Maternal and Child Health Services Title V Block Grant

Nevada

FY 2018 Application/ FY 2016 Annual Report

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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
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June 10, 2017

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 2016, Application FFY 2018

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 2018 application and FFY 2016 Annual Report to the Health Resources and Services Administration.

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

Sincerely,

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's Title V Maternal and Child Health (MCH) Program is dedicated to working with diverse public and private partners across the state to improve the health of families. Funded partners implement activities serving women of child bearing age, infants, adolescents, and children, including children and youth with special health care needs (CYSHCN). Nevada utilizes MCH Title V funding to collaborate with stakeholders and strengthen community partners in activities ensuring all target populations have access to health education and preventive services.

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

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 7.9% and is higher than the national average of 6%. The MCH Program partners with statewide and regional MCH coalitions, community-based programs, and public and private stakeholders to increase rates of coverage and prenatal care.

The MCH Program collaborates with partners to identify and reduce modifiable risk factors for improving birth outcomes, including racial and ethnic health disparities. Initiatives include the National Governors Association (NGA) Learning Network on Improving Birth Outcomes and the Collaborative Improvement and Innovation Network (CoIIN) to reduce Infant Mortality. Partners in these efforts include Nevada Governor's Office, Local Health Authorities (LHAs), March of Dimes, Community Health Nursing, Women, Infants and Children (WIC), Division of Health Care Financing and Policy/Medicaid (DHCFP), Nevada Hospital Association, Substance Abuse Prevention and Treatment Agency (SAPTA), insurers, and the Home Visiting Program.

Partner organizations provide critical screenings to women of childbearing age; especially women living in rural and frontier areas and at-risk populations. These screenings include: postpartum depression screens; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Go Before You Show; One Key Question campaign, and others. Collaboration with Nevada Home Visiting will promote relevant screenings, including: use of the Ages and Stages Questionnaire, workforce development, and inclusive culturally competent resources.

In response to Nevada's legalization of medical and recreational marijuana, informational resources on pregnancy and marijuana will be disseminated among MCH populations. The Pregnancy Risk Assessment Monitoring System (PRAMS) data will help inform activities. Efforts focused on reducing substance misuse in pregnancy and inter-conception for women of child bearing age will continue to include the promotion of the SoberMomsHealthyBabies.org website and associated media campaign, and focus perinatal quality activities on reduction of neonatal abstinence syndrome (NAS).

Domain: Perinatal/Infant Health

- Priority: Breastfeeding promotion (Percent of infants who are ever breastfed and Percent of infants breastfed exclusively through 6 months)

Nevada's rate for ever breastfeeding is slightly higher than the national average (82.6 and 81.1 respectively), and is also slightly higher than the national average for exclusive breastfeeding at six months (24.9 and 22.3, respectively). As the Centers for Disease Control and Prevention (CDC) supports the link between breastfeeding and improved health outcomes, the MCH Program partners with: WIC, MCH coalitions, community-based programs, LHAs, the public, and private stakeholders to increase breastfeeding rates by improved access to breastfeeding supports for new mothers.

An accomplishment in this area includes the training at four out of six Nevada maternity centers 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, supported in part by MCH Title V funding. Several Nevada hospitals, five in Clark County and one in Churchill County, have fully implemented the Baby Safe Sleep program.

In support of perinatal/infant health, the Southern Nevada Health District (SNHD) Home Visiting Nurse-Family Partnership Program served 246 women between 10/1/2015 and 9/30/2016. Washoe County Fetal Infant Mortality Review (WC FIMR) reviewed 53 cases between October 2015 and September 2016. MCH Safe Sleep efforts include funding Cribs for Kids, statewide radio and television media campaigns, brochures, and books with safe sleep messages statewide. Cribs for Kids distributed a total of 402 Safe Sleep Survival Kits which include a Pack and Play Crib, Crib Sheet with the safe sleep message, a Halo Sleep Sack, Safe Sleep ABC photo magnet, Philips Soothie Pacifier, Safe Sleep Educational Materials, a Safe Sleep DVD, and "Safe Baby, Safe Snug" children's book. Materials are available in English and Spanish.

Perinatal quality activities and CoIIN efforts will continue to support this domain. A Safe Sleep pilot is planned with Indian Health Service clinics in fall of 2017. PRAMS promotion and Healthy Start efforts also relate to improvements in this domain.

<u>Domain: Child Health</u>

- 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)

According to NS-CSHCN, Nevada (69.7%) is below the national average (78.6%) for children screened early and continuously for special health care needs. The MCH Program collaborates 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. CDC English and Spanish Milestone Moments distribution with multiple partners is ongoing. Partnerships with UNR's LEND and UCAN programs and distribution of the Nevada Children's Home Portal are accomplishments.

MCH and WIC co-funded breastfeeding supports for a Chronic Disease Prevention and Health Promotion (CDPHP) Early Childhood Education (ECE) activity. Seventy-five ECE providers received training and technical assistance to address breastfeeding and physical activity promotion. However, the MCH funded 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. MCH will co-fund an obesity prevention/physical activity promotion social media campaign, targeting children, and entirely fund two age groups of

adolescents in 2017. The MCH toll-free helpline will continue to be promoted.

Child health is also supported via Bullying Prevention efforts in partnership with the Nevada Department of Education and with the Office of Suicide Prevention efforts to decrease youth suicide.

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

According to the 2015 YRBSS, 49.4% of Nevada adolescents were not physically active at least 60 minutes per day on 5 or more days, which is slightly better than the national rate of 51.4%. In order to improve physical activity rates, the MCH Program will collaborate 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. These efforts will include continued support of trauma informed yoga via a partner entity serving high risk youth living in residential settings, as well as launching a social media campaign aimed at adolescents promoting physical activity. A Rapid Assessment for Adolescent Preventive Services (RAAPS) high risk screening pilot is ongoing to see if well visits can be enhanced to better identify risk.

Changes to the MCH Title V action plan included adding a priority to reduce teen pregnancy. This priority will be addressed through a state performance measure to track the prevalence of teen pregnancies and repeat births, and tracking the use of long acting reversible contraceptives (LARCs) provided by Local Health Authorities (LHAs) and Community Health Nurses (CHNs).

Nevada does not have either the highest or lowest rate of teen pregnancy among all states. However, since one in five births to teen mothers (ages 15-19) is a repeat teen birth, it is important to work to decrease both measures, with specific emphasis on health disparities. To improve teen birth measures, the MCH Program will partner with CoIIN, NGA, Nevada MCH Coalitions, LHAs, community-based programs, and public and private stakeholders to increase access to family planning information, and other educational materials, including funding LHAs and CHNs to provide education and promoting Medicaid coverage of LARCs immediately post-partum. The NGA Learning Network to Improve Insurance Enrollment and Access to Health Care for Adolescents ages 15-18, will continue, initially focusing on Clark County and expanding statewide.

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 with and without special health care needs should have access to a medical home, according to the NSCH, the percent of children with special health care needs in Nevada having a medical home is 44.6%, which is below the national average of 54.4%. Promotion of Nevada Children's Medical Home Portal will improve access to healthcare, the social service resources and information for children and their families. The MCH Program partners with MCH coalitions, community-based programs, Nevada's Family-to-Family/Family Voices entity, Family Training, Information, and Emotional Support (TIES), Nevada 2-1-1, and public and private stakeholders to increase promotion of health care resources and care coordination with the portal.

Major highlights include establishment of the Nevada Children's Medical Home Portal. This resource improves care coordination among children with and without special health care needs. One of the main partners for the CYSHCN program, Family TIES, participated in 22 Coalition meetings and shared resources for CYSHCN at the Nevada Health Conference. The Division of Public and Behavioral Health (DPBH), in collaboration with the Division of Health Care Finance and Policy (DHCFP)/Medicaid, 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 collects Critical Congenital Heart Disease (CCHD) data in accordance with Nevada Revised Statutes (NRS) 442.680 and a report will be available in winter 2018.

Developmental screening is provided by Nevada Home Visiting, LHAs, CHNs, Family TIES, and UNR partners, including statewide distribution of Milestone Moments. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) promotion will continue, as well as efforts to connect CYSHCN to insurance, funding the CYSHCN toll free line and participation in Nevada Governor's Council on Developmental Disabilities (NGCDD), Interagency Coordinating Council (ICC) and transition resource promotion.

Domain: Cross-Cutting/Life Course

- Priority: Reduce substance use during pregnancy (Percent of women who smoke during pregnancy)

Nevada collaborates across systems to collect information regarding the percent of women who smoke or use/misuse substances during pregnancy, as well as information regarding the percent of children exposed to secondhand smoke. Nevada began collecting information by implementing Baby BEARS, a survey similar to the Pregnancy Risk Assessment Monitoring System (PRAMS). Nevada was awarded a PRAMS grant by the CDC in 2016, 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 state and community programs to prevent and reduce substance use among adolescents, pregnant women, and women of childbearing age. 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, funding media campaigns statewide, and supporting the SoberMomsHealthyBabies.org website. CoIIN, NGA Nevada Improving Birth Outcomes Collaborative, Home Visiting, and perinatal quality activity efforts all support progress in this domain.

II. Components of the Application/Annual Report

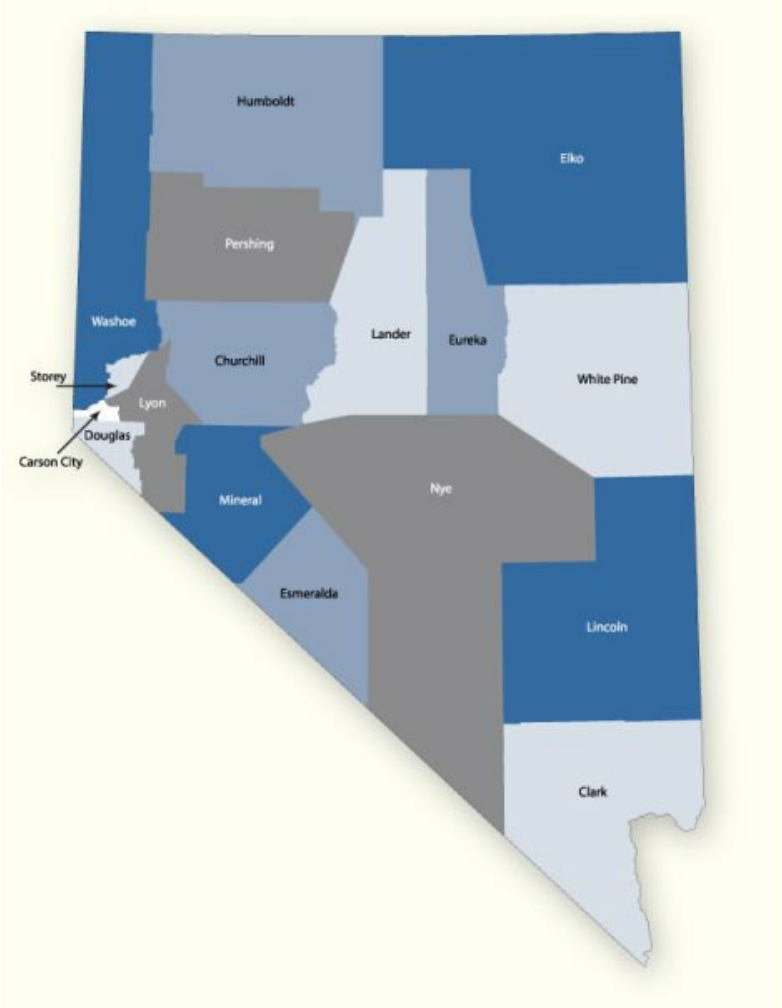
II.A. Overview of the State

Maternal and Child Health Block Grant: Application for 2018 and Report for 2016

State Overview

1. Geography

Nevada is the 7th largest state in the United States (U.S.) with a land mass of approximately 110,000 square miles. As defined by the State Demographer, Nevada has three urban counties (Carson City, Clark, and Washoe), three rural counties (Douglas, Lyon, and Storey), and eleven counties designated as frontier (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing, White Pine). The three rural counties (Douglas, Lyon, and Storey) also meet "micropolitan" classification due to their close proximity to the urban (metropolitan) counties (Carson City, Clark and Washoe).



The state has a unique topography, with vast distances separating frontier, rural, and urban communities. The distance between Washoe and Clark counties is 448 miles (approximately 7.5 hours by car). Residents in the rural and frontier counties are spread across 95,421 square miles or 86.9% of the state's land mass. Population density ranges from 379 people per square mile in Carson City to 0.22 people per square mile in Esmeralda County.

Approximately 90% of Nevada land is publicly owned and administered by federal, state, and tribal entities, with the remaining 10% privately owned.

2. Population

The Nevada State Demographer's Office and the U.S. Census Bureau estimates Nevada's population in 2016 as over 2.9 million. Between 2015 and 2016, Nevada had the second-highest percentage growth in the nation. Although Nevada's population continues to grow, some rural and frontier counties lose population annually. The most densely populated area in the state is Clark County with over two (2) million residents. The population in the rural and frontier counties ranges from approximately 1,000 to just under 55,000 residents. In 2016, 27% of the population was 19 years and younger and 34% between 20 and 44 years old. Among female-headed households, approximately 19,000 (25%) were receiving child support.

Nevada is becoming more ethnically diverse, with over 29% of the state's population in 2016 documented as Hispanic Origin of Any Race, in comparison to 52.3% White, 9.2% Asian/Pacific Islander, 8.4% Black, and 1.1% Native American. Overall population projections until 2020 are approximately 5% growth per year.

Kid's Count Data Center approximates 36% of Nevada's children are from non-U.S. national families. The U.S. Census Bureau indicates people who were not U.S.nationals comprised 24.4% of Nevada's workforce in 2013, impacting such industries as agriculture, construction, mining, entertainment, and tourism. Nevada's agricultural workforce is composed of migrant and seasonal farm workers with 61% of individual farm workers and 50% of farmers with families living below the poverty level. Low educational attainment, illiteracy, language barriers, lack of transportation, insurance, and sick leave have all been identified as issues limiting positive health outcomes for this population. Additionally, fear of immigration penalties and lack of awareness of assistance programs are barriers to health and social services for this demographic. Concerns about the health of migrant and diverse populations include, reproductive health, maternal–child health, women's health, chronic disease, behavioral, mental and psychosocial health. The availability of services, access to insurance, linguistic barriers, and use of health care services, hospitals, clinics, and doctors, can vary significantly, and an individual's point of origin can influence how and for what reasons mobile populations seek or utilize health care.

In order to reach diverse populations, MCH Title V funded partners provide interventions and support. Use of Promatores and Community Health Workers (CHW) are examples of how partners connect with diverse populations. Partners Allied for Community Excellence (PACE) Coalition, Healthy Start, Home Visiting, and other programs continue to expand program access to Black, Latino, and Native American populations by identifying target populations facing barriers accessing specific services and supports, health disparities, and developing recruitment strategies to mitigate barriers. MCH Title V funded programs will continue to expand services access using Promatores to address Perinatal Mood and Anxiety Disorders (PMAD) and better serve diverse populations in southern Nevada. PACE's CHW focuses efforts on Latino MCH populations in Elko.

Local groups and coalitions also continue to reach out to and support diverse populations in improving health outcomes. Community events, such as health fairs, include printed materials and available personnel to link people to specific programs providing culturally competent services. At the community, county, and state levels, programs funded by MCH Title V must build their systems to respect cultural differences and expand their knowledge of different cultures in their service catchment area, as well as provide bilingual supports to align with CLAS standards.

3. Public Health System/Organizational Structure

Governor Brian Sandoval is Nevada's current Governor, serving a 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 Governor-appointed. DHHS is comprised of five divisions, with multiple programs under 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 helping to promote MCH priorities in Nevada include: Nevada 2-1-1, Office of Consumer Health Assistance, Nevada Governor's Council on Developmental Disabilities, The Office of Health Information Technology (HIT), Individuals with Disabilities Education Act (IDEA) Part C Office, Nevada Early Intervention Services (NEIS), the Office of Minority Health, Tribal Liaisons (DHHS and DBPH partner with 27 Tribes across Nevada through a Tribal Consultation Process Agreement to strengthen ties and relationships with Tribal Governments), Primary Care Office (PCO addresses access to health care and identifies workforce shortage areas), Oral Health (initiatives focusing on pregnant women, infants, and young children), Community Health Nurses (rural communities), Office of Public Health Informatics and Epidemiology (OPHIE), Substance Abuse Prevention Treatment Agency (SAPTA), Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Division of Child and Family Services (DCFS), Chronic Disease Prevention and Health Promotion (CDPHP), Community Health Workers (CHW), Women, Infants, and Children (WIC) and Nevada State Immunization Program.

Nevada Revised Statute (NRS) Chapter 442 (http://www.leg.state.nv.us/NRS/NRS-442.html) details MCH public health authority of the the Division of Public and Behavioral Health (DPBH). The DPBH Administrator is Ms. Cody Phinney, MPH. The Bureau of Child, Family and Community Wellness (CFCW) within the Community Services Branch is led by Bureau Chief Beth Handler, MPH. She is also the MCH Title V Director. The Maternal, Child and Adolescent Health (MCAH) Section is led by Vickie Ives, MA. She is also the CYSHCN Director and manages programs including: Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; Teen Pregnancy Prevention (TPP) program including Personal Responsibility Education Program (PREP) and Abstinence Education Grant Program (AEGP); Pregnancy Risk Assessment Monitoring System (PRAMS); Rape Prevention and Education (RPE); Early Hearing Detection and Intervention (EHDI); and the Title V MCH program. The MCAH Section addresses health and social issues among the populations it serves by coordinating efforts with Nevada programs, local health authorities, public and private partners, MCH Coalitions, Community Coalitions, Family Resource Centers, Federally Qualified Health Centers (FQHC), stakeholders, and regional hospitals.

The MCAH Section includes the Title V Maternal and Child Health (MCH) Program, which is managed by a Health Program Manager I. The MCH Manager, Margot Chappel, is responsible for carrying out the policy, program, evaluation, and fiscal administration of Title V activities. The MCH program fiscal lead is Management Analyst II, Kristine Hughes. MCH Title V staff and programs include:

- The CYSHCN Program Coordinator collaborates with public and private partners, including those serving family advocates for CYSHCN, to promote the Nevada Children's Medical Home Portal, and provide services and supports for CYSHCN (e.g., cleft palate clinic, transition activities, etc.), health education, and training for families and health professionals.
- The MCH Epidemiologist is responsible for the assessment of the Title V MCH Block Grant and the MCH five-year needs assessment, as well as reviewing and evaluating program components such as performance measures and data trends for MCH populations and writing reports for federal, state and local use.
- The Rape Prevention and Education (RPE) Coordinator manages all aspects of this program, including collaborating with public and private partners on a variety of prevention of sexual violence and violence against women activities. The position, and RPE activities are co-funded collaboratively between MCH and the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant.
- The Adolescent Health and Wellness Coordinator collaborates with community partners on physical activity, improving access to insurance, health care, well visit services, school-based health center promotion, co-occurring disorders, and adolescent-friendly environments.

- The Maternal and Infant Health Coordinator collaborates with diverse community partners on a variety of pre/interconception care initiatives, including substance misuse prevention, Safe Haven, breastfeeding, perinatal quality collaborations, and Fetal and Infant Mortality Review (FIMR).

Title V MCH works closely with DPBH programs and sections supporting infants, prenatal care, children, CYSHCN, adolescents, and women of childbearing age. Nevada's Title V MCH activities occur at the local, regional and statewide levels. A sample of MCH funded partners conducting activities to meet the priorities indicated in the 5-year plan, include, but are not limited to:

- FIMR Program in Washoe County assesses factors affecting the health of the mother and fetal and infant birth outcomes to reduce fetal and infant mortality
- Local Health Authorities provide health services access information, care coordination, health education, outreach, and other functions to support public health
- Family Training, Information, and Emotional Support (TIES) supports CYSHCN and their families with a toll-free hotline, advocacy, education, training and other supports to families and healthcare professionals serving CYSHCN
- Financial Guidance Center/Nevada 2-1-1 provides information and referral via www.nv211.org, a toll-free phone number, text support, as well as hosting the MCH toll free line, supporting the Nevada Children's Medical Home Portal resource sections, and educating women on the priority status of pregnant women at SAPTA-funded treatment centers.
- Specific activities and initiatives focused on pregnancy, prenatal, and early childhood health including websites (e.g., sobermomshealthybabies.org and text4baby), safe sleep, and developmental screenings.
- Anti-bullying training across the Nevada Department of Education, including local school district personnel
- Pregnancy Risk Assessment Monitoring System (PRAMS) partner at University of Nevada, Reno, statewide survey administration similar to PRAMS called Baby BEARS and launch of PRAMS August 2017.
- Statewide MCH Coalition support to ensure website maintenance, communication, and advocacy across public and private health entities in Nevada and planning with partners for meeting community needs of diverse populations (activities also align with MCH 5-year plan priorities)
- March of Dimes supporting training of healthcare professionals and advocates, as well as providing MCH with educational materials focusing on pre/interconception with the 39 weeks hospital banner campaign
- Immunize Nevada training/workforce development including statewide Nevada Health Conference and symposiums with trainings to build topical knowledge
- Nevada Broadcasters Association Sober Moms Healthy Babies (SMHB), PRAMS, Safe Sleep, marijuana in pregnancy media campaigns.

To coordinate all MCH activities across Nevada, program management and fiscal staff meet weekly, and program personnel meet biweekly to discuss the status of funded programs. Discussions include status on meeting program and fiscal goals, identifying barriers, training needs, and new activities to consider as 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 focusing on MCH activities and action.

MCH Workforce Development and Capacity

Title V MCH supports 17 Full Time Employees (FTE) in the Bureau of CFCW. This number was changed since the last five year needs assessment to more accurately reflect the true number of full time employees funded by Title V MCH Block Grant. Beth Handler, MPH, Bureau Chief, provides oversight across diverse programs and sections, including MCAH. Nevada Title V MCH Program within the MCAH Section has built workforce capacity in the last five

years, including transitioning positions filled by contract employees into permanent state positions.

UNLV Medical School will open in the fall of 2017, and will increase the health care workforce capacity in Nevada.

Key partners within the MCAH Section, the Bureau of CFCW, or other areas of DPBH, not MCH-funded but collaborating on MCH-related activities include:

- Teen Pregnancy Prevention Program, 2 FTE Coordinators, 1 FTE Administrative Assistant (AA), and 0.6 FTE Grants Project Analyst (GPA) I
- Behavioral Health Prevention and Treatment (BHPT) provides assistance on activities and initiatives to meet priorities associated with substance misuse
- Early Hearing Detection and Intervention (EHDI), 4 FTE including a Coordinator, Audiologist, Data Analyst, and Administrative Assistant

Funded state partners include:

- Community Health Nurses (CHN) provide health promotion and prevention services, care coordination, health education, and outreach to support public health in Nevada's rural counties
- Community Health Worker, 1 FTE in Elko County (rural) to provide outreach and care coordination, focusing on the Latino population
- MCH co-funds two Home Visiting sites with MIECHV
- Nevada Immunization Program, A 0.5 FTE supports efforts at the community level which also help meet Title V MCH priorities
- Office of Public Health Informatics and Epidemiology, 1.7 FTE (1 Biostatistician 0.7 FTE and 1 Health Resources Analyst II,1 FTE) who provide data support across MCH programs
- Office of Suicide Prevention team collaborates with local school districts and other community partners on gun safety, youth mental health first aid, and suicide awareness
- Chronic Disease Prevention and Health Promotion (CDPHP), 0.5 FTE HPSII supports CHW program and childhood and school wellness efforts, as well as 1 FTE Oral Health HPSII

Culturally and Linguistically Appropriate Services (CLAS) Standards

Funded programs provide outreach to ensure people have a mechanism for getting culturally appropriate services. Case managers, nurses, and others receive training regarding culture and how to engage people. Licensed personnel are required to provide Culturally and Linguistically Appropriate Services (CLAS). All non-licensed, para-professionals, including CHWs and support staff, access CLAS training, and related training.

Sometimes, there are not sufficiently trained staff especially in the rural/frontier areas of Nevada. MCH continues to work with partners in remote areas to make improvements in this area. The MCH program, including funded partners, works with diverse communities across Nevada, including other partners/stakeholders who have a great understanding of the communities in which they live. Entities offer language and translation assistance, either through local community organizations, or over the phone. Several have personnel with language skills who can provide language assistance and translation responsive to people's needs.

Bilingual documents are provided by MCH to serve Spanish language speakers. When organizations struggle with getting forms and other documents translated, they work with MCH staff and community partners to determine how best to meet a community's needs relying on information provided by the community, including translation services. Additional assistance is provided by Nevada State Purchasing with the capacity to work with diverse entities who provide translation assistance, and can offer assistance with health care visits, or translation of documents or pieces needing updated.

Currently, the MCH program funds Family TIES to provide interpretation and translation at the University of Nevada Craniofacial Clinic. MCH also funds a CHW in Elko County, and works with a hospital in southern Nevada to hire Promatores to serve Hispanic populations in their respective regions. Information and materials disseminated by these partners are culturally appropriate and/or are in the process of being developed. Internal translation support is provided by MCAH staff members.

The MCH program collects accurate demographic information shared across all funded community partners. The MCH program works with community stakeholders to expand the MCH presence across hard-to-reach populations to address gaps, and service scope to engage all communities. Webinars and trainings emphasizing CLAS, Health Literacy, generational trauma, diversity, minority health, and tribal partnerships are participated in by all MCH and MCAH staff. A training related to equity and diversity is planned for Bureau staff in September 2017.

4. Healthcare

The Patient Protection and Affordable Care Act (ACA) and Medicaid expansion continue to have a positive effect in Nevada. According to the Kaiser Family Foundation, the uninsured population in Nevada is 13%. As of 2015, the number of children who were uninsured decreased from 10% to 8%; however, this is higher than the national average of 5%. Nevada will continue to monitor insurance enrollment through state agencies responsible for collecting enrollment data. The Title V MCH program will also collect data to monitor health outcomes through the Pregnancy Risk Assessment Monitoring System (PRAMS) to capture prenatal and postnatal data, and will develop a report on the PRAMS-like Baby BEARS survey.

Nevada Medicaid is administered through the Division of Health Care Financing and Policy (DHCFP), with enrollment administered by the Division of Welfare and Supportive Services (DWSS) for Nevada Check Up (Nevada's CHIPRA program) and Medicaid. Both Fee for Service (FFS) and Managed Care Organizations (MCOs) operate in the state. Rural areas are served by FFS providers and the urban areas of Clark and Washoe counties are served by four contracted MCO providers.

In February 2017, an estimated 629,560 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, was an estimated 24,216 members in 2016. These estimated numbers demonstrate continued growth in Nevada's Medicaid population from the previous calendar year.

Nevada continues to monitor the utilization of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings among Medicaid-eligible children under the age of 20. Healthy Kids, the Nevada 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. Continued collaboration between the DHCFP and MCH Program includes education and outreach to promote available preventive benefits and EPSDT screenings, particularly as they relate to maternal, child, and infant health.

To address access to health care for uninsured Nevadans is difficult; however, *Access to Healthcare Network* (AHN) offers a medical discount program for members, who pay a membership fee to access the discounted provider network and case management. Participating network providers receive a timely, yet reduced, payment. People unable to pay for their healthcare needs can access limited financial assistance. Additionally, free health care is provided through the University of Nevada, Reno, School of Medicine *Student Outreach Clinic* operated by medical students. The Clinic is operated in cooperation with the Family Medicine Center and the University of Nevada, Reno, School of Medicine, and made possible by faculty and community physicians who donate their time. Services include general and acute medical care, gynecological exams, immunizations, and discounted laboratory services. Currently there are three separate clinics (General, Children's, and Women's) run by the Student Outreach Clinic. Volunteers in Medicine provide free medical care in Nevada. The Mexican Consulate in Las Vegas provides information relating

to insurance for non-U.S. nationals. FQHCs in Nevada provide sliding scale fees for health care, irrespective of citizenship status.

5. Employment

According to the Nevada Department of Employment, Training, and Rehabilitation (DETR), there are approximately 1.43 million Nevadans in the state's work force. Kids Count Data Center reports the statewide median income of households with children was $56,100 in 2015. Job growth in Nevada dipped the latter part of 2015 and early part of 2016; however, it started to rebound in mid-2016. Minimum wage retail trade leads job growth, with construction and education/health services being the next highest growth areas. Some economic indicators are increasing, such as the number of visitors to Las Vegas between 2009 and 2016. Nevada's unemployment rate increased in 2016 while U.S. rates remained steady. The unemployment rate in Nevada, as of March 2017, was 4.8% compared to the national average of 4.5%. According to American Community Survey (ACS), in 2015 there were approximately 19,360 children who had at least one parent unemployed, and 79,947 with at least one parent not in the labor force. The highest rate of unemployment in 2016 was in Lyon County (rural) at 7.4% while the lowest rates were in Esmeralda and Elko counties at 4.5%. In the urban regions of Nevada, Carson City experienced the highest rate of unemployment at 6.1%. Washoe and Clark Counties have improved to 5.0% and 5.8% respectively. Nevada had the sixth highest unemployment rate level in the country in 2016.

6. Housing

In 2015, according to the US Census Bureau American Community Survey (ACS) 1-year estimates, there were 1,209,864 housing units in Nevada, with 14% of the units vacant. Nevada was negatively impacted by the housing crisis, and the 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%. The drop in home ownership rates in Nevada has recently been twice as large as the national average. 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 2015, home ownership for the U.S. as a whole was 63.7%. In the 3rd quarter of 2016, Nevada ranked eleventh 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. Data from the Comprehensive Housing Affordability Strategy (CHAS) special tabulations of the 2009-2013 Five year ACS indicate approximately 85,000 Nevada renter households making less than 50% of Housing and Urban Development (HUD) area median income pay 50% or more of their income for rent and utilities (64% of very low and extremely low income households). This is termed severe rent burden. This compares with 52% of U.S. average for severe rent burden of renter households with incomes at or below 50% of HUD median income. Which means that, of the 85,000 renter households with severe rent burden, 51,000 were extremely low income (ELI), 74% of which experienced severe rent burden, compared to the national average of 64%.

7. Income

According to data provided by the Kaiser Family Foundation, Nevada ranks #1 for 2015 in measures of state economic distress: housing foreclosures, changes in unemployment, and food stamp participation. Approximately 13% of Nevadans lived in poverty in 2015; with poverty in rural areas ranging from 8.6 to 20.5 and urban areas ranging from 15.9 to 17.6. By ethnicity, of those Nevadans living in poverty, African Americans represented 30%, followed by Hispanics at 18%, and Whites at 8% in 2015. In Nevada, in January 2016, 412,056 people received SNAP benefits. Nevada ranked number one in food stamp participation, according to the Kaiser Family Foundation. Other indicators of poverty include National School Lunch Program in Schools, and according to the most recent

data available, 205,536 Nevada children participate.

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 industry tourism economies 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 into 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.

8. Policy/Legislature

The 79th Legislative Session began February 6, 2017. 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. The Governor's budget for the 2017-2019 biennium supports economic growth and diversification, including expanding access and quality of health care services so communities are safe and graduating students are prepared for entering the workforce.

Governor Sandoval's budget is built with no new taxes, with the exception of a 15% Wholesale Tax, and additional 10% tax at the retail level, related to the Marijuana Act approved at the November 2016 election. Funds from this tax will support local entities tasked with implementing and enforcing the Act, with remaining funds sent to the Rainy Day Fund. DPBH's budget as a whole across the 2018-2019 biennium will decrease as a result of efficiencies implemented.

Chapter 442 of Nevada Revised Statutes contain the majority of statutes related to MCH, with NRS 442.133 providing the membership and terms of the Maternal and Child Health Advisory Board (MCHAB). The MCHAB is comprised of nine members appointed to 2-year terms by the State Board of Health, with two legislators appointed by the Legislative Counsel. The MCHAB is staffed by the MCH Manager and an AA III. MCHAB advises the DBPH Administrator on objectives related to primary care, infant mortality, preventing fetal alcohol syndrome and substance use by pregnant women, and increasing immunizations. Beyond Nevada's biennial legislative period, Nevada relies on MCHAB to assist with advice relating to MCH populations. The MCHAB works with diverse stakeholders, including a statewide MCH Coalition, to address the priorities documented in the 5-year action plan. The Advisory Board meets at least quarterly. The Statewide Maternal and Child Health Coalition includes two regional Coalitions and a Statewide Steering Committee.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

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 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 Advisory Board (MCHAB) members provided input into the Action Plan updates and will continue to review sections of the plan and advise on strategies for implementation.

