Maternal and Child Health Services Title V Block Grant

Nevada

FY 2017 Application/ FY 2015 Annual Report

Created on 9/30/2016 at 4:59 PM

Table of Contents

I. General Requirements	**4**
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
I.E. Application/Annual Report Executive Summary	5
II. Components of the Application/Annual Report	**9**
II.A. Overview of the State	9
II.B. Five Year Needs Assessment Summary	17
Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)	17
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	18
II.C. State Selected Priorities	34
II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures	35
II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures	39
II.F. Five Year State Action Plan	40
II.F.1 State Action Plan and Strategies by MCH Population Domain	40
Women/Maternal Health	40
Perinatal/Infant Health	47
Child Health	55
Adolescent Health	61
Children with Special Health Care Needs	69
Cross-Cutting/Life Course	84
Other Programmatic Activities	93
II.F.2 MCH Workforce Development and Capacity	97
II.F.3. Family Consumer Partnership	99
II.F.4. Health Reform	100
II.F.5. Emerging Issues	100
II.F.6. Public Input	101
II.F.7. Technical Assistance	105
III. Budget Narrative	**106**
III.A. Expenditures	107
III.B. Budget	108
IV. Title V-Medicaid IAA/MOU	**111**

V. Supporting Documents	**112**
VI. Appendix	**113**
Form 2 MCH Budget/Expenditure Details	114
Form 3a Budget and Expenditure Details by Types of Individuals Served	120
Form 3b Budget and Expenditure Details by Types of Services	122
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	125
Form 5a Unduplicated Count of Individuals Served under Title V	128
Form 5b Total Recipient Count of Individuals Served by Title V	130
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	132
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	134
Form 8 State MCH and CSHCN Directors Contact Information	136
Form 9 List of MCH Priority Needs	139
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	140
Form 10a National Outcome Measures (NOMs)	142
Form 10a National Performance Measures (NPMs)	184
Form 10a State Performance Measures (SPMs)	194
Form 10a Evidence-Based or-Informed Strategy Measures (ESMs)	195
Form 10b State Performance Measure (SPM) Detail Sheets	198
Form 10b State Outcome Measure (SOM) Detail Sheets	201
Form 10c Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets	202
Form 10d National Performance Measures (NPMs) (Reporting Year 2014 & 2015)	210
Form 10d State Performance Measures (SPMs) (Reporting Year 2014 & 2015)	240
Form 11 Other State Data	251
State Action Plan Table	252
Abbreviated State Action Plan Table	253

I. General Requirements

I.A. Letter of Transmittal

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director, DHHS

CODY L. PHINNEY, MPH
Administrator, DPBH

JOHN DIMURO, D.O., MBA
Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
4150 Technology Way, Suite 300
Carson City, Nevada 89706
Telephone: (775) 684-4200 · Fax: (775) 687-7570

July 5, 2016

Michele H. Lawler, M.S., R.D.
Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 5C-26, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Re: Maternal and Child Health Block Grant Submission
- Report FFY 2015, Application FFY 2017

Dear Ms. Lawler:

The Nevada State Division of Public and Behavioral Health, which administers the Title V Maternal and Child Health Block Grant, respectfully submits the FFY 2017 application and FFY 2015 Annual Report to the Health Resources and Services Administration.

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

Sincerely,

Cody L. Phinney, MPH
Administrator

CP:ch

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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Executive Summary

Nevada is committed to providing evidence-based or informed programs to the MCH population in the State. Nevada receives just over $2 million in Title V Maternal and Child Health funding from the Health Resources and Services Administration (HRSA). Nevada's Title V/Maternal and Child Health (MCH) Program is housed in the Maternal, Child and Adolescent Health (MCAH) Section; Bureau of Child, Family and Community Wellness; Division of Public and Behavioral Health. For additional information regarding this Executive Summary please visit the MCH Program website at: http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/.

ACCOMPLISHMENTS AND PRIORITIES BY POPULATION DOMAIN

Domain: Women/Maternal Health

- Priority: Improve preconception and interconception health among women of childbearing age (Percent of women with a past year preventive visit)

In Nevada women without health insurance receiving late or no prenatal care is slightly higher than the national average. Therefore, the MCH program will partner with coalitions, community-based programs and other public and private stakeholders to increase rates of coverage and prenatal care.
The MCH Program collaborates with partners to identify modifiable risk factors for improved birth outcomes, including racial/ethnic health disparities. Projects include the National Governors Association (NGA) Learning Network on Improving Birth Outcomes and the Collaborative Improvement and Innovation Network (CoIIN) to reduce Infant Mortality. Funded partners for these efforts included county Health Districts, March of Dimes, Medicaid, Community Health Services and Women, Infants and Children (WIC). Screenings are conducted by partners to provide critical screenings needed by women of childbearing age, especially women living in rural/frontier Nevada and at-risk populations.

Domain: Perinatal/Infant Health

- Priority: Breastfeeding promotion (Percent of women with past year preventive visit)

Nevada's rate for ever breastfeeding is slightly higher than the national average (80.9 and 79.2 respectively), but is slightly lower than the national average for exclusive breastfeeding at six months (18.0 and 18.8 respectively). As the Centers for Disease Control and Prevention (CDC) supports the link between breastfeeding and improved health outcomes, the MCH program will partner with coalitions, community-based programs and other public and private stakeholders to increase breastfeeding rates by improved access to breastfeeding for new mothers.
A major accomplishment in this area includes four out of six maternity centers receiving training on Baby Steps to Breastfeeding Success. Sixty Nevada businesses have pledged their commitment to provide welcoming environments to breastfeeding mothers through the Breastfeeding Welcomed Here campaign. Nevada received the USDA's Breastfeeding Bonus Award for the greatest increases in exclusive breastfeeding rates between 2013 and 2014. Several Southern Nevada hospitals have fully implemented the Baby Safe Sleep program. The Southern

Nevada Health District (SNHD) Home Visiting Nurse-Family Partnership Program served 209 women between 10/1/2014 and 9/30/2015. Washoe County Fetal Infant Mortality Review (WC FIMR) reviewed 26 cases between October 2014 and June 2015.

Domain: Child Health

- Priority: Increase developmental screenings (Percent of Children, ages 10-71 months, receiving a developmental screening using a parent-completed tool)
- Priority: Promote healthy weight (Percent of children 6-11 years of age who are physically active at least 60 minutes per day)

Nevada is below the national average for children screened early and continuously for special health care needs (69.7% and 78.6% respectively). The MCH program will collaborate with public and private partners to improve the percent of children receiving developmental screening and increase the number of applicable entities trained on developmental screenings.
Nevada scores just below the national average regarding adolescents (ages 12-17) who are physically active (81.6 and 82.7 respectively). In order to improve these numbers further, the MCH program will partner with public and private stakeholders and schools to improve the percent of children and adolescents who are physically active, including participation in school sports and after-school activities.
Nevada finalized a statewide school assessment on physical activity and nutrition in the spring of 2015. Nevada Wellness, a Nevada Title V partner, implemented the Healthy Hoops Campaign in collaboration with Reno Bighorns basketball team to promote healthy activity in northern Nevada. Seventy five Early Childhood Education (ECEs) providers received training and technical assistance to address physical activity. However, the Nevada Kindergarten Health Survey, conducted annually through the Nevada Institute of Children's Research and Policy (NICRP), continues to show an increase in the number of obese children entering kindergarten.

Domain: Adolescent Health

- Priority: Improve preconception and interconception health among women of childbearing age (Percent of adolescents 12-17 years of age with a preventive medical visit in the past year)
- Priority: Promote healthy weight (Percent of Adolescents 12-17 years of age who are physically active at least 60 minutes per day)
- Priority: Reduce teen pregnancy

Nevada scores just below the national average regarding adolescents (ages 12-17) who are physically active (81.6 and 82.7 respectively). In order to improve these numbers further, the MCH program will partner with public and private stakeholders and schools to improve the percent of children and adolescents who are physically active, including participation in school sports and after-school activities.
The MCH program works with partners on pregnancy prevention and reducing the rate of birth for teenagers (ages 15-17) such as promoting the Personal Responsibility Education Program (PREP) and the Abstinence Education Grant Program (AEGP). During the previous reporting year, 500 youth ages 13-18 participated in PREP. Changes to the action plan included adding a new priority to reduce teen pregnancy. This priority will be addressed through a newly developed state performance measure to track the prevalence of teen pregnancies and repeat births, and tracking the use of long acting reversible contraceptives (LARCs).
Nevada does not have either the highest or lowest rate of teen pregnancy and repeat teen pregnancy. In April, the CDC indicated an almost 50% rate reduction among Hispanic and Black teens; however, Hispanic teens still represent a significant population in relation to teen births in Nevada. And, because one in five births to teen mothers (ages 15-19) is a repeat teen birth, it is important to work on decreases in both measures, with specific emphasis on disparities. To improve teen birth measures, the MCH program will partner with coalitions, community-based programs, and public and private stakeholders to increase access to family planning information, long activing reversible contraceptives and other educational materials.

Domain: Children with Special Health Care Needs

- Priority: Improve care coordination (Percent of children with and without special health care needs having a medical home)

Although children (0-17 years of age) with and without special health care needs should have access to a medical home, the percent of children with special health care needs in Nevada having a medical home is 36.8%, which is below the national average of 43%. Development of a Medical Home Portal in Nevada will improve access to resources and information for children and their families. Therefore, the MCH program will partner with coalitions, community-based programs, Nevada's Family-to-Family/Family Voices entity, Nevada 2-1-1, and public and private stakeholders to increase promotion of health care resources and care coordination.

The major highlights for this domain include establishment of a Medical Home Portal. This resource will improve care coordination among children with and without special health care needs. One of the main partners for the CYSHCN program, Family TIES, distributed 4,005 Health Transition Checklists for youth with special health care needs to 162 middle/high schools across the State. The Division of Public and Behavioral Health (DPBH), in collaboration with the Division of Health Care Finance and Policy (DHCFP), is working towards the development of a statewide integrated behavioral health and primary care delivery model and Family TIES will assist DPBH and DHCFP in developing a delivery model. The CYSHCN Program currently houses data for Critical Congenital Heart Disease (CCHD) in accordance with Nevada Revised Statutes (NRS) 442.680. Changes to the action plan included revision of the priority to align with the associated National Performance Measures and the new Evidence-based/informed Strategy Measures.

Domain: Cross-Cutting/Life Course

- Priority: Reduce substance use during pregnancy (Percent of women who smoke during pregnancy)
- Priority: Reduce children's exposure to second-hand smoke (Percent of children who live in households where someone smokes)

Nevada has been collaborating across systems to collect information regarding the percent of women who smoke or use/misuse substances during pregnancy as well information regarding the percent of children exposed to secondhand smoke. Nevada began collecting information last year by implementing Baby BEARS, a survey similar to the Pregnancy Risk Assessment Monitoring System (PRAMS). Nevada was awarded a PRAMS grant by the CDC, which will guide activities and data collection to improve the measures related to the priorities of substance use/misuse during pregnancy and exposure to secondhand smoke.

MCH is engaged with various state and community programs to prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age; prevent and reduce substance use/misuse among adolescents, pregnant women and women of childbearing age; and, increase the percent of adequately insured children. Nevada is committed to reducing substance use during both preconception and interconception by supporting Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for health care providers. Nevada hosted the first Train the Trainer event on Youth Mental Health First Aid in June, 2015, with 19 trainers from various counties in the State.

II. Components of the Application/Annual Report

II.A. Overview of the State

Nevada's Title V Maternal and Child Health Title V program is dedicated to working with diverse public and private partners across the state to improve the health of families. Funded programs a have specific emphasis on women, infants, and children, including children and youth with special health care needs (CYSHCN). Nevada utilizes Title V funding to collaborate with stakeholders and strengthen community partners on activities to ensure that all target populations have access to health education and preventive services.

1. Geography

Nevada is the 7th largest state in the U.S. with a land mass of approximately 110,000 square miles. As defined by the State's Demographer, Nevada has three urban counties (Carson City, Clark, and Washoe), three rural counties (Douglas, Lyon, and Storey), and eleven counties designated as frontier. The three rural counties also meet micropolitan classification due to their close proximity to urban (metropolitan) counties.

The state has unique topography and vast distances separating frontier, rural and urban communities. The distance between the two urban areas is 450 miles. Nevada's rural and frontier populations are spread over 95,421 square miles or 86.9% of the state's land mass. Approximately 90% of Nevada's land is publicly owned and administered by federal, state, and tribal entities, with the remaining 10% privately owned.

2. Population

According to the Nevada State Demographer, the state's population for 2015 is approximately 2.9 million, with over 2.6 million living in the urban counties and less than 300 thousand living in the state's fourteen rural and frontier counties. Although Nevada's population is projected to grow by 9.5% over the next decade, some rural and frontier counties have lost population. The most densely populated area in the state is Clark County with approximately 2.1 million residents. The next largest urban area is Washoe County with just over 450 thousand residents and Carson City has just over 55 thousand residents. The population in the rural and frontier counties ranges from approximately one thousand to just under 55 thousand residents. Currently 24.1% of Nevada's population is 17 years and younger, 62.2% are between 18 and 64 years of age, and 13.7% are 65 years and older.

Race and ethnicity is changing in Nevada where the state is becoming more ethnically diverse and comprised of 45% ethnic minorities compared to 37.9% in 2006. In 2014, the racial/ethnic composition of Nevada was 54% white, 28% Hispanic/Latino, 8.2% African American, 8.7% Asian, and the remaining 1.1% Native American or Alaskan Native. The growth rate of Nevada's Hispanic population has grown 528% between 1990 and 2014 totaling 781,886 people. Projections through 2019 indicate a continued growth rate of 10.5%, which equates to an increase by 81,991.

According to the U.S. Census Bureau, 19.1% of Nevada's residents are foreign-born in comparison to the national average of 12.9%. Immigrants comprised 25.1% of the state's workforce in 2011 or 348,671 workers, impacting industries such as agriculture, construction, mining workforce, and entertainment and tourism. The State's agricultural workforce is made up of migrant and seasonal farm workers where 61% of the farm workers (individual) and 50% with families are below the poverty level and suffer from a range of barriers which limit access to healthcare and achieving optimal health. Low educational attainment, illiteracy, language barriers, lack of transportation, insurance, and sick leave have all been identified as issues within Nevada that limit positive health outcomes for this population. Additionally, fear of immigration penalties and a lack of knowledge about assistance programs continue to trouble this demographic.

The health of individuals and populations is influenced by complex factors such as mobility and migration. Each can play a role in health outcomes for both individuals and the community at large. Concerns about health for mobile populations include: reproductive health, maternal and child health, women's health, chronic illnesses, mental and psychosocial health. The availability of services and the nature and use of health care services, hospitals, clinics, and doctors, can vary significantly between an individual's point of origin and their destination and these differences have been shown to influence how and for what reasons mobile populations seek or utilize health care.

In response to the problems that plague Nevada's mobile and immigrant population, services and supports have been implemented to improve health outcomes. The Nevada Community Health Worker Program has developed over the last four years to create connections between vulnerable populations and healthcare systems. This lay health worker workforce ensures cultural competency by providing culturally and linguistically appropriate health education on topics related to chronic disease prevention, physical activity and nutrition, and effects of illicit drug use, among others. In addition, they advocate for underserved individuals to receive appropriate services. During the 2015 legislative session, Senate Bill (SB) 498 was passed requiring licensure of agencies for community health worker pools to assure standardization of training, accountability, and regulation.

DPBH, along with the three local health authorities (Washoe, Clark, and Carson City counties) and MCH partners, employ bilingual personnel and develop materials in both English and Spanish.

3. Public Health System

Nevada statewide health-related programs are joined together under the authority of the DPBH, which is within the Department of Health and Human Services (DHHS). DBPH has four branches including Community Services, Clinical Services, Regulatory and Planning Services, and Administrative Services. Community Services includes:

- Maternal, Child and Adolescent Health (MCAH);
- Nevada Immunization (IZ);
- Women, Infants, and Children (WIC);
- Chronic Disease Prevention and Health Promotion (CDPHP);
- HIV Prevention and Ryan White Part B;
- Environmental Health Services (EHS);
- Office of Public Health Informatics and Epidemiology (OPHIE); and
- Substance Abuse, Prevention and Treatment Agency (SAPTA).

MCAH section manages a portfolio of maternal and child health related programs, including the Title V MCH Block Grant; Maternal, Infant, and Early Childhood Home Visiting program; Adolescent Health and Teen Pregnancy Prevention; Early Hearing Detection and Intervention; Rape Prevention and Education; and Children and Youth with Special Health Care Needs. The MCAH Section addresses health issues amongst the population it serves by coordinating efforts with local health authorities, public partners (other program and agencies within and outside DPBH), MCH Coalitions, Community Coalitions, Oral Health Coalitions, the Crisis Call Center, Family Resource Centers, Federally Qualified Health Centers (FQHC's), MCH Advisory Board, Planned Parenthood, and regional hospitals, including their respective foundations.

4. Healthcare

The impact of the implementation of the Affordable Care Act (ACA), including Medicaid expansion has had positive impact across the country, including Nevada. The estimated number of uninsured Nevadans in 2013 (Pre-ACA) was 20.7%. Nevada reduced the overall number of uninsured people by more than 5% between 2013 and 2014. The 2014-2015 open enrollment period for the Silver State Health Insurance Exchange was moderately successful. As of February of 2015 there were 62,944 effectual enrollments. This was a 59% increase over the completed applications during the last open enrollment period. Nevada, and especially the Title V MCH program, will continue to monitor the impact of the ACA through programs such as the Pregnancy Risk Assessment Monitoring System (PRAMS) to capture prenatal and postnatal data that can be used as access and outcome indicators.

Nevada's Division of Health Care Financing and Policy (DHCFP) manages the state's Medicaid program and its Children's Health Insurance Program (CHIP). The DHCFP has contracted with two managed care organizations to provide coverage in the urban areas of the state. Medicaid and CHIP members residing in the rural and frontier regions of the state are enrolled in fee-for-service Medicaid. In calendar year 2015, an estimated 786,738 individuals were enrolled in Nevada, an increase from the previous calendar year in which 573,874 were enrolled. The total enrollment for Nevada Check Up, the State's CHIP program, was an estimated 43,894 members in 2015. These numbers are purely estimates, but still demonstrate continued growth in Nevada Medicaid's population from the previous calendar year.

Nevada continues to monitor the utilization and strive toward increasing EPSDT screenings among its Medicaid eligible children under the age of 20. Healthy Kids, Nevada Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program reimburses 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 MCAH. Webinars on the topic of EPSDT have been provided by MCH staff to providers to ensure a thorough understanding of this benefit. Letters are mailed to inform families that their children are due for their initial or periodic EPSDT visit. The goal is to increase awareness of the availability and necessity of these screenings.

Continued collaboration between the DHCFP and MCH also includes education and outreach. A Healthy Kids toolkit is made available on both websites. We share a mutual goal of improving the health of children in Nevada. The promotion of preventive benefits and screenings such as EPSDT under the Affordable Care Act (ACA), particularly as they relate to maternal and infant health, with an emphasis on Medicaid participants, is a key priority in increasing maternal and infant/child health.

Attempting to address access to healthcare for the uninsured population in the State is challenging. Nevada is home to a non-profit organization called Access to Healthcare Network (AHN), which offers a medical discount program which follows a shared responsibility model. Members pay a small, income-based membership fee for access to the discounted provider network and participating healthcare providers receive a timely, yet reduced, payment. In addition, to successfully negotiate lower costs of care, clients also receive case management. For clients who are unable to completely pay for their healthcare needs, a patient care fund also provides financial assistance. As the ACA has changed the insurance paradigm in Nevada, AHN has witnessed a transition as well and 82% of the medical discount program participants are the undocumented.

An additional safety net for free health care is the University of Nevada School of Medicine's (UNSOM) Student Outreach Clinic which is operated by medical students. The purpose of the clinic is to provide access to health care for those without medical insurance, providing them with medical care that they otherwise may not receive. The benefit to students is that they receive hands-on experience in treating patients from the first day of medical school. 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 to oversee the clinic. Services include general and acute medical care, gynecological exams, immunizations, and discounted laboratory services. Currently, there are three separate clinics (General, Children, and Women) run by the Student Outreach Clinic.

5. Employment

There are currently 1.42 million Nevadans in the state's labor force, including 1.32 million who are employed and 96,625 who are unemployed. The annualized unemployment rate for 2015 in Nevada was 6.8% compared to the national average of 5.3%. The highest rate of unemployment in 2015 was in Mineral County at 10.8%, while the lowest rate was in Esmeralda County at 4.5%. Within the urban regions of Nevada, Carson City experienced the highest rate of unemployment at 7.3% and Washoe and Clark counties were slightly lower at 6.3% and 6.9% respectively. Nevada had the fourth highest unemployment rate level in the country in 2015.

6. Housing

According the US Census Bureau American Community Survey 1-year estimates, there were 1,198,907 housing units in Nevada in 2014. Nevada was negatively impacted by the housing crisis, with a large shift towards a renter society now having taken place. Nevada's rate of homeownership is down about 11 percentage points from a pre-housing crisis peak of 65.7% in 2006 to a 2015 rate of 54.8%. National homeownership peaked at 69% in 2004 according to data from the US Census Bureau accessed through the Federal Reserve Bank of St. Louis. In the 4th quarter of 2015, Nevada ranked tenth in the nation for foreclosure inventory according to data published by the LIED Institute.

Market forces continue to create a squeeze on the affordable end of the rental market, increasing rates of rent burden for lower income households. For renters, levels of rent burden, the proportion of households paying more than 30% of their income for rent and utilities, increased from 39.1% in 2000 to 48.8% in 2010. Data from the 2008-2012 Five year American Community Survey indicates that approximately 80,000 Nevada renter households making less than 50% of Housing and Urban Development (HUD) median income (63% of very low and extremely low income households) now pay 50% or more of their income for rent and utilities. This is termed severe rent burden. This compares with 51% of U.S. average for severe rent burden of renter households with incomes at or below 50% of HUD median income.

7. Income

Approximately 15% of Nevadans lived in poverty in 2014, with poverty in rural areas ranging from 8.6% to 20.5% and urban areas ranging from 15.9% to 17.6%. African Americans bear the largest part of that percentage at 36%, followed by Hispanics, 26%, Whites,10%, and other, 14% in 2014. In January 2016, 412,056 people received SNAP benefits compared to 441,006 people in 2015. Nevada ranked number one in food stamp participation, according to the Kaiser Foundation. Other indicators of poverty include National School Lunch Program in schools and according to the most recent data available, 205,536 children are participating in the program.

Nevada's urban areas struggle with many of the problems associated with urban living but also with an unusually high cost of living relative to low wages and insecure work associated with service industries which constitute a large number of available jobs in these areas. 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 geographical access barriers, as well as difficulties in recruiting and retaining providers. This translates to low rates of routine preventive health services, such as recommended EPSDT screening and related 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.

According to the Kaiser Family Foundation, Nevada ranked first in measures of state economic distress in 2015. These measures include: housing foreclosures, changes in unemployment ,and food stamp participation.

8. Policy/Legislature

Nevada is one of six states that has a biennial legislative session, where the Legislature meets for 120 days during each odd-numbered year. Prior to the 2015 legislative session, the state identified continued economic challenges with a 120 million dollar budget shortfall. In addition, there were unanticipated K-12 educational costs due to increased enrollment, which was 30 million dollars higher than budgeted based projections. Therefore, the Governor and Legislature had far less funding to maintain existing services or expand support to increase Nevada's struggling education system where Nevada ranks near the bottom of every measurable education standard.

As a result of the budget shortfalls and Nevada's poor rankings on education, Governor Sandoval proposed a $1.3 billion dollar plan of new and extended taxes to support pre-K education, school readiness, full-day kindergarten, etc. Many requests included new public health initiatives, but the overall economic status of the state prohibited funding many new initiatives. The DPBH;s budget was approved and included fee revenues to support funding the State's Dental Officer and Public Health Dental Hygienist. This demonstrates Nevada's commitment to address oral health issues within our state because this is the first time these positions will be funded and filled since they were created during the 2001 legislative session.

The 2015 legislative session was active with a number of bills relating to improving the health of Nevadans, including:

- SB79 was passed to increase the state cigarette tax by $1 per pack
- AB 489 was passed supporting licensing agencies "Community Health Worker Pools"
- AB152 was passed setting forth requirements relating to childcare facilities to provide private space for breastfeeding mothers and also requiring the childcare providers ensure children receive periods of moderate to vigorous activity
- SB503 gives school districts the necessary funding to carry out a "*Breakfast After the Bell*" program

Nevada's Title V/MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of nine diverse, representative individuals appointed by the State Board of Health from a list provided by the DPBH Administrator to two year terms, and two legislators are appointed by the Legislative Counsel. MCHAB is staffed by the MCH Manager. Under NRS, MCHAB is charged to advise the DBPH Administration related to matters concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives. The MCHAB works with diverse stakeholders, including a statewide MCH Coalition to meet the priorities documented in the 5-year strategic plan. The Advisory Board meets quarterly every year with the in-person meeting in Carson City and via videoconference in Las Vegas and Elko.

Beyond Nevada's biennial legislative period, Nevada relies on the Deputy Attorney General and the MCHAB to provide Nevada's MCH program with direction and guidance on policy issues. This advisory body sets the stage for state priorities relating to the MCH populations and is used to guide Nevada's MCH Needs Assessment as well as planning interventions implemented by public and private partners. There is also ongoing communication between MCHAB and both regional and statewide MCH Coalition partners to ensure the activities in the recent 5-year action plan are moving in a positive direction. MCH Coalition entities participate in, and report to, the MCHAB.

Organizational Structure

Governor Brian Sandoval is Nevada's current Governor, initially elected in 2010 and now in his second 4-year term. The Nevada Department of Health and Human Services (DHHS) is the largest of the state's departments and reports

directly to the Governor. The director of DHHS, Richard Whitley, is a Governor-appointed position. This Department is comprised of five divisions, programs and other entities under the leadership of the DHHS Director. The Divisions 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), and Division of Welfare and Supportive Services (DWSS).

DHHS programs that help promote MCH priorities in Nevada include:

- *Nevada 2-1-1* – free health and human services information and referral for Nevadans
- *Office of Consumer Health Assistance* – information and advocacy to consumers to assist them to manage changes relating to Health Care Reform
- *Nevada Governor's Council on Developmental Disabilities* – advocacy, system's change and capacity building activities for people with developmental disabilities to promote equal opportunity, self-determination, and community inclusion
- *The Office of Health Information Technology (HIT)* – administers Nevada's ARRA HITECH State Health Information Exchange (HIE)
- *IDEA Part C Office* –community-based services for infants and toddlers (ages 0 up to 3) with disabilities, including children who may be at risk for disabilities
- *The Office of Minority Health* – works with others to improve access to, and quality of, health care services for members of minority groups
- *Tribal Liaisons* – partners with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to establish and strengthen ties and relationships with the Tribal Governments.

Nevada Revised Statute (NRS) Chapter 442 provides oversight of overarching health matters to reside within DPBH. The DPBH Administrator is Cody Phinney, having taken this position after Richard Whitley was appointed the DHHS Director. DPBH is charged with administering those parts of the Social Security Act which relate to MCH, including Children and Youth with Special Health Care Needs (CYSHCN). DBPH is comprised of four branches, including:

- Administrative Services Branch
- Clinical Services Branch
- Community Services Branch
- Regulatory and Planning Services Branch

A Deputy Administrator supervises the Community Services Branch, which includes:

- Bureau of Behavioral Health Prevention and Treatment Program (BHPT)
- Bureau of Child, Family and Community Wellness (CFCW)
- Office of Public Health Informatics and Epidemiology (OPHIE)

The organizational structure of the Bureau of CFCW, and the Community Services Branch, ensures communication and collaboration across public programs. A Bureau Chief oversees CFCW, which includes the Maternal, Child and Adolescent Health (MCAH) section overseen by a Health Program Manager II. The MCAH section includes the Title V/Maternal and Child Health (MCH) Program. The Title V/MCH program is supervised by a Health Program Manager I, with fiscal assistance by a Management Analyst II, as well as program and data assistance by an Epidemiologist who is responsible for the assessment and development of the Title V/MCH Block Grant and five-year needs

assessment.

Individual program components are staffed by Health Program Specialists who work across public and private entities to ensure services and any needed support is provided to target populations in Nevada. Title V/MCH program components include:

- Adolescent Health – Eileen Hough is the Adolescent Health and Wellness Coordinator who collaborates with school-based health centers and diverse healthcare providers on activities to support adolescents related to public health (coordinating with other adolescent health personnel within the MCAH).
- Children and Youth with Special Health Care Needs (CYSHCN) – MCAH is currently recruiting for this position. The CYSHCN Program Coordinator collaborates with diverse public and private agencies to coordinate activities targeted to this population (0-21 years of age), including advocacy, transition planning, training for parents and professionals, Critical Congenital Heart Disease (CCHD) reporting, establishing a Medical Home Portal, among other activities.
- Maternal and Infant Health Program (MIP) – Christina Turner is the MIP Coordinator who collaborates with diverse public and private entities on a variety of activities related to pre/interconception care, healthy pregnancies, substance use initiatives, and other activities related to target populations of women of childbearing age and infants.
- Rape Prevention and Education (RPE) Program – Deborah Duchesne is the RPE Coordinator who collaborates with diverse public and private entities, including institutions of higher education, on activities targeted to prevent sexual violence and violence against women

Agency Capacity

Title V/MCH works closely with programs and sections across DPBH

that support infants/prenatal care, children, adolescents and women of childbearing age. By supporting Nevada's Title V/MCH capacity within the CFCW Bureau and across DPBH, activities can occur at the local, regional and statewide levels. MCH-funded support includes activities related to oral health, breastfeeding, and a variety of programs noted throughout this grant application.

MCH is always looking on ways to fund and/or collaborate with programs that meet the priorities indicated in the 5-year plan; therefore, Title V funds, in whole or in part, assists the following entities in providing community-level public health functions, care coordination, health education, and outreach.

- Fetal Infant Mortality Review (FIMR) Program in Washoe County assesses the factors that affect the health of the mother, fetus, and infant as well as ways to reduce fetal and infant mortality.
- Local Health Authorities provide health services, care coordination, health education, outreach and other functions to support public health in the urban counties of Nevada.
- Family TIES – supports CYSHCN families who need assistance with a toll-free hotline, provides advocacy, education, training and other supports to families and the healthcare professionals who serve this population.
- Financial Guidance Center/Nevada 2-1-1 – provides information and referral via www.nv211.org and a toll-free number as well as the ability to dial 211.
- Specific activities/initiatives focused on pregnancy, prenatal and early health including websites (e.g.,

sobermomshealthybabies.org, text4baby), safe sleep, developmental screenings, etc.

- Anti-bullying training via the Nevada Department of Education, including local school district personnel.
- University of Nevada, Reno to build capacity for conducting Pregnancy Risk Assessment Monitoring System (PRAMS) by implementing Baby BEARS, a statewide survey similar to PRAMS.
- Statewide MCH Coalition support to ensure website maintenance, communication and advocacy across public and private health entities in Nevada and to conduct planning with partners for meeting community needs to diverse populations (activities also align with the MCH 5-year plan priorities).
- March of Dimes to support training of healthcare professionals and advocates as well as provide MCH programs with educational materials when conducting health services and outreach (materials focus on pre/interconception).
- Training/workforce development – this includes, but is not limited to statewide health conferences/symposiums, trainings to build topical knowledge (e.g., Screening, Brief Intervention, and Referral to Treatment: SBIRT) and attendance at national conferences.

Nevada's Title V/MCH program collaborates with, and can provide limited implementation funding, to initiate school-based health clinics statewide, and some ongoing funding for specific improvements. Some agencies include, but are not limited to, Community Health Alliance, Communities in Schools, Nevada Health Centers, University School of Medicine, etc.

In order to coordinate MCH activities across Nevada, program personnel meet at least monthly to discuss the status of funded programs, both public and private. Discussions include status on meeting program goals/outcomes, barriers/problems, training needs or upcoming training, and new activities to consider as additional funding allows. On an annual basis, all MCH program personnel work with community partners to determine the scope of work and budget needed for community-level activities. Program staff also participate in local and statewide meetings that may focus on activities related to maternal and child health populations including: MCAH Section meetings, Data meetings, MCHAB meetings, other advisory meetings, a variety of local and statewide coalition meetings, local action meetings, health fairs and activities.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

Action Plan Process

MCH Staff, in collaboration with partners re-evaluated the activities outlined in the five-year action plan and made appropriate revisions with special consideration of program and organizational capacity, existing programmatic strategies and realistic goals and objectives. In addition, priorities were either deleted and/or revised for clarity as well as to better align with the National Performance Measures (NPMs), State Performance Measures (SPMs) and newly developed Evidence-based or informed strategies (ESMs). The Maternal and Child Health (MCH) Advisory Board Members provided input into the final Action Plan.

MCH Workforce Development and Capacity

Nevada Maternal, Child and Adolescent Health (MCAH) Section has been undergoing changes including making contractual positions into state positions. This move has been welcomed by staff and it is hoped that having more state staff will help in program continuity, improve staff morale, and reduce staff turnover.

Title V continued to support 21 full time employees (FTEs) in various roles and capacities. Some of the changes in staffing include: Beth Handler, MPH, is the Bureau Chief for the bureau of Child, Family and Community Wellness as well as the MCH Director. The deputy Bureau Chief position is currently under recruitment. Vickie Ives, MA, is the Maternal, Child, and Adolescent Health Section Manager. Charlotte Andreason, MPH is the Nevada Home Visiting (NHV) Program Coordinator and Melissa Madera is the Health Resource Analyst for the program. MCAH is currently recruiting the Children and Youth with Special Healthcare Needs Program Coordinator position and the Adolescent Health Abstinence Education Grant Program Coordinator position.

The MCH program is in the process of hiring a Health Program Specialist (HPS) to assist in programmatic duties. The vacancy in this position has been created by the current HPS who will move to a biostatistician position to better focus on data analytic duties for the MCH Program.

Data Gaps

In May, 2016, Nevada was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) grant and through this surveillance system, many data gaps will be filled. For example, Nevada does not have state-specific data on perinatal mental health, oral health, and domestic violence among others. PRAMS will enable MCH and other state partners to obtain baseline data on various MCH-related outcomes, as well as provide information on associated behavioral factors.

Partnerships, Collaboration, and Coordination

Nevada Title V has plans to rebuild partnership with the Nevada Early Childhood Advisory Council (ECAC) to strengthen state-level coordination and collaboration among the various sectors and settings of early childhood programs. This will be accomplished by having staff attend the regularly scheduled ECAC quarterly meetings and inviting their members to attend the MCH Advisory Board meetings.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Introduction

Stakeholder involvement is a key component in the needs assessment process. An online survey was sent out to stakeholders to get feedback on a broad and diverse range of information about strengths, gaps, and state capacity. The survey also asked stakeholders to identify National Performance Measures and top priorities for the MCH populations. Stakeholders provided their contact information if they wanted to participate in focus groups. The survey was distributed via email to MCH Advisory board members, National Governors Association (NGA) improving birth outcome members, and other MCH Partners/stakeholders.

Electronic surveys (in English and Spanish) were also emailed to consumers seeking their input on the quality of the healthcare services that they, their children and/or families received as well as their unmet needs. The survey asked consumers to provide their contact information if they wanted to provide in-depth feedback in a focus group setting. The consumer survey was sent to the same list as the stakeholders but a request was made for the stakeholders to distribute.

