Nevada's Title V Maternal and Child Health and Maternal, Infant, and Early Childhood Home Visiting Programs

2020: Nevada's Maternal and Child Health Needs Assessment

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Health Management Associates Research Team

Contents

List of Acronyms

Acronym	Meaning
ACE	Adverse Childhood Experience
ACS	American Community Survey
AGR	Annual Growth Rate
AIDS	Acquired Immunodeficiency Syndrome
ASSB	Accidental Suffocation or Strangulation in Bed
BRFSS	Behavioral Risk Factor Surveillance System
CCHD	Critical Congenital Heart Disease
CDC	Centers for Disease Control and Prevention
COPD	Chronic Obstructive Pulmonary Disease
CPS	Child Protective Services
CYSHCN	Children and Youth with Special Health Care Needs
DHHS	Nevada Department of Health and Human Services
DPBH	Nevada Division of Public and Behavioral Health
DTaP	Diphtheria, Tetanus, and Pertussis
EBP	Evidence Based Practices
ED	Emergency Department
EHS	Early Head Start
ELI	Extremely Low Income
FAS	Fetal Alcohol Syndrome
FBI	Federal Bureau of Investigation
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
GDP	Gross Domestic Product
HepB	Hepatitis B
HIPPY	Home Instruction for Parents of Preschool Youngsters
HIV	Human Immunodeficiency Virus
HMA	Health Management Associates, Inc.
HRSA	United States Health Resources and Services Administration
HUD	United States Department of Housing and Urban Development
HVP	Home Visiting Program
IDD	Intellectual or Developmental Disability
IMR	Infant Mortality Rate
IPV	Intimate Partner Violence
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraceptive
LBW	Low Birth Weight
LGB	Lesbian, Gay and Bisexual
LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning
LIA	Local Implementing Agency

Acronym	Meaning
MCH	Maternal and Child Health Program
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MMR	Measles-Mumps-Rubella
NAEP	National Assessment of Educational Progress
NAS	Neonatal Abstinence Syndrome
NCEDSV	Nevada Coalition to End Domestic and Sexual Violence
NCHS	National Center for Health Statistics
NFP	Nurse Family Partnership
NISVS	National Intimate Partner and Sexual Violence Survey
NSCH	National Survey on Children's Health
NSDUH	National Survey on Drug Use and Health
NVSS	National Vital Statistics System
PAT	Parents as Teachers
PMS	Premenstrual Syndrome
Pre-K	Pre-Kindergarten
SAMHSA	Substance Abuse and Mental Health Services Administration
SIDS	Sudden Infant Death Syndrome
SNAP	Supplemental Nutrition Assistance Program
STD	Sexually Transmitted Disease
SUID	Sudden Unexpected Infant Death
TAY	Transitional Age Youth
TANF	Temporary Assistance for Needy Families
UNLV	University of Nevada, Las Vegas
UNR	University of Nevada, Reno
WIC	Women, Infants, and Children
YRBS	Youth Risk Behavioral Survey

Executive Summary

Every five years the Title V Maternal and Child Health (MCH) Program and Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) of the Division of Public and Behavioral Health (DPBH) assess the health and wellbeing of women of childbearing age, infants, children, adolescents, and children and youth with special health care needs (CYSHCN) across Nevada. Additionally, the five-year assessment is a review of the strengths and weaknesses of systems in place either facilitating or presenting barriers to the health and wellness of identified population groups. The assessment provides the information necessary to set Nevada's maternal and child health priorities for the next five years and allocate home visiting resources to areas of highest need.

Nevada's MCH Program is dedicated to improving the health of families, with an emphasis on women of childbearing age, infants, and children, including CYSHCN. Title V funding from the U.S. Health Resources Services Administration (HRSA) supports health education and prevention activities, increasing access to health care services, developing and leveraging key partnerships and collaborations, and planning and implementing program components that reach target populations, all in collaboration with community-level partners (e.g. stakeholders, coalitions, sub-grantees/contractors, etc.).[1]

The Nevada MIECHV program supports agencies and organizations which administer home visiting services to pregnant women, mothers, fathers, and caregivers in the education of their young children to improve maternal and newborn health, improve school readiness, and to reduce child injuries, neglect, and abuse. Nevada MIECHV exists to develop and promote a statewide coordinated system of evidence-based home visiting services that support healthy child development and ensure the safety of young children and family members.[2]

While this assessment aims to be comprehensive, it cannot adequately represent all possible populations of interest and these information gaps might in some ways limit the ability to assess all MCH health needs. For example, certain population groups may have additional barriers to accessing care and services such as those experiencing homelessness, youth who are involved in foster care, or children of parents who only speak a language other than English or Spanish and may be included in the assessment to varying extents.

A mixed method design using both quantitative and qualitative methods informed the needs assessment which was made up of five main components: key informant interviews, focus groups, a community survey, secondary analysis of population health and demographic data, and needs and resource mapping. Research focused on seven specific population groups representing the MCH and MIECHV program populations of interest (MCH population groups):

1. Women of Reproductive Age (15 - 44 years of age)
2. Pregnant Women and Women One Year Postpartum
3. Newborns and Infants (Birth up to One Year)
4. Young Children (1 - 5 years of age)
5. Children (6 - 11 years of age)

[1] Department of Health and Human Services Nevada Division of Public and Behavioral Health (DPBH). (n.d.). Title V MCH Program. Retrieved March 9, 2020 from http://dpbh.nv.gov/Programs/TitleV/TitleV-Home/.
[2] Department of Health and Human Services Nevada Division of Public and Behavioral Health (DPBH). (n.d.). Nevada Home Visiting (MIECHV). Retrieved March 9, 2020 from http://dpbh.nv.gov/Programs/MIECHV/Nevada_Home_Visiting_(MIECHV)_-_Home/.

6. Adolescents/Young Adults (12 - 21 years of age)
7. Children and Youth with Special Health Care Needs (Birth to 21 years of age)

Key Findings

The table below describes performance measures by population domain and compares Nevada to the United States (U.S.). Data suggest Nevada is doing better on some indicators relevant to the MCH population groups than the U.S. averages for those indicators (indicated with a check mark in the table below).

Domain	Indicator	Nevada	United States	Nevada is doing better than United States ✓ = True Ø = Not True
Women/ Maternal Health	Percent of women with a past year preventive visit (2017)[3]	63.9%	65.6%	Ø
Perinatal/Infant Health	Percent of infants who are ever breastfed (2015)[4]	83.5%	83.2%	✓
Perinatal/Infant Health	Percent of infants breastfed exclusively through 6 months (2016)[5]	20.8%	24.9%	Ø
Child Health	Percent of Children, ages 9 through 35 months, receiving a developmental screening using a parent-completed tool (2018)[6]	27.9%	33.5%	Ø
Child Health	Percent of children 6 to 11 years of age who are physically active at least 60 minutes per day (2018)[7]	29.6%	27.8%	✓
Adolescent Health	Percent of adolescents, ages 12 to 17,with a preventive medical care visit in the past 12 months (2018)[8]	71.7%	78.7%	Ø
Adolescent Health	Percent of Adolescents 12 to 17 years of age who are physically active at least 60 minutes per day (2018)[9]	16.8%	17.5%	Ø
Children and Youth with	Percent of children ages0 through 17, who have a medical home (2018)[10]	43.4%	49.4%	Ø

[3] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
[4] National Immunization Survey. (2015). National Performance Indicator 4A: Percent of infants who are ever breastfed.
[5] National Immunization Survey. (2015). National Performance Indicator 4B: Percent of infants breastfed exclusively through six months.
[6] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.
[7] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.
[8] National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
[9] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.
[10] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Domain	Indicator	Nevada	United States	Nevada is doing better than United States ✓ = True Ø = Not True
Special Health Care Needs				
Cross-Cutting/Systems Building	Percent of women who smoke during pregnancy (2017)[11]	4.2%	6.9%	✓

The assessment goes beyond these key performance measures to begin to understand root causes or drivers of MCH health and wellness outcomes in Nevada, including both strengths and opportunities for improvement.

The assessment identified strengths among MCH population groups, specifically:

- The community survey revealed respondents felt their communities were good places to raise children, including satisfaction with local schools and recreational facilities.
- Stakeholders felt a sense of commitment and urgency for improving the health and wellbeing of MCH population groups.
- Many communities engaged partners and leaders who are willing to work on solutions.
- A 10-year decline in teen pregnancy in Nevada ranks as the 11th largest decrease in the country.[12]

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

THE NEEDS ASSESSMENT IDENTIFIED SIGNIFICANT HEALTH EQUITY ISSUES BY **AGE, GENDER, GEOGRAPHY, RACE AND ETHNICITY, & INCOME**

For example, based on the needs assessment results for Nevada:

- Women are more likely to be uninsured compared to men (and more likely to be uninsured compared to other women in the U.S.).
- Across all MCH populations, Hispanic women and children are more likely to lack insurance than other race and ethnicity groups. Therefore, they are more likely to have needed a doctor, but could not go to the doctor because of cost.
- While insurance rates are generally high among children, access to consistent and adequate health insurance coverage is less common in Nevada compared to other states.
- Single mothers experience the highest poverty rates, and therefore experience health risk factors associated with poverty at more than twice the rate of two-parent households. Single mothers of children younger than five years are most vulnerable to poverty.

[11] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[12] Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19. Retrieved from https://powertodecide.org/what-we-do/information/national-state-data/teen-birth-rate.

- Families experiencing poverty in rural and frontier communities are less likely to be connected to benefits, such as food stamps/SNAP, with the greatest disparity existing in Mineral, Nye, and White Pine counties.
- Language and insurance status (i.e., uninsured or Medicaid) are shared risk factors across MCH population groups regarding access to services and are reported to be a common reason why people may experience or feel they are experiencing unequal treatment in receiving services.
- Overall, self-reported tobacco use among mothers during pregnancy decreased since 2010; however, the rate among mothers living in rural communities increased to an eight-year high.
- Lesbian, Gay, and Bisexual (LGB) youth experience high levels of bullying and violence, homelessness, fear, and mental health issues compared to their heterosexual peers.
- Access to a medical home (i.e., patient-centered comprehensive coordinated care) occurs for less than half of Nevada's children (and among CYSHCN, this is less than one third), which is a lower likelihood than children across the U.S. This access decreases as a child ages, with adolescents experiencing some of the greatest disparities in access, as well as those who lack private insurance or who have special health care needs.
- There is a race and ethnic disparity among statewide child deaths, as Black or African American child deaths (ages 0 to 17) are disproportionately higher than their population distribution in Nevada.

The assessment also identified significant health issues and concerns for MCH populations in both the data and from stakeholder engagement, specifically:

- Mental health was a predominant issue across all MCH population groups, in particular adolescents, pregnant and one-year postpartum women, and women of childbearing age. The number of deaths among all females and adolescents in Nevada due to intentional self-harm is one of the highest in the nation.
- Substance use was a concern among adolescents and pregnant and one-year postpartum women.
- Violence, including both violence to women and child abuse and neglect, was an issue for women of reproductive age and children zero to five years of age.
- Nevada ranks 41st among states in the teen pregnancy rate (includes all pregnancies rather than just those resulting in a birth); however, Nevada is 11th in rate of decrease with the same dramatic decrease seen across all racial and ethnic groups. Black or African American teens continue to experience the highest teen birth rates in Nevada.
- Nevada's rate of sudden unexpected infant death (SUID) reached a nine year high in 2016, with rates disproportionately affecting Black or African Americans.
- The highest rate of infants born with neonatal abstinence syndrome (NAS) was seen amongst White infants, with the lowest rates among Hispanic infants in 2017.
- More children in Nevada, compared to children nationwide, have ever experienced two or more Adverse Childhood Experiences (ACEs), particularly parental separation or divorce, living with someone with substance use problems, and having a parent who served time in jail.
- Alcohol and marijuana were the two most commonly reported substances used during pregnancy among Nevada mothers, with marijuana surpassing alcohol use in 2015 and increasing in 2017.

Limited access to services is a significant barrier to health and wellbeing, with community members reporting lack of providers, lack of specific needed services offered by a local provider, and physical access to providers as key barriers. Both community members and MCH professionals and service providers identified the same set of resources needing improvement (or those services not available, accessible, affordable, and/or high quality) in their community to benefit MCH population groups – mental health services, childcare options, housing, health care options, and good paying jobs with livable wages. These issues are particularly prevalent in rural or frontier communities in Nevada. Employment data support this disparity as only 5.3 percent of the health care and social assistance employees in Nevada live in rural and frontier counties (despite 9.5% of Nevada's population living in these areas).

Overall, more than two thirds of Nevada's population live in a federally designated primary medical care health professional shortage area (HPSA). The proportion of populations who reside in dental and mental health care HPSAs is even larger with up to 100 percent of the population in all rural and frontier counties living in a mental health HPSA. Protective factors against adverse health outcomes for MCH population groups are less prevalent in Nevada. For example:

- Nevada ranks 47th in the U.S. in the percent of children who experience protective family routines and habits.[13]
- One in ten youth (ages 16 to 19 years old) are disconnected in Nevada (defined by being neither working nor in school), putting them at greater risk of increased violent behavior, smoking, alcohol consumption and marijuana use, and emotional and cognitive deficits than their peers who are working and/or in school.[14]
- Nevada parents were least likely to report feeling their child lived in a safe neighborhood and was safe at school compared to parents across the U.S., and among minority populations, this disparity increases.[15]
- More children in Nevada ages three to four are not enrolled in school, including preschool or pre-kindergarten compared to other states; this disparity is most prevalent among children who are low-income and of color.[16]

Access to Services

- One in three children (33.7%) with a behavioral health condition received treatment or counseling compared to 50.3 percent of children nationwide in 2018.[17]
- Approximately one in five women in Nevada reported not being able to visit a doctor in the past year because of cost (higher than United States at 14.2%).[18]
- Approximately one in four (26.0%) pregnant women in Nevada did not access prenatal care in the first trimester (higher than United States at 22.7 percent).[19]

[13] America's Health Rankings Analysis of Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health, United Health Foundation. (2018) Accessed December 6, 2019 from http://americashealthrankings.org/.
[14] RWJF County Health Rankings. (2017). Education measure: Disconnected Youth. Retrieved on December 26, 2019 from https://www.countyhealthrankings.org/app/nevada/2019/measure/factors/149/datasource.
[15] National Children's Health Survey. (2018). Indicator 7.3: Is this child safe at school, age 6-17 years?
[16] KidsCount.org. (2018). Percent of young children not in school in Nevada. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.
[17] National Children's Health Survey. (2018). National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.

Funding for public health is, in part, an indicator of the resources available to improve population health. Nevada is identified as the least healthy state when considering the amount of public health funding available relative to other states, including both a combination of state dollars dedicated to public health and federal dollars directed to states by the Centers for Disease Control and Prevention (CDC) and HRSA. This amounts to $46 per person in Nevada, significantly lower than the U.S. average of $87 per person.[18]

Areas for Action

Since many social and economic issues impact the health of women, children and adolescents in Nevada, multifaceted approaches are needed to improve health and wellbeing among MCH population groups. Once MCH and MIECHV priorities are determined, specific strategies and actions can be developed based on state and local resources, programmatic or policy levers, and community will. Areas to consider for prioritization based on needs assessment feedback include:

- Access to care for all MCH populations
- Building a networked system of care in regions/communities, including increasing knowledge of community-based services and improving referral processes
- Single mothers experiencing poverty as a population of focus
- Mental health and pregnancy-related depression
- Suicide prevention
- Substance use in pregnant and parenting mothers
- Tobacco use among women in rural and frontier communities
- Sudden Unexpected Infant Death (SUID)
- Developmental screening
- Increasing access to a medical home CYSHCN

Introduction

Every five years the Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health Program (MCH) of Nevada DPBH assess the health and wellbeing of women of childbearing age, infants, children, adolescents, and CYSHCN across the state. Additionally, the assessment is a review of the strengths and weaknesses of the systems in place either facilitating or presenting barriers to health and wellness of these population groups. The assessment provides the information necessary to help Nevada set maternal and child health priorities for the next five years. Nevada DPBH contracted with Health Management Associates, Inc. (HMA), a national research and consulting firm, to conduct the statewide needs assessment of maternal and child health in Nevada for 2020. Assessment findings are solely the responsibility of HMA authors and do not necessarily represent the official views of MIECHV or MCH Programs, DPBH nor the Nevada Department of Health and Human Services (DHHS). This document presents methods and findings of the assessment. The MCH and MIECHV Programs will use these findings to inform development of program priorities, implementation of evidence-based strategies and measurements to improve the health and wellbeing of women of childbearing age, infants, children, adolescents, and CYSHCN in Nevada.

[18] America's Health Rankings analysis of Trust for America's Health; United States HHS; United States Census Bureau, Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018, United Health Foundation, AmericasHealthRankings.org, Accessed December 11, 2019.

Methodology

Research focused on seven specific population groups, including:

1. Women of reproductive age (15 - 44 years of age)
2. Pregnant women and women one-year postpartum
3. Newborns and Infants (Birth up to One Year)
4. Young Children (1 - 5 years of age)
5. Children (6 - 11 years of age)
6. Adolescents/Young Adults (12 - 21 years of age)
7. CYSHCN (Birth to 21 years of age)

Going forward, the needs assessment refers to these seven groups as "MCH population groups," unless otherwise specified.

HMA implemented a mixed method research design to inform the needs assessment, including multiple strategies to gather public input from across the state. First, HMA worked with MCH and MIECHV Program staff to identify and interview key stakeholders working in MCH and MIECHV funded programs or working with MCH population groups. Key stakeholders identified additional stakeholders for interviews or focus groups through the interview process, which allowed HMA to access a larger and diverse number of stakeholders for information gathering. Second, HMA hosted an online community survey dispersed via MCH and MIECHV partner organizations and social media channels. Third, a series of focus groups were conducted across the state. Finally, HMA conducted secondary analysis on publicly available population health and surveillance data.

Key Informant Interviews

Twenty semi-structured, in-depth interviews were conducted with a total of 33 key leaders working in maternal, child and adolescent health and wellness from Carson City, Churchill, Humboldt, Storey, Washoe, Mineral, Lyon, Clark, Elko, Eureka, and Nye counties. Interviews were designed to gather information about the most pressing health issues facing MCH population groups, and what is most needed to effectively address these health issues. Interviewees were also asked about gaps and barriers in services and programming for these population groups. Finally, key informant interviews sought to gather information about disparities related to geography, race and ethnicity, and other identified socio-cultural differences (see Appendix A for interview guide).

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

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

Community Survey

In October 2019, HMA developed an online community survey in collaboration with MCH and MIECHV Program staff to seek feedback from communities regarding the most important health needs for each MCH population group. Survey respondents were asked about health needs and issues in their community, and what resources exist to address those health needs and issues. They were also asked about inequities faced by certain groups within the MCH populations. Questions were also asked to better understand where MCH population groups turn for information and resources. For each MCH population group, respondents were provided a list of health topics and were asked to select the top three health needs for each group.

The survey was posted online from November 21, 2019 to December 16, 2019. A link to the survey was posted on the DPBH homepage. Internal and external partners, stakeholders, and program sub-awardees were sent the survey link via email, along with information on survey purpose. In addition, information about the survey, as well as the survey link, was posted on DPBH social media accounts. In all, 339 individuals responded to the online survey, of which 46 percent (n=157) identified as a "community member," 46 percent (n=157) as a "service provider/partner or public health professional in maternal and child health services," and 7 percent (n=25) as a "service provider/partner or public health professional in a Maternal, Child, and Infant Home Visiting Program."

Among service providers, 30 percent were health care professionals and approximately one quarter (26%) identified as community service providers (Table 1). Public health professionals identified as 16 percent of providers with just six percent identifying as an educator and one percent as a school nurse. There were no childcare providers who responded to the survey. Throughout the report, all service providers/partners and public health professionals who responded to the survey are noted as "MCH professionals and service providers."

Table 1. MCH Professionals and Service Provider Survey Respondents, by Provider Type (n=159)

MCH professionals and service provider type	Number	Percent
Health Care Professional and/or Physician (physical/medical, behavioral/mental, oral/dental, others)	60	38%
Community Service Provider (social worker, home visitor, infant-toddler specialist, others)	61	38%
Public Health Professional	14	9%
Local Public Health Department	12	8%
Educator (administrator, teacher, school-based preschool/after school care, Head Start, or other school-based professional)	9	6%
School Nurse	2	1%
Childcare Provider/Caregiver (home-centered based, school age)	0	0%
Other, please describe:	1	1%

Among those who responded to the demographic questions (n=224), survey respondents represented all 17 counties (Table 2, listed from highest to lowest in number of respondents):

Table 2. Survey Respondent, by County Affiliation

County	Number	Percent
Clark	66	29%
Washoe	50	22%
Elko	45	20%
Nye	38	17%
Carson City	28	13%
Humboldt	21	9%
Lyon	19	8%
Churchill	16	7%
Douglas	16	7%
Eureka	15	7%
Lander	15	7%
Lincoln	15	7%
Pershing	15	7%
White Pine	13	6%
Mineral	10	4%
Storey	9	4%
Esmeralda	5	2%
Total	**224**	**100%**

MCH professionals and service providers who responded to the survey represented all 17 counties. Community members represented seven of the 17 counties, as shown in Table 3 below (counties listed in alphabetical order).

Table 3. County of Residence or Service Area, by Respondent Type

County of Residence/Service Area	Community Member (n=66)	MCH professionals and service providers (n=158)
Carson City	8%	15%
Churchill	0%	10%
Clark	32%	28%
Douglas	3%	9%
Elko	12%	23%
Esmeralda	0%	3%
Eureka	0%	9%
Humboldt	2%	13%
Lander	0%	9%
Lincoln	0%	9%

Lyon	0%	12%
Mineral	0%	6%
Nye	23%	15%
Pershing	0%	9%
Storey	0%	6%
Washoe	20%	23%
White Pine	2%	8%
Statewide	N/A	13%

Descriptive analysis was conducted for each of the survey questions, including a description of the number of people who included a given topic as one of their top three issues, per MCH population group. Cross tabs were conducted to understand whether variation existed in responses between respondent type (i.e., service provider or community member). Themes for any open-ended responses were determined through manual review of the responses; no qualitative analysis software was used. Broad themes were identified through review of responses.

Focus Groups

Between August 2019 and January 2020, fourteen focus groups were held at different locations in the state facilitated by HMA staff. All focus groups took place in one of the following Nevada counties: Carson City, Washoe, Clark, Storey, and Nye. Participants were asked about: 1) health needs of different populations in Nevada; 2) health needs of friends/family members; 3) where clients receive health information; 4) what problems/barriers clients experience when trying to access services; 5) services needed but not accessible, available, and/or affordable; 6) things homes, schools, and communities can do to improve health and safety; and 7) things Nevada is doing well or areas where improvement is needed to address the health of MCH population groups.

Specific focus groups were convened to better understand the perspective of specific populations, including at-risk youth; parents engaged in home visiting; Spanish speakers; mothers in recovery from substance use; LGBTQ community members; families with CYSHCN; and participants from frontier or rural communities. To support free flow of information, a list of open-ended questions was used to explore insights of participants (see Appendix B for focus group discussion guide with recipients of services and programming and Appendix C for focus group discussion guide with community providers of mental health, physical health, and social services).

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

Population Health and Surveillance Data

The needs assessment gathered, organized, and analyzed publicly available data in the following areas:

Demographic data: Demographic data on geography, economic status, race, ethnicity, gender, age, language, religion, and sexual orientation.

Risk and protective factor data: Data on risk and protective factors related to the health and wellbeing of MCH population groups were collected and analyzed, including child welfare involvement (including youth in and aging out of foster care), housing security (including runaway youth), juvenile justice involvement, access to pro-social activities, involvement in healthy relationships, experience of violence, substance use, mental distress, and other risk and protective factors identified by MCH and MIECHV Program staff, literature review, or in data sources. Data sources included:

- National Vital Statistics System (NVSS) which offers data provided through contracts between the National Center for Health Statistics (NCHS) and vital registration systems operated in the various jurisdictions legally responsible for registration of vital events – births, deaths, marriages, divorces, and fetal deaths.
- National Survey on Children's Health (NSCH) sponsored by the MCH Bureau of the Health Resources and Services Administration (HRSA), which examines physical and emotional health of children from birth to 17 years. The NSCH was designed to produce nationally- and state-representative estimates.[19]
- Behavioral Risk Factor Surveillance System (BRFSS), a telephone survey, collects data from U.S. residents on health-related risk behaviors, chronic health conditions, and use of preventive services. With guidance and help from the CDC, BRFSS is conducted through state health departments and is the largest ongoing health survey in the world.[20]
- American Community Survey (ACS) which is administered by the United States Census Bureau each year. Approximately one in 38 U.S. households receive an invitation to complete the survey either as a hardcopy or online. Questions are diverse and relate to socioeconomics, demographics, household composition, occupational status, housing status, educational attainment, and more. The resulting data are available from national to local levels and are often available at census tract level.
- Nevada Report Card, released by Nevada Department of Education, with annual school district data at state, district (county), and school levels. Most data are collected from students or as administrative data reported by schools and include topics such a demographics, funding, staff and test scores.[21]
- Youth Risk Behavioral Survey (YRBS) is administered to middle and high school students on odd years in most every state across the nation. YRBS provides an estimated prevalence of risk behaviors and protective factors among adolescents. The survey is voluntary, and results include self-reported responses to questions related to the following areas: violence and violent behaviors; physical activity, nutrition, and obesity; substance use; sexual health behaviors; and home and family environment.[22]
- Nevada Rural and Frontier Data Book, released by the University of Nevada, Reno, School of Medicine, Office of Statewide Initiatives contains a wide range of up-to-date county-level information on the economy, social environment, population health, health workforce, and the health care delivery system.[23]

[19] Centers for Disease Control and Prevention. (2018, June 28). National Survey of Children's Health. Retrieved on November 21, 2019 from https://www.cdc.gov/visionhealth/vehss/data/national-surveys/national-survey-of-childrens-health.html.
[20] Centers for Disease Control and Prevention. (2018, January 2). BRFSS Frequently Asked Questions (FAQs). Retrieved November 16, 2019, from http://www.cdc.gov/brfss/about/brfss_faq.htm.
[21] Nevada Department of Education. Nevada Report Card, available at http://nevadareportcard.nv.gov/di/.
[22] Nevada Youth Risk Behavioral Survey, available at https://www.unr.edu/public-health/research/yrbs.
[23] 2019 Nevada Rural and Frontier Health Data Book - Ninth Edition, available at https://med.unr.edu/statewide/reports/data-book-2019.

- National Survey on Drug Use and Health (NSDUH) provides up-to-date information on tobacco, alcohol, and drug use, mental health, and other health-related issues. Information from NSDUH is used to support prevention and treatment programs, monitor substance use trends, estimate the need for treatment and inform public health policy.[24]
- PRAMS (Pregnancy Risk Assessment Monitoring System) is a joint research project between Nevada DPBH and CDC. The purpose is to find out why some babies are born healthy and others are not. To do this, the PRAMS questionnaire asks new mothers about their behaviors and experiences before, during, and after their pregnancy. Each year in Nevada there are hundreds of babies born with serious health problems. Answers to the PRAMS survey helps Nevada learn more about ways to improve the health of mothers and babies in Nevada.[25]

Existing MIECHV Program data: Program data were shared by MIECHV Program staff including participant demographics, program enrollment, program capacity, and HRSA performance measure data. Program data, in combination with the results of the needs assessment, were used to inform the program's capacity assessment and gap analysis.

Other community health resources: Data was collected to identify programs providing medical, social, educational, and behavioral health services for MCH population domains, including availability of medical and behavioral health providers. The inclusion of these types of services in the needs assessment provides the MCH and MIECHV Programs with a more complete picture of the full spectrum of gaps in services supporting the health and wellbeing of MCH population groups in Nevada. The primary data sources for services in Nevada were provided by Nevada's Medical Home Portal[26] and Nevada's Home Visiting 2019 Resource Directory.[27]

Quality and Capacity of Home Visiting Programs

The Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) aims to improve health, social, and academic outcomes for the most vulnerable young families. MIECHV develops and promotes a statewide coordinated system of evidence-based home visiting programming supporting healthy child development and ensuring the safety of young children and family members. The Nevada MIECHV Program provides home visiting services in seven Nevada counties through Local Implementing Agencies (LIAs) using the following service delivery models:

- Nurse Family Partnership (NFP) – This model is implemented in Clark County to address the needs of first- time mothers. This program utilizes public health nurses to serve pregnant women from 28 weeks gestation until the child is two years old.
- Early Head Start Home Based Option – This model is implemented in Clark, Washoe, and Elko counties and serves very low-income expectant mothers and families with children up to age three years.

[24] The National Survey on Drug Use and Health, available at https://nsduhweb.rti.org/respweb/homepage.cfm.
[25] Nevada Department of Public and Behavioral Health. PRAMS (Pregnancy Risk Assessment Monitoring System), available at http://dpbh.nv.gov/Programs/PRAMS/PRAMS/. For 2017 and 2018 PRAMS data, Nevada had a response rate below the required response rate threshold of 55% to publish data. All data must be interpreted with caution due to the response rate.
[26] Medical Home Portal, available at https://www.medicalhomeportal.org/about-portal/partnering-with-the-portal.
[27] Nevada Home Visiting. (n.d.). *2019 Resource Directory*. Nevada Division of Public and Behavioral Health. Retrieved from http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/MIECHV/dta/Publications/2019 Resource Directory.pdf.

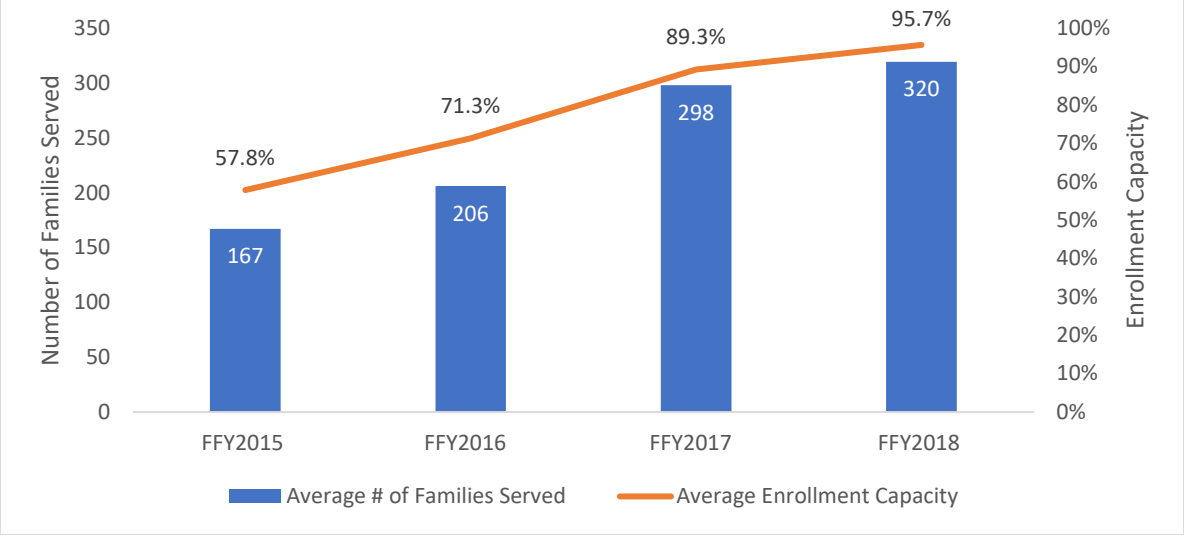
- Home Instruction for Parents of Preschool Youngsters (HIPPY) – This model is implemented in Clark, Washoe, and Elko counties and was selected based on school readiness data identified by needs assessments results from the areas served.
- Parents as Teachers (PAT) – This model is implemented in Lyon, Storey, Carson City, and Mineral counties and serves a broad range of ages and needs in low population communities. Models with a narrower opportunity for enrollment do not meet all the needs in low population areas. This model provides services to expectant mothers and families with children aged up to kindergarten entry.

All MIECHV funded agencies ensure their community partners, referring agencies, and enrollees are informed the services are voluntary and free to the family.

Identifying Quality and Capacity of Existing Programs

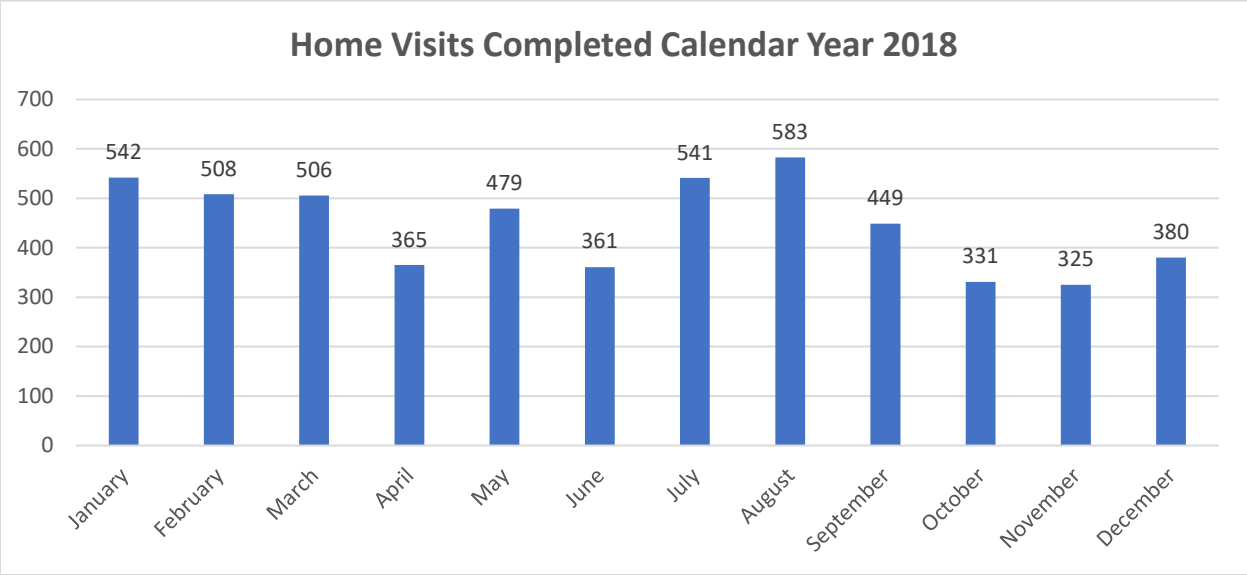
In the last four years, between Federal Fiscal Year (FFY) 2015 and 2018, MIECHV increased the number of families served by 91.6 percent, from an average number of 167 families to 320 families served annually. The Federal Fiscal Year spans October – September. Similarly, MIECHV increasingly met and exceeded its capacity goal. In FFY 2017, MIECHV LIAs succeeded in reaching at least 80 percent capacity for families served, as demonstrated in Figure 1. MIECHV began to operate over full capacity in July of FFY 2018. In FFY 2015, MIECHV had a monthly maximum enrollment capacity of 289 families which increased to 319 in FFY 2017 and 334 in FFY 2018 (Figure 1).

Figure 1. Average Number of Families Served Through MIECHV and Percent Enrollment Capacity, FFY 2015 to FFY 2018



The number of home visits provided to enrolled families in FFY 2017 fluctuated monthly into FFY 2019, ranging from a low of 311 families served in August 2017 to a high of 583 served in October 2018 (Figure 2).

Figure 2. Total Number of Home Visits Provided to Enrolled Families, September 2018 – October 2019



In FFY 2018, MIECHV LIAs served 501 households. Among these households, there were 166 pregnant women and 542 children served. Most of the households involved serving female caregivers (n=312) with male caregivers representing 23 households.

By service delivery model, the highest number of households served per model was HIPPY serving 161 households, followed by Parents as Teachers (n=133), Early Head Start Home-Based Option (n=125), and Nurse Family Partnership (n=82).

Substance use among families is tracked by MIECHV. Generally, from FFY 2018 to FFY 2019, there was an increase of 49 percent for families served who reported current or past substance use. This increase is found across nearly every LIA (Table 4), possibly reflecting an increasing need to have resources located in these areas to address substance use and/or increase screening for substance use issues.

Table 4. Families Reporting Current or Past Substance Use, FFY 2018 to FFY 2019, by Local Implementing Agency

Local Implementing Agency			Families reporting current or past substance use					Families served	
Name	Model	County	FFY2018 Number	FFY2018 Percent	FFY2019* Number	FFY2019* Percent	Change FFY2018 to 2019	FFY2018 Number	FFY2019* Number
The Children's Cabinet, Washoe	HIPPY	Washoe	11	18%	19	27%	**48%**	61	71
The Children's Cabinet, Elko	HIPPY	Elko	6	15%	9	25%	**67%**	40	36
Community Chest, Inc.	PAT	Storey, Carson, Lyon	13	26%	17	22%	**-16%**	50	78

Local Implementing Agency			Families reporting current or past substance use					Families served	
Name	Model	County	FFY2018 Number	FFY2018 Percent	FFY2019* Number	FFY2019* Percent	Change FFY2018 to 2019	FFY2018 Number	FFY2019* Number
Lyon County Human Service	PAT	Lyon, Storey	5	8%	7	10%	**26%**	65	72
Head Start of Northeastern Nevada	EHS	Elko	--	5%	--	6%	**19%**	19	16
Southern Nevada Health District	NFP	Clark	0	0%	0	0%	**0%**	82	66
Sunrise Children's Foundation	EHS, HIPPY	Clark, Nye	8	7%	9	12%	**57%**	109	78
University of Nevada, Reno	EHS	Washoe	5	9%	8	16%	**79%**	57	51
Yerington Paiute Tribe	PAT	Tribal - Lyon	2	11%	3	21%	**93%**	18	14
		Total	**51**	**10%**	**73**	**15%**	**49%**	**501**	**482**

**Federal Fiscal Year 2019 (Oct.1, 2018 - Sept. 30, 2019). The data in this report has been collected prior to the close of the federal reporting year. Data for quarter four (Jun. 1, 2019 - Sept. 30, 2019) is preliminary.*
***-- indicates data is suppressed due to small numbers.*

Families may be placed on a waitlist for MIECHV. Six of seven LIAs placed families on a waitlist in FFY 2018, primarily in Washoe, Clark, and Nye counties (Table 5). Eight percent (n=7) of community member survey respondents identified home visiting as a resource of which they would like more. These community members live in Nye (2), Washoe (1), Elko (1), Carson City (1), Douglas (1), and Clark (1) counties – two of which align with sites where waitlists are occurring. Sites that are at full capacity will not hold waitlists. When a waitlist is implemented in communities where the program is always at capacity, the families on the waiting list often age out of the program before they receive services. In order to prevent undermining the reputation of the program in the community, a waitlist is not utilized. Every effort is made to refer families to other programs where available. The annual average percent capacity of these counties' programs is over 90 percent.

Table 5. Families Placed on Waitlist and Annual Average Percent Capacity, by Local Implementing Agency, FFY 2018

Local Implementing Agency	Model	County	Number of Families Placed on Waitlist	Percent of Families Placed on Waitlist	Annual Average Percent Capacity
The Children's Cabinet, Washoe	HIPPY	Washoe	30	35%	93%
The Children's Cabinet, Elko	HIPPY	Elko	6	7%	93%

Community Chest, Inc.	PAT	Storey, Carson City, Lyon	1	1%	106%
Lyon County Human Service	PAT	Lyon, Storey	4	5%	90%
Head Start of Northeastern Nevada	EHS	Elko	0	0%	74%
Southern Nevada Health District	NFP	Clark	0	0%	96%
Sunrise Children's Foundation	EHS, HIPPY	Clark, Nye	38	44%	115%
University of Nevada, Reno	EHS	Washoe	7	8%	88%
Yerington Paiute Tribe	PAT	Tribal - Lyon	0	0%	79%
Total	-	-	**86**	**100%**	-

Throughout the year, local implementing agency's capacity fluctuates, generally increasing towards 100 percent capacity towards the end of the funding year (Table 6).

Table 6. Percent Enrollment Capacity, by Local Implementing Agency, FFY 2018

Local Implementing Agency	October 2017	September 2018	Change in Enrollment Capacity
All LEAs	85%	107%	Increase
University of Nevada, Reno (UNR)	90%	80%	Decrease
Sunrise Children's Foundation (SCF)	92%	98%	Increase
SCFN	84%	125%	Increase
Southern Nevada Health District (SNHD)	96%	88%	Decrease
Head Start of Northeastern Nevada (HSNN)	65%	85%	Increase
The Children's Cabinet, Elko (TCCE)	85%	91%	Increase
The Children's Cabinet, Washoe (TCCW)	73%	143%	Increase
Lyon County Human Service (LCHS)	83%	120%	Increase
Community Chest, Inc. (CCI)	97%	120%	Increase
Yerington Paiute Tribe (YPT)	80%	113%	Increase

MIECHV's attrition rate was 0.04 percent for Quarter Three in FFY 2019. This is an improvement from 0.09 percent for Quarter Four in FFY 2018.

Extent to which home visiting services meet the needs of families in Nevada

A review of the enrollment capacity suggests there are areas of the state where home visiting services and capacity to serve is not meeting the needs of families in Nevada. This is indicated by enrollment capacity that exceeds service capacity and prevalence of waitlists for enrollment. However, in those areas where MIECHV is reaching families, performance indicators suggest they are delivering the Evidence Based Programs as intended and families enrolled in MIECHV are experiencing better outcomes compared to similar families across the state.

In October 2016, HRSA revised the performance reporting requirements for MIECHV Program state and territory awardees after a year-long process including input from state awardees, federal partners, home visiting model developers, and other stakeholders.[28] The update aimed to ensure accountability in demonstrating outcomes. The measures are categorized into two types: performance indicators and systems outcomes.

- Performance indicators are relatively proximal to the home visiting intervention or shown to be sensitive to home visiting alone.
- Systems outcome measures are more distal to the home visiting intervention and/or are less sensitive to change due to home visiting alone due to many factors, including confounding influences or differences in available system infrastructure at the state- or community-level.[29]

The performance measurement system includes a total of 19 measures across six areas.

1. Improvements in maternal, newborn, and child health;
2. Prevention of child injuries, child abuse, neglect, or maltreatment and reductions of emergency room visits;
3. Improvements in school readiness and child academic achievement;
4. Reductions in crime or domestic violence;
5. Improvements in family economic self-sufficiency; and
6. Improvements in the coordination and referrals for other community resources and supports.

The series of tables below shows the HRSA Performance results for FFY 2018, by area. For the purpose of the assessment, statewide rates, where available, were included to suggest the extent to which MIECHV clients experiences align with those of other women, children, and families in Nevada.

Improvements in Maternal, Newborn, and Child Health

Table 7 shows a comparison between statewide and MIECHV client rates for each performance measure (where statewide data are available). These comparisons suggest MIECHV clients are experiencing higher quality outcomes in the areas of well-child visits, receipt of post-partum care, and breastfeeding. For example, more than twice as many infants of mothers enrolled in home visiting prenatally are breastfed any amount at six months of age (50% among MIECHV clients and 20.8% among other infants statewide).

Table 7. Performance Measures for Improvements in Maternal, Newborn, and Child Health, MIECHV Clients and Nevada

Performance Measure	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Depression Screening	Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within three months of enrollment	93.2%	Data not available (N/A)

[28] HRSA Maternal and Child Health. Data, Evaluation, and Continuous Quality Improvement. Retrieved on December 13, 2019, from https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance/performance-reporting-and-evaluation-resources.

[29] Systems outcome measures are denoted with an asterisk in the tables below.

Performance Measure	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
	(for those not enrolled prenatally) or within three months of delivery (for those enrolled prenatally)		
Well Child Visit	Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics (AAP) schedule	79.5%	71.7%[30]
Postpartum Care	Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within eight weeks (56 days) of delivery	78.8%	60.6%[31]
Tobacco Cessation Referrals	Percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within three months of enrollment	69.4%	N/A
Breastfeeding*	Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at six months of age	50.0%	20.8%[32]
Preterm Birth*	Percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment	9.6%	10.7%[33]

** Indicates a systems outcome measure*

Child Injuries, Maltreatment, and Reduction of Emergency Department (ED) Visits

Data limitations with PRAMS does not permit a comparison between statewide and MIECHV client rates for each performance measure related to child injuries, maltreatment, and reduction in ED visits. However, national data for safe sleep measures suggest MIECHV clients experience better outcomes for some key indicators; for example, 53.6 percent of infants enrolled in home visiting are always placed to sleep on their backs, without bed-sharing or soft bedding (Table 8).

- Percent of infants placed to sleep on their backs in the U.S. is 79.8 percent;
- Percent of infants placed to sleep on a separate approved sleep surface in the U.S. is 33.1 percent; and
- Percent of infants placed to sleep without soft objects or loose bedding in the U.S. is 46.7 percent.

[30] National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
[31] 2018 Adult Health Care Quality Measures. Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle. This indicator only includes women with Medicaid during FFY 2018.
[32] National Immunization Survey. (2015). National Performance Measure 4A: Percent of infants who are ever breastfed.
[33] National Vital Statistics System. (2016). National Outcome Measure 6: Percent of preterm births (<37 weeks gestation).

Table 8. Performance measures of Child Injuries, Maltreatment, and Reduction of Emergency Department Visits, MIECHV families and Nevada

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Safe Sleep	Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing or soft bedding	53.6%	N/A
Child Maltreatment*	Percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period	3.1%	41.0%*[34]
Child Injury	Rate of injury-related visits to the ED since enrollment among children enrolled in home visiting	.03%	N/A

** Indicates a systems outcome measure. In Nevada, 41.0 percent of children in Nevada between the ages zero to four are children who are confirmed by child protective services to be victims of maltreatment.*

Improvements in school readiness and child academic achievement

Among school readiness performance measures, those enrolled in MIECHV are exceeding state rates among similar aged children (Table 9). For example, the percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool is nearly three times as high as the screening rate among other children across the state (84.2% MIECHV enrolled families compared to 27.9% statewide). The likelihood of children with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily is nearly twice as high among families enrolled in MIECHV (81% MIECHV enrolled families compared to 45.2% statewide). While there is no state comparable data, nearly all MIECHV enrolled families (99.7%) were asked whether they had any concerns regarding their child's development, behavior, or learning. Just over three quarters of families (77.4%) received an observation of caregiver-child interaction by the home visitor using a validated tool.

Table 9. Performance measures for improvements in school readiness and child academic achievement, MIECHV families and Nevada

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Behavioral Concerns	Percent of home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning	99.7%	N/A
Developmental Screening	Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool	84.2%	27.9%[35]

[34] United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. National Child Abuse and Neglect Data System (NCANDS). (2017). Child File, FFY 2000–2017.
[35] National Survey of Children's Health (2018). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Early Language and Literacy Activities	Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day	81.0%	45.2%[36]
Parent-Child Interaction	Percent of primary caregivers enrolled in home visiting who received an observation of caregiver-child interaction by the home visitor using a validated tool	77.4%	N/A

Reductions in crime or domestic violence

Nearly all families (80.1%) enrolled in home visiting are screened for intimate partner violence within six months of enrollment using a validated tool (Table 10). As noted previously, Nevada ranks in the top 10 states with the highest rates of females murdered by males, predominately by someone they know. Continuing to screen given this high rate is important prevention for a significant issue in Nevada.

Table 10. Reductions in crime or domestic violence

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Intimate Partner Violence Screening	Percent of primary caregivers enrolled in home visiting who are screened for intimate partner violence (IPV) within six months of enrollment using a validated tool	80.1%	N/A

Improvements in family economic self-sufficiency

Families enrolled in MIECHV are more likely to have continuous health insurance coverage for at least six consecutive months (85.2% among enrolled families compared to 79.1% among families statewide, as shown in Table 11). Just over one third of families enrolled in MIECHV without a high school degree or equivalent have gone on to enroll in, maintain continuous enrollment in, or complete a high school equivalency degree during their participation in home visiting.

Table 11. Improvements in family economic self-sufficiency

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Continuity of Insurance Coverage	Percent of primary caregivers enrolled in home visiting who had continuous health insurance coverage for at least six consecutive months	85.2%	79.1%[37]

[36] National Survey of Children's Health. (2018). Indicators 6.8 and 6.9. Family sings and tells stories to children, 0-5 years and Family reads to children, 0-5 years.
[37] Behavioral Risk Factor Surveillance System. (2018). Adults aged 18-64 who have any form of health care coverage among pregnant women. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/viewReport.

Primary Caregiver Education*	Percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, maintained continuous enrollment in, or completed high school or equivalent during their participation in home visiting	34.4%	N/A

** Indicates a systems outcome measure*

Improvements in the coordination and referrals for other community resources and supports

Generally, families enrolled in MIECHV are receiving recommended screenings and referrals to services to respond to any concerns identified via those screens (Table 12). For example, nine in ten children (90.1%) enrolled in home visiting with a positive screen for developmental delays received services in a timely manner. Similarly, among those caregivers who have a positive screen for intimate partner violence (IPV), 88.5 percent receive referral information for IPV support services. However, timely referrals and services for positive screens for depression only occur for just over two thirds (66.7%) of caregivers.

Table 12. Improvements in the coordination and referrals for other community resources and supports

Performance Measures	Description	Rate or Percent Among MIECHV Clients	Nevada Statewide Rate
Completed Developmental Referrals	Percent of children enrolled in home visiting with positive screens for developmental delays (using a validated tool) who receive services in a timely manner	90.1%	N/A
Intimate Partner Violence Referrals	Percent of primary caregivers enrolled in home visiting with positive screens for IPV (using a validated tool) who receive referral information for IPV	88.5%	N/A
Completed Depression Referrals*	Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts	66.7%	N/A

** Indicates a systems outcome measure*

Delivery Gaps in Delivery of Early Childhood Home Visiting Services

Gaps in the delivery of early childhood home visiting services

Regional Gaps

Eight percent (n=7) of community member survey respondents identified home visiting as a resource of which they would like more. These community members live in Nye (2), Washoe (1), Elko (1), Carson City (1), Douglas (1), and Clark (1) counties.

Additionally, when asked what the top resources in the community that were needed but not available, home visiting was one of the top three resources reported by both providers and community members (Table 13).

Table 13. The top resources in the community that were needed but not available, by survey respondent type

Service/Resource	Services reported by MCH professionals and service providers to be needed by their clients but are not available (n=95)	Services reported to by community members to be needed but are not available (n=60)
Services to reduce stress, such as respite or time for yourself	77%	15%
Availability of medical homes (i.e., patient-centered comprehensive coordinated care)	53%	14%
Home visiting	**53%**	**18%**
Programs that promote community inclusion for children and youth with special health care needs	50%	18%
Transition to adult health care system support	49%	6%
Specialists and treatment centers	46%	14%
Pregnancy or birth-related depression service	45%	17%
Support to navigate the system of care for children and youth with special health care needs	45%	20%
Training for parents/caregivers on care coordination	45%	8%
Programs that help youth develop social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood	44%	9%
Mental health services, such as counseling	43%	13%
Parenting information	14%	15%

Survey respondents who identified as a service provider/partner or public health professional in MIECHV reported several locations across Nevada where they feel they do not have the capacity to serve. Barriers reported to serving these areas include travel time and funding. These areas included:

- "All remote, frontier communities in the northeastern Nevada area."
- "…Limited to 27 (out of 73) zip codes in Clark County"
- Southern Nevada outside of Las Vegas (i.e. Pahrump, Indian Springs/Creech AFB, Mesquite, Tonopah)

"Yes, rural Nevada can be difficult to provide service. We offer pretty consistent service within a 60-mile radius of Reno and Las Vegas, outside of that it is a little more challenging." – Service provider/partner or public health professional in MIECHV

Gaps in Population Served

In FFY 2017-18, more than half of MIECHV pregnant clients were in the age group 20 to 29 years (59.1%), similar to the percent of Nevada births for this age group in 2018 at 51.6 percent (Table 14).[38] This suggests MIECHV is aligning proportionally with the need among this age group.

In FFY 2017-18, women 19 years and younger represented 21.1 percent of MIECHV clients, but only represented 5.1 percent of births in Nevada during the same time. This contrast suggests MIECHV is effectively reaching and engaging teen mothers in programming, as LIAs are serving teen mothers proportionately higher than the percent of teen births in Nevada.

Similarly, MIECHV is serving a proportionately higher number of low-income single female caregivers compared to the proportion of low-income single female caregivers in Nevada (62.3% of MIECHV clients are low-income single females compared to 34.1% of households overall). Again, this suggests MIECHV is effectively reaching and engaging low-income single female caregivers with its programming.

There are proportionately more male caregivers (defined as either the sole caregiver in the home or the primary care giver, stay at home dad, or the parent receiving the bulk of the home visiting services) in Nevada overall compared to those served by MIECHV: 4.6 percent of MIECHV participants compared to 10.3 percent statewide, suggesting a gap in services for this caregiver group.

Table 14. MIECHV Participants by Age, FFY2017-2018

Age	Percent Pregnant Women Served by MIECHV	Percent of Pregnant Women in Nevada in 2018[39]	Female Caregiver	Percent of Low-Income Single Female Households with Children Nevada in 2017[40]	Male Caregiver	Percent of male householder, no wife present, with Children Nevada in 2017[41]	All Adults	Percent by Age Group in Nevada 2017[42]
<=17	6.6%	5.1%	0.6%	n/a	0.0%	n/a	2.6%	23.2%
18-19	14.5%	5.1%	1.9%	n/a	0.0%	n/a	6.0%	8.6%
20-21	15.1%	51.6%	3.5%	n/a	0.0%	n/a	7.2%	8.6%
22-24	21.7%	51.6%	12.5%	n/a	0.0%	n/a	15.0%	8.6%
25-29	22.3%	51.6%	24.7%	n/a	17.4%	n/a	23.6%	7.3%
30-34	12.7%	40.6% (Ages 30 to 39)	21.8%	n/a	34.8%	n/a	19.4%	7.2%
35-44	7.2%	3.3%	26.9%	n/a	26.1%	n/a	20.4%	13.4%
45-54	0.0%	n/a	3.5%	n/a	8.7%	n/a	2.6%	13.4%
55-64	0.0%	n/a	1.9%	n/a	8.7%	n/a	1.6%	12.3%
>=65	0.0%	n/a	1.0%	n/a	4.3%	n/a	0.8%	14.6%
Unknown	0.0%	n/a	1.6%	n/a	0.0%	n/a	1.0%	n/a
Total	**33.1%**	**n/a**	**62.3%**	**34.1%**	**4.6%**	**10.3%**	**100.0%**	**n/a**

MIECHV client racial and ethnic diversity is generally reflective of the populations at risk for adverse health outcomes (Table 15). The Nevada MIECHV Program is examining whether populations served are in proportion to the risks associated with the health outcomes of interest to Nevadans and identified in this report.

Table 15. Comparison of MIECHV Participant and State Population, by Race

	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unknown	Total Participants Served by MIECHV
Number of Adults Served by MIECHV (FFY2018)	27	10	55	7	358	30	14	**501**
Percent of Adults Served by MIECHV (FFY2018)	5%	2%	11%	1%	71%	6%	3%	**100%**
Percent of Adults by Race in Nevada (2019)	1%	12%	13%	1%	53%	5%	n/a	n/a
Difference (MIECHV compared to Nevada)	***4%***	***-10%***	***-2%***	***1%***	***19%***	***1%***	n/a	n/a
Number of Children Served by MIECHV (FFY2018)	34	6	47	8	364	69	14	**542**
Percent of Children Served by MIECHV(FFY2018)	6%	1%	9%	1%	67%	13%	3%	**100%**
Percent by Race of Nevada Public School Student Enrollment (School Year 2017/18)	1%	6%	11%	1%	33%	6%	n/a	n/a
Difference (MIECHV compared to Nevada)	***5%***	***-4%***	***-2%***	***0%***	***35%***	***7%***	n/a	n/a

[38] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: Natality Information, Live Births. Retrieved December 11, 2019 from https://wonder.cdc.gov/natality.html.
[39] CDC Wonder Natality.
[40] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=DP03%09&tid=ACSDP5Y2017.DP03.
[41] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=DP03%09&tid=ACSDP5Y2017.DP03.
[42] American Community Survey. (2017). Table S0101. Age and sex. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=s0101&tid=ACSST5Y2017.S0101.

Policies, training requirements, or initiatives to address cultural and linguistic humility or health equity

Service provider/partner or public health professionals in MIECHV who responded to the survey were asked to select the kinds of policies, training requirements, or initiatives that have been or are being implemented by their organization to address cultural and linguistic humility or health equity. Understanding this information highlights the potential to help MIECHV LIAs reach and serve at-risk, vulnerable populations more effectively. Among 13 MIECHV survey respondents, over half (54%) responded they work to increase culturally and linguistically appropriate materials and staff behaviors, followed by just over one-third (38%) reporting they have implemented implicit bias training (Table 16). Almost one-third (31%) of the 13 survey respondents reported they have obtained a safe space designation. Two (15%) respondents indicated they include non-binary gender and sexual minority options on demographic forms. Four (31%) respondents indicated they have no policies, training, or initiatives to address cultural and linguistic humility or health equity and five respondents (38%) report they are currently developing a plan to address health equity/disparities.

Table 16. Strategies to Increase Capacity for Culturally Competent service Delivery, MIECHV Survey Respondent (n=13)

Response Option	Number	Percent
Increasing culturally and linguistically appropriate materials and staff behaviors	7	54%
Developing a plan to address health equity or health disparities	5	38%
Implicit bias training	5	38%
Obtaining a safe space designation	4	31%
Including non-binary gender and sexual minority options on demographic forms	2	15%
None	4	31%

Gaps in staffing, community resources, and other requirements for delivering evidence-based home visiting services

Referral Network Adequacy

Community member and MCH professional and service provider survey results add context to network adequacy for making successful referrals, a key component of the Nevada MIECHV Program. For example, less than half (48%) of MCH professional and service provider respondents generally rated the adequacy of their community network of partners and resources to successfully refer clients as "acceptable." Another 29 percent reported network adequacy as "very poor/poor" (Table 17).

Table 17. Referral Network Adequacy

	Very Poor/Poor	Acceptable	Good/Very Good
Network Adequacy	29%	48%	23%

The perceived quality of the referral network varied to some extent by county and region (Table 18). Providers in Carson City were more likely to report a "poor" network whereas Washoe and Clark County providers generally thought it was "acceptable." The rural regions, including Douglas, Lyon, and Storey counties, were generally split on whether the referral network met the needs of their MCH population groups. Frontier regions predominately viewed the referral network as "acceptable" with eight of the 11 frontier counties reporting an "acceptable" rating.

Table 18. Quality of community networks for making successful referrals

Region	Service Area	Poor	Acceptable	Good	Very Good
Statewide	Nevada (n=10)	30%	50%	20%	0%
Urban	Carson City (n=19)	42%	37%	16%	5%
Urban	Clark (n=10)	29%	58%	13%	0%
Urban	Washoe (n=31)	27%	50%	14%	9%
Rural	Storey (n=12)	40%	40%	20%	0%
Rural	Lyon (n=29)	42%	42%	17%	0%
Rural	Douglas (n=4)	42%	42%	17%	0%
Frontier	Churchill (n=12)	30%	50%	20%	0%
Frontier	Elko (n=15)	31%	52%	14%	3%
Frontier	Esmeralda (n=10)	25%	50%	25%	0%
Frontier	Eureka (n=13)	42%	33%	25%	0%
Frontier	Humboldt (n=12)	27%	47%	27%	0%
Frontier	Lander (n=9)	20%	50%	30%	0%
Frontier	Lincoln (n=19)	23%	54%	23%	0%
Frontier	Mineral (n=12)	56%	33%	11%	0%
Frontier	Nye (n=5)	32%	32%	32%	5%
Frontier	Pershing (n=22)	42%	33%	25%	0%
Frontier	White Pine (n=11)	18%	64%	18%	0%

MCH professionals and service providers generally rated the difficulty in identifying a referral when one was needed as slightly (33.3%) to moderately difficult (33.3%) (Table 19).

Table 19. Difficulty in Identifying a Referral When One is Needed

Extremely difficult	Very difficult	Moderately difficult	Slightly difficult	Not at all difficult	I don't know, I have not needed or requested a referral
1.0%	4.9%	33.3%	33.3%	19.6%	7.8%

The top referrals typically made for MIECHV clients include mental health services (69.2%) and parenting information (52.9%) (Table 20). Approximately half (49%) of providers reported their typical referral was for substance use treatment, such as drug or alcohol counseling, and services addressing intimate partner/domestic violence. The next set of typical referrals are for infants and young children, including early intervention services (47.1%), infant feeding, including breastfeeding support (47.1%), and prenatal care (43.3%). Home visiting was a referral type for almost one third of MCH professional and service provider respondents (31.7%).

Table 20. Typical referral (n=104)

Answer Choices	Percent	Number
Mental health services, such as counseling	69.2%	72
Parenting information	52.9%	55
Substance use treatment, such as drug or alcohol counseling	49.0%	51

Services addressing intimate partner/domestic violence	49.0%	51
Early intervention: early identification of the need for testing and support services for young children with developmental delays	47.1%	49
Infant feeding, including breastfeeding support	47.1%	49
Prenatal care	43.3%	45
Well visits with a primary care provider or family doctor	41.4%	43
Pregnancy or birth-related mental health services	39.4%	41
After pregnancy and between pregnancy care	37.5%	39
Support for quitting smoking	37.5%	39
Well-baby and well-child visits with a pediatrician or family doctor	36.5%	38
Services to prevent injuries and violence, including self-harm	34.6%	36
Wellness services, such as those to increase healthy eating and physical activity	34.6%	36
Services to reduce stress, such as respite or time for yourself	33.7%	35
Specialists and treatment centers	33.7%	35
Creating safe sleep areas	32.7%	34
Home visiting	31.7%	33
Assistance getting, understanding, and using birth control	29.8%	31
Information on preventing infant deaths	29.8%	31
Services and treatment for infants and young children born with health issues related to drug, tobacco, or alcohol exposure/use	29.8%	31
Programs that help youth develop social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood	28.9%	30
Sexual health education	27.9%	29
Support to navigate the system of care for children and youth with special health care needs	26.0%	27
Newborn screening information	25.0%	26
Diagnostic testing as a result of newborn screening (e.g., follow up hearing testing and genetic testing)	22.1%	23
Programs that promote community inclusion for children and youth with special health care needs	22.1%	23
Pre-pregnancy care	20.2%	21
Training for parents/caregivers on care coordination	20.2%	21
Availability of medical homes (i.e., patient-centered comprehensive coordinated care)	20.2%	21
Bullying prevention	18.3%	19
I do not make referrals	15.4%	16
Lead poisoning prevention	13.5%	14
Transition to adult health care system support	11.5%	12

Community member responses suggest it is not just identification of a referral that is a challenge. It is also a challenge to overcome the many barriers or obstacles making it hard for MIECHV clients to access/use the referral.

As shown in Table 21, the top three barriers according to MCH professionals and service providers include referrals being unaffordable or clients having concerns about the cost of a treatment or service (71.2%), followed by health insurance not covering treatment or services (64.4%), and clients lacking transportation to get to locations where services are provided (63.5%). Lack of service providers was also a reported barrier for clients by more than half (59.6%) of the surveyed MCH professionals and service providers.

Table 21. MCH professionals and service providers report on barriers for people to use referrals

Answer Choices	Percent	Number
Financial/ affordability / concerned about the cost of treatment or service	71.2%	74
Health insurance does not cover a treatment or service	64.4%	67
Lack transportation to get to locations where services are provided	63.5%	66
Lack of service providers	59.6%	62
Did not meet program/financial assistance qualifications	45.2%	47
Understanding eligibility or found ineligible	42.3%	44
Inability to schedule an appointment soon enough	42.3%	44
Bad experience/quality of service	39.4%	41
Lack comfort in talking with a health professional or other service provider about personal problems	33.7%	35
Felt they didn't need it	33.7%	35
Too much paperwork	31.7%	33
Needed help to complete paperwork	26.9%	28
I do not make referrals	12.5%	13
Provider implicit bias	7.7%	8
Other, please describe:	4.8%	5

Optional Considerations

The Community Survey also collected perspectives on where MCH population groups turn for information about services and resources in their community. This data presents an opportunity to improve outreach efforts and/or tailor communications via specific information channels for specific MCH population groups. As shown in Table 22, word of mouth (from friends and family) and government services (Women, Infants and Children [WIC], local health departments, etc.) are two communication channels reported to reach both women and children who are looking for information about health or to talk about health. To target women specifically, in addition to these two channels, health clinics/hospitals (89%), virtual/internet groups/ social media (81%), and community-based organizations (75%) are places where survey respondents think women go for information about health or to talk about health.

Table 22. Where do people go for information about health or to talk about health, Community Survey

	Women/Maternal Issues, including prenatal, pregnancy, and post-natal care	Caregivers of infants (Children zero up to 1)	Total
I don't know	52%	56%	25
Faith-based organizations	67%	55%	33
Community based organizations	75%*	63%	48
Advocacy organizations	51%	41%	41
Schools	20%	13%	45
Government services (Women, Infants and [WIC], local health departments, etc.)	88%*	77%*	52
Health clinics/hospitals	89%*	67%	57
Virtual/internet groups/ social media	81%*	64%	47
Face-to-face groups	53%	44%	36
Libraries	48%	33%	21
Ads or brochures in public places	56%	52%	25
Word of mouth (from friends and family)	85%*	79%*	48
Nevada 211	63%	53%	19

** indicates where 75 percent or more respondents answered in the affirmative.*

Finally, MIECHV survey respondents shared their recommendations for improving the health, development, and wellbeing of MCH population groups in Nevada (n=6), including:

1. Access to comprehensive behavioral health services and holistic case management;
2. Increase the number of families served by home visiting;
3. Improve access to quality and accessible childcare;
4. Identify and implement new strategies to increase number of participating providers and cultivating support for MIECHV from local government and health districts;
5. Identify new and/or expanded funding sources for MIECHV; and
6. Encourage and support all agencies/programs serving pregnant and post-partum mothers and their children ages zero to five years in referring and working with each other to be able to provide more comprehensive and coordinated services.

While all Nevada counties need and benefit from MIECHV programming, there are a subset of counties at greater risk for negative children and family outcomes. In collaboration with MCH, HRSA considered a set of risk indicators as criteria for identifying target communities for Nevada's MIECHV (Appendix F). Indicators were grouped into five domains, including socioeconomic status, adverse perinatal outcomes, substance use disorder, crime, and child maltreatment. A county was identified as at-risk for any domain if half of the indicators within the domain were found to be greater than their comparable state average. Counties with two or more at-risk domains were then identified as at-risk.[43]

[43] HRSA methodology for defining a county at-risk using z-scores statistic, where if the proportion of indicators within each domain for which that county's z-score was greater than 1, that is, the proportion of indicators for which a given county is in the 'worst' 16% of all counties in the

Table 23 reveals the extent to which indicators within a domain were greater than the state average and therefore suggest a county is high risk for poor MCH outcomes. Clark, Mineral, Nye, and Washoe counties are considered high risk based on the criteria.

Table 23: At Risk Counties, by Domain[44]

Percent of Indicators Greater than Comparable State Average						
County	**Socio Economic Status**	**Adverse Perinatal Outcomes**	**Substance Use Disorder**	**Crime**	**Child Maltreatment**	**Number of At-Risk Domains (domain is 0.5 or greater)**
Churchill	0	0	0	1	0	1
Clark	**0**	**0.5**	**0.5**	**0.5**	**0**	**3***
Douglas	0.25	0	0	0.5	0	1
Elko	0	0	0	0	0	0
Esmeralda	0	0	0	0	0	0
Eureka	0	0	0	0	0	0
Humboldt	0.25	0	0	0	0	0
Lander	0	0	0	0	0	0
Lincoln	0.25	0	0	0	0	0
Lyon	0.5	0	0	0	0	1
Mineral	**0.5**	**0.5**	**0**	**0**	**0**	**2***
Nye	**0.5**	**1**	**0**	**0**	**0**	**2***
Pershing	0.25	0.5	0	0	0	1
Storey	0	0	0	0.5	0	1
Washoe	**0.25**	**0**	**0.75**	**0.5**	**1**	**3***
White Pine	0	1	0	0	0	1
Carson City	0	0	0	0.5	0	1

**County identified as at risk*

The indicators used in the HRSA analysis are referenced throughout the Title V MCH Needs Assessment and have therefore informed additional findings relevant to MIECHV as well as to larger MCH efforts.

MCH Population Group Trends

In 2019, Nevada had a population density of 16.7 people per square mile; however, 90.5 percent of the population live in urban areas where population density is 116.2 people per square mile.[45] Another 3.6 percent of Nevada residents live in rural areas, where population density is 22.1 people per square mile, and 5.9 percent live in areas considered to be frontier, in which there are only 1.2 people per square mile.[46] The State Demographer's Office indicates Nevada has three urban counties (Carson City, Clark, and Washoe), three rural counties (Douglas, Lyon, and Storey), and eleven counties designated as

state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains is identified as at-risk.

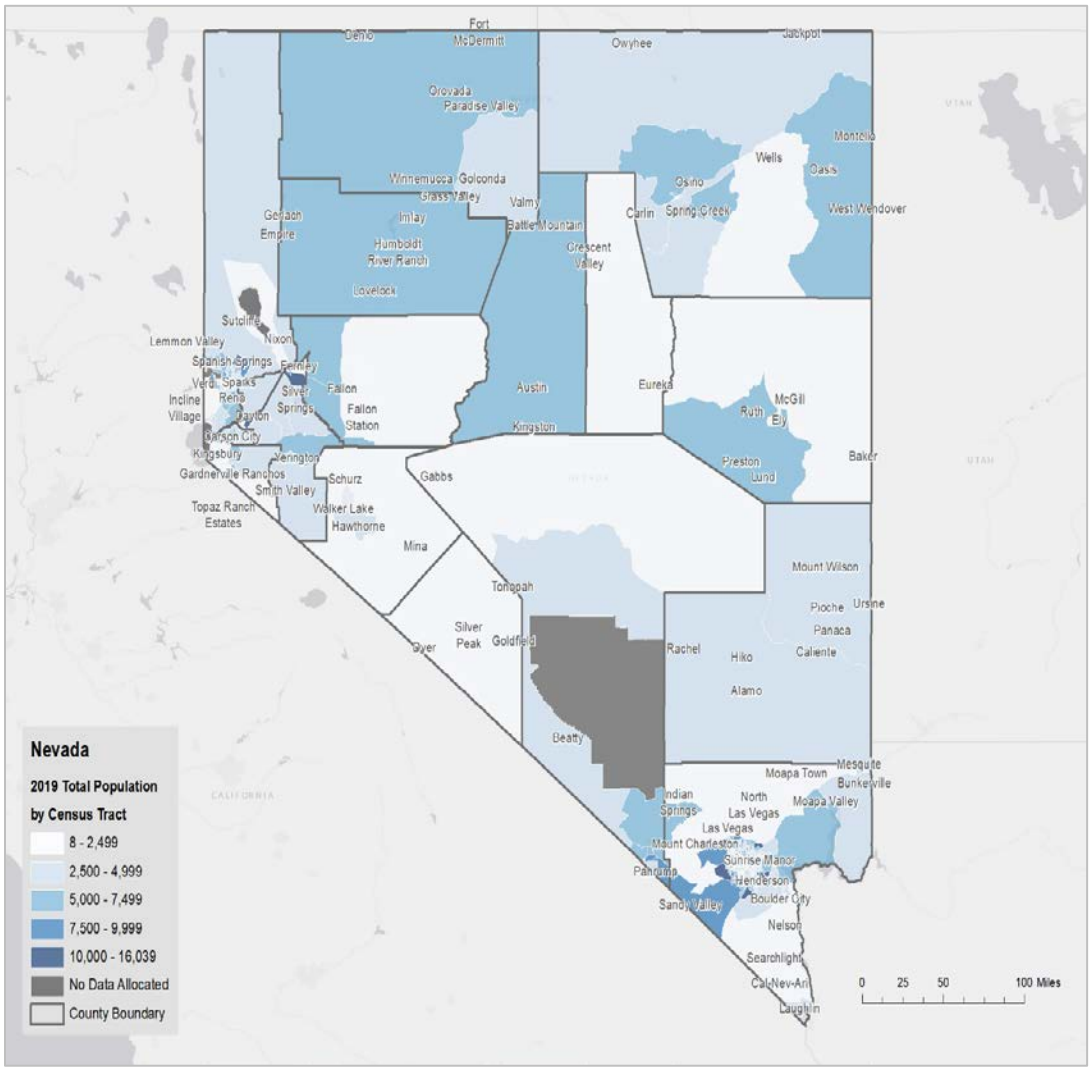
[44] HRSA, MIECHV Needs Assessment Data Summary.

[45] Esri, 2019.

[46] Esri, 2019.

frontier (Churchill, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Mineral, Nye, Pershing and White Pine). Figure 3 is a Nevada map showing total population in 2019, which was estimated to be 3,088,888 persons.[47]

Figure 3. Total Population, by Census Tract, 2019[48]

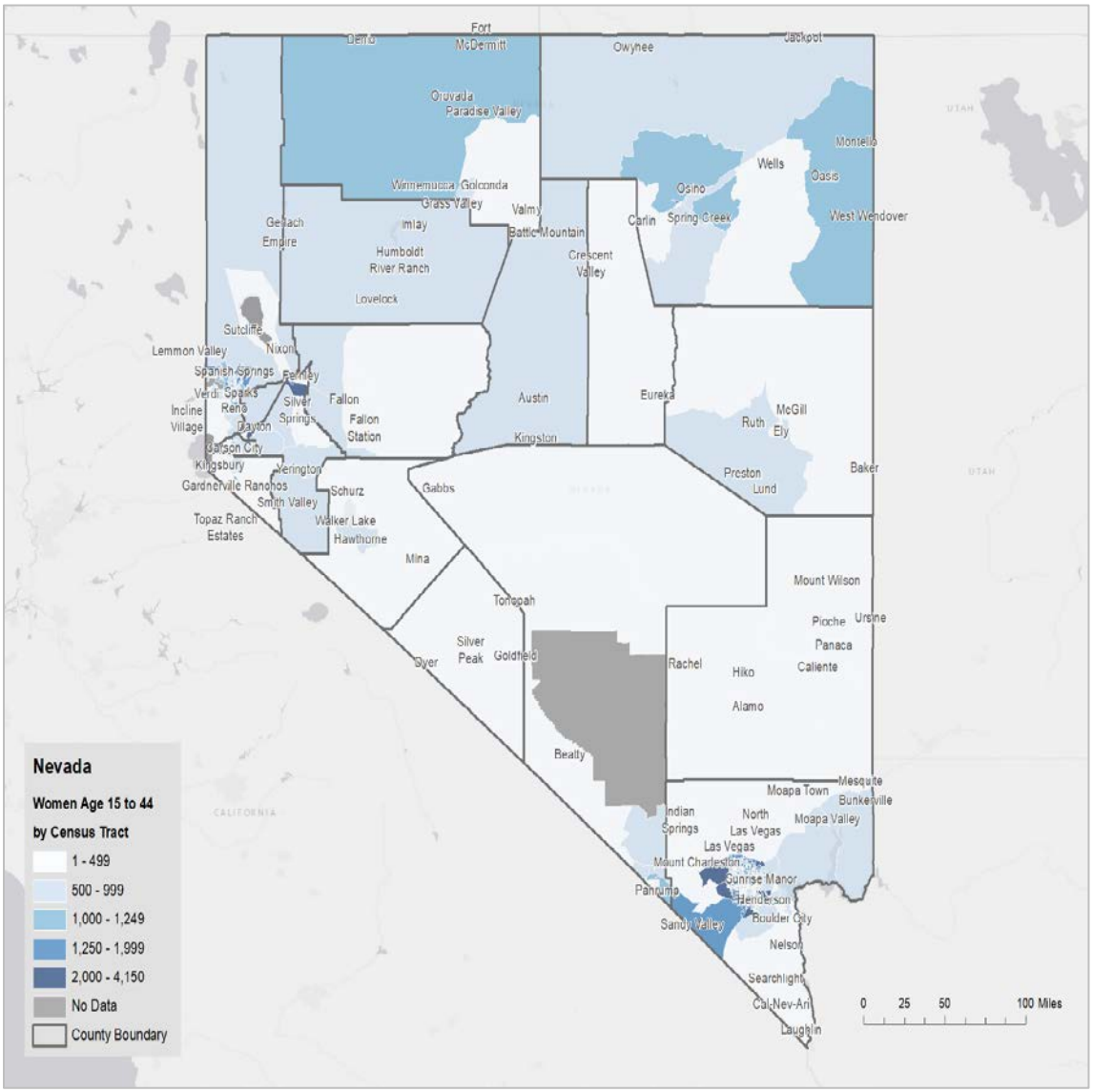


MCH Population Estimates and Growth

Maps below show the number of women and children living in Nevada in 2019. They follow similar trends to the overall population, primarily living in urban and frontier areas (Figures 4 and 5).

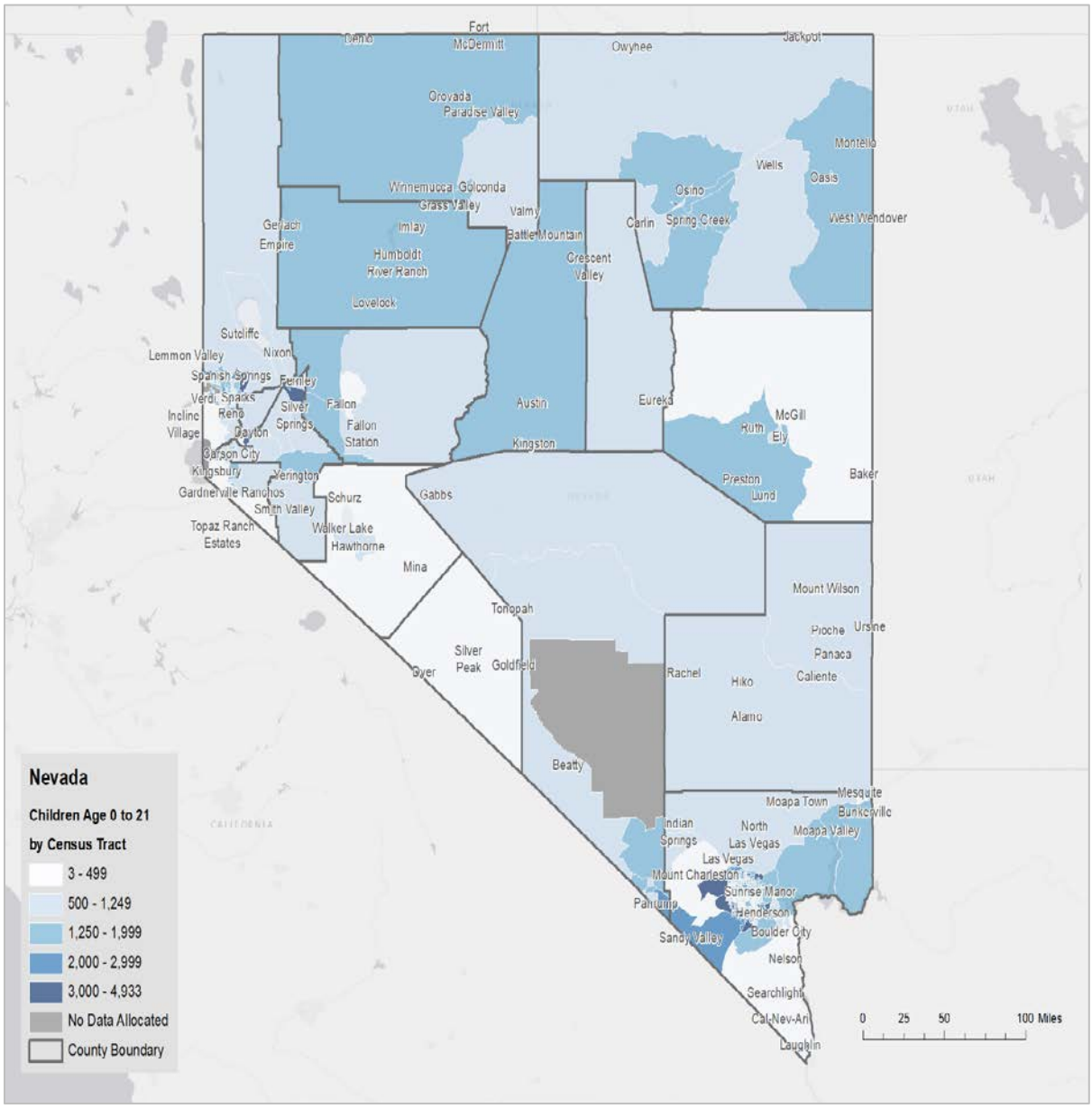
[47] Esri, 2019.
[48] Esri, 2019.

Figure 4. Women age 15 to 44 years, by Census Tract, 2019[49]



[49] Esri, 2019.

Figure 5. Children Age Zero to 21 years, by Census Tract, 2019[50]



Women of childbearing age currently represent 19.7 percent (n=609,668) of Nevada's population.[51] This group is projected to experience an annual growth rate (AGR) of 1.8 percent by 2024 (slightly higher than the state population AGR of 1.6%). Children, ages zero to 21 years, currently represent 27.6 percent (n=851,521) of Nevada's population, which is projected to increase at an AGR of 1.3 percent by 2024. Table 24 shows AGR by MCH population group and Nevada county.

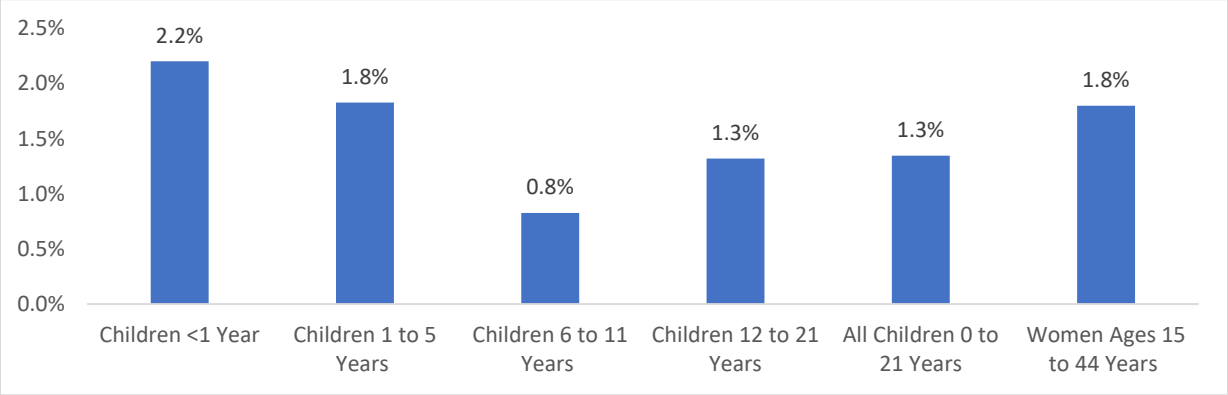
[50] Esri, 2019.
[51] Esri, 2019.

Table 24. Population Annual Growth Projections, by County, 2019 and 2024[52]

	Total Population			Women of Childbearing Age (15 to 44 Years)			Children (0 to 21 Years)		
	2019	**2024**	**AGR**	**2019**	**2024**	**AGR**	**2019**	**2024**	**AGR**
Carson City	56,289	57,412	0.4%	9,305	9,543	0.5%	13,495	12,823	-1.0%
Clark	2,257,890	2,455,999	1.7%	459,906	505,842	1.9%	630,849	686,281	1.7%
Churchill	22,938	23,318	0.3%	4,110	4,113	0.0%	6,244	6,012	-0.8%
Douglas	50,119	52,345	0.9%	7,182	7,523	0.9%	10,919	10,609	-0.6%
Elko	55,201	58,629	1.2%	10,670	11,312	1.2%	17,345	18,372	1.2%
Esmeralda	782	800	0.5%	78	81	0.8%	156	166	1.3%
Eureka	1,925	1,911	-0.1%	309	295	-0.9%	507	530	0.9%
Humboldt	17,713	18,364	0.7%	3,194	3,269	0.5%	5,288	5,487	0.7%
Lander	5,645	5,527	-0.4%	978	955	-0.5%	1,657	1,649	-0.1%
Lincoln	5,251	5,150	-0.4%	768	730	-1.0%	1,361	1,303	-0.9%
Lyon	56,984	60,525	1.2%	9,508	10,005	1.0%	15,292	15,485	0.3%
Mineral	4,647	4,551	-0.4%	675	651	-0.7%	911	836	-1.7%
Nye	48,813	51,028	0.9%	6,190	6,366	0.6%	10,304	10,467	0.3%
Pershing	6,652	6,583	-0.2%	795	791	-0.1%	1,441	1,448	0.1%
Storey	4,142	4,257	0.5%	507	511	0.2%	751	728	-0.6%
Washoe	481,595	519,315	1.5%	93,756	101,956	1.7%	132,065	135,339	0.5%
White Pine	9,815	9,663	-0.3%	1,339	1,303	-0.5%	2,325	2,292	-0.3%
Nevada	**3,088,888**	**3,337,845**	**1.6%**	**609,668**	**665,628**	**1.8%**	**851,521**	**910,415**	**1.3%**

The greatest AGR increase is projected to occur among children under one year (Figure 6) at 2.2 percent.[53] Young children ages one to five years and women ages 15 to 44 years are both expected to grow 1.8 percent per year by 2024 and adolescents at 1.3 percent. Children six to 11 years are expected to experience the least annual growth at 0.8 percent.

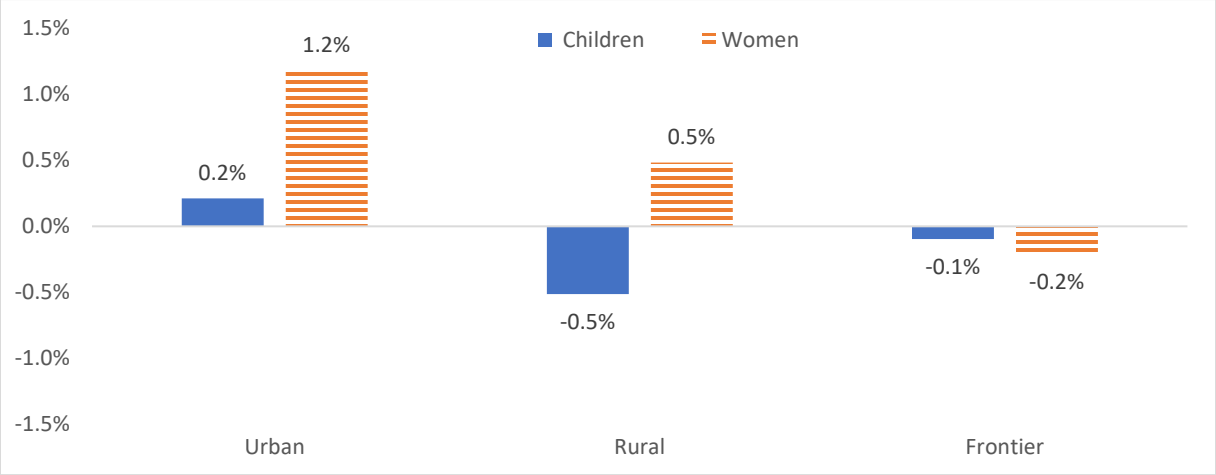
Figure 6. Projected Annual Growth Rate by MCH Population Age Group, Nevada, 2019 to 2024[54]



[52] Esri, 2019.
[53] Esri, 2019.
[54] Esri, 2019.

Urban counties are expected to see increases in the population of both women and children (Figure 7). Rural regions are expected to see an increase in the population of women and a decrease in the population of children, while frontier counties should see a decrease in both population groups. However, there are exceptions to this trend in three frontier counties: Elko, Humboldt, and Nye, which are expected to experience small increases in both population groups.

Figure 7. Projected Percent Change in Population by Region, Nevada, 2019 and 2024[55]



Population Race and Ethnicity

Table 25 provides the number and percent of Nevada's population by race and ethnicity in 2019.[56] Slightly more than one half of Nevada's population (52.6%) were non-Hispanic White. Nearly one third (29.6%) were Hispanic Origin of Any Race. The other racial groups and their respective percentages were Black or African American (13.1%), non-Hispanic Asian/Pacific Islander (12.1%), and American Indian, Eskimo, Aleut, (1.2%). Thirty-two Indian reservations stretch across Nevada.[57]

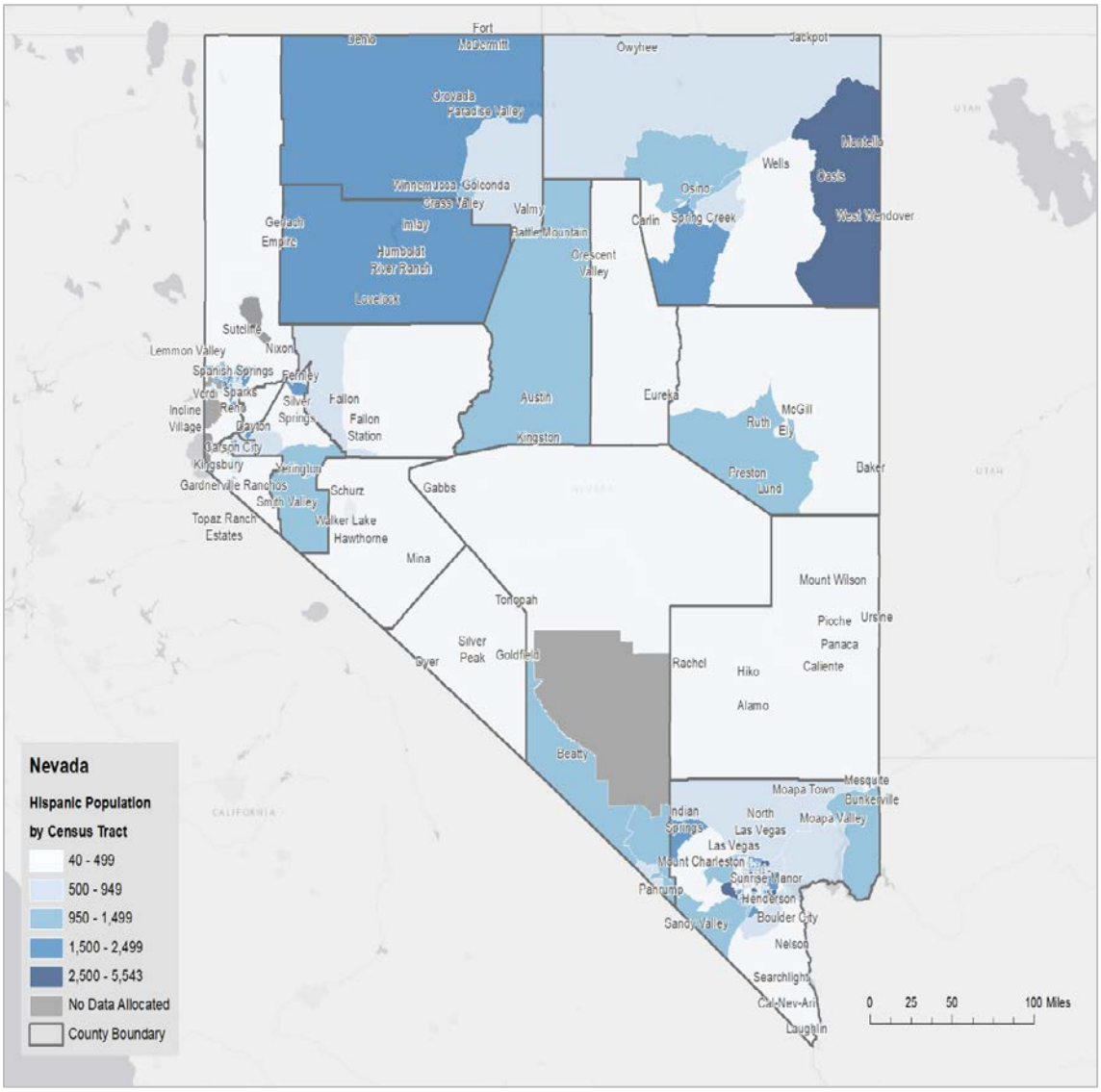
Table 25. Population by Race and Ethnicity, Number and Percent of State Population, Nevada, 2019[58]

Race/Ethnicity	Number	Percent of Nevada Population
White	1,624,154	52.6%
Black or African American	284,353	13.1%
American Indian, Eskimo, Aleut	25,703	1.2%
Asian/Pacific Islander	263,705	12.1%
Hispanic Origin of Any Race	913,345	29.6%

[55] Esri, 2019.
[56] Esri, 2019.
[57] Nevada's Indian Territory. (n.d.). Map of Nevada Tribes. Retrieved November 7, 2019 from https://nevadaindianterritory.com/map/.
[58] Esri, 2019.

There is racial and ethnic diversity across Nevada for Hispanic representation, in urban and northern frontier counties (Figure 8).

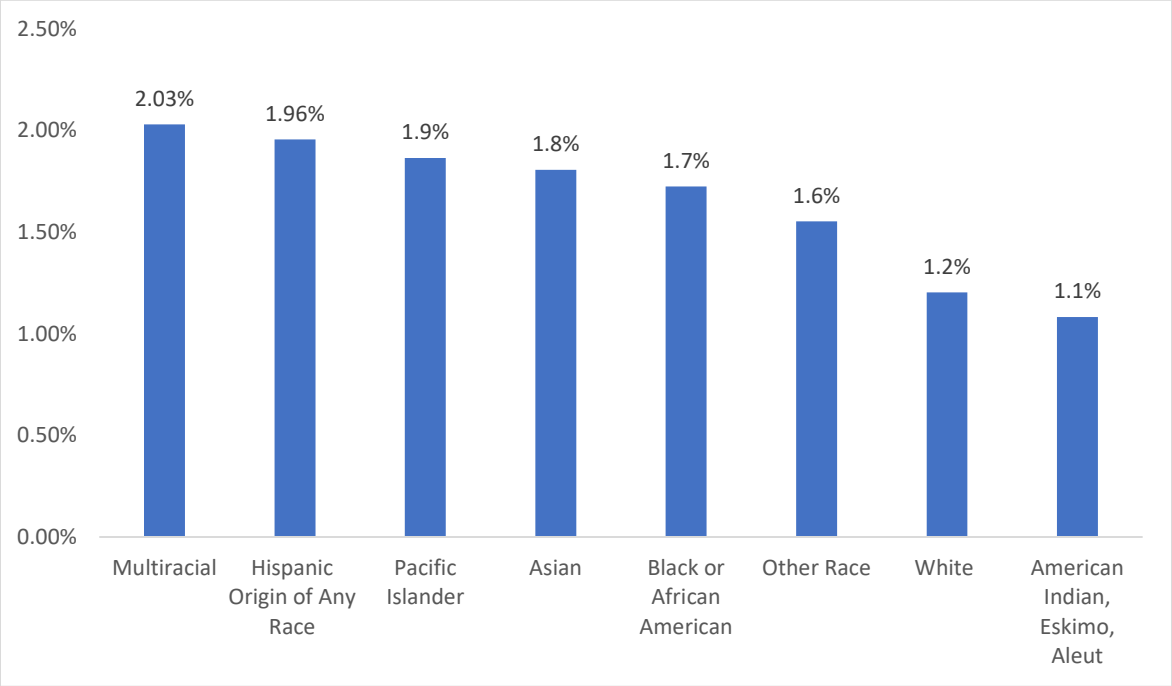
Figure 8. Hispanic Population, by Census Tract, 2019[59]



[59]Esri, 2019.

Figure 9 illustrates the projected change in race and ethnicity from 2019 to 2024. During this four-year period, populations projected to increase the most are those identifying as Multiracial (2.03%) and Hispanic (1.96%).[60]

Figure 9. Annual Population Growth Rates by Race and Ethnicity Groups, Nevada, 2019 to 2024[61]



Language Spoken

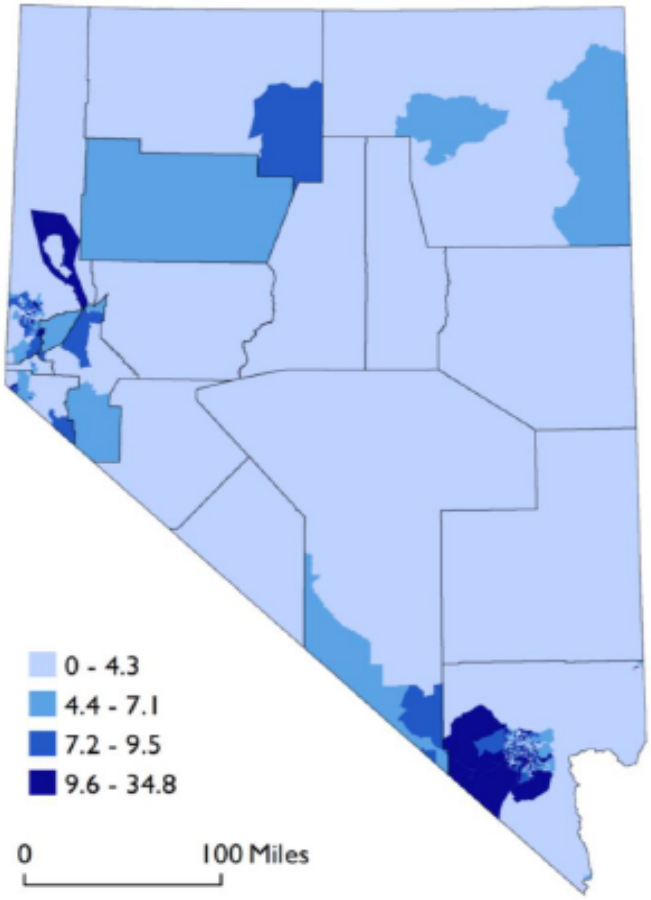
More Nevada residents speak a language other than English at home (30.5%) compared to 21.3 percent nationally. Of those who speak another language other than English at home, 70 percent speak Spanish (compared to 62% nationally) and 40 percent speak English less than "very well" (similar to national rate of 41%). Among children ages five to 17 years, 32.6 percent speak another language other than English at home. Among those ages 18 to 64 years, 32.4 percent speak a language other than English at home.[62]

Sexual Orientation and Gender Identity

In 2017, 5.5 percent of the adult population in Nevada identified as Lesbian, Gay, Bisexual, and/or Transgender (LGBT), making Nevada the third highest state in the nation for proportion of LGBT adults as a percentage of the total population.[63] The majority of those who identified as LGBT were White (49%), female (53%), and between the ages of 18 and 24 years (36%).[64] Regionally, there is variation among counties regarding the proportion of same-sex couple households (Figure 10).

[60] Esri, 2019.
[61] Esri. 2019.
[62] American Community Survey. (2017). Characteristics of People by Language Spoken at Home 2013-2017. Retrieved November 7, 2019, from https://data.census.gov/cedsci/table?q=S1603&hidePreview=false&tid=ACSST5Y2017.S1603&vintage=2018.
[63] The Williams Institute, UCLA School of Law. (2019, January). LGBT Demographic Data Interactive. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density. Note that LGBT is acronym used by the data source.
[64] The Williams Institute, UCLA School of Law. (2019, January). LGBT Demographic Data Interactive. Retrieved from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density.

Figure 10. Rate of Same-Sex Couples per 1,000 households, by Census Tract, 2010[65]



Source: Gates, G.J. & Cooke, A.M. 2010 US Census data, same-sex couples snapshot. Los Angeles, CA: The Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Census2010Snapshot_Nevada_v2.pdf Retrieved August 2019.

For youth, according to 2017 Nevada YRBS data, 83.7 percent of high school students self-identified as heterosexual or straight, while 9.6 percent identified as bisexual, 3.6 percent were not sure about their sexuality, and 3 percent identified as gay or lesbian.[66]

Per the Public Religious Research Institute, across Nevada, 68 percent of adults reported they favored LGBT non-discrimination laws (in housing, jobs, and public accommodations), while 26 percent oppose these laws. These rates resemble national opinion (69% vs 24% respectively).[67] Regarding same sex marriage, statewide, 70 percent of Nevadans support same sex marriages, while 23 percent oppose.[68]

[65] As in Nevada's Department of Health and Human Services 2019 Nevada State Health Needs Assessment.
[66] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[67] Public Religion Research Institute. (n.d.) 2018 American Values Atlas. Retrieved December 19, 2018 from http://ava.prri.org/.
[68] Public Religion Research Institute. (n.d.) 2018 American Values Atlas. Retrieved December 19, 2018 from http://ava.prri.org/.