MCH Workforce Development and Capacity

Nevada Maternal, Child and Adolescent Health (MCAH) Section has been undergoing changes including new staff in the MCH Program Unit. Training on cultural competence and MCH topics will help in program continuity, improve staff morale, and reduce staff turnover.

Title V continued to support 17 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 Title V Director. Vickie Ives, MA, is the Maternal, Child, and Adolescent Health Section Manager and the MCH Title V CYSHCN Director. The new MCH Manager is Margot Chappel, MS and the new Children and Youth with Special Healthcare Needs Program Coordinator is Elizabeth Kessler. The Epidemiologist is now Dr. Mitch DeValliere.

A MCH Biostatistician and HRA II position are now funded in OPHIE 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. Through this surveillance system, many MCH 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. Efforts to improve data on completed referrals to services and number of MCH referrals made to health and social services will continue.

The MCH Program was accepted for the CDC Harvard Practicum for assistance in determining the effectiveness of programs providing preconception and interconception health information to adolescents and women by reviewing current activities and data used for improving program operations. In January of 2017, Nevada MCH staff, CDC staff, and Harvard MPH and MPH/MD students worked together for one week at CDC offices in Atlanta, followed by Harvard MPH and MPH/MD students traveling to Nevada to work with Title V MCH staff for a week to understand program activities, data collection and data gaps, and to begin assessing an evaluation plan focused on data at the preconception and interconception periods. An evaluation plan was generated and shared with the Nevada Title V MCH staff in March of 2017, and the program is prioritizing how to best integrate the plan into quarterly and annual reporting requirements for programs and agencies supported by Title V funding in Nevada, and prioritizing next steps to address gaps.

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

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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

Nevada Title V MCH 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 Nevada 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 2016-2020 Priorities	Priorities Submitted in 2016 Application/2014 Report
Improve preconception and interconception health among adolescents and women of childbearing age	Improve preconception and interconception health among adolescents and women of childbearing age
Breastfeeding promotion	Breastfeeding promotion
Increase developmental screening	Increase developmental screening
Promote healthy weight	Promote healthy weight
Reduce teen pregnancy	Reduce teen pregnancy
Improve care coordination	Improve care coordination
Reduce substance use during pregnancy	Reduce substance use during pregnancy.
Increase adequate insurance coverage among children	Increase adequate insurance coverage among 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 NPMs. The priority needs were to be those priorities not addressed by the NPMs or Evidence-Based or -Informed Strategy Measures (ESMs). At the February 2016 meeting, the Board asked 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 or LARCs), and substance use beyond tobacco use (i.e., alcohol, prescription drugs, and illicit drugs). The Maternal and Child Health Bureau (MCHB) stipulates SPMs should be measurable and data 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; access to care, bullying, teen pregnancy prevention, mental health, and substance use.

- **Discussion Key Points**
    - Bullying and Cyber-bullying were removed from the list of potential SPMs because of existing efforts with the Nevada 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 SPM aligns with the efforts conducted by MCH under 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 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 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 sexually transmitted infection (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 SoberMomsHealthyBabies.org 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 reliable data for the two health outcomes. However, Nevada was recently awarded PRAMS funding and Title V MCH 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

After consulting with the review committee, the Title V MCH Program decided to split SPM2 into two separate measures. SPM2 originally read: “SPM2-A. Percent of teenage pregnancies and B. Percent of repeat teen births”. SPM2 now reads: “Repeat teen birth rate”. We created SPM4: “Teenage pregnancy rate”. Since it is a new measure, data will not be available until next year.

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 - Repeat teen birth rate
- SPM 3 - Percent of women who use substances during pregnancy
- SPM 4 - Teenage pregnancy rate

Nevada Title V linked the Selected State Priorities with State Performance Measures (SPMs) as well as National Outcome Measures (NOMs). The SPMs were developed based on the priorities 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

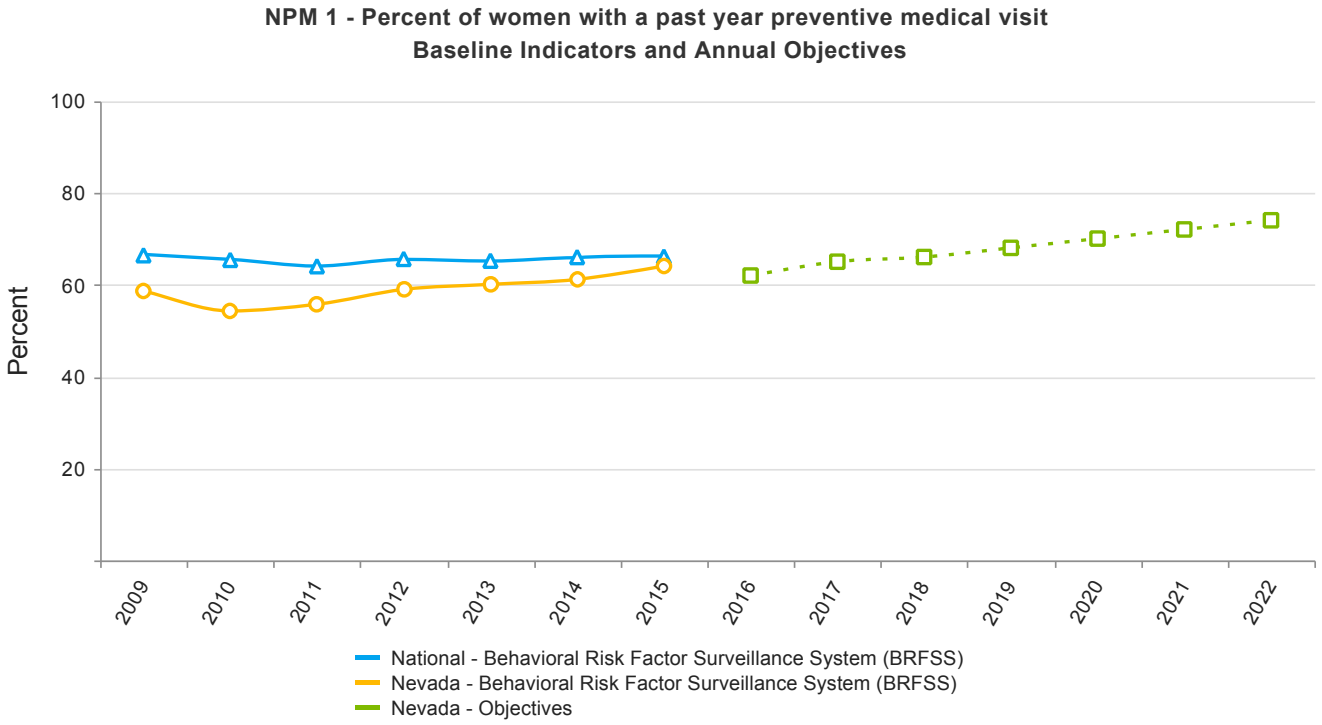
II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	152.2	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	6.2	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.5 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.3 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.2 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.0 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.7 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.3 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	26.3 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.0	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.8	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	186.8	NPM 1

National Performance Measures



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	64.0
Numerator	319,699
Denominator	499,724
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	65.0	66.0	68.0	70.0	72.0	74.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	9.0	10.0	11.0	12.0	13.0

State Performance Measures

SPM 1 - Percent of mothers reporting late or no prenatal care

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7.9
Numerator	2,805
Denominator	35,378
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	7.0	6.5	6.5	6.0	6.0

State Action Plan Table

State Action Plan Table (Nevada) - Women/Maternal Health - Entry 1

Priority Need

Improve preconception and interconception health among women of childbearing age

NPM

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	Status
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	Active

NOMs

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

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

NOM 4.1 - 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 (Nevada) - 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.

Perinatal/Infant Health – Plan for the Application Year

Breastfeeding

The Maternal and Child Health (MCH) Program will continue to partner with Women, Infants and Children (WIC) to provide training to hospitals in Reno, Fallon, and Las Vegas to increase implementation of baby friendly hospital practices. Twenty workshops will be held in northern and southern Nevada birthing hospitals to incorporate the five best practice steps for breastfeeding, and to increase hospital standards of care for nursing mothers.

Efforts will continue to encourage Nevada businesses to sign the *Breastfeeding Welcome Here* pledge. WIC applied for continued funding for the Pacify Smartphone application and is currently waiting on a notice of award.

Carson City Health and Human Services (CCHHS) efforts include providing breastfeeding trainings and technical assistance to early care and education centers statewide. Outreach to local businesses promoting and establishing breastfeeding friendly workplaces will continue.

MCH is collaborating with WIC to disseminate a breastfeeding toolkit. The National Governors Association Learning Network to Improve Birth Outcomes workgroup in Nevada also developed the *Substance Use During Pregnancy Provider Toolkit*. The provider toolkit includes information on screening pregnant women for substance use, substance use treatment providers by region, and lists state funded treatment centers required to prioritize pregnant women. A group of providers across the state is currently reviewing the final proposed version. Edits will be incorporated, and distribution should begin in late October 2017. The provider toolkit will also be made available on the Nevada Title V MCH website. MCH will fund printing and mailing of all materials to providers statewide. Marijuana fact sheets for providers and the public will also be disseminated statewide. Fact sheets discuss what happens to the body when marijuana is used, how it affects pregnancy and breastfeeding, as well as how it affects parenting interactions. MCH will promote materials and continue to partner with Child Death Review teams to distribute information and provide updates.

Cribs for Kids/Safe Sleep

The MCH funded Cribs for Kids (C4K) program will continue to provide program activities throughout the state. A minimum of twelve train-the-trainer sessions will be taught throughout the state, including six trainings in Las Vegas, three trainings in the rural areas, and three trainings in Reno. Additional trainings will be provided as requested by partners. Technical assistance will be provided to partners, as needed, along with ongoing support to ensure agencies are collecting and entering data on the required three and twelve month follow-up surveys. The C4K curriculum will be updated along with the C4K Safe Sleep poster. The C4K program will share additional MCH materials to the public, including promoting Nevada 2-1-1, the Tobacco Quitline, and the Nevada Children's Medical Home Portal at the numerous community events they attend.

Title V MCH began a Safe Sleep Media Campaign in October 2016. Thirty second radio and television public service announcements are broadcasted statewide and the campaign will continue.

C4K and MCH Title V will continue participation in the statewide Impact of Safe Sleep meetings. The group will collaborate with funds from Child Death Review teams to launch a public awareness campaign using floor talker stickers in grocery stores and advertisements on grocery carts.

A total of 402 Safe Sleep Survival Kits were distributed from October 1, 2015 through September 30, 2016. Safe Sleep survival kits include a Pack and Play Crib, Crib Sheet with the safe sleep message, a Halo Sleep Sack, Safe Sleep ABC photo magnet, Philips Soothie Pacifier, Safe Sleep Educational Materials (Brochures), a Safe Sleep DVD, and a "Sleep Baby Safe and Snug" children's book. Materials are available in English and Spanish.

MCH Title V will pilot a Safe Sleep and Injury Prevention Pilot program with four Indian Health Service clinics.

Conference calls have been completed with three sites. Two clinics confirmed participation in Infant Safe Sleep training, car seat installation, and training on using the Ages and Stages Questionnaire to increase developmental screenings in children ages 10 through 71 months. Also offered as part of this pilot is training and education to clinics on Shaken Baby Syndrome and Abusive Head Trauma, including materials for parents. Other topics available for consideration include: Not even for a minute/Never leave a baby in a car (car safety); drowning prevention; tobacco cessation; substance misuse; and other topics requested.

Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN)

Participation in the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) will continue. Data will be used to measure improvement and effectiveness of current activities. Efforts to address Adverse Childhood Experiences (ACEs) and Social Determinants of Health (SDoH) will include surveying providers on their knowledge of ACEs, SDoH, and trauma-informed care. Educational materials will continue to be disseminated and information on trauma-informed care trainings will be provided to the community. The group will be reaching out to various entities, including providers, partners and stakeholders to expand the IM CoIIN team statewide. In addition, the team will continue to focus on birth spacing, increasing postpartum visits and long-acting reversible contraceptives (LARCs). A one page LARC reimbursement guide will be shared and the group will work on efforts to promote *One Key Question.* Participation in these initiatives is vital to Nevada Title V MCH because goals align well with Nevada MCH priorities.

Title V MCH is developing a Perinatal Quality Collaborative (PQC). In November 2016, two staff members attended the National Network of Perinatal Quality Collaboratives Conference as an emerging collaborative. Nevada highlighted their participation in the IM CoIIN and the National Governors Association Learning Network on Improving Birth Outcomes. MCH applied for a Centers for Disease Control and Prevention (CDC) grant opportunity to establish a PQC focused on Neonatal Abstinence Syndrome efforts initially. Eight hospitals have agreed to participate along with several state agencies, including the Department of Child and Family Services, IDEA, Part C/Division of Aging and Disability, Medicaid, Substance Abuse Prevention and Treatment Agency (SAPTA) and Women, Infants and Children (WIC).

March of Dimes (MOD)

Nevada MOD will continue fundraising efforts to support its mission. The Signature Chefs Gala expects 300 attendees and the March for Babies event hopes to have 2000 people. The Nurse of the Year Awards Ceremony will be held again with 700 attendees expected. The 2017 Community Grants will fund the Zeta Phi Beta, Pi Pi Chapter's Stork's Nest Program and the University of Nevada, School of Medicine for their immediate long-acting reversible contraceptives (LARCs) insertion at delivery project. MOD will continue to disseminate patient education materials to hospitals, clinics and community organizations promoting full term pregnancies and preconception and interconception health. A training opportunity for providers on preterm labor and birth, interventions to prevent preterm births, and cultural competency in care will be held in partnership with community organizations.

Nevada Pregnancy Assessment Monitoring System (PRAMS)

Title V MCH will continue to co-fund a media campaign promoting the launch of the Nevada Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data will be used to monitor progress of national and state pregnancy and birth-related health measures. PRAMS will also identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants.

Approximately 157 mothers will be randomly selected from birth records each month. The selected mothers will be sampled between two and six months after delivery. Mothers will be sent questionnaires asking about their

pregnancies and the time immediately after the birth of their babies. The PRAMS questionnaire packets will include a cover letter, a question and answer brochure, and a consent document. If a mother does not respond after three questionnaires are sent, an attempt will be made to reach her by telephone. Mothers who complete the survey by mail or telephone will be offered a $10 Walmart gift card (funded by PRAMS). Nevada PRAMS will implement the web survey module of the survey after it is made available to PRAMS states by CDC. The web module is currently under development. Continued search for databases to provide reliable and working physical addresses and phone numbers for sampled mothers will be conducted. Use of other data sources will require forging relationships with other programs and agencies collecting mothers' contact information.

Fetal Infant Mortality Review (FIMR)

The MCH program will continue to fully fund the FIMR Program to continue its goal to reduce fetal and infant mortality in Washoe County. The FIMR Program will continue to examine contributing factors of fetal, neonatal, and postnatal deaths, and identify disparately impacted populations in Washoe County. WCHD FIMR staff will continue to facilitate monthly CRT and periodic CAT meetings. At least 50 cases will be reviewed at Case Review Team (CRT) Meetings. Based on case findings, CRT recommendations and community input, the CAT will continue to participate in implementing objectives, timelines, and evaluation components for interventions involving policy, systems, or community norm changes to reduce fetal, neonatal, and postnatal deaths. The MCH funded statewide "Go Before You Show" Campaign will be implemented to encourage early/on time prenatal care. Staff will also continue to participate in local Northern Nevada Maternal Child Health (NNMCH) Coalition meetings and events, Child Death Review (CDR) meetings, Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) and additional community program activities to provide FIMR program updates and build partnerships for improving birth outcomes in Washoe County.

Southern Nevada Health District Healthy Start Program

The Southern Nevada Health District (SNHD), in tandem with their Healthy Start program, will continue to improve the health of women of child bearing age with emphasis on the target population, African American women and their children through the age of two years, by providing education, support and developing a coordinated program of services, conducting home visits and providing case management. Healthy Start case managers will receive trainings to assist them in helping participants reach program benchmarks. The MCH funded Cribs for Kids Safe Sleep training for MCH, Nurse Family Partnership (NFP) and Healthy Start programs served through Home Visiting will continue. The Healthy Start program will continue to work specifically with two Urban League Women Infants and Children (WIC) sites serving the targeted zip codes to provide information for recruitment of participants to meet enrollment expectations. The program will work with community partners serving the targeted population and other high risk populations through the Community Action Network to provide program information. The *Partners for a Healthy Baby* curriculum will be used to educate participants served on topics related to family development, maternal, and family health, caring for baby and baby's development. A reproductive life plan will be developed for each woman served without a permanent method of birth control. In addition, Nevada Institute for Children's Research and Policy will conduct the annual satisfaction surveys with current and past program participants as well as survey program partners on their knowledge of the program and their involvement in making referrals to the program. The Healthy Start program will implement the continuous quality improvement plan to increase breastfeeding initiation and breastfeeding at six months and will evaluate the effectiveness of the plan. The program will maintain the numbers of participants served with a goal for 50% of the case load to be pregnant women, with at least 80 participants served. SNHD staff will continue to participate in the Infant Mortality Collaborative Improvement and Innovation Network.

The Nevada Early Hearing Detection and Intervention (EHDI)

The Early Hearing Detection and Intervention (EHDI) program will focus on quality improvement and improving evaluation processes. Collaborations will ensure all children in Nevada are screened for hearing loss at birth and timely, appropriate audiological, educational and medical intervention referrals are delivered to Nevada families. Efforts to decrease the number of infants lost to documentation and lost follow-up pertaining to diagnostic and intervention services will also continue through standard tracking protocols. EHDI and the MCH program will continue to collaborate on efforts related to the Zika virus.

Nellis Airforce Base

The Nevada Title V MCH program will continue to work with Nellis Airforce Base, in Southern Nevada, in relation to the EHDI and CCHHS programs and explore possible ways to partner on other MCH efforts with military bases.

Women/Maternal Health-Annual Report

Carson City Health and Human Services (CCHHS), a local health authority in Northern Nevada, was awarded Title V funding to promote women/maternal health. Priorities were to improve the health of women (ages 15 – 45 years) experiencing substance use, domestic violence, and depression. Information, counseling, and referrals were made to 1,304 users of alcohol, 195 substance users, 29 affected by domestic violence, and 202 women experiencing depression.

Title V co-funded the nursing personnel within the Community Health Services (CHS) to educate community members at outreach events in Nevada's rural and frontier areas. 4,340 community members were informed about topics such as; wellness, nutrition, reproductive health (inclusive of long-acting reversible contraception), sexually transmitted infections, depression, and domestic violence prevention. To educate on various topics, nursing personnel distributed diverse health-related brochures provided by the Title V/MCH program.

PACE Coalition (an entity within the Nevada Statewide Coalition Partnership) was awarded Title V funding the last quarter of the report year, to employ a Community Health Worker (CHW) to participate in MCH activities in Elko County and nearby communities. The PACE Coalition ensures the CHW collaborates with other community partners on key MCH objectives/priorities to improve health outcomes. Specific emphasis was placed on care coordination and increasing connections to resources and services for the Latino population. Through outreach events, the CHW distributed MCH-provided educational information to community members, including ways to access further information and/or how to work with local medical professionals to improve their health. 500 pamphlets were handed out on topics such as child health, pregnancy, resources for domestic violence assistance, tobacco cessation, and nutrition.

Collaboration

MCH Title V collaborates with the Maternal, Infant and Early Childhood Home Visiting (MIECHV) programs; co-funding activities for the Children's Cabinet Home Instruction for Parents of Preschool Youngsters (HIPPY) programs in both Washoe and Elko counties and the Community Chest, Inc., Parents as Teachers (PAT) program serving Lyon and Storey counties. The design and delivery of the MIECHV funded program is to provide comprehensive, coordinated health and social service fostering continuous access to care for women who are pregnant or who have young children. The Nevada Home Visiting (NHV) program focuses on many of the MCH priorities, including improving preconception and interconception health, breastfeeding promotion, increasing developmental screenings, reducing teen pregnancy, reducing substance use during pregnancy, and increasing adequate insurance coverage for families.

HIPPY programs (serving families with children aged four and five) co-funded with MCH help parents engage with their children in daily learning activities to help promote literacy and school readiness. The program fosters language development, problem solving, logical thinking, and perceptual skills in children. PAT (serving expectant mothers and families with children birth through five years of age) provides child development education, health education, activities to build cognitive and motor skills in children and parent-child interaction coaching. Both programs provide developmental and social development screening, screening for insurance coverage, depression screening (both post-partum and general), screening for domestic violence, necessary needs (housing, food, clothing, utilities), and substance misuse. Referrals are provided for any screening showing need. Referrals are followed up and assistance is given in making any appointments or any application follow through.

Continuous Quality Improvement

Agencies implementing home visiting programs for NHV pursue Continuous Quality Improvement (CQI) and conduct Plan Do Study Act (PDSA) cycles to test small changes in order to improve processes and outcomes. Significant improvements have been made to enrollment procedures, birth spacing education, reflective supervision and specific benchmark measures.

Training

NHV staff and all implementing agencies attended a Bridges out of Poverty training to promote understanding of the cycle of generational poverty and changes needed to break that cycle. Supporting Maternal Mental Health in Pregnancy training was also provided for local implementing agencies (LIAs). Technical assistance (TA) is provided to LIAs as requested or needed. Areas of TA provided include Data Collection and Entry, Domestic Violence screening and education, and other CQI topics.

Support and Referrals

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

NHV provides bilingual materials and agencies serving populations with the need for bilingual home visitors have bilingual staff. Families are also provided with Spanish language books for children to keep and agencies maintain a resource library for check-out in Spanish and English. In addition, families are administered Spanish language screenings and learning materials. 102 MIECHV families reported Spanish as their primary language.

A total of 387 referrals were made during program period: 41 health insurance referrals (application assistance was provided), 125 child injury prevention trainings were provided to parents, 20 intimate partner violence referrals, 77 community resource referrals, 112 completed and scored Ages and Stages Questionnaires (ASQ3) reviewed with parents, and 12 completed prenatal care referrals. NHV programs provided a total of 803 screenings during the program period. 106 Healthy Families Parenting Inventories were administered, 120 ASQ3s administered, 106 Ages and Stages: Social Emotional (ASQ:SEs) were administered, 197 intimate partner violence screening (20 safety plans completed with those identified as at-risk), 81 postpartum depression screenings, and 193 other service screenings were provided, including food assistance, substance use prevention, and housing assistance. In addition, birth spacing education was provided to 115 mothers.

National Governors Association Learning Network on Improving Birth Outcomes

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, Managed Care Organizations, March of Dimes (Nevada Chapter), and other Nevada Department of Health and Human Services divisions to improve birth outcomes by identifying modifiable risk factors for the incidence of preterm births, low birth weight, 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, encompassing 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, MCH 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 progress has been made.

MCH Program staff continue to utilize existing websites and community partner and coalition activities to promote preconception and interconception health. The group continues to focus on education and awareness by promoting the value of *One Key Question* to health professionals, and raising awareness on the importance of birth spacing, family planning, and wellness visits through statewide MCH postings.

MCH program staff, partners, and stakeholders continue to disseminate educational materials regarding the Affordable Care Act. Promotional campaigns and awareness materials on Nevada's Medicaid program have encouraged more Medicaid-eligible individuals to obtain coverage. The group has been successful in partnering with universities to support telehealth services. Various trainings are provided through the University of Nevada, Reno, School of Medicine Project ECHO (http://med.unr.edu/echo) such as a recent breastfeeding training. To address the provision of mental health assessments, Home Visiting programs have added mental health assessments to their curriculum. Medicaid providers (e.g., rural health clinics and family planning clinics) have expanded their ability to provide and bill family planning services. Long-acting reversible contraceptives (LARCs) are now a Medicaid covered benefit at the time of delivery, allowing more women access to the most effective forms of birth control.

Nevada's work group participation relating to substance use in pregnancy continues to yield partnerships with various agencies and programs. Activities continue the progress of increasing awareness and resources to reduce exposure to alcohol, drugs, and tobacco. Screening, Brief Intervention, Referral to Treatment (SBIRT) trainings are offered throughout the State to Community Health Nurses and Behavioral Health Nurses. Non-traditional partners and safety net providers have been identified, and will receive awareness materials and resources. In addition, SoberMomsHealthyBabies.org public service announcements continue.

MCH staff, along with March of Dimes (Nevada Chapter) participate in the workgroup aimed to decrease early elective deliveries. A sample policy template was shared to assist hospitals in drafting their own policies. A hospital banner program was created to encourage and acknowledge efforts of hospitals to decrease their early elective deliveries. Three hospitals were recognized for reducing their early elective delivery rates to 5% or less. MCH and March of Dimes work together to increase public awareness throughout the state on the importance of full term births and the risks of premature delivery.

Statewide Maternal Child Health (MCH) Coalition

The Nevada (NV) Statewide MCH Coalition continued to collaborate across diverse community stakeholders offering education, resources, promoting services, and raising public awareness regarding the first three National Performance Measures identified in Nevada's 2016-2020 MCH Strategic Plan. Collaboration activities focused on 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 Statewide MCH Coalition Coordinator continued the goal of building capacity of the MCH coalition partners to promote statewide MCH messaging for improving the health of women, infants, children and their families. The statewide MCH Coalition Coordinator facilitated coalition activities, improved networking of private and public partners, engaged partners in coalition goals, and served as a positive resource for MCH communities.

The MCH Coalition Steering Committee is comprised of members from both the Northern Nevada MCH Coalition and the Southern Nevada MCH Coalitions. Four committee meetings were held via conference call. Activities focused on updating the strategic plan, updating the MCH Coalition website, and proposing specific activities to address preconception and interconception health and breastfeeding promotion. Two additional in-person meetings addressed quality improvement activities, including ways to enhance services to diverse populations. Five Southern Nevada Coalition meetings were held and the Northern Nevada MCH Coalition held 12 meetings.

The Nevada Statewide MCH Coalition participated in the March of Dimes High Risk Pregnancy Center training, a presentation on folic acid, two MCH Advisory Board meetings and regular Immunize Nevada Coalition meetings. The Statewide MCH Coalition Coordinator attended the annual Association of Maternal Child Health Programs (AMCHP) conference. The MCH Coalitions participated in the March of Dimes Fall Symposium and assisted with facilitating the Spring MCH Symposium. The MCH Coalition was an exhibitor at both the Nevada Health Conference and Nevada Public Health Association conference.

The Statewide MCH Coalition distributed materials to its members and community partners throughout the State promoting MCH topics, including disseminating Foundation for Positively Kids brochures focused on special needs issues, flu and immunization materials, March of Dimes smoking cessation brochures, Safe Sleep materials, text4baby referral cards and incentives, SoberMomsHealthyBabies.org referral cards, Nevada 2-1-1 referral cards, Zika virus information, and AMCHP health resource bulletins provided by the MCH program and Title V MCH funding. Communication improved with coalition members through 20 MCH Coalition e-newsletters and enhancements to the MCH Coalition website funded by the Title V MCH Block Grant. All coalition meetings began offering conference lines for members unable to attend the meetings in person.

The Statewide Maternal Child Health Coalition was able to provide input on the Nevada MCH Needs Assessment, along with all other MCH partners and stakeholders. The Coalition developed a steering committee to offer opinions as priorities were selected. They also determined priorities the Coalition would specifically focus their interventions and efforts to improve, which included improving preconception and interconception health among women of childbearing age, increasing the percent of infants exclusively breastfed for six months, and increasing the percent of children ages 10-71 months who receive a developmental screening.

Data

Positive changes have occurred in the percent of pregnant women who receive prenatal care beginning in the first trimester. The outcome measure has improved from 65.9% in 2010 to 72.6% in 2015. The National Center for Health Statistics (NCHS) documentation table 8 indicates the national average is 77%. Some possible reasons for the improvement in Nevada are Medicaid expansion, statewide efforts in the National Governors Association Learning Network on Improving Birth Outcomes and Infant Mortality Collaborative Improvement and Innovation Networks (CoIIN).

Areas of concern are in the under 20 year old population (55.2%), those with less than a high school education (58.5%), the uninsured (55.4%), the American Indian/Alaska Native population (46.6%), and the Native Hawaiian/Other Pacific Islander population (56.9%). There is also concern those with Medicaid receive prenatal care at a lower rate (64.7%) than those with private insurance (82.4%).

The rate of severe maternal morbidity (SMM) per 10,000 delivery hospitalizations has increased from 113.3 in 2013 to 152.2 in 2014, and will require close monitoring in the coming year. Women over 35 years have a high rate (188.2) as do the uninsured (200.6). Non-Hispanic Black women (202.4), and those listing their ethnicity as Other (212.4) have higher rates of SMM than Non-Hispanic White women (125.1), and Hispanic women (157.4).

Perinatal/Infant Health

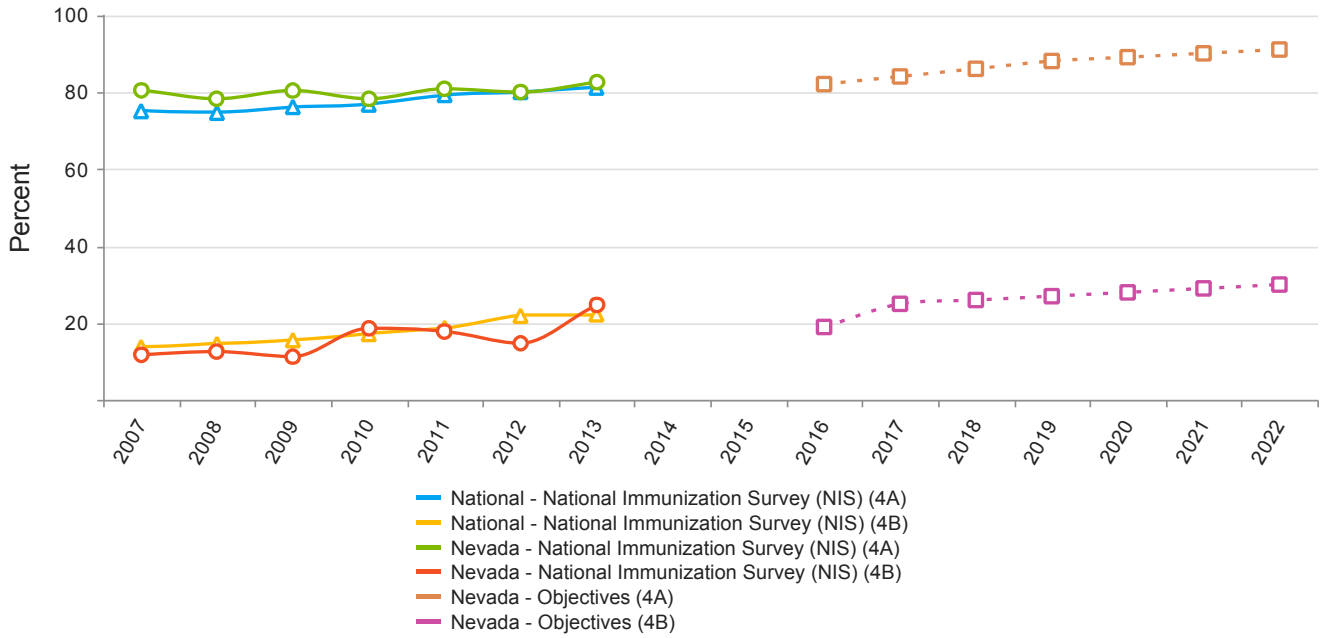
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	55.8	NPM 4

National Performance Measures

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

Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	82
Annual Indicator	82.6
Numerator	26,908
Denominator	32,591
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	86.0	88.0	89.0	90.0	91.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	19
Annual Indicator	24.9
Numerator	7,990
Denominator	32,061
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	26.0	27.0	28.0	29.0	30.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Nevada Statewide Breastfeeding Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	8.0	9.0	11.0	13.0	14.0

State Action Plan Table

State Action Plan Table (Nevada) - 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	Status
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	Active

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

Perinatal/Infant Health – Plan for the Application Year

Breastfeeding

The Maternal and Child Health (MCH) Program will continue to partner with Women, Infants and Children (WIC) to provide training to hospitals in Reno, Fallon, and Las Vegas to increase implementation of baby friendly hospital practices. Twenty workshops will be held in northern and southern Nevada birthing hospitals to incorporate the five best practice steps for breastfeeding, and to increase hospital standards of care for nursing mothers.