Stakeholders and consumers were invited to take part in focus groups which were held in three (3) communities across Nevada; Clark County, Washoe County and Elko. Stakeholders included people who worked for a variety of non-profit, for-profit, and governmental agencies serving the needs of women and their children in their communities. The goal of the stakeholder focus group was to brainstorm needs or priorities, solutions to those needs, and to select national performance indicators to measure progress related to each of the MCH domains.

Consumers included women with children who were primarily under or uninsured, had children with special needs, or utilized government funded social service programs such as Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). Consumer focus group participants were asked a series of questions related to health concerns, accessibility of services, interactions with providers, experience with health insurance, as well as awareness and experience with government funded service programs. A Spanish interpreter was available for non-English speakers.

To avoid duplication and maximize current resources in our state, MCH staff conducted a review of available quantitative data as well as existence of any needs assessments that had been recently completed by any state agency. The mixed methods approach of gathering qualitative and quantitative data provided information to inform the development of eight MCH priorities and selection of eight National Performance Measures that meet federal Block Grant requirements and address the top unmet needs of Nevada's MCH population.

Methodology

Qualitative Data

Both stakeholders and consumers of MCH services were recruited for one of six focus groups across Nevada. Two focus groups took place in each community, Reno, Las Vegas and Elko. Justification for choosing these locations was due to the size of Nevada, with the majority of the state's population residing in either Reno in the north, or Las Vegas and its surrounding communities in the south. Representation of rural MCH issues was gathered in Elko, a growing rural population in the eastern part of the state. Due to the different approach between stakeholder and client focus groups there are limitations in comparability of qualitative data, however if both groups raised an issue it was noted and examined within the regional analysis.

Quantitative Data

Data sources that were utilized to inform the needs assessment include: Nevada Vital Records, Youth Risk Behavior Surveillance, Behavioral Risk Factor Surveillance System (BRFSS), Nevada Rural and Frontier Health Data Book, Nevada State Demographer, U.S. Census Bureau, The American Community Survey (ACS), Healthy People 2020, Office of Adolescent Health, Nevada Survey of Children's Health, Kaiser Family Foundation, CDC Wonder, Breastfeeding Report Card among others. Reports from recently completed needs assessments in the state were also utilized.

Framework

The life course perspective, the revised MCH Pyramid of Health Services and the 10 MCH Essential Services were used as conceptual frameworks for Nevada Title V/MCH needs assessment including the data gathering process for the focus groups as well as the consumer electronic survey. Since Nevada experiences significant racial/ethnic disparities in health outcomes, a combination of these frameworks provided a better understanding of health across generations and throughout the lifetime as well as its implications on maternal and child health populations. In addition, the life course theory provided a framework to help us in aligning Title V activities with the six population domains. Results of our Needs Assessment were used to develop a five-year action plan to address the MCH priorities as well as objectives and strategies to address them.

Prioritization Process

Feedback from the stakeholder and consumer online surveys and focus groups yielded over 30 priorities. To narrow down to the current eight priorities, the following factors used in the prioritization process:

1. Federal requirements
2. Incidence and prevalence
3. State and local capacity
4. Evidence-based/informed strategies
5. Measurability
6. Cost

These factors are further discussed in the State Selected Priorities section.

II.B.2. Findings

II.B.2.a. MCH Population Needs

The needs assessment process yielded eight priorities for the six population domains. The priorities correspond to the eight National Performance Measures that were chosen through a survey used in the needs assessment. An overview of each population health domain is provided as well as areas that were identified as requiring intervention or "more work".

1. Women's/Maternal Health

One of the best ways to remain healthy is by preventing potential health problems and identifying illnesses before they become acute. Therefore, it is vital to get a wellness exam from a healthcare provider. For women, a wellness exam can lead to early diagnosis, treatment, and ultimately enhance a woman's health before, during, and after pregnancy. In accordance with the Affordable Care Act (ACA) stipulation, health care plans available in Nevada's Silver State Health Insurance Exchange (SSHIX) offer Essential Health Benefits (EHBs) which cover preventive and wellness services at low cost or no out-of-pocket costs.

Wellness screening

Some of the major priorities identified in the needs assessment for this population domain were wellness screening, prenatal care/visits, and access to family planning services. To address these needs, MCH developed two priorities: 1. *Improve preconception health among adolescents and women of childbearing age and 2. Increase the percent of adolescents and women of childbearing age who have access to healthcare services*. The objectives and strategies for these priorities will be aligned with NPM 1: the percent of women with a past year preventive medical visit. And NPM

Research has shown that improving preconception health can result in improved reproductive health outcomes. Nevada Title V in collaboration with various agencies and programs has been conducting numerous activities to educate Nevadans of the health insurance options available through ACA. In addition, SSHIX provides in-person help through Navigators and Enrollment Assisters at various community locations and organizations to individuals who would like to enroll in healthcare coverage. In 2013, 24% of Women ages 19-64 were uninsured in Nevada (Kaiser Family Foundation, 2014). Over the years, the prevalence of women with a past year preventive medical visit in Nevada has been slowly increasing. In 2013, 60.1% of women had a preventive medical visit compared to 58.6% in 2009. By race/ethnicity, Black women were far more likely to report having a preventive medical visit in the past year (83.8%) compared to Asian (61.9%), Hispanic (61.1%) and White (55.4%) in 2013. Title V is hopeful that the number of uninsured women will decline as a result of the ACA and will report on the changes when more recent insurance data becomes available. High insurance rates will ensure that women and adolescents have access to the healthcare services that they need thereby improving their wellbeing and quality of life.

Prenatal care

The percent of pregnant women who received prenatal care beginning in the first trimester in 2013 (68.4%) remained the same as 2012 (68.1%). More recent data (2014) indicates that this number slightly improved to 70% and this puts Nevada close to the Healthy People 2020 objective of 77.6%. In 2013, women with private insurance were the most likely to receive prenatal care in the first trimester (82.7%), followed by women with other type of public insurance (77.2%). Uninsured women (55.1%) and those enrolled in Medicaid (55.2%) were the least likely to receive prenatal care beginning in the first trimester. By race/ethnicity, White women were the most likely to receive prenatal care in the first trimester (77.2%) followed by Asian (76.3%), Hispanic (59.8%) and Black (59.6%).

Prenatal care was identified as a priority in the previous needs assessment (2011-2015) and will continue to be addressed in NPM 1. The Office of Public Health Informatics and Epidemiology, housed in DBPH will continue monitoring accurate reporting of prenatal care for all registered births in hospitals and birthing facilities in Nevada. Nevada tracks adequate reporting of prenatal care because research has shown that receiving early and regular prenatal care improves the chances of a healthy pregnancy and ensures that babies have better health outcomes. When hospitals provide complete information about prenatal care, DBPH can accurately allocate prenatal care resources where the needs are the greatest.

To address various aspects of prenatal and postnatal care, Amerigroup, a managed care organization in Nevada established Prenatal/Postpartum Quality Initiatives such as the OB Medical Record Review tool to monitor the providers' compliance with HEDIS and American Congress of Obstetricians and Gynecologists (ACOG) guidelines for prenatal and postpartum care. Amerigroup also oversees an intensive OB case management program for pregnant members known as *'Taking Care of Baby and Me*' which encourages members to optimize the outcome of their pregnancy.

2. Perinatal/Infant Health

Improving Birth Outcomes: Preterm Birth, Low Birth Weight and Infant Mortality

Nevada Title V is currently involved in various initiatives to reduce preterm birth, low birth weight and infant mortality. One such initiative is the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality.

Infant Mortality

Nevada's Infant Mortality Rate (IMR) in 2009 was 5.8 per 1,000 live births and significantly declined by 12 percent to 5.1 in 2014. This puts Nevada below the HP 2020 objective of 6.0. However, racial/ethnic disparities persist in infant mortality in our state. In 2012, Blacks (9.6) and American Indian/Alaska Natives (9.4) had the highest IMR while Asians had the lowest IMR (3.8). Hispanic IMR was 4.4 while White IMR was 5.2. Between 2011-2013, populations that participated in WIC had a lower IMR (4.7) compared to those who did not participate (5.5).

Nevada's Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births significantly declined (by 23 percent) from 93.1 in 2009 to 71.4 in 2013. In 2011-2013, Blacks had a significantly higher SUID rate (159.1) compared to Whites (84.1) and Hispanic (38.9). Infants born to moms with less than high school education experienced higher SUID rates (116.1) compared to infants born to moms with some college (40.1). Disparate SUID rates were seen in certain age groups with infants born to moms who were less than 20 years experiencing higher SUID rates (162.0) compared to infants born to moms 30-34 years (89.9).

Approximately 4,000 infants in the United States die each year due to preventable and unsafe situations such as asphyxia, suffocation, and other undetermined sleep-related deaths. Title V closely works with Safe Kids Washoe County, the lead agency for the Cribs for Kids (C4K) program in Nevada to provide educational resources to parents and caregivers on the importance of practicing safe sleep behaviors. In 2014, C4K conducted seven statewide trainings (five in Washoe County and two in rural areas--Carson City and Ely) and as a result, acquired four new partner agencies in these areas. C4K conducted also conducted public awareness campaigns such as ABC's of safe sleep banner ads on various websites through a digital advertising campaign targeting new mothers across the state and 30 second radio PSA's on safe sleep were aired in rural areas. Baby Safe Sleep initiative is currently being implemented by Dignity Health System hospitals in Southern Nevada.

Title V collaborates with Maternal, Infant and Early Childhood Home Visiting Program, which houses the Healthy Start Program. Healthy Start was recently awarded federal funding to focus on reducing racial disparities and improving perinatal health outcomes among African-American women Clark County. The design and delivery of the program is to provide comprehensive, coordinated, health and social services that will foster continuous access to care for women who are pregnant or of childbearing age.

Breastfeeding

Nevada Title V has been doing significant work to improve the health and wellbeing of infants. One of the initiatives surrounding this domain includes breastfeeding promotion. In 2014, the percent of infants who were ever breastfed in Nevada (80.9%) was about the same as that of the nation (79.2%). The prevalence was even higher in moms enrolled in Nevada's Home Visiting Program (92.1%). However, the percent of infants breastfed exclusively through 6 months remained the same in 2010 (18.7%) and 2011 (18.8%). The high rates of breastfeeding initiation in our state are not surprising considering the significant contributions that have been made by the Nevada Breastfeeding Program and Nevada Home Visiting Program to support women who wish to breastfeed. Breastfeeding efforts will continue to be addressed through *priority 2: Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months.* This priority aligns with *NPM 4A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 month.*

Other efforts in Nevada that support breastfeeding include designation of a lactation room in one of two Department of Public and Behavioral Health buildings, and the "*Bring Your Baby to Work*" program which expanded from two to four Department of Health and Human Services Divisions – adding on the Division of Health Care Financing and Policy and the Division of Aging and Disabilities. These new developments were overseen by Nevada WIC in FY '14.

3. Child Health

Nevada Title V is dedicated to improving the health of women, children and families in Nevada. It is through various collaborative efforts between families and agencies that a child can reach optimal physical growth, psychological development and overall health. MCH chose *priority 3: increase the percent of children aged 10 through 71 months receiving developmental screening* for this population domain. In 2007, only 18.6% of children, ages 10-71 months, received a developmental screening using a parent-completed screening tool. In 2011-2012, the percent of children receiving a developmental screening using a parent-completed screening tool increased by 18 percent to 21.9%. In the same year, only 19.5% of children without special health care needs received a developmental screening compared to 48.9% of children with special healthcare needs.

Early Screening and Developmental Screening

MCH collaborates with entities across the state to ensure children are provided with appropriate screening, follow-up, testing, and timely treatment. Nevada Early Hearing Detection and Intervention (NV EHDI) Program, housed in the Maternal, Child and Adolescent Health section works to ensure that all children in Nevada are screened for hearing loss at birth and those identified with hearing loss receive timely and appropriate audiological, educational and medical intervention. However, Nevada faces a shortage of audiologists who routinely treat newborns and this causes delays in diagnosis and increased loss to follow-up. Consequently, both parents and healthcare providers get frustrated. To deal with these issues, NV EHDI implemented the Guide By Your Side (GBYS) to address the Loss to Follow-up/Loss to Documentation Rate in Nevada. In addition, NV EHDI employs an audiologist to provide training on the correct newborn screening methods. The collaboration has led to improved screening and a reduction in the burden of conducting unnecessary diagnoses for audiologists.

The Nevada Home Visiting Program (NHV) provides referrals to a doctor if a family desires. In addition, all home visitors conduct periodic screenings to determine whether a child requires specialty care, and if necessary, a referral is provided. NHV ensures that families are involved in all decision-making processes and referrals and services are provided with the families input.

The Bright Futures initiative in Nevada strives to provide resources and information on healthy living for infants, children and, adolescents in order to promote increased access to regular well child visits. Bright Futures Tool and Resource Kit has been disseminated to distributed to various groups including: medical providers, school staff, parent groups, family resource centers, home visiting staff, childcare health consultants, coalition memberships, and community leaders. The purpose of the kit is to increase awareness of services offered by Bright Futures, as well as to increase awareness of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits to families.

Immunizations

CDC calls prevention of disease through vaccination as one of the 10 greatest public health achievements of the 20th century. However, immunization rates have dropped in the recent past in various populations, possibly attributed to nonmedical vaccine exemptions. MCH needs assessment findings found that parents and stakeholders were concerned about myths surrounding vaccines as well as the rising number of children in our

community who were not vaccinated. To address these concerns, parents suggested that they would like to receive information to clear up misconceptions. Additionally, parents stated provision of immunizations at schools would lessen the burden of taking time off from work in order to have their child vaccinated.

In 2013, the percent of children who received the combined series of vaccines significantly increased from 39.3% in 2009 to 60.6%, a 54 percent increase. Even with this large increase, Nevada is still below the national percentage of 70.4% as well as the HP 2020 objective of 80.0%. In 2011-2012, 26.2% of uninsured children and 26.5% of those on Medicaid received a developmental screening using a parent-completed screening tool in Nevada and only 18.0 % of those with private insurance received screening. By race/ethnicity, Black (23.5%) and Hispanic (23.3%) were more likely to receive a developmental screening using a parent-completed screening tool compared to White (20.8%).

Several initiatives are being carried out by MCH partners and stakeholders to increase vaccination rates in our state. In 2014, Immunize Nevada, the state's non-profit coalition funded primarily by the IZ Program of the DPBH, conducted its vaccination campaign and provided 78% more vaccines than last year at community and mobile food pantry sites in partnership with Walgreens. In addition, Immunize Nevada conducted community outreach and activities including HPV: Closing the Vaccination Gap project which focused on increasing HPV vaccination through parent and adolescent education along with healthcare provider outreach.

Nutrition and Physical Activity

Nevada Title V needs assessment emphasized the need to address obesity through proper nutrition and increased physical activity for women, children and adolescents. This will be addressed through priority 4, *Increase the percent of children, adolescents and women of childbearing age who are physically active*. In 2011-12, 29.8% of children ages 6-11 were physically active for at least one hour every day in the past week. White children, ages 6-11 (36.8%) were more likely to participate in daily physical activity than children of all other race/ethnic groups. Children (ages 6-11) born in the U.S. were two times more likely to participate in daily physical activity compared to children born outside the U.S.

In 2011-12, 33.2% of percent of children and adolescents in Nevada were overweight or obese (BMI at or above the 85th percentile). However, more recent data (2013-2014) from Nevada's Student Height-Weight Study shows that the prevalence of overweight or obese children in our state has increased by 15 percent to 38.1%. Results from the needs assessment indicated a lack of education and services related to factors that lead to obesity, including adult and child nutrition as well as physical activity. To address nutrition and physical activity, both parents and stakeholders suggested increasing regulation for foods serving children, promoting affordable sports, utilizing activity busses/tumble busses, and working with family resource centers to reach the populations they serve.

Plans are underway to create a Statewide Obesity Prevention Taskforce to look into ways to reduce overweight and obesity rates specifically through increased physical activity and physical education. The Comprehensive School Physical Activity Program (CSPAP) training has been provided to school staff and other partners and will be continued in urban areas, as well as rural and frontier Nevada.

4. Adolescent Health

Health coverage and access to health services were some of the top needs highlighted in the needs assessment for adolescents. This need will be addressed by *Priority 5, Increase the percent of adolescents and women of childbearing age who have access to healthcare services.*

Well-Visits

The American Academy of Pediatrics, the American Medical Association's Guidelines for Adolescent Preventive Services and the federal Bright Futures guidelines, recommend comprehensive annual check-ups for adolescents. In 2011-2012, 67.3% of Nevada's adolescents, ages 12 through 17 had a preventive medical visit in the past year. This put Nevada below the HP 2020 goal of 75.6%. In 2011-2012, White (72.0%) and Black (72.7%) adolescents were much more likely than Hispanic adolescents (62.1%) to get a preventive medical visit in the past year. Since Nevada has one of the highest Hispanic populations in the country, language may be a barrier to seeking important preventive services. Adolescents born outside the U.S. were the least likely to receive a preventive medical visit (57.8%) compared to adolescents born in the U.S. (73.1%). The needs assessment findings showed that insurance was a barrier to seeking and receiving health services. In 2011-2012, far fewer adolescents without insurance (33.6) reported receiving preventive services compared to those on Medicaid (70.1%) and private insurance (74.2%). Other disparities were gender related with more females (72.5%) receiving preventive services than males (61.8%).

Immunizations

Immunizations help to decrease the incidence of many preventable diseases (CDC, 1994). However, many adolescents are disproportionately affected by diseases that can be prevented by vaccines. In 2013, 57.3% of female adolescents aged 13-17 had at least 1 dose of the HPV vaccine nationwide. Nevada's percentage was lower with 53.8% of female adolescents aged 13-17 having received at least 1 dose of the HPV vaccine. Nevada males had a much lower percentage with 31.9% reporting having received at least 1 dose of the HPV vaccine in the same year. By race/ethnicity, Hispanic adolescents (71.2%) had higher vaccination rates than White (46.9%) or Black (48.5%) in 2011-2013. In the same period, female adolescents on Medicaid (65.6%) and other public insurance (61.7%) were more likely to get a HPV vaccine compared to those without insurance (58.0%) and on private insurance (49.4%). There were geographical differences in vaccine uptake with 69.5% of adolescents living in urban areas having higher vaccine rates compared to their rural counterparts (41.7%).

Nutrition and Physical Activity

Similar to the child health domain, the needs assessment outlined obesity, proper nutrition and increased physical activity as a priority for adolescents. MCH will continue to implement the preventive strategies for this need through *priority 4, Increase the percent of children, adolescents and women of childbearing age who are physically active.* In 2011-12, 14% of adolescents 12 -17 were physically active for at least one hour every day in the past week. Black adolescents (29.3%) were more likely to engage in physical activity compared to adolescents of other race/ethnic groups.

Sexual and Reproductive Health

Teen Pregnancy prevention was one of the priorities underscored in the needs assessment and efforts to support this need are supported by the Nevada Adolescent Health Program and its partners. In addition, MCH initiatives, such as the NGA collaborative on improving birth outcomes, address issues relating to teen pregnancy such as Long Acting Reversible Contraceptives (LARC).

Nevada's teen birth rate (ages 15 through 17) significantly declined by 53 percent from a high of 26.4 per 1,000 in 2007 to a record low of 12.3 in 2013. This rate is similar to the national birth rate for women in this age group (Hamilton et al, 2014). Although Nevada's teen birth rates have dropped in the past decade, racial /ethnic disparities persist. In 2011, the total number of births to females under 20 years of age in Nevada was 3,112 and over half (53%) were among Hispanic teens, 26% White, 16% Black, 4% Asian and 1% American Indian or Alaska Native (Office of Adolescent Health (OAH), 2014).

5. Children and Youth with Special Health Care Needs

In 2011-2012, the percent of children and Youth with special health care needs (CYSHCN) in Nevada was 14.9%. Majority of the CYSHCN were aged 12-17 years (23.6%), while the age group with the least CYSHCN was 0-5 years (6.8%). By insurance status, 16.8% of CYSHCN were covered by Medicaid, 15.2% had private insurance and 10.5% were uninsured. The largest proportion of CYSHCN were of multiple race (20.6%), followed by White (17.4%), then Black (13.1%) and Hispanic (9.0%). Other differences in this population were gender related with more males (18.0%) having more special health care needs than females (11.7%).

Medical Home

Medical home was the top priority for this population domain. This need will be addressed by *priority 6, promote establishment of a medical home for children*. MCH is currently working with several partners to address the needs of CYSHCN. Nevada Title V will continue to provide funding for the development of Nevada's medical home portal in collaboration with the Department of Pediatrics at University of Utah Health Sciences Center. Nevada medical home portal will contain state-specific components such as: information to support clinicians and parents responding to abnormal newborn screening tests, information to support parents in caring for CYSHCN among others. The ultimate goal of the medical home portal is to improve the care of CYSHCN by offering a comprehensive, coordinated and integrated state system.

In 2011-2012, the percent of children with and without special health care needs with a medical home in Nevada was 43.3%, a 16 percent increase from 37.2% in 2007. Children with and without special health care needs aged 6-11 were more likely to have a medical home (63.3%) than all other age groups. By race/ethnicity, children of multiple race (61.3%) were more likely to report having a medical home followed by White children (57.0%). Hispanic children (25.8%) were the least likely to have a medical home. By insurance status, children with private insurance (51.4%) were more likely to have a medical home than those on Medicaid (38.5%).

6. Cross-Cutting/ Life Course

Since many of the factors that influence health are cumulative, a life course approach can be used to link socioeconomic conditions in one phase of the life course to health outcomes at a later stage. A life-course approach can help address risk factors associated with these inequalities. MCH is engaged in numerous collaborative efforts with various programs and agencies to address these disparities and will monitor various types of disparities in this domain through priority 7, prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age and priority 8, increase the percent of adequately insured children.

Mental Health

One of the most prevalent unmet health care needs for women, children and adolescents in Nevada is mental health. In 2011-2012, 49.3% of children with a mental/behavioral condition received treatment or counseling. This puts Nevada far below the HP 2020 objective of 75.0%. White children (59.3%) were the most likely to receive mental/behavioral treatment or counseling.

In 2011-2013, the suicide rate for teens ages 15 through 19 was 9.6 per 100,000. White teens were more likely to commit suicide (11.7 per 100,000) than any other race/ethnic group. Male teens were three times more likely to commit suicide than female teens. Teens in the rural and frontier regions were twice as likely to commit suicide as teens in the urban areas of the state in 2009-2013. These patterns of suicide risk in Nevada are similar to those in the U.S. and most developed nations.

AB 164 was passed in 2013 to require all school administrators be trained in suicide and bullying prevention. As a result, the Office of Suicide Prevention (OSP) trained district superintendents and administrators in 5 counties: Lyon, Pershing, White Pine, Churchill, Lander and Humboldt in 2014. In addition, OSP collaborated

with Nevada Coalition for Suicide Prevention to train over 8,334 Nevadans on suicide intervention and alertness training and has brought Suicide Awareness to 921,000 of our states population through media and news outlets. A recent behavioral health survey confirmed that Nevada is reducing the stigma and taboo around the subject of suicide.

Title V will continue to provide funding to school based health centers as they are well positioned to provide comprehensive mental/behavioral health services to children. In addition, Nevada 2-1-1 will continue to provide physical and mental health resources and support for children, youth and families. Title V will also continue to collaborate with the Bureau of Behavioral Health, Wellness, and Prevention to ensure that behavioral health and mental health services are provided to MCH populations in Nevada.

Tobacco Cessation

Results from the needs assessment indicate that tobacco use was one of the top priorities for pregnant women and children. This need will be addressed through priority 7, prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age. In 2014, 3.8% of women in Nevada reported smoking in the last three months of pregnancy, a 12 percent decrease from 2013. This decline is encouraging and Nevada Title V will continue ongoing statewide collaborative efforts on tobacco cessation to reduce poor birth outcomes and smoking-related maternal morbidity. Specifically, Title V will continue to collaborate with The Tobacco Prevention and Cessation Program (TPCP) within the Bureau of Child Family and Community Wellness to provide prevention strategies for all women including pregnant women. Title V will continue to work with Medicaid to promote Medicaid funded cessation programs. Medicaid coverage provides a variety of tobacco cessation treatments in Nevada. Customized Text4Baby messages on tobacco cessation will continue to be sent to mothers who sign up for the services. Nevada Title V is greatly concerned about the potential health consequences of e-cigarettes on MCH populations and since there is no state-specific data on this new tobacco product, a question was included in the Title V-funded PRAMS-like survey to collect data on the use of e-cigarettes. Title V and SAPTA will continue to oversee the SoberMomsHealthyBabies.org website which provides substance use prevention information to pregnant women, women of childbearing age, providers, and concerned family and friends.

Health Insurance

According to the needs assessment findings, health insurance was a major concern for all population domains. Health coverage greatly impacts the ability to get access to health care services. Health insurance coverage can be obtained privately, through an employer, through the military or public programs such as Medicaid and Children's Health Insurance Program (CHIP). Individuals who are uninsured are less likely to seek health care services compared to their insured counterparts and this may lead to undesirable health outcomes. Some of the barriers to access to health services uncovered in the needs assessment were lack of insurance, limited number of providers accepting Medicaid, high volume of paperwork during application process and lack of transportation (in Clark County).

Nevada Medicaid is managed by the Division of Health Care, Financing, and Policy (DHCFP) and has two managed care organizations that serve Medicaid eligible individuals in Clark and Washoe County (Urban areas) while Medicaid *fee for service plan* serves individuals in the rural and frontier areas of the state. CHIP is also managed by the DHCFP and provides health care coverage to children who are not covered by private insurance or Medicaid. For the enrollment period of October 2013, 21,356 children were enrolled in CHIP and significantly increased to 32,825 in 2014.

In 2013, 13.9 % of the children in Nevada did not have health insurance. This is a 23 percent reduction from 18.0 % in 2009. Even with the decline in children insurance rates, Nevada has not met the HP 2020 objective to increase the proportion of persons with health insurance to 100%. In 2013, children with the highest insurance

rates were aged 12-17 (16.0%). By race/ethnicity, Native Hawaiian/other Pacific Islander children were the most likely to be uninsured (20.7%) while children of multiple race were the least likely to be uninsured (7.9%). Children born outside the U.S. were 2 times more likely to be uninsured than children born in the U.S. Nevada's MCH Program is aware of these disparities and will continue with various efforts to increase health insurance coverage for the affected populations.

The agency recognizes that capacity to address the identified priorities is limited, thus engages in collaborative activities with a myriad of agencies and organizations that serve the MCH population. The Primary Care Office oversees the J-1 Visa Waiver Program to combat the primary care physician shortage in the state. The Program recruits foreign medical graduates to work in medically underserved rural and frontier areas and allows them to remain in the U.S. after completion of medical school in return for their service in a Medically Underserved Area or Health Professional Shortage Area full-time for a minimum of three years. MCH also collaborates with Elko Regional hospital who are very supportive of nurse midwives. Nevada also faces the challenge of meeting the healthcare needs of undocumented persons. Currently, health centers provide healthcare services to undocumented immigrants.

References

1. Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplements).

2. CDC. Update: childhood vaccine-preventable diseases—United States, 1994. MMWR; 1994; 43:718–20.

3. Hamilton, B.E., Martin, JA, Osterman, M.J.K., & Curtin, SC. Births: Preliminary Data for 2013. National Vital Statistics Reports. vol 63 no 2. Hyattsville, MD: National Center for Health Statistics. 2014.

4. Office of Adolescent Health (2014). Nevada Adolescent Reproductive Health Facts. Retrieved June 26 from http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/states/nv.html

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

In Nevada's Executive Government, the elected Governor is the Head of State. Brian Sandoval, was elected Governor of Nevada on November 2, 2010 and is in his second four-year term. There are various departments, boards and commissions that make up the Executive Branch under the Governor. These include: Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch Includes: the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons.
The Nevada Department of Health and Human Services (DHHS) is the largest department, comprised of five divisions along with additional programs and offices overseen by the DHHS's Director's Office. Richard Whitley is the DHHS Director appointed by Governor Brian Sandoval. The five divisions under DHHS include: the state public health agency, known as 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), and Division of Welfare and Supportive Services (DWSS).

Various programs that help to promote MCH priorities in Nevada are also housed in DHHS. These include: *Nevada 2-1-1,* a free service that provides information about vital health and human service programs that are available throughout the State, *Office of Consumer Health Assistance,* provides information and advocacy to

consumers to assist them manage any changes relating to the Health Care Reform. The *Nevada Governor's Council on Developmental Disabilities* engages in advocacy, system's change and capacity building activities for people with developmental disabilities and their families in order to promote equal opportunity, self-determination, and community inclusion. *The Office of Food Security* was established in September 2013 and strives to leverage regional and local community-based efforts to reduce hunger. The *Grants Management Unit* administers grants to local, regional, and statewide programs serving Nevadans. *The Office of Health Information Technology (HIT)* is responsible for administering Nevada's ARRA HITECH State Health Information Exchange (HIE) Cooperative Agreement, facilitating the core infrastructure and capacity that will enable statewide HIE and coordinating related Health IT initiatives. *IDEA Part C Office* provides comprehensive, interagency, multidisciplinary, family-centered, and community-based services accessible to all infants and toddlers with disabilities and to many who are at risk for disabilities. *The Office of Minority Health's* mission is to improve the quality of health care services for members of minority groups; to increase access to health care services; and to seek ways to provide education, and to address, treat and prevent diseases and conditions that are prevalent among minority populations. *Tribal Liaisons*: DHHS is committed to partnering with the 27 Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the Tribal Governments as well as provides education and outreach. There is a network of Liaisons who represent each of the DHHS Divisions.

Nevada Revised Statute (NRS) 442 designates the DHHS through the DPBH to administer those parts of the Social Security Act which relate to Maternal and Child Health and Children with Special Health Care Needs. DBPH houses five bureaus including the 1). *Bureau of Child, Family and Community Wellness,* 2.) *Early Intervention Services*, 3). *Health care Quality and Compliance*, 4). *Preparedness, Assurance, Inspection and Statistics,* and 5). *Public Health and Clinical Services.* Title V/Maternal and Child Health Program is in the Bureau of Child, Family, and Community Wellness in the Maternal, Child and Adolescent Health section. Other programs in the section are: Maternal and Infant Health which includes Perinatal Substance use Prevention and SUID/SIDS, the Nevada Early Hearing Detection and Intervention (EHDI) Program, Adolescent Health Program; Rape Prevention and Education Program; and the Office of Suicide Prevention. The Section is headed by a Health Program Manager II and individual program managers range from Health Program Manager I to Health Program Specialist. The Bureau of Child, Family and Community Wellness under DBPH Administration is responsible for Title V MCH Block Grant oversight, management and reporting.

Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the State Board of Health from a list provided by the DPBH Administrator to two year terms, and two legislators are appointed by the Legislative Counsel. Its composition represents public health professionals, healthcare providers, legislators and a consumer to represent CYSHCN. The State Board of Health (SBOH) is a regulatory body that is staffed by the DPBH Administrator. The Advisory Board meets quarterly every year with the in person meeting in Carson City and via videoconference in Las Vegas and Elko. The MCH Advisory Board is staffed by the MCH Manager. Under NRS, MCHAB is charged to advise the DBPH Administration of the "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:

1. Ensuring the availability and accessibility of primary care health services;

2. Reducing the rate of infant mortality;

3. Reducing the incidence of preventable diseases and handicapping conditions among children;

4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;

5. Preventing the consumption of alcohol by women during pregnancy;

6. Reducing the need for inpatient and long-term care services;

7. Increasing the number of children who are appropriately immunized against disease;

8. Increasing the number of children from low-income families who are receiving assessments of their health;

9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and

10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);

11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and

12. Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."

Please see the organization chart under attachments.

II.B.2.b.ii. Agency Capacity

The Division of Public and Behavioral Health strives to use its resources to promote and protect the health of all the six MCH population domains it serves. This is achieved by partnering and collaborating with multiple agencies and programs, both government and private, across the state.
Title V collaborates with state's public health community including the Southern Nevada Health District (SNHD), Washoe County Health District (WCHD) and Carson City Health Department to promote the health and wellbeing of the MCH/CYSHCN populations in those counties, as well as with the other Bureaus within DBPH. Title V funding provides funding for Community Health Nurses in Nevada's rural and frontier counties. In addition, Title V provides funds and also collaborates with WCHD to conduct the Fetal Infant Mortality Review (WC FIMR) Program. The purpose of WC FIMR is to assess the factors that affect the health of the mother, fetus and infant to learn more about how to reduce fetal and infant mortality.

Title V also collaborates with the DHHS Tribal Liaison to address the MCH-related needs of the Tribes in our state. The Liaison works closely with the 27 Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the Tribal Governments as well as provides education and outreach. This position has been vacant for several months and got filled in early July, 2015.

II.B.2.b.iii. MCH Workforce Development and Capacity

Title V supports 21 Full Time Employees (FTE) serving in various capacities such as bureau chief, program managers, program specialists, program coordinators, management analysts, health resource analysts, accounting assistants, office manager, community health nurses and administrative staff at DPBH.

Nevada's Title V/MCH program is managed through its main office in Carson City, Nevada. Christine Mackie, MPH, is the Bureau Chief and MCH Director. Beth Handler, MPH, is the Deputy Bureau Chief and oversees the section managers in the Bureau of Child, Family and Community Wellness. Andrea Rivers, BA, is the Maternal, Child and Adolescent Health Section Manager.

Laura Valentine, MS, is the Program Manager for the Title V/Maternal and Child Health (MCH) program and serves as the Children and Youth with Special Health care Needs (CYSHCN) Director. Ms. Valentine is responsible for the policy, program, evaluation, and fiscal administration of Title V activities.

Ingrid Mburia, MPH, Maternal and Child Health Epidemiologist, is responsible for the assessment and development of the Title V/MCH Block Grant and the MCH five-year needs assessment. Ms. Mburia is also responsible for developing, reviewing & evaluating program components such as performance measures and data trends for the population in the state as well as writing reports for federal, state and local use. In addition, Ms. Mburia employs appropriate epidemiologic and statistical methods in data analysis using SAS and other statistical software to manipulate, tabulate, and analyze datasets and also utilizes matching programs to link records using available identifiers.

The Maternal and Infant Health Coordinator position oversees the Perinatal Substance Use Prevention (PSAP) initiative among other duties. This position is currently vacant.

Debra Vieyra, Children and Youth with Special Health Care Needs (CYSHCN) Program Coordinator, collaborates with multiple state agencies and programs, as well as other MCH partners and stakeholders to provide CYSHCN Care Coordination management among other duties.

Deborah Duschesne, BA, is the Rape Prevention Education Program Coordinator and she manages and coordinates all aspects of this federally funded program. Ms. Duschesne collaborates with many state and community level entities that have a stake in prevention sexual violence and violence against women.

Perry Smith is the Program Coordinator for the Nevada Early Hearing Detection and Intervention Program. Mr. Smith is responsible for the programmatic direction, operation, and evaluation of the state EHDI program. This involves writing and managing HRSA and CDC federal grants, working with collaborative partners through written agreements, writing reports for federal and state use, and supervising other EHDI staff.

Diane Miller, Au.D., CCC-A, is the EHDI Follow-up Coordinator and is a trained pediatric audiologist. Dr. Miller is responsible for working with the program data analyst to locate infants who are lost to follow-up and or lost to documentation and implementing processes and procedures to locate these infants. These procedures may include training of various professionals who may have had contact with these infants, making phone calls or sending letters to parents, and working with audiologists to appropriately test these infants.

Karli Dodge, EHDI Data Analyst, is responsible for overseeing accurate collection and analysis of demographic, hearing screening, diagnostic testing, and intervention services data through working with multiple data suppliers. Ms. Dodge also analyzes, compiles, and produces reports for state and federal users.