Trends in Social Determinants of Health: Risk and Protective Factors

Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work and age that shape health. These determinants are interconnected drivers of adverse health outcomes for MCH population groups. The underlying risk and protective factors associated with these outcomes are shared across health issues and include discrimination; insufficient health care coverage and access to services; economic injustice; as well as insufficient or discriminatory health, educational, economic, and social policies. This Needs Assessment sought to explore these shared risk and protective factors across MCH health issues as important context for improving the health and wellbeing of MCH population groups.

According to a brief published by the Robert Wood Johnson Foundation, data reveal maternal and child health in the U.S. is far worse than it should be given this is one of the wealthiest countries with the most advanced health care services in the world.[69] For many MCH indicators, racially and ethnically diverse and low-income families are disproportionately negatively impacted. Given the fact many health care, social, and economic issues impact the health of women, children, and adolescents, multifaceted approaches are needed to improve health among these MCH population groups.

This section explores a subset of these conditions, including Nevada's economy and its health care, criminal justice, children's protective services, education, and public health systems. Additionally, this section explores the extent to which poverty and homelessness exist in Nevada's communities. Finally, select protective factors described in this assessment include protective family routines and habits and social connectedness.

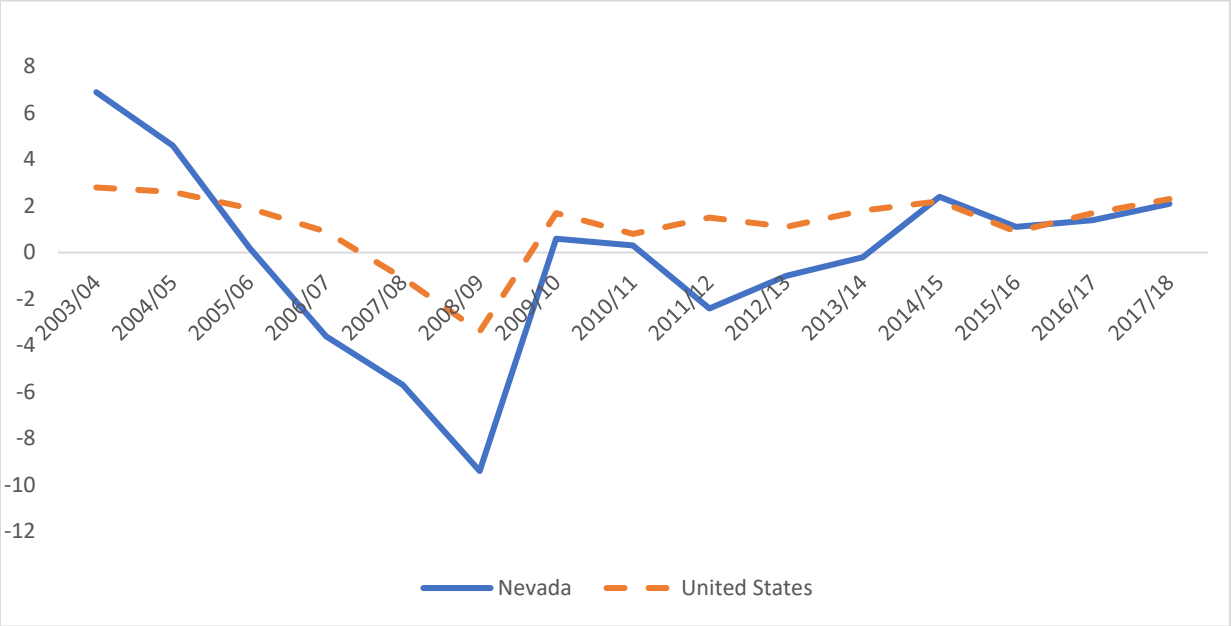
Economy

Nevada's economy has been growing since being hard hit during the 2008-2010 recession, with only positive growth since 2013-2014. The Bureau of Economic Analysis calculates the gross domestic product (GDP) of states, as well as the nation; GDP is the sum of what individuals, businesses and governments spend on goods and services, as well as investment and trade. Figure 11 shows the annual change in GDP from 2003 to 2018 for the U.S. and Nevada. Since 2012, Nevada's economy grew in 20 consecutive quarters. Year-over-year GDP growth in Nevada was 24th in the nation at 3.1 percent. The national GDP growth over the same period was 3.2 percent.[70]

[69] Ascend at the Aspen Institute. (2019, April 19). Giving Kids a Healthy Start to Life: A Briefing for New State Policymakers. Retrieved from https://www.rwjf.org/en/library/research/2019/04/maternal-and-child-health.html.

[70] Nevada Workforce. (August 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. Department of Employment, Training & Rehabilitation. Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.

Figure 11. Percent Change in GDP, United States and Nevada, 2003 to 2018 [71]



The largest contributors to Nevada's total GDP are real estate/rental leasing (14.7%) and accommodation/food services (11.7%). The industries with the largest over the year growth in Nevada's total GDP included manufacturing at 5.3 percent, followed by construction at 4.3 percent. Growth in arts, entertainment, and recreation represents three percent of Nevada's total GDP growth.[72]

Employment

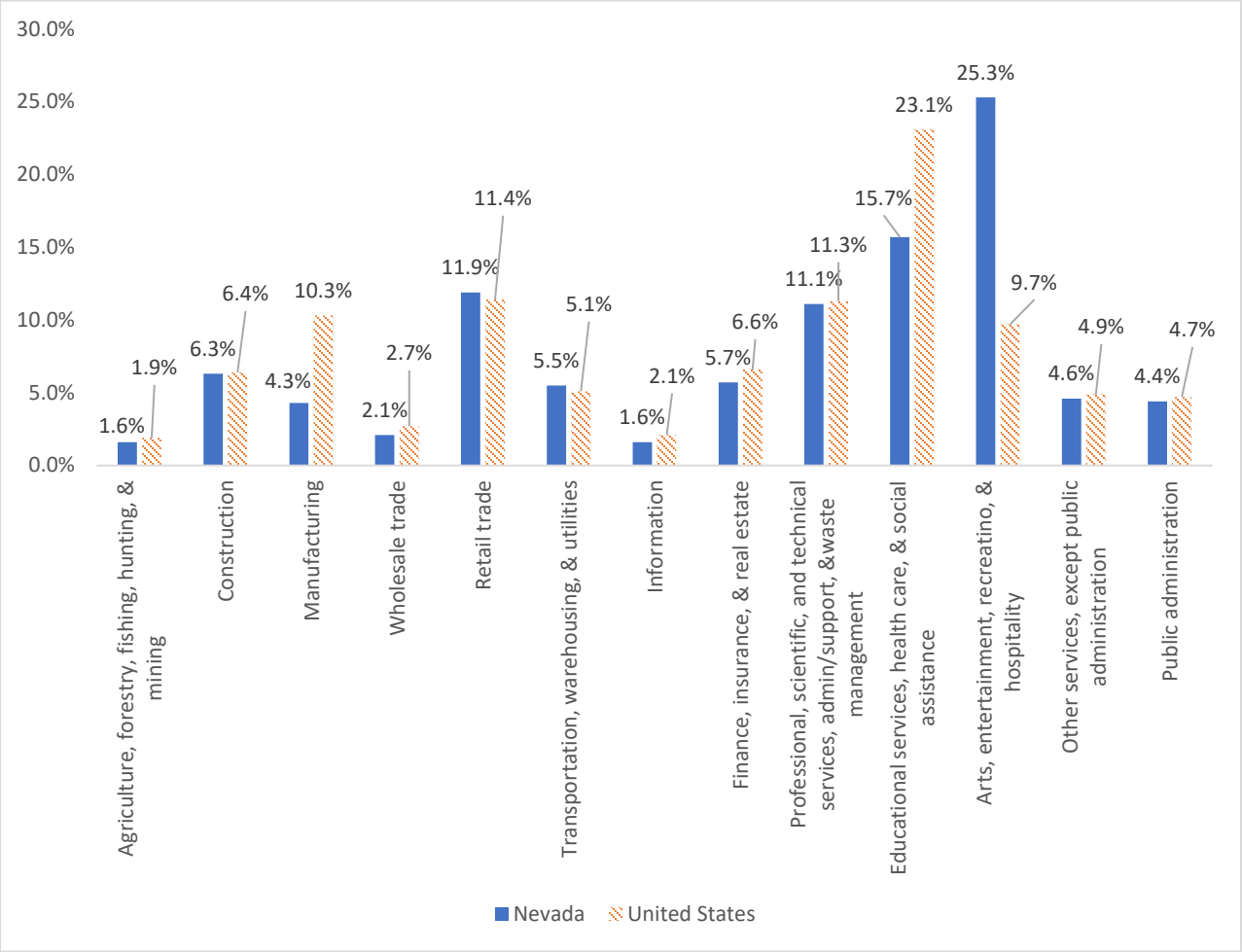
Approximately one in four (25.3%) currently employed Nevada residents are employed by the arts, entertainment, recreation, and hospitality industries, followed by education, health, and social services industries (15.7%).[73] However, the 15.7 percent of people employed in the education, health, and social services industries is much lower than the percent employed in these industries across the U.S. (23.1%), suggesting this is an under-resourced area in Nevada. Figure 12 displays a chart revealing employment in Nevada by type of industry.

[71] Nevada Workforce. (August 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. Department of Employment, Training & Rehabilitation. Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.

[72] Nevada Workforce. (August 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. *Department of Employment, Training & Rehabilitation.* Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.

[73] Nevada Workforce. (August 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. *Department of Employment, Training & Rehabilitation.* Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.

Figure 12. Percent Employment by Industry, United States and Nevada, September 2019 [74]



The unemployment rate for Nevada during the 12-month period of July 2018 to June 2019 was 4.1 percent, higher than the U.S. rate of 3.5 percent.[75] Unemployment rates vary by county, with a high of 5.7 percent unemployed in Nye County and a low of 2.7 percent in Eureka County.[76] Since 2014, unemployment rates in Nevada have been declining for all races and ethnicities. However, while Black or African Americans have tended to have higher unemployment rates, higher than those of the state or any city in Nevada, they have one of the largest decreases in unemployment from 15 percent to 5.9 percent between 2014 to 2019.[77]

[74] Nevada Workforce. (September 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. *Department of Employment, Training & Rehabilitation.* Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.
[75] Bureau of Labor Statistics. Data: Local Area Unemployment Statistics. (2018) Retrieved November 7, 2019 from https://www.bls.gov/lau/lastrk18.htm.
[76] Bureau of Labor Statistics. Data: Local Area Unemployment Statistics. (2018) Retrieved November 7, 2019 from https://www.bls.gov/lau/lastrk18.htm.
[77] Nevada Workforce. (September 2019). Nevada Economy in Brief: a monthly review of workforce and economic information. *Department of Employment, Training & Rehabilitation.* Retrieved November 8, 2019, from http://nevadaworkforce.com/Portals/197/EIB/2019/Current_EIB.pdf.

Household Income

In 2018, median annual earnings in the U.S. for men working full time, year-round were $53,318, compared to just $41,690 for women – suggesting women earn $0.80 for every $1.00 earned by men.[78] The disparity differs by region in Nevada, as shown in Table 26.

Table 26. Earnings by Congressional District, Nevada, 2018[79]

Congressional District	Men	Women	Earnings Ratio	Ranking in the State
NV-01 (Las Vegas)	$35,355	$32,323	91.4%	1
NV-02 (Northern Nevada)	$51,608	$40,762	79.0%	4
NV-03 (Southern Clark County)	$56,228	$45,509	80.9%	3
NV-04 (Southern Nevada, including Northern Clark County)	$45,790	$39,903	87.1%	2

This pay disparity increases when considering female-headed single households. Median household income in Nevada has historically tended to be lower than national averages. According to the U.S. Census, Nevada's median family household income in 2017 was $65,469 compared to the rest of the nation at $70,850.[80] In 2017, the median household income in Nevada varied widely by county. The highest median household income was in Eureka County ($109,085) and the lowest was in Esmeralda County ($47,396).[81] Median household income also varies by type of household, with married couple families earning $78,378 and female-headed single parent families earning $29,427. The median annual earnings for females in Nevada for the 2013 to 2017 five-year period was $37,184, which is $8,282 less than the median annual earnings for males during that same time period ($45,466).[82]

Health Insurance and Access to Care

Health care insurance coverage is a fundamental component of access to care in the United States. People with health care insurance coverage are more likely to receive medical care, less likely to die early, and less likely to have poor health.[83] According to data retrieved from the ACS, 344,104 Nevadans

[78] American Community Survey. (2017). Table S2002 Median earnings in the past 12 months (in 2018 inflation-adjusted dollars) of workers by sex. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=median%20annual%20earnings&lastDisplayedRow=27&table=S2002&tid=ACSST5Y2018.S2002&t=Earnings%20%28Individuals%29&vintage=2018&mode=&hidePreview=true.

[79] American Community Survey. (2017). Table S2002 Median earnings in the past 12 months (in 2018 inflation-adjusted dollars) of workers by sex. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=median%20annual%20earnings&lastDisplayedRow=27&table=S2002&tid=ACSST5Y2018.S2002&t=Earnings%20%28Individuals%29&vintage=2018&mode=&hidePreview=true.

[80] American Community Survey. (2017). Table S2002 Median earnings in the past 12 months (in 2018 inflation-adjusted dollars) of workers by sex. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=median%20annual%20earnings&lastDisplayedRow=27&table=S2002&tid=ACSST5Y2018.S2002&t=Earnings%20%28Individuals%29&vintage=2018&mode=&hidePreview=true3-2017.

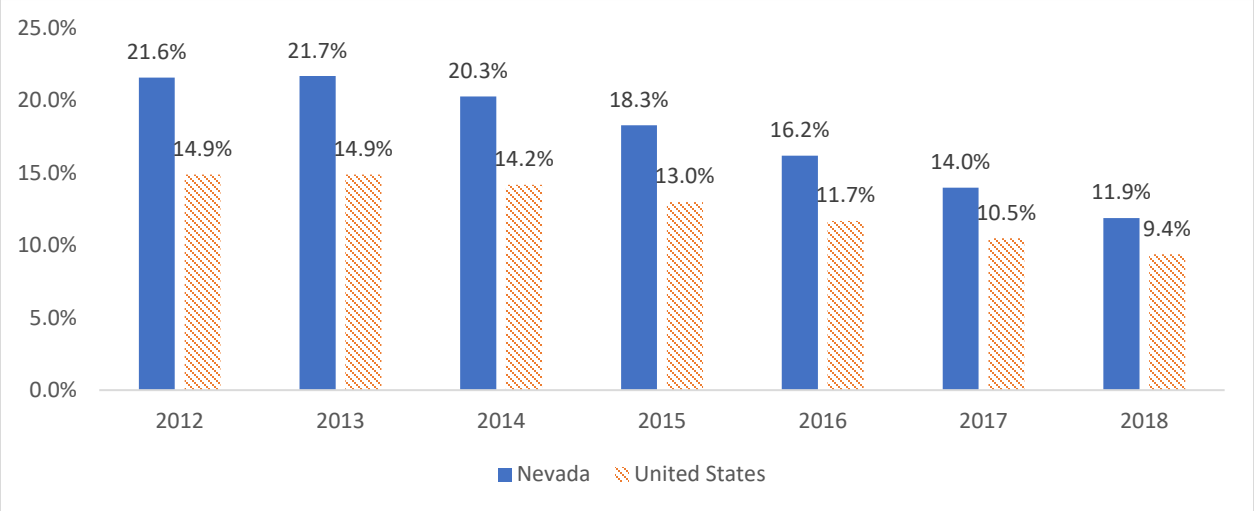
[81] American Community Survey. (2017). Median Income in the Last 12 Months. Retrieved November 7, 2019 from https://data.census.gov/cedsci/table?q=DP03%09&tid=ACSDP5Y2017.DP03.

[82] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=DP03%09&tid=ACSDP5Y2017.DP03.

[83] Healthy People 2020. (2019, November 16). Access to Health Services. Retrieved November 16, 2019, from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

(11.9%) were uninsured in 2018 (higher than the U.S. at 9.4%) as shown in Figure 13. [84] Nevada expanded Medicaid in 2014, and enrollment far surpassed projections, helping to reduce the uninsured rate by over eight percentage points in 2018. However, the uninsured percentage remained nearly twice as high in Nevada, at 11.9 percent, compared to other states that expanded Medicaid where the average uninsured rate was 6.6 percent in 2018. For states not expanding Medicaid, the uninsured rate was 12.4 percent in 2018. [85] Overall, while Nevada has greatly reduced the uninsured population by 44.9 percent between 2012 and 2018, and is closing the gap with the uninsured rate nationwide, it still remains higher.

Figure 13. Percent of Population Without Health Insurance, Nevada and United States, 2012 to 2018[86]



In 2017, among those uninsured, approximately 68,000 or 9.7 percent were younger than 18 years, almost double the rate for the same age group nationally (5.2%).[87] Additionally, only 62.2 percent of children in Nevada had consistent health care insurance coverage in the past year compared to 68.4 percent of children nationally.[88] Over time, this trend improved among children. However, uninsured rates among Nevada's children remained higher in 2017 than in the U.S. (Figure 14). Uninsured rates among children ages zero to 18 years dropped 44.3 percent, from a high of 17.4 percent in 2012 to 9.7 percent in 2017. Nationally, there was a smaller drop of 29.6 percent.

[84] American Community Survey. (2018). Table S2701. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=table%20S2701&g=&hidePreview=false&table=S2701&tid=ACSST1Y2018.S2701&lastDisplayedRow=31&vintage=2018.

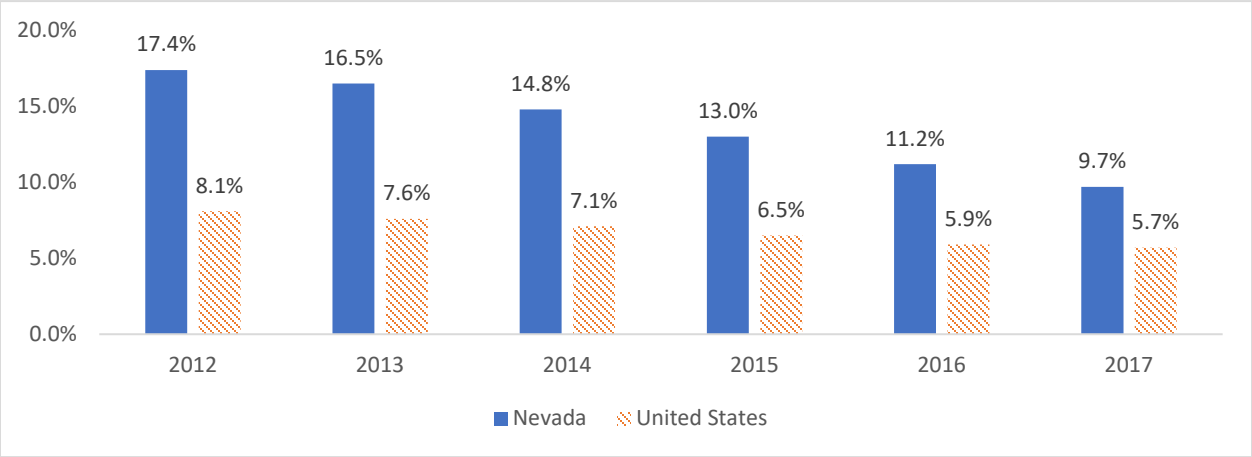
[85] Keith, K. (2019, September 11). Uninsured rate rose in 2018, says census bureau report. *Health Affairs*. doi: 10.1377/hblog20190911.805983.

[86] American Community Survey. (2018). Table S2701. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=table%20S2701&g=&hidePreview=false&table=S2701&tid=ACSST1Y2018.S2701&lastDisplayedRow=31&vintage=2018.

[87] American Community Survey. (2018). Table S2701. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved December 19, 2019 from https://data.census.gov/cedsci/table?q=table%20S2701&g=&hidePreview=false&table=S2701&tid=ACSST1Y2018.S2701&lastDisplayedRow=31&vintage=2018.

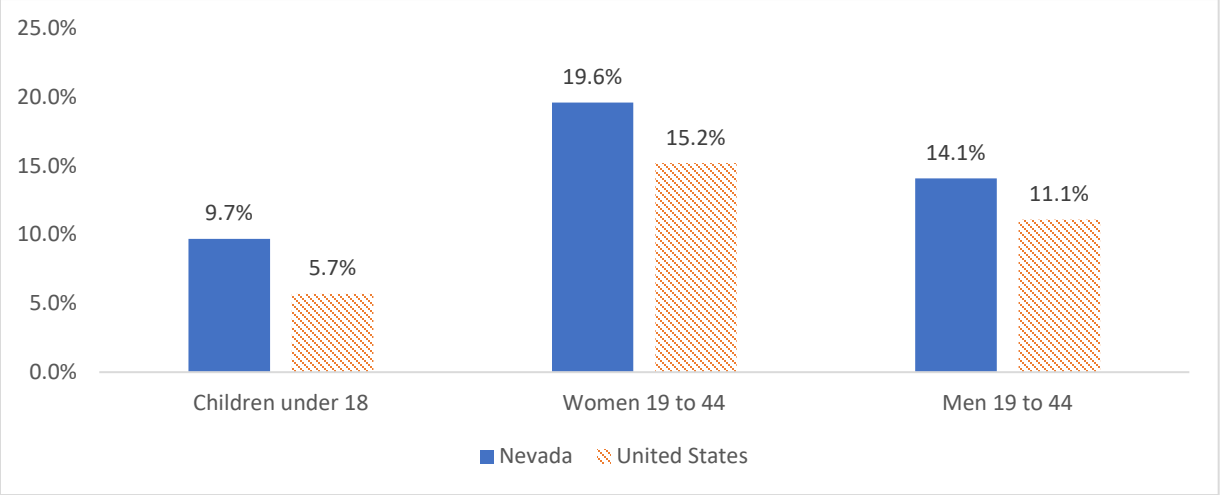
[88] National Children's Health Survey. (2017). Indicator 15, Percent of children, ages 0 through 17, who are continuously and adequately insured.

Figure 14. Percent of Children, Ages Zero Through 18, Without Health Insurance, Nevada and United States, 2012 to 2017[89]



Approximately 498,000 (19.6%) of uninsured individuals in Nevada were women ages 19 to 44 years (higher than for the same group nationally at 15.2%).[90] Meanwhile, men ages 19 years and older experienced lower uninsured rates (14.1%) compared to women, although this rate was still higher than in the U.S. (11.1%).[91] Figure 15 illustrates the disparity in health insurance coverage for MCH population groups.

Figure 15. Percent Uninsured by MCH Population Group, Nevada and United States, 2017[92]



The uninsured rates in Nevada among MCH population groups vary by county (Table 27). Lincoln County experienced the highest rates of uninsured among MCH population groups at 18.3 percent for children younger than 18 years, while Esmeralda County experienced high uninsured rates among women ages

[89] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S2701&prodType=table.
[90] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.
[91] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.
[92] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from .https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.

18 to 44 years at 53.6 percent (important to note the population size in rural/frontier counties is small and may result in unstable rates).[93]

Table 27. Uninsured Rates in Nevada by MCH Population Groups and County, 2017[94]

	Percent Uninsured Among Children Under 18	Percent Uninsured Among Females 18 to 44
United States	**5.70%**	**15.20%**
Nevada	**9.70%**	**19.60%**
Carson City	8.80%	14.80%
Churchill	10.70%*	21.70%*
Clark	9.80%*	20.30%*
Douglas	11.90%*	19.60%*
Elko	7.50%	18.10%
Esmeralda	14.40%*	53.60%*
Eureka	7.00%	11.60%
Humboldt	15.30%*	29.30%*
Lander	6.70%	11.40%
Lincoln	18.30%*	14.40%
Lyon	10.70%*	16.40%
Mineral	15.50%*	30.60%*
Nye	9.50%	19.40%
Pershing	16.70%*	21.90%*
Storey	5.10%	3.80%
Washoe	8.80%	16.50%
White Pine	8.10%	14.50%

*Note: * indicates counties which have higher rates of uninsured women and children compared to Nevada.*

There is disparity in health care insurance status in Nevada by race and ethnicity. Among children younger than 18 years, Hispanics were most likely to be uninsured (9.8%), followed by Asians (7.2%), American Indian/Alaska Natives (6.5%), and Black or African Americans (6.2%).[95] These disparities extend into adulthood (Table 8). Racial and ethnic minorities were more likely to need a doctor but not have access to one because of cost (in the past 12 months). They were also more likely to have one or more personal health care provider(s), as opposed to a consistent medical home.[96] Access to health care insurance coverage is also less frequent among Black or African American, Other race, and Hispanic race and ethnicity groups.

[93] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.
[94] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.
[95] American Community Survey. (2017). Table B27001. Selected Characteristics of Health Insurance Coverage in the United States. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=B27001&tid=ACSDT5Y2017.B27001.
[96] Nevada Department of Health and Human Services, Office of Analytics. (2019). Nevada Behavioral Risk Factor Surveillance Survey. Data provided upon request. Carson City, NV. Found in Nevada DHHS 2019 Nevada State Health Needs Assessment.

Table 8. Prevalence of Select Access to Health Care Indicators Among Adults by Race and Ethnicity, Nevada, 2018[97]

Indicator	White	Black or African American	Other Race	Hispanic	Disparity Ratio[98]
Have one or more personal health care provider(s)	76.9%	72.1%	74.4%	52.5 %	1.42
Needed a doctor but couldn't because of cost (past 12 months)	11.2%	15.4%	12.4%	19.8%	0.66
Have health insurance	92.9%	88.9%	84.8%	65.8 %	1.35

Literature has identified socioeconomic characteristics, including income, employment, citizenship, and language associated with being uninsured and are more prevalent in minority populations. The literature focuses on these factors as barriers to acquiring health insurance.[99] Medicaid expansion has been found to reduce coverage inequality between non-Hispanic White and minority groups. However, the inequities continue in part because people gain and lose their insurance plans quickly.

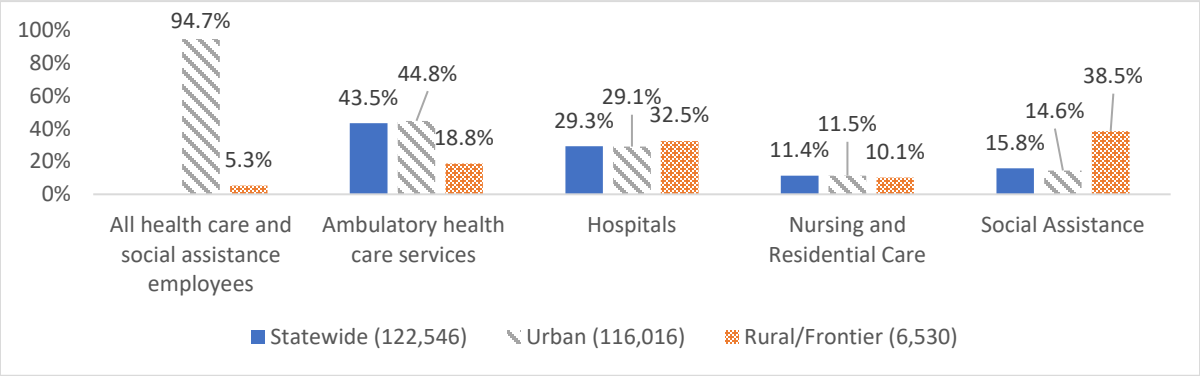
Minority populations are quicker to lose their health care insurance coverage or slower to gain coverage, because they often have socioeconomic characteristics associated with both factors. In the U.S., private health insurance coverage is tied to employment and marriage, but often minority populations have higher rates of unemployment, higher rates of job loss, a lower likelihood of marrying, and greater rates of divorce; therefore, they are more likely to become uninsured and have a harder time finding coverage.[100] Additionally, recent federal and state policies, including several changes to the Affordable Care Act and Medicaid waivers which have added eligibility restrictions, have the potential to reduce coverage gains and progress made in reducing disparities. These disparities may leave people of color at greater risk regarding access to health care insurance coverage and the financial instability from health care costs.[101]

Health Care and Social Services System

In 2019, there were an estimated 122,546 Nevadans employed in the health care and social assistance sector, including 53,258 employed in ambulatory health care services (43.5%), 35,900 employed in hospitals (29.3%), 13,969 employed in nursing and residential care facilities (11.4%), and 19,419 in social assistance (18.8%). Among these, 5.3 percent (6,530) are employed in rural and frontier counties (where 9.5% of the population live). As shown in Figure 16, Nevadans employed in rural and frontier counties are predominately in social assistance sector (38.5% compared to 14.6% in urban counties or 15.8% statewide) and slightly more working in hospitals (32.5% compared to 29.1% in urban counties).

[97] Nevada Department of Health and Human Services, Office of Analytics. (2019). Nevada Behavioral Risk Factor Surveillance Survey. Data provided upon request. Carson City, NV. Found in Nevada DHHS 2019 Nevada State Health Needs Assessment.
[98] The disparity ratio compares the racial/ethnic group with the lowest (or highest, if representing negative outcome or experience) indicator rate (comparison group) to the average of the indicator rate for all other groups. A disparity ratio closer to one is better, with a disparity ratio of 1 indicating no disparity.
[99] Sohn H. (2017). Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course. Population research and policy review, 36(2), 181–201. doi:10.1007/s11113-016-9416-y.
[100] Sohn H. (2017). Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course. Population research and policy review, 36(2), 181–201. doi:10.1007/s11113-016-9416-y.
[101] Artiga. S.et al. (2019). Changes in Health Coverage by Race and Ethnicity since Implementation of the ACA, 2013-2017. Kaiser Family Foundation. Retrieved on December 19, 2019 from http://files.kff.org/attachment/Issue-Brief-Health-Coverage-by-Race-and-Ethnicity-Changes-Under-the-ACA.

Figure 16. Estimated Employment in the Health Care and Social Assistance Sector, Urban and Rural/Frontier Counties, and Nevada, 2019[102]



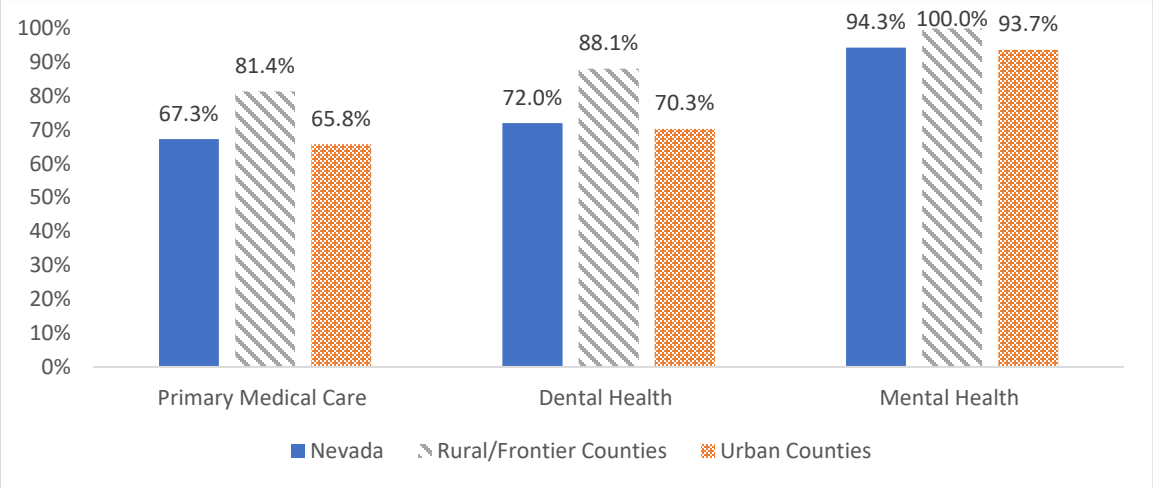
These employment patterns show the number of licensed health professionals per 100,000 persons is lower in rural and frontier counties compared to urban areas in Nevada. However, there are some important exceptions including registered nurse anesthetists, registered dental hygienists, drug and alcohol counselors, and paramedics which have a higher number of professionals per 100,000 persons in rural and frontier counties.[103]

Despite Nevada's health care employment numbers, an estimated 67.3 percent (n=2,026,181) of Nevada's population reside in a federally-designated primary medical care health professional shortage area (HPSA) — 11 of 17 counties in Nevada are single-county primary medical care HPSAs. This increases to 81.4 percent (n=234,076) when looking only at the population who live in rural and frontier counties, where 11 of 14 counties are single-county primary medical care HPSAs.[104] Those living in Elko, Douglas, and Humboldt counties experience less medical provider shortage compared to other rural and frontier counties with 39.9, 65.4, and 79.3 percent (respectively) of the county's population living in a primary medical care HPSA.[105]

The percent of Nevada's population living in dental health and mental health HPSAs is higher than medical care HPSA (Figure 17). In 2018, an estimated 72 percent (n=2,168,638) of Nevada's population lived in a federally designated dental HPSA — 13 of 17 counties in Nevada are single-county dental HPSAs. This again increases when looking only at the population living in rural and frontier Nevada, to 88.1 percent — 11 of 14 rural and frontier counties in Nevada are single-county dental HPSAs.[106] Approximately 2.8 million Nevadans (94.3%) live in a mental health HPSA, with 100 percent of rural and frontier county residents living in a mental health HPSA.[107] Washoe County is an exception, with only 62.9 percent of its residents living in a mental health HPSA.

[102] Nevada Department of Employment, Training, and Rehabilitation (2019). Cost Report Data Resources, LLC (2018). Retrieved from Nevada Rural and Frontier Health Data Book, 9th Edition.
[103] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.47: Health Workforce Supply by Region in Nevada — 2018.
[104] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.48: Population Residing in Health Professional Shortage Areas (HPSAs) in Nevada — 2019.
[105] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.48: Population Residing in Health Professional Shortage Areas (HPSAs) in Nevada — 2019.
[106] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.48: Population Residing in Health Professional Shortage Areas (HPSAs) in Nevada — 2019.
[107] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.48: Population Residing in Health Professional Shortage Areas (HPSAs) in Nevada — 2019.

Figure 17. Percent Population Residing in Health Professional Shortage Areas (HPSAs), Rural/Frontier Counties, Urban Counties, and Nevada[108]



In 2024, there will be a projected 140,415 Nevadans employed in the health care and social services sector - an increase of 17,869 jobs (14.6%) from 2019. This projected increase is smaller in rural and frontier counties. In 2024, there will be a projected 6,995 rural and frontier Nevadans employed in the health care and social services sector — an increase of 465 jobs (7.1%) from 2019.[109] With a projected AGR across Nevada of 1.6 percent (for five year growth of 8%), the projected growth in these employment sectors (14.6%) may help address barriers to accessing health, dental, and mental health care, especially in the urban counties.

Criminal Justice System

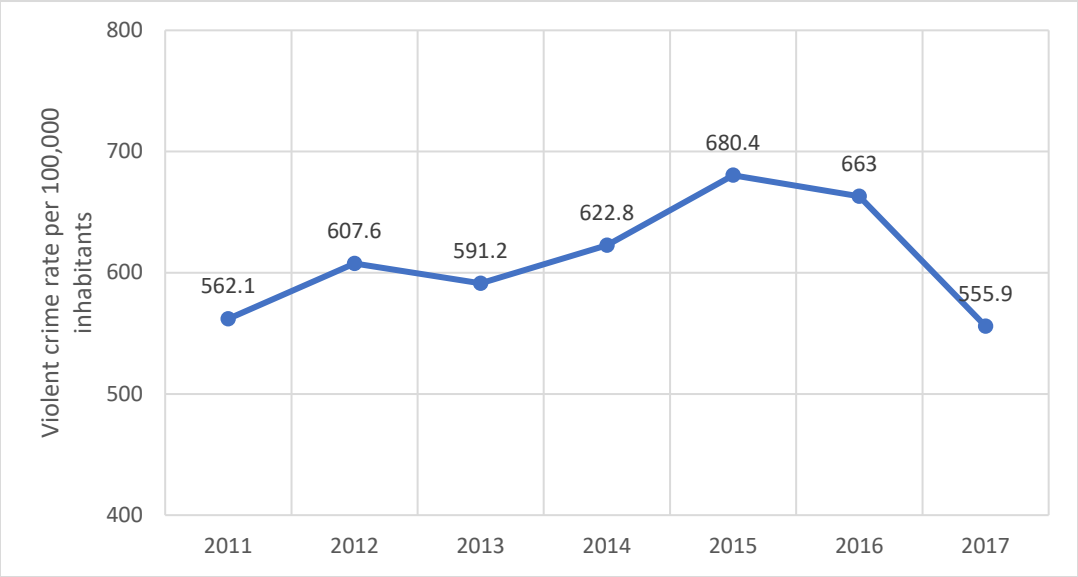
Since 2009, Nevada's total prison population has grown by seven percent, and the state's female prison population has grown at four times the pace of the overall prison population.[110] Nevada's female prison population is expected to increase by almost 1,200 inmates in the next decade. [111] The state currently has an imprisonment rate 15 percent higher than the national average (468 people per 100,000 vs. 406 people per 100,000). [112] Nevada's imprisonment rate, which is calculated relative to the state's population, more than doubled between 1980 and 2016, increasing from 227 to 468 people imprisoned per 100,000 residents.[113] While Nevada's overall population also increased in this time period, the proportional growth in the prison population was much greater than for the state as a whole. Recently,

[108] Nevada Rural and Frontier Health Data Book, 9th Edition. Table 5.48: Population Residing in Health Professional Shortage Areas (HPSAs) in Nevada, 2019.
[109] Nevada Department of Employment, Training, and Rehabilitation (2019). Cost Report Data Resources, LLC (2018). Retrieved from Nevada Rural and Frontier Health Data Book, 9th Edition.
[110] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.
[111] Clark, Daniel. (January 11, 2019). Group reviewing Nevada Criminal just system advanced 25 recommendations that could save the state $640 million in prison costs. *The Nevada Independent*. Retrieved on November 13, 2019 from https://thenevadaindependent.com/article/group-reviewing-nevada-criminal-justice-system-proposes-25-recommendations-that-could-save-state-640-million-in-prison-costs.
[112] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.
[113] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.

manyother high-growth states have experienced a decline in prison population numbers despite growth in their general population.

Between 2009 and 2017, Nevada experienced fluctuations in the crime rate, with violent crime climbing from the decade low rate in 2011 to a high in 2015, before experiencing a major drop in 2017. [114] Figure 18 illustrates this fluctuation.

Figure 18. Violent Crime Rate per 100,000, Nevada, 2011-2017[115]



Nevada had the third highest murder rate and the third highest robbery rate in the nation in 2017[116], with the bulk of these crimes occurring in the two most populated counties of Clark and Washoe.[117] In 2016, 52 percent of offenders in Nevada were incarcerated while 48 percent were under community supervision. Nationwide, only 31 percent of offenders were incarcerated, and 69 percent were on parole or probation.[118] Table 29 below shows the crime rate statewide and by county, per 1,000 population in 2017.

Table 29. Crime Rate per 1,000 Population by County, Nevada, 2017[119]

County	Crime Rate	County	Crime Rate
Carson City	19.67	**Lincoln County**	11.68
Churchill County	22.12	**Lyon County**	13.49
Clark County	33.95	**Mineral County**	14.36

[114] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.

[115] Reported data from the Federal Bureau of Investigation, "Crime in the United States 2011-2017" (Uniform Crime Reports, 2011-2017). Retrieved on June 30, 2020 from http://data.sagepub.com/sagestats/318

[116] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.

[117] State of Nevada, Department of Public Safety. (n.d.). Uniform Crime Reporting: 2017 Report. Retrieved January 7, 2020 from https://rccd.nv.gov/uploadedFiles/gsdnvgov/content/About/UCR/Crime%20in%20Nevada%202017%20(FINAL).pdf.

[118] Nevada Advisory Commission on the Administration of Justice – Justice Reinvestment Initiative. (January 2019). Final Report. Retrieved on November 13, 2019, from https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13671.

[119] State of Nevada, Department of Public Safety. (n.d.). Uniform Crime Reporting: 2017 Report. Retrieved January 7, 2020 from https://rccd.nv.gov/uploadedFiles/gsdnvgov/content/About/UCR/Crime%20in%20Nevada%202017%20(FINAL).pdf.

Douglas County	17.35	**Nye County**	19.61
Elko County	22.28	**Pershing County**	21.97
Esmeralda County	5.88	**Storey County**	31.70
Eureka County	15.81	**Washoe County**	29.68
Humboldt County	17.29	**White Pine County**	10.63
Lander County	26.52	***Statewide***	*31.60*

As in the other factors discussed, racial and ethnic disparities are common for incarcerated individuals. Nationally, female imprisonment exhibits a racial disparity. Black or African American women are imprisoned at twice the rate, and Hispanic women at 1.3 times the rate, of white women. According to the Sentencing Project, the rate of imprisonment for black women has been declining while the rate for Hispanic women is rising.[120]

According to the Crime and Justice Institute, half the U.S. female inmate population has mental health needs. Moreover, the National Sexual Violence Resource Center estimates one in three women will experience some form of sexual violence in their lives. Incarcerated pregnant women have a greater probability of having these and other risk factors for poor perinatal outcomes compared to nonincarcerated pregnant women.[121]

Prisons are constitutionally required to provide health care[122]; however, no mandatory standards, oversight, or requirements for data reporting are in place. Although voluntary accreditation programs exist (e.g., the National Commission on Correctional Health Care and the American Correctional Association), this lack of standardized health services results in tremendous variability in pregnancy care in prisons. [123]

Most youth in the juvenile justice system are also involved with the child welfare system as a result of family discord and disruption. In addition to child welfare, transitional age youth (TAY) (ages 14+) may interact with special education services, mental health services, vocational rehabilitation, and the housing authority, among other support services. Unfortunately, as noted by the Institute of Medicine and National Research Council, current programs and policies for TAY are often inadequately coordinated, fragmented, and not designed for specific developmental needs. Navigating these multiple and separate systems is reported to be incredibly challenging for a young adult facing multiple psychosocial problems.[124] Table 30 below provides select Nevada youth parole closure performance summary metrics for FY2015 to FY2018.

Table 30. Select Nevada Youth Parole Closure Performance Summary Metrics, Nevada, SFY15 to FY18[125]

	SFY	SFY	SFY	SFY	SFY	SFY	SFY	SFY

[120] The Sentencing Project. (2019, June 6). Incarcerated Women and Girls. Retrieved January 7, 2020 from https://www.sentencingproject.org/publications/incarcerated-women-and-girls/

[121] Sufrin, C. et al. (2019, May). Pregnancy Outcomes in US Prisons, 2016–2017. *American Journal of Public Health* 109 (5): 799-805. Available at https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305006.

[122] Sufrin, C. et al. (2019, May). Pregnancy Outcomes in US Prisons, 2016–2017. *American Journal of Public Health* 109 (5): 799-805. Available at https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305006.

[123] Sufrin, C. et al. (2019, May). Pregnancy Outcomes in US Prisons, 2016–2017. *American Journal of Public Health* 109 (5): 799-805. Available at https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305006.

[124] Annie E. Casey Foundation. (2018). Fostering Youth Transitions: Using Data to Drive Policy and Practice Decisions. As found in Nevada State Health Needs Assessment, 2019.

[125] Nevada Department of Health and Human Services, Office of Analytics. Data source DCFS Databook, UNITY report RPT745. Data provided upon request. Carson City, NV. As in the 2019 Nevada State Health Needs Assessment.

Statewide Youth Closure Performance Measure	2015 #	2015 %	2016 #	2016 %	2017 #	2017 %	2018 #	2018 %
Total Youth Parole Closure Records Approved	246	-	228	-	299	-	240	-
Youth with Successful Completion of Parole Program*	121	49%	108	47%	131	44%	109	45%
Youth with School/Employment at Closure**	78	32%	73	32%	97	32%	72	30%
Youth Re-offending While Under Parole Supervision†	133	54%	127	56%	171	57%	120	50%

*Successful completion = "Juvenile successfully completed court-ordered obligations" on case closure
**Youth with school/employment = "Yes" to enrolled in school, or "No" to enrolled in school and Reason = "Employed"
†Youth re-offending while under parole supervision = "Yes" to either Charges filed for committing new offense, or Youth's parole revoked while under parole supervision, on case closure

Washoe County Jail Home Visiting Pilot Program[126]

In October 2016, the Nevada Home Visiting Program Coordinator began conversations with the Washoe County Sheriff's Office, regarding providing Home Visiting services to pregnant inmates. In December 2016, the Washoe County Sheriff's Office Program Director and Sheriff agreed to allow the Nevada Home Vising Program to enter the jail and work with any pregnant inmates who were interested in Home Visiting services. After one and a half months of background checks, three of the University of Nevada, Reno (UNR) Home Visiting staff were approved to enter the jail and provide services. The first Home Visiting class for this population took place in February 2017.

The Home Visitors now enter the jail every Tuesday to meet with pregnant inmates. The meeting, held on Tuesdays, is a group class which all pregnant inmates can attend. During the class, the home visitors work with the women to educate them on topics such as making a plan for baby (if they will be incarcerated during the birth), preparing for birth, prenatal health, attachment to baby, development of baby, etc. All prenatal materials come from the Maternal Mental Health and Parents As Teachers curriculums. During each class the women are offered the chance to enroll into the Nevada Home Visiting Program. Upon enrollment, the women begin meeting with a home visitor once a week on a one-on-one basis. The curriculum for these meetings is tailored to fit each mom's questions and situation. When released from the jail, the women are asked if they would like to continue in the Home Visiting Program from their private residence.

During one of these classes, an inmate who had enrolled into the Nevada Home Visiting Program shared with her home visitor she had been bleeding. She had gone to the infirmary but was told she was fine and should return to her cell to rest. Upon hearing this, the home visitor contacted the jail's program director and asked for assistance in getting the inmate medical attention. The inmate and home visitor were transported to Labor & Delivery, where it was confirmed the woman was in labor. The baby was born premature and was admitted to the neonatal intensive care unit (NICU). Upon release from the hospital, the woman returned to jail to finish her sentenced time. Baby and mother were reunited upon the woman's release from jail and both are healthy. The woman continued as an enrollee in the Nevada Home Visiting Program and is grateful for the home visitor's assistance in keeping her and her baby safe.

[126] Nevada Division of Public & Behavioral Health, Bureau of Child, Family, & Community Wellness. (2020). Washoe County Jail Success Story.

As of December 2017, the UNR home visitors are providing home visiting services to seven incarcerated women, three of whom have enrolled for one-on-one weekly sessions.

Child Protective Services System

The total number of TAY in foster care in Nevada in 2018 was 1,240 children, representing 16 percent of the total foster care population. The top three reasons TAY entered foster care were neglect, physical abuse, and parental substance abuse.[127] The percentage of children in Nevada entering foster care in 2018 due to neglect and physical abuse were higher than the percentage nationwide, while the percentage of children entering due to parental substance abuse was lower than the percentage nationwide. Figure 19 illustrates the foster care entry reasons for TAY in Nevada compared to the U.S. in 2018.

Figure 19. Percentage of TAY Entering Foster Care, by Reason for Entry, Nevada and United States, 2018[128]

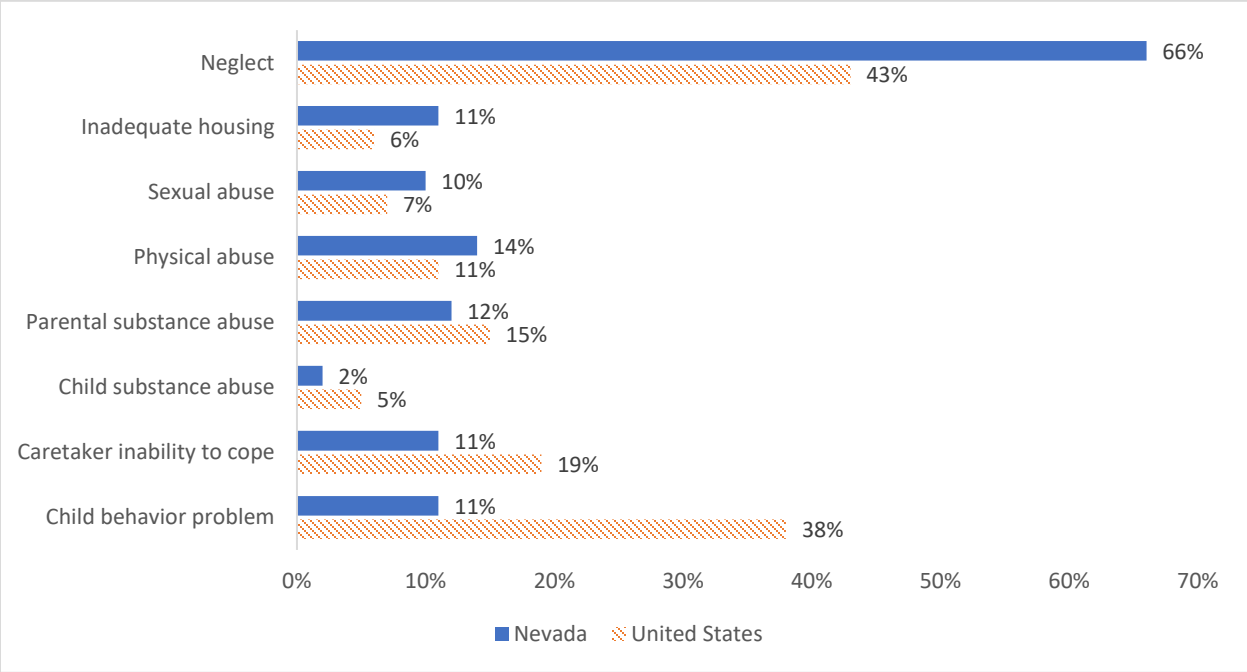


Table 31 summarizes the monthly average count for youth ages 14 and up, over a four-year period, by placement type in Nevada. Most placement types are family care, followed by unpaid placements. Only seventeen placements were supervised independent living types, which is both an in-state placement option and a program that helps prepare TAY for adulthood.[129]

Table 31. Monthly Average Count for Youth, Age 14 and Up, by Placement in Nevada, SFY2015 to SFY2018

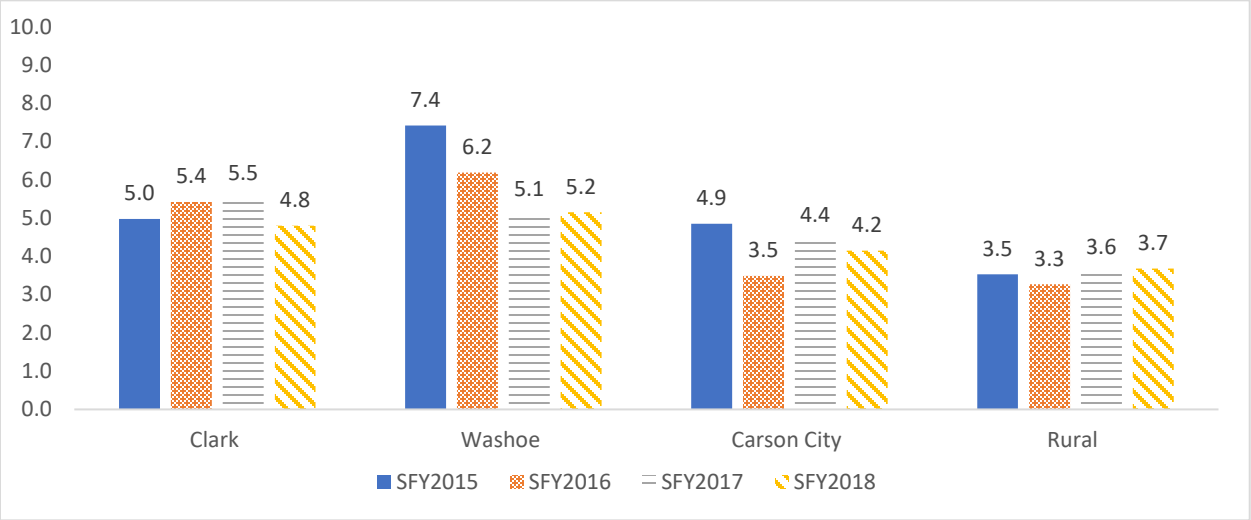
Placement Type	SFY2015	SFY2016	SFY2017	SFY2018
Family Care	224	208	225	379
Pre-Adoptive Home	2	2	2	2

[127] Child Trends. (n.d.). Transition-Age Youth in Foster Care in Nevada. https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_Nevada.pdf. Retrieved November 2019. As in 2019 Nevada State Health Needs Assessment.
[128] Child Trends. (n.d.). Transition-Age Youth in Foster Care in Nevada. Retrieved November 2019 from https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_Nevada.pdf. As in 2019 Nevada State Health Needs Assessment.
[129] Nevada Department of Health and Human Services, Office of Analytics. UNITY report CFS704. Data provided upon request. Carson City, NV.

Residential Care	211	206	157	43
Shelter Care	45	48	33	35
Unpaid Placements	204	234	240	234
Independent Living	21	17	12	17

The home removal rate per 1,000 children was generally decreasing by Nevada region for a four-year period (Figure 19). The county with the greatest removal rate in 2018 was Washoe County, at 5.2 per 1,000 children. The lowest removal rate occurred in rural regions at 3.7 per 1,000 children.[130]

Figure 20. Removal Rate per 1,000 Children by Region, Nevada, SFY2015 to SFY2018[131]



Public Health System

Nevada is identified as the least healthy state when considering the amount of public health funding available relative to other states. Public health funding is measured as a combination of state dollars dedicated to public health and federal dollars directed to states by the CDC and HRSA. This amounts to $46 per person in Nevada, lower than the U.S. average of $87 per person. The state with the most public health funding per person is Alaska, at $281.[132] As stated by America's Health Ranking, public health funding allows states to proactively implement programs to improve health. Public health program spending represents approximately ten percent of all health care spending in most countries, yet its impact can be substantial. As an example, an investment of $10 per person per year in evidence-based programs proven to increase physical activity, improve nutrition, and prevent smoking or other tobacco use could save the country more than $16 billion annually within five years. This is a potential savings of $5.60 for every $1 invested. [133]

[130] Nevada Department of Health and Human Services, Office of Analytics. DCFS Databook, UNITY report CFS7G6, ASRHO Population Tables. Data provided upon request. Carson City, NV. As in 2019 Nevada State Health Needs Assessment.
[131] Nevada Department of Health and Human Services, Office of Analytics. DCFS Databook, UNITY report CFS7G6, ASRHO Population Tables. Data provided upon request. Carson City, NV. As in 2019 Nevada State Health Needs Assessment.
[132] America's Health Rankings analysis of Trust for America's Health; United States HHS; United States Census Bureau, Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018, United Health Foundation, AmericasHealthRankings.org, Accessed December 11, 2019.
[133] America's Health Rankings analysis of Trust for America's Health; United States HHS; United States Census Bureau, Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018, United Health Foundation, AmericasHealthRankings.org, Accessed December 11, 2019.

Education System: Access to Quality Education and Educational Achievement

Nevada has 17 school districts, one for each county. Three schools closed in 2018/19 while 17 public schools opened, including four elementary schools in Clark County. Four school districts (Douglas, Nye, Washoe, and White Pine) also serve out-of-state students who live in border districts and travel into Nevada for school.[134] As reported in the 2019 Nevada State Health Needs Assessment from the Nevada DHHS, and as shown in Table 32, the counties with the greatest increase in public school enrollment were White Pine (37%), Lincoln (21%), and Eureka (18%). The counties with the lowest increase in public school enrollment in 2019 were Churchill (-23%), Lander (-19%), and Nye (-17%) counties.[135]

Table 32. Public School Enrollment Number and Percent Change by County, 2007/2008 to 2017/2018 School Years[136]

County/Region	2007/08 School Year	2017/18 School Year	% Change in Enrollment 2007/08 to 2017/18
Carson City	8,116	8,085	0%
Churchill	4,409	3,374	-23%
Clark	308,554	324,030	5%
Douglas	6,746	5,798	-14%
Elko	9,748	9,924	2%
Esmeralda CSD	77	73	-5%
Eureka	246	291	18%
Humboldt	3,379	3,573	6%
Lander	1,274	1,027	-19%
Lincoln	877	1,057	21%
Lyon	9,236	8,927	-3%
Mineral	617	565	-8%
Nye	6,438	5,337	-17%
Pershing	723	667	-8%
Storey	427	443	4%
Washoe	63,635	64,240	1%
White Pine	1,422	1,955	37%
Nevada	**432,850**	**485,768**	**12%**

Similarly, the 2019 DHHS Needs Assessment reports the following diversity among those enrolled in public school (Table 33). Public school students in Nevada are primarily Hispanic (of any race) and White, making up nearly three quarters of the student body (42.4% and 32.5%, respectively).[137]

[134] State of Nevada Department of Education, Nevada Schools and District Information. (n.d.). Retrieved November 7, 2019, from http://www.doe.nv.gov/Schools_Districts/Nevada_Schools_and_District_Information/.
[135] Nevada Department of Health and Human Services. (2019). Nevada State Health Needs Assessment. Retrieved from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/NV_SHNA_FINAL.pdf.
[136] Nevada Department of Health and Human Services. (2019). Nevada State Health Needs Assessment. Retrieved from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/NV_SHNA_FINAL.pdf.
[137] Nevada Department of Health and Human Services. (2019). Nevada State Health Needs Assessment. Retrieved from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Grants/NV_SHNA_FINAL.pdf.

Table 33. Percent of Students Enrolled in Public School by Race and Ethnicity and County, 2017/2018[138]

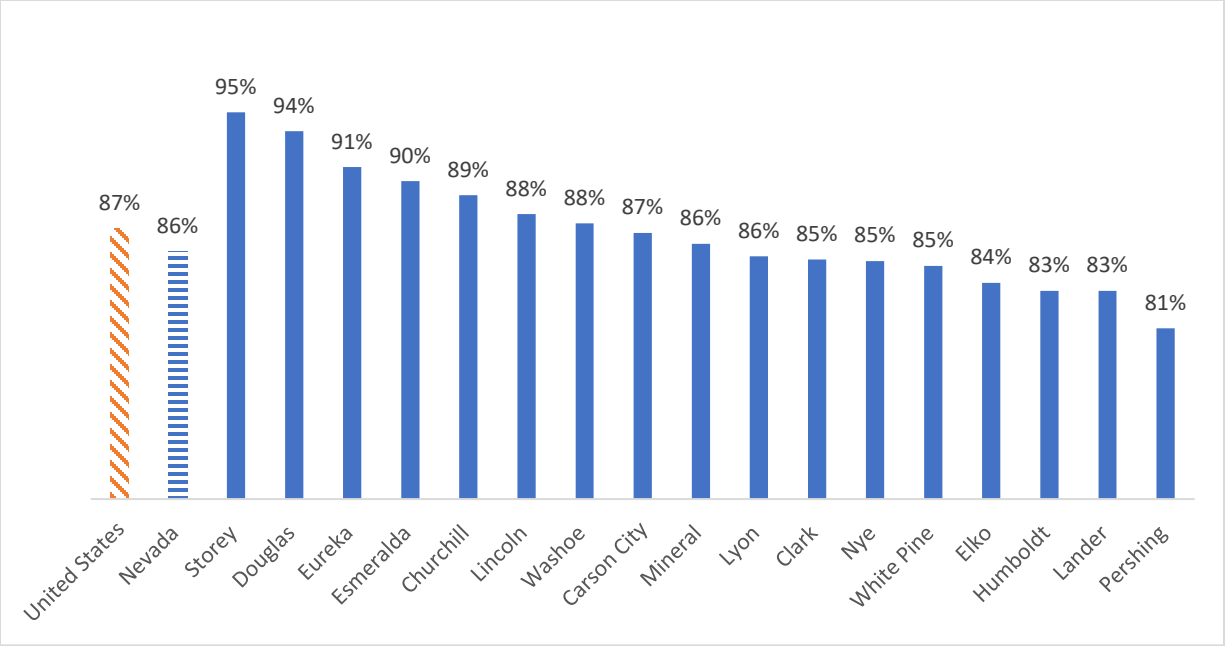
County	American Indian/ Alaskan Native	Asian	Hispanic/ Latino	Black or African American	White	Pacific Islander	Multiracial
Carson City	2.3%	1.9%	41.8%	0.5%	48.7%	0.2%	4.6%
Churchill	6.0%	1.7%	23.1%	1.8%	60.2%	0.7%	6.6%
Clark	0.4%	6.3%	46.5%	14.1%	24.5%	1.6%	6.5%
Douglas	3.2%	1.4%	22.4%	0.6%	66.3%	0.3%	5.9%
Elko	6.1%	0.6%	31.7%	0.8%	59.1%	0.2%	1.5%
Esmeralda	0.0%	0.0%	37.0%	0.0%	54.8%	0.0%	0.0%
Eureka	5.2%	0.0%	10.0%	0.0%	80.4%	0.0%	0.0%
Humboldt	4.3%	0.6%	36.7%	0.0%	55.6%	0.0%	2.3%
Lander	4.0%	0.0%	30.7%	0.0%	62.7%	0.0%	1.8%
Lincoln	1.0%	0.0%	9.7%	5.8%	80.1%	0.0%	2.1%
Lyon	3.6%	1.0%	25.7%	0.7%	64.4%	0.7%	3.9%
Mineral	12.7%	0.0%	17.5%	3.2%	60.2%	0.0%	5.7%
Nye	1.4%	1.5%	27.6%	2.9%	61.7%	1.2%	3.8%
Pershing	9.6%	0.0%	31.9%	2.3%	50.2%	0.0%	5.3%
Storey	0.0%	0.0%	7.9%	0.0%	84.7%	0.0%	2.9%
Washoe	1.4%	4.2%	40.6%	2.4%	44.4%	1.2%	6.0%
White Pine	3.0%	1.7%	15.9%	10.2%	64.3%	1.1%	3.8%
Nevada	**0.9%**	**5.5%**	**42.4%**	**11.1%**	**32.5%**	**1.4%**	**6.2%**
United States[139]	**1.0%**	**5.2%**	**26.7%**	**15.3%**	**47.6%**	**0.4%**	**3.8%**

Educational Achievement

In 2017/18, 83.2 percent of Nevada students graduated from high school. This rate is slightly lower than the nationwide rate as reported for the 2016/17 class (2017/18 data was unavailable at the time of this report) at 84.6 percent.[140] Nevada's graduation rate also varies by school district (Table 20). Eighty-six percent of Nevada's adult population holds a high school degree or higher, compared to 87 percent nationwide (Figure 21).[141] There is variation by county, with a high of 95 percent in Storey County to a low of 81 percent in Pershing County.

Figure 21. Percent of Population with a High School Degree or Higher, Nevada and United States, 2013-2017[142]

[138] Nevada Department of Education data do not delineate between white, non-Hispanic and white as a race alone, not combined with ethnicity, as in 2019 Nevada State Health Needs Assessment by Nevada DHHS.
[139] U.S. Department of Education, National Center for Education Statistics, Common Core of Data (CCD), "State Nonfiscal Survey of Public Elementary and Secondary Education," 1995-96 through 2016-17; and National Elementary and Secondary Enrollment by Race/Ethnicity Projection Model, 1972 through 2028. (This table was prepared March 2019.).
[140] Education Week. (2019, January 19). Data: U.S. Graduation Rates by State and Student Demographics. Retrieved on March 9, 2020 from https://www.edweek.org/ew/section/multimedia/data-us-graduation-rates-by-state-and.html.
[141] American Community Survey. (2017). Table S1501: Educational Attainment.
[142] American Community Survey. (2017). Table S1501: Educational Attainment.



Educational attainment for women ages 25 to 64 years living in Nevada is slightly lower than for women nationally. Overall, 86.5 percent of Nevada residents ages 25 to 64 years achieved a high school degree or greater compared to 89.9 percent nationally (Table 34).[143]

Table 34. Educational Attainment for Women Ages 25 to 64 Years, Nevada and United States, 2017[144]

Educational Attainment	Nevada	United States
Less than 9th grade	6.0%	4.0%
9th to 12th grade, no diploma	8.0%	6.0%
High school graduate (includes equivalency)	27.0%	24.0%
Some college, no degree	26.0%	22.0%
Associate's degree	9.0%	10.0%
Bachelor's degree	17.0%	22.0%
Graduate or professional degree	8.0%	13.0%
High school graduate or greater	86.5%	89.9%

The extent to which children and youth are engaged academically drives, in part, academic achievement. Factors affecting engagement, described below, include per pupil spending, percent of children enrolled in school, absenteeism, and academic performance; ultimately, these factors drive a state's high school graduation rates.

Per Pupil Spending

Nevada consistently ranks lower in the nation for per pupil spending. The National Center for Education Statistics reported Nevada spent $8,850 per student compared to the national average of $11,669 in

[143] American Community. (2017). Sex by Age by Educational Attainment for the Population 18 years and over, 2013-2017. Retrieved November 7, 2019, from https://data.census.gov/cedsci/table?q=b15001&tid=ACSDT5Y2017.B15001.
[144] American Community. (2017). Sex by Age by Educational Attainment for the Population 18 years and over, 2013-2017. Retrieved November 7, 2019, from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_B15001&prodType=table.

fiscal year 2016.[145] In 2019, Nevada ranked 50th on Education Week Research Center's Change for Success Index, which takes into consideration graduation rates, academic scores, and school finance, with an overall score of 66.9 out of 100 points and a grade of D-plus. The United States received a grade of C.[146]

School Enrollment Rate

Twelve percent of Nevada children, ages three to 17 years, are not enrolled in either public or private school (higher than the rate for the U.S. at 9.6%).[147] Table 35 shows within Nevada, Nye County experiences the highest rate of children not enrolled in school at 13 percent, followed by Clark and Douglas counties each at 12 percent.[148]

Table 35. Percentage of Children Three to 17 Years Not Enrolled in School, by Select Counties, 2013-2017[149]

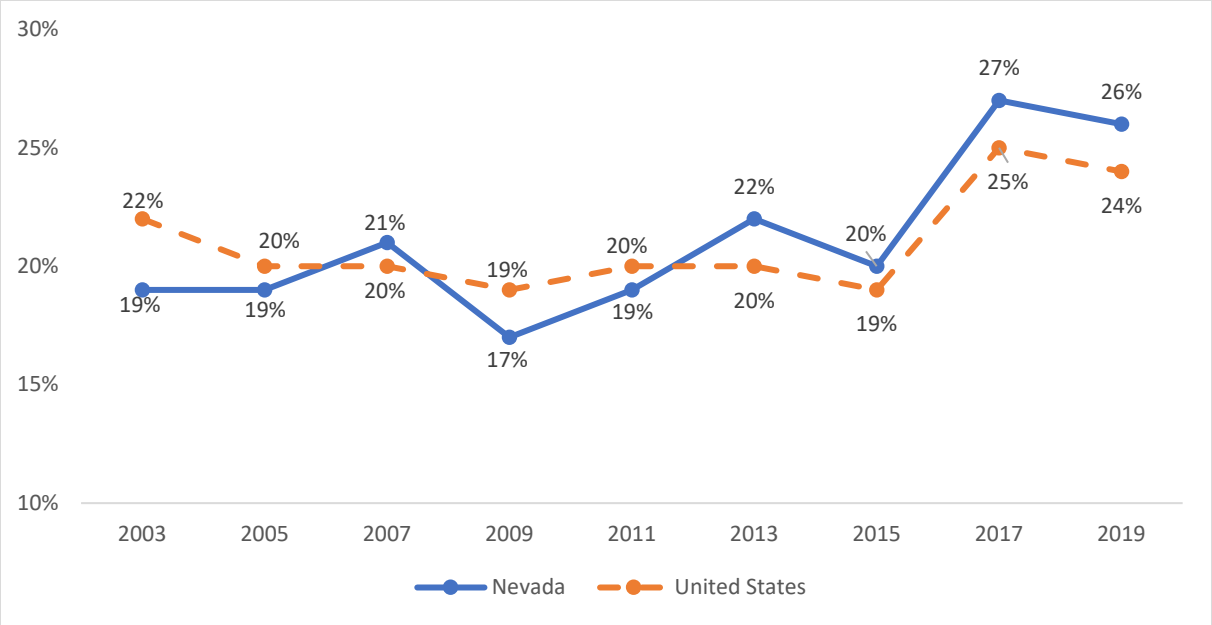
County	Children three to 17 years in households	Percent not enrolled in school
Nevada	563,133	12%
Clark	419,803	12%
Douglas	7,589	12%
Elko	12,358	10%
Lyon	9,899	11%
Nye	6,412	13%
Washoe	82,491	10%
Carson City	9,565	10%

Academic Performance

In 2016/17, the percent of children ages six to 17 years who repeated one or more grades since starting kindergarten is lower in Nevada than across the U.S. (5% vs. 7% respectively).[150] However, the percent of fourth graders who are chronically absent from school in Nevada has been increasing since 2003, from 19 percent to a high of 26 percent in 2019. Since 2011, Nevada has exceeded the national prevalence of fourth graders who are chronically absent from school, with Nevada at 26 percent compared to the U.S. at 24 percent (Figure 22). [151]

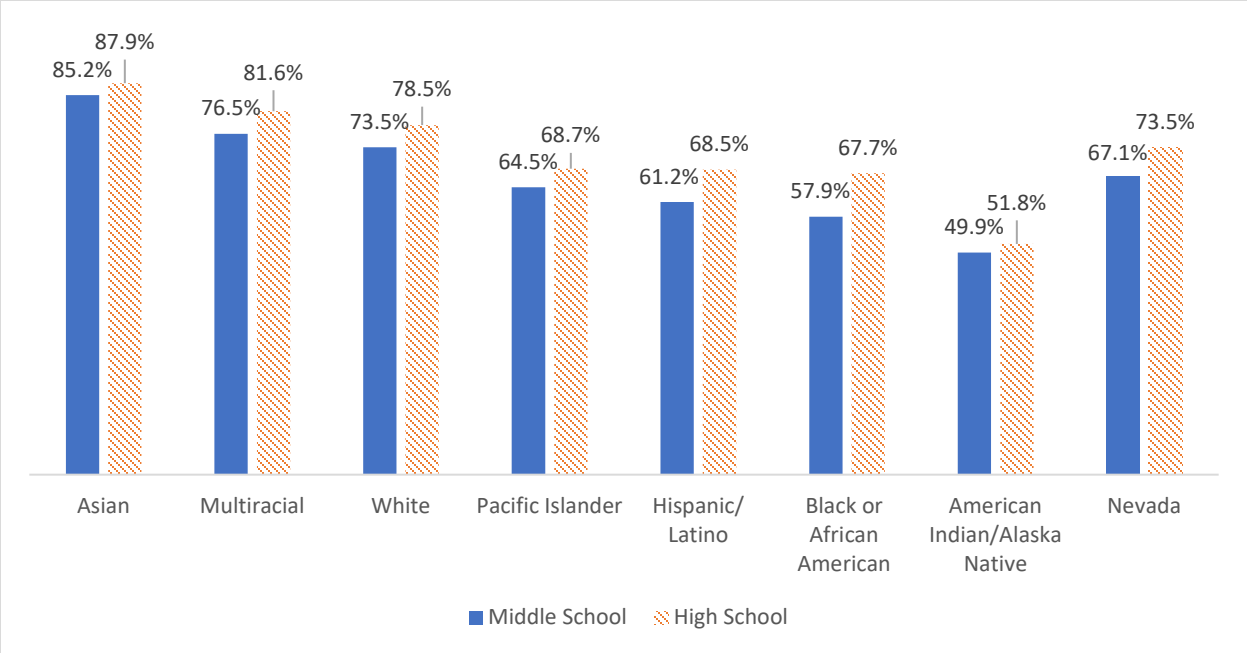
Figure 22. Percent of Fourth Graders who are Chronically Absent from School, Nevada and United States, 2003 to 2019[152]

[145] Revenues and Expenditures for Public Elementary and Secondary Education: School Year 2015-16 (Fiscal Year 2016). (2019, May). *National Center for Education Statistics (NCES)*. Retrieved November 7, 2019, from https://nces.ed.gov/pubs2019/2019303.pdf.
[146] Education Week. (n.d.). Quality Counts 2019: Grading the States Change for Success. Retrieved November 7, 2019, from https://www.edweek.org/ew/articles/2019/01/16/highlights-report-nevada.html.
[147] American Community Survey. (2017). S0901: Children Characteristics.
[148] Counties are missing due to due to data not being available because the number of sample cases is too small (<50 cases).
[149] American Community Survey. (2017). Table S0901: Children Characteristics.
[150] KidsCount.org. (2017). Children ages 6 to 17 who repeated one or more grades since starting kindergarten. Retrieved on December 6, 2019, https://datacenter.kidscount.org/
[151] KidsCount.org. (2019). Fourth graders who are chronically absent from school in the United States. Retrieved on December 6, 2019, https://datacenter.kidscount.org/
[152] KidsCount.org. (2019). Fourth graders who are chronically absent from school in the United States. Retrieved on December 6, 2019, https://datacenter.kidscount.org/



Additionally, the Youth Risk Behaviors Survey (YRBS) asks students to what extent they make mostly A's and B's in school. Among Nevada high school students, 73.5 percent reported they did, compared to 67.1 percent of middle school students (Figure 23).[153,154]

Figure 23. Percentage of Students who made Mostly A's or B's in School in the Previous 12 Months, 2017[155]



[153] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[154] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu/handle/11714/5001.
[155] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu/handle/11714/5001.

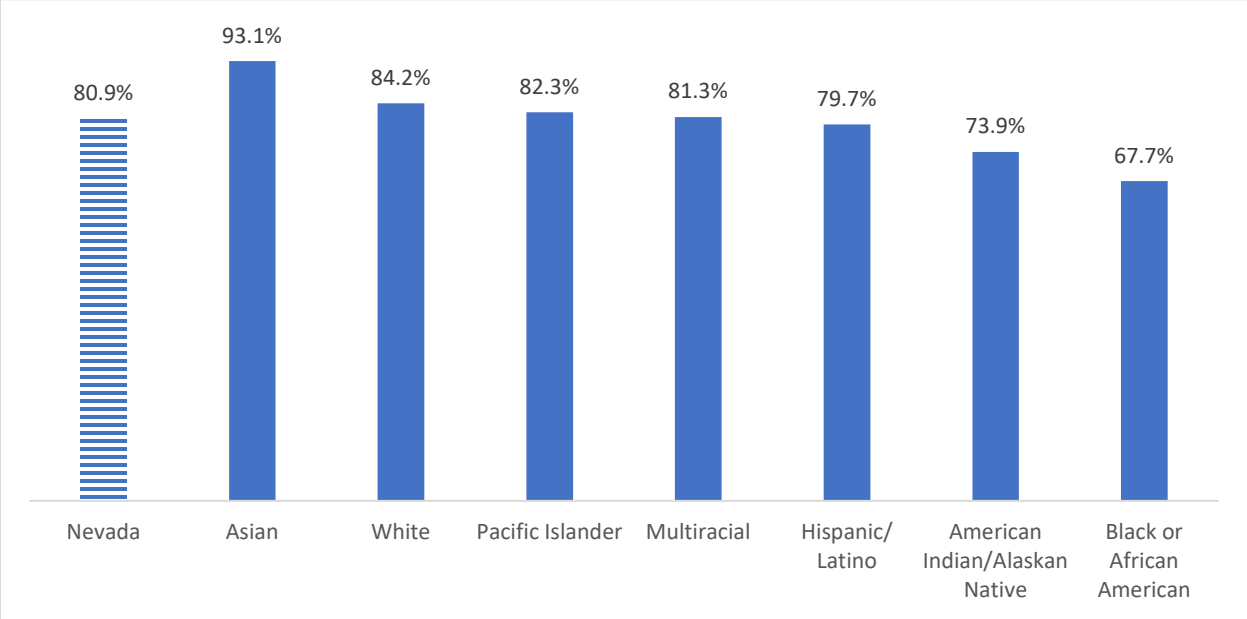
The National Assessment of Educational Progress (NAEP) is an assessment of what American students know. The percentage of students in Nevada who performed at or above the NAEP proficiency level in mathematics was 34 percent in 2019 (lower than the U.S. at 40%).[156] This percentage was not significantly different from 2017 (31%) and was more than twice the rate in 2000 (16%). For reading, in 2019, the percentage of students in Nevada who performed at or above the NAEP proficiency level was 31 percent (lower than the U.S. at 34%). This percentage was the same as in 2017 (31%) and has increased 11 percentage points since 1998 (20%). [157]

High School Graduation Rates

The four-year cohort graduation rate for Nevada was 83.2 percent among the graduating class of 2017-18, higher than for the prior year.[158] In school year 2016-17, the adjusted cohort graduation rate for U.S. public high school students was 85 percent, higher than the 81 percent in Nevada.[159]

In reviewing the 2017-18 cohort graduation rate in Nevada, there are racial and ethnic group disparities, with Black or African American students experiencing the lowest graduation rate (67.7%), followed by American Indian/Alaskan (73.9%) and Hispanic/Latino (79.7%), as shown in Figure 24.

Figure 24. Cohort Four Year Graduation Rates in Nevada, by Race and Ethnicity (Reported for Prior School Year), 2017/18[160]

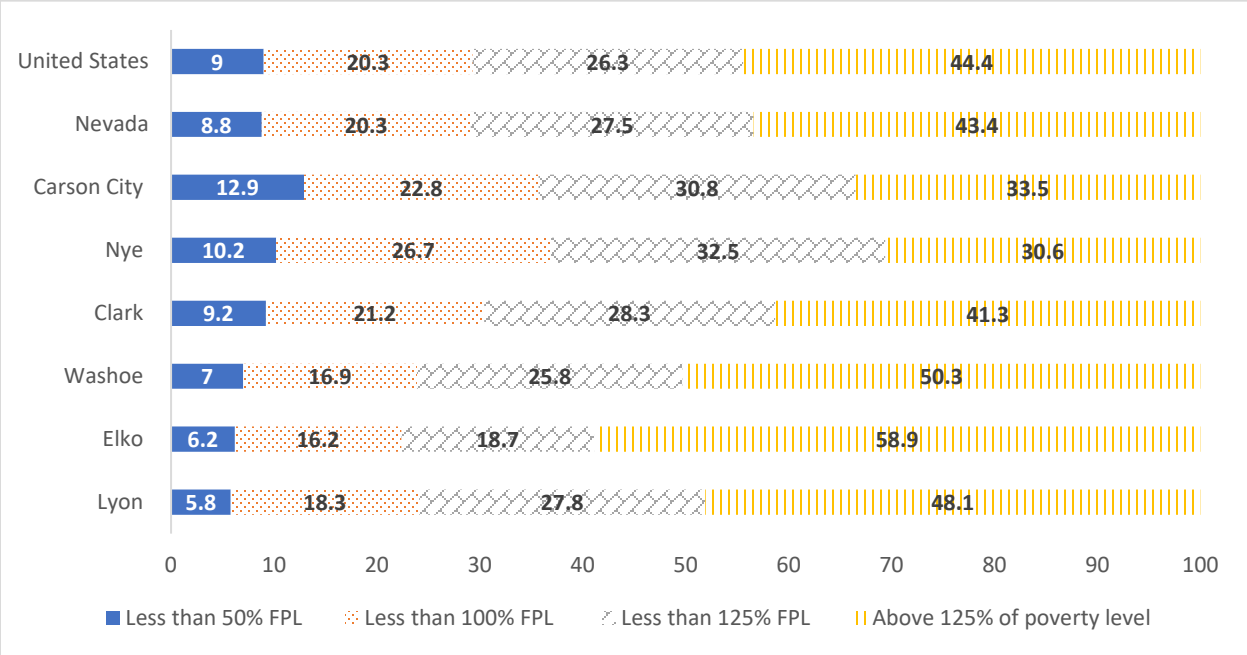


[156] NAEP State Comparison (2019). National Center for Education Statistics (NCES). Retrieved November 7, 2019, from https://www.nationsreportcard.gov/profiles/stateprofile?chort=1&sub=RED&sj=AL&sfj=NP&st=MN&year=2019R3.
[157] NAEP State Comparison (2019). National Center for Education Statistics (NCES). Retrieved November 7, 2019, from https://www.nationsreportcard.gov/profiles/stateprofile?chort=1&sub=RED&sj=AL&sfj=NP&st=MN&year=2019R3.
[158] Nevada Accountability Portal. (2019). Cohort 4Yr Graduation Rates (Reported for Prior School Year), Year 2018-2019. Retrieved November 7, 2019, from http://nevadareportcard.nv.gov/DI/nv/achievement/2019.
[159] United States Department of Education, Office of Elementary and Secondary Education. (2018). Consolidated State Performance Report, 2016–17. See Digest of Education Statistics 2018, table 219.46.
[160] United States Department of Education, Office of Elementary and Secondary Education. (2018). Consolidated State Performance Report, 2016–17. See Digest of Education Statistics 2018, table 219.46.

Poverty

For a family of four in 2017, the Federal Poverty Level (FPL) was $24,600/yr.[161] Since 2010, poverty among families has increased faster in Nevada than for families across the U.S. The 2013-2017 five-year estimate indicates 10.3 percent of all families in Nevada live in poverty, compared to 8.6 percent of families in 2010. This represents an increase of 19.8 percent. The rate in the U.S. has remained steady, from a rate of 10.1 percent in 2010 to a rate of 10.5 percent in 2013-2017, an increase of just 4 percent. .[162] In Nevada, 27.5 percent of children younger than 18 years and 17.7 percent of adults ages 18 to 64 years lived below 125% FPL between 2013-2017.[163] Figure 25 illustrates the percentage of Nevada's children in poverty.

Figure 25. Percent Poverty of Children Under 18 by FPL, Nevada, 2013-2017[164]



Extreme poverty, or living below 50 percent FPL, shows similar trends as poverty overall, with some groups disproportionately affected. From 2013 to 2017, the following percentages of Nevadans were living in extreme poverty: Among female-headed single parent families, 13.7 percent are in extreme poverty compared to 2.3 percent of married-couple families. Of the race and ethnicity groups in Nevada, Black or African Americans, and American Indian or Alaskan Natives experienced the highest rates of extreme poverty at 13.1 percent and 12.9 percent, respectively, exceeding the comparable national rates. Figure 26 presents selected percentages of groups living in extreme poverty.[165]

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[161] 2017 Federal Poverty Guidelines. (n.d.). *US Department of Health and Human Services.* Retrieved November 8, 2019 from https://aspe.hhs.gov/2017-poverty-guidelines.

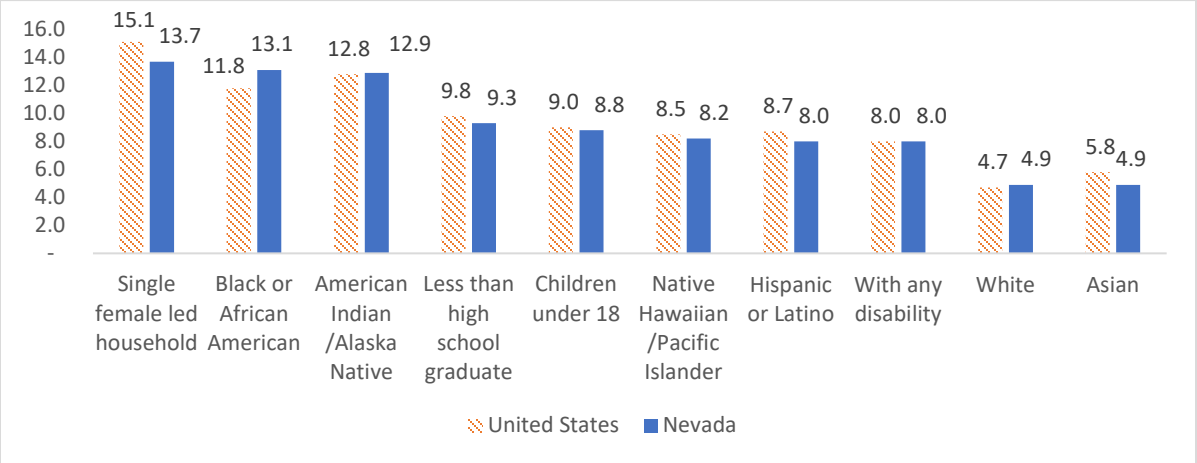
[162] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=dp03&tid=ACSDP1Y2017.DP03.

[163] American Community Survey. (2017). Table S1703. Selected characteristics of people at specified levels of poverty in the past 12 months. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.

[164] American Community Survey. (2017). Table S1703. Selected characteristics of people at specified levels of poverty in the past 12 months. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.

[165] American Community Survey. (2017). Table S1703. Selected characteristics of people at specified levels of poverty in the past 12 months. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.

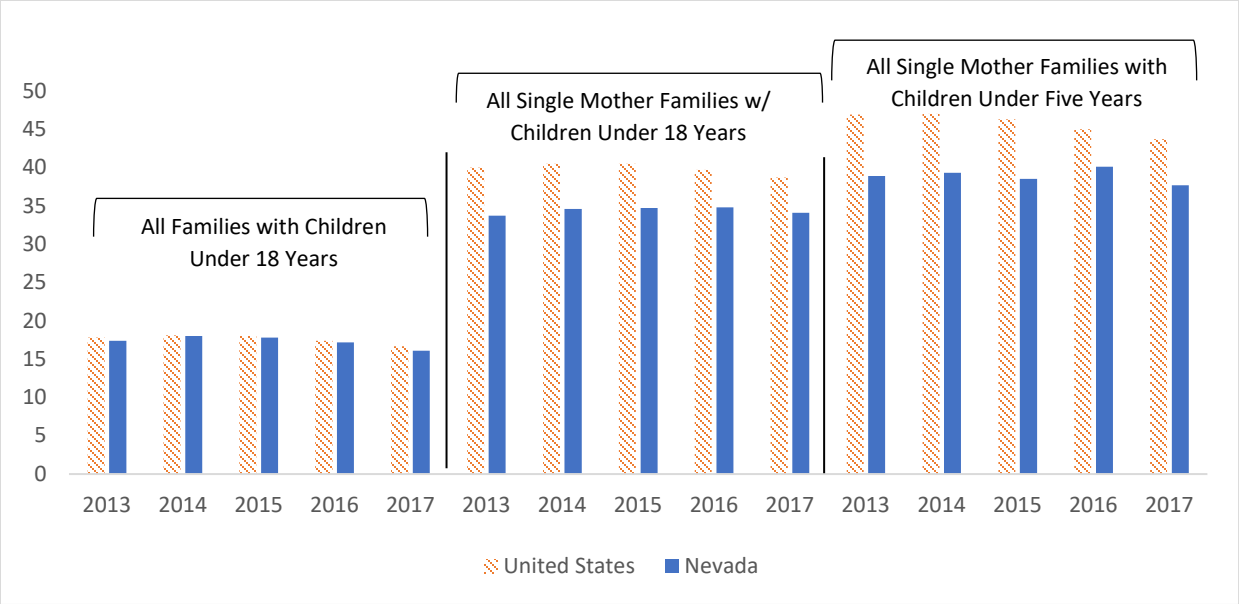
Figure 26. Percent Population below 50 percent of Federal Poverty Level by Characteristics, Nevada and United States, 2013-2017[166]



The percentage of Nevada families with children younger than age 18 years living below poverty is 16.1 percent (slightly lower than the U.S. at 16.7%).[167] Of the households with children aged five years and younger, 15.4 percent live below poverty (lower than the U.S. at 16.2%).[168] Families with a single female head experience much higher rates of poverty, jumping to 34.1 percent among these households with children younger than age 18 years (lower than the U.S. at 38.7%) and to 37.7 percent in single mother households with children under age five years (lower than the U.S. at 43.3%).[169] Figure 27 illustrates the increasing prevalence of poverty among Nevada families with single mother households and children under five years of age compared to those with two parent households and/or older children between 2013-2017.

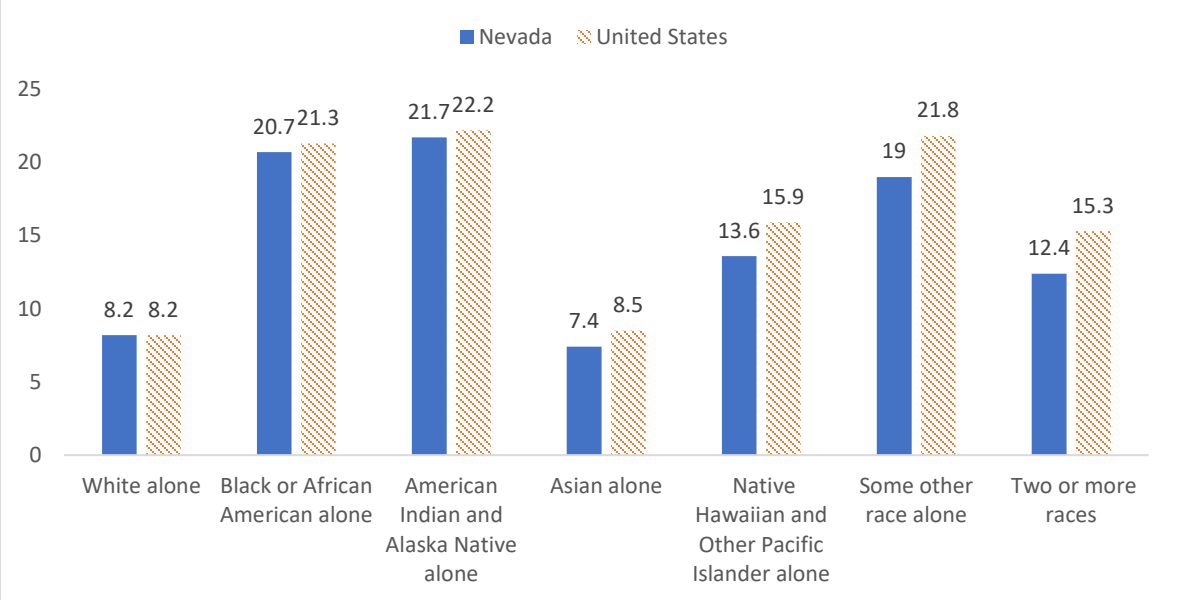
Figure 27. Poverty Rates Among Families, Nevada and United States, 2013 to 2017[170]

[166] American Community Survey. (2017). Table S1703. Selected characteristics of people at specified levels of poverty in the past 12 months. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.
[167] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=dp03&tid=ACSDP1Y2017.DP03.
[168] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=dp03&tid=ACSDP1Y2017.DP03.
[169] American Community Survey. (2017). Table S1703. Poverty status in the past 12 months of families. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.
[170] American Community Survey. (2017). Table S1703. Poverty status in the past 12 months of families. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.



Additionally, Nevada families with householders of a racial or ethnic minority are more likely to experience poverty (Figure 28).

Figure 28. Percent of Families Experiencing Poverty, by Race and Ethnicity of Householder, Nevada and United States, 2017[171]



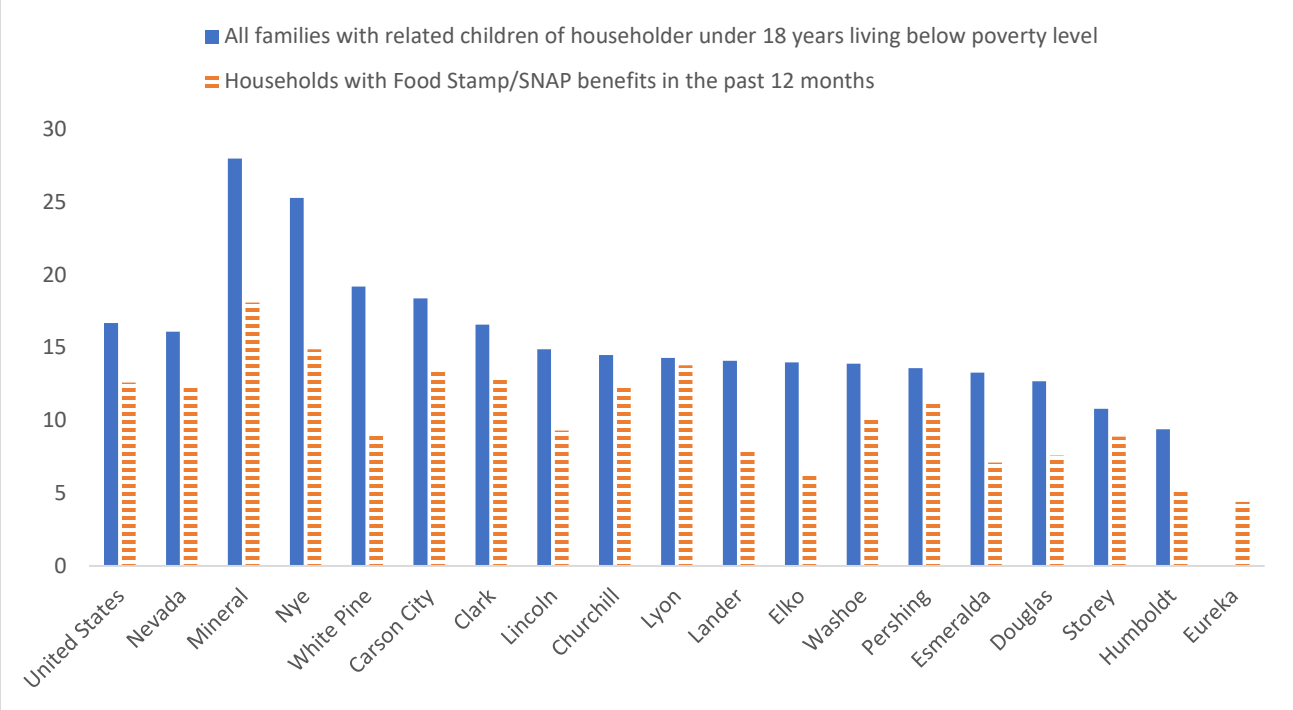
Food Security

Household food insecurity is often a consequence of poverty. The USDA definition of food insecurity can be paraphrased as: a limited or uncertain availability of food. Low food security is food insecurity

[171] American Community Survey. (2017). Table S1703. Poverty status in the past 12 months of families. Retrieved November 8, 2019, from https://data.census.gov/cedsci/table?q=S1703&tid=ACSST5Y2017.S1703.

without hunger. Very low food security is food insecurity with hunger.[172] Food insecurity is similar in Nevada and across the nation; however, Nevada has slightly lower rates of food insecurity among children. In 2017, 12.2 percent (n=365,160) of Nevadans were struggling with hunger (compared to 12.5% in the U.S.), of which 136,800 are children.[173] Feeding America estimates one in five children in Nevada struggle with hunger (compared to 17% of children nationally).[174] Figure 29 compares the percent of households with children younger than age 18 years living below the poverty level with the percent of all households with food stamp/SNAP benefits in the past 12 months. The greatest disparity in households living in poverty and those receiving food stamp/SNAP benefit is in Mineral, Nye, and White Pine counties. In Nevada, there are more people in need of these benefits than receive them.

Figure 29. Percent of Households with Children Living Below Poverty and Receiving Food Stamp/SNAP Benefits in the Past 12 Months, County, Nevada, and United States, 2018[175]



Homelessness

As of January 2019, an estimated 7,169 Nevadans were experiencing homelessness on any given day, as reported by Continuums of Care to the United States Department of Housing and Urban Development (HUD). Among those experiencing homelessness, 183 are known to represent individuals in the same family households, 674 individuals were Veterans, 1,285 individuals were unaccompanied young adults (ages 18-24 years), and 715 individuals were experiencing chronic homelessness (have experienced

[172] US Department of Agriculture. Definitions of Food Security. (n.d.). Definitions of Food Security. Retrieved November 8, 2019 from http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security.aspx
[173] Feeding America. (2018). Map the Meal Gap. Retrieved on November 8, 2019, from https://map.feedingamerica.org/county/2017/overall/nevada.
[174] Feeding America. (2018). Map the Meal Gap. Retrieved on November 8, 2019, from https://map.feedingamerica.org/county/2017/overall/nevada.
[175] American Community Survey. (2017). Table DP03. Selected economic characteristics. Retrieved November 8, 2019 from https://data.census.gov/cedsci/table?q=dp03&tid=ACSDP1Y2017.DP03.

homelessness for more than a year). The remaining are adults experiencing homelessness.[176] In 2018, Nevada was one of the top five states for rates of unsheltered homeless individuals, with 59.3 percent of the population experiencing homelessness living in places not meant for human habitation such as cars, parks, sidewalks, etc. Nevada also had the highest rate of unsheltered homeless youth, representing 83.8 percent of all youth experiencing homelessness.[177] There were 20,696 students in Nevada public schools identified as homeless in 2018, of which 483 individuals (2.3%) were unsheltered.[178] The vast majority of homeless youth were doubled up (73.2% or 15,150 youth), defined as having one or more adults, in addition to the head of household and spouse/partner, such as an adult child living at home, two related or unrelated families residing together, or a parent living with an adult child.

Between 2014 and 2018, the number of homeless individuals in Nevada decreased by 12.1 percent. During this period, Clark County experienced a decrease of 18.3 percent and the balance of the state (except Washoe County) decreased by 27.3 percent. Comparatively, Washoe County experienced a 55.5% increase in the homeless population over the same time period.[179] According to the National Low-Income Housing Coalition (2019), Nevada has the greatest shortage of affordable housing for Extremely Low Income (ELI) households in the nation. Nevada has more than 90,000 ELI households and a rate of 19 affordable and available rental homes per 100 extremely low-income renter households (compared to 37 affordable and available rental homes per 100 ELI renter households nationwide).[180]

Protective Factors Increasing Resilience Among MCH Population Groups or Making Them Less Likely to Experience Adverse Health Outcomes

Select protective factors described in this assessment include protective family routines and habits, social connectedness, and neighborhood and school safety.

Protective Family Routines and Habits

The environment at a child's home is an important protective factor against negative health outcomes. There are routines and habits parents or caregivers can control to foster a protective home environment, such as tobacco exposure, screen time, reading, and/or doing homework. Nevada ranks 47th nationally in the percent of children who experience protective family routines and habits at 9.6 percent (compared to 12.2% across the U.S.).[181]

Social Connectedness

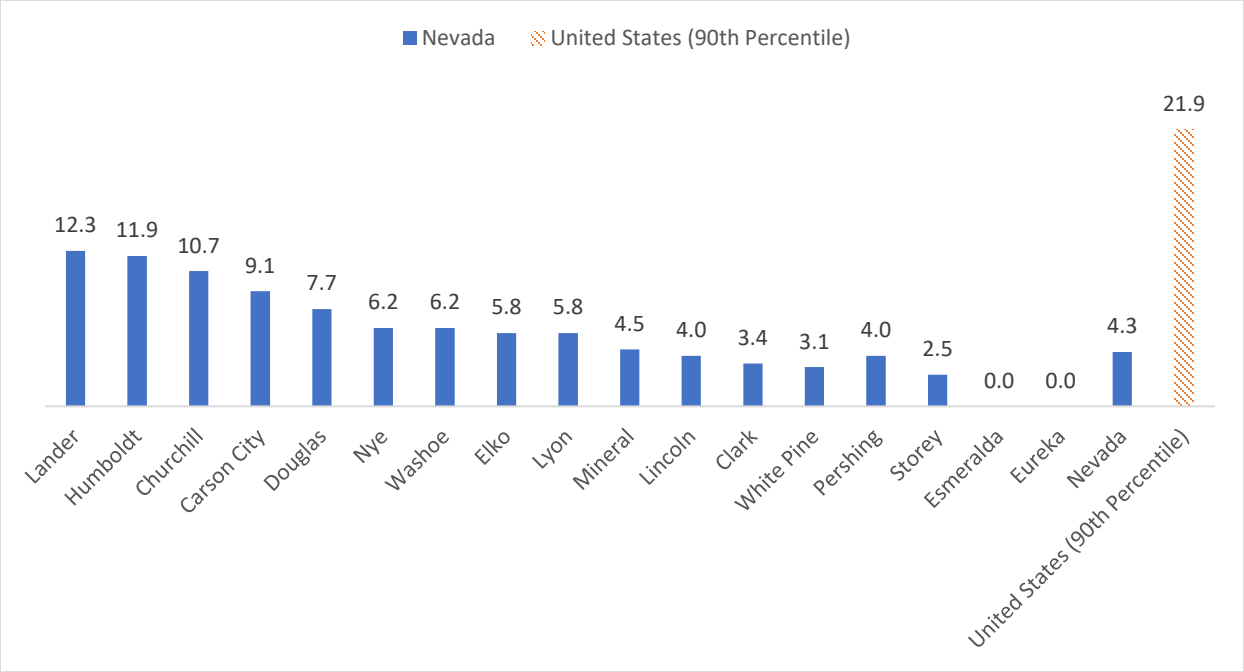
[176] United States interagency Council on Homelessness. (n.d.). Nevada Homelessness Statistics report. Retrieved November 13, 2019 from https://www.usich.gov/homelessness-statistics/nv/.
[177] United States Department of Housing and Urban Development, Office of Community Planning and Development (2018). *The 2018 Annual Homeless Assessment Report (AHAR) to Congress – Part 1: Point-in-Time Estimates of Homelessness*. Retrieved from https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf.
[178] United States interagency Council on Homelessness. (n.d.). Nevada Homelessness Statistics report. Retrieved November 13, 2019 from https://www.usich.gov/homelessness-statistics/nv/
[179] US Department of Housing and Urban Development. HUD Continuum of Care Homeless Populations and Subpopulations Reports, 2014-2018 data for Clark, Washoe, and Balance of State. Retrieved November 21, 2019 from https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=2018&filter_Scope=CoC&filter_State=NV&filter_CoC=&program=CoC&group=PopSub
[180] National Low-Income Housing Coalition. (March 2019). The Gap: A Shortage of Affordable Rental Homes. Retrieved on November 21, 2019 from https://reports.nlihc.org/gap.
[181] America's Health Rankings Analysis of Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Data Resource Center for Child and Adolescent Health, United Health Foundation. (2018) Accessed December 6, 2019 from http://americashealthrankings.org/.

