-visits, is intended to solicit more honest information than other tools to identify risk behaviors and depression. CCHHS chose to implement RAAPS in FF21. The pandemic necessitated CHS placing new projects on hold.

CCHHS and CHS Clinic staff conducted outreach events and marketing campaigns to promote adolescent health and wellness. Materials handed out covered reproductive health, STIs, the importance of a medical home, and annual well-visits value. COVID-19 hampered CCHHS from providing education and resources to high school students during health classes; however, some of the 2,254 individuals reached at community events were adolescents or parents of teens. CCHHS used Title V MCH funds to conduct a Facebook campaign promoting yearly well visits which reached 3,841 adolescents. CHS nursing personnel promoted wellness through six outreach events and partnerships with schools, coalitions at health fairs, point of dispensing sites, and vaccine clinics. COVID-19 resulted in some planned adolescent health and wellness activities not being scheduled.

Community Adolescent Health and Wellness in Rural Regions

Title V MCH funded Partners Allied for Community Excellence (PACE) Coalition, an entity within the Nevada Statewide Coalition Partnership, to employ a CHW. The CHW participated in adolescent health and wellness activities in Elko County and nearby rural communities. The CHW met with the Family Resource Center to help grow enrollment into the healthy teen programs: "Promoting Health Among Teens!" and "Making Proud Choices!" supported by the MCAH pregnancy prevention programs. Additionally, the PACE staff taught two Youth Mental Health First Aid (YMHFA) classes empowering 14 new community members to avert suicide attempts. During COVID-19, the CHW created content for the agency's Facebook page promoting adolescent mental health through mindfulness.

Trauma-Informed Approaches

The 2019 Nevada YRBS Middle and High School Adverse Childhood Experiences (ACE) Special Reports reveal the following differences in ACE scores: females were more likely to report two or more ACEs than males; children qualifying for free or reduced lunches were more likely to report one ACE score or higher; students identifying as gay, lesbian, or bisexual were more likely to report higher ACE scores than those identifying as heterosexual, and as the number of ACEs increased so did the likelihood of participating in violence, experiencing victimization, sexual and physical dating violence, as well as suicidal ideation. The percentage of middle schoolers with three or more ACES who reported feeling sad or hopeless almost every day was 292% higher than the percentage of middle schoolers with no ACES (67.8% vs. 17.3%). There was a 237% difference between students reporting 3 or more ACES and those reporting none (67% vs 19.9%) for high schoolers. This indicates the need for prevention and intervention strategies targeting ACEs to reduce mental health consequences into adulthood. Current statewide efforts address ACEs by building resiliency, using trauma-informed approaches, and providing social and emotional support services to children and their families. NDE, DCFS, several mental health consortia, MCH, and community agencies collaborate on specific issues, policy improvements, and systems-building projects.

MCAH staff attended conferences and webinars to understand how trauma affects the developing adolescent brain in healthy decision-making and to learn what it means to be trauma-informed with adolescent patients. The AHW, SRAE, and PREP programs shared resources obtained with youth-serving agencies and youth advisory councils to enhance their understanding of trauma-informed principles and better engage with youth impacted by ACEs.

Sex and Human Trafficking

MCAH staff expanded partnerships with groups working to eliminate sex and human trafficking, an issue of concern to populations served by Title V MCH Programs, especially adolescents. The AHWP Coordinator is on the Coalition to Prevent the Commercial Sex Exploitation of Children (CSEC); the MCH Director participated in the state plan process. The group held its first meeting at the end of the reporting period. Planned activities will be to complete mandates in Senate Bill 293 of the 80th Nevada Legislative Session to create safety nets assisting impacted youth with necessary services through 24/7 receiving centers. Standards of care will be developed, as well as staff training to include trauma-informed approaches. Facilities will provide a continuum of care to include specialized shelters, housing, and residential facilities to provide safe and secure spaces for exploited individuals to obtain trauma-informed screenings and services. MCAH staff attended numerous CSTE intensive trainings provided by ACF and FSYB.

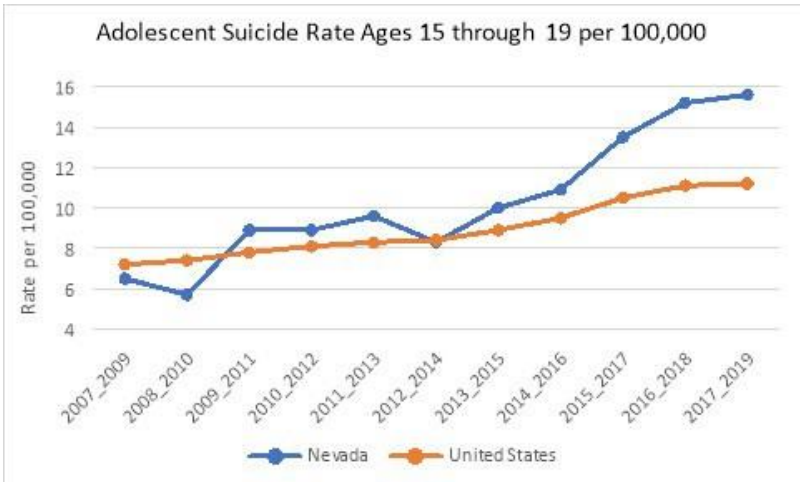
COVID-19 Efforts

MCAH staff added COVID-19 MCH population-related content into the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. Materials contained Nevada's response to the pandemic, as well as information and resources targeting adolescents, in addition to all other populations served by the award. Identified links sent viewers to the CDC COVID-19 resources in American Sign Language via YouTube, Spanish language content. The CDC materials and placement of the links were shared widely with funded partners and community members. The statewide MCH Coalition and PCO disseminated the materials through listservs.

In FFY 21, all Title V MCH funded partners were requested to promote the DPBH awarded Nevada Resilience Project, helping families and individuals experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, through text and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Additionally, state staff shared the Nevada 211 Youth app launch specifically helping young people locate services and resources such as health care, crisis support, employment services, food pantry locations, and emergency housing programs.

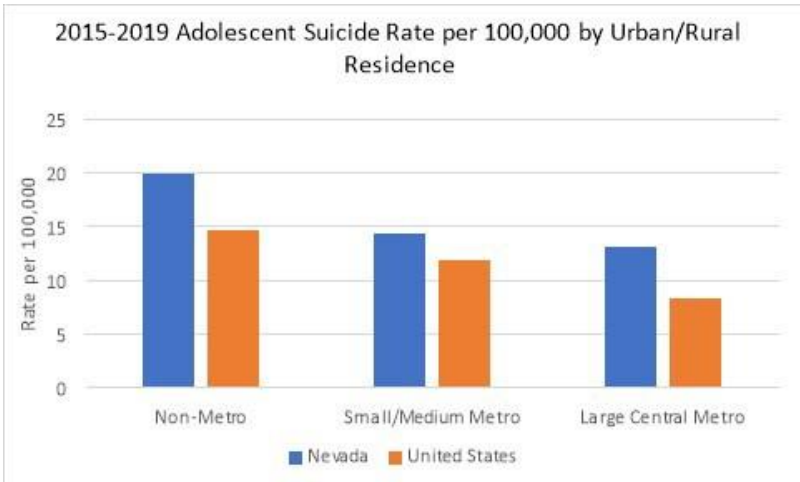
Suicide Prevention

The percent change in Nevada's adolescent suicide rate for ages 15-19 from 2007-2009 to 2017-2019 is 140%. The graph below illustrates the trends for Nevada and the US.



Data Source: Federally Available Data, National Vital Statistics Survey (NVSS)

In Nevada, the adolescent suicide rate is highest for Non-Hispanic Asian/Pacific Islander (21.3 per 100,000) followed by Non-Hispanic White (17.9), Non-Hispanic Black (12.8), and Hispanic (9.3). Compared to the United States, Nevada sees a disproportionately higher adolescent suicide rate for adolescents residing in Non-Metro areas. The graph below shows the break down.



Data Source: Federally Available Data, National Vital Statistics Survey (NVSS)

Overall, NVSS shows adolescent suicide rate for ages 15-19 y.o. per 100,000 in Nevada was 15.6 from 2017-2019, higher than the corresponding U.S. rate of 11.2 per 100,000 teens.

The 2019 Nevada YRBSS was a voluntary survey of students in 6th through 12th grade in regular public, charter, and alternative schools. Students self-reported their behaviors in six areas of health-related to morbidity and mortality. The Emotional Health section contains eight questions to measure mental health risks. The table below outlines the responses from the major areas of concern related to suicide.

2019 Nevada Youth Risk Behavior Survey		
	Middle School Students	High School Students
Percentage of students who seriously considered attempting suicide/killing themselves during the 12 months before the survey	21.8%	18%
Percentage of students who made a plan about how they would attempt suicide/kill themselves during the 12 months before the survey	12.9%	15.3%
Percentage of students who tried attempting suicide/killing themselves during the 12 months before the survey	8.1%	8.9%
Percentage of students who have done something to purposely hurt themselves without wanting to die, such as cutting or burning themselves on purpose during the 12 months before the survey	19.1%	N/A
Percentage of students whose suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the 12 months before the survey	N/A	2.8%

While the 2019 Needs Assessment did not list teen suicide as a priority, behavioral health encompasses mental health concerns such as suicide. Title V MCH state general fund MCH match funding helped support the Nevada OSP with teen suicide prevention and systems-building projects. OSP serves as Nevada's office for training and technical assistance pertinent to identifying, preventing, intervening, and survivor support of suicide. Strategic partnerships have been formed to advance public policy around stigma reduction, mandatory training for most school districts, and gatekeeper training for staff and parents. OSP worked with school districts to develop and implement a workforce development training plan to increase mental health awareness and literacy of school staff, administrators, parents, and others interacting with school-aged youth to recognize suicide signs and symptoms and link children/adolescents to appropriate services. Evidence-based training, Youth Mental Health First Aid (YMHFA), Applied Suicide Intervention Skills Training (ASIST), and SafeTALK will be offered to all levels of the school staff. Adult employees will be trained before programs are offered to students (e.g., Teen Mental Health First Aid, Signs of Suicide, youth peer to peer programs). Staff will receive refresher training at least every three years through a training portal website established by OSP to aid in recertifications.

Due to COVID-19 impacting children's emotional and behavioral health, OSP increased the number of suicide

awareness training for agency staff, health care providers, and parents with children. Virtual training was conducted for acute care hospitals, free-standing psychiatric hospitals, community-based providers, coalitions, faith-based providers, and volunteers. In FFY21, additional training will be conducted for school personnel to detect and respond to mental health issues. Other FFY21 activities will include several social media campaigns to reduce suicide rates among children and youth focused on safe firearm storage, coping skills during social isolation, and awareness of school peer support programs. The bilingual messaging reached Hispanic families with firearm safety awareness since Nevada's Hispanic children are at higher risk for firearm injuries. MCAH programs funded a bilingual social medial campaign for the resilience project.

Title V MCH match funds supported the Crisis Support Services of Nevada (CCSNV) phone and text lines and the OSP Manager's salary. CCSN assisted 5,269 youth with resources for depression, suicide, sexual assault, and intimate partner violence. In July 2020, the Federal Communications Commission (FCC) adopted rules designating a new phone number for individuals in crisis to connect with suicide prevention and mental health crisis counselors. CCSNV has partnered with DPBH to help build staff capacity to increase in-state Lifeline call answer rates. In FFY21, CCSNV will begin preparing for the two-year transition when phone service providers will direct all 988 calls to the National Suicide Prevention Lifeline.

NDE awarded OSP the second round of Project AWARE funding. This five-year program will increase mental health awareness, screening, and connections to community-based mental health services within a framework of a multi-tiered system of supports (MTSS). Project AWARE will raise awareness of mental health issues among school-aged youth. Project AWARE will provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues. They will also connect school-aged youth, who may have behavioral health issues, and their families to needed services; and strengthen state and local infrastructures to expand and sustain an integrated MTSS in the pilot schools.

Success Story

Shared by a participant who works with a youth-serving agency.

> "Thank you so much for the training and making it feel comfortable and secure. I just wanted to share with you that the same evening after the training, my daughter was having a complete breakdown. I suspect substance use, but she is not disclosing, but she was saying things like she just doesn't want to be here anymore and things of that nature. I just wanted you to know that your training immediately kicked in, and I was able to immediately address the situation and ask if she was suicidal. I would normally not know what to say, but I had the tools and was able to talk through it so much easier than we would normally try to dance around these things. We were able to openly discuss it, and she stated she has felt suicidal her whole life but really did not want to kill herself and did not have a plan. I just wanted to share that your training had a direct and ironically immediate impact in my life, so thank you for sharing and doing what you do."

Rape Prevention and Education Program

Nevada's RPE Program implements prevention strategies to avert sexual violence from occurring by using the public health approach to prevent first-time perpetration and victimization, reduce modifiable risk factors, and enhance protective factors associated with sexual violence. RPE has a particular focus on adolescents; however, the program also reaches young adults to reduce multiple forms of sexual and intimate partner violence. The RPE Program Coordinator is co-funded .25 FTE through Title V MCH Block Grant funds to create a full-time position dedicated to

supporting sexual assault and violence prevention. Federally approved strategies reflected the expansion of previous RPE Program work preventing sexual violence through approaches impacting agency professionals, advocates, as well as school-aged students.

The NCEDSV hosted an Economic Justice Series as a part of an annual conference to support domestic and sexual violence statewide prevention efforts (RPE funded). NCEDSV held 5 virtual forums focusing on economic justice as a tool for sexual violence prevention in Nevada, hosting 185 individuals statewide. Each forum explored a specific economic justice priority, and featured panelists with expertise in these areas. MCAH Program staff from the SRAE, PREP, and RPE programs attended the conference to increase strategies for linking adolescent health to risks and protective factors related to sexual assault and intimate partner violence.

NCEDSV continues to hold regional trainings to support domestic and sexual violence statewide prevention efforts. Additionally, NCEDSV attended the NDE Health Curriculum Standards committee, as did the MCH Director. The Committee is tasked to develop and identify evidence-based resources to help teachers implement Nevada's new health standards which include modules on healthy relationships. MCAH and NCEDSV's participation is to ensure the materials identified and developed include age-appropriate, evidence-based practices on educating youth about healthy relationships and the prevention of relationship abuse.

Using MCAH technical assistance from subject matter experts facilitated by the CYSHCN MCH Coordinator, NCEDSV created an advisory committee to identify needs of parents and caregivers who wish to support and protect youth and young adults living with developmental disabilities to prevent relationship abuse. The committee reviewed existing sexual assault prevention materials and made recommendations on preferred strategies to support parents and caregivers. A webpage was added to the NCEDSV website to provide appropriate resources for this population and continues to be updated. NCEDSV will provide training participants with at least five available community resources including links to the MHP at https://nv.medicalhomeportal.org/ and Nevada 211 at https://www.nevada211.org/ to promote and increase access for both providers and families to necessary services for children and youth with and without special health care needs.

RPE provided education and awareness on issues related to dating violence through Stay SAFE presentations. Stay SAFE focuses on identifying common predatory behaviors exhibited by perpetrators and provides skills to prevent sexual assault through active bystander behavior. Stay SAFE includes policy recommendations to venue managers for preventing sexual violence through mandatory training, changes in procedures while responding to concerning behavior, and employee reinforcement by
recognizing positive behaviors. Security personnel learn when supervisors or the Metropolitan Police Department need to be involved in the intervention. Protective environments are created when security procedures change the monitoring of patron safety and increase supervision in under-resourced areas.

The Rape Crisis Center (RCC) plans to expand the Stay SAFE curriculum, which targets security personnel and food and beverage staff, to include SAINT training to housekeeping, front desk, and support staff within the hospitality industry. The Stay SAFE/SAINT strategy's community component involves extensive meetings, conversations, and outreach to hospitality venues to define sexual assault and recognize how the entertainment culture contributes to the problem. An additional community component of StaySAFE and SAINT is public awareness, as well as a social media campaign targeted to partygoers in Las Vegas. The campaign PartySMART encourages patrons of hospitality venues to become active bystanders for friends through media messaging to "Arrive together, Stick together, Leave together" thereby reducing sexual assault opportunities. The campaign messaging is delivered through social media, a PartySMART website, and
advertisements including billboards, signs, and stickers placed in heavy tourist areas.

Rape Crisis Center (RCC) collects information to summarize the needs and barriers for Nevada schools to successfully implement new child safety standards and offer technical assistance for at least five schools. RCC

adapted to the challenges brought forth by the COVID-19 pandemic by assisting schools and teachers in an online, virtual format. RCC enhances collaboration with other agencies in Nevada to examine limitations and improvements to the current bullying statute.

In collaboration with the UNLV Jean Nidetch Women's Center, a CARE Peer Program 45-hour empowerment-based training curriculum was conducted virtually due to COVID-19. The interactive modules focused on increasing awareness of community and societal factors leading to sexual violence and harassment, as well as increasing social norms which protect against violence. Following leadership preparation, new peer advocates delivered trainings on campus to the student body and self-identified campus groups. Additionally, other institutions higher education in the Las Vegas area have reached out to UNLV to present CARE Peer Program to campus students. Additionally, an Interpersonal Violence Collaborative Interest Group, consisting of administrative and educational faculty, convened quarterly for the purpose of building campus infrastructure to establish best practices and evidence-based strategies for policy reform in response to interpersonal violence and harassment on the campus.

According to the 2015 National Intimate Partner and Sexual Violence Survey Summary Report, among adult victims of rape, physical violence, and/or stalking by an intimate partner, 25.8% of women and 14.6% of men first experienced some form of partner violence between the ages of 11 and 17 y.o. 43.2% of females experience the first rape before the age of 18. One quarter of male victims of completed rape were first raped before the age of 18.

State Teen Pregnancy Prevention Programs

MCAH houses two teen pregnancy prevention programs: SRAE and PREP. The SRAE Program funded agencies educated youth on the benefits of delaying sexual activity to avoid risky behaviors and prevent STIs, including HIV/AIDS. The SRAE and PREP Programs share positive youth development principles. In contrast, the PREP curricula focused on enhancing adulthood preparation by providing abstinence and comprehensive sex education to prevent pregnancy and STIs, including HIV/AIDS. Title V MCH funds do not directly support SRAE efforts. However, Title V MCH staff worked closely with SRAE and PREP on cross-cutting efforts to enhance positive youth development, outreach to youth who live in settings that put them at higher risk, teen pregnancy prevention, and preventing relationship violence by supporting healthy relationship education. The SRAE/PREP Coordinator participated in meetings, webinars, and email exchanges through AFP, LiHEAP, national youth reproductive health technical assistance agencies, and the National Network of State Adolescent Health Coordinators, allowing for learning best practices and sharing resources. . PREP and SRAE staff provided intensive technical assistance to all implementing agencies to move from in person to virtual curriculum delivery statewide.

The pandemic has disrupted youth's day-to-day lives, resulting in added stress and uncertainty. Thus, the PREP Program ran a social media campaign to promote emotional well-being among adolescents ages 13-19 y.o. The twelve messages targeted youth, parents, and guardians. English and Spanish messages, representing Nevada's race/ethnic and special needs populations, contained video descriptors for the visually impaired. Links inserted into each message provided resources and information. Facebook messages reached 68,817 people, with 48,998 video views, 722,920 media impressions, and 2,010 clicks on the links for additional resources. Twitter posts resulted in 957,803 media impressions.

Sexual Risk Avoidance Education Program

Over 830 youth ages 10-19 y.o. participated in SRAE in northern and rural Nevada. Despite COVID-19, more youth were served than the prior non-pandemic year. Priority enrollment was given to adolescents who are at higher risk, experiencing homelessness, or in foster care. Participants were recruited through CCHHS, Family Resource Center

of Northeastern Nevada-Elko, (FRCNEN), Quest Counseling, NyE Communities Coalition, and local partnerships. COVID-19 shifted in-person sessions to virtual programs due to school and community agency closures, allowing for the expansion of partnerships to serve more youth.

In 2019, NVSS data showed the teen birth rate in Nevada was 18.9 births per 1,000 females ages 15-19 y.o., whereas the teen pregnancy rate was 16.9 pregnancies per 1,000 teen girls ages 15-19 y.o. SRAE continues to build partnerships to reduce teen pregnancies and births through evidence-based curricula providing an inclusive, non-stigmatizing environment addressing the social, psychological, and health gains realized by abstaining from sexual activity.

The curricula, *Promoting Health Among Teens! -Abstinence-Only (PHAT! -AO* and *Teen Outreach Program (TOP)* used theoretical frameworks focused on positive youth development principles. Topics covered included healthy decision-making, engagement in healthy relationships, and peer group development for positive social values and norms. The curricula were designed to reduce teen pregnancy by teaching sexual responsibility through accountable sexual behavior decision-making, encouraging respect among themselves and others, increasing effective life management skills, and stress the importance of developing a positive self-image. The activities helped participants feel comfortable practicing abstinence, address concerns about the training, and provide strategies for overcoming obstacles through community service-learning projects.

Two data factsheets in English and Spanish, highlighting national, state, and county-specific statistics on teen pregnancy, were disseminated through the SRAE Program and sub-awardees for promotional events and conferences. Sub-awardees provided resources such as the brochure "*Does Your Teen Need Health Coverage?"*, one-page health care transition handouts, the Nevada Tobacco Quitline, and the Nevada 211 and the MHP websites. These resources are Nevada Title V MCH Program recommended and approved.

As a follow-up to the summer 2019 Adolescent Health Needs Assessment, the SRAE Program partnered with an independent contractor to evaluate the *PHAT! -AO* curriculum. The assessment used to process and outcome evaluations to determine program success from SRAE partners teaching *PHAT! -AO*. The report revealed awardees have similar outcomes of implementation fidelity and compliance.

Success Story

Partner implementing SRAE Program

> "This young client came to us with six barriers that put her at risk of finding meaningful employment and living a successful, healthy life. As her Career coach worked with her, she showed us that she had the strength, determination, and resiliency to make a change in her life.
>
> Working in our field, we never know what can walk through our doors or call us on the phone. One day her Career Coach received an upsetting and alarming phone call. This young client called sobbing, asking if she could come in to talk. Once she arrived, she proceeded to tell her story. Her boyfriend, the father of her two children, became extremely angry with her during a car ride. So angry that she was not engaging in the argument, he decided to stop the car on the side of the road. He pulled her out of the car and put his hands around her neck, choking her while lifting her off the ground. Thank goodness two cars saw what was happening, pulled over, and called the police. This resulted in him getting arrested.
>
> This young client expressed fear and anxiety about what would happen if, and when, he was released from jail and needed help. The Career Coach listened intently and allowed her the time to tell her story. When she finished, the Career Coach was quick on her feet and connected her to the local domestic violence shelter using a warm handoff method.
>
> Because of the rapport, this young girl had with her Career Coach and the Career Coaches office's safety,

this young girl was able to receive immediate resources. The young girl updated her Career Coach two weeks later to inform me that she could get a restraining order against her boyfriend. During this time, the young girl also decided to give her two children temporary custody to her mother to keep them safe. She is now in a safe place to live and employment. She is working toward saving enough money to live comfortably and safely with her children."

Personal Responsibility Education Program

The pandemic significantly impacted PREP awardees' ability to reach underserved youth, despite virtual programming. Less than 300 youth ages 13-19 y.o. participated in northern, southern, and rural Nevada, half of the last years' reach. PREP served youth experiencing homelessness, groups that have been marginalized, including sexual and gender minorities (SGM), individuals in foster care, and juvenile justice-involved youth. Participants were recruited through Planned Parenthood Mar Monte and Rocky Mountain, The Center, FRCNEN, and CCHHS. Project outcomes were to reduce teen pregnancy and teen births, decrease STIs, including HIV/AIDS, and implement activities to prevent sex trafficking of youth. Comprehensive sex education was taught using several evidence-based curriculums: *¡Cuidate!*, *Sexual Health and Adolescent Risk Prevention (SHARP)*, *Teen Success, Making Proud Choices (MPC),* and *Reducing the Risk* with the SGM supplemental adaptation. The curricula taught confidence and skills to reduce STIs, HIV/AIDS, and pregnancy through abstinence and increased condom use when choosing to have sex and reduce alcohol-related sexual risk behavior. The courses contain culturally based interventions to reduce HIV/AIDS sexual risk among Hispanic youth. Furthermore, the curricula empower teen parents through social-emotional learning skills for healthy relationships and self-care for a successful future.

SGM youth experience disproportionate burdens of priority health-risk behaviors and negative health outcomes. The 2019 Nevada High School YRBS Sexual and Gender Minority report found SGM students had increased risk burdens across six different risk categories than non-SGM students, as shown in the tables below.