Evelyn Dryer, Health Program Manager, is responsible for managing MIECHV grants to include budget and scope of work development; supervising MIECHV staff; monitoring sub-recipient programs to include scope of work, budget and expenditures, program fidelity; developing Continuous Quality Improvement plans and overseeing the CQI process for the state team and for implementing agencies. Ms. Dryer is also responsible for reporting progress and performance to HRSA.

Melanie Lopez, Nevada Home Visiting (NHV) Program Coordinator, is responsible for developing training for home visitors, collaborating with agencies to build statewide systems, and networking with stakeholders to address the health of Nevada mothers, infants, and children.

Yucui Liu, MS, Health Resource Analyst for Nevada Home Visiting Program is responsible for ensuring compliance to Federal, State and DBPH policies and regulations, providing technical assistance on data collection, interpretation and reporting. Ms. Liu is also responsible for developing data collection instruments, building a data warehouse and maintaining and upgrading the database. Ms. Liu also manages, analyzes and reports on family health and wellness indicators for NHV.

Sarah Demuth, Adolescent Health Abstinence Education Grant Program Coordinator, manages the federally funded Title V State Abstinence Education Grant Program. Ms. Demuth is responsible for monitoring pass through funds for three sub-grantees located in northern Nevada by reviewing expenditure and scope of work, evaluating program effectiveness, facilitating program growth and community involvement, and generating federally mandated progress reports.

Sandra Ochoa, MPH, State Systems Development Initiative (SSDI)/Women, Infants, and Children (WIC) Biostatistician, provides data support to the MCH program and program's needs, including the 5-year needs assessment and MCH Block Grant. Supplementary to MCH Block Grant work, data are also provided to support ongoing efforts with the Collaborative Improvement and Innovation Network (COIIN) to reduce infant mortality and SSDI, and maintaining minimum and core data sets related to MCH.

Melissa Slayden, BS, Management Analyst, Office of Public Health Informatics and Epidemiology, is responsible for data collection from internal Division resources and from external State agencies in order to complete the Maternal Child Health Block Grant application. Additionally, Ms. Slayden is responsible for some data analysis, report writing, and report reviewing for the MCH program.

Nevada Title V/MCH program has significantly built its workforce capacity in the last five years. This was achieved through the development of additional/ new positions. Kristine Hughes, the current MCH fiscal support, was brought directly into the program to help in developing, implementing, monitoring, and controlling grant-in-aid projects and provide grants management oversight for incoming funding.

Nevada's DPBH faces numerous workforce challenges in recruiting and maintaining adequate public health professionals. Even though challenges such as difficulty adding new state positions and dependency on temporary staffing still remain, many positive changes affecting state employees were made in the 2015 Legislative session. Some of these include: Assembly Bill 489 was passed and will increase the Cost of Living Adjustment (COLA) by one percent effective July 1, 2015 and by two percent in FY 2017. In addition, Merit pay will be reinstated for classified employees, and State employees will no longer have to furlough.

Nevada's population, as well as the MCH population, is becoming increasingly diverse. In order to provide culturally and linguistically competent approaches to services, health policies, and leadership for our MCH population, the MCAH workforce attended several trainings in 2014. One of the trainings was on cultural competence. The training discussed the importance of cultural competence as a key service delivery tool in addressing health disparities. In addition, Culturally and Linguistically Appropriate Services (CLAS) Standards, its components and relevance were also discussed in the training. Training on Cultural Diversity was also offered on the state's web training website, NEATS. The training offers an understanding of practical cross-cultural strategies that emphasize professionalism in the workplace as well as provides information on how to develop essential skills for improving relationships between communities of racial, cultural, and ethnical diversity.

II.B.2.c. Partnerships, Collaboration, and Coordination

Nevada Title V/MCH program has developed a statewide structure of partners and stakeholders to ensure that public health and preventive services for the MCH population are delivered within well-coordinated and comprehensive systems of care. Partnerships and collaborations are vital because no one agency has the capacity or resources to tackle the wide range of public health problems that exist in the society today. The partnerships and collaborations that Title V has are with the governor's office, state agencies, local health districts, academia, non-profit organizations, community organizations, advocacy groups and stakeholders.

Title V collaborates with Nevada Medicaid and the Office of Public Health Informatics and Epidemiology (OPHIE) (housed within DBPH) on the CDC/CMS data linkage project. The project's goal is to improve the measurement of the two measures in the CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP that

require data linkage (C-section and low birth weight rates). Through this project, Nevada will receive training and assistance in linking Medicaid claims and Vital Statistics data for surveillance, performance monitoring, and quality improvement. The results from the linkage will also help Nevada in identifying the prevalence and magnitude of the two measures among the Medicaid population and develop targeted prevention strategies. In addition, MCH collaborated with OPHIE on a data linkage research project to examine the prevalence of gestational diabetes among WIC women. WIC captures gestational diabetes based on a self-assessment survey. Preliminary results indicated that older mothers had a higher prevalence of gestational diabetes and this was consistent with both WIC and Pregnancy Risk Assessment Monitoring System (PRAMS) national data. Title V staff has sought a speaker to give a statewide presentation on gestational diabetes to WIC clinic nutritionists. The goal of the presentation is to educate the clinic nutritionists on the importance of identifying women at increased risk for developing Type 2 diabetes if they have a history of Gestational Diabetes Mellitus (GDM) as well as getting the identified women appropriate resources and information.

Nevada Title V/MCH program is collaborating with Medicaid (EPSDT) and March of Dimes (Nevada Chapter) on the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Nevada elected to address two strategic focus areas:

1. Pre/Interconception Care: Promote optimal women's health before, after and in between pregnancies, during postpartum visits and adolescent well visits.
2. Social Determinants of Health: Incorporate evidence-based policies/programs and place-based strategies to improve social determinants of health and equity in birth outcomes.

The state team has convened several meetings to discuss various SDOH Strategies including strategies that align with existing state priorities/activities/efforts and relevant publications, resources, materials, speakers/presenters, etc. that our state has in relation to the listed strategies.

Nevada Title V/MCH program is collaborating with various agencies on the National Governors Association (NGA) Learning Network for Improving Birth Outcomes. Nevada's goals in this collaborative venture are:

- Increased preconception and inter-conception planning and educational outreach
- Expanded access to health care for women/pregnant women and infants
- Reduce negative birth outcomes resulting from substance abuse disorders including exposure to tobacco/nicotine for infants, children, women of child-bearing age and pregnant women
- Decrease non-medically indicated early birth before 39 weeks

In 2010-2012, the infant mortality rate (IMR) in Washoe County (6.0) was higher than the rest of the state (5.3) and the nation (5.1). To address this high IMR in the county, Nevada Title V/MCH program provided funding and collaborated with Washoe County Fetal Infant Mortality Review (WC FIMR) to carry out an in-depth process to uncover the patterns and risk factors associated with fetal and infant death. WC FIMR is currently a pilot project and it is hoped that the project will be expanded to the rest of the state in the near future.

Data linkage of Medicaid, WIC, Nevada Early Hearing Detection and Intervention (EHDI) datasets with Baby Birth Evaluation Assessment of Risk Survey (Baby BEARS) sample to extract mothers addresses and telephone number(s). This contact information is required because the Baby BEARS protocol combines two modes of data collection; a survey conducted by mailed questionnaire with multiple follow-up attempts, and a survey by telephone. Telephone follow-up begins after the mailing of the last questionnaire for survey participants that do not respond to the repeated mailings. A key aspect of his approach is to make several and varied contacts with sampled mothers. Baby BEARS fills a gap in Nevada's data needs by providing state-specific population-level data on maternal attitudes and experiences before, during, and after pregnancy to better understand birth outcomes in our state.

Title V collaborates with Substance Abuse Prevention & Treatment Agency (SAPTA) on various activities that provide community-based prevention and treatment to the MCH population. In 2013, SAPTA was awarded the Partnerships for Success grant to decrease substance abuse rates in Nevada. The Partnership for Success grant is designed to address two of the nation's top substance abuse prevention priorities:

- Underage drinking among individuals ages 12 to 20
- Prescription drug misuse and abuse among individuals ages 12 to 25.

In addition, Title V collaborates with SAPTA to meet the MCH-related objectives for their Block Grant as well as the Community Mental Health Services Block Grant, which includes activities to prevent and treat substance abuse and behavioral health issues respectively.

Governor Gibbons, through a September 2009 executive order, established the Nevada Early Childhood Advisory Council (ECAC) to strengthen state-level coordination and collaboration among the various sectors and settings of early childhood programs. The executive order empowers the Director's Office of the Department of Health and Human Services (DHHS) to establish and maintain the ECAC. Nevada Title V/MCH program collaborates with ECAC which supports MCH efforts through their vision, "Nevada's children will be safe, healthy, and thriving during the first eight years of life, and the system will support children and families in achieving their full potential."

II.C. State Selected Priorities

No.	Priority Need
1	Improve preconception and interconception health among women of childbearing age
2	Breastfeeding promotion
3	Increase developmental screening
4	Promote healthy weight
5	Reduce teen pregnancy
6	Improve care coordination
7	Reduce substance use during pregnancy
8	Increase adequate insurance coverage among children
9	Reduce children's exposure to second-hand smoke

Nevada Title V revised the State-selected priorities for 2016-2020 to better align with the National Performance Measures and the newly developed State Performance Measures. The priorities still reflect findings from the needs assessment, however, the wording was changed to better articulate the State's Maternal and Child Health needs. A detailed five-year action plan is available in the supporting documents section.

The table below shows a comparison of the priorities submitted in the 2016 application and 2014 report with those submitted in this year's application.

Current 2016-2010 Priorities	Priorities Submitted in 2016 Application/2014 Report
Improve preconception and interconception health among women of childbearing age	Improve preconception and interconception health among adolescents and women of childbearing age
Breastfeeding promotion	Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months
Increase developmental screening	Increase the percent of children aged 10 through 71 months receiving developmental screening
Promote healthy weight	Increase the percent of children, adolescents and women of childbearing age who are physically active
Reduce teen pregnancy	Increase percent of adolescents and women of childbearing age who have access to health care services
Improve care coordination	
Reduce substance misuse during pregnancy	Prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age
Increase adequate insurance coverage among children	Increase the percent of adequately insured children

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- 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 having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
- NPM 15 - Percent of children ages 0 through 17 who are adequately insured

According to the Maternal and Child Health Bureau Guidance for 2015-2017, Nevada selected eight of the fifteen National Performance Measures (NPMs) from each of the domains in 2015 and maintained them in 2016. The Maternal and Child Health Advisory Board voted in February 2016 to create a subcommittee in order to investigate and decide on three to five State Performance Measures (SPMs) to address priority needs and link to the current National Performance Measures. The priority needs were to be those priorities not addressed by the National Performance Measures (NPMs) or Evidence-Based or -Informed Strategy Measures (ESMs). At the February 2016 meeting, the Board asked that the Subcommittee meet to consider the following topics: mental health, bullying/cyber bullying, access to care including access to prenatal care, teen birth rates with a focus on repeat teen births and Long Acting Reversible Contraceptives (LARCs), and substance use beyond tobacco use (i.e., alcohol, prescription drugs, and illicit drugs). The Maternal and Child Health Bureau (MCHB) stipulates that SPMs should be measurable and that data are available annually to ensure goals are measured in a timely fashion.

During the first meeting of the Subcommittee in March 2016, available data for each of the indicated areas was brought forward.

- **<u>Access to Care</u>**
  - Proportion of women with health insurance coverage (Data source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates)
    - Data show women without health insurance in Nevada is at a slightly greater proportion than the

National average

	18-24 years	25-34 years	35-44 years
Nevada	30.4%	29.5%	24.7%
U. S.	21.6%	21.9%	18.1%

- Timeliness and adequacy of prenatal care (Data source: Nevada Electronic Birth Records)
  - "Timeliness" for purposes of data examination is prenatal care beginning in the first trimester of pregnancy
  - Women in Nevada are receiving "late or no" prenatal care at a higher percent than the National figures

	2010	2011	2012	2013
Nevada	13%	11%	11%	10%
U. S.	6%	6%	6%	6%

  - Black, Native American, and Hispanic women are less likely to receive "timely" prenatal care
  - Teenaged pregnant young women are less likely to receive prenatal care
  - "Adequate/Adequate Plus" prenatal care is care beginning in the fourth month of pregnancy and 80% of recommended visits
  - The percentage of women in Nevada receiving Adequate/Adequate Plus care has progressively increased from 2010 to 2014, though Nevada has not achieved the Healthy People 2020 (HP 2020) goal of 77.6%

	2010	2011	2012	2013	2014
Nevada	53.6%	56.3%	57.8%	61.2%	70.1%

- **Bullying/Cyber-bullying** (Data source: Youth Risk Behavior Surveillance Survey (YRBS)).
  - High school and middle school aged adolescents are surveyed every other year Middle school surveys were added to YRBS in 2015, prior to this year only high school students were surveyed.
    - In 2013 high school student data collected indicated that Nevada was similar to the national average percent
    - In 2015 the Nevada middle school aged group had an higher average percentage of bullying/cyber bullying than that of the high school aged group
    - YRBS for high school indicated a slight drop between 2013 and 2015

	2015	**2013**
Middle school		

Bullying	44.7	N/A
Electronic Bullying	23.7	N/A
High School		
Bullying	18.5	19.6
Electronic Bullying	13.8	15.0

- **Family Planning: Teen Pregnancy Prevention** (Data source: Nevada Electronic Birth Records)
  - Nevada teen birth rate is comparable to the national average for 15-17 and 18-19 year old groups
  - Data for Black, Native American, and Hispanic teenaged women show a slightly higher birth rate
  - Teen pregnancy rates (per 1,000) have slightly declined between the years 2010 to 2013

	2010	2011	2012	2013
Nevada	49.5	43.88	40.63	35.36

- **Mental Health** (Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2011 and 2013-2014)
  - Data indicate 11.6% of Nevada adolescents and teens (aged 12 to 17 years) had at least one Major Depressive Episode (MDE) in the year preceding the survey, this is comparable to the national average
  - In Nevada less than a third of those teens with a MDE received treatment, this is comparable to the national average
  - Data indicate that of Nevada adults, 18 years and older, 4.3% (2013-2014) had a Serious Mental Illness (SMI)
  - Between 2010 and 2014, 32% of Nevada adults with Any Mental Illness (AMI) received treatment within the year prior to being surveyed
- **Substance Use** (Nevada Health Information Provider Performance System (NHIPPS) 2011-2014)
  - NHIPPS is a web-based computer system to capture demographic, service, and clinical data on substance abuse clients. Substance Abuse Treatment and Prevention Agency (SAPTA) funded providers use the system for case-management service delivery
  - Clients of SAPTA funded providers are of all age ranges
  - This data was discussed in public comment as the population is small and the data only comes from State funded providers
- **Discussion Key Points 3/14**
  - Bullying and Cyber-bullying was removed from the list of potential SPMs because of existing efforts with Department of Education and the Office of Suicide Prevention

At the second meeting of the Subcommittee (April 2016), the priorities outlined in the first meeting were scrutinized further using the following criteria:

- The rationale for choosing the current state measures was because of existing initiatives and collaborations in the State
- Priorities were rather broad
- Where were efforts being duplicated

- Which priorities would have the greatest effect

After discussion, the subcommittee selected the three following SPMs:

- **Priority: Access to Care**
  SPM#1: Percent of women with late or no prenatal care
  - This new SPM aligns with the efforts being conducted by MCH under National Outcome Measure (NOM) #1 (*Percent of pregnant women who receive prenatal care beginning in the first trimester*).
  - Data for this measure is available from Nevada vital records (birth certificates).
  - Efforts will focus on increasing receipt of prenatal care access and utilization.
- **Priority: Teen Pregnancy Prevention**
  SPM#2: Teen Pregnancy Prevention: Repeat Teen Births
  - Nevada State Personal Responsibility Education Program (PREP) oversees teen pregnancy prevention efforts
  - The population served by PREP includes teens 13 to 19 years old at risk of becoming pregnant, and parenting teens (up to 21 years) if they are currently parenting or pregnant
  - PREP partners with local agencies
  - Repeat teen pregnancies declined between 2010 and 2014
  - This SPM was chosen as an effective area to implement LARC efforts, though STI increases should be tracked as well
- **Priority: Reduce substance use during pregnancy**
  SPM#3: Substance Use During Pregnancy
  - This SPM was chosen because it is a priority of the Governor and aligns with the NPM on decreasing smoking during pregnancy
  - The measure will track alcohol, prescription drug use, and illicit drug use during pregnancy
  - MCH collaborates with SAPTA in oversight of the Sober Moms, Healthy Babies website
  - Data sources include PRAMS, SAPTA, Hospital Inpatient and Hospital Emergency Room data, and Behavioral Risk Factor Surveillance System (BRFSS) data, and Medicaid

Perinatal mental health and postpartum depression were not selected due to lack of a reliable data for the two health outcomes. However, Nevada was recently awarded PRAMS funding and Title V will revisit these outcomes for possible inclusion in the action plan as priorities.

In the July MCHAB meeting, the board members voted for the final SPMs as:
SPM #1: Percent of mothers reporting late or no prenatal care
SPM #2: A. Percent of teen pregnancies and B. Percent of repeat teen births
SPM #3: Percent of women who misuse substances during pregnancy

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of mothers reporting late or no prenatal care
- SPM 2 - A. Percent of teenage pregnancies and B. Percent of repeat teen births
- SPM 3 - Percent of women who misuse substances during pregnancy

Nevada Title V linked the Selected State Priorities with SPMs as well as National Outcome Measures. The SPMs were developed based on the priorities that were identified in the 2015-2020 needs assessment. Since there were no state-specific data sources available for oral health and domestic violence/intimate partner violence, those priorities were not chosen as SPMs because it would be difficult to track progress. Please see linkage in the state's action plan table.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Improve preconception and interconception health among women of childbearing age

NPM

Percent of women with a past year preventive medical visit

Objectives

Increase the percent of women ages 15-44 receiving routine checks-up in the previous year to 70% by 2020

Increase to 77.9% the percent of women receiving prenatal care in first trimester by 2020

Strategies

Collaborate with public and private partners to provide target population with information on the benefits available through the Affordable Care Act and link them to appropriate health care coverage options

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

Collaborate with public and private partners to conduct training at schools and on college campuses 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

ESMs

ESM 1.1 - Number of Title V funded partners that disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Improve preconception and interconception health among women of childbearing age

SPM

Percent of mothers reporting late or no prenatal care

Objectives

Increase to 77.9% by 2020 pregnant women/new mothers receiving prenatal care in first trimester.

Strategies

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

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62	64	66	68	77.9	77.9

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	61.1 %	3.0 %	299,106	489,272
2013	60.1 %	2.8 %	294,008	489,392
2012	59.0 %	2.1 %	285,334	483,462
2011	55.7 %	2.6 %	266,054	477,353
2010	54.2 %	3.0 %	250,611	462,455
2009	58.6 %	3.2 %	274,612	468,535

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Number of Title V funded partners that disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	8.0	11.0	14.0	17.0

Women/Maternal Health - Plan for the Application Year

Title V will continue the work of the National Governors Association (NGA) Learning Network on Improving Birth Outcomes. As the NGA Learning Network incorporates new participants in the planning process, implemented activities toward achieving birth outcome goals will be expanded. The outcomes Nevada has set out to achieve by participating in the NGA Learning Network include: 1. Integrate life course perspective into educational outreach promoting maternal, child and adolescent health - including the consideration of lifetime and intergenerational experiences and exposures. 2. Expand access to healthcare, including behavioral health, for women, pregnant women, and infants. 3. Reduce negative birth outcomes resulting from maternal substance use through education, prevention, intervention and treatment efforts. 4. Decrease elective non-medically indicated birth before 39 weeks. Nevada's workgroup participation focused on integrating life course perspective into educational outreach promoting maternal, child and adolescent health addresses the need of increasing preconception and interconception planning.

Efforts include collecting identified data available on birth spacing, prenatal care visits, post-partum visits, wellness visits, high risk behaviors and chronic illnesses. MCH will partner with the Office of Public Health Informatics and Epidemiology (OPHIE) and Women, Infants and Children (WIC) to gather data. MCH will engage Managed Care Organizations (MCOs) to collect and report data on the number of clients who receive wellness visits. MCH staff will carry out previously identified activities to increase community education and awareness about preconception and interconception health. These include providing information and resources on the Medical Home Portal to promote healthcare services for women and families with special healthcare needs, developing a campaign to educate Primary Care Physicians, MCOs, OBGYNs and other healthcare professionals on the value and benefits of One Key Question, and providing information on family planning, birth spacing, post-partum visits and wellness visits will be included in the pink packets new parents receive after giving birth in the hospitals.

Efforts to expand access to healthcare, including behavioral health, will focus on increasing the number of women who receive mental health assessments and increasing access to family planning. Home Visiting programs will partner to support the provision of mental health assessments. In collaboration with Community Health Centers, Substance Abuse Prevention and Treatment Agency (SAPTA) and Nursing personnel within Rural Community Health Services (RCHS) will adopt standardized behavioral health assessments. Nursing personnel within RCHS will provide preventive education, well-woman care (including depression and domestic violence screening), long-acting reversible contraception, oral health educational materials, and participate in local events to address the needs of this population in their communities as well as help to meet the Title V/MCH goals and objectives noted in the 5-year plan.

Increasing access to family planning will be targeted through providing National Training Center resources to behavioral healthcare clinics and partnering with Project Echo to develop and implement training modules on family planning and related issues. Reducing negative birth outcomes resulting from maternal substance use through education, prevention, intervention and treatment efforts are the focus of NGA workgroup three. Their goals include: increasing awareness and resources available to healthcare providers, partner agencies and the public. SBIRT

training will continue to be provided, along with the distribution of the data driven infographic. A guide for clinicians which clearly defines reimbursement for Medicaid-related services for maternal substance use will be created and distributed. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) brochure and standardized screening tool for health care providers will be disseminated.

Increasing collaboration with non-traditional partners and safety net providers will promote maternal substance use prevention, education and linkage of services. A resource guide that can be distributed to non-traditional partners and safety net providers that outlines resources for pregnant women with substance abuse problems will be developed. Increasing public awareness and available resources will be achieved by continuing Public Service Announcements (PSAs) promoting the Sober Moms, Healthy Babies website, advertising substance use prevention and treatment resources at food retailers and pharmacies, including information on substance use prevention and treatment services in the hospital pink packets provided to families after birth. Peel off information cards will be voluntarily posted in food establishment (bars, restaurants) restrooms. Distribution will be done during environmental health inspections.

To decrease elective, non-medically indicated early birth before 39 weeks, workgroup three will partner with public and community agencies to promote full term births. Model policies will be developed, supportive reimbursement policies will be promoted and public awareness of the risks of prematurity and benefits of full term gestation will be increased. An evidence based clinical pathway linking reimbursement to promote extended gestational periods will be created. Education and outreach during public health week will be provided along with information to public officials and key stakeholders about the importance of full term births. Although the set time for the learning collaborative expired in 2014, the workgroups continue to do the work they set out to achieve. Continued participation in these initiatives is vital to Nevada Title V because their goals align very well with Nevada's MCH priorities.

Title V will continue to participate in the Infant Mortality CoIIN initiatives. Nevada's CoIIN topic areas include Social Determinants of Health and Preconception and Interconception Care. Pilot sites will continue collecting data on well visits, postpartum visits, birth spacing, use of most effective contraceptives and Adverse Childhood Experiences (ACEs). Data will be used to measure improvement and effectiveness of current activities. ACEs-related educational materials will be developed, the number of people trained and events where materials are distributed, as well as the number of people reached will be analyzed. MCH will collaborate with Healthy Start and Home Visiting regarding education, training and planning activities addressing risk factors to reduce infant mortality and ensure proper birth spacing, including ways they can obtain information from families regarding quality of service provision.

Gestational diabetes mellitus (GDM) collaborations will continue with WIC to increase both targeted and general GDM messaging opportunities in relation to maternal type 2 diabetes risk. In addition, GDM informational posters will continue to be displayed at WIC sites to increase awareness of the increased risk of type 2 diabetes postpartum and the importance of conducting screenings. Title V/MCH Program will promote the Diabetes Prevention Program opportunities to mothers who experienced GDM in pregnancy.

The Nevada Statewide MCH Coalition will collaborate across diverse community stakeholders in order to offer education and resources, promote services, and continue to raise public awareness regarding the first three identified National Performance Measures noted on Nevada's 2016-2020 MCH Strategic Plan. Collaboration activities will focus on MCH members and applicable community partners improving preconception health among adolescents and women of childbearing age; increasing the percent of infants who are ever breastfed, percent of infants' breastfed exclusively through six months and safe sleep education measures; and increasing the percent of children ages 10-71 months receiving developmental screenings. The MCH coalition website will be updated and maintained with current information provided by MCH members, State of Nevada, and partnering organizations. In

addition, e-newsletters and breaking news emails will be provided to all MCH members. The Co-Chair will coordinate general meetings for Southern Nevada MCH Coalition members. Statewide meetings will be held for Steering Committee members, participation in community level meetings will continue, along with collaboration meetings between North and South MCH Coalitions. Conferences and trainings with a focus on maternal child health will be attended and the promotion of Text4Baby and resources made available by member organizations and collaborating partners will continue. The Coalition will build capacity and membership as well as mobilize community partnerships.

Title V will continue to fund the SoberMomsHealthyBabies.org website to prevent substance use in pregnant women. The public awareness campaign will also continue to promote the website in collaboration with SAPTA, in addition to the distribution of referral cards. The collaboration will ensure substance use in pregnancy materials and resources will reach the targeted audience. Improvements to the website will be made to make the website responsive and more user friendly. Additional resources will be added, including updated tobacco cessation information. An interactive component will be added to assist with accessing information in addition to increasing the amount of time users spend on the website. Additionally, a call to action button will be added to the site, linking users to the Crisis Call Center for those interested in speaking to a live person about their problem.

Women/Maternal Health - Annual Report

Through the initiatives of the National Governors Association (NGA) Learning Network on Improving Birth Outcomes, MCH collaborated with Nevada's Office of the Governor, Nevada Medicaid, March of Dimes (Nevada Chapter) and other Nevada Department of Health and Human Services programs to improve birth outcomes by identifying modifiable risk factors for the incidence of preterm births, low birth weight and infant mortality and associated racial/ethnic health disparities. The State's goals in the NGA initiative include: 1. Integrate life course perspective into educational outreach promoting maternal, child and adolescent health - including the consideration of lifetime and intergenerational experiences and exposures. 2. Expand access to healthcare, including behavioral health, for women, pregnant women, and infants. 3. Reduce negative birth outcomes resulting from maternal substance use through education, prevention, intervention and treatment efforts. 4. Decrease elective non-medically indicated birth before 39 weeks. Through this collaborative, Title V has been working with partners and stakeholders to identify modifiable risk factors for preterm births, low birth weight, infant mortality, and associated racial/ethnic health disparities. Workgroups have been formed around these goals and a lot of progress has been made in the state.

Title V funds the nursing personnel within the Rural Community Health Services (RCHS) to provide critical health services to this population in Nevada's rural and frontier areas by conducting screening for women seeking birth control or pregnancy tests, providing family planning and wellness services (which includes screening for depression and domestic violence) as well as referring and coordinating health services with other community health providers. In order to educate this population on various topics, nursing personnel distribute diverse health-related brochures provided by the Title V/MCH program.

MCH Program staff as well as our partners and stakeholders disseminated education materials and pamphlets regarding ACA. Navigator contact lists were distributed at the Nevada Transition Conference, Nevada Health Conference, and MCH staff made a presentation on the impact of the ACA on Maternal and Child Health providers at the March of Dimes Nevada Women's Health Symposium. MCH partners also posted links to the Silver State Health Insurance Exchange, Nevada's state-based marketplace exchange on their websites and social media sites. Prior to 2014, Nevada's Medicaid enrollment rates were low but the promotional campaigns and awareness materials surrounding it have encouraged more Medicaid-eligible individuals to get coverage.

MCH staff along with March of Dimes (Nevada Chapter) participate in the workgroup aimed to decrease early elective deliveries. A sample policy template was created to assist hospitals in drafting their own policies. A hospital banner program was also created to encourage and acknowledge the efforts of hospitals to decrease their early elective deliveries. To address issues relating to birth outcomes, Nevada Title V is involved in several statewide initiatives as part the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Partners include the Nevada Healthy Start grantee, the Southern Nevada Health District, Nevada Medicaid (Early and Periodic Screening, Diagnostic and Treatment (EPSDT), March of Dimes (Nevada Chapter) and Women, Infants and Children (WIC). Nevada participates in two learning networks through CoIIN, the Social Determinants of Health (SDoH) Learning Network and the Preconception and Interconception Care (PCICC) Learning Network. The aim of the SDoH Learning Network is to build state and local capacity and test innovative strategies to shift the impact of

social determinants of health by developing evidence based policies, programs and place based strategies to improve social determinants of health and equity in birth outcomes. The main goal of the PCICC Learning Network is to improve life course care for women related to preconception and interconception care. Efforts focus on improving the postpartum visit rate, improving adolescent well visit attendance and improving birth spacing and reducing short inter-pregnancy intervals. Messaging on the importance of 17P and Long Acting Reversible Contraception (LARC) is also embedded in CoIIN's efforts. Steps to unbundle LARC for Medicaid have been underway. Efforts have shown unbundling would at least be budget neutral. Pilot sites for collection of postpartum visit (PPV) Adverse Childhood Experiences (ACEs) screenings and birth spacing data were identified in WIC clinics, Healthy Start and Home Visiting Programs. Partner staff members attended the CoIIN Infant Mortality Summit to develop Quality Improvement Aims, specify strategies to achieve those aims, and identify measures which can be used to track progress.

Title V collaborated with Nevada Women, Infants, and Children (WIC) Program to increase Gestational Diabetes Mellitus (GDM) messaging opportunities in relation to maternal type 2 diabetes risk. MCH provided GDM risk factor posters in English and Spanish to 46 WIC clinics. MCH reached out to a type 2 diabetes expert from the community who provided training to 17 local WIC agencies. WIC nutritionists received education on GDM, which included a general overview, risks, referrals and the need for screening. Awareness of the increased risk of type 2 diabetes postpartum was also highlighted. Other collaborations with WIC include identifying pilot sites for collection of postpartum visit (PPV) data. A provider was identified to speak on PPV-related issues for grand rounds presentation.

The Nevada Statewide MCH Coalition works with community partners to advocate for preconception health, developmental screening, breastfeeding, physical activity and more for mothers and children. To better serve the entire state of Nevada, the MCH Coalition offers membership, resources and support in Northern and Southern Nevada. In October 2014, the NV Statewide Coalition held a documentary screening of The Raising of America. Members also attended the First Lady's Summit on Children's Mental Health in Carson City. In November 2014, the coalition partnered with March of Dimes to sponsor a MCH Fall Symposium with approximately 150 attendees. In January 2015, the 2015 MCH Adolescent Health Symposium was held with approximately 100 attendees. The coalition was also an exhibitor at both the NV Health Conference and NPHA conference.

Postpartum depression screenings for moms as a separate billable Medicaid service at a well-baby visit were added to Early Prevention Screening Diagnosis Treatment (EPSDT) services. Medicaid pays separately for depression screenings in children/youth during a wellness visit. Applied Behavior Analysis (ABA) therapy for autism was developed as a reimbursable service under EPSDT and was effective January 1, 2016.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Breastfeeding promotion

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the percent of children who are ever breastfed to 90% by 2020

Increase the percent of children who are exclusively breastfed at 6 months to 25% by 2020

Increase the percent of baby-friendly hospitals in Nevada to 33.3% by 2020

Strategies

Partner with MCH Coalition 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 to increase the number of Nevada hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly.

ESMs

ESM 4.1 - Number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA

NOMs

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

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

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82.0	84.0	86.0	88.0	88.0	88.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	80.1 %	2.9 %	28,183	35,188
2011	80.9 %	2.9 %		
2010	78.0 %	3.4 %		
2009	80.2 %	2.9 %		
2008	78.2 %	2.7 %		
2007	80.5 %	2.4 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	19.0	21.5	23.0	24.5	25.5	25.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	14.8 %	2.3 %	5,076	34,423
2011	18.0 %	2.6 %		
2010	18.7 %	3.6 %		
2009	11.2 %	2.3 %		
2008	12.5 %	2.0 %		
2007	11.9 %	1.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	3.0	6.0	9.0	12.0	19.0

Perinatal/Infant Health - Plan for the Application Year

The Breastfeeding Welcomed Here campaign will continue, and will implement phase II of the Baby Steps to Breastfeeding Success campaign. Phase II targets physicians who were (as a profession) identified in our statewide maternity center survey as having the lowest levels of breastfeeding knowledge and support.

The EHDI program will work with selected midwives to increase hearing screening rates of home-birth infants by providing OAE hearing screening equipment and training for midwives to screen their infants. The program's quality improvement and evaluation processes will be improved. Collaboration with audiologists and primary care physicians to decrease the number of infants lost to documentation and/or lost to follow-up will occur as it pertains to diagnostic and intervention services.

The Baby Safe Sleep-Healthy Tomorrow's Partnership for Children Grant program plans to be implemented in 8 Clark County hospitals by 2/28/2017. Expanded staff education and patient education remains pending at the Valley Hospitals. This hospital system requested a version of the video translated into Mandarin Chinese, as well as the English and Spanish versions currently available. Follow up parent surveys will continue at Sunrise Hospital. All surveys and analyses of these surveys are expected to be complete by 2/28/17. The follow up parent surveys and analyses will also continue with Sunrise Hospital, as well as the post training sleep position audits. The introductory meeting with Hospital #8, Mountain View, is planned for 4/12/16. It is expected the program will be implemented by

2/28/2017. In addition, Baby's Bounty plans to hold classes on a quarterly basis.

Healthy Start outreach to increase enrollment to 300-350 participants by 3/31/2017 will continue. Baselines for project benchmarks will be established and services will be provided to participants to achieve program benchmarks. CAN core members will also be identified.

The Nurse Family Partnership will add another nurse home visitor to increase number to 7 and capacity to 175 families. Participation will continue in the MIHOPE and MIHOPE-Strong Start studies. In addition, services will be provided to enrolled women with fidelity to the model to reach NFP program goals and Nevada Home Visiting Benchmarks.

The community-based Fetal Infant Mortality Review Program will continue its goal to reduce fetal and infant mortality in Washoe County. The FIMR program will identify disparately impacted populations in Washoe County while examining contributing factors to fetal, neonatal, and post neonatal deaths. At least 40 cases will be reviewed and three recommendations will be identified. At least one intervention involving policy, systems, or community norm changes will lead to the prevention of fetal, neonatal, and post neonatal deaths will be implemented. Participation in local MCAH trainings/meetings will continue. The WCHD will facilitate and maintain a Case Review Team (CRT) and a Community Action Team (CAT). Based on case findings with community input, the team will develop and implement objectives, interventions, timelines and evaluation components for identified recommendations addressing systems, community norm, or public policy changes.

Perinatal/Infant Health - Annual Report

Breastfeeding

The Nevada Breastfeeding Program continued to conduct statewide campaigns to improve infant feeding practices in hospitals, and increase community and business support for breastfeeding mothers. In addition, the breastfeeding program continues to support Women, Infants and Child (WIC) moms in breastfeeding by providing free professional lactation support, breast pumps, and an enhanced food package for moms who wish to breastfeed. Two major breastfeeding campaigns were delivered across the state, one focusing on hospital training and one focused on community support.