Research shows when an adolescent feels connected to caring adults, their school or their community, they experience a protective factor against a wide range of adverse health-related outcomes. Youth who feel connected are more likely to engage in healthy behaviors and excel academically.[182] Therefore, promoting shared protective factors, such as youth connectedness, has important implications for overall health and wellbeing for children. Youth disconnectedness portrays a dynamic between individuals and their environment. Disconnected youth are at an increased risk of violent behavior, smoking, alcohol consumption and marijuana use, and may have emotional deficits and less cognitive and academic skills than their peers who are working and/or in school. Studies show both a lack of educational attainment and unemployment is linked to depression, anxiety, and poor physical health. One in ten Nevada youth, ages 16 to 19 years, are disconnected, defined by being neither working nor in school. This rate varies by county, from a low of 6 percent in Washoe County to a high of 26 percent in Humboldt County.[183]

Additionally, the number of membership associations per 10,000 population or "social associations" is a measure of connectedness within communities. Membership associations include memberships to civic organizations, bowling centers, golf clubs, fitness centers, sports organizations, religious organizations, political organizations, labor organizations, business organizations, and professional organizations. Across Nevada in 2015, the overall rate of membership associations per 10,000 people was 4.3, compared to 21.9 (90th percentile) among top U.S. performers. There is great variation for this measure across communities within Nevada, with a low in Esmeralda and Eureka counties of zero membership associations to a high in Lander County of 12.3 membership associations per 10,000 people (Figure 30).[184]

Figure 30. Number of Membership Associations per 10,000 Population, County, Nevada, and United States, 2015[185]

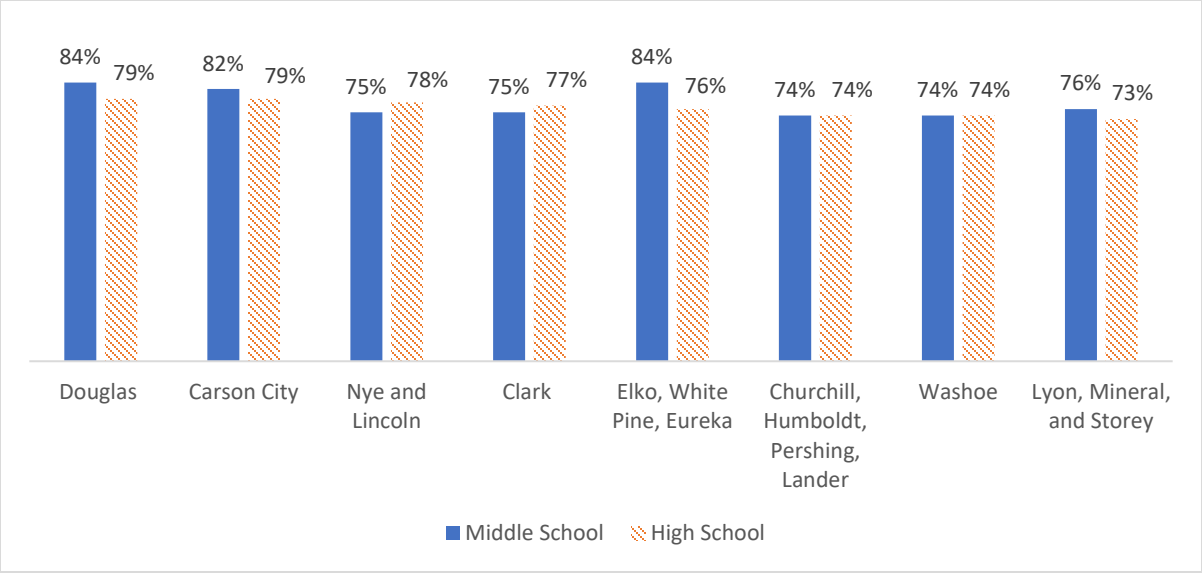
[182] Centers for Disease Control and Prevention. (2019, June). Adolescent Connectedness and Adult Health Outcomes. *NCHHSTP Newsroom*. Retrieved on December 12, 2019, from https://www.cdc.gov/nchhstp/newsroom/2019/adolescent-connectedness-press-release.html.
[183] RWJF County Health Rankings. (2017). Education measure: Disconnected Youth. Retrieved on December 26, 2019 from https://www.countyhealthrankings.org/app/nevada/2019/measure/factors/149/datasource.
[184] RWJF County Health Rankings. (2017). Family and Social Support Measure: Social associations. Retrieved on December 26, 2019 from https://www.countyhealthrankings.org/app/nevada/2019/measure/factors/140/description.
[185] RWJF County Health Rankings. (2017). Family and Social Support Measure: Social associations. Retrieved on December 26, 2019 from https://www.countyhealthrankings.org/app/nevada/2019/measure/factors/140/description.



Similarly, the percentage of Nevada students whose parents or other adults asked where they were going or who they would be with most of the time/always was 78 percent among high school and 75 percent among middle school students. This experience among students varies slightly by county, ranging from a high of 84 percent among middle school students in Douglas, Elko, White Pine, and Eureka counties to a low of 74 percent in Churchill, Humboldt, Pershing, Lander, and Washoe counties (Figure 31).[186,187] Among high school students, this percent ranges from a high of 79 percent in Douglas County and Carson City to a low of 73 percent in Lyon, Mineral, and Storey counties.

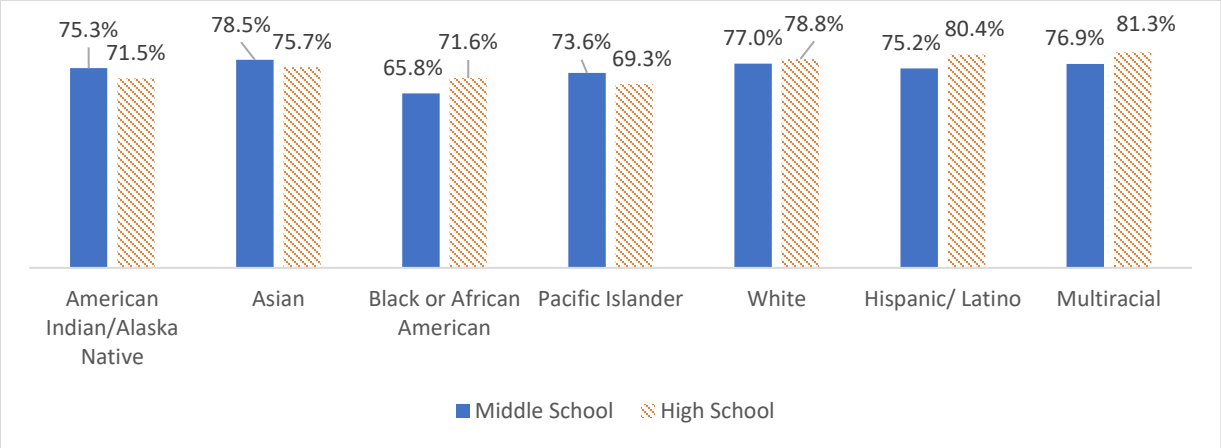
Figure 31. Percentage of Middle and High School Students Whose Parents or Other Adults Asked Where They Were Going or Who They Would Be with Most of the Time/Always, by Region, 2017[188,189]

[186] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[187] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu/handle/11714/5001.
[188] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[189] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu/handle/11714/5001.



The racial and ethnic group with the lowest rate of parents or other adults who asked where they were going or who they would be with most of the time/always were among middle school students who identified as Black or African American (66%), with the highest rate among multiracial or Hispanic high school students (Figure 32).[190]

Figure 32. Percentage of Students Whose Parents or Other Adults Asked Where They Were Going or Who They Would Be with Most of the Time/Always, by Race and Ethnicity, 2017[191,192]



[190] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

[191] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

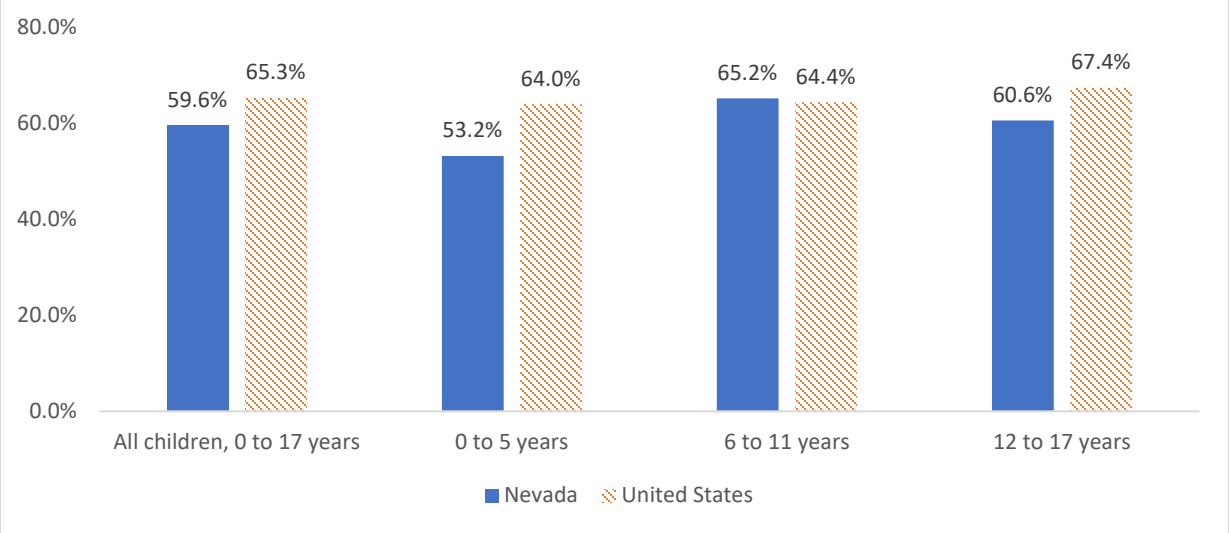
[192] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.

Overall, 83.8 percent of high school female students (compared to 79.3% of middle school female students) have parents who ask where they are going or who they will be with compared to 73.5 percent of high school males (and 71% of middle school male students). [193,194]

Neighborhood and School Safety

In 2017/18, 59.6 percent of Nevada parents reported their child (ages zero to 17 years) definitely lived in a safe neighborhood. A smaller percentage (34.9%) reported they somewhat felt their child lived in a safe neighborhood and 5.6 percent reported they somewhat or definitely disagreed their child lived in a safe neighborhood. These proportions are all below the comparable rates nationwide, with 65.3 percent of parents of U.S. children reporting their child definitely lived in a safe neighborhood, 30 percent somewhat agreeing, and only 4.7 percent somewhat or definitely disagreeing. These values also differed by age group in Nevada and the U.S. (Figure 33).[195]

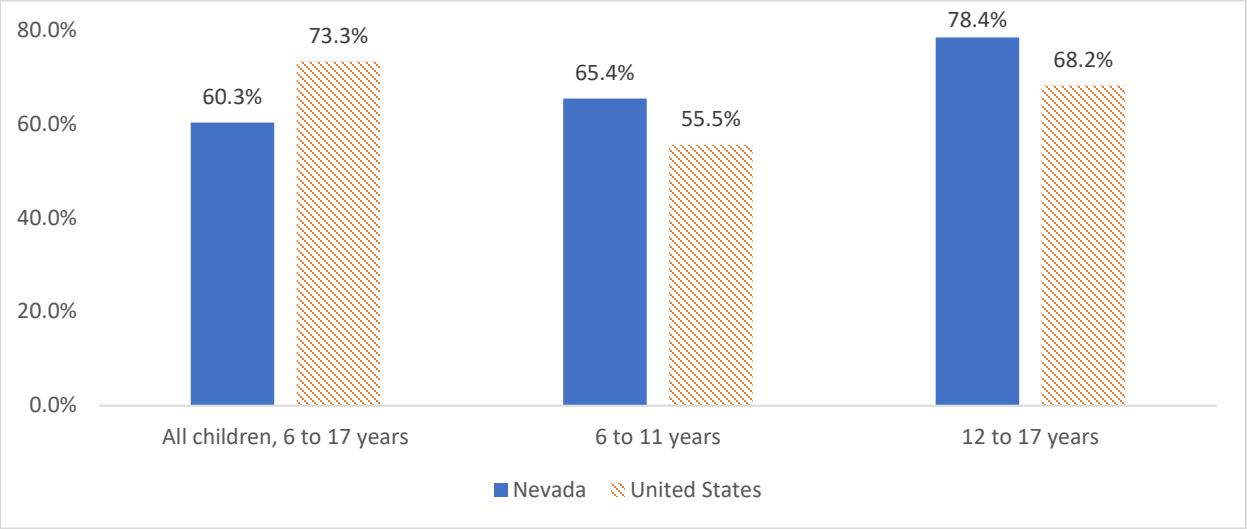
Figure 33. Percentage of Parents Who Report Their Child, Ages Zero to 17, Lives in a Safe Neighborhood, Nevada, 2017 to 2018[196]



Looking at school safety, in Nevada from 2017 to 2018, 60.3 percent of parents said they felt their child, between the ages of six and 17 years, was safe at school. This was much lower than the percentage of parents who said the same nationwide (73.3%). For children between the ages of six and 11 years, 65.4 percent of parents said they felt their child was safe in school in Nevada. This percentage drops to 55.5 percent among adolescents (ages 12 to 17 years), suggesting Nevada parents worry more about their child's safety in middle and high school than they do in elementary school. The same trend is seen nationally, with 78.4 percent of parents with children between the ages of six and 11 years saying they felt their child was safe at school, but only 68.4 percent of parents with children between the ages of 12 and 17 years saying the same (Figure 34).[197]

[193]Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[194] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[195] National Children's Health Survey. (2018). Indicator 7.2: Does this child live in a safe neighborhood?
[196] National Children's Health Survey. (2018). Indicator 7.2: Does this child live in a safe neighborhood?
[197] National Children's Health Survey. (2018). Indicator 7.3: Is this child safe at school, age 6-17 years?

Figure 34. Percentage of Parents Who Report Their Child, Ages Six to 17, is Safe at School, Nevada, 2017 to 2018[198]



Racial/ethnic disparity exists in parents' perception of school safety. Parents of White children in Nevada have a greater prevalence of reporting feeling their child is safe at school (67.2%), compared to parents of Asian (59%) or Hispanic (53.1%) children.[199] Parents in households with incomes at or greater than 400 percent FPL were more likely to report feeling their child is safe at school (69.2%), while this drops to 62.6 percent for parents with household incomes at or below 100 percent FPL.[200]

Community Voices

Incorporating community voices is of utmost importance to the needs assessment process. Key informant interviews, a community survey, and focus groups with community members provide opportunities for community stakeholders to share individual thoughts and perspectives and present their ideas for change. Community input in describing the problem ensures a clear and agreed-upon understanding of the problem's definition, scope, and impact on community members. This is important level setting for any research.

Community members may also have insights into how to best address the problem within their specific community context as they are the subject matter experts on their community. Building consensus among various stakeholder groups may also prove beneficial in implementing change; spending time engaging community members in the needs assessment process often creates a market for better results.[201] Sharing needs assessment results with community stakeholders and participants fosters transparency and accountability and supports communities leveraging data for grant applications, program development, and project implementation.

[198] National Children's Health Survey. (2018). Indicator 7.3: Is this child safe at school, age 6-17 years?
[199] Data are not available for Black or African American children.
[200] National Children's Health Survey. (2018). Indicator 7.3: Is this child safe at school, age 6-17 years?
[201] United States Department of Health and Human Services Centers for Disease Control and Prevention. Office of the Director, Office of Strategy and Innovation. (2011). Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide. Atlanta, GA: Centers for Disease Control and Prevention.

In the community survey, focus groups, and key informant interviews, discussions were facilitated to explore the strengths and gaps in different communities, needs of MCH population groups, gaps in services and resources, and solutions for the future. The following section presents a synthesis of these data sources representing community voices.

Community Strengths and Gaps

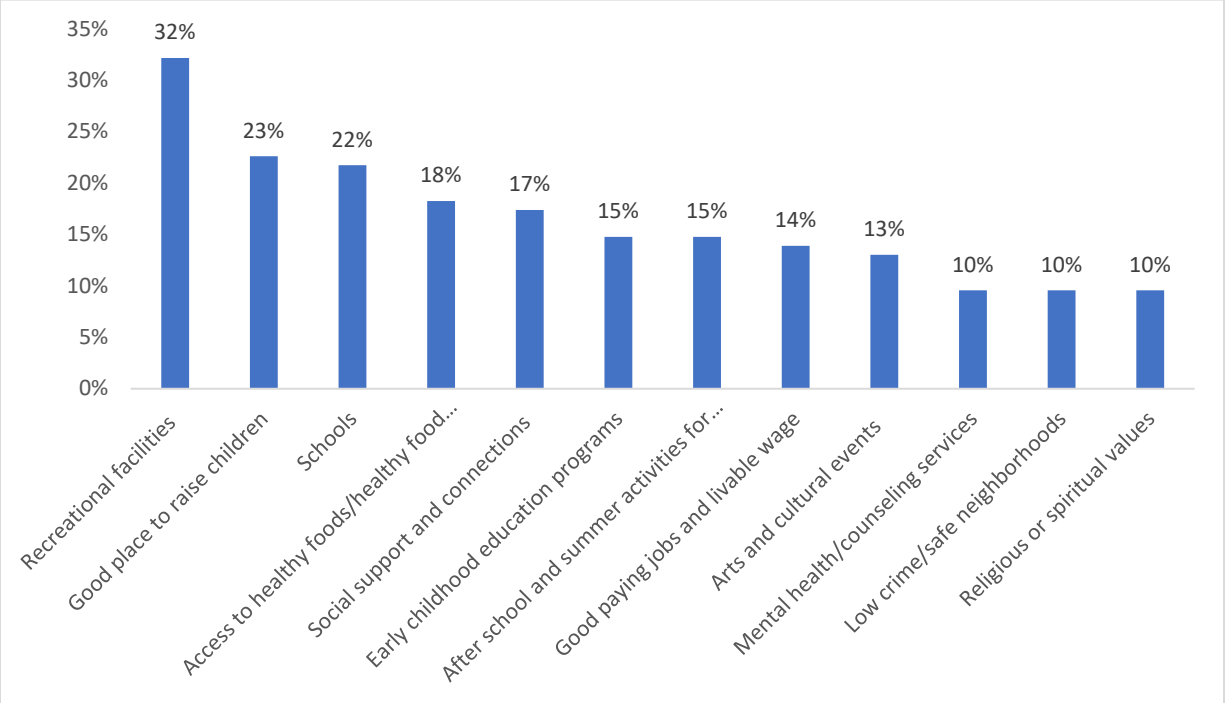
Via the community survey, community members and MCH professionals and service providers were asked to identify the top three concepts in their community benefiting MCH population groups which are considered strengths (Table 36). These are resources considered accessible, affordable, and/or high quality. Community members identified recreational facilities and schools as strengths, in addition to the general feeling their communities are a good place to raise children (Figure 35).

Table 36. Top Five Strengths

Identified by Community Members (n=115)	Percent
Recreational facilities	32%
Good place to raise children	23%
Schools	22%
Access to healthy foods	18%
Social support and connections	17%

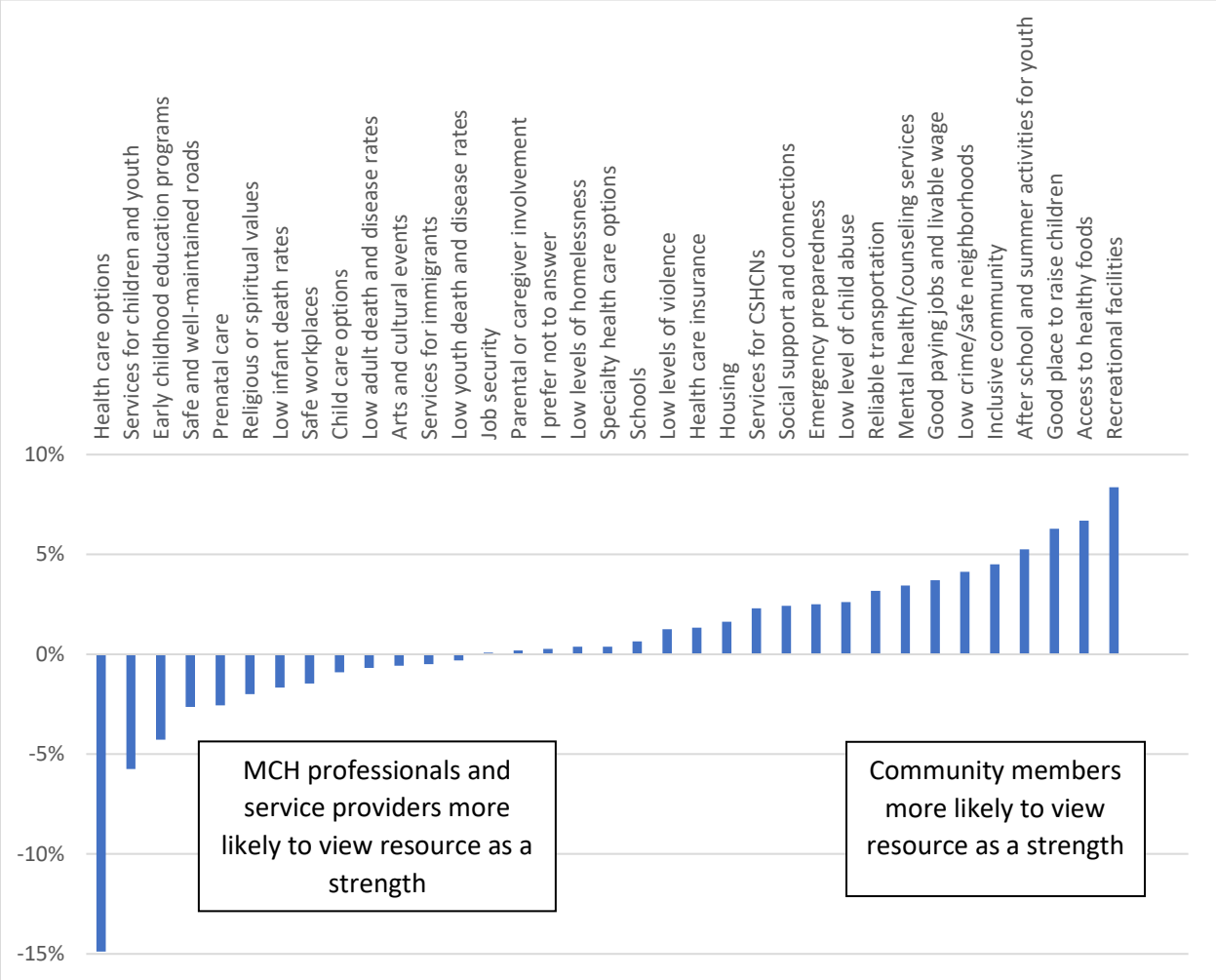
Identified by MCH professionals and service providers (n=147)	Percent
Recreational facilities	24%
Schools	21%
Early childhood education programs	19%
Health care options	18%
Good place to raise children	16%

Figure 35. Community Resources Identified as Available, Accessible, Affordable, and/or High Quality by More Than 10.0 Percent of Community Member Survey Respondents (n=115)



MCH professionals and service providers identified the same top three resources community members identified as strengths of their community benefitting MCH population groups – recreational facilities, schools, and that many of Nevada's communities are good places to raise children. Looking beyond the top three strengths of communities, differences included MCH professionals and service providers reporting early child education programs and health care options as strengths, compared to access to healthy foods and social support and connections among community members. Comparing MCH professionals and service providers and community member responses shows general agreement regarding to what extent these items are community strengths (Figure 36).

Figure 36. Absolute Difference in Percent of Respondents Who Perceived These Things to be Strengths Benefiting MCH Population Groups in their Community



Community members and MCH professionals and service providers identified the same set of resources needing improvement (or those services not available, accessible, affordable, and/or high quality) in their community to benefit MCH population groups – mental health services, childcare options, housing, health care options, and good paying jobs with livable wages.

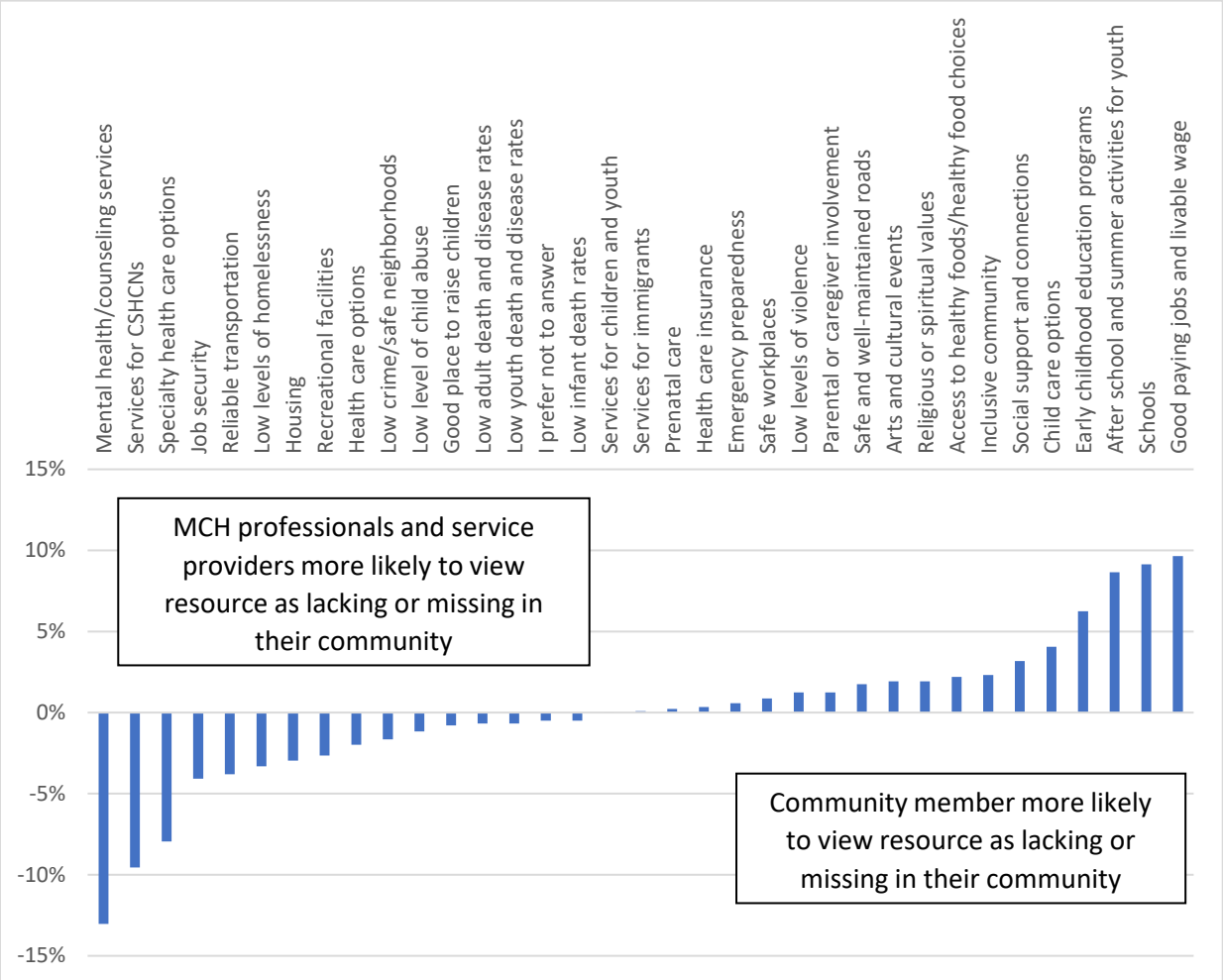
Despite this agreement, the extent to which respondents identified with these top five areas needing improvement was different (Figure 37). For example, the portion of providers who responded mental health/counseling services were lacking or missing was greater than the portion of community members thinking so (47% and 34%, respectively). Similarly, while good paying jobs and livable wages were considered lacking or missing in communities, community members were more likely to select it as an issue than MCH professionals and service providers (29% and 19%, respectively).

Table 37. Top Five Things Needing Improvement

Identified by community members (n=115)	
Childcare options	37%
Mental health/counseling services	34%
Good paying jobs and livable wage	29%
Housing	27%
Health care options	25%

Identified by MCH professionals and service providers(n=147)	
Mental health/counseling services	47%
Childcare options	33%
Housing	30%
Health care options	27%
Good paying jobs and livable wage	19%

Figure 37. Absolute Difference in Percent of Respondents Who Perceived These Things Benefiting MCH Population Groups as LACKING OR MISSING in their Community



Key informants and focus group participants generally supported the findings of the survey data regarding community strengths and areas lacking or needing improvement.

Behavioral Health - Mental Health and Substance Use Treatment Services

Key informants reported mental health services are lacking for all population groups, reporting "mental health is an issue."

Key informants mentioned a wide range of **mental health service gaps in Nevada, including evidence-based screening tools, long wait lists for existing services, lack of providers, and lack of funding for mental health services**. Some feel depression and anxiety screenings should be happening more often, especially six weeks postpartum as "…anything after that is difficult." Screening for depression and anxiety among new mothers needs to be a higher priority to get them "…the support they need, which will maximize the positive impact on the entire family."

> "Mental health care is really scary in terms of what is available and how accessible." – *Key informant, Clark County*

> "We can identify a lot of these issues but then have nowhere to send them; have counseling on staff but don't have enough or are widespread enough. This is one of our biggest challenges." – *Key informant, Storey County*

Key informants reported low availability of providers for children's behavioral health (i.e., child psychiatrists). School-based services were also a focus of discussion related to behavioral health, where key informants indicated a lack of providers, with some individual school-based providers serving up to four schools.

Key informants frequently discussed substance use treatment services for pregnant women. One individual pointed out the importance of a continuum of care from pregnancy to postpartum, specifically for individuals with opioid use disorder. Other key informants indicated there is a lack of access to providers who specifically treat substance use disorder, while others discussed a lack of programs assisting with recovery and support.

> "[I] think that there is a lack of comprehensive coordinated continuous services for certain populations like for opioid use disorder among pregnant women and follow-up care, a lack of awareness within multiple systems around what postpartum really looks like and the treatment for it (i.e., peer support), inconsistent access to training and education to provide services". – *Key informant, Carson City*

Childcare Options

There is a reported need for more Head Start programs, as well as more spaces in existing programs. Capacity to deliver and fund childcare are two items highlighted by all community voices as barriers to increasing the availability and affordability of childcare services. Key informants cited the example of Lyon County, reporting the Head Start program is currently at a standstill with no teacher. Home visiting in the community is helping to fill the gap in services.

> "The cost of living is rising, and we can't afford to pay for childcare on a daily basis." – *Focus group participant, Las Vegas*

Key informants often pointed out that three-year-old children are particularly vulnerable to insufficient childcare. For example, Early Head Start programs are offered to pregnant women and families with children ages three years and younger, whereas Head Start programs are for children between three and five-years old. Spaces are reserved for limited to low-socioeconomic status, but there are many children outside those limits who are not being served. Key informants feel they need more subsidizing with looser rules, as childcare affordability continues to be an issue.

One key informant also noted there are children experiencing behavior issues resulting in removal from daycare or school and attributed this to a lack of discipline or parents working and leaving children alone. Another key informant indicated a need for early childhood interventions for infants and toddlers. Rural communities are facing a particularly large deficit of developmental programs and early interventions; children not in school also miss out on these services.

Good Paying Jobs, Paid Family Leave, and Livable Wage

Focus group participants noted the lack of jobs providing paid leave (including maternity and postpartum) and paid time off to tend to family health care needs. Some focus group participants expressed a desire for employers to be held accountable to provide these "basic human rights" to their employees. When coupled with transportation issues or long distances to services, these barriers often mean children and families are not receiving basic, preventive care and instead rely on emergency care. Key informants echoed this sentiment, sharing they see families using emergency departments instead of being served in medical homes.

Health Problems or Issues in the Community

All survey respondents were asked to select the three most important health problems/issues in the community for each of the MCH population groups (Table 38, below, shows the three most common responses and includes a fourth issue if the response rate tied the third most common issue). Appendix D includes all responses, and responses by survey respondent type.

Mental health was the health problem or issue identified the most across four MCH population groups: women of reproductive age, pregnant and postpartum women, and children and adolescents without special health care needs. Violence, including domestic violence and child abuse/neglect was another common theme for four MCH population groups: women, pregnant and postpartum women, children, and adolescents without special health care needs. ACEs and other trauma are key drivers of mental health. Lack of family support and connectedness were other challenges identified as drivers of poor mental health across Nevada's MCH population groups.

Table 38. Three Most Important Health Problems/Health Issues in the Community, by MCH Population Group, All Survey Respondents (n=227)

Women of Reproductive Age	Pregnant Women	Newborns and Infants (Birth up to 1 Year of Age)	Young Children (1 to 5 Years of Age)	Children (6 to 11 Years of Age)	Adolescents/ Young Adults (12 to 21 Years of Age)	Children with Special Health Care Needs (Birth to 21 Years of Age)
Mental health; i.e., anxiety, depression, etc. (56%)	Mental health; i.e., postpartum depression, anxiety, etc. (44%)	Child abuse / neglect (34%)	Access to affordable childcare and/or pre-school (37%)	Overuse of technology/ excessive screen time (26%)	Mental health; i.e., anxiety, depression, etc. (39%)	Lack of adequate access to specialty medical care[202] (29%)
Domestic or intimate partner violence (23%)	Postnatal care (24%)	Maternal substance use during or after pregnancy (33%)	Caregiver substance use or mother/ father substance use (28%)	Physical activity (25%)	Lack of social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood (28%)	Navigation of the system of care for children and youth with special health care needs (24%)
Illicit substance use; i.e., heroin, cocaine, etc. (22%)	Prenatal care (21%)	Not receiving developmental screenings (30%)	Child abuse / neglect (26%)	Mental health; i.e., anxiety, depression, etc. (24%)	E-cigarettes or vaping (15%)	Lack of social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood (23%)
				Poor eating habits (24%)	Unsafe Sex (15%)	

Note: Responses do not add up to 100 percent because respondents could select multiple options.

[202] Such as genetics, pediatric neurology, child psychiatry, developmental-behavioral pediatrics, etc.

MCH professionals and service providers were asked to identify the **top emerging health issue** for each MCH population group.

- Across the board, access to health care services was noted most frequently.
- Substance use related issues, particularly marijuana and vaping, were the second most common issues identified across nearly all population groups.
- Education and awareness about the issues and resources specific to each MCH population group were also mentioned frequently across all groups.

For detailed responses by MCH population group, see Appendix E. Focus group and key informant discussions present an opportunity to explore these issues further, and are presented in a "community voice" section for each MCH population group.

Resource Needs

Community members reported **well visits, wellness services, and mental health services were the top services or resources needed to stay physically and mentally healthy** (Table 39). Focus group participants reported engaging in mental health services for themselves and their children. Foster parents use mental health services to deal with the complexities of raising multiple children and have also taken their foster children to counseling to help them cope with being away from their birth parents. Other parents report taking their children to counseling to deal with family separation. Parents of CYSHCN reported using mental health services for individual and family counseling. The fourth most depended upon resource was **bullying prevention**, of which nearly half (65%) of community members said they "very much/somewhat" depend on this resource.

Table 39. Community Member Report on the Things They Most Need to Stay Physically and Mentally Health

Response option	Very much/ Somewhat	Very little/ Not at all	I need these services, but they are not available in my community
Well visits with a primary care provider or family doctor	81%	13%	5%
Well-baby and well-child visits with a pediatrician or family doctor	75%	20%	5%
Wellness services, such as those to increase healthy eating and physical activity	66%	27%	7%
Bullying prevention	65%	32%	4%
Prenatal care	63%	29%	8%
Infant feeding, including breastfeeding support	62%	31%	7%
Parenting information	56%	29%	15%
Programs that help youth develop social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood	55%	32%	13%

Response option	Very much/ Somewhat	Very little/ Not at all	I need these services, but they are not available in my community
Early intervention: early identification of the need for testing and support services for young children with developmental delays	54%	35%	10%
Transition to adult health care system support	54%	37%	10%
Mental health services, such as counseling	54%	36%	9%
Pre-pregnancy care	54%	39%	7%
After pregnancy and between pregnancy care	53%	39%	8%
Sexual health education	53%	42%	6%
Diagnostic testing as a result of newborn screening (e.g., follow-up hearing testing and genetic testing)	52%	38%	10%
Programs that promote community inclusion for children and youth with special health care needs	51%	31%	18%
Newborn screening information	51%	40%	9%
Support for quitting smoking	50%	44%	6%
Assistance getting, understanding, and using birth control	49%	41%	10%
Information on preventing infant death	48%	40%	12%
Pregnancy or birth related mental health service	46%	38%	17%
Services addressing intimate partner/domestic violence	46%	51%	3%
Training for parents/caregivers on care coordination	45%	42%	13%
Services to prevent injuries and violence, including self-harm	45%	48%	8%
Specialists and treatment centers	43%	43%	14%
Support to navigate the system of care for children and youth with special health care needs	41%	39%	20%
Availability of medical homes (i.e., patient-centered comprehensive coordinated care)	41%	45%	14%
Substance use treatment, such as drug or alcohol counseling	40%	53%	7%
Creating safe sleep areas	39%	50%	11%
Services to reduce stress, such as respite or time for yourself	37%	48%	15%
Lead poisoning prevention	36%	55%	9%

Response option	Very much/ Somewhat	Very little/ Not at all	I need these services, but they are not available in my community
Services and treatment for infants and young children born with health issues related to drug, tobacco, or alcohol exposure/use	36%	56%	8%
Home visiting	23%	59%	18%

Table 40. Services Needed in the Community not Typically Available, MCH Professionals and Service Provider and Community Members

Service/Resource	Top services reported by MCH professionals and service providers to be needed by their clients but are not available (n=95)	Top services reported to by community members to be needed but are not available (n=60)
Services to reduce stress, such as respite or time for yourself	77%	15%
Availability of medical homes (i.e., patient-centered comprehensive coordinated care)	53%	14%
Home visiting	53%	18%
Programs that promote community inclusion for children and youth with special health care needs	50%	18%
Transition to adult health care system support	49%	6%
Specialists and treatment centers	46%	14%
Pregnancy or birth-related depression service	45%	17%
Support to navigate the system of care for children and youth with special health care needs	45%	20%
Training for parents/caregivers on care coordination	45%	8%
Programs that help youth develop social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood	44%	9%
Mental health services, such as counseling	43%	13%
Parenting information	14%	15%

MCH professionals and service providers and community members generally agreed upon services needed in the community that are not typically available (Table 40 above). **Services to reduce stress, availability of a medical home, and home visiting were top services needed but not available among providers**. Community members ranked support to navigate the system of care for CYSHCN, home visiting, and programs that promote community inclusion among CYSHCN as their top three needed but not available services.

Among this same list of services and resources, community members were asked what they would like in their community currently not existing or not existing in the way needed. The number one response was **mental health services (34%), followed by programs that help youth develop social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood (25%) and services to reduce stress, such as respite or time for yourself (17%).** Also, providers were asked to note whether there are specific communities where they experience limited capacity to provide health and social services. Below are provider quotes shared via the survey, by region, illustrating these challenges:

Northern Nevada

- "Limited in capacity to outreach for northern Nevada rural communities."
- "Yes, I would like to provide more outreach to the northern Nevada rural communities."
- "In northern Nevada and rural/frontier Nevada, we are constantly understaffed and have high turnover rates. When we have open positions, it is difficult to attract qualified professionals."

Southern Nevada

- "We are a clinic for the uninsured and we are only able to serve approximately 2,000 people a year when there are over 200,000 uninsured residents of southern Nevada."

General Rural

- "There are so few services for our counties since they are so rural. We do not have adequate services for families in the area such as treatment programs or sometimes even housing that allow for children."
- "Yes, our state is spread out and we have a limited staff. It is difficult to reach all counties, especially rural, to provide any additional support they may need."
- "Distant communities as there is not enough time and money to give them services."
- "You can't even get into our clinic for two weeks and there is no urgent care…have to go out of town to get kids' needs met."
- "Access, particularly in rural areas, where mothers are scheduling c-sections rather than a natural birth because it takes three hours to go to a hospital if they go into labor."
- "We don't have a hospital that delivers babies so if you go into labor, you are looking at an hour and a half potentially to get to a facility that could safely deliver the baby."

Additional comments were shared regarding the barriers to serving these hard to reach communities, including:

- Limited number of providers in rural areas, and related, difficulty recruiting clinicians/providers in rural areas;
- Distance to travel to see families;
- Limited staff and travel budget to support services in rural areas;
- Limited capacity and resources to serve the growing population and expansive urban region, as well as rural communities; and

"All rural areas are challenging for serving, we have great difficulty recruiting clinicians / providers for areas that have low census and low services" – *MCH professional and service provider*

- Funding limitations, with one key informant noting "if the feds don't fund it, we might not be doing it."

Seek Information and Resources

The most common resource for information was word of mouth (from friends and family) with three MCH population groups using this resource for information most often (Table 41). Government services (Women, Infants and Children [WIC], local health departments, etc.) were the second common go-to source for information among two MCH population groups, including women of childbearing age and caregivers of infants. Otherwise, people learn about resources in their community in greatly varying ways, suggesting community members access more than one channel of information.

Families of CYSHCN shared in focus groups they rely on word of mouth and informal information networks to learn about services to potentially benefit their children. They report they are almost always their own advocates, receiving little support in finding services they need. They also often self-refer to specialists. Parents mentioned this can be especially challenging for those without in-depth knowledge of the health care system. **One recommendation by parents was a central, online directory of services**. Such an online directory, when kept up to date with current services, is thought to be one tool to help alleviate the burden of information sharing among families.

Noting there is a medical home portal for Nevada, including a one-stop-shop for information related to supporting CYSHCN and their families, suggests a need for building awareness and access to the portal among the general public, as well as to Nevada 211.[203] Additionally, **families agree more support groups to share knowledge and information about services would be helpful.**

Table 41. Community Member Reported Information Source, by MCH Population Group

Information Source	Women/Maternal Issues, including prenatal, pregnancy, and post-natal care	Caregivers of infants (Children zero up to 1)	Caregivers of and/or Children 1 to 21 years, without special health care needs	Caregivers of and/or children 1 to 21 years, with special health care needs	Total
I don't know	52%	56%	56%	72%	25
Faith-based organizations	67%	55%	52%	48%	33
Community based organizations	75%*	63%	58%	67%	48
Advocacy organizations	51%	41%	34%	78%*	41
Schools	20%	13%	78%*	67%	45
Government services (Women, Infants and [WIC], local health departments, etc.)	88%*	77%*	56%	63%	52
Health clinics/hospitals	89%*	67%	60%	67%	57

[203] Medical Home Portal. (n.d.). Retrieved on December 26, 2019, from https://www.medicalhomeportal.org/about-portal/partnering-with-the-portal

Virtual/internet groups/ social media	81%*	64%	68%	72%	47
Face-to-face groups	53%	44%	33%	64%	36
Libraries	48%	33%	57%	52%	21
Ads or brochures in public places	56%	52%	68%	76%8	25
Word of mouth (from friends and family)	85%*	79%*	75%*	73%	48
Nevada 211	63%	53%	42%	68%	19

*Note: * indicates information sources selected by more than 75 percent of the MHC population group*

Individual-level Barriers to Services

Community members were asked about barriers experienced when accessing services and resources. Barriers were grouped by those related to "getting services," "affordability," and "quality." The top three barriers most commonly faced by community members are those related to "getting services" (Table 42). **Specifically, "getting services" as defined by needing a specific service not offered by a local provider (39%), physical access (39%), and no service provider available in their area (36%).** A fourth barrier identified by more than 30 percent of community members was related to "affordability" and out of pocket costs for services. Focus group participants noted physical access and service providers in their area are both major issues. Participants reported it is "normal" to need to travel hours to bigger cities to receive services or needing to plan appointments months in advance to make appropriate accommodations.

Table 42. Barriers to Accessing Care Among Community Members (n=67)

Type of Barrier	Barrier	Always/ Usually (about 75% to 100% of the time)	About half (50% of the time)	Seldom/ Never (about 25% to 0% of the time)	Number of Community Member Respondents
Getting Services	Needed specific service not offered by local provider	39%	26%	35%	46
Getting Services	Physical access	39%	13%	48%	23
Getting Services	No service provider available in my area	36%	36%	29%	45
Affordability	Out-of-pocket-costs	35%	35%	30%	57
Getting Services	Not eligible for services	27%	32%	41%	37
Affordability	Needed services not covered by insurance	22%	31%	46%	54
Getting Services	Transportation	21%	32%	46%	28
Affordability	Lack of insurance	19%	28%	53%	43
Getting Services	Application forms too complicated	16%	34%	50%	32

Type of Barrier	Barrier	Always/ Usually (about 75% to 100% of the time)	About half (50% of the time)	Seldom/ Never (about 25% to 0% of the time)	Number of Community Member Respondents
Quality	Language barriers	16%	21%	63%	19
Getting Services	Do not know what services are available	15%	57%	28%	54
Getting Services	Access to information	15%	44%	40%	52
Quality	Feels embarrassed about getting services	12%	41%	46%	41
Quality	Services were not helpful	12%	35%	53%	49
Quality	Staff were not helpful	10%	39%	51%	49
Quality	Discrimination (if sensed by service recipients)	9%	31%	60%	35

Providers were asked to reflect on the barriers experienced by their clients (Table 43). Across five of the six population groups, helpfulness of staff and services was identified as a barrier to receiving services, including pregnant women, newborns and infants, young children, and adolescents. Across four MCH population groups, limited access to information and education about resources and unaffordable out-of-pocket costs were barriers. Notably, pregnant women were the only group to mention discrimination as one of the top barriers preventing them from receiving services.

Table 43. MCH Professional and Service Provider Reflection on the Barriers That Might Prevent People from Receiving Services or Resources, by MCH Population Group

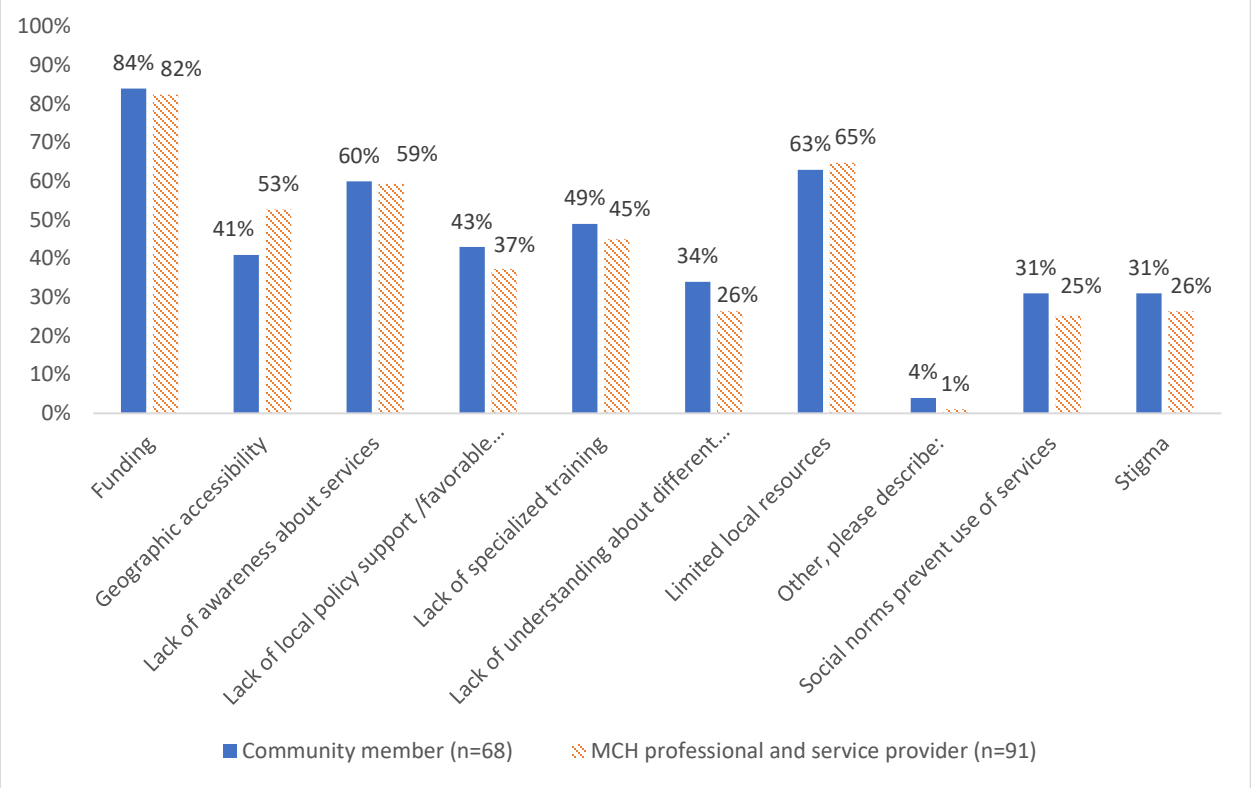
Pregnant women	Percent	Number		Children (6 - 11 years of age)	Percent	Number
Application forms too complicated	83%	43		Feels staff are not helpful	60%	24
Discrimination	82%	40		Out-of-pocket-costs	57%	13
Feels services are not helpful	78%	33		Access to information and education about resources	51%	30
Newborns and Infants (Birth Up to 1 year of age)	**Percent**	**Number**		**Adolescents/Young Adults (12 – 21 years of age)**	**Percent**	**Number**
Out-of-pocket-costs	65%	15		Lack of insurance	71%	37
Feels staff are not helpful	60%	24		Feels staff are not helpful	70%	28
Access to information and education about resources	59%	35		Access to information and education about resources	69%	41

Young Children (1 - 5 years of age)	Percent	Number		Children and Youth with Special Health Care Needs (Birth to 21 years of age)	Percent	Number
Feels staff are not helpful	60%	24		Language barriers	79%	31
Access to information and education about resources	58%	34		Feels embarrassed about getting services	77%	40
Out-of-pocket-costs	56%	13		Transportation	77%	26

Community-Level Barriers to Services

Community members (n=68) and MCH professional and service providers were both asked about barriers making it hard to have health and wellness supporting programs and resources in their communities and wellness of MCH population groups. There was alignment in barriers identified by both respondent types (Figure 38). First and foremost, funding. More than 80 percent of both groups said funding was a community level barrier. Key informants **shared funding is a limiting factor for a host of services**, including for mental health services, medical homes, behavioral health screenings, early childhood programs, rural health providers, sexual and reproductive health, and home visiting. Potentially related to the funding barrier, the second most common barrier to services is **limited numbers of local resources identified**- by just over 60 percent of both groups (community members at 63% and MCH professional and service providers at 65%). Third, **lack of awareness about services** was a predominate barrier in communities. Sixty percent of community members and 59 percent of providers identified this as a barrier.

Figure 38. Community-level Barriers to Services, by Survey Respondent Type



Equity

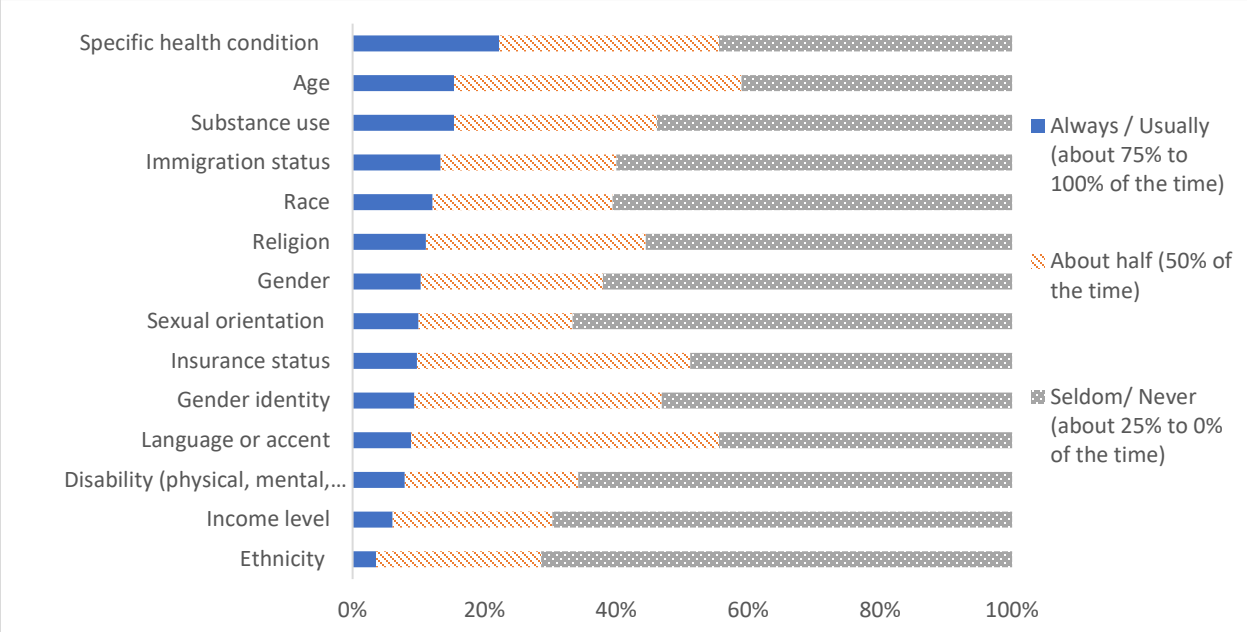
Community members were asked about possible reasons why people may experience or feel like they are experiencing unequal treatment when receiving services (Figure 38). Among those who responded, the most common reasons individuals experience unequal treatment "always/usually (about 75% to 100% of the time)" included having a special health condition (22%), age (15%), substance use (15%), immigration status (13%), and race (12%) (Table 24). When you incorporate "about half the time," language or accent (56%), insurance status (51%), and gender identity (47%) were identified as leading reasons for unequal treatment. In focus groups, **community members reported a lack of equity specifically related to language and documentation status**. Language, transportation, being a legal resident and fear of being asked for an identification card and not having one, adequate and low-cost translation services, need for English classes, friendly staff/or lack of, and fear of authority figures were all mentioned by focus group participants.

> "There is no health equality. There is a language barrier in the medical facilities and a lack of culturally competent medical providers. We opt to seek clandestine home remedies because there aren't enough facilities that understand my needs. The sun shines differently in Henderson than it does in North Las Vegas. There is an inequality in the quality of life, even the roads and parks are better. The medical facilities within these communities differ just as much. We have less doctors, less educators."
>
> *-Focus group participant, Las Vegas*

> "People with a legal residency status are afraid of applying for state insurance or seeking sliding scale services due to the fear of being penalized by the Public Charge and being denied Citizenship in the future."
>
> *-Focus group participant, Las Vegas*

Participants also mentioned fear in accessing services due to public charge. Families of CYSHCN discussed how a lack of health equity affects their families. One participant shared they would just like to see a "level playing field." **Parents shared they would like to see their children's basic needs met for them to have the best chance at a healthy life.** Things like special foods, g-tubes, and assistive technology are often not available in certain areas or are too expensive to access.

Figure 39. Community Member Reasons Why People May Experience or Feel Like They Are Experiencing Unequal Treatment When Receiving Services (n=66)



The top three MCH population groups reported by MCH professionals and service providers as **least likely to get the services and supports they need when they need them included adolescents, women of reproductive age, and CYSHCN** (Table 44). Key informants reported economic status greatly affects pregnant women's access to care. For Medicaid patients, there is great difficulty seeing specialists such as neurologists or endocrinologists, or wait lists are several months long. Other challenges for low income individuals include transportation to get to and from appointments, lack of low-income housing and high rates of homelessness, and lack of affordable services for individuals with cognitive disabilities. One key informant stated, "It is harder to find services because there are just none in general." Another key informant indicated many individuals they serve are single-parents or teen parents, who often have school or work getting in the way of health care.

Table 44. MCH Professionals and Service Providers Report of Three MCH Population Groups LEAST LIKELY TO GET the Services and Supports They Need When They Need Them in The Communities You Serve

MCH Population Groups	Percent	Number
Adolescents/Young Adults (12 - 21 years of age)	56%	52
Women of Reproductive Age (15 - 44 years of age)	55%	51
Children and Youth with Special Health Care Needs (Birth to 21 years of age)	52%	48
Pregnant Women and Postpartum Women	39%	36
Newborns and Infants (Birth Up to 1 year of age)	15%	14
Children (6 - 11 years of age)	15%	14
Young Children (1 - 5 years of age)	9%	8
I prefer not to answer	5%	5

MCH professionals and service providers were also asked about the top three vulnerable groups least likely to get the services and supports they need when they need them. The top three groups included undocumented individuals or refugees, those living with mental health issues, and individuals experiencing homelessness (Table 45).

Table 45. MCH Professionals and Service Providers Report of Three Population Groups LEAST LIKELY TO GET the Services and Supports They Need When They Need Them in The Communities You Serve

Population Groups	Percent	Number
Undocumented individuals or refugees	51%	47
Those living with mental health issues	48%	45
Individuals experiencing homelessness	39%	36
Those living with substance use disorder	31%	29
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning (LGBTQ) Youth	26%	24
Individuals with trauma	22%	20
Those newly released from incarceration, or with family members incarcerated	17%	16
Those living with an intellectual or developmental disability (IDD) and a behavioral health need	14%	13
Those involved with child welfare services	12%	11
Those living with an intellectual or developmental disability (IDD)	8%	7
LGBTQ Adults	6%	6
I prefer not to answer	5%	5
Other, please describe:	1%	1

Finally, providers were asked which three racial and ethnic groups are least likely to get the services and supports they need when they seek to engage in them in the communities they serve (Table 46). MCH professionals and service providers responded Hispanic populations, Black or African American, and Native American race and ethnic groups were the top underserved groups. Key informants shared similar information. Undocumented families particularly face difficulty, “especially right now.” They also reported specific difficulty among Native Americans living in Nevada, with one key informant noting often, multiple Tribes inhabit the same reservation but qualify for different services. Hispanic populations face great difficulty in accessing bilingual services. Key informants noted many providers say they provide bilingual services, but many do not.

Table 46. MCH Professionals and Service Providers Report of Three Race and Ethnicity Groups LEAST LIKELY TO GET the Services and Supports They Need When They Need Them in The Communities You Serve

Race and Ethnicity Groups	Percent	Number
Latina/o and/or Hispanic Descent	51%	47
Black or African American	45%	42
Native American or American Indian	42%	39
I prefer not to answer	23%	21
Multiracial	18%	17
Asian or Asian American	13%	12
White/Caucasian	13%	12

Race and Ethnicity Groups	Percent	Number
Other, please describe	6%	6
Native Hawaiian or other Pacific Islander	3%	3

MCH professionals and service providers noted the types of policies, training requirements, or initiatives that have been or are being implemented by their organization to address cultural and linguistic humility or health equity (Table 47). The most common response is increasing culturally and linguistically appropriate materials and staff behaviors.

Table 47. MCH Professionals and Service Providers Report on the Kind of Policies, Training Requirements, or Initiatives That Have Been or Are Being Implemented by Their Organization to Address Cultural and Linguistic Humility or Health Equity

Cultural and Linguistic Humility or Health Equity Initiatives	Percent	Number
Increasing culturally and linguistically appropriate materials and staff behaviors	64%	54
Including non-binary gender and sexual minority options on demographic forms	43%	36
Developing a plan to address health equity or health disparities	43%	36
Implicit bias training	43%	36
Obtaining a safe space designation	27%	23
None	13%	11

MCH Professionals and Service Provider Recommendations

MCH professionals and service providers were asked what recommendations they had for improving the health, development, and wellbeing of MCH population groups. These recommendations are summarized in the bulleted list below:

Access to Care

- Increase access to affordable health and wellness care, including postnatal care services, health and prevention screenings, and resources and access to healthy eating;
- Increase access to comprehensive, behavioral health services with holistic case management; and
- Increase the number of health care providers who accept Medicaid.

Education

- Need more maternal and family health trainings tied in with cultural sensitivity;
- Increase focus on education and incentives for providers to obtain licenses to work in rural areas;
- Access to education on prenatal care, substance use prevention and early intervention, and importance of developmental screenings;
- More information among community providers on where and when to refer; and
- Sexual health education needs to be targeted to parents and caregivers, as well as children, including a focus on healthy relationships and how to talk to children about sexual health issues, including the importance of routine preventive care.

Women's Health

- Increase services available for prenatal and postnatal care;
- Increase affordable daycare services for women who struggle to go to work and care for children;
- Ensure women are as healthy as possible prior to conception with increased funding to support family wellbeing (i.e. mental health counseling, housing, food assistance, job training);
- Support the Nevada legislative mandate to form a Maternal Mortality Committee; and
- Increase the number of midwives with access to birthing centers.

Resources/Services

- Increase resources for the insured, as well as the uninsured, by implementing less restrictive eligibility requirements for accessing mental health services, substance use and non-emergency referral resources for women of childbearing age, and expedited appointments for pregnant and postpartum women in need of counseling services;
- Increase support for mental health professionals to live in Nevada's communities;
- School based health centers should provide certain sexual health services such as access to condoms, birth control options, sexually transmitted disease/infection screening and treatment, and HIV screening/testing; and
- Increase the number of nurses, psychologists, and counselors working in school-based settings.

> "[We] do hear a lot about – particularly down in Clark County – that you have one nurse that serves multiple schools and school psychologists and counselors that are serving 3-4 schools which could have a population per school of like 3,000 at some high schools; heard a lot of people saying it would be helpful to expand those positions and create that infrastructure that could have more frequent, meaningful contact with kids." – *Key informant, Statewide*

- Continued implementation of the safeTALK Program, a community-oriented suicide alertness workshop that prepares anyone over the age of 16 years to become a suicide-alert helper;[204]
- Increase childcare options, including loosening restrictions on subsidized programs and more funding for Early Head Start;
- Increase access to mobile health and other services;
- Mandate newborn testing;
- Support early intervention and detection of ACEs; and
- Increase the number of programs available to address nutrition and obesity issues.

Coordination

- Support coordination with the early childhood system, including consistent messaging to parents about services, consistent needs assessments, and using the same data;
- Greater collaboration from the state with existing community networks and resources (i.e., coordinated community response); and
- Better and easier data sharing from state public health agencies.

[204] Nevada Division of Public and Behavioral Health Office of Suicide Prevention. (n.d.). Office of Suicide Prevention Training Programs. Accessed January 7, 2020 from http://suicideprevention.nv.gov/Training/Training/.

Workforce Development

- Develop and support the pipeline and recruitment of health care providers to Nevada (e.g., programs like the new medical school in Las Vegas and the new residency program in Elko); and
- Support specific training opportunities for providers to better serve CYSHCN.

Community Member Recommendations

Community members were asked what recommendations they had for improving the health, development, and wellbeing of themselves and their children. These recommendations are summarized below:

Access

- Greater consideration for local context and cultural factors in the state's services funding allocations.

Women's Health

- More resources for undocumented women to feel safe seeking care.

Resources/Services

- More childcare options, including loosening restrictions on subsidized programs;
- Better/more specialty care; and
- Easier access to respite care and relief for caregivers.

Coordination

- Develop and/or build awareness of a statewide, online directory of services and resources.

Workforce Development

- Develop and support pipeline and recruitment of health care providers to Nevada (e.g., University Medical Center to encourage research and specialists to move to the area).

Children's Health

This section focuses on the physical and behavioral health of children (defined here as children between the ages of zero and 21 years), including access to health care, behavioral health conditions, and mortality. This section also looks at prevalence of ACEs among children as important determinants of health outcomes. Table 48 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.S., and where the MCH and MIECHV programs might prioritize efforts, if not doing so already. Opportunity for prioritization is informed by how much MCH and/or MIECHV programming could impact or influence outcomes, and where there was an identified gap or need from community voices and/or data.

Table 48. Summary of Indicators for Children's Health, Nevada and United States

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Health	Percent of children (ages zero to 17) reported to be in fair/poor health (2018)[205]	2.4%	1.4%	✓
Access to Health Care	Percent of children (ages zero to 17) with consistent and adequate health insurance coverage during the past 12 months (2018)[206]	63.4%	67.5%	✓
Access to Health Care	Percent of children (ages zero to 17) who have a medical home (2018)[207]	43.4%	49.4%	✓
Access to Health Care	Percent of children (ages 12 to 17) had a preventive medical care visit in the past 12 months (2017)[208]	71.7%	78.7%	✓
Access to Health Care	Percent of children (ages one to 17) had one or more preventive dental visits in the past 12 months (2018)[209]	72.3%	79.7%	✓
Access to Health Care	Percent of children without a place he or she usually goes to first when he or she is sick, or when a caregiver needs advice about his or her health (2018)[210]	31.1%	23.4%	Ø
Access to Health Care	Percent of children (ages six months to 17 years) who are vaccinated annually against seasonal influenza (2017/18)[211]	49.5%	57.9%	✓
Mortality	Child mortality rate per 100,000 among children (ages one to 9) (2017)[212]	17.3	17.2	✓
Behavioral Health	Percent of children (ages three to 17) with a mental/behavioral health condition (2018)[213]	17.0%	21.0%	Ø

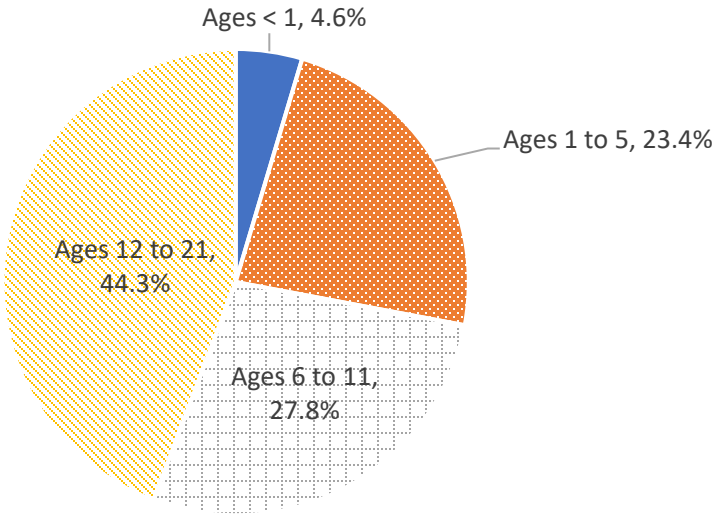
[205] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in fair or poor health.
[206] National Children's Health Survey. (2018). National Performance Measure 15: Percent of children, ages 0 through 17, who are continuously and adequately insured.
[207] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.
[208]National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
[209] National Children's Health Survey. (2018). National Performance Measure 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
[210] National Children's Health Survey. (2018). Indicator 4.12b: Does this child have a place that he or she usually goes to first when he or she is sick, or a caregiver needs advice about his or her health?
[211] National Immunization Survey-Flu. (2018). National Outcome Measure 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza.
[212] National Vital Statistics System. (2017). National Outcome Measure 15: Child mortality rate ages 1 through 9 per 100,000.
[213] Child Trends analysis of data from the United States Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Behavioral Health	Percent of children (ages three to 17) with a mental/behavioral condition who receive treatment or counseling (2018)[214]	33.7%	50.3%	✓
Adverse Childhood Experiences and Safety	Percent of children (ages zero to 17) who experience two or more ACEs	22.0%	18.6%	✓

Demographics of Children, Ages Zero to 21 Years

Children, ages zero to 21 years, currently represent 27.6 percent (n=851,521) of Nevada's population (the same population proportion as seen nationwide). This population is projected to increase by an AGR of 1.3 percent by 2024 (compared to 0.5% nationally). Among children in Nevada, almost half (44.3%) are ages 12 to 21 years (compared to 46.8% nationally) and more than half are children ages one to 11 years (51.2% compared to 48.9% nationally) as shown in Figure 40. Children younger than one year of age make up 4.6 percent of the child population in Nevada (compared to 4.3% nationally).[215]

Figure 40. Percent of Children by Age Group, Nevada, 2019[216]



[214] National Children's Health Survey. (2018). National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.
[215] Esri, 2019.
[216] Esri, 2019.

While statewide there is projected to be an increase in the population of each child age group each year, there are specific counties which are not expected to experience this increase. Lincoln, Mineral and White Pine counties (frontier counties) are not expected to experience an increase in the population of children by 2024 (Table 49).

Table 49. Total and Percent of Nevada Population by MCH Population Child Group by County, 2019[217]

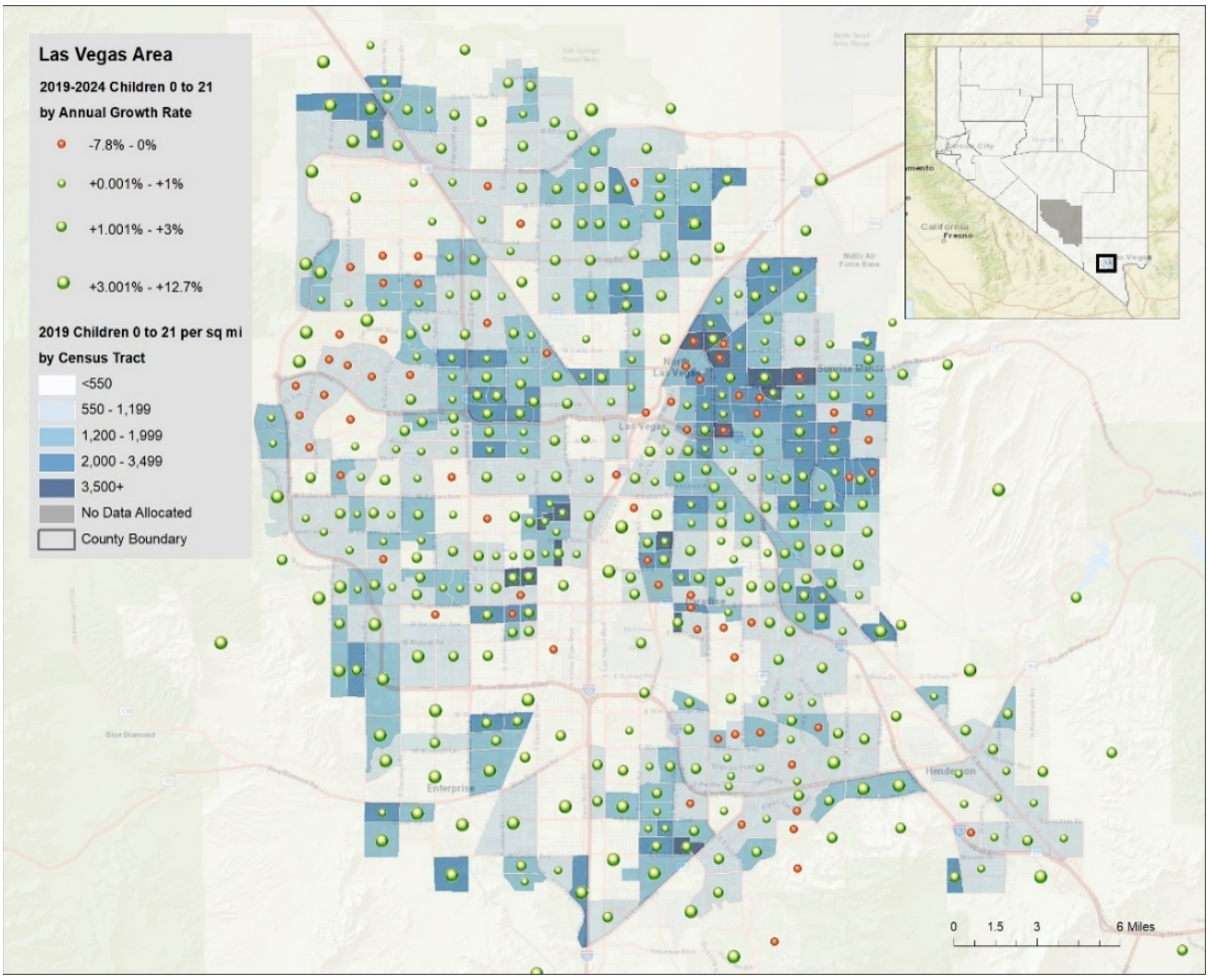
County	2019 Population		Children <1 Year		Children 1 to 5 Years		Children 6 to 11 Years		Children 12 to 21 Years	
County	**Population**	**% of Children in County**	**2019**	**AGR**	**2019**	**AGR**	**2019**	**AGR**	**2019**	**AGR**
Carson City	56,289	24.0%	620	0.5%	3,072	0.6%	3,509	-2.6%	6,294	-1.1%
Clark	2,257,890	27.9%	29,485	2.4%	149,338	2.0%	176,525	1.7%	275,501	1.5%
Churchill	22,938	27.2%	299	0.2%	1,425	0.3%	1,755	-3.5%	2,765	0.2%
Douglas	50,119	21.8%	425	1.0%	2,274	0.9%	2,998	-3.3%	5,222	0.1%
Elko	55,201	31.4%	852	1.6%	4,206	1.1%	4,798	1.1%	7,489	1.2%
Esmeralda	782	19.9%	5	3.7%	38	0.0%	45	-0.4%	68	2.8%
Eureka	1,925	26.3%	24	-1.7%	129	-0.6%	144	-0.3%	210	2.8%
Humboldt	17,713	29.9%	241	0.5%	1,264	0.5%	1,482	0.7%	2,301	0.9%
Lander	5,645	29.4%	82	-1.5%	406	-0.2%	455	-0.7%	714	0.5%
Lincoln	5,251	25.9%	67	-1.2%	304	-0.9%	364	-0.3%	626	-1.1%
Lyon	56,984	26.8%	659	1.2%	3,426	1.1%	4,326	-2.4%	6,881	1.3%
Mineral	4,647	19.6%	45	0.0%	192	-0.8%	235	-4.6%	439	-0.8%
Nye	48,813	21.1%	375	0.6%	2,174	0.5%	2,918	0.1%	4,837	0.3%
Pershing	6,652	21.7%	64	0.0%	303	-0.2%	406	-0.3%	668	0.5%
Storey	4,142	18.1%	27	0.0%	163	0.0%	208	-3.3%	353	0.5%
Washoe	481,595	27.4%	5,863	2.2%	29,529	1.8%	35,469	-2.4%	61,204	1.3%
White Pine	9,815	23.7%	118	-0.3%	528	-0.6%	606	-0.6%	1,073	0.0%
Nevada	**3,088,888**	**27.6%**	**39,274**	**2.2%**	**198,899**	**1.8%**	**236,411**	**0.8%**	**376,937**	**1.3%**

Note: Red areas indicated negative (declining) AGR and green areas indicate positive (increasing) AGR

[217] Esri, 2019.

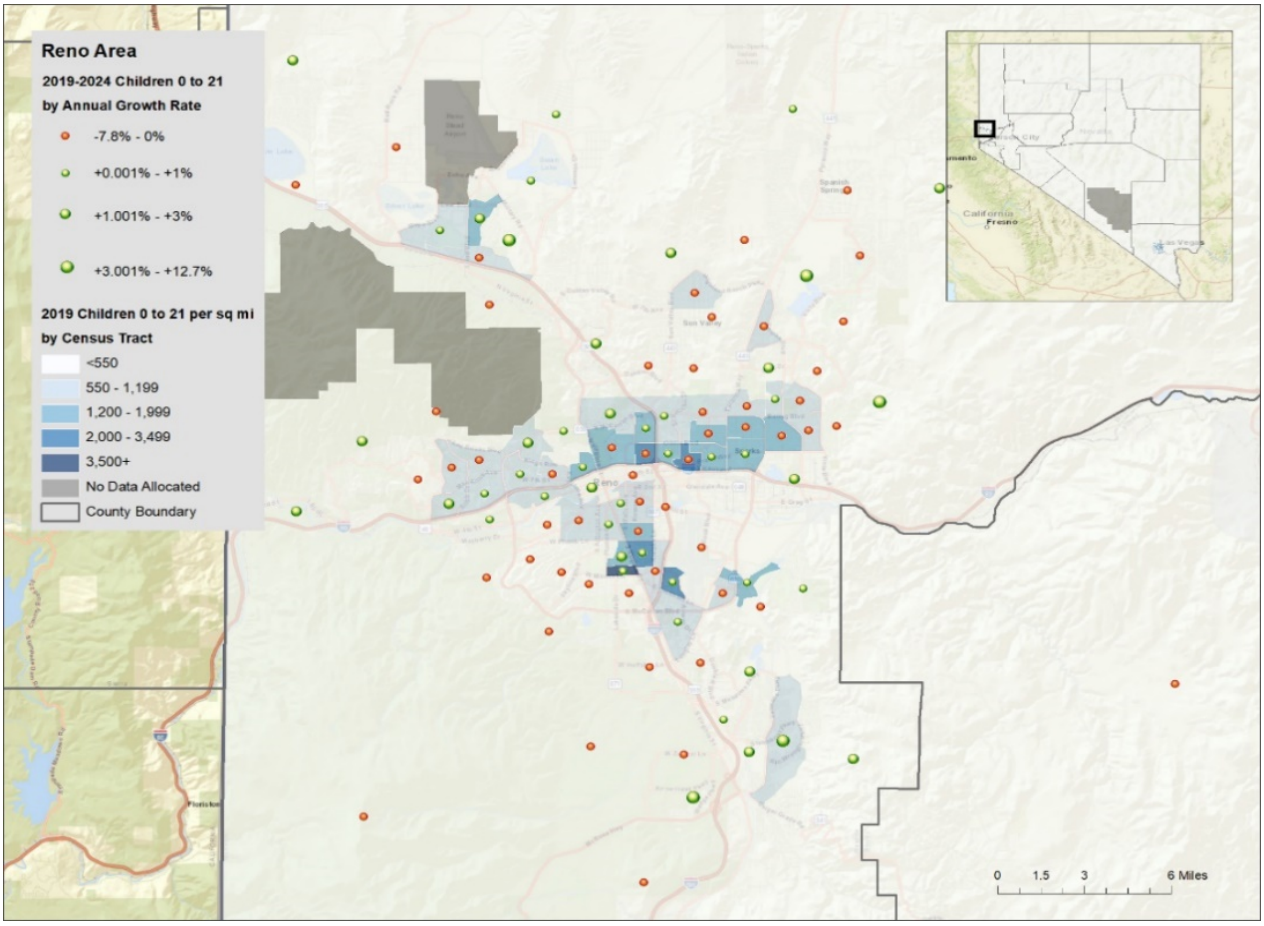
Within Nevada's high population density areas, there is variation in where and how much the population of children ages zero to 21 years will grow up, as shown in Figures 41 and 42. Additionally, there is projected to be more growth per year in Las Vegas (Clark County) as compared to the Reno area (Washoe County).

Figure 41. Number of Children Ages Zero to 21 in Las Vegas and AGR, by Census Tract, 2019[218]



[218] Esri, 2019

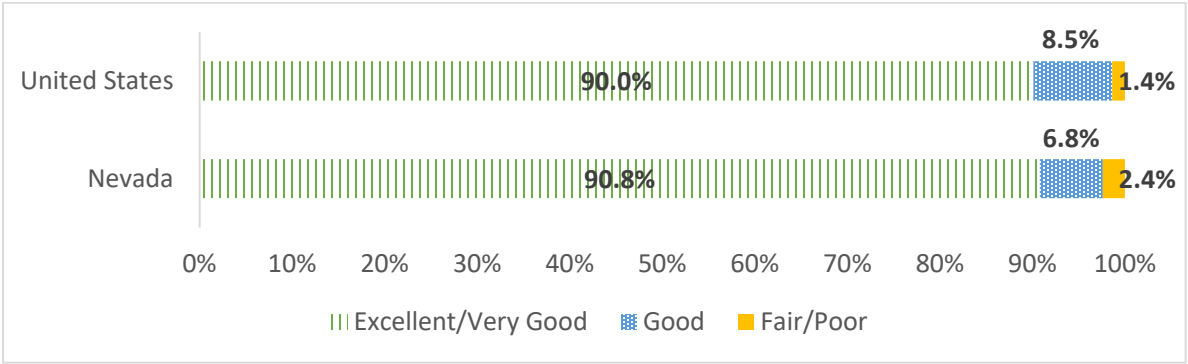
Figure 42. Number of Children Ages Zero to 21 and AGR in Reno, by Census Tract, 2019[219]



Overall Health

Between 2017 and 2018, 90.8 percent of Nevada parents described the health of their children as excellent or very good, comparable to all parents nationwide (90.0%), as shown in the Figure 43.[220]

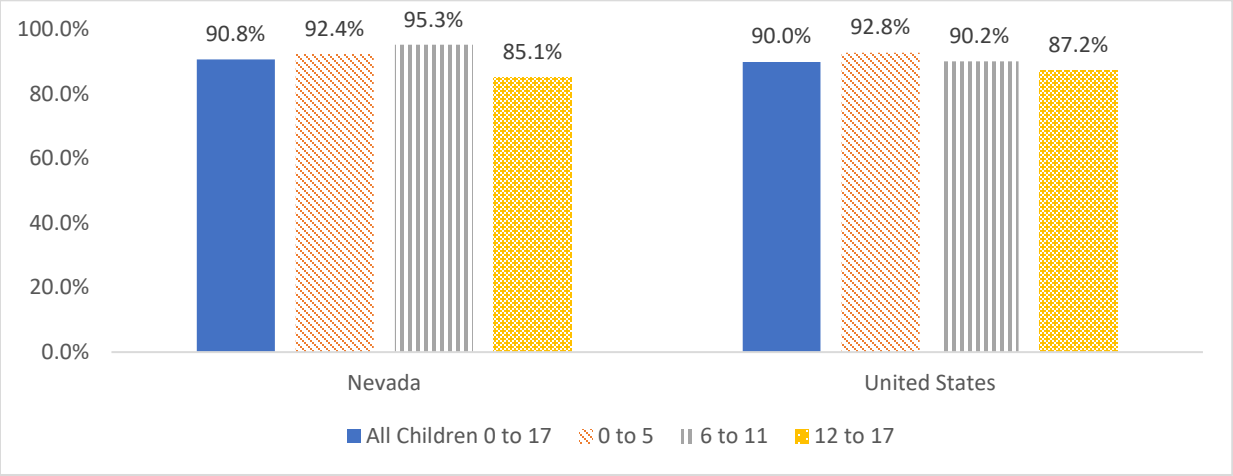
Figure 43. Child Health Status, Nevada and United States, 2017-2018[221]



[219] Esri, 2019
[220] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.
[221] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.

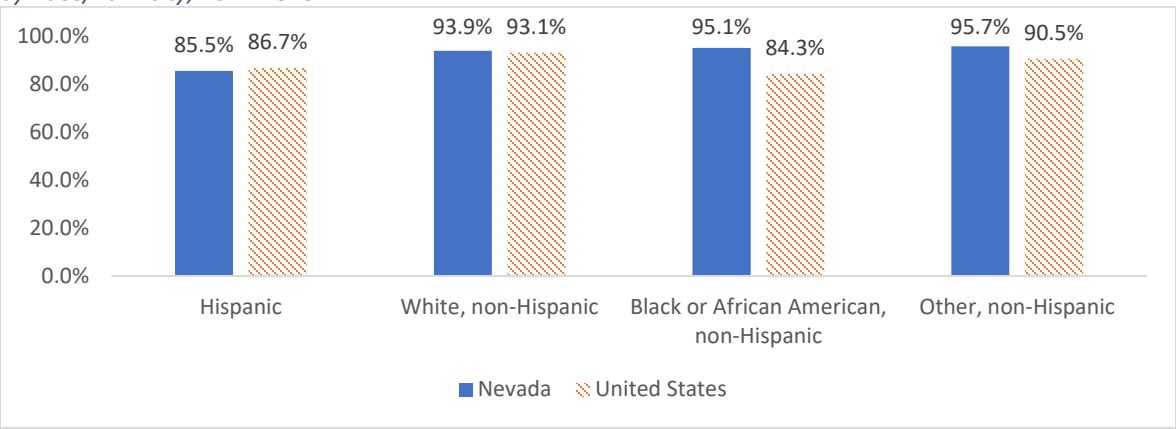
The health of children in the different age groups was generally higher in the U.S. than Nevada with one exception (Figure 44). Nevada children ages six to 11 years were more likely to be described as having excellent or very good health (95.3%) compared to children in the U.S. (90.2%). The health of adolescents ages 12 to 17 years was least likely to be described as excellent or very good among all the age groups in both Nevada and the U.S.[222]

Figure 44. Percent of Children, Ages Zero through 17, in Excellent or Very Good Health, Nevada and United States, by Age Group, 2017-2018[223]



In Nevada, the health of Asian children ages zero to 17 years was most likely to be described as excellent or very good (97.2%), followed by multiracial children (96.2%). Black or African American children and White, non-Hispanic children had similar rates of being described as in excellent or very good health (95.1% and 93.9%, respectively), while Hispanic children were the least likely to be described as having excellent or very good health (85.5%) (Figure 45).[224]

Figure 45. Percent of Children, Ages Zero through 17, in Excellent or Very Good Health, Nevada and United States, by Race/Ethnicity, 2017-2018[225]



[222] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.
[223] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.
[224] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.
[225] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.

Health Insurance and Access to Care

In 2017-18, 91.2 percent of Nevada children (zero to 17 years) had heath care insurance coverage, slightly lower than the U.S. at 93.6 percent. [226] However, only 63.4 percent of Nevada children had *consistent and adequate* health care insurance coverage during the past 12 months (meaning the benefits usually or always met the child's needs, the insurance usually or always allows the child to see needed providers, and the insurance either has no out-of-pocket expenses or they are usually or always reasonable), lower than children nationwide (67.%).[227]

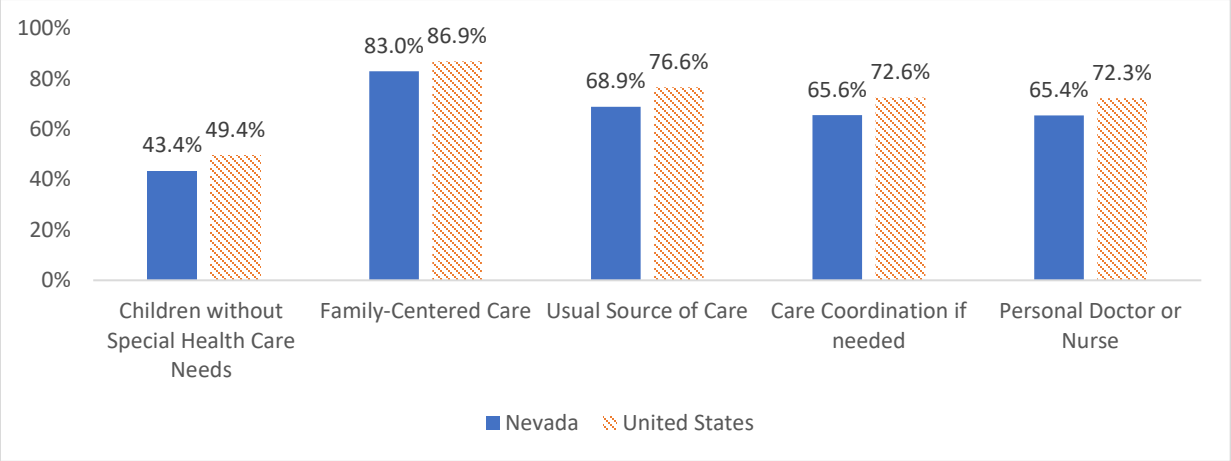
The National Children's Health Survey revealed racial/ethnic and socio-economic disparities related to health care insurance status for Nevada children. Between 2017 and 2018, the percentage of Hispanic children who were insured was 84.3 percent, compared to 97 percent of White, non-Hispanic children.[228] Asian children, children who identify as another race, and Black or African American children had similar rates of being insured at 95 percent, 94.5 percent, and 94.4 percent respectively. Children in households with incomes zero to 99 percent FPL were insured at 85.4 percent, compared to 96.9 percent of children in households with incomes 400 percent FPL or greater. Overall, one of the greatest disparities in a child's health insurance status was related to education level of their parent(s), as only 78.6 percent of children whose parents have less than a high school education were insured, compared to 95.7 percent of children whose parents have a college degree or higher.[229]

Medical homes for children help to ensure consistent and comprehensive care. A medical home means the child has a personal doctor or nurse, has a usual source for care, and has family-centered care from which they receive referrals or care coordination, if needed. The percentage of children without special health care needs who have a medical home is lower in Nevada (43.4%) compared to the U.S. (49.4%) (see Figure 42). Health insurance status impacts whether a child has a medical home, as children without special health care needs who are privately insured are almost twice as likely to have a medical home than those who are uninsured (50.2% and 29.1%, respectively).[230] For children with public health insurance (e.g., Medicaid or Nevada Check-Up), 32.4 percent had a medical home.[231]

Looking closer at components of a medical home (Figure 46), 65.4 percent of Nevada children have at least one personal doctor or nurse, lower than the U.S. at 72.3 percent. This is likely influenced by availability of health care providers in more rural areas. Additionally, 83 percent of Nevada children have access to family-centered care, compared to 86.9 percent nationwide, which means the doctor or nurse spends enough time with the child and the family feels like a partner in the child's care. Further, 68.9 percent of Nevada children had a usual source of care (compared to 76.6% nationwide) and 65.9 percent had care coordination when they needed it (compared to 72.7% nationally).[232]

[226] National Children's Health Survey. (2018). Indicator 3.1: Is this child currently covered by health insurance or health coverage plan?
[227] National Children's Health Survey. (2018). National Performance Measure 15: Percent of children, ages 0 through 17, who are continuously and adequately insured.
[228] National Children's Health Survey. (2018). Indicator 3.1: Is this child currently covered by health insurance or health coverage plan?
[229] National Children's Health Survey. (2018). Indicator 3.1: Is this child currently covered by health insurance or health coverage plan?
[230] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.
[231] Percent of children with a medical home on public health insurance and uninsured should be interpreted with caution.
[232] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home; Due to changes in items between survey years, the component related to referrals is not available for this year.

Figure 46. Percent of Children Without Special Health Care Needs, Ages Zero Through 17, Who Have a Medical Home, Nevada and United States, 2017 to 2018[233]



There is disparity in access to a medical home by child age group (Table 50). The older the child, the less likely they are to have a medical home. Across all three age groups, Nevada lags the U.S. in terms of children having medical homes, but the greatest disparity can be seen in the 12 to 17 years age group.

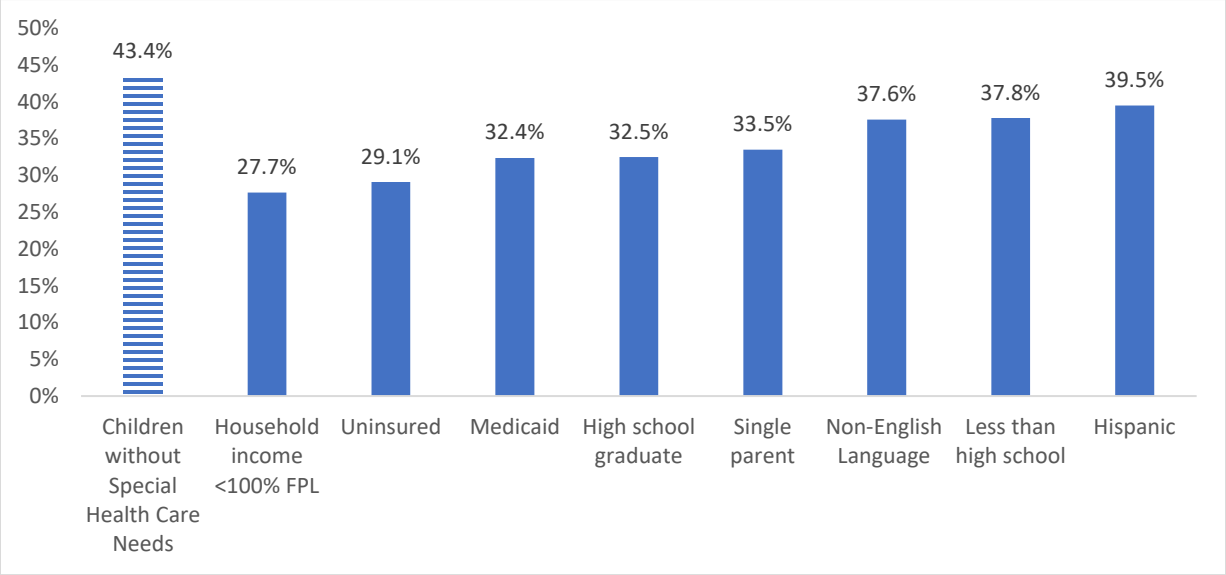
Table 50. Percent of Children without Special Health Care Needs, Ages Zero Through 17, Who Have a Medical Home, by Age Group, Nevada and United States, 2017-2018[234]

Age Group	Nevada	United States
0-5 Years	47.9%	50.9%
6-11 Years	44.4%	49.8%
12-17 Years	37.4%	47.5%

Disparity also exists by income, education status, and race and ethnicity among children without special health care needs in accessing a medical home (Figure 47). The greatest disparity is among low income children and families. **Households with incomes at or greater than 400 percent FPL are twice as likely to access a medical home (55.8%) than those with incomes below 100 percent FPL (27.7%)**. Education also impacts access, with just 35.2 percent of high school graduates accessing a medical home compared to 54.9 percent of college graduates. Access to **private insurance greatly increases the likelihood of having a medical home among children without special health care needs (50.2% compared to 32.4% with Medicaid and 29.1% uninsured**[235]).[236] This is similar in the U.S., where 52 percent of children with private insurance have access to a medical home compared to 36.4 percent with Medicaid and 26.5 percent who are uninsured.

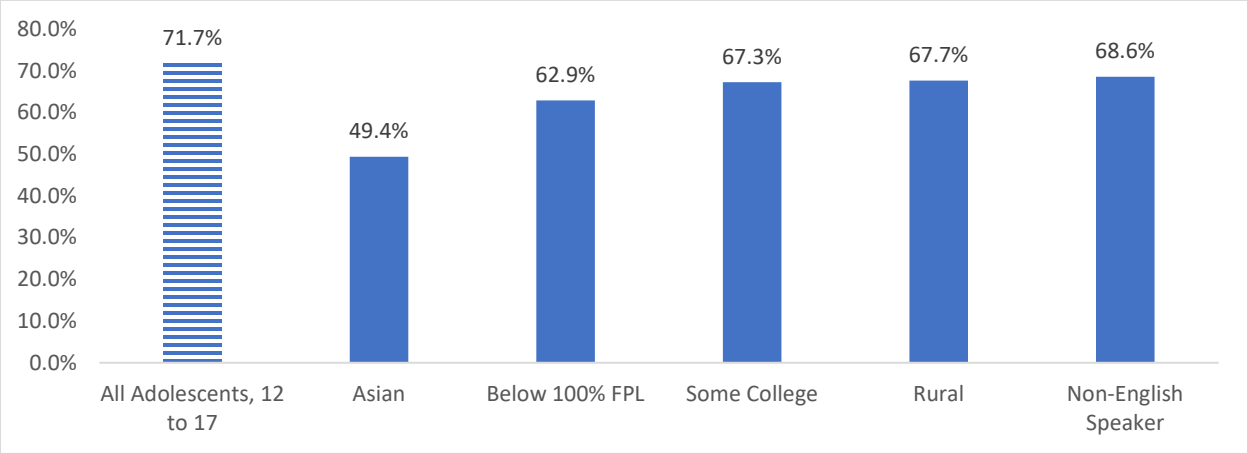
[233] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.
[234] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.
[235] Interpret the percentage of uninsured children with caution.
[236] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.

Figure 47. Percent of Children Without Special Health Care Needs, Ages Zero Through 17, Who Have a Medical Home in Nevada, by Risk or Disparity Factor, 2017-2018[237]



Regarding children accessing care, between 2016 and 2017, 71.7 percent of Nevada children between the ages of 12 and 17 years were seen by a care provider for a preventive medical care visit. This was lower than the rate nationally (78.7%). While this indicator is limited to those ages 12 to 17 years, it still provides an idea of major barriers for children needing preventive medical visits; a similar set of barriers exists for these same ages in accessing a medical home (Figure 48). [238]

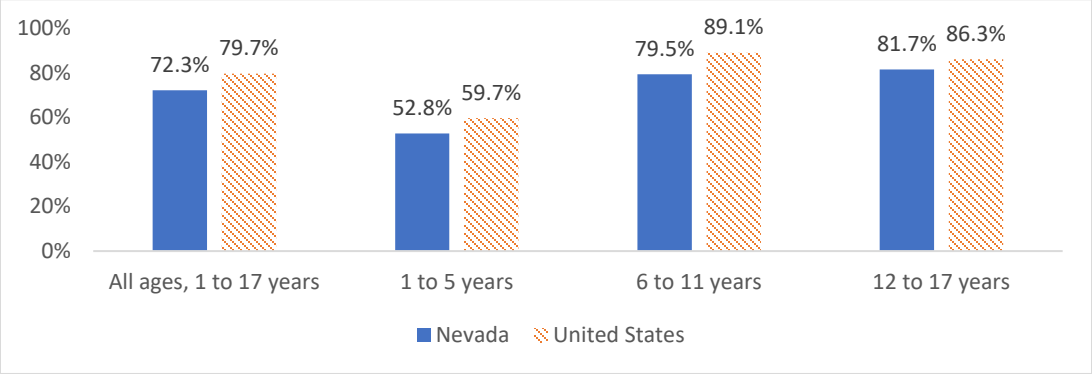
Figure 48. Percent of Adolescents, Ages 12 Through 17, With a Preventive Medical Visit in the Past Year in Nevada, by Risk or Disparity Factor, 2016-2017[239]



[237] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children without special health care needs, ages 0 through 17, who have a medical home.
[238] National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
[239] National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

For dental care between 2017 and 2018, 72.3 percent of Nevada children between the ages of one and 17 years were seen for one or more preventive dental visits, lower than the rate across the U.S. (79.7%). By age group, children ages 12 to 17 years were the most likely to have had a preventive dental visit in the past year at 81.7 percent, followed by children between the ages of six and 11 years (79.5%), and children between the ages of one and five years (52.8%). A similar trend is seen nationwide (Figure 49).[240]

Figure 49. Percent of Children with Preventive Dental Visits in Past 12 Months, Nevada and United States, by Age Group, 2017-2018[241]



Among kindergarteners, the 2018/19 Nevada Kindergarten Health Survey results show 89.3 percent of kindergartners had at least one routine medical check-up in the twelve months before the date of the survey. Similarly, 89.1 percent of parents reported their kindergartener had a primary care provider. Compared to the 2017/18 results, fewer kindergarteners had a routine check-up (a decrease of 0.89 percent) in 2018/19, but more had a primary care provider (an increase of 0.79 percent). Also, 77.8 percent of survey respondents indicated their kindergartner had seen a dentist in the past twelve months, a slight increase from 2017/18.[242]

Whether a child has regular preventive and dental visits may be related to access to regular sources of health care. There is a disparity in regular sources of sick care for children in Nevada compared to the U.S. Between 2017 and 2018, almost one in four children (23.4%) in the U.S. did not have a usual source for sick care, compared to almost one in three children (31.1%) in Nevada. There is little difference depending on the age of the child, with 28.5 percent of children ages zero to five years and 28.4 percent of children ages six to 11 years not having a usual source of care for illness. However, of those ages 12 to 17 years, 36.5 percent did not have a usual source of care. Disparity exists among households with lower incomes, with half of children (50.2%) in families making below 100 percent FPL not having a usual source of care, while the number drops significantly, to 16 percent, for those in households making at or above 40 percent FPL (Table 51).[243]

[240] National Children's Health Survey. (2018). National Performance Measure 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
[241] National Children's Health Survey. (2018). National Performance Measure 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.
[242] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[243] National Children's Health Survey. (2018). Indicator 4.12b: Does this child have a place that he or she usually goes to first when he or she is sick, or a caregiver needs advice about his or her health?