Efforts will continue to encourage Nevada businesses to sign the *Breastfeeding Welcome Here* pledge. WIC applied for continued funding for the Pacify Smartphone application and is currently waiting on a notice of award.

Carson City Health and Human Services (CCHHS) efforts include providing breastfeeding trainings and technical assistance to early care and education centers statewide. Outreach to local businesses promoting and establishing breastfeeding friendly workplaces will continue.

MCH is collaborating with WIC to disseminate a breastfeeding toolkit. The National Governors Association Learning Network to Improve Birth Outcomes workgroup in Nevada also developed the *Substance Use During Pregnancy Provider Toolkit*. The provider toolkit includes information on screening pregnant women for substance use, substance use treatment providers by region, and lists state funded treatment centers required to prioritize pregnant women. A group of providers across the state is currently reviewing the final proposed version. Edits will be incorporated, and distribution should begin in late October 2017. The provider toolkit will also be made available on the Nevada Title V MCH website. MCH will fund printing and mailing of all materials to providers statewide. Marijuana fact sheets for providers and the public will also be disseminated statewide. Fact sheets discuss what happens to the body when marijuana is used, how it affects pregnancy and breastfeeding, as well as how it affects parenting interactions. MCH will promote materials and continue to partner with Child Death Review teams to distribute information and provide updates.

Cribs for Kids/Safe Sleep

The MCH funded Cribs for Kids (C4K) program will continue to provide program activities throughout the state. A minimum of twelve train-the-trainer sessions will be taught throughout the state, including six trainings in Las Vegas, three trainings in the rural areas, and three trainings in Reno. Additional trainings will be provided as requested by partners. Technical assistance will be provided to partners, as needed, along with ongoing support to ensure agencies are collecting and entering data on the required three and twelve month follow-up surveys. The C4K curriculum will be updated along with the C4K Safe Sleep poster. The C4K program will share additional MCH materials to the public, including promoting Nevada 2-1-1, the Tobacco Quitline, and the Nevada Children's Medical Home Portal at the numerous community events they attend.

Title V MCH began a Safe Sleep Media Campaign in October 2016. Thirty second radio and television public service announcements are broadcasted statewide and the campaign will continue.

C4K and MCH Title V will continue participation in the statewide Impact of Safe Sleep meetings. The group will collaborate with funds from Child Death Review teams to launch a public awareness campaign using floor talker stickers in grocery stores and advertisements on grocery carts.

A total of 402 Safe Sleep Survival Kits were distributed from October 1, 2015 through September 30, 2016. Safe Sleep survival kits include a Pack and Play Crib, Crib Sheet with the safe sleep message, a Halo Sleep Sack, Safe Sleep ABC photo magnet, Philips Soothie Pacifier, Safe Sleep Educational Materials (Brochures), a Safe Sleep DVD, and a "Sleep Baby Safe and Snug" children's book. Materials are available in English and Spanish.

MCH Title V will pilot a Safe Sleep and Injury Prevention Pilot program with four Indian Health Service clinics.

Conference calls have been completed with three sites. Two clinics confirmed participation in Infant Safe Sleep training, car seat installation, and training on using the Ages and Stages Questionnaire to increase developmental screenings in children ages 10 through 71 months. Also offered as part of this pilot is training and education to clinics on Shaken Baby Syndrome and Abusive Head Trauma, including materials for parents. Other topics available for consideration include: Not even for a minute/Never leave a baby in a car (car safety); drowning prevention; tobacco cessation; substance misuse; and other topics requested.

Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN)

Participation in the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) will continue. Data will be used to measure improvement and effectiveness of current activities. Efforts to address Adverse Childhood Experiences (ACEs) and Social Determinants of Health (SDoH) will include surveying providers on their knowledge of ACEs, SDoH, and trauma-informed care. Educational materials will continue to be disseminated and information on trauma-informed care trainings will be provided to the community. The group will be reaching out to various entities, including providers, partners and stakeholders to expand the IM CoIIN team statewide. In addition, the team will continue to focus on birth spacing, increasing postpartum visits and long-acting reversible contraceptives (LARCs). A one page LARC reimbursement guide will be shared and the group will work on efforts to promote *One Key Question.* Participation in these initiatives is vital to Nevada Title V MCH because goals align well with Nevada MCH priorities.

Title V MCH is developing a Perinatal Quality Collaborative (PQC). In November 2016, two staff members attended the National Network of Perinatal Quality Collaboratives Conference as an emerging collaborative. Nevada highlighted their participation in the IM CoIIN and the National Governors Association Learning Network on Improving Birth Outcomes. MCH applied for a Centers for Disease Control and Prevention (CDC) grant opportunity to establish a PQC focused on Neonatal Abstinence Syndrome efforts initially. Eight hospitals have agreed to participate along with several state agencies, including the Department of Child and Family Services, IDEA, Part C/Division of Aging and Disability, Medicaid, Substance Abuse Prevention and Treatment Agency (SAPTA) and Women, Infants and Children (WIC).

March of Dimes (MOD)

Nevada MOD will continue fundraising efforts to support its mission. The Signature Chefs Gala expects 300 attendees and the March for Babies event hopes to have 2000 people. The Nurse of the Year Awards Ceremony will be held again with 700 attendees expected. The 2017 Community Grants will fund the Zeta Phi Beta, Pi Pi Chapter's Stork's Nest Program and the University of Nevada, School of Medicine for their immediate long-acting reversible contraceptives (LARCs) insertion at delivery project. MOD will continue to disseminate patient education materials to hospitals, clinics and community organizations promoting full term pregnancies and preconception and interconception health. A training opportunity for providers on preterm labor and birth, interventions to prevent preterm births, and cultural competency in care will be held in partnership with community organizations.

Nevada Pregnancy Assessment Monitoring System (PRAMS)

Title V MCH will continue to co-fund a media campaign promoting the launch of the Nevada Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data will be used to monitor progress of national and state pregnancy and birth-related health measures. PRAMS will also identify and monitor self-reported maternal behaviors and experiences occurring before, during, and shortly after pregnancy among women who deliver live-born infants.

Approximately 157 mothers will be randomly selected from birth records each month. The selected mothers will be sampled between two and six months after delivery. Mothers will be sent questionnaires asking about their

pregnancies and the time immediately after the birth of their babies. The PRAMS questionnaire packets will include a cover letter, a question and answer brochure, and a consent document. If a mother does not respond after three questionnaires are sent, an attempt will be made to reach her by telephone. Mothers who complete the survey by mail or telephone will be offered a $10 Walmart gift card (funded by PRAMS). Nevada PRAMS will implement the web survey module of the survey after it is made available to PRAMS states by CDC. The web module is currently under development. Continued search for databases to provide reliable and working physical addresses and phone numbers for sampled mothers will be conducted. Use of other data sources will require forging relationships with other programs and agencies collecting mothers' contact information.

Fetal Infant Mortality Review (FIMR)

The MCH program will continue to fully fund the FIMR Program to continue its goal to reduce fetal and infant mortality in Washoe County. The FIMR Program will continue to examine contributing factors of fetal, neonatal, and postnatal deaths, and identify disparately impacted populations in Washoe County. WCHD FIMR staff will continue to facilitate monthly CRT and periodic CAT meetings. At least 50 cases will be reviewed at Case Review Team (CRT) Meetings. Based on case findings, CRT recommendations and community input, the CAT will continue to participate in implementing objectives, timelines, and evaluation components for interventions involving policy, systems, or community norm changes to reduce fetal, neonatal, and postnatal deaths. The MCH funded statewide "Go Before You Show" Campaign will be implemented to encourage early/on time prenatal care. Staff will also continue to participate in local Northern Nevada Maternal Child Health (NNMCH) Coalition meetings and events, Child Death Review (CDR) meetings, Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN) and additional community program activities to provide FIMR program updates and build partnerships for improving birth outcomes in Washoe County.

Southern Nevada Health District Healthy Start Program

The Southern Nevada Health District (SNHD), in tandem with their Healthy Start program, will continue to improve the health of women of child bearing age with emphasis on the target population, African American women and their children through the age of two years, by providing education, support and developing a coordinated program of services, conducting home visits and providing case management. Healthy Start case managers will receive trainings to assist them in helping participants reach program benchmarks. The MCH funded Cribs for Kids Safe Sleep training for MCH, Nurse Family Partnership (NFP) and Healthy Start programs served through Home Visiting will continue. The Healthy Start program will continue to work specifically with two Urban League Women Infants and Children (WIC) sites serving the targeted zip codes to provide information for recruitment of participants to meet enrollment expectations. The program will work with community partners serving the targeted population and other high risk populations through the Community Action Network to provide program information. The *Partners for a Healthy Baby* curriculum will be used to educate participants served on topics related to family development, maternal, and family health, caring for baby and baby's development. A reproductive life plan will be developed for each woman served without a permanent method of birth control. In addition, Nevada Institute for Children's Research and Policy will conduct the annual satisfaction surveys with current and past program participants as well as survey program partners on their knowledge of the program and their involvement in making referrals to the program. The Healthy Start program will implement the continuous quality improvement plan to increase breastfeeding initiation and breastfeeding at six months and will evaluate the effectiveness of the plan. The program will maintain the numbers of participants served with a goal for 50% of the case load to be pregnant women, with at least 80 participants served. SNHD staff will continue to participate in the Infant Mortality Collaborative Improvement and Innovation Network.

The Nevada Early Hearing Detection and Intervention (EHDI)

The Early Hearing Detection and Intervention (EHDI) program will focus on quality improvement and improving evaluation processes. Collaborations will ensure all children in Nevada are screened for hearing loss at birth and timely, appropriate audiological, educational and medical intervention referrals are delivered to Nevada families. Efforts to decrease the number of infants lost to documentation and lost follow-up pertaining to diagnostic and intervention services will also continue through standard tracking protocols. EHDI and the MCH program will continue to collaborate on efforts related to the Zika virus.

Nellis Airforce Base

The Nevada Title V MCH program will continue to work with Nellis Airforce Base, in Southern Nevada, in relation to the EHDI and CCHHS programs and explore possible ways to partner on other MCH efforts with military bases.

Perinatal/Infant Health-Annual Report

Breastfeeding

The Women, Infants and Children (WIC) Nevada Breastfeeding Program conducted statewide campaigns to improve infant feeding practices in hospitals and increase community and business support for breastfeeding mothers. The Breastfeeding Program offers breastfeeding support to WIC families by providing free professional lactation support, breast pumps, and an enhanced food package for breastfeeding mothers. Two major breastfeeding campaigns were delivered across the state, one focusing on hospital training, and one focused on community support.

After evaluating Nevada's current breastfeeding support climate, WIC selected an existing (previously CDC-funded) campaign to model: *Baby Steps to Breastfeeding Success*: (http://www.azdhs.gov/phs/bnp/gobreastmilk/BFAzBabySteps.htm). Each maternity center hospital was given a chance to participate in the campaign to assist in making five evidence-based practices their standard of care; 1. Initiate breastfeeding in the hour after birth; 2. Promote 24-hour rooming-in; 3. Avoid giving infants any food or liquid other than breast milk unless medically indicated; 4. Avoid artificial nipples for healthy term infants; and 5. Give mothers a breastfeeding resource to help with breastfeeding after discharge. Six maternity centers have received training, including 600 nurses and 15 medical doctors.

The second campaign is the *Breastfeeding Welcomed Here* campaign, in which businesses were asked to pledge their commitment to provide welcoming environments to breastfeeding mothers. To date, 77 Nevada businesses have signed this pledge. The goal of the campaign is for breastfeeding mothers to feel supported in nursing their children in public, thereby normalizing breastfeeding in public.

WIC received a grant to link rural program participants with Internationally Board Certified Lactation Consultants (IBCLCs) support through the Pacify Smart Phone Application. Prior to funding, there were not IBCLCs for hundreds of miles from most rural towns in Nevada. Each rural WIC agency received training on how to facilitate use of the application for each WIC mother. Once downloaded, mothers were able to access professional lactation assistance 24 hours a day, 7 days a week in English or Spanish. Since March 2016, 1,200 rural WIC mothers are utilizing this service.

In the last quarter of the funding period, Carson City Health and Human Services (CCHHS) notified 384 local businesses of a new initiative to assist in creating breastfeeding friendly workspaces. The program was designed to survey businesses for breastfeeding friendly workplace practices and their interest in establishing a breastfeeding friendly workplace. Arrangements were made to provide lactation information for four interested businesses, and provide privacy screens, end tables and refrigerators.

Childcare Providers Breastfeeding Project

The State Chronic Disease Obesity Prevention and Control Program funds the Children's Cabinet to provide trainings and technical assistance to early care and education centers (ECEs) statewide. ECE trainings served 159 attendees for breastfeeding support. Maternal Child Health (MCH) and WIC partnered with the Nevada Children's Cabinet to assist child care providers in providing space and support (fridge, rocking chair, privacy screens) for mothers choosing to breastfeed. Child care providers qualified for items after receiving a two-hour breastfeeding training class. Participants learned ways to help mothers who breastfeed continue breastfeeding while they return to school or work. The training also emphasized the benefits of a nutrition policy, including breastfeeding, and how to incorporate healthy nutrition in their child care centers from day one. A total of 66 sites received the breastfeeding

training. For most child care provider sites, a glider rocker chair was provided for their infant room, allowing mothers to sit and breastfeed in the classroom. Thirty breastfeeding gliders were provided and assistance was given to place the gliders in a space easily accessible to mothers. The spaces were also able to be converted into a private area, if desired. Three childcare sites needed storage for breastmilk and received a mini-fridge to help with storage issues. Two sites received small partitions to create private space for their breastfeeding mothers.

Safe sleep materials were revamped to promote the role of breastfeeding.

Safe Sleep

MCH Title V funds the Regional Emergency Medical Services Authority (REMSA) as 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.

C4K conducted four statewide train-the-trainer training sessions; two in Las Vegas, and two in Reno. Two Safe Sleep parent classes were held at the Reno Babies R Us as part of their *Grow Healthy* education series. All participating C4K agencies received technical assistance conference calls for the RedCAP relational data system to ensure agencies were updating their parent Safe Sleep classes, survival kit dissemination and follow-up survey data entry. REMSA staff held a Paramedic Refresher course on Safe Sleep available for all first responders.

Fifteen agencies actively participated in the C4K program and assisted with distributing 402 Safe Sleep Survival Kits. A total of 38 agencies are listed as partners, and ongoing communication efforts are underway to ensure their participation in C4K activities with C4K materials to provide Safe Sleep education.

C4K staff attended 14 community events and health fairs, promoting the importance of Safe Sleep education and preventive measures to ensure infants have a greater chance of survival. Approximately 1000 people were reached through the community and health fair events.

C4K program staff attended trainings to increase their knowledge and better enhance program activities, including Child Death Review Training, the Nevada Health Conference, webinars for the National Action Partnership to Promote Safe Sleep (NAPPS) by Health Resources and Services Administration (HRSA), webinars by Children's Safety Network on Infant Safe Sleep, and Sudden Unexpected Infant Death National Categorization Webinars.

A statewide Impact of Safe Sleep task force was established with representation from all local health authorities, MCH Title V, C4K, Department of Child and Family Services, Child Death Review and other interested stakeholders. Safe Sleep updates are included in the Child Death Review Executive Committee meetings.

The C4K brochure was updated in English and Spanish with the most recent recommendations from the American Academy of Pediatrics, as well as the Title V MCH media campaign.

Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN)

To address issues relating to birth outcomes, Nevada Title V Maternal Child Health (MCH) is involved in several statewide initiatives as part the Infant Mortality Collaborative Improvement and Innovation Network (IM CoIIN). Partners include the Nevada Healthy Start grantee, the Southern Nevada Health District (SNHD), 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, improving birth spacing, and reducing short inter-pregnancy intervals.

Messaging on the importance of 17-alpha-hydroxyprogesterone caproate (17P) and long-acting reversible contraception (LARCs) are embedded in CoIIN's efforts. Nevada Medicaid has unbundled LARCs at the time of delivery. LARCs are covered at delivery and in the 60 days immediately following delivery, if the mother was covered by Medicaid at the time of delivery.

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. Nevada Title V MCH funds three Home Visiting sites. All Home Visiting sites gather birth spacing data. Data will be reviewed to monitor learning network activities and recommendations will be made to improve PPV visit rates and birth spacing intervals.

March of Dimes (MOD)

Maternal Child Health (MCH) Title V partners with March of Dimes (MOD) on numerous efforts focused on ethnic/racial disparities in preterm birth and infant mortality. The MOD Signature Chefs Gala had 250 attendees at the annual gathering in Las Vegas, featuring the area's finest culinary talent. The program included an overview of the MOD mission and personal accounts from families affected by prematurity. Sponsorships and support were provided by numerous community partners and businesses.

MCH Title V put forth funds towards a Women's Health Symposium focused on ethnic/racial disparities in preterm birth and infant mortality resulted in 132 health professional attendees. The event, live in Las Vegas, was video-conferenced to Reno.

The Nurse of the Year Awards Ceremony was attended by 650 people. The event honoring Nevada nurses for their exceptional impact on patients and their families raised funds for the MOD mission to improve the health of babies by preventing birth defects, premature birth, and infant mortality. The March for Babies fundraising event in Las Vegas was attended by 500 people. Various organizations disseminated wellness information and St. Rose Siena Hospital held their Neonatal Intensive Care Unit (NICU) Family Reunion.

Outreach was conducted to community partners, including service organizations, hospitals, clinicians, and businesses to partner on initiatives and fundraising events. Provider and patient education materials were distributed to numerous community partners.

MOD awarded funding to five programs through their community grant program. Nevada Obstetrical Charity Clinic and Women's Health of Southern Nevada received funding for their group prenatal care program and served 200 women. An additional group prenatal care project was funded through the University of Nevada, School of Medicine and served 180 women. HealthInsight received funding for their Strong Start for Newborns and Mothers Project, which increased enrollment by 180 women.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The Nevada Pregnancy Risk Assessment Monitoring System (PRAMS) is part of a national effort to reduce infant mortality and adverse birth outcomes. A PRAMS-like survey, BabyBEARS, was implemented in advance of receiving PRAMS funding. PRAMS provides valuable information for developing and implementing intervention programs, as well as evaluating existing programs. Nevada submitted the application for *Component A: Core Surveillance* in November 2015, and received the Notice of Award in May 2016 for a five-year project period. Title V MCH co-funded staff salary of the University of Nevada, Reno. In June, the Title V MCH Epidemiologist attended the

PRAMS New State Orientation to discuss the PRAMS protocol, and meet with program and data managers. The remainder of the report period was spent laying the groundwork for implementation as outlined by CDC PRAMS protocols. The Maternal and Child Health Advisory Board reviewed the Nevada-specific survey questions to ensure they aligned with the Title V MCH State priority measures.

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

Fetal Infant Mortality Review (FIMR)

The MCH funded FIMR Case Review Team (CRT) in Washoe County met 10 times between October 2015, and September 2016, reviewing 53 cases. The CRT progressed to reviewing five to seven cases per meeting. Ninety-five new cases were received and data was abstracted from local hospitals and health care providers on 75 of those cases during this time period. A total of five maternal interviews were conducted between October 2015, and September 2016. Some of the barriers to completing maternal interviews continue to be transiency, invalid phone numbers, and incomplete information.

The FIMR Community Action Team (CAT) which aims to implement recommendations of the CRT, held two formal meetings between October 2015 and September 2016 in conjunction with the Northern Nevada Maternal Child Health (NNMCH) Coalition; however, staff provided brief FIMR updates at all monthly NNMCH coalition meetings. There were 18 CAT members as of September 2016; however, meeting attendance varied. The “Go Before You Show” public awareness campaign was selected by CAT to encourage early/on time prenatal care, based on the 2015 FIMR Annual Report and recommendations from the CRT. The initial request for funding letters were distributed to CAT members in September 2016 for distribution to raise funds.

FIMR brochures and various educational materials were disseminated at the Washoe County Health District and to local hospitals. The FIMR program serves diverse populations. Spanish sympathy cards were provided to Spanish-speaking families, in addition to the many educational materials available in Spanish. Interpreter services were available as needed.

FIMR staff attend Child Death Review meetings every other month and present summaries of fetal and infant death cases not under investigation by Child Protective Services or local law enforcement. FIMR staff also attended monthly Pregnancy and Infant Loss Support Organization of the Sierras (PILSOS) committee meetings and was the keynote speaker at the “Day of Remembrance” event in October 2015.

FIMR staff represented the Washoe County Health District (WCHD) at various community meetings including Join Together Northern Nevada (JTNN), Children’s Justice Act (CJA), Child Death Review (CDR), and Northern Nevada Breastfeeding Coalition. FIMR staff also participated on a statewide workgroup for the Washoe County Child Death Review: “Increasing the Impact of Safe Sleep Education.” A statewide Safe Sleep campaign was successfully launched on October 28, 2016.

FIMR staff attended trainings and informational events including; the Women’s Health Symposium; a presentation by Dr. Laura Knight, the Assistant Chief Medical Examiner on the role of the Washoe County Coroner, including the criteria for performing an autopsy; Nevada Statewide MCH Coalition Spring Symposium; Nevada Children’s Report Card presentation; and the Nevada Health Conference.

Other meetings attended by FIMR staff included; a RedCAP technical assistance meeting, a workgroup for Nevada Pregnancy Risk Assessment Monitoring System (PRAMS), National Governors Association to Improve Birth Outcomes meetings, a MCH Advisory Board meeting and Infant Mortality CoIIN meetings.

FIMR staff presented FIMR Program information at the Nevada Health Conference, to the Maternal Child Health

Services staff at Saint Mary's Regional Medical Center during a Saint Mary's Perinatal Loss Committee meeting, and staff also presented an overview of FIMR at the University of Nevada, Reno, Project Extension for Community Healthcare Outcomes (ECHO) through the Nevada Public Health Training Center and the University of Nevada School of Medicine.

Southern Nevada Health District Healthy Start Program

During the reporting period, staff at Southern Nevada Health District (SNHD) continued their Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Coordinator roles. Priority areas of focus included increasing developmental screenings and increasing insurance coverage for children. To address the goal of increasing insurance coverage, families newly eligible for Nevada Check-Up were contacted by the EPSDT Coordinator. The receipt of benefit packets were verified and coverage of benefits reviewed. The coordinator helped confirmed families establish a Medical Home and provided information about Healthy Kids Exams for new enrollees, screening benefits, and preventive services disclosed using *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* All families received referrals to SNHD's Kids Clinic for Healthy Kids exams, sports physicals, and day care exams. A partnership with the Foundation for Positively Kids for an enrollment specialist to assist families in applying to Medicaid or Nevada Check Up at two SNHD locations continued to be effective.

Case management of high risk populations in targeted zip codes through the Nurse Family Partnership (NFP) and Healthy Start Programs were an area of focus. Nevada Institute for Children's Research and Policy (NICRP) was the evaluator for the Healthy Start program and conducted satisfaction surveys with current and past program participants. Program partners were surveyed on their knowledge of the program and involvement in making referrals to the program. Healthy Start and NFP participated in the Infant Mortality Collaborative Improvement and Innovation Network activities, including the Adverse Childhood Experiences (ACEs) survey project, birth spacing and long-acting reversible contraceptives data collection.

The NFP program continued to participate in the Nevada Home Visiting continuous quality improvement activities on decreasing subsequent pregnancies at 18 and 24 months post-delivery and on improving the percent of conversion of referrals to enrollments. The project began participation in the Peer Learning Network Quality Improvement for Breastfeeding Initiation to improve performance benchmarks with a goal of increasing breastfeeding initiation to 51% among program participants.

Outreach and education was conducted through various activities. The Healthy Start program conducted six outreach activities: a special event with insurance navigators from the Nevada Insurance Exchange Marketplace, seven strategically located bus shelters were populated with posters promoting the program, Healthy Start partnered with a local African American managed radio station to run 30 second radio spots promoting the program, and additional events were held at Nevada Health Center's Women, Infants and Children (WIC), Southwest Medical Associates, and Sunrise Children's Foundation WIC. NFP conducted two outreach activities; participation in the Urban League WIC World Breastfeeding Event and the Step Up for Kids event attended by 555 community members.

The MCH funded Cribs for Kids Safe Sleep Training was provided by both the NFP and Healthy Start programs in addition to the Baby Safe Sleep hospital based program. The goal was to reduce Clark County child deaths due to unsafe sleeping environments through the design and delivery of a multi-pronged preventive education program to help families create safe sleep environments. The hospital-based safe sleep program "Baby Safe Sleep" consisted 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, and 5. evaluation and expansion. Sunrise Hospital fully implemented the program during the reporting period and trained more than 300 staff. Sleep position audits observed 95 infants under one year of age. Safe Sleep video screenings and associated surveys were shared with more than 500 parents. In addition to coordinating hospital implementation, NICRP and SNHD worked with three of the Valley Health Systems hospitals to execute the program. To date, the Valley hospitals have all completed the pre-training sleep position audit, staff trainings, and provided parent education. There was a

delay in obtaining parent surveys from two of the three hospitals and post-training sleep position audits are pending at all three hospitals. Seven hospitals implemented the parent education by the end of the reporting period. Safe sleep fact sheets were disseminated to active participants and SNHD's Baby Safe Sleep video was shared with participants, the Healthy Start Community Action Network and community partners through the Healthy Start Listserv.

Various trainings were attended by staff, including: How Marijuana affects Pregnant Women by the Community-based PACT Coalition; Promoting Healthy Weight for Children and Adolescents with Special Health Care Needs by the MCH Collaborative at the University of Tennessee Knoxville; Baby Behaviors by Nevada Women Infants and Children (WIC); Maternal Mental Health by California's 2020Mom, Key to Human Papillomavirus (HPV) Cancer Prevention by Nevada Public Health Project ECHO; Statutory Rape Awareness for Mandated Reporters by the Nevada Public Health Foundation/Division of Welfare and Social Services; Teen Relationship Abuse: Increasing Safety in a Digital World by the Nevada Network Against Domestic Violence; the Home Visitor's Toolkit by the Nevada State Home Visiting Program; Toxic Stress and Child Development; and True Colors (Communication Styles).

The Nevada Early Hearing Detection and Intervention (EHDI) Program

The Nevada Early Hearing Detection and Intervention (NV EHDI) program, housed in the Maternal, Child and Adolescent Health Section, continues its purpose of ensuring 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.
Preliminary data from 2015 shows 35,945 births in NV with 34,709 or 96.6% documented as receiving a newborn hearing screening. Of the infants who received a newborn hearing screening, 34,233 passed the screening and 476 infants did not pass. For those infants who did not pass, 233 were documented with a diagnosis on file.181 of these infants were diagnosed with normal hearing and 52 infants were diagnosed with hearing loss. 44 of the 52 infants diagnosed with hearing loss were enrolled in Early Intervention programs and 8 infants were not enrolled or their enrollment status was unknown. Of the 1,236 infants who were not screened, 138 of the infants passed away and 138 had a parent or family member decline the screening. There were 960 infants whose screening status was unknown or not performed. Of the 243 infants who did not pass the Newborn Hearing Screening and did not receive a diagnosis, it was found 10 were in progress, 22 passed away, and 27 families declined diagnosis. 184 of these 243 infants had an unknown diagnosis.

Nevada continues to face a shortage of audiologists who routinely treat newborns which 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 correct newborn screening methods. These collaborations led to improved screening and a reduction in the burden of conducting unnecessary diagnoses for audiologists.

The EHDI program worked with selected midwives to increase hearing screenings of home-birth infants by providing Otoacoustic Emissions (OAE) hearing screening equipment and training for midwives to screen infants. The EHDI program continues collaborations with Pediatric Audiology Facilities, Early Intervention Services, hospitals and the Office of Vital records to ensure timely processes, accurate reporting, and education to parents and providers. Collaborations help to decrease the number of infants due to lost documentation and/or lost follow-up diagnostic and intervention services.

Nevada Home Visiting

The Nevada Home Visiting Program (NHV) provided referrals related to hearing to a doctor if a family desires. All home visitors conduct periodic screenings to determine whether an infant requires specialty care, and if necessary, a

referral is provided. NHV ensures families are involved in all decision-making processes and services are coordinated with family input.

Bright Futures, AAP

The Bright Futures initiative in Nevada provided information and resources to improve healthy living for infants, children, and adolescents, and increase access to regular well child visits. The Bright Futures Tool and Resource Kit was distributed to medical providers, school staff, parent groups, family resource centers, home visiting staff, childcare health consultants, coalition memberships, and community leaders for the purpose of increasing awareness of services and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program's benefits to families, as well as the promotion of well child visits.

Special Events attended by MCH Staff

MCH staff attended a presentation on Neonatal Abstinence Syndrome (NAS) at St. Mary's Hospital on October 9, 2015. The keynote speaker was Barbara Drennen, the Executive Director of Pediatric Interim Care Center. Materials for parents, providers and community members have been developed and are being distributed through documents as well as social media. Additional activities to address NAS are described in the CrossCutting/Lifecourse section of the application.

MCH staff was invited to attend the Babies "R" Us Open House Learning Center Celebration. Various MCH Program materials were given to the Learning Center and included in the baby registry gift bags, such as the SoberMomsHealhtyBabies.org referral cards, Early Periodic Screening Diagnosis and Treatment growth charts, Smoking Cessation Brochures, and text4baby referral cards and pens.

Data

The number of infants born with neonatal abstinence syndrome has increased since 2008. According to the HCUP State Inpatient Databases, Nevada's rate of children born with NAS in 2008 was 3.9 per 1,000 delivery hospitalizations and increased to 12.4 in 2014. Non-Hispanic Whites (17.7) and those listing their ethnicity as Other (21.8) are the ethnicities with the highest rates. The uninsured (22.9) and those on Medicaid (21.5) have the highest rates amongst health insurance stratifiers.

Infant Mortality Rate (IMR)

National Vital Statistics System (NVSS) period linked birth/infant death statistics for the Nevada infant mortality rate (IMR) per 1,000 live births by race/ethnicity is 5.26 from 2012-2014. The US rate is 5.92 for the same period. There is disparity in IMR for the Non-Hispanic Black population with an IMR of 9.6 compared to the Non-Hispanic White rate of 4.9, Non-Hispanic Asian/Pacific Islander (4.4) and Hispanic (4.3) IMRs. The Non-Hispanic American Indian/Alaska Native data is not reportable due to sample size.

NVSS also supplied an IMR by county for 2013 to 2015 via the compressed mortality file. The rate is 5.38 for Nevada. The US rate is 5.89 per 1,000 live births. Douglas County (12.61), Lyon County (10.52), Carson City (6.4), and Elko County (6.56) are higher than other counties, but due to small sample sizes, the data should be interpreted with caution. Washoe County (5.79) and Clark County (5.01) are the most populous counties and IMRs for both counties are below the U.S. rate.

Low Birth Weight (LBW)

NVSS natality data for 2015 shows the percent of low birth weight (LBW) deliveries for Nevada based on race/ethnicity, as well as by county. The percent of LBW deliveries in Nevada (8.52) is slightly higher than the United States (8.07). The Non-Hispanic White (7.82) and Hispanic (7.34) populations have the lowest LBW rates while the

Non-Hispanic Black (13.58) and Non-Hispanic Asian/Pacific Islander (9.25) populations indicate disparities and have the highest. The Non-Hispanic American Indian/Alaska Native population (8.43) is slightly below the state average but exceeds the national average.

The LBW statistics by county demonstrate disparity with high LBW rates in the rural counties of Lander (10.89), Lyon (10.0), and Nye (9.58). Other rural counties including Esmeralda, Eureka, Lincoln, Mineral, Pershing, Storey, and White Pine do not have reportable data. Elko (5.92) and Churchill (6.69) counties are better than the state average percentages, as are Carson City (7.75) and Washoe counties (8.34), while Clark County (8.63) and Humboldt County (8.57) are slightly higher.

Breastfeeding

Nevada's rate for ever breastfeeding is slightly higher than the national average (82.6 and 81.1 respectively), and is also slightly higher than the national average for exclusive breastfeeding at six months (24.9 and 22.3, respectively). As the Centers for Disease Control and Prevention (CDC) supports the link between breastfeeding and improved health outcomes, the MCH Program partners with: WIC, MCH coalitions, community-based programs, LHAs, the public, and private stakeholders to increase breastfeeding rates by improved access to breastfeeding supports for new mothers. The MCH Program also funds Baby Steps to Breastfeeding with hospitals to increase breastfeeding success rates in Nevada.