After evaluating our state's current breastfeeding support climate, we selected an existing (previously CDC-funded) campaign to model: Baby Steps to Breastfeeding Success: http://www.azdhs.gov/phs/bnp/gobreastmilk/BFAzBabySteps.htm. Surveys were sent to our state's 15 non-Baby Friendly Hospitals (we have 3 Baby-Friendly) to assess their current policies and practices in five identified areas. Each maternity center was informed of their ability to participate in our campaign to assist them in making these five evidence-based practices their standard of care: 1. Initiate breastfeeding in the first 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. No artificial nipples for healthy term infants 5. Give mothers a breastfeeding resource to help with breastfeeding after discharge. To date, six maternity centers have agreed to receive the training, four of which have already received them. We have trained roughly 300 nurses and are scheduled to train an additional 300 by the end of the fiscal year. The second campaign is the Breastfeeding Welcomed Here campaign, in which businesses are asked to pledge their commitment to provide welcoming environments to breastfeeding mothers. To date, sixty Nevada businesses have signed this pledge. The goal of this campaign is for breastfeeding mothers to feel safe nourishing their children in public, thereby normalizing breastfeeding amongst a community who is not used to seeing nursing mothers. Lastly, Nevada was the recipient of the USDA's Breastfeeding Bonus Award for the greatest increases in exclusive breastfeeding rates between 2013 and 2014.

Substance use Prevention

MCH continued to work with the Substance Abuse Prevention and Treatment Agency (SAPTA) to oversee the SoberMomsHealthyBabies.org website to prevent substance use in pregnant women and provide information to women of childbearing age, providers, and concerned family and friends. A public awareness campaign promotes the website through television and radio advertisements. The website provides Nevada 2-1-1, the substance use help line (1-800-450-9530) and the Nevada tobacco quitline (1-800-784-8689), among other resources. A public awareness campaign through radio and TV ads continued to promote the website.

Nevada's work group participation relating to substance use in pregnancy has yielded partnerships with various agencies and programs. Through the new partnerships, Screening and Brief Intervention and Referral to Treatment (SBIRT) training was identified as a need. SBIRT is an early intervention strategy designed to identify those who present for medical or behavioral healthcare who are at particular risk due to alcohol or drug misuse or abuse. Research has shown substance abuse is a risk factor for multiple illnesses including cardiovascular disease, cancer, liver problems, and damage to the nervous system. The primary goal of SBIRT is to screen and provide intervention before the problem becomes critical thereby alleviating possible health problems and societal issues. Title V provided funding to support the SBIRT training. MCH staff actively participate in the National Governor's Association Learning Collaborative to improve birth outcomes and through collaboration with the Center for the Application of Substance Abuse Technologies (CASAT), a data driven infographic to increase awareness of substance use during pregnancy to health care providers was developed.

Title V provided the Reality Works Dolls to partners within the Division of Public and Behavioral Health (DPBH) for use as educational resources for probable outcomes of negative behaviors such as child abuse and substance use. The dolls are interactive and educational and simulate key characteristics of shaken baby syndrome and highlight the key features of a baby with fetal alcohol syndrome.

Early Hearing Detection and Intervention

MCH collaborates with entities across the state to ensure children are provided with appropriate screening, follow up, testing, and timely treatment. Nevada Early Hearing Detection and Intervention (NV EHDI) Program, housed in the Maternal, Child and Adolescent Health section works to ensure that all children in Nevada are screened for hearing loss at birth and those identified with hearing loss receive timely and appropriate audiological, educational and medical intervention. Modifications and enhancements were made to the EHDI information system (WEVRRS now VRS) to better track Nevada infant hearing screenings, hearing diagnostics, and early intervention services. In addition, the hearing screening data submission was streamlined with the EHDI program. This has improved the timeliness, accuracy, and completeness of the data being submitted.

Baby Safe Sleep program

The Baby Safe Sleep-Healthy Tomorrow's Partnership for Children Grant aims to reduce Clark County, NV child deaths due to unsafe sleeping environments through the design and delivery of a multi-pronged, preventative education program to promote messages to help families create safe sleep environments for babies. The hospital based safe sleep program, "Baby Safe Sleep," is composed of five key components: 1. Review/establish a comprehensive policy on sleep positioning 2. Sleep position audit before and after staff training 3. Staff training on safe sleep 4. Patient education on safe sleep 5. Evaluation/Expansion.

University Medical Center previously implemented the Baby Safe Sleep program. Sunrise Hospital and two Dignity Health System hospitals (San Martin and Siena) fully implemented the program in Year 4 of the grant. This included training more than 430 of their staff, a sleep position audit observing 145 infants under 1 year of age and showing the video and associated survey to more than 656 parents. The program has also worked with three of the Valley System hospitals to begin implementation of the program. Post-training sleep position audits at the Dignity Hospitals were completed and the initial sleep position audits for all Year 4 participating hospitals (Sunrise, Spring Valley, Centennial Hills and Summerlin) were also conducted. The staff training with the Valley Hospitals System began with

27 targeted staff in attendance. This set of hospitals requested the PowerPoint training with the voiceover. Patient education at the Dignity Hospitals occurred with 156 parents completing the initial parent survey. 67 parent follow-up surveys representing nearly 45% of all parents who completed the initial survey were completed. Patient education at Sunrise Hospital began with over 500 parents agreeing to complete the post video survey. Work also began with Stacey Welling from Clark County Public Communications on a Safe Sleep PSA to air on the Clark County video network which includes the pilot hospital system, UMC. The English and Spanish versions of the Baby Safe Sleep video were provided to Ms. Welling, as well as the Caregiver Training PowerPoint developed in 2013 for foster parents. The PSA aired and featured footage from the Baby Safe Sleep video and poster, as well as a reference to the Southern Nevada Health District for more information. In addition, Baby's Bounty, a local non-profit that provides essential supplies for new parents, provided free infant safe sleep classes in collaboration with the local Head Start for the community. The non-profit chose the Baby Safe Sleep brochures, FAQs and video for their class.

Healthy Start

The home visiting program, Healthy Start, works to decrease infant mortality and decrease social disparities in 16 targeted zip codes in the cities of Las Vegas and North Las Vegas. Healthy Start targets African-American women and their children through the age of 2 years. Women do not have to be African-American to be served. The goals of the program are to improve women's health, promote quality services, strengthen family resilience, achieve collective impact, and increase accountability through quality improvement, performance monitoring and evaluation. Case management services are provided by registered nurses and health educators. The program is to serve 500 women/and or children. Staff training on screening and data collection forms were modeled after the San Antonio Healthy Start Program. Contracts were established with Nevada Institute for Children's Research and Policy (NICRP) with the University of Nevada at Las Vegas for Program Evaluator, and with a community partner, Positively Kids (PK) Foundation, Inc., for the provision of an Enrollment Specialist for Medicaid. The project also launched the Healthy Start Community Action Network (HS CAN) with a Summit. There were 70 community members in attendance representing over 30 organizations. Organizations were both traditional and non-traditional stakeholders in the local Maternal Child Health community. Outcomes for this included 27 individuals committing to joining the HS CAN and a mission and vision were developed. The parenting curriculum, Partners for a Healthy Baby, held staff training. Project staff in attendance included all four case managers, the project coordinator/team lead, and the project supervisor. Training was provided to case managing staff with a standardized educational tool to implement with families. The parent curriculum will be personalized in its use with families served. In addition, case managers will use additional hands on tools developed and shared with a sister program to enrich the curriculum. The program selected and began working with ChallengerSoft, an electronic case management record and data collection system. ChallengerSoft held a site visit with the project leadership, the project evaluator, and Nevada Institute for Children's Research and Policy (NICRP). Activity in follow-up to this meeting included adopting/editing forms, mapping data to generate reports, and developing/testing the forms in the system. The project manager reviewed and amended forms for use, which were also reviewed with the vendor's consultant prior to staff training. In addition, the Project Coordinator, the project evaluator, and NICRP, initiated routine monthly calls to establish formal communications between the project and its evaluation team.

Contact was initiated with Leslie Patton and Associates, a TA Consultant through the EPIC Center, to assess and develop a formal communication plan to increase enrollment numbers. The goal was to establish a formal communication plan that included strategies for marketing/branding the project locally, usage of social media, partner/community engagement, and creating a message that focuses on the benefits to the program. Prior to this, the Southern Nevada Health District Public Information Office teamed up with the project in support of new marketing tasks. Meetings were also held with project staff for their input and surveys were created for program's participants to assess communication styles of the target population. As a result, contracts were initiated with local community organizations to increase enrollment. The program served 91 participants through 9/30/15.

Nurse-Family Partnership Program

The Southern Nevada Health District (SNHD) Nurse-Family Partnership Program is the first nurse family partnership unit in the state of Nevada and is one of the evidence-based home visiting programs recognized by the Maternal Infant and Early Childhood Home Visiting Program. Research by the National Service Office of Nurse-Family Partnership and Southern Nevada Health District's contract with the National Office limits each nurse's caseload to twenty-five active clients. The capacity was 150 women. There were 6 nurse home visitors serving clients in the program. 48 clients were actively participating through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program made available through the Nevada Division of Public and Behavioral Health under the Affordable Care Act (ACA). The Southern Nevada Health District's Nurse-Family Partnership is one of the evidence-based home visiting program sites participating in the national Maternal and Infant Home Visiting Program Evaluation (MIHOPE) - Strong Start, a study designed to assess the effects of home visiting services on maternal and infant health. The Centers for Medicare and Medicaid Services (CMS) may use the results of the evaluation to help inform Medicaid reimbursement policies. 131 clients were enrolled in the Strong Start study. The District's Nurse-Family Partnership program committed to enroll 150 study participants through September 2015. The goals of the program are improved pregnancy outcomes; improved children's subsequent growth and development; and increased family economic self-sufficiency. The program has been in existence since 2008. Two nurse home visitors are funded under the Nevada Home Visiting Program. Accomplishments: 209 women were served between 10/1/2014 and 9/30/2015. 641 women were served from 2008 to 9/30/2015.

Current Education and Work Status for Active Clients: There are currently 64 (50%) clients without a High School Diploma or GED. 56 clients have a High School Diploma or GED (44%). 1% have vocational training. 9 clients (14%) are enrolled in school. 20 clients (15.7%) are working full-time and 23 clients (18.1%) are working part-time. Cumulative Workforce Participation Over Time: At intake, 26% of Southern Nevada Health District Nurse-Family Partnership clients are working. At 24 months post-delivery, 54% are working.

Washoe County Fetal Infant Mortality Review

Title V Program funds and collaborates with Washoe County Fetal Infant Mortality Review (WC FIMR) in Washoe County, Nevada, to assess issues relating to fetal/infant loss with the goal of reducing fetal and infant mortality. The FIMR Case Review Team met eight times between October 2014 and June 2015 and reviewed 26 of the 83 cases. All of the cases reviewed were Washoe County residents. The initial meeting focused on orientation to the Case Review Team. The second meeting was a site visit from National Fetal Infant Mortality Review (NFIMR) staff for technical support.

The Case Review Team reviewed the definition of fetal versus infant classification at delivery. It was determined more education is needed for providers. A representative from the Division of Public and Behavior Health, Maternal Child Health program addressed this need for education with staff at the state level. The Case Review Team assisted with the identification of barriers and suggestions were made to simplify the notification materials. In addition, staff met with the Yolo County FIMR Program to obtain guidance regarding the maternal interview process. Sympathy cards were developed and mailed out to mothers. This resulted in an increase in the number of maternal interviews conducted. A Medicaid representative provided information to the Case Review Team regarding application processing time, coverage for prenatal services, and transportation to medical appointments.

The FIMR team worked with the Division of Public and Behavioral Health to develop the REDCap database which will provide more complete and accessible data. The Community Action Team is assisting the Northern Nevada Maternal Child Health Coalition with updating agency information on the online data base to increase awareness and accuracy of available services. FIMR staff presented at the March of Dimes Women's Health Symposium in Las Vegas on FIMR Implementation in Washoe County in November 2014. The National FIMR director attended the Washoe County CRT meeting in November 2014 and provided guidance and feedback to the members. FIMR staff

attended the Association of Maternal and Child Health Programs (AMCHP) conference in January 2015. The FIMR Supervisor was one of six participants from Nevada who attended the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) Summit in July 2014. The summit provided training in quality improvement as well as collaborative learning methods which will help the Nevada stakeholders develop infant mortality reduction strategies.

The FIMR supervisor is a board member of the State of Nevada Maternal Child Health Advisory Board. The Case Review Team initially reviewed one to two cases per meeting and has progressed to reviewing four to five cases per meeting. Five maternal interviews were conducted between October 2014 and June 2015. The team found this to be one of the most challenging parts of the FIMR process. Barriers to speaking directly to mothers were transiency, invalid phone numbers, and incomplete information. The FIMR Community Action Team held its first meeting on April 20, 2015. Approximately 22 community members participated and reviewed recommendations from the Case Review Team. The Community Action Team developed two objectives at their second meeting which was held on September 21, 2015. Objective one is focused on substance use in pregnant women. Objective two is focused on education/public awareness of the importance of prenatal care.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Increase developmental screening

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

Increase the percent of children (10-71 months) who receive a developmental screening using a parent-completed screening tool to 31.9% by 2020

Strategies

Collaborate with public and private partners to develop to communicate the importance of developmental screenings, including referral to appropriate health professionals

Collaborate with MCH public and private partners to conduct outreach to educate individuals, families and communities regarding the benefits of the medical home portal for CYSHCN

Collaborate with 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 MCH partners to pilot a project to develop a Medical Home toolkit to bridge the gap between families and health care providers

ESMs

ESM 6.1 - Number of Title V funded partners providing developmental screening in the past year

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23	25	27	29	31	31

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	21.9 %	3.1 %	38,504	175,661
2007	18.6 %	2.9 %	33,716	181,306

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Number of Title V funded partners providing developmental screening in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	3.0	4.0	5.0	7.0

Child Health - Plan for the Application Year

Access to health care

Extensive provider outreach is planned for the future to increase EPSDT services. Southern Nevada Health District (SNHD) field and clinic staff will continue to routinely screen and refer individuals served for Medicaid. Home visiting programs such as NFP and Healthy Start remind families to renew their Medicaid or Nevada Check-Up one month before renewal is due. These program staffs also refer to the Positively Kids enrollment worker to assist families with

their Medicaid/Nevada Check-Up applications. This will continue as both programs work with families served to obtain a medical home and needed resources. Rural Community Health Services (RCHS) nursing personnel will continue to provide children with immunizations in their respective counties.

Physical Activity and Nutrition

The School Health Coordinator will conduct professional development sessions on Comprehensive School Physical Activity Program (CSPAP) and nutrition. The School Health Coordinator will meet with Nevada Department of Transportation Safe Routes to School Manager and Carson City Coordinator and Safe Schools staff will be contacted to explore opportunities for promotion on the Nevada Wellness website. The local wellness policies have been put into place for LEAs, the next step is implementation. The Nevada School Wellness policy includes: Schools must provide the opportunity for moderate to vigorous physical activity for at least 30 minutes during each regular school day (as defined by USDA). It is recommended students be given physical activity opportunities in bouts of 10 minutes at a minimum and passing periods do not qualify as physical activity time. Teachers, school personnel, and community personnel will not use physical activity or withhold opportunities for physical activity (e.g. recess, physical education) as punishment.

Early Childhood Education

Children's Cabinet will continue to provide training to targeted ECEs Trainings will include an emphasis on physical activity standards and decreasing screen/media time within four main counties (Washoe, Clark, Carson City and Elko).

Data

MCH Program will work with NICRP to revise the 2017 survey questionnaire.
The changes will be to ensure the questions align with the current MCH priorities, measures, and address specific issues of ongoing and emergent public health concern in our state.

Nevada Home Visiting Program

The Nevada Home Visiting (NHV) plans to collaborate with other state agencies to create a more centralized system of entry into home visiting programs and to cross-refer to appropriate services. Title V will provide funds to NHV to expand home visiting programs to the rural/frontier counties.

In addition, NHV program plans to:

- Introduce Parents as Teachers Program in Churchill, Humboldt and Carson City counties.
- Publish of Families Understanding Nutrition (FUN) booklet.
- Hire a Reflective Supervision consultant to provide support and training statewide.
- Provide Bridges Out of Poverty training to all home visiting agencies (to include entire staff).
- Provide diversity training.

Child Health - Annual Report

Access to care

The Early Prevention Screening Diagnosis Treatment (EPSDT) Program at Southern Nevada Health District (SNHD)

contacted 3847 families with children newly eligible for Nevada Check-Up out of 6785 families with attempted contacts from 10/1/2014-9/30/2015. All families contacted received referrals the SNHD's Kids Clinic for Healthy Kids exams, sports physicals, day care exams, etc. and were advised of their benefits under Nevada Check-Up. SNHD staff also participated in two community events/health fairs during this time period with information on Medicaid and enrollment assistance available through the Positively Kids enrollment workers stationed at two SNHD locations. In addition, geographical limitations to the EPSDT telehealth policy were removed to improve access to care in Nevada.

Nursing personnel within Rural Community Health Services (RCHS) attend a variety of local events in their communities to encourage and provide immunizations to young children. They also provide fluoride varnish to all children aged 1-5 years. Additionally, they conduct immunization clinics at elementary schools. Within a limited scope, the nursing personnel also conduct well-child visits but, primarily, they refer to local physicians to conduct EPSDT.

Physical Activity

The statewide school assessment on physical activity and nutrition was finalized by Dr. Lounsbery in the spring of 2015. The School Health Program Coordinator began working with School Wellness Committees in the spring of 2015 to include CDC recommended standards for physical education, physical activity, and nutrition policy inclusion. These standards were used in the development of the School Wellness Policy. Nevada Legislature considered a bill draft to increase physical activity in schools starting in February 2015, but this was not established. Information on CDC best practices was provided. The School Health Program Coordinator fully executed the Healthy Hoops Campaign (including a dance challenge) and 8 scheduled elementary school assemblies in partnership with the Reno Bighorns professional basketball team (D-league). The campaign promotes physical activity of 60 minutes per day, healthy nutrition, and reduce screen time among students in northern Nevada, and is being assessed by the NBA for possible replication in other franchise states. In addition, the School Health Program Coordinator attended Comprehensive School Physical Activity Program (CSPAP) training in February 2015. CSPAP training in 2 areas was provided in spring/summer 2015. The School Health Program Coordinator worked with professionals in physical education and physical activity organizations to provide professional development opportunities, which included offering CSPAP to school staff and stakeholders. The School Health Coordinator worked with local education agencies and school wellness policies to include physical education and physical activity best practice language. Technical assistance and follow up will be conducted with CSPAP and other professional development attendees.

Early Childhood Education

A meeting to identify Early Childhood Educators (ECEs) within targeted areas to receive training and technical assistance took place in September 2014 with the Children's Cabinet, Nevada Child Care Licensing and the Obesity Prevention Program Coordinator. 75 ECE providers were identified to be targeted in 4 main counties (Washoe, Clark, Carson City, and Elko) to receive training and technical assistance on evidence-based standards addressing physical activity and decreasing screen/media time. These ECEs were identified using data from Lets Move Childcare provided to Nevada by CDC. Upon identification of these ECEs, an initial survey of their individual practices and policies was completed. These survey results were used for quality improvement of training materials and curriculum, as well as, helping to guide on-site technical assistance activities. ECE trainings on physical activity and decreased screen/media time began in November 2014. These trainings continued through June 2015. Training was provided to 54 sites, reaching over 75 providers and approximately 3,514 children. Trainings were conducted on physical activity standards and decreasing screen/media time within 4 main counties (Washoe, Clark, Carson City and Elko) and addressed areas of greatest need for these specific ECEs.

Data

Nevada Institute for Children's Research and Policy (NICRP), in partnership with all Nevada School Districts and the Nevada Division of Public and Behavioral Health (DPBH), conducts an annual health survey of children entering kindergarten in Nevada. Data from the survey provides estimates for monitoring MCH indicators and for reporting to local, state and federal entities. In the fall of 2014, NICRP distributed questionnaires to all public elementary schools in the state, except Clark County School District, who requested that a sample of their schools be surveyed. The survey had an overall response rate of 30.6 percent, with a total of 7,480 surveys received from parents in all 17 school districts in Nevada. NICRP develops an annual report that is posted on the NICRP website as well as distributed across DPBH and to statewide and local advisory and coalitions. Survey information informs local efforts to improve future survey data as well as improve the health of Nevada communities. NICRP receives funding to conduct the survey from Nevada Title V.

Nevada Home Visiting

Nevada Title V collaborates with the Nevada Home Visiting Program (NHV) to provide services to vulnerable families in the State including those in the rural counties. In response to a recent rural needs assessment, NHV launched the Home Instruction for Parents of Preschool Youngsters (HIPPY) in Nye County because it was determined that it was one of the counties with the highest need in the state. Sunrise Children's Foundation, one of the agencies implementing home visiting in southern Nevada, was contracted to provide HIPPY services as an expansion to their existing program. HIPPY helps parents to engage their children in daily learning activities that promote literacy and school readiness. The program fosters language development, problem solving, logical thinking, and perceptual skills in children. Results from the needs assessment also showed that Mineral County was a priority area thus NHV launched the Parents as Teachers (PAT) Program to serve the families in that community. NHV had five positions approved legislatively to convert contract positions to State FTEs. This change will provide stability to the program and allow staff to attain the experience needed to provide expertise to agencies. Previously, contracted employees were temporary, and typically moved into other employment as opportunities became available.

Agencies implementing home visiting programs in the State continue to pursue Continuous Quality Improvement and have become experts in conducting Plan Do Study Act (PDSA) cycles. Significant improvements have been made to enrollment procedures, birth spacing education, reflective supervision and specific benchmarks.

Yale New Haven Health Services recently conducted an evaluation of home visitor retention and indicated that some areas required improvement. Some of the recommendations made were to implement reflective supervision. Agencies have been given guidance and training on reflective supervision and accountability processes are in place.

Home Visitors from each agency were afforded the opportunity to attend the Pew National Summit on Quality in Home Visiting in Washington, DC. This important national conference provided a broad perspective for home visitors on the success and innovation of programs nationwide.

From October 1, 2014 – September 30, 2015, NHV program served 265 families and 278 new families. The total number of home visits during this time period was 3,505.

Chart 1: Primary Enrollee Categories

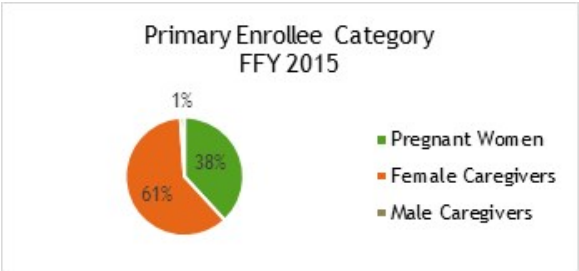

Chart 1 shows the percentage of primary enrollees served by the program, broken down into categories. Female caregivers (most often mothers) are the highest served.

Chart 2: Family Retention across all Home Visiting Models

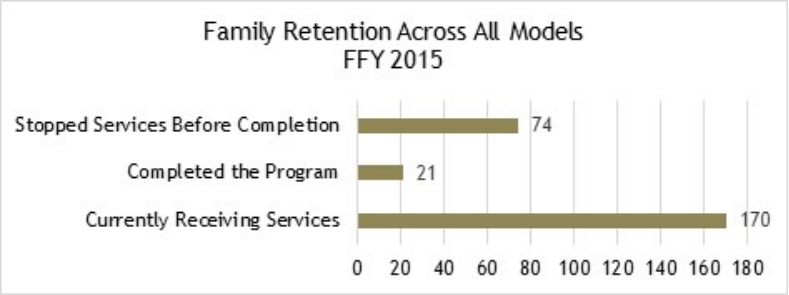

Chart 2 shows the retention of families in the program. Families who stopped services before completion do so for a variety of reasons including: moving out of service area and not having time to participate in the program.

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Promote healthy weight

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

Increase the percent of middle school and high school students who are physically active at least 60 minutes a day to 48.8%.

Strategies

Collaborate with public and private partners to conduct survey activities to track and trend weight data for target population

Collaborate with state partners, including the educational system, to increase the percent of elementary schools that adopt a physical activity plan/policy

Collaborate with public and private partners to link children to appropriate health services, including screenings, vaccinations, etc.

Collaborate with public and private partners to expand physical activity opportunities outside of school hours

Disseminate educational materials to partners for statewide distribution

Collaborate with public and private partners to provide target population with information on the benefits available through the Affordable Care Act

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 bullying, rape and sexual assault prevention, suicide, and other factors that negatively impact health

ESMs

ESM 8.1 - Percent of middle and high schools that implement a physical activity plan

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Improve preconception and interconception health among women of childbearing age

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the percent of adolescents aged 12-17 with a preventive medical visit in the past year to 78% by 2020.

Reduce pregnancies among adolescent females aged 15 to 17 years to 36.2 pregnancies per 1,000 by 2020

Reduce pregnancies among adolescent females aged 18 to 19 years to 105.9 pregnancies per 1,000 by 2020

Strategies

Collaborate with public and private partners to provide target population with information on the benefits available through the Affordable Care Act 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 bullying, rape and sexual assault prevention, suicide, and other factors that negatively impact health

ESMs

ESM 10.1 - Number of Title V partners that conducted activities to promote preventive well visits for youth in the past year

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 with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 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

State Action Plan Table - Adolescent Health - Entry 3

Priority Need

Reduce teen pregnancy

SPM

A. Percent of teenage pregnancies and B. Percent of repeat teen births

Objectives

Reduce pregnancies and repeat pregnancies among adolescent females aged 15 to 17 years to 36.2 pregnancies per 1,000 by 2020.

Reduce pregnancies and repeat pregnancies among adolescent females aged 18 to 19 years to 105.9 pregnancies per 1,000 by 2020

Strategies

Collaborate with State Abstinence Education Grant Program (AEGP) and the State Personal Responsibility Education Program (PREP) on meetings with partners to ensure evidence-informed education is provided.

Collaborate with community partners on educational campaign focused on decreasing teen pregnancy (repeat pregnancy).

Measures

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	16	18	20	22	24	24

Data Source: Youth Risk Behavior Surveillance System (YRBSS) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	24.0 %	1.2 %	30,430	126,834
2009	24.9 %	1.2 %	31,516	126,740
2007	22.6 %	1.0 %	25,352	112,309

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.8 %	2.1 %	31,350	211,533
2007	18.8 %	2.2 %	39,691	211,298
2003	21.0 %	1.9 %	38,516	183,651

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Percent of middle and high schools that implement a physical activity plan

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	70	72	74	76	78	78

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	67.3 %	2.9 %	144,809	215,102
2007	71.3 %	2.8 %	153,259	214,950
2003	60.3 %	2.1 %	112,436	186,593

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - Number of Title V partners that conducted activities to promote preventive well visits for youth in the past year

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	4.0	7.0	10.0	13.0	17.0

Adolescent Health - Plan for the Application Year

Title V developed a State Performance Measure (SPM) to reduce teenage pregnancy and repeat births among teenagers. The MCH Program will collaborate with the Personal Responsibility Education Program (PREP), the Abstinence Education Grant Program (AEGP) and other partners to implement the goals and objectives outlined in the five-year state action plan.

Personal Responsibility Education Program

Nevada PREP plans to maintain the five PREP subgrantees (Planned Parenthood Mar Monte, Planned Parenthood of the Rocky Mountains, Elko Family Resource Center, Carson City Health and Human Services, and The Center). These subgrantees will continue to teach comprehensive sex education using several evidence-based curriculums including "¡Cuidate!", "Sexual Health and Adolescent Risk Prevention" and "Be Proud! Be Responsible!". Subgrantees will continue to grow partnerships with other community organizations and attend community events to raise awareness of PREP. The PREP Coordinator will develop policies and procedures to strengthen programming at the grantee and subgrantee levels. Planned Parenthood of the Rocky Mountains will be continuing implementing "¡Cuidate!" with Hispanic/Latino in a home based setting around Las Vegas and have hired additional staff to implement PREP activities at a higher capacity. The Center will change their curriculum from "Reducing the Risk" to "Be Proud! Be Responsible!" which will enable them to engage and retain more youth from the LGBTQ community. Carson City Health and Human Services will continue implementing "Be Proud! Be Responsible!" in Carson City, Douglas, Lyon and Storey counties. Planned Parenthood Mar Monte will continue implementing "¡Cuidate!" with community partners and their Teen Success group in Reno, which is a weekly support group serving pregnant and parenting mothers. Additionally, they will continue implementing "Sexual Health and Adolescent Risk Prevention" in settings with detained and at-risk youth.

Abstinence Education Grant Program

The AEGP Coordinator will be developing and implementing a policy and procedure manual to strengthen grantee and subgrantee programming. The Adolescent Health statewide media campaign, in collaboration with the Nevada Broadcasters Association, will continue the “Parents Talk to Your Kids” radio spots. In addition to these radio spots, there will also be corresponding television non-sustaining commercial announcements created. PHAT! classes will continue to be offered by Carson City Health and Human Services in Carson City, Douglas County, and Storey County. The Elko Family Resource Center will also continue to offer PHAT! classes in Elko and outlying rural communities in Winnemucca, Lovelock, Jackpot and Wendover. In addition, Quest Counseling and Consulting in Reno will continue to conduct PHAT! classes with male youth who are living at the Quest House for substance abuse and mental health treatment, and both female and male youth utilizing their outpatient counseling treatment services.

MCH will continue to work collaboratively with the Chronic Disease School Health Coordinator to complement and promote their activities related to increasing physical activity in adolescents.
Nevada MCH will continue to provide educational resources such as the Reality Works Dolls to partners to educate teens about pregnancy.
MCH will continue funding the nursing personnel within Rural Community Health Services (RCHS) to provide adolescents with educational materials and immunizations in their respective counties.

Adolescent Health - Annual Report

Nevada Title V collaborates with the Personal Responsibility Education Program (PREP), the Abstinence Education Grant Program (AEGP) and other partners on teen pregnancy prevention activities.

Personal Responsibility Education Program

The Adolescent Health staff at the Division of Public and Behavioral Health (DPBH) worked on several projects aimed at pregnancy prevention and reducing the rate of birth for teenagers ages 15-17. Nevada PREP is housed at the DPBH and its goal is to reduce teenage pregnancies and births, reduce the transmission of sexually transmitted infections, and to prepare adolescents for the successful transition into adulthood. PREP worked with subgrantees to implement evidence-based programming that educates adolescents on both abstinence and contraception. Subgrantees have partnered with over 28 community organizations and attended 23 community events around the state. The five PREP subgrantees (Planned Parenthood Mar Monte, Planned Parenthood of the Rocky Mountains, Elko Family Resource Center, Carson City Health and Human Services, and The Center) taught comprehensive sex education using several evidence-based curriculums: "¡Cuidate!", "Reducing the Risk" and "Be Proud! Be Responsible!”. Carson City Health and Human Services was approved by the Storey County School District for PREP to be implemented in their 10th grade health class, and will be available for all high school students who need health credits in 2016. Planned Parenthood of the Rocky Mountains implemented "¡Cuidate!" with Hispanic/Latino in a home based setting around Las Vegas. The Center has curriculum inclusive to and supports the LGBTQ community. Planned Parenthood Mar Monte continued their Teen Success group in Reno, which is a weekly support group serving pregnant and parenting mothers, and will be implementing classes for teens within the Sierra Nevada Job Corps system. In Federal Fiscal Year 2015, over 500 youth ages 13-18 participated in the PREP, with the highest number of participants reached through Planned Parenthood Mar Monte and Planned Parenthood of the Rocky Mountains.

Abstinence Education Grant Program

AEGP had previously established an abstinence only program for youth ages 9-15, with preference given to youth in foster care, who are significantly more likely than their peers to become pregnant or to father a child at an early age. In Federal Fiscal year 2015, over 200 youth ages 9-12 and 13-15 participated in the AEGP in northern and rural Nevada. Subgrantees partnered with over 18 community organizations and attended 10 community events around the state. Carson City Health and Human Services offered the “Promoting Health Among Teens-Abstinence Only!” (PHAT!) classes in Carson City, Douglas County, and Storey County. Storey County School District allowed PHAT! curriculum as a part of their 5th and 8th grade Health Class, facilitated by CCHHS AEGP staff. Quest Counseling and Consulting in Reno continued to seamlessly conduct PHAT! classes with male youth who are living at the Quest

House for substance abuse and mental health treatment. Both female and male youth utilizing their outpatient counseling treatment services were also able to attend PHAT! classes. The Elko Family Resource Center continued to conduct PHAT! classes in Elko and outlying rural communities in Winnemucca, Lovelock, Jackpot, and Wendover. The Adolescent Health statewide media campaign, in collaboration with the Nevada Broadcasters Association, continued the “Parents Talk to Your Kids” radio spots. The “Parents Talk to Your Kids” campaign consists of 3 radio spots that promote parents/guardians talking to their kids and teens about teen pregnancy prevention, STIs, and general health topics. The campaign provides tips to parents on how to have an open, honest, and consistent dialogue with their kids and teens. Information from the CDC regarding Sexually Transmitted Infections (STIs) is also provided.

The MCH program provided educational resources such as the Reality Works Dolls to partners in the Nevada Public Health Foundation to educate teens about pregnancy.

Physical Activity

The Adolescent Health Program Specialist housed in the MCAH Section held several meetings with the State Chronic Disease Section School Health Coordinator to learn how to best complement and promote their activities related to increasing physical activity in adolescents. MCH desired to expand the number of after-school physical activity programs reaching adolescents. Evidence-based after-school programs targeting middle and high school age youth were sought out. Sports, Play and Active Recreation for Kids (SPARK) looked promising as it has selected activities for children in grades pre-K through 12. Further investigation lead us to discover the SPARK after-school program has only been deemed a viable evidence-based program up to age 14 (testing was not done with older adolescents). Thus, this program did not meet the needs to serve adolescents through age 17. Regrettably there were no available evidence-based after-school physical activity programs reaching our target audience for middle and high school age youth. The Nevada Department of Education’s 21st Century Community Learning Center reports most adolescents are enrolled in school or community team sports, thus do not participate in their mandated physical activity programs. Coordinated Approach to Child Health (CATCH) only targets children ages 7-12, and Triple Play which reaches all school-aged children is a propriety program belonging to the Boys and Girls Club. It was decided to not move forward with implementing after-school physical activity programs until evidence-based programs were developed/tested to include adolescents through age 17. Title V financially supports nurses within the Rural Community Health Services (RCHS). In the reporting year, the nurses provided educational materials on nutrition and physical activity to adolescents in their communities. Within a limited scope, the nurses also conducted well-visits.

Children with Special Health Care Needs

State Action Plan Table

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

Priority Need

Improve care coordination

NPM

Percent of children with and without special health care needs having 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, Healthy Start, and other program participants that received information on the benefits of a medical home

Increase the number of referrals to Nevada's medical home portal

Strategies

Partner to support the implementation of Medical Home Portal including awareness, professional development, Nevada 2-1-1 activities, etc.

Partner to identify and conduct outreach to population groups (including families) with the greatest need (e.g. racial/ethnic group, payer, rural/urban) regarding availability and benefits of Medical Home Portal

ESMs

ESM 11.1 - Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 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

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	36	39	42	45	54.8	54.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	43.3 %	4.6 %	42,016	96,943
2007	37.2 %	4.8 %	35,148	94,395

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	44.8 %	2.0 %	242,287	541,063
2007	46.8 %	1.9 %	253,882	542,275

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	9.0	12.0

Children with Special Health Care Needs - Plan for the Application Year

The Children and Youth with Special Healthcare Needs (CYSHCN) Program Coordinator position recently became vacant, however, a lot of collaborations with partners were developed to support programs and services related to this population.