Table 51. Percent of Children with Usual Sources of Care by Household Income, Nevada and United States, 2016-2018[244]

Factor	Location	Household income 0-99% FPL	Household income 100-199% FPL	Household income 200-399% FPL	Household income 400% FPL or greater
Usual Source of Care, 2017-18	**Nevada**	50.2%	66.2%	70.9%	84.0%
Usual Source of Care, 2017-18	**United States**	64.3%	69.6%	79.5%	87.1%
Usual Source of Preventive Care, 2016-17	**Nevada**	78.2%	74.7%	91.1%	92.5%
Usual Source of Preventive Care, 2016-17	**United States**	84.1%	88.1%	93.2%	96.6%

When examining whether children have a usual source for preventive care, such as a physical examination or well-child check-up, between 2016 and 2017 it was more likely for children in both the U.S. and Nevada to have access to a usual source of preventive care relative to a usual source of sick care. Nationally, 91.2 percent of children were reported to have a usual source of preventive care, yet only 82.2 percent were seen for a preventive visit in the past year; compared to 84.5 percent of children in Nevada, though only 76 percent were seen for a preventive visit in the past year. Children ages zero to five years in Nevada are more likely to have a usual source of preventive care than older children. Approximately nine in 10 (90.9%) Nevada children ages zero to five years have a usual source of preventive care compared to approximately only eight in 10 (81.4%) children ages 12 to 17 years.[245]

Access to adequate and continuous health insurance influences whether children have regular sources of preventive and/or sick care. In 2016-17, 12.4 percent of children nationwide whose insurance was inadequate or who had a gap in coverage in the past year reported they did not have a regular source of preventive care (compared to 7% of children who had adequate insurance or no gaps in coverage). In Nevada, this jumps to 17.2 percent (compared to 14.5% who had adequate insurance or no gaps in coverage).[246]

Similarly, in 2017-18, 25.8 percent of children nationally whose insurance was inadequate or who had a gap in coverage in the past year did not have a regular source of care for illness (compared to 22.1% who had adequate insurance or no gaps in coverage). In Nevada, children whose health insurance was inadequate or who had a gap in coverage were less likely to have a regular source of care for illness (39.1%) than children who had adequate insurance or no gaps in coverage (29.9%).[247]

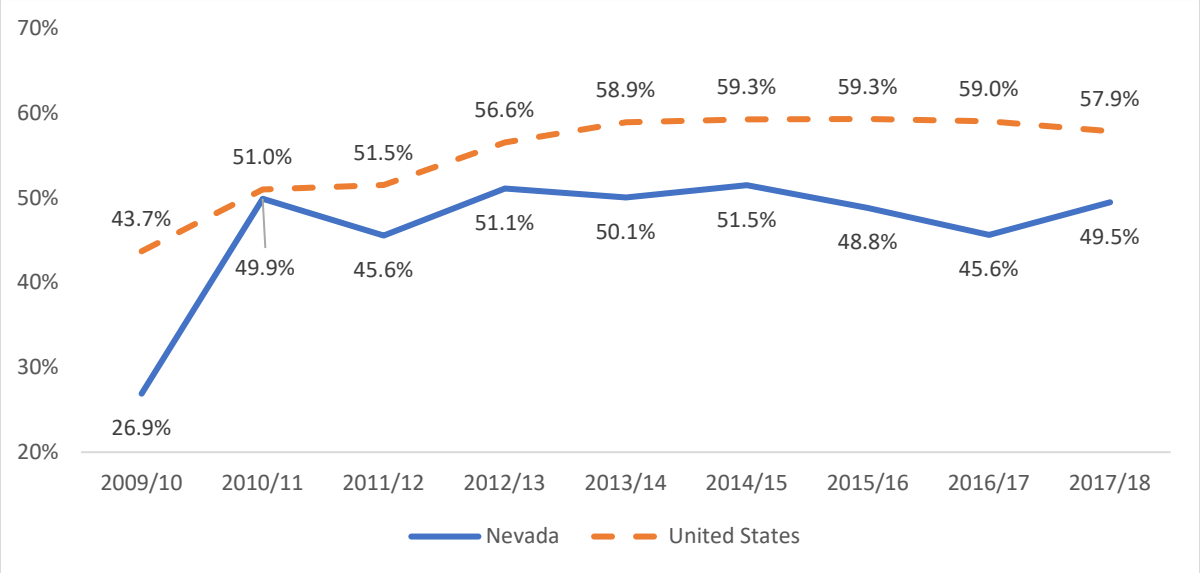
[244] National Children's Health Survey. (2018). Indicator 4.12b: Does this child have a place that he or she usually goes to first when he or she is sick, or a caregiver needs advice about his or her health? National Children's Health Survey. (2017). Does this child have a place that he or she usually goes to when he or she needs routine preventive care, such as a physical examination or well-child check-up?
[245] National Children's Health Survey. (2017). Does this child have a place that he or she usually goes to when he or she needs routine preventive care, such as a physical examination or well-child check-up?
[246] National Children's Health Survey. (2017). Does this child have a place that he or she usually goes to when he or she needs routine preventive care, such as a physical examination or well-child check-up?
[247] National Children's Health Survey. (2018). Indicator 4.12b: Does this child have a place that he or she usually goes to first when he or she is sick, or a caregiver needs advice about his or her health?

Despite many children not having a usual source for either preventive visits or sick visits, only a small percentage of children were not able to obtain needed health care in the last year. In Nevada, only two percent of children ages zero to 17 years were not able to obtain any needed health care, less than the rate for children across the U.S. (3.1%).[248]

Influenza Vaccination

Overall, Nevada ranks 46th among states regarding children ages six months to 17 years receiving an influenza vaccine.[249] Disease prevention via influenza vaccination has remained steady for this age group in Nevada since 2010/11, with approximately 50 percent of children being immunized annually (compared to a steady rate of 58% to 59.% nationwide) (Figure 50).[250]

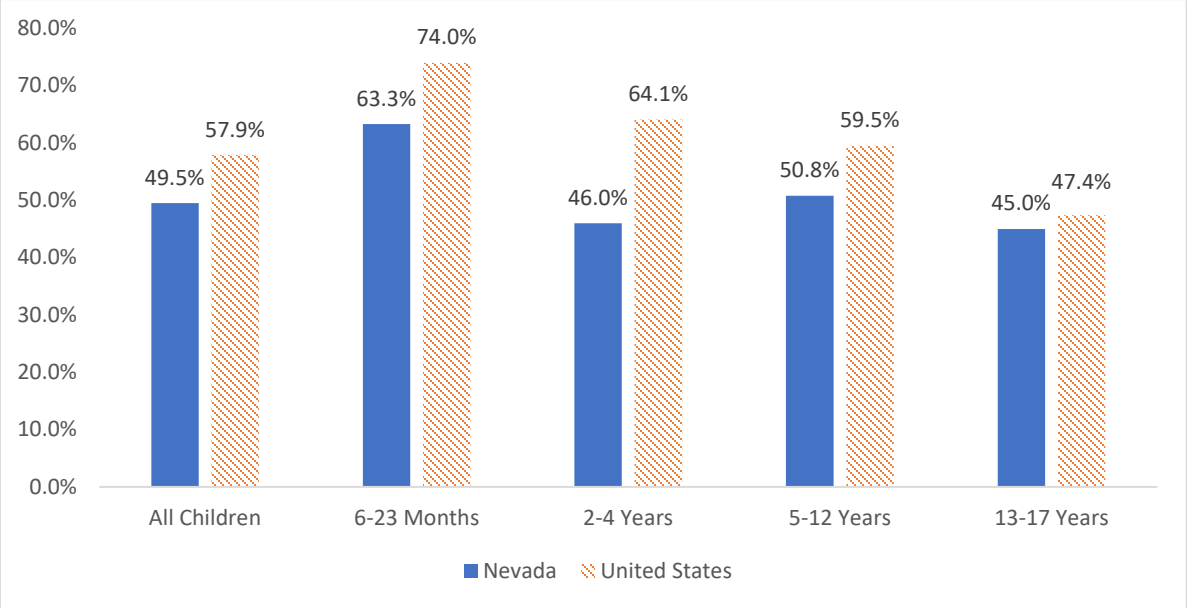
Figure 50. Percent of Children, Ages Six Months Through 17 Years, Who Are Vaccinated Annually Against Seasonal Influenza, Nevada and United States, 2009/10 to 2017/18[251]



As children age, the likelihood of receiving an annual influenza vaccine decreases. Among adolescents ages 13 to 17 years, just 45 percent received an influenza vaccine in the 2017/18 season compared to 63.3 percent of infants and children ages six to 23 months (Figure 51). Children living in rural areas were least likely to receive an annual influenza vaccine, (42% in 2017/18).[252]

[248] National Children's Health Survey. (2018). National Outcome Measure 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year.
[249] CDC School Vaccination Assessment. (2019). 2019 Immunization Report Card. Retrieved on December 6, 2019 from https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card_2019.pdf.
[250] National Immunization Survey-Flu. (2018). National Outcome Measure 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza.
[251] National Immunization Survey-Flu. (2018). National Outcome Measure 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza.
[252] National Immunization Survey-Flu. (2018). National Outcome Measure 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza.

Figure 51. Percent of Children, Ages Six Months Through 17 Years, Who Are Vaccinated Annually Against Seasonal Influenza in Nevada and United States, By Age Group, 2017/18[253]



Child Mortality

In 2016, the most recent year of data available for cause of death analysis, the four leading preventable causes of child death (excluding natural and undetermined deaths) were non-motor vehicle accidents (10.1%), homicide (7.2%), suicide (6.3%), and motor vehicle accidents (4.4%), as shown in Table 52.[254]

Table 52. Four Leading Manners of Child Death Statewide, Excluding Natural and Undetermined Deaths, Nevada, 2016[255]

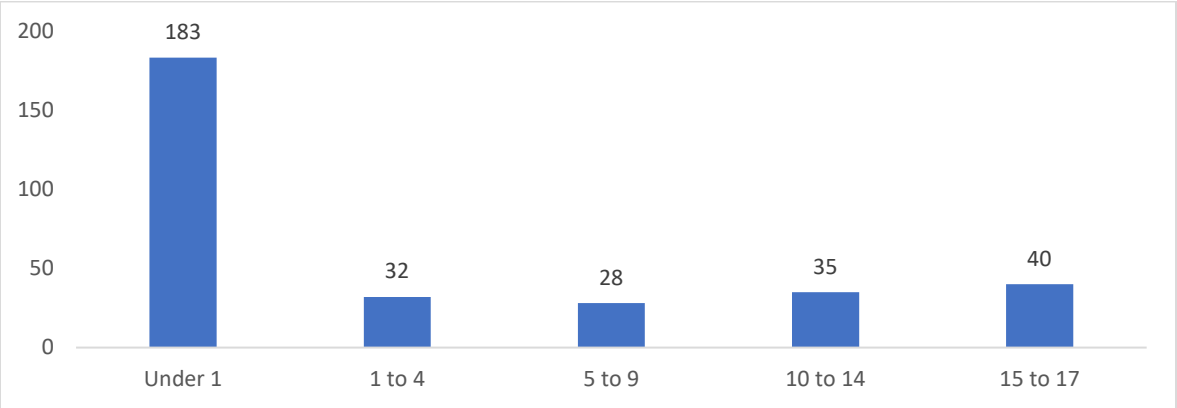
Leading Manner	Total Deaths by Manner	Percentage of Total 2016 Deaths
Non-motor vehicle accidents such as asphyxia (suffocation), drowning, and drug overdose	32	10.1%
Homicide	23	7.2%
Suicide	20	6.3%
Motor Vehicles Accidents	14	4.4%
Total	89	28.0%

In 2016, 318 children ages zero to 17 years died in Nevada, representing a 17.3 percent increase from 2015 (271).[256] The greatest number of child deaths in 2016 occurred among infants less than one year of age. This is consistent with national death data, which also indicate the highest number of deaths

[253] National Immunization Survey-Flu. (2018). National Outcome Measure 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza.
[254] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[255] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[256] State of Nevada, Division of Child and Family Services. (2018). CDR Case Reporting System. Carson City, NV: Nevada Division of Child and Family Services, found the 2016 Statewide Child Death Report.

occur among infants less than one year of age.[257] Nevada child deaths in other age groups are considerably lower, with decreasing numbers through the five to nine-year age group but increasing deaths as adolescents move through their teen years. This u-shaped data pattern is consistent with national death data for the same age groups (Figure 52).[258]

Figure 52. Nevada Child Deaths by Age, 2016[259]



In 2016, 57.5 percent of child deaths in Nevada were among children less than one year of age; 10.1 percent among children ages one to four years; 8.8 percent among children ages five to nine years; 11 percent among adolescents ages 10 to 14 years; and 12.6 percent among adolescents ages 15 to 17 years.

Infants less than one year of age were more likely to die of asphyxia (cause of 32.5% of deaths in this age group), accidents involving maternal substance use (23.9% of deaths), and for reasons involving abuse and neglect (30.8% of deaths) than any other age group. Adolescents between the ages of 10 and 14 years were most likely to die by suicide, the cause of 42 percent of deaths in this age group. [260]

There is a racial and ethnic disparity in statewide child deaths. For Black or African American children, 2016 child deaths are disproportionately higher at 23.6 percent compared to their statewide population distribution of 10 percent. Child deaths among White and Hispanic children are less frequent based on their statewide population distribution when comparing the child death review race and ethnicity data to statewide race and ethnicity data.

There are also regional differences in child deaths. The highest number of child deaths occurred among residents of Nevada's two largest counties, Clark and Washoe. Clark County's child and adolescent population is 75.4% of the statewide child and adolescent population. Therefore, in 2016, the proportion of child deaths in Clark County was slightly below their statewide population average

[257] National Center for Injury Prevention and Control. (2018). Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2016 [custom data query]. Retrieved October 6, 2018, from http://www.cdc.gov/injury/wisqars/index.html., as reported in 2016 Statewide Child Death Report.
[258] National Center for Injury Prevention and Control. (2018). Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2016 [custom data query]. Retrieved October 6, 2018, from http://www.cdc.gov/injury/wisqars/index.html., as reported in 2016 Statewide Child Death Report.
[259] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[260] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.

(73%).[261] Washoe County's child and adolescent population is 14.8 percent of the statewide child and adolescent population. Therefore, in 2016, the proportion of child deaths in Washoe County was slightly above their statewide population average (15.7%).[262] Nevada child deaths in 2016 occurred more often among males than females. This is consistent with national data, which indicate male children and adolescents die at a higher rate than females.[263] Of the 318 deaths, 52.8 percent (n=168) were males and 47.2 percent (n=150) were female. In most types of death with disaggregated data available, males were more likely to die than females in most types of death except drownings and suicides.[264]

Emotional and Mental Health

In 2017-18, the percent of children in Nevada ages three to 17 years with a mental/behavioral health condition was 18.9 percent (lower than 21.9% percent nationwide).[265] One in three Nevada children (33.7%) with a behavioral health condition received treatment or counseling compared to 50.3 percent of children nationwide.[266]

While data are not available specifically for Nevada children ages three to five years, 41 percent of Nevada children ages 12 to 17 years were able to receive mental health or counseling while only 37.2 percent of children ages six to 10 years received the same. Since some age group data are not available for Nevada children, a look at national trends can provide further information. In the U.S., the likelihood of receiving mental health treatment or counseling is lower for younger Americans, probably linked to a lack of mental health professionals who specialize in treating children.[267] Over half (56.5%) of U.S. children ages 12 to 17 years with a behavioral health condition receive treatment, compared to 46.5 percent of children ages six to 11 years and 30.7 percent of children ages three to five years.[268] Based on these findings, there may be a similar trend in Nevada, where children become more likely to get connected to behavioral health treatment as they get older.

Looking more closely at services received by Nevada children ages 12 to 17 years in 2016-17, approximately 17.2 percent received non-specialty mental health services and 13.7 percent received specialty mental health services. For adolescents seeking treatment for emotional problems, 10.2 percent received treatment from a therapist, 3.8 percent stayed overnight in a hospital, 3.5 percent received treatment in a mental health clinic, three percent received treatment from an in-home counselor, 1.9 percent received treatment from a family doctor, and one percent stayed in a residential center.[269]

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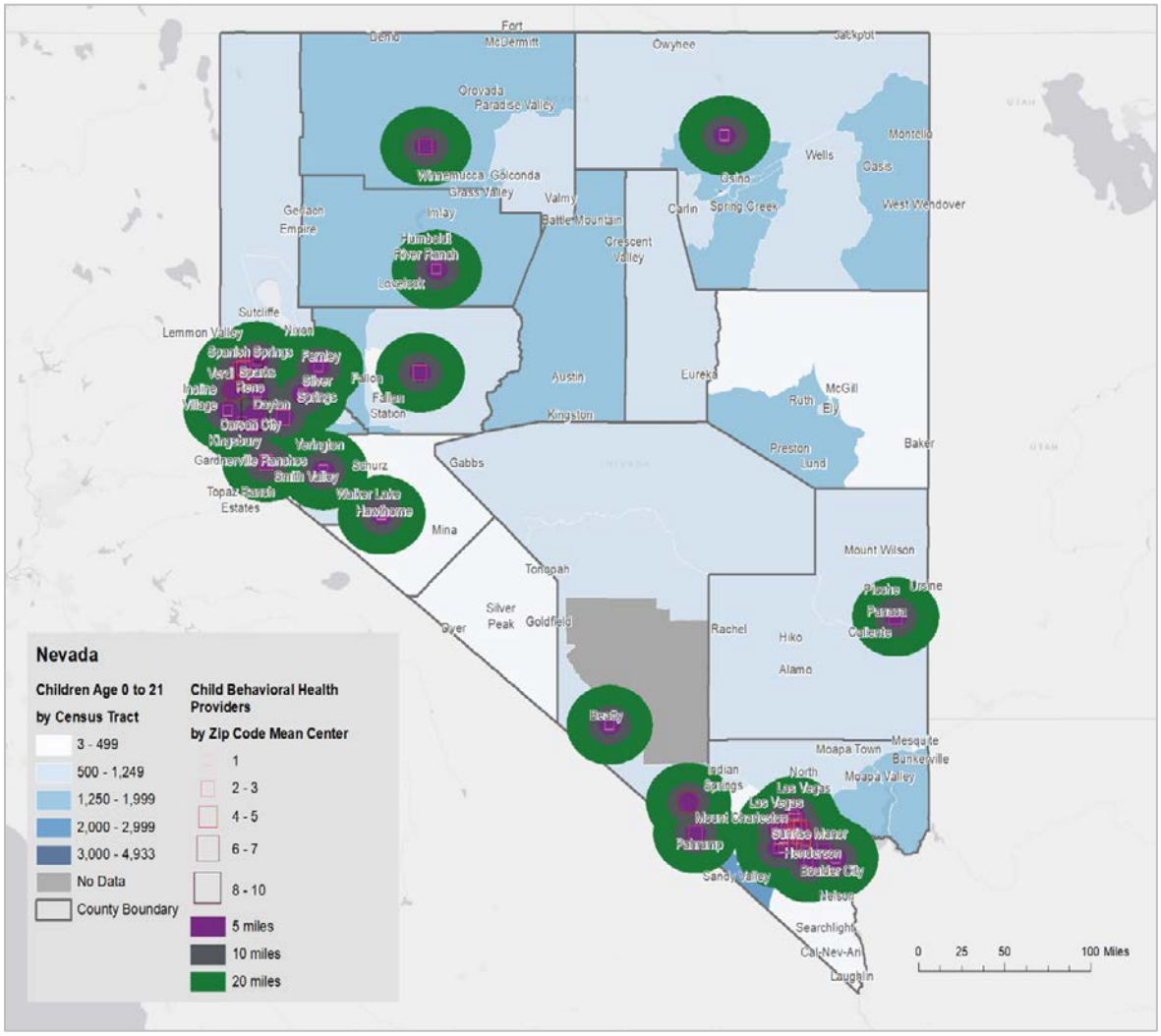
[261] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[262] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[263] National Center for Injury Prevention and Control. (2018). *Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2016* [custom data query]. Retrieved December 6, 2019, from http://www.cdc.gov/injury/wisqars/index.html.
[264] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[265] Child Trends analysis of data from the United States Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.
[266] National Children's Health Survey. (2018). National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.
[267] American Academy of Child & Adolescent Psychiatry. (2018, May 22). Severe Shortage of Child and Adolescent Psychiatrists Illustrated in AACAP Workforce Maps. Retrieved December 12, 2019 from https://www.aacap.org/App_Themes/AACAP/Docs/press/2018/Press-Release-Workforce-Maps.pdf.
[268] National Children's Health Survey. (2018). National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.
[269] Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). (2017). Recoded Youth Mental Health Service Utilization. https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.

Figure 53 illustrates how behavioral health care access is especially difficult in rural areas where the geographic distribution of psychiatrists and other behavioral health specialists is most pronounced. Behavioral health provider locations were flagged as child providers by searching for words in the organization description of services and organizational names including family, school, child, youth, boy, girl, kid, adolescent, and teen. State spatial patterns of child behavioral health provider locations differed considerably across counties, with more providers located in urban areas.

Figure 53. Distance to Child Behavioral Health Providers and Children Ages Zero to 21, by Census Tract, 2019[270]

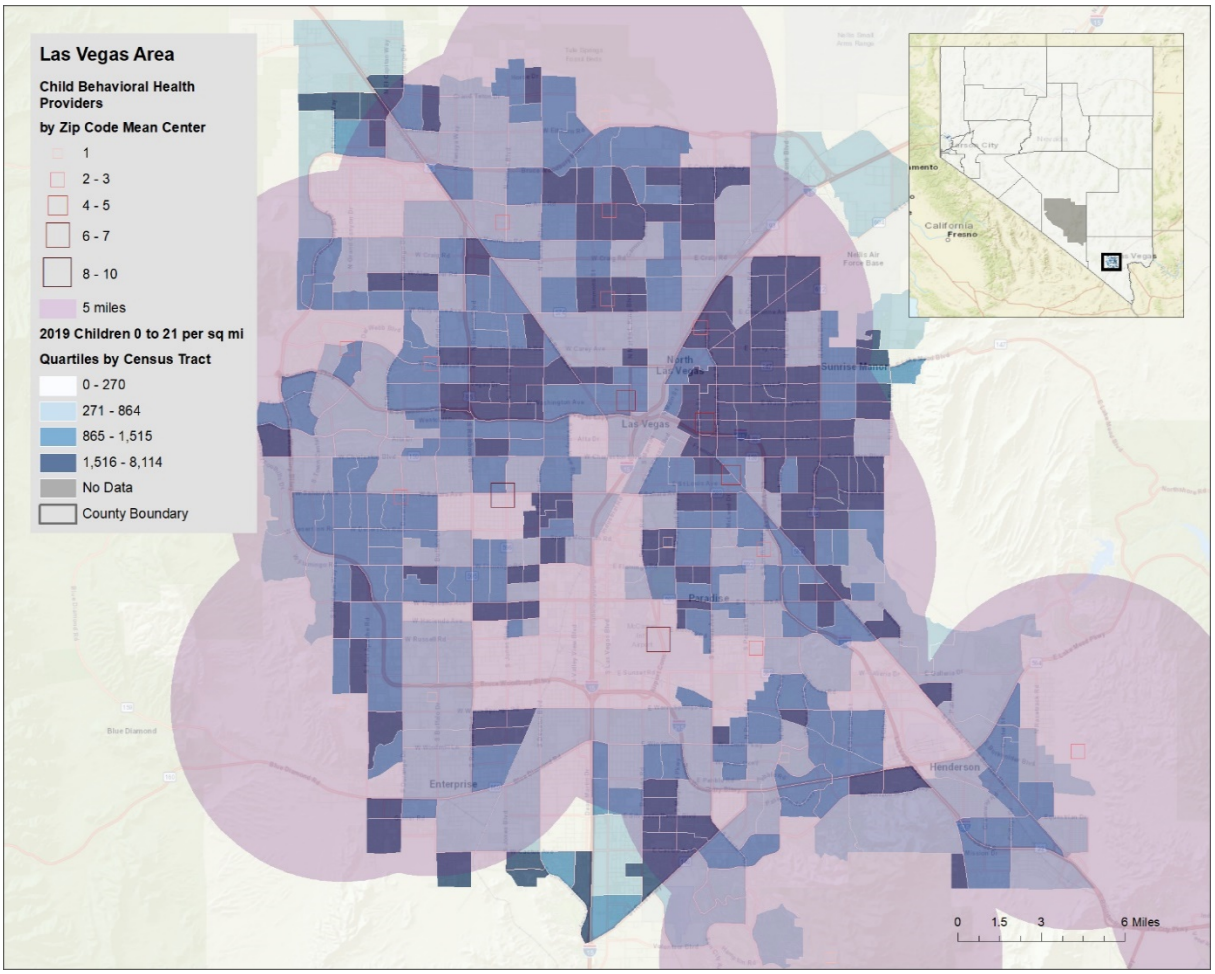


Note: Behavioral health provider access findings may be affected because the mean center of zip codes was selected as the unit of analysis rather than actual address data.

Zooming in on the population dense areas of Las Vegas and Reno reveals behavioral health provider locations are quite well placed, with all children within high density census tracts living closer than 5 miles to the nearest behavioral health provider (Figure 54 and Figure 55). Data was not available on whether these providers accept health insurance, including Medicaid or private insurance, which is an important factor in the accessibility and affordability of behavioral health services.

[270] Esri, 2019.

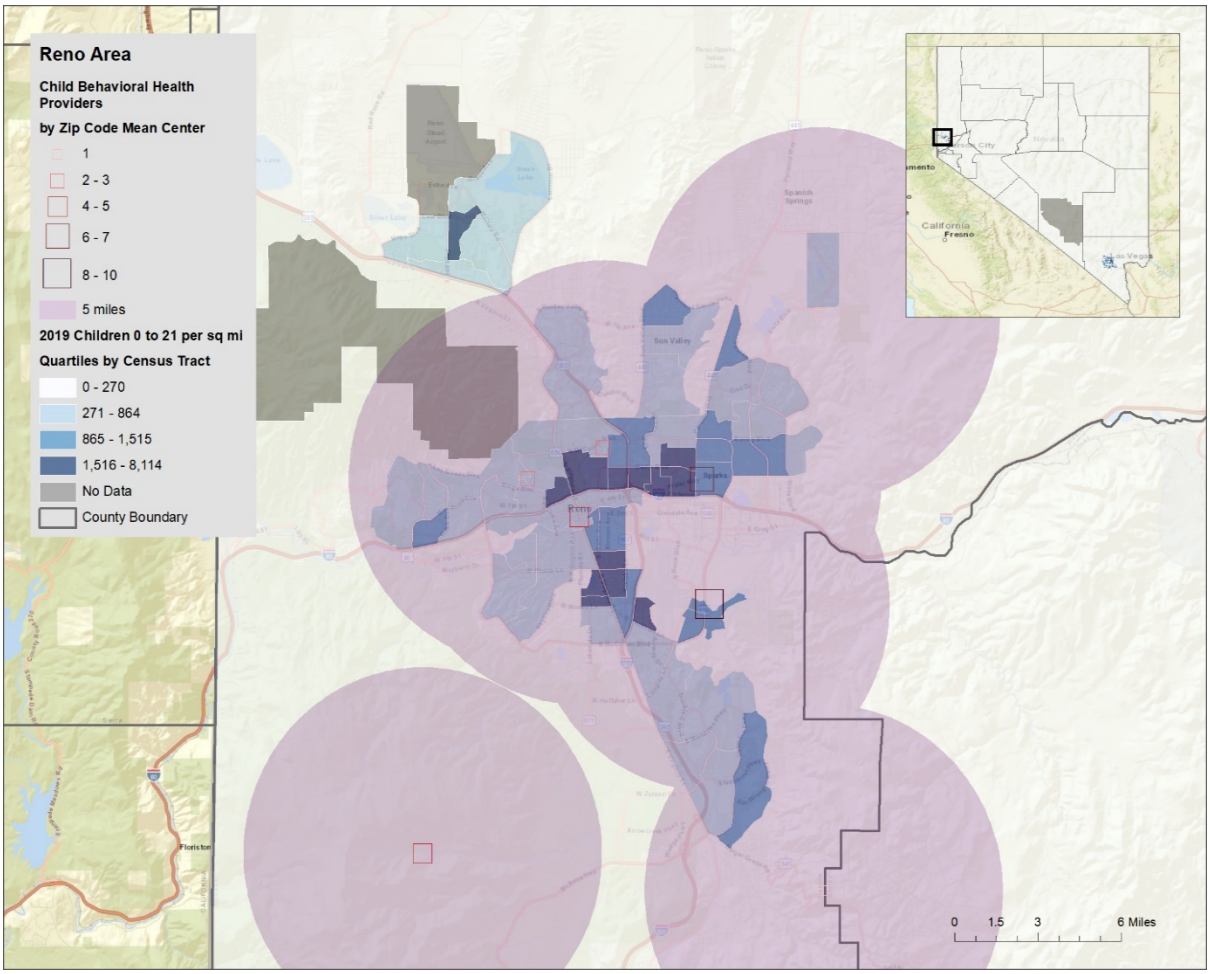
Figure 54. Distance to Child Behavioral Health Providers and Children Ages Zero to 21, Las Vegas Area, by Census Tract[271]



Note: Behavioral health provider access findings may be affected because the mean center of zip codes was selected as the unit of analysis rather than actual address data.

[271] Esri, 2019.

Figure 55. Distance to Child Behavioral Health Providers and Children Ages Zero to 21, Reno Area, by Census Tract[272]



Note: Behavioral health provider access findings may be affected because the mean center of zip codes was selected as the unit of analysis rather than actual address data.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) is the term used to describe all types of abuse, neglect, and other potentially traumatic experiences occurring to people under the age of 18 years.[273] ACEs have been linked to risky health behaviors, chronic health conditions, low-life potential, and early death.[274]

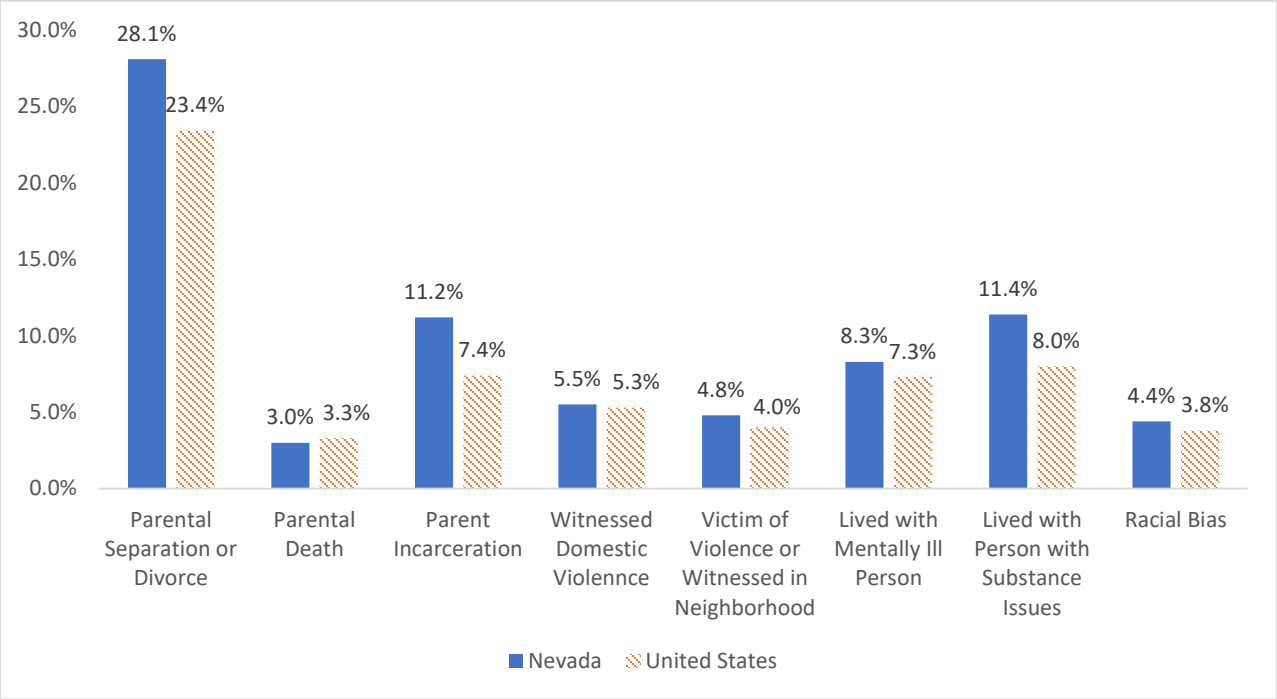
Children in Nevada are more likely than children nationwide to have ever experienced two or more of the following ACEs: frequent socioeconomic hardship, parental divorce or separation, parental death, parental incarceration, family violence, neighborhood violence, living with someone who was mentally ill or suicidal, living with someone who had a substance use problem, or racial bias. As the number of ACEs increases, so does a child's risk for negative health outcomes. In 2016-17, almost one in four (22%)

[272] Esri, 2019.
[273] National Center for Injury Prevention and Control, Division of Violence Prevention. (2019, April 2). Adverse Childhood Experiences (ACEs). Retrieved December 12, 2019 from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html.
[274] National Center for Injury Prevention and Control, Division of Violence Prevention. (2019, April 2). Adverse Childhood Experiences (ACEs). Retrieved December 12, 2019 from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html.

Nevada youth ages zero to 17 years experienced two or more ACEs, compared to approximately one in five (18.6%) youth across the U.S. Among different race and ethnicities, Nevada's Hispanic children are the most likely to experience two or more ACEs (25.4%) compared to White children (20.2%).[275]

Looking at specific ACEs, Nevada has a higher prevalence than the U.S. of nearly every ACE indicator, other than having a parent die (Figure 56). The most common ACE experienced is parental separation or divorce, with 28.1 percent of children in Nevada having this experience, followed by living with someone with substance use problems (11.4%), and having a parent who served time in jail (11.2%).[276]

Figure 56. Prevalence of ACE Indicators, Nevada and United States, 2017-2018[277]



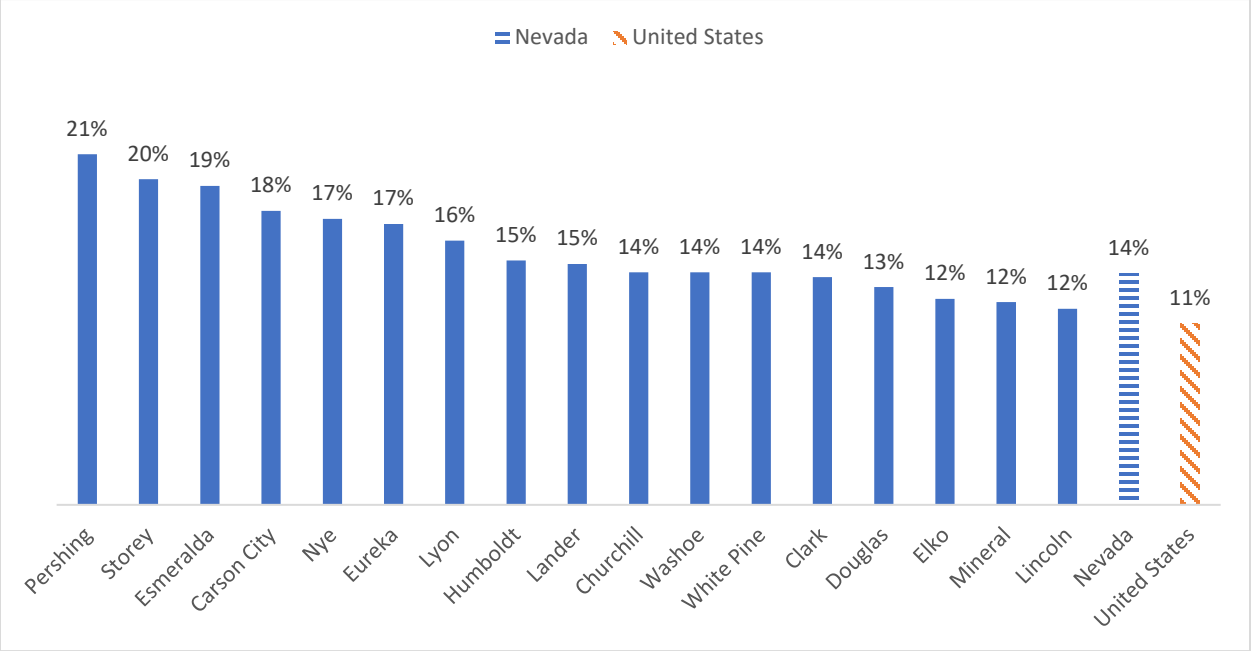
The assessment explored the prevalence of four ACEs in Nevada, including divorce, child abuse and neglect, household substance use, and depression.

Divorce: Adults 18 years of age and older in Nevada are more likely to respond they are divorced at 13.9 percent, compared to 10.9 percent nationally.[278] Potentially driving high divorce rates are lenient requirements for divorce, such as no waiting period and a lenient residency requirement of six weeks.[279] Divorce is a risk factor for adverse health outcomes among youth and adolescents as it can introduce intense feelings of uncertainty, create an environment of chronic stress from anger and fighting, and cause economic strain on one of the divorcing parents. Additionally, it may separate children from a parent and parent's family members who have been a positive influence or expose youth to parent's

[275] National Children's Health Survey. (2018). Indicator 6.13: Has this child experienced one or more adverse childhood experiences (ACEs) from a list of 9 ACEs?
[276] National Children's Health Survey. (2018). Indicator 6.13: Has this child experienced one or more adverse childhood experiences (ACEs) from a list of 9 ACEs?
[277] National Children's Health Survey. (2018). Indicator 6.13: Has this child experienced one or more adverse childhood experiences (ACEs) from a list of 9 ACEs?
[278] American Community Survey. (2017). Table S1201: Marital Status.
[279] Ngo, Sheiresa. (2018, May 30). Couples in This State Are Most Likely to Get Divorced. Retrieved from https://www.cheatsheet.com/culture/couples-state-likely-get-divorced.html/.

new partners increasing the risk of physical or sexual abuse. Some counties in Nevada experience twice the rate of divorce, such as Pershing County at 21 percent or Storey County at 20 percent, relative to the U.S. (Figure 57). While most individuals younger than age 18 years live in a married-couple family household in Nevada (62.8%), there is a significant proportion of children and youth living in a male (10.3%) or female (26%) only household with no partner present.[280]

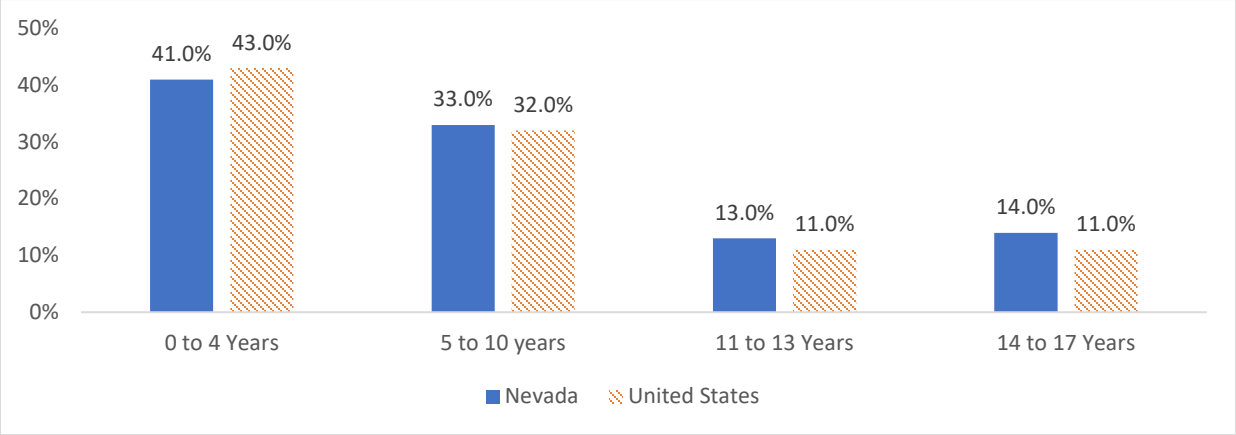
Figure 57. Divorce Rate in Nevada, by County, 2013 to 2017[281]



Child abuse and neglect: In Nevada, children have a lower probability of experiencing child abuse compared to children nationally. The rate of abuse in Nevada was seven per 1,000 children between 2015 and 2017, lower than the rate of nine per 1,000 children nationwide; these numbers represent children who are confirmed by child protective services (CPS) to be victims of maltreatment. There is disparity in the likelihood of experiencing child abuse among different age groups, with younger children more likely to experience abuse (Figure 58). Specifically, 41 percent of children confirmed by Nevada CPS to be victims of maltreatment were ages zero to four years, compared to children ages five to ten years (33%), 11 to 13 years (13%) or 14 to 17 years (14%). This trend is similarly seen nationwide.[282]

[280] American Community Survey. (2017). Table S1201: Marital Status.
[281] American Community Survey. (2017). Table S1201: Marital Status.
[282] United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.

Figure 58. Percent of Children Who Are Confirmed by Child Protective Services as Victims of Maltreatment, Nevada and United States, by Age Group, 2015 to 2017[283]

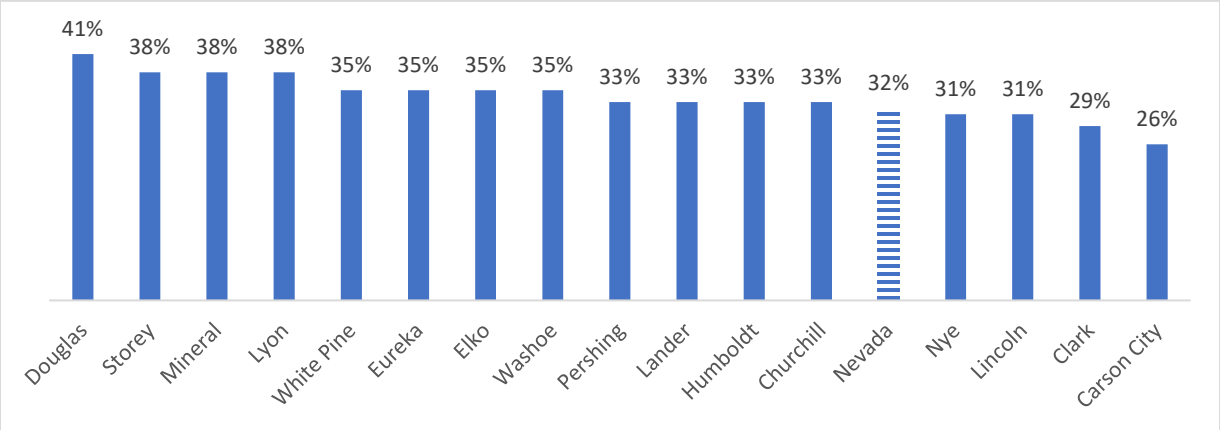


Most children confirmed to be victims of child maltreatment experience neglect (83%), followed by physical abuse (22%), sexual abuse (5%), and medical neglect (2%).[284] Compared to children across the U.S., Nevada's children are more likely to experience neglect and physical abuse.

Household Substance Use and Depression: In Nevada, the 2017 YRBS asked youth whether they have ever lived with someone who was a problem drinker or alcoholic, or abused street or prescription drugs, of which 32.3 percent reported "Yes".[285]

Household Depression: Over 30 percent of Nevada high school students have lived with someone who was depressed, mentally ill, or suicidal. Across the state, there are some counties with a higher prevalence for adolescents experiencing one or more of these factors, including Douglas, Storey, Mineral, and Lyon counties (Figure 59).

Figure 59. Percentage of High School Students Who Ever Lived with Someone Who Was Depressed, Mentally Ill, or Suicidal, by County, 2017[286]



[283] United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.
[284] United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.
[285] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[286] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

Community Voices on Children's Health

Issues of violence, community resources, and immunizations were highlighted as a need among infants and children. For young children, specifically, healthy behaviors related to physical activity and nutrition, obesity, and specialty services (i.e., home healthcare services and high-fidelity wraparound case management for home visiting) were highlighted. Breastfeeding support, post-partum care and health, and developmental screening were specific to infants. Specific issues identified for this population include:

- Low availability of providers for children, including both primary and behavioral health. There are limited numbers of providers let alone providers with specialties needed for children. Where providers do exist, there may be long wait lists.
- Need for evidence-based screening tools and universal, on-going assessments for young children to support early identification of developmental and behavioral needs.
- Lack of early childhood interventions for infants and toddlers, particularly for children who are not in preschool and among those living in rural communities.
- High risk of neglect and abuse thought to be related to issues of substance use, poor mental health, domestic violence, and/or lack of parenting skills.
- Other issues facing children ages one to ten years include lack of community building, childcare, and transportation.
- Immunizations are also an issue, with families not accessing and/or following through on immunization schedules for a number of reasons, including lack of access to primary care, fear of accessing care (in the case of undocumented families), personal beliefs which promote forgoing immunization, and/or lack of education on importance of vaccinations and completing vaccination schedules.

Newborns and Infants (Birth Up to 1 year of age)

Infant health focuses on the health of babies less than one year of age. Topics explored include infant mortality, preterm birth, and low birth weight. This section also describes important indicators related to a child's first year of development, including breastfeeding, maternal substance use, immunizations and vaccines, and developmental screening. Table 34 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.S., and where MCH and MIECHV programs might prioritize efforts, if not doing so already.

Table 53. Summary of Indicators, Nevada and United States

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Infant Mortality	Infant mortality rate per 1,000 live births (2016)[287]	5.8	5.9	✓
Preterm Births	Percent of infants born preterm (<37 weeks gestation) (2017)[288]	10.7%	9.9%	✓

[287] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.
[288] National Vital Statistics System. (2016). National Outcome Measure 5.0: Percent of preterm births (<37 weeks gestation).

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Breastfeeding	**Percent of infants who are ever breastfed (2015)[289]**	83.5%	83.2%	✓
Breastfeeding	**Percent of infants breastfed exclusively through six months (2015)[290]**	20.8%	24.9%	✓
Low Birth Weight	Percent of low birth weight infants (2017)[291]	9.1%	8.3%	✓
Sleep-related Sudden Unexpected Infant Death (SUID)	SUID rate per 100,000 live births (2016)[292]	124.1	91.2	✓
Maternal Substance Use	Rate of neonatal abstinence syndrome (NAS) per 1,000 infants (2017)[293]	8.3	n/a	✓
Vaccinations	Percent of children ages 19 to 35 months completed the combined 7-vaccine series (2017)[294]	71.3%	70.4%	✓
Developmental Screening	Percent of children, ages nine through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (2017)[295]	27.9%	33.1%	✓

Newborn and Infant Demographics

In 2018, there were 35,567 births to Nevada women between the ages of 15 and 44 years and children under the age of one year in 2019 totaled 39,274.[296] Home births made up 1.3 percent (480) of all births in 2018 (compared to one percent of all births in the U.S.).[297]

Infant Mortality

Infant mortality, or the death of a baby before its first birthday, is an important indicator of the general health status of a population and can be seen as a broad proxy measure of socioeconomic status and

[289] National Immunization Survey. (2015). National Performance Indicator 4A: Percent of infants who are ever breastfed.
[290] National Immunization Survey. (2015). National Performance Indicator 4B: Percent of infants breastfed exclusively through 6 months
[291] National Vital Statistics System. (2017). National Outcome Measure 4.0: Percent of low birth weight deliveries (<2,500 grams).
[292] National Vital Statistics System. (2017). National Outcome Measure 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.
[293] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is reflective of self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf
[294] CD CDC School Vaccination Assessment. (2019). 2019 Immunization Report Card. Retrieved on December 6, 2019 from https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card_2019.pdf
[295] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.
[296] Esri, 2019.
[297] Centers for Disease Control and Prevention (2019, November 27). National Vital Statistics Report, Births Final Data for 2018 Supplemental Tables. Vol. 68, No. 13.

availability and quality of health care services within a community.[298] In addition, a standardized measure, such as the infant mortality rate or number of infant deaths per 1,000 live births, allows for comparison between different populations so areas of disparity can be identified.[299] According to the 2016 Statewide Child Death Report, children less than one year of age are the largest subgroup of childhood deaths in Nevada. Natural deaths are the leading manner of child death, accounting for 59.4 percent of all deaths in 2016 and occurring primarily in infants less than one year of age (Table 35).[300]

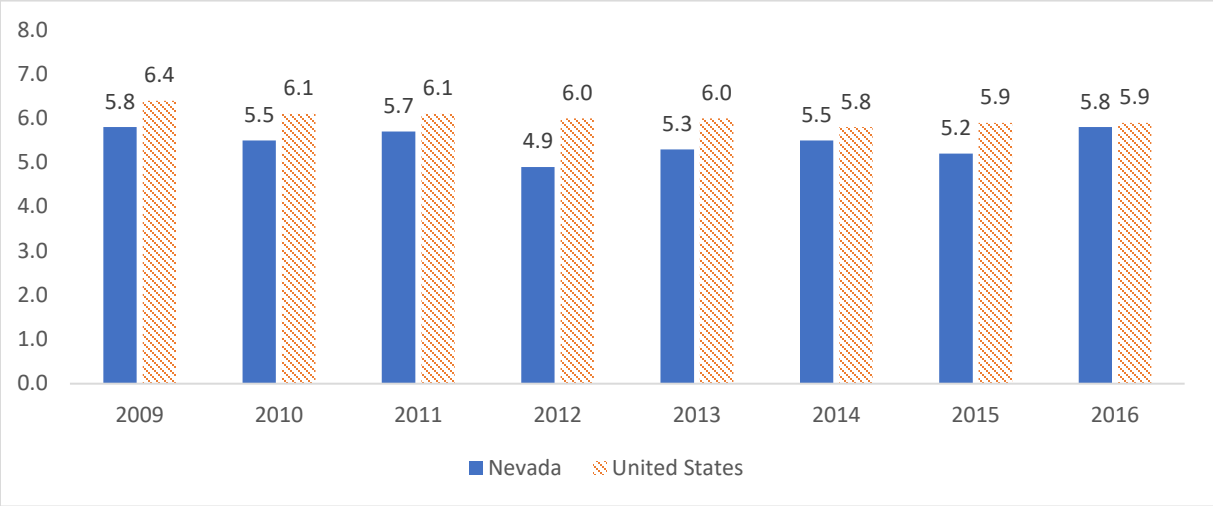
Table 54. Total Deaths and Percentage for Infant Natural Deaths in Nevada, 2016[301]

Cause	Total Deaths	Percentage
Prematurity	63	19.8%
Congenital anomaly	41	12.9%
Other medical issue	20	6.3%
Cancer	14	4.4%
Other infection	13	4.1%
Cardiovascular	7	2.2%
Asthma/respiratory	6	1.9%
Neurological	5	1.6%
Pneumonia	4	1.3%
Influenza	3	0.9%
SIDS	2	0.6%
Perinatal condition	1	0.3%
Other/unknown	10	3.1%
Total	**189**	**59.4%**

Between 2009 and 2016, Nevada's infant mortality rate (IMR) was consistently lower than the rate across the U.S. (Figure 60). However, while the U.S. IMR generally decreased during this period, Nevada's IMR decreased to a low of 4.9 per 1,000 live births in 2012 and then increased to 5.8 in 2016 (compared to 5.9 in the U.S).[302]

[298] Association of Maternal & Child Health Programs. (2013). State Infant Mortality Collaborative: Infant Mortality Toolkit. Retrieved November 12, 2019, from http://www.amchp.org/programsandtopics/data-assessment/InfantMortalityToolkit/Pages/default.aspx
[299] Reidpath, D., and Allotey, P. (2003). Infant mortality rate as an indicator of population health. Journal of Epidemiology & Community Health, 57(5), 344-46.
[300] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[301] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[302] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.

Figure 60. Infant Mortality Rate, Nevada and United States, 2009 to 2016[303]



In Nevada the highest IMR in 2016 was among Black or African American infants, while the lowest rate was among White non-Hispanic infants. In 2016, the IMR in Nevada for White non-Hispanic infants was 4.7 deaths per 1,000 live births, followed by a rate of 5.2 for Asian or Pacific Islander infants, and 5.0 for Hispanic infants.[304] The IMR in Nevada for American Indian or Alaska Native infants is not available for 2016 due to a small sample size. In 2016, the IMR in Nevada among Black or African American infants was 9.4 deaths per 1,000 live births, far exceeding the state average IMR (5.8). This is consistent with national data showing Black or African American infants have a marked disparity with an IMR over twice the rate of White infants nationwide (11.1 deaths per 1,000 live births for Black or African Americans versus 4.9 deaths per 1,000 live births for Whites).[305]

Risk Factors

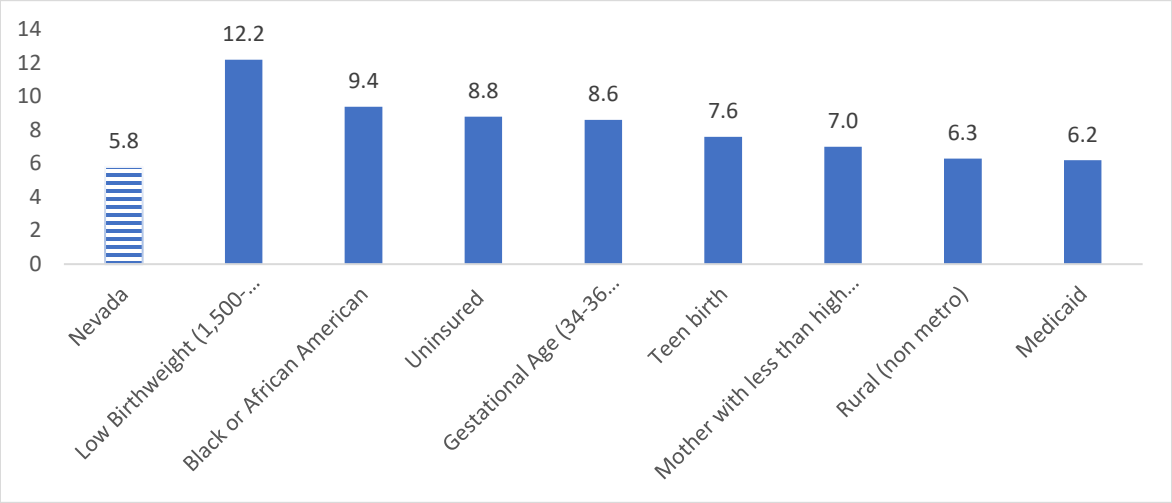
There are several risk or disparity factors which can result in higher IMRs among certain populations compared to the state rate (Figure 61). One significant risk factor for infant mortality is low birthweight. In Nevada, infants born weighing less than 1,500 grams (approximately 3.3 pounds) have an infant mortality rate of 202.8 per 1,000 live births and infants born weighing 1,500 to 2,499 grams (3.3 to 5.5 pounds) have an infant mortality rate of 12.2 per 1,000 live births. Related to birthweight, Nevada infants born prematurely (before 37 weeks) also experience high IMRs at 8.6 per 1,000 live births (premature birth is one of the leading causes of infant death in the U.S., as described in the next section).

Insurance status and coverage type also seem to be associated with IMRs as uninsured Nevada mothers experience an IMR of 8.8 per 1,000 live births, while those on Medicaid experience an IMR of 6.2 per 1,000 live births. Nevada infants born to teen mothers and mothers with less than a high school education also have higher IMRs, making both characteristics risk factors. Infants born to teen mothers (those between the ages of 15 and 19 years) experience an IMR of 7.6 per 1,000 live births and infants born to mothers with less than a high school degree have an IMR of seven per 1,000 live births. Finally, rural counties experienced a higher IMR than urban counties, exceeding the state rate. In 2016, urban

[303] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.
[304] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.
[305] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.

IMRs ranged from 5.4 to 5.7 (small urban area to large central urban area, respectively) compared to 6.3 per 1,000 live births in rural areas.[306]

Figure 61. Risk or Disparity Factors for Infant Mortality Rates, Nevada, 2017[307]



Sudden Unexpected Infant Death (SUID)

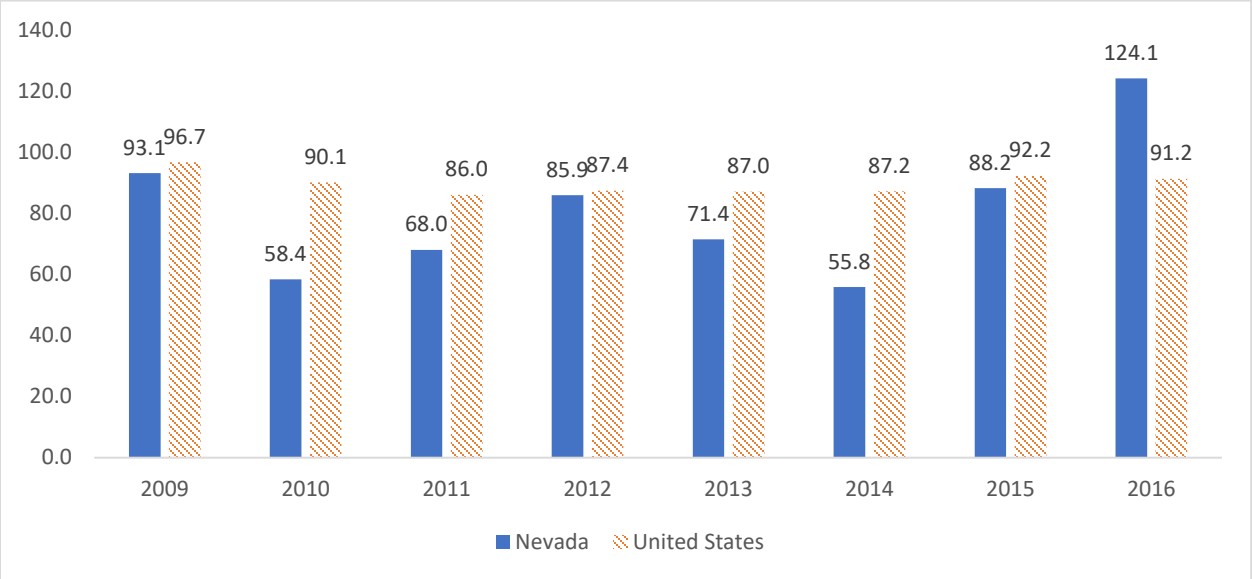
According to the CDC, SUID is an abrupt death with no obvious cause in an infant less than one year of age. The deaths can be reported as one of three types[308]:

1. Sudden Infant Death Syndrome (SIDS): this occurs when a death cannot be explained after a thorough investigation is conducted
2. Accidental Suffocation or Strangulation in Bed (ASSB): this can occur because of suffocation due to soft bedding (i.e., the material accidentally covers an infant's nose and mouth), overlay (i.e., rolling on or against an infant), wedging or entrapment (i.e., infant gets stuck between the mattress and wall), or strangulation (i.e., neck is caught between crib railings).
3. Unknown cause: this occurs when the cause of death is undetermined, but a thorough investigation was not conducted.

The SUID rate per 100,000 live births in both the U.S. and Nevada has fluctuated since 2009 (Figure 62). In Nevada, the SUID rate decreased 40.1 percent from a rate of 93.1 per 100,000 in 2009 to a low of 55.8 per 100,000 in 2014. It has since increased 122.4 percent to a high of 124.1 per 100,000 in 2016. The U.S. rate has fluctuated less so since 2009 from a high of 96.7 per 100,000 to 91.2 per 100,000 in 2016.[309] Overall, 3,500 U.S. infants die due to SUID every year.[310]

[306] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.
[307] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.
[308] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[309] National Vital Statistics System. (2017). National Outcome Measure 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.
[310] Centers for Disease Control and Prevention and Prevention. (2015, May 16). Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Retrieved December 3, 2019, 2015 from http://www.cdc.gov/sids/aboutsuidandsids.htm.

Figure 62. SUID rate per 100,000 live births, Nevada and United States, 2009 to 2016[311]



In 2016, there were 38 SUID cases in Nevada and roughly 34.2 percent (n=13) were due to ASSB with the remaining being related to an undetermined cause.[312] All asphyxia deaths were associated with unsafe sleep environments due to excessive or inappropriate bedding (34%), adults/children sharing a bed with infants (45%), or a combination of those factors (21%).[313] In 2016, White children in Nevada accounted for 52.6 percent of SUIDs, followed by Black or African American children (29%). The SUID rate for Black or African Americans is disproportionately higher than their statewide population distribution of ten percent and indicates a disparity and need for increased prevention efforts related to safe sleep environments in the home. Approximately 26.3 percent (n=10) of asphyxia deaths in 2016 occurred among Nevada Hispanics. This is disproportionately lower than their statewide population distribution of 40.3 percent, indicating Hispanic families are practicing more positive factors which prevent SUID and which should be explored and replicated in other communities, if possible.[314]

Preterm Births

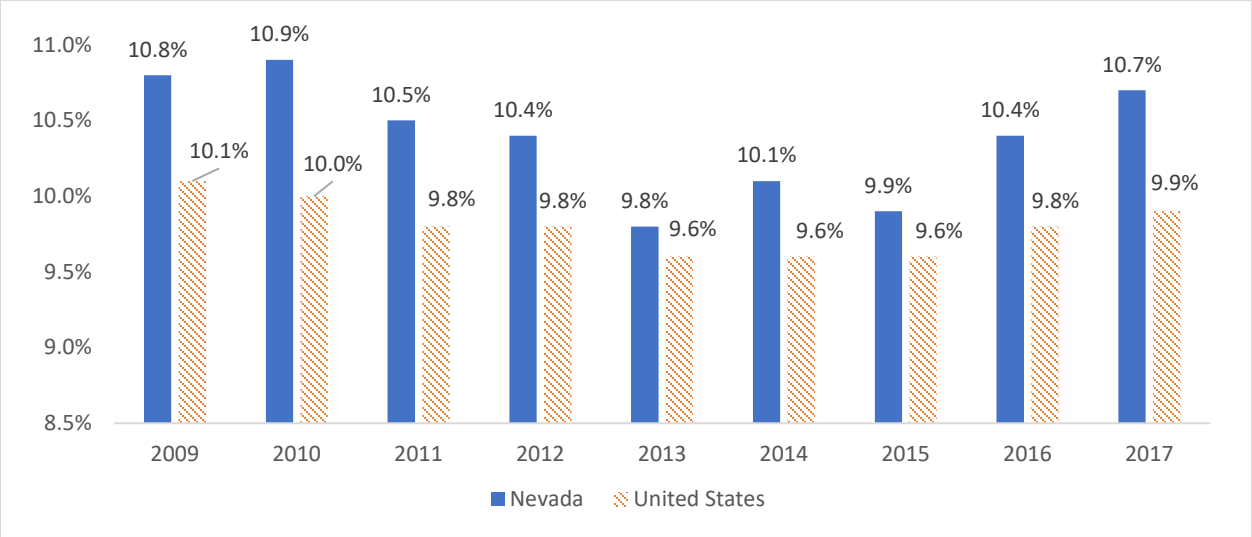
Preterm births, or births before 37 weeks gestation, is one of the leading causes of infant death in the U.S., with prematurity-related issues accounting for 17 percent of infant deaths in 2017.[315] In 2016, 19.8 percent of all child deaths in Nevada were due to prematurity (number of infant deaths due to premature birth out of all child deaths).[316]

[311] National Vital Statistics System. (2017). National Outcome Measure 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births.
[312] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[313] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[314] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[315] Centers for Disease Control and Prevention. (2019, October 21). Maternal and Infant Health: Preterm Birth. Retrieved on December 3, 2019, from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm.
[316] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.

Preterm birth is associated with longer hospitalization (compared to infants born at term), increased risk for birth defects, and long-term consequences such as physical impairments and neurological disabilities, as well as extracting an emotional and physical toll on families. Since 2009, Nevada consistently experienced higher rates of preterm births than the U.S. [317]

Nationally, since 2010, the percentage of preterm births decreased from a high of 10.1 percent to a low of 9.6 percent in 2013. From 2013, the percentage remained steady until it increased to 9.9 percent in 2017. This trend was also reflected in Nevada's numbers, which declined from ten percent in 2010 to 9.8 percent in 2013; however, the percent of preterm births in Nevada has since increased to 10.7 percent as of 2017 (Figure 63).[318]

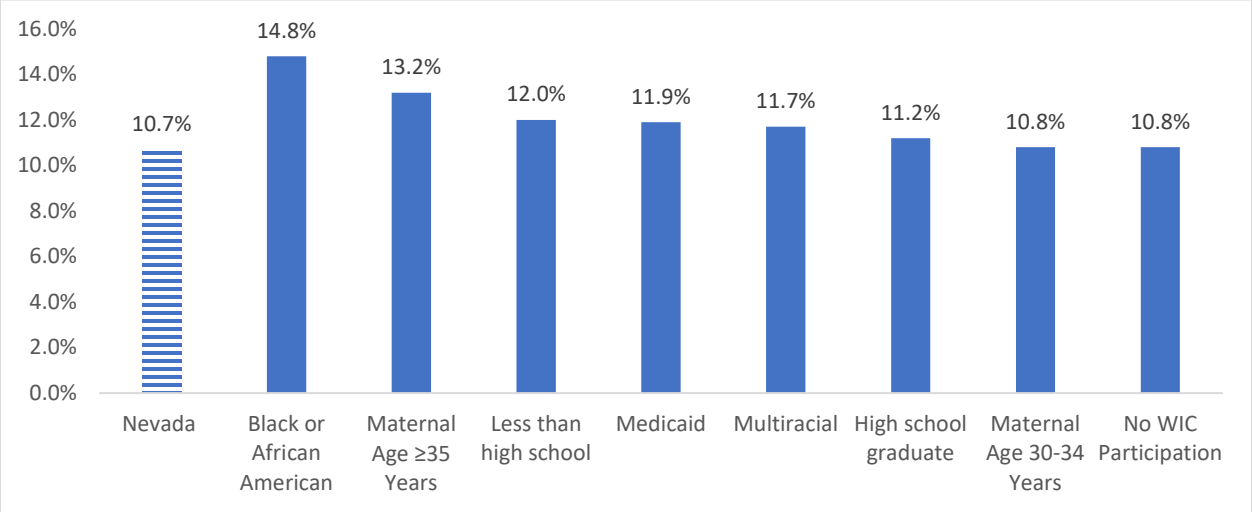
Figure 63. Percent of Infants Born Preterm (<37 weeks gestation), Nevada and United States, 2009 to 2017[319]



There are several risk or disparity factors associated with a higher percentage of preterm births among certain populations compared to the state (Figure 64). These risk or disparity factors for preterm birth are similar to those for infant mortality, except for maternal age and WIC (Special Supplemental Nutrition Program for Women, Infants and Children) participation. One disparity of note is the prevalence of preterm birth is 38.3 percent greater for Black for African American infants in Nevada compared to the statewide prevalence and 49.5 percent greater than the prevalence among White infants in Nevada.[320]

[317]Honein, M., Kirby R., Meyer, R., Xing, J., Skerrette N., and Yuskiv, N., (2009). The association between major birth defects and preterm birth. Maternal and Child Health Journal, 13(2), 164-75.
[318] National Vital Statistics System. (2016). National Outcome Measure 5.0: Percent of preterm births (<37 weeks gestation).
[319] National Vital Statistics System. (2016). National Outcome Measure 5.0: Percent of preterm births (<37 weeks gestation).
[320] National Vital Statistics System. (2016). National Outcome Measure 5.0: Percent of preterm births (<37 weeks gestation).

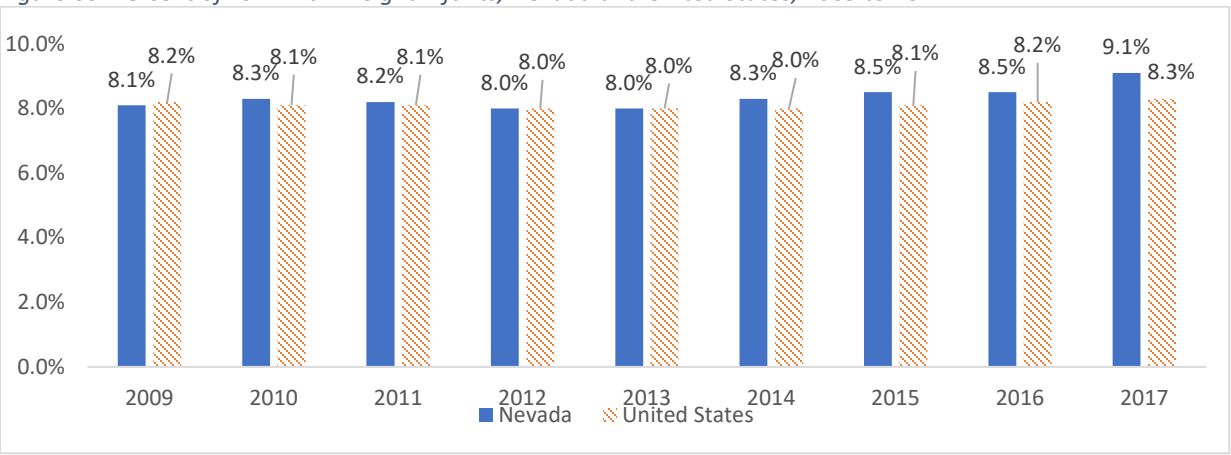
Figure 64. Risk or Disparity Factors for Preterm Birth, Nevada, 2017[321]



Low Birth Weight

Low birth weight (LBW), defined as less than 2,500 grams or five pounds, eight ounces, is another leading cause of infant mortality and morbidity. LBW infants are at a substantially increased risk of death compared to normal weight infants. Often this is because LBW infants are not as strong as an infant of normal birth weight and they have a harder time fighting infections, staying warm, eating, and gaining weight.[322] In addition, LBW increases the risk of adverse health conditions later in life, such as diabetes, hypertension, and cardiac disease. From 2009 to 2017, the percentage of LBW babies was similar between Nevada and the U.S., and both percentages remained stable over this time period (Figure 65). However, between 2016 and 2017, the percentage of LBW babies born in Nevada experienced a 7 percent increase from 8.5 percent to 9.1 percent. In 2017, Nevada's measures for very low birth weights (<1,500 grams) and moderately low birth weights (1,500-2,499g) were 1.5 percent and 7.7 percent respectively. Both measures were slightly higher compared to LBW infants nationwide (1.4% and 6.9% respectively).[323]

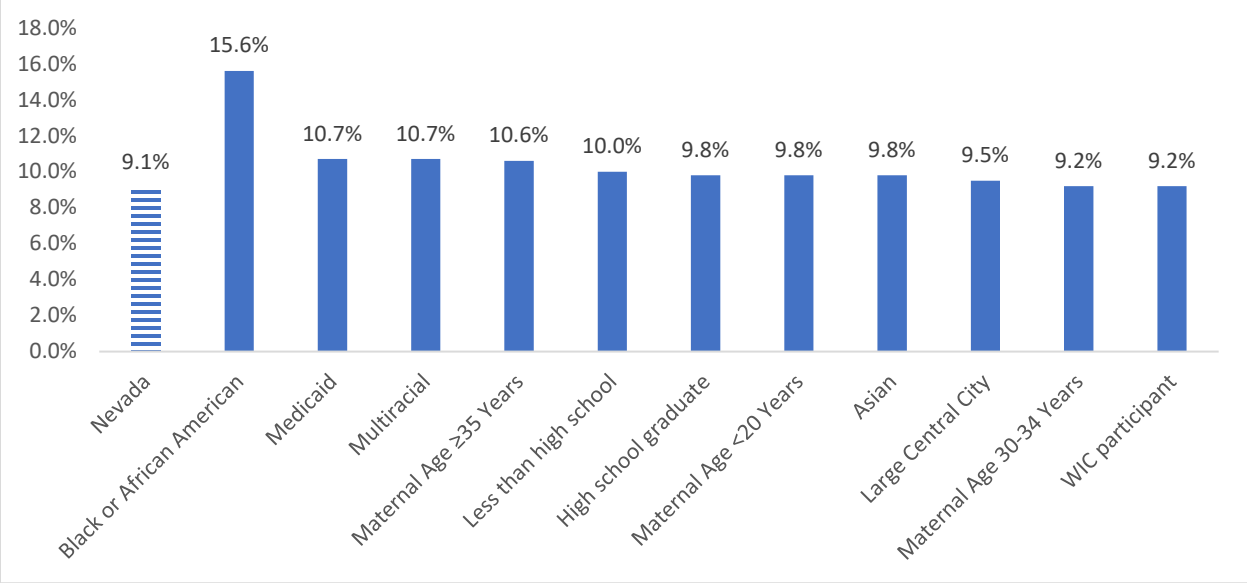
Figure 65. Percent of Low Birth Weight Infants, Nevada and United States, 2009 to 2017[324]



[321] National Vital Statistics System. (2016). National Outcome Measure 5.0: Percent of preterm births (<37 weeks gestation).
[322] University of Rochester Medical Center, Health Encyclopedia. (n.d.). Low Birth Weight. Accessed December 10, 2019. https://www.urmc.rochester.edu/encyclopedia/content.aspx?contenttypeid=90&contentid=p02382.
[323] National Vital Statistics System. (2017). National Outcome Measure 4.0: Percent of low birth weight deliveries (<2,500 grams).
[324] National Vital Statistics System. (2017). National Outcome Measure 4.0: Percent of low birth weight deliveries (<2,500 grams).

There are several risk or disparity factors associated with a higher percentage of LBW infants among certain populations compared to Nevada overall (Figure 66).[325] For example, the percentage of Black or African American infants in Nevada born with LBW is 71.4 percent greater than the statewide percentage and 97.5 percent greater than the percentage of White infants.

Figure 66. Risk or Disparity Factors for Low Birth Weight, Nevada, 2017[326]



Congenital Syphilis

Congenital syphilis is a disease occurring when a mother with syphilis passes the infection to her baby during pregnancy. Congenital syphilis can cause miscarriage, stillbirth, prematurity, low birth weight, or even infant death. For babies born with congenital syphilis, it can cause deformed bones, severe anemia, enlarged liver and spleen, jaundice, brain and nerve problems (i.e., blindness or deafness), meningitis, and skin rashes. However, congenital syphilis is preventable. Blood tests can identify infection in pregnant people and the treatment is relatively simple and effective. When caught during pregnancy and at least 30 days before delivery, transmission to the baby can generally be stopped.[327]

Nationwide, 1,306 infants acquired syphilis from their mother in 2018, a 40 percent increase from 2017. Of these 1,306 infants, 78 infants were stillborn, and 16 died after birth. Nevada's congenital syphilis rate in 2018 was 85.5 cases per 100,000 live births, the second highest rate in the nation.[328] Nevada's congenital syphilis rate has increased more than five times (or 515%) since 2014, from approximately 13.9 cases per 100,000 births to the 85.5 cases per 100,000 births recorded in 2018.[329] Regarding maternal risk factors in Nevada for 2016-2017 cases, more than a third of pregnant women had more than one sexual partner in the past 12 months, 44 percent reported drug use, and 85 percent reported sex without a condom. Preliminary data from 2018 indicated over **half of the pregnant women (52%)**

[325] National Vital Statistics System. (2017). National Outcome Measure 4.0: Percent of low birth weight deliveries (<2,500 grams).
[326] National Vital Statistics System. (2017). National Outcome Measure 4.0: Percent of low birth weight deliveries (<2,500 grams).
[327] Barry-Jester, A. (2019, October). 1,306 U.S. infants were born with syphilis in 2018, even though it's easy to prevent. *LA Times.* Retrieved on January 28, 2020 from https://www.latimes.com/science/story/2019-10-08/congenital-syphilis-rising-at-alarming-rate.
[328] CDC. Sexually Transmitted Disease Surveillance 2018. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2018. Retrieved on January 28, 2020 from https://www.cdc.gov/std/stats18/tables/40.htm.
[329] CDC. Sexually Transmitted Disease Surveillance 2018. Congenital Syphilis — Reported Cases and Rates of Reported Cases by State, Ranked by Rates, United States, 2018. Retrieved on January 28, 2020 from https://www.cdc.gov/std/stats18/tables/40.htm.

with syphilis did not receive prenatal care and among those cases who did receive prenatal care the detection of syphilis was too late to prevent congenital syphilis[330]

Critical Congenital Heart Disease

Critical congenital heart disease (CCHD) represents a group of heart defects occurring in an infant before birth. These include abnormal or absent heart chambers, holes in the heart, abnormal connections in the heart, and abnormalities in the function of the heart. CCHD is a life-threatening condition requiring intervention within the first year of life, and proper screenings must occur to identify the defects.[331]

In 2017 in Nevada, 9.7 infants per 10,000 live births were identified as needing follow-up care related to pulse oximetry (i.e., amount of oxygen in an infant's blood which gives an indication of heart function); 91 percent of all infants born in Nevada hospitals received pulse oximetry screening prior to discharge. Based on preliminary birth data for 2017, there were 43 diagnosed cases of CCHD. There were disparities indicated in CCHD data with higher percentages of CCHD occurring among Asian infants, representing 14 percent of CCHD cases but only four percent of all births, and Black or African American infants, representing 23 percent of CCHD cases but only 14 percent of all births. However, there are many challenges related to gathering CCHD data, such as inconsistent reporting from hospitals and a lack of data from home births; more data is needed to better understand CCHD and its prevalence among infants in Nevada.[332]

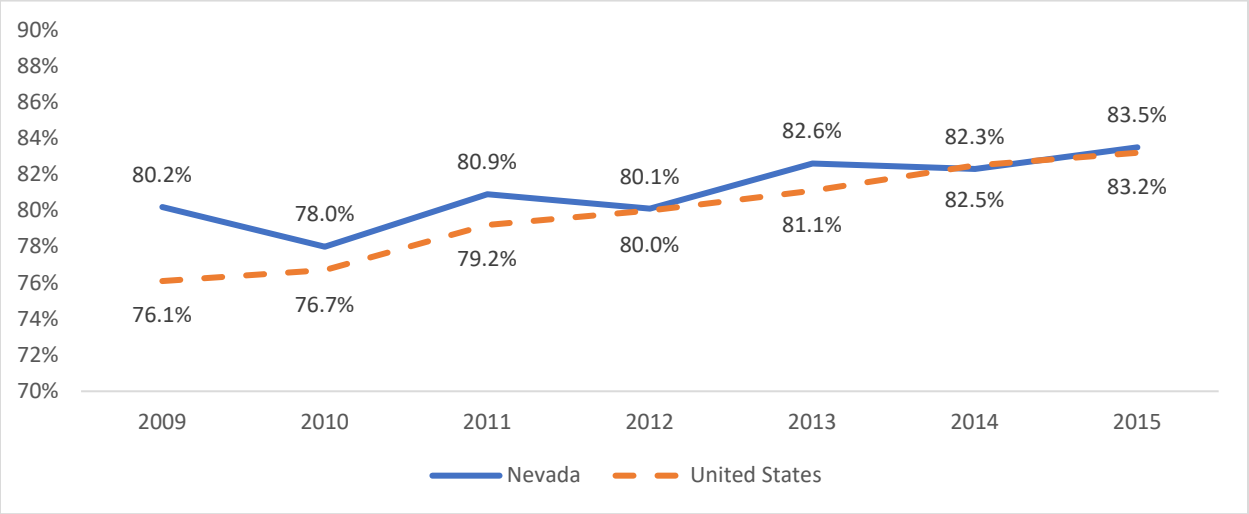
Breastfeeding

Research suggests breastfeeding is correlated as a protective factor associated with numerous health concerns such as asthma; obesity; ear, respiratory, or gastrointestinal infection; sudden infant death syndrome; and type one diabetes.[333] Research further indicates breastfeeding may benefit the mother as well, helping to lower her risk of type two diabetes, high blood pressure, and ovarian and breast cancer.[334]

Breastfeeding rates have been increasing nationwide with 83.2 percent of newborns who were born in 2015 ever breastfed compared to 76.1 percent in 2009 (Figure 67).[335] Nevada's breastfeeding initiation rates tend to be above national rates; however, the gap is closing.

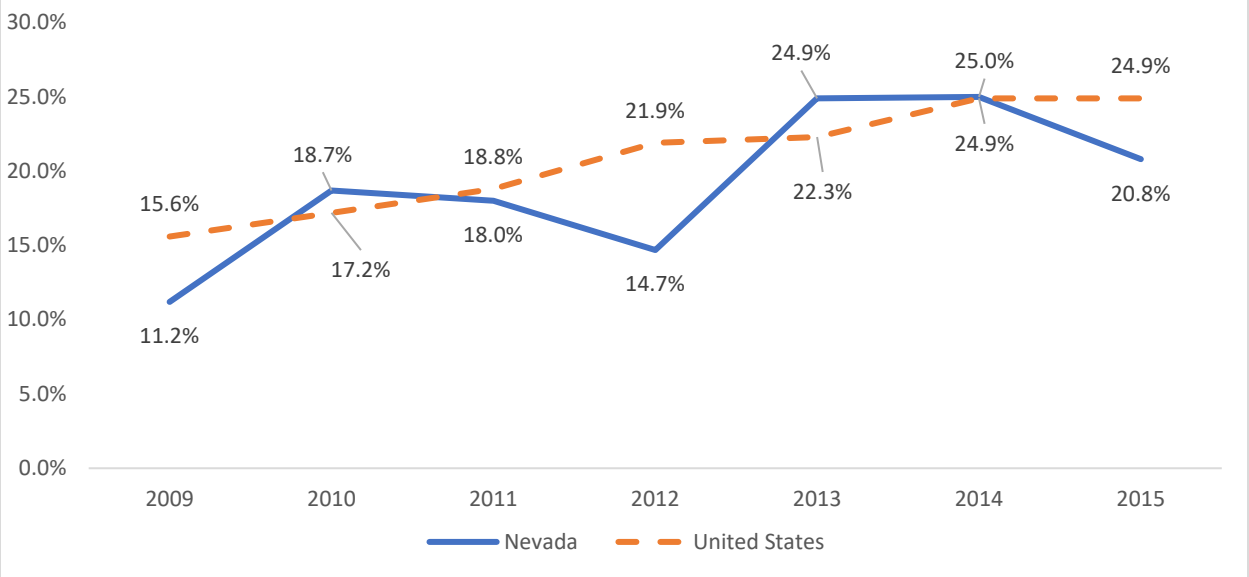
[330] Nevada Department of Health and Human Services, Division of Public and Behavioral Health. (November 9, 2018). Epidemic of Syphilis: Understanding the Clinical & Public Health Need for Acton. Retrieved on February 13, 2020 from https://med.unr.edu/Documents/med/statewide/echo/clinics/public-health/2018/Project%20ECHO%20Syphilis%20presentation%20-%2011-9-18.pdf.
[331] Nevada Bureau of Child, Family and Community Wellness. Nevada Division of Public and Behavioral health, Department of Health and Human Services. (2017). Nevada Critical Congenital Heart Disease Annual Report.
[332] Nevada Bureau of Child, Family and Community Wellness. Nevada Division of Public and Behavioral health, Department of Health and Human Services. (2017). Nevada Critical Congenital Heart Disease Annual Report.
[333] Centers for Disease Control and Prevention. (2019, November 4). Breastfeeding: Why it matters. Retrieved on December 11, 2019 from https://www.cdc.gov/breastfeeding/about-breastfeeding/why-it-matters.html.
[334] Centers for Disease Control and Prevention. (2019, November 4). Breastfeeding: Why it matters. Retrieved on December 11, 2019 from https://www.cdc.gov/breastfeeding/about-breastfeeding/why-it-matters.html.
[335] National Immunization Survey. (2015). National Performance Indicator 4A: Percent of infants who are ever breastfed.

Figure 67. Percent of Infants Who Are Ever Breastfed, Nevada and United States, 2009 to 2015[336]



Breastfeeding rates begin to decline as the infant ages. In 2015, the percent of infants breastfed exclusively through age six months was 24.9 percent in the U.S. and 20.8 percent in Nevada, compared to approximately 40 percent of infants who ever breastfed (Figure 68). While breastfeeding has varied over time, the percent of infants breastfed in Nevada exclusively through six months increased between 2009 and 2015.[337]

Figure 68. Percent of Infants Breastfed Exclusively Through Six Months, Nevada and United States, 2009 to 2015[338]



[336] National Immunization Survey. (2015). National Performance Indicator 4A: Percent of infants who are ever breastfed.
[337] National Immunization Survey. (2016). National Performance Indicator 4B: Percent of infants breastfed exclusively through 6 months
[338] National Immunization Survey. (2016). National Performance Indicator 4B: Percent of infants breastfed exclusively through 6 months

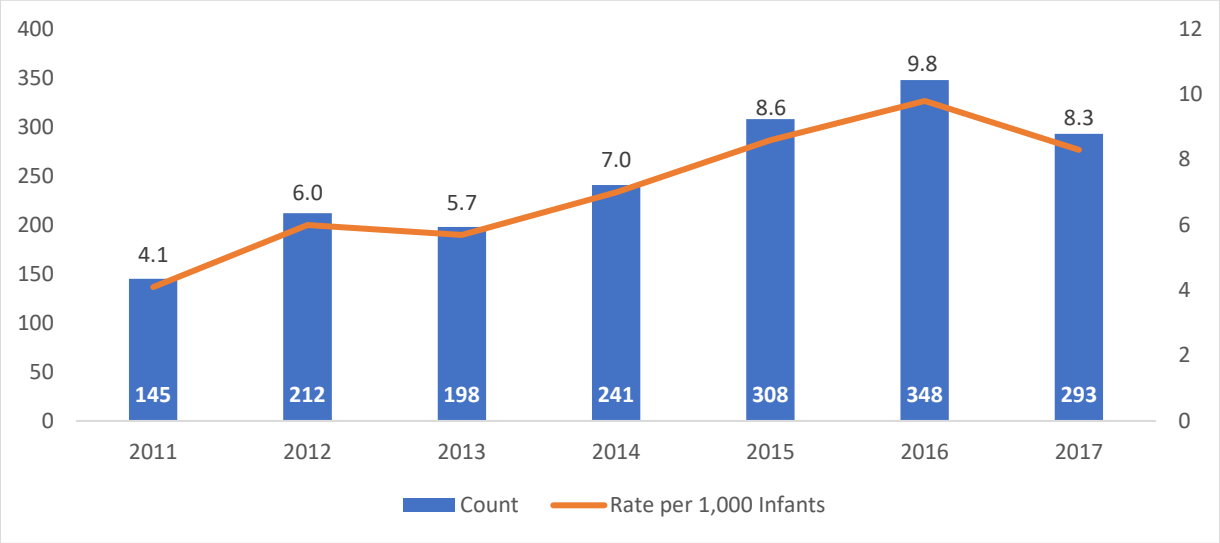
Prenatal Substance Exposure

Between 2015 and 2017, there were approximately 210,000 births in Nevada. During this time, 545 birth records indicated the mother self-reported using alcohol while pregnant, 698 indicated marijuana use, 356 indicated methamphetamine/amphetamine use, 111 indicated opiate use (opioids excluding heroin), and 54 indicated heroin use.[339] Nationally, it is estimated 15 percent of infants are affected by prenatal alcohol or illicit drug exposure (or between 550,000 and 600,000 births).[340]

Neonatal Abstinence Syndrome

Maternal opiate use during pregnancy, both illegal and prescribed, is associated with neonatal abstinence syndrome (NAS), a condition in which infants are born exposed to these substances and experience withdrawal symptoms after birth.[341] Various studies show NAS to be associated with significant medical complications for the newborn, in addition to longer hospital stays and increased costs. Inpatient admissions for NAS have doubled since 2011 in Nevada, from a rate of 4.1 infants per 1,000 admitted (n=145 newborns) to a rate of 8.3 per 1,000 admitted (n=293) in 2017 (Figure 69). [342]

Figure 69. Neonatal Abstinence Syndrome, Count and Rate per 1,000 Infants, Nevada, 2011-2017[343]



[339] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is reflective of self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

[340] National Center on Substance Abuse and Child Welfare. (n.d.). Infants with Prenatal Substance Exposure. Retrieved January 8, 2020 from https://ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx.

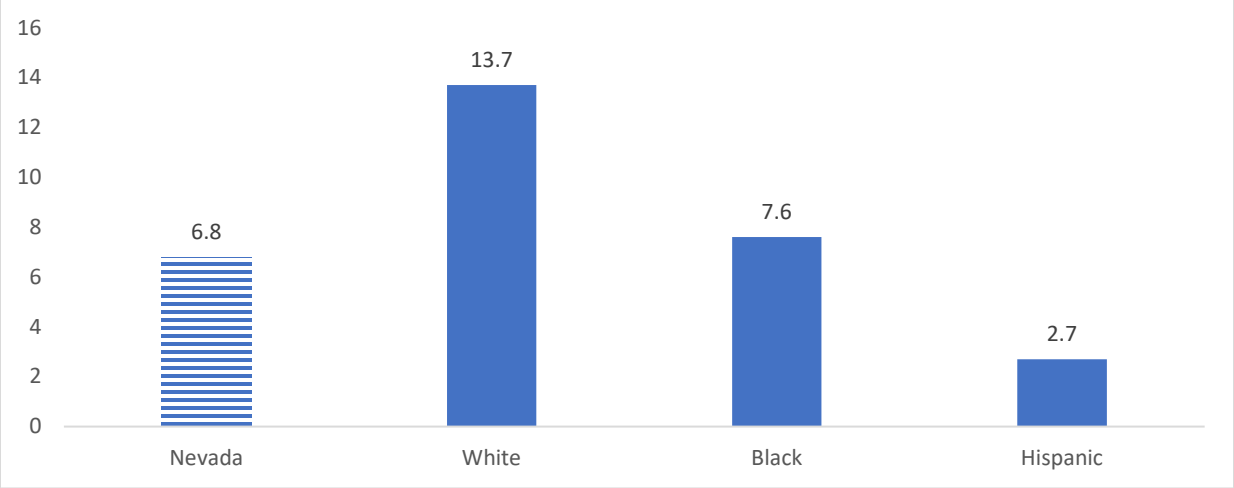
[341] NIH Medline Plus. (2019, December 2). Neonatal abstinence syndrome. Retrieved on December 3, 2019, from https://medlineplus.gov/ency/article/007313.htm.

[342] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

[343] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

In Nevada, the highest rate of infants born with NAS was among White infants while the lowest rates were among Hispanic infants (Figure 70). In 2017, the rate of NAS per 1,000 hospital births in Nevada among White infants was 13.7, higher than the rate for Black or African American infants (7.6) and Hispanic infants (2.7)[344]

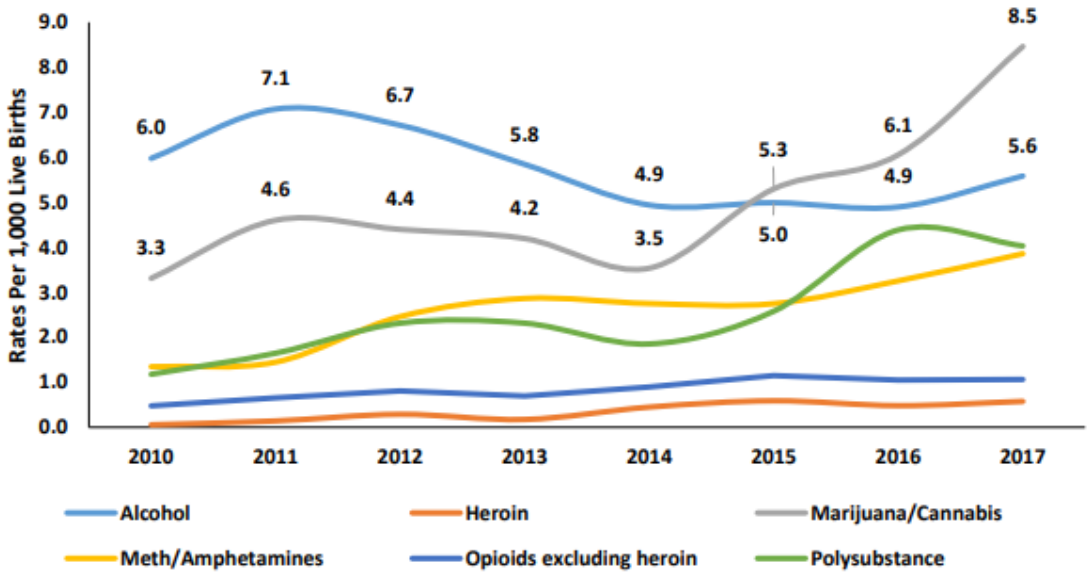
Figure 70. Rate of Infants Born with NAS per 1,000 Birth Hospitalizations in Nevada, by Race and Ethnicity, 2016[345]



Alcohol and marijuana were the two most commonly self-reported substances to have been used by Nevada mothers between 2010 and 2017, with marijuana use showing a spike in 2017 (from 6.1 per 1,000 live births in 2016 to 8.5 per 1,000 live births in 2017), possibly due to legalization. Since 2015, the marijuana use rate has surpassed the alcohol use rate in Nevada (Figure 71). In 2017, a rate of four per 1,000 live births was reported for methamphetamines, an increase from 2010 (1.3 per 1,000). For polysubstance use, the use rate was 3.9 per 1,000 live births in 2017, up from 1.1 per 1,000 live births in 2015.[346] Because alcohol and other substance use during pregnancy is self-reported by mothers, these rates are likely lower than actual rates due to underreporting; expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.

[344] Healthcare Cost and Utilization Project-State Inpatient Databases. (2016). National Outcome Measure 11: The rate of infants born with neonatal abstinence syndrome per 1,000 birth hospitalizations.
[345] Healthcare Cost and Utilization Project-State Inpatient Databases. (2016). National Outcome Measure 11: The rate of infants born with neonatal abstinence syndrome per 1,000 birth hospitalizations.
[346] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf.

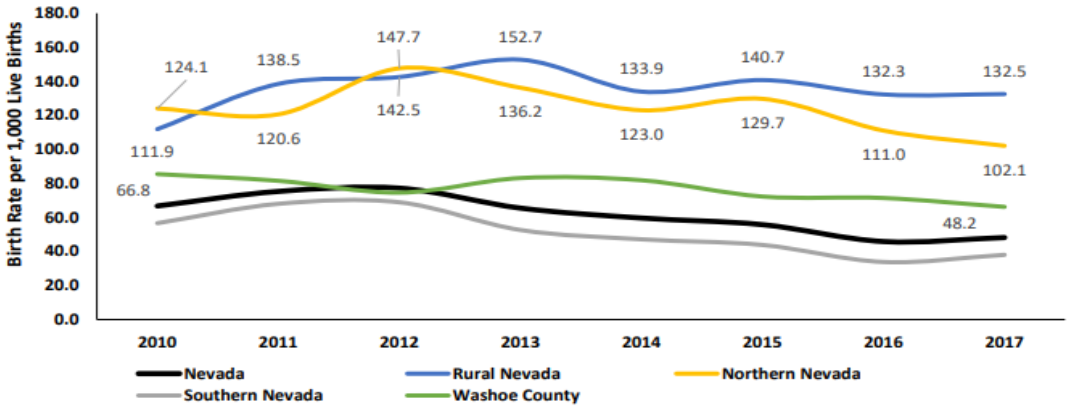
Figure 71. Prenatal Substance Use Birth Rates (self-reported) for Select Substances, Nevada, 2010-2017[347]



Prenatal Tobacco Use Birth Rates

In Nevada, mothers who self-reported tobacco use decreased from 66.8 to 48.2 per 1,000 live births from 2010 to 2017 (Figure 72). Rural counties recorded the highest self-reported tobacco use in 2017 at 132.5 per 1,000 live births, representing an increase of 18.4 percent since 2010.[348] For additional discussion on tobacco use, please see page 251.

Figure 72. Prenatal Tobacco Use Birth Rates (self-reported), Nevada, 2010-2017[349]



[347] State of Nevada, Office of Analytics, Department of Health and Human Service (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

[348] State of Nevada, Office of Analytics, Department of Health and Human Service. (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

[349] State of Nevada, Office of Analytics, Department of Health and Human Service. (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

Immunizations and Vaccines

Before children reach their second birthday, a series of vaccines is recommended to prevent a variety of illnesses. More specifically, this combined 7-vaccine series includes[350]:

- Four or more doses of the DTaP vaccine (diphtheria, tetanus, and pertussis);
- Three or more doses of the Polio vaccine;
- One or more doses of the MMR vaccine (measles-mumps-rubella);
- Full Hib series (Haemophilus influenzae), which can be three or four shots depending on the product type;
- Three or more doses of the HepB vaccine (Hepatitis B);
- One or more doses of the Varicella vaccine (chicken pox); and
- Four or more doses of the PCV vaccine (pneumococcal).

Nevada ranked 21st in the nation for immunization rates among children ages 19 to 35 months for the combined 7-vaccine series in 2017.[351] Seventy-one percent of Nevada children ages 19 to 35 months completed the combined 7-vaccine series in 2017, slightly higher than the average rate in the U.S. at 70.4 percent (Figure 73).