2019 Nevada YRBS Sexual and Gender Minority Report: Summary of Risk Behaviors or Health Outcomes with Significant Differences based on Sexual Identity

Risk Behavior Category	Proportion of Risk Behaviors or Health Outcomes with Significant Differences Based on Sexual Identity	
	Fraction	Percent
All Categories	64/73	87.7%
Violence-Related Behaviors	7/8	87.5%
Adverse Childhood Experiences	6/6	100%
Emotional Health	7/7	100%
Substance Use	34/39	87.2%
Sexual Behaviors	4/7	57.1%
Resiliency Factors	6/6	100%

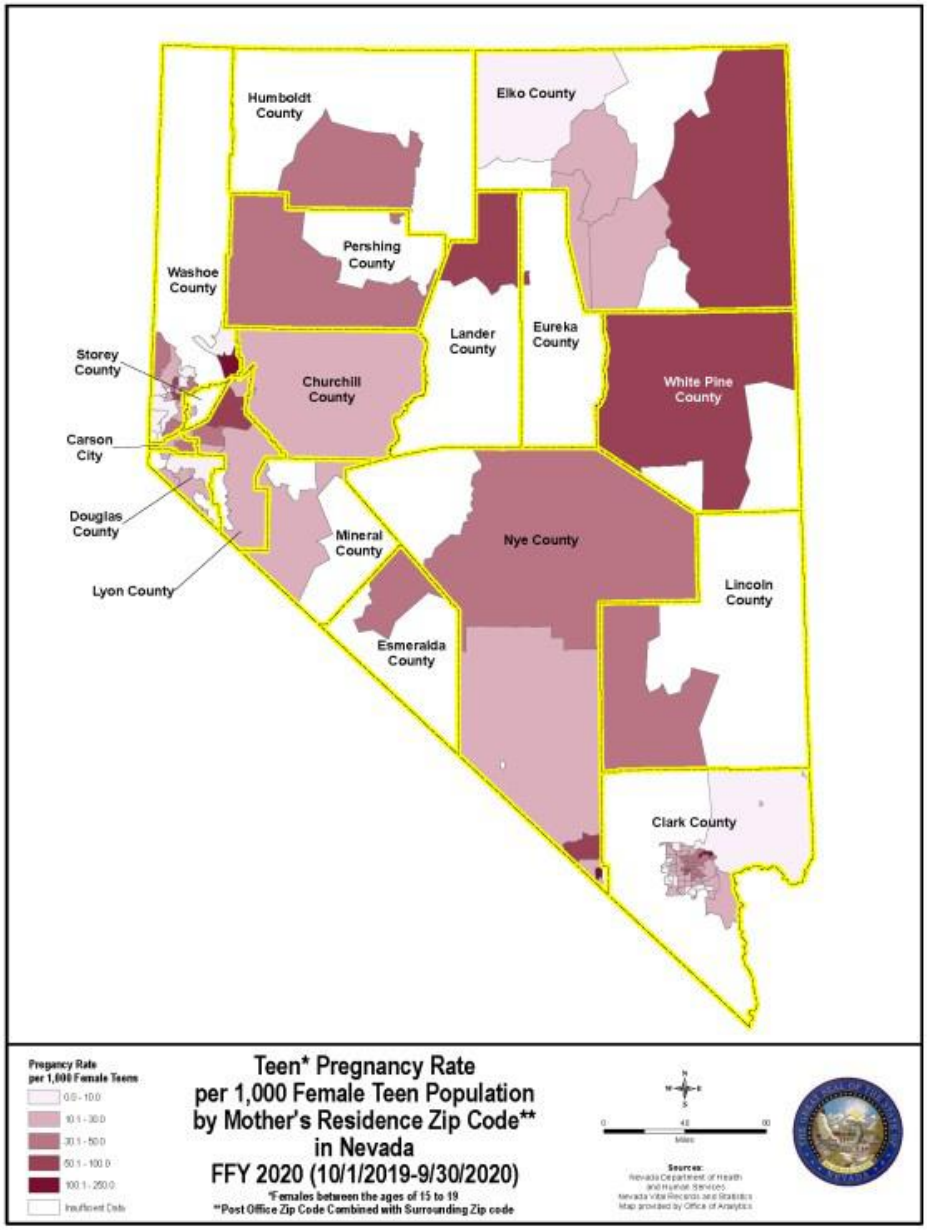
Footnote: Students were asked to report on risk behaviors and health outcomes for each risk category. The number of behaviors per category varies. The tables below show how many risk behaviors or health outcomes within each risk category were significantly different for SGM youth.

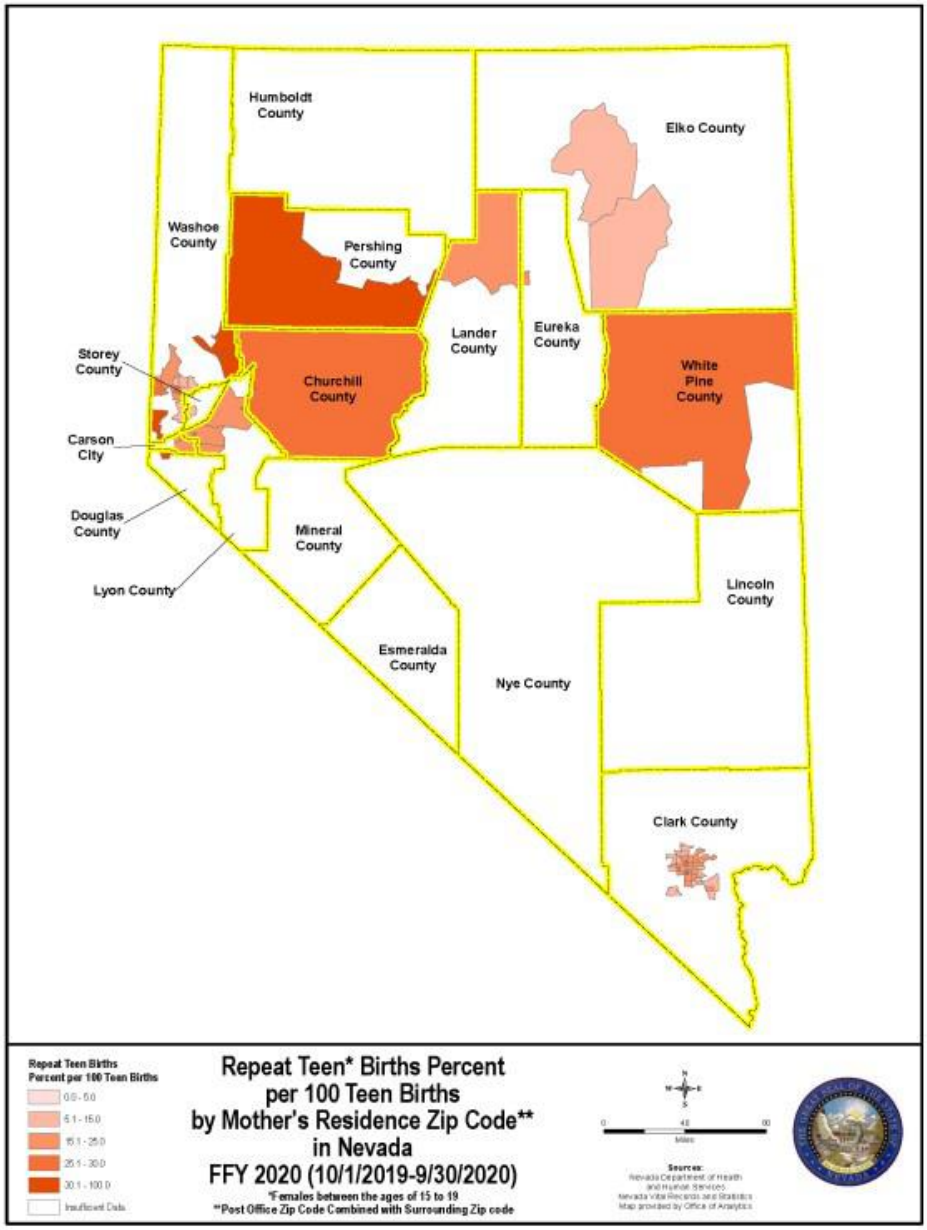
2019 Nevada YRBS Sexual and Gender Minority Report: Summary of Risk Behaviors or Health Outcomes with Significant Differences based on Gender Identity

Risk Behavior Category	Proportion of Risk Behaviors or Health Outcomes with Significant Differences Based on Sexual Identity	
	Fraction	Percent
All Categories	58/73	79.5%
Violence-Related Behaviors	7/8	87.5%
Adverse Childhood Experiences	4/6	66.6%
Emotional Health	6/7	85.7%
Substance Use	32/39	82.1%
Sexual Behaviors	3/7	42.9%
Resiliency Factors	6/6	100%

Footnote: Students were asked to report on risk behaviors and health outcomes for each risk category. The number of behaviors per category varies. The tables below show how many risk behaviors or health outcomes within each risk category were significantly different for SGM youth.

The maps below illustrate Nevada's teen pregnancy rate and repeat teen birth rate by mother's residence zip code.


Humboldt County
Elko County
Pershing County
Washoe County
Lander County
Eureka County
Storey County
Churchill County
White Pine County
Carson City
Douglas County
Mineral County
Nye County
Lincoln County
Lyon County
Esmeralda County
Clark County
Pregnancy Rate per 1,000 Female Teens
0.0 - 10.0
10.1 - 30.0
30.1 - 50.0
50.1 - 100.0
100.1 - 250.0
Insufficient Data
Teen* Pregnancy Rate
per 1,000 Female Teen Population
by Mother's Residence Zip Code**
in Nevada
FFY 2020 (10/1/2019-9/30/2020)
*Females between the ages of 15 to 19
**Post Office Zip Code Combined with Surrounding Zip code
Sources:
Nevada Department of Health and Human Services
Nevada Vital Records and Statistics
Map provided by Office of Analytics



The 80th Legislative Session of the Nevada Legislature passed Senate Bill (SB) 94 allocating 6 million dollars over the biennium in state general funds to support reproductive health and contraceptive access statewide. While funding is focused on supporting reproductive health and access, SB 94 also allows for the use of funds for immunizations. The LHAs, university, community, public health clinic, and county partners were awarded funds to implement the goals of SB 94. The Reproductive Health Coordinator funded by SB 94 is situated within the MCAH Section and has worked closely with MCAH data and teen pregnancy prevention staff.

Success Story

Partner Implementing PREP

"Class always begins with a round of introductions where everyone shares their pronouns. Those introductions are followed by a set of group agreements. The final agreement shared by the educator is to 'Respect Diversity'. The educator takes this opportunity to define in detail the meaning of terms like 'gender', 'gender identity', 'gender expression', and 'sexual orientation'. This functions both to educate and to make gender and sexual minority students feel as though this class is a welcoming and safe space for them from the very beginning.

After her first ever session with the high school students, a non-binary student reached out to the educator to let her know how grateful and excited they were to take the class. The student indicated that they felt seen, heard, and accepted in a way that isn't typical for them at school. The student also shared their hopes that with so many of their peers receiving this education from a trusted source, that it might increase their respect and understanding of them and other non-binary folks they meet. In a rural Nevada community, this is a big deal and a fantastic step in promoting the acceptance of diversity and inclusion. When the program concluded, the student reached out again and let the educator know that the class had indeed served one of its intended goals: starting important conversations between peers and increased understanding and acceptance. Being able to make these connections and have this impact all while instructing virtually in the age of COVID-19 feels like an even greater success."

Adolescent Physical Activity Report

The Title V MCH Program sought to increase the percent of adolescents, ages 12-17 y.o. who are physically active at least 60 minutes a day (NPM 8). Research demonstrates consistent exercise (60 minutes per day) provides physical and mental health benefits such as weight management, building healthy muscles and bones, increased endurance, reduction in anxiety and stress, and improvement in self-esteem. The 2018-2019 NSCH revealed 11.1% of Nevadan's ages 12-17- y.o., were physically active every day at least 60 minutes per day, compared to 16.5% nationally, indicating a need to increase awareness about the value of the physical activity and movement programs for adolescents. Efforts to meet this goal included social media campaigns focused on adolescents and their parents/caregivers and a program designed to improve health and wellness through yoga.

Adolescent Physical Activity Social Media Campaign

Title V MCH awarded DP Video funding to arrange promotional efforts of physical activity video posts on Facebook, Instagram, and Twitter, using the state-operated Nevada Wellness website. The campaign focused on youth and parents/caregivers to promote change in adolescent daily physical activity habits. The messages were pilot tested by Nevada youth of various socioeconomic and cultural backgrounds, including individuals experiencing special health needs.

DP Video created two seasonal social media campaigns to increase the number of middle school and high school students engaging in at least 60 minutes of daily physical activity. All English and Spanish messages met CLAS standards. Video descriptors were used to assist visually impaired viewers. Each social media campaign displayed six videos and messages (three each in English and Spanish) promoting physical activity among adolescents and families with teens. The pre-pandemic campaign resulted in 214,746 Twitter media impressions. The Facebook ads led to 78,126 media impressions, 55,181 views, and 35,584 engaged users. The second campaign, run during the early COVID-19 shutdown, resulted in significantly more Facebook viewers looking at the videos and clicking on the links for further information. The physical activity Facebook posts contained 120,13 media impressions, 86,305 views, and 60,400 engaged users. However, Twitter had less in the pandemic period, resulting in 190,259 media impressions.

Trauma-Informed Yoga

Student self-reports from the 2019 Nevada YRBS disclosed 21.9% of middle school and 20.5% of high school students engaged in physical activity at least 60 minutes daily, indicating the need for more movement programs. Furthermore, Nevada lacks enough specialized physical activity programs for youth living with special needs or who are placed at higher risk, although state physical activity education standards are predicated on inclusivity. Consequently, the Title V MCH Program funded Urban Lotus Project (ULP) to provide physical activity to youth at higher risk and those experiencing special health care needs. ULP offers Trauma-Informed Yoga for Youth to benefit adolescents impacted by a high lifetime prevalence of ACEs. Trauma-Informed Yoga for Youth helps increase physical activity, provide resilience, support mindfulness, combat obesity, and chronic disease, enhance wellness, and help mitigate other harmful public health outcomes.

The trauma-informed yoga practice allowed the physical activity to be available at no cost in a safe environment to young people experiencing disadvantage. It provided access to physical activity for 60 minutes, often only available at a significant financial cost to youth from all socioeconomic statuses and restrictive circumstances for other physical activity alternatives. Urban Lotus Project provided inclusive environments, regardless of social and cultural factors. Cultural humility allowed teachers to nurture each student's strengths, interests, and talents and honor each person's beliefs, customs, and values.
Adolescents were served through 20 different venues including, charter schools, drop-in youth centers, juvenile detention centers, residential substance and mental health treatment facilities, and youth-serving community organizations. At least 854 individuals participated in one of the 797 yoga classes. Most students attended multiple yoga classes resulting in at least 3,704 pupil exposures. Unique student counts were unable to be reported during the six-month COVID-19 period when yoga classes were conducted virtually. COVID-19 significantly impacted the ability to provide yoga instruction since none of the facilities offered in-person classes during the shutdown. ULP shared its trauma-informed approach and yoga's science and benefits to several organizations during the pandemic. These discussions allowed agencies to learn the value of the yoga practice helping youth heal from the disruptions, social isolation, and losses experienced by COVID-19. In FFY21, plans will be developed to bring yoga classes into the Washoe County School District to assist students and teachers deal with their daily stressors, especially those brought on by the pandemic. Several agencies will discuss adding the services to their programs once in-person courses can be resumed.

The collaboration with ULP and MCH resulted in two products inside the *AMCHP Innovation Hub* in hopes of replicating the success of this effort elsewhere, allowing adolescents to reap the benefits of specialized yoga and mindfulness instruction. The promising practice is housed inside *AMCHP's MCH Innovations Database* and showcased as one of the NPM 8 adolescent physical activity implementation toolkits. https://create.piktochart.com/output/44298021-npm-8-disseminating-tools-and-resources. In FY21, AMCHP awarded Replication Project Implementation funds to a Nashville, Tennessee yoga organization already providing trauma-informed yoga and meditation. The award allows Small World Yoga to serve more middle and high school-aged adolescents on school campuses and in the community. In the next Title V MCH funding year, AMCHP will begin providing technical assistance to ULP and Title V MCH staff to better coach the yoga organization towards a successful replication.

Furthermore, ULP received additional local and national recognition. The agency was a recipient of the Renown Regional Medical Center Diversity, Equity, and Inclusion Grant as a small non-profit group serving racial and ethnic minorities, SGM young people, individuals experiencing disabilities, and youth of low socioeconomic status and other underrepresented groups. ULP became a Champion of the National Youth Sports Strategy (NYSS), promoting youth sports participation. The US Department of Health and Human Services organizes NYSS through the Office of Disease Prevention and Health Promotion’s Physical Activity Program.

Success Story

Student Responses to Yoga Exposure

> “Using some things I learned when I am angry.” - age, 15
>
> “The yoga classes help me thing positive and make me calm and safe.” - age, 17
>
> “I’m going to do more yoga often cause it helps me.” - age, 16
>
> “They have made me realize to not judge myself nor my body, to accept me as me.” -age, 15

Accomplishments of Adolescent Health and Wellness Program

MCAH staff focused activities on improving adolescent health status, which has long-term implications for adult health, productivity, and longevity. The staff members successfully promoted public health approaches to protect, promote, and improve adolescent physical, behavioral, emotional, and mental health statewide. Best practices were shared with funded agencies and community members on how to serve adolescents through promoting yearly well-visits and health care transition education. Resources were disseminated on healthy weight management, exercise, immunizations, sexual behavior, nicotine/tobacco/vaping, alcohol/substance use, and emotional and mental health.

MCAH staff enhanced partnerships with state agencies working to build adolescent health and wellness. Despite the pandemic challenges, funded partners were able to dedicate efforts to help adolescents with education, resources, and referrals improve their health outcomes. MCAH staff added COVID-19 adolescent-related content into the DPBH website and shared pandemic information and resources with partners pertinent to adolescents. MCAH staff created new partnerships with state agencies to build childhood resiliency due to gaps identified in the Title V Five-Year Needs Assessment. Furthermore, COVID-19 necessitated collaboration to leverage program information and resources.

The collaboration with ULP and MCH resulted in two products inside the *AMCHP Innovation Hub* in hopes of replicating the success of this effort elsewhere, allowing adolescents to reap the benefits of specialized yoga and mindfulness instruction. The AHWP expanded its knowledge base about authentic youth engagement, trauma-informed principles, health equity, cultural humility, and intersectionality when building systems for engaging youth into organizations and community projects.

Adolescent Health Data

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

According to the 2019 NSCH, 64.5% of adolescents ages 12 through 17 had a preventive medical visit in the past year. This is significantly below the 2019 national average of 79.6%. Nevada ranks last out of the 50 states and D.C. for this measure.

NPM 8.2 - Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day

Data from the 2018-2019 NSCH shows 11.1% of adolescents in Nevada were physically active at least 60 minutes per day, a statistically significant decrease from 16.8% in 2017-2018. This is lower than the 2018-2019 national average of 16.5%, and Nevada ranks 50th out of 50 states and D.C. for this measure. Disparities for race and ethnicity exist for this measure in Nevada. Non-Hispanic Multiple Race (16.9%) and Non-Hispanic White (15.5%) adolescents have a higher percentage of physical activity than Hispanic (8.8%) and Non-Hispanic Asian (3.6%)

adolescents.

NPM 12- Percent of adolescents without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care

The percent of adolescents without special health care needs who received services to prepare for the transitions to adult health care has been slightly increasing every year in Nevada, from 9.4% in 2016 to 13.5% in 2018-2019 (NSCH). Nevada is slightly below the 2018-2019 national average of 16.9%, and ranks 46th out of the 50 states and D.C.

NPM 15- Percent of children, ages 0 through 17, who are continuously and adequately insured

According to data from the NSCH, the percent of children who are continuously and adequately insured has remained stable from 2016 to 2018-2019 at 62.4%. This is significantly lower than the 2018-2019 US national average of 66.8%. Nevada ranks 43rd lowest out of the 50 states, and D.C. Disparities exist in Nevada for this measure Non-Hispanic Black children are least likely to be continuously and adequately insured (54.9%). Hispanic children are also slightly below the Nevada average at 61.6%. Non-Hispanic White, Non-Hispanic Asian, and Non-Hispanic Multiple Race are above the Nevada average, at 62.8%, 65.1%, and 70.2% respectively.

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

According to NVSS data, Nevada has steadily been decreasing teen birth rate from 44 per 1,000 in 2009 to 18.9 per 1,000 in 2019. This represents a 57.05% decrease. Nevada is below the 2019 national average of 16.7 per 1,000 and ranks 34th out of the 50 states and D.C. Race and ethnicity disparities are apparent from the data, with Non-Hispanic Black (32.2 per 1,000), Non-Hispanic American Indian/Alaska Native (26.8), Non-Hispanic Native Hawaiian/Other Pacific Islander (25.7), Hispanic (24.2), and Non-Hispanic Multiple Race (21) females having higher teen birth rates than Non-Hispanic White (10.6) and Non-Hispanic Asian (3.8) females.

Adolescent Health Plan for the Application Year

Adolescent Well-Visits and Health and Wellness

The Title V MCH AHWP Coordinator will work with funded partners and community agencies to improve access to care through yearly well visits and promotion of health care transition materials to providers, youth, and parents/caregivers. Other areas of focus will be to enhance the health status of adolescents associated with healthy nutrition and weight management, exercise, sexual behavior, use of nicotine/tobacco/vaping, alcohol and substances, and emotional health issues related to depression and suicide.

Service will continue to serve on several committees. MCAH participation will continue with the Youth Advisory Council through the NVPCA's award with the Healthy Tomorrows Partnership for Children Program. The AHWP Coordinator will remain on the Coalition to Prevent the Commercial Exploitation of Children committee to create safety nets to assist impacted youth with necessary services through 24/7 receiving centers. MCAH staff will continue to enhance partnerships with state agencies working to build resiliency in adolescents.

Outreach with DPBH adolescent-focused programs will identify opportunities to leverage efforts. Programs will share relevant materials and events crossing over into areas impacting adolescents, such as positive youth development, emotional well-being, and prevention of intimate partner violence, teen pregnancy, suicide, and cessation of tobacco/nicotine/vapes and substances.

Suicide Prevention

The Crisis Support Services of Nevada phone and text lines will be awarded funds by another agency to continue its work and expand its staff capacity to answer in-state Suicide Prevention Lifeline calls. OSP will work with collaborators to develop a plan to launch the new Suicide Prevention Lifeline 988 phone number.

OSP will work with NDE on a multi-tiered system of support (MTSS) to threat assessment teams and protocols across Nevada school districts. A newly funded Project AWARE grant will increase mental health awareness, screening, and connections to community-based mental health services within the MTSS framework. Training will continue to reach school staff, health care providers, community helpers with safeTALK, Applied Suicide Intervention Skills Training (ASIST), Youth Mental Health First Aid (YMHFA), and Nevada Gatekeeper information. School district workforce development training will be enhanced to increase mental health awareness and literacy of adults interacting with school-aged youth to recognize suicide signs and symptoms and link children and adolescents to appropriate services.

OSP will increase its social connectedness within communities, schools, families, and peer groups to enhance protective factors and reduce the risk for suicide. This includes increasing culturally relevant and linguistically appropriate messaging and services and enhancing community engagement activities to integrate family and culturally specific resources to empower people and communities to locate information and develop community programs.

Rape Prevention and Education Program

Title V MCH funds will continue funding 0.25 FTE of the full-time MCAH RPE Program Coordinator position. The RPE Program will align five-year project activities with the Title V MCH State Action Plan by designing safer environments and fostering economic growth for adolescent and young women. RPE will address shared risk and protective factors through collaborative partnerships within DPBH including Title V MCH, PREP, and SRAE, as well as external agencies working with young adult populations. The program will support school implementation of new

statewide health curriculum standards increasing socio-emotional skills for children grades K-12 to expand primary prevention and evaluation increasing community and societal-level changes shown to reduce sexual violence reaching the greatest amount of people. Goals will focus on increasing the number of community strategies implemented, creating protective environments to protect against violence, and providing opportunities to empower and support adolescent and young women. The Title V MCH and RPE programs will continue exploring building evaluator capacity through shared contracted staff.

Sexual Risk Avoidance Education and Personal Responsibility Education Programs

Within the MCAH Section, the PREP and SRAE Programs conduct outreach for trauma-informed care and positive youth development will continue to be a priority. PREP will continue to engage with DCFS about human trafficking, foster youth, and youth involved with the juvenile justice system. Title V MCH funds do not support SRAE and PREP efforts directly. However, MCH staff will closely work on cross-cutting interests in positive youth development, teen pregnancy prevention, supports for pregnant and parenting teens, and outreach to youth and underserved groups, including sexual and gender minorities.