Medical Home Portal

The Medical Home Portal (MHP) will be fully established by September 2016 with resources provided throughout the State serving CYSHCN and their families. CYSCHN Program will work with MCH partners to publicize the new resource and encourage utilization. Trainings will be developed to educate CYSHCN, their families, providers, professionals, schools, and other agencies on the importance of the MHP. Title V will continue to maintain a toll-free CYSHCN information line to provide a broad range of resources and accurate information to families of CYSHCN across the state. In addition, Nevada 2-1-1 website will also continue to be funded by Title V to allow users access to resources for physical and mental health via text or the internet.

Craniofacial Clinics

Craniofacial Clinics in Northern and Southern Nevada will continue through calendar year 2016-2017. The clinics held once a month will provide families with the foundation of care for their child or youth with craniofacial conditions. Nevada's Title V Program will continue to fund the administrative assistant position for the Northern Nevada Cleft Palate Clinic (NNCPC).

CYSHCN is looking to increase funding for NNCPC to improve family clinical services and provide bilingual support for Hispanic Families. This project will anticipate a strong collaboration between Title V, Family TIES, and NNCPC.

Pulse Oximetry screening for Critical Congenital Heart Disease

CCHD for newborn screening will continue reporting within the current database housed in CYSHCN.

Family TIES

Funding provided through CYSHCN will allow an opportunity for two staff members from Family TIES along with the CYSHCN Program Coordinator to attend a Family Leadership Conference through HRSA hosted by Family Voices (federal Family-to-Family Information Center) that will take place at the end of March 2016 in Rockville, Maryland. This will demonstrate the strong relationship between Nevada Title V and Nevada's Family-to-Family Information Center. The education available will provide an opportunity to promote family leadership statewide as family leaders from every state connect and share; learn innovative strategies and best practices; and strengthen our collective impact on systems serving children and youth with special healthcare needs.

Goal 1: Ensure access to care for families who have children (and youth) with special healthcare needs (CYSHCN) by collaborating across stakeholders, public and private entities, and communities. Includes implementing and/or expanding service provision for CYSHCN within a Medical Home/Portal, and to increase developmental screenings.

- Maintain the CYSHCN toll-free telephone line.
- Provide family-centered outreach and support that is culturally and linguistically competent.
  - Bi-lingual staff is based in Reno and Las Vegas offices to expand reach to Spanish speaking families.
- Review and disseminate validated tools such as the Nevada Medical Home Portal, AAP Medical Home Fact Sheets, Medical Home Index, and Family Centered Care Self-Assessment Tool for Providers/Families to practice sites and trained providers including Medical Students, Physicians, Nurses, Community Clinics and/or Health Centers, Early Intervention Clinics and School Linked Health Centers.
- Medical Home tools will be made available to the public through presentations, agency website, newsletters and social media.
- Training and education with AAP endorsed curricula will be provided to health care providers in the definition and implementation of the Medical Home and Family Centered Care model. Trainings will be evaluated for effectiveness. Providers include Medical Pediatric Residents and Students, Program Directors, Nurses and other identified health professionals.
- Participation in coalitions, focus groups and other forums to ensure CYSHCN have access to a medical home:
  - Nevada Statewide Maternal and Child Health Coalition/Steering Committee/Strategic Planning
  - Southern and Northern Nevada Maternal Child Health Coalitions
  - Immunize Nevada Community Meetings in Northern and Southern Nevada (includes SNIHC)
  - Interagency Coordinating Council Family Support Resource Subcommittee
  - Hispanic Parent groups in Las Vegas
  - Learn the Signs Act Early Steering Committee
  - Annual NvLEND Educational Forum for trainees
  - Nevada 211 Focus Groups
  - University Center for Autism and Neurodevelopment (UCAN)/Strategic Planning
  - Washoe County Children's Mental Health Consortium
  - Certified Community Behavioral Health Clinic Planning Grant Committee

- Fallon Child Health and Wellness Fair Planning Committee (Aug. 2016)
- Las Vegas Child Health and Wellness Fair Planning Committee (Aug. 2016)
- Early Intervention 2017 Community Health and Outreach Event Planning Committee to promote parent leadership

Goal 2: Provide education and resources for the public and for providers to help youth with special health care needs make transitions to all aspects of adult life, including adult health care, work, and independence.

- Taking Charge of Your Medical Care Health Transition Checklist for Youth Fact Sheets will be disseminated to middle/high schools, healthcare professionals, and at the NV Transition Conference.
- Participate in the Think College Nevada Capacity Building Institute Strategic Planning
- Supervise Interns from the UNR School of Community Health Sciences to link up with school sites.

Goal 3: Disseminate information to expand family knowledge of Medicaid and Nevada Check Up coverage for Early and Periodic Screening, Diagnosis and Treatment Services, and to link identified children with developmental delays to Early Intervention related Programs

- Craniofacial Clinic (Las Vegas) - Collaborating with Craniofacial Clinic to support their patient services
- Cleft Palate Clinic (Reno) - Collaborating with Cleft Palate Clinic to support their patient services
- R.E.A.C.H. (Research, Education and Access to Community Health) Events
- Immunization and Health Fairs
- Back to School Fairs
- Community education events
- In-services, Workshops and Trainings

- Collaborate with Easter Seals to expand referrals to reach Hispanic families with children with autism in Northern Nevada.
- Provide outreach and awareness for Sibshop events and trainings to include flyers, brochures, email listservs and through parent education.
- Disseminate AAP/Family Voices Bright Futures Family Pocket Guide.
- Disseminate Milestone Moments Learn The Signs Act Early Nevada Booklets.

Goal 4: Training/education for parents/families, the community and professionals providers

- Present a 9-Part Parent Training Series in Spanish in Las Vegas.
- Present Family Centered Care and Medical Home Trainings with the University of Nevada School of Medicine's Pediatric Residency Training Program, Northern Nevada Maternal Child Health Coalition, and other Medical Professionals.

Goal 5: Outreach, information dissemination and referral assistance to link families to appropriate services

- **Provide referrals assistance and disseminate resources and information to families, parents, and caregivers; and follow-up to ensure referrals are completed.**

In addition, Nevada Title V tasked Family TIES, Nevada's Family-to-Family Information and Resource Center, to strengthen their outreach efforts and connect to Hispanic families and communities utilizing linguistically and culturally appropriate activities. Nevada Title V is proud of the work Family TIES has accomplished in this area. In appreciation of their work, the Mexican Consulate has publicly recognized Family TIES for their generosity and

impact they have made in the Hispanic community.
MCH continues to collaborate with Family Ties to support services in local and statewide communities. As mentioned prior the Children and Youth with Special Health Care Needs has a subgrant with Family Ties that allows one-to-one guidance for families and loved ones of children with any chronic illness, disability or other condition through a bilingual helpline 1-866-326-8437.

Nevada Technical Assistance Center on Social Emotional Interventions (Nevada TACSEI) for Young Children

1. Provide training, resources and technical assistance on supporting the social emotional competence of young children, their families, and caregivers, to prevent and address challenging behavior,
2. Increase access to inclusive settings for young children with disabilities, and promote behavioral health practices
3. Participate in work groups, committees, and/or meetings involving young children, families, and in supporting social emotional development and preventing challenging behavior
4. Collect and report data on training activities, program-wide implementation and related Nevada TACSEI activities
5. Maintain communication with Nevada TACSEI staff and State Leadership Team members
6. Support Implementation and Demonstration Sites with training, coaching and technical assistance in program-wide implementation.

Nevada PEP

Title V will continue funding Nevada PEP to provide information, services, and training to Nevada families of children with disabilities. NV PEP has a resource library available and they encourage parents who suspect their child has a disability to utilize the books, videos and handouts. Personnel are supportive and compassionate because they have been impacted by disability in some way and are aware that navigating a challenging support system alone can be overwhelming.

Nevada Center for Excellence in Disabilities (NCED)

Title V will continue to fund NCED to conduct Sib workshops.
Partners in Policy training classes will continue to be held with the same competencies and expectations. Specifically, the Sibshop Facilitator Trainings, Sibling Issues Workshops, and Demonstration Sibshops in the Northern and Southern Nevada will the number of trained Sibshop Facilitators in Nevada and educate more parents and professionals on sibling issues though the lifespan.

Nevada Lend (NvLEND)

1. Maintain the NvLTSAE website and upload all training videos so childcare providers can obtain training and CEUs. Further discussion about other possible topics will occur to determine future training needs.
2. There has been a request by multidisciplinary teams who were trained with the ADOS-2 to maintain contact to help in reliability. This will occur through Project Echo.
3. The pilot project for online ASQ-3 & ASQ-Social-Emotional will be expanded to add 3-4 more sites.
4. Completion of training modules and further discussion will be conducted to determine future training needs for childcare workers.
5. Print additional Milestone Moment Booklets and include Year 6 so they can be distributed throughout the state. Several agencies have committed financial support for this project.
6. The annual NvLTSAE summit will be held in Las Vegas, NV in February.
7. Maintain LTSAE NvLEND Leadership Project and maintain and participate in the NvLTSAE Steering Committee to insure participation of stakeholders from across the State.

Nevada Early Intervention Services

Nevada Early Intervention Services will increase parent engagement opportunities and support parents advocacy and training initiatives to link families using social media connections. The focus will be on providing evidenced-based early intervention practices, emphasizing coaching and teaming approaches. The trainings will also strive to improve social-emotional outcomes for all children.

CYSHCN Program will continue to serve on the Advisory Board for Positively Kids Neonatal Center in Las Vegas.

Children with Special Health Care Needs - Annual Report

The Children and Youth with Special Healthcare Needs (CYSHCN) coordinator position is currently vacant. However, Nevada strengthened collaborations and partnerships with stakeholders to meet the needs of CYSHCN and their families. In addition, numerous activities were implemented to provide ongoing support and enhance resources for struggling families in Nevada.

Medical Home Portal

Medical home is one of Nevada Title V National Performance Measures (NPM) for the CYSHCN domain. In 2015, Title V funded the development of a Medical Home Portal (MHP). The MHP which is expected to be fully functional by September 2016, will be established in partnership with the Department of Pediatrics at the University of Utah. The MHP will have Nevada-specific components and will act as a key aspect to comprehensive, coordinated, and integrated systems for improving the care of CYSHCN in our state. The MHP will offer the following services:

- Clinical decision support for primary care clinicians caring for children with chronic conditions;
- Information to support clinicians and parents responding to abnormal newborn screening tests;
- Information to support parents in caring for CYSHCN from birth or diagnosis, through transition to adulthood;
- Information about professional and community providers, services and appropriate referrals as needed;
- Translation of the entire website; and
- Automatic creation of custom lists of services and resources for users, based on medical diagnosis and zip code.
- Information will be provided to clinicians to support and refer patients and families to the Medical Home Portal, provide comprehensive care, integrate best practices, and partner with families.

Through the MHP, the CYSHCN Program will be better equipped to link resources and provide educational materials that support, educate and empower families of CYSHCN throughout Nevada.
In November 2014, the CYSHCN program participated in the Nevada's Student Leadership Transition Summit to provide workbooks to participants on preparing for transition into adult life. Even though this event was not funded by Title V, CYSHCN Program partnered with the Department of Education to provide materials to high school students. The conference, hosted by the Department of Education, included high school students with disabilities and their parents, as well as teachers and counselors from school districts and state public charter schools across Nevada. The purpose of the Summit was to enhance statewide systems for transition planning, to increase graduation rates, and improve postsecondary preparation for students with special health care needs. Young adult speakers with disabilities shared motivational stories on lessons learned as they moved from high school to adult life. Attendees were encouraged to embrace leadership and increase community building opportunities to ensure future success.

Nevada Disabilities Conference

An additional priority for 2014-2015 included serving on the Executive Planning Committee to plan a two day Nevada Disabilities Conference (NDC) hosted by Family TIES. Nevada Title V participated as a sponsor for this major statewide event which provided a one -stop shop platform for connecting families to resources, trainings, best practices and support through national keynote speakers and numerous vendors. Total attendance included over 400 advocates, caregivers and families of CSHCN, as well as, administrators, educators, healthcare and service providers who serve those communities. Several successful breakout sessions were presented including a Fathers Panel: "*Guy Talk – Fathers Speak about Raising a Child with Disabilities.*" Four dads of children with disabilities related their personal story to help others to better understand a father's perspective. Photos of their children were projected overhead as they spoke about their experiences at the beginning and/or diagnosis of their child, their

hopes and fears for the future, highlighting some barriers they had to overcome, and concluded with how things finally came together so they could see a future for their child. The presentation was followed by responding to questions from the facilitator and audience. One attendee shared, “Sometimes hearing other fathers relate their stories you realize you are not the only man to experience both the joys and heartaches of being a father of a child with disabilities.” Activities at the Disabilities Conference align with the previous National Performance Measures 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive; 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily; and 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Pulse Oximetry screening for Critical Congenital Heart Disease

Beginning July 1, 2015, the CYSHCN Program has been working closely with Nevada Hospital Association to increase reporting of pulse oximetry screening for Critical Congenital Heart Disease (CCHD). Infants suffering from CCHD are reported by attending physicians and screening results are housed in the CYSHCN Program. Collection of CCHD data is in support of Nevada legislative bill NRS 442.680.

Family TIES

As a MCH Title V key partner, Family TIES of Nevada is dedicated to providing culturally competent support, information, and assistance to achieve family-centered care for individuals with disabilities or special health care needs through family, community and professional partnerships as the Nevada Family-to-Family Healthcare Information and Education Center (F2FHIC).

The following activities relate to all the old National Performance Measures for CYSHCN.

Highlights of Family TIES in 2014-2015

- Family TIES collaborated with Mexican Consulate’s R.E.A.C.H. (Research, Education, and Access to Community Health) to offer direct support and resources to families and individuals who visit the Consulate and throughout Consulate special events. Family TIES was recognized in January 2015 at the REACH/Ventanilla de Salud 2nd annual R.E.A.C.H. (Research, Education, and Access to Community Health) “Promotores” and Providers Recognition Ceremony in partnership with the Consulate of Mexico. This award recognizes community partners assisting R.E.A.C.H. in making a difference for all communities, but in particular, the Hispanic/Latino community.

- In 2014-2015, Family TIES logged over 2,200 instances of support to Nevada families of CYSHCN and over 500 instances of support to professionals who work with families of CYSHCN – showing a 120% increase since 2010. Of the families served, 43% were known to be Hispanic or Latino.

- Family TIES teamed up with Hispanic parent groups to present a new 3-Part Parent Training Series in Spanish, reaching 116 participants. The trainings were designed to address the concerns of Hispanic families living with a chronic illness, disability or other condition within Las Vegas communities. The trainings covered a variety of important topics, ways to improve the quality of life for their CSHCN, and how to play an active role in their child’s health care. Due to positive feedback, the Project was expanded in 2015-16, with a 9-part Parent Training Series in Spanish and English, reaching 246 participants.

- Family TIES was the lead planning agency for the first and second Statewide Conferences on Disabilities, Nevada Disability Conference (NDC), which took place in March 2013 and July 2015.

- NDC 2015 was a display of collaborative and integrative efforts to improve health outcomes for individuals with disabilities and special healthcare needs across the lifespan. The 2015 conference drew 336 attendees, 100 speakers and 51 vendors who came together during 40 breakout sessions and 3 keynote presentations. In addition, approximately 200 attendees attended the National Association of Councils on Developmental Disabilities Annual Meeting and combined luncheon which took place day two of the conference. The Conference drew over 500 people from across the nation to celebrate diversity and advocacy.

- Family TIES facilitated a Hispanic Partners meeting to advance and support its cultural competences through focused collaboration with 14 community partners representing the Hispanic community.

- During this period, Family TIES distributed 4,005 Health Transition Checklists for Youth (with special health care needs) to 162 middle/high schools across the state. This document continues to be disseminated to schools to help students learn to take care of their health when they transition into adulthood.

A valuable project developed with Family TIES and the American Academy of Pediatrics demonstrated efforts aligned with performance measure 04-the percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. The manner and results of this activity are defined as follows.

Introduction/Background

As part of the Alliance for Innovation on Maternal and Child Health (AIM) program, the American Academy of Pediatrics (AAP) was tasked with gathering background information to better understand access to care and coverage issues from the patient/family and provider perspectives. This was accomplished through several different mechanisms: telephone interviews with pediatrician leaders, an online reporting form (survey) of patients/families, and telephone interviews with families to capture their stories; taking place through September 2015. The intent of this information is to educate state teams about the challenges patients/families and providers are experiencing, and to highlight potential opportunities. Below is a summary of the findings.

Physician Interview Findings

A phone interview was held between AAP staff and pediatrician leaders from Nevada's Chapter. The physician was asked questions about access, coverage and payment issues they or their patients encounter and encouraged to share other successes or challenges they are facing. The interview highlights are documented below.

Pediatric Care Challenges	
Lack of Providers / Hospitals	· Not enough pediatric providers per capita to ensure children have pediatric care · Rural areas have very few pediatric providers · Not enough subspecialists – only one pediatric geneticist and one pediatric cardiology group in the state (requiring a 6 month wait for referrals) · Lack of providers and specialists for CYSHCN · No pediatric hospital in the state
Bright Futures	· Most insurance carriers pay for recommended BF services
Medicaid	· One Medicaid program throughout the state – easier to understand / deal with · Very low payment – so low many physicians do not sign up as providers
Population	· Very transient population · Many illegal immigrants without insurance

Pediatric Care Successes	
Bright Futures	· Some small self-funded plans (union plans) do not cover all BF services
Medicaid	· Re-enrollment is often a challenge and families fail to do it · Many illegal immigrants in the area and are afraid to enroll their children · Very low payment rates for physicians

Opportunities
· Improve the retention of providers: Nevada does not have a pediatric fellowship program so many residents leave the State · Better Medicaid payment by reinstating the Medicaid fee increase · Open a pediatric hospital (has been voted down by tax payers)

Family Survey Results

In an effort to gather data about the access, coverage, and payment issues patients and families experience at the community level, AAP partnered with Family Voices to create an online reporting form (i.e. survey) in both English and Spanish. The online reporting form was disseminated through the state Family-to-Family Health Information Center via Family Voices, as well as via other AAP information dissemination mechanisms to families. 33 complete responses were received from patients/families in Nevada. The three most common issues reported for access, coverage and payment are listed below:

Access	· The wait time to get an appointment is too long (57%) · The recommended doctor or service is not available in my area (37%) · My provider does not accept / no longer accepts my insurance plan (23%)
	· A recommended service is not covered by my insurance plan (41%)

Coverage	· Recommended services were limited (41%) · A recommended doctor / provider is out-of-network (38%)
Payment	· Out of pocket (deductibles / co-pays) costs are too high (50%) · My child's health plan does not cover all the cost of care such as specific medications, therapy services, equipment, in-home services, etc. (46%) · Premiums are too high (34%)

Common Themes:

Several sections of the online reporting form invited participants to provide additional comments. Many respondents took the opportunity to offer information about their experience and several recurring themes emerged:

- Behavioral Health
- Lack of Specialists
- Inadequate Coverage
- Coordination of Care
- Cost

Conclusion

Parents in Nevada and each of the other target states are encountering many of the same access, coverage, and payment issues and are frustrated with the lack of available assistance. When children, especially children with special healthcare needs, are referred for specific services and parents are told the earlier they receive care the better the outcome will be, it can be incredibly frustrating to be unable to obtain the recommended care due to a lack of providers or unmanageable out-of-pocket costs.

To address this issue, Family TIES became a member of the Certified Community Behavioral Health Clinics (CCBHC) planning grant committee. The Division of Public and Behavioral Health (DPBH) in collaboration with the Division of Health Care Finance and Policy (DHCFP) are working towards the development of a state wide integrated behavioral health and primary care delivery model. Family TIES serves as a consumer participant on the Steering Committee to assist DPBH and DHCFP in developing a delivery model around the needs of our community.

Another solution to the above issue is technical assistance (TA) for Healthy Tomorrows Partnership for Children Program. The TA is a collaborative effort between the federal Maternal and Child Health Bureau (MCBH) and the American Academy of Pediatrics (AAP), through Positively Kids Neonatal Follow-Up Program, in Southern Nevada. The program aims to stimulate the development of innovative health programs in areas where access to health care has been limited or identified child health needs are not being met. A public/private partnership, Healthy Tomorrows, is designed to demonstrate how agencies can work together with others in the communities to identify child health problems and devise local solutions. The Positively Kids Neonatal Follow-Up Program was launched in March 2015 with a full scale pediatric medical office to house the Program. To date, 128 children meeting the criteria of premature and/or low birthweight have been enrolled in the program. CYSHCN Program is honored to serve on the Advisory Board Council as of February 2016.

Craniofacial Clinics

As a collaboration of Nevada Early Intervention Services (NEIS) and the University of Nevada, School of Medicine, Title V offers financial support to Craniofacial Clinics held in Las Vegas and in Reno, Nevada. Each clinic has a dedicated interdisciplinary team committed to caring for and treating children with cleft lip and palate and other craniofacial disorders. The Northern Nevada Cleft Palate Clinic (NNCPC) is housed within the Department of Speech Pathology and Audiology at the University of Nevada, Reno. The Southern Nevada Clinic and Craniofacial Team is a cooperative effort between Nevada's Department of Health and Human Services (DHHS), Division of Public and Behavioral Health, and community healthcare professionals. The Southern Nevada Cleft Palate and Craniofacial team offers online resources, including a cleft advocate, family-to-family connection, and medical financing options, as well as insurance assistance. In addition, the Southern Nevada Cleft Palate and Craniofacial team maintains a toll-free 24-hour Hotline. NNCPC examines and counsels children with cleft palate or other craniofacial disorders involving the head, face and mouth. NNCPC's Director attends the American Cleft Palate Craniofacial Association annual convention each year, keeping up with the most current information, products and

services in field.

Highlights for Northern Nevada Cleft Palate Clinic (NNCPC)

The NNCPC provided services to 79 patients. Of the 79 diverse patients, 45 of them were males and 34 were females, one was Black, 33 were Caucasian, 4 were Asian, 28 were Hispanic, 5 were Native American and 8 were of mixed ethnicity. Also, 34 had Medicaid as their primary insurance, while 27 had private insurance, one had Tribal and 17 had none at all. Every patient is given an individualized plan for treatment and they are recalled at least once a year to monitor their treatment plan and make any necessary adjustments. For patients who do not have the financial plan to pursue treatment, NNCPC may grant pro bono services or connect the patient with community organizations who can provide treatment at free or reduced costs. Most patients were recommended to establish routine dental and medical care or continue their current care, if already established.

Finally, NNCPC introduced a new program involving an informal training in the clinic for the use Bottles, Nipples & Pacifiers. Dr. Brown's Natural Flow® is the only baby bottle to feature an internal vent system that provides positive-pressure vacuum-free feeding similar to breastfeeding; and helps reduce colic, spit-up, burping and gas by eliminating negative pressure and air bubbles. Any patient one year old and under received a free cleaning kit, bottles and nipples for every stage of the baby's feeding and pacifiers up until 12 months. The family is welcome to return for any refills or replacements at any time.

Nevada Technical Assistance Center on Social Emotional Interventions

Nevada Title V provides funding to Nevada Technical Assistance Center on Social Emotional Interventions (Nevada TACSEI) for Young Children. The funds are passed on to TACSEI through 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 5 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 for supporting social emotional competence and addressing challenging behaviors in young children at-risk for, or with identified developmental delays. This project addresses former MCH National Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive and 06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

Highlights for 2014-2015.

1. **Incorporate family perspectives and needs into project development, implementation and evaluation.**

- Met with Family Engagement Strategic Plan Subcommittee to review and update Strategic Plan.
- Attended State Leadership Team meetings monthly.
- Presented and had a resource table at the Nevada Association for the Education of Young Children (NevAEYC) State Conference.
- Talked with administrators at multiple early care and education sites each month, providing materials for parents about the importance of social emotional skills in English, Spanish, and Chinese, and partnering with programs to increase/improve parent engagement practices.
- Participated in meetings for Part C state systems improvement plan (SSIP) process to provide input on parent perspectives and state plan activities.
- Met with Nevada Department of Education Parent Engagement Professional regarding Parent Engagement Council and attended Council meetings.
- Met with Clark County School District Family and Community Engagement Services (FACES) Administrator.
- Presented at Southern Nevada AEYC (Association for the Education of Young Children) Mini Conference, Nevada AEYC Conference, Nevada Disabilities Conference, NEIS South staff, Nevada Early Childhood Inclusion Conference.
- Quarterly meetings with other Nevada TASCEI Coordinators.
- Participated on Planning Committee for Nevada's first Early Childhood Inclusion Conference.
- Attended Early Childhood Personnel Center (ECPC) Leadership Institute; Raising of America, U.S.

Department of Education on Early Childhood; and Parent Engagement, NV LEND Conference.
- Attended and participated in Early Childhood System of Learning Leadership Team.

2. Build and sustain project data collection and evaluation capacity.
- Collected data from implementation and demonstration sites (6 sites statewide)
- Provided training/technical assistance to sites on data collection responsibilities, as needed
- Collected, summarized and reported data to sites and State Leadership Team in November 2014 and June 2015
- Provided updates at monthly State Leadership Team meetings

3. Increase and maintain local and regional project support in southern Nevada.
- Provided initial contact for Nevada TACSEI interest in southern Nevada and coordinated southern training activities for infant/toddler and preschool modules.
- Coordinated and provided Train the Trainer for 7 new Trainers in southern Nevada.
- Attended and participated in monthly State Leadership Team meetings and hosted and facilitated monthly Community Training and Coaching Subcommittee meetings.
- Continued recruitment for potential implementation sites
- Maintained communication with Nevada TACSEI State Leadership Team and key stakeholders.
- Monitored and updated website subscription and sent updates to subscribers.

- Provided multiple trainings/presentations on Pyramid Model practices in each quarter at Peach Garden, Bright Horizons, QRIS Director's Luncheons, Coronado Prep Preschool, The Children's Cabinet, Venetian Child Development Center, The Hills Preschool, Kids Learning Path, NEIS - South, Kids First, Nevada AEYC Conference, Stupak Center, KinderCare Summerlin, Early Childhood Inclusion Conference, Acelero Head Start.

Nevada PEP

As the statewide Parent Training and Information (PTI) Center, Nevada PEP provides services to parents of children with special needs, and to professionals.
Nevada PEP offers the following services:
• Information, referral and technical assistance.
• Individual assistance and support.
• Specialized workshops on: Special Education Law, Due Process, Early Intervention Transition, and Parent/Professional Partnerships.
• Newsletter and Resource Library.
• Event speakers.

Nevada Center for Excellence in Disabilities (NCED)

NCED is located in the College of Education at the University of Nevada, Reno and serves as Nevada's University Center for Excellence in Developmental Disabilities (UCEDD) as established by the Developmental Disabilities Rights Assistance and Rights Act (DD Act). The NCED is working on a multitude of programs/projects in service to people with disabilities, and the professionals in the field, across the lifespan, including: Partners in Policymaking, Nevada Leadership Education in Neurodevelopment and Related Disabilities (NvLEND) which houses the Nevada State Learn the Signs. Act Early (NvLTSAE) team, Technical Assistance Center on Social Emotional Intervention (TACSEI) for young children, Nevada Sibling Network, Positive Behavioral Supports (PBS) – Nevada, etc.

CYSHCN participated in planning with NCED for a two day sib workshop provided by Don Meyers, the nation's leading trainer and educator on sibling support. The workshop is designed for professionals including psychologists, social workers, service providers, teachers, adult siblings, parents, and other family members. The purpose of the workshop is to train and certify facilitators how to run a local sib shop and will address sibling issues and concerns impacting siblings. Sib shops provide an opportunity for the sibling of the child who has special needs to be celebrated. The sibling is acknowledged individually and collectively in a positive environment which strongly connects with other siblings their age facing different but similar challenges. Building lifetime friendships and support not only benefits the sibling but also the entire family. NCED has expressed appreciation for continued financial support from Nevada Title V to address the needs of siblings with special health care needs in Nevada.

Nevada Learn the Signs. Act Early

Nevada Learn the Signs. Act Early (NvLTSAE) team is a Leadership Education in Neurodevelopmental and Related Disabilities (LEND) leadership project. The purpose of the LEND training program is to improve the health of infants, children, and adolescents with disabilities. 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. There are 43 LEND programs in 37 states across the nation. Collectively, they form a national network sharing information and resources and maximizes their impact. They work together to address national issues of importance to children with special health care needs and their families, exchange best practices and develop shared products. The program is funded by the Autism CARES Act and is administrated by the Health Resources and Service's Administration's (HRSA) Maternal and Child Health Bureau (MCHB). NvLTSAE was formed in September 2011. Four statewide summits bringing together parents and professionals have been conducted. Primary outcomes established from the summits include:
(1) Children are identified earlier (reduce time between first concern and diagnosis)
(2) Individuals of all geographical locations have access to evidence-based, culturally competent, family centered services and care to assure optimal outcomes
(3) Professionals and families collaborate across disciplines, agencies, and a statewide system of care.
NvLTSAE has been able to develop collaborations with several state, private, and public agencies.
Accomplishments and major activities for NvLTSAE in 2014-2015 are as follows:
1. NvLTSAE website for professional and family education.
2. Training of 11 interdisciplinary teams (approximately 55 professionals) from across the state in administration of the Autism Diagnostic Observation Schedule, 2nd Edition to conduct evidence based assessment for possible autism. Subsequent follow up on a monthly basis using Nevada's Project Echo was conducted to maintain contact and insure reliability. Project ECHO is an innovative health care delivery solution pioneered in New Mexico and has been replicated by over 40 sites worldwide. The University of Nevada, School of Medicine was early to adopt Project ECHO, with only Washington, and urban Chicago replicating sooner. ECHO is a simple telehealth linkage connecting university-based faculty specialists to primary care providers in rural and under-served areas to extend specialty care to patients with chronic, costly, and complex medical illnesses.
3. Pilot project to develop an integrated online screening system in which childcare workers and parents will have access to the Ages and Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2). Currently three childcare sites are participating in the pilot. Data indicates the ASQ is effective in identifying children who require specialized services at 15% rate, which is comparable to the national average.
4. Develop eight training modules to be housed on the NvLTSAE website for continuing education of childcare workers. The eight modules are as follows:
a) What is autism?
b) 2 Modules: Developmental Screening: Ages and Stages, Milestone Booklet, M-CHAT, Milestone Booklet
c) Referral & diagnostic process
d) Strategies for inclusion
e) IFSP-IEP information and process
f) Review of other neurodevelopmental disabilities that might look like autism
g) Challenging behaviors
5. 50,000 Milestone Moment Booklets developed by the Centers for Disease Control were adapted for Nevada and included referral information for parents. These booklets have been distributed statewide over the past 2 years. We are now working with the Department of Education and the CDC to include Year Six.
6. The NvLTSAE annual summit was held in March 2015 bringing together approximately 70 stakeholders from across the State to discuss a state of the state address about what is occurring in the State with regard to children with special needs. Summit goals were as follows:
a) Increase community awareness of pressing issues to facilitate parent action and advocacy.
b) Increase access to screenings.
c) Develop post-screening referral system.

Nevada Governor's Council on Developmental Disabilities (NGCDD)

• MCH Title V continues to participate in collaboration with the NGCDD to assist with events and planning for CYSHCN, families and caretakers. Personnel encourage and support advocacy, capacity building, and systemic change activities that contribute to a coordinated, consumer driven, family-centered and family-directed, comprehensive system. NGCDD participated in the following activities during 2014-2015.
• Job Readiness Summer Camp by the Washoe County School District in Reno.

• People First Self-Advocacy Project: An in-house project of the NGCDD to support People First in ensuring the goals and activities of their 5-Year State Plan are being met.
• Consumer Leadership Grants: Provided through Community Chest to provide financial assistance to individuals with disabilities and their families to attend conferences and obtain information related to their disabilities and services
• CitiCare Transportation Coalition Project: Working to provide reliable transportation for individuals with developmental disabilities.
• Nevada Rural Transit Association in Elko: Working to create more connectivity between rural areas and metropolitan areas through coordination of services.
• PACE events – each year, the NGCDD partners with communities across the state to host, at a minimum, 12 free public events to educate and inform individuals with intellectual/developmental disabilities, their families and professionals about services and supports available in their own communities.

CYSHCN was able to participate as a vendor in two PACE events that took place March 2015 in Elko and June 2015 in Carson City. This outreach supports transition planning for teens and young adults meeting the standards of National Performance Outcome 06: the percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

IDEA Part C/Early Intervention

The Part C Office is within the Department of Health and Human Services (DHHS). Personnel within this office are responsible for assuring compliance with Public Law 108-446, Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Part C personnel collaborate across the Early Intervention services system to meet the needs of children and families. As such, the Part C Office is responsible for a Central Directory and public awareness.

Project ASSIST is Nevada's Central Directory for families of children with disabilities or special health care needs, as well as agencies, organizations, and programs serving them. Information is available on a variety of subjects, including: parent support groups, therapies and other health and human services, financial and legal assistance, and advocacy. In the month of September 2015, 85 calls for information requests were received by Project ASSIST, and 30 referrals to early intervention services were made.

Public Awareness and Child Find is an active, ongoing process of locating, identifying and evaluating children with developmental delays so they may receive appropriate early intervention services. The Nevada Child Find Project is a statewide system serving two primary functions. First, it is designed to identify unserved children who are eligible for early intervention services. The project's other major focus is to provide information to the general public, physicians, childcare providers, hospitals and health care providers about early childhood development, and how to make referrals for early intervention services. There were 5,793 referrals to Nevada Early Intervention Services (NEIS) in SFY14 and 6,309 in SFY15. That is 516 more referrals than in SFY14.

Early intervention is a system of coordinated services and supports for eligible children from birth through two years of age with developmental delays or disabilities and their families. Nevada's Early Intervention system encourages family participation, ensures parents are informed and provides consent for all evaluations and services. From the determination of eligibility until children transition at age three, Nevada programs strive to support families through family-centered and family-friendly practices. Early intervention promotes the child's growth and development and supports families in meeting the developmental needs of their child.

Nevada Early Intervention Services (NEIS)

Nevada Early Intervention Services (NEIS) collaborates with the MCH program, community private providers, Tribal and Native American Organizations, infant mental health organizations, and others to effectively service children under three and their families, including, but not limited to: Screening and Monitoring Program for infants discharged from neonatal hospital intensive care units, genetic and metabolic disorder specialty clinics, hearing screening program, developmental screenings, CAPTA referrals, and Autism Screenings and Diagnostic Services.

Early Intervention community providers

Early Intervention services include private entities across Nevada such as: Advanced Pediatric Therapies, the Continuum, Easter Seals, Therapy Management Group, Positively Kids, and various supporting organizations. Positively Kids strives to embrace each child's unique needs while providing the services essential to their well-being and happiness. Advanced Pediatric Therapies (APT) offer services to children from the ages of infancy through adolescence. The therapists are skilled in the areas of communication, feeding, sensory integration, self-help, gross motor, play/social, and fine motor skills. All of the therapists are also certified and highly skilled to treat children with a varying range of developmental, genetic and neurodevelopmental disabilities. Regardless of the diagnosis, APT works with the child and the family based on his/her areas of strength and areas of need. The vision is for each individual to build positive social connections within his or her home and community using effective communication, self-help and gross motor skills. Although MCH Title V does not directly fund APT services, the Children and Youth with Special Health Care Needs program is collaborating to support APT's. This meets the National Performance standards moving in a direction to provide children with a Medical Home Portal to improve access to services through a one stop shop for families.
Easter Seals, in Las Vegas and Reno, provides many services to children and CYSHCN Program has strengthened its partnership to increase early intervention services to the CYSHCN population.