Figure 73. Percent of Children, Ages 19 Through 35 Months, Who Have Completed the Combined 7-Vaccine Series (4:3:1:3:3:1:4), Nevada and United States, 2009-2017*[352]

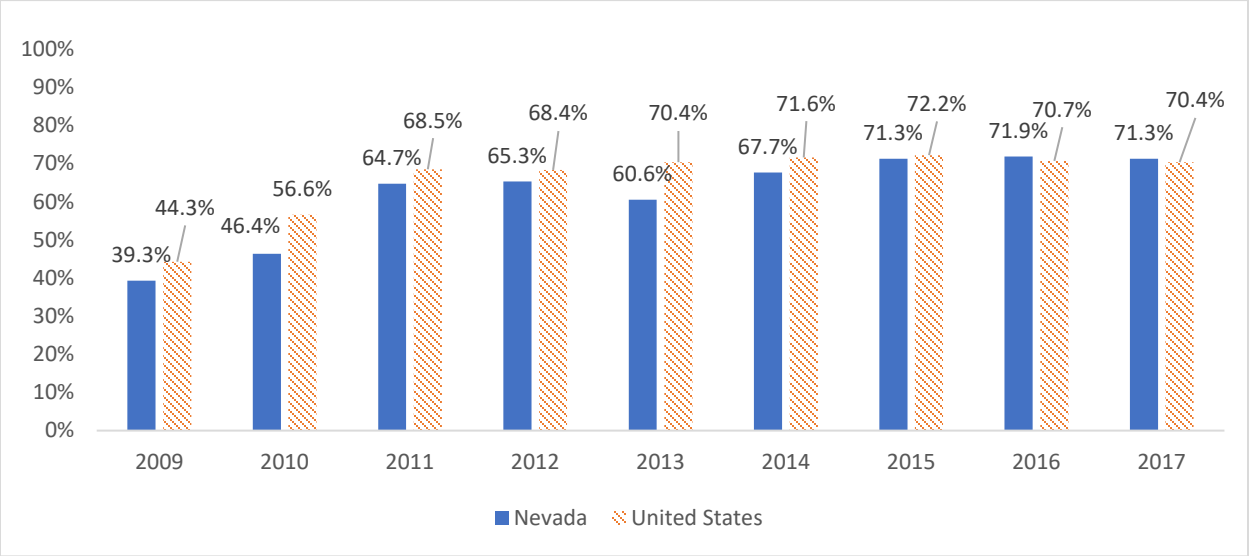
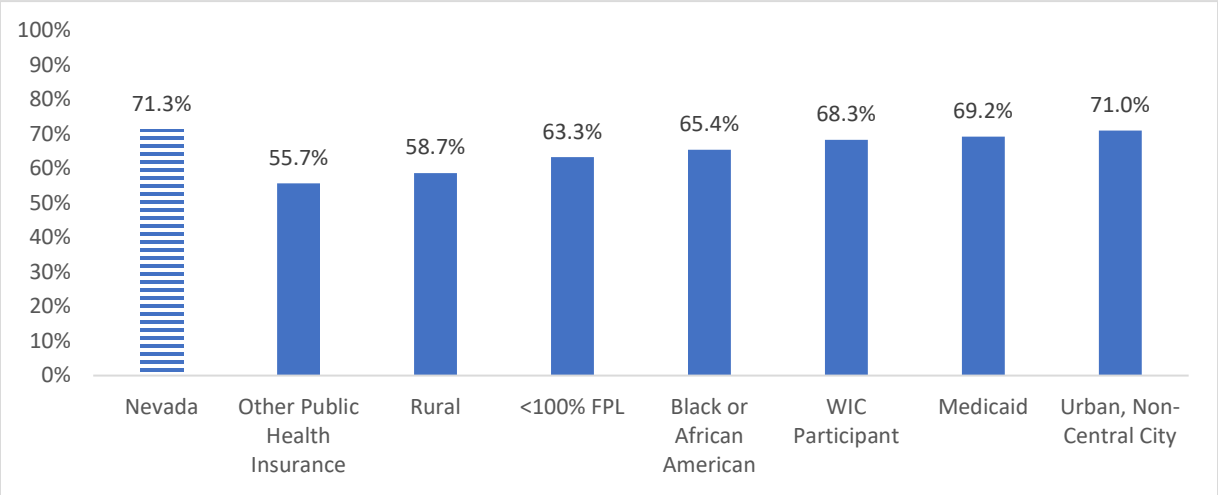


Figure 74 indicates infants are less likely to get the full combined 7-vaccine series if they have Medicaid, public health insurance other than Medicaid (e.g., are covered by Indian Health Services or military health care), live in a rural area or a small/medium urban area, live in a family with an income below 100 percent FPL, are Black/African American, and/or participate in WIC.[353]

[350] Centers for Disease Control and Prevention. (2016, October 6). Technical Notes for NIS Surveillance Tables. Retrieved December 12, 2019 from https://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tech-notes.html.
[351] CDC School Vaccination Assessment. (2019). 2019 Immunization Report Card. Retrieved on December 6, 2019 from https://immunizenevada.org/sites/default/files/Advocacy/iz%20report%20card_2019.pdf.
[352] National Immunization Survey-Child. (2017). National Outcome Measure 22.1: Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4).
[353] National Immunization Survey-Child. (2017). National Outcome Measure 22.1: Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4).

Figure 74. Risk or Disparity Factors for Low Percent of Children, Ages 19 Through 35 Months, Who Have Completed the Combined 7-Vaccine Series (4:3:1:3:3:1:4), 2015 to 2017*[354]



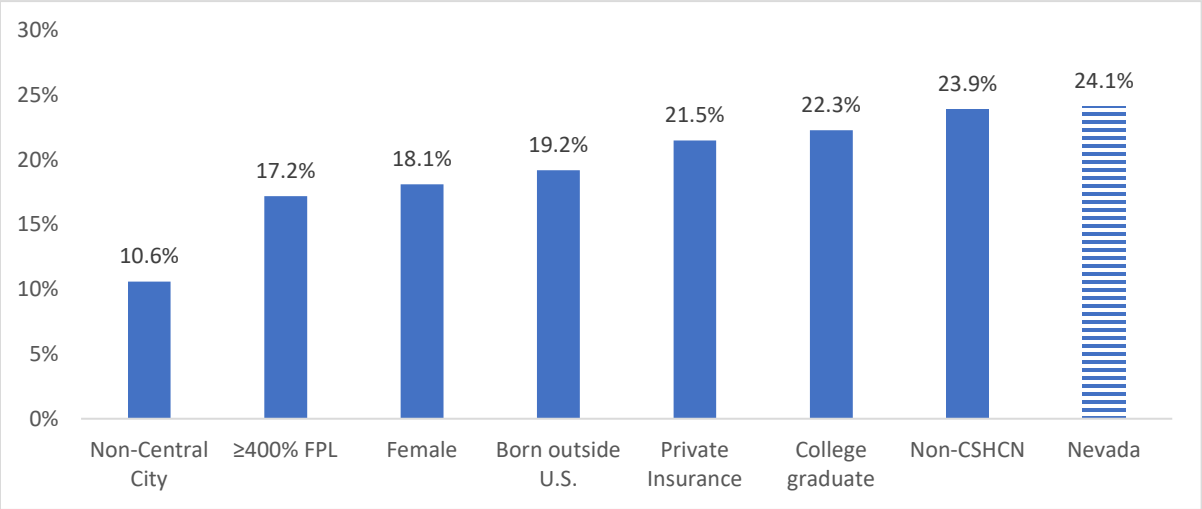
Developmental Screenings

Recommended periodic screenings and routine check-ups are known to improve surveillance, early detection, and early intervention of undesirable health outcomes.[355] NSCH (2017-18) data showed 27.9 percent of Nevada children ages nine to 35 months received a developmental screening using a parent-completed screening tool.[356] This was lower than the rate of screening nationally (33.1%), but was an increase from 2016-17 data, when only 24.1 percent of Nevada children were screened.

Between 2016 and 2017, the most recently available data which can be disaggregated, female children between ages nine and 35 months were less likely to be screened (18.1%) compared to male children (27.7%). Children who lived in non-central cities were 56 percent less likely to receive a developmental screening than children statewide, and 61.3 percent less likely than children living in central cities. Also, children whose parents live at or above 400 percent FPL, who were born outside the U.S., who have private health insurance, and/or whose parents were college graduates had lower rates of screening than the state average (Figure 75).[357]

[354]National Immunization Survey-Child. (2017). National Outcome Measure 22.1: Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4).
[355] Earls, M. F. (2013). The importance of routine screening for strengths and risks in primary care of children and adolescents. NC Med J, 74(1), 60-65.
[356] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.
[357] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

Figure 75. Risk or Disparity Factors for Not Receiving Developmental Screening, Ages Nine Through 35 Months, Nevada, 2015 to 2017[358]



Community Voices on Infants and Newborns

Community voices suggest **the major issues of concern for newborns and infants in Nevada are child abuse and neglect, maternal substance use during or after pregnancy, and access to developmental screenings**. Key informants believe there should be a **greater focus on speech and language**, including education on communicating with your child and how to improve speech and language. Respondents expressed how imperative it is to focus efforts on increasing "…knowledge of parents about the critical importance of birth to five and getting kids off to a good start."

> *"[I] think [we] will see more about marijuana use and pregnancy and how that affects infants because a lot of our families are using marijuana – now that it is accepted and a feeling that it is healthy and natural, so they are just more open about it and have access to it."*– Key informant

Summary of Key Findings for Infants and Newborns from the Data

- The highest infant mortality rate in Nevada is among Black or African American infants while the lowest rates are among White non-Hispanic infants. This is consistent with national data, which show Black or African American infants have an infant mortality rate more than twice the rate of White infants.
- Since 2009, Nevada women consistently experienced higher rates of preterm births than their counterparts nationwide. Additionally, a formerly decreasing trend in preterm births has since reversed, increasing from a low of 9.6 percent of births in 2015 to 10.7 percent in 2017.
- SUID rates per 100,000 live births in Nevada have fluctuated since 2009, increasing to a new high of 124.1 per 100,000 in 2016. All SUIDs were associated with unsafe sleep environments due to excessive or inappropriate bedding, adults/children sharing a bed with children, or both.

[358]National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

- Nevada's breastfeeding initiation rates tend to be above national rates at 83.5 percent in 2015; however, breastfeeding exclusively by age six months is less prevalent in Nevada, with one in four infants meeting this measurement (24.9%) in the U.S. compared to one in five infants (20.8%) in Nevada.
- Inpatient admissions for neonatal abstinence syndrome (NAS) doubled since 2011, from a rate of 4.1 infants per 1,000 admitted to a rate of 8.3 in 2017.[359] In Nevada, the highest rate of infants born with NAS was among White infants with Hispanic infants experiencing the lowest rate.
- Of the data on self-reported substance use during pregnancy among Nevada mothers who gave birth between 2010 and 2017, alcohol and marijuana were the two most reported substances, with marijuana increasing in 2017 to 8.5 per 1,000 live births, possibly due to legalization.
- NSCH data indicate 27.9 percent of children between ages nine and 35 months received a developmental screening using a parent-completed screening tool in 2017-18.[360] This was lower than the rate of screening nationally (33.1%), but was an increase from 2016-17, when only 24.1 percent of Nevada children were screened. Living in a rural area was the most significant risk factor for children not receiving developmental screening.

Young Children (One to Five Years of Age)

A focus on children during the formative years of childhood is important given the impact this stage has on a child's emotional and physical development and future wellbeing. Research has shown a positive association between early high-quality childhood care and higher academic achievement, better social development, and fewer behavior issues in adolescence.[361] In this section, developmental screenings, child obesity, safety, and kindergarten readiness are explored regarding young children ages one to five years. Table 36 presents a summary of key indicators described in this section, including a comparison of data from Nevada and the U.S., and where MCH and especially evidence based MIECHV programs might prioritize their efforts, if not doing so already.

Table 55. Summary of Indicators for Young Children's Health, Nevada and United States

Topic	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Developmental Screening	**Percent of children, ages 9-35 months, receiving a developmental screening using a parent-completed tool[362]**	27.9%	33.5%	✓

[359] State of Nevada, Office of Analytics, Department of Health and Human Service. (2018, November). Substance Abuse Prevention and Treatment Agency 2018 Epidemiologic Profile, Special Populations, Newborns. The data in this section is self-reported information provided by the mother on the birth record. Retrieved on December 3, 2019, from http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Programs/Office_of_Analytics/Images/SAPTA%20EPI%20Profile%20Nevada%202018.pdf

[360] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

[361] Vandell, D. L., et al. (2010). Do Effects of Early Childcare Extend to Age 15 Years? Results from the NICHD Study of Early Childcare and Youth Development. Child Development, 81(3), 737–756.

[362] National Children's Health Survey. (2016-2017). National Performance Measure 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

Topic	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Obesity	Percent of children (ages two to four) considered overweight (2014)[363]	12.0%	14.6%	✓
Safety	Rate of hospitalization for non-fatal injury per 100,000 children (ages zero to nine) (2016)[364]	135.5	128.8	Ø
Kindergarten Readiness	Percent of young children, ages three to four years, not enrolled in school , including nursery school, preschool school, or kindergarten (2018)[365]	62.0%	52.0%	✓

Demographics of Young Children

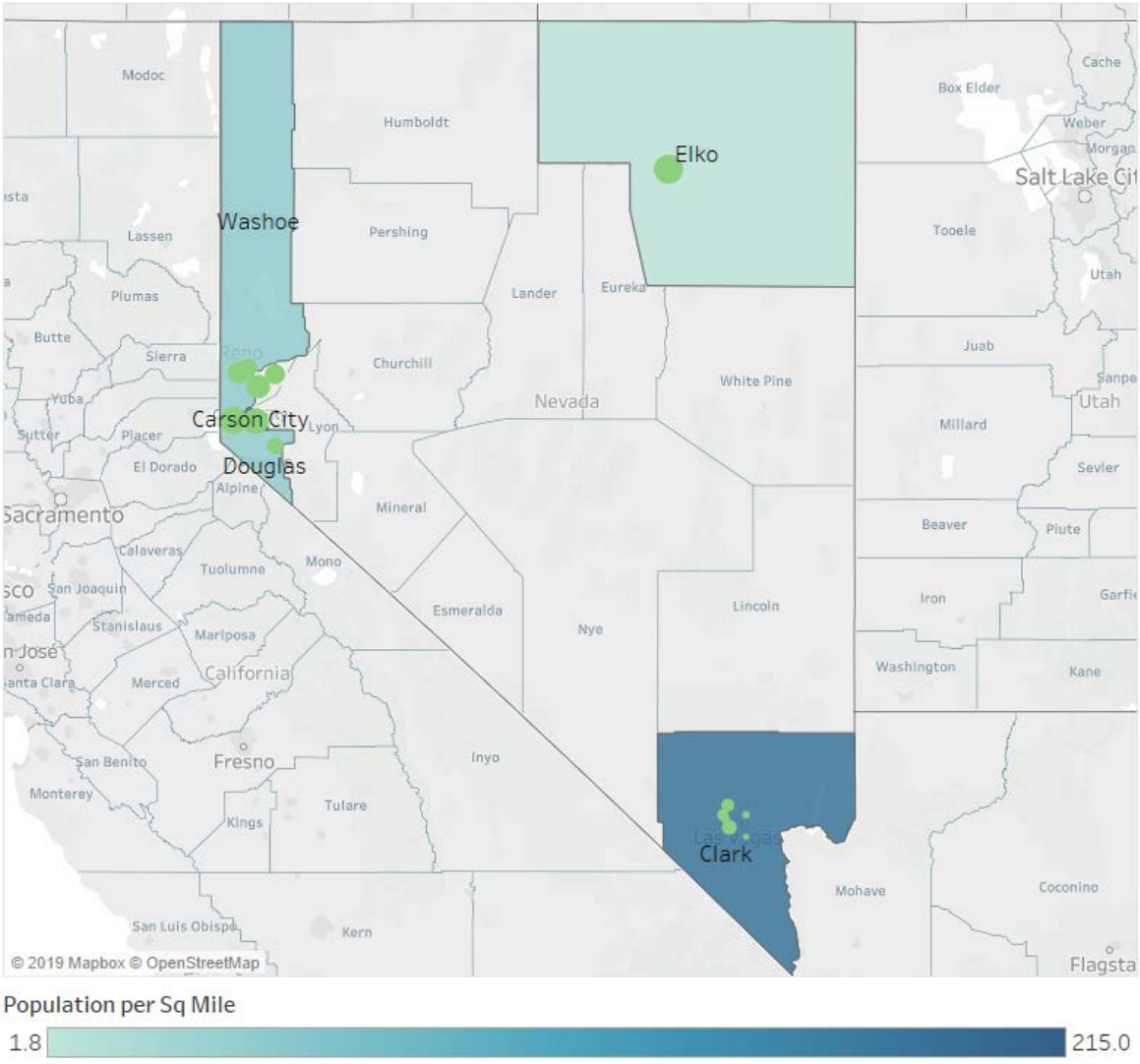
Children between ages of one and five years made up 14.1 percent (n=435,310) of Nevada's population in 2019.[366] By 2024, this age group is expected to experience an AGR of 1.8 percent.[367]

Developmental Screenings

Self-reported survey results from the Nevada Kindergarten Health Survey found 42.8 percent of parents reported their child did not have a developmental screening and 25.8 percent of parents reported they were unsure.[368] When exploring differences among counties, more respondents in rural counties (38.3%) reported their child aged one to five years had been screened for developmental concerns as compared to those in Washoe (37.1%) and Clark counties(29.1%) (Figure 76). When exploring race/ethnicity differences in screenings, results indicate children identified as Native American/Alaska Native reported the highest screening rates, while those classified as Asian/Pacific Islander reported the lowest screening rates.[369]

[363] Women, Infants, and Children. (2014). National Outcome Measure 20: Percent of children, ages 2 through 4, who are obese (BMI at or above the 95th percentile).
[364] Healthcare Cost and Utilization Project – State Inpatient Databases – CHILD. (2016). National Performance Measure 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.
[365] KidsCount.org. (2018). Percent of young children not in school in Nevada. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.
[366] Esri, 2019.
[367] Esri, 2019.
[368] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[369] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.

Figure 76. Map of Organizations Providing Developmental Assessments in Nevada, by Zip Code, Compared to Population Per Sq. Mile by County, 2019[370]



[370] Nevada Medical Home Portal. (n.d.). Services Directory. Retrieved December 11, 2019 from https://nv.medicalhomeportal.org/services.

Immunizations

The CDC School Vaccination Assessment estimates the number of Nevada students who have received all required school immunizations. Those who do not have all required immunizations may have a medical or religious exemption to the school requirements, be conditionally enrolled based on being in the process of getting up to date per the CDC immunization schedule or noted as non-compliant. When immunization rates among this group are low, diseases can spread quickly in schools. The CDC goal for vaccination rates among kindergartners is 95 percent or greater. Table 37 shows kindergarteners in Nevada met the goal for MMR, DTaP, and Polio during the 2018-19 school year. Nevada's Hepatitis B immunization rates surpassed the CDC goal at 97.4 percent. Religious exemption is the primary exemption claimed for Nevada children (3.2%) and is higher than the rate claimed nationwide (2.2%). [371]

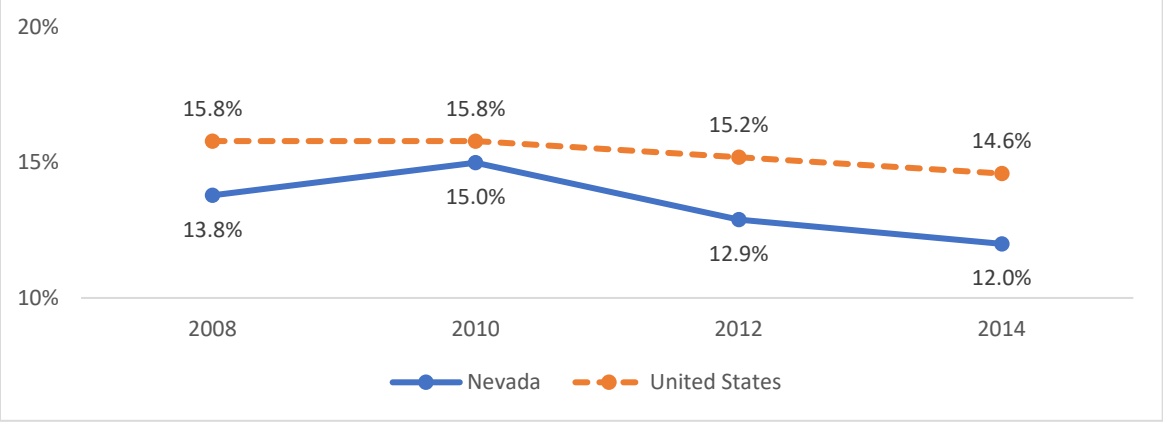
Table 56. Percent Vaccinated Kindergartners 2018/19 School Year[372]

Location	MMR	DTaP	Varicella 2 Dose	Hepatitis B	Polio	Medical Exemption	Religious Exemption
United States	94.7%	94.9%	94.3%	95.8%	94.7%	0.3%	2.2%
Nevada	95.1%	95.0%	94.7%	97.4%	95.4%	0.2%	3.2%

Child Obesity

The percent of Nevada children ages two to four years who were overweight or obese remained lower compared to the rate for the U.S. between 2008 and 2014. Based on data from the Women, Infants and Children (WIC) Participant and Program Characteristics file, 12 percent of Nevada children in this age group are considered overweight compared to 14.6 percent nationally (Figure 77).[373] The rate of child obesity generally decreased in Nevada between 2008 and 2014, from a high in 2010 of 15 percent to a low of 12 percent in 2014, with the U.S. showing a similar decreasing trend.

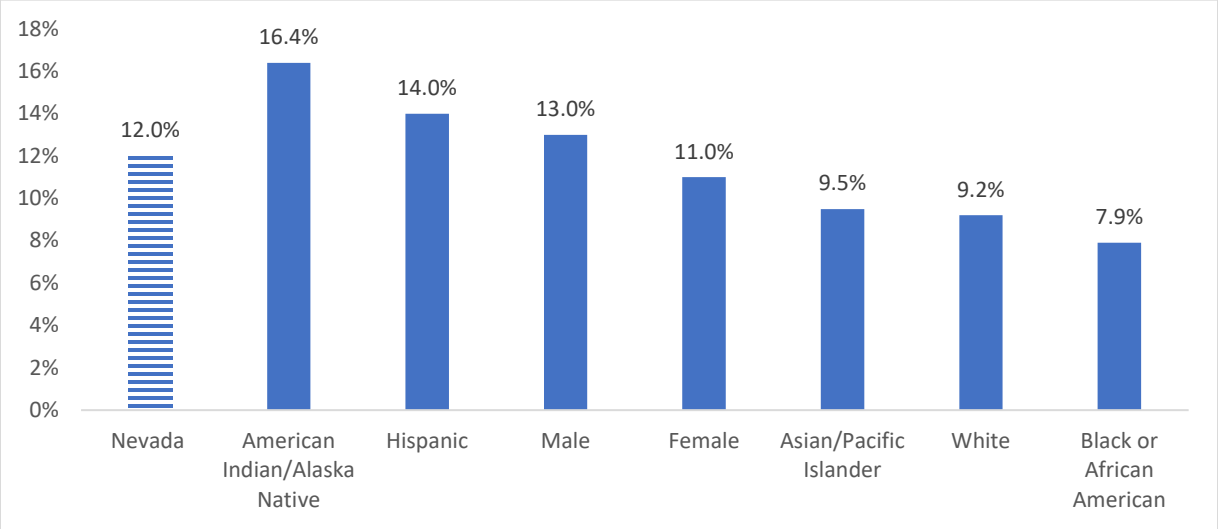
Figure 77. Percent of Children, Ages Two Through Four, Who Are Obese (BMI at or Above the 95th Percentile), Nevada and United States, 2008-2014[374]



[371] CDC School Vaccination Assessment. (2019). 2018/19 Immunization Report Card. Retrieved on December 6, 2019 from https://www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/data-reports/coverage-trend/index.html
[372] CDC School Vaccination Assessment. (2019). 2018/19 Immunization Report Card. Retrieved on December 6, 2019 from https://www.cdc.gov/vaccines/imz-managers/coverage/schoolvaxview/data-reports/coverage-trend/index.html.
[373] Women, Infants, and Children. (2014). National Outcome Measure 20: Percent of children, ages 2 through 4, who are obese (BMI at or above the 95th percentile).
[374] Women, Infants, and Children. (2014). National Outcome Measure 20: Percent of children, ages 2 through 4, who are obese (BMI at or above the 95th percentile).

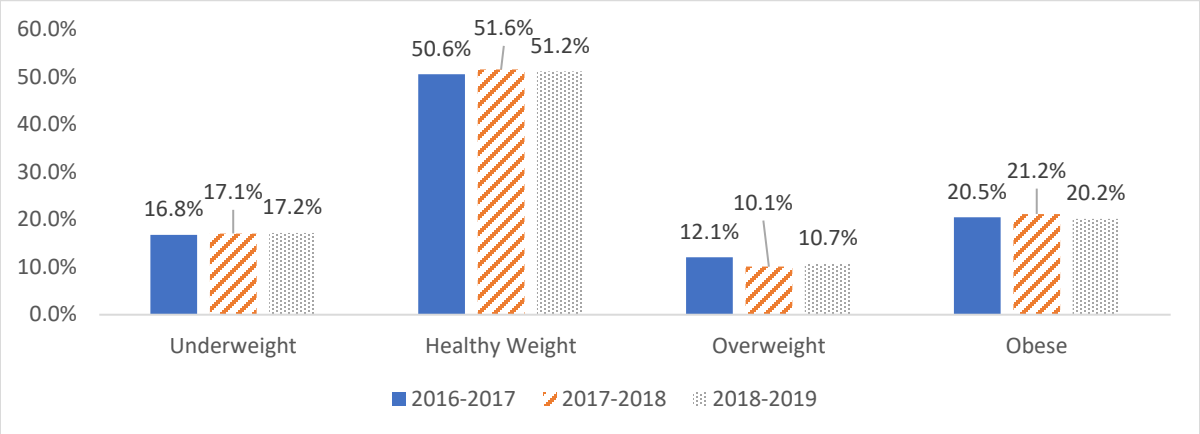
In Nevada, individuals who are American Indian/Alaska Native experienced the highest child obesity rates among those ages two to four years (16.4%), followed by Hispanic children (14%). Further, male children in this age group experience higher rates of obesity relative to females (13% vs 11% respectively) (Figure 78).[375]

Figure 78. Percent of Children, Ages Two Through Four, Who Are Obese (BMI at or Above the 95th Percentile), Nevada, By Risk or Disparity Factor, 2014[376]



Kindergarteners experience higher rates of obesity than younger children. According to the Nevada Kindergarten Health 2018-19 survey, 20.9 percent of Nevada kindergarteners are considered obese (includes children ages four to six years). Approximately half of kindergarteners (51.2%) are considered a healthy weight, 17.2 percent are considered underweight, and 10.7 percent are considered overweight. The percentage of overweight children in Nevada increased slightly compared to the previous year (Figure 79). However, the percentage of obese children showed a slight decrease. [377]

Figure 79. Child's Weight Status Category, Nevada, 2016 to 2019[378]



[375] Women, Infants, and Children. (2014). National Outcome Measure 20: Percent of children, ages 2 through 4, who are obese (BMI at or above the 95th percentile).
[376] Women, Infants, and Children. (2014). National Outcome Measure 20: Percent of children, ages 2 through 4, who are obese (BMI at or above the 95th percentile).
[377] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[378] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.

There were only small geographic differences in Nevada's child obesity rates, with the percentage of obese children being similar across counties: Clark County (21.2%), Washoe County (20.2%), and rural counties (20.1%).[379] There was some disparity by race/ethnicity, including:

- The highest percentage of obese children was reported among children who identify as Native American/Alaskan Native (44.6%).[380]
- Children identified as Black or African American (27.4%), Hispanic (32.1%), and Native American/ Alaskan Native (44.6%) had obesity rates above 25 percent.
- Children identified as White had the lowest rates of obesity (15.3%), nearly two to three times lower than the rates among minority children.[381]

Physical Activity

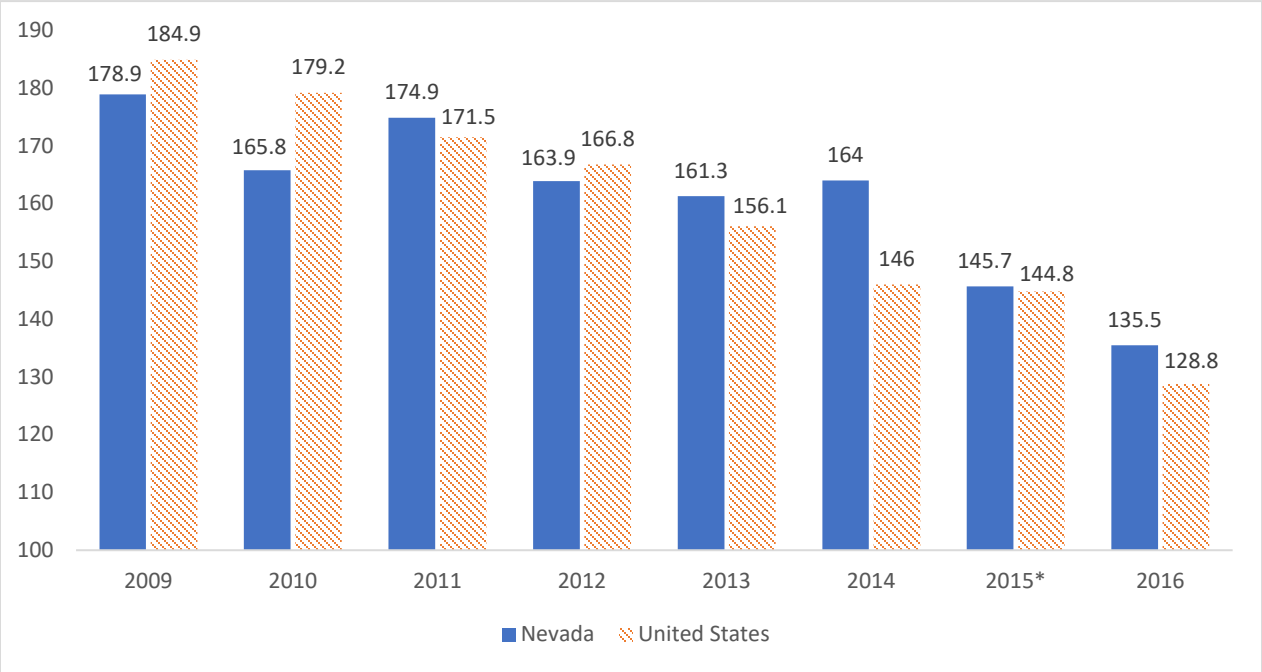
In 2018-19, parents/guardians of kindergarteners were asked to report the number of times per week their child is physically active for at least 60 minutes. Just under half of survey respondents (47.6%) indicated their child was physically active six to seven days per week for at least 60 minutes at a time, and only 1.2 percent indicated their child was not active during the week.[382]

Non-Fatal Injuries

In 2016, the rate of hospitalization for non-fatal injuries per 100,000 children, ages zero through nine years, was 135.5 in Nevada. The rate was highest for those younger than age one year (246.1 per 100,000 children), followed by those between ages one and four years (175.6), and five to nine years (83.2). Disparities are evident among Black or African American children between ages zero and nine years who experience a high hospitalization rate of 226 per 100,000 children, followed by non-Hispanic White children (145.1), and Hispanic children (102). Asian children experienced the lowest hospitalization rate of 75.4 per 100,000 children. Looking at other stratifiers, rural children experienced a higher rate of hospitalization of 160 per 100,000 children compared to children living in large urban areas (134). Additionally, male children experienced a higher rate (146.2) of hospitalization compared to female children (124.3). The hospitalization rate trend has largely declined since 2009, both in Nevada and the U.S. (Figure 80).[383]

[379] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[380] Interpret with caution due to small sample size.
[381] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[382] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[383] Healthcare Cost and Utilization Project – State Inpatient Databases – CHILD. (2016). National Performance Measure 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.

Figure 80. Rate of Hospitalization for Non-Fatal Injury Per 100,000 Children, Ages Zero Through Nine, Nevada and United States, 2009 to 2016[384]



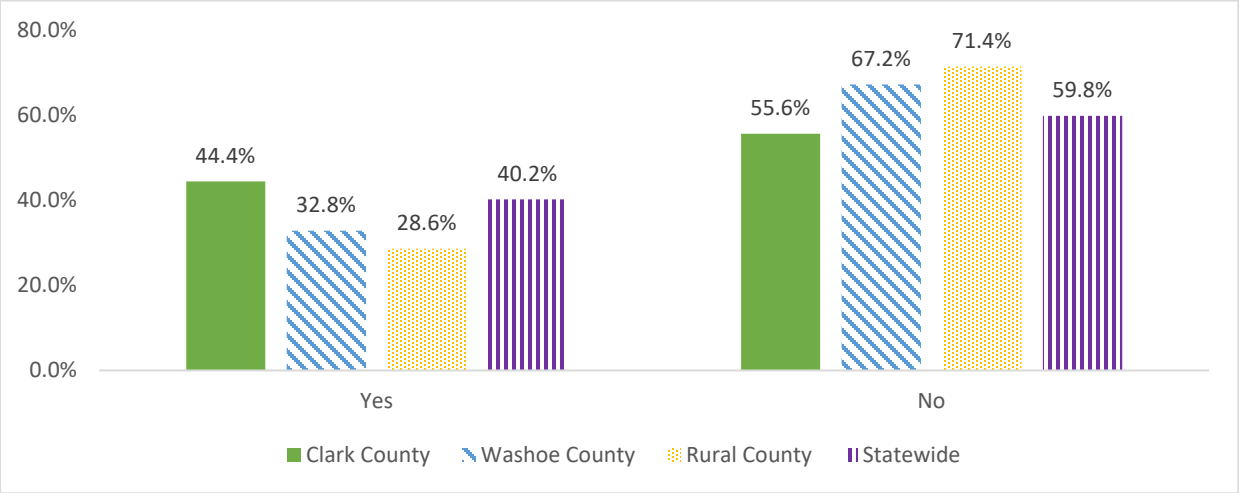
**The 2015 rates are only based on the first three quarters of the calendar year.*

Emotional and Mental Health

Among Nevada kindergarteners in 2018-19, 6.5 percent of parents reported having tried to access mental health services for their child(ren), an increase from 2017-18 (5.7%). Of those 6.5 percent who attempted to access services, two in five parents (40.2%) reported having trouble obtaining the services, an increase from the previous survey year (37.9%). When examining this percentage across counties, there were slight differences, with those in rural counties reporting less trouble obtaining services (Figure 81). Additionally, parents who had trouble accessing mental health services stated wait times and availability of appointments were the most significant barriers. Other barriers included lack of services in their area, difficulties receiving services, lack of coverage by insurance or other insurance issues, services were too expensive, and services were bad or not helpful.[385]

[384] Healthcare Cost and Utilization Project – State Inpatient Databases – CHILD. (2016). National Performance Measure 7.1: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9.
[385] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.

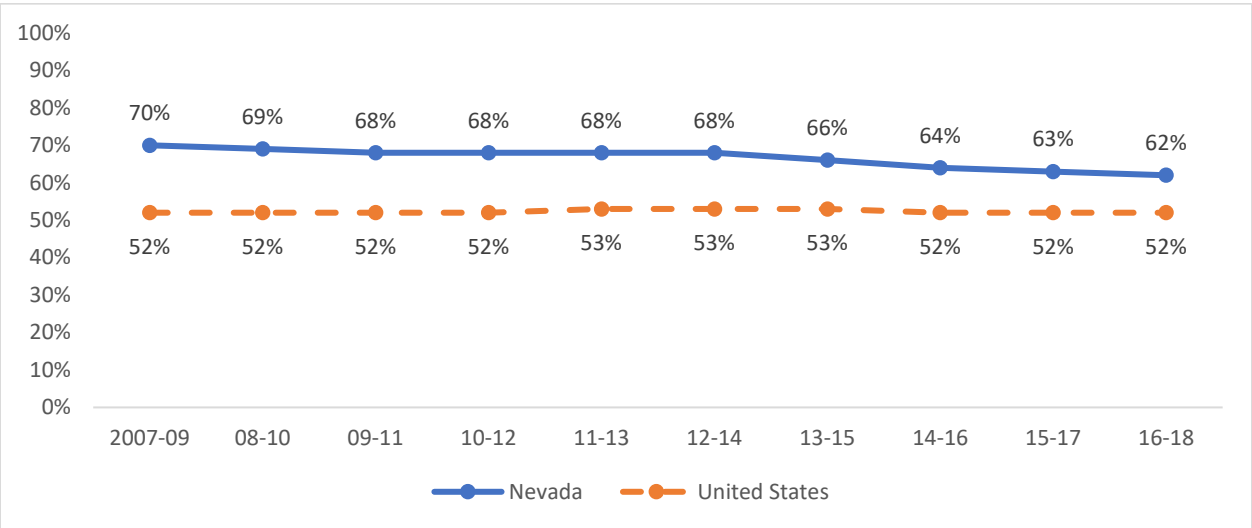
Figure 81. Trouble Obtaining Mental Health Services by County, Nevada, 2018/19[386]



Kindergarten Readiness

High-quality pre-kindergarten (pre-K) or early education programs for three- and four-year-old children can improve school readiness for kindergarten and beyond, often with the greatest benefits occurring for the highest-risk children. Head Start and the expansion of state-funded programs since the 1990s have greatly increased access to preschool across the country, but many children, especially those aged three years, continue to be left out, widening the gaps in educational achievement between various social groups.[387] In 2018 in Nevada, almost two thirds (62%) of children ages three to four years were not enrolled in preschool or pre-kindergarten during the previous three months (Figure 82). This is a higher rate compared to nationwide data (52%); unfortunately, this gap has been closing since 2007.

Figure 82. Percent of Young Children, Three to Four Years Old, Not in School, Nevada and United States, 2007-2018[388]



[386] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[387] KidsCount.org. (2018). Percent of young children not in school in Nevada. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.
[388] KidsCount.org. (2018). Percent of young children not in school in Nevada. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.

Poverty and race/ethnicity data reveal disparities impacting whether children are in school. Children ages three to four years living below 200 percent FPL are less likely to be in preschool, with 70 percent of children in this income level not attending (compared to 59% nationwide).[389] However, this measure has improved for Nevada children, decreasing 13.4 percent, from a high of 82 percent in 2009. Among different race and ethnicities, the greatest disparity of 72 percent is among Hispanic or Latino children ages three to four years (higher than the 64% of all young children in Nevada and the 58% of all young children nationwide).[390]

A significant issue related to children not being able to attend a pre-kindergarten or early childhood education program is cost. In 2018, Nevada ranked as the least affordable state in the nation for the cost of infant care in licensed family childcare and the 8th least affordable in licensed childcare centers. In Nevada, the cost of infant care represents over half of the income (55%) for a family of three living at 100 percent FPL and 40 percent for a family of three living at 140 percent FPL. Families living at or below 140 percent FPL do have access to childcare subsidies to help cover the cost, but access would still remain out of reach for many. In 2018, the annual average cost of care for a licensed pre-kindergarten center was $4,835 and for a licensed family care center it was $8,188, both of which exceeded the tuition and fees for one semester at the University of Nevada Reno or the University of Nevada Las Vegas (averaged at $7,764 per year).[391]

There were geographic disparities in terms of licensed childcare by county for pre-kindergarten, with rural counties often having less expensive options in terms of annual cost of care compared to the urban counties (Washoe, Clark). Although, when considering the cost of childcare as a percentage of the parent(s) income, many rural families must still spend a greater portion of their income compared to families in the urban counties (Table 57).[392]

Table 57. Affordability of Licensed Childcare for Pre-Kindergarten, by County, Nevada, 2018[393]

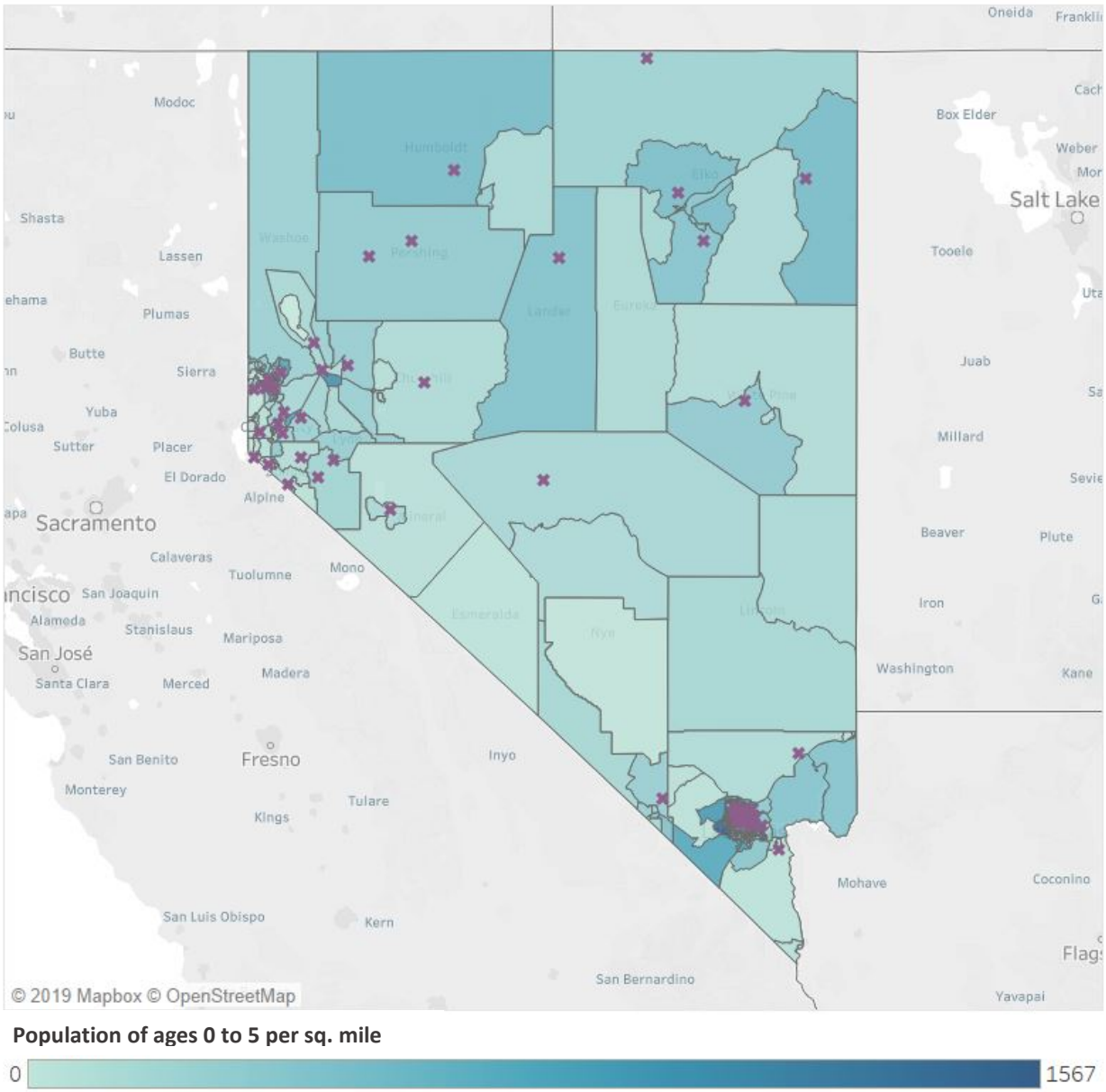
County	Average Annual Cost of Care		Cost of Care as a % of Married Couple Median Income		Cost of Care as a % of Female Household Median Income	
	Center	Family Childcare	Center	Family Childcare	Center	Family Childcare
Carson City	$7,400	$7,821	10%	11%	22%	23%
Churchill	$6,878	$8,342	11%	13%	35%	43%
Clark	$9,472	$8,530	13%	12%	26%	23%
Douglas	$7,959	$7,473	10%	10%	19%	18%
Elko	$6,433	$7,387	7%	8%	19%	22%
Humboldt	$6,909	-	8%	-	35%	-
Lander	$5,794	-	6%	-	31%	-
Lyon	$7,108	$7,165	11%	11%	24%	24%
Mineral	$5,475	$7,821	8%	12%	26%	37%

[389] KidsCount.org. (2017). Young children not in school by poverty status in Nevada, 2013-2017 combined estimates. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.
[390] KidsCount.org. (2017). Young children not in school by race in Nevada, 2013-2017 combined estimates. Retrieved on December 6, 2019, https://datacenter.kidscount.org/.
[391] Children's Cabinet. (2018). Nevada 2018 Early Education & Care Fact Sheet.
[392] Children's Cabinet. (2018). Nevada 2018 Early Education & Care Fact Sheet.
[393] Children's Cabinet. (2018). Nevada 2018 Early Education & Care Fact Sheet.

Nye	$7,517	-	13%	-	29%	-
Pershing	$7,039	-	12%	-	35%	-
Washoe	$8,760	$8,098	11%	10%	24%	22%
White Pine	$5,692	-	8%	-	25%	-

**Esmerelda, Eureka, Lincoln, and Storey counties did not have licensed childcare facilities at the time of the market rate study.*

Figure 83. Map of Organizations Providing Childcare Services in Nevada, by Zip Code, Compared to Population of Children Zero to Five Per Sq. Mile by Census Tract, 2019[394]



[394] Nevada Medical Home Portal. (n.d.). Services Directory. Retrieved December 11, 2019 from https://nv.medicalhomeportal.org/services.

Sixty-five percent of children in Nevada ages zero to five years require childcare because they live in a household where both parents work, increasing to 70 percent of children ages six to 12 years. However, Nevada's early childhood care capacity only meets 23 percent of the need for children ages zero to five years. Yet, between 2008 and 2017, Nevada experienced a 52 percent decline in licensed family childcare programs and a five percent decline in licensed childcare centers, further exacerbating the gap between need and supply.[395]

Finally, considering the quality of childcare centers available across Nevada, of centers that participate in Nevada's Quality Rating & Improvement System (QRIS), only 10.4 percent were rated five stars, indicating they are high quality; slightly more than half (55.7%) of the centers received three or more stars, indicating they are of adequate quality. The remaining centers were rated two stars or less indicating poor quality. [396]

Community Voices on Young Children

Community voices noted the **high risk of neglect and abuse unique to children ages five years and younger**, reporting many referrals for children in this age group, and they attribute this to a higher degree of vulnerability. There are often surrounding issues of substance use, mental health, domestic violence, or a general lack of parenting skills. Key informants believe **children need help navigating the violence happening in their homes**.

Other common themes are issues with gaps in Head Start and other affordable quality childcare providers, meaning parents cannot find a center for their child due to age restrictions or a lack of available slots. Additionally, distance to services can be prohibitive, with some families traveling 70 to 100 miles for pediatric healthcare appointments. Key informants report seeing people "settling" for services that may not be the best fit due to the long distance they must travel to receive the services they need.

Adolescents/Young Adults (12 to 21 Years of Age)

This section focuses on adolescent health (defined as youth ages 12 to 21 years), chronic disease prevention, immunizations, sexual behaviors, mental health, substance use, and safety. Table 58 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.S., and where MCH and MIECHV programs might prioritize efforts, if not doing so already.

Table 58. Summary of Indicators for Adolescent Health, Nevada and United States

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Chronic Disease Prevention	Percent of adolescents (10 to 17) who are obese[397]	14.9%	15.4%	Ø

[395] Children's Cabinet. (2018). Nevada 2018 Early Education & Care Fact Sheet.
[396] Children's Cabinet. (2018). Nevada 2018 Early Education & Care Fact Sheet.
[397] National Survey of Children's Health. (2017). Percent of adolescents, ages 10 to 17, who are obese.

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Chronic Disease Prevention	**Percent of adolescents (ages 12 to 17) who are physically active at least 60 minutes per day) (2018)[398]**	16.8%	17.5%	✓
Chronic Disease Prevention	Percent of children living in households that received one to four types of food or cash assistance (2017)[399]	49.0%	40.5%	Ø
Immunizations	Percent of adolescents (ages 13 to 17) who had their HPV vaccine (2018)[400]	51.1%	51.1%	Ø
Sexual Behaviors	Percent of adolescents (grades 9-12) who reported not ever having sexual intercourse (2017)[401]	63.2%	60.5%	Ø
Sexual Behaviors	Percent of adolescents (grades 9-12) who did not use any method to prevent pregnancy during their last sexual intercourse (2017)[402]	16.8%	13.8%	✓
Sexual Behaviors	Percent of adolescents (grades 9-12) who reported experiencing sexual dating violence (2017)[403]	5.7%	6.9%	Ø
Sexual Behaviors	Teen birth rate per 1,000 girls[404]	21.9	20.3	✓
Emotional and Mental Health	Percent of youth who reported experiencing severe major depression (2018)[405]	10.6%	8.2%	Ø
Emotional and Mental Health	Percent of youth who reported experiencing severe major depression and did not receive any mental health treatment (2018)[406]	64.0%	63.1%	✓
Emotional and Mental Health	Adolescent suicide rate ages 15 through 19 per 100,000 (2017)[407]	9.6	7.1	✓
Substance Use	Percent of adolescents (grades 9-12) who reported smoking cigarettes in the past 30 days (2017)[408]	6.4%	8.8%	✓

[398] National Survey of Children's Health. (2017-18). Physical activity, age 6-17 years.
[399] National Survey of Children's Health. (2017). Percent of children living in households that received one to four types of food or cash assistance.
[400] Centers for Disease Control & Prevention. (2018, August). TeenVaxView Interactive! - Results for Adolescent HPV Vaccination Coverage. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/index.html.
[401] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[402] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[403] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[404] National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.
[405] The State of Mental Health in America 2018. Mental Health America.
[406] The State of Mental Health in America 2018. Mental Health America.
[407] National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.
[408] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Substance Use	Percent of adolescents (grades 9-12) who reported ever using electronic vapor products (2017)[409]	42.6%	42.4%	✓
Substance Use	Percent of adolescents (grades 9-12) who reported having at least one drink of alcohol in the past 30 days (2017)[410]	26.5%	29.8%	Ø
Substance Use	Percent of adolescents (grades 9-12) and middle school students who reported using marijuana in the past 30 days (2017)[411]	5.2% / 19.7%	19.8%	✓
Substance Use	Percent of adolescents (grades 9-12) who were offered, sold, or given an illegal drug on school property (2017)[412]	30.0%	20.0%	✓
Safety	Percent of adolescents (ages 12 to 17 years) who reported being bullied, picked on, or excluded by other children (2017)[413]	14.9%	21.0%	✓
Safety	Percent of adolescents (ages 12 to 17) who were safe in their neighborhoods (2017-2018)[414]	60.6%	67.4%	Ø
Safety	Percent of children (ages six to 17) who were safe at school (2017-2018)[415]	55.5%	68.2%	Ø

Demographics of Adolescents/Young Adults

Adolescents/Young Adults ages 12 to 21 years made up 12.2 percent (n=376,937) of Nevada's population in 2019. By 2024, this age group is expected to grow in population by 1.3 percent per year.[416]

Chronic Disease Prevention

Obesity

In 2017, 14.9 percent of Nevada children ages 10 to 17 years were obese (defined as having a BMI at or above the 95th percentile) and 12.7 percent were overweight (BMI between 85th and 94th percentile). BMI rates among Nevada's youth are lower compared to national rates (15.4% obese and 15.3% overweight), but nearly 30 percent of Nevada youth were struggling with their weight in 2017.[417]

[409] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[410] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[411] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[412] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[413] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[414] National Children's Health Survey. (2018). Indicator 7.2: Does this child live in a safe neighborhood?
[415] National Children's Health Survey. (2018). Indicator 7.3: Is this child safe at school, age 6-17 years?
[416] Esri, 2019.
[417] Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.

Obesity has become an increasing public health challenge among adolescents with rates increasing by 29.6 percent in the past decade, from 10.8 percent of high school students in 2007 to 14 percent in 2017.[418] Issues related to weight can be linked to physical activity and nutrition.

Physical Activity

In 2017-18, 11.9 percent of Nevada youth ages six to 17 years were completely inactive over the last week (meaning they had zero days of physical activity for at least 60 minutes), higher than the national rate of 9.5 percent.[419] Older Nevada youth have an even lower prevalence of reporting being active for 60 minutes every day. One in four (25.5%) children six to 11 years old are reported by their parents as physically active for 60 minutes per day compared to 16.8 percent of youth 12 to 17 years.[420] Nevada's rates for both age groups are lower than the comparative U.S. rates (27.7% and 17.5%, respectively).

Nevada's 2017 YRBS data indicate 53.9 percent of middle school and 54.9 percent of high school students watched TV, played video or computer games, or used a computer for three or more hours per day.[421,422] Additionally, 49.9 percent of middle school and 48.7 percent of high school students, reported playing on at least one sports team run by their school or community.[423] National YRBS data show 54.3 percent of high school students played at least on one sports team, compared to 47.3% of Nevada high school students.[424] The percentage of students who played on at least one sports team decreased between 2015 and 2017, from 54.3 percent to 47.3 percent.[425] In 2017, 24.9 percent of Nevada adolescents met current federal physical activity guidelines, compared to 26.1 percent nationwide.[426]

Female adolescents were more likely to report they did not participate in at least 60 minutes of physical activity in the week prior (17.4% compared to 12.2% for males), along with American Indian/Alaska Native, Black or African American, and Asian students (24%, 22.7%, and 21.6% respectively).[427] Similarly, female adolescents were more likely to report they were not physically active at least 60 minutes per day on five or more days (64.2% compared to 48.5% for males). This disparity also exists across different race and ethnicity groups, with almost three in four Asian students reporting not participating in daily physical activity (74%).[428]

Lesbian, gay, and bisexual (LGB) students, as defined by YRBS, also reported higher rates of not participating in physical activity for at least 60 minutes on at least one day during the week prior (20.2% vs. 13.5% for their heterosexual peers), and reported lower rates of being physically active for at least 60 minutes per day on five or more days in the week prior (32.1% compared to 46.7% for their

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[418] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[419] National Survey of Children's Health. (2017-18). Physical activity, age 6-17 years.
[420] National Children's Health Survey. (2017-18). National Performance Measure 8.1 and 8.2. Youth who are physically active at least 60 minutes per day.
[421] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[422] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[423] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[424] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.
[425] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[426] United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. (n.d.). Physical Activity. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity.
[427] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[428] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

heterosexual peers). This trend continues with the percentage of LGB students who played video or computer games, watched TV, or used a computer for three or more hours per day at 63.3 percent (compared to 53.3% for heterosexual peers).[429]

Nutrition

In Nevada in 2017, 3.3 percent of children lived in families that often could not afford enough to eat (higher than the national rate of 1.1%). In 2017, almost half (49%) of Nevada children lived in households receiving one to four types of food or cash assistance (higher than the national rate of 40.5%).[430]

According to 2017 Nevada High School YRBS data, 3.8 percent of high school students most of the time or always go hungry because there is not enough food in the house and 9.8 percent sometimes go hungry. For Nevada middle school students, 4.9 percent most of the time or always go hungry and 10 percent sometimes go hungry. Furthermore, 6.6 percent of high school students reported they did not eat fruit or drink fruit juice during the week prior (higher than the national rate of 5.6%) and 12.2 percent did not eat vegetables (higher than the national rate of 7.2%).[431]

Among racial and ethnic groups, Nevada Hispanic/Latino high school students were most likely to report always or most of the time going hungry because there was not enough food (1.6%), followed by White students (1.3%), and Asian students (0.3%). Hispanic/Latino high school students were also more likely to not have eaten vegetables with six percent reporting not having a vegetable in the past seven days. For fruit and fruit juice consumption, there were no differences between racial and ethnic groups.[432]

LGB high school students in Nevada were more likely to report always or most of the time going hungry because there is not enough food in the house (5.7% vs. 3.4% of their heterosexual peers). LGB high school students also reported higher percentages of being overweight (19.5% vs. 15.2% of their heterosexual peers) and obese (16.7% vs. 12.4% of their heterosexual peers).[433]

Immunizations

The primary vaccines to consider for adolescents include the annual flu vaccine, completed Tdap and meningococcal (MenACWY) vaccine series, and completed HPV vaccine series. Nevada ranks 46th in the nation for children ages six months to 17 years receiving an annual flu vaccine and 29th for adolescents being up to date with the HPV vaccine series (2-3 doses depending on age).[434]

For adolescents ages 13 to 17 years in 2018, 51.1 percent were considered up-to-date on their HPV vaccine series, matching the 51.1 percent rate nationwide.[435] For Tdap vaccination coverage, 85.2 percent of Nevada adolescents had received one or more doses in 2018, compared to 88.9 percent

[429] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[430] Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.
[431] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[432] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[433] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[434] Immunize Nevada. (2019). *Nevada Immunization Report Card*. *Nevada Immunization Report Card*. Immunize Nevada. Retrieved from https://immunizenevada.org/sites/default/files/Advocacy/iz report card_2019.pdf.
[435] Centers for Disease Control & Prevention. (2018, August). TeenVaxView Interactive! - Results for Adolescent HPV Vaccination Coverage. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/hpv/index.html.

nationally.[436] For MenACWY vaccination coverage, 80.6 percent of Nevada adolescents had received one or more doses in 2018, compared to 86.6 percent nationally.[437] Finally, for annual flu vaccine coverage, from 2017 to 2018, 47.4 percent of Nevada adolescents received the flu vaccine (lower than the national rate of 59%).[438]

Disparities exist for adolescent vaccine coverage across the three non-annual vaccines – HPV, Tdap, and MenACWY (Table 59). In 2018, adolescents living below the poverty level had higher vaccine coverage than those living at or above the poverty level. White non-Hispanic individuals had the lowest vaccine coverage among the three prominent racial/ethnic groups in Nevada, and those living in rural areas had lower rates than those living in more populated areas. [439]

Table 59. Nevada's Vaccination Coverage Percentages for Adolescents ages 13 to 71, by Vaccination Type, 2018[440]

Demographic Category	Demographic Descriptor	HPV	Tdap	MenACWY
Poverty	*Living at or Above Poverty*	48.2%	85.8%	80.1%
Poverty	*Living Below Poverty*	61.5%	86.7%	84.9%
Race/Ethnicity	*Black or African American (non-Hispanic)*	45.2%	82.4%	80.4%
Race/Ethnicity	*White (non-Hispanic)*	41.5%	81.7%	72.8%
Race/Ethnicity	*Hispanic*	65.4%	89.2%	87.6%
Urbanicity	*Living in a Rural Area*	39.4%	85.3%	78.4%
Urbanicity	*Living in Populated Area*	52.5%	86.3%	82.0%

Nevada's estimated childhood and adolescent immunization coverage rates for 2018 are the highest they have been since 2007.[441] For Tdap vaccination coverage, the proportion of adolescents receiving one or more doses has increased 85.6 percent since 2008.[442] Coverage rates for adolescents receiving one or more doses of a MenACWY vaccination has increased 172.3 percent since 2008.[443] The annual flu vaccination coverage rate increased 92.7 percent for those ages six months to 17 years since 2009-2010. [444]

Sexual Behaviors

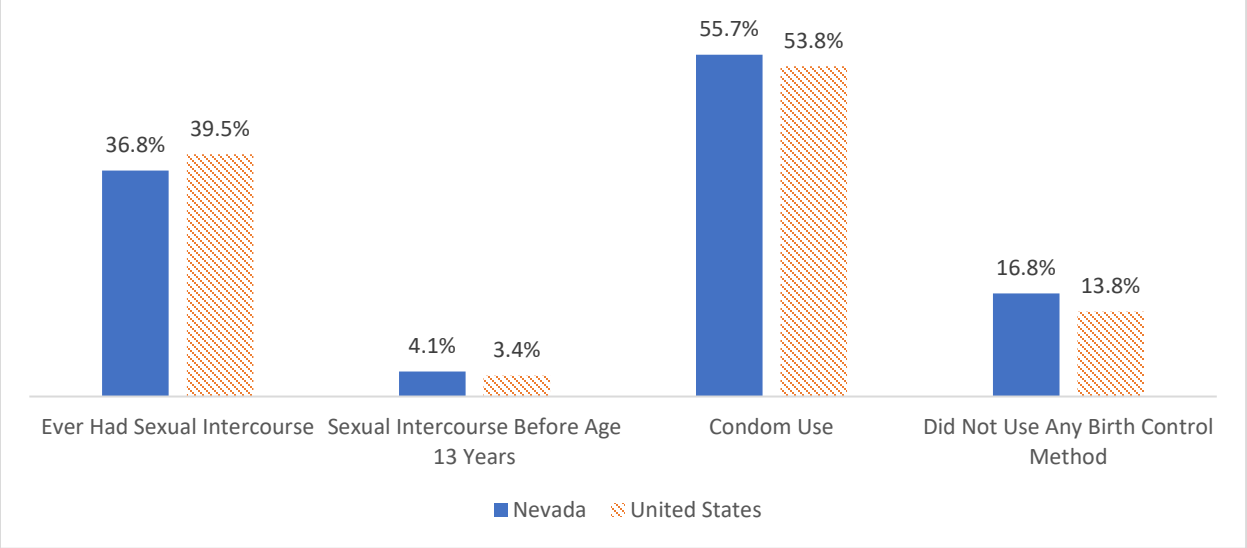
The topic of sexual health includes sexual history, interpersonal and sexual violence, teen pregnancy, and sexually transmitted infections. According to 2017 Nevada High School YRBS data, 63.2 percent of high school students reported not ever having sexual intercourse (higher than the national rate of 60.5%) and 4.1 percent reported having sexual intercourse for the first time before the age of 13 (higher than the national rate of 3.4 percent).[445,446] Figure 80 shows the proportion of sexually active high

[436] Centers for Disease Control & Prevention. (2017, August). TeenVaxView Interactive! - Results for Adolescent Td or Tdap Vaccination Coverage. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/td-tdap/index.html.
[437] Centers for Disease Control & Prevention. (2017, August). TeenVaxView Interactive! - Results for Adolescent MenACWY Vaccination Coverage. Retrieved from https://www.cdc.gov/vaccines/imz-managers/coverage/teenvaxview/data-reports/menacwy/index.html.
[438] Centers for Disease Control & Prevention. (2018, September). FluVaxView. 2017-18 Dashboard. Retrieved from https://www.cdc.gov/flu/fluvaxview/coverage-1718estimates-children.htm.
[439] CDC, TeenVaxView Interactive!
[440] CDC, TeenVaxView Interactive!
[441] Immunize Nevada. (2019). *Nevada Immunization Report Card*. *Nevada Immunization Report Card*. Immunize Nevada. Retrieved from https://immunizenevada.org/sites/default/files/Advocacy/iz report card_2019.pdf.
[442] Centers for Disease Control & Prevention. TeenVaxView Interactive! - Results for Adolescent Td or Tdap Vaccination Coverage.
[443] Centers for Disease Control & Prevention. TeenVaxView Interactive! - Results for Adolescent MenACWY Vaccination Coverage.
[444] Centers for Disease Control & Prevention. FluVaxView. 2017-18 Dashboard.
[445] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[446] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017. Morbidity and Mortality Weekly Report: Surveillance Summaries, 67(8), 1–114.

school students by grade based on 2017 YRBS data. Just over a quarter (25.8%) of Nevada high school students reported having sexual intercourse with at least one person in the past three months and 9.5 percent reported having sexual intercourse with four or more persons during their life. Almost a fifth (17.3%) of Nevada high school students reported drinking alcohol or using drugs before their last sexual intercourse.[447]

When considering harm reduction behaviors, 55.7 percent of Nevada's high school students reported using a condom during their last sexual intercourse (higher than the national rate of 53.8%), 16.7 percent reported using birth control pills, and 5.8 percent reported using a long-acting reversible contraceptive (LARC) (e.g., IUD, Depo-Provera, NuvaRing). Overall, 16.8 percent of Nevada high school students did not use any method to prevent pregnancy during their last sexual intercourse (higher than the national rate of 13.8%) (Figure 84).[448]

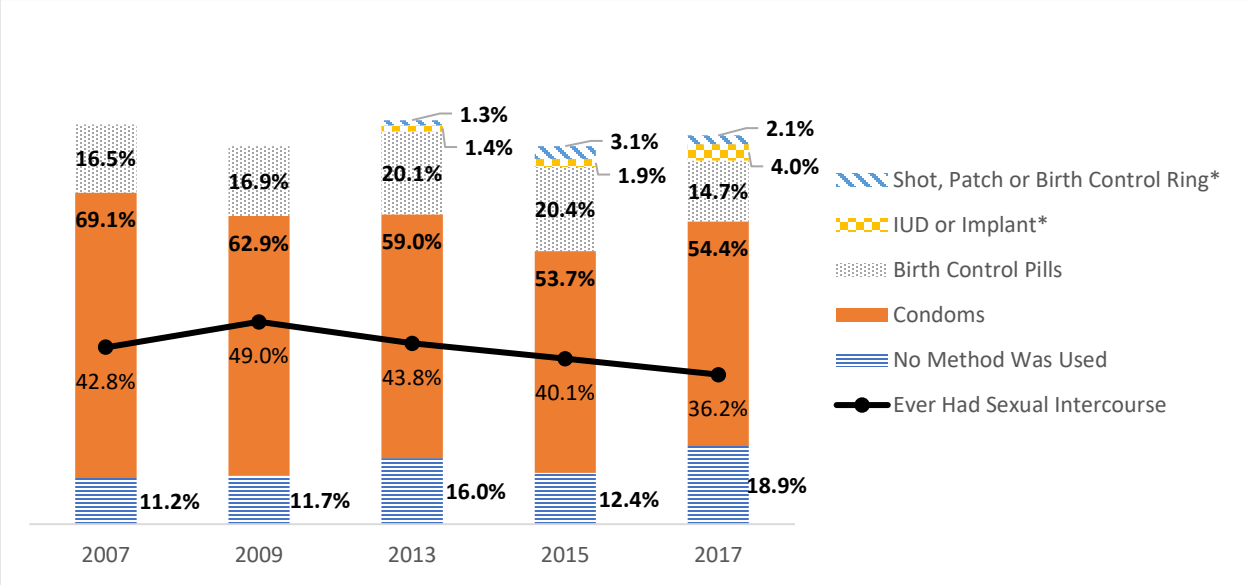
Figure 84. Proportion of High School Students Engaging in Certain Sexual Behaviors, Nevada and United States[449]



Between 2007 and 2017, the percentage of Nevada high school students who ever had sexual intercourse decreased by 15.4 percent (slightly lower than the 17.4% decrease seen nationally over the same time period) and the percentage of students who had sexual intercourse for the first time before age 13 also decreased by over 33 percent (lower than the 52.1% seen nationally).[450] However, over the past decade, the percentage of Nevada high school students who used a condom during their last sexual intercourse also decreased by 21.3 percent (slightly higher than the 20% decrease seen nationally) (Figure 85).[451] Additionally, the percentage of students who reported not using any method to prevent pregnancy during their last sexual intercourse increased by 68.8 percent (there was no statistical difference seen nationally).[452] These trends suggest while teens may be having less sexual intercourse overall, when they are having sex, it is overwhelmingly unsafe.

[447] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.
[448] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.
[449] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017.
[450] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*. University of Nevada, Reno. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017 Nevada High School CDC YRBS 10 Year Trends.pdf
[451] University of Nevada, Reno.*2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[452] University of Nevada, Reno.*2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.

Figure 85. Trends in Contraceptive Methods Used for Birth Control Among Sexually Active Youth, Nevada 2007-2017[453]



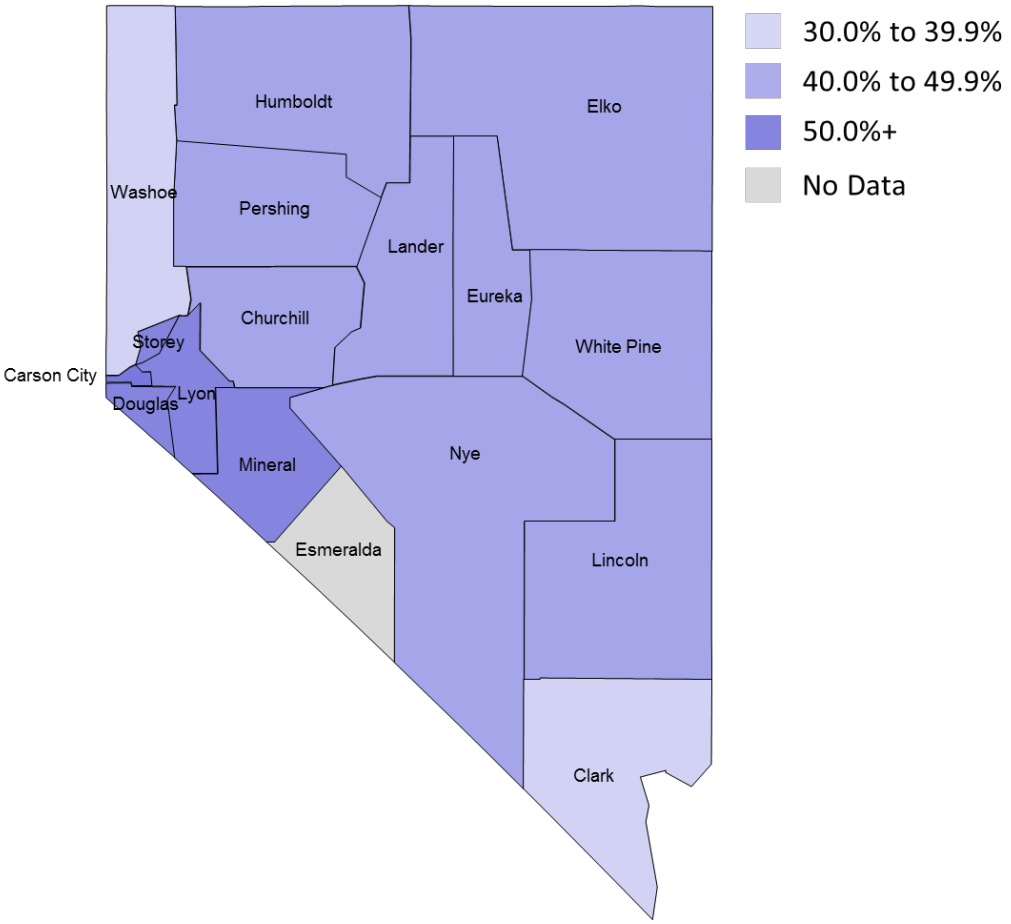
**Data not available for these methods for 2007 and 2009*

Looking closely at differences in sexual behaviors among different demographic groups, Asian high school students had the lowest proportion of sexually active students (23.8% of all Asian students) while the highest rates were reported among Native Hawaiian/Pacific Islander students (43% of all Native Hawaiian/Pacific Islander).[454] However, when reviewing the entire student body, White students accounted for 41.4 percent of all students who ever had sexual intercourse, followed by Hispanic/Latino students (39.7%), and all other race/ethnicities (18.9%).[455]

Geographically, the regions with the highest proportion of sexually active high school students were Region 2 (Douglas County) and Region 5 (Lyon, Mineral, and Storey counties), where over half of students reported having had sexual intercourse.[456] Both Region 7 (Washoe County) and Region 8 (Clark County) had 35 percent of high school students report being sexually active (Figure 86).[457]

[453] University of Nevada, Reno.*2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[454] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[455] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[456] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[457] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

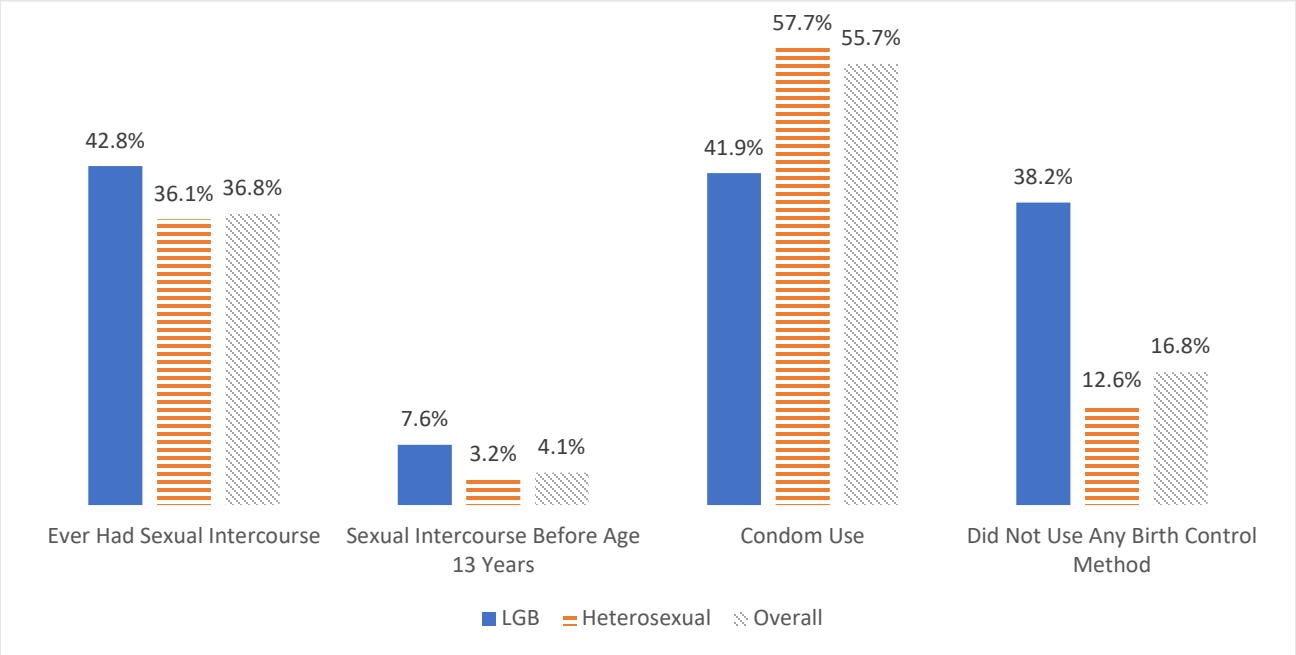
Figure 86. Proportion of Nevada High School Students Who Ever Had Sexual Intercourse by Region[458]



Among youth who identify as LGB, 42.8 percent reported ever having sexual intercourse and 7.6 percent reported having sexual intercourse for the first time before age 13.[459] LGB high school students also reported lower levels of condom use (41.9%) and higher levels of not using any method to prevent pregnancy during their last sexual intercourse (38.2%) compared to both the overall student body and students who identified as heterosexual (Figure 87).[460]

[458] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[459] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[460] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

Figure 87. Proportion of Nevada High School Students Engaging in Certain Sexual Behaviors by Sexual Identity[461]



Interpersonal and Sexual Violence

In Nevada, 7.9 percent of high school students experienced physical dating violence and 5.7 percent experienced sexual dating violence in the year prior to taking the survey.[462] Slightly more than one in ten students reported they were forced to do sexual things when they did not want to (10.5%, higher than the national rate of 7%), and 7.3 percent reported they were ever physically forced to have sexual intercourse when they did not want to (similar to the 7.4% reporting nationally). For Nevada middle school students, 3.9 percent reported being ever physically forced to have sexual intercourse.[463]

Between 2007 and 2017, the percentage of Nevada students reporting having ever been physically forced to have sexual intercourse decreased 25 percent; however, the current percentage has been stable since 2013 (there was no statistical difference seen nationally between 2007 and 2017). The percentages of Nevada students experiencing physical and sexual dating violence have also decreased between 2013 (the first year this data was collected in YRBS) and 2017, with a 57.6 percent decrease and 47.7 percent decrease respectively.

In 2015, three percent of calls to the National Domestic Violence Hotline in Nevada were from individuals younger than 18 years (lower than the national rate of 4%).[464] For Nevada callers to the "loveisrespect" hotline (the National Domestic Violence Hotline's dating abuse, prevention, and

[461] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[462] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[463] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno. Retrieved from https://www.unr.edu/Documents/public-health/2017_yrbs/2017%20Nevada%20High%20School%20YRBS%20-%20Sexual%20Identity%20Special%20Report_acc.pdf.
[464] The National Domestic Violence Hotline. (n.d.). *2015 Nevada State Report*. Administration on Children, Youth and Families, Family and Youth Services Bureau, United States Department of Health and Human Services. Retrieved from https://www.ncedsv.org/wp-content/uploads/2016/12/2015_NDVH_Nevada.pdf.

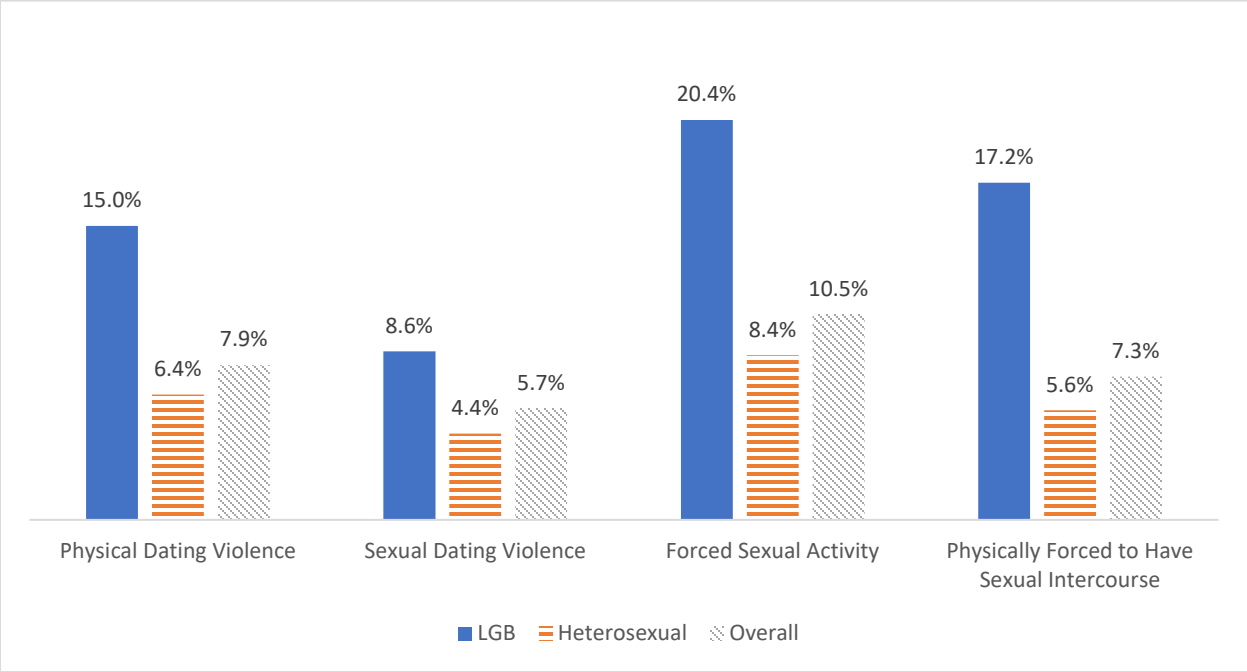
education project for youth), 14.3 percent were younger than 15 years (almost two times the national rate of 8.7%), and another 14.3 percent were ages 16 to 18 years (lower than the national rate of 21.3%).[465] For the "loveisrespect" hotline, 82 percent of all calls originating in Nevada came from Las Vegas and 14 percent from Reno.[466] A large majority of individuals who called the hotline were experiencing emotional or verbal abuse (98%, higher than the national rate of 92%) while 53 percent were experiencing physical abuse (higher than the national rate of 48%).[467]

Among those experiencing interpersonal violence in Nevada's high schools, adolescent males were more likely to report experiencing physical violence (8.4% compared to 7.3% for adolescent females) while adolescent females were more likely to report experiencing sexual violence (7.1% compared to 4.2% for males).[468] The same holds true nationwide, with 15.2 percent of adolescent females experiencing sexual violence compared to 4.3 percent of adolescent males.[469] Adolescent females were also more likely to report forced sexual activity when they did not want to (13.4% compared to 7.6% for males) and to report being physically forced to have sexual intercourse (9.3% compared to 5.3% for males).[470] Nationally, 11.3 percent of adolescent females report being physically forced to have sex compared to 3.5 percent of adolescent males.[471] This same disparity also holds for Nevada's middle school students reporting they were physically forced to have sexual intercourse (5.1% females compared to 2.6% of males).[472]

High school students who identify as LGB reported at higher percentages for all the metrics mentioned above – forced sexual activity when they did not want to, experiencing physical dating violence, experiencing sexual dating violence, and being physically forced to have sexual intercourse – in comparison to both the overall student body and students who identify as heterosexual.[473] These disparities can be more clearly seen in Figure 88. These disparities are **approximately double the rate for heterosexual student reports of physical and sexual dating violence and forced sexual activity and triple the likelihood of being forced to have sexual intercourse.**[474]

[465] loveisrespect (2016). *Nevada State Report*. Administration on Children, Youth and Families, Family and Youth Services Bureau, United States Department of Health and Human Services. Retrieved from https://www.ncedsv.org/wp-content/uploads/2016/12/2015-LIR-Nevada.pdf.
[466] loveisrespect. *Nevada State Report*.
[467] loveisrespect. *Nevada State Report*.
[468] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[469] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017. Morbidity and Mortality Weekly Report: Surveillance Summaries, 67(8), 1–114.
[470] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[471] Kann, L., et al. (2018). Youth Risk Behavior Surveillance — United States, 2017. Morbidity and Mortality Weekly Report: Surveillance Summaries, 67(8), 1–114.
[472] Lensch, T., et al. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[473] Lensch, T., et al., *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[474] Lensch, T., et al., *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.

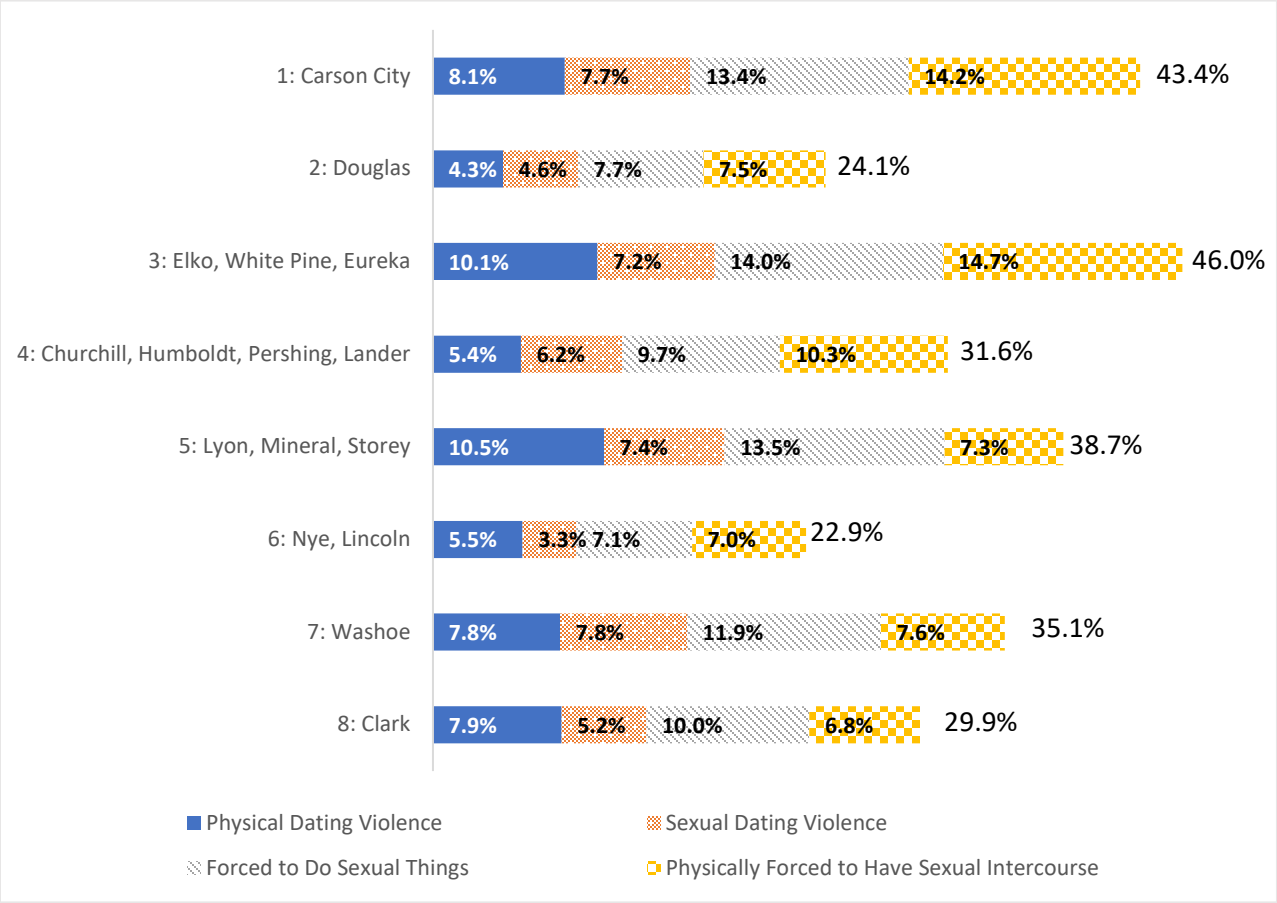
Figure 88. Proportion of Nevada High School Students Experiencing Victimization by Sexual Identity, 2017[475]



There are statewide variations in the proportions of students experiencing these different forms of dating and interpersonal violence. Figure 89 shows Regions 1 and 3 have more students reporting different forms of violence, although there is likely overlap between students.[476] Regions 3 and 5 have the highest proportion of students reporting physical dating violence, while Regions 1 and 3 have the highest proportion of students reporting being physically forced to have sexual intercourse.[477] The data indicate there are regional disparities in where different forms of dating and interpersonal violence are taking place across Nevada.

[475] Lensch, T., et al., *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[476] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[477] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

Figure 89. Proportion of Nevada High School Students Experiencing Victimization by Region, 2017[478]

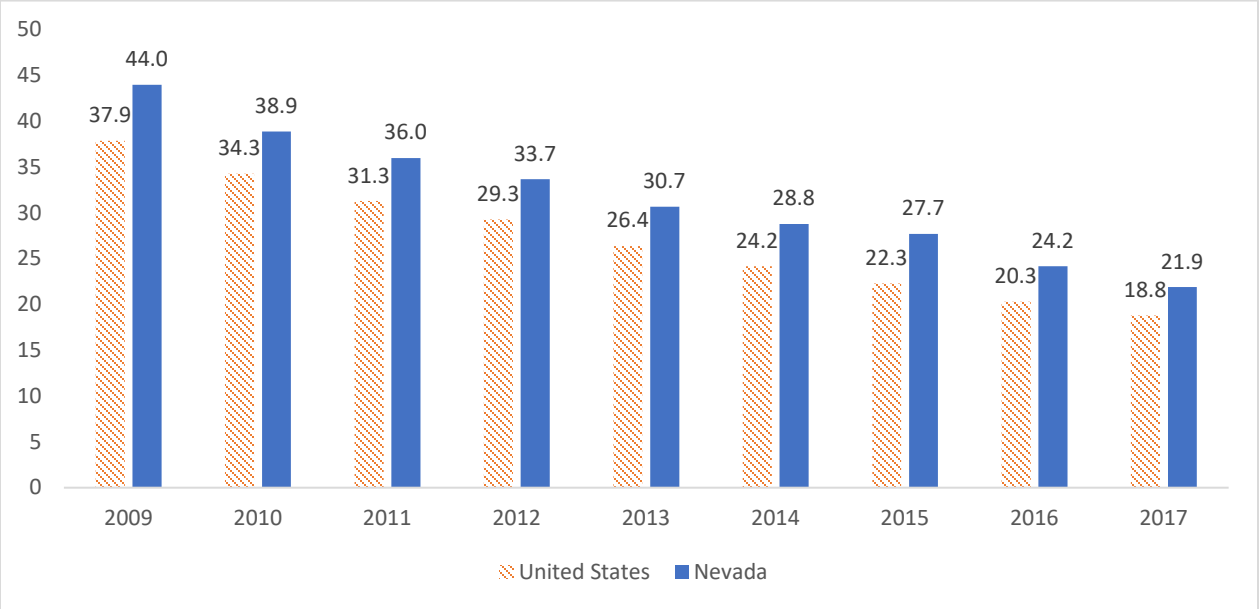


Teen Pregnancy

In Nevada in 2017, the teenage birth rate for women ages 15 to 19 years was 21.8 births per 1,000 women, higher than the national rate of 18.8 births.[479] However, between 2009 and 2017, the teen birth rate decreased 50.2 percent, following the national trend of a 50.4 percent decrease over the same time (Figure 90).[480]

[478] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[479] National Vital Statistics System. (2017). National Outcome Measure 23: Teen birth rate, ages 15 through 10, per 1,000 females.
[480] National Vital Statistics System. (2017). National Outcome Measure 23: Teen birth rate, ages 15 through 10, per 1,000 females.

Figure 90. Teen Birth Rate, Ages 15 to 19 years, per 1,000 Women, Nevada and United States, 2009 to 2017[481]

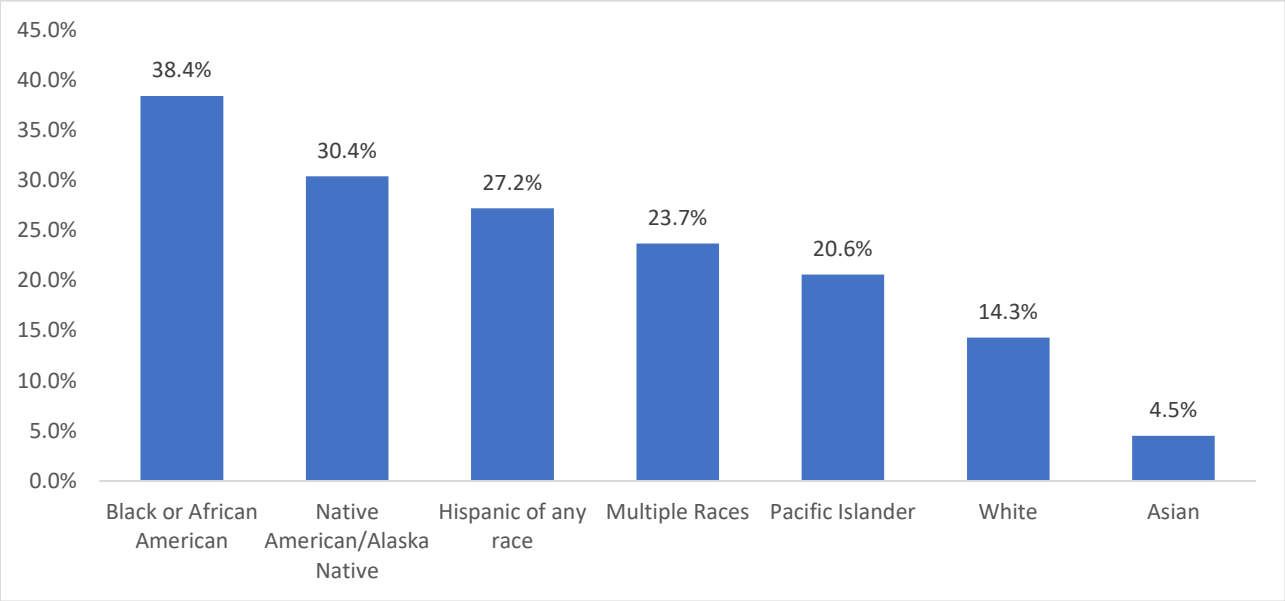


Most teen births were to older teens (18-19 years), accounting for 45.2 percent of Nevada teen births in 2017; teens ages 15 to 17 years accounted for 8.7 percent of teen births.[482] Additionally, 16 percent of births were to teens who already had one child.[483] Further, 2017 Nevada High School YRBS data shows 2.2 percent of high school students reported having ever been pregnant or gotten someone pregnant.[484] The majority of the 2.2 percent consisted of students in 12th grade (36.3%) and who were 17 years of age (31.9%).[485]

In Nevada, Black or African American teens experience the highest birth rates at 38.4 births per 1,000 women ages 15 to 19 years, followed by 30.4 births for American Indian/Native Americans and 27.2 births for Hispanic teens. The rates for these population groups are higher than the state rate of 21.9 births per 1,000 women ages 15 to 19 years (Figure 91).[486] Since 2009, the teen birth rate has declined both in Nevada, as stated previously, and among all racial and ethnic groups. However, Hispanic teens experienced a seven percent increase in the birth rate between 2015 and 2017, while both Non-Hispanic Whites and Non-Hispanic Blacks or African Americans experienced a 25 percent and 12 percent decrease respectively.[487]

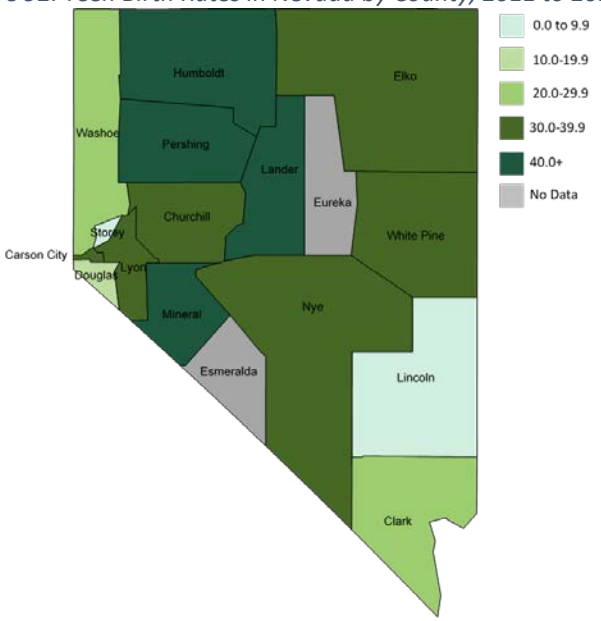
[481] National Vital Statistics System. (2017). National Outcome Measure 23: Teen birth rate, ages 15 through 10, per 1,000 females.
[482] National Vital Statistics System. (2019). National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.
[483] Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19.
[484] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[485] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[486] National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through 19, per 1,000 females.
[487] Power to Decide. Teen Birth Rate Comparison, 2017: Teen Birth Rate Among Girls Age 15-19.

Figure 91. Proportion of Teen Births in Nevada, by Race/Ethnicity, 2017[488]



Geographically, rural Nevadans experience higher teen birth rates compared to the state at 26.7 teen births per 1,000 girls (compared to a rate of 21.9 across the state). Specifically, the teen birth rate also varies by county, with Lander County reporting the highest teen birth rate between 2011 and 2017 at 47 teen births per 1,000 girls ages 15 to 19 years.[489] Lincoln County reported the lowest rate at 8.0 per 1,000 girls.[490] The rates by county can be seen in Figure 92, below.[491]

Figure 92. Teen Birth Rates in Nevada by County, 2011 to 2017[492]



[488] National Vital Statistics System. National Outcome Measure 23: Teen birth rate, ages 15 through19, per 1,000 females.
[489] County Health Rankings & Roadmaps. (2019). Teen births. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/sexual-activity/teen-births.
[490] County Health Rankings & Roadmaps. Teen births.
[491] County Health Rankings & Roadmaps. Teen births.
[492] County Health Rankings & Roadmaps. Teen births.

According to 2017 Nevada YRBS data, high school students who identified as LGB reported higher percentages of having ever been pregnant or gotten someone pregnant (4.3%) compared to their heterosexual peers (1.9%).[493]

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are another health issue related to having unprotected sexual intercourse. In 2018 in Nevada, there were 3,959 chlamydia cases among adolescents ages 10 to 19 years, and those ages 15 to 19 year accounted for 22 percent of all chlamydia cases statewide (corresponding to a rate of 1,917 cases per 100,000 population).[494] Nationally in 2018, females ages 15 to 19 years experienced 3,306.8 chlamydia cases per 100,000 population, making up almost one in five (19.4%) cases nationwide.[495] Female adolescents in Nevada were much more likely to report chlamydia, making up 75.4 percent of all cases reported in 2018 among those ages 10 to 19 years. The chlamydia rate in Nevada increased by 5.8 percent between 2017 and 2018 for those ages 15 to 19 years.[496]

Among Nevada adolescents ages 10 to 19 years there were 1,075 reported cases of gonorrhea in 2018. Female adolescents accounted for 58.1 percent of gonorrhea cases in this age group. Gonorrhea cases increased 44.9 percent between 2017 and 2018 for those ages 10 to 19 years, with cases among those between ages 10 to 14 years more than doubling.[497] Nationally in 2018, females ages 10 to 19 years made up only 10.1 percent of all gonorrhea cases.[498]

There was one reported case of primary and secondary syphilis in Nevada in 2018 for those younger than 14 years and 17 cases reported for those ages 15 to 19 years. The 17 cases made up only 2.5 percent of all cases statewide (lower than the national percentage of 4.7%) and represented a 6.3 percent increase from 2017. There were no reported cases of early latent syphilis for those younger than 14 years in 2018, and a total of 12 cases for those ages 15 to 19 years. The 12 cases made up 2.3 percent of all cases statewide, a decrease of 7.7 percent from 2017.[499]

There were 98 new HIV diagnoses in Nevada in 2018 for those ages 13 to 24 years, accounting for almost one in five (19.3%) new cases of HIV statewide. Male adolescents accounted for 92.9 percent of new cases in this age group.[500] Nationally in 2018, there were 7,734 new HIV diagnoses among those ages 13 to 24 years, with 87.5 percent occurring among males.[501] In 2018 in Nevada, there were 12 cases of HIV Stage 3 (AIDS) among those ages 13 to 24 years, all of them occurring among male adolescents.[502,503]

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[493] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[494] Office of Public Health Informatics and Epidemiology, and Division of Public and Behavioral Health (2019). *2018 STD Fast Facts*. Retrieved from http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/STD/dta/Publications/Fast%20Facts%202018%20State%20final.pdf.
[495] Centers for Disease Control and Prevention. (2019, August 20). Table 10. Chlamydia — Reported Cases and Rates of Reported Cases by Age Group and Sex, United States, 2014–2018. Retrieved March 10, 2020 from https://www.cdc.gov/std/stats18/tables/10.htm.
[496] Office of Public Health Informatics and Epidemiology, *2018 STD Fast Facts*.
[497] Office of Public Health Informatics and Epidemiology, *2018 STD Fast Facts*.
[498] Centers for Disease Control and Prevention. (2019, August 20). Table 21. Gonorrhea — Reported Cases and Rates of Reported Cases by Age Group and Sex, United States, 2014–2018. Retrieved March 10, 2020 from https://www.cdc.gov/std/stats18/tables/21.htm.
[499] Office of Public Health Informatics and Epidemiology. *2018 STD Fast Facts.*
[500] Office of Public Health Informatics and Epidemiology. *2018 HIV Fast Facts.*
[501] Centers for Disease Control and Prevention. (2019, November). HIV Surveillance Report, 2018 (Preliminary); vol. 30. Retrieved on March 10, 2020 from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.
[502] Office of Public Health Informatics and Epidemiology. *2018 HIV Fast Facts.*
[503] Stage 3 (AIDS) diagnoses and HIV diagnoses may duplicate case counts if the person was diagnosed with both stage 3 (AIDS) and HIV in the same year.

There are 332 individuals living with HIV in Nevada between the ages of 13 and 24 years, making up two percent of all Nevadans living with HIV.[504] According to Nevada 2017 YRBS data, 9.8 percent of high school students had ever been tested for HIV, indicating the proportion of high school youth who may present risk factors for HIV (compared to 8.3% of high school youth nationally).[505] The number of new HIV diagnoses for Nevadans ages 13 to 24 years increased by 22.5 percent from 2017.[506] Additionally, between 2015 and 2017, the rate of HIV testing reported by Nevada high school students decreased 26.4 percent, suggesting a decline in the proportion of high school youth who may present risk factors for HIV.[507]

Students who identify as LGB had a much higher percentage of reporting being ever tested for HIV, at 14.2 percent, compared to 9.1 percent for students who identify as heterosexual.[508] Regionally, there were differences between Clark County, Washoe County, and the rest of the state (i.e., rural and frontier counties) in terms of new HIV cases in 2018. Table 60 helps illustrate those differences for chlamydia, gonorrhea, primary and secondary syphilis, and HIV.

Table 60. Number of New Cases and Corresponding Rates for Sexually Transmitted Infections by County ages 10 to 24, 2018[509]*

STI	Age Group	Clark County	Clark County	Washoe County	Washoe County	Rural & Frontier Counties	Rural & Frontier Counties
		No. of Cases	Rate	No. of Cases	Rate	No. of Cases	Rate
Chlamydia	*10-14*	75	46.0	16	50.6	8	38.8
Chlamydia	*15-19*	2,923	1,934.8	676	2,235.3	261	1,302.4
Gonorrhea	*10-14*	35	21.4	3	9.5	0	0.0
Gonorrhea	*15-19*	912	603.7	102	337.3	23	114.8
Primary and Secondary Syphilis	*10-14*	1	0.6	0	0.0	0	0.0
Primary and Secondary Syphilis	*15-19*	14	9.3	3	9.9	0	0.0
HIV	*13-24*	86	23.9	9	12.2	NR	NR

**Rate is the rate of the population per 100,000 persons. NR = Not Reported.*

Emotional and Mental Health

Beyond physical health and wellbeing, emotional and mental health are important facets when considering the overall wellbeing of youth. Nationwide in 2018, it was estimated 11.9 percent of all youth (ages 12 to 17 years) suffered from at least one major depressive episode in the past year. Among all states, Nevada ranks 49th with 12.9 percent of youth experiencing at least one major depressive episode in the past year.