Trauma-Informed Yoga for Youth

Title V MCH will continue to fund the Urban Lotus Project (ULP) to conduct Trauma-Informed Yoga for Youth. The Teacher Evaluation Survey and Student Response Questionnaire will be used to ensure quality improvement and to assess the benefits of Trauma-Informed Yoga on adolescents' ability to cope with stress and increase resiliency. ULP will expand into neighboring Northern Nevada counties to increase the number of youths benefiting from this practice. Additionally, ULP will bring trauma-consciousness to all system levels of care through a professional development program educating on trauma science, nervous system health, and embodiment practices for front-line support workers, care providers, social workers, teachers, etc., across multiple social service settings. AMCHP will continue providing technical assistance to ULP and Title V MCH staff to support the Nashville, Tennessee yoga organization awarded AMCHP Replication Project Implementation funds.

Children with Special Health Care Needs

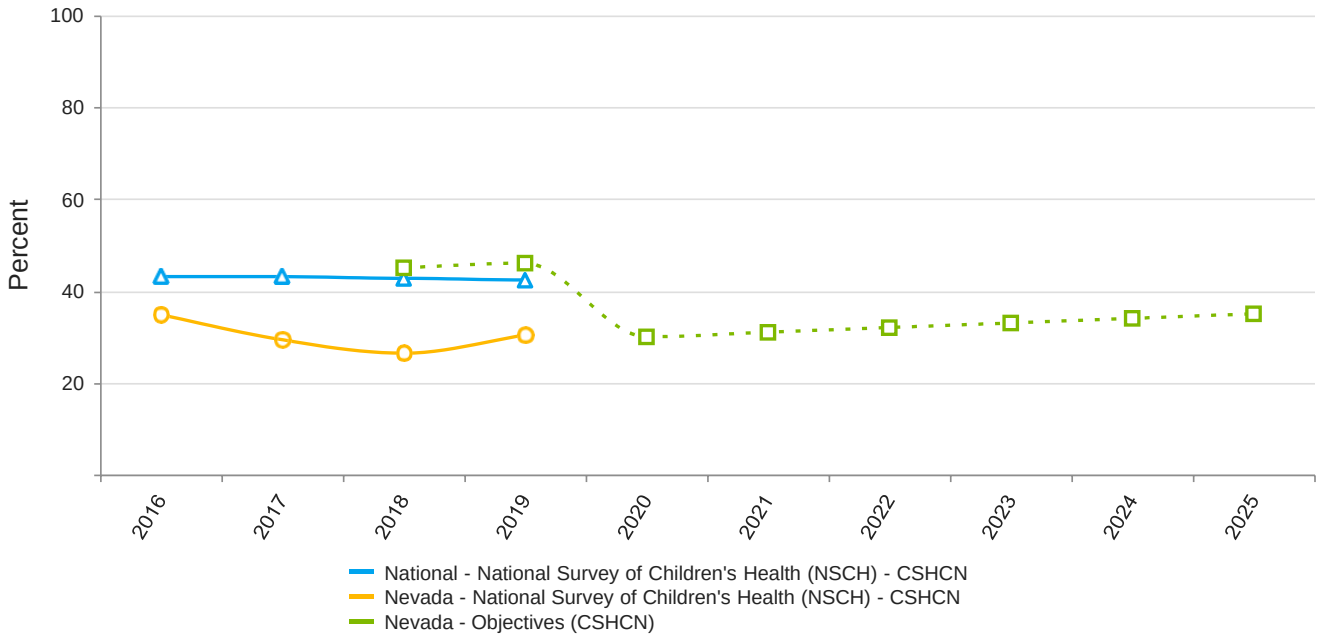
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	8.5 %	NPM 11 NPM 12 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	39.2 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 11 NPM 15
NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months	NIS-2016	63.8 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	52.0 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	68.9 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.0 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	87.0 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.9 %	NPM 11 NPM 15

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children s Health (NSCH) CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			45	46	30
Annual Indicator		34.9	29.5	26.3	30.3
Numerator		35,648	31,552	28,106	32,151
Denominator		102,067	106,845	106,689	106,188
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Evidence-Based or –Informed Strategy Measures

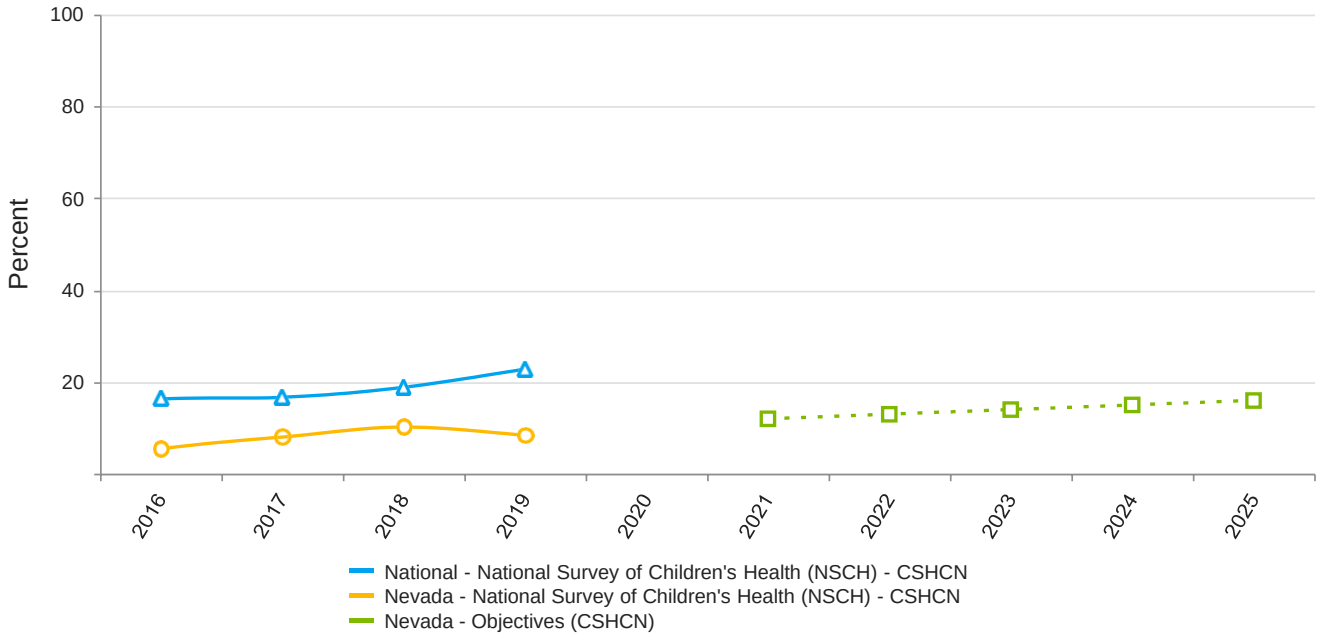
ESM 11.1 - Number of Nevada Medical Home Portal website views.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			17,000
Annual Indicator	4,838	12,390	64,132
Numerator			
Denominator			
Data Source	Medical Home Portal	Medical Home Portal	Medical Home Portal
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65,000.0	66,000.0	68,000.0	70,000.0	72,000.0	75,000.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	10.3	8.3
Numerator	4,248	3,493
Denominator	41,437	41,899
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	12.0	13.0	14.0	15.0	16.0	17.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	55.0	60.0	65.0	70.0	70.0

ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	50.0	60.0	65.0	70.0

State Action Plan Table

State Action Plan Table (Nevada) Children with Special Health Care Needs Entry 1	
Priority Need	
Promote a Medical Home	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percent of children with special health care needs with a medical home in the past year to 35% by 2025	
Increase the percent of children without special health care needs with a medical home in the past year to 50% by 2025	
Increase the number of WIC, Home Visiting, and other program participants that received information on the benefits of a medical home by 20% by 2025	
Increase the number of unique users of Nevada's medical home portal to 9,000 by 2025	
Strategies	
Partner to support the utilization of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc.	
Partner to identify and conduct outreach to CYSHCN, including families, with the greatest need (e.g. racial/ethnic group, payer, rural/urban) regarding availability and benefits of Medical Home Portal	
ESMs	Status
ESM 11.1 - Number of Nevada Medical Home Portal website views.	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

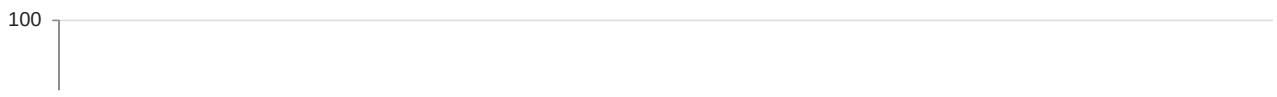
State Action Plan Table (Nevada) Children with Special Health Care Needs Entry 2
Priority Need
Increase transition of care for adolescents and CYSHCN
NPM
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Objectives
Increase the percent of children with special health care needs ages, 12 through 17, who received services necessary to make transitions from pediatric to adult health care to 16% by 2025
Strategies
Coordinate with partners and local health authorities to improve the messaging about transition from pediatric to adult care to youth with and without special health care needs.
Collaborate with public and private partners to provide children with special health care needs and their families with information on the benefits available and link them to appropriate health care coverage options
Conduct health transition trainings among health care providers to support transition efforts and gather information regarding changes in knowledge, practices, and policy.

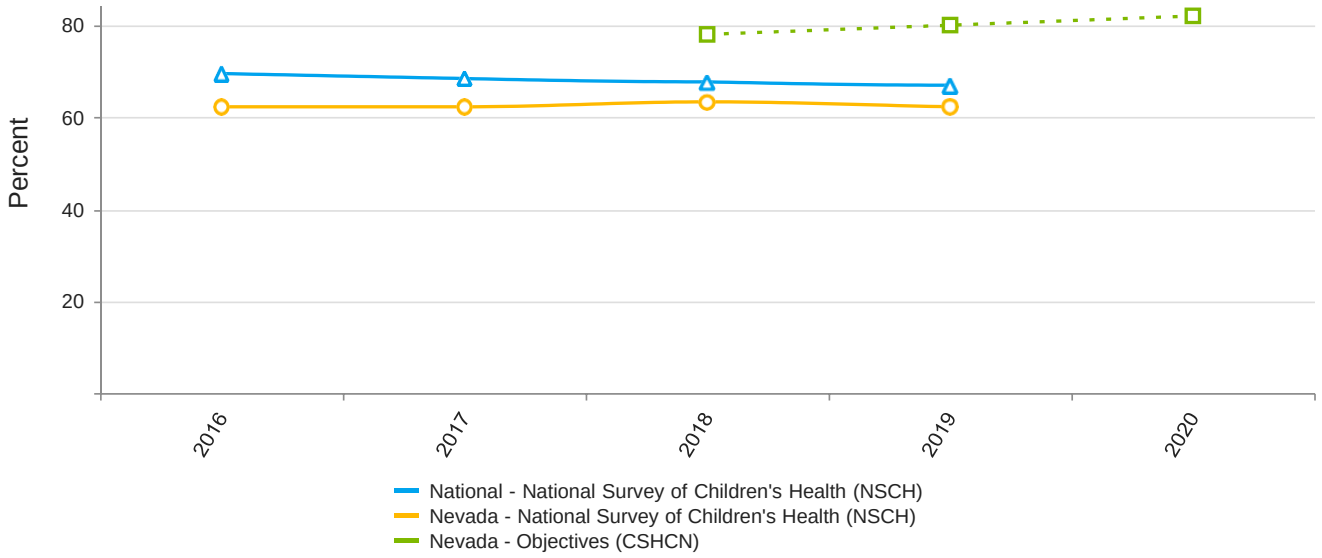
ESMs	Status
ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition	Active
ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition	Active

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

2016-2020: National Performance Measures

2016-2020: NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Indicators and Annual Objectives





2016-2020: NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	80	82
Annual Indicator		62.2	62.2	63.4	62.4
Numerator		415,085	417,372	429,828	423,713
Denominator		667,147	670,675	678,451	679,500
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 15.2 - Percent of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up.

Measure Status:		**Active**	
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			70
Annual Indicator		40.3	41.2
Numerator		293,607	302,489
Denominator		728,298	734,488
Data Source		Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year		CY 2019	CY 2020
Provisional or Final ?		Final	Provisional

Children and Youth with Special Health Care Needs Annual Report

The Title V MCH Block Grant, through the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), requires at least 30% of Title V funding to be targeted to CYSHCN.

According to HRSA, CYSHCN are defined as: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally". CYSHCN are a diverse group with wide-ranging health concerns, such as chronic and acute conditions, including emotional and behavioral health.

The CYSHCN Program provides resources and support to community agencies serving children from birth to age 21. The CYSHCN Program successfully moved away from a direct services approach to focus on funding various community programs bridging service gaps, linking families to appropriate resources and providers. This includes developing strategies to better serve children and families through a network of federal, state, and local community and family-based partners.

The CYSHCN Director manages the MCAH Section of the Nevada DPBH. Section programs include the Title V MCH Program, RPE, AIM, MMRC, PREP, SRAE, PRAMS, EHDI, and MIECHV. The Director also uses a systems-building strategy by developing relationships with outside CYSHCN entities, attending innovative training and annual conferences, and participating in community and family-led coalitions and committees. Examples include the NGCDD and the Nevada Newborn Screening Advisory Committee (NSAC), Childhood Sexual Assault Prevention Advisory Board, Nevada HRSA Mental Health Evaluation Committee, fatality reviews, and the MHP Advisory Committee. The CYSHCN Program Coordinator works closely with the Director to evaluate if program activities are achieving expectations and to modify these goals when appropriate.

The CYSHCN Program Coordinator participates in the Nevada MCH Coalition, Nevada State Team of the Mountain States Regional Genetics Network, Statewide Children's Mental Health Consortia, and the Nevada Early Intervention Interagency Coordinating Council through the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) Part C Office.

To improve CYSHCN health outcomes, the Title V MCH Program selected NPM 11, NPM 15, and NPM 12. The Title V MCH Program sought to increase:

1. The percent of children with special health care needs, ages 0 through 17, who have a medical home (NPM 11).
2. The percent of children, ages 0 through 17, who are continuously and adequately insured (NPM 15).
3. The percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care (NPM 12).

Health outcomes are anticipated to improve when children and youth have access to a medical home, are adequately insured, and successfully transitioned from pediatric to adult health care. Program activities and successes on these efforts are highlighted in the report and supplementary activities that support CYSHCN and their families in other areas.

Medical Home

The Title V MCH Program sought to increase the percent of children with special health care needs, ages 0 through 17, who have a medical home (NPM 11). According to the NSCH 2018-2019 report, 30.3% of Nevadan children with special health care needs, ages 0 through 17 years, have a medical home compared to 42.3% nationwide.

Most chronic conditions are uncommon or rare - for many diagnoses, primary care physicians are likely to have only

one, or a few, patients. However, the cumulative prevalence of chronic conditions is substantial. According to the NSCH 15% of children meet the criteria for classification as CYSHCN in Nevada. Through the Medical Home Model, effective care coordination provides substantial value for CYSHCN, their families, and their clinicians and requires knowledge of their conditions, available resources, and relevant service providers. However, it is impossible to maintain enough current knowledge of medical information and community resources to provide high-quality primary care for each of these conditions. From Medical Home Model strategies, it is known families of CYSHCN desire more information about raising a child with special health care needs, about their condition(s), and about how to manage their care and navigate the health care system. Families are motivated and may have more time than clinicians to devote to learning about their child's condition and finding resources. Families will learn to understand relatively technical language and be better able to understand and communicate with professionals. Numerous other professionals (therapists, dentists, care coordinators, educators, pediatric and adult subspecialists, etc.) could also benefit from information about various aspects of caring for CYSHCN. Physicians and families sharing information and working together as partners in the Medical Home model will improve outcomes for CYSHCN.

The Title V MCH Program, in conjunction with the University of Utah Department of Pediatrics, promotes the MHP to governmental and community partners at the local, regional, and state levels to improve medical home access in Nevada for CYSHCN. The MHP is an easy-to-use conduit to connect children with and without special health care needs, their families/caregivers, and providers to health and social service resources and is also available in Spanish. To increase awareness of the MHP, each Title V MCH-funded partner is required to promote the MHP. CCHHS promoted the MHP through digital clinic signage and Facebook. Social media MHP messages reached 2,124 individuals with 21 user engagements. Promotion of the MHP is a condition of funding for Title V MCH subawardees.

Title V MCH awarded funding to DP Video to create and arrange a month-long social media ad campaign promoting the MHP. Video posts on Facebook and Twitter promoted the MHP to providers and other health professionals, as well as families and CYSHCN advocates in both English and Spanish. These campaigns highlighted the need for inclusion in care coordination throughout Nevada and how the MHP can be used to benefit current efforts whether through modules like gold-standard information concerning diagnoses or conditions, tips for families navigating the system of care, or the service directory of over 3,350 resources. Twelve video ads on Twitter resulted in 267,988 media impressions. Six video ads on Facebook and Instagram resulted in 206,128 media impressions and 166,826 views by 86,576 unique users.

Medical Home Portal

Title V MCH funds the MHP in conjunction with the University of Utah Department of Pediatrics (UUDP) to serve CYSHCN by addressing clinicians' information and resource access needs, care coordinators, other healthcare professionals, educators, families, and patients. The MHP's vision is for all CYSHCN and their families to achieve the best possible outcomes for their health, well-being, and success. The MHP's mission is to assist and support professionals and families using the Medical Home model to care and advocate for CYSHCN by providing reliable and helpful information about CYSHCN conditions, care, and valuable local and national services and resources. The MHP's long-range goal is to improve outcomes for CYSHCN and their families by enhancing the availability and quality of healthcare, related services, and care coordination.

Title V MCH staff continued to promote the MHP, in partnership with the University of Utah Department of Pediatrics, to increase access to a medical home for children and youth living in Nevada. Two social media campaigns were conducted using Title V MCH funds. DP Video promoted the MHP through social media on the Nevada Wellness social media sites (Facebook, Instagram, and Twitter), targeting providers, parents, and caregivers of CYSHCN. All posts signified Nevada races and ethnicities, met National CLAS guidelines, included descriptors for visually impaired viewers, and aired in Spanish and English.

The campaigns highlighted the need for inclusion in care coordination throughout Nevada and how the MHP can

benefit current efforts, whether through modules like gold-standard information concerning diagnoses or conditions, tips for families navigating the system of care, or the service directory of over 3,350 resources. The ad campaign allowed for enhanced boosting of sponsored ads, which resulted in a notable mention from other states using the MHP. The animated video ad campaigns on Twitter resulted in 157,971 media impressions, and Facebook content led to 349,631 views by 6,144 unique users clicking on links for further information. The 12 boosted social media campaigns on Twitter resulted in 267,988 media impressions, and Facebook social media reached 86,576 individuals. A smaller Facebook campaign promoted by CCHHS in Northern Nevada, reached 4,188 individuals with 124 engaged users.

The MHP integrates with Nevada 211, the state's Information and Resource (IR) platform, as the main source of referral information for community and professional service providers serving Nevada's CYSHCN population. Data from Nevada 211 is exported quarterly for presentation on the MHP. Community and professional service providers can also import their referral information directly to the MHP. Usage of the MHP is evaluated utilizing Google Analytics, where the number of website views by page and unique users are quantified and reported monthly.

For FFY 2020, there were 28,657 MHP unique users (compared to 5,961 unique users in FFY 2019) and 64,132 website views (compared to 12,390 website views in FFY 2019). As of December 2020, the MHP contains:

- Over 500 pages of content and resources, including
  - 55 "Diagnosis Modules" addressing the comprehensive primary care of those conditions;
  - 38 Newborn Disorder pages addressing primary care response to notification of abnormal results of newborn screening for those conditions;
- Over 3,100 links to other reliable and valuable websites or downloadable, including components on Sickle Cell Disease (SCD) screening and family resources added by the CYSHCN Program Coordinator;
- Over 2,200 citations of scientific and other expert literature to provide users with the evidence behind recommendations or to explore topics in greater depth;
- Over 3,350 service listings in the directory for CYSHCN and their families in Nevada;
- New nationwide service directory, including telehealth resources accessible to families living in rural and frontier areas. Nevada's CYSHCN Program was the first MHP partner to launch this new feature.

Title V MCH Program-funded partners promoted the MHP through their scopes of work and promotional materials were provided to both funded and non-funded partners to increase awareness. Materials included teddy bears, med-spoons, sippy cups, pens, and bookmarks showcasing the MHP logo and website address. The Title V MCH Program also launched social media campaigns on Facebook and Twitter. Social media posts were inclusive of age, gender, race/ethnicity, and disability through carefully chosen images and text. In FFY 2020, there was a 416% increase in website views and 381% increase in unique users compared to FFY 2019.

The MHP expanded to include nationwide resources. Visitors to the site can now search not only UUDP partner state directories (to include Idaho, Montana, New Mexico, Rhode Island, and Utah), but also a nationwide directory of resources and services which may not be available in Nevada or those mainly provided online or through phone consultations.

Adequate Insurance

The Title V MCH Program sought to increase the percent of children, ages 0 through 17, who are continuously and adequately insured (NPM 15). According to the NSCH 2018-2019 report, 62.4% of Nevadan children, ages 0 through 17, were continuously and adequately insured compared to 66.8% nationwide. To improve the percent of children who are adequately insured, all AHWP and CYSHCN Program partners provide insurance application

assistance in English and Spanish, referrals to Medicaid and other social service programs, and informational materials on topics such as eligibility criteria and coverage of preventive services. Future efforts within the CYSHCN Program will continue these services while also focusing on increasing collaboration with DHCFP (agency includes NV Medicaid, EPSDT, and Katie Beckett Programs) and DWSS to improve referrals and thereby, continuous and adequate insurance coverage for Nevadan children.

Health Care Transition

According to the NSCH 2018-2019 report, the percent of CYSHCN in Nevada who received services necessary to transition to adult health care decreased from 10.3% in 2017-2018 to 8.3%. Meanwhile, the national average increased from 18.9% to 22.9%. Thus, Title V MCH selected *NPM 12: percent of adolescents with and without special health care needs, ages 12 – 17 (y.o), who received services necessary to make transitions to adult health care,* as a new priority measure to align with Title V MCH staff's desire to empower youth with and without special health care needs to engage in their health care as they transition into adulthood. Health care transition education engages and allows adolescents and young adults to advocate for themselves by breaking down health and wellness, insurance coverage, and self-advocacy in a way they can easily understand.

The CYSHCN and AHWP Programs initiated a new collaborative partnership with the Title V MCH-funded partner DP Video Productions for a social media campaign on health care transition and health literacy. DP Video arranged for the promotional efforts of health care transition video posts on Facebook, Instagram, and Twitter, using the state-operated Nevada Wellness website. DP Video conducted a month-long social media campaign displaying videos and messages promoting the concept of youth learning how to advocate for themselves instead of relying on parents/caregivers to meet all these needs. English and Spanish messages, representing Nevada's race/ethnic and special needs populations, contained video descriptors for the visually impaired. The campaign met the targeted audience of adolescents and families with teens. Facebook led to 133,154 views, 275,751 media impressions, and 50,640 engaged users, while six video ads were displayed on Twitter, resulting in 500,633 media impressions.

Nevada Center for Excellence in Disabilities

The CYSHCN Program and AHWP continued collaborating with the Title V MCH-funded partner, NCED, to expand resources on health care transition and health literacy. This partnership aims to improve the transition from pediatric to adult health care using new and innovative strategies for health professionals, youth, and families.

The Title V MCH Program funded health transition efforts with NCED in the College of Education at UNR, which serves as Nevada's University Center for Excellence in Developmental Disabilities (UCEDD). The work of UCEDD's is to accomplish a shared vision that foresees a nation where all Americans, including Americans with disabilities, participate fully in their communities. Independence, productivity, and community inclusion are critical components of this vision. The mission of the NCED is to cooperatively work with consumers, agencies, and programs to assist Nevadans with disabilities of all ages to be independent and productive citizens who are included in their communities. This mission is accomplished by providing interdisciplinary training, offering model exemplary services, conducting interdisciplinary evaluations, disseminating information on developmental disabilities and service options, providing technical assistance, and conducting relevant research and evaluation studies.

Using Title V MCH funds, NCED conducted fifteen trainings to 594 professionals and high school/college staff working with parents and students with special health care needs. All trainings disseminated resources to improve health care education and integration for youth and young adults using no-cost one-page information sheets through Got

Transition www.GotTransition.org. The handouts educate young people and their parents/caregivers about the steps necessary to navigate the transition from the pediatric to the adult health care system. The trainings included resources to promote the Medical Home and the MHP. Trainings were offered to those affiliated with UNR, Washoe County School District, NDE, and some rural school districts. COVID-19 resulted in virtual formats for training after March 15, 2020. Unfortunately, the pandemic delayed several planned trainings in rural regions; however, several were conducted later in the reporting year.