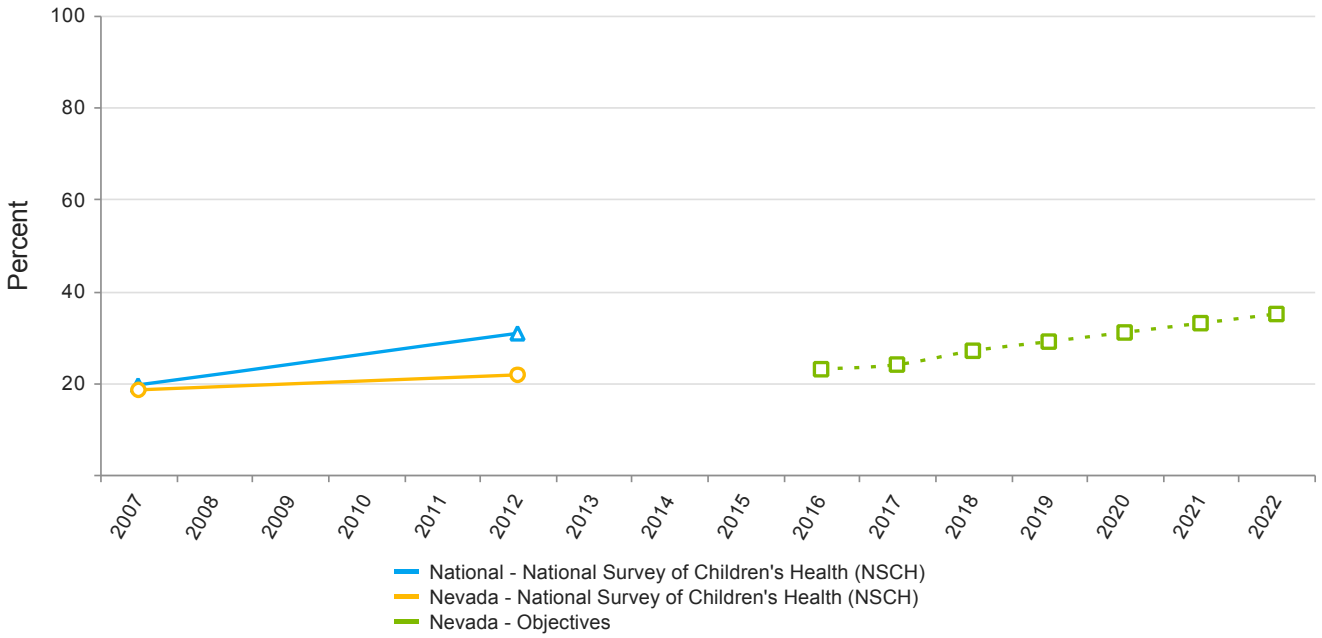
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	79.0 %	NPM 6

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23
Annual Indicator	21.9
Numerator	38,504
Denominator	175,661
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.0	27.0	29.0	31.0	33.0	35.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.0	16.0	16.0	16.0	16.0

ESM 6.2 - Number of children receiving a developmental screening using the Ages and Stages Questionnaire (ASQ)

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	700.0	1,000.0	1,300.0	1,600.0	1,900.0

State Action Plan Table

State Action Plan Table (Nevada) - 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 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	Status
ESM 6.1 - Number of Title V funded partners providing developmental screening in the past year	Inactive
ESM 6.2 - Number of children receiving a developmental screening using the Ages and Stages Questionnaire (ASQ)	Active

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

Child Health-Plan for the Application Year

The State Chronic Disease Obesity Prevention and Control Program will continue to fund the Children's Cabinet to provide trainings and technical assistance to early care and education centers (ECEs) statewide, inclusive of enhancing/increasing physical activity, healthy eating, and breastfeeding support. The Childhood Obesity Prevention Committee will meet to discuss management of childhood obesity. The Chronic Disease Section School Health Coordinator will provide technical assistance to at least two school districts to implement elementary school Comprehensive School Physical Activity Programs (CSPAP). Additionally, school wellness nutrition education trainings will be offered in the four largest Nevada counties, reviewing each district's School Wellness Policy and Smart Snack Standards.

Carson City Health and Human Services (CCHHS) will continue to be awarded Title V funding to promote children's health. Childhood immunizations and text4baby will be promoted through outreach events and health promotion marketing campaigns (local bus advertising and Facebook). CCHHS will connect children to specialty care through referrals for developmental, hearing or vision screenings, including staff attending training on Ages and Stages Questionnaire (ASQ) delivery. Additionally, CCHHS will assist families in identifying a medical home for their children.

Nursing personnel within the Community Health Services (CHS), through outreach events, will provide information about child wellness, nutrition and physical activity, and immunization schedules. Nursing personnel will distribute diverse health-related brochures provided by the Title V/MCH program

The PACE Coalition will continue to use a Community Health Worker (CHW) to conduct culturally competent outreach and education to the Latino population. Through community events, the CHW will distribute educational information provided by the MCH Program, including ways to access further information and/or how to work with local medical professionals to improve child health. Childhood vaccinations, developmental screenings, obesity prevention, and well-child visits will be promoted.

Physical Activity and Nutrition

The Chronic Disease Section Obesity Prevention and Control Coordinator will continue to promote and run a one month obesity prevention awareness campaign reaching parents/caregivers of children aged 0 – 8 years, throughout the State. Title V MCH and WIC will co-fund efforts in the social media campaign on Facebook, Twitter, and Pinterest. The State School Health Coordinator will continue working with each school district Wellness Coordinator to assist in implementation of their CSPAP ensuring schools are meeting the required guidelines for physical activity and nutrition.

Nevada 2-1-1

Nevada 2-1-1, a program of the Financial Guidance Center, is committed to helping Nevada citizens connect with the services they need. Whether by phone or internet, their goal is to present accurate, well-organized and easy-to-find information from state and local health and human services programs. 2-1-1 is a special telephone number reserved in Canada and the United States to provide information and referrals to health and social service organizations. Dialing 2-1-1 in almost every part of the United States will connect an individual to health and social services in their area.

2-1-1 services include places to find food, housing, emergency shelter locations, children's services, adoption and foster care resources, mental health and counseling services, support for seniors, domestic violence resources, and for people with disabilities. Services for children include breastfeeding support, diapers, child care and assistance with related expenses, clothing for children, family support, and respite care.

Nevada 2-1-1 assists the MCH program by staffing the MCH Hotline and providing quarterly reports regarding the number of MCH calls answered, demographics of the callers, and referrals to services. Nevada 2-1-1 provides the

University of Utah, Department of Pediatrics (UUDP) with a quarterly export of all Nevada 2-1-1 agency level information. The information is added to the database supporting the Nevada Children's Medical Home Portal, a website project of the UUDP serving Nevada. A key offering of the Medical Home Portal is information about local community and professional services to assist families and augment the care of Children and Youth with Special Health Care Needs (CYSHCN).

Nevada 2-1-1 will continue to provide information on health and human service programs throughout the state, including physical and mental health resources and support for children, youth and families. All DHHS staff will include information in their email closings to find help 24/7 by dialing 2-1-1; texting 898-211; or visiting www.nevada211.org. All MCH Title V subgrantees have language in their contracts to include updating their information with 2-1-1 and promoting the 2-1-1 services.

Nevada Institute for Children's Research and Policy (NICRP)

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), will continue to conduct an annual health survey of children entering kindergarten in Nevada with funding from MCH Title V. An annual report will be posted on the NICRP website and distributed across DPBH and to statewide and local advisory boards and coalitions.

Child Health-Annual Report

Carson City Health and Human Services (CCHHS), a local health authority in Northern Nevada, was awarded Title V funding to promote children's health. Childhood immunizations and Text4Baby were endorsed through outreach events and health promotion marketing campaigns, inclusive of local bus advertising and on Facebook. Social media reached 13,128 families with children. CCHHS connected 37 children to specialty care through referrals for developmental, hearing, or vision screenings from findings outside of age-based norms. The agency assisted 51 families in identifying a medical home for their children.

Nursing personnel within the Community Health Services (CHS), through outreach events in Nevada's rural and frontier areas, provided information about child wellness, nutrition and physical activity, and immunization schedules. To educate, nursing personnel distributed diverse health-related brochures provided by the Title V/MCH program

The PACE Coalition was Title V funded for one Community Health Worker (CHW) to conduct outreach and education to the Latino population in Elko County and nearby rural areas. Through community events, the CHW distributed educational information provided by the MCH Program, including ways to access further information and/or how to work with local medical professionals to improve child health. Childhood vaccinations, developmental screenings, nutrition, obesity prevention, and well-child visits were promoted.

The State Chronic Disease Obesity Prevention and Control Program funds the Children's Cabinet to provide trainings and technical assistance to early care and education centers (ECEs) statewide, inclusive of enhancing breastfeeding support, and increasing physical activity and healthy eating. ECE trainings served 159 attendees for breastfeeding support, 168 for nutrition, and 184 on physical activity. The Children's Advocacy Alliance led the early Childhood Obesity Prevention Committee, met with key stakeholders regarding childhood obesity prevention issues.

Title V funding supported anti-bullying trainings conducted by the Nevada Department of Education (NDE), targeting local school district personnel and parents. Additionally, NDE trained 45 volunteers staffing the Nevada Crisis Call Center how to handle bullying calls.

Physical Activity and Nutrition

The State Chronic Disease Obesity Prevention and Control Coordinator promoted and ran a one-month statewide obesity prevention awareness campaign to reach parents/caregivers of children aged 0 – 8 years. The campaign reached 14,097 viewers through movie theatre advertising and social medial messaging (via Facebook, Twitter and Pinterest).

The State Chronic Disease School Health Program Coordinator conducted professional development sessions on the Comprehensive School Physical Activity Program (CSPAP), nutrition trainings, and information on the Nevada School Wellness Policy at the elementary school level, in five of the 17 school districts statewide. A Parent Teacher Association (PTA) Resources Manual was provided at the Nevada PTA Conference, inclusive of national, state, and local resources to reduce obesity and improve physical activity. Nevada Wellness conducted the Healthy Hoops Campaign in collaboration with Reno Bighorns basketball team to promote physical activity for 60 minutes per day, healthy nutrition, and reduce screen time among elementary school aged students in northern Nevada.

Nursing personnel within Community Health Services (CHS) attend a variety of local events in their communities to encourage and provide immunizations, as well as fluoride varnish to young children. Additionally, they conduct immunization clinics at elementary schools.

Nevada 2-1-1

Nevada 2-1-1, housed in the Nevada Department of Health and Human Services (DHHS), is a free service providing information about vital health and human service programs available throughout the State. Financial

Guidance Center is the lead agency for Nevada 2-1-1 and provides information and referral via www.nv211.org and a toll-free number as well as the ability to dial 211 or text message to 898-211. Operators are trained to provide relevant and accurate information to the caller. Nevada's 2-1-1 website is easy to navigate, and their texting service has staff members who respond via text messages. Some of the resources provided by 2-1-1 include: physical and mental health resources and support for children, youth and families, among others.

Nevada Institute for Children's Research and Policy (NICRP)

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), conducted 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. 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 MCH Title V.

In the fall of 2015, NICRP distributed questionnaires to all public elementary schools in the state, except Clark County School District, who requested a sample of their schools be surveyed. The survey had an overall response rate of 24.2 percent, with a total of 5,736 surveys received from parents in 15 school districts in Nevada. The data were weighted so the survey data collected represented each district and all children in the state (32,151). Weighted data are presented to compare Clark County (73.2 percent), Washoe County (15.4 percent) and the rural counties combined (11.4 percent).

When compared to last year, behaviors in the health status category remain relatively steady with only slight fluctuations. There was a slight increase in obesity, inactivity, and video game play/computer play, but also a slight reduction in soda drinking. There was also an increase in the percent of parents reporting feeding their infant breast milk only at one and three months, but a decrease at 12 months.

Nevada Tribal Partners

MCAH presented at the Spring Tribal Consultation quarterly meeting on the Title V MCH and Home Visiting programs, and met with IHS regional and state representatives, and Inter-Tribal council of Nevada Leadership in addition to working with other state Title V MCH programs in in relation to Tribal outreach. A possible safe sleep pilot with IHS clinical site in the state was discussed and is being evaluated for possible implementation.

Additionally, Title V MCH 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.

Data

The percent of children without health insurance has also shown positive gains. Although Nevada continues to exceed the national average of 5%, the number of children without health insurance in 2016 was reduced to 7.6%. In 2014 the annual indicator was 9.7 % and in 2009 the indicator was 18%. Populations most at risk include the American Indian/Native Alaskan population, those in households with less than a high school education, and Hispanic populations. Income level is also a concern as those with a low household income to poverty ratio are less likely to have health insurance than those with a higher ratio.

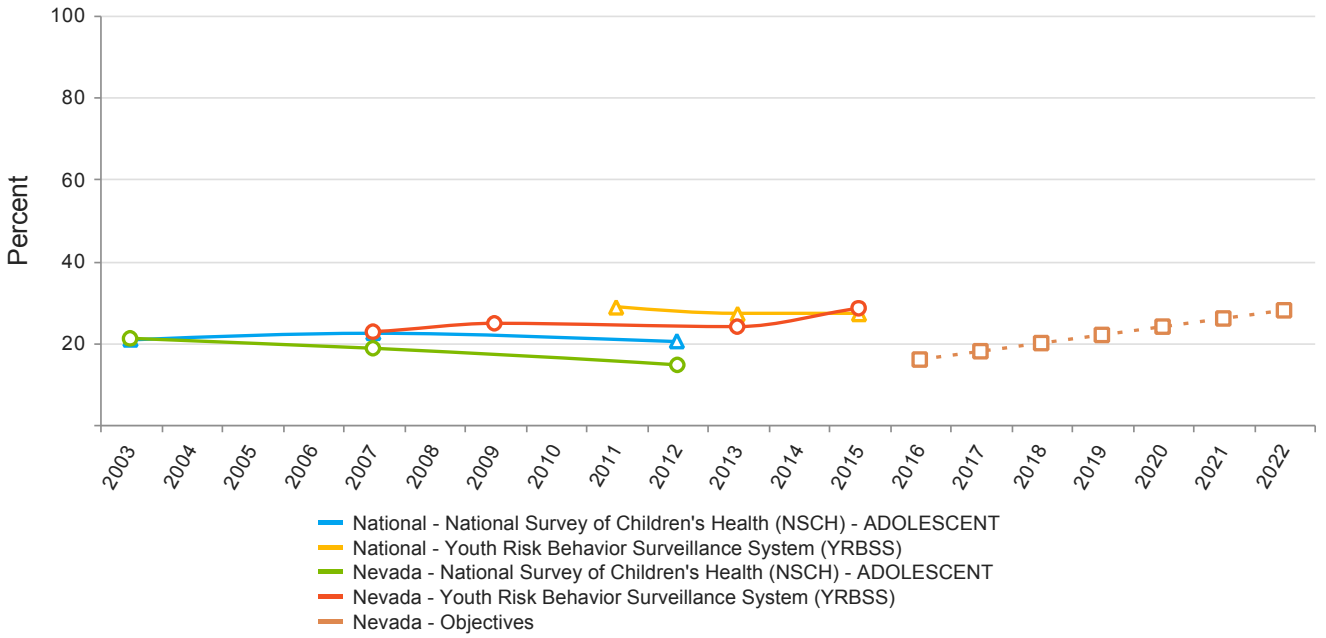
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	38.1	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	12.3	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	10.0	NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	49.3 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	79.0 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	33.2 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	26.9 %	NPM 8 NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	27.2 %	NPM 8 NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	48.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	72.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	44.5 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	88.3 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	78.0 %	NPM 10

National Performance 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
Baseline Indicators and Annual Objectives



NPM 8 - Adolescent Health

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	16
Annual Indicator	28.6
Numerator	34,940
Denominator	122,356
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	16
Annual Indicator	14.8
Numerator	31,350
Denominator	211,533
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	18.0	20.0	22.0	24.0	26.0	28.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 8.2 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

ESM 8.3 - Number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.

Measure Status:	Active

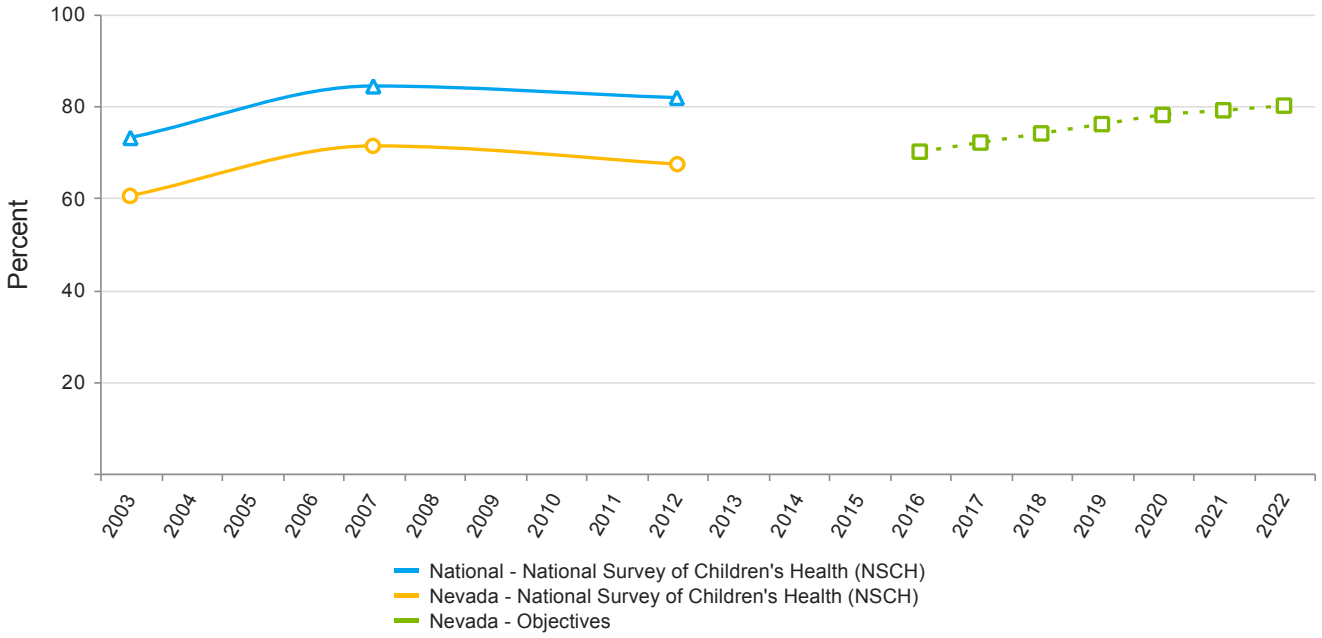
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60,000.0	70,000.0	80,000.0	90,000.0	100,000.0	110,000.0

ESM 8.4 - Number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5,000.0	6,000.0	7,000.0	8,000.0	9,000.0	10,000.0

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	70
Annual Indicator	67.3
Numerator	144,809
Denominator	215,102
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	72.0	74.0	76.0	78.0	79.0	80.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	8.0	9.0	10.0	11.0	12.0

State Performance Measures

SPM 2 - Repeat teen birth rate

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16.6
Numerator	339
Denominator	2,040
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.0	15.0	15.0	14.0	14.0

SPM 4 - Teenage pregnancy rate

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	28.0	27.0	26.0	25.0	24.0

State Action Plan Table

State Action Plan Table (Nevada) - 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	Status
ESM 8.1 - Percent of middle and high schools that implement a physical activity plan	Inactive
ESM 8.2 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.	Active
ESM 8.3 - Number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.	Active
ESM 8.4 - Number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11.	Active

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

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

NOM 18 - Percent of children 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 (Nevada) - Adolescent Health - Entry 3

Priority Need

Reduce teen pregnancy

SPM

Repeat teen birth rate

Objectives

Reduce repeat pregnancies among adolescent females aged 15 to 19 years to 15 percent by 2020.

Strategies

Collaborate with State Abstinence Education Grant Program (AEGP) and the State Personal Responsibility Education Program (PREP).

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

State Action Plan Table (Nevada) - Adolescent Health - Entry 4

Priority Need

Reduce teen pregnancy

SPM

Teenage pregnancy rate

Objectives

Reduce pregnancies among adolescent females to 26 pregnancies per 1,000 by 2020

Strategies

Collaborate with State Abstinence Education Grant Program (AEGP) and the State Personal Responsibility Education Program (PREP).

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

Adolescent Health-Plan for the Application Year

Adolescent Well-Visits

The National Governors Association (NGA) Learning Collaborative on *Improving Quality and Access to Care in Maternal and Child Health* will focus outreach in Clark County. The intended outcomes will be a surge in insurance enrollment and increased utilization of adolescent well-visits. Flyers will provide information about the value of no-cost yearly well-visits and insurance, and how to access insurance resources. Activities planned for fall 2017 include: dissemination of flyers to families of high school students, placement of insurance enrollment assisters on school campuses, and collaboration with community partners to assist in enhanced outcomes. After Clark County efforts, the State Team is interested in reaching other Nevada counties.

School-Based Health Centers (SBHCs) provide easy access for youth to receive adolescent well-visits. To help grow the number of SBHCs statewide, the MCH Adolescent Health and Wellness Coordinator plans to develop a toolkit guiding emerging SBHCs in the planning and implementation phases**.** There is interest in including information about telehealth carts and data exchange materials such as Memoranda of Understanding (MOU), the Health Insurance Portability and Accountability Act (HIPAA), and the Family Educational Rights and Privacy Act (FERPA). Clark County houses 10 of the 12 operating SBHCs statewide, the University of Nevada, Las Vegas, School of Medicine has plans to serve as a technical assistance center helping with needs assessments, formation, and operation of facilities. New SBHCs are in the planning phase in three rural counties, and one in Las Vegas will enhance services to include comprehensive care. Two SBHCs will pilot the MCH-funded RAAPS electronic risk assessment tool, performed at well-visits and sports physicals, to test its viability in addressing risk behaviors impacting adolescent health and well-being.

The MCH Adolescent Health and Wellness Coordinator will continue to grow the number of Title V partners conducting activities promoting yearly adolescent well-visits. Funded partners will focus efforts on the value of routine well-visits. Opportunities will include educating families about no-cost well-care visits.

Carson City Health and Human Services (CCHHS) will continue to be awarded Title V funding to promote adolescent health. Education, counseling, and/or referrals will be made to adolescents afflicted by substance use, domestic violence, and depression. CCHHS will promote routine well-visits through Facebook, local bus advertising, and digital signage. Additionally, current Personal Responsibility Education Program (PREP) and Abstinence Education Grant Program (AEGP) outreach on positive youth development will continue.

MCH will continue funding the nursing personnel within Community Health Services (CHS) through outreach events, to provide adolescents educational materials about teen health, immunizations, reproductive health, nutrition, physical activity, general wellness, and the value of yearly check-ups.

PACE Coalition will continue to be awarded Title V funding to employ a Community Health Worker (CHW) to participate in MCH activities. Specific emphasis will be placed on care coordination and increasing connections to resources and services for the Latino and hard-to-reach populations. The CHW will distribute educational information to adolescents on health and wellness and the value of annual well-visits.

The School Health Program Coordinator will encourage each School-District's Wellness Coordinator to include information on the value of yearly adolescent well-visits, as each district updates their local School Wellness Policy. Promotion of the Office of Adolescent Health, Think, Act, Grow (TAG) to the School District School Wellness Coordinators has been discussed as a potential activity, as it outlines how schools can incorporate its guide advocating the five essentials for healthy adolescents. The Comprehensive School Physical Activity Program (CSPAP) can be developed at every level, and the School Health Program Coordinator anticipates once more schools start implementing them, there will be after-school physical activities promoted through the middle and high schools.

Adolescent Physical Activity

The MCH Adolescent Health and Wellness Coordinator will continue discussions with the State Chronic Disease Prevention Section School Health Program Coordinator on how best to complement and leverage their activities. Through the State Obesity Prevention and Control Program, the Interactive Health Technologies pilot program in Washoe County School District will be implemented in several middle and high schools to track moderate to vigorous activity. The pilot will assist physical education teachers in improving instruction capabilities, student engagement, and lesson planning to meet Nevada physical education standards. The MCH Program desires to support outside of school projects dedicated to increasing physical activity for adolescents, ages 12-17 years. Messages will contain distinct content for youth ages 12-13 years and adolescents ages 14-17 years by associating physical activity with things they already value.

Urban Lotus Project will be supported by Title V MCH, in a pilot, to provide yoga instruction and mindful awareness to 3,000 at-risk and underserved youth in Reno and surrounding areas. Urban Lotus serves at-risk youth, inclusive of foster and homeless youth presenting at drop-in centers, juvenile justice centers, in-patient mental health and substance use facilities. Activities will focus on increasing physical activity outside of school settings and promoting adolescent health. Instructors will distribute a pre-test questionnaire and subsequent post-test one month after starting the Trauma-Informed Yoga for Youth classes to assess whether the physical activity benefits their ability to cope with stress and increase resilience. Heart rate variability will be measured in selected groups.

A SBHC toolkit will be produced and promoted in 2017.

Abstinence Education Grant Program (AEGP)

The AEGP Program 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 Teens” television and radio spots. Promoting Health Among Teens!-Abstinence Only (PHAT!-AO) classes will continue to be offered by Carson City Health and Human Services in Carson City, Douglas County, and Storey County. The FRCNEN will also continue to offer PHAT!-AO classes in Elko and outlying rural communities in Winnemucca, Lovelock, Jackpot, Battle Mountain, and Wendover. In addition, Quest Counseling and Consulting in Reno will continue to conduct PHAT!-AO classes with male youth who are living at the Quest House for substance use and mental health treatment, and for both female and male youth utilizing their outpatient counseling treatment services.

Nye Community Coalition will continue to pilot the Teen Outreach Program promoting abstinence and positive youth development in Nye County. AEGP training on Families Talking Together will be offered for Teen Pregnancy Prevention partners statewide in September, 2017. MCH and AEGP programs work together to promote positive youth development and both serve on regional positive youth development, as well as leveraging AEGP subgrant relationships for teen physical activity promotion.

Personal Responsibility Education Program (PREP)

Nevada PREP plans to maintain the five PREP subgrantees (Planned Parenthood Mar Monte, Planned Parenthood of the Rocky Mountains, Family Resource Centers of Northeastern Nevada, Carson City Health and Human Services, and The Center). These subgrantees will continue to teach comprehensive sex education using several evidence-based curricula including "¡Cuidate!", "Sexual Health and Adolescent Risk Prevention", “Teen Success”, “Making Proud Choices”, and "Reducing the Risk”. Planned Parenthood Mar Monte will be implementing classes for teens within the Sierra Nevada Job Corps system, as a pilot peer-to-peer education program. Nevada PREP is looking to reestablish partnerships with sister agencies within the Department of Health and Human Services and

agencies throughout the state working with youth. Nevada PREP aims to continue fostering connections with the Division of Child and Family Services (DCFS), the agency responsible for child welfare services in Nevada including foster youth, and youth involved with the juvenile justice systems. Another collaboration Nevada PREP hopes to create is with the Intertribal Council of Nevada (ITCN) to address teen pregnancy among Native youth throughout Nevada. Additional partnerships include the University of Nevada, Las Vegas (UNLV) and the Southern Nevada Health District. Both organizations currently receive Teen Pregnancy Prevention Program Tier 1 funding for evidence based programs. These partnerships and collaborations will help strengthen the effort to reduce teen pregnancy and births in Nevada.

MCH and PREP programs will partner on physical activity promotion for adolescents and continue to work together to support positive youth development opportunities.

Rape Prevention and Education (RPE)

Nevada expects to improve the healthy development, physical health, safety, and well-being of adolescents and young adults through its proposed activities to: increase the use of the public health approach in addressing sexual assault and violence, train agencies to collect and report all required program information in an accurate and timely manner, implement violence prevention strategies which are evidence-based or evidence-informed, increase program effectiveness through data driven evaluation, increase staff knowledge for implementing effective sexual violence prevention strategies, support statewide efforts to prevent intimate partner violence and sexual assault, and increase opportunities for training and technical assistance to funded agencies. The focus for new activities will include the following:

1. The RPE staff will develop a data collection tool to gather specific and accurate data from funded agencies to analyze data trends and continue to implement strategies and principles which are shown to be effective over time.
2. New evidence-based strategies will be considered to expand positive teen relationship education.
3. RPE staff will provide increased training and technical assistance to funded agencies on implementing community change strategies to reduce incidences of sexual violence in Nevada.
4. The RPE Program will support opportunities for training and policy reform through a new dual coalition.
5. All funded agencies will be required to implement the following proven principles of prevention in strategies selected for the target population: assess and address risk and protective factors, ensure strategies are culturally appropriate, practice collaboration, include varied teaching methods, maintain well-trained staff, and promote positive relationships.

Adolescent Health-Annual Report

Adolescent Well-Visits

Nevada's MCH Program was selected to participate in The National Governors Association (NGA) Learning Collaborative on *Improving Quality and Access to Care in Maternal and* Child Health. At the preliminary November 2015 meeting, the NGA chose to focus efforts on systems of care for uninsured youth by expanding access to coverage and services. The State Leadership Team consists of a diverse group from Nevada's Office of the Governor; State Legislative Assembly persons; and the following Health and Human Services Divisions: Health Care Financing and Policy, Child and Family Services, Welfare and Supportive Services, Tribal Liaison/Office of Minority Affairs, Community Health Services, and Public and Behavioral Health. The State Team developed a Strategic Action Plan to increase enrollment in health insurance coverage, engage stakeholders, and collaborate with health care providers on strategies for service provision for adolescents ages 15-18 years. A survey was disseminated to providers, families, and adolescents. Agencies providing insurance application assistance reported the most common barriers to families obtaining insurance were legal status, lack of necessary identification/information to fill out paperwork, language barriers, and parental fears. For adolescents not receiving a health check-up within a year, most common responses were not having insurance, being unaware of the need for annual well-visits, inconvenient clinic hours, not wanting their parents to know, and legal status. A technical assistance site visit (November 3, 2016), enabled members from the NGA Center for Best Practices to assist Nevada.

The MCH Adolescent Health and Wellness Coordinator disseminated materials to promote adolescent well-visits to several community partners and stakeholders. Nevada Wellness, a Nevada Title V partner, and the MCH Coalition placed materials on their website promoting adolescent health and wellness, inclusive of the Office of Adolescent Health's, Think, Act Grow (TAG) program, and the Society for Adolescent Health and Medicine's Teen Health resources, Information and Vaccine Education (THRIVE) app. The Nevada Chapter of the American Academy of Pediatrics disseminated the University of Michigan's youth-driven video *Adolescent Health Friendly Medical Care*.

Nursing personnel within the Community Health Services (CHS) educated adolescents at outreach events in Nevada's rural and frontier areas on wellness, teen immunizations, nutrition, reproductive health (inclusive of long-acting reversible contraception) sexually transmitted infections, depression, domestic violence prevention, and the value of yearly check-ups. Nursing personnel distributed diverse health-related brochures provided by the Title V/MCH program.

Carson City Health and Human Services (CCHHS), a local health authority in Northern Nevada, was awarded Title V funding to promote adolescent health and wellness. Priorities focused on providing education, counseling and/or referrals to substance users and teens afflicted by domestic and interpersonal violence and depression.

PACE Coalition (an entity within the Nevada Statewide Coalition Partnership) was awarded Title V funding to employ a Community Health Worker (CHW) to participate in MCH activities in Elko County and nearby communities. Specific emphasis was placed on care coordination and increasing connections to resources and services for the Latino population. The CHW distributed educational information to adolescents on health and wellness and the value of annual well-visits. Materials covered reproductive health, sexually transmitted infections, depression, domestic violence prevention, tobacco cessation, and nutrition.

The MCH Adolescent Health and Wellness Coordinator collaborates with the 13 School-Based Health Centers (SBHCs) on activities supporting health and well-being for children and adolescents. Title V funds supported the SBHC at Wooster High School, in Reno, with a focus on creating a sustainable facility. To help accomplish the objective, outreach and education to 6,573 families resulted in increased clinic visits (inclusive of well-visits) each month, serving 1,265 students and/or family members. The MCH Adolescent Health and Wellness Coordinator researched SBHCs across the U.S. providing telehealth services, and shared the information with Community Health Alliance, operating the SBHC at Wooster High School.