[504] Office of Public Health Informatics and Epidemiology. *2018 HIV Fast Facts.*
[505] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[506] Office of Public Health Informatics and Epidemiology, *2018 STD Fast Facts*.
[507] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[508] University of Nevada, Reno. (n.d.). *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[509] Office of Public Health Informatics and Epidemiology, *2018 STD Fast Facts;* Office of Public Health Informatics and Epidemiology, *2018 HIV Fast Facts.*

Considering youth with severe major depression, 8.2 percent of this group nationally reported experiencing a mental health issue, and Nevada youth reported at a higher 10.6 percent (ranked 45 out of 51). It is estimated 63.1 percent of youth nationwide with major depression do not receive any mental health treatment, with an estimated 64 percent not receiving treatment in Nevada.[510]

Nevada's 2017 YRBS data demonstrate 55.3 percent of high school students never or rarely felt they could get the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious.[511] For middle school students, 46.8 percent felt they never or rarely got the kind of help they needed.[512] Nevada's YRBS data additionally revealed 34.6 percent of high school and 29.3 percent of middle school students felt sad or hopeless almost every day for two or more consecutive weeks in 2017.[513] For Nevada high school students, 16.6 percent reported seriously considering attempting suicide in the year prior (lower than the national rate of 17.2%) and 8.5 percent attempted suicide in the year prior (higher than the national rate of 7.4%)[514], while for middle school students 21.3 percent seriously considered attempting suicide and 8.2 percent made an attempt. National data for middle school students is not available.[515]

The adolescent suicide rate in Nevada for those ages 10 to 19 years was 9.6 per 100,000 persons in 2017; higher than the national rate of 7.1.[516] Among older adolescents, those 15 to 19 years, the rate increases to 13.5 per 100,000 persons, higher than the national rate of 10.5.[517] Nevada ranked 40th in the nation in 2017 for number of suicide deaths per 100,000 people.[518] In the past five years in Nevada, the adolescent suicide rate doubled (from 6.5 in 2009 to 13.5 per 100,000 in 2017), indicating it is a significantly growing problem both in Nevada and nationally. National adolescent suicide rates have increased 45.8 percent (from 7.2 to 10.5 per 100,000) since 2009.[519] Suicidal ideation among Nevada's high school students increased by 16.8 percent between 2007 and 2017, while suicide attempts have declined 16.9 percent, with a 30 percent decrease in attempts resulting in injury, poisoning, or overdose.[520]

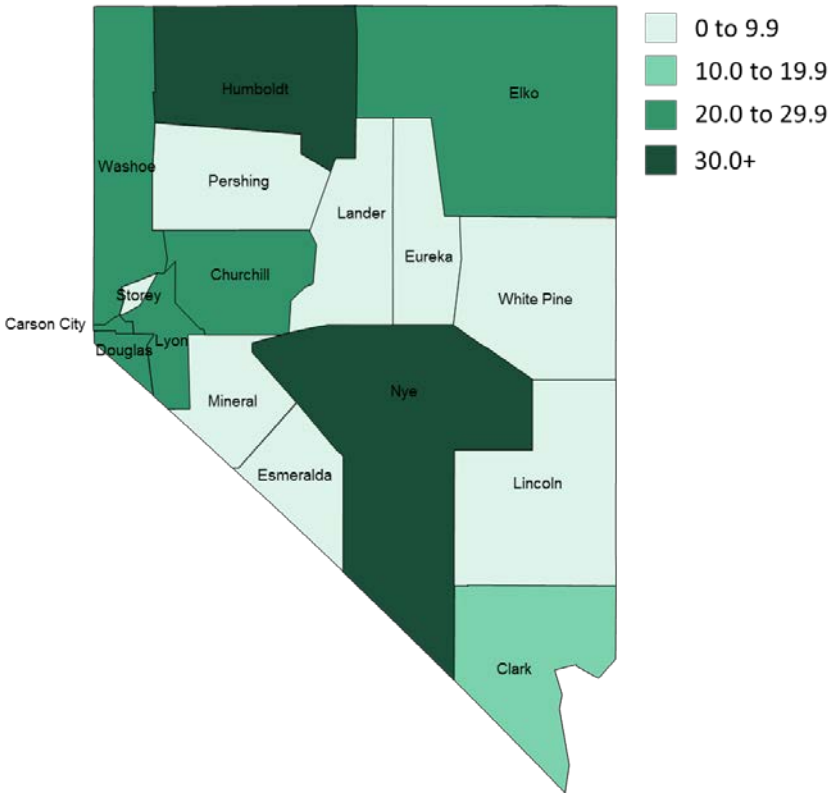
According to 2017 Nevada High School YRBS data, more female (45.9%) than male (24%) students reported feeling sad or hopeless almost every day for two or more consecutive weeks during the year prior.[521] The trend holds true for students who seriously considered attempting suicide during the year prior (21.7% of females vs. 11.6% of males) and for students who attempted suicide during the year

[510] The State of Mental Health in America 2018. Mental Health America.
[511] CDC National Center for Health Statistics, Suicide Mortality by State, 2017.
[512] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[513] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[514] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[515] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[516] CDC WISQARS, 2017.
[517] National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.
[518] CDC National Center for Health Statistics, Suicide Mortality by State, 2017. Retrieved from https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.
[519] National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.
[520] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[521] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

prior (10.4% of females vs. 6.6% of males).[522] For middle school students, this gender disparity persists with more females reporting feeling sad or hopeless almost every day for two or more consecutive weeks (38.3% female vs. 20.4% male), seriously considering killing themselves (28.7% female vs. 14.2% male), and attempting suicide (12% female vs. 4.4% male).[523] However, the adolescent suicide rate in 2017 among Nevada males ages 10 to 19 years was 15.4 per 100,000 persons, higher than the 9.7 per 100,000 persons rate seen among all genders in this age group.[524]

According to NVSS, non-Hispanic White adolescents ages 15 to 19 years experienced a higher suicide rate at 17.5 deaths per 100,000 adolescents compared to 7.9 for Hispanic adolescents.[525] Adolescent suicide rates for Nevada adolescents ages 15 to 19 years also vary by county, as shown in part in Figure 87. Specifically, the highest rates can be found in Nevada's rural regions at 21.7 deaths per 100,000 adolescents (2013 to 2017), compared to 7.5 per 100,000 adolescents (2013 to 2017) living in urban regions.[526] Figure 93 presents statewide age adjusted suicide rates.

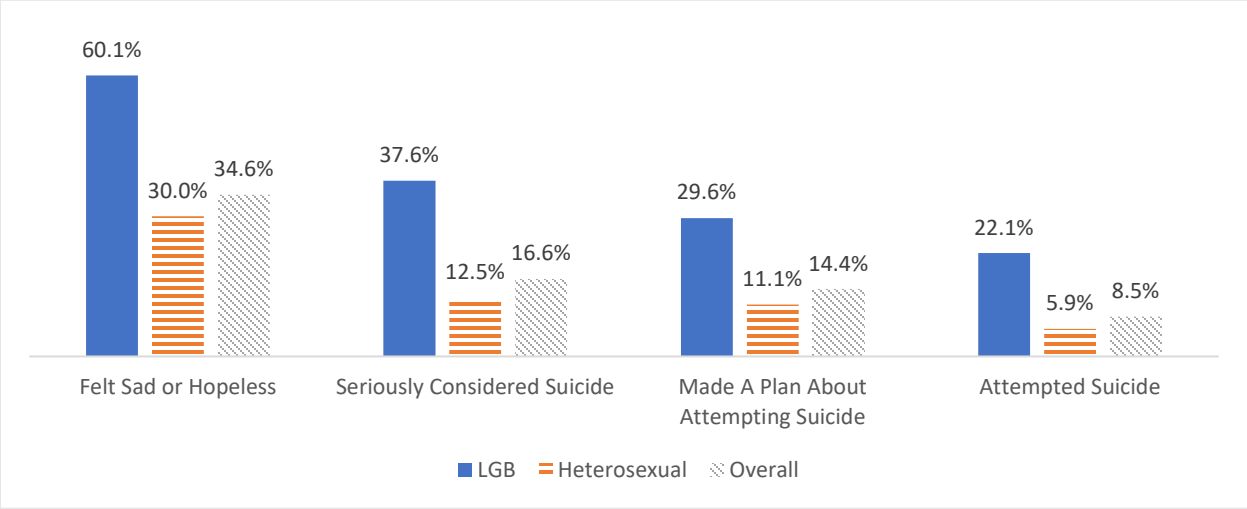
Figure 93. Adolescent Age Adjusted Suicide Rates per 100,000 individuals by County, 2017[527]



[522] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[523] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[524] CDC WISQARS, 2019.
[525] National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.
[526] National Vital Statistics System. (2019). National Outcome Measure 16.3: Adolescent suicide rate ages 15 through 19 per 100,000.
[527] Centers for Disease Control & Prevention. (n.d.). CDC WONDER. Retrieved from http://wonder.cdc.gov.

Among students who identify as LGB, there were significant disparities for all the YRBS emotional health indicators compared to their heterosexual peers. One of the most concerning disparities is LGB students are 3.7 times as likely to attempt suicide than their heterosexual peers (Figure 94).

Figure 94. Proportion of Nevada High School Students with Emotional Health Difficulties by Sexual Identity, 2017[528]



Substance Use

Substance use includes both use and abuse of a variety of substances including tobacco, alcohol, and illicit drugs. According to the 2017 Nevada High School YRBS results, approximately one third of students had ever lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs.

In Nevada, 13.7 percent of middle school students reported ever smoking cigarettes and 2.2 percent reported smoking cigarettes at some point in the month prior.[529] For high school students, these rates rise to 23 percent and 6.4 percent, respectively (compared to 28.9% and 8.8% nationally).[530] However, when reviewing the percentage of students who have ever used electronic vapor products (e-cigarettes, vape pipes, vaping pens, etc.), 18.6 percent of middle school and 42.6 percent of high school students have reported using these products, much higher than those who report smoking cigarettes.[531,532]

Tobacco use among youth in Nevada has trended downward over the past 10 years. The proportion of Nevada high school students who have ever tried cigarettes has decreased 45 percent since 2007, and 50.7 percent fewer high school students report smoking cigarettes at least one day during the 30 days prior to taking the survey (i.e., "current" smokers). Further, the proportion of daily cigarette smokers decreased 76.3 percent. Between 2015 and 2017, 19 percent fewer high school students tried electronic

[528] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[529] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[530] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[531] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[532] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

vapor products and the use of electronic vapor products on at least one day during the 30 days prior to the survey decreased 39.5 percent.[533]

Native Hawaiian/Pacific Islander middle and high school students report the highest percentages of ever having smoked cigarettes at 26.2 and 40.4 percent, respectively. Among Native Hawaiian/Pacific Islander middle school students, 4.1 percent smoked cigarettes during the 30 days prior to taking the survey. Among high school students, American Indian/Alaska Native students show the greatest disparity of current smoking at 12.7 percent. Use of electronic vapor products is also highest among Native Hawaiian/Pacific Islander middle (29.7%) and high school students (52.8%). Among middle school students, 12.4 percent of Native Hawaiian/Pacific Islander students used electronic vapor products during the 30 days prior to taking the survey. Among high school students, American Indian/Alaska Native students again show the greatest disparity for using electronic vapor products at 24.1 percent.[534,535]

Regarding alcohol, 60.6 percent of high school students reported ever having drank alcohol (similar to the 60.4% nationally), with 18.2 percent reporting having their first drink before age 13 years (higher than the 15.5% nationally).[536] Slightly more than one in four (26.5%) Nevada high school students reported having at least one drink of alcohol in the month prior to taking the survey (lower than the 29.8% nationally). For middle school students, only 27.4 percent reported alcohol use. [537]

The percentage of students who ever drank alcohol decreased 15.9 percent, and the percentage of students who currently drink alcohol on at least one day during the 30 days prior to taking the survey decreased 30.2 percent. Reports of ever drinking alcohol are higher among Native Hawaiian/Pacific Islander middle school students in Nevada (32.2%) and Other/Multiple race/ethnicity high school students (66.4%). Native Hawaiian/Pacific Islander middle school students were also more likely than middle school students of other race/ethnicities to have had at least one drink in the 30 days prior to taking the survey (13.4%). Native Hawaiian/Pacific Islander high school students were also more likely to have had at least one drink in the 30 days prior to taking the survey (30.2%).[538] [539] .

Regarding marijuana, recreational use for adults has been legal in Nevada since January 1, 2017.[540] According to 2017 Nevada YRBS data, 9.8 percent of middle school students reported having ever used marijuana; this rate rises significantly for Nevada high school students, with 36.6 percent reporting having ever used marijuana.[541] Most high school students reported smoking marijuana in a joint, bong,

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[533] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[534] United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020.
[535] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[536] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[537] Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*
[538] Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*
[539] Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.; Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[540] United States, Congress, Stinnesbeck, Jann. "Fact Sheet: Recreational Marijuana in Nevada." *Fact Sheet: Recreational Marijuana in Nevada*, Nevada Legislature, Sept. 2018. https://www.leg.state.nv.us/Division/Research/Publications/Factsheets/RecreationalMarijuana.pdf.
[541] Lensch, T., et al. 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.; Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.

pipe, or blunt (83.9%), followed by eating it in a food product (10.7%), and vaporizing (2.1%).[542] Figure 95 illustrates the similarities in marijuana use among Nevada and U.S. students in 2017. Disparities among marijuana use exist for Native Hawaiian/Pacific Islander middle school students (14.7% overall, and 6.9% in the 30 days before the survey) and American Indian/Alaska Native high school students (47.2% overall, and 34.3% in the 30 days before the survey).[543]

Figure 95. Marijuana Use Among Students, Nevada and United States, 2017[544]

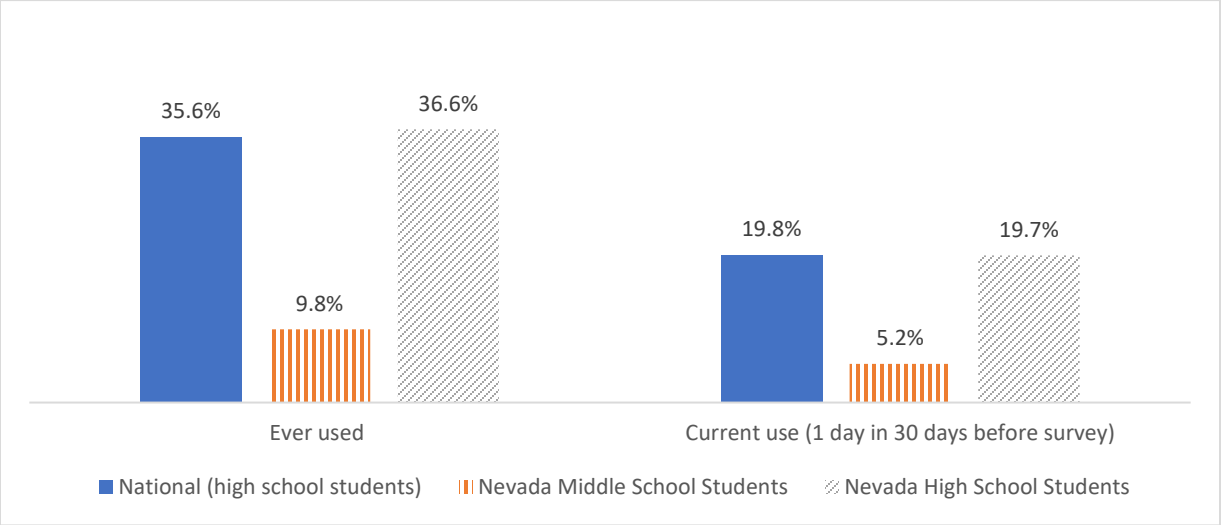
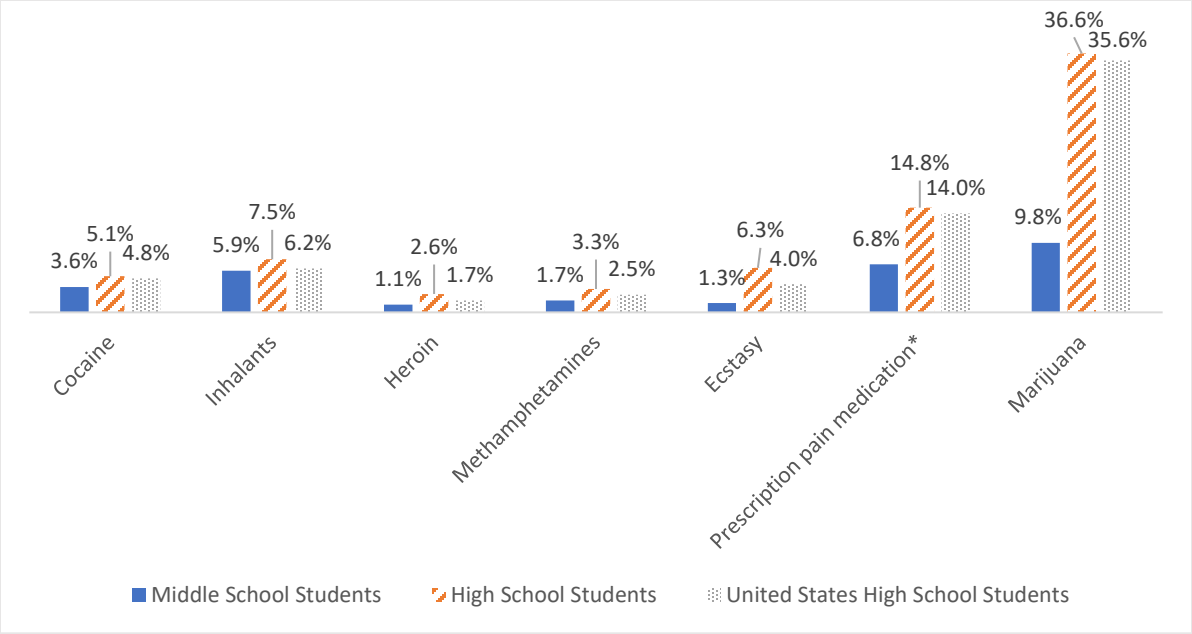


Figure 96 shows the percentage of students, in both middle and high school, who reported having ever used different substances.[545,546]

Figure 96. Percentage of Middle and High School Students Who Ever Used Other Drug Substances, by Drug Type, 2017[547]

[542] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[543] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[544] Lensch, T., et al. *2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report*.; Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[545] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[546] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[547] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.



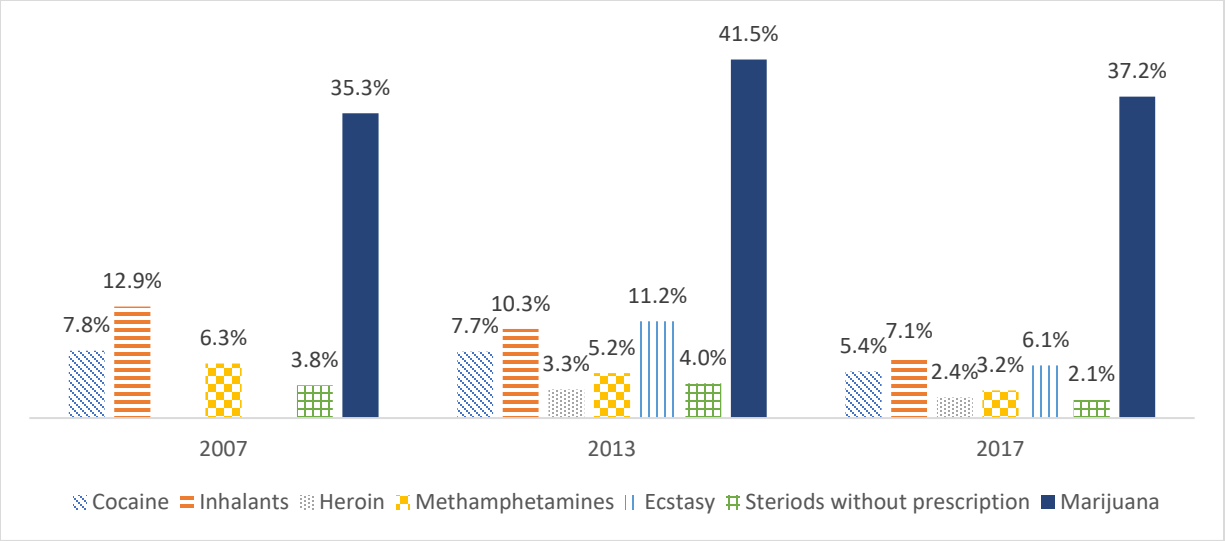
**This includes prescription pain medicating taken without a doctor's prescription or differently than prescribed.*

Generally, drug use has declined among Nevada adolescents since 2007, with the exception of marijuana, with 5.4 percent more high school students trying marijuana at least once (35.3% in 2007 to 37.2% in 2017), and 15.5 percent more high school students using marijuana at least one day during the 30 days prior to taking the survey (15.5% in 2007 to 17.9% in 2017). Figure 97 illustrates the trends in the percentage of high school students who ever used other drug substances.

Native Hawaiian/Pacific Islander middle school students were disproportionately impacted by use of inhalants (9.7%) and prescription pain medication without a doctor's prescription or differently than prescribed (12%). For high school students, American Indian/Alaska Native students were more affected for the same issues, at 17 and 28 percent, respectively. American Indian/Alaska Native students were also more likely to have lived with someone who was a problem drinker, alcoholic, or abused street or prescription drugs (middle school at 28.2% and high school at 43.6%).[548]

Figure 97. Trends in Percentage of High School Students Who Ever Used Other Drug Substances, by Drug Type, 2007 to 2017[549]

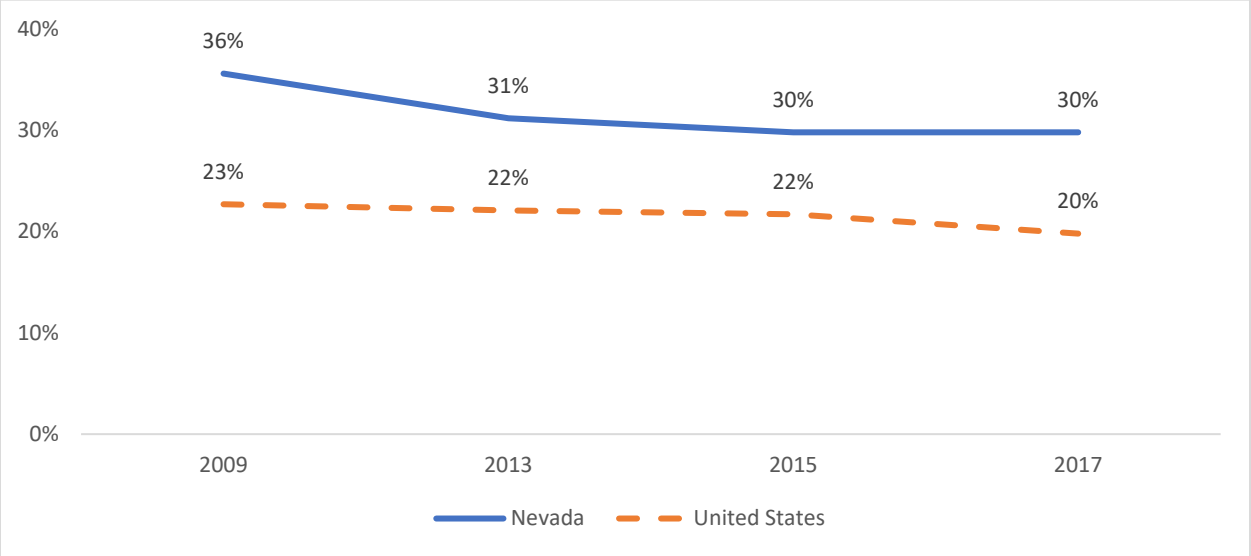
[548] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[549] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.



**Note: 2007 data for heroin and ecstasy is not available for reporting.*

YRBS explores to what extent youth access illegal drugs on school property. In 2017, 30 percent of high school students reported being offered, sold, or given illegal drugs on school property; this measure has been on a decreasing trend since the 2009 high of 36 percent. Consistently over the last six years there is a reported higher level of perceived access to illegal drugs on school property in Nevada compared to the U.S. (Figure 98).

Figure 98. Percent of Adolescents (Grades 9-12) Who Have Been Offered, Sold, or Given an Illegal Drug on School Property, 2009-2017[550]



[550] United States Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020. Adolescent Health. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/objectives.

Across the board in Nevada, LGB high school students experienced higher rates than their heterosexual peers of currently smoking cigarettes (11.3% vs. 5.6%); currently using electronic vapor products (18.9% vs. 14.2%); having ever used cocaine (9.3% vs. 4.2%); inhalants (17.6% vs. 5.7%); heroin (5.8% vs. 1.7%); methamphetamines (7.8% vs. 2.3%); ecstasy (11.9% vs. 4.9%); synthetic marijuana (11.9% vs. 6.5%); steroids without a prescription (6.1% vs. 2.3%); or prescription pain medicine without a prescription or differently than prescribed (26.3% vs. 12.6%).[551]

Unintentional Injury and Violence Prevention

In addition to the direct and catastrophic impact of a child's death, a community's child mortality rate is an important indicator of underlying problems, such as violence in neighborhoods.[552] Different age groups of children and adolescents are at risk for different types of death. In 2017, the adolescent mortality rate in Nevada for ages 10 to 19 years per 100,000 persons was 33.7 (similar to the national rate of 33.1), a 23.6 percent decrease from the state's high of 44.1 deaths per 100,000 in 2014.[553]

In Nevada, the leading causes of death in 2017 for youth ages 10 to 19 years were unintentional injury (29.6% of all deaths in age group), suicide (27.8%), and homicide (17.5%).[554] Table 61 compares Nevada's rates to the U.S., noting the percentage of deaths due to suicide and homicide are higher in Nevada.

Table 61. Percent of All Death Among Youth, ages 10 to 18 years, Nevada and United States, 2017[555]

Cause of Death	Nevada	United States
Unintentional Injury	29.6%	34.1%
Suicide	27.8%	21.3%
Homicide	17.5%	14.3%

In 2016, the leading manner of unintentional injuries for Nevada children and adolescents ages zero to 17 years was a non-motor vehicle accident, such as asphyxia, drowning, or overdose. This differs from the national trend of motor vehicle accidents being the leading cause of unintentional injury for these groups.[556] Between 2015 and 2017, the adolescent motor vehicle mortality rate was 10.5 deaths per 100,000 persons ages 15 to 19 years[557], similar to the national adolescent motor vehicle morality rate of 11 deaths per 100,000 persons.[558]

[551] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[552] Infant, Child and Teen Mortality, Indicators on Children and Youth, Child Trends Data Bank.
[553] Health Resources and Services Administration. National Outcome Measures.
[554] National Center for Health Statistics (NCHS), National Vital Statistics System, accessed via CSC WISQARS.
[555] National Center for Health Statistics (NCHS), National Vital Statistics System, accessed via CSC WISQARS.
[556] The Executive Committee to Review the Death of Children. (n.d.). *2016 Statewide Child Death Report*. *2016 Statewide Child Death Report*. State of Nevada, Division of Child and Family Services. Retrieved from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[557] National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.
[558] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/

Among Nevada high school students, 17 percent reported riding in the car with someone in the past 30 days who had been drinking (similar to national rate of 16.5%).[559] For middle school students, this rate increases to 21.9 percent, putting this group at greater risk of being involved in a motor vehicle accident.[560] The risk of riding in a car with a driver who has been drinking recently decreased for Nevada high school students. Between 2013 and 2017, the percentage of high school students who drove a car or other vehicle when they had been drinking alcohol decreased 28.8 percent. Between 2007 and 2017, the percentage of high school students who rode with a driver who had been drinking alcohol decreased 28.2 percent.[561]

Most homicide deaths for children and adolescents in 2016 were related to abuse, followed by gunshot wounds, and general neglect.[562] According to Nevada YRBS data, 5.7 percent of high school and 3.2 percent of middle school students reported carrying a weapon on school property during the 30 days prior to taking the survey (compared to 15.7% of high school students nationwide). One in five Nevada high school students (20%) and a similar 19.6 percent of middle school students reported being in a physical fight in the year prior (slightly lower than the 23.6% of high school students nationwide). Additionally, five percent of Nevada middle school students reported they were threatened or injured by someone with a weapon on school property during the year prior and 7.7 percent of high schoolers reported the same (slightly higher than the 6% of high school students nationwide). [563,564]

Prevalence of carrying a weapon onto school property in Nevada is higher among males (5.6%) than females (1.9%); national prevalence for this measure for all students is 3.8 percent. Black or African American males reported the highest incidence of being threatened or injured with a weapon on school property in Nevada (10%), higher than the national average (6%); they also reported the highest incidence of being in a physical fight (37.2%), higher than the national average (23.6%).[565] In Nevada, the incidence of high school students carrying a weapon on school property did not change between 2007 and 2017, remaining steady at 4.7 percent, while the proportion of students feeling unsafe at school or on their way to or from school or who were threatened or injured with a weapon on school property increased, 28.6 percent and four percent, respectively.[566]

In 2017, two-thirds of Nevada high school students reported having ever been sworn at, insulted by, or put down by an adult, with almost three quarters (72.8%) of middle school students reporting the same.[567,568] Beyond verbal abuse, 17.7 percent of Nevada high school and 12.8 percent of middle school

[559] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[560] Lensch, T., et al. 2017 *Nevada Middle School Youth Risk Behavior Survey (YRBS) Report.*
[561] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[562] The Executive Committee to Review the Death of Children. *2016 Statewide Child Death Report.*
[563] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[564] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[565] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[566] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[567] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[568] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

students reported having ever been hit, beaten, kicked, or physically hurt in any way by an adult.[569,570] Further, 14.9 percent of children ages 12 to 17 years were reported as being bullied, picked on, or excluded by other children (lower than the national rate of 21%).[571] Bullying on school property declined between 2013 and 2017 by 18.8 percent (from 19.7% to 16%) and electronic bullying declined 13.3 percent (from 15% to 13%) in the same time period.[572]

Across Nevada, 60.6 percent of parents with adolescents ages 12 to 17 years reported their child lived in safe neighborhood in 2017-18. This was lower than the percent nationwide (67.4%).[573] Similarly, 55.5 percent of Nevada parents reported they felt their child was safe in school. Again, this was much lower than the percent nationwide (68.2%).[574] Within the Nevada juvenile justice system, as of August 2019, there were 146 juveniles housed in the three resident youth centers across the state.[575] In the 11 judicial districts across the state, there were 313 children with a new commitment, meaning they had been adjudicated by a juvenile court in 2018.[576] Of those, 29 percent were sentenced due to violent offenses, 23 percent to probation offenses, 17 percent to property offenses, nine percent to drug offenses, and eight percent to weapons offenses.[577] The average age of committed youth in Nevada was 16.2 years.[578]

Both northern and southern Nevada urban counties are grappling with issues of gang violence. In southern Nevada, particularly Clark County (where Las Vegas is located), gang violence has been a rising concern for youth in the area.[579] In 2019, the U.S. Department of Justice awarded $1.2 million in grants to Nevada to prevent youth in Clark County from joining gangs.[580] Approximately 148 youth in Clark County were reported to be in a gang in 2017. Almost half of those youth were Black or African American (45%) or Hispanic (44%). White youth made up five percent of the gang population, followed by Asian/Pacific Islander youth (3%), and youth of other races or ethnicities (3%).[581]

In northern Nevada, Washoe County (where Reno is located) has experienced a 30 percent increase in gang membership between 2007 and 2016. Currently, 15 to 20 active gangs are reportedly operating in the Reno region. While the rate of gang-related crimes remains steady, the number of organizations is growing. As of April 2016, there were an estimated 1,200 active and known gang members in Washoe

[569] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[570] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[571] Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.
[572] University of Nevada, Reno. *2017 Youth Risk Behavior Survey Results - Nevada High School Survey: 10-Year Trend Analysis Report*.
[573] National Children's Health Survey. (2018). Indicator 7.2. Does this child live in a safe neighborhood?
[574] National Children's Health Survey. (2018). Indicator 7.3. Is this child safe at school, age 6-17 years?
[575]Nevada Department of Health & Human Services, Division of Child & Family Services. (n.d.). Juvenile Justice Services. Retrieved from http://dcfs.nv.gov/Programs/JJS/.
[576] Nevada Department of Health & Human, Division of Child & Family Services. (n.d.). Youth Parole Bureau Data. Retrieved from http://dcfs.nv.gov/Programs/JJS/Youth_Parole_Bureau_Data/.
[577] Division of Child & Family Services. "Youth Parole Bureau Data."
[578] Nevada Department of Health & Human, Division of Child & Family Services. (n.d.). Youth Parole Bureau Data. Retrieved from http://dcfs.nv.gov/Programs/JJS/Youth_Parole_Bureau_Data/.
[579] Minarek, Cassandra. "Gang Activity Possibly on the Rise Among Valley Kids in Las Vegas." *KVVU-TV*, 15 Aug. 2019, https://www.fox5vegas.com/news/gang-activity-possibly-on-the-rise-among-valley-youths/article_d8ee9800-bfe0-11e9-b408-9b1ab6395745.html.
[580] Shoro, M. 2019, March 13. $1.2M grant aims to suppress gangs in Southern Nevada. The Las Vegas Review Journal, available at https://www.reviewjournal.com/crime/1-2m-grant-aims-to-suppress-gangs-in-southern-nevada-1617466/.
[581] Statistical Report Calendar Year 2017. Clark County, Nevada, Department of Juvenile Justice Services. 2018.

County. In response, agencies such as the Reno and Sparks Police Departments, the Washoe County Sheriff's Office, and the local school district have created a regional gang unit. [582]

In 2016, unintentional injury, suicide, and homicide made up 28 percent of all child deaths (ages zero to 17 years) in Nevada. Among these, male children and adolescents experience increased death rates from asphyxia (61%), motor vehicle accidents (64%), homicides (60%), and non-homicide abuse/neglect (58%), while females had slightly higher rates of drowning (60%) and suicide (55%).[583] Between 2015 and 2017, male adolescents (ages 10 to 19 years) in Nevada also experienced a general mortality rate almost two times higher (47.2 per 100,000) than the rate experienced by females (24.3 per 100,000). The NVSS shows the majority of deaths between 2015 and 2017 occurred in the 15 to 19 years age group (55.7 per 100,000) compared to the rate for those ages 10 to 14 years (17.6 per 100,000).[584]

A disproportionate number of Black or African American adolescents are affected by non-homicide abuse and neglect (40%), homicide (30%), asphyxia (25%), and motor vehicle accidents (21%) compared to the statewide population of Black or African Americans (10%).[585] Between 2015 and 2017, Hispanic adolescents experienced the lowest adolescent mortality rate for those ages 10 to 19 years (28.9 per 100,000), followed by Asian/Pacific Islanders (31.7 per 100,000), non-Hispanic Whites (40.3 per 100,000), and non-Hispanic Black or African Americans (47.8 per 100,000).[586]

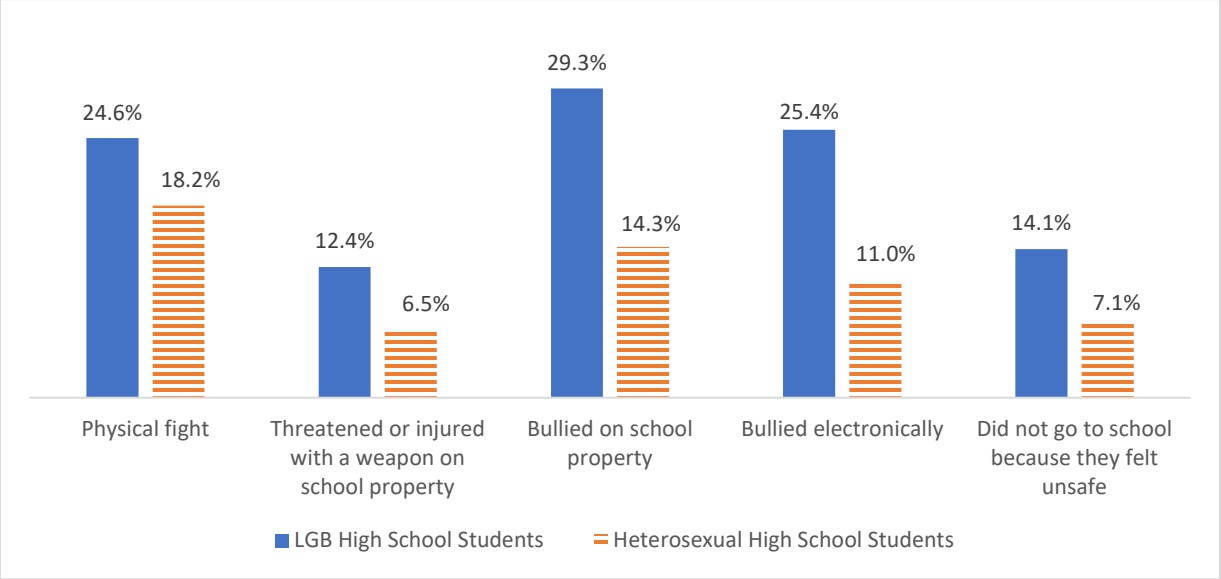
Among violence-related behaviors, Native Hawaiian/Pacific Islander middle school students and American Indian/Alaska Native high school students were most at risk for being threatened or injured by someone with a weapon on school property (8.6% and 16%, respectively).[587, 588] However, Hispanic/Latino students experienced the highest number of violent incidents (126 middle school students and 171 high school students).[589,590] Female students experienced higher rates of bullying on school property (25.5% vs. 20% of male middle school students and 19.3% vs. 13.9% of male high school students), and an even greater disparity exists for their exposure to electronic bullying (18.9% vs. 9% of male middle school students and 16.5% vs. 9.9% of male high school students).[591,592] Students of color in both middle and high school, with the exception of Asian students, experienced higher incidences of not going to school because they felt unsafe at school or on their way to or from school.

High school students who identify as LGB were more likely to be involved in a physical fight (24.6%), be threatened or injured with a weapon on school property (12.4%), be bullied on school property or

[582] Hernandez, Ricio. (2016, May 25). Tackling the Growth of Gangs in Reno. KUNR. Retrieved from https://www.kunr.org/post/tackling-growth-gangs-reno#stream/0.
[583] The Executive Committee to Review the Death of Children. *2016 Statewide Child Death Report*.
[584] National Vital Statistics System. (2019). National Outcome Measure 16.1: Adolescent mortality rate ages 10 through 19 per 100,000.
[585] National Vital Statistics System. (2019). National Outcome Measure 16.1: Adolescent mortality rate ages 10 through 19 per 100,000.
[586] National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.
[587] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[588] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[589] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[590] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.
[591] Lensch, T., et al. (2017). 2017 Nevada Middle School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5001.
[592] Lensch, T., et al. (2017). 2017 Nevada High School Youth Risk Behavior Survey (YRBS) Report. State of Nevada, Division of Public and Behavioral Health and the University of Nevada, Reno, 2018. Retrieved from https://scholarworks.unr.edu//handle/11714/5007.

electronically (29.3% and 25.4%), and not go to school because they felt unsafe at school or on their way to or from school (14.1%), when compared to their heterosexual peers (Figure 99).[593]

Figure 99. Proportion of Nevada Students Experiencing Violence and Victimization by Sexual Identity, 2017[594]



Finally, between 2015 and 2017, geographic residence of adolescents ages 10 to 19 years living in rural areas correlated with a higher adolescent mortality rate at 46.4 deaths per 100,000 adolescents, compared to those living in large central urban areas (34.4 per 100,000) and small/medium urban areas (37.8 per 100,000).[595]

Community Voices on Adolescents/Young Adults

The most significant issues on the rise for U.S. youth are anxiety and depression, according to the Pew Research Center. Seventy percent of youth ages 13 to 17 years reported anxiety and depression as a major problem, followed by bullying, drug addiction, drinking alcohol, poverty, teen pregnancy, and gangs. Some of the stressors teens face include pressure to get good grades, look good, fit in socially, and be involved in extracurriculars.[596] While anxiety and depression cross income brackets, teen pregnancy and poverty were perceived as bigger issues to teens living in households with annual incomes of less than $30,000. Approximately two in five teens living in lower income households report they spend too little time with their parents compared to only one in five teens living in higher income households.[597] While Nevada has unique characteristics and demographics, many teens across the state face the same issues and pressures as their peers across the country. This can be seen in the data captured above, as well as through key interviews with stakeholders, parents, providers, community members, and teens. Stakeholders participating for this report have a strong sense of the challenges facing adolescents/young adults in Nevada, including:

[593] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[594] Lensch, T., et al. *2017 Nevada High School Youth Risk Behavior Survey (YRBS): Sexual Identity Special Report*.
[595] National Vital Statistics System. (2019). National Outcome Measure 16.2: Adolescent motor vehicle mortality rate ages 15 through 19 per 100,000.
[596] Horowitz, J. M., & Graf, N. *Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers*.
[597] Horowitz, J. M., & Graf, N. *Most U.S. Teens See Anxiety and Depression as a Major Problem Among Their Peers*.

1. Respondents perceived the rates of substance use among adults and teens to be significant and having a large impact. Easy access, peer pressure, lack of parental monitoring and involvement, and boredom are seen as leading teens to turn to vaping, heroin, alcohol, marijuana, opioids, and prescription drugs, and were thought to be driving up crime, suicide, mental health issues, truancy, unemployment, and child placements to foster care.
2. LGBTQ youth experience high levels of bullying and violence, homelessness, fear, and mental health issues. Additionally, there are few schools or organizations engaging in LGBTQ-specific sexual health education inclusive of their needs and concerns putting them at greater risk due to a lack of information, role modeling, and support.
3. Generally high rates of domestic and dating violence, as well as high suicide rates, are also factors for concern, with some adolescents experiencing toxic home environments.
4. Youth in rural areas experience social isolation since many have both parents working outside of the home and are geographically isolated from other people and resources.
5. These youth have a hard time finding jobs, particularly in areas where the work is centered around alcohol and gambling (meaning they need to be 21 years of age) and so turn to sex work for income, which is linked to issues of trafficking.
6. Many teens have friends who are sexually active, or who they believe to be, playing into the issue of peer pressure and perceived norms around the acceptance of having sex at a young age. Additionally, most teens have easy access to pornography, which can provide them with incorrect, unhealthy messages about relationships and sex.

> "For our teens, the struggle is keeping them engaged; we do have activities and they do come out for them, but they happen maybe once a month so the rest of the time what are the kids doing?" – *Focus Group Participant*

Children and Youth with Special Health Care Needs

Children and youth with special health care needs (CYSHCN) are those children who have, or are at increased risk for any chronic physical, developmental, behavioral, or emotional condition and thus often require health and related services of a type or amount beyond what is needed for most children. This can include physical, intellectual, and developmental disabilities (IDD), but also chronic medical conditions such as asthma, diabetes, behavioral or mental health issues, or muscular dystrophy, as well as homelessness, poverty, and foster system involvement.[598]

This section focuses on overall health status, access to health care, special services, and chronic disease prevention, including obesity and physical activity, and safety for CYSHCN. Table 62 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.*S.*, and where MCH and MIECHV program might prioritize its efforts, if not doing so already.

Table 62. Summary of Indicators for CYSHCN Health, Nevada and United States

[598] Centers for Disease Control and Prevention. (2019, November 1). Children with Special Healthcare Needs. Retrieved December 12, 2019 from https://www.cdc.gov/childrenindisasters/children-with-special-healthcare-needs.html.

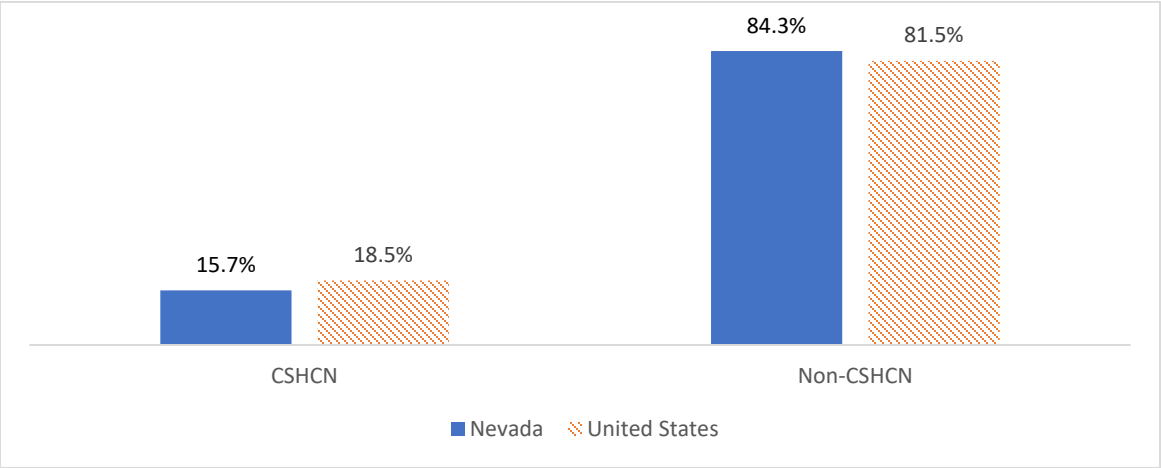
Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Health Status	Percent of children considered in poor health in Nevada as described by their parents (2018)[599]	12.1%	5.9%	✓
Access to Health Care	Percent of CYSHCN who receive care in a well-functioning system (2017)[600]	5.9%	13.9%	✓
Access to Health Care	Percent of CYSHCN who were continuously and adequately insured (2018)[601]	54.5%	62.3%	✓
Access to Health Care	**Percent of CYSHCN reported to have a medical home (2017)[602]**	**26.3%**	**43.4%**	✓
Access to Special Services	Percent of CYSHCN who received special services to meet their developmental needs, such as speech, occupational, or behavioral therapy (2018)[603]	30.9%	27.7%	Ø
Chronic Disease	Percent of CYSHCN, ages 10 to 17 who were obese (2018)[604]	17.7%	19.5%	Ø
Chronic Disease	Percent of CYSHCN, ages 6 to 11, who were physically active at least 60 minutes per day in the previous week (2018)[605]	26.3%	26.5%	✓
Chronic Disease	Percent of CYSHCN, ages 12 to 17, who were physically active at least 60 minutes per day in the previous week (2018)[606]	22.8%	15.1%	Ø
Safety	Percent of CYSHCN reported being bullied (2017)[607]	39.2%	37.8%	✓

Demographics of CYSHCN

Based on the National Survey of Children's Health (NSCH) results collected in 2017 and 2018, it is estimated 15.7 percent of Nevada children ages zero to 17 years have a special health care need; the NSCH also estimated 18.5 percent of children nationwide have a special health care need (Figure 100).[608]

[599] National Children's Health Survey. (2018). National Outcome Measure 19: Overall health status.
[600] National Children's Health Survey. (2017). National Outcome Measure 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.
[601] National Children's Health Survey. (2018). National Performance Measure 15: Adequate and continuous insurance.
[602] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[603] National Children's Health Survey. (2017). Indicator 4.11: Special services for developmental needs.
[604] National Children's Health Survey. (2018). National Outcome Measure 20: Percent of adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile).
[605] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.
[606] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day.
[607] National Children's Health Survey. (2018). National Performance Measure 9: Percent of adolescents, ages 12 through 17, who are bullied.
[608] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.

Figure 100. Prevalence of Children with Special Health Care Needs, Nevada and United States, 2016/17[609]



The number of CYSHCN per 1,000 enrolled students varies by county, with a high of 154.2 per 1,000 enrolled students in Humboldt County to a low of 61.6 per 1,000 enrolled students in Eureka County (Table 63). The type of disability also varies, with learning disabilities being the most prevalent types of special needs reported, with particularly high proportions in Pershing County (Table 63).

Table 63. Number of Children with a Disability per 1,000 Enrolled Students in Nevada by County of Residence, 2017[610]

Region/County	Autism Spectrum Disorder	Develop-mentally Delayed or IDD	Emotional Disturbance	Learning Disability	Speech/ Language/ Hearing Impairment	Other Impairment Disabilities	Total
Churchill	11.3	21.0†	1.8*	84.8	23.5	5.9*	146.4
Douglas	10.8	12.1	2.5	57.8	30.8	22.3	136.4
Elko	7.0*	14.1	2.0	58.9	24.0	10.7	116.8
Esmeralda	-	-	-	-	-	-	-
Eureka	-	-	-	61.6	-	-	61.6*
Humboldt	16.2	18.5	5.3†	80.6	26.5	7.1	154.2†
Lander	-	13.9	-	52.8	30.9	-	97.6
Lincoln	-	16.6	2.9	68.2	47.0†	-	131.8
Lyon	12.6	15.7	-	44.8*	35.6	26.0†	137.5
Mineral	21.2†	-	-	61.8	27.0	-	110.0
Nye	11.3	19.9	7.8	79.3	14.7	13.5	146.5
Pershing	-	20.7	-	105.3†	17.5	-	143.5
Storey	10.8	12.1	2.5	94.1	28.2	22.3	122.4

[609] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.
[610] Nevada Rural and Frontier Health Data Book, 9th Edition. (2019). Table 4.20: Childhood Disability in Nevada by County of Residence – 2017

Region/County	Autism Spectrum Disorder	Develop-mentally Delayed or IDD	Emotional Disturbance	Learning Disability	Speech/ Language/ Hearing Impairment	Other Impairment Disabilities	Total
White Pine	-	18.7	-	66.2	16.5*	23.0	124.5
Carson City	8.8	14.2	1.8*	60.4	37.5	19.4	142.2
Clark	18.8	18.2	4.4	53.1	17.5	10.3	122.4
Washoe	13.2	16.9	4.0	64.0	22.5	17.7	125.8
Nevada - Total	16.4	16.6	4.1	54.0	19.6	12.0	122.6

*† indicates a high rate of children living with a disability per 1,000 enrolled students. * indicates a low rate.*

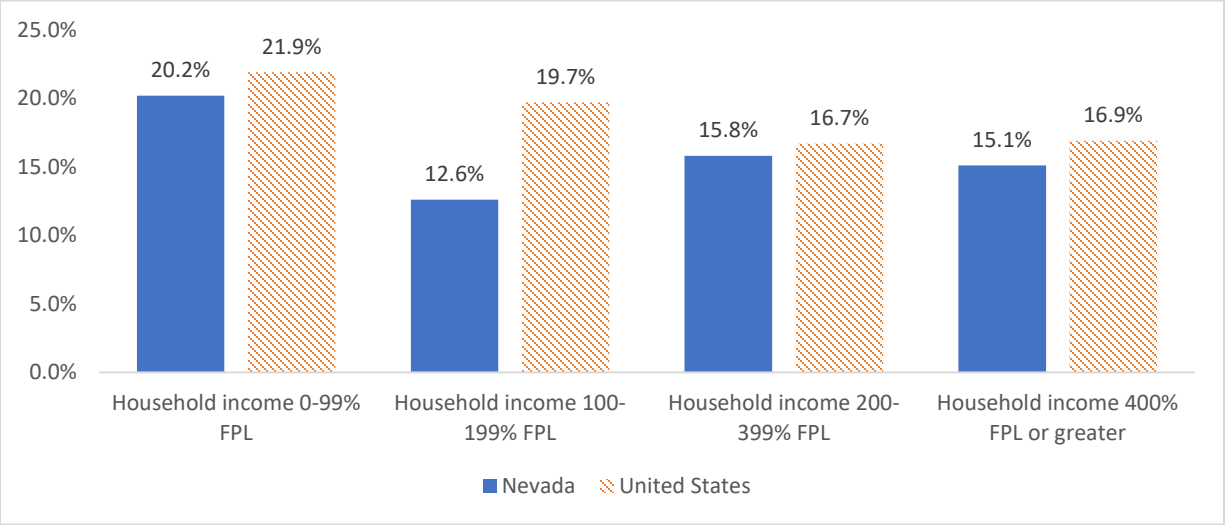
Among all Nevada children, 19.6 percent of males and 11.7 percent of females have a known special health care need. Among race and ethnicity groups, 17.3 percent of White children have a special health care need, followed by 15.7 percent of children who identify as another race and 14.3 percent of Hispanic children (sample sizes were too small to yield reliable estimates for each racial/ethnic group). CYSHCN in Nevada tend to be identified when they are older, with only 13.2 percent of children ages zero to five years identified as having a special health care need. The highest numbers of CYSHCN are ages 12 to 17 years (18.9%) (Table 64).[611] Additionally, almost one third of the Nevada children who have a special health care need (32.8%) live in a household with an annual income below 200 percent FPL (Figure 101).[612]

Table 64. Age Distribution of CYSHCN Population, Nevada and United States, 2017-2018[613]

Location	0 to 5 years	6 to 11 years	12 to 17 years
Nevada	13.2%	15.05	18.9%
United States	10.3%	20.6%	24.2%

[611] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.
[612] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.
[613] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.

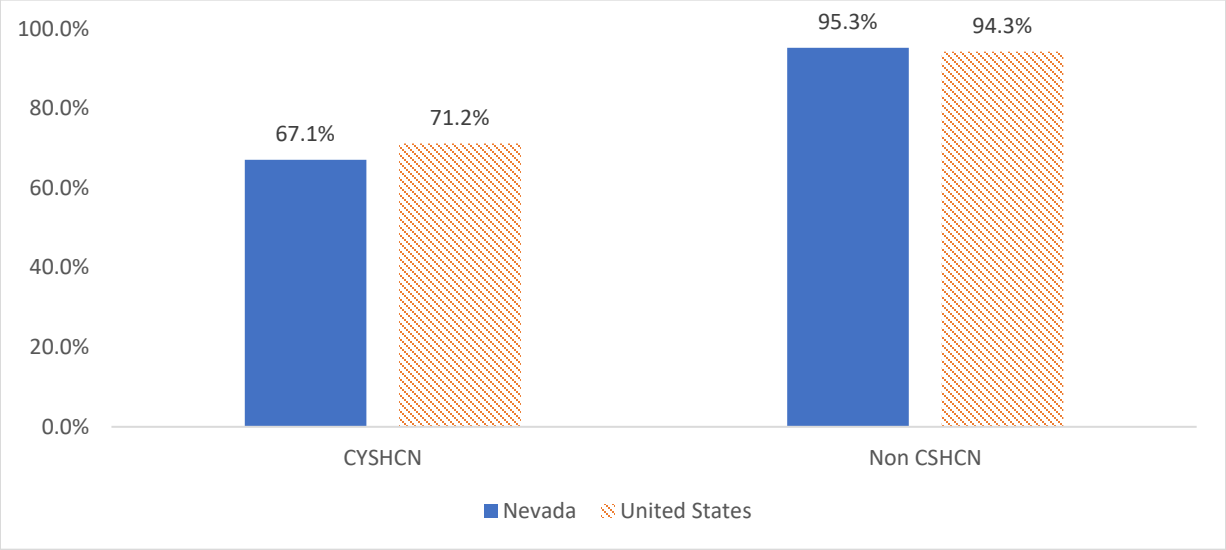
Figure 101. Distribution of Income Levels for Families of CYSHCN in Nevada and United States, 2017-2018[614]



Health Status

In 2017 and 2018 in Nevada, 2.4 percent of children were considered in poor health as described by their parents, higher than the national rate of 1.4 percent. Among CYSHCN in Nevada, this rate is 12.1 percent, approximately twice the national rate of 5.9 percent. A strong majority of (95.3%) Nevada children without special health care needs were reported to be in excellent or very good health compared to only two-thirds (67.1%) of CYSHCN (Figure 102).[615] CYSHCN in Nevada are also less likely to be reported as in excellent or very good health compared to their peers nationwide (71.2%).[616]

Figure 102. Child's Health (Zero to 17 Years) Described as Excellent or Very Good, Nevada and United States, 2017-2018[617]



[614] National Children's Health Survey. (2018) Indicator 1.11: Children and youth with special health care needs.
[615] National Children's Health Survey. (2018). National Outcome Measure 19: Overall health status.
[616] National Children's Health Survey. (2018). National Outcome Measure 19: Overall health status.
[617] National Children's Health Survey. (2018). National Outcome Measure 19: Overall health status.

Access to Health Care

The percent of Nevada children ages zero to 17 years who were continuously and adequately insured in 2017-18 was lower among CYSHCN (54.5%) compared to non-CYSHCN (65%).[618] A similar trend is seen nationwide with 54.5 percent of CYSHCN continuously and adequately insured compared to 68.7 percent of non-CYSHCN.[619] Among CYSHCN in Nevada, 6.9 percent were not able to obtain needed health care in 2016-17 (much higher than non-CYSHCN at 1.9%)[620] and 32.4 percent of adolescents with special health care needs had no preventive care or wellness visit with a doctor or other health care professional in 2016-17 (compared to only 10.3% among non-CYSHCN).[621] Finally, 27.1 percent of CYSHCN in Nevada received no dental services in 2016-17 (compared to 23.2% among non-CYSHCN).[622]

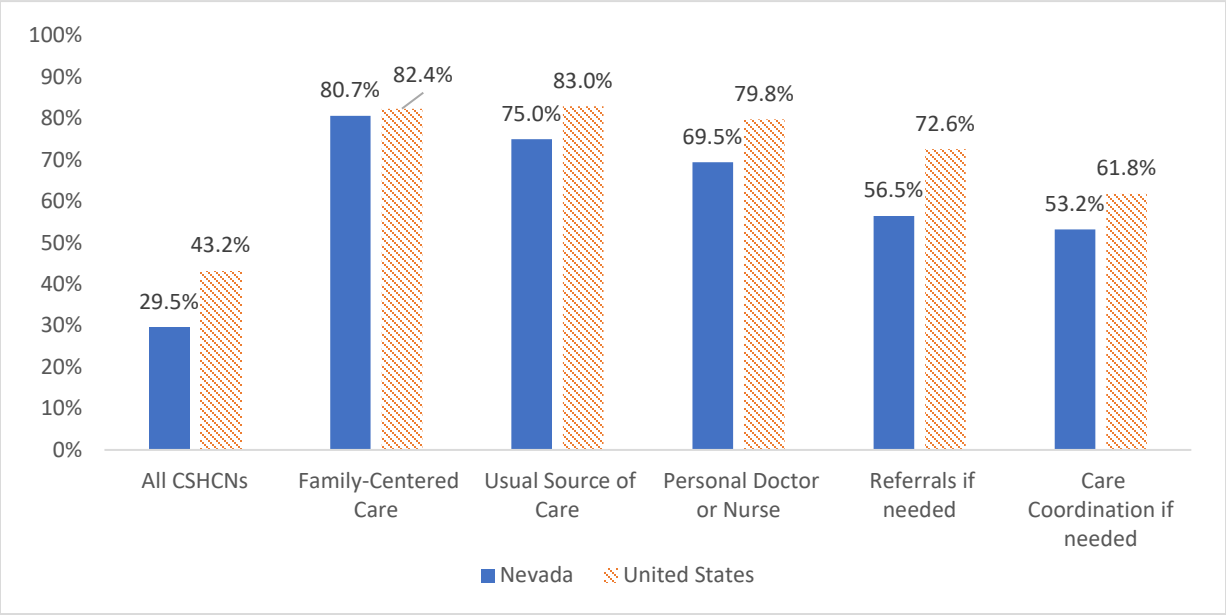
Medical homes for children help ensure they can receive consistent and comprehensive care. The percentage of CYSHCN reported by their parents to have a medical home is lower in Nevada compared to the U.S. (and lower than for non-CYSHCN). In Nevada between 2017 and 2018, 26.3 percent of CYSHCN were reported to have a medical home (compared to 29.5% of non-CYSHCN), much lower than the 43.4 percent of CYSHCN with a medical home across the U.S. (Figure 103). The extent to which children have health insurance impacts the extent to which they have a medical home. CYSHCN in Nevada with private insurance are more than twice as likely to have a medical home compared to those with Medicaid (38.2% and 15.2%, respectively).[623,624]

In 2016-17, the most recent years for which disaggregated data is available, CYSHCN in Nevada were more likely to experience family centered care (80.7%). The American Academy of Pediatrics (AAP) defines Family Centered Care (FCC) as a partnership between patients, families, and health professionals to support and help families to make informed decisions regarding their children's health. This comprehensive care paradigm focuses on empowering families to participate at all levels of decision making, having physicians providing culturally competent health care delivery, and improving outcomes and satisfaction.[625]

The second most common component of a medical home among 75 percent of CYSHCN is having a usual source of care. The prevalence of CYSHCN having a personal doctor or nurse, referrals, or care coordination, if needed, is much lower in Nevada than across the U.S. (75% vs 83%). Fewer Nevada children with special health care needs have access to a personal doctor or nurse compared to in the U.S. (69.5% and 79.8%, respectively), receive fewer referrals (56.5% and 72.6%, respectively), and receive less care coordination (53.2% and 61.8%, respectively).[626]

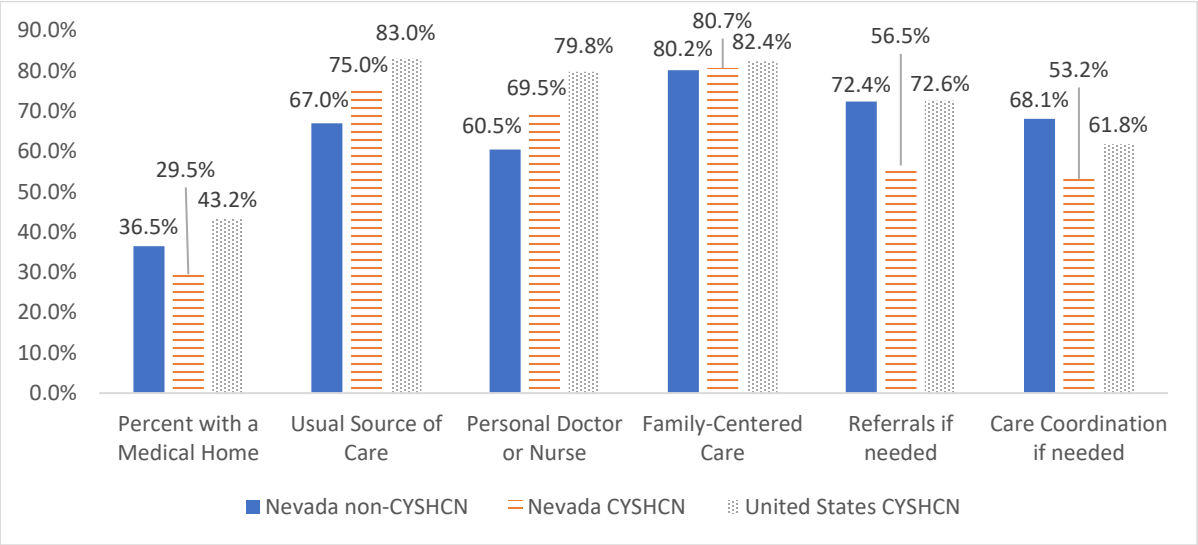
[618] National Children's Health Survey. (2018). National Performance Measure 15: Adequate and continuous insurance.
[619] National Children's Health Survey. (2018). National Performance Measure 15: Adequate and continuous insurance.
[620] National Children's Health Survey. (2017). National Outcome Measure 25: Forgone health care.
[621] National Children's Health Survey. (2017). National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
[622] National Children's Health Survey. (2017). National Performance Measure 13.2: Preventive dental visit, age 1-17 years.
[623] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[624] Percent of children with a medical home on Medicaid should be interpreted with caution.
[625] Committee on Hospital Car and Institute for Patient- and Family-Centered Care. Patient- and Family-Centered Care and the Pediatrician's Role. Pediatrics. February 2012, 129 (2) 394-404; doi: 10.1542/peds.2011-3084
[626] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Figure 103. Percent of Children with Special Health Care Needs, Ages Zero to 17, Who Have a Medical Home, by Care Component, Nevada and United States, 2016-2017[627]



Within Nevada, there are disparities in access to and the type of medical home between children with or without special health care needs. Fewer CYSHCN are given referrals or care coordination, if needed, compared to non-CYSHCN (Figure 104).[628] However, CYSHCN are more likely to have a usual source of care, personal doctor or nurse, and family centered care, relative to non-CYSHCN.

Figure 104. Percent of Children With or Without Special Health Care Needs, Ages Zero Through 17, Who Have a Medical Home and Component, Nevada, 2016-2017[629]



[627] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[628] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[629] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

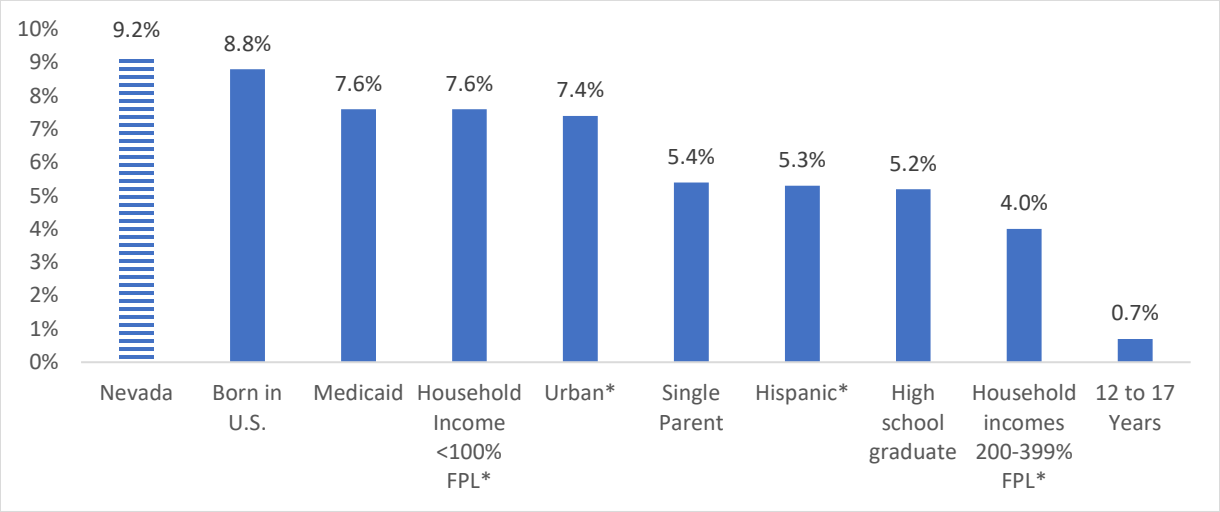
There is also disparity in access to a medical home by age group (Table 65). Between 2017 and 2018, the percent of children ages six to 11 years and 12 to 17 years with a medical home was nearly twice as high as the rate for children ages zero to five years. Compared to children without special needs, the age group with the greatest disparity are those ages zero to five years.[630]

Table 65. Percent of Children with and Without Special Health Care Needs, Ages Zero Through 17, Who Have a Medical Home, Nevada, by Age Group[631]

Age Group	Percent of Children with Special Needs with a Medical Home	Percent of Children without Special Needs with a Medical Home
0-5 Years	16.3	40.8
6-11 Years	29.3	41.3
12-17 Years	31.4	44.7

Finally, among CYSHCN, the likelihood of receiving care in a well-functioning system was lower in Nevada compared to the U.S. between 2017 and 2018. In Nevada, only 5.9 percent of CYSHCN received care in a well-functioning system compared to 13.9 percent nationwide. This means a child is receiving care including a medical home, family partnership, early screenings, adequate insurance, easy access to services, and preparation for adult transition from a pediatrician. [632] While data should be interpreted with caution, some risk factors appear to be associated with having a lower probability of receiving care in a well-functioning system (Figure 105). The greatest of these is being an adolescent aged 12 to 17 years, followed by family income level and educational achievement. CYSHCN of single mothers are less likely than other CYSHCN across the state to receive care in a well-functioning system.[633]

Figure 105. Percent of CYSHCN Receiving Care in a Well-Functioning System, by Risk or Disparity Factor, Nevada, Risk or Disparity Factors for Not Receiving Care in Well-Functioning System, Nevada, 2017-2018[634]



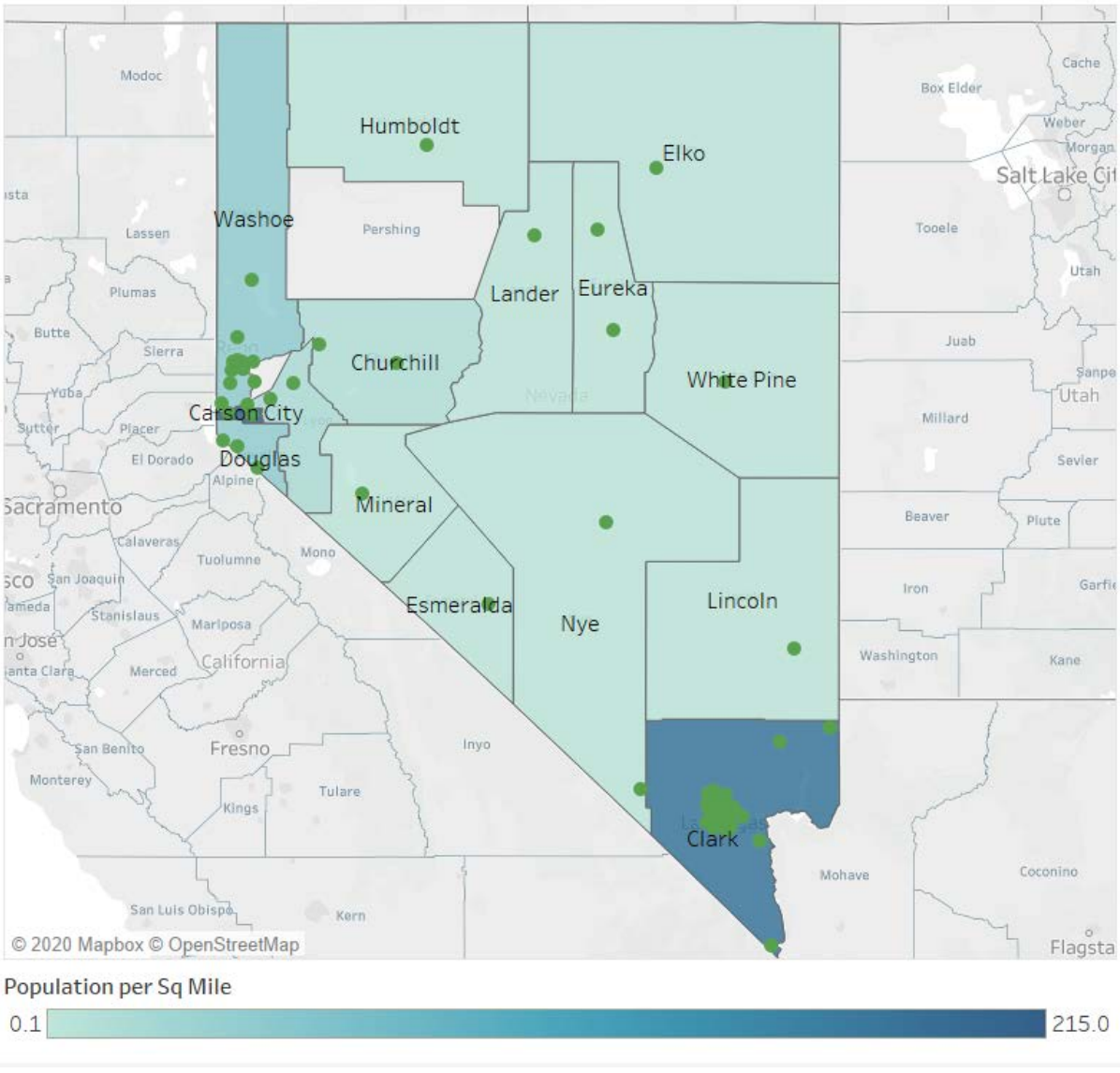
**These measures must be interpreted with caution.*

[630] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[631] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[632] National Children's Health Survey. (2017). National Outcome Measure 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.
[633] National Children's Health Survey. (2017). National Outcome Measure 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.
[634] National Children's Health Survey. (2017). National Outcome Measure 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system.

Access to Special Services

Children in Nevada experience a lower prevalence of receiving special services to meet their developmental needs such as speech, occupational, or behavioral therapy compared to children nationwide. In Nevada in 2017-18, six percent of all children received special services, compared to 7.6 percent of children nationwide. [635] Among CYSHCN in Nevada, 30.9 percent currently receive special services to meet their developmental needs, higher than the rate nationally (27.7%) (Figure 106). As children age, the percent of CYSHCN adolescents ages 12 to 17 years who receive services necessary to make transitions to adult health care is expected to reach 10.3 percent, or one in 10 adolescents. This is lower than for adolescents nationwide (18.9%), or closer to one in five CYSCHN adolescents. [636]

Figure 106. Map of Organizations Serving CYSHCN in Nevada, by Zip Code, Compared to Population per Sq. Mile by County, 2019[637]



[635] National Children's Health Survey. (2017). Indicator 4.11: Special services for developmental needs.
[636] National Children's Health Survey. (2018). National Performance Measure 12: Percent of adolescents with special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care.
[637] Nevada Medical Home Portal. (n.d.). Services Directory. Retrieved December 11, 2019 from https://nv.medicalhomeportal.org/services.

Obesity and Physical Activity

Among CYSHCN ages 10 to 17 years in Nevada, 17.7 percent were obese in 2017-18 (higher than non-CYSHCN at 12.9%). Nationwide, 19.5 percent of CYSHCN are obese, compared to 14 percent of non-CYSHCN.[638] A similar trend is seen regarding the percent of CYSHCN who are physically active. Nevada data suggest 11.8 percent of CYSCHN adolescents ages 12 to 17 years are physically active at least 60 minutes per day, lower than for the 18 percent of those without special health care needs. Nationally, 15.1 percent of CYSHCN exercise at least 60 minutes per day, compared to 18.3 percent of non-CYSHCN.[639] Among younger children ages six to 11 years, this disparity is greater. Overall, 26.3 percent of CYSHCN are physically active at least 60 minutes per day compared to 25.4. percent of non-CYSHCN.[640]

Safety

In 2017 in Nevada, 14.9 percent of all adolescents ages 12 to 17 years were reported as being bullied, picked on, or excluded by other children (lower than the national rate of 21%). For CYSHCN in Nevada, 39.2 percent reported being bullied in 2017, much higher than the 6.3% among non-CYSHCN. A similar disparity is seen nationwide, with 37.8 percent of CYSHCN reporting being bullied in 2017 compared to only 15.3 percent of non-CYSHCN.[641]

Community Voices on CYSHCN

Community voices report the top issues for CYSHCN are:

- CYSHCN ranked third among MCH population groups who were thought to be "least likely get the services and supports they needed when they need them" according to MCH professionals and providers responding to community survey;
- Lack of adequate access to specialty medical care (genetics, pediatric neurology, child psychiatry, developmental-behavioral pediatrics, etc.);
- Navigation of the system of care for CYSHCN;
- Lack of social, ethical, emotional, physical, and cognitive skills needed during adolescence and to transition into adulthood; and
- Mental health (i.e., anxiety, depression, etc.).

> "There is a lack of providers in the community comfortable with special health care needs among children." *– MCH professional and provider*

A general concern from community members regarding issues facing CYSHCN is the lack of coordination and funding across the state, with key **informants indicating there are too many silos, different areas of the government not collaborating, and a lack of understanding of where services are and how to get connected to them (i.e., respite care).** Key informants reported a perception providers are not fully aware of resources in their community to which families can be referred, and families **often rely on word of mouth to find services they need.**

[638] National Children's Health Survey. (2018). National Outcome Measure 20: Percent of adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile).
[639] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day.
[640] National Children's Health Survey. (2018). National Performance Measure 8.2: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.
[641] National Children's Health Survey. (2018). National Performance Measure 9: Percent of adolescents, ages 12 through 17, who are bullied.

Another concern is the way families access services or become eligible for services. For example, **access to mental health services** for CYSHCN was highlighted as a community gap by both focus group and key informant participants, particularly among children without an autism diagnosis. Parents in focus groups expressed facing challenges with being seen by a psychiatrist who specializes in anything other than autism. Key informants noted positively the extensive advocacy for services for children with autism; however, other developmental diagnoses do not have the same attention or magnitude of services. Key informants suggested children "are left out in the cold because they don't have the autism label, which is the 'doorway into services'".

Women's Health

Women's health is an important predictor of an overall population's health, not only because it affects a large portion of the population, but also because of its effects on the health of future generations. This section focuses on the physical, behavioral, and sexual health of women of childbearing age (defined here as women ages 15 to 44 years), including access to care, chronic disease, mental health, and substance use. It also focuses on wellbeing, including mortality, unintentional injury, and violence.

Table 66 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.S., and where MCH and MIECHV programs might prioritize efforts, if not doing so already.

Table 66. Summary of Key Indicators for Women's Health, Nevada and United States

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Physical Health	Percent of women who reported their general health as good, very good, or excellent (2018)[642]	76.5%	80.6%	✓
Wellness / Access to Health Care	**Percent of women with a past year preventive visit (2017)[643]**	**63.9%**	**65.6%**	✓
Wellness / Access to Health Care	Percent of women who needed but could not see a doctor because of cost in past 12 months (2018)[644]	17.4%	14.2%	✓
Chronic Disease	Percent of women (age 18 to 44) told they have diabetes (2018)[645]	3.8%	3.3%	Ø

[642] Behavioral Risk Factor Surveillance System. (2018). General health status. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[643] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
[644] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[645] Centers for Disease Control and Prevention and Prevention. (2018, April 16). Diabetes and Women. Retrieved December 10, 2019 from https://www.cdc.gov/features/diabetes-women/index.html.

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Chronic Disease	Cancer incident rates among women (2012-2016, Average annual rate per 100,000, age adjusted to the 2000 US standard population)[646]	382.0	421.2	Ø
Physical Activity	Percent of women (age 18 to 44) who participated in any physical activities or exercise in the past month (2018)[647]	80.3%	79.2%	Ø
Emotional and Mental Health	Percent of women (age 18 to 44) who reported having 14 or more days when their mental health was not good (2018)[648]	21.6%	17.4%	✓
Emotional and Mental Health	Percent of women (age 18 to 44) ever told they have a depressive disorder, including depression, major depression, dysthymia, or minor depression (2018)[649]	17.8%	24.8%	Ø
Emotional and Mental Health	Number of deaths among females due to intentional self-harm per 100,000 population (2018)[650]	11.0	6.2	✓
Substance Use	Percent of women (age 18 to 44) who are current smokers (2018)[651]	15.1%	16.4%	Ø
Substance Use	Percent of women who used marijuana in the past month (2017)[652]	10.1%	7.0%	✓
Substance Use	Percent of women who reported misuse of prescription pain relievers (2017)[653]	6.7%	5.3%	✓
Sexual Health	Percent of women (age 18 to 49) who reported having used one or more contraceptive methods the last time they had sex with a partner (2017)[654]	68.4%	62.0% to 78.0%	✓
Violence	Homicide rate among women murdered by men per 100,000 (2017)[655]	2.03	1.29	✓

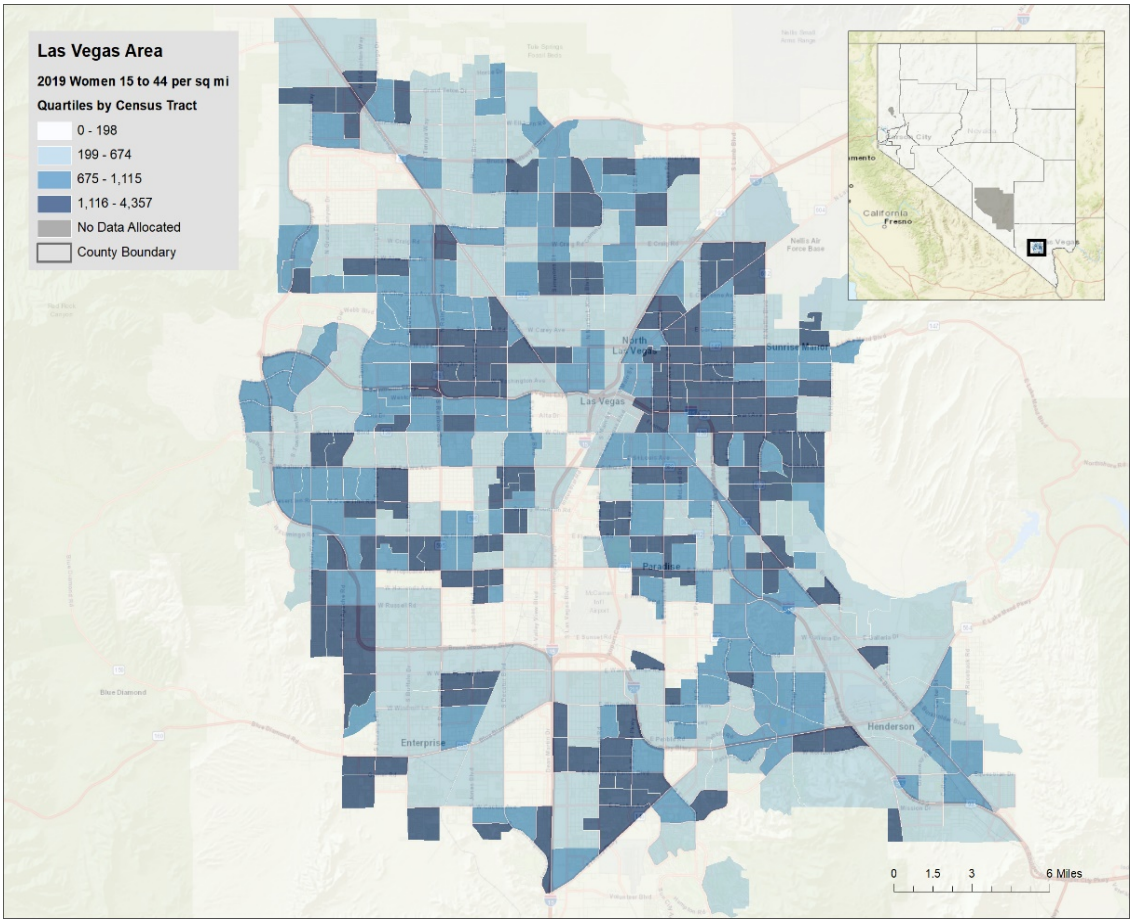
[646] American Cancer Society. (2019). Cancer Statistics Cancer. Estimated new cases, 2019 for women in Nevada. Retrieved December 10, 2019 from https://cancerstatisticscenter.cancer.org/#!/.
[647] Behavioral Risk Factor Surveillance System. (2018). During the past month, any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[648] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for frequent (14+ days) poor mental health. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[649] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[650] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: About Underlying Cause of Death, 1999-2017. Retrieved December 11, 2019 from https://wonder.cdc.gov/ucd-icd10.html.
[651] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[652] National Survey on Drug Use and Health. (2017). Marijuana Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[653] National Survey on Drug Use and Health. (2017). Pain Reliver Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR. This variable captures all pain relivers, not just opioid pain relivers, as breakdown by pain reliver type is suppressed.
[654] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017, New York: Guttmacher Institute. https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.
[655] Violence Policy Center. (2019, September). When Men Murder Women: An Analysis of 2017 Homicide Data.

Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Mortality	Age adjusted injury-related death rate per 100,000 women, ages 15 to 44 (2017)[656]	40.9	38.7	Ø

Demographics of Women Ages 15 to 44

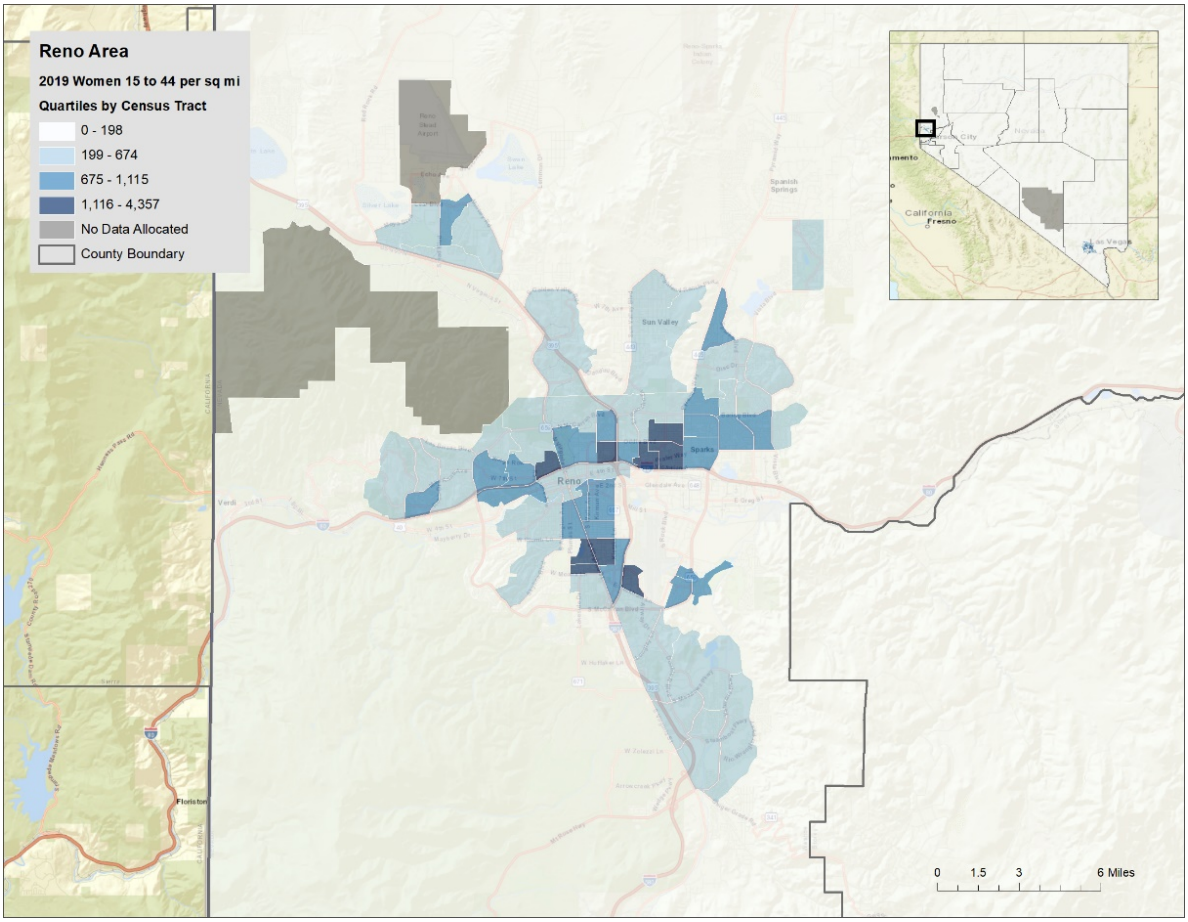
Women ages 15 to 44 years made up 19.7 percent (n=609,668) of Nevada's population in 2019.[657] By 2024, women ages 15 to 44 years are expected to grow in population by 1.8 percent annually.[658] A closer look at high population density areas reveals pockets of communities where women of childbearing age are living. Figure 107 represents the Las Vegas area followed by Figure 108 representing the Reno area. This information suggests areas of potential high need for MCH services among women of childbearing age.

Figure 107. Women of Childbearing Age, by Population Density and Census Tract, Las Vegas Area, 2019[659]



[656] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[657] Esri, 2019.
[658] Esri, 2019.
[659] Esri, 2019.

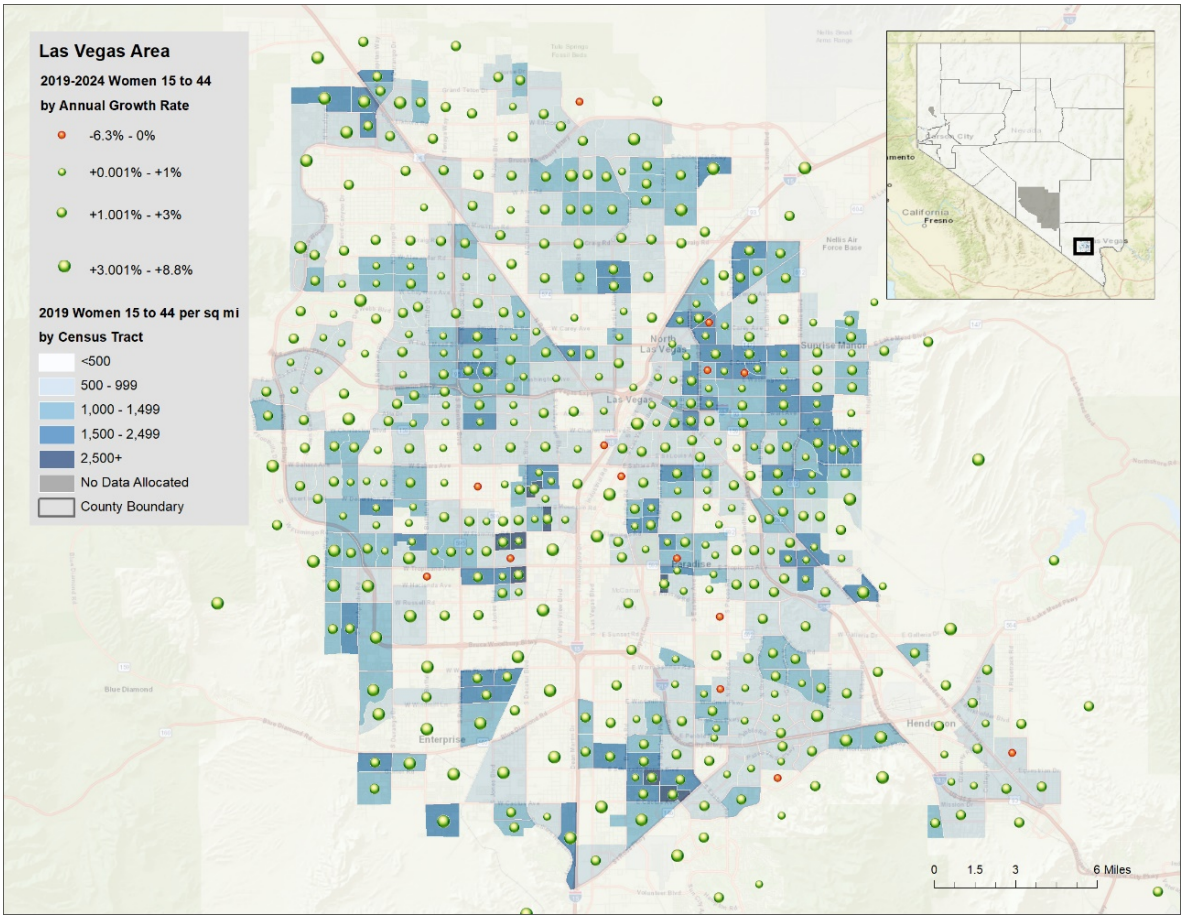
Figure 108. Women of Childbearing Age, by Population Density and Census Tract, Reno Area, 2019[660]



Within the high population density areas, there is variation in where and how much the population of women of reproductive age will grow, as shown in Figures 109 and 110. Generally, growth among this population is expected in both the Las Vegas and Reno areas.

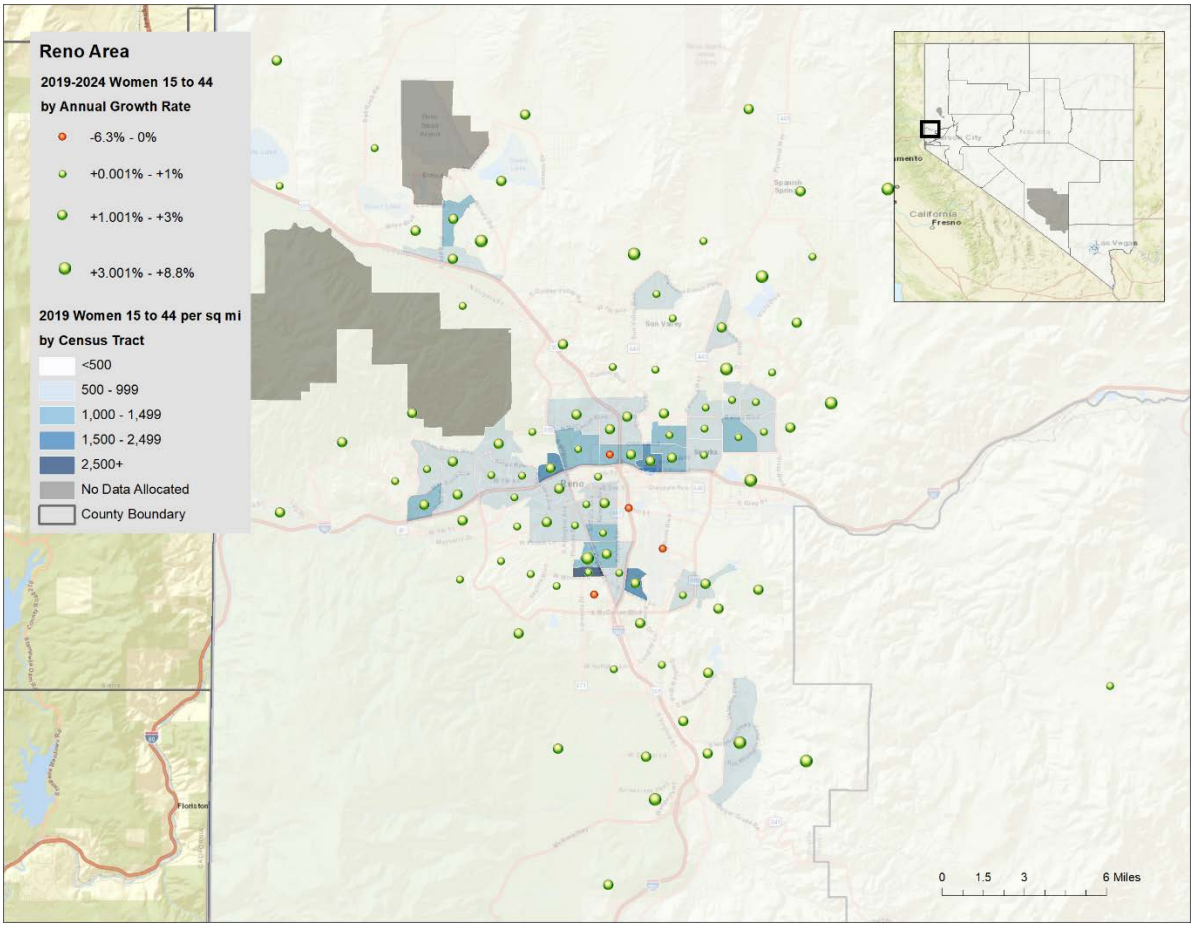
[660] Esri, 2019.

Figure 109. Women Ages 15 to 44 Per Square Mile, by Annual Growth Rate in Las Vegas Area, 2019 to 2024[661]



[661] Esri, 2019.

Figure 110. Women Ages 15 to 44 per square mile, by Annual Growth Rate in Reno Area. 2019 to 2024[662]



Health Status

Good health is an important contributor to an individual's quality of life and general wellbeing, as well as a vital indicator of a population's health. In 2018 in Nevada, 76.5 percent of all women reported their general health as good, very good, or excellent, lower than the percentage of women nationally (80.6%) (Figure 111), and slightly lower than the rate for the general population in Nevada (79.7%).[663]

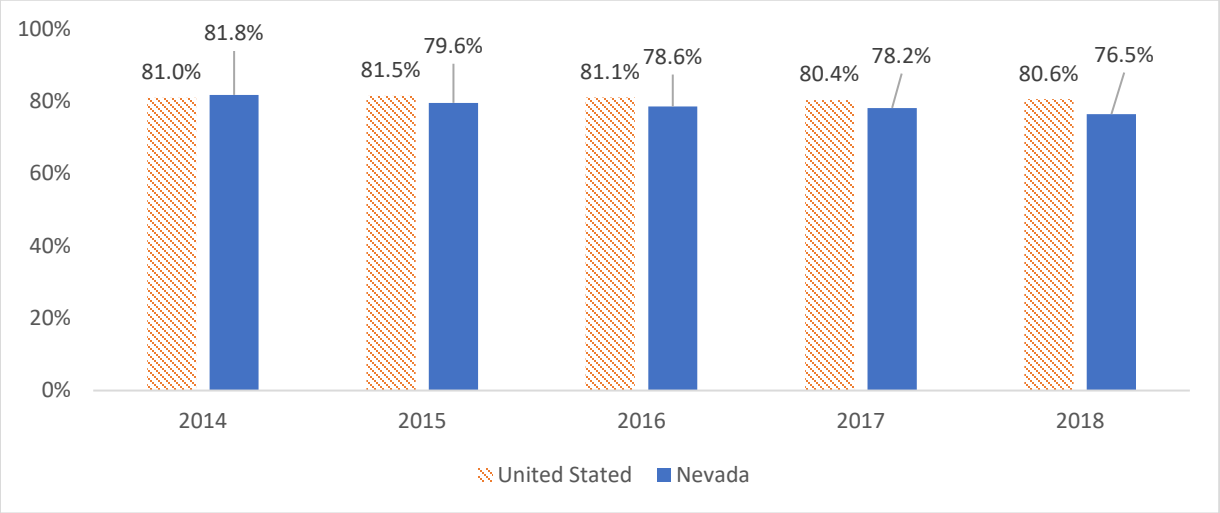
Younger women (18-24 years) were more likely to report good to excellent health than women ages 25 to 44 years, at 88.4 and 85.7 percent, respectively. Good to excellent health was correlated with both education and income. Women with higher levels of education (i.e., college graduates) were most likely to report good to excellent health (85.9% in 2018). Women who were not high school graduates were least likely to report good to excellent health (30.4% in 2018).

Likewise in 2018, 92.7 percent of women in the highest income group ($75,000+) reported good to excellent health compared to 29.8 percent of women in the lowest income level (< $15,000).[664] White non-Hispanic women were most likely to report good to excellent health (80% in 2018), with Black or

[662] Esri, 2019.
[663] Behavioral Risk Factor Surveillance System. (2018). General health status. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[664] Behavioral Risk Factor Surveillance System. (2018). General health status. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

African American non-Hispanic women least likely at 57.9 percent. Almost 70 percent of Hispanic women reported good to excellent health (68.1% in 2018), while data were not available for American Indian, Asian, or Native Hawaiian and other Pacific Islander women in 2018.[665]

Figure 111. Percentage of Women Reporting Good to Excellent Health, Nevada and United States, 2014 to 2018[666]



Access to Health Care Services

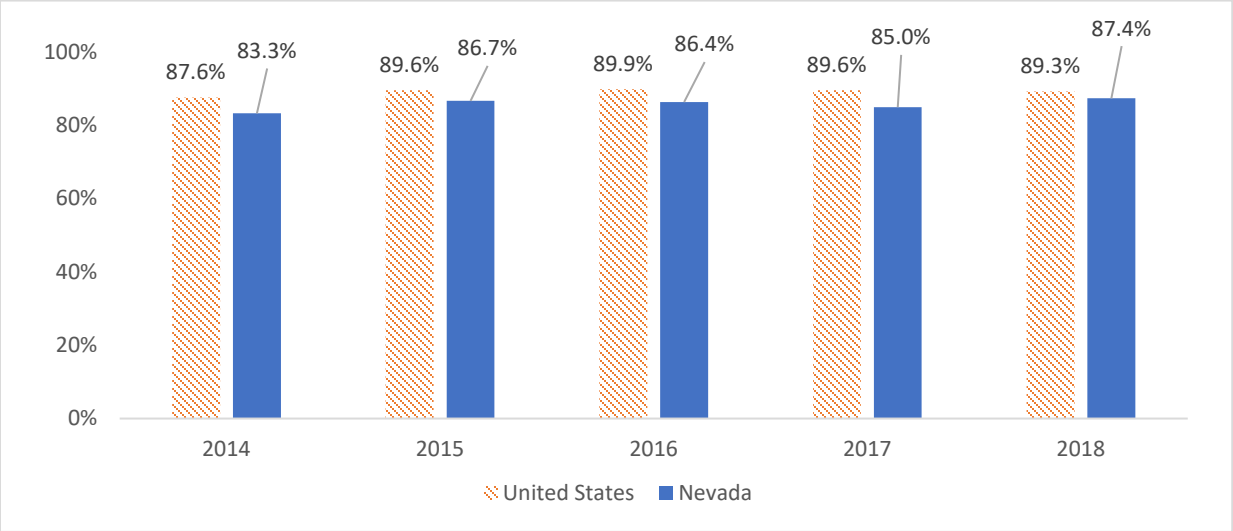
Access to health care services is the ability to reach necessary health services in a timely manner for the most optimal health outcomes. Access to care is an important health measure, as it allows for early identification, treatment, and prevention of health conditions, reducing mortality and morbidity, promoting a higher quality of life, and positively impacting life expectancy.[667] To assess this issue as it affects women's health, various measures were assessed, such as health care insurance coverage, routine checkups, and the inability to visit a doctor due to cost, which were used as proxy indicators (among others) of access to care.