NCED made inquiries and learned some school districts had health care transition policies. Unfortunately, school staff are not mandated to include health care transition as part of their transition policies for CYSHCNs outlined through the Individuals with Disabilities Education Act and the Nevada Administrative Code built into all Individualized Educational Plan (IEP) documents. Thus, continued education for staff and students is deemed essential, so youth can learn to engage in their health care transition into adulthood.

NCED staff attended three Healthcare Transition Learning Group workshops to receive further resources to share with professionals and families. These sessions proved valuable to enhance staff knowledge and provide additional training content.

In FFY21, NCED will enhance its content for health care transition training, and provider reach to align with activities focused on NPM 12: percent of adolescents with and without special health care needs, ages 12 – 17 (y.o.), who received services necessary to make transitions to adult health care. Discussions began with NCED to conduct six Project ECHO online trainings on pediatric to adult health care transition to professionals serving youth with and without special health care needs using the Got Transition www.GotTransition.org Six-Core Elements of Health Care Transition. The courses will share each core element, related resources, and include case-based discussions.

COVID-19 Efforts

COVID-19 guidelines requiring masks in public can pose communication barriers for individuals who are deaf and hard of hearing (D/HH). Title V MCH funded the purchase of face masks, with a clear window, to six school districts and two partners working with children or parents who are D/HH. The transparent section of the mask allows the wearer's lips to be visible, making lip-reading and the speaker's facial expressions possible.

The CYSHCN Director participated in population specific COVID-19 workgroups.

AMCHP awarded the Title V MCH Program the AMCHP CARES ACT Telehealth Grant to support CYSHCN with access to health care through technical supports.

MCAH staff added COVID-19 MCH-population-related content into the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. Materials contained Nevada's response to the pandemic, as well as information and resources targeting CYSHCNs, in addition to all other populations served by the award. Identified links sent viewers to the CDC COVID-19 resources in American Sign Language via YouTube and Spanish language content. The CDC materials and placement of the links were shared widely with funded partners and community members. The statewide MCH Coalition and PCO disseminated the materials through listservs.

In FFY 21, Title V MCH requested all funded partners promote the DPBH awarded Nevada Resilience Project, helping families and individuals experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, through text and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Additionally, state staff shared the launch of two Nevada 211 mobile apps to help Nevadans connect with needed resources in response to the pandemic. The Nevada 211 Youth app complements the initial one for individuals and families. It specifically helps young people

locate services and resources such as health care, crisis support, employment services, food pantry locations, and emergency housing programs.

Family TIES of Nevada

Family TIES of Nevada (FTON) is Nevada's Family Voices representative and Family-to-Family Healthcare Information and Education Center, which provides culturally competent support and information to CYSHCN and their families. FTON, a Title V MCH funded partner, provides a bilingual CYSHCN toll-free hotline and assistance to family-centered care for individuals living with disabilities or special health care needs.

The Title V MCH Program understands CYSHCN and their families' journeys have value and offer essential knowledge, hope, and inspiration to others, and inform programmatic efforts. FTON engages CYSHCN communities by fostering peer support, mutual growth, and resilience in families and programs. The agency applies evidence-based practices to ensure consistency and quality throughout the parent-to-parent network, utilizing leadership, integrity, and partnership to build capacity and sustainability statewide.

FTON team members participate in various outreach events and committee meetings to distribute resources to families and stay knowledgeable on emerging topics related to CYSHCN. FTON partners with nonprofits to actively communicate the mission of providing family-centered care for individuals living with disabilities or special health car needs and their families. FTON continues to participate in health promotion campaigns supported by Immunize Nevada, Healthy Nevada, Cribs for Kids, Respite and Volunteer Experiences (RAVE), and NEIS. Of these organizations, Cribs for Kids and Immunize Nevada receive Title V MCH funding through our Maternal and Infant Program (MIP) to emphasize Safe Sleep activities and childhood immunizations.

FTON made extensive referrals to the MHP, the FTON website, NEIS, and other specialized information sources. Eligibility assistance for Medicaid, Supplemental Security Income (SSI), affordable housing, and Katie Beckett programs was provided to increase continuous and adequate insurance coverage among CYSHCN. Transportation services were made available to rural and frontier families so their children could attend clinical appointments and obtain other supplementary needs.

Care coordination and case management were provided to CYSHCN and their families receiving clinical and enablin services from Title V MCH-funded partners, the Northern Nevada Cleft Palate Clinic (NNCPC), and UNLV. Care coordination involved organized child activities and shared information among the family and other health professiona to achieve safer and more effective care. Case management was provided to children with complex medical needs (physical, mental, and emotional) and families living in rural and frontier regions. Translation and interpretation service were offered at NNCPC and UNLV. Overall, FTON has identified a need for translation services among CYSHCN and is considering certifying bilingual team members to serve in this capacity. FTON is committed to improving referral systems and community partnerships to increase access to care for CYSHCN and their families in Nevada.

Due to COVID-19, FTON team members were unable to attended trainings after March 2020. Prior to the COVID-19 outbreak, team members were able to attend some outreach events and committee meetings to present information to families of CYSHCN as described below. In addition, FTON partnered with nonprofits to actively communicate the mission of providing family-centered care for individuals living with disabilities or special health care needs and their families. FTON distributed over 4,682 brochures and informational resources at outreach events and nonprofit partnership events. Also, FTON participated in various health promotion campaigns with Immunize Nevada, Healthy Nevada, Cribs for Kids, Lyft, RAVE, NEIS, Reno Fire Department, and Toys for Tots.

FTON made over 1,500 referrals to the MHP, the FTON website, and other specialized information resources. Care coordination and case management services were offered to individuals attending Northern Nevada Cleft Palate Clin (NNCPC) in both northern and southern Nevada, but this service was also limited due to COVID-19.

The FTON Executive Director continued participation with the Nevada State Team of the Mountain States Regional Genetics Network by serving as one of the team's co-leaders.

Prior to March 2020, FTON routinely attended community events to increase awareness of the organization and the resources offered, including: the Washoe County School District Summit, NEIS, Turkey Trot, Chevy Classic Car Summer Salute, RAVE Trunk or Treat, and the Caregivers Coalition prior.

Emergency Preparedness and Response Action Learning Collaborative

MCAH staff participated in the Emergency Preparedness and Response Action Learning Collaborative (EPR-ALC). The EPR-ALC is a collaboration between the CDC and AMCHP to provide technical assistance to states to aid in developing or enhancing the integration of MCH populations in their EPR plans. Title V MCH staff are working with the Public Health Emergency Preparedness (PHEP) Program and the LHAs to meet ALC action items. PHEP is drafting Nevada's first Pediatric Medical Surge Annex and is receiving support from MCAH staff. The plans address access and functional needs, behavioral health, newborn screening, coordination of services with WIC and other MCAH components during a medical surge event.

Multiple emergency response annexes or components may need to be activated simultaneously in order to thoroughly address the needs of those affected by a disaster. For example, pediatric burn patients, neonates, neonatal intensive care unit (NICU), pediatric intensive care unit (PICU), and CYSHCN.

Adaptive and Inclusive Physical Activity

The CYSHCN Program and AHWP participated in the Association of State Public Health Nutritionists (ASPHN) Children's Healthy Weight CoIIN to support Title V MCH programs to promote nutrition, physical activity and breastfeeding through collaborative learning and quality improvement practices. Title V MCH staff, in partnership with our state family-led organization, FTON, sought to increase physical activity in the CYSHCN population.

Title V MCH staff identified a bilingual infographic from the National Center on Health, Physical Activity, and Disability. Staff then contacted parks and recreation departments (where available) across Nevada to identify inclusive playgrounds and programs, as well as locate local and online businesses providing adaptive sporting equipment to develop a resource guide for families with CYSHCN. A link to both guides, accessed through the MHP, was posted on the back of the infographic. FTON disseminated the infographics to their client population and the information was also posted on the MHP site. When developing the list, Title V MCH staff identified rural and frontier counties needing physical activity equipment. Local agencies were then directed to federal and private funding opportunities for playground development and adaptive equipment.

Northern Nevada Cleft Palate Clinic (NNCPC)

As a collaboration of NEIS and the UNRSOM, Title V MCH offers financial support to the Northern Nevada Cleft Palate Clinic (NNCPC) held in Reno, Nevada. Each clinic has a dedicated multidisciplinary team committed to caring for and treating children with cleft lip and palate and other craniofacial impacts using a grand rounds style where each family receives an individualized case review. The NNCPC is housed within the Department of Speech Pathology and Audiology at UNR. The NNCPC is a cooperative effort between Nevada's DHHS, DPBH, and community healthcare professionals. The NNCPC offers online referral resources and collaborates with Family TIES of Nevada to provide a Spanish language interpreter for Spanish-speaking families. The NNCPC examines children with cleft palate or other craniofacial disorders involving the head, face, and mouth. Each patient and their family are taught how to care for the specific cleft palate or craniofacial disorder and what to expect. Speech therapy is offered when necessary.

COVID-19 restricted access to services from March 2020 until the end of the subaward period. Title V MCH did not renew the subaward after June 30, 2020.

University Center for Autism and Neurodevelopment (UCAN)

The University Center for Autism and Neurodevelopment (UCAN) in the Department of Speech Pathology and Audiology in the UNRSOM is a multi-disciplinary team of professionals concerned with autism and neurodevelopmental disorders in children. The purposes of the UCAN Assessment Team are to provide diagnostic evaluation for children in need and improve differentiation between autism and other neurodevelopmental disorders. The Team is a diverse group of professionals from different disciplines and agencies throughout Northern Nevada comprised of child psychiatrists, child psychologists, school psychologists, an occupational therapist, marriage and family therapist, speech language pathologists, and a developmental specialist. The Team provides three extensive assessments per month, as well as follow-up to help families access recommended treatments.

UCAN is associated with the Nevada *Learn the Signs. Act Early* (NvLTSAE) Program, which is a Leadership Education in Neurodevelopmental and Related Disabilities (LEND) project. The purpose of the LEND training project is to improve the health of CYSHCN. This is accomplished by preparing trainees from diverse professional disciplines to assume leadership roles in their respective fields and by insuring high levels of interdisciplinary clinical competence. LEND programs across the nation work together to address issues of importance to CYSHCN and their families, exchange best practices, and develop shared products.

UCAN attended to a total of 33 children and families who received guidance and assistance in obtaining necessary services. In conjunction with the NvLTSAE Program, UCAN collaborated with several state, private, and public agencies to disseminate CDC Milestone Moments booklets adapted for Nevada, which included referral information for parents.

The Department of Speech Pathology & Audiology at UNR had no cleft palate patients, in clinic, from 4/1/20 thru 6/30/20 due to mandatory clinic closure and the extensive safety precautions and requirements for the re-opening process during the COVID19 pandemic.

Mountain States Regional Genetics Network

The CYSHCN Program staff participate in the Mountain States Regional Genetics Network (MSRGN) as part of the Nevada State Team. The MSRGN is a HRSA-funded project which spans eight states, including Arizona, Colorado, Montana, Nevada, New Mexico, Texas, Utah, and Wyoming. The MSRGN ensures individuals with heritable disorders and their families have access to quality care and appropriate genetic expertise through facilitating a network of genetics clinics, primary care practices, consumer advocates, and state health department resources. The MSRGN facilitates regional networking, encourages diverse populations, and supports activities to inform quality improvement and access for underserved populations in the clinical genetics health care delivery systems. These collaborative efforts bring together clinicians, public health professionals, and affected families to fulfill the MSGRN mission. The Nevada State Team implemented an ECHO series on genetic service delivery in primary care settings. The ECHO series is designed to better inform medical professionals on newborn screenings, genetic evaluations for developmental delays and autistic behaviors, and caring for a child with multiple special health care needs. Upon identifying a gap regarding genetic counseling, the group decided to implement genetic “pop-ups,” or impromptu, casual discussion sessions between experts and community members on the advantages of genetic counseling for CYSHCN.

Pediatric Mental Health Care Access Program

To support CYSHCN Program goals specific to mental health, the CYSHCN Director and Program Coordinator

continue to participate in the Nevada DCFS HRSA Pediatric Mental Health Care Access Program (PMHCAP). PMHCAP uses telehealth strategies such as Mobile Crisis Response teams to expand mental health services for children. The program goals are to:

1. Promote behavioral health integration in pediatric primary care by supporting the development of statewide pediatric mental health telehealth and telephone access program.
2. Provide training and education on the use of evidence-based, culturally and linguistically appropriate telehealth protocols to support the treatment of children and adolescents with behavioral disorders.
3. And serve as a resource for pediatric primary care providers seeing children and adolescents including but not limited to pediatricians, family physicians, nurse practitioners, physician assistants, and case coordinators.

Sexual Assault Prevention in Individuals with Developmental Disabilities

Title V MCH continued funding 0.25 FTE of the full-time MCAH RPE Program Coordinator position. The CYSHCN and RPE programs, in conjunction with the NCEDSV and CDC PHHSBG, continue to provide cross-training workshops for the prevention of relationship abuse in young adults with developmental disabilities to communities in Nevada. NCEDSV also continues developing resources and collecting data regarding sexual violence against individuals with disabilities nationwide. Nationwide, a lack of resources and data have been identified regarding sexual violence against individuals with disabilities. Thus, NCEDSV developed infographics to increase awareness of local community-based organizations offering sexual assault prevention and victim services resources. NCEDSV is also committed to providing training to participants with at least five available community resources, including links to the MHP at https://nv.medicalhomeportal.org/, and Nevada 211 at https://www.nevada211.org/. The resources promote and increase access for both providers and families to necessary services for children and youth with and without special health care needs. NCEDSV built a web page listing resources, policies, and myths regarding sexual violence geared towards those who are developmentally delayed, parents, caregivers, self-advocates, and service providers.

Sickle Cell Disease Regulation and Registry

CYSHCN staff participated in policy and implementation planning in relation to new statutory language passed in 2019 related to development of a sickle cell registry and resources for CYSHCN and their families. Assembly Bill (AB) 254 (https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/6459/Text) of Nevada's 80th Legislative Session requires Medicaid to cover certain supplements, prescription drugs, and services for the treatment of SCD and its variants, and authorization of a prescription of certain controlled substances for the treatment of acute pain caused by SCD and its variants for a longer period than otherwise allowed. The CYSHCN Program worked with the Nevada Newborn Screening Program, specialty providers, and various family centered SCD advocacy organizations to also develop a letter focused on improving parental screening of SCD and sickle cell trait (SCT) statewide. This resource will be mailed to the family's primary care provider in the event of a presumptive positive result of SCD/SCT; the letter encourages parental screening of SCT/SCT as a family planning measure and informs the family of available resources in their area.

Nevada's Sickle Cell Registry (SCR) was also developed through AB 254. The SCR is designed to collect information on the number of newly diagnosed cases of SCD and its variants (incidence) and the number of cases living in Nevada (prevalence).

Data sources for the registry include:

- Reports from health care facilities, providers of healthcare, and medical laboratories
- State newborn screening program

- Administrative claims data from NV Medicaid
- Hospital in-patient and emergency room discharge data

Critical Congenital Heart Disease Registry

The CYSHCN Program manages the CCHD Registry, which ensures Nevada-born infants are screened for CCHD and those diagnosed with CCHD receive timely and appropriate medical care. The CYSHCN Program works in partnership with Nevada birthing hospitals, the NHA, and the American Heart Association (AHA) to provide technical assistance, ensure all Nevada birthing hospitals are reporting, and produce an annual CCHD report. Title V MCH staff within the CYSHCN Program and MIP are currently exploring the possibility of partnering with state and regional organizations representing Certified Nurse Midwives (CNMs) to include their newborn screenings into the CCHD Registry. The EHDI Program includes CNMs in their data collection and if the CCHD Registry can accommodate this change, there may be an increase in reportable coverage of CCHD screenings.

Congenital heart defects (CHDs) are malformations of the heart or major blood vessels and the most common type of birth defect (CDC, 2018a). In the US, about 40,000 births per year are affected by CHDs, accounting for 4.2% of all infant deaths (AHA, 2019; CDC, 2018b). About 25% of infants who have CHDs will be diagnosed with CCHD (CDC, 2018c). CCHD is a life-threatening condition requiring surgical intervention within the first year of life (CDC, 2018c). Fortunately, pulse oximetry screening increases the chances for early diagnosis and detection of CCHD when coupled with routine newborn screening practices (CDC, 2018c; AAP, 2019). Once detected, many heart defects can be surgically repaired (CDC, 2018c; AAP, 2019).

The State of Nevada worked with the AHA and other partners to implement NRS 442.680 to address CCHD screenings.

Since July 2015, all hospitals or obstetric centers must screen all newborns after 24 hours of birth and prior to 48 hours of life to determine if the newborn suffers from CCHD. The attending physician must report the infant if they have failed the CCHD screening to the DPBH Chief Medical Officer, or a representative thereof, and discuss the condition with those responsible for the infant's care.

Pulse oximetry is a lifesaving, low cost, non-invasive diagnostic test completed in as little as 45 seconds at just $4 per infant (AAP, 2019). Pulse oximetry estimates the percentage of hemoglobin in the blood saturated with oxygen (CDC, 2018c). When screening identifies newborns with low blood oxygen levels, echocardiography then provides definitive diagnosis of heart defects (CDC, 2018c; AAP, 2019).

Working in partnership with Nevada birthing hospitals, NHA, and AHA, the Title V MCH Program has provided technical assistance and ensured all Nevada birthing hospitals are reporting.

The CCHD registry contains monthly counts for the number of screens, number of births, number of failed screens, and percent of failed screens. The registry also includes details on discrepancies in the number of screens and births for the month reported, patient information for failed screenings, and whether the failed screening was found via prenatal detection.

In 2019, the CCHD Registry included a total of 34,301 births. A total of 30,810 (89.82%) were documented as receiving a pulse oximetry screening. Of the 3,491 (10.18%) infants without documentation of a screen, 116 passed away, 1,821 were sent to NICU, 846 infants received echocardiograms, 574 were believed to be home births, 26 were confirmed missed screens, 107 were transferred to another facility, and parents or family members declined services for one infant. The confirmed missed screens were all documented as receiving either doctor or family notification from the birthing facility. A total of 32 failed pulse oximetry screenings were reported.

There is no funding allocation related to NRS 442.680 and the CCHD registry receives no portion of newborn screening fees or dedicated federal funds.

Centers for Disease Control and Prevention [CDC]. (2018a). What are congenital heart defects? Retrieved from https://www.cdc.gov/ncbddd/heartdefects/facts.html

American Heart Association [AHA]. (2019). The impact of congenital heart defects. Retrieved from https://www.heart.org/en/health-topics/congenital-heart-defects/the-impact-of-congenital-heart-defects

CDC. (2018b). Data and statistics on congenital heart defects. Retrieved from https://www.cdc.gov/ncbddd/heartdefects/data.html

CDC. (2018c). Critical congenital heart defects. Retrieved from https://www.cdc.gov/ncbddd/heartdefects/cchd-facts.html

American Academy of Pediatrics [AAP]. (2019). Newborn screening: Critical congenital heart defects. Retrieved from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx.

Children and Youth with Special Health Care Needs Data

NPM 11 - Percent of children with special health care needs, ages 0 through 17, who have a medical home

According to the NSCH the percent of children in Nevada with special health care needs ages 0 through 17 who have a medical home has fluctuated from over time, from a high of 34.9% in 2016, to a low of 26.3% in 2017-2018, and 30.3% in 2018-2019. Nevada is significantly below the 2018-2019 national average of 42.3%, and ranks last out of the 50 states and D.C.

NPM 12- Percent of adolescents with special health care needs, ages 12 through 17, who receive the services necessary to transition to adult care.

According to the NSCH the percent of adolescents in Nevada with special health care needs ages 12 through 17 who receive services necessary to transition to adult care has remained low over time. The percent has ranged from a high of 10.3% in 2017-2018, to a low of 5.6% in 2016, and most recently is 8.3% from 2018-2019. Nevada is significantly below the 2018-2019 national average of 22.9%, and ranks last out of the 50 states and D.C.

NPM 15- Percent of children, ages 0 through 17, who are continuously and adequately insured

According to the NSCH the percent of children who are continuously and adequately insured has remained stable from 2016 to 2018-2019 at 62.4%. This is significantly lower than the 2018-2019 US national average of 66.8%, and Nevada ranks 43rd lowest out of the 50 states and D.C. Disparities exist in Nevada for this measure, as Non-Hispanic Black children are least likely to be continuously and adequately insured (54.9%). Hispanic children are also slightly below the Nevada average at 61.6%. Non-Hispanic White, Non-Hispanic Asian, and Non-Hispanic Multiple Race are above the Nevada average, at 62.8%, 65.1%, and 70.2% respectively.

Children with Special Health Care Needs - Application Year

Children and Youth with Special Health Care Needs Plan

CYSHCN Program staff integrated with Title V MCH Programs serving infants, children, and adolescents through projects funded to increase developmental screening, access to care and the medical home, insurance assistance, health care transition, family support and wraparound services, adaptive and inclusive physical activity, sexual assault prevention for young adults with developmental disabilities, and CCHD. The CYSHCN Program also collaborated with partners to support projects focused on genetic counseling and screening and child mental health.

Future endeavors include collaboration with other MCAH Programs, including PRAMS to reach families and pregnant people, TPP to further sexual assault prevention and sexual health efforts, and MIECHV to reach families and women of childbearing age. The CYSHCN Program will also continue to build or sustain relationships with state agencies DHCFP (Medicaid, EPSDT, and Katie Beckett Programs); NEIS and the IDEA Part C Office; Department of Education (DOE; Office of Inclusive Education and Child Find Department); DCFS (Children's Mental Health and Independent Living Programs); Department of Employment, Training, and Rehabilitation (DETR; Bureau of Vocational Rehabilitation); and the Nevada Chapter of American Academy of Pediatrics (AAP). With this expansion in connectedness, the CYSHCN Program will further improve services, referrals, and specialized resources for CYSHCN and their families in Nevada. The CYSHCN Program will continue to share COVID-19 resources with community members and families, emphasizing resources related to CYSHCN and to ensure MHP resources are up to date. Specific needs of high priority CYSHCN will be shared with NSIP; for example, conversations related to sickle cell anemia and hemoglobinopathies are ongoing in preparation and planning efforts.

Medical Home Portal

To increase awareness of the MHP, each Title V MCH funded partner will continue to promote the MHP as part of their scope of work. The MHP will continue to be promoted to medical providers in Nevada to increase referrals to needed resources and to families to provide easy access to local or statewide resources for a variety of health-related and social services. With prior promotional success utilizing social media, more campaigns will be launched in FFY 2020. The MHP increases knowledge of the Medical Home Model and CYSHCN-specific content, is available in multiple languages, and is an easy-to-use conduit to connect CYSHCN, their families, and providers to resources for needed services state and nationwide. The CYSHCN Program Coordinator provided COVID-19 resources to the MHP which are now available and changes in search terms queried by end users will be monitored for feedback on CYSHCN areas of need.

Nevada Center for Excellence in Disabilities

NCED will continue to develop a program with Title V MCH funding designed to help children and youth with and without special health care needs transition from pediatric to the adult health care system without loss of medical coverage, as well as increased referrals to and promotion of the MHP. The program will continue to offer online trainings using the Got Transition six core elements, related resources, and case-based discussion. Online courses allow easy access to providers in the rural and frontier communities and Nevada's larger counties.

Social Media Promoting Access to Care

Title V MCH will continue to fund social media efforts to promote the MHP and health care transition. Messages and videos will target providers, parents, and caregivers of children and youth with and without special health care needs. Social media exposure allows information to be available through individuals' personal Facebook, Instagram, and Twitter accounts with opportunities to reach those not actively seeking services.

Family TIES of Nevada (FTON)

The board of directors for Family TIES of Northern Nevada decided to disband the organization effective June 30,

2021. The activities, goals and objectives will be administered by another agency. Title V MCH staff is drafting a subaward with UNR through the NCED.

Emergency Preparedness and Response Action Learning Collaborative

MCAH staff will continue to participate in EPR-ALC collaborative efforts to enhance the integration of MCH populations in EPR plans. The PHEP Program and MCAH will continue to collaborate to meet ALC action items.

Northern Nevada Cleft Palate Clinic

COVID-19 affected the NNCPC, and they were unable to perform normal operations from March through September 2020. In cooperation with NNCPC, Title V MCH decided to redirect the funding to the NCED to enhance transition to adult healthcare efforts for children with and without special health care needs.

University Center for Autism and Neurodevelopment

Title V MCH funded UCAN to purchase and disseminate Milestone Moments booklets. However, Title V funding will not be used for UCAN to attend trainings for professionals and parents related to neurodevelopmental disorders.