Other statewide projects and activities

The Governor's Taskforce on Integrated Employment (herein referred to as "Taskforce") was established through Executive Order 2014-16 by Governor Brian Sandoval to create a more diversified, inclusive and integrated workforce. There are 17 members representing state agencies, transportation, education, community training centers, the Governor's Council on Developmental Disabilities, the Nevada Disability Advocacy and Law Center, and an individual or parent of an individual with an intellectual or developmental disability. The Taskforce is charged with examining and evaluating current employment programs, resources, and funding, available training and employment opportunities for individuals with an intellectual/developmental disability.

The Silver State Health Insurance Exchange was aggressive in its outreach activities to inform the uninsured population in Nevada about the availability of affordable health coverage through the exchange, as well as of Medicaid Enrollment opportunities. The marketplace was very helpful to families with CYSHCN because it provided in-person help through Navigators and Enrollment Assisters at various community locations and organizations. By the end of December 2015, the Nevada Health Link had appointed 13 Navigators, 40 Enrollment Assisters, and 113 Certified Application Counselors certified by Nevada Division of Insurance to enroll individuals and employers into the exchange. Navigators and Enrollment Assisters sat down with families with CYSHCN and walked them through the entire application and enrollment process in-person. Activities conducted by the Silver State Exchange have been vital in creating access, understanding and set a new standard for obtaining health insurance coverage, especially for families with CYSHCN. Nevada's Title V Program partners and stakeholders continued to keep their clients updated on any changes in enrollment at NevadaHealthLink.com.

Nevada Commission on Autism Spectrum Disorders (ASD) was initially created in 2008 by a Governor Executive Order and is comprised of five members. Previously, *the 2008 Report of the Nevada Autism Task Force: An Action Plan for Nevada's Legislators and Policymakers* indicated the need for this Commission. Due to the extent of recommendations, the Governor requested the Commission on ASD submit an Annual Report outlining the progress made on the report recommendations. During the December 2013 meeting, and in the subsequent report to the Governor that month, the Commission on ASD indicating spending 2014 on meeting with experts, state agencies, advocates and others to develop a 5-year strategic plan to address the needs of individuals with Autism Spectrum Disorder across the lifespan, including prioritizing the 146 recommendations made in 2008 Report. To accomplish this task, the Commission developed a Steering Committee and four Subcommittees. The Chairs of the Subcommittees were part of the Steering Committee. The focus of the four Subcommittees was on: 1) Children 0-6 years of age, 2) Youth 7-21 years of age, 3) Adults, and 4) Rural communities. The Strategic Plan identified the following goals to accomplish between January 2015 and December 2019. They are: 1) Maximize public and private funding sources to support the full scope of services needed for all Nevadans with ASD, 2) Increase the system's capacity for diagnosis, treatment, services and supports for individuals with ASD across the lifespan, 3) Expand the number and quality of professionals providing services, and 4) Promote a well-informed, empowered and supportive Nevada population around the issues of ASD.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Reduce substance use during pregnancy

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

Reduce the percent of women who smoke during pregnancy

Reduce the percent of children who are exposed to secondhand smoke

Increase the percent of women who call the quitline for assistance

Reduce the percent of women using substances during pregnancy

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 the use/misuse of other substances

ESMs

ESM 14.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months

NOMs

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

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

Increase adequate insurance coverage among children

NPM

Percent of children ages 0 through 17 who are adequately insured

Objectives

Increase the percent of adequately insured children

Increase the number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations and in multiple languages

Strategies

Collaborate with MCH partners to provide information on the benefits available through the Affordable Care Act

Increase information and referral across the lifespan into Medicaid and Nevada CHIP

Partner to ensure assistance with all aspects of the enrollment and renewal is provided (navigators)

ESMs

ESM 15.1 - Number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations (e.g. in multiple languages)

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 21 - Percent of children without health insurance

State Action Plan Table - Cross-Cutting/Life Course - Entry 3

Priority Need

Reduce children's exposure to second-hand smoke

SPM

Percent of women who misuse substances during pregnancy

Objectives

Reduce the percent of children who are exposed to secondhand smoke.

Increase the percent of women who call the quitline for assistance.

Reduce the percent of women using substances during pregnancy.

Strategies

Collaborate with public and private partners to ensure pregnant women and new mothers have access to smoking cessation services

Promote sobermomshealthybabies website.

Measures

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	5.0	4.5	4.0	3.5	3.0	3.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.2 %	0.1 %	1,830	35,558
2013	5.8 %	0.1 %	1,997	34,514
2012	6.3 %	0.1 %	2,131	34,052
2011	5.9 %	0.1 %	2,041	34,637
2010	5.4 %	0.1 %	1,903	35,160

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	21.0	19.0	17.0	15.0	15.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.0 %	1.6 %	169,917	654,896
2007	25.4 %	1.6 %	167,443	660,118
2003	29.3 %	1.3 %	145,690	496,607

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	183.0	366.0	549.0	732.0	915.0

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76	79	82	85	88	88

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	73.0 %	1.8 %	413,200	566,418
2007	73.1 %	1.7 %	390,939	534,831

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 15.1 - Number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations (e.g. in multiple languages)

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	2.0	3.0	4.0	5.0	6.0

Cross-Cutting/Life Course - Plan for the Application Year

Screening, Brief Intervention, and Referral to Treatment Training

The Children's Cabinet has expressed an interest in offering SBIRT training to medical providers and clinical staff serving maternal, adolescent, and child populations in Southern Nevada in the Federal Fiscal Year 2017.

Tobacco Cessation

Title V will continue funding the Rural Community Health Services (RCHS) to support the nursing personnel in providing tobacco cessation counseling, educational materials, and referrals to pregnant women and women of child bearing age.

State Systems Development Initiative Program

The State Systems Development Initiative (SSDI) program will work towards addressing data voids with the state biostatistician identified in the minimum and core datasets. Collaborations across programs who could add depth to MCH data will be fostered and vice versa. Methodology will be established for the selected state performance measures to keep consistency over the next few years. Data support in MCH projects such as CoIIN and other related projects will continue. A uniform basis for data linkage across the available datasets of vital records, the Women, Infants, and Children Program (WIC), and Medicaid will be created. Other potential sources/ programs for additional data to use for larger linking datasets will be sought.

Office of Suicide Prevention

OSP will establish a leadership group to update the Suicide Prevention Plan of Nevada. A needs assessment was completed in the summer of 2015, but office staff time and resources are limited to develop an updated plan. The complexity of suicide as a public health crisis merits a diverse and focused effort to strategize next steps for Nevada’s suicide prevention efforts. OSP will adopt standardized protocols for following up with suicidal patients

after discharge from emergency departments (ED) and other hospital settings. Research shows after hospitalization, the risk for suicide increases over the next thirty days. Members of the Committee recommend establishment of protocols to provide continuity of care and appropriate outpatient follow-up of persons at risk for suicide. Referring emergency department patients to follow-up services is a critical piece of developing a thorough discharge plan. The Committee recognizes the barriers that currently exist to appropriate follow-up care with ever-increasing admissions to emergency departments and mental health hospitals. Exploring effective programs where hospitals follow up with patients after release, ensure the patient is still taking the medication and is connected to outpatient services will help the person stay well. The committee suggests the booklet, “Caring for the Adult Patient with Suicide Risk: A consensus guide for emergency departments.” A similar guide for pediatric patients will be sought out and encouraged as a resource in the emergency response community. The Committee recommends exploring current programs to facilitate patient connection to services within the community which would encourage follow through with discharge plans, reduce return visits to the emergency department, and provide caring outreach post-discharge when risk can be highest. Community programs exist that collaborate with psychiatric hospitals for follow-up such as the MOST team, Crisis Call Center and DCFS’s Mobile Crisis Response Team. These are all programs that can introduce patients and their families to alternatives which might help avoid visiting an emergency department if services are needed in the future. Funding to support these important programs and the collaboration with hospitals is crucial to solidify the safety net of this recommendation. According to the recently released Joint Commission Sentinel Event Alert, “identifying, developing and integrating comprehensive behavioral health, primary care and community resources so these people don’t fall through the cracks. For hospitals and EDs, critical is discharge follow-up and care transitions. Closing this post-discharge engagement gap between settings is vital for immediate and ongoing safety. 'Owning' responsibility for a high-risk individual in the community, once they leave the hospital yet before they’ve walked into the outpatient clinic for their first post-discharge appointment, may not come naturally to providers, yet is key to keep people safe from suicide.”

OSP will continue to expand early identification and intervention through school and primary care based screening for depression, mental health concerns and suicide in youth from age 11 to 18. In December 2015, a recent change was made in the recommendations for depression screenings for ages 11 through 21. The American Academy of Pediatrics said with suicide now a leading cause of death among adolescents they felt it was important to add the screening to their list of recommendations. Surveillance improvements will continue around suicide deaths and non-fatal attempts, as well as, improvements to the collection of data pertaining to suicide attempts. Attempt data shows missed opportunities that can support primary care, emergency department and follow up protocols to improve continuity of care for suicide attempt survivors and those discharged from care. Suicide attempt data is hard to collect as not all who attempt suicide go to a facility and not all attempts are documented. Also discerning between firearm accidents and medication overdose versus suicide attempts is difficult. The State is beginning to improve data collection. Possible situations could arise where hospitals wish to discharge a person who is physically ready but not mentally ready for discharge. Patients might rationalize, minimize, or deny the attempt, and dismiss inpatient and outpatient counseling.

DPBH leads the way toward a Zero Suicide aspiration by training staff in early intervention and suicide prevention. OSP will encourage systems across Nevada’s healthcare system to adopt this initiative. OSP provides advanced training in suicide prevention to those doing direct interventions. This increases the system capacity by having counselors and other critical professionals proficient and efficient in suicide prevention, training, and clinical assessment allowing provision of culturally competent interventions, deeper, more efficient crisis response and better infrastructure of those involved in helping. Passage of AB93 will mandate training. Resources to sustain training are limited and new and evidence-based trainings need to be investigated and provided to Nevada’s behavioral healthcare providers.

OSP will identify an Anti-stigma and Suicide Prevention Public Information Campaign recommended by the Governor’s Council on Behavioral Health and Wellness. This recommendation did not come with funding. OSP

recommends the investigation of existing national campaigns to promote stigma reduction, recovery and help-seeking.

OSP will increase public awareness around the Reducing Access to Lethal Means program and expand participation of diverse partners to reduce access to other common but more challenging means. According to research from the Harvard School of Public Health, 'Means reduction' (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention." Jumping from a great height such as a tall building or a bridge is a highly lethal method. "Erecting barriers at popular suicide jump sites has been largely effective in stopping or dramatically reducing suicide deaths from that jump spot. Most studies have also found that erecting a barrier does not result in more jumps from nearby sites." The Committee will work to develop relationships with the Nevada Department of Transportation, Bridge Division, Operation Lifesaver Rail Safety Education, and the hotel and casino industry, as well as other potential partners to develop prevention strategies for high structures, railways, and other potential means.

Lastly, OSP plans to reduce stigma in the Hispanic community through culturally appropriate outreach. While the majority of risk factors apply to all ethnic groups, there are additional risk factors which might be more prevalent in the Hispanic-Latino community. This may include generational differences, customs and beliefs; added stress for recent immigrants and reduced access to mental health care. In turn, protective factors and social support, religiosity and moral objection to suicide, and culturally appropriate behavioral healthcare will be addressed.

Cross-Cutting/Life Course - Annual Report

Tobacco Prevention and Cessation Program

Title V collaborates with the Tobacco Prevention and Cessation Program to ensure women are provided with tobacco cessation services and appropriate referrals. The Tobacco Prevention and Cessation Program will continue to disseminate targeted Quitline promotional material for pregnant and postpartum women who use tobacco, via Nevada providers, WIC clinics, early childhood educators, Nevada Head Starts and Safeway pharmacies. The Nevada Tobacco Quitline (NTQ) will continue to provide callers with up to five (5) 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 up. In the rural /frontier counties, women receiving family planning and in need of tobacco cessation are referred for the appropriate services by the community health nurses.

Screening, Brief Intervention, and Referral to Treatment Training

The Children's Cabinet offered Northern Nevada medical providers and clinical staff serving maternal, adolescent, and child populations were trained in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool for identification of and intervention for substance abuse. The two-day SBIRT course trained 25 providers/clinic staff in the use of this evidence-based practice. Using motivational interviewing techniques, attendees learned how to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. The training was funded by Title V.

Kindergarten Health Survey

Nevada Title V funds the Nevada Institute for Children's Research and Policy to conduct the Kindergarten Health Survey. The 2014-2015 findings show approximately 87.2% of the respondents indicated their child had some type of health insurance and 12.8% percent of respondents stated their child did not have coverage. Title V has been working closely with its partners to provide resources about the availability of affordable health coverage through the Silver State Health Exchange, Nevada Check Up and expansion of Medicaid in the state.

State Systems Development Initiative Program

Nevada Title V funds .5 FTE in the State Systems Development Initiative (SSDI) program. SSDI has focused on meeting the data needs of the MCH program and exploring additional venues to tell the story of Nevada's MCH status. The SSDI program provided analysis on vital records for the requested sections of the 2015 Title V Block Grant Application. Methodology was established to keep consistency in the reporting of the various indicators in the minimum and core datasets. Ongoing data support and involvement was provided in the state's Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality on a quarterly basis. Training sessions on Medicaid data were attended to establish an understanding of the system and available data to use for future projects.

Suicide Prevention

The Nevada suicide rate is 6th in the nation at 19.4 per 100,000 population compared to the US at 13.0. The Office of Suicide Prevention (OSP) has partnered with the Nevada National Guard, the Veterans Affairs (VA) and the Office of Veterans Policy to greatly increase and enhance suicide prevention efforts for Service Members, Veterans, and their families (SMVF). In a unique collaboration of service member/civilian training teams, we have reached over 400 soldiers and airmen in ASIST or safeTALK, including the Adjutant General and over 80% of his leadership staff. Nevada has participated in three SAMHSA academies with the most recent focusing on Substance Use Disorders. We will enhance current suicide prevention strategies with SUD prevention strategies. With regard to School-Based Screening, OSP has established sustainable screening programs in Lyon, Washoe, Storey and Pershing counties through partnerships with the Children's Cabinet, Community Chest, Healthy Communities Coalition, Nye Community Coalition and the Frontier Community Coalition. These community coalitions have been funded and mentored to the point of sustaining their local screening programs annually with their local school districts. OSP is currently working to develop screening programs in Elko and Carson counties with the support of PACE and Carson community coalitions.

AB 164 was passed in 2013 to require all school administrators be trained in suicide and bullying prevention. In collaboration with the Nevada Department of Education and local school districts, OSP has trained over 200 of the 900 district superintendents and administrators in 10 counties: Lyon, Pershing, White Pine, Churchill, Elko, Carson, Nye, Lincoln, Lander and Humboldt. Other counties such as Clark and Washoe are addressing AB 164 on their own.

The Reducing Access to Lethal Means program has educated over 3,300 state firearm owners in firearm security and safety, to include gun shop and shooting ranges employees in Suicide Alertness and Intervention skills. Electronic firearm securing and safety brochures were supplied to 85% of the state's middle and high schools, in order to educate parents of at-risk students about suicide-proofing their homes.

OSP developed review tools and an online database, as well as forging relationships with veteran-serving organizations to facilitate information-sharing to improve prevention. Three face-to-face reviews have been held and the first report with recommendations will be ready in the fall of 2015.

OSP in collaboration with the Nevada Coalition for Suicide Prevention, has trained over 4,200 Nevadans in suicide intervention and alertness training and has brought Suicide Awareness to tens of thousands of our states population through media and news outlets; a recent behavioral health survey confirmed we are reducing the stigma and taboo on the subject of suicide.

The second statewide suicide prevention conference was held in Las Vegas, October 22-23, 2015, with several national suicide prevention experts and local prevention partners. Topics will include lived experience, SMVF initiatives, reducing access to lethal means, youth suicide prevention, post intervention, juvenile justice and corrections and elder suicide prevention. Through a subgrant with the Department of Education, OSP hired a Youth Mental Health Coordinator and program assistant and data specialist to coordinate and evaluate statewide Youth Mental Health First Aid implementation. Nevada hosted the first Train the Trainer event in June, 2015, with 19 trainers

representing multiple counties. OSP will mentor new trainers to maintain fidelity of the curriculum. Nevada Title V funds 1 FTE at the OSP.

Other Programmatic Activities

Primary Care Office

Nevada Title V funds 1 FTE in the Primary Care Office (PCO). PCO Staff in Nevada attended a reverse site visit in the fall of 2014 to the federal Health Resources Service Administration (HRSA), to meet with their Project Officer and to participate in multiple training and discussion sessions with HRSA Administrators. Significant policy and procedural changes were introduced regarding the *Health Professional Shortage Area* (HPSA) designation process, with a proposed year-long transition period, to move to a new *Shortage Designation Management System* (SDMS) and to leverage provider data from the National Provider Identifier (NPI) Database. No updates of Health Professional Shortage Areas (HPSA) were required during this transition period, but state PCOs were required to update their existing provider data and to complete a statewide needs assessment; Nevada's report is available on our website at http://dpbh.nv.gov/Programs/Primary_Care_Office/ .

The year-long transition period extended to a two-year period due to significant system problems with the new SDMS and data problems with the NPI database. Nevada PCO staff have participated in monthly trainings for the new system as well as volunteering for national workgroups for provider maintenance and rural health policy. Provider data collection is an ongoing process and is labor intensive because providers are not required to respond to surveys, so manual telephone surveys are conducted with medical practices and hospitals throughout the state. Automated systems were developed to merge multiple data sources, and temporary staff or interns were contracted to support the manual survey process.

Although HPSA updates have not been required in this timeframe, the PCO did submit an application for a new Medically Underserved Area (MUA) in Boulder City, to support New Access Point applications for federal funding, as well as a new HPSA application for mental health in Boulder City. Both applications were subsequently approved by HRSA. In addition, HPSA scores for multiple Rural Health Clinics, Community Health Centers and Tribal Clinics were increased, raising their competitive eligibility for loan repayment programs under the National Health Service Corps (NHSC).

With regard to NHSC, staff in the PCO have substantially increased outreach and awareness efforts related to both the NHSC and the Nurse CORPS. Technical Assistance was provided for multiple new and renewal safety net sites for the online application process to NHSC, increasing the number of approved sites in Nevada to over one hundred; the increased number of sites relates directly to the number of awards the state can receive. While the number of awards have increased from 16 in 2013 to 38 in 2015, we still have a ways to go to catch up to other states.

In addition to outreach and technical assistance for new safety net sites, dozens of presentations have been made to students in medical, nursing, dental, social work, and physician assistant schools. The PCO has partnered with our Clinical Services programs in the Division of Public and Behavioral Health to host events during National Health Service Corps month to recognize current NHSC participants, and to raise awareness among other state employees about these opportunities. We also partnered with Nevada System of Higher Education (NSHE) to conduct a campus-based event with outreach to nine-separate campuses via video-conference, in collaboration with the state loan-repayment program. Following up on the event, staff presented to financial aid directors from all of the NSHE campuses. PCO newsletters are published quarterly to highlight these programs and to feature other state-based recruitment and retention activity. All of this outreach achieved impressive results, with a **70% success rate for Nevada applicants to the NHSC in 2015, which was the second highest rate in the nation.**

The NV PCO also administers the J-1 Physician Visa Waiver program to recruit international medical graduates (IMG) to practice in designated HPSA or flex slots reaching underserved populations. Two new applications were approved in the 2014-2015 cycle, including two Internal Medicine Physicians for Desert Springs Hospital Medical

Center in Las Vegas. Two other J-1 waiver physicians successfully completed their three-year obligations in 2015. Assembly Bill 39 was passed in the 2015 Legislative Session to raise the cap on the application fee from $500 to $2,500 to help sustain the program; fee waivers are provided in case of hardship.

The PCO Manager served as the workgroup lead to *Expand Healthcare Access* under the *Nevada Improved Birth Outcomes Collaborative.* Working with partners from Nevada Medicaid and community-based providers, SMART objectives were developed to 1) Expand eligibility for and utilization of telehealth by 25% by December 2017; 2) Provide mental health assessments to 25% of new mothers participating in programs under the Division of Public and Behavioral Health (DPBH), by December 2016; and 3) Increase Access to Family Planning by providing training to 100% of participating behavioral health clinics by December 2016.

In other efforts to expand healthcare access, the PCO Manager facilitated the behavioral health professional pipeline mapping project in the spring of 2014, resulting in multiple recommendations for education and training, licensure and certification, scopes of practice, Medicaid reimbursement, state personnel classification, and health care professional loan repayment. Ongoing work extending through 2015 included collaboration with Nevada *Western Interstate Commission for Higher Education* (WICHE), DPBH Clinical Services, and the Orvis School of Nursing to fund internships for Psychologists and training for Psychiatric Nurses with online courses. Regular review and reporting is conducted with state Medicaid to develop strategies for expanding the pipeline and to track progress on recommendations. The PCO was approved for two new workforce development positions in the 2015 Legislative Session to follow up on many of the other recommendations, and to expand the mapping effort to primary care provide

Plan for the coming year (FFY 10/1/2016--9/30/2017)

The PCO has filled one of the two newly approved positions for workforce development, at the Management Analyst level; the Workforce Development Manager position will be filled in the coming months. Plans are underway to work with the health professional licensing boards to improve data collection, increase transparency, and develop or improve online systems. Research and documentation of best practices from within Nevada, as well as from other states, will be used to support proposed improvements. Collaboration with other state of Nevada entities may result in bill draft requests to create more streamlined processes and standards where possible.

The PCO has applied for supplemental funding to support provider data development, including the following: 1) review and update data sharing agreements with all partners to ensure all available data is applicable to designation is shared on a regular and automated basis; 2) Engage licensing boards and professional associations to increase rates for survey participation and expand data collection; 3) Conduct outreach to large medical groups and hospitals in urban areas to establish partnerships, and renew partnerships in rural and frontier areas, for data reviews and updates; 4) Replace a substantial volume of provider telephone surveys with Medicaid claims data for urban areas where low-income HPSA designations exist; 5) Collaborate with other state PCOs to conduct regional training and webinar, and share best practices, for data development and data management; and 6) enhance staff skills through advanced training with Statistical Analysis System (SAS) programing and MS Access, to support data development and data management.

Strategic planning for improved health care access, through shortage designation and recruitment and retention, will continue with stakeholders, including Maternal, Child and Adolescent Health, area health education centers, health care training programs, community health centers, rural health clinics, tribal clinics, rural hospitals, and other National Health Service Corps approved sites. Based on the provider data development described above, analysis will be conducted for all areas of the state to determine whether current designations should be updated, or new designations should be established. Working with our federal partners at the Health Resources Services Administration, we will review the impact analysis of data downloads from the National Provider Identification

Database, to prioritize areas requiring immediate attention to ensure appropriate designation.

Based on updated designations, PCO will schedule outreach to employers to expand participation in the National Health Service Corps. Quarterly conference calls are facilitated to share information and develop strategies, and dozens of outreach presentations are scheduled each year to raise awareness about loan repayment and scholarship programs, with health care professional students, residents and interns, as well as with employers.

PCO hopes to expand participation in the J-1 Physician Visa Waiver program with outreach to international medical graduates who are practicing in Nevada. Preliminary discussions have been engaged with the Nevada State Medical Association to help identify interested members.

Staff in the PCO will continue to support *Nevada Improved Birth Outcomes Collaborative* through regular participation and reporting of progress on goals and objectives.

Community Health Worker Program

Title V funds a Community Health Worker (CHW) to provide public health services to the Hispanic community in Elko County. By January 1, 2016, the CHW had reached 118 households in Elko County. The CHW focuses on chronic diseases, such as diabetes and heart disease, as well as violence prevention, oral health, nutrition, physical activity, and provides information on how to gain access to health care. In July 2016, there will be a MCH-specific focus to address physical activity as a priority for children and adolescents. Currently the CHW in the field is housed in the Partners Allied for Community Excellence (PACE) Coalition under the Nevada Statewide Coalition Partnership (NSCP). PACE is based in Elko County and in the reporting year, they conducted key activities including outreach, referral provision, community education, informal counseling, social support, and advocacy.

CHWs are particularly effective in reaching minority populations and socioeconomically disadvantaged populations in resource-poor neighborhoods where they help to address health disparities in both urban and rural settings. Currently, they are improving underserved Nevadans' access to health care by increasing health knowledge and self-sufficiency in this population through a range of activities.

From October 1, 2014 to September 30, 2015, the CHW Program accomplished the following: trainings to groups, violence prevention education, attending continuing education, providing outreach to the public on what a CHW does, connecting to care through referral establishment, case management, and reaching individuals through media activities, including social media.

CHWs will continue to focus on community engagement, education and outreach, case management, and referrals. In addition, CHWs continue to build relationships within their respective communities and attend numerous trainings to increase their knowledge and skills and serve their communities effectively. The program is also in the process of developing relationships with the clinical sector to address the clinical linkage piece of the program as well as gather data to evaluate health outcomes, and has been actively reaching out to several agencies that have shown interest in hiring CHWs, including FQHCs. The Center for Program Evaluation at the University of Nevada, Reno, conducted surveys of CHWs and employers to evaluate the need for a CHW Association in Nevada. A CHW Association was founded in May, 2016.

The Education Development Workgroup comprised of the Nevada Systems of Higher Education (NSHE) and the Governor's Office of Economic Development was awarded a grant from the Department of Education, Training, and Rehabilitation (DETR), which was used to develop a standardized CHW curriculum with Truckee Meadows Community College (TMCC) and College of Southern Nevada (CSN). The curriculum was implemented during the 2014 Fall semester at TMCC and CSN. The 8-week course allowed 39 new Community Health Workers to graduate from TMCC and CSN on December 6 and December 13, 2014 respectively. The CHWs graduated with a certificate of completion, first aid/ CPR card, WorkKeys certificate, Mental Health First Aid certificate (optional), and a certificate of recognition. NSHE performed an evaluation of students and employers to see if new CHWs are being

hired. TMCC offered additional classes beyond the pilot class, as has CSN.

The program has hosted Community of Practice State-to-State Calls to discuss CHWs and sustainability efforts for this thriving workforce. Topics discussed have include reimbursement mechanisms to sustain CHWs, how to incorporate CHWs into the clinical sector, and approaches to implement a successful CHW Association. Representatives from over 25 different states have joined the calls.

Major activities and accomplishments include the passage of SB 498 relating to the establishment of licensing of agencies for CHW pools in the 78th Legislative Session; implementation of both Train the Trainer trainings in partnership with the state of Washington's CHW program and an Online Hybrid CHW curriculum; support of the PACE Coalition CHW in partnership with the MCAH Program and Title V Block Grant funding; funding scholarships for the Truckee Meadows Community College CHW in-person training courses; and numerous presentations on CHWs and possible routes to reimbursement.

Success Story

In one of the quarterly reports, the CHW shared a success story to highlight the impact of the program in Elko County:

"This past quarter I continued to help people fill out applications for Medicaid, for health insurance (if they qualified for a special enrollment period) and for jobs. I also have seen many single mothers' that need help. Some of them need help to pay rent and utilities. For example: one single mother that I just started seeing more frequently this quarter needed help paying for utilities. I was able to put her in touch with staff from Human Services and they were able to provide her with the help she needed.

But there is one mother that has been with me since I started working as a CHW. This mother was 18 when she started coming to me. She had a one-year-old at the time, which her mother has custody of, because she is addicted to drugs and alcohol. She came in 2013 and said she wanted help getting off the drugs. At that time, she wanted to go into New Frontier in Fallon Nevada. We submitted the application, but unfortunately she did not get accepted. Through the years, I saw her a few times more, but she never committed to quitting. In May she came back again and said she was really ready. She did mention to me she did not want to go to Fallon or stay here in Elko and so I found her a place with Vitality Center in Carson City. I was able to talk with her the day she left for Carson City and she reiterated that she was ready to go. I mentioned to her that I will continue to be a support for her and when she gets out, we will talk about her goals for the future.

These mothers are just some examples of the people that I see. I feel that they are strong people and I am just their conduit to the needs that they are looking for. I believe me being here not only gives them a place to find the resources they need, but also someone that is willing to just listen and be a support for them."

Next Steps

The CHW Program worked with Talance company from Massachusetts to develop a hybrid training course for CHWs living in rural and frontier Nevada. The CHW hybrid training course begins with an introductory in-person session, followed by a sequence of six online training modules, and a concluding in-person closing session. The online trainings include modules specific to chronic disease prevention and management. These health-based modules include; health insurance navigation, cardiovascular health and cancer screenings. The hybrid model online training course will be available to residents who live in the rural and frontier regions of Nevada who wish to be trained as CHWs, but cannot access the community college-based training, and will be offered four times between October 1, 2016 and September 30, 2017 of the upcoming funding period, with a goal of training 70-80 CHWs during that time.

The program is working with the Center for Program Evaluation (CPE) at the University of Nevada, Reno (UNR) to

conduct a return on investment study to assess the impacts on medical costs associated with CHWs in the clinical sector. This project is being conducted in conjunction with Health Plan of Nevada in Las Vegas, Nevada, with completion expected by February, 2017.

The CHW Program will be working with the Nevada Rural Health Network (via Healthy Communities Coalition acting as the fiscal agent) to design the organizational structure of the Community Health Worker Association in Nevada. The association as a whole will assist with the promotion and understanding of CHWs as a workforce, and to help oversee standards, trainings, guidelines, continuing education promotion, and requirements relating CHWs in Nevada.

The Nevada Division of Public and Behavioral Health was active in passing SB498 in the 78th Session of the Nevada Legislature. This bill allows the Bureau of Health Care Quality and Compliance (HCQC) of the DPBH, whose mission is to protect the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement and education, to license agencies that want to provide CHW pools. The law establishes guidelines and oversight on licensure of agencies with community health worker pools, and helps establish standards for the qualifications, scope of work, and training of CHWs. In the upcoming funding period, the CHW Program will participate in ongoing draft Nevada Administrative Code language development and in the public workshop process for SB 498.

II.F.2 MCH Workforce Development and Capacity

State and Division Staff Training

The State of Nevada continues to maintain its Online Professional Development Center (https://nvelearn.nv.gov). The Development Center contains information various some of which include: developing and applying logic models for planning, implementation, and evaluating programs, effective techniques for effectively presenting data, effective methods for making decisions among others. Information on the website is accessible to employees from various Divisions and Departments in the State. The Division of Public and Behavioral (DPBH) employees use the site to enhance their professional careers as well as to further their education and job-related skills. Employees value the continuing education credits offered by some of the trainings to keep up with licensure requirements. Other workforce development opportunities are provided to staff by State Programs, federal agencies, academic institutions, and professional organizations.

MCAH Staff Training

In the reporting year (October 1, 2014 through September 30, 2015), Nevada Maternal, Child and Adolescent Health (MCAH) staff participated in various workforce development opportunities. Title V funded five MCAH staff to attend the Grant Writing and Grant Management courses. Staff reviews indicated the trainings were valuable and the information they received will enhance their regular job duties. Other trainings provided to MCAH staff are highlighted below.

Early Hearing Detection & Intervention (EHDI) program staff participated in Centers for Disease Control and Prevention (CDC) sponsored Early Hearing Detection and Intervention all grantee meeting in Atlanta, GA and gained information on program evaluation, quality improvement processes, logic model design & use, information system functional standards, and annual data submission processes. In addition, staff received training and information on the current status and directions concerning the Ebola outbreak. During the National Center for Hearing Assessment

and Management (NCHAM) annual conference, Nevada EHDI team presented on *reducing loss to follow-up.* The presentation was a collaboration with Nevada Hands & Voices, a statewide non-profit organization that supports families and their children who are deaf or hard of hearing as well as the professionals who serve them. EHDI staff also made a presentation to the Intertribal Council Women, Infants, and Children (WIC) staff in Nevada on EHDI processes used to screen and follow-up with infants.

Adolescent Health Program staff attended the Nevada Home Visiting training summit whereby they received information to increase their skills and knowledge for interacting with clients as well as improving personal resiliency and fostering it in others. The summit also provided information on the ACES Study. Staff indicated information was critical in understanding how ACEs are related to some of the adolescent health issues such as mental health, suicide attempts, alcohol and drug use among others. In January, 2015, staff attended the Adolescent Health Symposium where they learned new technologies being used by teenagers such as using ghost applications (apps) to send texts and pictures that are sexual in nature. During the symposium, staff also learned about laws regarding cyber bullying and received information on adolescent mental health and suicide.

Adolescent Health Program Staff participated in the progress review of the Health People (HP) 2020 objective on the Social Determinants of Health (SDOH), and Lesbian, Gay, Bisexual, and Transgender (LGBT) health. Resources to the SDOH and LGBT health were shared with other MCAH staff for use in their respective programs. Adolescent Health Program staff received training on evaluation basics, process evaluation and outcome evaluation, evaluating community-based strategies and logic models for evaluation from the Pacific Institute for Research and Evaluation (PIRE).

Adolescent Health Program has several subgrantees throughout the state and staff provide Technical Assistance (TA) to them from time to time. In September, 2015, an opportunity for program staff became available to receive TA on how to deliver effective and efficient TA to their subgrantees and how to enhance pregnancy prevention programs. The information has been very valuable to the staff as well as the subgrantees.

One of Nevada's MCH priorities is to increase care coordination for children with and without special health care needs. To address this priority, MCH is in the process of developing a Medical Home Portal (MHP) to help in coordinating care across multiple providers, and ensure families receive family-centered and culturally sensitive care. As a result, the Children and Youth with Special Health Care Needs (CYSHCN) Program Coordinator has received extensive training from various sources on the MHP. In January, 2015, Debra Kawcak received training from Nevada 2-1-1 Alliance of Information and Referral System (AIRS) Taxonomy on how to implement AIRS taxonomy for the Medical Home Portal. Specifically, the training was on how to index and access human service resource databases and how to search and transfer information from one database to another. In March, 2015, Ms. Kawcak received training on how to successfully implement care coordination using practical strategies and specific outcomes from the perspectives of families and clinicians.

Sandra Ochoa, the State Systems Development Initiative (SSDI)/WIC Biostatistician attended the annual MCH epidemiology training in June 2015 and shared information with various staff on the knowledge gained at the training. The training Ms. Ochoa received greatly enhanced Nevada's analytic capacity because she provides data support to the MCAH section as well as the WIC Program. Specifically, Ms. Ochoa shared informational tools that assisted in ranking priorities identified in the five-year Needs Assessment conducted in 2015.

Nevada Home Visiting (NHV) training staff attended the national summit on Home Visiting and participated in weekly webinars from the technical assistance center for MIECHV programs. NHV staff also participated in the Healthy Moms Happy Babies Domestic Violence training. The training provided tools and resources to help home visitation staff address the complex issue of domestic violence, a federal benchmark of the program. The NHV manager received training on reflective supervision, a tool for relationship-based services. Through this training the manager received strategies to help her staff think about, understand, and put in perspective the information shared by families, the emotions experienced from that sharing, and the feelings generated from their own life experiences.

DPBH values and supports workforce development and will continue to do so in FFY 16. Adolescent Health Program staff plan on attending at least one (of three) in-person Topical Training presented by Department of Health and Human Services Administration on Children, Youth and Families (ACYF), Family and Youth Services Bureau (FYSB) Adolescent Pregnancy Prevention Program (APP). The subject and location of these trainings will be provided by November 2017. These topical trainings cover various topics related to adolescent pregnancy prevention. The Adolescent Health & Wellness Program Specialist will attend the Nevada Health Conference to get insight on pertinent and timely adolescence health and wellness topics.