They are looking at using telehealth carts at the six surrounding feeder sites to enhance uptake of services. Title V supported the Bowers SBHC to pilot the viability of the Rapid Assessment for Adolescent Preventive Services (RAAPS) tool, performed during well-visits and sports physicals. The youth-friendly tool, filled out on an electronic tablet, is intended to solicit more honest information than other assessments. The pilot started the last month of the application year, thus information was not available from participants and providers to report.

Adolescent Physical Activity

The MCH Adolescent Health and Wellness Coordinator researched evidence-based after-school physical activity programs with inclusion of high school aged adolescents. Discussions began in the last month of the funding period with Urban Lotus Project, an organization providing yoga instruction and mindful awareness to at-risk and underserved youth in Reno and surrounding areas. There was mutual interest in a future partnership, to support a pilot to assess whether Trauma-Informed Yoga for Youth physical activity benefits high-risk adolescents' ability to cope with stress and increase resilience. The Coordinator held several meetings with the State Chronic Disease Prevention Section School Health Coordinator to learn how to best complement and promote their activities related to increasing physical activity in adolescents.

The School Health Program Coordinator conducted professional development sessions on the Comprehensive School Physical Activity Program (CSPAP), nutrition trainings, and information on the Nevada School Wellness Policy, in five of the 17 school districts statewide at elementary schools; the need to expand CSPAP into middle and high schools was identified. A Parent Teacher Association (PTA) Resources Manual was provided at the Nevada PTA Conference, inclusive of national, state, and local resources to reduce obesity and improve physical activity.

Title V co-funds nurses within Community Health Services (CHS). In the reporting year, the nurses provided educational materials on nutrition and physical activity to adolescents in their communities.

Abstinence Education Grant Program (AEGP)

Over 351 youth ages 9-12 and 13-19 participated in the Abstinence Education Grant Program (AEGP) in northern and rural Nevada. Priority enrollment was given to at-risk youth. Carson City Health and Human Services (CCHHS), Family Resource Center of Northeastern Nevada-Elko (FRCNEN), Quest Counseling and Consulting (Quest) in Washoe County have all been able to recruit participants in-house, as well as through local organizations working with at-risk youth. AEGP continues to build partnerships throughout the life of the project to provide a comprehensive approach to reducing teen pregnancies and births in Nevada. AEGP provides an inclusive, non-stigmatizing environment for youth to learn about social, psychological, and health gains to be realized by abstaining from sexual activity.

Continuous efforts to create more robust marketing strategies and materials for the program occurred. This included adding specific AEGP user friendly website content on the CCHHS website and developing AEGP information on the DPBH website. A statewide radio media campaign, "Parents Talk to your Kids" promoting abstinence education saw approximately 400 radio spots aired statewide each month.

Subgrantees partnered with 12 community organizations and attended 12 community events around the state to promote AEGP. Carson City Health and Human Services offered the "Promoting Health Among Teens!-Abstinence Only" (PHAT!-AO) classes in Carson City, Douglas County, Lyon County and Storey County. Storey County School District allowed PHAT!-AO curriculum as a part of their 5th and 8th grade Health Class, facilitated by CCHHS AEGP staff. Quest continued to seamlessly conduct PHAT!-AO classes with male youth living at the Quest House for substance use and mental health treatment. CCHHS worked with Storey County School District and Bishop Manogue High School to implement the program at the middle school level. Both FRCNEN and CCHHS have worked in their communities to create more buy in and identify local stakeholders to champion their programs. The FRCNEN continued to conduct PHAT!-AO classes in Elko and outlying rural communities in Winnemucca, Lovelock,

Jackpot, Battle Mountain, and Wendover.

Personal Responsibility Education Program (PREP)

The major goals of the Personal Responsibility Education Program (PREP) are to reduce teen pregnancy and teen births in Nevada and to reduce sexually transmitted infections, including HIV. In Federal Fiscal Year 2016, over 600 youth ages 13-18 participated in the Personal Responsibility Education Program (PREP), with the highest number of participants reached through Planned Parenthood Mar Monte and Planned Parenthood of the Rocky Mountains. Subgrantees have partnered with over 28 community organizations and attended 36 community events around the state. The five PREP subgrantees (Planned Parenthood Mar Monte, Planned Parenthood of the Rocky Mountains, Family Resource Centers of Northern Nevada, Carson City Health and Human Services, and The Center) taught comprehensive sex education using several evidence-based curriculums: "¡Cuidate!", "Reducing the Risk", "Be Proud! Be Responsible!" (BPBR) and Sexual Health and Adolescent Risk Prevention (SHARP).

Carson City Health and Human Services was approved by the Storey County School District to teach PREP in their 10th grade Health Class, and was available for all high school students who needed Health credits in 2016. Planned Parenthood of the Rocky Mountains implemented "¡Cuidate!" with Hispanic/Latino youth in a home based setting around Las Vegas using Promatores to provide culturally competent information. The Center used curriculum inclusive to and supports the LGBTQ community, specifically with the BPBR curriculum. Planned Parenthood Mar Monte taught "¡Cuidate!", BPBR, SHARP and continued their Teen Success group in Reno, which is a weekly support group serving pregnant and parenting adolescent mothers.

Rape Prevention and Education (RPE)

Through leveraged Preventive Health and Health Services (PHHS) funding, the Nevada Rape Prevention and Education (RPE) Program implemented prevention strategies targeting teens to provide education and awareness on issues relating to dating violence and to prevent sexual violence episodes from occurring in the future. Legislatively approved prevention strategies reflect the expansion of previous work for preventing sexual violence among teens and young adults through: trainings for professionals, healthy relationship education, bystander training for students and campus personnel, and activities to increase awareness about drugs and alcohol used in the facilitation of rape and sexual violence. Emphasis for Nevada's RPE Program was placed on accomplishing the following goals: preventing first-time perpetration and victimization; reducing modifiable risk factors and enhancing protective factors associated with sexual violence; utilizing the best available evidence when planning, implementing, and evaluating prevention programs; incorporating behavior and social change theories into prevention programs; using population-based surveillance to inform program decision making and monitor trends; and evaluating prevention efforts using the results to improve future program plans. The RPE Program served as a liaison for the support of primary prevention measures statewide and supported one full-time sexual violence prevention manager, three full-time outreach coordinators, one half-time campus coordinator, five educational presenters, as well as executive staff, policy staff, and fiscal staff from funded agencies. After receiving federal recognition in January 2016, Nevada holds a new dual domestic/sexual violence coalition through the Nevada Coalition to End Domestic and Sexual Violence.

In collaboration with national efforts and in support of the White House Task Force directive requiring federally funded colleges to comply with efforts in the prevention of campus sexual violence, and Campus Sexual Violence Elimination (SaVE) Act for safe college campuses, the RPE program supported a bystander awareness and intervention campaign on the University of Nevada, Las Vegas (UNLV) campus. The Green Dot Bystander Model of prevention increases behavior skills and intervention strategies in the prevention of violence-related behaviors and have been proven effective in engaging community involvement in sexual violence prevention. Green Dot Bystander

4-day trainings were given to 117 students and staff, and weekly Facebook activity included 239 users on average per week. A statewide workgroup met quarterly to provide networking opportunities and technical support for Nevada universities implementing bystander intervention activities on campus. A bystander website entitled *Step Up Stop Violence* promotes community change strategies by challenging individuals to become agents of change in their own communities as a way to combat sexual violence. Browsers can read information about the history and theory behind bystander intervention, as well as locate sexual and domestic violence resources in Nevada. In addition, a community-based task force convened to spearhead the implementation of a *Green Dot Bystander* pilot project on one high school campus, impacting 166 high school youth. A program logic model and assessment tools were created by program evaluators and revised through a series of committee meetings. A final summary of findings was compiled for dissemination.

The RPE Program funded an Alcohol Wise online training for new incoming students at the University of Nevada, Reno (UNR) campus. Alcohol Wise explores the dangers of excessive alcohol use and creates scenarios to assist users in making wise choices. The online training offers a preventive sexual assault component which collects information from participants on sexual attitudes and behaviors. Alcohol Wise is highly encouraged as part of the orientation process for all new incoming students. The data collected is used to evaluate potential problems and inform UNR school policy.

The RPE Program funds activities to support a Party Smart Campaign in Las Vegas, Nevada. The Party Smart Campaign, developed in 2009, originated in Las Vegas through the Rape Crisis Center and is supported through collaborative efforts with the Las Vegas Metropolitan Police Department to address the dangers of drugs and alcohol in the perpetration and victimization of sexual violence. A total of over 500 bartenders and bar owners, servers, and security personnel in Las Vegas received training in active bystander intervention and signs of predatory behavior to increase awareness of alcohol in the facilitation of sexual assault, and assist management in creating policies to avert potentially dangerous situations for bar patrons. Party Smart endorses the avoidance of sexual violence through planning and awareness and is intended to remind party goers to use common sense and follow some simple tips to ensure they have a good time without compromising safety. The Party Smart Campaign included 5 press releases, 68 print media and television mentions/stories. Britney Spears appeared in a Party Smart Las Vegas Public Service Announcement for New Year's Eve and received over 20,000 views.

Healthy relationship education, through train-the-trainer workshops, were provided to professionals and teen peer educators in (4) rural communities. YourSPACE educational presentations promote healthy respectful relationships, and increase knowledge and awareness of sexual abuse in connection to dating violence. A total of 9,600 Nevada youth received healthy relationship presentations through YourSPACE educational sessions, including an additional 69 school and community staff. Teen Dating Violence and Sexual Assault Brochures were distributed in English and Spanish to 4,344 youth and 4,053 parents of youth.

Data

Immunize Nevada launched an extensive media campaign to raise public awareness about HPV, and the campaign was promoted by the Nevada Title V MCH program and partners. The percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine increased from 54.2% in 2014 to 72.0% in 2015 for females. There was no significant change for males.

An area of concern for the Nevada Title V MCH program is the increase in adolescent mortality for ages 10 through 19 years. There has been an increase from 30.3 per 100,000 in 2014 to 38.1 in 2015, and is attributed to an increase in non-transport accidents and unintentional injuries. White non-metropolitan males and those aged 15-19 years have the highest rates. Because Nevada has small numerators, any increase in the value can increase the percentages. The overall rate is more consistent with the 2014 value. However, the adolescent mortality rate will

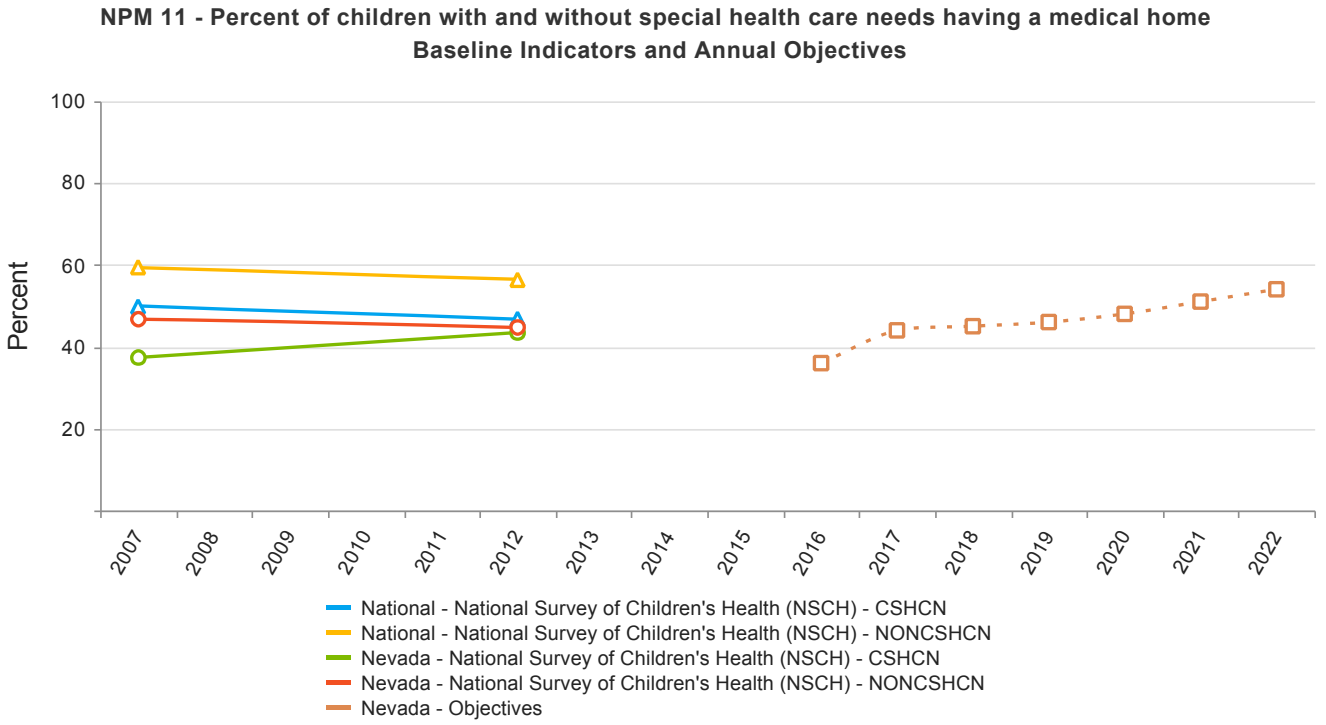
require monitoring.

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	11.2 %	NPM 11
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	79.0 %	NPM 11
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)	NIS-2015	71.3 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	48.8 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	72.0 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	44.5 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	88.3 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	78.0 %	NPM 11

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	36
Annual Indicator	43.3
Numerator	42,016
Denominator	96,943
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.0	45.0	46.0	48.0	51.0	54.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	9.0	10.0	11.0	12.0	12.0

State Action Plan Table

State Action Plan Table (Nevada) - 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	Status
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	Active

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

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

The Nevada Children's Medical Home Portal (MHP) is live as of spring 2017, and fully funded by MCH Title V. The continued partnership with the Department of Pediatrics at the University of Utah will allow the CYSCHN Program to increase the number of CYSHCN families with a medical home. 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 for clinicians to support a Medical Home, providing comprehensive care, integrating best practices, and partnering with families;
- 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.

The MHP will help strengthen care coordination throughout Nevada. In addition, MCH's partnership funding Nevada 2-1-1 will also be strengthened. Nevada 2-1-1's vital role in the uploading of local services to the MHP quarterly will allow a stronger partnership to form between the two entities and current, local, and relevant social and health services to be provided to CYSHCN and their families. The CYSHCN Coordinator will offer trainings on using the MHP and distribute materials promoting MHP statewide.

Critical Congenital Heart Disease

The MCH Program will continue overseeing Critical Congenital Heart Disease data collection and communications with all birthing facilities. Once a full year of data has been collected from all birthing hospitals, a report will be created by the MCH and CYSHCN programs. The report will be used for evaluating the screening data and results. Data points collected with CCHD reporting include: monthly counts for number of screens, number of births, number of failed screens, and percent of failed screens.

Family TIES

Family TIES is evaluating its existing presentation materials and overall brand. In order to improve services and accessibility for all communities, the agency will work to modify areas necessary to increase exposure and resource availability. For the period of 2017-2018, the organization will continue serving all populations with an increased focus on rural areas (i.e., Douglas County, Storey County and Lyon County), as well as increased outreach to the Hispanic population statewide. MCH staff will train Family TIES in presenting on the use of the MHP. They will then train parents to use the MHP. They will continue to offer Parent Training series and offer supports to parents of CYSHCN. They will staff the CYSHCN helpline and track all assistance and referrals provided. Family TIES will continue to distribute the Milestone Moments developmental tool, transition, and MHP resources.

TACSEI

Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI) will continue outreach to programs supporting diverse families. Nevada TACSEI sites include Head Start and Early Head Start programs serving families living in poverty and include diverse populations. Additional Nevada TACSEI sites include children with

disabilities and will work to provide inclusive opportunities to include young children with disabilities with their same age peers. Coordinators will disseminate materials relevant to social emotional development of young children, as well as other areas of development, as needed. Multiple sources of data are collected from Nevada TACSEI implementation and demonstration sites, with data collection occurring at annual, biannual, and monthly cycles, depending on the data being collected. Annual summaries of data collected are summarized and reported each June. Quality improvement is a continuous and ongoing goal, including national work addressing disproportionality in early childhood centers and programs. The program plans to increase capacity for information dissemination to more rural/frontier counties.

The coordinators have plans to increase capacity to support additional implementation sites, increasing numbers of children and families supported, and increasing the number of reported Ages and Stages Questionnaires, Social Emotional Second Edition (ASQ-SE2) statewide in partnership with NHV and trainings in ASQ. An increased capacity for coaching is needed to help early childhood practitioners implement strategies to support young children's social emotional development and engage families on the importance of social emotional development. The training and information is provided, but practitioners (teachers, caregivers, etc.) need more direct support and coaching in how to implement the information and strategies on a consistent basis. This includes supporting young children with disabilities and those with persistent challenging behaviors.

Craniofacial Clinics

As a collaboration of Nevada Early Intervention Services (NEIS) and the University of Nevada, School of Medicine, Title V MCH will offer 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 will maintain 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 the field.

Nevada Center for Excellence in Disabilities (NCED):

Nevada Center for Excellence in Disabilities is changing focus of MCH funded activities from sibling issues workshops, sibshop facilitator trainings, and sibshops to a Nevada Partners Leadership Program. Outreach to recruit for the Nevada Partners Leadership Program will be a focus, utilizing social media, email communications, and flyer distribution. The program will include information for families on parent advocacy for CYSHCN, care coordination for CYSHCN and the Nevada Children's Medical Home Portal. A new project, iCan Shine Bike Camp, will offer a bike camp to teach kids with disabilities how to ride a two wheel bike without training wheels in Southern Nevada.

Nevada *Learn the Signs. Act Early*

The Nevada *Learn the Signs. Act Early* (*NvLTSAE*) Program will continue distributing Milestone Moments booklets

as part of the NvLTSAE campaign. The University Center for Autism and Neurodevelopment (UCAN) will provide diagnostic evaluation for children in need. MCH will provide funding to support assessments provided by a cognitive psychologist at no cost to families with referrals provided to families for access to appropriate services. A Children's Special Health Service Survey will be sent to the parents of Children and Youth with Special Health Care Needs (CYSHCN). The information gained from the survey will document first-hand the needs parents of CYSHCN have throughout Nevada.

Nevada Governor's Council on Developmental Disabilities (NGCDD)

The MCAH Section Manager will serve on the NGCDD and ensure bidirectional information sharing with the MCH Title V program, funded partners, and stakeholders, leveraging opportunities to serve CYSHCN.

Tribal Partnerships

Efforts to engage with Tribal partners in Nevada will continue, including CYSHCN related efforts. The MCH program presented at the Tribal Consultation meeting in spring 2017, and met with the Intertribal Council of Nevada Director and WIC lead, as well as with Regional and Nevada Indian Health Services staff. A Safe Sleep/injury prevention pilot with tribal clinics is in the planning stages.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) plan for next year:

The promotion of preventive benefits and screenings such as EPSDT, with an emphasis on Medicaid participants, is a key priority for increasing maternal, child and infant health. Collaborations between DHCFP and MCAH will continue, including the promotion and distribution of EPSDT materials and exploring value based payment opportunities. MCH will partner with the Association of State and Territorial Health Officials (ASTHO) Community Health Worker MCH project in the upcoming year to increase access to insurance. MCH will continue to partner with the Chronic Disease Prevention and Health Promotion (CDPHP) Section Community Health Worker Program in relation to MCH issues, including the Connecting Kids to Coverage Program. MCH will continue as the lead agency for the National Governors Association initiative to improve insurance enrollment and access to health care for adolescents 15-18 years of age. The Children and Youth with Special Health Care Needs (CYSHCN) Program will promote the Children's Medical Home Portal and will disseminate resources to increase insurance coverage. The PACE Coalition Community Health Worker will promote and support access to insurance.

Staff will continue to attend Transition conferences and training, distribute transition resources, and partner with NDE, Vocational Rehabilitation, NGCDD, and family advocacy groups to best serve CYSHCN and their families. A social media campaign for substance use and mental health co-occurring disorders will be funded in fall 2017, targeting adolescents and young adults, and the Urban Lotus pilot will serve CYSHCN as well as meeting physical activity priorities.

Children and Youth with Special Health Care Needs-Annual Report

The Children and Youth with Special Health Care Needs (CYSHCN) Program had a coordinator position change. The position was vacant from July 2016 through the remainder of the Federal Fiscal year. Although the position was vacant for an extended period of time, the program continued to maintain its direction. During the vacancy, collaborations and partnerships with stakeholders to meet the needs of CYSHCN and their families were strengthened. Maternal and Child Health (MCH) staff worked with CYSHCN collaborators to create subgrants with scopes of work which allowed partners to maximize efforts to assist families of CYSHCN.

Work continued on the development of the Nevada Children's Medical Home Portal (MHP), as part of Nevada's Title V medical home National Performance Measures (NPM). Originally expected to be live in September of 2016, the CYSHCN Program Coordinator vacancy and difficulties with the contractual language caused a delay in MHP implementation. The MHP will help strengthen care coordination throughout Nevada. In addition, MCH's partnership with Nevada 2-1-1 has also strengthened in this time. Nevada 2-1-1's vital role in the uploading of local services to the MHP has allowed a stronger partnership to form between the two entities.

In November 2015, the CYSHCN program participated in the Nevada 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, a valuable linkage between health and education by providing information about available transition resources. The conference, hosted through the Department of Education, included high school students living 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.

In July of 2016, a committee was created consisting of Easter Seals, Family TIES (Nevada's Family Voice affiliate), Nevada Early Intervention Services (NEIS), Nevada Governor's Council for Developmental Disabilities (NVGCDD), and MCH to develop a community outreach event for families of CYSHCN. This event, known as The Spring Fling, was held in May 2017 in Northern Nevada. The objective of this no cost event was to bring together providers and families of CYSHCN in order to help families identify available services and providers. MCH's role aside from planning assistance is as a vendor and funder for the event. The Spring Fling event was the inaugural event with plans from the committee to continue the event annually, while also expanding to various locations throughout the State.

Critical Congenital Heart Disease

As of January 2017, all of the birthing hospitals in Nevada have been reporting data related to Critical Congenital Heart Disease (CCHD). The MCH and CYSHCN programs have created a state specific fact sheet and screening report used by all Nevada birthing hospitals. The reporting form includes discrepancy explanation for differences in number of screens and births for the month reported, patient information for failed screenings, whether or not the failed screening was found via prenatal detection and any follow-up needed. Once a full year of data has been collected from all birthing hospitals a report will be created by the MCH and CYSHCN programs. The report will be used for evaluating the screening data and results. Data points collected with CCHD reporting include: monthly counts for number of screens, number of births, number of failed screens, and percent of failed screens.

Family TIES

As a MCH Title V funded key partner, Family TIES of Nevada is dedicated to providing culturally competent support, information, CYSHCN toll free hotline, and assistance to achieve family-centered care for individuals living 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).

Highlights of Family TIES

- Family TIES logged over 2,242 instances of support to Nevada families of CYSHCN and over 517 instances of support to professionals who work with families of CYSHCN –a 121% increase since 2010. Of the families served, 45% were 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 CYSHCN, and how to play an active role in their child's health care. Due to positive feedback, the Project was expanded in 2016-17, with a 9-part Parent Training Series in Spanish and English reaching more than 200 participants.
- 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 originally held in 2015-2016. The organization continues to engage Hispanic populations and is currently planning a multicultural resource fair in Douglas County.
- During this period, Family TIES distributed 4,101 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.
- Numerous trainings and technical assistance opportunities were provided directly by Family Ties, including a seminar featuring Temple Grandin, Managed Care 101, Youth in Transition, a parent information session at University of Nevada Las Vegas, Parent and Teachers as Allies, Nevada Leadership Education in Neurodevelopmental and Related Disabilities (NvLEND), and National Alliance on Mental Illness.

A valuable project developed with Family TIES and the American Academy of Pediatrics demonstrated efforts aligned with performance measures. 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; originally taking place through September 2015.This information was once again gathered and reviewed, and revealed results as indicated in the graphs below for 2016-17. The intent of this information was to educate state teams about the challenges patients/families and providers are experiencing, and to highlight potential opportunities. Below is an updated summary of the findings for this current period.

Physician Interview Findings

A phone interview was held between AAP staff and pediatrician leaders from Nevada's AAP 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	• Some small self-funded plans do not cover all Bright Futures services
Medicaid	• Very low payment rates for physicians-so low, many physicians do not sign up as providers • Re-enrollment is often a challenge and families fail to do it • Many non-US nationals in the area and are afraid to enroll their children
Population	• Very transient population • Many non-US nationals without insurance

Pediatric Care Successes	
Bright Futures	• Most insurance carriers pay for recommended Bright Futures services
Medicaid	• Single point of enrollment throughout the state – easier to understand / deal with

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

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. Thirty-three 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 (52%). *Please note: Down from 57% in 2014-2015.* • The recommended doctor or service is not available in my area (37%) • My provider does not accept / no longer accepts my insurance plan (23%)
Coverage	• A recommended service is not covered by my insurance plan (41%) • Recommended services were limited (41%) • A recommended doctor / provider is out-of-network (37%). *Please note: Decrease of 1% over period 2014-2015.*
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 continued to encounter many of the same access, coverage, and payment issues and are concerned 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 alarming to be unable to obtain the recommended care due to a lack of providers or unmanageable out-of-pocket costs. Family TIES continued to participate as a member of the Certified Community Behavioral Health Clinics (CCBHC) planning grant committee to address these issues.

An additional solution to the above mentioned 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 devise local solutions.

Craniofacial Clinics

As a collaboration of Nevada Early Intervention Services (NEIS) and the University of Nevada, School of Medicine, Title V MCH 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 the field. Title V MCH supports .5 FTE bilingual staff and program support for the Northern location.

Nevada Technical Assistance Center on Social Emotional Interventions (TACSEI)

Nevada Title V provides funding to Nevada Technical Assistance Center on Social Emotional Interventions (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 of TACSEI

- The Family Engagement Coordinator (FEC) provided ongoing technical assistance to programs and centers in southern Nevada on parent engagement practices. The FEC reviewed and provided feedback on policies and documents related to family engagement, including Nevada Department of Education Family and Community Engagement Services (FACES) staff, Nevada's Suspension and Expulsion Policy in early childhood settings, policies and procedures manuals, and the State Leadership Team. The FEC provided seven conference presentations at the regional and state levels.
- The Coordinators attended multiple events throughout Nevada relating to young children and families. Materials such as the Backpack Series, visual supports, and social stories were shared with parents, caregivers, teachers and others who care for young children. The FEC attended a series of back to school events for Clark County in September 2016 with over 5,000 participants. Coordinators worked with implementation and demonstration sites to conduct developmental screening and/or assessments for all children in their program, including a social emotional screening tool.
- Trainings and technical assistance emphasized the importance of developmental and social emotional screening tools, typically the Ages and Stages. Questionnaire 3rd Edition (ASQ-3) and the Ages and Stages Questionnaire – Social Emotional 2nd Edition (ASQ-SE2). Resources were provided to programs and/or parents on how to get access to the ASQ-3 and/or ASQ-SE2. This supports MCH developmental screening goals as well.
- Nevada TACSEI sites reported over 104 children screened for social emotional concerns using the ASQ-SE2. Many more children were screened or assessed at sites, but may not have been reported, as sites are required to submit ASQ-SE2 data only and are not required to report developmental screening/assessment results. In addition, data collection for screening occurs bi-annually, therefore many children who begin services after the

start of the school year may not be a part of the beginning of the school year screenings/assessments. The 104 reported children is an underestimate of the actual numbers of children who are receiving developmental screening/assessment.

- Nevada TACSEI specifically addressed developmental screenings and screenings for social emotional development. The implementation and demonstration sites TACSEI supports implemented developmental screening or assessment and social emotional screening, at minimum. Annual statewide data is compiled and reported in June of each year.
- Coordinator staff met regularly over the phone and/or in person for data review, communication, and continuous professional development and improvement. Resources from those who attended conferences or trainings relevant to the collaborative work are shared during meetings to improve services statewide and ensure services are being delivered in similar and equitable ways.

Nevada Parents Encouraging Parents (PEP)

As the statewide Parent Training and Information (PTI) Center, Nevada Parents Encouraging Parents (PEP) provides services to parents and 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 continued to work on a multitude of programs and 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, and Positive Behavioral Supports (PBS) Nevada.

CYSHCN participated in planning with NCED for a two day sibling workshop (Sib shop) provided by Don Meyers, trainer and educator on sibling support. The workshop was designed for professionals including psychologists, social workers, service providers, teachers, adult siblings, parents, and other family members. The purpose of the workshop was to train and certify facilitators how to run a local sib shop addressing sibling issues and concerns. 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.

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. LEND programs across the nation work together to address 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 featured four statewide summits bringing together parents and professionals. 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 developed collaborations with several state, private, and public agencies. As part of the NvLTSAE project, MCH purchased 100,000 Milestone Moments Booklets to disseminate throughout the state, developed by the Centers for Disease Control and Prevention (CDC) and adapted for Nevada, including referral information for parents.

Healthy Kids, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Healthy Kids, Nevada Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program reimburses providers for well-child visits for all children enrolled in Nevada Medicaid and Nevada Check Up. Nevada continues to monitor the utilization and strives to increase EPSDT screening utilization among Medicaid eligible children under the age of 20. Outreach to providers and families to encourage EPSDT screenings is a continuing effort for the Division of Health Care Financing and Policy (DHCFP) and Maternal Child Health (MCH). MCH provides flyers and brochures to increase awareness of EPSDT.

Materials promoting the EPSDT program are shared with all partners and stakeholders. MCH Title V created a bilingual growth chart with developmental milestones and the recommended child wellness visits. A bilingual one page version of the growth chart was also created and included in the PINK packets distributed statewide to all new mothers after giving birth in hospitals. The growth charts were shared with all partners and promoted at the statewide Nevada Health Conference. Updates were made to the EPSDT brochure, and a one page reimbursement guide promoting coverage for postpartum depression screenings as part of the first three well child visits was created and shared with partners, providers, the MCH Advisory Board, and stakeholders.

Home Visiting program providers continue to remind families to renew their Medicaid or Nevada Check–up one month before renewal is due. NHV staff refers clients to Positively Kids enrollment workers at two Southern Nevada Health District locations, as appropriate.

MCH partners with the Chronic Disease Prevention and Health Promotion (CCPHP) Community Health Worker Program in relation to MCH issues, including the Connecting Kids to Coverage Program. MCH is the lead agency for the National Governors Association initiative to improve insurance enrollment and access to health care for adolescents 15-18 years of age. The Children and Youth with Special Health Care Needs program is in the process of launching a Children’s Medical Home Portal and disseminates resources to increase insurance coverage. The PACE Coalition Community Health Worker promotes and supports access to insurance.

Special Events attended by MCH Staff

MCH staff attended the Nevada Early Intervention Services Family Trick or Treat Event on October 21, 2015. Program staff handed out toothbrushes for children of all ages, along with program materials promoting the Early Periodic Screening Diagnosis and Treatment Program, SoberMomsHealthyBabies.org website, Bright Futures, and additional resources for accessing insurance and health care providers.

Data

The percent of children with and without special healthcare needs having a medical home in Nevada has exceeded the annual objective of 36. The annual indicator is 43.3, and as a result, the annual objectives have been modified for the coming years. The Nevada Title V MCH program is looking forward to the NSCH updates as well as the information gathered from the newly implemented Nevada Medical Home Portal once one full year of data is available.