Nevada Critical Congenital Heart Disease Registry

The Nevada CCHD Registry's goal is to increase survival of newborns with CHD and to reduce loss to follow-up. The Registry will continue to ensure Nevada-born infants are screened for CCHD and those diagnosed with CCHD receive timely and appropriate medical care. The Title V MCH Program will continue to collect and report data annually. The Title V MCH Program, in conjunction with NHA and AHA, will continue to provide technical assistance to ensure Nevada birthing hospitals report CCHD screenings. Emerging CCHD data will be explored.

Developmental Screening

The Children's Cabinet will be awarded Title V MCH funds for developmental screenings using the Pyramid Model framework. The ASQ-SE2 and ASQ-3 developmental screenings will continue statewide, focusing on Nevada's frontier and rural areas. Online implementation of ASQ-SE2 and ASQ-3 screenings will be available, along with promoting the *Learn the Signs. Act Early* campaign. Nevada WIC staff will provide resources to refer a child when indicated. Families will be provided with Milestone Moment booklets in English and Spanish or given information on accessing the CDC mobile app tracker to monitor their child's development. MCH will participate in a statewide co-funded effort led by UNR related to printing and distributing Nevada-customized CDC Milestone Moments booklets.

The Children's Cabinet and Nevada Technical Assistance Center on Social Emotional Interventions

The Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) will continue to focus on frontier and rural areas of the state. TACSEI will meet with staff at private, religious, charter, public, preschools, and daycares to implement screenings and programs. The Family Engagement Coordinator (FEC) will continue to conduct technical assistance (TA) and training based on the Pyramid Model to personnel within organizations serving CYSHCN 0-5 years of age. The FEC will also continue to facilitate parent involvement in TA development, implementation, and evaluation to support family engagement in early care and education settings. The Regional Coordinator (RC) and fellow TACSEI staff will attend summit and leadership meetings to increase program reach. Online implementation of the ASQ-SE2 screenings and data collection will continue, along with the distribution of Milestone Moment booklets in English and Spanish. Through CCDF funding, The Children's Cabinet contributed $5,000 towards the reprinting of these booklets and our Reno, Elko and Las Vegas offices all serve as statewide distribution locations for these booklets.

Cross-Cutting/Systems Building Annual Report

Primary Care Office Report

The Nevada PCO improves health care access through its efforts to coordinate the federal shortage designation process, the J-1 Physician Visa Waiver Program, and other recruitment and retention programs. These efforts are supported by a strong collaboration between the PCO and MCH, Area Health Education Centers, the Office of Rural Health, health care training programs, community health centers, rural health clinics, Tribal clinics, rural hospitals, and other safety-net healthcare sites. The PCO receives base funding from the federal Health Resources Services Administration (HRSA) to support its efforts. Because this work helps to improve healthcare access for maternal, child, and adolescent populations, the HRSA MCH Title V grant to Nevada supports 0.29 FTE in the PCO. Staff in the PCO continue to support MCH initiatives through regular participation in MCHAB meetings and quarterly reports of PCO progress relating to MCH goals. The PCO is also regularly briefed by and collaborates with MCAH staff at quarterly Data Sharing Meetings hosted by the PCO and push out MCH information to provider listservs.

PCO Shortage Designation

Auto-HPSAs support FQHCs, the Indian Health Service, Tribal health care sites, and Rural Health Clinics throughout Nevada. The PCO strongly advocated for communication measures that support state safety net clinics. The PCO provided technical assistance related to expansion and designations to 41 clients. The PCO facilitated quarterly meetings to identify critical priorities and sources for the five-year Needs Assessment report. The PCO provided technical assistance to 39 clients relating to needs assessment and data sharing.

PCO National Health Service Corps and Nurse Corps Program Coordination

During this year, National Health Service Corps (NHSC) outreach activities included 11 health clinic site visits, 16 webinars/outreach events. These activities increase awareness of the program and subsequent program participation, which leads to increased recruitment and retention of health providers for underserved maternal, pediatric, and adolescent populations. The PCO reviewed 19 NHSC site applications. These safety-net health care sites serve all patients regardless of ability to pay and represent critical primary care, mental health, and dental access points for maternal, pediatric, and adolescent populations in Nevada. There were 154 total loan repayment participants in Nevada FY2020 within the Primary Care, Mental Health, and Dental provider types. The PCO provided technical assistance to 157 clients.

PCO J-1 Visa Waiver Program

Eleven applications were reviewed, public hearings held, and letters of support completed for primary care, mental health, and specialist physicians to participate in the J-1 Physician Visa Waiver program. These doctors will serve underserved populations in Las Vegas, Carson City, Reno/Sparks, including maternal, pediatric, and adolescent populations. Additionally, 11 participant compliance site visits were completed to provide technical assistance and ensure compliance with program requirements. The PCO offered technical assistance to 216 clients.

Interorganizational Collaborations

The PCO Newsletter was published in January, April, and July and included multiple articles supporting maternal, child, and adolescent health. Informational articles included: resources promoting Healthy Behavioral and Emotional Development in Adolescents; Bright Futures Highlights; The Nevada Leadership Education in Neurodevelopmental and Related Disabilities solicitation for applications; Clinical Management of MIS-C Associated with Coronavirus Disease; #WellChildWednesdays to encourage parents to keep up with pediatric checkups and immunizations; Six Core Elements of Health Care Transition and Revamped Got Transition Website; HRSA MCH COVID-19 FAQs; Medicaid provider relief fund for Medicaid/Chip/Dental providers; Nurse Corps loan repayment with highlights on Psychiatric Nurses and Women's Health to increase field strength of nurses that provide maternity care to women living in rural and underserved communities; NHSC programs; New Systemic review of HCT outcomes, free online transition CME available; CYSHCN; Sickle Cell Disease and Mentoring program; Nevada Medicaid provider announcement regarding Telehealth services from NV Medicaid; and the 2020 National Health Service Corps New Site Application cycle.

The PCO attended the Washoe County School District Career Expo two-day event in November 2019. Over 5,000 8th graders attended, and the students were introduced to the NHSC loan and scholarship opportunities for health care providers. PCO also participated at the Nevada Rural Health Day, where they presented building health workforce capacity in rural Nevada and the role of loan repayment programs and Conrad 30 J-1 Visa Waiver Program. In February 2020, PCO presented to approximately 400 UNLV resident students on the NHSC programs.

The PCO experienced some challenges due to the pandemic and position vacancies/absences but overall has been able to stay on track and fulfill the major responsibilities and goals of the program.

The PCO was unable to travel or complete any in-person visits during the pandemic but was able to smoothly transition to mainly electronic processing and virtual visits through Zoom and Teams.

Adequate Insurance Report

The Title V MCH Program sought to increase the percentage of children, ages 0 through 17, who are continuously and adequately insured (NPM 15). According to the NSCH 2017-2018 report, 63.4% of Nevadan children, ages 0 through 17, were continuously and adequately insured compared to 67.5% nationwide. To improve the percent of children who are adequately insured in Nevada, the Title V MCH Program utilized several strategies to accomplish this goal. Title V MCH collaborated with other programs, agencies, and community organizations, and drafted and distributed informational brochures. Title V MCH also funded groups to provide insurance application assistance and referrals.

The Title V MCH Program increased access to care by actively promoting Medicaid referral, annual open enrollment periods, Katie Beckett information, and essential health benefits. Title V MCH provided training on what Medicaid expansion means for MCH populations to providers and community-based partners and allies. A Title V MCH Program one-sheet on Senate Bill 325 of the 79 Session of the Nevada Legislature to increase Medicaid utilization for legally present youth under 19 years old was promoted. Additional resources, including Medicaid information on the Nevada 211 MCH page, within the customized state text4baby messaging, on the MHP, and through the CYSHCN statewide helpline, were also promoted.

Title V MCH staff arranged for a training to Nevada 211 call specialist staff on Medicaid enrollment and expansion at the beginning of 2021's open enrollment period. Experts from DWSS, DHCFP/NV Medicaid, and Nevada Health Link provided an overview of Nevada's public and private insurance system and how the call specialists can assist individuals with the application process. Updated guidance to call staff was valuable since COVID-19 necessitated a shift to online or telephone services for enrollment, rather than individuals using local offices and outreach workers in the field.

Title V MCH staff disseminated 17,325 brochures (9,175 English/8,150 Spanish) highlighting the value of yearly adolescent checkups and how to apply for health insurance. Primary distribution partners included DWSS, DCFS, Nevada

Health Link, Title V MCH funded partners, and community agencies working to enhance the uptake of yearly adolescent well-visits. Due to COVID-19, hard copy brochure distribution was 44% less than the previous year as agencies mainly conducted business online or through the telephone. All distribution partners received electronic links to the documents for posting on agency websites or disseminating listservs.

Adequate Insurance – Partner Efforts

Family TIES of Nevada (FTON), Nevada's Family Voices affiliate, awarded Title V funding, provided enabling resources and care coordination to families with CYSHCN statewide. FTON assisted clientele with insurance applications, disseminated informational health insurance brochures, including Katie Beckett waiver information, and referred families to applicable providers for needed services in southern and northern Nevada.

CCHHS in northern Nevada, awarded Title V MCH funding, disseminated brochures with information regarding insurance enrollment. CCHHS referred uninsured families to Nevada 211 to obtain health insurance benefits information and conducted Facebook campaigns promoting Nevada 211 and the MHP, reaching 6,486 individuals. Staff assisted five local health and social service agencies in placing business listings into the Nevada 211 database. CCHHS also partnered with DWSS for on-site Medicaid application assistance. Before the pandemic, 303 individuals were enrolled before on-site activities were discontinued. Promotion of services and resources to access insurance were distributed to clinic patients and displayed on the clinic's digital signage.

Partners Allied for Community Excellence (PACE) Coalition, serving Elko and the nearby counties, was awarded Title V MCH funds to support a CHW. The CHW enrolled eligible community members into Nevada Medicaid and Nevada Check Up (Nevada's Children's Health Insurance Program) and referred families to Nevada 211 to obtain additional resources related to health insurance benefits. Additionally, the CHW provided information to local health and social service agencies to place business listings into the Nevada 211 database. The CHW enrolled two individuals into Medicaid and assisted eight people in accessing healthcare services and other supports necessary to improve health outcomes. Due to staff turnover early in the award period, PACE discontinued on-site insurance assistance since the newly hired CHW did not have the necessary training. The new employee did not speak Spanish, leaving PACE Coalition unable to assist the usual clientele with health and social service resources since patrons were primarily Spanish speakers and needed translation.

The MIECHV Program within the MCAH Section exists to develop and promote a statewide coordinated system of evidence-based home visiting supporting healthy child development and ensures the safety of young children and family members. MIECHV works directly with families to facilitate completion of insurance enrollment referrals to increase adequate insurance coverage and is partly funded by Title V MCH.

CHNs are part of the DPBH CHS Program and provide access to medical services in underserved areas including, but not limited to family planning outreach and education and referral and navigation to care as needed. CHNs, awarded Title V MCH funding, provided insurance resources and referrals to uninsured people in Nevada's rural and frontier regions through Nevada Medicaid, Nevada Check Up, and Nevada Health Link (state online insurance marketplace). Undocumented residents and those not eligible for Medicaid or other insurance were referred to the AHN Medical Discount Plan.

The Title V MCH-funded Washoe County FIMR studies a variety of factors affecting the health of the mother, fetus, and infant to learn more about how to reduce fetal and infant mortality. To identify insurer-specific opportunities to reduce infant mortality gaps and look for opportunities to expand care, FIMR tracks the mother's insurance type during pregnancy and separates categories based on private, Medicaid, and no insurance.

The DHCFP/NV Medicaid works in partnership with the U.S. Centers for Medicare & Medicaid Services to provide quality

medical care for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of traditional FFS provider networks and three large contracted MCOs. Medicaid partners with Title V MCH for informational and referral resources on the Katie Beckett waiver program, development of the one-sheet on Medicaid coverage for legally present children, and many other NPM 15-related efforts. Efforts between DHCFP/NV Medicaid, DHHS, and Title V MCH staff focused on increasing adequate prenatal care.

Office of Suicide Prevention and Hotline Report

Title V MCH funding helps support the Nevada OSP through the provision of outreach and education, facilitated information-sharing, and consensus-building among multiple constituent groups. New partnerships were created with numerous urban and rural hospitals across the state to expand Nevada's Zero Suicide Initiative to improve depression and suicide care in healthcare systems.

OSP conducted suicide education and prevention courses for participants across the state. Due to COVID-19, most trainings were provided virtually, allowing for enhanced opportunities for suicide awareness trainings to health care providers, DPBH staff, and parents. Statewide trainings were conducted for acute care hospitals, free-standing psychiatric hospitals, community-based providers, coalitions, faith-based providers, and volunteers. The safeTALK training, a suicide prevention course using the model *Tell, Ask, Listen, and Keepsafe*, reached 1,518 community members and school staff. The evidence-based Applied Suicide Intervention Skills Training (ASIST) taught Pathway for Assisting Life model intervention skills to 259 providers or caregivers. The Nevada Gatekeeper trainings provided information about suicide prevention, statistics, and what to look for, and how to help. The trainings reached 1,779 participants, including nurses and other healthcare providers, school personnel, family and youth-serving staff from Nevada DCFS, Clark County Department of Family Service, and Washoe County Human Services.

OSP supported Youth Mental Health First Aid (YMHFA) and school-based suicide prevention programs which enables adults to better recognize and assist adolescents in need of intervention. Statewide, mental health literacy was enhanced by training 561 community helpers to identify youth mental health risks using the YMHFA model. OSP worked with the NDE Office of Safe and Respectful Learning Environments on a multi-tiered system of support (MTSS) to threat assessment teams and practicing of protocols across Nevada school districts. OSP provided technical assistance and resources to help school districts implement the requirements passed in the previous legislative session.

Title V MCH funds supported the Crisis Support Services of Nevada (CCSNV) phone and text lines which served 87,968 people. The most common issues of concern were:

- Family/relationship issues.
- Finances/basic needs.
- Mental health worries.
- Suicide ideation/attempts.
- Domestic/intimate partner violence.

Suicide-related concerns represented 15% of users. Of those who provided gender, 40% were female, 30% male, and less than 1.5% reported as transgender or gender fluid. Most users were between ages 25-40 y.o. with 6% under age 18 y.o.

In July 2020, the Federal Communications Commission (FCC) adopted rules designating a new phone number for individuals in crisis to connect with suicide prevention and mental health crisis counselors. CCSNV has partnered with DPBH to help build staff capacity to increase in-state Lifeline call answer rates. In FFY21, CCSNV will begin preparing for the two-year transition when phone service providers will direct all 988 calls to the National Suicide

Prevention Lifeline.

Nevada Oral Health Program Report

Title V MCH provided funding to the Oral Health Program in support of a pilot that included outreach to pregnant people and children, including mobile services and prescriptions of prenatal oral health care. Dr. Antonina Capurro, the State Dental Health Officer, and Ms. Shauna Tavcar, Social Services Program Specialist III with DHCFP, collaborated in reviewing and rewriting the Medicaid Services Manual 1000 Dental with the goal to increase preventive dental services while identifying areas to reduce redundancies and clarify the intent of the chapter. Dr. Capurro and Ms. Tavcar also collaborated with Dr. Amy Tongsiri, Nevada Dental Director of Liberty Dental Plan, to analyze the coverage, limitations and prior authorization requirements for the Nevada Medicaid and Nevada Check Up Dental Program. CPT codes and service limits are under review and the fiscal impact is under evaluation.

The Oral Health Program collaborated with Liberty Dental Plan and the University of Medical Center of Southern Nevada to redirect non-traumatic dental conditions within the emergency department and refer for definitive dental care. The project team provided a formal presentation to the April meeting of the Nevada Medical Care Advisory Committee.

Tobacco Cessation Report

All Title V MCH funded programs promoted the Nevada Tobacco Quitline to pregnant persons and women of childbearing age. CCHHS and CHS clinics provided people who smoke tobacco education and counseling. Referrals to the Nevada Tobacco Quitline were supplied to 7,159 individuals of all ages. CCHHS promoted the Nevada Tobacco Quitline through paid and earned media that reached over 14,500 individuals. CCHHS collaborated with health care providers working in behavioral health settings and substance use treatment facilities to educate them on Nevada Tobacco Quitline. These collaborations are intended to help a disparate population (with behavioral health conditions and/or substance use issues) be connected to a Tobacco Quitline resource.

The Tobacco Control Program Annual Report

The CDPHP TCP disseminates Nevada Tobacco Quitline (NTQ) promotional material to Nevada providers, WIC clinics, early childhood educators, and Nevada Head Start sites. The promotional materials are given to pregnant and postpartum women who use tobacco. The NTQ continues to provide callers 13 years and older with up to five scheduled personalized, culturally competent coaching sessions, unlimited inbound calls, web and text support, and Nicotine Replacement Therapies (NRTs) free of charge to callers ages 18 and older, upon availability. The Pregnancy/Postpartum Program (PPP) offered mothers in Nevada a designated trained coach throughout each session along with incentivized gift cards for each completed counseling call. According to the guidelines of the PPP program, each pregnant caller was enrolled before giving birth to ensure eligibility for both programs. PPP provides five (5) coaching sessions during pregnancy and four (4) coaching sessions postpartum, and the same coach administers each session. This allows the parent to focus on their health and the baby, creating longevity for both through cessation. Comprehensive printed educational materials on the benefits of quitting smoking during pregnancy and harmful effects on babies were provided upon each enrollment process.

The NTQ enrolled 1,828 callers during the program period, which included five (5) pregnant people. The NTQ offers a free program specializing in helping pregnant people quit smoking. The tailored treatment plan meets their needs by providing intensive behavioral support, including an increased number of coaching calls compared to the general population. As an incentive, reward gift cards for $5 and $10 are given after scheduled and completed counseling calls. For pregnant and new parents who have quit, additional postpartum support is available to prevent relapse. NTQ uses evidence-based treatment practices to help pregnant smokers quit and remain tobacco-free. Although the

call volume was limited, outreach was expanded to CHWs, women's health care providers, WIC clinics, and events in the community. MCH opportunities to heighten NTQ awareness are being implemented, including promotion by all Title V MCH funded partners and the Chronic Disease Coalition monthly newsletters.

Sober Moms Healthy Babies Report

Title V MCH continued to work with the SAPTA list of SAPTA-funded treatment providers to update the *SoberMomsHealthyBabies.org* website to prevent substance use in expectant parents, as well as provide information to women of childbearing age, providers, and concerned family and friends. The website provides the substance use help line number, Nevada 211, Crisis Call Center, the Nevada Tobacco Quitline, and other resources. The website specifies the treatment priority status for pregnant people at SAPTA-funded agencies and the importance of women identifying they are pregnant. SAPTA-funded treatment centers must not deny treatment to persons unable to pay. All treatment centers listed on the website are SAPTA-funded.

The public awareness campaign uses radio and television public service announcements in English and Spanish throughout the state to promote the www.SoberMomsHealthyBabies.org website, in addition to the distribution of window clings and referral cards. The collaboration ensures substance use in pregnancy materials and resources will reach the intended audience. The 2020 media campaign had a total of 10,742 total spots aired (9,118 radio advertisements and 1,624 television advertisements), promoting the *SoberMomsHealthyBabies.org* website and the importance of pregnant persons receiving treatment and preventing substance use in persons of childbearing age. All LHAs and MCH subgrantees promoted the *SoberMomsHealthyBabies.org* website and shared SMHB referral cards.

To raise awareness on the priority admission of pregnant people at state-funded treatment centers, Title V MCH continued to disseminate removable wall stickers promoting the *SoberMomsHealthyBabies.org* website. Title V MCH is in contact with state agencies and LHAs that have agreed to help with distribution and promotion. Partnerships with the Department of Taxation, Division of Health Care Finance and Policy (DHCFP), SAPTA, local hospitals and providers, March of Dimes, faith based and MCH Coalitions, and other DPBH programs continue. PRAMS data inform efforts and will be presented to the OMNI Core Team.

All three LHAs participated in sharing substance use in pregnancy resource distribution. CCHHS, with Title V MCH funds, endorsed pregnant and postpartum women being substance free through their clinic digital signage and social media. Facebook messages with information about the SMHB website reached 4,082 families.

Title V staff participated in CARA and NAS focused efforts and serve as a core team member on the ASTHO OMNI and PRISM Nevada Team and on numerous subcommittees focused on reduction of substance use in pregnancy and building systems of referral for families with substance exposed infants. LARC and Community Reproductive Engagement Committee MCH Director staff involvement also dovetailed with substance use prevention efforts, as did engagement on possible Title V Families First efforts.

Marijuana Efforts Annual Report

he Nevada Title V MCH Program has continued to disseminate Spanish and English marijuana awareness materials to partners statewide. These materials were developed in the last funding year in response to Nevada's legalization of medical and recreational marijuana, and the Title V MCH program developed informational resources on pregnancy, breastfeeding, and marijuana. The Title V MCH Program developed public service announcements (PSAs) promoting awareness, in addition to posters displayed in all dispensaries related to use in pregnancy and injury prevention and marijuana for children. The Title V MCH program funds efforts to reduce substance misuse in pregnancy and improve inter-conception care. They include promoting the SoberMomsHealthyBabies.org website and associated media campaigns and focusing on perinatal activities and reduction of NAS. Title V MCH funded partners promote SoberMomsHealthyBabies.org through social media and print materials developed by Title V MCH, in addition to the

Substance Use During Pregnancy Toolkit, marijuana use and pregnancy information and posters, and marijuana and childhood injury prevention warnings.

SoberMomsHealthyBabies.org referral cards, Title V MCH marijuana awareness posters, and removable wall stickers are provided to all dispensaries; informational sheets are distributed widely through FIMR and the LHAs.

COVID-19 Efforts

COVID-19 guidelines requiring masks being worn in public can pose communication barriers for individuals who are deaf and hard of hearing (D/HH). Title V MCH funded the purchase of face masks with a clear window to six school districts and two partners working with children or parents who are D/HH. The transparent section of the mask allows the wearer's lips to be visible, making lip-reading and the speaker's facial expressions possible.

MCAH staff added COVID-19 MCH population-related content to the DPBH website http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/. Materials included Nevada's response to the pandemic, as well as information and resources for children with and without special health care needs, in addition to all other populations served by the award. Identified links sent viewers to the CDC COVID-19 resources in American Sign Language via YouTube and Spanish language content. The CDC materials and placement of the links were shared widely with funded partners and allies. The statewide MCH Coalition and PCO disseminated the materials through listservs. MCAH staff are engaged in COVID-in-pregnancy surveillance monitoring discussions with CDC as part of an OPHIE-led team; MIS-C efforts; share COVID-19 resources and technical bulletins to partners to support rapid information sharing; and have reached out to partners and subawardees to see how COVID-19 is affecting their efforts/activities and to assist with any technical assistance and/or adaptations or fiscal redirects as needed.

DPBH selected Nevada 211, one of the partially Title V MCH funded programs to operate the statewide Nevada Resilience Project https://www.nevada211.org/nevada-resilience-project/. In cooperation with the Federal Emergency Management Agency (FEMA), the one-year grant established through SAMHSA helps families and individuals experiencing struggles and challenges due to COVID-19. Bilingual ambassadors provide education, information, counseling, and resource navigation over the phone, through text and video chat, and face-to-face while promoting resilience, healthy coping, and empowerment. Title V MCH staff promoted NRP to funded partners and collaborators. Additionally, in FFY 21, state staff shared the launch of two Nevada 211 mobile apps to help Nevadans connect with needed resources in response to the pandemic. The Nevada 211 Youth app complements the initial app for individuals and families. It specifically helps young people locate services and resources such as health care, crisis support, employment services, food pantry locations, and emergency housing programs. All Title V MCH funded partners were requested to promote the NRP.

Emergency Preparedness and Response Action Learning Collaborative

MCAH staff participated in the Emergency Preparedness and Response Action Learning Collaborative (EPR-ALC). The EPR-ALC is a collaboration between the CDC and AMCHP to provide technical assistance to states to aid in developing or enhancing the integration of MCH populations in their EPR plans. Title V MCH staff are working with the PHEP Program and the LHAs to meet ALC action items. PHEP is drafting Nevada's first Pediatric Medical Surge Annex and is receiving support from MCAH staff. The plans address access and functional needs, behavioral health, newborn screening, coordination of services with WIC and other MCAH components during a medical surge event.

Multiple emergency response annexes or components may need to be activated simultaneously to address the needs of those affected by a disaster, including CYSHCN, and expectant parents. Other examples include providing contraception for nonpregnant and postpartum people and preventing intimate partner violence.