Health Care Coverage

According to data from the 2018 BRFSS, 87.5 percent of Nevada women reported having health care insurance coverage (compared to 86.5% of Nevada's general population), slightly lower than women across the U.S. (89.3%) (Figure 112).[668] Women ages 25 to 34 years were least likely to have health care insurance coverage (79.8%) in 2018, with rates increasing for women ages 35 to 44 years (80.7%) and 18 to 24 years (89.2%).[669]

[665] Behavioral Risk Factor Surveillance System. (2018). General health status. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[666] Behavioral Risk Factor Surveillance System. (2018). General health status. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[667] Healthy People 2020. (2019, November 16). Access to Health Services. Retrieved November 16, 2019, from http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.
[668] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[669] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Figure 112. Percentage of Women with Health Care Coverage, Nevada and United States, 2014 to 2018*[670]



** Any kind of health care coverage including health insurance, prepaid plans, or government plans*

Health care insurance coverage follows a clear gradient by income and education level in Nevada. Almost all women whose annual household income was $50,000 or greater had health care insurance coverage, compared to approximately three in four (73.8%) women whose annual household income was less than $20,000. Women whose annual household income was less than $20,000 were least likely to have health care insurance coverage. In Nevada in 2018, 96.8 percent of women in the highest annual income level ($75,000+) had health care insurance coverage, compared to 77.8 percent of women in the middle-income level ($20,000 to $34,999) and 68.9 percent of women in the lowest income level (<$10,000). The greatest number of Hispanic women fall into the <$50,000 annual income level and the greatest number of White women fall into the >$75,000 income level.[671]

Similarly, college or technical school graduates were most likely to have health care insurance coverage, while women who were not high school graduates were least likely to have health care insurance coverage. In 2018, 95.4 percent of college or technical school graduates had health care insurance coverage, compared to 85.5 percent of women who were high school graduates and 63.9 percent of women who were not high school graduates.[672]

Disparities are seen in health care access in Nevada with Hispanic women markedly less likely to have health care insurance coverage. In 2018, 96.2 percent of non-Hispanic White women had health care insurance coverage, compared to 91.8 percent of women of other races, 90.7 percent of Black or African American women, 86.6 percent of Asian women, and 67.3 percent of Hispanic women.[673] Data were not available for American Indian or Native Hawaiian and other Pacific Islander women in 2018.

[670] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[671] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[672] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[673] Behavioral Risk Factor Surveillance System. (2018). Do you have any health care coverage? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Routine Checkups

Routine checkups are another integral part of access to care. Routine checkups, defined by BRFSS as a general physical exam and not an exam for a specific injury, illness, or condition, are crucial in the early detection and thus early treatment of health conditions.[674] In Nevada in 2017, slightly more than 63.9 percent of women ages 18 to 44 years visited a doctor for a routine checkup within the past year, slightly lower than the national rate of 65.6 percent and lower than the rate among Nevada's general population (73.1%).[675] Among women without health care insurance coverage, this rate decreases to 41.7 percent (compared to 69.6% of those with insurance).[676]

In 2017, Hispanic women in Nevada were least likely to have visited a doctor for a routine checkup within the past year (56.8%), followed by non-Hispanic White women (59.7%). Data were not available or were unstable for Black or African American, American Indian, Asian, or Native Hawaiian/Pacific Islander women in 2017.[677] Approximately half (49.2%) of non-English speaking women visited a doctor for a routine checkup within the past year.[678] The percentage of women who visited a doctor for a routine checkup within the past two years followed a clear trend by income. Women in the highest annual income level ($50,000+) in Nevada were most likely to have visited a doctor for a routine checkup (65.9% in 2017), followed by women in the next highest income level ($20,000-$49,999, 65.2%), and finally women in the lowest income level (<$15,000, 53.6%).[679]

Educational disparities included women in Nevada who attended college or technical school being most likely to have visited a doctor for a routine checkup within the past year (68.6% in 2017), followed by college graduates (66.4%), and high school graduates (63.7%). Approximately half of women without a high school diploma visited a doctor for a routine checkup within the past year (51%).[680] Women ages 18 to 24 years were the most likely of any age group to have visited a doctor for a routine checkup within the past year, with 70.8 percent doing so in 2017, followed by 65.3 percent of women ages 35 to 44 years, and 58.4 percent of women ages 25 to 34 years.[681]

The two maps below reveal the relationship between adults who have not visited a doctor in the past year with uninsured status (Figures 113 and 114). The blue areas indicate census tracts where adults are generally insured, but they are not visiting the doctor. The red to brown areas indicate census tracts where adults are not insured and have not visited a doctor in the past year; these areas suggest different barriers to care.

[674]Behavioral Risk Factor Surveillance System. (2018). How long has it been since last routine checkup? Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

[675] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution.

[676] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution.

[677] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

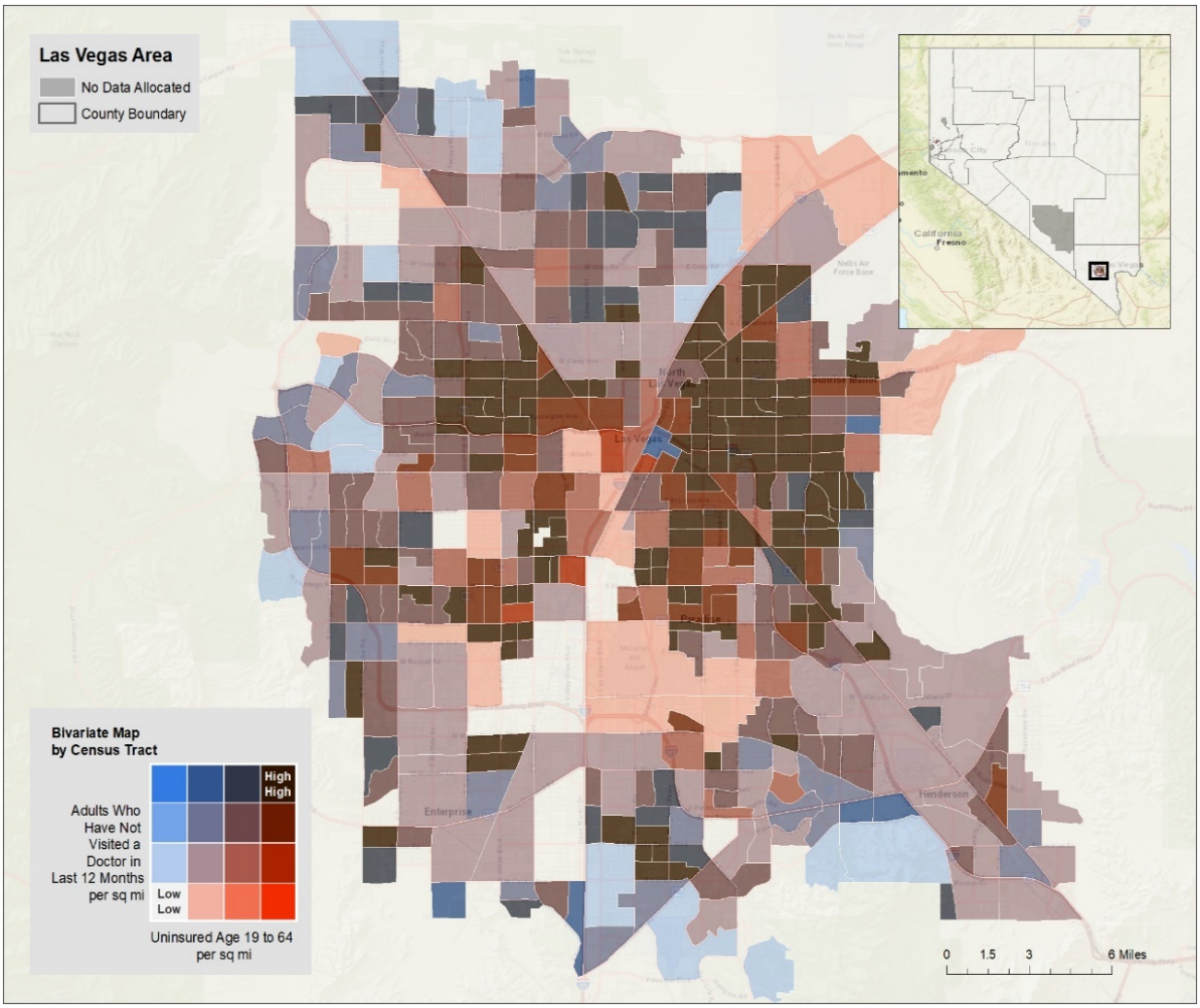
[678] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution.

[679] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution.

[680] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution less than high school and high school graduate rates.

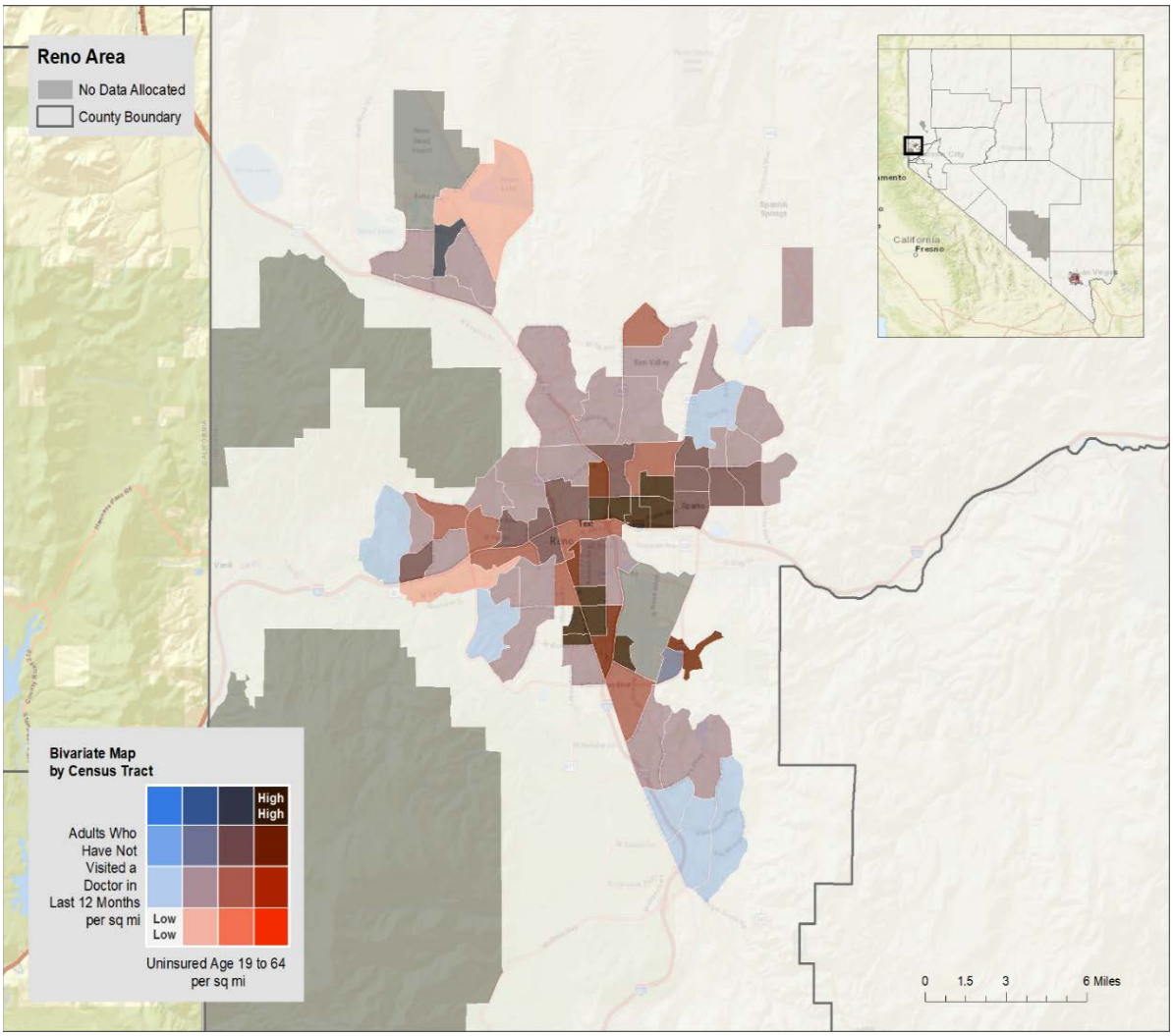
[681] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution age group 18 to 24.

Figure 113. Adults Who Have Not Visited a Doctor in The Last 12 Months and Insurance Status, Per Square Mile, Las Vegas Area[682]



[682] Esri and GfK MRI, 2019.

Figure 114. Adults Who Have Not Visited a Doctor in the Last 12 Months and Insurance Status, Per Square Mile, Reno Area[683]



[683] Esri and GfK MRI, 2019.

In addition to routine check-ups, Table 67 looks closer at reproductive health care visits specific for women's health for women of childbearing age (ages 18 to 44 years).

Table 67. Women's Health Care Visits in Nevada, by Race/Ethnicity and Age Group (18 to 44 Years), 2018[684]

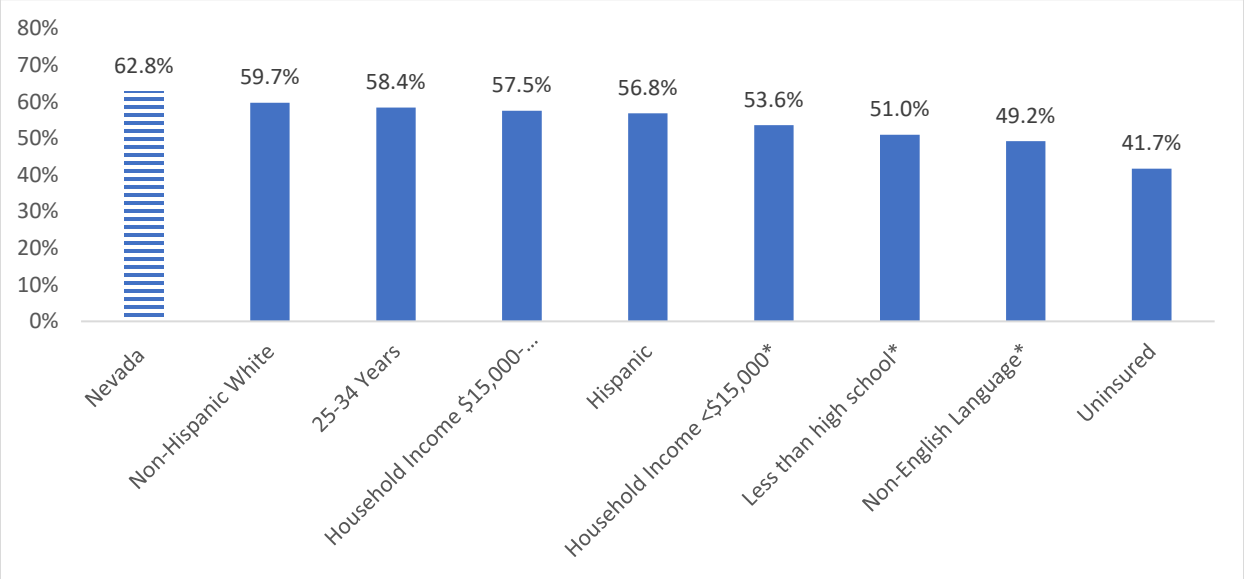
Health Service	Age Group	White	Black or African American	Hispanic	Multiracial	Other Race	Total
Pap Test in Past Three Years	*18-24*	64.9%	**	76.9%*	50.0%*	66.7%*	67.2%
Pap Test in Past Three Years	*25-34*	84.1%	100%*	90.0%	71.4%*	72.7%*	85.4%
Pap Test in Past Three Years	*35-44*	80.6%	85.7%*	85.7%	80.0%*	66.7%*	81.3%
Ever Had Pap Test	*18-24*	50.0%	100%*	45.7%	75.0%*	28.6%*	49.5%
Ever Had Pap Test	*25-34*	95.4%	100%*	96.5%	77.8%*	81.8%	94.2%
Ever Had Pap Test	*35-44*	99.1%	100%*	96.2%	100%*	85.7%*	97.5%
Ever Had Mammogram	*18-24*	8.6%	0%*	25.0%	0%*	0%*	12.7%
Ever Had Mammogram	*25-34*	26.1%	44.4%*	31.0%	25.0%*	18.2%*	28.2%
Ever Had Mammogram	*35-44*	51.3%	62.5%*	39.6%	40.0%*	64.3%*	49.0%

**Data should be interpreted with caution due to low sample sizes.*

*** Data not available*

Risk factors associated with not having a routine doctor visit in the past year, and therefore likely not receiving preventive care important to women's health, include insurance status, education, income level, and race/ethnicity (Figure 115).

Figure 115. Risk or Disparity Factors for Women Not Visiting A Doctor for a Routine Checkup Within the Past Year Nevada, 2017[685]



** Data should be interpreted with caution due to low sample sizes.*

[684] Behavioral Risk Factor Surveillance System. (2018). Ever had a pap test; Have you ever had a mammogram. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

[685] Behavioral Risk Factor Surveillance System. (2017). National Performance Measure 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year. Interpret with caution age group 18 to 24.

Could Not Visit a Doctor Because of Cost

One barrier to accessing necessary health care services is cost. Approximately one in five Nevada women (17.4% in 2018) reported not being able to visit a doctor in the past year because of cost, higher than for women across the U.S. (14.2%) and among all Nevadans (14.5%).[686] In 2018, women ages 25 to 44 years were the most likely to report not being able to visit a doctor because of cost with almost a quarter of women (23%) reporting this barrier. Women ages 18 to 24 year were less likely to have this experience (16.9%), possibly due to this age group being the most likely (89.2%) to have health care insurance coverage (as described above).[687]

The percentage of women who could not visit a doctor because of cost in the past year followed clear trends by both income and education: women in the lowest annual income or education levels (<$20,000, not a high school graduate) were between three and four times more likely to report not being able to visit a doctor because of cost compared to women in the highest annual income or education levels ($50,000 or more, college or technical school graduate). In 2018, 27.8 percent of Nevada women in the annual income level of $15,000 to $24,999 reported not being able to visit a doctor because of cost in the last year compared to 11.8 percent of women in the highest annual income level (>$50,000).[688]

Also in 2018, 34.1 percent of Nevada women who had not graduated high school reported not being able to visit a doctor because of cost in the last year, compared to 14.7 percent of high school graduates, 16.2 percent of those who attended college or technical school, and 13.5 percent of college or technical school graduates.[689] An ethnic disparity also exists in Nevada; Hispanic women were more likely than non-Hispanic White women to report not being able to afford a doctor visit (24.8% vs. 13.6% in 2018, respectively). Data are not available for any other races and ethnicities in 2018.

Chronic Diseases

Diabetes

Among women, diabetes is of particular concern as it can have a greater impact on women's health than on the health of men. For example, women with diabetes have a four times greater risk of heart disease (only two times for men). Women are also at higher risk of other diabetes-related complications such as kidney disease, blindness, and depression. For women of color, these risks are even greater compared to White women.[690] In 2018 in Nevada, 11.8 percent of women of all ages had ever been told they have diabetes. The prevalence of diabetes increases with age, with women ages 18 to 24 years being least likely to have diabetes (0.8%) and women ages 34 to 44 years most likely (4.4%). Compared to the U.S., the overall prevalence of diabetes among Nevada women is similar, while generally the U.S. has greater prevalence among all age groups, except for women ages 25 to 34 years (Figure 116).[691]

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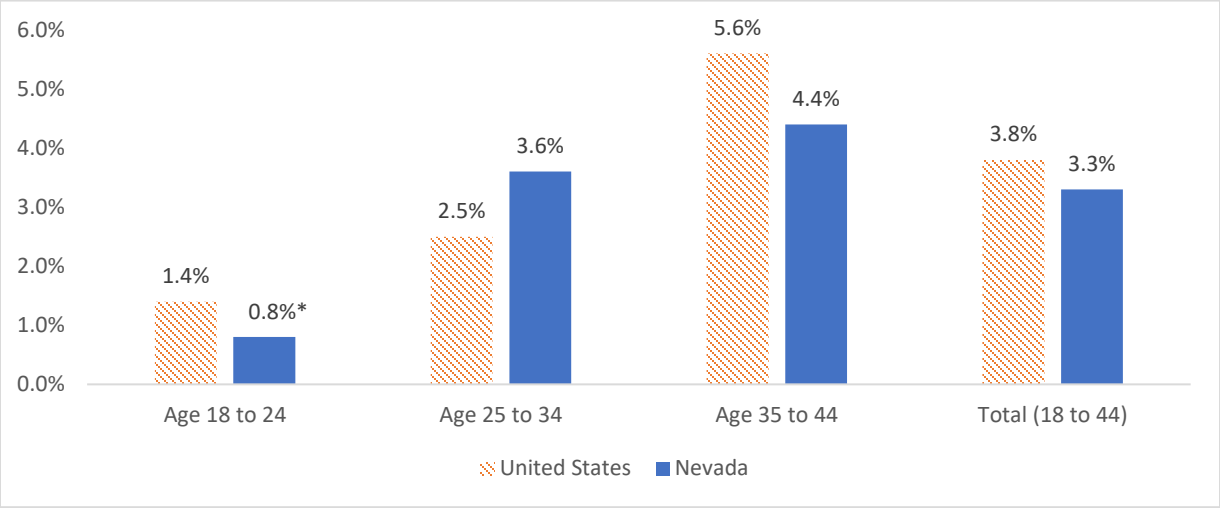
[686] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[687] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[688] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[689] Behavioral Risk Factor Surveillance System. (2018). Past 12 months needed but could not see a doctor because of cost. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[690] Centers for Disease Control and Prevention and Prevention. (2018, April 16). Diabetes and Women. Retrieved December 10, 2019 from https://www.cdc.gov/features/diabetes-women/index.html.
[691] Behavioral Risk Factor Surveillance System. (2018). Ever told you have diabetes excluding pregnancy. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Figure 116. Percentage of Women Ever Told They Have Diabetes, Nevada and United States, by Age Group, 2018[692]



**Data should be interpreted with caution due to low sample sizes.*

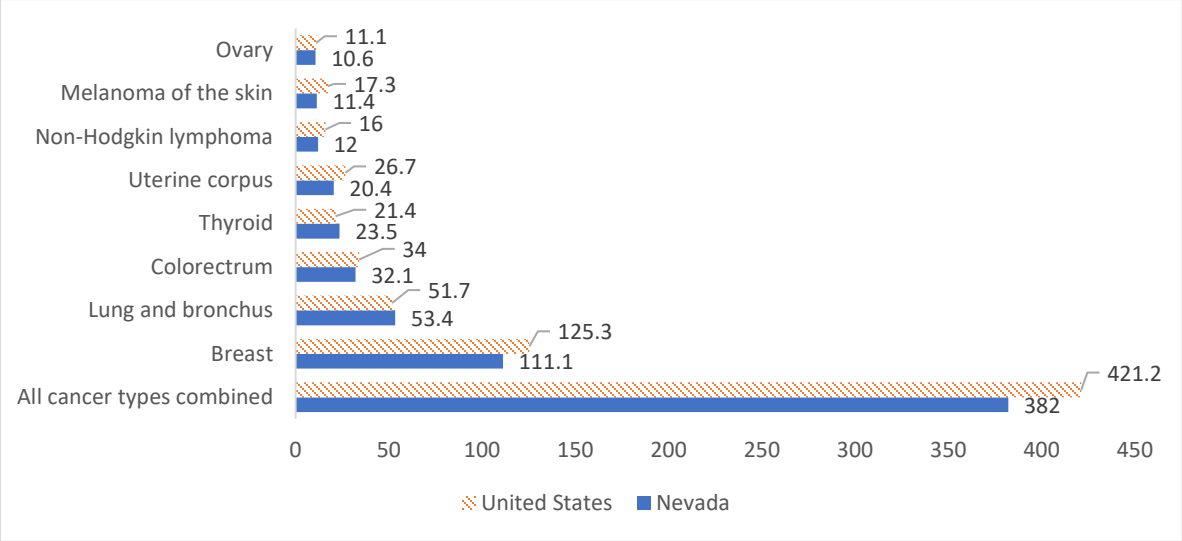
Looking closer at the diabetes prevalence, among all women with diabetes in Nevada in 2018, the majority are White women (58.9%), followed by Hispanic women (22.3%), and Black or African American women (7.4%). Other races/ethnicities fall at or below 3.5 percent. When considering income, women with annual incomes less than $15,000 had the highest prevalence of diabetes in 2018 (25.3%), followed by those with annual incomes below $50,000 (15.8%), and finally women with annual incomes greater than $75,000 (4.8%).[693]

Cancer

Cancers most often affecting women are breast, colorectal, lung, cervical, skin, and ovarian.[694] In 2019, the top cancers affecting all women in Nevada based on estimated new cases were breast cancer (2,190 new cases), followed by uterine corpus cancer (420 new cases), ovarian cancer (190 new cases), and cervical cancer (140 new cases).[695] Cancer also accounted for more than 600 deaths among Nevada women in 2019, with the majority coming from breast cancer deaths (n=400), followed by ovarian cancer deaths (n=150), and uterine corpus cancer deaths (n=90).[696] Between 2012 and 2016, the most common cancer occurring among Nevada women was breast cancer, followed by lung and bronchus cancer, and colorectum cancer (Figure 117); a similar trend was seen nationally. [697]

[692] Behavioral Risk Factor Surveillance System. (2018). Ever told you have diabetes excluding pregnancy. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[693] Behavioral Risk Factor Surveillance System. (2018). Ever told you have diabetes excluding pregnancy. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[694] American Cancer Society. (2019, August 2). Cancer Facts for Women. Retrieved December 10, 2019 from https://www.cancer.org/healthy/find-cancer-early/womens-health/cancer-facts-for-women.html.
[695] American Cancer Society. (2019). Cancer Statistics Cancer. Estimated new cases, 2019 for women in Nevada. Retrieved December 10, 2019 from https://cancerstatisticscenter.cancer.org/#!/.
[696]American Cancer Society. (2019). Cancer Statistics Cancer. Estimated new cases, 2019 for women in Nevada. Retrieved December 10, 2019 from https://cancerstatisticscenter.cancer.org/#!/.
[697] American Cancer Society. (2019). Cancer Statistics Cancer. Incidence Rates, 2012-2016 for women in Nevada and United States. American Cancer Society. https://cancerstatisticscenter.cancer.org/#!/

Figure 117. Incidence Rates of Eight Most Frequent Cancers Among All Women, 2012 to 2016, Nevada and United States, 2016[698]



Other diseases

Other chronic diseases of note for Nevada women include coronary heart disease, or myocardial infarction (i.e., a heart attack), having a stroke, and having Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis. Table 68 illustrates the prevalence of each chronic disease for women of childbearing age, broken down by race/ethnicity and age group.

Table 68. Women's Chronic Disease Prevalence in Nevada, by Race/Ethnicity and Age Groups (18-44), 2018[699]

Chronic Disease	Age Group	White	Black or African American	Hispanic	Multiracial	Other Race	Total
Coronary Heart Disease	*18-24*	0.0%	0.0%	2.6%	0.0%	0.0%	0.8%
Coronary Heart Disease	*25-34*	3.2%	0.0%	1.6%	0.0%	0.0%	2.1%
Coronary Heart Disease	*35-44*	0.9%	12.5%*	1.7%	0.0%	0.0%	1.4%
Stroke	*18-24*	1.6%	0.0%	0.0%	0.0%	0.0%	0.8%
Stroke	*25-34*	6.5%	0.0%	0.0%	10.0%*	0.0%	3.7%
Stroke	*35-44*	0.0%	0.0%	3.3%	10.0%*	0.0%	1.9%
COPD	*18-24*	4.8%	0.0%	2.6%	12.5%*	0.0%	4.2%
COPD	*25-34*	1.1%	10.0%*	4.6%	0.0%	0.0%	2.6%
COPD	*35-44*	0.2%	12.5%*	3.4%	0.0%	7.1%*	2.9%

*Data should be interpreted with caution due to low sample sizes.

The table above shows COPD, emphysema, or chronic bronchitis are the more frequent chronic diseases affecting women of childbearing age in Nevada, particularly Hispanic women. The prevalence of women of childbearing age reporting they ever had a stroke, coronary heart disease or myocardial infarction is

[698] American Cancer Society. (2019). Cancer Statistics Cancer. Incidence Rates, 2012-2016 for women in Nevada and United States. American Cancer Society. https://cancerstatisticscenter.cancer.org/#!/

[699] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who have ever reported having coronary heart disease or myocardial infraction; Ever told you had a stroke; Ever told you have COPD, emphysema or chronic bronchitis. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear

less common, likely due in part to those being diseases with an onset later in a person's lifespan.[700]Another health issue to consider among women is maternal morbidity and mortality, which is discussed in greater detail on page 256.

Physical Activity

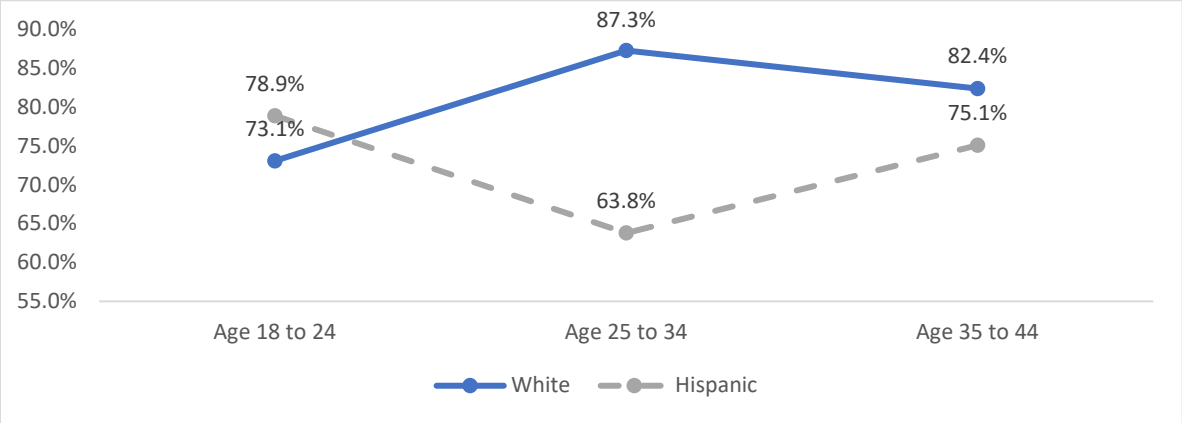
Women were less likely to report participating in physical activities compared to men in Nevada (72.7% vs. 77.4%, respectively). When compared to the U.S., women ages 18 to 44 years living in Nevada were slightly more likely to be physically active (Table 69). During the previous month, the percent of women who reported completing any physical activities or exercises such as running, gardening, or walking for exercise was greatest among those ages 18 to 24 years (81.5%). The age group least likely to be physically active were women ages 35 to 44 years at 74.9 percent (slightly lower than those across the U.S. at 76.4%).[701]

Table 69. Prevalence of Women Ages 18 to 44 Who, During the Past Month, Participated in Any Physical Activities or Exercise, 2018, Nevada and United States[702]

Location	Age 18 to 24	Age 25 to 34	Age 35 to 44	Total 18 to 44
United States	80.6%	78.0%	76.4%	79.2%
Nevada	81.5%	77.5%	74.9%	80.3%

The prevalence of women exercising or participating in a physical activity in the last month differs by race and ethnicity in Nevada; among White and Hispanic women (the two groups with available data in 2018), generally White women ages 18 to 44 years had a higher prevalence (86% vs. 73.8% for Hispanic women), although this varies by age group (Figure 118).[703] There is a wide gap between White and Hispanic women ages 25 to 35 years, suggesting this may be a prime group to engage for increasing physical activity.

Figure 118. Prevalence of Women Ages 18-44 Years Who, During the Past Month, Participated in Any Physical Activities or Exercise in Nevada by Race and Ethnicity, 2018[704]



[700] American Stroke Association. (2018, October 10). Stroke Risk Factors You Can Control, Treat and Improve. Retrieved December 10, 2019 from https://www.stroke.org/en/about-stroke/stroke-risk-factors/stroke-risk-factors-you-can-control-treat-and-improve.
[701] Behavioral Risk Factor Surveillance System. (2018). During the past month, any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[702] Behavioral Risk Factor Surveillance System. (2018). During the past month, any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[703] Behavioral Risk Factor Surveillance System. (2018). During the past month, any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[704] Behavioral Risk Factor Surveillance System. (2018). During the past month, any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

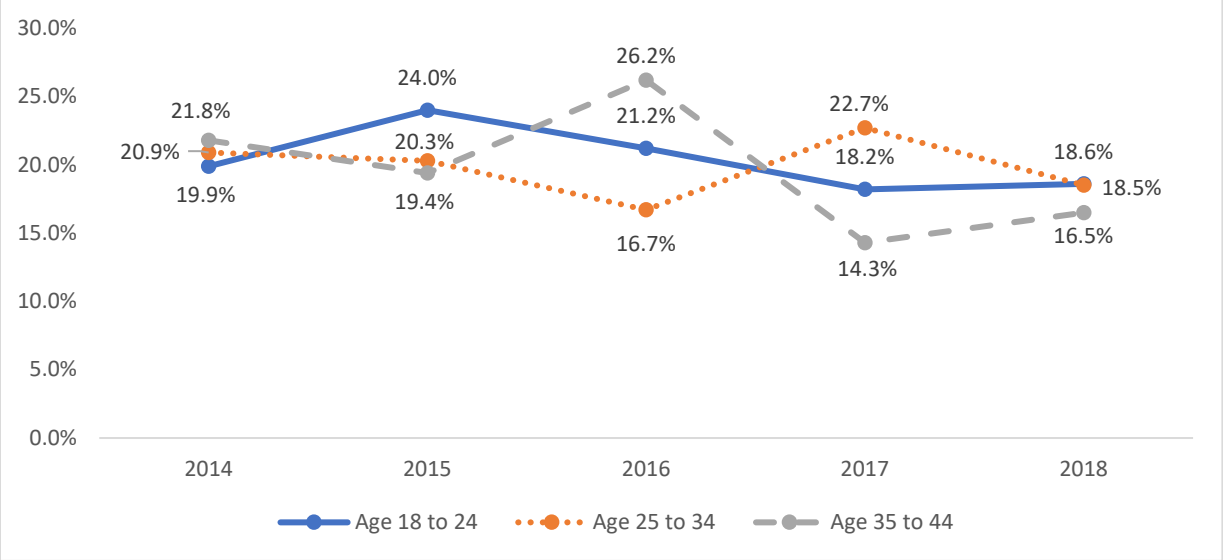
Related to physical activity, 29.2 percent of Nevada women ages 18 years and older were obese in 2018, slightly lower than the 31.3 percent of women nationwide. By age group, 33.6 percent of women ages 25 to 34 years and 36.7 percent of women ages 35 to 44 years were obese in 2017 in Nevada, compared to 32.1 percent of women ages 25 to 34 years and 34.8 percent of women ages 35 to 44 years nationwide.[705]

Emotional and Mental Health

Another key indicator for a woman's overall wellbeing is emotional and mental health. In 2018 in Nevada, 21.6 percent of women ages 18 to 44 years reported having 14 or more days when their mental health was not good (compared to 17.4% of U.S. women ages 18 to 44 years). For women ages 18 to 24 years in Nevada, this rises to 27 percent.[706]

In 2018 in Nevada, 17.8 percent of women ages 18 to 44 years had ever been told they have a depressive disorder, including depression, major depression, dysthymia, or minor depression (lower than the 24.8% of U.S. women ages 18 to 44 years).[707] Nevada women ages 18 to 24 years experienced the highest prevalence (18.6%), followed by women ages 25 to 34 years (18.5%), and women ages 35 to 44 years (16.6%).[708] Figure 119 illustrates the trends of women in Nevada having a depressive disorder over the last five years.

Figure 119. Ever Told You That You Have a Depressive Disorder, Including Depression, Major Depression, Dysthymia, or Minor Depression, Among Women by Age Group (18 to 44 Years), Nevada, 2014 to 2018[709]



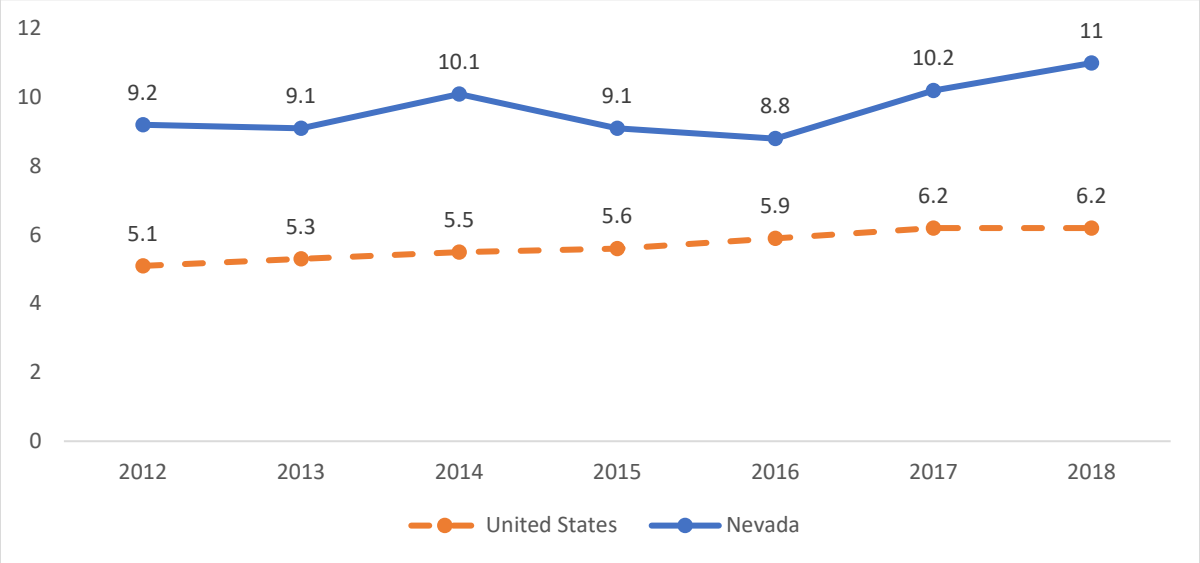
[705] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for body mass index. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[706] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for frequent (14+ days) poor mental health. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[707] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[708] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[709] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Considering race and ethnicity for women in Nevada in 2018, 25.5 percent of White women ages 18 to 44 years reported ever being told they had a depressive disorder. This was the highest rate among the race/ethnicities in Nevada with available data, followed by Black or African American women (23.8%) and Hispanic women (10.4%).[710] Considering income and education, women ages 18 to 44 years earning between $10,000 and $15,000 annually experience the highest rate of being told they have a depressive disorder (41%). Nevada women earning over $75,000 annually experienced the lowest prevalence of being told they have a depressive disorder (15.3%), followed by women who earn between $25,000 and $35,000 annually (18.3%).

Regarding education, women who did not complete high school experienced the lowest rate (15.1%) of ever being told they had a depressive disorder, followed by women who completed college or technical school (17.1%), and who finished high school (19%). Individuals who only attended college or technical school, but did not graduate, experienced the highest rate of being told they have a depressive disorder (26.1%).[711] It is important to note this data is only relevant for the proportion of Nevada women who are visiting a doctor/accessing the health care system.

In 2018 in Nevada, the number of deaths among all females of all ages due to intentional self-harm per 100,000 population was 11. This rate is one of the highest in the nation, with only Wyoming and Alaska having higher rates in 2018 and is nearly double the rate for all women in the U.S. (6.2) (Figure 120). The rate of intentional self-harm for females in 2018 has risen since 2016 and is the highest rate seen in Nevada since 2012.[712]

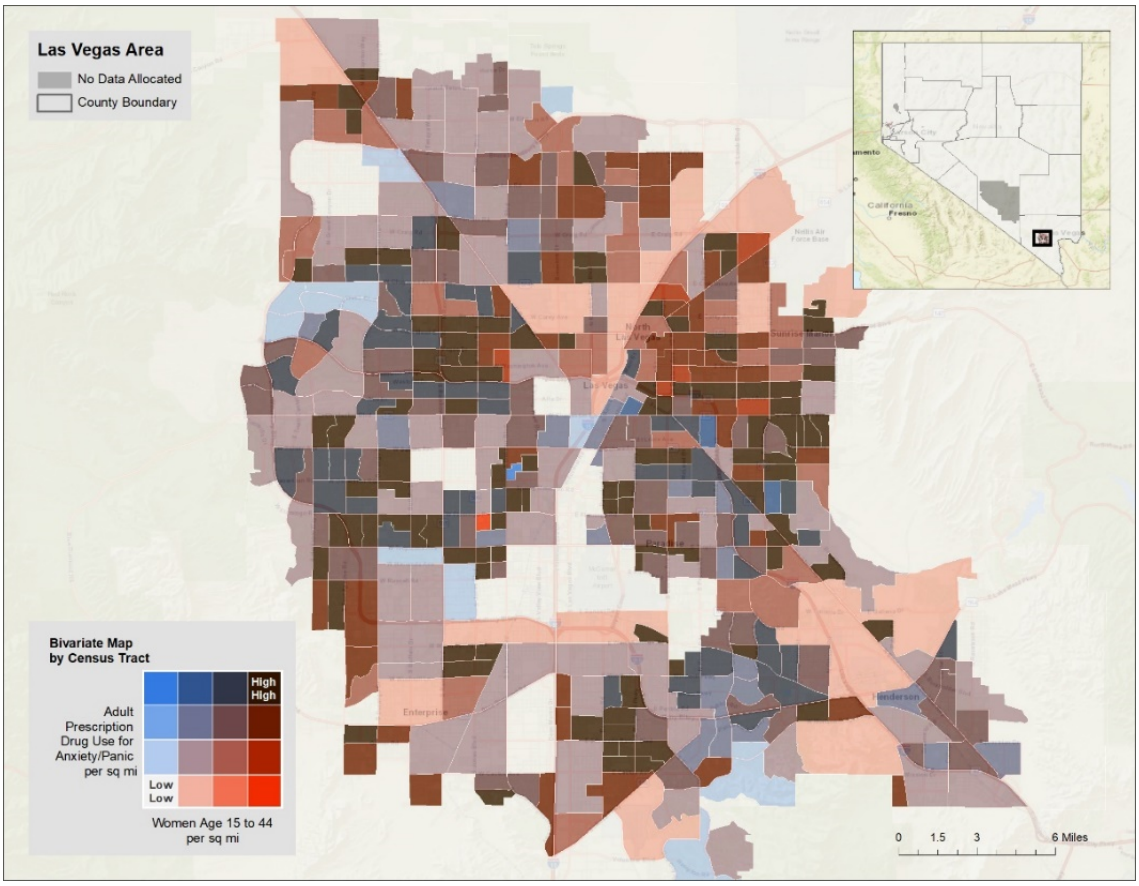
Figure 120. Number of Deaths Among Females Due to Intentional Self-Harm Per 100,000 Population (Age-Adjusted to Data Year), Nevada and United States, 2012 to 2018[713]



[710] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[711] Behavioral Risk Factor Surveillance System. (2018). Ever told you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[712] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: About Underlying Cause of Death, 1999-2017. Retrieved December 11, 2019 from https://wonder.cdc.gov/ucd-icd10.html.
[713] CDC WONDER Online Database, Underlying Cause of Death, Multiple Cause of Death files.

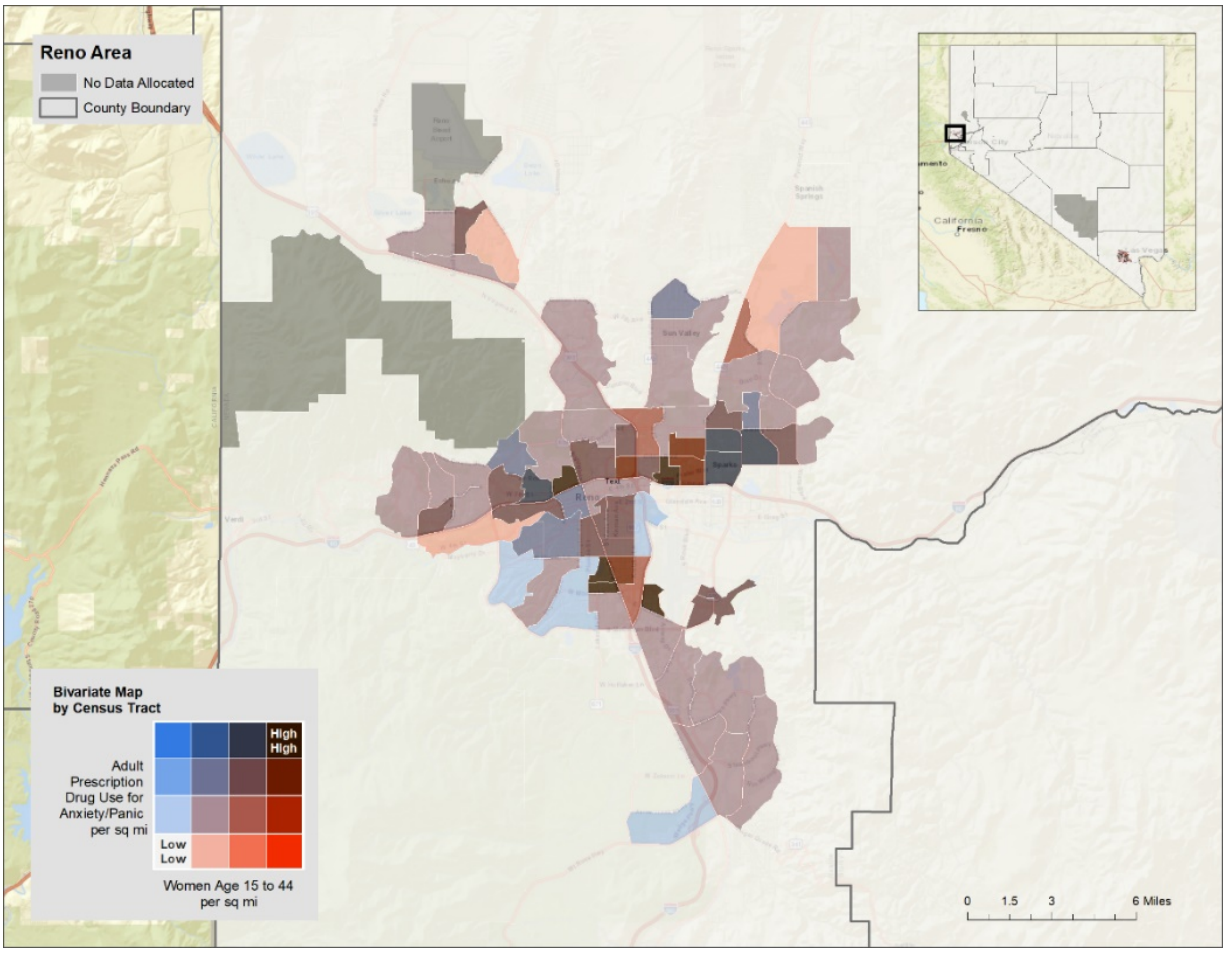
The suicide rate is a major concern across Nevada, for all population groups. Protective factors to prevent intentional self-harm include effective clinical care for both mental and physical health, along with easy access to clinical interventions and family and community support, all of which are important to consider when thinking of ways to prevent suicide.[714] Prescription medication for mental health diagnoses is considered another indicator for a high behavioral health need. The maps below display the communities where there are both a high concentration of women of childbearing age and a high rate of prescriptions among all adults for anxiety or panic disorders (Figures 121-122). Light red and bright red areas in the map may suggest a potential gap in mental health care and treatment among women of childbearing age. Dark areas in the map may suggest women are connected to mental health treatment.

Figure 121. Adult Prescription Drug Use for Anxiety/ Panic Attacks per Square Mile and Women Ages 15 to 44 per Square mile, Las Vegas Area, 2019 [715]



[714] Centers for Disease Control and Prevention and Prevention. (2019, September 3). Protective Factors for Suicide. Retrieved December 11, 2019 from https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html.
[715] Esri and GfK MRI, 2019.

Figure 122. Adult Prescription Drug Use for Anxiety/ Panic Disorder Per Square Mile and Women Ages 15 to 44 Per Square Mile, Reno Area, 2019 [716]



Similarly, the maps below show communities where there are both a high concentration of women of childbearing age and a high rate of prescriptions among all adults for depression (Figures 123-124).

[716] Esri and GfK MRI, 2019.

Figure 123. Adult Prescription Drug Use for Depression Per Square Mile and Women Ages 15 to 44 Per Square Mile, Las Vegas Area, 2019[717]

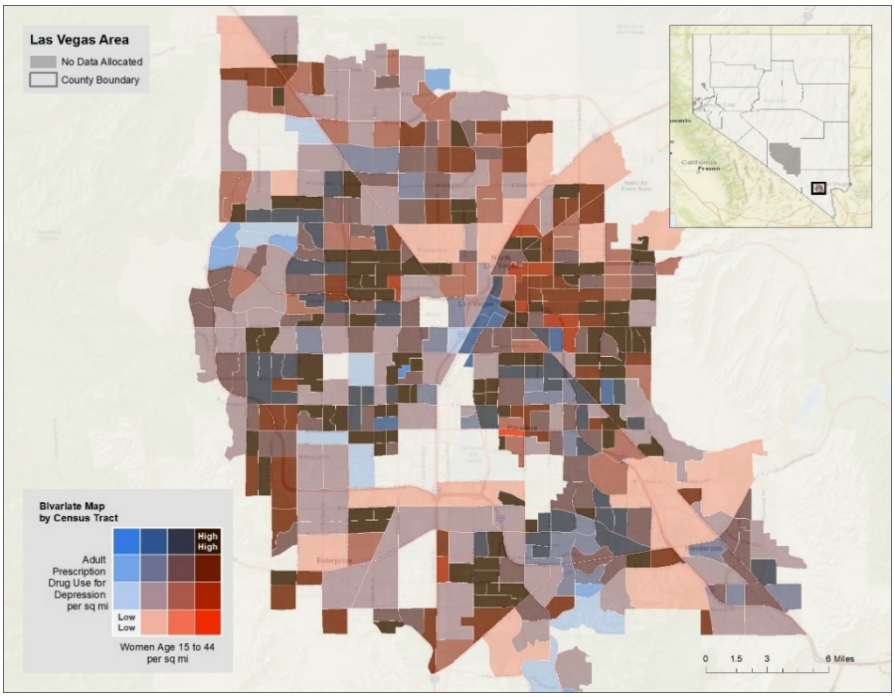
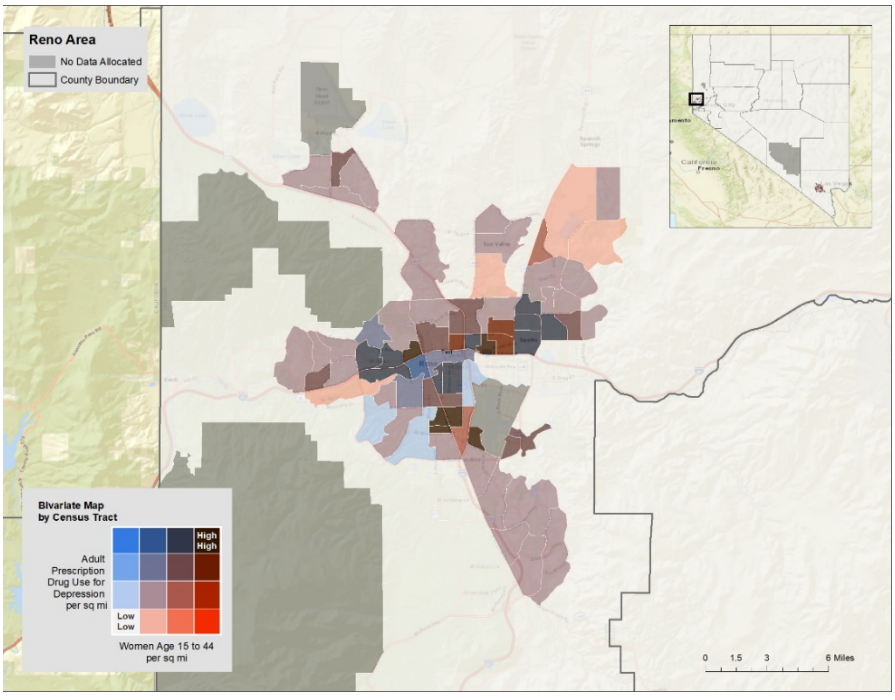


Figure 124. Adult Prescription Drug Use for Depression Per Square Mile and Women Ages 15 to 44 Per Square Mile, Reno Area, 2019[718]



[717] Esri and GfK MRI, 2019.
[718] Esri and GfK MRI, 2019.

Substance Use

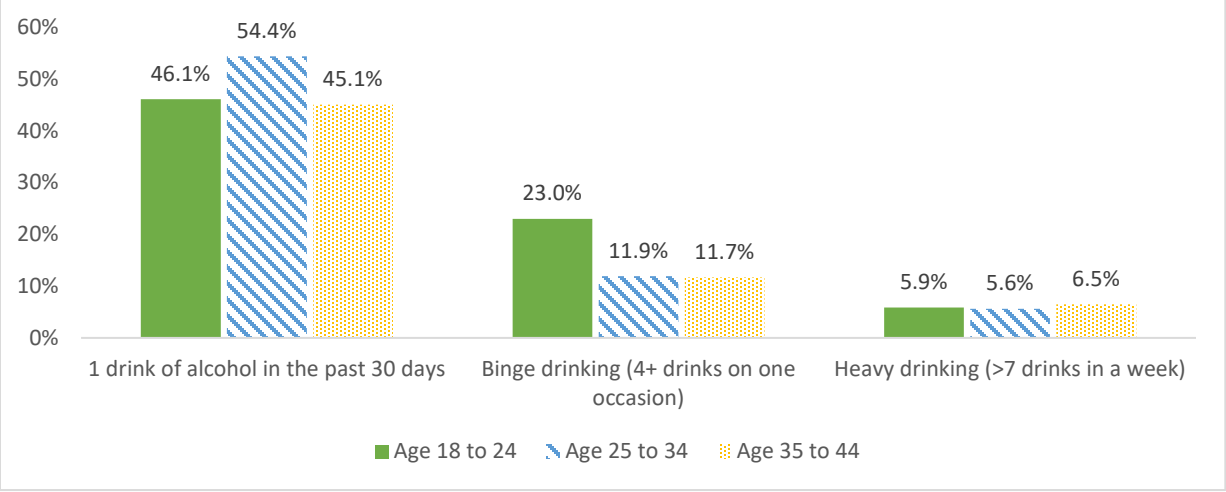
Another important issue to consider relating to women's health is substance use. This includes alcohol, tobacco, marijuana, the use and misuse of prescription drugs, and illicit substances (i.e., cocaine, methamphetamine, heroin, etc.). Substance use becomes a health concern when it involves Illicit substances and/or when the use of the substance(s) (legal or illicit) leads to an inability to control use, despite the harm it may cause. In the following section, substance abuse is defined as "the harmful or hazardous use of psychoactive substances, including legal (e.g., alcohol, marijuana, etc.) and illicit drugs."[719]

Alcohol

Research has shown alcohol use and misuse among women is increasing across the country, which is concerning because women face greater health risks from drinking compared to men. For example, women start to have alcohol-related problems sooner and at lower drinking levels than men due to usually weighing less and having less water in their bodies. This can lead to liver damage, such as alcoholic hepatitis, along with heart disease, brain damage, and breast cancer, morbidities women are more susceptible to compared to men.[720]

In 2018 in Nevada, more than half (53%) the women surveyed who were ages 18 to 44 years reported having at least one drink of alcohol in the last 30 days (lower than the 58.8% nationally); 6.1 percent reported being heavy drinkers (similar to the 6.3% nationally), defined for women as having more than seven drinks per week. Women in this age group experienced a higher rate of heavy drinking compared to all adults living in Nevada (5.6%). Binge drinking for women is defined as having four or more drinks on one occasion; binge drinking prevalence for women in Nevada is 16.1 percent (lower than the 18.1% nationally). For specific age groups, women ages 18 to 24 years report the highest rate of binge drinking (23%), while women ages 35 to 44 years report the highest rate of heavy drinking (6.5%) (Figure 125).[721]

Figure 125. Calculated Variables for Alcohol Consumption for Women, Ages 18 to 44 Years, by Age group, Nevada, 2018[722]



[719] World Health Organization. (n.d.). Substance abuse. Accessed November 27, 2019. https://www.who.int/topics/substance_abuse/en/.
[720] National Institute on Alcohol Abuse and Alcoholism. (2019, June). Women and Alcohol. Retrieved December 10, 2019 from https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/women-and-alcohol.
[721] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[722] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Among race/ethnicity groups, it can be hard to discern actual differences due to small sample sizes. However, 2018 Nevada BRFSS data shows 62.4 percent of White women ages 18 to 44 years had at least one drink of alcohol in the past 30 days, followed by 58 percent of Hispanic women, and 52.9 percent of Black or African American women. Additionally, 18 percent of White women ages 18 to 44 years reported binge drinking, followed by 17.6 percent of Black or African American women, and 13 percent of Hispanic women. Finally, 7.4 percent of White women ages 18 to 44 years reported heavy drinking, followed by 4.8 percent of Black or African American women, and 4.3 percent of Hispanic women.[723]

Considering education level, women ages 18 to 44 years who attended some college reported the highest rate of heavy drinking (7.9%) and binge drinking (19.4%). For having at least one drink in the past 30 days, college or technical school graduates reported the highest rate (65%), followed by women who attended some college (52.6%). Across all three alcohol-related variables considered in the BRFSS, women who did not graduate high school reported the lowest rates for binge drinking (6.3%) and having at least one drink in the past 30 days (32.7%), while high school graduates reported the lowest rate for heavy drinking (2.8%).[724]

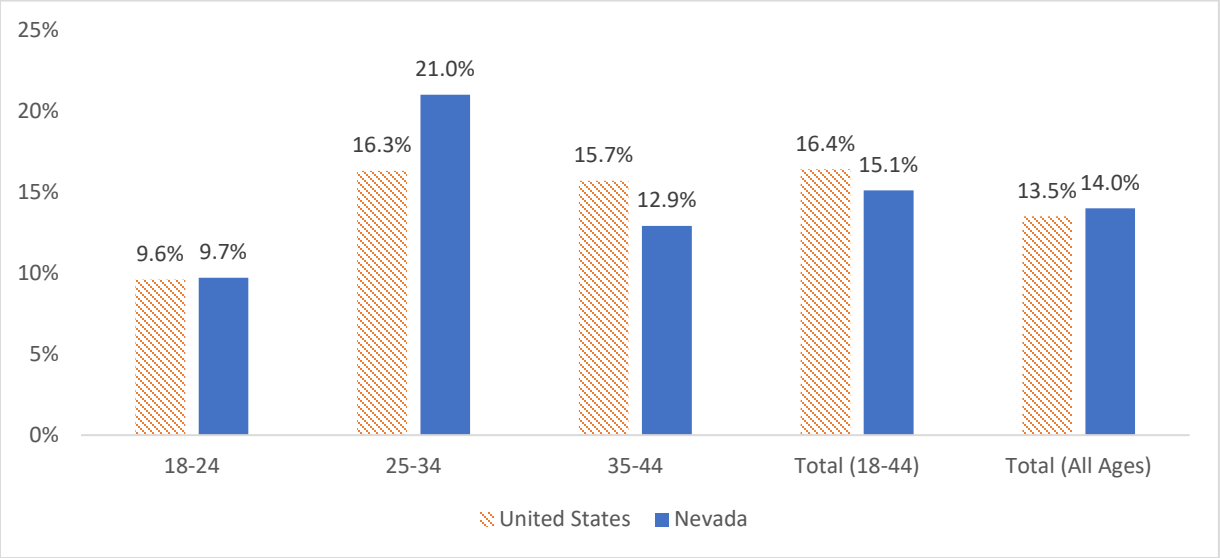
Considering income, women ages 18 to 44 years with annual incomes greater than or equal to $75,000 were most likely to report having at least one drink of alcohol in the past 30 days (64.9%)[725]. The income group most likely to report having four or more drinks on one occasion (binge drinking) was women earning $35,000 to $50,000 annually (23.9%), followed by women earning $50,000 to $75,000 (21.3%), and finally women earning $75,000 or more annually (19.4%). Women earning less than $10,000 annually reported the highest rate of heavy drinking (16.7%), followed by women earning $35,000 to $50,000 annually (10.2%).[726] This data suggests women with higher incomes are more likely to drink alcohol, but women with lower incomes are more likely to report drinking issues.

Tobacco

Tobacco use and exposure poses a serious risk of early death and disease for women, such as lung and bronchus cancer, COPD, and coronary heart disease. However, women face other risks from smoking, such as a greater risk for breast and cervical cancer, development of moderate or severe premenstrual syndrome, premature menopause, and even infertility.[727] In 2018 in Nevada, 14 percent of all women reported being a current smoker, lower than the prevalence of male smokers in Nevada (17.3%) but slightly higher than the rate for women nationwide (13.5%) (Figure 126). For women ages 18 to 44 years, 15.1 percent reported being a current smoker (lower than the rate for men in the same age range at 19.8%) with women ages 25 to 34 years reporting the highest prevalence (21%), followed by women ages 35 to 44 years (12.9%), and women 18 to 24 years (9.7%).[728]

[723] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[724] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[725] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[726] Behavioral Risk Factor Surveillance System. (2018). Alcohol Consumption variables. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear
[727] The Truth Initiative. (2019, March 5). The facts about women and tobacco. Retrieved December 9, 2019 from https://truthinitiative.org/research-resources/targeted-communities/facts-about-women-and-tobacco
[728] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear

Figure 126. Prevalence of Current Smokers Among Women, Nevada and United States, by Age Group, 2018[729]



White women ages 18 to 44 years in Nevada reported a higher prevalence of current smoking compared to Hispanic women (17.6% vs. 5.3%, respectively). For other race/ethnicity groups, information must be interpreted with caution due to small sample sizes, but Black or African American women reported the highest prevalence of current smoking at 33.3 percent, followed by women who identify as multiracial (25.9%), and women who identify with another race (21.2%).[730]

Considering income, women ages 18 to 44 years earning less than $15,000 annually reported the highest prevalence of current smoking, with almost one third reporting being a current smoker (28.6%), followed by women earning $25,000 to $50,000 annually (18.2%), women earning $15,000 to $25,000 annually (14.5%), and women earning $50,000 or more annually (10.7%).[731]

Considering education level, women ages 18 to 44 years who graduated high school reported the highest prevalence of current smoking (22.6%), followed by women with some college (17.1%), women who did not graduate high school (12%), and women who graduated college (8%).[732] Women in the highest annual income brackets and with the most education were least likely to smoke, while those in lower annual income brackets and with less education reported a higher prevalence of current smoking, suggesting a correlation between income and education and smoking/tobacco use for women in Nevada.

Marijuana

On November 8, 2016, Nevadans voted to legalize the purchase, possession, and consumption of recreational marijuana for adults 21 years and older, with marijuana becoming legal on January 1,

[729] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear
[730] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[731] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[732] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for adults who are current smokers. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

2017.[733] Between 2016-17, 43.6 percent of Nevada women ages 12 years and older reported they had ever used marijuana or hashish (another drug made from the cannabis plant). Among women ages 18 to 25 years, prevalence of current marijuana use increased to 62.4 percent, the highest of any age group. Hispanic women ages 12 years and older report the lowest prevalence of use at 24.4 percent, with White and Black or African American women both having a prevalence near 60 percent, suggesting race and ethnicity may be an important factor to consider when measuring marijuana use in Nevada. Another important factor to consider is 32.4 percent of women who have ever used marijuana reported using before age 21 years (the legal age of consumption in Nevada) and 25.4 percent said they used before age 18 years. [734]

While almost half of all women ages 12 years and older in Nevada have ever used marijuana, only 14.5 percent reported they had used it in the past year (higher than the 12.1% of the general population) and 10.1 percent said they had used it in the past month (slightly lower than the 11% of the general population). Regarding use, it is estimated only 0.3 percent of all women ages 12 years and older abused marijuana in the past year and 1.1 percent had a dependence on marijuana.[735,736] Women ages 18 to 25 years experienced the highest dependence prevalence among all women at 5.6 percent, suggesting the bulk of dependence is occurring within this age demographic as men ages 18 to 25 years also had a high prevalence.[737]

Other Substances

Other substances of interest in Nevada include illicit drugs such as cocaine and methamphetamine, as well as opioids, both prescription (legal) and heroin (illicit). For women, addiction to these drugs, as well as alcohol, is particularly concerning, as they progress faster in addiction than men and face different barriers to receiving help (e.g., childcare responsibilities). It is important to consider these differences when considering how to help women access treatment and recovery support.[738]

In 2016-17 in Nevada, 17.2 percent of women reported they had ever used cocaine, with 17.6 percent of women ages 18 to 25 years responding they had ever used cocaine (slightly lower than the 18.2% for all Nevadans in this age group). White women reported the highest prevalence of using cocaine at 26.9 percent, almost four times the prevalence of Hispanic women (6.8%) and over five times the prevalence of Black or African American women (5.1%). However, while almost one in five women (20%) reported ever having used cocaine, only 0.2 percent reported they were dependent on cocaine or abused cocaine in the past year, and two percent reported they had ever used crack cocaine in the past year.[739]

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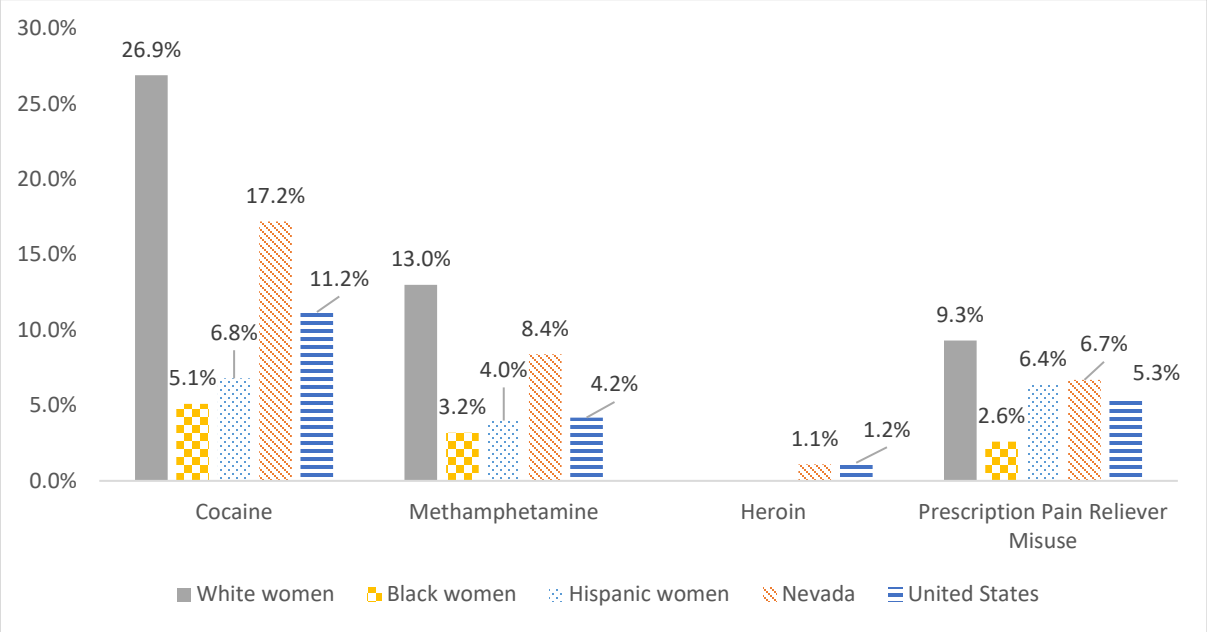
[733] Marijuana in Nevada. (n.d.). Legal Use. Retrieved on December 2, 2019 from http://marijuana.nv.gov/Legal/Legal_Use/.
[734] National Survey on Drug Use and Health. (2017). Marijuana Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[735] National Survey on Drug Use and Health. (2017). Marijuana Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[736] Abuse is defined as people who use a substance excessively on a regular basis but do not show signs of dependence. Dependence is defined as exhibiting symptoms such as greater tolerance, loss of control over use, preoccupation with the substance, etc., over a time period of a year or more. (Harvard Health Publishing. Addiction in women. (2010, January). Retrieved December 10, 2019 from https://www.health.harvard.edu/newsletter_article/addiction-in-women.
[737] National Survey on Drug Use and Health. (2017). Marijuana Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[738] Brenda Iliff. (2016, March 18). Women, Addiction and Recovery. Hazelden Betty Ford Foundation. https://www.hazeldenbettyford.org/articles/iliff/unique-challenges-of-women-and-addiction.
[739] National Survey on Drug Use and Health. (2017). Cocaine Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.

Compared to cocaine, fewer Nevada women reported using methamphetamine between 2016-17; 8.4 percent of women said they had ever used the substance (twice as high as the statewide rate of 4.2%) and 0.2 percent said they were dependent. White women reported the highest prevalence of methamphetamine use (13%), followed by Hispanic women (4%), and Black or African American women (3.2%).[740] Figure 127 illustrates the prevalence of women who have ever used a substance broken down by race (when available) and the difference in use prevalence between Nevada and the U.S.

Figure 127. Prevalence of Substance Use for Women, by Substance Type and Race, Nevada and United States, 2016-2017[741]



Regarding opioids, the two main categories are heroin and prescription opioid pain relievers (e.g., codeine, hydrocodone, oxycodone, morphine, fentanyl, etc.). Use/misuse of prescription pain relievers is a risk factor for heroin use. Many heroin users say their initiation to opioid use began with the misuse of prescription drugs, leading to heroin use when accessing prescription drugs became difficult or impossible.[742] Statewide in 2016-17, 5.7 percent of Nevada women reported misusing opioids in the past year (lower than the general population at 6.1%), 1.3 percent reported misusing opioids in the past month, and 1.4 percent reported opioid dependence or abuse.[743]

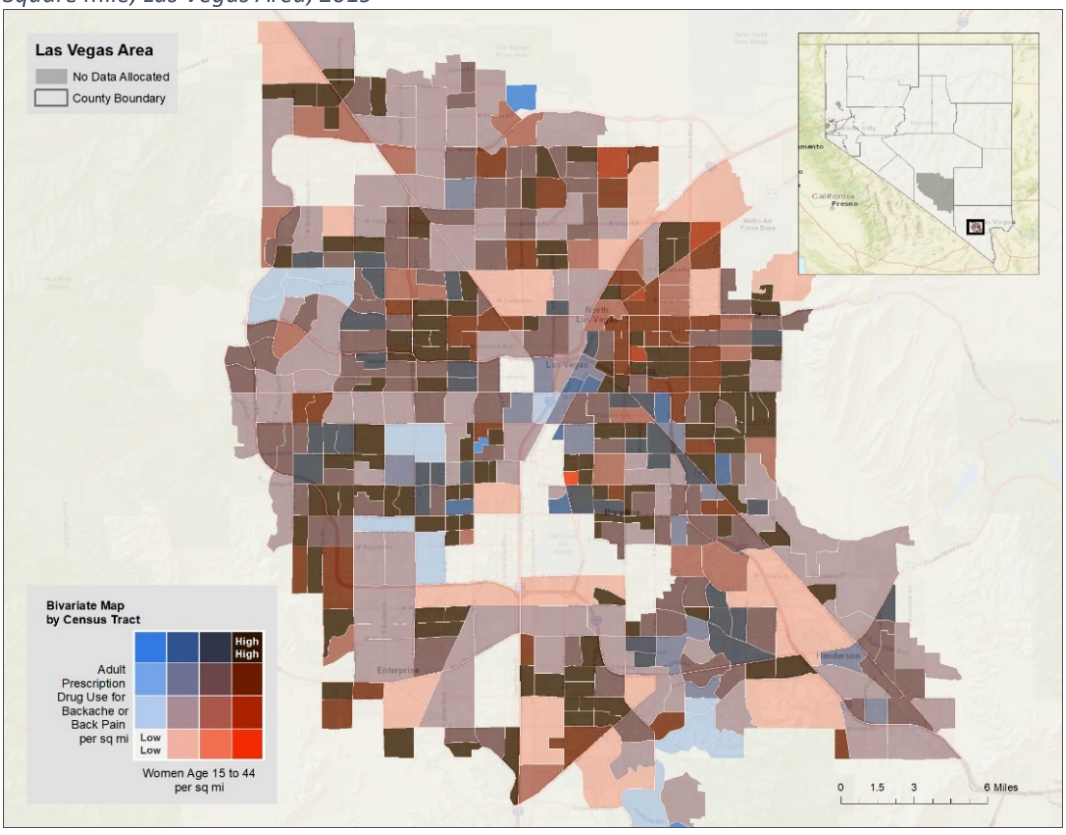
As defined in the National Survey on Drug Use and Health (NSDUH), misuse of prescription drugs includes use of the drug in any way a doctor did not direct, including 1) use without a prescription of the respondent's own; 2) use in greater amounts, more often, or longer than the respondent was prescribed; or 3) use in any other way a doctor did not direct. Misuse does not include use of over-the-

[740] National Survey on Drug Use and Health. (2017). Methamphetamine Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[741] National Survey on Drug Use and Health. (2017). Cocaine< Methamphetamine, Heroin, Prescription Pain Reliever Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[742] National Institute on Drug Abuse. (2018, January). Prescription Opioids and Heroin. Retrieved December 11, 2019 from https://www.drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use.
[743] National Survey on Drug Use and Health. (2017). Opioid Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.

counter drugs or legitimate use of prescription drugs. The manner in which prescription drugs were misused by Nevada women include: 6.7 percent reported they had ever used a pain reliever not directed by their doctor, 0.4 percent reported they abused prescription pain relievers in the past year, and 1.1 percent reported dependence.[744] Misuse and abuse of opioid prescriptions are linked to addiction. One study showed 80 percent of persons who abused opioids had a prescription for opioids before the start of their addiction.[745] If patients do not take all prescribed medication, remaining pills can be misused by other family members, become a target for theft, or sold illegally.

The two maps below reveal communities in the Las Vegas area where women ages 15 to 44 years live and the number of prescriptions for opioids for backpain or back ache, suggesting areas where there is a risk for misuse and possible addiction to opioids among women (Figures 128-129). Red areas in the map are areas where there is a high density per square mile of women and a high number of prescriptions for backache or backpain.

Figure 128. Adult Prescription Drug Use for Backache or Back Pain Per Square Mile and Women Ages 15 to 44 Per Square mile, Las Vegas Area, 2019[746]

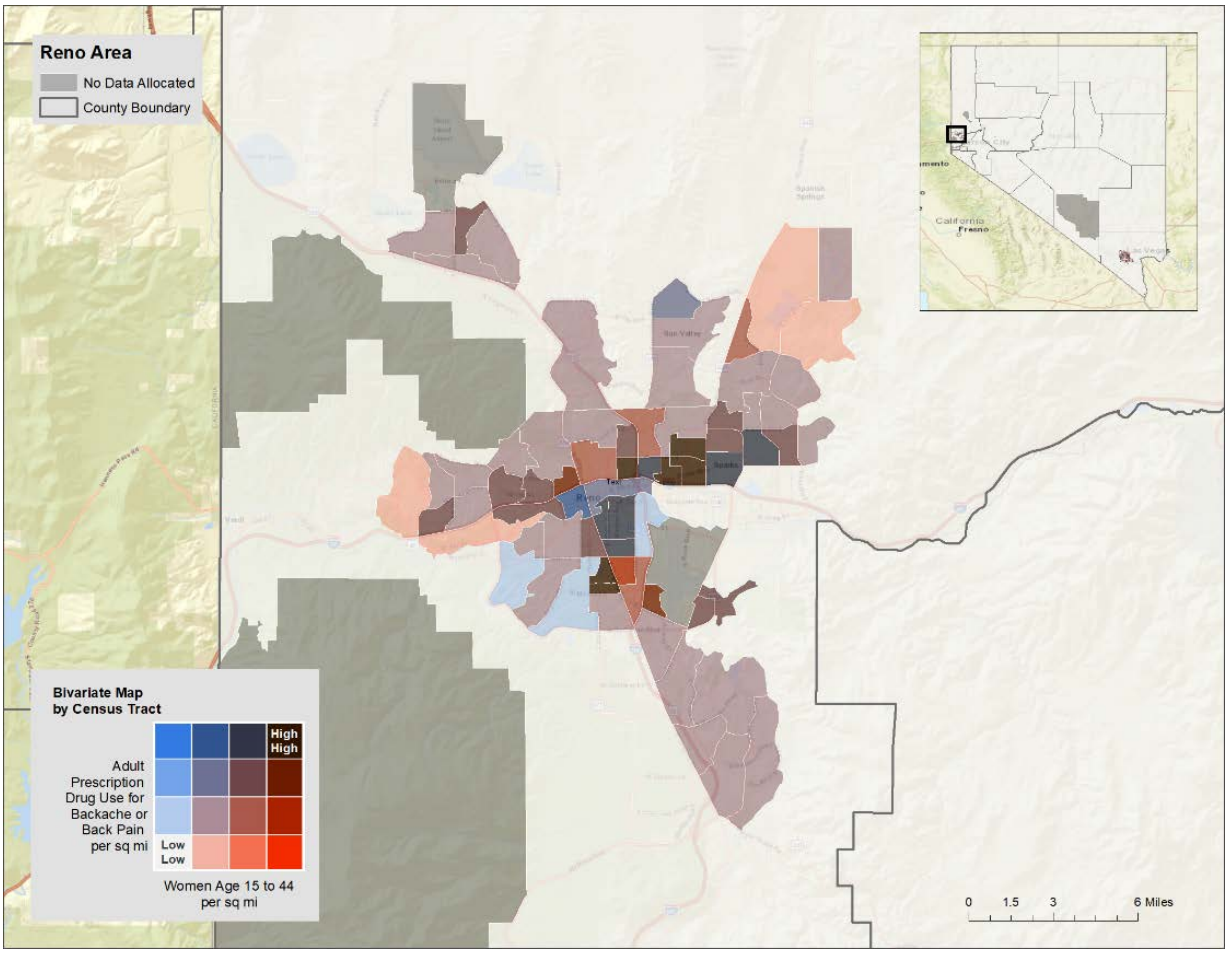


[744] National Survey on Drug Use and Health. (2017). Pain Reliver Variables. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR. This variable captures all pain relivers, not just opioid pain relivers, as breakdown by pain reliver type is suppressed.

[745] Rummans, T.A., et al. (2018, March). How Good Intentions Contributed to Bad Outcomes: The Opioid Crisis. *Mayo Clin Proc.* 93(3):344-350. Retrieved on December 15, 2019, from https://www.mayoclinicproceedings.org/article/S0025-6196(17)30923-0/pdf.

[746] Esri and GfK MRI, 2019.

Figure 129. Adult Prescription Drug Use for Backache or Back Pain Per Square Mile and Women Ages 15 to 44 Per Square Mile, Reno Area, 2019[747]



Reproductive and Sexual Health

Sexual health is another key facet of a woman's wellbeing, connected to both her physical and behavioral/mental health. This section focuses on birth control methods used in Nevada and the prevalence of sexually transmitted diseases (STDs).

Birth Control Methods

A 2017 study found most U.S. women ages 18 to 49 years reported having used one or more contraceptive methods the last time they had sex with a partner, ranging from 62 percent in Hawaii to 78 percent in Oregon and Maine.[748] The study estimated 68.4 percent of women in Nevada used contraceptives. The most common methods used are male condoms (14.3%), birth control pills (13.8%), female sterilization (13.6%), and intrauterine devices (IUD) (13.2%).[749] One in four (25.5%) women in Nevada at risk of unintended pregnancy reported using no primary contraceptive method.[750]

[747] Esri and GfK MRI, 2019.
[748] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017, New York: Guttmacher Institute. https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.
[749] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017, New York: Guttmacher Institute. https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.
[750] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017, New York: Guttmacher Institute. https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.

In 2018 in Nevada, the Family Planning Annual Report found there were 9,236 women using family planning methods from the Title X National Family Planning Program (a federal program administered by the United States Department of Health and Human Services, Office of Population Affairs). Most women had an annual income under 101 percent FPL and were uninsured. [751] Of the 9,236 women, only a quarter (25%) were given the most effective permanent (i.e., sterilization) or reversible methods (e.g., LARCs such as implants or IUDs), while the remaining women were using moderately or less effective methods (i.e., birth control pills, male condoms, injectables, withdrawal method, etc.), putting them at greater risk of experiencing unintended pregnancy.[752]

A 2016 Douglas-Hall study estimated there were 366,790 women in Nevada ages 13 to 44 years with potential demand for contraceptive services and supplies, meaning they may demand contraception to avoid or delay becoming pregnant at some point during the year.[753] Of those, it is estimated 64,970 women ages 13 to 44 years in Nevada likely need *public* support for contraceptive services and supplies, meaning they are low-income and/or uninsured and would get contraceptive supplies at Title X-funded clinics.[754] Of those women who would need public support, 44.9 percent are Hispanic women, 41 percent are White women, and 14 percent are Black or African American women. Finally, 29 percent of Nevada women ages 20 to 44 years are uninsured and fall below 138 percent FPL.[755]

Sexually Transmitted Diseases (STDs)

Sexually transmitted diseases are infections passed from one person to another through sexual contact and include chlamydia, gonorrhea, syphilis, and HIV/AIDs.

Chlamydia

Chlamydia is a common STD and is curable. Left untreated, it can be particularly harmful to women, making it difficult to get pregnant and can be passed congenitally, causing pneumonia or eye infections for the newborn. Chlamydia can also cause pelvic inflammatory disease in women and may cause permanent damage to the reproductive system leading to long-term pelvic pain, infertility, and ectopic pregnancies (pregnancies outside the uterus which can be deadly).[756] In 2018 in Nevada, there were 11,057 cases of chlamydia among women with 96.6 percent occurring among women ages 15 to 44 years. Nevada women ages 20 to 24 years were most likely to report a case of chlamydia, making up 36.3 percent of cases among women, followed by women ages 15 to 19 years (26.2%). Between 2017 and 2018, Nevada women experienced a 7.7 percent increase in chlamydia cases.[757]

Gonorrhea

Gonorrhea is a common STD and is curable. Left untreated, it can lead to pelvic inflammatory disease among women and subsequent long-term pain, ectopic pregnancies, and infertility; it can also be passed

[751] Office of Population Affairs, United States Department of Health and Human Services. (2019, August). Family Planning Annual Report: 2018 National Summary.
[752] Office of Population Affairs, United States Department of Health and Human Services. (2019, August). Family Planning Annual Report: 2018 National Summary.
[753] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017, New York: Guttmacher Institute. https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.
[754] Frost, J. et al. (2019, October). Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016. https://www.guttmacher.org/report/publicly-supported-FP-services-us-2016.
[755] Frost, J. et al. (2019, October). Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016. https://www.guttmacher.org/report/publicly-supported-FP-services-us-2016.
[756] Centers for Disease Control and Prevention and Prevention. (2014, January 23). Chlamydia – CDC Fact Sheet. Retrieved December 11, 2019 from. https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm.
[757] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2018, November). 2018 STD Fast Facts. e1.0.

congenitally and can cause serious health problems for newborns.[758] In 2018 in Nevada, there were 2,477 cases of gonorrhea among women with 92.3 percent occurring among women ages 15 to 44 years. The age group most likely to report a case of gonorrhea in Nevada are women ages 20 to 24 years (27% of new cases), followed by those ages 15 to 19 years (24%). Between 2017 and 2018, Nevada women experienced a 15.5 percent increase in gonorrhea cases.[759]

Syphilis

Syphilis is a STD and develops in four stages – primary, secondary, latent, and tertiary. Primary syphilis generally presents as a sore or sores at the site of infection while secondary syphilis usually includes skin rashes, swollen lymph nodes, and fever. In the latent state, there are no visible signs or symptoms, but the infection can continue in the body for years and ultimately, left untreated, syphilis can develop into tertiary syphilis where it can begin to have a serious health impact and can result in death. For women, syphilis is of concern because the infection can be passed congenitally, leading to low birth weight, skeletal deformities, and an increased chance the baby will be premature or stillborn.[760]

Nevada ranks first in the nation for reported cases of Primary and Secondary Syphilis and second for Congenital Syphilis.[761] In 2018 in Nevada, there were 119 cases of primary and secondary syphilis and 69 cases of early latent syphilis among women. Many primary and secondary cases were among women ages 25 to 29 years and those ages 30 to 34 years, both at 21.8 percent, followed by women ages 35 to 39 years (16%) and ages 20 to 24 years (10.9%). Between 2017 and 2018 in Nevada, there was a 2.8 percent increase in primary and secondary syphilis cases among women. For early latent syphilis, most new cases occurred in women ages 20 to 24 years (20.3%), followed by those ages 30 to 34 years and 35 to 39 years (both at 17.4%). Between 2017 and 2018 in Nevada, there was a 0.2 percent increase in early latent syphilis cases among women.[762]

HIV/AIDS

Human Immunodeficiency Virus (HIV) is a virus that attacks a body's immune system and, left untreated, can develop into Acquired Immunodeficiency Syndrome (AIDS). While not curable, HIV is treatable and people who take HIV medicine as prescribed can keep an undetectable amount of the virus in their system and can have no risk of transmitting HIV. For mothers this is important as HIV can be passed to a child during pregnancy, birth, or breastfeeding.[763] In 2018 in Nevada, there were 63 new cases of HIV reported among women with 61.9 percent occurring in those ages 13 to 44 years. Most cases occurred among women ages 35 to 44 years (28.6%) followed by those ages 25 to 34 years (22.2%). The most common way the virus was reported as being transmitted (when identified) was through heterosexual contact (42.9%).

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[758] Centers for Disease Control and Prevention and Prevention. (2014, January 29). Gonorrhea – CDC Fact Sheet. Retrieved December 11, 2019 from https://www.cdc.gov/std/syphilis/stdfact-gonorrhea.htm.

[759] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2018, November). 2018 STD Fast Facts. e1.0.

[760] Centers for Disease Control and Prevention and Prevention. (2017, June 8). Syphilis – CDC Fact Sheet. Retrieved December 11, 2019 from https://www.cdc.gov/std/syphilis/stdfact-syphilis.htm.

[761] Technical Bulletin Division of Public and Behavioral Health. (2019, April). Retrieved March 11, 2020 from http://dpbh.nv.gov/uploadedFiles/dpbh.nv.gov/content/Programs/STD/dta/Providers/CS%20Technical%20Bulletin%202019%20Signed%20(1).pdf.

[762] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2018, November). 2018 STD Fast Facts. e1.0.

[763] Centers for Disease Control and Prevention and Prevention. (2019, December 2). About HIV/AIDS. Retrieved December 11, 2019. https://www.cdc.gov/hiv/basics/whatishiv.html.

Between 2017 and 2018 in Nevada, there was a 1.6 percent increase in the number of new HIV cases among women.[764] In terms of new cases of AIDS in 2018 (i.e., HIV Stage 3), there were 34 reports among all Nevada women with 44.1 percent occurring among those ages 25 to 44 years. There were zero cases in the younger age group of 13 to 24, with 26.5 percent of all new cases from women between ages 35 and 44 years old. This makes sense in terms of how the virus works as it takes time to develop from HIV into AIDS and younger individuals often have not had the virus long enough to have it develop into later stages of the infection. Once again, the most common reported type of transmission was heterosexual contact (44.1% of new cases among women), followed by injection drug use at 8.8 percent.[765]

As of 2018, there were 1,879 women in Nevada living with HIV, with over a third of them between ages 13 and 44 years (37.7%). Over one-fifth of Nevada women living with HIV are ages 35 to 44 years, while those ages 13 to 24 years only make up 2.3 percent. Black or African American women have the greatest disparity and prevalence (47.2%) of all Nevada women living with HIV, followed by White women (31.4%), and Hispanic women (15.3%). More than half of women reported they contracted HIV through heterosexual contact (56.2%), followed by injection drug use (14.5%), and perinatal exposure (2.4%).[766] Table 70 shows the prevalence of new cases of STDs among women in Nevada broken down by race.

Table 70. New Cases of Sexually Transmitted Diseases (STDs) Among Women in Nevada, by Race, 2018[767]

STD	White	Black or African American	Hispanic	AI/AN	Asian/ Hawaiian/PI	Other/ Unknown
Chlamydia	18.7%	13.2%	17.4%	0.8%	2.9%	47.0%
Gonorrhea	21.6%	22.9%	12.1%	1.0%	1.5%	40.8%
Primary and Secondary Syphilis	50.4%	31.1%	12.6%	3.4%	0.0%	2.5%
Early Latent Syphilis	36.2%	31.9%	21.7%	1.4%	5.8%	2.9%
HIV	33.3%	55.6%	7.9%	0.0%	3.2%	0.0%
HIV Stage 3 (AIDS)	38.2%	47.1%	8.8%	0.0%	5.9%	0.0%

Violence Against Women

Violence against women is a serious public health concern which includes intimate partner violence, domestic violence, sexual violence, and stalking. Violence can lead to serious injury and even death for women and is an important factor to consider when thinking about all factors influencing a woman's health and wellbeing.

In 2017, Nevada ranked among the top 10 states with the highest rates of females murdered by males resulting in a homicide rate for women murdered by men of 2.03 per 100,000 women (higher than the national rate of 1.29 per 100,000 women). Of the women who were killed, the average age was 34

[764] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2019, April). 2018 HIV Fast Facts e1.0.
[765] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2019, April). 2018 HIV Fast Facts e1.0.
[766] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2019, April). 2018 HIV Fast Facts e1.0.
[767] Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2018, November). 2018 STD Fast Facts. e1.0.; Office of Public Health Informatics and Epidemiology, Division of Public and Behavioral Health, State of Nevada. (2019, April). 2018 HIV Fast Facts e1.0.

years. Most women killed in Nevada were White (63.3%) and slightly more than half of all women killed (55%) were shot and killed with firearms. Each woman was murdered by someone she knew, with 56 percent of the victims being wives, common-law wives, ex-wives, or girlfriends of the offender.[768]

In 2017, the Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) identified 19 domestic violence incidents resulting in 21 deaths, including 15 women and two children. More than half of these deaths (52.4%) were caused by gunshot wounds, with the rest due to stab wounds (19.1%) or strangulation (14.3%). Almost half (47.6%) of the murders were perpetrated by current dating or formerly dating partners, while the rest occurred between married individuals (14.3%) or cohabitating individuals (14.3%).[769]

The National Intimate Partner and Sexual Violence Survey (NISVS), one of the most comprehensive studies done on intimate partner and sexual violence in the U.S., estimated 39.2 percent of Nevada women (or approximately 392,000 women) experienced sexual contact violence (e.g., includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact) in their lifetime. The two most common types of sexual contact violence experienced were rape (23%) and unwanted sexual contact (27.4%); however, 33.7 percent of women also reported non-contact unwanted sexual experiences in their lifetime (e.g., harassed in a public space, made to participate in or view sexually explicit media). [770]

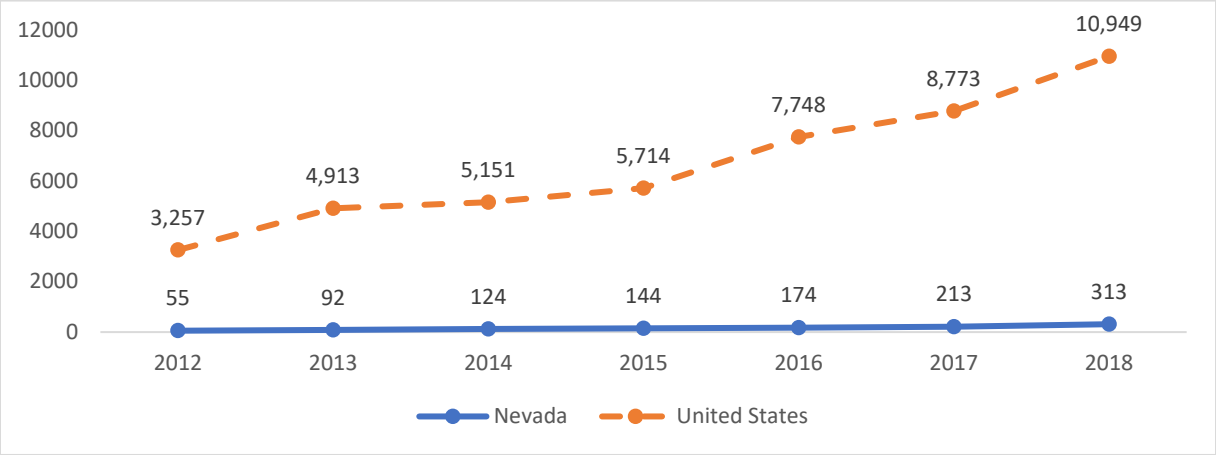
NISVS also found of those who experienced any type of sexual violence, nearly half of the women (48.7%) reported it was a current or former intimate partner who committed the violence. Overall, most of the violence was committed by a person the woman knew, with only 21.4 percent reporting the violence was perpetrated by a stranger. Most of the violence perpetrated against women was done so by men, accounting for 96 percent of the estimated rapes against women, 96.5 percent of the sexual coercion, 96.8 percent of the non-contact unwanted sexual experiences, and 93.7 percent of unwanted sexual contact. The survey also found 24.1 percent of Nevada women experienced stalking in their lifetime, with men making up 86.9 percent of the stalkers.[771]

Human Trafficking

Human trafficking is another significant issue for women, because most trafficking victims are women and girls worldwide, often for marriage and sexual slavery.[772] In 2018, the National Human Trafficking Hotline reported 313 cases of human trafficking in Nevada, an increase of 469 percent in the number of cases since 2012 (Figure 130). Most of the cases were sex trafficking (83.1%), with the rest being labor trafficking, sex and labor trafficking, or unspecified trafficking. From those 313 cases, investigators identified 592 victims, 212 traffickers, and 86 trafficking businesses.[773]

[768] Violence Policy Center. (2019, September). When Men Murder Women: An Analysis of 2017 Homicide Data.
[769] Nevada Coalition to End Domestic and Sexual Violence (NCEDSV). (2018, November). Intimate Partner Violence Homicides in Nevada 2017.
[770] Smith, S. et al. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
[771] Smith, S. et al. (2017). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
[772] UN News Center. (2016, December 22). Report: Majority of trafficking victims are women and girls; one-third children. https://www.un.org/sustainabledevelopment/blog/2016/12/report-majority-of-trafficking-victims-are-women-and-girls-one-third-children/.
[773] National Human Trafficking Hotline. (2019, July 25). Nevada Spotlight: 2018 National Human Trafficking Hotline Statistics. https://humantraffickinghotline.org/sites/default/files/NV-2018-State-Report.pdf.

Figure 130. Number of Human Trafficking Cases in Nevada and United States, 2012-2018[774]



In 2018, the Federal Bureau of Investigation identified 212 commercial sex acts related to human trafficking in Nevada, the second highest number contributed to any state. Of those 212 offenses, 30 arrests were made, with most arrests occurring among adult males (63.3%) and Black or African American males (66.7%). Of those 30 arrests, two were juvenile Hispanic females arrested for acts of involuntary servitude.[775] This data, combined with information from the National Trafficking Hotline, indicate human trafficking is a serious concern in Nevada.

Injury Related Mortality

In 2017 in Nevada, there were 239 deaths among women ages 15 to 44 years due to a fatal injury, resulting in an age-adjusted injury-related death rate of 40.9 deaths per 100,000 women (compared to 38.7 deaths per 100,000 women nationwide). Over half of the deaths (56.9%) were due to unintentional injuries, followed by suicide (27.2%), and homicide (10.9%). [776] Among unintentional injuries causing death in Nevada, almost 60 percent were due to drug poisonings (i.e., a drug overdose).

The other significant cause of death for Nevada women was motor vehicle crashes (22.8%), with the rest of the deaths occurring from non-drug poisonings, falls, fires, or drowning (exact numbers are not available due to data suppression).[777] Nationally, 60.1 percent of unintentional deaths among women ages 15 to 44 years were due to drug overdoses, followed by motor vehicle crashes (29.5%), non-drug poisonings (2.2%), drowning (1.5%), and falls (1.3%).[778] For deaths by suicide, many were due to the use of a firearm (36.9%), followed by suffocation (30.8%), and drug overdose (26.2%). For deaths due to homicide, most occurred with the use of a firearm (76.9%), while the rest were due to suffocation or being cut/pierced.[779]

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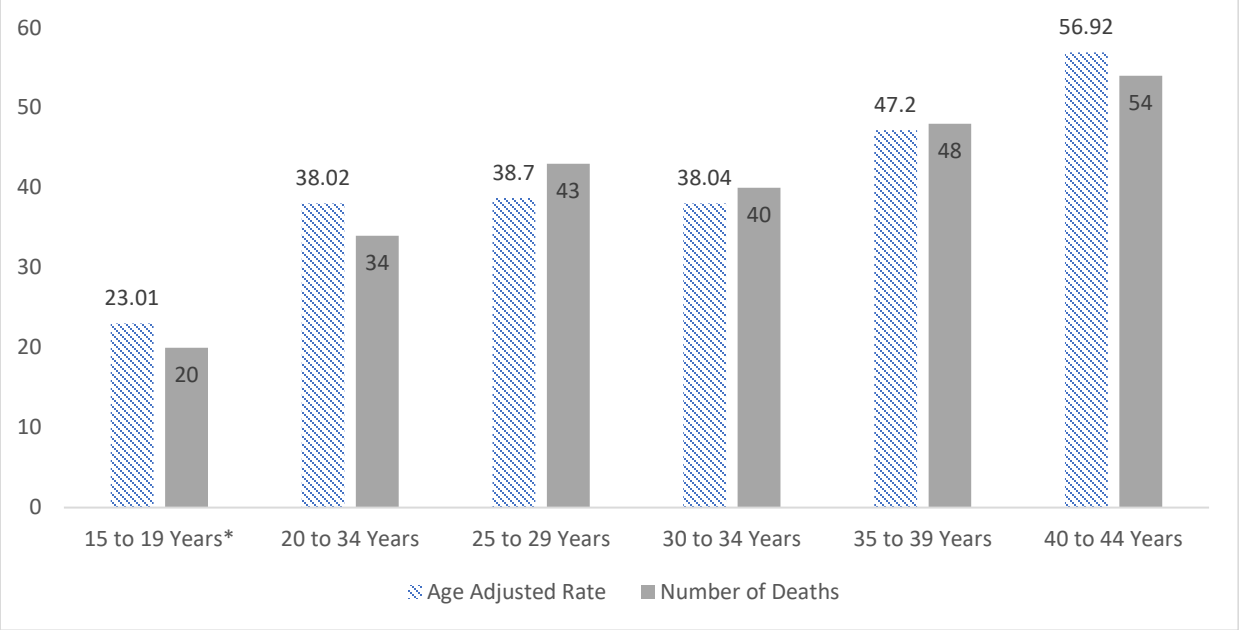
[774] National Human Trafficking Hotline. (2019, July 25). Nevada Spotlight: 2018 National Human Trafficking Hotline Statistics. https://humantraffickinghotline.org/sites/default/files/NV-2018-State-Report.pdf.
[775] Uniform Crime Reporting Program, Federal Bureau of Investigation. (2018). Human Trafficking. Retrieved December 13, 2019 from https://ucr.fbi.gov/crime-in-the-u.s/2018/crime-in-the-u.s.-2018/additional-data-collections/human-trafficking/human-trafficking.pdf.
[776] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[777] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[778] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[779] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.

Older Nevada women ages 40 to 44 years were the age group experiencing the greatest number of deaths (Figure 131). Most deaths in this age group were due to unintentional injuries (63%), mainly from drug overdose (70.6% of unintentional injuries). Suicide was also a leading cause of death for this age group (25.9%). [780]

Figure 131. Number of Deaths and Age-Adjusted Death Rates for Women, by Age Group, Nevada, 2017[781]



** Interpret with caution due to small sample.*

Regarding race and ethnicity, 6.2 percent of these deaths occurred among White women ages 15 to 44 years, giving this group an age-adjusted rate of 58.8 deaths per 100,000 women. However, the racial/ethnic group with the highest age-adjusted mortality rate is Black or African American women representing 61.4 deaths per 100,000 women even though they only accounted for 16.3 percent of all deaths among women 15-44 years. White, Hispanic women[782] contributed to 12.6 percent of the deaths, giving them an age-adjusted mortality rate of 16.4 deaths per 100,000 women, followed by Asian women making up 6.7 percent of deaths (a rate of 25.6 deaths per 100,000 women).[783]

Pregnant Women and Postpartum Women

This section focuses on the health of pregnant and postpartum women, including family planning, access to early prenatal care and other health care, substance use, emotional and mental health, physical health, and maternal mortality. Table 71 presents a summary of key indicators described in this section, including a comparison of Nevada and the U.S., and where MCH and MIECHV programs might prioritize efforts, if not doing so already.