Cross-Cutting/Life Course

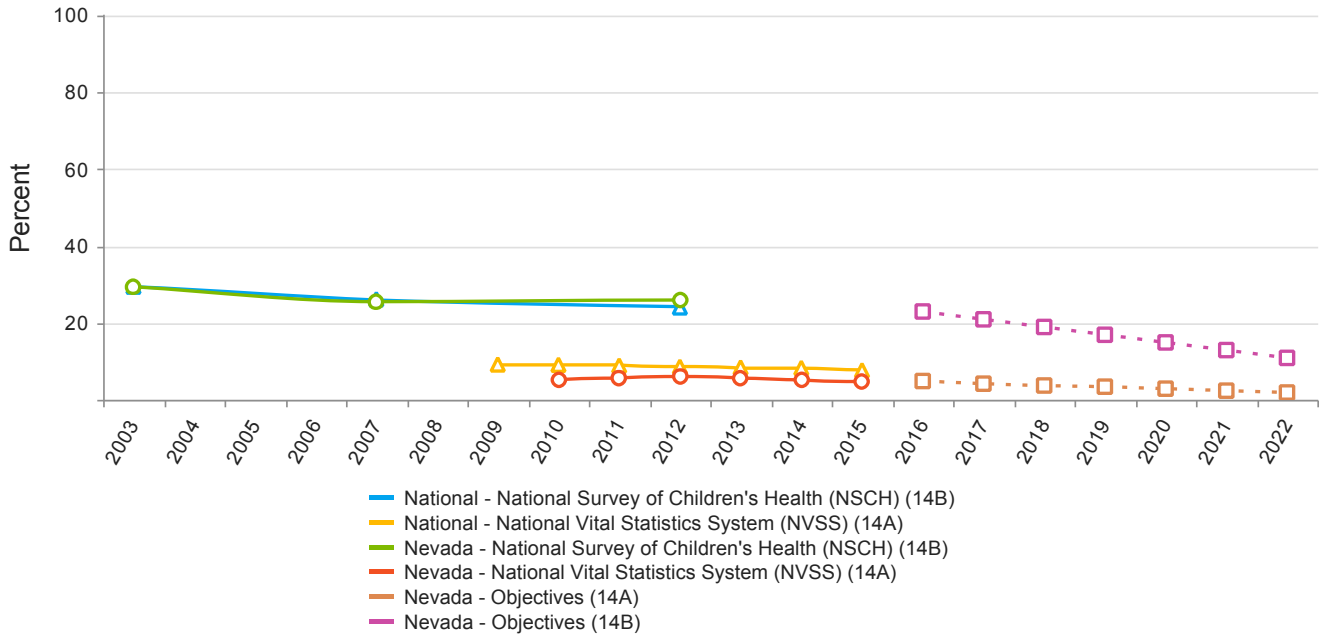
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	152.2	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	6.2	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.5 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.3 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.2 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.0 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.7 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.3 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	26.3 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	6.0	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.5	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.8	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	186.8	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	55.8	NPM 14
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	11.2 %	NPM 15

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	79.0 %	NPM 14
NOM 21 - Percent of children without health insurance	ACS-2015	7.6 %	NPM 15

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	5
Annual Indicator	4.8
Numerator	1,726
Denominator	35,965
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	4.3	3.8	3.5	3.0	2.5	2.0

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23
Annual Indicator	26.0
Numerator	169,917
Denominator	654,896
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	21.0	19.0	17.0	15.0	13.0	11.0

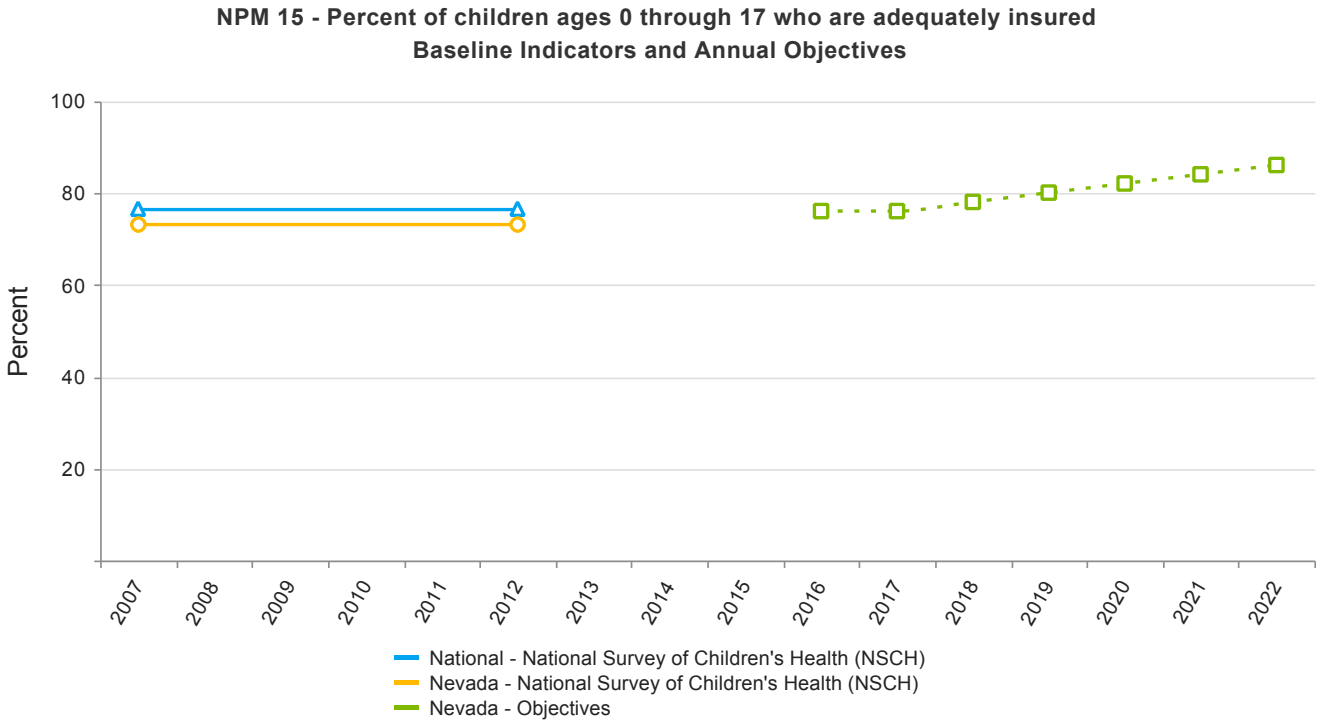
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Nevada Tobacco Prevention and Control Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	76
Annual Indicator	73.0
Numerator	413,200
Denominator	566,418
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	76.0	78.0	80.0	82.0	84.0	86.0

Evidence-Based or –Informed Strategy Measures

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)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Nevada Title V MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	7.0	8.0	8.0	9.0	9.0

State Performance Measures

SPM 3 - Percent of women who use substances during pregnancy

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5.5
Numerator	1,950
Denominator	35,378
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	5.0	4.5	4.5	4.0	4.0

State Action Plan Table

State Action Plan Table (Nevada) - 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	Status
ESM 14.1 - Number of pregnant women and new mothers who called the quitline for assistance in the past 12 months	Active

NOMs

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

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

NOM 4.1 - 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 (Nevada) - 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	Status
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)	Active

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 (Nevada) - Cross-Cutting/Life Course - Entry 3

SPM

Percent of women who use 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.

Cross Cutting/Life Course-Plan for the Application Year

The Tobacco Prevention and Cessation Program and Tobacco Quitline

All Title V funded agencies will continue to promote the Nevada Tobacco Quitline. Sharing information regarding the Quitline with women of childbearing age is explicitly articulated within the scope of work for each funded program serving this population. MCH staff is working with Quitline staff and 2-1-1 to improve data collection so utilization by women of childbearing age can better be tracked. In addition, the Community Health Services (CHS) branch, Carson City Health and Human Services (CCHHS), and PACE Coalition will provide tobacco cessation counseling, educational materials, and referrals to pregnant women and women of child bearing age. A Brief Tobacco Intervention will also be used by CCHHS.

The Chronic Disease Prevention and Health Promotion (CDPHP) Tobacco Prevention and Cessation Program will monitor and revisit increasing support for tax incentives in the next year of the project period, in addition to continuing dissemination of targeted Quitline promotional material for pregnant and postpartum women who use tobacco.

One of Nevada's Medicaid MCOs, Amerigroup, will sponsor the Baby and Me Tobacco Free Program. MCH will serve as a key partner and collaborate with appropriate pilot agencies to increase awareness to expand the program into areas with the highest smoking rates. Pregnant women who currently smoke will qualify to participate in the program. Four cessation counseling sessions will occur during the pregnancy period with monthly sessions postpartum. Participants will qualify for $25 diaper vouchers after each completed session. One additional household member may qualify to participate in the program along with the mother and may receive an additional $25 diaper voucher if they complete counseling sessions and remain tobacco free.

MCH will continue to work with March of Dimes in co-branding tobacco education and cessation materials and distributing the March of Dimes pamphlet: *Smoking and Pregnancy* to WIC offices, MCH Coalitions, and Rural Community Health Nurses as well as at outreach events organized by Division of Public and Behavioral Health (DPBH) staff and/or MCH partners. Efforts will continue to address smoking and pregnancy along with smoking and sudden unexpected infant deaths.

Sober Moms Healthy Babies Plan for next year:

As indicated in form 10a, the rate of infants born with neonatal abstinence syndrome increased dramatically between 2010 and 2014 in Nevada. To address that, Title V will continue to fund the *SoberMomsHealthyBabies.org* website to prevent substance use among pregnant women. The public awareness campaign will also continue to promote the website, in addition to the distribution of referral cards. Collaboration with local health authorities and SAPTA will ensure substance use in pregnancy materials and resources will reach the targeted audience. Additional resources will be added to the website, including updated tobacco cessation information.

SoberMomsHealthyBabies.org information, including referral cards, will be included in substance use provider toolkits. All local health authorities and MCH subgrantees will continue to promote the *SoberMomsHealthyBabies.org* website and share Sober Moms Healthy Babies referral cards.

Adequately Insured Children

The State Chronic Disease Prevention Section Connecting Kids to Coverage Program will continue efforts with six Community Health Workers (CHWs) in several agencies across the state to conduct outreach, recruitment, and enrollment of eligible children and families into Nevada Medicaid, Nevada Check Up (Nevada's Children's Health Insurance Program), and the Silver State Health Insurance Exchange (Nevada's health insurance marketplace). The

State CHW Program will continue to build the structure and organization of the Nevada Community Health Workers Association (NVCHWA). The CHW Program will focus on partnership building and sustainability efforts. Activities include increasing participation among the NVCHWA members, hosting an annual CHW meeting, and conducting meaningful engagements with community partners through networking and outreach. In collaboration with the Healthy Community Coalition, the CHW Program will help identify potential funding sources to continue to sustain the NVCHWA, including grant writing projects, hosting fundraising events, and increasing annual membership buy-in.

In 2017, Nevada was one of five states awarded an Association of State and Territorial Health Officer (ASTHO) technical assistance grant to host a series of tailored webinars and conference calls from national leading experts to address the goals of certification, reimbursement mechanisms, and sustainability of the NVCHWA and CHW workforce in Nevada. This grant will allow CHW partners and stakeholders to come together to discuss CHW initiatives and progress with future activities. Of the five states, Nevada was also selected for an on-site visit.

With the growing interest in the CHW Hybrid Training, the CHW Program will continue expanding the course to include chronic disease modules such as colorectal, cervical, breast and prostate cancer, and cardiovascular health and screening. Additional modules in Spanish will also be implemented. “Train the Trainer” Training will be brought to Nevada using the curriculum taught by Washington State. Increasing the number of trained trainers will be beneficial for the growing number of students taking the course.

All Title V funded agencies will refer uninsured families to Nevada 2-1-1 to obtain health insurance benefits information.

CCHHS will continue its partnership with the Division of Welfare and Social Services (DWSS) for onsite, walk-in application assistance to enroll in Medicaid. In-reach will continue to uninsured clientele on options for health care coverage. DWSS will place an additional staff member on-site due to its success.

Nursing personnel within CHS will provide information to uninsured patients about Nevada Medicaid, Nevada Check Up, and the Silver State Health Insurance Exchange. Non-US national residents and those not eligible for Medicaid or other insurance will be referred to Access to Healthcare Network.

The PACE Coalition’s CHW will assist the Latino population to access insurance/Medicaid, healthcare services, and other supports necessary to improve health.

Office of Suicide Prevention

The Nevada Office of Suicide Prevention (OSP) will focus efforts in four priority areas. OSP will adopt standardized protocols for following up with suicidal patients after discharge from emergency departments and other hospital settings. OSP will utilize syndromic surveillance (attempt data) and partnerships throughout *Continuity of Care for Suicidality Workgroup* to recognize and monitor trends in real time and develop a system of follow-up care and minimize repeated attempts. OSP will enhance data collection to capture information about specific characteristics of the population including veterans; active duty military and families; lesbian, gay, bisexual, transgender, queer (LGBTQ); and race/ethnicity. Additionally, OSP will address sustainability of efforts through funding, infrastructure, and system change.

OSP will continue working with the Department of Education’s Office of Safe and Respectful Learning Environments on the vision of a multi-tiered system of support to include Youth Mental Health First Aid (YMHFA) as a universal tier one support across Nevada school districts. This year activities will include ongoing support and training of 30 instructors statewide through the Project Advancing Wellness and Resilience Education (AWARE) grant to train 1,500 community helpers to recognize mental health concerns or crises in youth.

Nevada Health Conference

Immunize Nevada will continue to host the Nevada Health Conference in 2017 with a focus on maternal, child and adolescent health topics and funding, planning and support provided by the MCH program and other Bureau

programs. The MCH program will be a key partner and sponsor, including assistance providing funds for scholarships to individuals unable to attend due to cost. MCH program resources will be provided with conference materials, including a bilingual one page document promoting child well visits, the Early, Periodic Screening Diagnostic and Treatment program, and the Pregnancy Risk Assessment Monitoring survey. MCH staff are members of the Planning Committee and staff often present at the conference.

Cross Cutting/Life Course-Annual Report

The Tobacco Prevention and Cessation Program and Tobacco Quitline

The Chronic Disease Prevention and Health Promotion (CDPHP) Tobacco Prevention and Cessation Program disseminates targeted Quitline promotional material for pregnant and postpartum women who use tobacco via Nevada providers, WIC clinics, early childhood educators, Nevada Head Start sites, and Safeway pharmacies. The Nevada Tobacco Quitline (NTQ) continues 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 older. Advancements were made to the program for pregnant and post-partum mothers in Nevada through designated pregnancy counseling coaches, along with incentivized gift cards for each completed counseling call. Education on benefits of quitting smoking during pregnancy and harmful effects on babies was provided during each enrollment process.

The NTQ enrolled 1,953 callers during the program period. NTQ offers a free program specializing in helping pregnant mothers quit smoking. The tailored treatment plan meets their needs by providing intensive behavioral support, including an increased number of coaching calls compared to the general population. As an incentive, reward gift cards for $5 and $10 are given after completed, scheduled counseling calls. For pregnant and new mothers who have quit, additional postpartum support is available to prevent relapse. NTQ uses evidence-based treatment practices to help pregnant smokers quit and remain tobacco free. NTQ reported serving 20 pregnant women during the reporting period. Although the call volume is limited, outreach is being expanded to Community Health Workers, women's health care providers, WIC clinics, and events in the community. MCH opportunities to heighten NTQ awareness are being implemented, including embedding language in all Title V MCH fiscal documents to promote visibility and use.

The CDPHP Tobacco Prevention and Cessation Program shared talking points and data to encourage the increase of tax credits for building new low-income housing with smoke-free policies.

Efforts continued to create a smoke-free city in Mesquite; tobacco partners educated and coordinated support to promote and adopt a comprehensive smoke-free ordinance to protect Mesquite residents from secondhand smoke exposure. Three businesses in Mesquite adopted minimum distance policies, in addition to existing smoke-free indoor policies. Staff, partners and volunteers worked together to reach out to local Mesquite businesses to provide education on supporting a smoke-free Mesquite by adding their name and business to a sign-on letter of support provided to city council members. Nearly 130 Mesquite businesses have signed the letter of support. One tobacco-free outdoor event was held in Mesquite with more outdoor events scheduled in late 2016.

The local health authority in southern Nevada and supportive partners met with 324 stakeholders to promote comprehensive clean indoor air policy. This included reaching two city councilmen, as well as attending two city council meetings, a coalition event, and speaking with advocates. Local polling data from one city shows 61 percent of voters favoring a comprehensive smoke-free ordinance and 50 percent strongly in favor. These efforts have also generated media attention from the local newspaper.

The Cribs for Kids Program includes tobacco cessation messaging in the Safe Sleep curriculum and accompanying materials. The Cribs for Kids Program promotes the NTQ at trainings and community events.

Carson City Health and Human Services (CCHHS) provided tobacco education, counseling and/or referrals to the NTQ to 643 smokers. Nursing personnel within Community Health Services (CHS), provided information on tobacco cessation; smokers were referred to the NTQ. The PACE Coalition Community Health Worker (CHW) provided 200 people with tobacco cessation materials and made referrals to the NTQ.

March of Dimes

MCH continued to work with Nevada March of Dimes on the March of Dimes Prematurity Campaign, co-branding tobacco education and cessation materials and support for public and practitioner education to reduce preterm births. The campaign conducted a statewide distribution of March of Dimes pamphlets, *Smoking and Pregnancy*, to WIC offices, including Intertribal Council WIC, MCH Coalitions, and Rural Community Health Nurses, as well as several outreach events organized by the Division of Public and Behavioral Health (DPBH) staff and/or MCH partners. The pamphlet, available in English and Spanish, provides information on the risks of smoking to an infant's health, and gives tips and referrals to assist pregnant women to quit smoking.

Sober Moms Healthy Babies

MCH continued to work with the Substance Abuse Prevention and Treatment Agency (SAPTA) list of SAPTA funded treatment providers to update 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. The website provides the substance use help line number, Nevada 2-1-1, and the Nevada Tobacco Quitline, among other resources. Improvements to the website were made to make the website responsive and more user friendly. A call now button was added for immediate assistance. The website specifies the treatment priority status for pregnant women at SAPTA-funded agencies and the importance of women identifying they are pregnant. SAPTA-funded treatment centers must not deny treatment to persons unable to pay. All treatment centers listed on the website are SAPTA-funded. An interactive component was added to assist with accessing information, in addition to increasing the amount of time users spend on the website. These changes occurred during the end of the grant period and are not accurately reflected in the analytics below.

For this funded period, the website had 4,931 sessions and 4,149 users. New users were represented by 84% and 16% were returning visitors. A total of 8,335 page views occurred. The average session duration was 51 seconds. The duration time is expected to increase with recent changes to the website. A majority of these sessions were accessed from Reno and Las Vegas.

The public awareness campaign promoting the website continued throughout the state, in addition to the distribution of referral cards. The collaboration ensures substance use in pregnancy materials and resources will reach the targeted audience. The media campaign had 13,076 radio advertisements and 9,372 television advertisements, for a total of 22,448 total spots aired, promoting the *SoberMomsHealthyBabies.org* website and the importance of pregnant women receiving treatment and preventing substance use in women of childbearing age. All local health authorities and MCH subgrantees promoted the *SoberMomsHealthyBabies.org* website and shared Sober Moms Healthy Babies referral cards.

Adequately Insured Children

All Title V funded agencies refer uninsured families to Nevada 2-1-1 to obtain health insurance benefits information.

Carson City Health and Human Services (CCHHS) developed a partnership with the Division of Welfare and Social Services (DWSS) for onsite, walk-in application assistance to enroll in Medicaid. In-reach was conducted to uninsured clientele on options for health care coverage. The new partnership, initiated the last quarter of the award period, resulted in 56 families being assisted with Medicaid applications onsite.

Nursing personnel within Community Health Services (CHS), through outreach events, provided information to uninsured people in the rural and frontier regions about insurance resources through Nevada Medicaid, Nevada Check Up

(Nevada's Children's Health Insurance Program), and the Silver State Health Insurance Exchange (Nevada's health insurance marketplace). Undocumented residents and those not eligible for Medicaid or other insurance were referred to Access to Healthcare Network.

The PACE Coalition's Community Health Worker (CHW), through targeted work in Elko and nearby communities, assisted Latinos and hard-to-reach populations to access insurance/Medicaid, healthcare services, and other supports necessary to improve health. The CHW advocated for people with barriers to access healthcare services.

The State Chronic Disease Prevention and Health Promotion (CDPHP) Program assists MCH in meeting goals to improve the health of infants, children, and women of childbearing age. Title V funds one half-time staff to help support MCH population activities. CDPHP's CHW Program focused on the organizational development of the Nevada Community Health Worker Association (NVCHWA). In collaboration with the CHW Program Coordinator, the NVCHWA advertised the CHW State Hybrid Training which has received positive feedback from the community and offered no charge training to support CHW workforce development. The CHW Program collaborated with the Center for Program Evaluation at the University of Nevada, Reno, and Health Plan of Nevada on a CHW Return on Investment Study to assess the financial impacts of embedding CHWs within a managed care organization. The study assessed whether CHW services reduce overall medical costs for super-utilizer clients (more than three emergency room visits in six-months), increase primary care provider visits, and reduce readmission into the emergency room. A final report and presentation will be developed in 2017. A needs assessment was conducted to analyze the demographics of CHWs and address the gaps, barriers, and challenges CHWs face in their day-to-day work environment. In June 2016, CDPHP was awarded funding through the Centers for Medicare and Medicaid Services *Connecting Kids to Coverage Outreach and Enrollment Cooperative Agreements*. This two-year project will use CHWs to assist uninsured families to access healthcare and support services by providing application assistance and connecting families to community resources.

Office of Suicide Prevention

Title V/MCH funding supports the Nevada Office of Suicide Prevention (OSP), through the provision of outreach and education, facilitated information-sharing and consensus building among multiple constituent groups, including new partnerships with Carson City School District, Douglas County Project AWARE, and Lincoln County School District. OSP established relationships with the Nevada Nursing Association, Nevada Association of Social Workers and multiple licensing boards to facilitate continuing education credits to meet the AB 93 of the 78th legislative session mandate for suicide prevention education. OSP also collaborated with Truckee Meadows Community College in Northern Nevada to provide an online gatekeeper training.

OSP provided 138 safeTALK trainings, reaching 3,575 community members, including 376 school administrators. OSP provided 20 ASIST two-day suicide intervention workshops to 447 providers and caregivers, 22 Youth Mental Health First Aid (YMHFA) trainings to 324 participants, and 21 Nevada Gatekeeper trainings to 550 participants. 1,400 veterans and service members received awareness or intervention training, as well. The Reducing Access to Lethal Means program provided outreach to 293 gun shop and shooting range staff.

OSP expanded school-based screening across the state with Pershing, Elko, Nye, Mineral and Humboldt counties through partnerships with the Children's Cabinet, Community Chest, Healthy Communities Coalition, Nye Community Coalition, and the Frontier Community Coalition. These community coalitions are funded to sustain local screening programs with their local school districts. Through the Project AWARE grant, 400 community helpers were trained to recognize mental health concerns or crises in youth using YMHFA guidelines.

The statewide suicide prevention conference held in Las Vegas, October 22-23, 2015 had 170 attendees. Several

national suicide prevention experts and local prevention partners presented on youth suicide prevention, juvenile justice and corrections, reducing access to lethal means, postvention, and Service Members, Veterans and their Families initiatives. OSP also offered the keynote address for the Child Abuse and Neglect (CAN) Prevent/Child Safety Annual Conference, June 15, 2016, in Reno. The theme was youth suicide prevention, and OSP focused on state initiatives, suicide prevention in young children and reducing access to lethal means. Attendees were teachers, counselors, social workers, nurses, family court judges, peace officers, and advocates for children.

Nevada Health Conference

The 2015 Nevada Health Conference, hosted by Immunize Nevada, was an interdisciplinary conference educating practitioners from across health professions with information to help support the communities in which they live and work. The conference highlighted the importance of addressing health disparities, barriers, and challenges across the lifespan. A total of 28 partners sponsored portions of the conference, including four programs within the Division of Public and Behavioral Health; Maternal and Child Health, Children and Youth with Special Health Care Needs, Nevada Home Visiting, and Personal Responsibility Education Programs.

The annual conference occurred November 9-10 in Las Vegas, Nevada, at the SLS Hotel, opened with a keynote speaker, and featured more than a dozen knowledgeable public health professionals. 246 participants registered for the conference with a total of 225 in attendance during the two day event. Continuing education credits issued through the University of Nevada were available for multiple healthcare-related fields including: Certified Health Education Specialists (CHES), certified public health (CPH), nursing, pharmacists, physicians, and social work. A total of 92 continuing education units were distributed.

Each year, the Nevada Health Conference awards a number of MCH funded scholarships to individuals unable to attend due to cost. Immunize Nevada, Nevada Public Health Training Center, and the Nevada Division of Public and Behavioral Health, including the MCH Program, offered 59 applicants scholarships for the conference in 2015.

The first day of the conference contained specialized concurrent and plenary sessions focused on “Building Healthy Communities – Touching One Life at a Time”, and opened with keynote speaker, Tara Haelle, science journalist and author. The second day held four specialized, all-day intensive mini-sessions focusing on maternal, child and adolescent health; immunizations; chronic disease; and youth mental health first aid. Home Visiting and MCH presented; MCH on life course theory as it relates to Gestational Diabetes.

Other events were held during the conference to provide additional networking opportunities and special acknowledgement to presenters. A thank you dinner was hosted the night prior to the conference start to offer a networking opportunity for all speakers and to allow Immunize Nevada to acknowledge speakers who dedicated their time to present. A Roundtable (sit-down) lunch was offered on day one of the conference allowing attendees to interact with one another on health-related topics. Finally, a networking reception was hosted at the end of day one to allow attendees to interact with one another and revisit the exhibitor booths with more time allotted.

Special Events attended by MCH Staff

MCH staff attended the Nevada Urban Indians, Inc. Healthcare and Community Services Community Health Fair on March 5, 2016. Materials were distributed on a variety of topics, including Safe Sleep, Breastfeeding, SoberMomsHealthyBabies.org, text4baby, Early Periodic Screening Diagnosis and Treatment, CYSHCN Sibshop, CYSHCN Transition booklets, and Tobacco Cessation.

MCH staff attended a presentation and training on Trauma Informed Care and Adverse Childhood Experiences on April 29, 2016. Guest speaker, Leah Harris used the Trauma Informed Care treatment framework to help educate attendees to understand, recognize, and respond to the effect of trauma on physical and mental health.

MCH staff attended the Refugee Resettlement Stakeholders presentation on May 24, 2016. The focus of this

presentation was to understand the resettlement process in the United States, learn about the Northern Nevada International Center's application to become a refugee resettlement site, and to meet stakeholders who would be assisting with the resettlement process in Northern Nevada. MCH staff was able to share their contact information and offer program materials to help support refugees resettling in the State.

Data

The percent of women who smoke during pregnancy in Nevada has reduced from 5.2% in 2014 to 4.8% in 2015. Those who live in a non-metropolitan area are more likely to smoke than those born in a large metropolitan area or small/medium metro area. Married women smoke less than unmarried women. Those who are born outside of the U.S. are less likely to smoke than those born in the U.S. Non-Hispanic Whites (8.1%) are more likely to smoke than Non-Hispanic American Indian/Alaskan Natives (7.5%), Non-Hispanic Multiple Race (7.4%), Non-Hispanic Blacks (5.0%) or Non-Hispanic Hawaiian/Other Pacific Islanders (4.5%). Non-Hispanic Asians (1.6%) and Hispanics (1.5%) are the least likely to smoke during pregnancy.

The number of infants born with neonatal abstinence syndrome has increased since 2008. Nevada's rate of children born with NAS in 2008 was 3.9 per 1,000 delivery hospitalizations and increased to 12.4 in 2014. Non-Hispanic Whites (17.7) and those listing their ethnicity as Other (21.8) are the ethnicities with the highest rates. The uninsured (22.9) and those on Medicaid (21.5) have the highest rates amongst health insurance stratifiers.

Other Programmatic Activities

MCAH Staff Training

The Adolescent Health and Wellness Coordinator will attend the Nevada Health Conference to get insight on adolescence health and wellness topics. Other trainings will include web-based trainings focused on adolescents and may include the Healthy Teen Network Annual Conference and intermediate Excel coursework.

The Adolescent Health and Wellness Coordinator attended several conferences and trainings to get insight on pertinent and timely adolescence health and wellness topics. These included the Nevada Health Conference: Building Health Communities – Touching one life at a Time, Conference on Adolescent Health – Translating Research into Practice, Nevada Transition Conference – Youth in Transition: Expect Educate Employ Empower, and the New State Adolescent Health Coordinator Orientation: Keys to Success. Additionally, the Adolescent Health and Wellness Coordinator participated in various adolescent health focused webinars, and the Association of Maternal and Child Health Programs (AMCHP) monthly online Youth Engagement Community of Practice (CoP) devoted to improving the capacity of MCH professionals and advocates to increase youth engagement in Title V programming.

Oral Health Program

The Title V/MCH Block Grant will continue to support the State Oral Health Program Manager position. The Oral Health Program Manager will provide staff support to the Advisory Committee on the State Program for Oral Health (AC4OH) and help facilitate the regular quarterly meetings. Oral Health will collaborate with Medicaid and community partners to increase utilization of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) oral health screenings, prevention services, and dental treatment. The program will ensure Medicaid policies support the targeted population receiving high-quality, timely dental services, including preventive, restorative, and when medically necessary, orthodontia.

Nevada's Teledentistry infrastructure will be developed by leveraging existing telehealth sites and adding intraoral cameras supporting teledentistry. This practice allows dentists to see patients and advise on needed care, regardless of the location. A hygienist or another caregiver can easily obtain and share live streaming or "store and forward" diagnostic images, videos and documentation, allowing the dentist to remotely conduct an evaluation, triage the patient and recommend next steps. Novel partnerships utilizing the equipment will also be explored and possibly piloted; e.g., emergency rooms (reduce utilization for non-traumatic dental services), assisted living centers (staff training and/or patient exams for non-mobile patients), oral cancer detection projects, and school-based sealant and varnish programs.

Several community projects will take place in the rural Nevada. The Community Health Nursing offices in rural Nevada will be provided with additional resources and educational materials to expand the fluoride varnish and oral health screenings. Nevada plans to implement a safety-net dentistry program, in the coming year, utilizing volunteer dentist(s) to provide mobile services in rural Nevada for prevention and restorative care. Equipment will be purchased and volunteer(s) will be mobilized. This project will be complimentary and concurrent with teledentistry initiatives. The Oral Health Program will partner with Southern Nevada Health District (SNHD) rural health van initiative. They will be traveling to rural Nevada (as far North as Ely), support will be provided for the van to include oral health components and possibly dental hygiene services. Findings from the Rural Nevada Head Start Oral Health Screening will be used to advocate for services, prioritize needs and programs, and address disparities in oral health among Nevada's young children.

Numerous collaborations are planned for this funded year. As Human Papilloma Virus (HPV) is now the number one cause of oral cancer, the Oral Health Program will partner with the State Immunization Program to provide education and resources to increase access and utilization of the HPV vaccine in Nevada. The Early Start – Cavity Free

Initiative will continue by promoting utilization of dental services among pregnant women, infants, and young children in multiple environments, including WIC, Home Visiting, Day Care, and others. The Oral Health Program will support Special Olympics Special Smiles programs. They will continue to collaborate with tobacco cessation programs to promote cessation services and work to increase dental provider and oral health stakeholders' knowledge of Nevada Tobacco Quitline services. To increase chronic disease and oral health bi-directional knowledge and awareness of systemic health, the Oral Health Program Manager will participate in the Heart and Stroke Task Force. Nevada's Oral Health Program will continue to maintain federal Water Fluoridation Reporting System information for Nevada's community water fluoridation data and contacts.

Oral Health will participate in HealthInsight's Antimicrobial Stewardship Program (ASP) Toolkit Subcommittee, to promote proper prescribing and utilization of antibiotics among Nevada practitioners. They will continue research and support policy change to mandate dental screening and dental home identification prior to school entry. Oral Health will utilize multi-modal evaluation to research dental workforce challenges in the state and explore a wide variety of potential solutions. They will collaborate with others to strengthen dental systems of care for children and adults with disabilities. Education will be provided to caregivers on how to help maintain their client's oral health. Additionally, they will continue to educate the public and health providers of oral-systemic connections. Poor oral health can critically impact quality of life and wellness.

The Oral Health Program will partner with SNHD to train University of Nevada, Las Vegas (UNLV) School of Dental Medicine students and staff on conducting rapid HIV Testing. SNHD will provide clinical and cultural guidance on offering testing, relaying information regarding the results, and steps the client needs to take. It is anticipated this dental workforce development project will increase the availability of HIV testing and the comfort level new providers have testing and discussing HIV/AIDS and other screening services in their future dental careers. Dentists have played an active role in referring high risk patients to medical services for screening and follow up care since the beginning of the HIV epidemic, but only recently, could test patients for HIV in the dental office. New rapid HIV tests, have made testing in the dental office feasible and this pilot possible.

During this fiscal year, the Oral Health Program will finalize the Oral Health Surveillance Plan, creating a system of standard data collection and reporting on oral health data for the State. The program will continue to support dental programs and dental education in school settings, and School-Based Health Centers. They anticipate expanding dental sealant, fluoride varnish, and in-school tooth brushing programs throughout the State.