Cross Cutting Domain Accomplishments

Despite challenges posed by the pandemic, funded partners were able to dedicate efforts to help MCH populations with education, resources, and referrals to improve overall health. MCAH staff added COVID-19 MCH population-related content into the DPBH website and shared pandemic information and resources with partners pertinent to all populations served by the Title V MCH award. To gain more data about opioid use during pregnancy, Nevada PRAMS staff applied for supplemental opioid funding in 2017 and were awarded funds in September 2018. Thirteen additional questions pertaining to opioid use during pregnancy were included in the 2019 survey. In response to Nevada's legalization of medical and recreational marijuana, informational resources on pregnancy and marijuana use continue to be disseminated. Nevada's Title V MCH Program partnered with the Department of Taxation to distribute Child Injury Prevention and Pregnancy and Marijuana prevention materials to all marijuana dispensaries in Nevada.

Cross Cutting Domain Data

NPM 14.1- Percent of women who smoke during pregnancy

According to NVSS data, the percent of women who smoke during pregnancy in Nevada has been steadily declining from 2012 to 2019, from 6.3% to 3.5%. This is significantly lower than the 2019 U.S. national average of 6%. Nevada ranks 7th lowest for this measure of the 50 states and D.C. When 2019 Nevada data is stratified by health insurance, 5.6% of women on Medicaid were found to smoke during pregnancy, compared to 4% of those who were Uninsured, 1.9% of those who had other public insurance, and 1.7% of those who had private insurance.

NPM 14.2- Percent of children, ages 0 through 17, who live in households where someone smokes

The 2018-2019 NSCH found that 15% of Nevada children ages 0 through 17 live in households where someone smokes, a percentage that has been steadily declining from a high of 17.7% from 2016-2017. Nevada is slightly higher than the national average of 14.4% over 2018-2019. Nevada ranks 22nd lowest of 50 states and D.C. When stratifying Nevada data by health insurance, households with Medicaid insurance have the highest percentage for someone who smokes, with 21.2%. Households with private insurance have 12.9%.

NPM 15- Percent of children, ages 0 through 17, who are continuously and adequately insured

According to NSCH the percent of children who are continuously and adequately insured has remained stable from 2016 to 2018-2019 at 62.4%. This is significantly lower than the 2018-2019 US national average of 66.8%, and Nevada ranks 43rd lowest out of the 50 states and D.C. Disparities exist in Nevada for this measure, as Non-Hispanic Black children are least likely to be continuously and adequately insured (54.9%). Hispanic children are also slightly below the Nevada average at 61.6%. Non-Hispanic White, Non-Hispanic Asian, and Non-Hispanic Multiple Race are above the Nevada average, at 62.8%, 65.1%, and 70.2% respectively.

Cross-Cutting/Systems-Building Plan for the Application Year

Primary Care Office Plan

Most of the activities outlined above will be repeated in the new budget year to continue coordinating the PCO's functions with the NHSC and Nurse Corps, the shortage designation process, and the J-1 Physician Visa Waiver Program. The major efforts of the PCO will include the following:

1. Coordinate the shortage designation process in Nevada. The National Shortage Designation Update (NSDU) modernization project involves updates to existing geographic, population and facility HPSA designations, at a single point in time, using national, standardized data sets. The next NSDU is currently scheduled for Late-Summer/Early-Fall 2021 and those designations proposed for withdrawal during the 2021 NSDU will be officially withdrawn in 2022 when published in the Federal Register unless additional updates are made to the designation prior to that.
2. Complete a gap analysis to identify Rational Service Areas (RSA) that support contiguous area analysis for the entire state and define boundaries for RSAs to cover all of Nevada. Work with strategic partners to draft a RSA Plan RSAP) for Nevada to include a profile and data driven justification.
3. Utilize innovative technologies and methodologies to provide outreach and expand utilization of BHW programs and the J-1 Physician Visa Waiver Program;
4. Support Nevada DHHS efforts to expand utilization of BHW programs and to expand healthcare access to underserved populations in the state.

PCO Utilization of Technology and Methodologies in Outreach

One of the PCO's major goals is to increase the effective utilization of technology and new methodologies to reach a wider audience. In the upcoming budget year, training webinars are being planned to provide outreach for the major NHSC and Nurse Corps programs and for the NHSC new site and site recertification application cycles. Because not all students or staff can attend a webinar, the PCO will create outreach videos that will be accessible through YouTube or other platforms so that individuals can watch at their convenience. These videos will be advertised in the newsletter and via community partners.

A similar method will be utilized to promote and market the Conrad 30 J-1 Visa Waiver program. This technique involves utilizing existing J-1 Visa Waiver Program participants to market the Nevada program to their social and professional circles. The PCO will develop videos and messages that can easily be shared.

PCO Support of DHHS and State Health Workforce Development Efforts

The PCO has been assigned to fulfill an active role in many DHHS efforts to improve the delivery of healthcare resources to disproportionately affected populations throughout the state. One such initiative was an assignment to work with health professionals, the Nevada Office of Rural Health, and the legislature to strategically improve rural and frontier health access. One of the most innovative state efforts in mental health has been supporting value-based payment methodologies in Certified Community Behavioral Health Clinics (CCBHCs) in urban and rural areas. The PCO also provided technical assistance to existing CCBHCs to become approved NHSC sites to support their recruitment and retention efforts. Lastly, DHHS has tasked the PCO with providing support to assist Medicaid and Healthcare Quality and Compliance efforts to improve access to primary care.

The PCO also reviews and facilitates the Certificate of Need program on behalf of the Director for the construction of new health facilities that cost over $2 million in all rural communities in Nevada to control the cost of health care,

provide adequate supply and distribution of resources, and provide equal access to health care of good quality at a reasonable cost.

The PCO will continue to partner with the MCH program to achieve the common goal of increasing primary care providers statewide that support child, adolescent, and maternal health. Additionally, PCO staff will support data requests that assist the MCH program in identifying primary care workforce shortages and in targeting their resources to the areas of greatest need.

Adequate Insurance Plan

The Title V MCH Program will continue to actively work with our partners to promote insurance referral and enrollment, especially among underserved populations and those living in rural and frontier regions. All Title V MCH-funded agencies will continue to refer uninsured families to Nevada 211 and the MHP to obtain health insurance benefits information. CCHHS will continue its partnership with Nevada DWSS to support onsite, walk-in application assistance to enroll in Medicaid. Additionally, CCHHS will promote Nevada 211, the MHP, and onsite walk-in insurance enrollment through digital signage and social media campaigns. Outreach will continue to uninsured clientele on options for health care coverage. In the rural and frontier regions, nursing personnel within DPBH CHS will provide information about Nevada Medicaid, Nevada Check-Up, and Nevada Health Link (state online insurance marketplace). Non-US national residents and those not eligible for Medicaid or other insurance will continue to be referred to AHN.

The Tobacco Prevention and Control Program Plan

All Title V MCH funded agencies will continue to promote the Nevada Tobacco Quitline (NTQ). Sharing information regarding the Quitline with women of childbearing age is explicitly articulated within the scope of work for each funded program serving this population. MCH staff will work with NTQ staff and Nevada 211 to improve data collection so utilization by women of childbearing age can be tracked efficiently. CHS and CCHHS and other MCH funded partners will provide tobacco cessation counseling, educational materials, and referrals to pregnant persons and women of childbearing age.

Increasing collaboration between the NTQ and MCH will help promote tobacco cessation for pregnant/postpartum persons. In addition, CDPHP will continue disseminating targeted NTQ promotional material for pregnant and postpartum persons who use tobacco to increase uptake and utilization. Resources specific to pregnant people will continue to be shared by the Title V MCH MIP Coordinator.

Tobacco Cessation Plan

All Title V MCH funded agencies will continue to promote the Nevada Tobacco Quitline. DPBH CHS nursing clinics and CCHHS will provide tobacco cessation counseling, educational materials, and referrals to expectant parents and women of childbearing age. Additionally, CCHHS and CHS will continue to utilize the Brief Tobacco Intervention developed by the Agency for Healthcare Research and Quality (AHRQ) to address tobacco use.

Sober Moms Healthy Babies Plan

Title V MCH will continue to fund the *SoberMomsHealthyBabies.org* website to prevent substance use among pregnant people. The public awareness campaign will also continue to promote the website, in addition to the distribution of referral cards and removable wall stickers. Collaboration with LHAs, ASTHO OMNI and PRISM members, and SAPTA will ensure substance use in pregnancy materials and resources will be promoted.

All LHAs and MCH subgrantees will continue to promote the *SoberMomsHealthyBabies.org* website and share

SMHB referral cards. CCHHS will use Title V MCH funds to promote the website through their clinic's digital signage and social media posts.

Title V staff will participate in CARA and NAS focused efforts and serve as a core team member on the ASTHO OMNI/PRISM Nevada Team and on numerous subcommittees focused on reduction of substance use in pregnancy and building systems of referral for families with substance exposed infants as efforts continue to create a robust continuum of care for families.

Marijuana Efforts Plan

Title V MCH will continue to disseminate marijuana awareness materials to partners statewide. The Substance Abus Prevention and Treatment Agency (SAPTA) will continue the work started by Title V MCH, funding the media campaig aimed to raise awareness on marijuana use during pregnancy. Title V MCH staff will work with Nevada WIC to ensure marijuana materials are administered to WIC clinic statewide, as well as continue the SoberMomsHealthyBabies.org website promotion through public service announcements (PSAs) in English and Spanish on radio and television stations statewide.

Emergency Preparedness and Response Action Learning Collaborative

MCAH staff will continue to participate in EPR-ALC collaborative efforts to enhance the integration of MCH populations in EPR plans. The PHEP Program and MCAH will continue to collaborate to meet ALC action items.

Nevada Health Conference Plan

Immunize Nevada hosted the Nevada Health Conference in March 2021 and will likely hold the next conference in March 2022. The Title V MCH program will again provide funding, planning, and support. The Title V MCH program will also continue to provide funds for a number of scholarships to individuals unable to attend due to cost-related issues. Title V MCH Program will provide resources to participants along with conference materials, including crucial information on perinatal information and a pamphlet promoting the value of adolescent well visits and educating on how to sign up for health insurance, substance use during pregnancy awareness materials, and PRAMS. Title V MCH staff are members of the planning committee, and staff often present and facilitate at the conference.

Rape Prevention and Education Program Plan

The RPE Program will look for areas to align five- year project activities with the Title V MCH State Action Plan, particularly in relation to designing safer environments and fostering economic growth for adolescent and young women. RPE will address shared risk and protective factors through collaborative partnerships within the MCAH Section and other DPBH programs, as well as external agencies working with populations of interest. Goals for the coming year will focus on increasing the number of community strategies implemented, creating protective environments to protect against violence and provide opportunities to empower and support young women, and continuing efforts related to CYSHCN and sexual assault prevention in partnership with the Title V MCH CYSHCN Coordinator and Director.

III.F. Public Input

Public Input and Report

The Nevada Title V MCH Program strives to involve families and consumers in programmatic activities by collaborating with programs and agencies at the state and local levels. Realizing they bring with them diverse backgrounds and expertise, Nevada Title V MCH seeks feedback from families, adolescents, consumers, and stakeholders in the development and implementation of program activities. The initial draft and subsequent revisions of the MCH Block Grant were posted on the DPBH website.

A Five-Year Needs Assessment was required for the previous Title V MCH Block Grant application. The NHV Program was also required to include a Five-Year Needs Assessment for their previous grant application. Title V MCH and NHV Programs contracted with Health Management Associates (HMA) to conduct the needs assessment. HMA implemented a mixed method research design to inform the needs assessment, including multiple strategies to gather public input from across the state. First, HMA worked with MCH and NHV program staff to identify and interview key stakeholders working in MCH and NHV funded programs or working with MCH/NHV population groups. Key stakeholders identified additional contacts for interviews or focus groups through the interview process, which allowed access to a diverse number of stakeholders for information gathering. Second, an online community survey was dispersed via MCH and NHV staff, partner organizations, and on social media channels. Third, a series of focus groups were conducted across the state. Finally, HMA conducted secondary analysis on publicly available population health and surveillance data.

The Title V MCH Program Manager and the MCH Epidemiologist present a synopsis of the Title V Application and Annual Report to the Maternal and Child Health Advisory Board (MCHAB) after the grant is submitted and prior to the site visit. The MCHAB asks engaging questions and there is occasional input from other attendees from the public.

Since COVID-19 changed the needs for many of the Title V MCH partners, the MCH Epidemiologist and SSDI Manager used a public input survey to update the information supplied in the Five-Year Needs Assessment. The public input survey had 107 responses in English, with a 100% completion rate.

In the public input survey, the top three most important health problems/health issues for newborns and infants in the community where they live are: maternal substance use during or after pregnancy (49%), child abuse and neglect (40%), and not receiving developmental screenings (39%).

The top three most important health problems/health issues for young children (one to five years old) in the community where they live are: access to affordable childcare and/or pre-school (74%), caregiver substance use or mother/father substance use (32%), and child abuse/neglect (23%). For children (six to 11 years old), the top three most important health problems/health issues in the community where they live are: overuse of technology/excessive screen time (65%), mental health (38%), and physical activity (37%).

The top three most important health problems/health issues for adolescents (12 to 21 years old) in the community where they live are: mental health (79%), lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood (63%), and excessive use/inappropriate use of social media (26%).

Finally, for children and youth with special healthcare needs (birth to 21 years old) the top three most important health problems/health issues in the community where they live are: lack of adequate access to specialty medical care (60%), navigation of the system of care for CYSHCN (50%), and inadequate respite care (29%).

Title V MCH Block Grant applications and the Five-Year Needs Assessment are shared on the DPBH website.

III.G. Technical Assistance

Technical Assistance

Nevada Title V MCH is interested in exploring receiving Technical Assistance (TA) in the following areas:

1. Congenital Syphilis (CS) continuation of the prior TA request to convene peer states and look for connections to innovative practices to better integrate MCH and STI programs
2. SSDI and MCH integration best practices

Nevada Title V MCH initiated efforts to collaborate with other states experiencing high congenital syphilis (CS) rates, including Arizona, California, Florida, Louisiana and Texas . Nevada currently has the fourth highest CS rates in the United States and would benefit from any supports related to innovative practices to lower CS rates.

In addition, Nevada Title V MCH staff would like to learn more about how Title V MCH Programs integrate SSDI efforts and grow internal data evaluation capacity.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - C 17815 DHCFP(6-30-26)Executed.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Acronym List For Title V Block Grant 2022_2020.pdf

Supporting Document #02 - Nevada MCH Partners 2021.pdf

Supporting Document #03 - Nevada Title V MCH Logic Model.pdf

Supporting Document #04 - Newborn Screening Flow Chart.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - 3222 MCAH Org Chart June 2021.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Nevada

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,236,205	
A. Preventive and Primary Care for Children	$ 670,862	(30%)
B. Children with Special Health Care Needs	$ 670,862	(30%)
C. Title V Administrative Costs	$ 223,619	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,565,343	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,677,154	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,677,154	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,913,359	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 111,476,910	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 115,390,269	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 537,717
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 465,826
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 184,562
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 603,718
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 450,883
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 307,041
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 1,384,475
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 16,850,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,429,045
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 2,594,817
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 45,608,882
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 848,840
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Peer Counseling (BFPC)	$ 757,143

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market Nutrition Program (FMNP)	$ 399,918
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1815 Diabetes Heart and Stroke Programs	$ 2,065,826
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1817 Diabetes Heart and Stroke Innovation Funds	$ 750,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > BOLD Public Health	$ 350,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Cancer (NCPR)	$ 690,156
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > 1816 WISEWOMAN	$ 500,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > COVID-19 Health Disparities	$ 32,288,061

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,236,205		$ 2,002,924	
A. Preventive and Primary Care for Children	$ 670,862	(30%)	$ 609,001	(30.4%)
B. Children with Special Health Care Needs	$ 670,862	(30%)	$ 617,884	(30.8%)
C. Title V Administrative Costs	$ 223,619	(10%)	$ 128,446	(6.5%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,565,343		$ 1,355,331	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,677,154		$ 1,516,837	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 1,677,154		$ 1,516,837	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,913,359		$ 3,519,761	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 68,159,072		$ 82,532,152	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 72,096,270		$ 86,051,913	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 760,359	$ 487,750
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 564,708	$ 323,802
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 149,933	$ 145,330
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 191,665	$ 182,913
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 397,602	$ 361,624
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 2,174,000	$ 2,199,177
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000	$ 225,075
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 1,024,846	$ 959,867
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 847,137	$ 352,605
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 611,831	$ 700,519
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 794,315	$ 723,136
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 3,285,682	$ 5,599,569

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 48,077,330	$ 41,108,882
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,598,658	$ 3,585,236
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 344,117	$ 53,157
US Department of Agriculture (USDA) > Food and Nutrition Services > Child Nutrition	$ 3,021,889	$ 20,163,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1805 Cooperative Agreement	$ 2,065,000	$ 2,065,826
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Peer Counseling (BFPC)		$ 547,898
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > 1815 Diabetes Heart and Stroke Programs		$ 1,477,853
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1817 Diabetes Heart and Stroke Innovation Funds		$ 716,505
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Comprehensive Cancer (NCPR)		$ 552,365

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Title V MCH spending for FY 20 is less than the budgeted amount due to salary savings, restrictions imposed by the state budget and expenditure shortages due to COVID-10	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Title V MCH spending for FY 20 is less than the budgeted amount due to restrictions imposed by the state budget and expenditure shortages due to COVID-10	
3.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budget includes carry forward.	
4.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Funding for Vaccines for Children/Immunizations was increased due to additional COVID-19 funding	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Expended amount only. There isn't any budgeted funds for FFY22	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The Vaccines for Children/Immunizations Program was awarded additional funding due to COVID-19	
7.	**Field Name:**	**Other Federal Funds, US Department of Agriculture (USDA) > Food and Nutrition Services > Child Nutrition**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The Coronavirus Aid, Relief and Economic Security (CARES) funding was issued late in the SFY. $582,991.65 expended Oct 2020 – Dec 2020; Requested Extension of funds	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > 1805 Cooperative Agreement**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Actual budget exceeded the projected budget	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Nevada

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 255,706	$ 277,526
2. Infants < 1 year	$ 300,431	$ 271,140
3. Children 1 through 21 Years	$ 670,862	$ 609,001
4. CSHCN	$ 670,862	$ 617,884
5. All Others	$ 114,725	$ 98,927
Federal Total of Individuals Served	$ 2,012,586	$ 1,874,478

IB. Non Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 268,345	$ 228,867
2. Infants < 1 year	$ 301,887	$ 236,171
3. Children 1 through 21 Years	$ 503,147	$ 400,542
4. CSHCN	$ 503,146	$ 491,614
5. All Others	$ 100,629	$ 79,339
Non-Federal Total of Individuals Served	$ 1,677,154	$ 1,436,533
Federal State MCH Block Grant Partnership Total	$ 3,689,740	$ 3,311,011

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Nevada

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 559,051	$ 348,444
3. Public Health Services and Systems	$ 1,677,154	$ 1,654,480
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,236,205	$ 2,002,924

IIB. Non Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 419,288	$ 221,777
3. Public Health Services and Systems	$ 1,257,866	$ 1,295,060
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 1,677,154	$ 1,516,837

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Nevada

Total Births by Occurrence: 33,250 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out of Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	33,070 (99.5%)	1,502	63	60 (95.2%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Nevada Early Hearing Detection and Intervention (EHDI) Program	32,319 (97.2%)	509	53	51 (96.2%)
Critical Congenital Heart Disease	29,493 (88.7%)	31	31	31 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Once a case is acknowledged by the follow-up coordinator, the primary care physician (PCP) is contacted. If the PCP is incorrect or unknown, the parent is contacted. As soon as contact is made with the PCP, the American College ofMedical Genetics ACTion Sheet, parent information, diagnostic test information, and specialist contact information are sent to the PCP. At the same time, confirmatory testing is recommended. The follow-up coordinator helps organize and guide the PCP and the lab to complete appropriate testing. The reference lab is called again until the diagnostic results are received. If results are normal, they are faxed to the PCP, and the determination is closed. If positive results are confirmed, the PCP is contacted again for applicable treatment information. In metabolic cases, short term and long term follow up coordinate and the case is transferred. Once treatment is received or the infant is scheduled to a metabolic clinic, the determination is closed.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: NetSmart 2020 Births. This includes Nevada and non-Nevada resident births.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2020**
	Column Name:	**Data Source Year Notes**
	Field Note: Calendar Year 2020	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Newborn Screening Report Calendar Year 2020. Data are preliminary and subject to change.	
4.	**Field Name:**	**Core RUSP Conditions - Total Number of Out-of-Range Results**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Data are preliminary and subject to change.	
5.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Data are preliminary and subject to change.	
6.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**

	Field Note: Data are preliminary and subject to change.	
7.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: Nevada EHDI data uses calendar year 2019 data and are preliminary and subject to change. Due to EHDI data being on 2019 calendar year and Newborn Screening being on 2020 calendar year, the total number of occurrent births used to calculate the percentage of screenings done is not accurate for EHDI data. 2020 calendar year was unable to be obtained for EHDI. Thus, 2019 EHDI data was scaled so that the percentages matched between 2019 and 2020, which slightly changed the actual numbers. For example, 2019 EHDI data had 33770 screenings out of 34735 total occurrent births in calendar year 2019= 97.2%. When adjusting the percentage to 2020 occurrent births (33,250), the total number of screenings inputted was 32,319.	
8.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Presumptive Positive Screens**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The percentage of presumptive positive screens to 2019 total occurrent births was 1.53% (530). Scaling to 2020 total occurrent births gave 509 which was inputted.	
9.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The percentage of number of confirmed cases to 2019 total occurrent births was 0.16% (54). Scaling to 2020 total occurrent births gave 53 which was inputted.	
10.	**Field Name:**	**Nevada Early Hearing Detection and Intervention (EHDI) Program - Total Number Referred For Treatment**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**
	Field Note: The percentage of number referred to treatment out of the total number of confirmed cases in 2019 was 96.3%. Using the scaled number of confirmed cases to 2020 births (53), the total number referred to treatment that was inputted is 51.	

11.	**Field Name:**	**Critical Congenital Heart Disease - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Other Newborn**

Field Note:
Data from 2019 Critical Congenital Heart Disease (CCHD) screening registry. 2019 data are preliminary and subject to change. CCHD data uses calendar year 2019 data. Due to CCHD data being on 2019 calendar year and Newborn Screening being on 2020 calendar year, the total number of occurrent births used to calculate the percentage of screenings done is not accurate for CCHD data. CCHD data for 2020 was unable to be obtained. Thus, the percentages for each item out of 2019 total occurrent births were used to scale numbers to be out of 2020 births. For example, for total number of screenings this percentage was 30810 screenings out of 34735 total occurrent births in calendar year 2019= 88.7%. Using 2020 births to make a new ratio, the number inputted was 29,492

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Nevada

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	26,812	43.0	0.0	52.0	5.0	0.0
2. Infants < 1 Year of Age	29,291	43.0	0.0	52.0	5.0	0.0
3. Children 1 through 21 Years of Age	90,236	31.0	0.0	60.0	9.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	38,342	35.0	0.0	53.0	12.0	0.0
4. Others	136,484	13.0	0.0	74.0	13.0	0.0
Total	282,823					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	35,072	Yes	35,072	97.4	34,160	26,812
2. Infants < 1 Year of Age	34,731	Yes	34,731	97.2	33,759	29,291
3. Children 1 through 21 Years of Age	791,653	Yes	791,653	42.2	334,078	90,236
3a. Children with Special Health Care Needs 0 through 21 years of age^	128,240	Yes	128,240	86.7	111,184	38,342
4. Others	2,252,802	Yes	2,252,802	14.4	324,403	136,484

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Counts derived from FFY 2020 Medicaid report, total number of unique pregnant women served. Medicaid data is used as Medicaid has the widest reach.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Counts derived from FFY 2020 Medicaid report, number of infants <1 year served. Medicaid data used as Medicaid has the widest reach.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Counts derived from FFY 2020 Medicaid Report, number of children ages 1-21 served. Medicaid data is used as Medicaid has the widest reach.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Counts derived from FFY 2020 Medicaid Report, CYSHCN served. The following were used: ICD10 codes starting with: A15, B18, B20,C64, C69, C71, C80, C85, C95, D18, D56-D57, D68, D75, D82, D89, E00, E05, E10-E11, E20, E23, E27, E66, E70, E72, E74, E84, E88,F41, F80-F82, F84, F90-F91, F98, G40, G43, G71, G80, G93, H26, H35, H53-H55, H90-H91, I10, I42, I49-I51, I61, I72-I73, J45, L20, M40 M41, N18-N19, P04-P05, P07, P22, P27-P28, P35, P77, P84, P96, Q02-Q03, Q05, Q20-Q21, Q24-Q25, Q28, Q35, Q43, Q45, Q54, Q65, Q68, Q75, Q77, Q79, Q85-Q87, Q89-Q91, Q93, Q96, Q98-Q99, R62-R63, S06, T74, T76, T78. Z21, Z93, and Z97. Medicaid data is used as Medicaid has the widest reach.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Counts derived from FFY 2020 Medicaid report, number of men aged over 21 served + number of women over 21 who were not pregnant served. This is slightly different from the methodology used in the FFY 2019 report, which utilized men ages 15-44 and women who were not pregnant ages 15-44 as "Other." Differences between FFY 2019 and 2020 are due to this change, as individuals 15-21 should be captured in the "children 1-21" category. Medicaid data is used as Medicaid has the widest reach.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2020**
	Field Note: Calculated from above. Medicaid data used as Medicaid has the widest reach.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
Counts derived from Nevada Office of Vital Statistics, 2019-2020 Birth and Death Vital Records; Calculated by subtracting the number of home births from the total occurrent births. These are births that take place in a hospital. Every mother that gives birth in the hospital receives PINK packets that provides many resources for new mothers. The percentages for the primary source of coverage were provided by HRSA.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
Counts derived from 2019 Early Hearing Detection and Intervention (EHDI) Hearing Screening and Follow up Survey; total infants documented as screened. These numbers were used because EHDI has the widest reach in this population. The percentages for the primary source of coverage were provided by HRSA.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Counts derived from FFY 2020 Medicaid Report, total number of children ages 1-21. Medicaid data used as Nevada Medicaid has the widest reach in this population. The percentages for the primary source of coverage were provided by HRSA.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Counts derived from FFY 2020 Medicaid Report, Number of CYSHCN.
change. The following were used: ICD10 codes starting with: A15, B18, B20,C64, C69, C71, C80, C85, C95, D18, D56-D57, D68, D75, D82, D89, E00, E05, E10-E11, E20, E23, E27, E66, E70, E72, E74, E84, E88,F41, F80-F82, F84, F90-F91, F98, G40, G43, G71, G80, G93, H26, H35, H53-H55, H90-H91, I10, I42, I49-I51, I61, I72-I73, J45, L20, M40-M41, N18-N19, P04-P05, P07, P22, P27-P28, P35, P77, P84, P96, Q02-Q03, Q05, Q20-Q21, Q24-Q25, Q28, Q35, Q43, Q45, Q54, Q65, Q68, Q75, Q77, Q79, Q85-Q87, Q89-Q91, Q93, Q96, Q98-Q99, R62-R63, S06, T74, T76, T78. Z21, Z93, and Z97. These numbers were used because Nevada Medicaid has the widest reach in this population. The percentages for the primary source of coverage were HRSA provided

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Counts derived from FFY 2020 Medicaid report, number of men aged over 21 served + number of women over 21 who were not pregnant served. This is slightly different from the methodology used in the FFY 2019 report, which utilized men ages 15-44 and women who were not pregnant ages 15-44 as "Other." Differences between FFY 2019 and 2020 are due to this change, as individuals 15-21 should be captured in the "children 1-21" category. These numbers were used because Nevada Medicaid has the widest reach in the population. The percentages for the primary source of coverage were provided by HRSA.