Other MCAH staff training opportunities planned for FFY include: Association of Maternal and Child Health Programs (AMCHP) Conference. AMCHP conference provides an opportunity for MCAH staff to learn about changes in the MCH field such as Block Grant Transformation, Affordable Care Act implementation, technology and innovative ways to advance MCH outcomes, cultural competency, and family-centered care. Staff will also attend the NCHAM conference, and CityMatCH Leadership and MCH Epidemiology Conference.

Nevada Title V funding supported a Screening, Brief Intervention, and Referral to Treatment (SBIRT) training in Northern Nevada. The Children's Cabinet offered Northern Nevada medical providers and clinical staff serving MCH populations training of the SBIRT tool for identification of and intervention for substance abuse. The two day course trained 25 providers/staff in the use of this evidence based practice. Using motivational interviewing techniques, attendees learned how to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work or family issues. Substance use during pregnancy is one of Nevada Title V's priorities and the SBIRT training will help to provide tools and resources to provide effective strategies for intervention before more extensive and specialized treatment is required.

II.F.3. Family Consumer Partnership

Family Consumer Partnership

Nevada Title V Program collaborates with other agencies, programs, organizations at the local and state level to meet the needs of the Maternal and Child Health (MCH) population in the state as well as the priorities indicated in the 5-year plan. Through these collaborations, Title V is able to reach families and consumers to get input and recommendations on the development and implementation of the programs provided to MCH populations in the State.

In 2015, Nevada Division of Public and Behavioral Health (DPBH) revamped its website. As a result of the new enhancements, the MCH Program is able to solicit feedback from consumers and the general public on MCH issues as well as any other concerns via a survey link posted on the website. The statewide MCH coalition provides an avenue for families to provide input through their website. Consumers can provide information directly to the MCH coalition by telephone or email. During the quarterly MCH Advisory Board meetings, public members are given an opportunity to provide feedback or any information related to the MCH population.

Title V partners with and provides funding to Family TIES which works directly with children and youth with special health care needs to provide much needed resources. Nevada TACSEI, a Title V partner, has a Family Engagement Coordinator on staff to facilitate parent involvement in the social emotional Pyramid Model activities.

Additionally, Title V collaborates with the Tribal Liaison to address the MCH-related needs of Nevada's Tribes. The Liaison works closely with the 27 Tribes within the State of Nevada through a Tribal Consultation Process

Agreement. This coordination establishes and strengthens ties and relationships with the Tribal Governments, as well as fostering education and outreach.

II.F.4. Health Reform

Health Reform

The Silver State Health Insurance Exchange (SSHIX) also known as Nevada Health Link www.nevadahealthlink.com is the health insurance marketplace in Nevada. The marketplace is governed by a 10-member board. In 2015, four carriers were offering Qualified Health Plans (QHPs) on Nevada Health Link including: Health Plan of Nevada (United Healthcare's HMO), Prominence (formerly Saint Mary's HealthFirst), Anthem BCBS (HMO Nevada), and Anthem BCBS (PPO, also called Rocky Mountain Hospital and Medical Service, Inc.). Carriers are allowed to use telemedicine to meet accessibility requirements.

Nevada is one of the states that expanded Medicaid to allow more low-income adults to have access to health insurance. One of the successes that Nevada has achieved is a reduction in children's uninsured rates. In 2014, the uninsured rate for Hispanic children dropped from 20 percent in 2013 to 13.3 percent. This was largest percent reduction in the country. Open enrollment for 2016 ended on January 31, and by February 1, there were 88,145 enrollees. During the same time in 2015, there were 73,596 enrollees. The 2016 enrollment is more than double what it was in 2014, when it peaked at around 38,000 enrollees. However, Nevada is far from the initial goal of 118,000 enrollees that Nevada Health Link had projected prior to the first open enrollment period in 2013.

According to a Kaiser Family Foundation report, there were still 350,000 uninsured residents in Nevada in 2015. Out of these, 42 percent were eligible for Medicaid, and 17 percent were eligible for premium subsidies in the Exchange. 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. MCH partners and stakeholders will continue to conduct various activities to inform consumers of the benefits of signing up for health insurance and that help to enroll for health insurance is available to those who need it.

References

Center for Children and Families, Health Policy Institute, Georgetown University (2016). Retrieved from http://ccf.georgetown.edu/wp-content/uploads/2016/01/CCF-NCLR-Uninsured-Hispanic-Kids-Report-Final-Jan-14-2016.pdf

New Estimates of Eligibility for ACA Coverage among the Uninsured (2016). Retrieved from http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/

II.F.5. Emerging Issues

Immigration

With Nevada's immigrant population continuing to grow, Title V is committed to ensuring that staff receive training in Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards). In addition, MCH ensures that all program materials, resources, websites and PSA's are provided in both English and

Spanish. Title V funds a Community Health Worker (CHW) to provide outreach to the Hispanic population especially in gaining insight on specific health needs and providing assistance in applying for health insurance through the state health insurance website.

Health Care Access in Rural Nevada

Nevada experiences provider shortages and this issue is magnified in the rural and frontier counties. In Nevada, there are 14 out of 17 counties classified as rural or frontier and designated as federal shortage areas. Even though the majority of the state's population lives in the urban areas (Clark, Carson, and Washoe County), residents who live in the rural/frontier counties have poor access to public and health care services due to the vast distance from areas that provide services and a sheer lack of providers. Title V is addressing healthcare access in its strategic plan and financially supports the Primary Care Office (PCO) to increase providers in the rural/frontier areas through the J-1 Physician Visa Waiver and National Interest Waiver programs. These programs provide incentives to physicians to encourage them to work in federal shortage areas.

Telemedicine

Telemedicine has continued to be a vital tool in providing rural and frontier populations with access to healthcare without having to travel long distances from their homes. Telehealth connects healthcare practitioners with patients in rural sites using video technology. Nevada telehealth program has been able to provide specialty consults with physicians from University of Nevada, Reno School of Medicine, and transportation of 200,000 to 400,000 radiology images a month through the rural tele-radiology program, among others. The Nevada Telehealth program offers weekly telemedicine sessions for psychiatry and pediatric services. The telemedicine sessions allow patients in rural locations across Nevada to be seen immediately when they have the need and gives support to the community when they need it. Technical assistance is available to help set up clinic exam rooms with telehealth technology and for maintenance of existing equipment. This greatly reduces the burden on physicians and patients adding greater efficiency to telemedicine appointments.

Zika Virus

As of July 7, 2016, Nevada had nine confirmed cases of the Zika Virus. All the cases were travel-related with the individuals having travelled to countries with Zika outbreaks. There are no locally acquired cases of Zika virus reported in the State. Zika virus is spread to people mainly through the bite of an infected mosquito. However, Zika virus can also be spread during sex by a man infected with Zika to his partners. Evidence in research has linked prenatal Zika virus infection to microcephaly and other serious brain anomalies.

Nevada Division of Emergency Management-Homeland Security has dedicated a website to provide information on the Zika virus http://dem.nv.gov/Resources/Zika_Virus/ . The website has links to other websites such as the CDC and DPBH. In January, 2016, Nevada's Chief Medical Officer and the DPBH administrator sent out a bulletin to all health care providers in the State informing them of the current situation of Zika Virus in the State and information on the signs and symptoms, diagnosis, treatment, and prevention methods.
Through the MCH Coalition, Nevada Title V has provided information on the Zika virus to health care providers and the general population on transmission and association with birth defects.

II.F.6. Public Input

Public Input

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 level. Realizing they bring with them diverse backgrounds and

expertise, MCH seeks feedback from families, consumers and stakeholders in the development and implementation of the program activities. The initial draft and subsequent revisions of the MCH Block Grant was posted on the Division of Public and Behavioral Health website and public feedback was collected through an electronic survey mechanism provided on the same website. In addition, Title V requested its partners to distribute the survey link to its consumers and families through emails sent via a listserv. The input received was used to make any necessary modifications and to ensure quality and appropriateness of the strategies.
Title V stakeholders were also asked to provide input on the most important unmet needs and emerging issues in their community impacting the health of infants, children, adolescents, children and youth with special health care needs, and women of reproductive age. Broad categories of the concerns included: access to health care; dental care services;
lack of insurance and lack of providers that accept Medicaid; safe, quality and low cost housing; transportation, substance abuse prevention and treatment; mental health education; education for pregnant women; and education and awareness on physical and sexual abuse, including intimate partner violence.

Some of the issues identified in the public input were taken into consideration in developing the State Performance Measures (SPMs) and Evidence-based or informed measures and will be addressed in the five-year state action plan. Specifically, the SPMs are:

- Percent of mothers reporting late or no prenatal care
- A. Percent of teenage pregnancies and B. Percent of repeat teen births
- Percent of women who misuse substances during pregnancy

Title V has also addressed some of the concerns from the public input including:

- Zika educational materials and resources were distributed through the MCH Coalition newsletters and information on Zika virus was posted on the Nevada Division of Emergency Management-Homeland Security website as well as the Division of Public and Behavioral Health (DBPH) website.
- Nevada Chief Medical Officer and the DPBH administrator sent an informational bulletin on the Zika virus to health care providers in Nevada
- Title V will provide funding to Nevada Home Visiting Program to expand home visiting programs to the rural areas.

Title V will continue to look into ways to address the concerns of families, consumers, and public health professionals in Nevada where possible.

The input received is provided below.
Access to Health Care:
Access to public health services in Pershing County are needed. This includes immunizations, communicable disease, reproductive services, as well as general public health and case management services.
Elko County lacks specialty care in women's health and free immunization outreach and education. Outlets and affordable health facilities are needed for use of all ages. In addition, long winter months pose an issue with obesity.
Dental Care Services:
Low income families have limited access to dental care. While Medicaid enrollment has increased, untreated dental disease remains high.
Rampant tooth decay and associated pain and infection in Las Vegas needs to be addressed.
Lack of Insurance/Lack of Providers accepting Medicaid:
The number of people who have Medicaid as their insurance but no access to primary or specialty medical professionals.
The need for insurance for the Cleft Palate, Lip, and Craniofacial Community, as well as insurance.

Many clients are not able to afford the cash pay programs for prenatal care and Labor and Delivery, which includes pregnant teens and undocumented people.
Utilization of Medicaid benefits are not serving at-risk families. There are few Medicaid providers in low income communities.
Safe, Quality, Low Cost Housing:
Quality, low cost and safe housing is needed.
Transportation:
Transportation is a barrier. Many cannot afford to take the bus and are not able to take children to wellness checkups or to pursue other goals.
Substance Use:
Substance use prevention and treatment for women of childbearing age in Clark County
The entire state of Nevada has one of the highest prenatal/drug use, yet there doesn't seem to be much attention given to this issue
Mental Health Education:
Limited resources for mental health services for children under 5 years of age in Las Vegas
Education for expecting mothers about mental illness during and after pregnancy
Lack of mental health services for perinatal and postnatal care in the rural areas
Health care provider education on screening for postpartum and mental illness
Education for Pregnant Women:
The recent spike in infant deaths in Washoe County.
The need for agencies and providers to refer their clients to Nurse Family Partnership to help first time mothers from pregnancy until the child is 2 years old.
Social Determinants of Health
Zika Education
Infant and maternal mortality
Nutrition education for expecting mothers, safe sleep education, benefits of breastfeeding, positive encouragement for birth control resources
CPR education and safe sleep education for mothers before discharge from hospitals
Prenatal and postnatal education for mothers regarding breastfeeding, general parenting advice
Education on Physical and Sexual Abuse and Intimate Partner Violence:
Physical and Sexual abuse education in schools, for teachers, mandated reporters, and students
Other:
Access to internet to attend online school while caring for children.
The need for assistance in Spanish for the Cleft Palate, Lip, and Craniofacial Community.
Agencies, providers and other contacts need to refer clients to available programs, such as the Nurse Family Partnership.
Specific recommendations were made to strengthen and improve the health of infants, children and adolescents, children youth with special health care needs, and women of reproductive age.
Access to Healthcare:
Expand novel provision of services, such as telehealth

Let clients know and encourage them to participate and take advantage of the services that are available to them. Have the State be the Central intake center, have all the Medicaid and WIC recipients who are pregnant be referred to the different home visiting programs in our State.

We need more programs that address access and utilization for families of poverty. Particularly programs that go into Title I schools. These programs need to address barriers of Medicaid contracting, school regulations that do not allow parents to have care at school based health centers and we need to grow these programs so that more Title I school can have direct access to healthcare providers, which included dental healthcare.

Reducing food deserts, increase access to proper health care, more health care providers in Clark County. Policy changes to combat the above issues.

We need more community events, community health fairs, community events to get the message out to the community. Also there needs to be involvement within the CCSD school district to help to spread awareness of resources.

Increasing the number of days a community health nurse is present in the community. Currently only one day per week (Pershing County).

Education for caregivers and individuals. More supportive, trustworthy health outreach sources available to meet individuals specific health needs or questions in acute crisis situations. Identifying needs efficiently would help to give direction for long term support and health related care. Outreach programs not only based on income but instead based on need.

In the Las Vegas area, expanding the home nursing visitors program to ALL mothers is imperative, regardless of income, parity and other demographic characteristics.

Dental Care Services:
Las Vegas, Nevada. More access to affordable dental care or supportive preventative oral health care through public health dental hygienists.

Lack of Insurance/Lack of Providers accepting Medicaid:
Approve ALL women for Medicaid if they are pregnant, or have quality free prenatal care for all pregnant women.
Safe, Quality, Low Cost Housing
Transportation:
Providing bus passes to women so they can attend all healthcare appointments.
Mental Health Education:
Increase awareness and access to existing early childhood mental health services in Las Vegas.

Greater focus on improving knowledge in women about post partum depression (PPD) and improving help seeking behavior through accurate and adequate education in hospitals, primary care offices, and community programs. Health care providers need to be aware of effects of PPD (the mother and child implications) and the current recommendations for screening. Telepsychiatry could be a strategy to improve perinatal and postpartum mental illness.

Education for Pregnant Women:
One key question integration and Zika education

Education on Physical and Sexual Abuse and Intimate Partner Violence:
Need to reduce the number of women dying from domestic violence. Need to focus activities and resources on those populations who are most at risk for adverse health outcomes. Stop working in silos and promote more collaborative work.

Other:
Additional funding for current partners that are willing to expand their level of effort to specific or all of these populations
Working with partners to seek out other funding for their initiatives

For the Cleft Palate, Lip and Craniofacial Community, I would suggest advocates who are bilingual and versed in obtaining insurance for the families.

Screen and refer!

II.F.7. Technical Assistance

Technical Assistance

About one percent of Nevada's population is Native American. The Division of Public and Behavioral Health (DPBH) has a Tribal Liaison to foster government-to-government relations, communication, and education to help the Tribes and the agency work effectively with each other. Even though Nevada Title V has developed collaborations with Tribal entities in the past, it has been difficult sustaining these relations due to staff turnover. Native Americans in Nevada are faced with poor health outcomes and without a committed partner from the Tribes, it is challenging for MCH to conduct public health interventions. MCH Program is requesting assistance to explore strategies to reach the Native American population in order to implement MCH-related interventions.

Perinatal mental health was one of the high ranking priorities in the needs assessment that was conducted in 2014-2015. However, Title V could not choose this outcome as a priority to address in the State's five-year action plan due to lack of valid and reliable data. Assistance in acquiring reliable data sources, as well as associated evidence-based/informed strategies to address this issue would be welcomed.

Nevada is one of the states that chose to expand Medicaid. Currently, about 1 in 5 Nevadans are enrolled in Medicaid, making it one of the largest health programs and health data sources in the State to conduct research of various health outcomes among Medicaid enrollees. Having guidance and assistance to appropriately gather, analyze, and disseminate data will help the state to better understand Nevada's health needs among the Medicaid enrolled population.

One of the requirements in the Title V/MCH Block Grant Guidance is the development of evidence-based or informed measures (ESMs) that demonstrate the impact of Title V investments on National Performance Measures (NPMs) and National Outcome Measures (NOMs). Nevada Title V has developed several ESMs in accordance with the Guidance, however, assistance in identifying data sources to help in objective-setting and tracking of the measures is requested.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,752,177	$1,760,014	$1,716,274	$1,998,800
Unobligated Balance	$0	$0	$0	$0
State Funds	$1,314,133	$1,320,011	$1,287,206	$1,499,100
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$3,066,310	$3,080,025	$3,003,480	$3,497,900
Other Federal Funds	$12,830,824	$12,830,824	$18,005,000	
Total	$15,897,134	$15,910,849	$21,008,480	$3,497,900

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,960,060	$2,023,152	$1,998,800	
Unobligated Balance	$0	$61,856	$0	
State Funds	$1,470,045	$1,563,756	$1,499,100	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$3,430,105	$3,648,764	$3,497,900	
Other Federal Funds	$76,074,243	$76,059,842	$56,588,684	
Total	$79,504,348	$79,708,606	$60,086,584	

	2017	
	Budgeted	Expended
Federal Allocation	$2,085,007	
Unobligated Balance	$0	
State Funds	$1,563,756	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$3,648,763	
Other Federal Funds	$70,778,207	
Total	$74,426,970	

III.A. Expenditures

Federal Fiscal Year 2017 Application - Expenditure Narrative

In FFY 2015, the Nevada MCH program will expend $2,023,152 in federal funds and $1,563,756 in state match funds for a total of $3,586,908. $61,856 (3%) in funds remains unobligated due to an unexpected postponement of a planned project. The state match funds will be comprised of $1,268,024 from the State General Fund and $295,732 from the Fund for a Healthy Nevada. FFY 2015 state match funds expended will be adequate to meet Nevada's maintenance of effort amount of $853,034.

Budgeted vs. Expended by Types of Individuals Served:

The $2,085,007 award received for FFY 2015 was 6% higher than the budget of $1,960,060 submitted for FFY 2015.

Pregnant Women:

Budget: $473,469
Expended: $523,790
Variance: Expenditures are 10.6% more than budget

Infants <1 year old:

Budget: $684,800
Expended: $570,174
Variance: Expenditures are 16.7% less than budget

Children 1 to 22 years old:

Budget: $705,398
Expended: $1,104,687
Variance: Expenditures are 56.6% more than budget

Children with Special Healthcare Needs:

Budget: $1,033,352
Expended: $1,078,904
Variance: Expenditures are 4.4% more than budget

Others:

Budget: $377,080
Expended: $60,694
Variance: Expenditures are 83.9% less than budget

Administration:

Budget: $196,006 (10% of $1,716,627)
Expended: $201,824 (9.997% of $2,023,152 in expenditures)
Variance: Expenditures are 2.9% more than budget

Budgeted vs. Expended by Types of Services:

In response to direction received, Nevada moved budgeted funds from Direct Health Care Services to Enabling Services increasing expenditures within that service level significantly and creating the following variances between budgeted and expended:

Direct Health Care Services:

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

Enabling Services:

Budget: $1,215,037
Expended: $1,365,816
Variance: Expenditures are 12% more than budget

Public Health Services and Systems:

Budget: $2,293,034 (combined Population-based & Infrastructure Services)
Expended: $2,221,02
Variance: Expenditures are .3% less than budget

III.B. Budget

Federal Fiscal Year 2017 Application – Budget Narrative

The total estimated Federal Fiscal Year FFY 2017 Maternal Child Health (MCH) budget is $3,648,763. As required, the state of Nevada's FFY 2017 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 $2,085,007. State matching funds are budgeted at $1,563,756 and are comprised of State General Funds, $1,249,953, and Funds for a Healthy Nevada, $313,803. The amount of state funds that will be used to support Maternal and Child Health programs in FFY 2017 is shown in the budget documentation of the state application. We assure that the $853,034 maintenance of effort requirement (FY89 level of state funding) will be satisfied.

For FFY 2017, $625,502, 30% of the federal Title V allocation, is budgeted for Preventive and Primary care of

Children and Adolescents. An equal amount, 30% of the federal Title V allocation, is budgeted for Children and Youth with Special Healthcare Needs. Administrative costs for Federal Fiscal Year 2016 are budgeted at $208,501, 10% of the MCH allotment. Administrative expenditures will not exceed this amount.

The remaining FFY 2017 Federal Title V award is directed towards services for pregnant women, postpartum women and infants up to age 1 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 non-profit 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 $70,778,207 in FFY17. All federally funded programs referenced below provide indirect and direct services to the populations served by the Maternal and Child Health Block Grant Program.

Administration for Children and Families:

Abstinence Education
Personal Responsibility Education

Centers for Disease Control and Prevention:

Rape Prevention and Education
Early Hearing Detection
Chronic Disease
Diabetes
Tobacco
Cancer Prevention and Control Programs
Immunization
Pregnancy Risk Assessment Monitoring System (PRAMS)

Preventative Health and Health Services

Sexual Assault

Health Resources and Services Administration

ACA Maternal, Infant and Early Childhood Home Visiting Program
Maternal, Infant and Early Childhood Home Visiting Expansion Program
Newborn Hearing Screening

United Department of Agriculture

Women, Infants and Children

Budget by Types of Individuals Served

In FFY 2017, the Nevada MCH program is budgeting the following federal and state match funds towards the individuals served requirements:

Pregnant Women - $547,314
Infants < 1 year old - $547,314
Children 1 to 22 years old - $1,094,629

Children and Youth with Special Healthcare Needs - $1,094,629

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 2016, the Nevada MCH program plans to allocate federal and state match funds as follows:

Direct Health Care Services - $0
Enabling Services - $1,215,037
Public Health Services and Systems - $2,433,726

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MCH-DHCFP MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Maternal, Child, and Adolescent Health Org Chart June 2016.pdf

Supporting Document #02 - Newborn Screening Nevada Public Health Lab flowchart.pdf

Supporting Document #03 - Updated 5 year plan - current final_V4.pdf

Supporting Document #04 - Nevada MCH Partnersv3.pdf

VI. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Nevada

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,085,007	
A. Preventive and Primary Care for Children	$ 625,502	(30%)
B. Children with Special Health Care Needs	$ 625,502	(30%)
C. Title V Administrative Costs	$ 208,501	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,563,756	
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)	$ 1,563,756	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 3,648,763	
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)	$ 70,778,207	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 74,426,970	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 666,706
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 448,745
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 158,308
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 596,915
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 357,769
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,885,343
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 98,131
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project AWARE	$ 175,063
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,213,618
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 791,734
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 4,202,424
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 860,775
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 511,799
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 57,287,919

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > MACRA Connecting Kids	$ 347,958

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,960,060		$ 2,023,152	
A. Preventive and Primary Care for Children	$ 588,018	(30%)	$ 611,809	(30.2%)
B. Children with Special Health Care Needs	$ 588,018	(30%)	$ 610,472	(30.2%)
C. Title V Administrative Costs	$ 196,006	(10%)	$ 201,824	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 61,856	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,470,045		$ 1,563,756	
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)	$ 1,470,045		$ 1,563,756	
A. Your State's FY 1989 Maintenance of Effort Amount $ 853,034				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 3,430,105		$ 3,648,764	
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)	$ 76,074,243		$ 76,059,842	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 79,504,348		$ 79,708,606	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 444,028
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 405,035
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 129,776
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,213,678
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 596,915
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 358,623
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 964,088
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 7,668,801
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 3,803,698
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 98,131
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project AWARE	$ 175,063
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 57,217,919
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease	$ 1,123,310
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 860,777

Form Notes for Form 2:

Unobligated balance due to postponement of a project in spend plan due to staffing shortage. Will be implemented under next award.
.

Field Level Notes for Form 2:

1.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Unobligated balance due to postponement of a project in spend plan because of staffing shortage. Will be implemented under next award.	

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	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 256,456	$ 274,523
2. Infants < 1 year	$ 312,751	$ 290,900
3. Children 1-22 years	$ 625,502	$ 611,809
4. CSHCN	$ 625,502	$ 610,472
5. All Others	$ 56,295	$ 33,624
Federal Total of Individuals Served	$ 1,876,506	$ 1,821,328

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 192,342	$ 249,267
2. Infants < 1 year	$ 234,563	$ 279,274
3. Children 1-22 years	$ 469,127	$ 492,878
4. CSHCN	$ 469,127	$ 468,432
5. All Others	$ 42,221	$ 27,070
Non Federal Total of Individuals Served	$ 1,407,380	$ 1,516,921
Federal State MCH Block Grant Partnership Total	$ 3,283,886	$ 3,338,249

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: This includes: preconception screening services provided to women as well as family planning counseling provided to both men and women.	
2.	**Field Name:**	**IB. Non Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: This includes: preconception screening services provided to women as well as family planning counseling provided to both men and women.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Nevada

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 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	$ 694,307	$ 702,185
3. Public Health Services and Systems	$ 1,390,700	$ 1,320,967
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	$ 2,085,007	$ 2,023,152

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 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	$ 520,730	$ 663,631
3. Public Health Services and Systems	$ 1,043,026	$ 900,125
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
Non-Federal Total	$ 1,563,756	$ 1,563,756

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: 35,217

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	35,217 (100.0%)	259	45	33 (73.3%)

Program Name(s)				
3-Methylcrotonyl-CoA carboxylase deficiency	Medium-chain acyl-CoA dehydrogenase deficiency	Classic phenylketonuria	Tyrosinemia, type I	Primary congenital hypothyroidism
Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S,C disease	Biotinidase deficiency	Cystic fibrosis
Hearing loss	Very long-chain acyl-CoA dehydrogenase deficiency	3-Hydroxy-3-methyglutaric aciduria	ß-Ketothiolase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Glutaric acidemia type I		

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	35,217 (100.0%)	470	147	147 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Once a case is acknowledged, the primary care physician (PCP) is contacted. As soon as contact is made with the PCP,
the American College of Medical Genetics ACTion Sheet, diagnostic test information, and specialist contact information are
sent to the PCP. At the same time confirmatory testing is requested. 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. Once treatment information is received the
determination is closed. Children confirmed to have metabolic disorders are referred specialty metabolic clinics
conducted monthly in Reno and Las Vegas through Nevada's Part C Early Intervention Services by Dr. Longo
(Pediatric Metabolic Specialist) from University of Utah School of Medicine, Salt Lake City.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2015**
	Column Name:	**Core RUSP Conditions**
	Field Note: Even if presumptive positive screens are conducted using first, second and third specimens, if a baby showed presumptive positive results on more than one specimen, it is counted only once. Therefore, the data presented here is NOT duplicative.	
2.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Core RUSP Conditions**
	Field Note: There were 11 confirmed cases of Duarte variant of Galactosemia that did not require treatment. There was one (1) confirmed case of SCAD- 1 which was benign and did not require treatment.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Nevada

Reporting Year 2015

		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	6,446	39.0	1.0	31.0	22.0	7.0
2. Infants < 1 Year of Age	36,189	34.0	3.0	49.0	11.0	3.0
3. Children 1 to 22 Years of Age	41,313	46.0	2.0	34.0	8.0	10.0
4. Children with Special Health Care Needs	5,594	41.7	1.3	42.5	7.2	7.3
5. Others	2,955	39.0	1.0	31.0	22.0	7.0
Total	92,497					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

None

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Nevada

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	6,446
2. Infants < 1 Year of Age	36,189
3. Children 1 to 22 Years of Age	41,313
4. Children with Special Health Care Needs	5,594
5. Others	2,955
Total	92,497

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

None

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

State: Nevada

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	35,664	24,831	4,134	374	3,599	309	0	2,417
Title V Served	6,446	4,488	747	68	650	56	0	437
Eligible for Title XIX	11,056	7,697	1,282	116	1,116	96	0	749
2. Total Infants in State	36,269	25,252	4,204	381	3,660	314	0	2,458
Title V Served	36,189	25,196	4,195	380	3,652	313	0	2,453
Eligible for Title XIX	11,243	7,828	1,303	118	1,135	97	0	762

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	22,351	12,892	421	35,664
Title V Served	4,040	2,330	76	6,446
Eligible for Title XIX	6,928	3,997	131	11,056
2. Total Infants in State	22,730	13,111	428	36,269
Title V Served	22,680	13,082	427	36,189
Eligible for Title XIX	7,046	4,065	132	11,243

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Nevada

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting 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"	Laura A. Valentine	Laura A. Valentine
4. Contact Person's Telephone Number	(775) 684-5901	(775) 684-8901
5. Number of Calls Received on the State MCH "Hotline"		33,396

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names	Nevada 2-1-1	Nevada 2-1-1
2. Number of Calls on Other Toll-Free "Hotlines"		33,396
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		54
5. State Title V Social Media Websites	None	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

The State MCH toll-free 'hotline' telephone number is connected to 2-1-1. During the reporting year, the vendor contracted to manage Nevada 2-1-1 website and telephone calls changed. The new vendor answers calls from several state programs thus numbers reported are not a true reflection of the calls received from the MCH toll-free telephone number.

The total number of hits to the Title V website reported in this year's application are for only two months in FFY 15. This is because the State has a new website and information from the old website was not available.

Form 8
State MCH and CSHCN Directors Contact Information

State: Nevada

1. Title V Maternal and Child Health (MCH) Director	
Name	Beth A. Handler, MPH
Title	Maternal and Child Health (MCH) Director
Address 1	4150 Technology Way, Suite 210
Address 2	
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-5902
Extension	
Email	bhandler@health.nv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Laura A. Valentine, M.S.
Title	Children with Special Health Care Needs Director
Address 1	4150 Technology Way, Suite 210
Address 2	
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-5901
Extension	
Email	lvalentine@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 2017

No.	Priority Need
1.	Improve preconception and interconception health among women of childbearing age
2.	Breastfeeding promotion
3.	Increase developmental screening
4.	Promote healthy weight
5.	Reduce teen pregnancy
6.	Improve care coordination
7.	Reduce substance use during pregnancy
8.	Increase adequate insurance coverage among children
9.	Reduce children's exposure to second-hand smoke

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve preconception health among adolescents and women of childbearing age	New	
2.	Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months	New	
3.	Increase the percent of children aged 10 through 71 months receiving developmental screening	New	
4.	Increase the percent of children, adolescents and women of child bearing age who are physically active	New	
5.	Increase the percent of adolescents and women of child bearing age who have access to healthcare services	New	
6.	Promote establishment of a medical home for children	New	
7.	Prevent and reduce tobacco use among adolescents, pregnant women and women of child bearing age	New	
8.	Increase the percent of adequately insured children	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 2

Field Note:
Breastfeeding promotion

Form 10a
National Outcome Measures (NOMs)

State: Nevada

Form Notes for Form 10a 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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	70.0
Numerator	24,816
Denominator	35,464
Data Source	Electronic Vital Records
Data Source Year	2015

NOM 1 - Notes:

Nevada residents, 2015 data.

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	113.6	5.9 %	373	32,832
2012	127.4	6.3 %	419	32,885
2011	106.2	5.7 %	353	33,252
2010	111.9	5.8 %	380	33,973
2009	103.8	5.4 %	370	35,660
2008	102.2	5.3 %	381	37,283

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
2010_2014	6.8	2.0 %	12	177,032
2009_2013	10.6	2.4 %	19	178,783
2008_2012	9.8	2.3 %	18	183,259

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data	
	2014
Annual Indicator	16.5
Numerator	29
Denominator	175,746
Data Source	Electronic Death and Birth Certificates
Data Source Year	2011-2015

NOM 3 - Notes:

Maternal deaths from 2011-2015 of women who died within 42 days of delivery.

Data Alerts: None

NOM 4.1 - 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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	8.5
Numerator	3,046
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.4 %	0.1 %	509	35,851
2013	1.3 %	0.1 %	445	35,028
2012	1.3 %	0.1 %	449	34,903
2011	1.3 %	0.1 %	471	35,289
2010	1.3 %	0.1 %	470	35,931
2009	1.3 %	0.1 %	477	37,604

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	1.3
Numerator	476
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.9 %	0.1 %	2,463	35,851
2013	6.8 %	0.1 %	2,365	35,028
2012	6.7 %	0.1 %	2,332	34,903
2011	6.9 %	0.1 %	2,435	35,289
2010	6.9 %	0.1 %	2,495	35,931
2009	6.8 %	0.1 %	2,569	37,604

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	7.2
Numerator	2,570
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	9.9
Numerator	3,553
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.8 %	0.1 %	1,009	35,845
2013	2.7 %	0.1 %	936	34,937
2012	2.8 %	0.1 %	970	34,742
2011	2.7 %	0.1 %	952	35,187
2010	2.7 %	0.1 %	950	34,842
2009	2.6 %	0.1 %	959	36,710

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	2.7
Numerator	958
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.3 %	0.1 %	2,614	35,845
2013	7.2 %	0.1 %	2,501	34,937
2012	7.6 %	0.1 %	2,628	34,742
2011	7.8 %	0.1 %	2,742	35,187
2010	8.2 %	0.2 %	2,841	34,842
2009	8.2 %	0.1 %	3,022	36,710

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	7.3
Numerator	2,595
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

NOM 5.3 - Notes:

Only gestation weeks of 34 and 35 are included.

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
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%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	26.3
Numerator	9,396
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

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
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:

Indicator results were based on a shorter time period than required for reporting

State Provided Data	
	2014
Annual Indicator	36.2
Numerator	12,949
Denominator	35,768
Data Source	Electronic Birth Certificate Records
Data Source Year	2015

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
2013	5.8	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
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

State Provided Data	
	2014
Annual Indicator	5.1
Numerator	184
Denominator	35,768
Data Source	Electronic Birth and Death Certificate
Data Source Year	2015

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
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

State Provided Data	
	2014
Annual Indicator	3.2
Numerator	115
Denominator	35,768
Data Source	Electronic Birth and Death Certificates
Data Source Year	2015

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
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

State Provided Data	
	2014
Annual Indicator	1.9
Numerator	69
Denominator	35,768
Data Source	Electronic Birth and Death Certificates
Data Source Year	2015

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
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

State Provided Data	
	2014
Annual Indicator	170.5
Numerator	61
Denominator	35,768
Data Source	Electronic Birth and Death certificates
Data Source Year	2015

NOM 9.4 - Notes:

Preterm births were considered under 365 days and with the following ICD-10 code: P22,P36,P77,K550,'P000,P010, P011,P015, P020, P021, P027, P102 , P280, P281, P77, P070-P073, P250-P279, P520- P523, P360-P369.

Data Alerts: None

NOM 9.5 - Sleep-related 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
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

State Provided Data	
	2014
Annual Indicator	89.5
Numerator	32
Denominator	35,768
Data Source	Electronic Birth and Death Certificate
Data Source Year	2015

NOM 9.5 - Notes:

SUID deaths were under 365 days and with the following ICD-10 death codes: R95, R99, and W75.