Nevada's Oral Health Program consisted solely of a Program Manager and was fiscally supported through the Title V/MCH Block Grant. The Oral Health Program Manager devoted considerable time pursuing funding and collaboration opportunities, as well as recruiting a State Dental Health Officer and State Public Health Dental Hygienist to be hired in fall 2016. The Oral Health Program Manager continued to serve on the Nevada Governor's Council on Developmental Disabilities, bringing information regarding DPBH initiatives to attendees and members, as well as conveying population and family concerns back to DPBH staff and programs.

The Oral Health Program Manager provided staff support to the Advisory Committee on the State Program for Oral Health (AC4OH) and helped facilitate the regular quarterly meetings. The AC4OH is a 13-member committee to advise and make recommendations to DPBH concerning the Oral Health Program. The AC4OH supports DPBH to promote the health and well-being of Nevadans through the delivery or facilitation of essential services ensuring families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency.

The Oral Health Program provided community education and oral health care resources to individuals with disabilities and their families, pregnant women, women of child bearing age, and families with infants, children, and, adolescents. Oral Health collaborated with Chronic Disease Programs to include oral health self-care and regular dental check-ups in chronic disease self-management programs. Oral Health kept the federal Water Fluoridation Reporting System for Nevada's community water fluoridation data and updated contacts with fluoridating local water systems. These local water systems as well as the State received fluoridation quality awards from the Centers for

Disease Control and Prevention. The Oral Health Program Manager worked closely with Medicaid to increase utilization of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental services; assessment, prevention, and treatment.

Primary Care Office (PCO)

Strategic planning for improved health care access will continue through the shortage designation, J-1 Physician Visa Waiver, and recruitment and retention programs in collaboration with MCH, area health education centers, the Office of Rural Health, health care training programs, community health centers, rural health clinics, tribal clinics, rural hospitals and other NHSC approved sites. The PCO will complete the required update of all statewide primary care, dental health and mental health HPSAs. Based on an exhaustive analysis, the PCO anticipates four of Nevada's primary care and dental HPSA designations will be geographically expanded to meet increased need, and three new designations will be created in Clark County covering areas not previously designated. Significant resources will be invested to update and revise the mental health HPSAs to meet the increasing needs of the state's population.

Due to supplemental funding and extensive shortage designation analysis, the PCO has a wealth of new data resources, including primary care provider, dental, and psychiatrist provider data, statewide Medicaid claims data and new HPSA designation data. PCO staff will develop reports and data tools to share with partners, including MCH, to assist in their strategic planning and needs assessment.

Based on critical need identified by updating Nevada's statewide designations, PCO staff will complete at least two outreach trips, including one to rural and frontier Nevada, and one to Las Vegas. This outreach will allow PCO staff to visit existing NHSC and J-1 waiver physician participant sites and to schedule outreach to employers to expand participation in the NHSC and J-1 Physician Visa Waiver Programs. Quarterly conference calls will be facilitated to share information and develop strategies, and dozens of outreach presentations will be scheduled each year to raise awareness about loan repayment and scholarship programs, with health care professional students, residents, interns and employers.

The PCO plans to expand participation in the J-1 Physician Visa Waiver program by increasing outreach to international medical graduates and practices which would benefit from hiring these highly trained medical professionals. The PCO will develop online tools including videos and updated training documents to orient potential program participants regarding the program policies and procedures. PCO staff will also host a training webinar available statewide to engage interested parties.

The PCO is part of the newly-expanded Primary Care Workforce Development Office (PCWDO), which has two additional positions focusing on broader workforce development initiatives in Nevada. The PCWDO will continue to work with health professional licensing boards to improve data collection, increase transparency and develop or improve online systems. Additionally, PCWDO staff will work on multiple initiatives to improve recruitment and retention efforts by state clinical staff and other safety net providers in Nevada.

Staff in the PCO will continue to support MCH initiatives through regular participation in Maternal and Child Health Advisory Board meetings and through quarterly reports of PCO progress relating to MCH goals. The PCO will also be regularly briefed by and will collaborate with MCAH staff at quarterly Data Sharing Meetings.

The Primary Care Office (PCO) receives base funding from the federal Health Resources Services Administration (HRSA) to support health professional shortage area (HPSA) designation, the National Health Service Corps (NHSC), and the J-1 Physician Visa Waiver program. Because this work helps to improve healthcare access for maternal, child and adolescent health, the HRSA MCH Title V grant to Nevada supports a 0.5 FTE in the PCO.

Based on extensive systemic changes, HRSA required all states to update all provider data and to review all designations for possible updates by July 2017, based on this data. Over the last year, Nevada PCO staff completed its statewide provider survey of primary care doctors, dentists and psychiatrists, followed by a designation impact analysis to assess potential score changes and a strategic plan to update all the designations in the allotted timeframe. To engage statewide stakeholders in the designation process, the PCO organized two designation workgroups, holding six video-conferenced meetings with 38 representatives of Nevada's urban, rural, and frontier areas, including the Office of Rural Health, Federally Qualified Health Centers (FQHC), the Maternal, Child, and Adolescent Health (MCAH) program, rural and urban clinics, multiple health districts, the Nevada Primary Care Association, the Nevada Rural Hospital Partners, State of Nevada clinical program managers, public health professionals, and other partners. As a result of these outreach efforts, the PCO developed productive new partnerships with Southern Nevada and Washoe County Health Districts, organizations providing health care and public health support to more than 85% of Nevada's population.

In the last year, the PCO submitted 13 HPSA applications to support emergent need. Among these designations is a new four-county rural and frontier primary care HPSA providing new support to a hospital and medical center in Churchill County providing OB/GYN and pediatric services to patients throughout three surrounding counties with no other access to these services. The PCO also submitted 12 other designation applications for geographic areas, rural health clinics, correctional centers and a Federally Qualified Health Center look-alike serving at risk populations.

The PCO applied for and received supplemental funding from HRSA, which was utilized in 2016-2017 to support PCO collaboration with state partners and data development in the designation process. PCO staff reviewed data sharing agreements and efforts with partners including licensing boards and medical groups and worked to expand the data received in support of the shortage designation process. Medicaid claims data was requested, obtained, and processed for use in the designation management system, eliminating the need for a substantial volume of provider telephone surveys in urban areas with low-income HPSA designations. The Nevada PCO collaborated with other state PCOs to conduct a regional training and webinar, and share best practices, for data development and data management in July 2016. Lastly, these supplemental funds helped PCO staff to receive advanced training in data analysis and management software to support data development and data management for the designation process. These supplemental funds and initiatives were critical for the PCO to obtain the required data and to develop a process to meet the upcoming shortage designation update deadline.

Regarding NHSC outreach and coordination, PCO staff coordinated with Clinical Services in the Nevada Division of Public and Behavioral Health in October 2016 to host an event during NHSC Corps Community Month to recognize current NHSC participants and raise awareness of the program to other state employees. For the second year, PCO staff partnered with Nevada System of Higher Education to conduct campus-based outreach events to six separate campuses via video-conference, in collaboration with the State Office of Rural Health. PCO staff traveled to Clark County twice and to rural and frontier Nevada once and visited a total of nine clinics, 11 post-secondary health provider training programs, one hospital system and five other stakeholders. The PCO developed two new successful initiatives to increase awareness of the NHSC: online training videos about the NHSC program and an NHSC outreach mailer to providers who treat a substantial population of Medicaid patients. These initiatives resulted in many inquiries and technical assistance calls regarding the NHSC. Four new NHSC sites were approved in Nevada, bringing the total approved NHSC sites to 106. PCO newsletters were published quarterly to highlight these programs and to feature other state-based recruitment and retention activities. These outreach efforts helped Nevada to achieve close to a 50% application success rate, which is 6% above the National average.

The PCO also administers the J-1 Physician Visa Waiver program to recruit international medical graduates to

practice in designated HPSA or flex slots reaching underserved populations. In the 2015-2016 cycle, applications were reviewed, public hearings were held, and letters of support were completed for eight J-1 physician visa waivers, including a pediatric critical care specialist in Las Vegas, an OB/GYN doctor in Elko, and primary care physicians in Fernley and Carson City. This 2015-2016 cohort of physicians represent a four-fold increase in participation in the J-1 Physician Visa Waiver program compared to the 2014-2015 cycle. Additionally, the PCO received six applications and anticipates receipt of at least two more applications for the 2016-2017 cycle.

Office of Public Health Informatics and Epidemiology (OPHIE)

Nevada Title V MCH utilizes a Memorandum of Understanding (MOU) between the MCH Program and the Office of Public Health Informatics and Epidemiology (OPHIE) to enable OPHIE to support MCH programs and serve MCH populations through the collection, analysis, and reporting of relevant data for use in program planning, reporting and applications for funding.

A Biostatistician II (0.7 FTE) is responsible for managing ongoing data collection, analysis, and reporting for the Title V MCH Block Grant, and conducting all Biostatistician activities within state and federal deadlines. The Biostatistician II also develops verbal presentations, in diverse formats, to community groups, the Maternal and Child Health Advisory Board (MCHAB), and other stakeholders. In addition, the Biostatistician II manages other projects including statistical analysis of available datasets for use in Maternal, Child, and Adolescent (MCAH)-related programs.

A Health Resources Analyst II (HRA II) will provide support for data collection, analysis and reporting for the Federal MCH Block Grant. The HRA II will contact partners and subgrantees to ensure data is available for Title V Block Grant reporting. The HRA II will also perform ad hock linking and statistical analysis of available datasets for use in MCAH related program planning and the preparation of funding applications, as well as development of program reports, presentations, GIS maps and publications.

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), as well as provide in person classes to employees. The Development Center contains various information, some of which includes: developing and applying logic models for planning, implementation, and evaluating programs; effective techniques for presenting data; effective methods for making decisions; and others. Information on the website is accessible to employees from various Divisions and Departments in the State. Division of Public and Behavioral Health (DPBH) employees use the site to meet required HIPAA and information security classes and enhance their professional careers, as well as to further their education and job-related skills. Employees value the continuing education offered by MCH trainings to stay current on topical MCH developments in all the priority areas. Tribal, substance use, and cultural competency trainings were taken by MCH staff. Other workforce development opportunities are provided to staff by state programs, federal agencies, academic institutions, and professional organizations such as The Association of Maternal and Child Health Programs, Nevada Health Conference, and Nevada Public Health Association conferences.

MCAH Staff Training

In the reporting year (October 1, 2015 through September 30, 2016), Nevada Maternal, Child and Adolescent Health (MCAH) section staff participated in various workforce development opportunities. Title V MCH funded five MCAH staff to attend 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 and Intervention (EHDI) program staff participated in Centers for Disease Control and Prevention (CDC) sponsored Early Hearing Detection and Intervention all grantee meeting in Atlanta, Georgia, and gained information on program evaluation, quality improvement processes, logic model design and use, information system functional standards, and annual data submission processes. Nevada EHDI team also attended the National Center for Hearing Assessment and Management (NCHAM) annual conference.

The Adolescent Health and Wellness Coordinator attended several conferences and trainings to get insight on pertinent adolescence health and wellness topics. These included the Nevada Health Conference, Conference on Adolescent Health – Translating Research into Practice, Nevada Transition Conference – Youth in Transition: Expect Educate Employ Empower, and the New State Adolescent Health Coordinator Orientation: Keys to Success. Additionally, the Adolescent Health and Wellness Coordinator participated in various adolescent health focused webinars, and the Association of Maternal and Child Health Programs (AMCHP) monthly online Youth Engagement Community of Practice (CoP) devoted to improving the capacity of MCH professionals and advocates to increase youth engagement in Title V programming.

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 developed the Nevada Children's Medical Home Portal (MHP) to help coordinate 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 received extensive training from various sources on the MHP. In March 2016, Debra Kawcak, the former CYSHCN Program Coordinator, received training from Family Voices. In March 2016, Ms. Kawcak also received training from Sibling Support Project.

Christina Turner, the Maternal and Infant Health Coordinator, attended several trainings including AMCHP and the Statewide MCH Spring Symposium. She also attended Cribs for Kids Train the Trainer, Cultural Considerations in Health Care Event, University of Nevada, Governor's Drug Prescription Summit, and Nevada Public Health Conference.

Ingrid Mburia, PhD, MPH, the MCH Epidemiologist until July 2016, and Biostatistician II throughout the remainder of the reporting period, attended AMCHP and City MatCH Leadership and MCH Epidemiology conference. Both conferences provided an opportunity to share experiences and enhance knowledge to improve the health of the MCH population.

Attendance of data analysis training courses, such as SAS and other analytic software, is planned for the current MCH Epidemiologist.

Nevada Home Visiting (NHV) 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. NHV staff also attended the Parents as Teachers Conference, the Nevada Health Conference, and the Adolescent Health Symposium. The NHV manager received training on reflective supervision, a tool for relationship-based services. Through this training the manager received strategies to help staff 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.

Teen Pregnancy Prevention Program (TPP) also receives training on how to deliver effective and efficient TA to their subgrantees and how to enhance pregnancy prevention programs at national and regional meetings. The information has been very valuable to the staff as well as the subgrantees. TPP 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). These topical trainings cover various topics related to adolescent pregnancy prevention.

Other MCAH staff training opportunities planned for FFY include the Association of Maternal and Child Health Programs (AMCHP) conferences.

Nevada Title V MCH 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 on the SBIRT tool for substance use. The two day course trained 25 providers 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 MCH 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.

Nevada's MCH population is becoming increasingly diverse. In order to provide culturally and linguistically competent approaches to services, health policies, and leadership for MCH populations, the MCAH workforce attended several trainings in 2016. Many of the trainings were on cultural competence, tribal outreach, and Office of Minority Health trainings. The trainings discussed the importance of cultural competence as a key tool in addressing health disparities. In addition, Culturally and Linguistically Appropriate Services (CLAS) standards, components, and relevance were discussed in training and implemented in programming including provision of bilingual media campaigns and resources. Training on Cultural Diversity was also offered on the state's training website and in person. The training offers an understanding of cross-cultural strategies emphasizing professionalism, as well as providing information on how to develop essential skills for improving relationships with diverse communities. CDPHP and MCH are co-funding an in-person Diversity, Inclusion and Equity training in 2017.

Pediatricians, Family and General Practitioners, and Obstetricians and Gynecologists

Using Bureau of Labor statistics and the U.S. Census, the number of Obstetricians and Gynecologists (OB-GYN) per 100,000 U.S. population is 6.3 and the rate in Nevada is 5.2 per 100,000. This is due to the absence of full time OB-

GYNs in 10 of 17 Nevada counties. Two counties of the remaining 7 have only 1 full time practitioner.

The number of Pediatricians in Nevada is also 5.2 per 100,000 and is well below the national rate of 8.9. This disparity is also due to the lack of any full time Pediatricians in 10 of 17 Nevada counties.

The US rate for Family and General Practitioners (GP) is 39.7 per 100,000 while the Nevada rate is 30.8. Esmeralda, Eureka, and Storey counties do not have any Family doctors or GPs. White Pine, Pershing, Mineral, Lyon, Lincoln, and Lander counties each have less than five Family doctors or GPs.

The Primary Care Office (PCO) supplied the MCH Title V Program with maps and data demonstrating the Health Professional Shortage Areas (HPSA) in Nevada for OB-GYNs and Pediatricians. The information is attached as Supporting Document 4.

II.F.3. Family Consumer Partnership

Family Consumer Partnership

Nevada Title V MCH Program collaborates with other agencies, programs, and 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 MCH 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 as well. 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 MCH 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 Technical Assistance Center on Social Emotional Intervention (TACSEI), a Title V MCH funded partner, has a Family Engagement Coordinator on staff to facilitate parent involvement in the social emotional Pyramid Model activities.

Staff participate on the Nevada Governor's Council on Developmental Disabilities (NGCDD) and Interagency Coordinating Council (ICC) which include person's living with developmental disabilities, and family representatives. In 2017, a Parent Policy Leadership event will be supported by Title V MCH funds for families of CYSHCN.

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) as a health maintenance organization (HMO) or preferred provider organization (PPO) 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 expanding Medicaid to allow more low-income adults to have access to health insurance. One of the successes 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 in 2014. This was the largest percent reduction in the country. Open enrollment for 2017 ended on January 31, 2017, and by February 1, 2017 there were 89,061 enrollees. During the same time in 2015, there were 73,596 enrollees. The 2017 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 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 to help consumers enroll for health insurance, if needed.

References

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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

Opioids, Marijuana and Other Substances

Nevada is confronted with issues related to opioid use and addiction, and illicit substance use secondary to opioid use and addiction. Attention to opioid and other substance use is critical for the Maternal Child Health (MCH) program. According to the Centers for Disease Control and Prevention (CDC), Neonatal Abstinence Syndrome (NAS) has been increasing in the state (https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm#T1down).

In 2002, the Nevada rate of NAS was 1.1 per 1,000 hospital births, and rose to 4.8 per 1,000 hospital births in 2013. The CDC also points out the difficulty in preventing opioid use prior to conception with nearly 50% of all pregnancies in the United States unintended. This number jumps to 86% for women who use opioids (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3052960/).

On April 27, 2017, Nevada was awarded a grant from the U.S. Department of Health and Human Services (HHS) for $5,663,328 to help combat the opioid addiction problem in the state.

In terms of policy, SB 459 was signed into law (NRS 453C.150) during the 2015 Legislative Session to reduce potential criminal penalties for people who report drug overdoses. The law also requires doctors to monitor patients and their prescription history more thoroughly. People can now access drugs like Naloxone, a non-addictive drug which can help reverse opioid overdoses.

According to *The Opioid Epidemic* by Esri, 7.5% of the prescription claims in Nevada are for opioids, giving the State the highest rate of opioid prescription claims in the United States (http://urbanobservatory.maps.arcgis.com/apps/Cascade/index.html?appid=f86499d99e4340b68229eaccfb02b29f).

The FAD from HCUP State Inpatient Databases indicates the number of infants born with neonatal abstinence syndrome (NAS) in Nevada has increased alarmingly since 2008. Nevada's rate of children born with NAS in 2008 was 3.9 per 1,000 delivery hospitalizations and increased to 12.4 in 2014. Non-Hispanic Whites (17.7) and those listing their ethnicity as Other (21.8) are the ethnicities with the highest rates. The uninsured (22.9) and those on Medicaid (21.5) have the highest rates among health insurance stratifiers.

Marijuana Legalization

Marijuana became legal in Nevada for recreational use after Question 2 was approved by the voters on November 8, 2016. The law will go into effect with regulations allowing for the sale of marijuana as early as July 1, 2017. The concern for the MCH program are the short and long term effects of smoking marijuana during pregnancy, and the effects of second hand smoke for children in a household where marijuana is smoked. Perhaps the biggest unknown will be the effects of edible marijuana. Tetrahydrocannabinol (THC) in these forms still has to be processed by the body and may get passed on to the fetus in pregnancy or infant during breastfeeding. The ingestion of edibles by infants, toddlers, and children is a safety concern for prevention as many edibles are packaged in a way to be attractive to children. There are issues regarding possible health concerns for pregnant women and their babies (https://www.colorado.gov/pacific/marijuana/effects-while-pregnant-or-breastfeeding), so the MCH program is sharing resources adapted from Colorado's experience. Nevada has developed resources about marijuana and pregnancy for the public and providers and will be distributing them widely.

Close monitoring of legal marijuana in Nevada will be a priority for the DPBH in general and the MCH program specifically. Keeping in close contact with our colleagues in Colorado and Washington State will help with our ability to observe the effects of legal marijuana in Nevada. The DPBH will also follow any changes to use of recreational marijuana among youth, adolescents, and young adults. MCH has been working with Child Death Review to keep key partners apprised of substance use in pregnancy, marijuana and pregnancy, and substance use in

breastfeeding. PRAMS surveys inquire about substance use in pregnancy and will provide self-report data of use to MCH efforts.

Zika Virus

Zika (a mosquito-borne flavivirus similar to arbovirus dengue fever carried by the same species, *Aedes aegypti* which carries yellow fever) is classified by the Centers for Disease Control and Prevention (CDC) as *Level 1*, just as Hurricane Katrina (2005), Ebola (2014), Anthrax (2002), and Influenza A subtype H1N1 (2008). Transmission of Zika is primarily through mosquito bite. The virus can also be transmitted from a pregnant woman to her fetus and through sex whether a person is exhibiting symptoms or not. Infection during pregnancy has shown to cause microcephaly and other birth defects. Zika is also a trigger for Guillain-Barre Syndrome, a neurological disorder leading to paralysis and sometimes death.

Congenital Zika Syndrome

Information from CDC defines Congenital Zika Syndrome as a pattern of birth defects found among fetuses and babies infected with Zika virus during pregnancy. Congenital Zika Syndrome is described by the following five features:

Severe microcephaly where the skull has partially collapsed
Decreased brain tissue with a specific pattern of brain damage
Damage to the back of the eye
Joints with limited range of motion, such as congenital talipes equinovarus
Too much muscle tone restricting body movement soon after birth

Not all babies born with congenital Zika infection will have every one of these problems. Some infants with congenital Zika virus infection who do not have microcephaly at birth may later experience slowed head growth and develop postnatal microcephaly. Cognitive effects later in life will require observation and monitoring and is an area of active research.

Travel Restrictions:

Pregnant women should not travel to any area where there is a risk of Zika virus infection. The CDC has published an interactive map showing areas with Zika risk (https://wwwnc.cdc.gov/travel/page/zika-travel-information). In the continental United States, the highest risk occurs in Brownsville, Texas, and South Florida. These areas are considered relatively lower risk areas as compared to Mexico, Puerto Rico, Cuba, South America, and Central America. There is also significant risk in Africa, India, and most tropical Asian islands. Anyone who is pregnant or considering becoming pregnant should review this map prior to making travel plans. Women who have travelled to an area with known Zika infection should not engage in unprotected sexual activity for 8 weeks. Men should only engage in sexual activity with a condom for at least 6 months upon returning from a known area of infection.

Zika in Nevada

As of May 3, 2017, there have been 22 symptomatic Nevada cases of Zika since 2015. The first known case was confirmed in March 2016 when a man returned to Las Vegas from Guatemala in early February. All cases were travel-related except for one which was deemed to be via unprotected sex. Eleven of those infected are women.

The effects of Zika on specific programs such as Early Hearing Detection Intervention (EHDI) and Children and Youth with Special Health Care Needs (CYSHCN) is an area of active monitoring as it is an evolving issue. It is hypothesized the impact could be significant due to the devastating effects of the Zika virus to the neurological and craniofacial development of infants and children, as well as the subtler or time dependent effects of exposure manifesting later in life.

Nevada Title V MCH is promoting Zika resources on the DPBH website MCH pages such as provider guidelines for treatment, travel warnings, general public guidelines for travel, and incidences of occurrence. Nevada Title V MCH has begun to meet with Zika surveillance partners at the Newborn Screening Program, Office of Public Health Informatics and Epidemiology, and Southern Nevada Health District to discuss referral to MCH services, supports, and pathways to facilitate referral to early intervention, and care for families living with Zika virus. Possibilities for EHDI data utilization, developing bidirectional electronic referral system opportunities, and current MCAH referral processes are ongoing discussions.

The following links provide Nevada MCH populations Zika resources:

Nevada Department of Public and Behavioral Health (DPBH)

http://dpbh.nv.gov/Programs/OPHIE/dta/Hot_Topics/Hot_Topics/

Nevada Maternal, Child and Adolescent Health Program Zika Resources

http://dpbh.nv.gov/Programs/Maternal,_Child_and_Adolescent_Health_(MCH)/

Southern Nevada Health District

http://www.southernnevadahealthdistrict.org/zika/index.php

Telemedicine

Title V MCH Program staff participate in the Nevada Rural Health Network efforts which include an emphasis on increasing rural access to health care services via promotion of telemedicine, among other routes. Current efforts in Nevada telemedicine of particular import to MCH populations served by the Title V MCH Program include the recent partnership between the Washoe County School District (WCSD) and Renown Hospital in Reno to provide health care to WCSD students in the school environment using telemedicine, school-based health center use of telemedicine in Las Vegas, and Nevada Rural Mental Health use of telemedicine to provide behavioral health services. While no funding from the Title V MCH Grant currently supports telemedicine facilitation, program staff actively participate in keeping informed of state-level policy changes relating to recent parity requirements in Medicaid reimbursement for in-person and telemedicine reimbursement rates, cross state border policy relating to use of medical specialists in telemedicine contexts, broadband efforts (some parts of the state do not have broadband access), and existing and planned implementation of telemedicine efforts which could be of particular use to MCH populations.

II.F.6. Public Input

Public Input and Report

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, adolescents, consumers, and stakeholders in the development and implementation of program activities. The initial draft and subsequent revisions of the MCH Block Grant were posted on the Division of Public and Behavioral Health (DPBH) website and public feedback was collected through an electronic survey provided on the website. The MCH Epidemiologist developed the survey using Survey Monkey, and asked open-ended questions specific to MCH topics. In addition, Title V MCH requested all coalitions, local health districts, funded partners, and subgrantees (see attachment in Supporting Documents) distribute the survey link to consumers, adolescents, and families through emails, listservs, and newsletters. The input received was used to make any necessary modifications and to ensure quality and appropriateness of the strategies.

Coalitions include Family and Youth Advisor input. The National Governors Association (NGA) Adolescent Survey also provided valuable information. Some of the issues identified in past public input were taken into consideration in developing the State Performance Measures (SPMs) and Evidence-based or informed measures and were addressed in the five-year state action plan. Specifically, the SPMs are:

- Percent of mothers reporting late or no prenatal care
- Repeat teen birth rate
- Percent of women who misuse substances during pregnancy
- Teenage pregnancy rate

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

The 2017 Public Input survey generated 63 responses. Respondents were asked to identify themselves as a public health professional (46%), parent (3.2%), advocate (6.4%), non-profit professional (25.4%), healthcare provider (14.3%), or other (4.8%). When respondents chose “other”, they were able to fill in the details. The three topics with the highest number of respondents were access to healthcare, education and breastfeeding.

Survey respondents also had the opportunity to write their concerns regarding unmet needs and emerging issues in the MCH community, as well as topics specific to improving the health of children, children and youth with special health care needs (CYSHCN), women of reproductive age, and pregnant women. Feedback from the survey is presented below.

Access to Healthcare

“Working with the rural population, many patients struggle to find healthcare services in their area.”

“The constant problem throughout Nevada and my community is access to affordable healthcare, especially Mental Health Services for uninsured, Medicaid and those under 200% of the federal poverty level. Doctors, dentists and mental health professionals need to limit their care to the underserved because the reimbursement is not good. Access to Mental Health Services is dire in this community with access to some providers taking at least 6 months.”

“It is my opinion that children in the rural area require additional attention. Due to resource unavailability in rural areas, these children often do not receive necessary services.”

“Elko, Eureka and White Pine Counties have a lack of access to services. They don't exist enough in the communities that we work in. Even as simple as access to car seats in rural communities that have no stores. Lack of all services - access to doctors, dentists, pharmacies in some instances, specialized medicine. All areas.”

“Depending on the age of the person, services are still fragmented and/or lack of service providers in many rural areas, especially providers that will serve people on Medicaid.”

“My community is Clark County, Las Vegas, Nevada. The most important unmet needs include a continuing struggle for access to prenatal care, and access to mental health services for children and adolescents.”

“Continuity of care and access to a regular health provider. The turnover of healthcare providers and limited amount of healthcare providers makes it hard for all age children and young adults to access proper care.”

Education

“Lack of education on effects of alcohol and drug use.”

“Lack of education about reproductive and sexual health and knowledge of the resources that are available to them in the community. Ignorance among community leaders about what it means to make these resources available to all income groups.”

“Education and access to health care. Sometimes we overlook teaching the basic to mother, fathers and families of how to be able to make appointments for care. Care for pregnant women, simple checkup and vaccination appointments.”

“Supportive educational opportunities that are ongoing and interactive. Classes and peer support groups open to a wider range of adults and their children.”

“Educating the educators on health through nutrition and then providing community outreach programs to teach parents how to provide whole food nutrition to their children within their budgets.”

“Funding for programs like Healthy Start here in Las Vegas where nurse practitioners are paired with young, first time mothers for education and mentoring purposes.”

“Targeted education on nutrition, physical activity and overall health when pregnant.”

Breastfeeding Support

“Lactation services to all populations. I can speak only to Northern Nevada but suspect our Southern cohort is similar. Hospitals have taken huge steps to support breastfeeding…”

“A very small percentage of births occur at Baby Friendly Hospitals (hospitals which have demonstrated delivery of best practices in infant feeding). Increasing the number of hospitals with this designation will coincide with higher rates of breastfeeding initiation and duration, leading to improved health outcomes from mother and infant and reduced health care costs.”

“I think focusing on education among schools, especially high school kids, on the importance of breastfeeding. If we can accomplish this it would take care of a large amount of disease affecting our communities.”

Nutrition

“The impact of poor nutrition on the next generation--a mother's health, and her mother's health (nutritional status) determines much of the health for the child in future generations.”

“Improving information about the importance of nutrition, smoking cessation, folic acid, avoiding drugs and alcohol…”

“Educating parents how to provide whole food nutrition to their children within their budgets.”

“I would recommend holding classes for families to receive nutritional education and skills that could enhance their parenting through effective techniques.”

Mental Health

“As a shelter provider we are experiencing an increase in the number of expectant mothers and new mothers going through a mental health crisis. Also children experiencing mental health symptoms are not able to receive care if they don't have a home.”

“Better Medicaid reimbursement for all services, make it easier for mental health providers to come and become licensed in the state.”

“Access to Mental Health Services is dire in this community with access to some providers taking at least 6 months.”

“In Nevada mental health care for children and adolescents is not necessarily an emerging issue but one that persists for lack of adequate diagnostic and treatment services.”

“We need a greater array of services that are offered to address mental health concerns for children.”

Specialty Providers

“The most important emerging issues is the soon to be lack of pediatricians and OB services. Although there are currently more options than there has ever been, we still have doctors leaving our area.”

“Adequate access to OB/GYN.”

“More qualified OB/GYN doctors and more information about pregnancy health and nutrition, parenting classes.”

“More OB services that are affordable to community who may or may not have insurance.”

Rural Needs

“Depending on the age of the person, services are still fragmented and/or lack of service providers in many rural areas, especially providers that will serve people on Medicaid.”

“Elko, Eureka and White Pine Counties have a lack of access to services. They don't exist enough in the communities that we work in. Even as simple as access to car seats in rural communities that have no stores. Lack of all services - access to doctors, dentists, pharmacies in some instances, specialized medicine.”

“Rural populations are not given education or resources on pregnancy and STD education. For many rural populations like Elko County, this is a taboo subject.”

“Increase the amount of providers in rurals who can offer OBGYN and prenatal services. Some counties are currently being forced to send women to other states to obtain treatment.”

In addition to the Public Input Survey, the Nevada NGA state team sent surveys to providers, families, and adolescents asking for their input on ways to improve insurance coverage and access to care, and to learn about their knowledge and uptake of yearly adolescent well-care visits. The survey was disseminated statewide with 378 responses. The survey identified barriers families and/or adolescents face obtaining insurance are legal status, lack of necessary identification to fill out paperwork, language barriers and parental fears. Approximately 54% of the adolescents surveyed had not received a health checkup within the past year. The reasons for not having a checkup included a lack of insurance, they did not feel there was a reason to go, and that they did not want their parents to know they went.

Technical Assistance

According to the Nevada State Demographer's Office, approximately 1.1% 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 together. Even though Nevada Title V MCH has developed collaborations with Tribal entities in the past, staff turnover has created challenges in sustainability. Native Americans in Nevada are faced with health outcome disparities including the lowest percentage of pregnant women receiving prenatal care in the first trimester (46.6%) according to the National Vital Statistics System, and the highest percentage of children without health care insurance (16.2%) as reported by the American Community Survey. MCH Program has requested assistance to explore strategies for better collaboration with Nevada Native American populations in order to implement MCH-related interventions. Nevada Title V MCH has presented at the Tribal Consultation Meetings, met with state and regional Indian Health Service Staff, and contacted other Title V programs for TA on best serving Native American populations.