Data Alerts: None

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

State: Nevada

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non Hispanic White	(C) Non Hispanic Black or African American	(D) Hispanic	(E) Non Hispanic American Indian or Native Alaskan	(F) Non Hispanic Asian	(G) Non Hispanic Native Hawaiian or Other Pacific Islander	(H) Non Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	33,674	12,401	4,851	12,390	289	3,103	0	0	640
Title V Served	30,046	11,551	4,317	11,056	235	2,762	0	0	125
Eligible for Title XIX	14,479	5,332	2,086	5,328	124	1,334	0	0	275
2. Total Infants in State	33,674	12,401	4,851	12,390	289	3,103	0	0	640
Title V Served	30,046	11,551	4,317	11,056	235	2,762	0	0	125
Eligible for Title XIX	14,479	5,332	2,086	5,328	124	1,334	0	0	275

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: 2019 Calendar Year data from Nevada Electronic Birth and Death Registry	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data from 2018 Nevada CDC EHDI Hearing Screening and Follow Up Survey	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Data obtained by using percentage of infants eligible for Title XIX from Form 5a (43%), and multiplying by number of total deliveries	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Nevada

A. State MCH Toll Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 429-2669	(800) 429-2669
2. State MCH Toll-Free "Hotline" Name	MCH Campaign	MCH Campaign
3. Name of Contact Person for State MCH "Hotline"	Mitch DeValliere, DC	Mitch DeValliere, DC
4. Contact Person's Telephone Number	(775) 684-4134	(775) 684-4134
5. Number of Calls Received on the State MCH "Hotline"		574

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Nevada 211	Nevada 2-1-1
2. Number of Calls on Other Toll-Free "Hotlines"		574
3. State Title V Program Website Address	http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/	http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/
4. Number of Hits to the State Title V Program Website		1,203
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Nevada

1. Title V Maternal and Child Health (MCH) Director	
Name	Vickie Ives, MA
Title	Section Manager, Maternal, Child, and Adolescent Health Section
Address 1	4150 Technology Way
Address 2	Suite 210
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-2201
Extension	
Email	vives@health.nv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Vickie Ives, MA
Title	Section Manager, Maternal, Child, and Adolescent Health Section
Address 1	4150 Technology Way
Address 2	Suite 210
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-2201
Extension	
Email	vives@health.nv.gov

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

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Nevada

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five year reporting period)
1.	Improve preconception and interconception health among women of childbearing age	Continued
2.	Promote Breastfeeding	Continued
3.	Promote Safe-Sleep	New
4.	Increase developmental screening	Continued
5.	Improve care coordination among adolescents	Revised
6.	Increase transition of care for adolescents and CYSHCN	New
7.	Reduce substance use during pregnancy	Continued
8.	Promote a Medical Home	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Improve preconception and interconception health among women of childbearing age	Continued
2.	Promote Breastfeeding	Continued
3.	Promote Safe-Sleep	New
4.	Increase developmental screening	Continued
5.	Improve care coordination among adolescents	Revised
6.	Increase transition of care for adolescents and CYSHCN	New
7.	Reduce substance use during pregnancy	Continued
8.	Promote a Medical Home	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Nevada

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.4 %	0.2 %	24,800	32,897
2018	74.6 %	0.2 %	25,805	34,573
2017	74.0 %	0.2 %	24,893	33,651
2016	73.1 %	0.2 %	25,133	34,402
2015	72.6 %	0.2 %	25,632	35,325
2014	70.7 %	0.2 %	24,770	35,014
2013	68.4 %	0.3 %	22,159	32,417
2012	68.1 %	0.3 %	21,698	31,869
2011	66.8 %	0.3 %	21,445	32,113
2010	65.9 %	0.3 %	20,999	31,884

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	65.2	4.4	223	34,211
2017	69.1	4.5	237	34,302
2016	60.6	4.2	211	34,801
2015	73.1	5.3	189	25,841
2014	85.1	5.0	289	33,979
2013	63.5	4.4	210	33,087
2012	69.3	4.6	230	33,203
2011	63.5	4.4	213	33,541
2010	69.2	4.5	237	34,247
2009	62.0	4.2	223	35,949
2008	66.8	4.2	251	37,568

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	14.5	2.9	26	179,068
2014_2018	9.5	2.3	17	179,857

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.8 %	0.2 %	3,077	35,066
2018	8.7 %	0.2 %	3,097	35,668
2017	9.1 %	0.2 %	3,265	35,748
2016	8.5 %	0.2 %	3,065	36,251
2015	8.5 %	0.2 %	3,093	36,289
2014	8.3 %	0.2 %	2,972	35,851
2013	8.0 %	0.2 %	2,810	35,028
2012	8.0 %	0.1 %	2,781	34,903
2011	8.2 %	0.2 %	2,906	35,289
2010	8.3 %	0.2 %	2,965	35,931
2009	8.1 %	0.1 %	3,046	37,604

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.7 %	0.2 %	3,742	35,061
2018	10.1 %	0.2 %	3,616	35,668
2017	10.7 %	0.2 %	3,833	35,741
2016	10.4 %	0.2 %	3,758	36,246
2015	9.9 %	0.2 %	3,609	36,283
2014	10.1 %	0.2 %	3,623	35,845
2013	9.8 %	0.2 %	3,437	34,937
2012	10.4 %	0.2 %	3,598	34,742
2011	10.5 %	0.2 %	3,694	35,187
2010	10.9 %	0.2 %	3,791	34,842
2009	10.8 %	0.2 %	3,981	36,710

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	28.2 %	0.2 %	9,874	35,061
2018	27.7 %	0.2 %	9,886	35,668
2017	27.3 %	0.2 %	9,744	35,741
2016	26.7 %	0.2 %	9,673	36,246
2015	26.3 %	0.2 %	9,544	36,283
2014	25.7 %	0.2 %	9,228	35,845
2013	25.7 %	0.2 %	8,980	34,937
2012	27.4 %	0.2 %	9,517	34,742
2011	29.8 %	0.2 %	10,499	35,187
2010	28.2 %	0.2 %	9,841	34,842
2009	29.7 %	0.2 %	10,899	36,710

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019/Q1-2019/Q4	3.0 %			
2018/Q4-2019/Q3	3.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	3.0 %			
2015/Q2-2016/Q1	5.0 %			
2015/Q1-2015/Q4	5.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.9	0.4	210	35,788
2017	5.8	0.4	209	35,866
2016	6.0	0.4	218	36,384
2015	6.1	0.4	222	36,410
2014	6.0	0.4	214	35,958
2013	5.7	0.4	202	35,131
2012	6.0	0.4	209	35,037
2011	6.7	0.4	237	35,433
2010	5.9	0.4	212	36,054
2009	5.8	0.4	220	37,718

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.1	0.4	219	35,682
2017	5.8	0.4	209	35,756
2016	5.8	0.4	209	36,260
2015	5.2	0.4	188	36,298
2014	5.5	0.4	198	35,861
2013	5.3	0.4	186	35,030
2012	4.9	0.4	172	34,911
2011	5.7	0.4	201	35,296
2010	5.5	0.4	198	35,934
2009	5.8	0.4	219	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.6	0.3	129	35,682
2017	3.6	0.3	128	35,756
2016	3.3	0.3	118	36,260
2015	3.3	0.3	119	36,298
2014	3.8	0.3	137	35,861
2013	3.7	0.3	128	35,030
2012	2.9	0.3	102	34,911
2011	3.5	0.3	124	35,296
2010	3.5	0.3	125	35,934
2009	3.9	0.3	146	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.5	0.3	90	35,682
2017	2.3	0.3	81	35,756
2016	2.5	0.3	91	36,260
2015	1.9	0.2	69	36,298
2014	1.7	0.2	61	35,861
2013	1.7	0.2	58	35,030
2012	2.0	0.2	70	34,911
2011	2.2	0.3	77	35,296
2010	2.0	0.2	73	35,934
2009	1.9	0.2	73	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	148.5	20.4	53	35,682
2017	148.2	20.4	53	35,756
2016	148.9	20.3	54	36,260
2015	126.7	18.7	46	36,298
2014	186.8	22.9	67	35,861
2013	171.3	22.1	60	35,030
2012	128.9	19.2	45	34,911
2011	167.2	21.8	59	35,296
2010	125.2	18.7	45	35,934
2009	175.5	21.6	66	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	142.9	20.0	51	35,682
2017	81.1	15.1	29	35,756
2016	124.1	18.5	45	36,260
2015	88.2	15.6	32	36,298
2014	55.8	12.5	20	35,861
2013	71.4	14.3	25	35,030
2012	85.9	15.7	30	34,911
2011	68.0	13.9	24	35,296
2010	58.4	12.8	21	35,934
2009	93.1	15.7	35	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

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

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

NOM 10 - Notes:

Data not available for this measure. Nevada PRAMS did not meet CDC required response rate threshold.

Data Alerts:

1.	Data has not been entered for NOM 10. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	7.6	0.5	259	34,183
2017	7.6	0.5	261	34,521
2016	8.6	0.5	299	34,861
2015	7.7	0.6	202	26,076
2014	5.6	0.4	193	34,462
2013	5.3	0.4	175	33,311
2012	5.0	0.4	165	33,138
2011	3.5	0.3	118	33,846
2010	2.9	0.3	101	34,549
2009	1.9	0.2	69	36,168
2008	1.6	0.2	62	37,786

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	13.4 %	1.6 %	86,461	645,291
2017_2018	11.2 %	1.4 %	70,139	628,193
2016_2017	12.4 %	1.5 %	77,422	623,173
2016	12.2 %	1.8 %	76,072	625,200

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	17.5	2.3	60	342,924
2018	18.1	2.3	62	341,821
2017	17.3	2.3	59	341,141
2016	20.7	2.5	70	338,564
2015	21.9	2.6	73	333,144
2014	17.8	2.3	59	331,182
2013	18.1	2.3	60	331,294
2012	18.6	2.4	62	332,660
2011	19.5	2.4	65	333,347
2010	19.2	2.4	64	334,050
2009	20.9	2.5	70	334,461

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	29.9	2.8	114	381,647
2018	35.2	3.1	133	378,120
2017	33.7	3.0	126	373,593
2016	36.3	3.2	133	366,187
2015	38.1	3.2	139	364,784
2014	30.3	2.9	110	362,802
2013	28.8	2.8	104	361,031
2012	29.1	2.8	105	360,693
2011	41.1	3.4	148	359,993
2010	34.2	3.1	125	365,773
2009	36.7	3.2	134	365,053

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	9.7	1.3	53	544,043
2016_2018	11.1	1.4	60	539,074
2015_2017	10.5	1.4	56	534,861
2014_2016	12.0	1.5	64	531,334
2013_2015	12.2	1.5	65	530,795
2012_2014	12.4	1.5	66	531,382
2011_2013	10.4	1.4	55	531,349
2010_2012	11.0	1.4	59	536,826
2009_2011	11.6	1.5	63	541,615
2008_2010	14.1	1.6	77	544,431
2007_2009	17.1	1.8	92	536,460

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	15.6	1.7	85	544,043
2016_2018	15.2	1.7	82	539,074
2015_2017	13.5	1.6	72	534,861
2014_2016	10.9	1.4	58	531,334
2013_2015	10.0	1.4	53	530,795
2012_2014	8.3	1.3	44	531,382
2011_2013	9.6	1.3	51	531,349
2010_2012	8.9	1.3	48	536,826
2009_2011	8.9	1.3	48	541,615
2008_2010	5.7	1.0	31	544,431
2007_2009	6.5	1.1	35	536,460

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

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

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.5 %	1.4 %	106,188	685,673
2017_2018	15.7 %	1.5 %	106,689	679,188
2016_2017	15.9 %	1.5 %	106,845	671,412
2016	15.3 %	1.8 %	102,067	667,147

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	8.5 %	2.3 %	9,027	106,188
2017_2018	5.9 %	2.0 %	6,270	106,689
2016_2017	9.2 %	2.1 %	9,882	106,845
2016	13.7 %	3.5 %	13,958	102,067

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.0 %	0.6 %	17,078	572,010
2017_2018	3.4 %	0.8 %	18,874	554,403
2016_2017	2.7 %	0.7 %	15,349	561,709
2016	2.7 %	0.9 %	14,947	562,099

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

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

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	5.9 %	0.9 %	33,225	567,335
2017_2018	6.0 %	0.9 %	33,017	548,062
2016_2017	5.6 %	1.0 %	31,662	561,761
2016	5.2 %	1.2 %	29,419	566,373

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	39.2 %	6.1 %	26,247	66,919
2017_2018	33.7 %	5.3 %	22,036	65,440
2016_2017	33.7 %	5.4 %	22,296	66,115
2016	34.4 %	7.8 %	22,154	64,414

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	89.7 %	1.4 %	614,896	685,512
2017_2018	90.8 %	1.3 %	613,809	675,647
2016_2017	89.3 %	1.4 %	596,321	667,839
2016	87.6 %	1.9 %	584,197	666,760

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	11.7 %	0.2 %	2,857	24,429
2016	11.6 %	0.2 %	2,834	24,493
2014	12.0 %	0.2 %	3,237	26,884
2012	12.9 %	0.2 %	3,570	27,649
2010	15.0 %	0.2 %	3,891	25,855
2008	13.8 %	0.3 %	2,528	18,366

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	12.3 %	1.0 %	14,884	121,330
2017	14.0 %	1.1 %	18,404	131,376
2015	12.2 %	1.0 %	14,743	120,749
2013	11.4 %	0.9 %	14,509	126,805
2009	10.9 %	0.9 %	13,268	122,099
2007	10.8 %	1.1 %	12,053	111,450

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	12.9 %	1.8 %	36,911	286,259
2017_2018	13.7 %	2.5 %	37,548	273,456
2016_2017	14.7 %	2.7 %	39,336	267,747
2016	14.5 %	3.2 %	38,248	263,342

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	7.6 %	0.6 %	52,479	690,646
2018	7.9 %	0.6 %	54,059	688,493
2017	7.1 %	0.6 %	48,571	683,349
2016	6.1 %	0.5 %	41,028	676,543
2015	7.6 %	0.5 %	51,029	668,401
2014	9.7 %	0.8 %	63,977	660,829
2013	13.9 %	0.8 %	91,948	662,058
2012	16.6 %	0.8 %	110,085	663,964
2011	16.1 %	0.9 %	106,640	662,057
2010	17.9 %	0.7 %	118,672	664,484
2009	18.0 %	0.9 %	123,042	685,085

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	63.8 %	3.6 %	23,000	37,000
2015	59.1 %	3.8 %	22,000	37,000
2014	70.5 %	4.2 %	26,000	37,000
2013	66.7 %	3.9 %	24,000	36,000
2012	64.3 %	4.0 %	23,000	36,000
2011	56.2 %	3.8 %	21,000	37,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	52.0 %	1.9 %	337,477	648,994
2018_2019	51.8 %	2.1 %	334,067	644,420
2017_2018	49.5 %	2.2 %	313,179	632,682
2016_2017	45.6 %	2.0 %	286,404	627,665
2015_2016	48.8 %	2.1 %	296,420	607,293
2014_2015	51.5 %	2.3 %	317,981	617,438
2013_2014	50.1 %	2.0 %	310,104	619,540
2012_2013	51.1 %	2.1 %	315,349	617,143
2011_2012	45.6 %	3.3 %	288,232	632,828
2010_2011	49.9 %	4.4 %	317,389	636,051
2009_2010	26.9 %	1.9 %	167,991	624,500

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	68.9 %	3.4 %	133,342	193,574
2018	66.0 %	3.0 %	127,020	192,415
2017	64.9 %	3.2 %	124,083	191,304
2016	64.9 %	3.2 %	123,262	190,018
2015	57.9 %	3.2 %	108,790	187,816

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	89.0 %	2.3 %	172,351	193,574
2018	85.2 %	2.3 %	163,941	192,415
2017	82.5 %	2.7 %	157,772	191,304
2016	87.1 %	2.3 %	165,427	190,018
2015	88.3 %	2.2 %	165,842	187,816
2014	87.6 %	1.9 %	162,423	185,485
2013	88.3 %	2.1 %	162,824	184,426
2012	86.3 %	2.6 %	158,159	183,248
2011	80.2 %	2.9 %	148,616	185,214
2010	68.3 %	3.0 %	119,169	174,407
2009	64.0 %	3.2 %	113,692	177,632

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	87.0 %	2.5 %	168,382	193,574
2018	80.6 %	2.6 %	154,993	192,415
2017	77.3 %	2.9 %	147,792	191,304
2016	78.7 %	2.8 %	149,605	190,018
2015	78.0 %	2.7 %	146,535	187,816
2014	66.5 %	3.0 %	123,337	185,485
2013	64.0 %	3.1 %	118,108	184,426
2012	66.4 %	3.2 %	121,579	183,248
2011	60.3 %	3.7 %	111,737	185,214
2010	54.3 %	3.2 %	94,611	174,407
2009	39.5 %	3.2 %	70,129	177,632

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	18.9	0.5	1,668	88,483
2018	20.5	0.5	1,800	87,691
2017	21.9	0.5	1,906	86,909
2016	24.2	0.5	2,078	85,963
2015	27.7	0.6	2,369	85,389
2014	28.8	0.6	2,448	85,039
2013	30.7	0.6	2,604	84,892
2012	33.7	0.6	2,863	84,844
2011	36.0	0.7	3,073	85,293
2010	38.9	0.7	3,421	87,849
2009	44.0	0.7	3,879	88,257

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

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

NOM 24 - Notes:

Data not available for this measure. Nevada PRAMS did not meet CDC required response rate threshold.

Data Alerts:

1.	Data has not been entered for NOM 24. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.9 %	1.0 %	26,677	680,373
2017_2018	2.0 %	0.5 %	13,556	676,677
2016_2017	2.7 %	0.6 %	18,251	670,399
2016	4.0 %	1.1 %	26,357	666,208

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Nevada

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					67
Annual Indicator				64.6	65.6
Numerator				346,488	350,884
Denominator				536,239	534,782
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	68.0	69.0	70.0	71.0	72.0	73.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	82	84	86	88	80
Annual Indicator	82.6	82.3	83.5	79.0	81.8
Numerator	26,908	25,695	29,014	27,212	26,457
Denominator	32,591	31,207	34,751	34,427	32,331
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	81.0	81.0	82.0	82.0	83.0	83.0

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	19	25	26	27	25
Annual Indicator	24.9	25.0	20.8	23.6	21.7
Numerator	7,990	7,700	7,086	7,914	6,799
Denominator	32,061	30,787	34,093	33,557	31,379
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.0	28.0	27.0	27.0	28.0	28.0

Field Level Notes for Form 10 NPMs:

None

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	77.6	76.8
Numerator	25,230	25,805
Denominator	32,492	33,607
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. For the 2018 PRAMS weighted data, Nevada PRAMS had a response rate of 39.4%, which is less than the CDC threshold of 55%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his or her back."

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #49 (In which one position do you most often lay your baby down to sleep now?") which has 3 answer choices, with the option to select only one. Responses were calculated from those who selected "on his or her back."

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	35	34.1
Numerator	11,072	10,334
Denominator	31,599	30,290
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. For the 2018 PRAMS weighted data, Nevada PRAMS had a response rate of 39.4%, which is less than the CDC threshold of 55%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #50 ("In the past 2 weeks, how often has your new baby slept alone in his or her own crib or bed") which has 5 answer choices, with the option to select only one. Percent of infants were calculated from those who selected "Always, often, or sometimes."

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

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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	43.1	39.7
Numerator	13,539	12,275
Denominator	31,413	30,901
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	44.0	45.0	46.0	47.0	48.0	49.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. For the 2018 PRAMS weighted data, Nevada PRAMS had a response rate of 39.4%, which is less than the CDC threshold of 55%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. For the 2019 PRAMS weighted data, Nevada PRAMS had a response rate of 42%, which is less than the CDC threshold of 50%. Data should be interpreted with caution. Data was obtained from PRAMS question #52 ("How did your new baby usually sleep in the past 2 weeks?") which has 8 sleep environments with the option to select yes or no for each environment. Percent of infants placed to sleep without soft objects or loose bedding was obtained by those who responded "yes" to "In a crib, bassinet, or pack and play" (choice a) and "no" to all choices b-h.

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children s Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			31	33	30
Annual Indicator		30.9	24.1	27.9	30.6
Numerator		23,385	19,924	26,239	25,096
Denominator		75,745	82,645	94,028	82,133
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children s Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			74	76	72
Annual Indicator		68.2	71.7	71.7	64.5
Numerator		145,792	164,488	164,488	143,969
Denominator		213,715	229,387	229,387	223,281
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children s Health (NSCH) CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			45	46	30
Annual Indicator		34.9	29.5	26.3	30.3
Numerator		35,648	31,552	28,106	32,151
Denominator		102,067	106,845	106,689	106,188
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	43.4	41.8
Numerator	248,300	240,683
Denominator	572,498	576,398
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	45.0	46.0	47.0	48.0	49.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) CSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	10.3	8.3
Numerator	4,248	3,493
Denominator	41,437	41,899
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	12.0	13.0	14.0	15.0	16.0	17.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Adolescent Health - NONCSHCN

Federally Available Data		
Data Source: National Survey of Children s Health (NSCH) NONCSHCN		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	13.5
Numerator	21,585	23,357
Denominator	186,655	173,474
Data Source	NSCH-NONCSHCN	NSCH-NONCSHCN
Data Source Year	2017_2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	13.0	14.0	15.0	16.0	17.0	18.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	5	4.3	3.8	3.5	3
Annual Indicator	4.8	4.0	4.2	4.2	3.5
Numerator	1,726	1,440	1,491	1,492	1,217
Denominator	35,965	35,964	35,462	35,400	34,682
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	2.5	2.0	2.0	1.5	1.5	1.5

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Nevada

2016-2020: NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CHILD				
	2017	**2018**	**2019**	**2020**
Annual Objective			32	34
Annual Indicator	31.0	29.8	25.5	19.4
Numerator	73,747	66,162	54,124	45,602
Denominator	237,722	221,688	212,017	235,095
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2016	2016_2017	2017_2018	2018_2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	16	18	20	22	24
Annual Indicator	28.6	28.6	24.9	24.9	21.7
Numerator	34,940	34,940	33,324	33,324	27,320
Denominator	122,356	122,356	134,051	134,051	126,074
Data Source	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT	YRBSS-ADOLESCENT
Data Source Year	2015	2015	2017	2017	2019
Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			20	22	24
Annual Indicator		18.7	19.6	16.8	11.1
Numerator		39,329	44,325	37,886	23,534
Denominator		210,143	226,517	225,199	212,773
Data Source		NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT	NSCH-ADOLESCENT
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	80	68
Annual Indicator		62.2	62.2	63.4	62.4
Numerator		415,085	417,372	429,828	423,713
Denominator		667,147	670,675	678,451	679,500
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Adolescent Health

Field Level Notes for Form 10 NPMs:

None

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Nevada

SPM 1 - Percent of mothers who reported late or no prenatal care

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		7	4.5	4	4
Annual Indicator	7.9	4.6	4.7	4.9	3.3
Numerator	2,805	1,601	1,634	1,680	1,109
Denominator	35,378	34,838	34,577	34,357	33,261
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	3.5	3.5	3.0	3.0	2.5	2.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data are for Nevada Residents only. Data are preliminary and subject to change. Late prenatal care is care received in the third trimester.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada residents aged 15-44 years old.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada residents aged 15-44 years old.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada residents aged 15-44 years old.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Late prenatal care is care beginning in the third trimester. Denominator is Nevada residents aged 15-44 years old.	