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	11.7	0.6 %	385	32,833
2012	11.0	0.6 %	363	32,885
2011	8.4	0.5 %	279	33,253
2010	6.9	0.5 %	234	33,974
2009	5.6	0.4 %	200	35,660
2008	3.9	0.3 %	144	37,286

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)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

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 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.2 %	1.6 %	138,408	623,452

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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
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

State Provided Data	
	2014
Annual Indicator	20.2
Numerator	70
Denominator	346,882
Data Source	Electronic Death Certificates
Data Source Year	2015

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
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

State Provided Data	
	2014
Annual Indicator	33.9
Numerator	127
Denominator	374,139
Data Source	Electronic Death Certificates, State Demographer (Population Estimates)
Data Source Year	2015

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
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	17.2	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

State Provided Data	
	2014
Annual Indicator	12.0
Numerator	22
Denominator	182,886
Data Source	Electronic Death Certificates, State Demographer (population estimates)
Data Source Year	2015

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
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

State Provided Data	
	2014
Annual Indicator	9.3
Numerator	17
Denominator	182,886
Data Source	Electronic Death Certificates, State Demographer (population estimates)
Data Source Year	2015

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.9 %	1.3 %	98,638	661,419
2007	14.5 %	1.3 %	96,530	664,311
2003	15.1 %	0.9 %	87,423	579,030

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	11.2 %	1.4 %	8,102	72,197

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children 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
2011_2012	1.8 %	0.5 %	10,018	551,374
2007	1.0 %	0.4 %	5,460	549,728

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children 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
2011_2012	4.1 %	0.7 %	22,251	548,383
2007	3.6 %	0.8 %	19,576	547,910

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children 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
2011_2012	49.3 %	7.0 %	21,051	42,702
2007	53.4 %	8.5 %	20,764	38,923
2003	53.0 %	5.0 %	20,160	38,048

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children 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
2011_2012	79.0 %	1.5 %	522,315	661,375
2007	79.8 %	1.5 %	530,170	664,311
2003	79.6 %	1.1 %	460,820	579,030

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	33.2 %	2.6 %	86,088	259,654
2007	34.2 %	2.7 %	88,754	259,298
2003	26.6 %	1.7 %	61,907	232,854

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	27.5 %	0.3 %	7,622	27,684

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.0 %	1.7 %	32,999	126,805
2009	24.1 %	1.3 %	29,435	122,099
2007	25.2 %	1.3 %	28,050	111,450

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	9.6
Numerator	63,732
Denominator	661,634
Data Source	ACS 1-Year
Data Source Year	2014

NOM 21 - Notes:

ACS B27001: HEALTH INSURANCE COVERAGE STATUS BY SEX BY AGE - Universe: Civilian

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	67.7 %	3.4 %	34,908	51,586
2013	60.6 %	3.3 %	31,735	52,403
2012	65.3 %	3.4 %	35,311	54,074
2011	64.7 %	4.4 %	37,209	57,495
2010	46.4 %	3.7 %	28,722	61,949
2009	39.3 %	3.4 %	24,080	61,202

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	72.0
Numerator	62,314
Denominator	86,490
Data Source	Nevada Immunizations
Data Source Year	2015

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	45.5 %	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 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	54.7
Numerator	436,612
Denominator	798,457
Data Source	Nevada Immunization
Data Source Year	2015

NOM 22.2 - Notes:

The numbers for influenza vary each year.

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) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	54.2 %	4.4 %	48,928	90,223
2013	53.8 %	4.8 %	48,446	90,107
2012	62.5 %	4.9 %	56,019	89,569
2011	55.3 %	5.7 %	49,975	90,390
2010	47.4 %	4.5 %	40,065	84,455
2009	39.0 %	4.7 %	33,621	86,311

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	43.4 %	4.6 %	41,328	95,263
2013	31.9 %	4.4 %	30,060	94,319
2012	11.6 %	2.8 %	10,828	93,680
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	41.2
Numerator	111,495
Denominator	270,638
Data Source	Nevada Immunization
Data Source Year	2015

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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	92.1
Numerator	171,509
Denominator	186,299
Data Source	Nevada Immunization
Data Source Year	2015

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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	59.0
Numerator	159,446
Denominator	270,368
Data Source	Nevada Immunization
Data Source Year	2015

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Nevada

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	62.0	64.0	66.0	68.0	77.9	77.9

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	61.1 %	3.0 %	299,106	489,272
2013	60.1 %	2.8 %	294,008	489,392
2012	59.0 %	2.1 %	285,334	483,462
2011	55.7 %	2.6 %	266,054	477,353
2010	54.2 %	3.0 %	250,611	462,455
2009	58.6 %	3.2 %	274,612	468,535

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82.0	84.0	86.0	88.0	88.0	88.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	80.1 %	2.9 %	28,183	35,188
2011	80.9 %	2.9 %		
2010	78.0 %	3.4 %		
2009	80.2 %	2.9 %		
2008	78.2 %	2.7 %		
2007	80.5 %	2.4 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	19.0	21.5	23.0	24.5	25.5	25.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	14.8 %	2.3 %	5,076	34,423
2011	18.0 %	2.6 %		
2010	18.7 %	3.6 %		
2009	11.2 %	2.3 %		
2008	12.5 %	2.0 %		
2007	11.9 %	1.7 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	25.0	27.0	29.0	31.0	31.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	21.9 %	3.1 %	38,504	175,661
2007	18.6 %	2.9 %	33,716	181,306

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	16.0	18.0	20.0	22.0	24.0	24.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	14.8 %	2.1 %	31,350	211,533
2007	18.8 %	2.2 %	39,691	211,298
2003	21.0 %	1.9 %	38,516	183,651

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	70.0	72.0	74.0	76.0	78.0	78.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	67.3 %	2.9 %	144,809	215,102
2007	71.3 %	2.8 %	153,259	214,950
2003	60.3 %	2.1 %	112,436	186,593

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	36.0	39.0	42.0	45.0	54.8	54.8

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	43.3 %	4.6 %	42,016	96,943
2007	37.2 %	4.8 %	35,148	94,395

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	44.8 %	2.0 %	242,287	541,063
2007	46.8 %	1.9 %	253,882	542,275

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	5.0	4.5	4.0	3.5	3.0	3.0

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.2 %	0.1 %	1,830	35,558
2013	5.8 %	0.1 %	1,997	34,514
2012	6.3 %	0.1 %	2,131	34,052
2011	5.9 %	0.1 %	2,041	34,637
2010	5.4 %	0.1 %	1,903	35,160

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 14 - B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	23.0	21.0	19.0	17.0	15.0	15.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.0 %	1.6 %	169,917	654,896
2007	25.4 %	1.6 %	167,443	660,118
2003	29.3 %	1.3 %	145,690	496,607

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	76.0	79.0	82.0	85.0	88.0	88.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	73.0 %	1.8 %	413,200	566,418
2007	73.1 %	1.7 %	390,939	534,831

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Nevada

SPM 1 - Percent of mothers reporting late or no prenatal care

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.0	8.0	8.0	8.0	8.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - A. Percent of teenage pregnancies and B. Percent of repeat teen births

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	36.2	36.2	36.2	36.2	36.2

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Percent of women who misuse substances during pregnancy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: Nevada

ESM 1.1 - Number of Title V funded partners that disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	8.0	11.0	14.0	17.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - Number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	3.0	6.0	9.0	12.0	19.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.1 - Number of Title V funded partners providing developmental screening in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	3.0	4.0	5.0	7.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1 - Percent of middle and high schools that implement a physical activity plan

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Number of Title V partners that conducted activities to promote preventive well visits for youth in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	4.0	7.0	10.0	13.0	17.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	4.0	6.0	9.0	12.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	183.0	366.0	549.0	732.0	915.0

Field Level Notes for Form 10a ESMs:

None

ESM 15.1 - Number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations (e.g. in multiple languages)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	2.0	3.0	4.0	5.0	6.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Nevada

SPM 1 - Percent of mothers reporting late or no prenatal care
Population Domain(s) – Women/Maternal Health

Goal:	Increase percent of women receiving prenatal care in first trimester
Definition:	**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 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective 16.1: Increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy Related to Access to Health Services (AHS) Developmental Objective 7.0: Increase the proportion of persons who receive appropriate clinical preventive services
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 - A. Percent of teenage pregnancies and B. Percent of repeat teen births
Population Domain(s) – Adolescent Health

Goal:	To decrease the number of teen pregnancies and repeat teen births in Nevada.
Definition:	**Numerator:** Number of teen births ages 10 to 19 years old **Denominator:** Number of Nevada resident births for the same year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective 16.6(Developmental) Increase the proportion of women delivering a live birth who used contraception to plan pregnancy.
Data Sources and Data Issues:	Electronic Birth Registry System Data Note: Abortion data has a one year lag.
Significance:	Teenage pregnancy and repeat teen births are a priority in the state. Repeat teen births account for more than 10% of the teen births. Tracking of data to help prevent repeat teen births will help programs across the state to see impacts of their own programs and continuation of health education respective of their programs.

SPM 3 - Percent of women who misuse substances during pregnancy
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To reduce the percent of women who report using substances during pregnancy.
Definition:	**Numerator:** Number of reported substance use during pregnancy **Denominator:** Number of Nevada resident births for the same year **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective MICH: MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women. MICH-11.1: Increase abstinence from alcohol among pregnant women. MICH-11.2Increase abstinence from binge drinking among pregnant women MICH-11.3Increase abstinence from cigarette smoking among pregnant women MICH-11.4Increase abstinence from illicit drugs among pregnant women
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 illicit 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.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Nevada

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: Nevada

ESM 1.1 - Number of Title V funded partners that disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	To increase percent of programs raising awareness of the well-woman visit, coverage benefits, and how to find a provider
Definition:	

Numerator:	Number of Title V funded partners that disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider.
Denominator:	All Title V Partners
Unit Type:	Count
Unit Number:	18

Data Sources and Data Issues:	Data Source: Nevada Title V/MCH Program
Significance:	Title V funded partners will help to disseminate materials to raise awareness of the importance of a well-woman visit, coverage benefits, and how to find a provider and reach a large proportion of the MCH population including hard-to-reach populations such as non-English speakers and those living in rural areas

ESM 4.1 - Number 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 and B) Percent of infants breastfed exclusively through 6 months

Goal:	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.
Definition:	

Numerator:	Number of hospitals (birthing facilities) receiving training on Baby Steps to Breastfeeding Success or designated as Baby Friendly by Baby Friendly USA.
Denominator:	Number of birthing facilities in Nevada
Unit Type:	Count
Unit Number:	19

Data Sources and Data Issues:	Data Source: Nevada Statewide Breastfeeding Program.
Significance:	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.

ESM 6.1 - Number of Title V funded partners providing developmental screening in the past year
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To increase the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Definition:	

Numerator:	Number of Title V funded partners that serve children 10-71 months providing developmental screening in the past year.
Denominator:	All Title-V funded partners that serve children 10-71 months
Unit Type:	Count
Unit Number:	7

Data Sources and Data Issues:	Data Source: Nevada Title V/MCH Program
Significance:	Parents using a developmental screening tool to screen their children before reaching school age are able to detect when a child is at risk for a developmental problem and discuss it with their health care provider. This ensures early identification of developmental disorders which is critical to the well-being of children and their families.

ESM 8.1 - Percent of middle and high schools that implement a physical activity plan
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	To promote healthy weight in children ages 6-17
Definition:	

Numerator:	Number of middle and high schools that implement a physical activity plan
Denominator:	All middle and high schools in the state
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	Nevada School Health Program
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

ESM 10.1 - Number of Title V partners that conducted activities to promote preventive well visits for youth in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	To promote preconception wellness.
Definition:	

Numerator:	Number of Title V partners that conduct activities to promote preventive well visits for youth
Denominator:	All Title V partners that conduct activities to promote preventive well visits for youth
Unit Type:	Count
Unit Number:	17

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 and address any of these issues in a timely fashion.

ESM 11.1 - Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	To increase the number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year.
Definition:	

Numerator:	Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year.
Denominator:	All partners that serve the CYSHCN population.
Unit Type:	Count
Unit Number:	12

Data Sources and Data Issues:	Data Source: Nevada Title V/MCH Program
Significance:	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 wellbeing. 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 14.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months

NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	To decrease the percent of women of child-bearing age who are smokers
Definition:	

Numerator:	Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months
Denominator:	All pregnant women who use nicotine
Unit Type:	Count
Unit Number:	1,830

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.

ESM 15.1 - Number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations (e.g. in multiple languages)
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Goal:	To increase the percent of children ages 0 through 17 who are adequately insured
Definition:	

Numerator:	Number of Title V funded partners that offer assistance with completing insurance applications, including assistance to at-risk populations (e.g., in multiple languages).
Denominator:	Number of Title V funded partners
Unit Type:	Count
Unit Number:	6

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. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Nevada

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	44	34	39	80	80
Denominator	44	34	39	80	80
Data Source	Oregon Public Health Lab	Oregon Public Health Lab	Oregon Public Health Lab	Oregon Public Health Lab and Nevada Public Health Lab	Oregon Public Health Lab and Nevada Public Health Lab
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   This data is the data provided for the 2014 annual report/2016 application. 2015 data are unavailable at this time.

2. **Field Name:** **2014**

Field Note:
On July 1, 2014, the first day of the State Fiscal Year in 2014 (SFY14) the State of Nevada changed the laboratory used to perform newborn screening from the Oregon Public Health Laboratory (OPHL) to the Nevada Public Health Laboratory (NPHL).

From January 1, 2014 to June 30, 2014 the following methodology was used by OPHL to follow-up on presumptive positive cases:

From July 1, 2014 to December 31, 2014 the method used by NPHL:
According to the University of Nevada, Reno, Nevada Public Health Laboratory, Newborn Screening program, the following methodology guidelines are used in presumptive positive cases. Once a case is acknowledged, the primary care physician (PCP) is contacted. As soon as contact is made with the PCP the American College of Medical Genetics ACTion Sheet, diagnostic test information, and specialist contact information are sent to the PCP. At the same time the reference lab is called to get the

3. **Field Name:** **2013**

Field Note:
Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.

4. **Field Name:** **2012**

Field Note:
Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.

5. **Field Name:** **2011**

Field Note:
Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	55.0	70.0	73.0	76.0
Annual Indicator	64.0	64.0	64.0	64.0	64.0
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	51.0	51.0	51.0	53.0	57.0
Annual Indicator	36.8	36.8	36.8	36.8	36.8
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	62.0	62.0	70.0	75.0	80.0
Annual Indicator	55.2	55.2	55.2	55.2	55.2
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	60.0	63.0	66.0
Annual Indicator	57.2	57.2	57.2	57.2	57.2
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	33.0	37.0	41.0
Annual Indicator	31.7	31.7	31.7	31.7	31.7
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

5. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	70.0	71.0	65.0	65.0	70.0
Annual Indicator	60.2	55.9	57.9	60.8	72.0
Numerator	67,905	64,235	68,077	64,453	62,314
Denominator	112,813	114,854	117,652	106,053	86,490
Data Source	NV Immunization	NV Immunization	NV Immunization	NV Immunization	NV Immunization
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

2. **Field Name:** **2012**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

3. **Field Name:** **2011**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

According to the Centers for Disease Control (CDC) the difference between 2010 and 2011 is based upon changes in measurement and definitions related to the Hib vaccine the CDC explanation is quoted below:

"4:3:1:3:3 series coverage reported in column B is based on the original definition for this series. We made it available in the 2009 web tables but not 2010; it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. We do recognize that some grantees use this measure, so we will be including it in future releases of the NIS data on our website. Column B relates to 2008 and previous years (remember though that the estimates are not directly comparable since they do not consider the brand type where some children may be counted as up to date with 3 doses but may require 4 doses to be up to date). Coverage estimates in column C are based on the new definition for Hib that takes into consideration the brand type (meaning some children only need 3 doses to be up to date, while others need 4 doses to be up to date), this began with the 2009 data. Column C can be compared with 2009 HIb estimates that are based on this new definition."

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	18.0	17.0	14.0	12.0	11.0
Annual Indicator	18.9	15.3	12.3	12.4	11.7
Numerator	977	810	662	651	623
Denominator	51,694	53,108	53,679	52,610	53,416
Data Source	Vital Stats	Vital Stats	Vital Stats	Vital Stats	Vital Stats
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   The data in 2015 are provisional

2. **Field Name:** **2014**

   Field Note:
   The 2014 data is provisional.

3. **Field Name:** **2013**

   Field Note:
   The data for 2013 is preliminary. 2013 data will be available in December of 2015.

4. **Field Name:** **2012**

   Field Note:
   The data for 2012 is preliminary. 2012 data will be available in December of 2014.

5. **Field Name:** **2011**

   Field Note:
   Data entered is for 2011. The data is preliminary and will be available in December of 2013.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	42.0	42.0	42.0
Annual Indicator	37.0	37.0	37.0	37.0	37.0
Numerator	13,321	13,321	13,321	13,321	13,321
Denominator	36,003	36,003	36,003	36,003	36,003
Data Source	BSS 2008	BSS 2008	BSS 2008	BSS 2008	BSS 2008
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Division of Public and Behavioral Health Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

2. **Field Name:** **2013**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Division of Public and Behavioral Health Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

3. **Field Name:** **2012**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Health Division's Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

4. **Field Name:** **2011**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Health Division's Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.8	1.7	1.4	1.3
Annual Indicator	1.8	1.7	1.5	1.9	1.7
Numerator	9	9	9	11	10
Denominator	512,943	527,473	586,919	568,512	574,586
Data Source	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	ICD 10 Codes - Cause of Death
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

Field Note:
Data entered is from 2013. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

2. **Field Name:** **2012**

Field Note:
Data entered is from 2012. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

3. **Field Name:** **2011**

Field Note:
Data entered is from 2011. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	28.0	28.0	28.0	25.0	27.0
Annual Indicator	18.4	19.9	26.3	28.0	24.1
Numerator			5,933	6,194	6,943
Denominator			22,561	22,098	28,865
Data Source	PedNSS	WIC	WIC	WIC	WIC
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Includes children 6 to 24 months of age.

2. **Field Name:** **2014**

   Field Note:
   Percent Nevada infants 6 to 24 months in WIC who were breastfed at least 6 months.

3. **Field Name:** **2013**

   Field Note:
   Percent Nevada infants 6 to 24 months in WIC who were breastfed at least 6 months.

4. **Field Name:** **2012**

   Field Note:
   NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extracted from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programmatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistency in the report.

   In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2012.

5. **Field Name:** **2011**

   Field Note:
   NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extracted from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programmatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistency in the report.

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.5	99.5	99.5	99.5	99.5
Annual Indicator	99.1	95.8	95.9	95.7	94.0
Numerator	34,263	33,175	33,411	33,969	33,776
Denominator	34,580	34,616	34,827	35,507	35,936
Data Source	EHDI database	EHDI database	EHDI database	EHDI Database	EHDI Database
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

   Field Note:
   Nevada Early Hearing Detection and Intervention program's data systems, Nevada electronic birth records, and Nevada birthing hospitals & birthing facilities. Data matches Nevada submission to 2012 CDC annual EHDI survey. More accurate birth counts which include home births and births from a Federal hospital account for a slight decrease in percent screened. Accurate screening data from the Federal hospital will bring the percentage back up to the 99% level.

2. **Field Name:** **2012**

   Field Note:
   From the state Early Hearing Detection & Intervention (EHDI) database.

3. **Field Name:** **2011**

   Field Note:
   From the state Early Hearing Detection & Intervention (EHDI) database.

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	15.0	15.0	12.0
Annual Indicator	17.5	19.3	20.0	17.8	9.6
Numerator	117,196	134,300	139,405	129,100	63,732
Denominator	668,200	694,600	697,026	724,800	661,634
Data Source	U.S. Census Bureau 2011.	HKFF 2012 State Report	HKFF 2012 State Report	HKFF 2013 State Report	ACS 1-year Estimate
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   ACS 1-year estimate for the state, 0 to 17 years old.

2. **Field Name:** **2014**

   Field Note:
   http://kff.org/other/state-indicator/children-0-18/

   Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2013.

3. **Field Name:** **2013**

   Field Note:
   http://kff.org/other/state-indicator/children-0-18/

   Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2012.

4. **Field Name:** **2012**

   Field Note:
   Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2012.

5. **Field Name:** **2011**

   Field Note:
   Niether the Great Basin Primary Care Association (GBPCA) annual report for 2011 nor the Kaiser Family State Health Facts for 2011 have been released, so U.S. Census Bureau 2011 data was utilized. Children are calculated for 0-17 years of age.

   Data Source: Number and Percent of Uninsured Children: U.S. Census Bureau. 2011. “Health Insurance Historical Tables - HIB Series,” Table HIB-5, data for 2010 for children under age 18 - Nevada listing. http://www.census.gov/hhes/www/hlthins/data/historical/files/hihistt5B.xls

Data Alerts: None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	11.0	11.0	25.0	25.0	23.0
Annual Indicator	27.1	26.8	26.8	26.0	25.4
Numerator					8,694
Denominator					34,236
Data Source	PedNSS tables	WIC	WIC	WIC	WIC
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

Field Note:
Using the CDC's 2013 Pediatric Nutrition Surveillance Nevada Summary of Demographic Data as reported by the Nevada Women, Infants and Children (WIC) Program.

In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2013.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

2. **Field Name:** **2012**

Field Note:
Using the CDC's 2012 Pediatric Nutrition Surveillance Nevada Summary of Demographic Data as reported by the Nevada Women, Infants and Children (WIC) Program.

In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2012.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

3. **Field Name:** **2011**

Field Note:
Using the CDC's 2010 Pediatric Nutrition Surveillance
Nevada Summary of Demographic Indicators Table 2C.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	6.0	4.0	3.0
Annual Indicator	6.7	6.9	4.3	3.8	3.7
Numerator	2,354	2,398	1,488	1,368	1,331
Denominator	35,196	34,526	34,371	35,676	35,768
Data Source	vital stat/birth cert	vital stat/birth cert	vital stat/birth cert	Vital Stats	Vital Stats
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
This data is addressing the third trimester smoking habits of the mother. Previous to 2013 the data includes all mothers who indicated tobacco use during pregnancy.

2. **Field Name:** **2013**

Field Note:
Data for 2013 is preliminary. Data will be finalized in December 2015.

From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.

3. **Field Name:** **2012**

Field Note:
2012 reported data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2012 is preliminary. Data will be finalized in December 2014.

From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.

4. **Field Name:** **2011**

Field Note:
2011 reported data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2011 is preliminary. Data will be finalized in December 2013.

From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	5.5	5.0	4.5
Annual Indicator	14.8	6.0	7.6	8.2	9.3
Numerator	26	11	14	15	17
Denominator	175,953	182,183	184,109	182,149	182,886
Data Source	vital stats/ death cert	vital stats/ death cert	vital stats/ death cert	Vital Stats/Death Certs	Vital Stats
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2013**

   Field Note:
   Data entered is from 2013. Data will be available in December, 2015. Data for 2013 is preliminary.

2. **Field Name:** **2012**

   Field Note:
   Data entered is from 2012. Data will be available in December, 2014. Data for 2012 is preliminary.

3. **Field Name:** **2011**

   Field Note:
   Data entered is from 2011. Data will be available in December, 2013. Data for 2011 is preliminary.

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	97.0	97.0	98.0	98.0	99.0
Annual Indicator	90.9	90.6	90.6	90.1	91.2
Numerator	432	403	378	464	434
Denominator	475	445	417	515	476
Data Source	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	Vital Stats/Birth Certs	Vital Stats/Birth Certs
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Level III hospital data only. Data for 2015 are preliminary.

2. **Field Name:** **2014**

   Field Note:
   Data for 2014 included level 3 only. Data for 2014 is preliminary.

3. **Field Name:** **2013**

   Field Note:
   Data for 2013 included level 3 only. Data for 2013 is preliminary.

4. **Field Name:** **2012**

   Field Note:
   Data for 2012 included level 3 only. Data for 2012 is preliminary. Data will be available in December, 2014.

5. **Field Name:** **2011**

   Field Note:
   Data for 2011 included level 3 only. Data for 2011 is preliminary. Data will be available in December, 2013.

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	65.5	70.0	73.0
Annual Indicator	63.7	65.2	65.9	68.6	69.8
Numerator	22,406	22,517	22,647	24,466	24,956
Denominator	35,196	34,526	34,371	35,676	35,768
Data Source	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	Vital Stats/Birth Certs	Vital Stats/Birth Certs
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data are provisional.	
2.	**Field Name:**	**2014**
	Field Note: Data are provisional.	
3.	**Field Name:**	**2013**
	Field Note: Data for 2013 is preliminary. Data will be available in December, 2015.	
4.	**Field Name:**	**2012**
	Field Note: Data for 2012 is preliminary. Data will be available in December, 2014.	
5.	**Field Name:**	**2011**
	Field Note: Data for 2011 is preliminary. Data will be available in December, 2013.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Nevada

SPM 2 - The rate (per 1,000 MCH Medicaid population) of Medicaid dental providers.

	2011	2012	2013	2014	2015
Annual Objective	2.3	2.4	2.4	10.5	11.0
Annual Indicator	7.2	10.1	9.0	1.9	1.9
Numerator	462	665	620	885	885
Denominator	64,308	66,122	68,947	462,204	462,204
Data Source	NV DHCFP	NV DHCFP	NV DHCFP	State of Nevada Medicaid	State of Nevada Medicaid
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data are of 2014. Data for 2015 are incomplete and will be updated when available.

2. **Field Name:** **2014**

   Field Note:
   Extracted all children and women 15 to 44 (per month) then combined all months and removed duplicates for the year.

3. **Field Name:** **2013**

   Field Note:
   Data is for federal fiscal year 2013.

   Numerator
   FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access.
   Data was not requested from Anthem for the first quarter of the fiscal year.
   Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database.
   Denominator
   All Children: All members age 0-18 during the reporting period (by birthdate).
   Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
   Note: Report counts all women 15-18 as children and does not duplicate them.

4. **Field Name:** **2012**

Field Note:
Data is for federal fiscal year 2012.

Numerator
FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access.
Data was not requested from Anthem for the first quarter of the fiscal year.
Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database.
Denominator
All Children: All members age 0-18 during the reporting period (by birthdate).
Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
Note: Report counts all women 15-18 as children and does not duplicate them.

5. **Field Name:** **2011**

Field Note:
Data is for federal fiscal year 2011.

Numerator
FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access.
Data was not requested from Anthem for the first quarter of the fiscal year.
Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database.
Denominator
All Children: All members age 0-18 during the reporting period (by birthdate).
Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
Note: Report counts all women 15-18 as children and does not duplicate them.

Data Alerts: None

SPM 3 - The percent of women, ages 18 to 44, who are obese.

	2011	2012	2013	2014	2015
Annual Objective	16.0	16.0	21.0	21.0	19.0
Annual Indicator	24.6	23.9	24.2	24.2	26.3
Numerator	107,104	104,368	103,095	103,235	142,170
Denominator	436,178	436,061	426,014	426,592	540,570
Data Source	BRFSS 2011	BRFSS 2012	BRFSS 2013	BRFSS 2014	BRFSS 2015
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   BRFSS data updated with 2015 data.

2. **Field Name:** **2014**

   Field Note:
   Denominator and numerator represent weighted frequencies from the 2014 Behavioral Risk Factor Surveillance System.

3. **Field Name:** **2013**

   Field Note:
   Information was produced by the Office of Public Health Informatics and Epidemiology from the BRFSS report.

Data Alerts: None

SPM 5 - The number of public schools (K-12) that have access to a school based health center.

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	20.0	20.0	20.0
Annual Indicator			13.8	13.8	13.8
Numerator			100	100	100
Denominator			723	723	723
Data Source			NSPF	NSPF	NSPF
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   100 schools were served by the 11 SBHC's that were operating in 2014. Nevada School Performance Framework shows 723 K-12 public schools in the state.

2. **Field Name:** **2014**

   Field Note:
   100 schools were served by the 11 SBHC's that were operating in 2014. Nevada School Performance Framework shows 723 K-12 public schools in the state.

3. **Field Name:** **2013**

   Field Note:
   Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County.

   Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and may contract with a sponsoring facility for the operation of
   the school-based health center, including, without limitation, for
   the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session.

   There is no 2013 data to report.

4. **Field Name:** **2012**

Field Note:
Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County.

Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and may contract with a sponsoring facility for the operation of
the school-based health center, including, without limitation, for
the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session.

There is no 2012 data to report.

5. **Field Name:** **2011**

Field Note:
Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County.

Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and may contract with a sponsoring facility for the operation of
the school-based health center, including, without limitation, for
the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session.

There is no 2011 data to report.

Data Alerts: None

SPM 6 - The percent of positive hearing screening newborns who have received additional screening and diagnosis by 3 months.

	2011	2012	2013	2014	2015
Annual Objective	15.0	20.0	31.0	33.0	41.0
Annual Indicator	13.7	25.9	24.2	31.3	26.6
Numerator	75	88	119	147	125
Denominator	547	340	491	470	470
Data Source	NB hearing database	NB hearing database	NB hearing database	NB hearing database	NB Hearing Database
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2013**

   Field Note:
   Newborn Hearing Screening Program's data system, electronic birth records, Nevada Early Intervention Services data and other follow-up data received from clinical evaluations. Data matches Nevada submission to 2012 CDC annual EHDI survey.

   Nevada's Universal newborn hearing screening program is successful with initial screening and is working to raise the screening percentage even higher by focusing on home births, Federal Hospital screening reporting and screener education. Strategies are in place to reduce the number of lost to rescreening and diagnostic follow-up with significant strides already realized.

2. **Field Name:** **2012**

   Field Note:
   Data for 2012 is from the Newborn Hearing database.

3. **Field Name:** **2011**

   Field Note:
   Data for 2011 is from the Newborn Hearing database.

Data Alerts: None

SPM 8 - Percentage of Nevada public school students who are obese and overweight.

	2011	2012	2013	2014	2015
Annual Objective	22.0	22.0	22.0	22.0	22.0
Annual Indicator	24.1	24.1	25.8	38.1	38.1
Numerator	478	478	977	3,652	3,652
Denominator	1,982	1,982	3,783	9,595	9,595
Data Source	YRBS 2009	YRBS 2009	YRBS 2013	Washoe/Clark School Districts	Washoe/Clark School Districts (2014)
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Data is from student height weight data collected from the 2013-2014 Washoe County and Clark County school district Fourth, Seventh, and Tenth grade students. Total sample size was 9,595.

2. **Field Name:** **2014**

Field Note:
Data is from student height weight data collected from the 2013-2014 Washoe County and Clark County school district Fourth, Seventh, and Tenth grade students. Total sample size was 9,595.

3. **Field Name:** **2013**

Field Note:
In 2013 the YRBS data was collected by the University of Nevada , Reno. This resulted in a much greater sample population. This data only includes high school aged students.

The data can be viewed at http://chs.unr.edu/subpages/research/documents/2013NevadaYRBSReport.pdf.

The pages are 104 and 105.

4. **Field Name:** **2012**

Field Note:
Reported dietary behavioral data is from 2009. The Youth Risk Behavior Survey (YRBS) is normally reported every other year, thus data is available for 2011 and 2012 which may not yet be reported. The Centers for Disease Control and Prevention's (CDC), Youth Risk Behavior Surveillance (YRBS) report has not been updated since 2009 as of July 9th, 2012.

YRBS only counts High School students, grades 9 through 12.

The YRBS survey at: http://apps.nccd.cdc.gov/youthonline/App/Default.aspx gives percentages and total respondents (the denominator) so you can determine the numerator by multiplying the percent times the total respondents.

Overweight = 13.2 percent and the denominator is 1,982;
The numerator is .132 X 1,982 = 261.6
Obese = 10.9% with the same denominator - 1,982.
The numerator is .109 X 1,982 = 216.0

Adding the two numerators together = 261.6 +216.0 = 478 (round up)

Therefore, to fill out the block grant form we used 478 as the numerator and 1982 as the denominator and the percent will automatically be calculated at (478 / 1982) X100 = 24.1%

5. **Field Name:** **2011**

Field Note:
Reported dietary behavioral data is from 2009. Youth Risk Behavior Survey (YRBS) is normally reported every other year, thus data is available for CY 2011 and 2012 which may not yet be reported. The Centers for Disease Control and Prevention's (CDC), Youth Risk Behavior Surveillance (YRBS) has not been updated since 2009 as of May 13th, 2012.

YRBS only counts High School students, grades 9 through 12.

The YRBS survey at: http://apps.nccd.cdc.gov/youthonline/App/Default.aspx gives percentages and total respondents (the denominator) so you can determine the numerator by multiplying the percent times the total respondents.

Overweight = 13.2 percent and the denominator is 1,982;
The numerator is .132 X 1,982 = 261.6
Obese = 10.9 percent with the same denominator - 1,982.
The numerator is .109 X 1,982 = 216.0

Adding the two numerators together = 261.6 +216.0 = 478 (round up)

Therefore, to fill out the block grant form we used 478 as the numerator and 1982 as the denominator and the percent will automatically be calculated at (478 / 1982) X100 = 24.1 percent

Data Alerts: None

SPM 9 - The percent of high school students who experience dating violence.

	2011	2012	2013	2014	2015
Annual Objective		0.0	0.0	10.0	10.0
Annual Indicator	0.0	0.0	11.3	11.3	10.2
Numerator		0	310	310	333
Denominator		1	2,747	2,747	3,268
Data Source	Nevada Vital Stat	Nevada Vital Stat	Nevada YRBS	Nevada YRBS 2013	Nevada YRBS 2015
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
In 2015, 333 of 3268 high school aged students reported experiencing physical dating violence in the past 12 months on the Youth Risk Behavioral Survey.

2. **Field Name:** **2014**

Field Note:
In 2013 there were 310 cases of dating violence out of sample size of 2747 which gives 11.3%.

YRBS is conducted every other year on high school students 9-12.

3. **Field Name:** **2013**

Field Note:
In 2013 there were 310 cases of dating violence out of sample size of 2747 which gives 11.3%.

YRBS is conducted every other year on high school students grades 9-12.

4. **Field Name:** **2012**

Field Note:
The Attorney General-Domestic Violence Fatality Review Statewide Team (AG-DVFRST) is appointed and is considered our primary source for the data.

There were no fatal cases of domestic violence or intimate partner violence reported in 2012 for ICD-10 codes Z61.4, Z61.6-Z61.9, Z62.3, Z63.0-Z63.9, and T74.1-T74.9 listed as the underlying cause of death in 2012.

5. **Field Name:** **2011**

Field Note:
Data are not currently available for this newly formed State Performance Measure around domestic and intimate partner violence. This is due to the fact that the Attorney General-Domestic Violence Fatality Review Statewide Team is newly appointed and is considered our primary source of the data. We anticipate a rich collection of data next year to report after cases of domestic violence and intimate partner violence are reviewed and reported on.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2012 SPM 9. Please review your data to ensure this is correct.

SPM 10 - The percent of live births weighing less than 2,500 grams among African Americans.

	2011	2012	2013	2014	2015
Annual Objective				12.5	12.5
Annual Indicator	12.9	13.5	12.5	12.4	12.5
Numerator	471	496	485	688	719
Denominator	3,642	3,678	3,880	5,549	5,755
Data Source	Nevada Vital Stats	Nevada Vital Stats	Nevada vital Stats	Nevada Vital Stats	Nevada Vital Stats
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data is inclusive of all children born to either African American mothers or fathers, regardless of Hispanic ethnicity within 2,500 gram weight.

2. **Field Name:** **2014**

   Field Note:
   Data is inclusive of all children born to either African American mothers or fathers, regardless of Hispanic ethnicity within 2,500 gram weight. Previous year's (2013) method does not seem to match the method moving forward from 2014.

Data Alerts: None

Form 11
Other State Data

State: Nevada

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Nevada

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: Nevada

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve preconception and interconception health among women of childbearing age	NPM 1 - Well-Woman Visit	ESM 1.1	
Improve preconception and interconception health among women of childbearing age			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Breastfeeding promotion	NPM 4 - Breastfeeding	ESM 4.1	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Increase developmental screening	NPM 6 - Developmental Screening	ESM 6.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Promote healthy weight	NPM 8 - Physical Activity	ESM 8.1	
Improve preconception and interconception health among women of childbearing age	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Reduce teen pregnancy			SPM 2

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve care coordination	NPM 11 - Medical Home	ESM 11.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Reduce substance use during pregnancy	NPM 14 - Smoking	ESM 14.1	
Increase adequate insurance coverage among children	NPM 15 - Adequate Insurance	ESM 15.1	
Reduce children's exposure to second-hand smoke			SPM 3