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

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,716,274	$1,998,800	$1,960,060	$2,023,152
Unobligated Balance	$0	$0	$0	$61,856
State Funds	$1,287,206	$1,499,100	$1,470,045	$1,563,756
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$3,003,480	$3,497,900	$3,430,105	$3,648,764
Other Federal Funds	$18,005,000		$76,074,243	$76,059,842
Total	$21,008,480	$3,497,900	$79,504,348	$79,708,606

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.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,998,800	$2,074,764	$2,085,007	
Unobligated Balance	$0	$0	$0	
State Funds	$1,499,100	$1,556,073	$1,563,756	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$3,497,900	$3,630,837	$3,648,763	
Other Federal Funds	$56,588,684	$53,251,776	$70,778,207	
Total	$60,086,584	$56,882,613	$74,426,970	

	2018	
	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	$59,515,762	
Total	$63,164,525	

III.A. Expenditures

III.A. Expenditures

Federal Fiscal Year 2018 Application - Expenditure Narrative

In FFY 2016, the Nevada MCH program will expend $2,074,764 in federal funds and $1,556,073 in state match funds for a total of $3,630,837. The state match funds will be comprised of $1,190,938 from the State General Fund and $365,135 in in-kind contributions from the Nevada Broadcaster's Association. FFY 2016 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 $2,074,764 award received for FFY 2016 was 3.8% higher than the budget of $1,998,800 submitted for FFY2016.

Pregnant Women:

Budget: $395,931
Expended: $442,229
Variance: Expenditures are 11.69% more than budget

Infants <1 year old:

Budget: $663,376
Expended: $636,643
Variance: Expenditures are 4.03% less than budget

Children 1 to 22 years old:

Budget: $993,449
Expended: $1,004,106
Variance: Expenditures are 1.07% more than budget

Children with Special Healthcare Needs:

Budget: $988,675
Expended: $1,055,286
Variance: Expenditures are 6.74% more than budget

Others:

Budget: $106,679
Expended: $129,545
Variance: Expenditures are 21.43% more than budget

Administration:

Budget: $349,790
Expended: $363,026
Variance: Expenditures are 3.78% more than budget

Budgeted vs. Expended by Types of Services:

Direct Health Care Services:

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

Enabling Services:

Budget: $1,439,392
Expended: $823,752
Variance: Expenditures are 42.77% less than budget

Public Health Services and Systems:

Budget: $2,058,508
Expended: $2,807,085
Variance: Expenditures are 36.37% more than budget

III.B. Budget

Federal Fiscal Year 2018 Application – Budget Narrative

The total estimated Federal Fiscal Year (FFY) 2018 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, $1,198,621, and in-kind contributions from Nevada State Broadcasters Association, $365,135. The amount of state funds that will be used to support Maternal and Child Health programs in FFY 2018 is shown in the budget documentation of the state application. We assure that the $853,034 maintenance of effort requirement (FFY89 level of state funding) will be satisfied.

For FFY 2018, $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 $208,500, 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 nonprofit agencies.

Other Federal Funds

Nevada's Title V Program is housed in the Bureau of Child, Family, and Community Wellness. The Bureau also administers the following federal grant programs/funding streams totaling $59,515,762 in FFY18. All federally funded programs referenced below provide services to the populations served by the Maternal and Child Health Block Grant Program.

Administration for Children and Families:

Abstinence Education
Personal Responsibility Education

Centers for Disease Control and Prevention:

Adult Hepatitis B
Breast and Cervical Cancer Early Detection
Cancer Prevention and Control
Colorectal Cancer Screening
Early Hearing Detection
Enhancing Nevada's Immunization Program
Nevada Immunization and Vaccines for Children
Nevada State Immunization Program
Nevada Adult Immunization Partnership and Improvement Project

Nevada Teen AFIX Improvement Projects
Pregnancy Risk Assessment Monitoring System (PRAMS)
Preventive Health Services
Rape Prevention and Education
Sexual Violence Prevention and Education
State Public Health Actions to Prevent and Control Diabetes, Heart Disease, and Obesity
Tobacco Control Program
Tobacco Use Prevention Capacity

Centers for Medicare and Medicaid Services:

Connecting Kids to Coverage

Health Resources and Services Administration

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

United Department of Agriculture

Child Nutrition
Commodity Assistance Program
Summer Food Service for Children
Women Infants and Children

Budget by Types of Individuals Served

In FFY 2018, the Nevada MCH program is budgeting the following federal and state match funds towards the individuals served requirements:
Pregnant Women - $485,649
Infants < 1 year old - $485,651
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 2018, the Nevada MCH program plans to allocate federal and state match funds as follows:

Direct Health Care Services - $0
Enabling Services - $826,028
Public Health Services and Systems - $2,822,735

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 - Acronym List For Title V Block Grant.pdf

Supporting Document #02 - Nevada MCH Partners 2.0.pdf

Supporting Document #03 - Newborn Screening Nevada Public Health Lab flowchart.pdf

Supporting Document #04 - 2016 Ped and OB Doctors by County Nevada.pdf

Supporting Document #05 - Org Chart for Block Grant.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nevada

	FY18 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	$ 625,503	(30%)
B. Children with Special Health Care Needs	$ 625,503	(30%)
C. Title V Administrative Costs	$ 208,500	(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)	$ 59,515,762	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 63,164,525	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 823,131
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 867,638
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 599,891
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 132,985
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 2,671,431
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 252,444
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) > State Public Health Actions-1305 Chronic Disease	$ 1,123,310
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control Programs	$ 794,315
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 3,929,237
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 2,741,406
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 132,985
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 213,892
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project AWARE	$ 139,428
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 1,052,058

OTHER FEDERAL FUNDS	FY18 Application Budgeted
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 32,015,043
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 154,867
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) > Centers for Disease Control and Prevention (CDC) > Nevada Immunization Interoperabiliy Capacity Building	$ 114,037
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Nevada Adult Immunization	$ 469,303
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Nevada Teen AFIX Improvement	$ 112,817
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Nevada Utilization of NVWebIZ	$ 224,896
US Department of Agriculture (USDA) > Food and Nutrition Services > Child Nutrtion	$ 9,995,964

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,998,800		$ 2,074,764	
A. Preventive and Primary Care for Children	$ 599,640	(30%)	$ 624,259	(30%)
B. Children with Special Health Care Needs	$ 599,640	(30%)	$ 622,532	(30%)
C. Title V Administrative Costs	$ 199,880	(10%)	$ 207,476	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,499,100		$ 1,556,073	
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)	$ 1,499,100		$ 1,556,073	
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)	$ 3,497,900		$ 3,630,837	
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)	$ 56,588,684		$ 53,251,776	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 60,086,584		$ 56,882,613	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 405,035	$ 295,186
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 428,321	$ 457,051
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 125,813	$ 97,541
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 396,046	$ 640,135
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 1,050,524	$ 1,850,299
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 255,000	$ 254,744
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 358,623	$ 283,584
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 2,083,359	$ 2,881,664
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 47,259,474	$ 40,341,890
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)		$ 136,702
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project AWARE		$ 59,370
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Public Health Actions-1305 Chronic Disease		$ 450,308

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)		$ 2,318,874
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Cancer Control	$ 920,113	$ 735,839
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Screening	$ 500,785	$ 679,535
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Home Visit Expan	$ 1,126,895	$ 73,863
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control	$ 856,207	$ 857,874
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Diabetes Control	$ 48,865	$ 385,561
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Billing Imp Project	$ 488,999	$ 105,521
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > III Enhancement	$ 284,625	$ 346,235

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

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	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 277,514	$ 277,166
2. Infants < 1 year	$ 277,515	$ 275,178
3. Children 1-22 years	$ 625,503	$ 624,259
4. CSHCN	$ 625,503	$ 622,532
5. All Others	$ 70,472	$ 68,153
Federal Total of Individuals Served	$ 1,876,507	$ 1,867,288

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 208,135	$ 165,064
2. Infants < 1 year	$ 208,136	$ 361,465
3. Children 1-22 years	$ 469,127	$ 379,847
4. CSHCN	$ 469,127	$ 432,755
5. All Others	$ 52,855	$ 61,393
Non Federal Total of Individuals Served	$ 1,407,380	$ 1,400,524
Federal State MCH Block Grant Partnership Total	$ 3,283,887	$ 3,267,812

Form Notes for Form 3a:

Added notes to totals to confirm that addition of 10% admin cost equals total 2018 budget and matches Form 2. Also added notes to total to confirm that addition of 10% admin equals total 2016 expenditures and matches Form 2 (page 166).

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: $1,876,507 + $208,500 (admin) = $2,085,007 total budget. Matches with Form 2.	
2.	**Field Name:**	**IB. Non Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: $1,407,380 + $156,376 (10% admin) = $1,563,756 (total budget). Matches Form 2.	
3.	**Field Name:**	**FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: $3,283,887 + ($208,500 + $156,376) = $3,648,763 (total budget). Matches Form 2.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: $1,867,288 + $207,476 (admin) = $2,074,764 total expended. Matches Form 2 (page 166).	
5.	**Field Name:**	**IB. Non Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: $1,400,524 + $155,549 (10% admin) = $1,556,073 (total award expended). Matches Form 2 (page 166).	
6.	**Field Name:**	**FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: $3,267,812 +($207,476 + $155,549 admin) = $3,630,837 total expended. Matches Form 2 (page 166).	

Form 3b
Budget and Expenditure Details by Types of Services

State: Nevada

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 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	$ 364,876	$ 362,630
3. Public Health Services and Systems	$ 1,720,131	$ 1,712,134
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	$ 2,074,764

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 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	$ 461,152	$ 461,122
3. Public Health Services and Systems	$ 1,102,604	$ 1,094,951
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	$ 1,556,073

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: 35,992

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	34,997 (97.2%)	1,317	37	37 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Cystic fibrosis	Hearing loss	Classic galactosemia	

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
Hearing Loss	34,576 (96.1%)	552	260	260 (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 to specialty metabolic clinics in Reno and Las Vegas through Nevada's Part C Early Intervention Services by Dr. Nikola Longo (Pediatric Metabolic Specialist) from the 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 - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: All newborns in the state did not receive at least one screen due to factors such as home births and out-of-state births of Nevada residents.	
2.	**Field Name:**	**Hearing Loss - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Other Newborn**
	Field Note: Numbers for the preliminary dataset were derived using averages for the calendar years 2013-2015 and the actual birth data for 2016.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Nevada

Reporting Year 2016

		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	11,237	39.5	0.0	50.7	9.8	0.0
2. Infants < 1 Year of Age	78,917	39.5	0.0	50.7	9.8	0.0
3. Children 1 to 22 Years of Age	34,986	39.5	0.0	50.7	9.8	0.0
4. Children with Special Health Care Needs	9,986	39.5	0.0	50.7	9.8	0.0
5. Others	8,000	39.5	0.0	50.7	9.8	0.0
Total	143,126					

Form Notes for Form 5a:

Data in Form 5a is an estimate of unduplicated count of individuals served under Title V and includes the number who received an individually-delivered service funded in part or in full by the Title V program within the top two levels of the MCH Pyramid (direct and enabling services).

Data sources include:
• Medicaid (Managed Care Medicaid and Fee for-Service)
• Rural clinics
• North Metabolic Clinic
• South Metabolic Clinic
• Newborn Screening (NBS) Program
• Early Hearing Detection and Intervention (EHDI) Program
• Nevada Early Intervention Services (NEIS)

These estimates may not completely reflect a true unduplicated count as the data received from the various sources is aggregate and does not include identifiers to determine whether the individuals are also served through other direct assistance programs.

The rural clinics provide family planning (FP) services to both men and women, child health services and adult wellness services. Men who received FP services are included in the ‘other’ category.

Data for primary source of insurance coverage were provided by HRSA from population-based data sources.

Field Level Notes for Form 5a:

None

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

State: Nevada

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	12,355
2. Infants < 1 Year of Age	93,679
3. Children 1 to 22 Years of Age	91,940
4. Children with Special Health Care Needs	10,037
5. Others	24,053
Total	232,064

Form Notes for Form 5b:

Data in form 5b are estimates from population-based services and partnerships and include all service levels of the working framework of the MCH Pyramid (direct, enabling, and public health services and systems).

Data sources include:
• Medicaid (Managed Care Organizations and Fee for-Service)
• Rural clinics
• North Metabolic Clinic
• South Metabolic Clinic
• Newborn Screening (NBS) Program
• Early Hearing Detection and Intervention (EHDI) Program
• Nevada Early Intervention Services (NEIS)

Data such as Medicaid, NBS and EHDI have been used to report the number from the service or program with the largest reach for a given population thus may include 100% of the target population.

Rural clinics provide family planning (FP) services to both men and women, child health services and adult wellness services. Men who received FP services are included in the 'other' category.

Numbers in Form 5b are higher than those in 5a because more people are reached through population-based services and partnerships than individually delivered direct/enabling services.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**

Field Note:
Data include all infants in Nevada. Data are reflective of children born in Nevada and outside of Nevada.

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

State: Nevada

Reporting Year 2016

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	35,377	26,568	3,396	566	3,079	283	1,485	0
Title V Served	11,237	8,439	1,079	180	977	90	472	0
Eligible for Title XIX	4,439	3,334	426	71	386	36	186	0
2. Total Infants in State	35,377	26,568	3,396	566	3,079	283	1,485	0
Title V Served	78,917	59,267	7,576	1,263	6,866	631	3,314	0
Eligible for Title XIX	31,172	23,410	2,993	499	2,712	249	1,309	0

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	25,295	10,082	0	35,377
Title V Served	8,034	3,203	0	11,237
Eligible for Title XIX	3,174	1,265	0	4,439
2. Total Infants in State	25,295	10,082	0	35,377
Title V Served	56,426	22,491	0	78,917
Eligible for Title XIX	22,288	8,884	0	31,172

Form Notes for Form 6:

Form 6 includes the number for the population-based total of all deliveries in the State for the reporting year by race/ethnicity. There may be overlap between the reported totals for “Title V Served” and “Eligible for Title XIX”, due to an individual’s changing insurance eligibility status during the course of the year.

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	2018 Application Year	2016 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"	Vickie Ives	Laura Valentine
4. Contact Person's Telephone Number	(775) 684-2201	(775) 684-5901
5. Number of Calls Received on the State MCH "Hotline"		77

B. Other Appropriate Methods	2018 Application Year	2016 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"		77
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		407
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Nevada

1. Title V Maternal and Child Health (MCH) Director	
Name	Beth Handler
Title	Bureau Chief, CFCW
Address 1	4150 Technology Way #210
Address 2	
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-4200
Extension	
Email	bhandler@health.nv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Vickie Ives
Title	Section Manager, MCAH
Address 1	4150 Technology Way #210
Address 2	
City/State/Zip	Carson City / NV / 89706
Telephone	(775) 684-2201
Extension	
Email	vives@health.nv.gov

3. State Family or Youth Leader (Optional)	
Name	Mary E. Meeker
Title	Executive Director, Family TIES of Nevada
Address 1	5250 Neil Road
Address 2	Suite 200
City/State/Zip	Reno / NV / 89502
Telephone	(775) 823-9500
Extension	
Email	mary@familyfiesnv.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Nevada

Application Year 2018

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

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:

None

Form 10a
National Outcome Measures (NOMs)

State: Nevada

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

After consulting with the review committee, the Title V MCH Program decided to split SPM2 into two separate measures. SPM2 originally read: “SPM2-A. Percent of teenage pregnancies and B. Percent of repeat teen births”. SPM2 now reads: “Repeat teen birth rate”. We created SPM4: “Teenage pregnancy rate”. Since it is a new measure, data will not be available until next year.

Teenage pregnancy calculation is based on live births, fetal deaths and abortions (all among teens). The reporting of abortions to Nevada Division of Public and Behavioral Health is often delayed, therefore data on teenage pregnancies were not reported for 2016.

In September of 2017, the 2016 Teen pregnancy rate was made available. The teen pregnancy rate per 1,000 is 29.6.

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
2015	72.6 %	0.2 %	25,632	35,325
2014	70.7 %	0.2 %	24,770	35,014
2013	68.4 %	0.3 %	22,159	32,417
2012	68.1 %	0.3 %	21,698	31,869
2011	66.8 %	0.3 %	21,445	32,113
2010	65.9 %	0.3 %	20,999	31,884

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	152.2	6.8 %	512	33,637
2013	113.3	5.9 %	372	32,833
2012	127.1	6.3 %	418	32,885
2011	106.2	5.7 %	353	33,252
2010	111.9	5.8 %	380	33,973
2009	103.2	5.4 %	368	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
2011_2015	6.2	1.9 %	11	177,396
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

NOM 3 - Notes:

None

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
2015	8.5 %	0.2 %	3,093	36,289
2014	8.3 %	0.2 %	2,972	35,851
2013	8.0 %	0.2 %	2,810	35,028
2012	8.0 %	0.1 %	2,781	34,903
2011	8.2 %	0.2 %	2,906	35,289
2010	8.3 %	0.2 %	2,965	35,931
2009	8.1 %	0.1 %	3,046	37,604

Legends:

Indicator has a numerator <10 and is not reportable

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

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
2015	1.3 %	0.1 %	478	36,289
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

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
2015	7.2 %	0.1 %	2,615	36,289
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

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
2015	10.0 %	0.2 %	3,609	36,283
2014	10.1 %	0.2 %	3,623	35,845
2013	9.8 %	0.2 %	3,437	34,937
2012	10.4 %	0.2 %	3,598	34,742
2011	10.5 %	0.2 %	3,694	35,187
2010	10.9 %	0.2 %	3,791	34,842
2009	10.8 %	0.2 %	3,981	36,710

Legends:

Indicator has a numerator <10 and is not reportable

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

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
2015	2.7 %	0.1 %	976	36,283
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

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
2015	7.3 %	0.1 %	2,633	36,283
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

NOM 5.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	26.3 %	0.2 %	9,544	36,283
2014	25.7 %	0.2 %	9,228	35,845
2013	25.7 %	0.2 %	8,980	34,937
2012	27.4 %	0.2 %	9,517	34,742
2011	29.8 %	0.2 %	10,499	35,187
2010	28.2 %	0.2 %	9,841	34,842
2009	29.7 %	0.2 %	10,899	36,710

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	5.0 %			
2015/Q1-2015/Q4	5.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

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

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
2014	6.0	0.4 %	214	35,958
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
2014	5.5	0.4 %	198	35,861
2013	5.3	0.4 %	186	35,030
2012	4.9	0.4 %	172	34,911
2011	5.7	0.4 %	201	35,296
2010	5.5	0.4 %	198	35,934
2009	5.8	0.4 %	219	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.8	0.3 %	137	35,861
2013	3.7	0.3 %	128	35,030
2012	2.9	0.3 %	102	34,911
2011	3.5	0.3 %	124	35,296
2010	3.5	0.3 %	125	35,934
2009	3.9	0.3 %	146	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.7	0.2 %	61	35,861
2013	1.7	0.2 %	58	35,030
2012	2.0	0.2 %	70	34,911
2011	2.2	0.3 %	77	35,296
2010	2.0	0.2 %	73	35,934
2009	1.9	0.2 %	73	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	186.8	22.9 %	67	35,861
2013	171.3	22.1 %	60	35,030
2012	128.9	19.2 %	45	34,911
2011	167.2	21.8 %	59	35,296
2010	125.2	18.7 %	45	35,934
2009	175.5	21.6 %	66	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - 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
2014	55.8	12.5 %	20	35,861
2013	71.4	14.3 %	25	35,030
2012	85.9	15.7 %	30	34,911
2011	68.0	13.9 %	24	35,296
2010	58.4	12.8 %	21	35,934
2009	93.1	15.7 %	35	37,612

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.4	0.6 %	417	33,648
2013	11.7	0.6 %	386	32,871
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
2015	21.9	2.6 %	73	333,144
2014	17.8	2.3 %	59	331,182
2013	18.1	2.3 %	60	331,294
2012	18.6	2.4 %	62	332,660
2011	19.5	2.4 %	65	333,347
2010	19.2	2.4 %	64	334,050
2009	20.9	2.5 %	70	334,461

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	38.1	3.2 %	139	364,784
2014	30.3	2.9 %	110	362,802
2013	28.8	2.8 %	104	361,031
2012	29.1	2.8 %	105	360,693
2011	41.1	3.4 %	148	359,993
2010	34.2	3.1 %	125	365,773
2009	36.7	3.2 %	134	365,053

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	12.3	1.5 %	65	530,795
2012_2014	12.4	1.5 %	66	531,382
2011_2013	10.4	1.4 %	55	531,349
2010_2012	11.0	1.4 %	59	536,826
2009_2011	11.6	1.5 %	63	541,615
2008_2010	14.1	1.6 %	77	544,431
2007_2009	17.2	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

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
2013_2015	10.0	1.4 %	53	530,795
2012_2014	8.3	1.3 %	44	531,382
2011_2013	9.6	1.3 %	51	531,349
2010_2012	8.9	1.3 %	48	536,826
2009_2011	8.9	1.3 %	48	541,615
2008_2010	5.7	1.0 %	31	544,431
2007_2009	6.5	1.1 %	35	536,460

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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
2014	26.9 %	0.3 %	7,228	26,884
2012	27.5 %	0.3 %	7,609	27,649
2010	30.4 %	0.3 %	7,867	25,855
2008	28.1 %	0.3 %	5,167	18,366

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
2015	27.2 %	1.7 %	32,868	120,749
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
2015	7.6 %	0.5 %	51,029	668,401
2014	9.7 %	0.8 %	63,977	660,829
2013	13.9 %	0.8 %	91,948	662,058
2012	16.6 %	0.8 %	110,085	663,964
2011	16.1 %	0.9 %	106,640	662,057
2010	17.9 %	0.7 %	118,672	664,484
2009	18.0 %	0.9 %	123,042	685,085

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 21 - Notes:

None

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
2015	71.3 %	3.6 %	36,649	51,393
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	
	2016
Annual Indicator	72.6
Numerator	62,893
Denominator	86,578
Data Source	Nevada WebIZ
Data Source Year	2016

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) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	48.8 %	2.1 %	296,420	607,293
2014_2015	51.5 %	2.3 %	317,981	617,438
2013_2014	50.1 %	2.0 %	310,104	619,540
2012_2013	51.1 %	2.1 %	315,349	617,143
2011_2012	45.5 %	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

	2016
Annual Indicator	19.8
Numerator	149,690
Denominator	754,966
Data Source	Nevada WebIZ, State Demographer
Data Source Year	15-16

NOM 22.2 - Notes:

Data are representative of Flu Season 15-16. Denominator is based on estimates by the Nevada State Demographer

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	72.0 %	4.0 %	65,958	91,572
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	44.5 %	4.5 %	42,832	96,244
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	
	2016
Annual Indicator	47.0
Numerator	126,454
Denominator	269,080
Data Source	Nevada WebIZ
Data Source Year	2016

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	88.3 %	2.2 %	165,842	187,816
2014	87.6 %	1.9 %	162,423	185,485
2013	88.3 %	2.1 %	162,824	184,426
2012	86.3 %	2.6 %	158,159	183,248
2011	80.2 %	2.9 %	148,616	185,214
2010	68.3 %	3.0 %	119,169	174,407
2009	64.0 %	3.2 %	113,692	177,632

Legends:

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

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data

	2016
Annual Indicator	76.6
Numerator	206,076
Denominator	269,080
Data Source	Nevada WebIZ
Data Source Year	2016

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	78.0 %	2.7 %	146,535	187,816
2014	66.5 %	3.0 %	123,337	185,485
2013	64.0 %	3.1 %	118,108	184,426
2012	66.4 %	3.2 %	121,579	183,248
2011	60.3 %	3.7 %	111,737	185,214
2010	54.3 %	3.2 %	94,611	174,407
2009	39.5 %	3.2 %	70,129	177,632

Legends:

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

Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2016
Annual Indicator	62.7
Numerator	168,620
Denominator	269,080
Data Source	Nevada WebIZ
Data Source Year	2016

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

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62
Annual Indicator	64.0
Numerator	319,699
Denominator	499,724
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	65.0	66.0	68.0	70.0	72.0	74.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	82
Annual Indicator	82.6
Numerator	26,908
Denominator	32,591
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	86.0	88.0	89.0	90.0	91.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	19
Annual Indicator	24.9
Numerator	7,990
Denominator	32,061
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	25.0	26.0	27.0	28.0	29.0	30.0

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23
Annual Indicator	21.9
Numerator	38,504
Denominator	175,661
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.0	27.0	29.0	31.0	33.0	35.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: 2020 goal is 31.9	

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)

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	16
Annual Indicator	28.6
Numerator	34,940
Denominator	122,356
Data Source	YRBSS-ADOLESCENT
Data Source Year	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2016
Annual Objective	16
Annual Indicator	14.8
Numerator	31,350
Denominator	211,533
Data Source	NSCH-ADOLESCENT
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	18.0	20.0	22.0	24.0	26.0	28.0

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.

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	70
Annual Indicator	67.3
Numerator	144,809
Denominator	215,102
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	72.0	74.0	76.0	78.0	79.0	80.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	36
Annual Indicator	43.3
Numerator	42,016
Denominator	96,943
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	44.0	45.0	46.0	48.0	51.0	54.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	5
Annual Indicator	4.8
Numerator	1,726
Denominator	35,965
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	4.3	3.8	3.5	3.0	2.5	2.0

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: 1.4% is the 2020 goal.	

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23
Annual Indicator	26.0
Numerator	169,917
Denominator	654,896
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	21.0	19.0	17.0	15.0	13.0	11.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	76
Annual Indicator	73.0
Numerator	413,200
Denominator	566,418
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	76.0	78.0	80.0	82.0	84.0	86.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7.9
Numerator	2,805
Denominator	35,378
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	7.0	6.5	6.5	6.0	6.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data are for Nevada Residents only. Data are preliminary and subject to change. Late prenatal care is care received in the third trimester.

SPM 2 - Repeat teen birth rate

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16.6
Numerator	339
Denominator	2,040
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.0	15.0	15.0	14.0	14.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Data provided are for percent of repeat teen births.
Data are for Nevada Residents only.
Data are preliminary and subject to change.
Repeat teen births include previous live births and previous live but dead births.

SPM 3 - Percent of women who use substances during pregnancy

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5.5
Numerator	1,950
Denominator	35,378
Data Source	Nevada Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	5.0	4.5	4.5	4.0	4.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Substance use includes: smoking, drinking, and drug use during pregnancy. Drug use includes all mothers who self-reported as having used: cocaine, heroin, illicit drugs, unspecified drugs, marijuana, meth/amphetamines, opiates, and polysubstance (multiple substances). Data are for Nevada Residents only. Data are preliminary and subject to change.

SPM 4 - Teenage pregnancy rate

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	28.0	27.0	26.0	25.0	24.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	9.0	10.0	11.0	12.0	13.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Nevada Statewide Breastfeeding Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	8.0	9.0	11.0	13.0	14.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.0	16.0	16.0	16.0	16.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.2 - Number of children receiving a developmental screening using the Ages and Stages Questionnaire (ASQ)

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	500.0	700.0	1,000.0	1,300.0	1,600.0	1,900.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Completed

State Provided Data	
	2016
Annual Objective	
Annual Indicator	100
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Nevada State Physical Activity Policy

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 that students be given physical activity opportunities in bouts of 10 minutes at a minimum. 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.

ESM 8.2 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.3 - Number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	60,000.0	70,000.0	80,000.0	90,000.0	100,000.0	110,000.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.4 - Number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5,000.0	6,000.0	7,000.0	8,000.0	9,000.0	10,000.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	8.0	9.0	10.0	11.0	12.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	8
Numerator	
Denominator	
Data Source	Nevada Title V/MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	8.0	9.0	10.0	11.0	12.0	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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	Nevada Tobacco Prevention and Control Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	30.0	40.0	50.0	60.0	70.0	80.0

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)

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7
Numerator	
Denominator	
Data Source	Nevada Title V MCH Program
Data Source Year	FY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.0	7.0	8.0	8.0	9.0	9.0

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

Measure Status:	Active
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 - Repeat teen birth rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of repeat teen births in Nevada.
Definition:	**Numerator:** Number of repeat teen births ages 10 to 19 years old **Denominator:** Number of Nevada resident teen 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 and Family Planning Objectives FP-8 MICH-16 Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years
Data Sources and Data Issues:	Electronic Birth Registry System
Significance:	Decreasing repeat teen birth rates is a priority in the state, and account for more than 10% of teen births. Tracking of data to help prevent repeat teen births helps programs across the state see impacts of their programs and the need for continuation of health education their programs need to sustain or develop.

SPM 3 - Percent of women who use substances during pregnancy
Population Domain(s) – Cross-Cutting/Life Course

Measure Status:	Active
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.

SPM 4 - Teenage pregnancy rate
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To decrease the number of teenage pregnancies in Nevada.
Definition:	**Numerator:** Number of teenage pregnancies **Denominator:** Number of teenage females **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to FP-8 Reduce pregnancies among adolescent females FP-8.1 Reduce pregnancies among adolescent females aged 15 to 17 years FP-8.2 Reduce pregnancies among adolescent females aged 18 to 19 years
Data Sources and Data Issues:	Electronic Birth Registry System Data Note: Abortion data has a one year lag.
Significance:	Reducing teenage pregnancy is a priority in the state. Although teenage pregnancy rates are reducing in Nevada, disparities exist among at-risk populations. Tracking of data to help prevent teenage pregnancies will help programs across the state see the impacts of their programs and the need for continuation of health education.

Form 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 Measures (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

Measure Status:	Active
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

Measure Status:	Active
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

Measure Status:	Inactive - Completed
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:** 16
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 6.2 - Number of children receiving a developmental screening using the Ages and Stages Questionnaire (ASQ)
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	To increase the number of children receiving a developmental screening using the ASQ.
Definition:	**Numerator:** Number of children receiving a developmental screening using the ASQ **Denominator:** N/A **Unit Type:** Count **Unit Number:** 3,000
Data Sources and Data Issues:	Nevada Title V/MCH Program ASQ Hub
Significance:	The Ages and Stages Questionnaire is the most commonly used developmental screening tool by publicly funded and private programs serving infants, toddlers, and their families in Nevada. Collection of this data will allow the Title V MCH Program to track the number of children screened. In the future, the data should allow us to see the developmental status of children by age and program.

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

Measure Status:	Inactive - Completed
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 8.2 - Number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages 12-17.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of facilities providing Trauma-Informed Yoga (TIY) for at-risk adolescents ages12 through 17 to increase physical activity for 60 minutes per day.
Definition:	**Numerator:** Number of programs providing TIY **Denominator:** N/A **Unit Type:** Count **Unit Number:** 25
Data Sources and Data Issues:	Nevada Title V/MCH Program
Significance:	TIY programs make physical activity available in a safe environment to at-risk adolescents ages 12-17 without specialized equipment, dedicated space, or unsafe outdoor environment.

ESM 8.3 - Number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17.
Definition:	**Numerator:** Number of unique visitors to MCH social media and marketing materials including physical activity, healthy lifestyle messages, and activity challenges for adolescents ages 12 through 17 **Denominator:** NA **Unit Type:** Count **Unit Number:** 120,000
Data Sources and Data Issues:	Nevada Title V/MCH Program Google Analytics
Significance:	With adolescents increasingly utilizing social media, this campaign is likely the best way to reach them. The English and Spanish messages generated for this ongoing campaign were field tested with adolescents.

ESM 8.4 - Number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11.
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	Increase the number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11.
Definition:	**Numerator:** Number of unique visitors to Chronic Disease Prevention and Health Promotion Section social media and marketing materials including physical activity and healthy lifestyle messages for parents and caregivers of children ages 6-11. **Denominator:** NA **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Nevada Title V/MCH Program Chronic Disease Prevention and Health Promotion Section Google Analytics Facebook analytics are for parents and caregivers of children ages 6 through 8 .
Significance:	With parents and care-givers increasingly on social media, the reach of this campaign is expected to grow.

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.

Measure Status:	Active
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of public outreach events to educate the CYSHCN population about how to access and benefits of medical home portal in the past year.</td></tr>
<tr><td>Denominator:</td><td>All partners that serve the CYSHCN population.</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>12</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Nevada Title V/MCH Program</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

Measure Status:	Active
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

Measure Status:	Active
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:** 9
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 11
Other State Data

State: Nevada

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: Nevada

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

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 *Inactive* ESM 6.2	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Promote healthy weight	NPM 8 - Physical Activity	ESM 8.1 *Inactive* ESM 8.2 ESM 8.3 ESM 8.4	
Improve preconception and interconception health among women of childbearing age	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Reduce teen pregnancy			SPM 2
Reduce teen pregnancy			SPM 4

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	
			SPM 3