SPM 2 - Percent of women who used substances during pregnancy

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		5	4.5	4	5
Annual Indicator	5.5	5.5	6	5.3	5.8
Numerator	1,950	1,924	2,060	1,817	1,932
Denominator	35,378	34,838	34,577	34,357	33,261
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	4.5	4.5	4.0	4.0	3.5	3.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Substance use includes: smoking, drinking, and drug use during pregnancy. Drug use includes all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada Residents only. Data are preliminary and subject to change.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2017 data are preliminary and subject to change.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2018 data are preliminary and subject to change.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2019 data are preliminary and subject to change.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Substance use during pregnancy includes: smoking, alcohol use and drug use including all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada residents aged 15-44. 2020 data are preliminary and subject to change.	

SPM 3 - Repeat teen birth rate

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		16	16	15	15
Annual Indicator	16.6	22.9	22.4	16.4	14.3
Numerator	339	436	395	275	221
Denominator	2,040	1,901	1,762	1,679	1,543
Data Source	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records	Nevada Vital Records
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	14.0	14.0	13.0	13.0	12.0	12.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Data provided are for percent of repeat teen births. Data are for Nevada Residents only. Data are preliminary and subject to change. Repeat teen births include previous live births and previous live but dead births.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2017 data are preliminary and subject to change. Data are for Nevada residents only.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2018 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2019 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data are preliminary and subject to change. Data are for Nevada residents only. Ages 15-19.	

SPM 4 - Teenage pregnancy rate

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective	29	25	24	21
Annual Indicator	25.9	24.4	21.3	16.9
Numerator	2,485	2,377	2,124	1,758
Denominator	96,038	97,485	99,599	104,108
Data Source	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System	DPBH Electronic Birth Registry System
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	19.0	18.0	17.0	16.0	15.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2019 data is preliminary and subject to change.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Teenage Pregnancy Nevada Residents, Ages 15-19. 2020 data is preliminary and subject to change.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Nevada

ESM 1.1 - Percent of pregnant women who received prenatal care beginning in the first trimester

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			76
Annual Indicator	74	74.6	75.4
Numerator	24,893	25,805	24,800
Denominator	33,651	34,573	32,897
Data Source	Federally Available Data-NVSS	Federally Available Data-NVSS	Federally Available Data-NVSS
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	77.0	78.0	79.0	80.0	81.0	82.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	1.8	1.9
Numerator	6	6
Denominator	328	320
Data Source	Nevada PRAMS	Nevada PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1.5	1.3	1.0	0.8	0.5	0.4

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate. Data was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate. Data was gathered from NV PRAMS question #48 (what were your reasons for stopping breastfeeding?) which has a check all that apply response. The response "I did not have support from family or friends" was utilized for this ESM.

ESM 5.1 - Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	73.2	74.6
Numerator	25,078	25,082
Denominator	34,250	33,607
Data Source	Nevada PRAMS	Nevada PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	72.0	70.0	68.0	65.0	63.0	61.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.
High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk:
#49 On his or her side, On his or her stomach
#50 Sometimes Rarely Never
#51 No
#52 b. Twin or larger mattress or bed
c. Couch, sofa, or armchair
d. Infant car seat or swing
e. Sleeping sack or wearable blanket
f. With Blanket
g. With toys, cushions, or pillows, including nursing pillows
h. With crib bumper pads

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to the response rate.
High risk sleep positions are defined as not being laid to sleep on the back, using soft bedding, and/or not having a separate approved sleep surface. The following survey questions and responses were used to define high risk:
#49 On his or her side, On his or her stomach
#50 Sometimes Rarely Never
#51 No
#52 b. Twin or larger mattress or bed
c. Couch, sofa, or armchair
d. Infant car seat or swing
e. Sleeping sack or wearable blanket
f. With Blanket
g. With toys, cushions, or pillows, including nursing pillows
h. With crib bumper pads

ESM 6.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			7
Annual Indicator	6.4	7.5	7.5
Numerator	3,358	3,903	3,687
Denominator	52,790	51,977	49,222
Data Source	Nevada Medicaid Data	Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	8.0	9.0	10.0	11.0	12.0	13.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2018. Data was updated for FFY 2020 Block Grant Application from FFY 2019 Application due to finalized numbers and the acquisition of a more modernized Medicaid data gathering tool from Office of Analytics	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2019. Data was updated for FFY 2020 Block Grant Application from FFY 2019 Application due to finalized numbers and the acquisition of a more modernized Medicaid data gathering tool from Office of Analytics	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: EPSDT screenings were used for this measure. Data is for federal fiscal year 2020	

ESM 10.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			26
Annual Indicator	32	24	31
Numerator			
Denominator			
Data Source	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416	Center for Medicare and Medicaid Services Form 416
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.0	34.0	36.0	38.0	40.0	42.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT."	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT."	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Percentage was obtained from Center for Medicare and Medicaid Services Form CMS-416: Annual EPSDT Participation Report; modified for ages 12-17 only. Percentage was calculated by dividing the "Total Eligibles receiving at least one initial or periodic screen" by "Total individuals eligible for EPSDT." The reports needed to provide the data in the document were recreated using CMS's methodology document for the CMS416. A different source was utilized from last year's CMS416 form so there may be some slight variance in data between datasets.	

ESM 11.1 - Number of Nevada Medical Home Portal website views.

Measure Status:	Active

State Provided Data			
	2018	2019	2020
Annual Objective			17,000
Annual Indicator	4,838	12,390	64,132
Numerator			
Denominator			
Data Source	Medical Home Portal	Medical Home Portal	Medical Home Portal
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	65,000.0	66,000.0	68,000.0	70,000.0	72,000.0	75,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data is for Federal Fiscal year 2018	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data is for Federal Fiscal Year 2019	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data is for Federal Fiscal Year 2020	

ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	10.0	55.0	60.0	65.0	70.0	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Once this data becomes available next year, annual objectives will be determined.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Once this data becomes available next year, annual objectives will be determined.	

ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	40.0	50.0	60.0	65.0	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Once this data becomes available next year, annual objectives will be determined.

ESM 14.1.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	88.8	91.9
Numerator	732	30,895
Denominator	824	33,607
Data Source	NV PRAMS	NV PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data represents 2019 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2020 data is not received until fall 2021). That is why 2019 calendar year was used. 2019 Nevada PRAMS data had a response rate of 42% which falls under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 50% to publish data. Interpret data with caution due to response rate. Data was gathered from NV PRAMS question #20c, which is a yes/no question. Numerators and Denominators differ dramatically from 2018 data due to weighted frequencies being utilized	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Percent of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			60	75	80
Annual Indicator	31.6	57.9	73.7	63.2	66.7
Numerator	6	11	14	12	12
Denominator	19	19	19	19	18
Data Source	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program	Title V MCH Program	Title V MCH Program
Data Source Year	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Final	Final	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 8.1.2 - Number of sites conducting training and technical assistance to early care and education centers to reduce childhood obesity.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			260
Annual Indicator	266		0
Numerator			
Denominator			
Data Source	State Obesity Prevention and Control Program		NA
Data Source Year	2018		NA
Provisional or Final ?	Final		Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data for this ESM was collected from a grant funded program that did not receive additional funding and ended June 30 2018. 2018 data is for FFY 2018, but only for nine months (Oct 2017-June 2018)

The State Chronic Disease Prevention and Health Promotion (CDPHP) Section program, the State Obesity Prevention and Control (OPC) Program, funded the Children's Cabinet to provide statewide trainings and technical assistance to Early Care and Education (ECE) Centers in the areas of nutrition, physical activity improvement and sedentary time reduction, as well as breastfeeding support.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The program that provided this data lost funding in 2018 and was not continued. There is no data available for 2019.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The program that provided this data lost funding in 2018 and was not continued. There is no data available for 2019.

2016-2020: ESM 8.2.1 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			14	16
Annual Indicator	9	13	18	5
Numerator				
Denominator				
Data Source	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program
Data Source Year	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
COVID-19 significantly impacted the ability for in-person courses and only one facility held on-site classes during this six-month period.

2016-2020: ESM 8.2.2 - Number of unique visitors to MCH social media including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			105,000	110,000
Annual Indicator	99,000	131,396	117,179	141,486
Numerator				
Denominator				
Data Source	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program	Nevada Title V MCH Program
Data Source Year	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.1.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		30	40	25	30
Annual Indicator	20	14	1	1	5
Numerator					
Denominator					
Data Source	Nevada Tobacco Prevention and Control Program	Nevada Tobacco Prevention and Control Program	Nevada Tobacco Prevention and Control Program	Nevada Tobacco Prevention and Control Program	Nevada Tobacco Prevention and Control Program
Data Source Year	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 15.2 - Percent of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up.

Measure Status:		Active	
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			70
Annual Indicator		40.3	41.2
Numerator		293,607	302,489
Denominator		728,298	734,488
Data Source		Nevada Medicaid Data	Nevada Medicaid Data
Data Source Year		CY 2019	CY 2020
Provisional or Final ?		Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Denominator is 2019 Nevada Demographer Vintage Data	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Denominator is from calendar year 2020 Nevada Demographer Vintage Data	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Nevada

SPM 1 - Percent of mothers who reported late or no prenatal care
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase percent of women receiving prenatal care in first trimester
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of births without prenatal care or late prenatal care listed on birth certificate **Denominator:** Number of Nevada resident births for the same year
Data Sources and Data Issues:	Electronic Birth Registry System
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well-woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing

SPM 2 - Percent of women who used substances during pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce the percent of women who report using substances during pregnancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of reported substance use during pregnancy **Denominator:** Number of Nevada resident births for the same year
Data Sources and Data Issues:	Electronic Birth Registry System and PRAMS (future)
Significance:	Optimal health of mother is desired to help provide a healthy foundation for an infant. To reach optimal health, substance free mothers can help achieve a healthier outcome for their babies, potentially avoiding adverse birth outcomes. Awareness and availability of services is crucial to help provide appropriate resources and access to treatment for alcohol, smoking, and drug use. Information sites such as Sober Moms Healthy Babies from the Maternal, Child and Adolescent Health Section and the Substance Abuse Prevention and Treatment Agency (SAPTA) Program provide resources.

SPM 3 - Repeat teen birth rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of repeat teen births in Nevada.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of repeat teen births ages 10 to 19 years old **Denominator:** Number of Nevada resident teen births for the same year
Data Sources and Data Issues:	Electronic Birth Registry System
Significance:	Decreasing repeat teen birth rates is a priority in the state, and account for more than 10% of teen births. Tracking of data to help prevent repeat teen births helps programs across the state see impacts of their programs and the need for continuation of health education their programs need to sustain or develop.

SPM 4 - Teenage pregnancy rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of teenage pregnancies in Nevada.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** Number of teenage pregnancies **Denominator:** Number of teenage females
Data Sources and Data Issues:	Electronic Birth Registry System Data Note: Abortion data has a one year lag.
Significance:	Reducing teenage pregnancy is a priority in the state. Although teenage pregnancy rates are reducing in Nevada, disparities exist among at-risk populations. Tracking of data to help prevent teenage pregnancies will help programs across the state see the impacts of their programs and the need for continuation of health education.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Nevada

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Nevada

ESM 1.1 - Percent of pregnant women who received prenatal care beginning in the first trimester
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase percent of women accessing prenatal care in the first trimester.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of pregnant women who received prenatal care beginning in the first trimester.</td></tr>
<tr><td>Denominator:</td><td>Number of pregnant women in Nevada</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Federally available data (FAD)</td></tr>
<tr><td>Significance:</td><td>Prenatal care access ensures opportunities for the provision of preventive services including screenings, identification of high risk behaviors and nutritional needs, and education for new parents. Prenatal care reduces the risk of pregnancy complications and women who receive prenatal care within their first trimester are more likely to have a healthy birth outcome. Prenatal care visits help monitor maternal and fetal well being throughout pregnancy. Early detection and treatment of potential complications improves chances of healthy pregnancy and healthy infant.</td></tr>
</table>

ESM 4.1 - Percent of Nevada PRAMS respondents who stopped breastfeeding due to a lack of support from family or friends
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Reduce the number of women who stop breastfeeding due to lack of support from family or friends.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who stop breastfeeding due to lack of support from family or friends **Denominator:** Number of PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System; Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.
Significance:	Breast milk provides the ideal nutrition for infants. It provides the proper mix of vitamins, protein, and fat to help babies grow. Breastmilk is more easily digested than infant formula, and contains antibodies to help babies fight off viruses and bacteria. Babies who are breastfed exclusively for the first 6 months, without any formula, have fewer health issues. They also have fewer hospitalizations and trips to the doctor.

ESM 5.1 - Percent of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Reduce the number of infants (under 1 year of age) who are laid to sleep in a high-risk sleep position and/or environment
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who report their infants (under 1 year of age) were laid to sleep in a high-risk sleep position and /or environment **Denominator:** Number of PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System; Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.
Significance:	In 2016, the American Academy of Pediatrics (AAP) developed specific recommendations expanding on the importance of sleep position for infants up to 1 year old. To reduce the risk of SIIDS, for safe sleep in a supine position (wholly on the back) for every sleep by every caregiver until the child reaches 1 year of age. Side sleeping is not safe and is not advised.

ESM 6.1 - Percent of Medicaid enrolled children, ages 9 through 35 months, who received a developmental screening using a standardized tool.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	To increase the number of children receiving a developmental screenings using a standardized tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children receiving a developmental screening using a standardized tool. **Denominator:** Members 9-35 months
Data Sources and Data Issues:	Nevada Title V/MCH Program, Office of Analytics
Significance:	Parents Evaluation of Developmental Status (PEDS), Ages and Stages (ASQ-3 and ASQ:SE-2) and Early Language Milestone Screen are the most commonly used standardized developmental screening tool. Collection of this data will allow the Title V MCH Program to track the number of medicaid enrolled children receiving a developmental screening.

ESM 10.1 - Percent of Medicaid EPSDT eligible adolescents, ages 12 through 17, who received at least one initial or periodic screen
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the number of adolescents, ages 12 through 17, receiving preventive well visits.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of Medicaid EPSDT eligible adolescents, ages 12 through 17, receiving at least one initial or periodic screen **Denominator:**
Data Sources and Data Issues:	Data Source: Nevada Title V/MCH Program
Significance:	Adolescents face a variety of health risks and health problems including unintended pregnancies, sexually transmitted diseases, substance use disorders, and depression, among others. Getting an annual well-visit provides an opportunity for adolescents to discuss any physical, emotional and behavioral health issues they may have.

ESM 11.1 - Number of Nevada Medical Home Portal website views.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the users visiting the Nevada Medical Home Portal website to help the CYSHCN population about how to access and benefits of medical home portal in the past year.
Definition:	**Unit Type:** Count **Unit Number:** 100,000 **Numerator:** Number of Nevada Medical Home Portal website views during reporting period. **Denominator:**
Data Sources and Data Issues:	Medical Home is an approach to providing comprehensive primary care in which the primary care provider and her/his team work in partnership with the family/patient to meet the medical and non-medical needs of the child/youth. The family/patient is able to access coordinated care from specialists, receive education, family support and other community services to improve their health and well being.
Significance:	A Medical Home Portal is a “one-stop shop” credible source of information about children and youth with special health care needs (CYSHCN). It is a valuable resource for families, physicians and medical home teams, and other professionals and caregivers.

ESM 12.1 - Percent of participants reporting a change in knowledge who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN and non-CSHCN</td></tr>
<tr><td>Goal:</td><td>Increase the percent of transition training participants with a change in knowledge</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of transition training participants who reported a change in knowledge, practice, or policy</td></tr>
<tr><td>Denominator:</td><td>Number of transition training participants</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V MCH Program. The results of the pre- and post-test surveys administered to Health Care Transition training participants.</td></tr>
<tr><td>Significance:</td><td>The transition of youth to adulthood, including the movement from a child to an adult model of healthcare, has become a statewide priority issue based on the 2020 Needs Assessment. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.</td></tr>
</table>

ESM 12.2 - Percent of participants reporting intent to change practices or policies who completed the Project ECHO online course using Got Transitions Six-Core Elements of Health Care Transition
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>CSHCN and non-CSHCN</td></tr>
<tr><td>Goal:</td><td>Increase the percent of transition training participants with a change in practice or policies</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of transition training participants who reported a change in practice, or policy</td></tr>
<tr><td>Denominator:</td><td>Number of transition training participants</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Title V MCH Program. The results of the pre- and post-test surveys administered to Health Care Transition training participants.</td></tr>
<tr><td>Evidence based/informed strategy:</td><td>Aligns with MCH best strategy Provider Training/Workforce Development. Encourages health care providers to participate in evidence-based health care transition training that includes strategies to improve care coordination, implement transition readiness assessments, checklists, and understand clinical pathways. Source (https://www.mchevidence.org/documents/reviews/NPM-12-Transition-Report.pdf)
This ESM will influence the NPM, as literature shows gaps exist at the provider level for transition. Transition planning at the provider level for youth can be inexplicit, incomplete, or late (Cooley et al., 2011), and strategies to remedy this are provided by the HRSA MCHB funded National Health Care Transition Center (Got Transition) Six Core Elements of Health Care Transition report. By measuring health care provider knowledge and policy changes as they are trained to better assist patients with transition, this will translate into a higher percentage of adolescents receiving services to prepare for the transition to adult health care.</td></tr>
<tr><td>Significance:</td><td>The transition of youth to adulthood, including the movement from a child to an adult model of healthcare, has become a statewide priority issue based on the 2020 Needs Assessment. Poor health has the potential to impact negatively the youth and young adults' academic and vocational outcomes. Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.</td></tr>
</table>

ESM 14.1.1 - Percent of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Reduce the percentage of pregnant women who smoke during pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of PRAMS respondents who report that a doctor, nurse, or other health care worker asked if they were smoking cigarettes during any prenatal care visits **Denominator:** Number of total PRAMS respondents
Data Sources and Data Issues:	Nevada Pregnancy Risk Assessment Monitoring System (PRAMS); Data represents 2018 calendar year births. Nevada PRAMS receives data in fall of the preceding birth year, resulting in a year lag (2019 data is not received until fall 2020). That is why 2018 calendar year was used. 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.
Significance:	Tobacco smoke contains a deadly mix of more than 7,000 chemicals; hundreds are harmful, and about 70 can cause cancer. Smoking during pregnancy is a public health problem because of the many adverse effects associated with it. These include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function, preterm premature rupture of membranes, low birth weight, perinatal mortality, and ectopic pregnancy. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity. Secondhand prenatal exposure to tobacco smoke also increases the risk of having an infant with low birth weight by as much as 20%. Smoking by women during pregnancy has been shown to increase the risk for Sudden Infant Death Syndrome (SIDS). Providers and public health professionals should provide support mothers to stop perinatal smoking. Public health awareness of the risks associated with smoking and substance use during pregnancy can reach more of the population by mass media. Knowledge of available resources may help reduce the risk of adverse birth outcomes associated with smoking and substance use. Public health initiatives could lead to a decrease in smoking by pregnant women and nonpregnant women of reproductive age by providing access to smoking cessation programs.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.1 - Percent of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA.</td></tr>
<tr><td>Denominator:</td><td>Number of birthing facilities in Nevada (19)</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Nevada Statewide Breastfeeding Program.</td></tr>
<tr><td>Significance:</td><td>Birth facilities that have achieved Baby Friendly designation typically experience an increase in breastfeeding rates. Research has found a relationship between the number of Baby Friendly steps (included in the Ten Steps to Successful Breastfeeding) in place at a birth facility and a mother’s breastfeeding success. In addition, mothers experiencing none of the Ten Steps to Successful Breastfeeding during their stay were eight times as likely to stop breastfeeding before 6 weeks compared to those experiencing five out of the ten steps. These findings emphasize the value of having hospitals acquire Baby Friendly designation.</td></tr>
</table>

2016-2020: ESM 8.1.2 - Number of sites conducting training and technical assistance to early care and education centers to reduce childhood obesity.
2016-2020: NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of early care and education centers conducting training to reduce childhood obesity.
Definition:	**Unit Type:** Count **Unit Number:** 320 **Numerator:** Number of site conducting training and technical assistance to early care and education centers **Denominator:**
Data Sources and Data Issues:	Nevada Title V/MCH Program
Significance:	The training consists of 3 parts: breastfeeding, nutrition and physical activity. The goal is to decrease obesity via nutrition and physical activity.

2016-2020: ESM 8.2.1 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages12 through 17 to increase physical activity for 60 minutes per day.
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of programs providing TIY **Denominator:**
Data Sources and Data Issues:	Nevada Title V/MCH Program
Significance:	TIY programs make physical activity available in a safe environment to at-risk adolescents ages 12-17 without specialized equipment, dedicated space, or unsafe outdoor environment. It provides access to physical activity for 60 minutes often only available at a significant financial cost, to youth of all socioeconomic statuses and in restrictive contexts for other physical activity alternatives.

2016-2020: ESM 8.2.2 - Number of unique visitors to MCH social media including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.
2016-2020: NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of unique visitors to MCH social media including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.
Definition:	**Unit Type:** Count **Unit Number:** 500,000 **Numerator:** Number of unique visitors to MCH social media including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17 **Denominator:**
Data Sources and Data Issues:	Nevada Title V/MCH Program Google Analytics
Significance:	With adolescents increasingly utilizing social media, this campaign is an effective way to reach them. The English and Spanish messages generated for this ongoing campaign were field tested with adolescents.

2016-2020: ESM 14.1.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To decrease the percent of women of child-bearing age who are smokers
Definition:	**Unit Type:** Count **Unit Number:** 1,830 **Numerator:** Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months **Denominator:**
Data Sources and Data Issues:	Nevada Tobacco Prevention and Control Program
Significance:	Tobacco smoke contains a deadly mix of more than 7,000 chemicals; hundreds are harmful, and about 70 can cause cancer. Smoking during pregnancy is a public health problem because of the many adverse effects associated with it. These include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function, preterm premature rupture of membranes, low birth weight, perinatal mortality, and ectopic pregnancy. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity. Secondhand prenatal exposure to tobacco smoke also increases the risk of having an infant with low birth weight by as much as 20%. Smoking by women during pregnancy has been shown to increase the risk for Sudden Infant Death Syndrome (SIDS). Providers and public health professionals should provide support mothers to stop perinatal smoking. Public health awareness of the risks associated with smoking and substance use during pregnancy can reach more of the population by mass media. Knowledge of available resources may help reduce the risk of adverse birth outcomes associated with smoking and substance use. Public health initiatives could lead to a decrease in smoking by pregnant women and nonpregnant women of reproductive age by providing access to smoking cessation programs.

2016-2020: ESM 15.2 - Percent of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up.
2016-2020: NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	To increase the percent of children ages 0 through 17 who are adequately insured
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 0 -17 on Nevada Medicaid and/or Nevada Check-Up. **Denominator:** Number of children ages 0-17
Data Sources and Data Issues:	Data source: Nevada Title V/MCH Program
Significance:	Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care.

Form 11
Other State Data

State: Nevada

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Nevada

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	1		
2) Vital Records Death	Yes	Yes	More often than monthly	1	Yes	
3) Medicaid	Yes	Yes	More often than monthly	1	Yes	
4) WIC	Yes	Yes	More often than monthly	1	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	No	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None