[780] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[781] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/.
[782] Data was not available for Hispanic women of other races.
[783] Centers for Disease Control and Prevention. WISQARS Fatal Data Visualization. Retrieved December 3, 2019 from https://wisqars-viz.cdc.gov/. This value is unstable.

Table 71. Summary of Indicators for Maternal Health, Nevada and United States

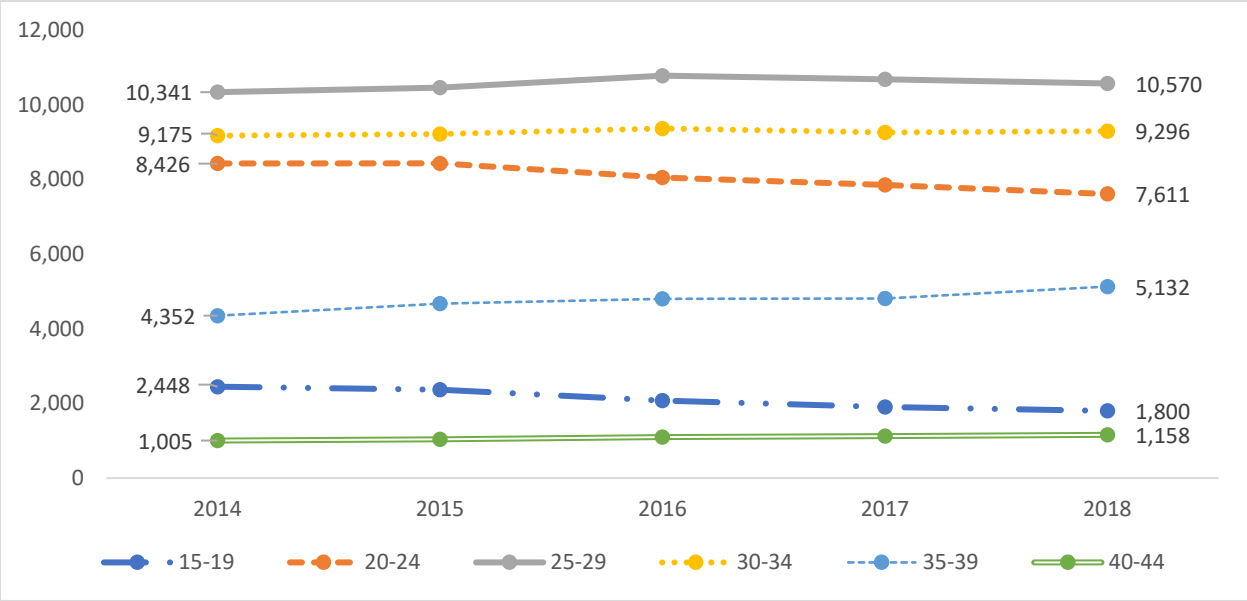
Area	Indicator (BOLD = Nevada MCH Priority Indicator as of 2019)	Nevada	United States	Opportunity for MCH and MIECHV Prioritization
Family planning	Birth rate per 1,000 teens ages 15 to 19 (2018)[784]	21.8	18.8	✓
Family planning	Abortion rate per 1,000 women (ages 15 to 44) (2017)[785]	16.4	13.5	Ø
Early prenatal care	Percent of pregnant women who did not receive prenatal care beginning in the first trimester (2017)[786]	26.0%	22.7%	✓
Access to Health Care	Percent of pregnant women needed but could not see a doctor because of cost in the past year (2018)[787]	18.0%	17.8%	✓
Access to Health Care	Percent of women on Medicaid had a postpartum care visit on or between 12 and 56 days after delivery (2018)[788]	60.6%	58.5%	✓
Substance use (cross cutting)	**Percent of women who smoke during pregnancy (2017)[789]**	4.2%	6.9%	Ø
Substance use (cross cutting)	Percent of pregnant women (ages 12 to 44) who reported using marijuana in past month (2017)[790]	15.3%	5.7%	✓
Emotional and Mental Health	Rate of severe maternal morbidity (i.e., any physical or mental illness or disability directly related to pregnancy and/or childbirth) per 10,000 delivery hospitalizations (2014)[791]	132.1	143.9	Ø
Physical Health	Percent of women (age 18 to 44) diagnosed with diabetes while pregnant (2018)[792]	2.1%	2.9%	Ø

[784] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: Natality Information, Live Births. Retrieved December 11, 2019 from https://wonder.cdc.gov/natality.html.
[785] Jones R., Witwer E., and Jerman J. (2019) Abortion Incidence and Service Availability in the United States, 2017. New York: Guttmacher Institute. Retrieved December 12, 2019 from https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.
[786] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who did not receive prenatal care beginning in the first trimester.
[787] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost among pregnant women. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[788] 2018 Adult Health Care Quality Measures. Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle.
[789] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[790] National Survey on Drug Use and Health: 2-Year RDAS. (2016-2017). Marijuana variables among pregnant women. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.
[791] Health care Cost and Utilization Project (HCUP) State Inpatient Databases (SID). (2014). National Outcome Measure 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations.
[792] Behavioral Risk Factor Surveillance System. (2018). Ever told you have diabetes. Retrieved on December 11, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Births

In 2018 in Nevada, there were 35,567 births to women ages 15 to 44 years; more than half (51.6%) were to women ages 20 to 29 years, followed by those ages 30 to 39 years (40.6 percent). The remaining births were to women ages 15 to 19 years (5.1%) or women 40 to 44 years (3.3%).[793] More than one-third of the births were to women of Hispanic origin (37.3%), followed by White women (36.5%), and Black or African American women (12.8%). The birth rate for Nevada women in 2018 was 11.8 births per 1,000 women. The age group with the highest rate is women ages 25 to 29 years at 94.4 births per 1,000 women, followed closely by women 20 to 24 years (85.6) and women 30 to 34 years (87.6). The birth rate drops for women ages 35 to 39 years (49.2) and even further for women 40 to 44 years (12.1).[794] The age group with the most births between 2014 and 2018 was women ages 25 to 29 years, followed by women ages 30 to 34 years (Figure 132). The number of births to women ages 15 to 24 years has slowly declined since 2014 while the number of births to those ages 35 to 44 years has slowly increased over the same time period.[795]

Figure 132. Total Number of Births for Women in Nevada by Age Group, 2014 to 2018[796]



Unplanned Pregnancies and Abortions

Unplanned pregnancies are the number and percentage of pregnancies that were either wanted later or were unwanted. In 2014, the year with the most recent data available, 42 percent of all pregnancies in Nevada were wanted later or unwanted. Of those pregnancies wanted later or unwanted, 39 percent ended in birth and 46 percent ended in abortion.[797]

[793] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: Natality Information, Live Births. Retrieved December 11, 2019 from https://wonder.cdc.gov/natality.html.
[794] Martin, J., Hamilton, B., Osterman, M., and Driscoll, A. (2019, November 27). Births: Final Data for 2018. National Vital Statistics Report. Vol. 68, No. 13. Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_13-508.pdf.
[795] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: Natality Information, Live Births. Retrieved December 11, 2019 from https://wonder.cdc.gov/natality.html.
[796] Centers for Disease Control and Prevention. (2019, November 19). CDC WONDER: Natality Information, Live Births. Retrieved December 11, 2019 from https://wonder.cdc.gov/natality.html.
[797] Kost K., Maddow-Zimet I., and Kochhar S. (2018). Pregnancy Desires and Pregnancies at the State Level: Estimates for 2014. New York: Guttmacher Institute. Retrieved December 11, 2019 from https://www.guttmacher.org/reports/ pregnancy-desires-and-pregnancies-state-level-estimates-2014.

In 2017 in Nevada, the abortion rate, or the number of abortions per 1,000 women ages 15 to 44 years, was 16.4 (approximately 9,690 abortions). While the abortion rate in Nevada (13.5) is higher than the rate nationally, it did experience a decline of 15 percent between 2014 and 2017.[798] From the most recent data available in 2013, there were 970 abortions by Nevada women ages of 15 to 19 years. Women ages 18 to 19 years experienced the greatest percentage of those abortions (69.7%). In 2013, the abortion rate among girls ages 15 to 19 years in Nevada was 11, the same as the rate in the U.S. (11). However, between 2008 and 2013, the rate decreased by 54.2 percent in Nevada and 38.9 percent in the U.S.[799]

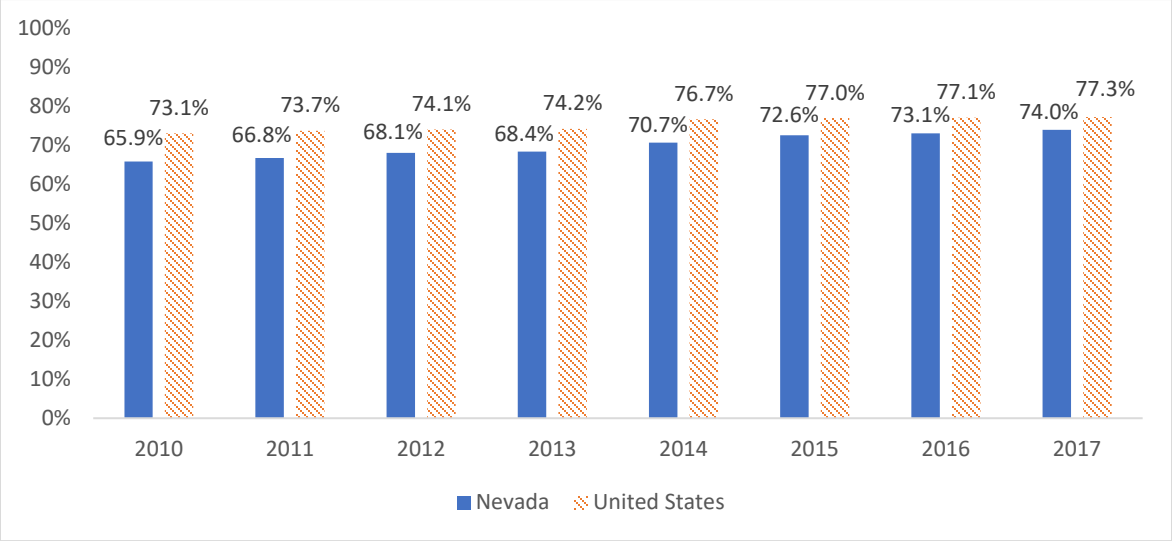
Access to Prenatal Care

Early prenatal care allows women and their health care providers to identify and, when possible, treat or correct health problems and health-compromising behaviors which can be damaging during initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.[800] In 2017 in Nevada, 26 percent of pregnant women did not access prenatal care in the first trimester, higher than for U.S. pregnant women (22.7%) (Figure 133).[801]

However, more pregnant women are likely to receive prenatal care today than eight years ago in Nevada. Nevada experienced a 12.3 percent increase (compared to a 5.7 percent increase nationally) in the number of pregnant women receiving prenatal care. Insurance coverage influences the probability women will access early prenatal care. In Nevada, among pregnant women, 20.9 percent do not have a form of health insurance (a similar percentage is calculated among non-pregnant women at 20.7%).[802] Additionally, 18 percent of pregnant women needed but could not see a doctor because of cost in the past year (lower than non-pregnant women at 22.1%).[803]

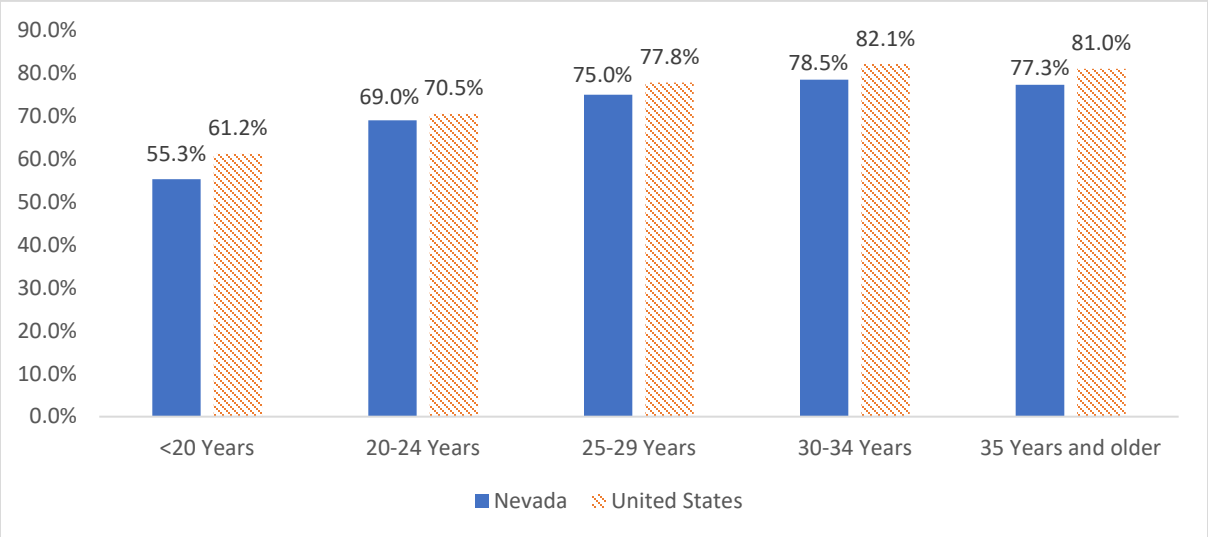
[798] Jones R., Witwer E., and Jerman J. (2019) Abortion Incidence and Service Availability in the United States, 2017. New York: Guttmacher Institute. Retrieved December 12, 2019 from https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.
[799] Kost, K., Maddow-Zimet I., and Arpaia, A. (2017). Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity. New York: Guttmacher Institute.
[800] Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health. (2017, January 31). What is prenatal care and why is it important? Retrieved December 12, 2019 from https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care.
[801] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who did not receive prenatal care beginning in the first trimester.
[802] Behavioral Risk Factor Surveillance System. (2018). Adults aged 18-64 who have any form of health care coverage among pregnant women. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[803] Behavioral Risk Factor Surveillance System. (2018). Past 12 months, needed but could not see a doctor because of cost among pregnant women. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Figure 133. Percent of Women Received Prenatal Care Beginning in the First Trimester, Nevada and United States, 2010 to 2017[804]



Access to prenatal care was correlated with educational attainment. Women with the most education (college graduates) were more likely to receive prenatal care beginning in the first trimester (86.7% in 2017), compared to women who were not high school graduates (61.4% in 2017). Being a college graduate increased the likelihood of receiving prenatal care more than any other demographic type. Age also seemed to correlate with likelihood of receiving prenatal care. Approximately three in four women ages 25 years old and older received prenatal care during the first trimester compared with one in two women less than 20 years old (55.3%) (Figure 134).[805]

Figure 134. Percent of Women Receiving Prenatal Care Beginning in the First Trimester in Nevada and United States, by Age Group, 2017[806]

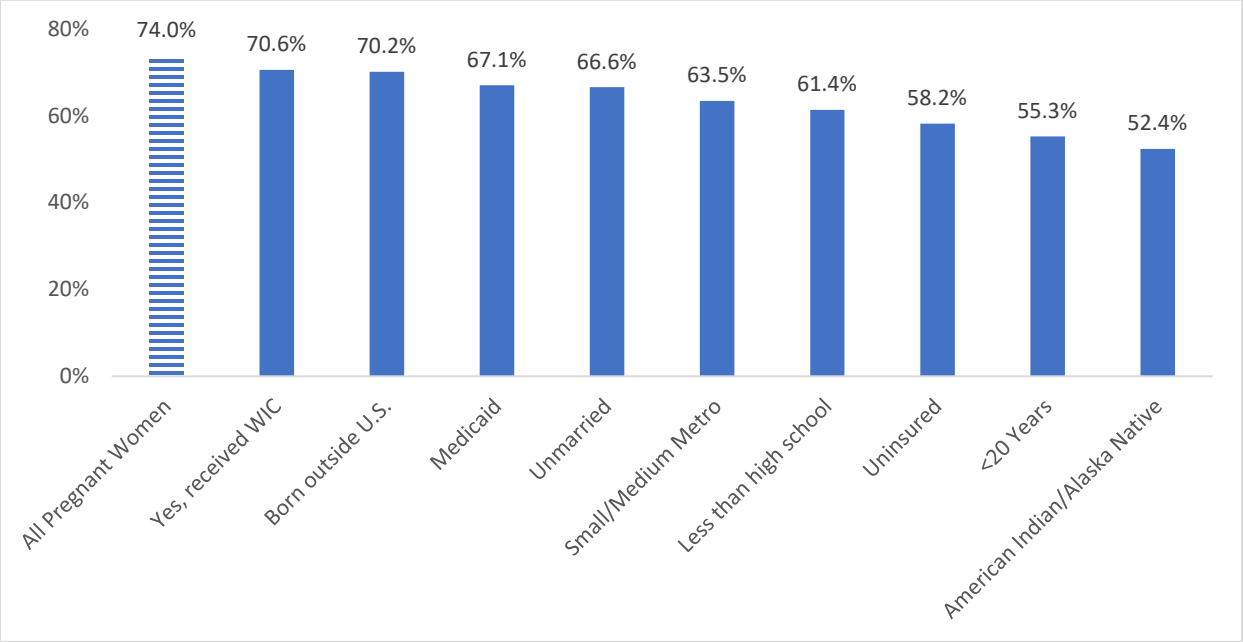


[804] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.
[805] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.
[806] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.

Race and ethnicity, as well as whether women were born in the U.S., influenced their likelihood of receiving prenatal care in Nevada. In fact, across the various demographics, American Indian/Alaska Native women were the least likely to receive prenatal care beginning in the first trimester at 52.4 percent in 2017 (Figure 135).[807] White non-Hispanic women were the most likely at 79.1 percent, compared to Hispanic women at 70.3 percent.

Marriage and insurance coverage were also strongly associated with whether a woman received prenatal care beginning in the first trimester. Married women were one of the demographics most likely to receive prenatal care (80.8%) compared to non-married women (66.6%). Just three in five uninsured women (58.2%) received prenatal care in 2017, but this can be influenced by where the mother lives, as 76.9 percent who live in an urban area received prenatal care (compared to small/medium urban community at 63.5%).[808] For more information, please review page 57 on HPSAs.

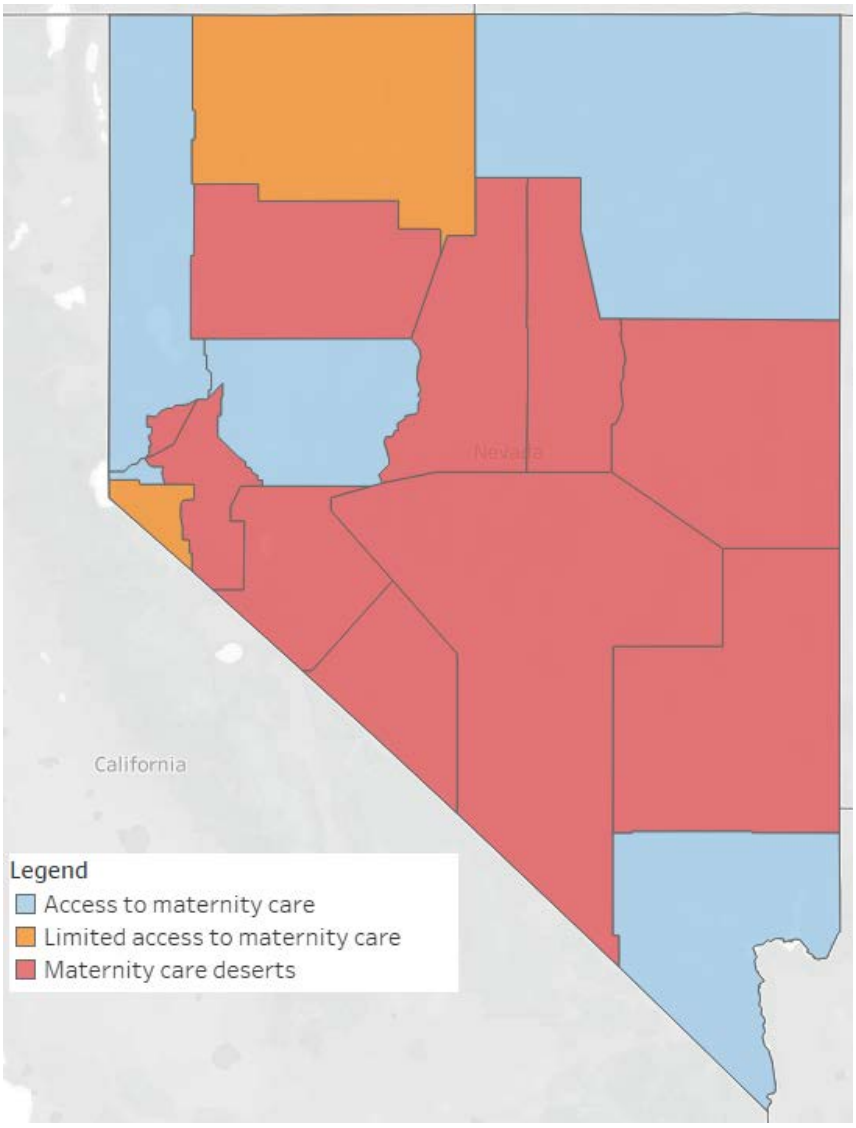
Figure 135. Percent of Women Who Received Prenatal Care Beginning in the First Trimester, by Risk or Disparity Factor, Nevada, 2017[809]



Finally, in Nevada in 2018, it was estimated 50,000 women live in a maternity care desert meaning access to maternity health care services is limited or absent, either through lack of services in the county or by presence of barriers limiting the woman's ability to access care (such as transportation) (Figure 136).[810]

[807] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.
[808] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.
[809] National Vital Statistics System. (2017). National Outcome Measure 1: Percent of pregnant women who receive prenatal care beginning in the first trimester.
[810] March of Dimes. (2018). Nowhere to Go: Maternity Care Deserts Across the U.S. Retrieved December 12, 2019 from https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf.

Figure 136. Access to Maternity Care in Nevada Counties, 2016[811]



Access to Postpartum Care

Postpartum care, defined here as care given to the mother in the 60 days following birth, was provided to 60.6 percent of Nevada women who are Medicaid clients on or between 12 and 56 days after delivery (slightly higher than the national rate of 58.5%). While the Medicaid population does not capture all women and births, it provides a snapshot of the prevalence of postpartum visits in Nevada.[812] One common item provided during postpartum care visits is contraception to allow for reproductive life planning and optimal birth spacing. Among women in Nevada on Medicaid who are ages 21 to 44 years who were postpartum, 31.3 percent were provided the most effective (i.e., LARCs) or a moderately effective method (i.e., birth control pills) of contraception within 60 days of delivery in 2018 (slightly lower than the national average of 36.8%).[813]

[811] March of Dimes. (2018). Nowhere to Go: Maternity Care Deserts Across the U.S. Retrieved December 12, 2019 from https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf
[812] 2018 Adult Health Care Quality Measures. Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle.
[813] 2018 Adult Health Care Quality Measures. Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle.

Substance Use

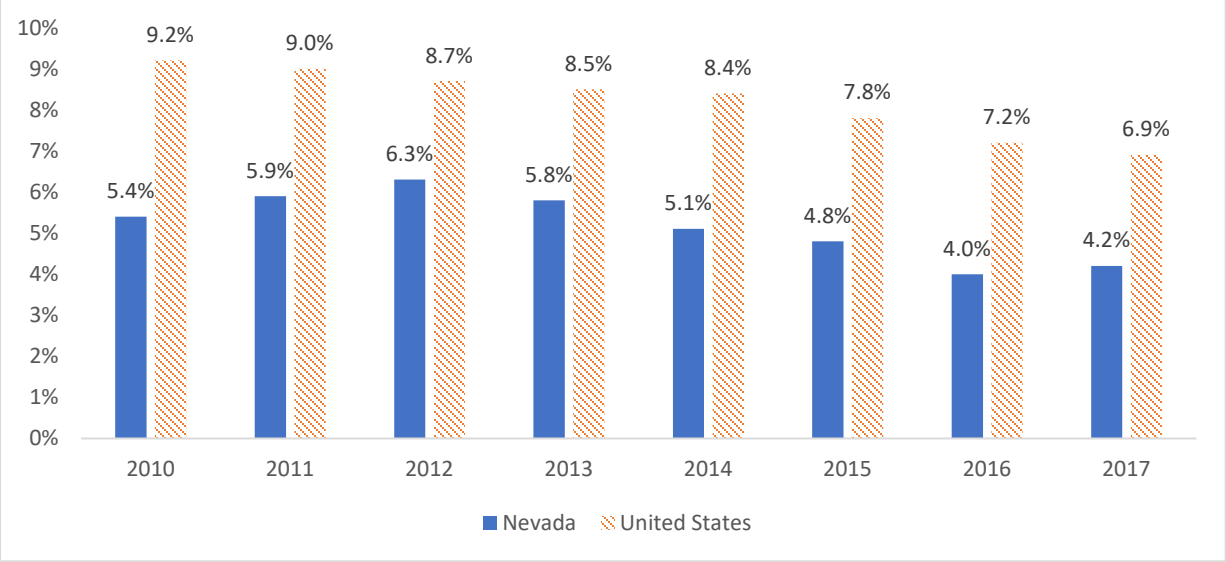
Alcohol and other substance use, including tobacco and licit and illicit drugs, can lead to long-lasting consequences for both mother and child. These risks include miscarriage, stillbirth, fetal alcohol syndrome (FAS), and neonatal abstinence syndrome (NAS).[814] It is important to understand the rate of pregnant women who use substances (see additional information on page 140) to ensure adequate access to available evidence-based treatments.

Tobacco

Smoking during a pregnancy, including both traditional cigarettes and e-cigarettes, increases the risk of health problems for women and their pregnancies, including preterm birth, low birth weight, and birth defects. It can also increase the infant's risk for sudden infant death syndrome (SIDS) and SUID after birth. Further, nicotine and some flavorings in e-cigarettes may be harmful to a developing baby.[815]

Fewer Nevada women reported smoking during pregnancy compared to women nationwide. In 2017, 4.2 percent of Nevada women smoked during pregnancy (lower than the national rate of 6.9%). Nevada has experienced a rate lower than the nation since 2010 (Figure 137). However, the rate across the U.S. has experienced a steady 25 percent decrease since 2010 (from 9.2% to 6.9% in 2017). In Nevada, the rate has fluctuated from a high of 6.3 percent in 2012 to a low of four percent in 2016. [816]

Figure 137. Percent of Women who Smoke During Pregnancy, Nevada and United States, 2010 to 2017[817]



As with other risky behaviors, the extent to which women experience protective factors such as a higher education level, older age, living in a supportive community, and marriage determine the likelihood of their decision to smoke during pregnancy. Women with less than a high school education are five times more likely to smoke during pregnancy than those with a college degree, 6.5 percent vs. 0.7 percent, respectively. Among those women with a high school diploma, the rate of smoking during pregnancy is

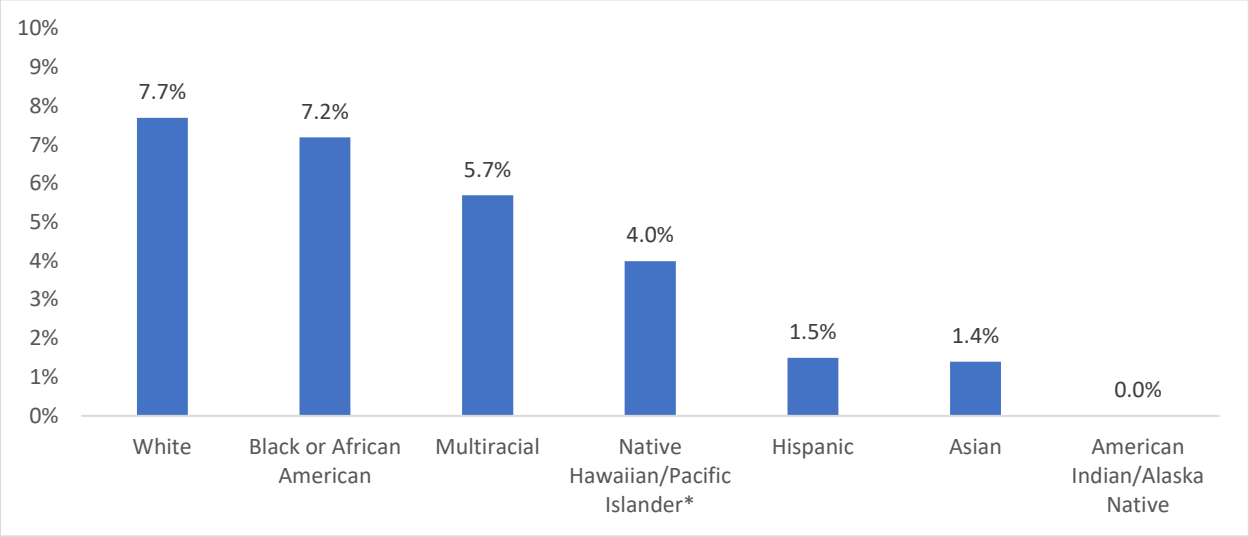
[814] SAMSHA-HRSA Center for Integrated Health Solutions. (n.d.). Substance Use Disorder and Pregnancy. Retrieved on December 5, 2019 from https://www.integration.samhsa.gov/about-us/integration-edge/substance-use-disorder-and-pregnancy.
[815] Centers for Disease Control and Prevention. (2019, July 24). Substance Abuse During Pregnancy. Retrieved on December 11, 2019 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/substance-abuse-during-pregnancy.htm.
[816] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[817] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.

5.5 percent, and for those with some college it is 3.8 percent. Marriage status also appears to be associated with a woman's likelihood of smoking during pregnancy, with those who are unmarried experiencing a rate of 6.5 percent compared to married women at two percent. Finally, women who live in a rural community are more likely to smoke during pregnancy (10.8%) compared to women who live in an urban community (3.4%).[818]

Nevada women who are Medicaid beneficiaries are also more likely to smoke during pregnancy. Among Medicaid beneficiaries the likelihood is 6.5 percent – higher than the likelihood among all women, higher than for those with public health insurance other than Medicaid (e.g., are covered by Indian Health Services or military health care) at 2.3 percent, and higher than for those with private insurance at two percent.[819]

Finally, race and ethnicity appear to be associated with smoking during pregnancy, with non-Hispanic White women experiencing the highest rates at 7.7 percent, followed by Black or African American women at 7.2 percent, multiracial women at 5.7 percent, and Native Hawaiian/Pacific Islander women at four percent (Figure 138).[820]

Figure 138. Percent of Women who Smoke During Pregnancy in Nevada, by Race and Ethnicity, 2017[821]



*Interpret with caution due to small sample size.

Other Substances

In 2018, 11.8 percent of pregnant women ages 18 to 44 years reported they consumed up to seven drinks in the past week.[822] Research has shown there is no safe time to drink alcohol during pregnancy and all types of alcohol are equally harmful. Since alcohol can pass through the umbilical cord, it can cause a wide range of lifelong physical, behavioral, and intellectual disabilities, as well as miscarriage and stillbirth.[823]

[818] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[819] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[820] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[821] National Vital Statistics System. (2017). National Performance Measure 14.1: Percent of women who smoke during pregnancy.
[822] Behavioral Risk Factor Surveillance System. (2018). Alcohol consumption among adults aged 18-64 form of health care coverage among pregnant women. Retrieved on December 11, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[823] Centers for Disease Control and Prevention. (2018, March 27). Alcohol Use in Pregnancy. Retrieved on December 11, 2019 from https://www.cdc.gov/ncbddd/fasd/alcohol-use.html.

Another substance for which data is available is marijuana. While the risks of using marijuana during pregnancy are not fully understood, early research shows it is linked to health concerns among infants such as low birth weight and developmental problems as it is understood to pass through to the fetus via the placenta and to the infant via breastmilk.[824] In Nevada from 2016 to 2017, 15.3 percent of pregnant women ages 12 to 44 years reported using marijuana in the past month and 16.7 percent reported using marijuana in the past year.[825]

More recent data from 2017 indicates approximately six percent of pregnant women used marijuana or hash, which almost doubled to 11.6 percent in 2018. Relatedly, in 2018, only 77.7 percent of pregnant women reported their doctor, nurse, or other health care worker asking if they were using any substances.[826] This suggests more education may be needed on both sides – for pregnant women and their providers – to ensure pregnant women using substances are fully informed and aware of the associated risks.

Newer data from 2018 shows 5.4 percent of women took prescription pain relivers (e.g., hydrocodone, oxycodone, codeine) during their pregnancy, suggesting this may also be a substance of growing concern as prescription pain medications can lead to birth defects, stillbirth, preterm delivery, preeclampsia, low birthweight, and NAS.[827] However, more pregnant women reported being asked by their health care provider if they were taking any prescription medications (90.4% in 2018) so it is more likely this risk factor is identified during the course of a woman's pregnancy.[828]

Emotional and Mental Health

Postpartum depression is a mood disorder affecting women after childbirth. Mothers with postpartum depression experience feelings of extreme sadness, anxiety, and exhaustion making it difficult for them to complete daily care activities for themselves or others.[829] In 2017, 12.6 percent of U.S. women experienced postpartum depressive symptoms following a recent live birth; this is an increase of 6.6 percent from a low of 11.8 percent in 2012.[830] Risk factors for postpartum depressive symptoms include symptoms of depression during or after a previous pregnancy, previous experience with depression, a stressful event during or shortly after giving birth, medical complications during childbirth, mixed feelings about the pregnancy, a lack of strong emotional support, and/or alcohol and other drug use.[831]

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[824] Centers for Disease Control and Prevention. (2019, July 24). Substance Abuse During Pregnancy. Retrieved on December 11, 2019 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/substance-abuse-during-pregnancy.htm.

[825] National Survey on Drug Use and Health: 2-Year RDAS. (2016-2017). Marijuana variables among pregnant women. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.

[826] 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.

[827] March of Dimes. (June 2019). Prescription Opioids During Pregnancy. Retrieved March 9, 2020 from https://www.marchofdimes.org/pregnancy/prescription-opioids-during-pregnancy.aspx#.

[828] 2018 Nevada PRAMS data had a response rate of 39.4% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. Interpret data with caution due to the response rate.

[829] National Institute of Mental Health Office of Science Policy, Planning, and Communications Science Writing, Press, and Dissemination Branch. (n.d.). Postpartum Depression Facts. Retrieved on November 22, 2019 from https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml

[830] Pregnancy Risk Assessment Monitoring System. (2017). National Outcome Measure 24: Percent of women who experience postpartum depressive symptoms following a recent live birth.

[831] National Institute of Mental Health Office of Science Policy, Planning, and Communications Science Writing, Press, and Dissemination Branch. Postpartum Depression Facts. Retrieved on November 22, 2019 from https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml

A study using data gathered through the 2015-16 Nevada Baby Birth Evaluation and Assessment of Risk Survey found 8.8 percent of women who completed the survey reported being diagnosed with postpartum depression disorder. This study also found pre-pregnancy depression and intimate partner violence before/during pregnancy made it significantly more likely for a woman to be diagnosed with postpartum depression.[832] Among pregnant women in Nevada, 20.5 percent have ever been told they had a depressive disorder, including depression, major depression, dysthymia, or minor depression (similar to 20.1% percent of all women in Nevada).[833] Relatedly, 3.5 percent of pregnant women in Nevada reported having 14 or more poor mental health days in the past 30 days (compared to 17% of all women in Nevada).[834]

In 2016 in Nevada, the rate of severe maternal morbidity (i.e., any physical or mental illness or disability directly related to pregnancy and/or childbirth) was 127.2 occurrences per 10,000 delivery hospitalizations.[835] This rate has increased 46 percent since 2008, when Nevada recorded a low of 87.1 occurrences per 10,000 delivery hospitalizations. Black or African American and Asian women were more likely to experience severe maternal morbidity disparities, with rates of 174.8 and 148.1 occurrences per 10,000 delivery hospitalizations, respectively. Severe maternal morbidity was much less prevalent among White women compared to all women in 2016 (102.3 per 10,000). Women ages 40 years and older saw the highest rate of severe maternal morbidity of any age group (93.6 per 10,000), with women ages 20 to 24 years experiencing the lowest rate (25.4 per 10,000).[836]

Physical Health

Pregnant women are at risk of developing certain health issues related to pregnancy, highlighting the importance of access to prenatal care to help identify any issues early and treat them appropriately. One of those health issues is diabetes related to pregnancy (i.e., gestational diabetes), which is when a woman's blood sugar levels are too high during pregnancy. While there are different diagnostic criteria and risk profiles to determine exact frequency, in 2018 in Nevada, approximately 2.1 percent of women ages 18 to 44 years developed gestational diabetes (compared to 2.9% nationwide).[837] This is an important condition to treat as it can raise the risk of the baby being too large, high blood pressure, and having a cesarean birth.[838] Another health condition of concern for pregnant women is high blood pressure as it can affect blood supply to the fetus, raising the risk for organ damage, preterm birth, pregnancy loss, and stroke.[839]

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[832] Alexander-Leeder C., Yang W., and Mburia I. (2019). Effects of Mental Health Exposure Factors on the Prevalence of Postpartum Depression: A Nevada Population-Based Study. J Preg Child Health 6:401. DOI: 10.4172/2376-127X.1000401.

[833] Behavioral Risk Factor Surveillance System. (2018). Ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/viewReport.

[834] Behavioral Risk Factor Surveillance System. (2018). Healthy Days: Calculated variable for 3 level not good mental health status. Retrieved on November 22, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/viewReport.

[835] 2017 Nevada PRAMS data had a response rate of 40.6% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. 2017 consists of seven months of data collection. Interpret data with caution due to the response rate and seven months of data collection.

[836] 2017 Nevada PRAMS data had a response rate of 40.6% which is under the Centers for Disease Control and Prevention (CDC) required response rate threshold of 55% to publish data. 2017 consists of seven months of data collection. Interpret data with caution due to the response rate and seven months of data collection.

[837] Behavioral Risk Factor Surveillance System. (2018). Ever told you have diabetes. Retrieved on December 11, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

[838] Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health. (2017, January 31). What health problems can develop during pregnancy? Retrieved December 11, 2019 from https://www.nichd.nih.gov/health/topics/preconceptioncare/conditioninfo/health-problems.

[839] Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health. (2017, January 31). What health problems can develop during pregnancy? Retrieved December 11, 2019 from https://www.nichd.nih.gov/health/topics/preconceptioncare/conditioninfo/health-problems.

In Nevada in 2017, 3.7 percent of women were told they had high blood pressure only during their pregnancy, slightly higher than the prevalence of pregnant women in the U.S. (3.4%). Looking closer at Nevada, most women with high blood pressure were ages 25 to 34 years.[840]

Sexually Transmitted Diseases

Pregnant women have the same chance of becoming infected with STDs as women who are not pregnant, however the results of a STD can be more serious, and even life-threatening, for both the pregnant woman and the fetus. STDs can complicate a pregnancy and have serious effects on a developing baby, some of which may not be seen until years after birth.[841] Chlamydia has been linked to problems during pregnancy including preterm labor, premature rupture of membranes, and low birth weight; exposed newborns can also develop eye and lung infections if they become infected during delivery. Gonorrhea has been linked to miscarriages, low birth weight, premature birth, premature rupture of membranes, and chorioamnionitis (i.e., bacterial infection of fetal membranes); newborns exposed during delivery can develop eye infections.

Additionally, syphilis has been linked to premature births, stillbirths, and death shortly after birth; untreated infants that become infected tend to develop problems in multiple organs including the brain, heart, and bones (see section on congenital syphilis on page 137). Finally, HIV, while not linked to specific complications during pregnancy, can be passed congenitally during pregnancy, labor, and delivery, or even through breastfeeding, but steps can be taken to reduce the risk of mother-to-child transmission. [842]

Testing is key in Nevada and it is a requirement all pregnant women be tested in their first and third trimester for syphilis; lack of testing is a misdemeanor. While there are requirements regarding testing for HIV, hepatitis B, hepatitis C, gonorrhea, and chlamydia, there are no penalties for a failure to test a pregnant woman for these STDs.[843] Most STDs, including chlamydia, gonorrhea, and syphilis can be treated and cured with antibiotics during a pregnancy, while others such as genital herpes, hepatitis B, or HIV cannot yet be cured but can be treated to reduce the risk of passing the infection to the baby.[844] In particular, taking anti-HIV drugs can reduce the risk of passing HIV to a fetus by 99% and although there may be side effects for mother and baby, such as nausea and effects on the development of the fetus, not taking medication greatly increases the chances of passing HIV to the fetus.[845]

Maternal Mortality

In Nevada in 2018, there were 24 pregnancy-associated deaths among women 10 to 60 years; the pregnancy-associated death rate was 67.5 deaths per 100,000 live births. A pregnancy-*associated* death is the death of a woman while pregnant or within one year of the termination of pregnancy. This is different from a pregnancy-*related* death, which is a death from a pregnancy complication, a chain of

[840] Behavioral Risk Factor Surveillance System. (2017). Ever told you have high blood pressure. Retrieved on December 11, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.
[841] Centers for Disease Control and Prevention. (2016, March 28). STDs during Pregnancy - CDC Fact Sheet. Accessed February 14, 2020 from https://www.cdc.gov/std/pregnancy/stdfact-pregnancy.htm.
[842] Centers for Disease Control and Prevention. (2016, March 28). STDs during Pregnancy - CDC Fact Sheet. Accessed February 14, 2020 from https://www.cdc.gov/std/pregnancy/stdfact-pregnancy.htm.
[843] Nevada Division of Public and Behavioral Health. (n.d.). Sexually Transmitted Disease and Hepatitis Nevada Testing Requirements and National Recommendations.
[844] Centers for Disease Control and Prevention. (2016, February 11). STDs during Pregnancy - CDC Fact Sheet (Detailed). Accessed February 14, 2020 from https://www.cdc.gov/std/pregnancy/stdfact-pregnancy-detailed.htm.
[845] The American College of Obstetricians and Gynecologists. (July 2017). HIV and Pregnancy. Accessed February 14, 2020 from https://www.acog.org/Patients/FAQs/HIV-and-Pregnancy?IsMobileSet=false.

events initiated by pregnancy, or the aggravation of an unrelated condition due to the pregnancy either while the woman is pregnant or within one year after the termination of the pregnancy. Between 2015 and 2019 in Nevada, more than half the recorded pregnancy-associated deaths were from medical causes (56%), followed by non-transport accidents (16.8%), intentional self-harm (13.5%), and assault (9.6%).[846]

For the race/ethnicity subgroups for which data are available in Nevada, the pregnancy-associated death rate was highest for Black or African American women at 130.5 deaths per 100,000 live births between 2015 and 2019. Hispanic women experienced the lowest pregnancy-associated death rate at 51.2 deaths per 100,000 live births while White women experienced a rate of 66.6 deaths per 100,000 live births. Women older than 40 years have a much higher pregnancy-associated death rate than the average woman (201.1 per 100,000), followed by women ages 35 to 39 years (121 per 100,000). Women younger than 20 years had the lowest pregnancy-associated death rate at 31.1 deaths per 100,000 live births. [847] This suggests older age is likely a risk factor for pregnancy-associated deaths.

Community Voices for Pregnant, Postpartum and Women of Childbearing Age

Community voices reported the top issues facing Nevada women ages 15 to 44 years were:

- Mental health (i.e., anxiety, depression, etc.)
- Domestic or intimate partner violence
- Illicit substance use (i.e., heroin, cocaine, etc.)

Key informants and focus group participants confirmed survey responses, including behavioral health issues being the most discussed health issue facing women of childbearing age, pregnant and/or post-partum women, followed by access to well-woman care, including sexual health and family planning, substance use, and domestic violence and sexual assault. Specific issues identified include:

1. Access to health care, specifically OB/GYNs, is an issue across the state driven by a lack of overall providers, and transportation and/or long distances to care, particularly in rural and frontier communities.
2. Access to family planning, specifically, contraception options (e.g., LARCs, etc.) are limited due in part to high costs and lack of prescribers.
3. Lack of depression and anxiety screenings among post-partum women.

Telehealth is thought to be helping with increasing access to care for women and pregnant women in some communities, but “needs to be more inclusive”. Resources to screen and address mental health and substance use are lacking. There are insufficient numbers of providers who specifically treat substance use disorder, while others highlighted a lack of programs “that assist with recovery and support.” There is also a specific need for prenatal services as related to substance use.

> “There is a lack of awareness within multiple systems around what postpartum really looks like and the treatment for it (i.e., peer support), and there is inconsistent access to training and education to provide these kinds of services”. *Key informant*

[846] Nevada Department of Health and Human Services. (2020, February 21). Pregnancy-Associated Deaths in Nevada, 2015-2019.
[847] Nevada Department of Health and Human Services. (2020, February 21). Pregnancy-Associated Deaths in Nevada, 2015-2019

Providers are hesitant to do screenings because of a perceived lack of referral opportunities. One person noted, "…we can identify a lot of these issues but then have nowhere to send them; have counseling on staff but don't have enough or are widespread enough so that is one of our biggest challenges". Marijuana and opioid use are thought to be prevalent among women of childbearing age and pregnant women, and key informants have seen the relationship between substance use and violence against women, stating "some survivors utilize substances to help cope with the violence and some abusers use substances as an excuse for the violence."

One key informant noted they only know of one program in the state that takes moms and children in for treatment. Key informants indicated a need for better safety planning across the state, including knowledge about resources, referrals, and understanding how to work with people who are in abusive situations. Key informants are seeing more intimate partner violence in homes, "…where a parent feels unsafe but can't talk about it," and they "…believe ongoing impact and threat of violence impacts the families tremendously".

Pregnant and Parenting Women Who Have Been or Are in Treatment for Substance Use Disorder

Among pregnant and parenting women who have been or are in treatment for substance use disorder (SUD), the two most discussed social service needs in a focus group were housing and transportation. Focus group participants shared current housing options provided by the state while part of SUD treatment are insufficient. Housing options discussed included extended stay motels and inpatient treatment options. Participants also expressed both a need and desire for long-term, independent living options.

> "I was already doing all the things that I was supposed to do. All I needed was help with housing and it was just very frustrating. Very, very frustrating. I didn't get my house, my emergency housing, until two days before I gave birth."
>
> *-Focus group participant*

Transportation was also identified as a priority. Focus group participants expressed they often rely on public transportation which, while mostly reliable, is very time consuming and can be difficult with children in extreme temperatures. Participants expressed having their own vehicles would help, and that services such as Lyft and Uber are preferable to public transit. Participants discussed how setting up services such as WIC and Temporary Assistance for Needy Families (TANF) and running errands such as going to the grocery store are increasingly difficult without reliable transportation options.

Participants also shared that accessing benefits such as WIC and TANF is an ongoing challenge in ways other than transportation. Difficulties with WIC include rations seem to be based on the age and weight of the child, and not the child's specific developmental needs. Other women shared TANF has volunteer/work requirements often not possible for them to meet while pregnant. One woman shared getting a part time job would have paid her more than the amount she could have received from TANF after completing the volunteer requirements.

Pregnant and parenting women in treatment for SUD shared discrimination and negative stigma are commonplace in the hospital setting, from both health care providers and representatives of CPS. Most of the focus group participants shared they use methadone for Medication-Assisted Treatment (MAT). One participant shared she uses buprenorphine. Most participants shared they felt they were treated

differently when providers and CPS representatives learned they were on methadone. “We’re still junkers. We’re still looked at like we’re still shooting heroin.” Another participant noted, “They criminalize Methadone, they really do. They look at it like you're doing something wrong. They look at you, just like you're doing heroin still,” while another said hospital providers “…were nice to me until they found out I was on Methadone.” Other participants shared their babies were removed from them immediately after delivery and often not seen again for several hours. Some participants noted they were not allowed to be alone with or nurse their babies.

The participant who received buprenorphine treatment shared a different experience. This participant had a positive experience receiving treatment and did not report any negative experiences after delivering her baby. The hospital encouraged skin to skin contact with her baby immediately after birth. This participant shared when she initially sought SUD treatment, the MAT provider explained the difference in medication options and explained the effect both would have on her and her baby, including the associated detoxification time for her baby. This participant shared she “…can’t say enough good things about” her SUD treatment.

Other women shared they did not receive the same information about medication options and the accompanying effects on themselves and their babies, and therefore could not make an informed choice about their treatment. Providers in the focus group shared they know of only three providers in the Las Vegas area who will prescribe buprenorphine for SUD treatment, while all others prescribe methadone.

> “They need to come up with a plan. They need to have a protocol. The same for everyone. If you're not getting high and you're in a treatment plan, in a treatment center and you're not getting high and you're passing your urine tests, you're doing what you're supposed to be doing and stuff. There should be a basic protocol.”
>
> *-Focus group participant*

Lack of care coordination was also discussed in the focus group. Participants expressed often no health plan (Medicaid) representative or case worker ever contacted them about their care. Another participant shared she has not been able to get proper referrals for a necessary surgery for several months. This delay has affected her ability to work and to care for her baby.

Key Takeaways

Summary of Key Findings from Data

Children's Health (birth to 17 years)

- Adolescent health (12 to 17 years) has a lower probability of being described as excellent or very good in Nevada compared to the U.S. In Nevada in 2018, 85.1 percent of parents described their adolescent's health as excellent or very good, lower than the percentage of parents nationally (87.2%).[848]
- In 2016 in Nevada, almost one in five (19.8%) child deaths was due to prematurity (number of infant deaths due to premature birth out of all child deaths).[849] While health insurance coverage rates are generally high among Nevada children, access to *consistent and adequate* health insurance coverage is less likely in Nevada compared to the U.S.[850]
- Fewer Nevada children were reported to have a medical home compared to those nationwide. Data suggest health insurance status has a large impact on whether a child has a medical home, as children without special health care needs who are privately insured are almost twice as likely to have a medical home compared to those who are uninsured (50.2% vs. 29.1%, respectively).
- Adolescents are least likely to have a medical home, and children ages zero to five years are the most likely (37.4% vs 47.9%, respectively). Adolescents were also the most common age group to not have a usual source of sick or preventive care.
- Children whose health insurance was inadequate and/or experienced a gap in coverage were less likely to have a usual source of sick care at (39.1%) percent compared to 29.9% percent with adequate and continuous insurance.
- The greatest number of child deaths in 2016 occurred among infants birth to one year in age.[851] Nevada child death rates in the older age groups are lower, with a decreasing number of deaths in the five to nine years age group but then increasing again in adolescence. This u-shaped data pattern is consistent with national death rates for the same age groups.
- There is a race and ethnic disparity among statewide child deaths. In 2016 in Nevada, Black/African American children experienced a disproportionately higher child death rate (23.6%) compared to their respective statewide population distribution of ten percent.[852]
- In 2016/17 in Nevada, 17 percent of children ages three to 17 years had a diagnosed mental/behavioral condition (lower than the 21% percent

> "We don't have enough early mental health child consultants that can work with early learning providers".
>
> *-Key informant*

[848] National Children's Health Survey. (2018). National Outcome Measure 19: Percent of children, ages 0 through 17, in excellent or very good health.
[849] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.
[850] National Children's Health Survey. (2018). National Performance Measure 15: Percent of children, ages 0 through 17, who are continuously and adequately insured.
[851] National Center for Injury Prevention and Control. (2018). Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2016 [custom data query]. Retrieved October 6, 2018, from http://www.cdc.gov/injury/wisqars/index.html., as reported in 2016 Statewide Child Death Report.
[852] State of Nevada, Division of Child and Family Services. (2018). 2016 Statewide Child Death Report. Retrieved on December 6, 2019 from http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2016_Statewide_Child_Death_Report_final.pdf.

nationwide).[853] Among these children, the percent who received treatment or counseling in 2018/19 was significantly lower in Nevada compared to the U.S; in Nevada, only one in three children (33.7%) with a condition received treatment or counseling, compared to one in two children (50.3%) nationwide.[854]

- Children in Nevada are more likely than children nationwide to ever experience two or more ACEs. In 2016/17, almost one in four (22.0%) Nevada youth (0 to 17 years) experienced two or more ACEs, compared to approximately one in five (18.6%) youth nationwide. The most common ACE experienced is parental separation or divorce (28.1% of Nevada children have this experience), followed by living with someone with substance use issues (11.4%), and having a parent who served time in jail (11.2%).
- Age group disparities exist in Nevada regarding the likelihood of experiencing child abuse with younger children more likely to experience abuse. As confirmed by Nevada CPS, 41 percent of Nevada children ages zero to four years were victims of maltreatment, compared to only 13 percent of children 11 to 13 years and 14 percent of those 14 to 17 years. This trend of younger children being more vulnerable to abuse/maltreatment is similarly seen nationwide.[855]

Young Children

- In 2018/19, more Nevadans living in rural counties (38.3%) report their kindergarten child received screening for developmental concerns as compared to Washoe County (37.1%) and Clark County (29.1%).[856]
- In 2016 in Nevada, the highest IMR was seen among Black or African American infants at 9.6 deaths per 1,000 live births, far exceeding the rate seen statewide (5.8) and the rate seen in White non-Hispanic infants (4.7).[857]
- Nevada Kindergarteners met or surpassed the CDC's goal for adequate MMR, DTaP, Hepatitis B, and Polio immunizations; Hepatitis B is the only vaccination surpassing the CDC's goal at 97.4 percent of kindergartners being adequately immunized upon school entry.
- There was little geographic difference in the percent of Nevada children who are obese. However, there was some disparity by race and ethnicity, with White children having the lowest rates of obesity (15.3%) compared to Black or African American children (27.4%) and Hispanic children (32.1%).
- Among Nevada kindergarteners in 2018/19, 6.5 percent of parents reported having tried to access mental health services for their child(ren), a slight increase from 2017/18 (5.7%). Of those 6.5 percent who attempted to access services, 40.2 percent reported having trouble

> "Obesity is probably the number one problem seen in kids and we can link that to health and psych – ADHD, depression, bullying. So, there is a network effect where if we can impact this one thing, we could avoid so many other issues."
> *– Provider Focus Group Participant, Washoe County*

[853] Child Trends analysis of data from the United States Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health.
[854] National Children's Health Survey. (2018). National Outcome Measure 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling.
[855] United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2000–2017.
[856] Nevada Institute for Children's Research Policy. (2019, May). UNLV Results of the 2018-19 Nevada Kindergarten Health Survey.
[857] National Vital Statistics System. (2016). National Outcome Measure 9.1: Infant mortality rate per 1,000 live births.

obtaining services, an increase from the previous survey year (37.9%). When examining this percentage across counties, slight differences between exist, with those in rural counties reporting less trouble obtaining services. Additionally, parents who had trouble accessing mental health services stated wait times and availability of appointments were the biggest barriers. Other barriers included lack of services in the area, difficulties receiving services, lack of coverage by insurance or other insurance issues, services were too expensive, and services are bad or not helpful.

- In total, 65.1 percent of Nevada children ages zero to five years need childcare, because they live in a household where all parents work, and this increases to 70.1 percent of children ages six to 12 years. When looking at the need for childcare compared to supply, Nevada's early childhood care capacity meets less than a quarter (23%) of the need for children ages zero to five years. Yet between 2008 and 2017, Nevada experienced a 52 percent decline in licensed family childcare programs and a five percent decline in licensed centers, exacerbating the gap between need and supply.
- In 2018, Nevada ranked as the least affordable state in the nation for the cost of infant care in licensed family childcare and eighth least affordable in licensed childcare centers. In Nevada, the cost of infant care represents over half of the income (55%) for a family of three living at 100 percent FPL and 40 percent for a family of three living at 140 percent FPL.

Adolescent/Young Adult

- BMI rates among Nevada adolescents are slightly lower compared to national rates; nevertheless, nearly 30 percent of Nevada adolescents are struggling with their weight.[858]
- In Nevada between 2016 and 2017, 11.7 percent of youth ages six to 17 years were completely inactive over the last week (meaning they had zero days of physical activity for at least 60 minutes), higher than the national rate of 9.4 percent.
- In 2017 in Nevada, almost half (49%) of all children lived in households receiving one to four types of food or cash assistance (higher than the national rate of 40.5%).
- Nevada's estimated childhood and adolescent immunization coverage rates are the highest they have been since 2007. For those ages 13 to 17 years, 51.1 percent received their initial dose of HPV vaccine in 2018 (equal to the national rate).
- According to 2017 Nevada High School YRBS data, 63.2 percent of students reported not ever having sexual intercourse (higher than the national rate of 60.5%) and 4.1 percent reported having sexual intercourse for the first time before age 13 years (higher than the national rate of 3.4 percent). Additionally, 16.8 percent of students did not use any method to prevent pregnancy during their last sexual intercourse (higher than the national rate of 13.8%).
- In Nevada between 2007 and 2017, the percentage of high school students reporting having ever been physically forced to have sexual intercourse decreased 25 percent (from 7.6% to 5.7%); however, the current percentage has been stable since 2013.
- For high school students who identify as LGB, they reported being more likely to have been forced to do sexual things when they did not want to, experience physical dating violence, experience sexual dating violence, and being physically forced to have sexual intercourse – compared to both the overall student body and students who identify as heterosexual.

[858] Data Resource Center for Child & Adolescent Health. (2017). National Survey of Children's Health.

- Nationally, Nevada ranked 17th in 2017 for the teen birth rate, 41st for the teen pregnancy rate (this rate includes all pregnancies rather than just those resulting in a birth), and 11th in terms of the 10-year decline in the teen birth rate. Nevada Black or African American teens experience the highest rates of birth at 38.4 per 1,000 girls ages 15 to 19 years, followed by rates of 30.4 for American Indian/Native American girls, and 27.2 for Hispanic girls.
- In 2017 in Nevada, the adolescent suicide rate for ages 10 to 19 years was 9.6 per 100,000 adolescents (higher than the national rate of 7.1); an estimated 63.1 percent of adolescents with major depression do not receive any mental health treatment nationwide, with a higher percent (64%) not receiving treatment in Nevada.
- According to NVSS, non-Hispanic White adolescents ages 15 to 19 years had a higher adolescent suicide rate at 17.5 deaths per 100,000 adolescents compared to 7.9 for Hispanic adolescents.
- Generally, drug use has declined among adolescents since 2007 except marijuana use, with 5.4 percent more high school students trying marijuana at least once in 2017 (37.2%) compared to in 2007 (35.3%). Additionally, 15.5 percent more high school students reported using marijuana at least one day in the prior 30 days (15.5% in 2007 to 17.9% in 2017).
- In 2017 in Nevada, the leading causes of death for youth ages 10 to 19 years were unintentional injury (29.6%), suicide (27.8%), and homicide (17.5%).[859] The percentage of deaths due to suicide and homicide are higher for Nevada adolescents compared to the U.S.
- A disproportionate number of Nevada Black or African American adolescents are affected by non-homicide abuse and neglect (40%), homicide (30%), asphyxia (25%), and motor vehicle accidents (21%) compared to the statewide population for Black or African Americans at ten percent.

Children and Youth with Special Health Care Needs

- Nine in 10 (95.3%) Nevada children without special health care needs were reported to be in excellent or very good health compared to approximately only seven in 10 (67.1%) Nevada CYSHCN (and lower compared to their CYSHCN peers nationwide at 71.2%).
- The percent of children ages zero to 17 years who were continuously and adequately insured from 2017-2018 in Nevada is lower among CYSHCN (54.5%) compared to non-CYSHCN (65.0%).
- Among CYSHCN in Nevada, 6.9 percent were not able to obtain needed health care in 2016-17 (higher than non-CYSHCN at 1.9%) and 32.4 percent of adolescents with special health care needs had no preventive care or wellness visit with a doctor or other health care professional in 2016-17 (compared to 10.3% among non-CYSHCN).
- In Nevada between 2017-18, 26.3 percent of CYSHCN were reported to have a medical home (compared to 29.5% of non-CYSHCN), much lower than the 43.4 percent of CYSHCN with a medical home across the U.S. CYSHCN in Nevada with private health insurance are more than twice as likely to have a medical home than those with Medicaid (38.2% vs. 15.2%, respectively).

> "I think it [medical home] is a wonderful priority and ideal we want to aspire to but not sure we've been able to pull it off in our state yet so still in the aspirational stage; hard to do in practice."
>
> *-Key Informant*

[859] National Center for Health Statistics (NCHS), National Vital Statistics System, accessed via CSC WISQARS.

- Fewer Nevada CYSHCN receive quality referrals or care coordination, if needed, compared to their non-CYSHCN peers.
- The percent of children six to 11 years and 12 to 17 years with a medical home is nearly twice as high as children zero to five years between 2017 and 2018. Compared to children without special needs, the age group with the greatest disparity are those ages zero to five years.[860]
- In Nevada, only 5.9 percent of CYSHCN receive care in a well-functioning system compared to 13.9 percent nationwide. A well-functioning system is defined as including a medical home, family partnership, early screenings, adequate insurance coverage, easy access to services, and preparation for adult transition from a pediatrician. Being an adolescent, followed by income and educational achievement, are risk factors for not receiving care in well-functioning system. Additionally, CYSHCN of single mothers are even less likely than other CYSHCN across the state to receive care in a well-functioning system (3.6% vs. 6.9%, respectively).
- Fewer Nevada children are currently receiving special services to meet their developmental needs such as speech, occupational, or behavioral therapy compared to children nationwide. In Nevada in 2017-18, six percent of children currently receive services compared to 7.6 percent of children nationwide. This disparity increases as children age.
- The percent of adolescents with special health care needs, ages 12 to 17 years, who receive services necessary to make transitions to adult health care is 10.3 percent, much lower than for adolescents nationwide at 18.9 percent.

Women

- In 2018 in Nevada, 76.5 percent of all women reported their general health as good, very good, or excellent; this was lower than the percentage of U.S. women who rated their general health as good, very good, or excellent (80.6%). Race and income are significant risk factors for women reporting good health, with only 29.8 percent of low-income women and 57.9 percent of Black or African American women reporting good to excellent health.
- While more Nevada women had health insurance coverage in 2018 (increasing 4.9% from 2014), the percentage reporting good health has been trending down (decreasing 6.5% from 2014 to 2018). This may in part be a response to increasing poverty in the state as a risk factor for poor health; the percentage of families living in poverty in 2017 in Nevada was 10.3 percent, up from 8.6 percent in 2014.
- There is a significant disparity between White and Hispanic/Latina women ages 25 to 35 years regarding engaging in exercise and other physical activity (87.3% and 63.8%, respectively), suggesting this may be a prime group to engage in interventions for increasing physical activity.
- In 2018 in Nevada, 16.8 percent of women ages 18 to 44 years reported having 14 or more days in the past 30 days when their mental health was not good (compared to 13.1% among the general population in Nevada); for women ages 18 to 24 years, this rises to 20.7 percent.[861]
- In 2018 in Nevada, the rate of death among women due to intentional self-harm was 11 per 100,000 women. This rate is one of the highest in the nation, with only Wyoming and Alaska having higher rates in 2018 and is nearly double the rate for U.S. women (6.2 per 100,000). This rate has risen for women since 2016 and is the highest rate experienced in Nevada since 2012.

[860] National Children's Health Survey. (2018). National Performance Measure 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
[861] Behavioral Risk Factor Surveillance System. (2018). Calculated variable for frequent (14+ days) poor mental health. Retrieved December 10, 2019 from https://nccd.cdc.gov/weat/#/crossTabulation/selectYear.

Based on this data, suicide is a major concern in Nevada, for both men and women. Protective factors to prevent intentional self-harm include effective clinical care for both mental and physical health and easy access to clinical interventions and family and community support, all of which are important factors to consider when considering ways to prevent suicide.

- In Nevada, methamphetamine use among women is nearly twice the rate of statewide use generally (8.4% vs. 4.2%, respectively). Additionally, women are more likely than other Nevadans to report being heavy drinkers (6.1% vs. 5.6%, respectively) and to misuse prescription pain medication (9.2% vs. 6.7%, respectively). Substance use rates are generally higher among White women for illicit substances compared to other race/ethnicities.
- Almost one in four Nevada women at risk of unintended pregnancy reported using no primary contraceptive method. Almost one in five Nevada women need public support to obtain contraceptive services and supplies, meaning they are low-income and/or uninsured and would obtain contraceptive supplies at Title X-funded clinics.
- Approximately 60 percent of deaths among Nevada women are attributable to unintentional injury due to drug poisoning (i.e., a drug overdose).
- Women living in Nevada disproportionately experience violence compared to women nationwide. In 2017, Nevada was ranked in the top 10 states with the highest rates of females murdered by males with 30 women murdered that year, resulting in a homicide rate for women murdered by men of 2.03 per 100,000 women. Of the women who were killed, the average age was 34 years. It is also estimated 39.2 percent of Nevada women (approximately 392,000 women) have experienced sexual contact violence (includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact) in their lifetime.
- Human trafficking is increasing in Nevada; the National Human Trafficking Hotline reported 313 cases of human trafficking in Nevada in 2018, an increase of 469 percent in the number of cases since 2012. Most of the cases were sex trafficking (83.1%). The Federal Bureau of Investigation also found in 2018 there were 212 commercial sex acts related to human trafficking in Nevada, the second highest number nationwide.

Pregnant Women

- Nevada ranks 17th in nation for teen birth rate at 21.8 births per 1,000 women, higher than the U.S. rate of 18.8.[862] However, it is trending downward at a similar rate to the nation.
- In 2017, nearly one in four (26.0%) pregnant women in Nevada did not access prenatal care in the first trimester, higher than pregnant women nationwide at 22.7 percent, suggesting the need for better access to care for all women. However, more pregnant women are likely to receive prenatal care today than eight years ago in Nevada. Nevada experienced a 12.3 percent increase and the U.S. a 5.7 percent increase among pregnant women receiving prenatal care. Cost is a barrier to care as 18.0 percent of pregnant women needed but could not see a doctor because of cost in the past year (lower than non-pregnant women at 22.1%).
- A 2017 study found most U.S. women ages 18 to 49 years reported having used one or more contraceptive methods the last time they had sex with a partner, ranging from 62 percent in

[862] National Vital Statistics System. (2017). National Outcome Measure 23: Teen birth rate, ages 15 through 10, per 1,000 females.

Hawaii to 78 percent in Oregon and Maine.[863] The study estimated 68.4 percent of Nevada women ages 18 to 49 years used contraceptives in 2017.

- Approximately 50,000 women live in a maternity care desert meaning access to maternity health care services is limited or absent, either through lack of services in the county or by the presence of barriers limiting the woman's ability to access care (e.g., transportation).[864]
- In Nevada from 2016-2017, 15.3 percent of pregnant women ages 12 to 44 years reported using marijuana in the past month and 16.7 percent reported using marijuana in the past year.[865]

Areas for Action

Since many health care, social, and economic issues impact the health of women, children, and adolescents, multifaceted approaches are needed to improve health and wellbeing among MCH population groups. As MCH and MIECHV priorities are determined, specific strategies and actions can be implemented based on state and local resources, programmatic or policy levers, and community will. Areas to consider for prioritization include:

- Access to care for all MCH populations
- Building a networked system of care in regions/communities, including increasing knowledge of community-based services and improving referral processes
- Single mothers as a population of focus
- Mental health and pregnancy-related depression
- Suicide prevention
- Substance use in pregnant and parenting mothers
- Tobacco use among women in rural and frontier communities
- Sudden Unexpected Infant Death
- Developmental screening
- Increasing access to a medical home for CYSHCN

[863] Douglas-Hall A., Kost K., and Kavanaugh M. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017. New York: Guttmacher Institute. Retrieved December 12, 2019 from https://www.guttmacher.org/report/state-level-estimates-contraceptive-use-us-2017.

[864] March of Dimes. (2018). Nowhere to Go: Maternity Care Deserts Across the U.S. Retrieved December 12, 2019 from https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf.

.[865] National Survey on Drug Use and Health: 2-Year RDAS. (2016-2017). Marijuana variables among pregnant women. Retrieved on December 11, 2019 from https://rdas.samhsa.gov/#/survey/NSDUH-2016-2017-RD02YR.

Appendices

Appendix A: Key Informant Interview Discussion Guide

INTRODUCTION

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado is working with the Nevada Division of Public and Behavioral Health, Maternal, Child and Adolescent Health Section, including the Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health (MCH) Program to conduct a statewide needs assessment on the health and safety of women of childbearing age, infants, children, and adolescents, including children and youth with special health care needs and their families.

As part of the needs assessment, HMA is conducting interviews with key stakeholders identified by the MIECHV and MCH programs. The purpose of these interviews is to gather information from the perspective of key leaders about what is most needed across the state and where there are gaps and barriers in maternal and child health services and programming. We are also interested in what your community is doing/can do to improve maternal and child health, development and wellbeing.

There are no wrong answers to the questions we ask. We really want to know what you think, so we hope you feel free to talk openly. What you share is up to you. You don't have to answer any questions you don't want to answer, and you are free to stop taking part at any time.

We will be taking notes and these notes are only to make sure we remember what you have said. Your name or any identifying information will not be reported with findings from this discussion.

Questions

A. Please tell us about your organization and your role within the maternal and child health, development and wellbeing system of care in Nevada.

B. To which group of people do you or your organization primarily provide services?
    1. Women of Childbearing Age, 15 to 44 Years
    2. Perinatal/infants (before and after birth, up to 1 year of age)
    3. Children with or without special health care needs, ages 1 to 10 years of age
    4. Adolescents with or without special health care needs, ages 11 to 19 years of age

C. For the population(s) you or your organization serve, we have questions we'd like your perspective on, keeping in mind the community in which these services are delivered:
    1. What do you see as the major health, development and wellbeing issues affecting the people you serve (by population)?

2. Do these issues affect different populations within the group? For example, and where appropriate, LGBTQ, gender, race/ethnicity, undocumented, and/or disability.

3. The state identified the following health, development and wellbeing priorities in the 2019 MCAH Block Grant Application. Do you think these continue to be the most pressing health, development and wellbeing issues in the state?

    a. Women of Childbearing Age, 15 to 44 Years
        i. Well women care

    b. Infants, Under 1 Year of Age
        i. Breastfeeding

    c. Children, Ages 1 to 10 Years
        i. Developmental screening
        ii. Physical activity

    d. Adolescents, Ages 11 to 19 Years
        i. Physical activity
        ii. Adolescent well-visit

    e. Children and Youth with Special Health Care Needs
        i. Medical home

4. What other organizations in your community or in the state are addressing the health, development and wellbeing issues you've identified?

5. Within the state's public health system, what are the barriers or gaps in services and programs associated with the issues you mentioned?

6. Are these barriers/gaps unique to your community? Please explain.

7. Within the state public health system, what would you like to see more of, or what changes would you like to see regarding programs, interventions, information, support, etc.?

    a. Are there barriers at the state or community level to what you have mentioned?

8. What specific recommendations do you have for improving the health of mothers, children and families in the state and overcoming the barriers/gaps mentioned?

D. Closing

1. These are all the questions we have for you today. Does anyone have anything they would like to add that might've not been covered?

Appendix B: Focus Group Discussion Guide Recipients of Services and Programming

INTRODUCTION

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado is working with the , Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health Program (MCH) of the Nevada Division of Public and Behavioral Health to conduct a statewide needs assessment on the health and safety of women of childbearing age, infants, children, and adolescents, including children and youth with special health care needs and their families. As part of the needs assessment, HMA is talking to groups of community members: providers of mental health, physical health, and social services to women of childbearing age, infants, children, adolescents, children and youth with special health care need, and families in different parts of the state. The primary goal of the conversations is to understand the perspective of community members regarding the needs of these Nevada residents, as well as barriers and gaps in services and programming within the state's public health systems as it relates to mothers, children, adolescents and children and youth with special health care needs.

Focus groups will be conducted in areas such as: Washoe County, Clark County, Carson City, Douglas, Storey, Lyon, Elko, and Nye Counties.

FOCUS GROUP OBJECTIVES

Focus groups will allow participants to interact in a discussion of their opinions about the topics and issues raised by facilitator's questions. Facilitation will combine the technique of open communication with attentive listening, observation, and skillful direction. The discussion will provide insight to deepen HMA's understanding of the health, development and wellbeing needs of women of childbearing age, infants, children, adolescents, children and youth with special health care needs in Nevada. Information collected will be analyzed and summarized in aggregate. No individual identifying information will be collected or shared. The following type of analysis and summarized information will be provided in a report to the programs:

- Summaries by type of group
- Summary of identified themes across groups
- Summaries of any identified differences across geographic communities

Objectives of the focus groups are to:

1. Gather participant feedback to better guide successful establishment of recommendations for effective strategies to improve the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs.
2. Engage community members working on or impacted by issues related to the health, development and wellbeing needs of women of childbearing age, infants, children, adolescents, children and youth with special health care needs to better understand common and unique ideas, opinions and attitudes about issues affecting these populations.
3. Understand the climate, attitudes, and existing risk and protective factors related to the health, development and wellbeing of women of childbearing age, infants,

children, adolescents, children and youth with special health care needs in regions across Nevada.

FOCUS GROUP COMPOSITION

The focus group facilitation team consists of two HMA team members, one focused on active listening to feedback and facilitating the discussion, and one focused on taking notes and capturing the general sentiment of the discussion.

HMA will aim for focus groups consisting of a minimum of six and a maximum of 12 participants. HMA will work with stakeholders in each region and staff of the Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health (MCH) Program to recruit a diverse set of participants with a spectrum of ideas– language, ethnicity, race, age, gender, sexual orientation, gender identity, education level and mobility.

FOCUS GROUP GUIDING PRINCIPLES

HMA will conduct focus groups according to the following guiding principles:

- Ensure an accessible location and room set up; create a friendly, comfortable environment.
- Conduct group in a welcoming tone, assuring participants there are no wrong answers and responses in the discussion will not be attributed to specific individuals.
- Establish ground rules for the discussion.
- Ensure neutrality in words, expressions, and sensitivity to participants' emotions.
- Encourage those who are less talkative to participate.
- Ensure all participants feel their voices are heard and valued.
- Ensure participants are respectful of each other and different opinions.
- Provide refreshments for focus group participants.

AGENDA AND SCRIPT FOR FOCUS GROUPS

1. Welcoming remarks and level setting by HMA

1.1. Hello and welcome. Thank you for being here today.

1.1.1. Facilitators introduce themselves and a bit about their background and qualifications.

1.2. Background and purpose

1.2.1. We are talking to groups of community members across the state. The Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health Program (MCH) of the DPBH contracted with HMA to work with stakeholders in these regions in an effort to identify gaps and barriers to improving the health,

development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs across the state. The primary goal of the project is to understand from the community perspective what is most needed across the state and where there are barriers and gaps in services and programming.

1.2.2. We have invited you to share your ideas so that we can better understand concerns and thoughts about the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs in your community. We are also interested in what your community is doing/can do to improve the health, development and wellbeing of these populations.

1.2.3. If you don't feel like sharing your thoughts with others, you can always decline to answer, or you can answer by jotting notes on your note pad.

1.2.4. We are not here to collect names or personal stories. Rather, we want to know what you think about these issues, community solutions that already exist, and ideas for solutions that need to be implemented.

1.2.5. We have a few ground rules and would like to have you offer some as well. Notes will be taken so we can capture important ideas and information, but no names will be used in reporting results of the session.

1.2.5.1. This focus group is a space where each of you can share your experiences and ideas without judgement.

1.2.5.2. The purpose of the session is to get as many opinions and ideas as possible.

1.2.5.3. Please do feel free to share your personal opinions.

1.2.5.4. We are here to help guide the discussion and ensure everyone gets a chance to speak. Please speak one at a time – refrain from sidebar conversations - and allow each other to speak without interrupting.

1.2.5.5. We understand you may need to have a cell phone for emergencies, but we ask that you please put it on silent and put it away, so it does not distract you or others in the group.

1.2.5.6. Please follow the rule of "what is shared in the group stays in the group."

1.2.6. There are no wrong answers to the questions we ask. We really want to know what you think, so we hope you feel free to talk openly. What you share is up to you. You don't have to answer any questions you don't want to, and you are free to stop taking part at any time.

1.2.7. We will be taking notes and these notes are only to make sure we remember what the group said and so we can include everyone's point of view in our report. Your name or any

identifying information will not be reported with findings from this discussion.

1.2.8. Does anybody have any questions about what I've just said or anything else? Please help yourself to the refreshments at any time.

2. Discussion guide

2.1. What services in your community have you used to help you, your children, and your family with health and wellbeing-related issues or to stay physically and mentally healthy? (Prompts, if needed: WIC, family planning, early intervention services, playgroups, parenting support, health services, housing assistance, utility support, counseling support for substance use disorder or mental health issues, etc...)

2.2. If you have received a referral for services to help or support you and/or your family, did you use the referral?

2.2.1. If no, why not? Were there barriers or things that made it hard to use the referral? (Prompts if needed: financial, hard to access, bad experience/quality of service, and/or bureaucracy-eligibility, paperwork, inability to schedule an appointment soon enough, lack of service providers, etc.)

2.2.2. If yes, what worked about accessing that referral service or program?

2.2.3. How was the referral provided? (Prompts if needed: Did your referral provider personally connect you to the resource? Were you handed a form?)

2.2.4. Did the referral provider follow-up with you about the outcome of the referral? Did you feel supported through the referral process? (Prompts if needed: Were your phone calls returned? Was there continuing correspondence between you and the referral provider?)

2.3. What do the mothers and families in your community struggle most with when it comes to their health, development and wellbeing?

2.4. What are barriers to increasing health equity in your community? For this project, health equity means that everyone has a fair and just opportunity to be as health as possible.

2.5. How are these struggles different for:

2.5.1. Women of reproductive age (15 - 44 years of age)

2.5.2. Pregnant Women

2.5.3. Families with:

2.5.3.1. Newborns and Infants (Birth to 1 year of age)
2.5.3.2. Young Children (1 - 5 years of age)

2.5.3.3. School Age Children (6 - 12 years of age)
2.5.3.4. Youth and Adolescents (13 - 22 years of age)

2.5.4.Children with Special Health Care Needs (Birth to 12 years of age)

2.5.5.Youth with Special Health Care Needs (13-26 years of age)

2.6. What programs and services would you like to see offered in your community to help mothers and families stay healthy?

2.7. What do you think are the barriers to using or having these services in your community? (Prompts, if needed: funding, lack of local policy support, limited local resources, lack of specialized training)

2.8. What are your ideas for improving the ways in which mothers and families access and benefit from programs and services that support health, development, wellbeing and safety?

3. Closing

3.1. These are all the questions we have for you today. Does anyone have anything they would like to add that might've not been covered?

3.2. Please remember that whatever has been said in this room stays in this room.

3.3. Thank you very much for your time and participation

Appendix C: Provider Focus Group Discussion Guide

PROVIDERS OF MENTAL HEALTH, PHYSICAL HEALTH, AND SOCIAL SERVICES TO WOMEN OF CHILDBEARING AGE, INFANTS, CHILDREN, ADOLESCENTS, CYSHCN, AND FAMILIES.

INTRODUCTION

Health Management Associates, Inc. (HMA), a national research and consulting firm with an office based in Colorado is working with Nevada Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and Title V Maternal and Child Health Program (MCH) of the Nevada Division of Public and Behavioral Health, to conduct a statewide needs assessment on the health, development, wellbeing and safety of women of childbearing age, infants, children, and adolescents, including children and youth with special health care needs and their families. As part of the needs assessment, HMA is talking to groups of community members: providers of mental health, physical health, and social services to women of childbearing age, infants, children, adolescents, children and youth with special health care need, and families in different parts of the state. The primary goal of the conversations is to understand the perspective of community members regarding the needs of these Nevada residents, as well as barriers and gaps in services and programming within the state's public health systems as it relates to mothers, children, adolescents and children and youth with special health care needs.

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1. Gather participant feedback to better guide successful establishment of recommendations for effective strategies to improve the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs.
2. Engage community members working on or impacted by issues related to the health, development and wellbeing needs of women of childbearing age, infants, children,

adolescents, children and youth with special health care needs to better understand common and unique ideas, opinions and attitudes about issues affecting these populations.

3. Understand the climate, attitudes, and existing risk and protective factors related to the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs in regions across Nevada.

FOCUS GROUP COMPOSITION

The focus group facilitation team consists of two HMA team members, one focused on active listening to feedback and facilitating the discussion, and one focused on taking notes and capturing the general sentiment of the discussion.

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- Ensure neutrality in words, expressions, and sensitivity to participants' emotions.
- Encourage those who are less talkative to participate.
- Ensure all participants feel their voices are heard and valued.
- Ensure participants are respectful of each other and different opinions.
- Provide refreshments for focus group participants.

AGENDA AND SCRIPT FOR FOCUS GROUPS

4. Welcoming remarks and level setting by HMA

4.1. Hello and welcome. Thank you for being here today.

4.1.1. Facilitators introduce themselves and a bit about their background and qualifications.

4.2. Background and purpose

4.2.1. We are talking to groups of community members across the state. HMA is contracted through the Nevada Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Title V Maternal and Child Health (MCH) Programs of the DPBH to work with stakeholders in these regions in an effort to identify gaps and barriers to improving the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs across the state. The primary goal of the project is to understand from the community perspective what is most needed across the state and where there are barriers and gaps in services and programming.

4.2.2. We have invited you to share your ideas so that we can better understand concerns and thoughts about the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special health care needs in your community. We are also interested in what your community is doing/can do to improve the health, development and wellbeing of these populations.

4.2.3. If you don't feel like sharing your thoughts with others, you can always decline to answer, or you can answer by jotting notes on your note pad.

4.2.4. We are not here to collect names or personal stories. Rather, we want to know what you think about these issues, community solutions that already exist, and ideas for solutions that need to be implemented.

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4.2.6. There are no wrong answers to the questions we ask. We really want to know what you

think, so we hope you feel free to talk openly. What you share is up to you. You don't have to answer any questions you don't want to, and you are free to stop taking part at any time.

4.2.7. We will be taking notes and these notes are only to make sure we remember what the group said and so we can include everyone's point of view in our report. Your name or any identifying information will not be reported with findings from this discussion.

4.2.8. Does anybody have any questions about what I've just said or anything else? Please help yourself to the refreshments at any time.

5. Discussion guide

5.1. Let's start by going around the room and saying our first names and briefly describing your role within the maternal and child health system of care in Nevada and who it is you primarily serve.

5.2. What services in your community do you refer clients to in order to best support their health, development, wellbeing and safety needs? (Prompts if needed: WIC, family planning, early intervention services, playgroups, parenting support, health services, housing assistance, utility support, counseling support for substance use disorder or mental health issues, etc...)?

5.3. What are the barriers to making a successful referral in your community, one in which an individual or family receives and engages in the referred service? (Prompts if needed: financial, accessibility, quality of service, structure/bureaucracy)?

5.4. In your community, do you have an adequate network of partners and resources where you are able to successfully refer clients?

5.4.1. What resources are needed but do not exist/are not known?

5.5. What do you think are the most pressing health, development and wellbeing concerns for each population group?

5.5.1. Women of reproductive age (15 - 44 years of age)

5.5.2. Pregnant Women

5.5.3. Newborns and Infants (Birth to 1 year of age)

5.5.4. Young Children (1 - 5 years of age)

5.5.5. School Age Children (6 - 12 years of age)

5.5.6. Youth and Adolescents (13 - 22 years of age)

5.5.7. Children with Special Health Care Needs (Birth to 12 years of age)

5.5.8. Youth with Special Health Care Needs (13-26 years of age)

5.6. What services would you like to see offered in your community to help these populations stay healthy?

5.7. What are the barriers to offering these services in your community? (Prompts if needed: funding, limited local resources, lack of specialized training)?

5.8. What particular populations or specific regions in the state need additional supports? Please indicate who or where and what types of supports are needed. Specific populations include:

5.8.1. Race / ethnicity

5.8.2. Undocumented

5.8.3. LGBTQ

5.8.4. Age (infants, school age children, adolescents, transitional age youth, older adults)

5.8.5. Those living with an intellectual or developmental disability

5.8.6. Those living with substance use disorder

5.8.7. Those living with behavioral or mental health issues

5.8.8. Those newly released from incarceration, or with family members incarcerated

5.8.9. Those involved with child protective services

5.9. What are barriers to increasing health equity in your community? For the sake of this project, health equity means that everyone has a fair and just opportunity to be as healthy as possible.

5.9.1. What efforts are you familiar with in your community to address cultural and linguistic competence or health equity, such as policies and training requirements or initiatives? These might be efforts that work to remove obstacles to health such as poverty, discrimination, and their consequences, including lack of access to good jobs with fair pay, quality education, safe and affordable housing, safe neighborhoods and communities, and health care. (Prompts if needed: increasing culturally and linguistically appropriate materials and staff behaviors, including non-binary gender and sexual orientation data on demographic forms, obtaining a safe space designation, developing a plan to address health equity or health disparities)

5.10. What recommendations do you have for improving the health, development and wellbeing of women of childbearing age, infants, children, adolescents, children and youth with special

health care needs across the state? (Prompts if needed: collect certain types of data to better understand an issue; reform or restructure an aspect of the service system; improve availability, development, or quality of programs, including cultural competence of systems and services; strengthen an existing policy that impacts health, development and wellbeing; share information with stakeholders to provide education about)

6. Closing

6.1. These are all the questions we have for you today. Does anyone have anything they would like to add that might've not been covered?

6.2. Please remember that whatever has been said in this room stays in this room.

6.3. Thank you very much for your time and participation.

Appendix D: Community Survey Results on top THREE things currently in your community that benefit women, children, and families

Table 1. What do you think are the top THREE things currently in your community that benefit women, children, and families? These are the things that you feel are a strength in your community, and are available, accessible, affordable, and/or high quality. Select one to three options.

Answer Choices	Community Member Responses	
Recreational facilities	32%	37
Good place to raise children	23%	26
Schools	22%	25
Access to healthy foods/healthy food choices	18%	21
Social support and connections	17%	20
Early childhood education programs	15%	17
After school and summer activities for youth	15%	17
Good paying jobs and livable wage	14%	16
Arts and cultural events	13%	15
Inclusive community	11%	13
Mental health/counseling services	10%	11
Low crime/safe neighborhoods	10%	11
Religious or spiritual values	10%	11
Prenatal care	7%	8
Health care insurance	6%	7
Childcare options	5%	6
Emergency preparedness	5%	6
Reliable transportation	5%	6
Services for children and youth with special health care needs	4%	5
Housing	4%	5
I prefer not to answer	4%	5
Health care options (e.g., doctors, clinics)	3%	4
Safe and well-maintained roads	3%	4
Job security	3%	4
Low level of child abuse	3%	3
Low levels of violence	3%	3
Safe workplaces	3%	3
Specialty health care options	2%	2
Services for children and youth	2%	2
Low infant death rates	2%	2
Low levels of homelessness	2%	2
Low youth death and disease rates	2%	2
Services for immigrants	1%	1
Parental or caregiver involvement	1%	1

Answer Choices	Community Member Responses	
Low adult death and disease rates	0%	0
Answered	33.6%	115
Skipped	66.4%	227

Table 2. What do you think are the top THREE things in your community LACKING OR MISSING that benefit women, children, and families? These are the things that you feel need improvement in your community, and are not available, accessible, affordable, and/or high quality. Select one to three options.

Answer Choices	Community Member Responses	
Childcare options	37%	43
Mental health/counseling services	34%	39
Good paying jobs and livable wage	29%	33
Housing	27%	31
Health care options (e.g., doctors, clinics)	25%	29
After school and summer activities for youth	15%	17
Schools	14%	16
Early childhood education programs	13%	15
Specialty health care options	10%	12
Prenatal care	10%	12
Health care insurance	8%	9
Access to healthy foods/healthy food choices	7%	8
Services for children and youth with special health care needs	6%	7
Services for children and youth	6%	7
Social support and connections	5%	6
Reliable transportation	4%	5
Inclusive community	4%	5
Recreational facilities	3%	4
Services for immigrants	3%	4
Low levels of homelessness	3%	4
Arts and cultural events	3%	3
Emergency preparedness	3%	3
Good place to raise children	3%	3
Low levels of violence	3%	3
Religious or spiritual values	3%	3
Parental or caregiver involvement	3%	3
Low crime/safe neighborhoods	2%	2
Safe and well-maintained roads	2%	2
Other, please describe:	2%	2
Low infant death rates	1%	1
Low level of child abuse	1%	1
Safe workplaces	1%	1

Answer Choices	Community Member Responses	
I prefer not to answer	1%	1
Low adult death and disease rates	0%	0
Low youth death and disease rates	0%	0
Job security	0%	0
Answered	33.6%	115
Skipped	66.4%	227

Table 3. THREE most important health problems/health issues in the community where you serve for WOMEN OF REPRODUCTIVE AGE (15 TO 44 YEARS OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Mental health (i.e., anxiety, depression, etc.)	127	56%
Domestic or intimate partner violence	52	23%
Illicit substance use (i.e., heroin, cocaine, etc.)	50	22%
Health care insurance	35	15%
Not receiving regular health screenings	32	14%
Chronic disease (i.e., diabetes, obesity, heart disease and stroke, high blood pressure)	30	13%
Equitable pay	28	12%
Poor eating habits	27	12%
Sexually Transmitted Diseases (STDs), HIV / AIDS, and other infectious diseases	26	11%
Marijuana use	24	11%
Prescription drug abuse	21	9%
Birth control	20	9%
Dental/ Oral health	20	9%
Rape / sexual assault / sex and human trafficking	20	9%
Alcohol use	18	8%
E-cigarettes or vaping	18	8%
Suicide	16	7%
Other, please describe:	14	6%
Teenage pregnancy	11	5%
Lack of access to healthy foods	10	4%
Dropping out of school	9	4%
Tobacco use (i.e., cigarettes, chew, etc.)	9	4%
Unsafe sex	9	4%
Community violence (i.e., bullying, gang violence, homicide)	6	3%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	6	3%
Cancer	5	2%
Driving while intoxicated	4	2%
I prefer not to answer	4	2%

Answer Choices	Number	Percent
Lack of safe places to exercise	4	2%
Dating or intimate partner violence among youth	3	1%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	3	1%
Unsecure firearms	2	1%
Access to immunizations and vaccines	0	0%
Not using seat belts	0	0%
Respiratory / lung disease (i.e., asthma)	0	0%

Table 4. THREE most important health problems/health issues in the community where you live for PREGNANT WOMEN AND POST-PARTUM WOMEN, All Survey Respondents (n=227)

Answer Choices	Number	Percent
Mental health (i.e., postpartum depression, anxiety, etc.)	100	44%
Postnatal care	54	24%
Prenatal care	47	21%
Breast feeding support	41	18%
Health care insurance	40	18%
Illicit substance use (i.e., heroin, cocaine, etc.)	33	15%
Domestic or intimate partner violence	31	14%
Limited or no prenatal care	25	11%
Equitable pay	22	10%
Not receiving regular health screenings	22	10%
Poor eating habits	21	9%
Birth control	20	9%
Chronic disease (i.e., diabetes, obesity, heart disease and stroke, high blood pressure)	19	8%
Marijuana use	19	8%
Access to midwives and/or doulas	16	7%
Other, please describe:	15	7%
Dental/ oral health	12	5%
Tobacco use (i.e., cigarettes, chew, etc.)	11	5%
Alcohol use	10	4%
Prescription drug abuse	10	4%
Severe maternal morbidity/birth complications	10	4%
Lack of access to health foods	9	4%
E-cigarettes or vaping	8	4%
Rape / sexual assault / sex and human trafficking	8	4%
Sexually Transmitted Diseases (STDs), HIV / AIDS, and other infectious diseases	8	4%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	7	3%
I prefer not to answer	6	3%

Answer Choices	Number	Percent
Maternal death	6	3%
Unsafe sex	4	2%
Cancer	3	1%
Suicide	3	1%
Access to immunizations and vaccines	2	1%
Lack of safe places to exercise	2	1%
Unsecure firearms	2	1%
Community violence (i.e., gang violence, homicide)	1	0%
Driving while intoxicated	1	0%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	1	0%
I don't know	0	0%
Not using seat belts	0	0%
Respiratory / lung disease (i.e., asthma)	0	0%

Table 5. THREE most important health problems/health issues in the community where you live for NEWBORNS AND INFANTS (BIRTH UP TO 1 YEAR OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Child abuse / neglect	77	34%
Maternal substance use during or after pregnancy	76	33%
Not receiving developmental screenings	67	30%
Breastfeeding	51	22%
Health care insurance	46	20%
Low birth weight / Born before estimated due date (preterm birth)	45	20%
Tobacco or second-hand smoke exposure or smoking in home	43	19%
Ability to access healthy foods	36	16%
Ability to purchase diapers	31	14%
Access to immunization and vaccines	30	13%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	29	13%
Safe sleep options (i.e., alone in a crib, on back)	25	11%
Other, please describe:	19	8%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	11	5%
I prefer not to answer	10	4%
Infant death (i.e., sudden unexpected infant death)	10	4%
Not using child safety seats	7	3%
Community violence (i.e., gang violence, homicide)	1	0%
Respiratory / lung disease (i.e., asthma)	1	0%
I don't know	0	0%

Table 6. THREE most important health problems/health issues in the community where you live for YOUNG CHILDREN (1 to 5 YEARS OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Access to affordable childcare and/or pre-school	84	37%
Caregiver substance use or mother/father substance use.	63	28%
Child abuse / neglect	58	26%
Poor eating habits	36	16%
Physical activity	35	15%
Kindergarten readiness	33	15%
Not receiving developmental screenings	33	15%
Dental/oral health	32	14%
Health care insurance	30	13%
Obesity	27	12%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	24	11%
Tobacco or second-hand smoke exposure or smoking in home	23	10%
Mental health (i.e., anxiety, depression, etc.)	22	10%
Access to healthy foods	21	9%
Rape / sexual assault / sex and human trafficking	21	9%
Screen time	20	9%
Access to safe places to play	15	7%
Other, please describe:	14	6%
Access to immunizations and vaccines	11	5%
I prefer not to answer	9	4%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	8	4%
Not using child safety seats	7	3%
Breastfeeding	5	2%
Community violence (i.e., gang violence, homicide)	3	1%
Respiratory / lung disease (i.e., asthma)	3	1%
Unsecure firearms	1	0%
I don't know	0	0%

Table 7. THREE most important health problems/health issues in the community where you live for CHILDREN (6 TO 11 YEARS OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Overuse of technology/excessive screen time	58	26%
Physical activity	57	25%
Mental health (i.e., anxiety, depression, etc.)	55	24%
Poor eating habits	54	24%
Obesity	45	20%
Caregiver substance use or mother/father substance use	42	19%
Child abuse / neglect	42	19%
Dental/ oral health	29	13%
Access to healthy foods	26	11%
Health care insurance	26	11%
Child abuse / neglect	24	11%
Tobacco or second-hand smoke exposure or smoking in home	22	10%
Not receiving developmental screenings	19	8%
Access to safe places to play	18	8%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	17	7%
Community violence (i.e., bullying, gang violence, homicide)	14	6%
I prefer not to answer	11	5%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	11	5%
Other, please describe:	10	4%
Access to immunizations and vaccines	8	4%
Access to sexual health education	7	3%
Suicide	7	3%
E-cigarettes or vaping	6	3%
Not using seat belts / child safety seats	6	3%
Rape / sexual assault / sex and human trafficking	6	3%
Not wearing a helmet use (skiing, biking, etc.)	4	2%
Unsecured firearms	4	2%
Tobacco use (i.e., cigarettes, chew, etc.)	1	0%
Dating or intimate partner violence	0	0%
I don't know	0	0%
Respiratory / lung disease (i.e., asthma)	0	0%

Table 8. THREE most important health problems/health issues in the community where you live for ADOLESCENTS/YOUNG ADULTS (12 TO 21 YEARS OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Mental health (i.e., anxiety, depression, etc.)	89	39%
Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood	63	28%
E-cigarettes or vaping	34	15%
Unsafe Sex	34	15%
Excessive use / inappropriate use of social media	26	11%
Health care insurance	26	11%
Overuse of technology / excessive screen time	26	11%
Illicit substance use (i.e., heroin, cocaine, etc.)	24	11%
Lack of access to safe places for activities (i.e., sports, hanging out with friends)	22	10%
Suicide	22	10%
Obesity	20	9%
Marijuana use	19	8%
Physical activity	19	8%
Alcohol use	18	8%
Bullying	17	7%
Caregiver substance use or mother/father substance use.	16	7%
Poor eating habits	16	7%
Sexually Transmitted Diseases (STDs), HIV / AIDS, and other infectious diseases	15	7%
Access to immunizations and vaccines	14	6%
Lack of parent/caregiver understanding of care coordination	13	6%
Community violence (i.e., bullying, gang violence, homicide)	11	5%
Dental/ oral health	11	5%
Teenage pregnancy	10	4%
Birth control	9	4%
Dating or intimate partner violence	9	4%
I prefer not to answer	9	4%
Access to sexual health education	8	4%
Rape / sexual assault / sex and human trafficking	8	4%
Lack of access to healthy foods	7	3%
Prescription drug abuse	6	3%
Child abuse / neglect	5	2%
Lack of medical homes (i.e., patient-centered comprehensive coordinated care)	5	2%
Other, please describe:	5	2%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	5	2%
Tobacco or second-hand smoke exposure or smoking in home	4	2%
Tobacco use (i.e., cigarettes, chew, etc.)	4	2%
Unsecure firearms	2	1%

Answer Choices	Number	Percent
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	2	1%
Not wearing a helmet use (skiing, biking, etc.)	1	0%
I don't know	0	0%
Not using seat belts	0	0%
Respiratory / lung disease (i.e., asthma)	0	0%

Table 9. THREE most important health problems/health issues in the community where you live for CHILDREN WITH SPECIAL HEALTH CARE NEEDS (BIRTH TO 21 YEARS OF AGE), All Survey Respondents (n=227)

Answer Choices	Number	Percent
Lack of adequate access to specialty medical care (genetics, pediatric neurology, child psychiatry, developmental-behavioral pediatrics, etc.)	65	29%
Navigation of the system of care for children and youth with special health care needs	54	24%
Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood	53	23%
Mental health (i.e., anxiety, depression, etc.)	50	22%
Health care insurance	39	17%
Inadequate respite care (e.g., services to reduce stress, such as a break or time for yourself)	39	17%
Lack of parent/caregiver understanding of care coordination	37	16%
In adequate school accommodations and interventions	31	14%
Lack of medical homes (i.e., patient-centered comprehensive coordinated care)	25	11%
Not receiving developmental screenings	22	10%
I prefer not to answer	21	9%
Child abuse / neglect	19	8%
Lack of access to safe places to play or participate in activities	14	6%
Caregiver substance use or mother/father substance use	12	5%
Bullying	11	5%
Poor eating habits	11	5%
Dental/ oral health	9	4%
Access to sexual health education	8	4%
Illicit substance use (i.e., heroin, cocaine, etc.)	8	4%
Alcohol use	7	3%
Marijuana use	7	3%
Overuse of technology/excessive screen time	7	3%
Suicide	7	3%
Obesity	6	3%
Excessive use / inappropriate use of social media	5	2%
Lack of access to healthy foods	5	2%
Other, please describe:	5	2%
Maternal substance use during or after pregnancy	4	2%

Answer Choices	Number	Percent
Physical activity	4	2%
Rape / sexual assault / sex and human trafficking	4	2%
Dating or intimate partner violence	3	1%
E-cigarettes or vaping	3	1%
Tobacco or second-hand smoke exposure or smoking in home	3	1%
Unintentional injuries (i.e., motor vehicle accidents, drowning)	3	1%
Vaccine preventable diseases (i.e., measles, influenza, mumps, pertussis (whooping cough), etc.)	3	1%
Birth control	2	1%
Community violence (i.e., bullying, gang violence, homicide)	2	1%
Not using seat belts / child safety seats	2	1%
Unsafe sex	2	1%
Access to immunizations and vaccines	1	0%
Prescription drug abuse	1	0%
Teenage pregnancy	1	0%
Unsecured firearms	1	0%
I don't know	0	0%
Not wearing a helmet use (skiing, biking, etc.)	0	0%
Respiratory / lung disease (i.e., asthma)	0	0%
Sexually Transmitted Diseases (STDs), HIV / AIDS, and other infectious diseases	0	0%
Tobacco use (i.e., cigarettes, chew, etc.)	0	0%

Appendix E: Survey Results on top THREE most important health problems/health issues in the community, by Survey Respondent Type

Table 10. Community member's three most important health problems/health issues in the community, by MCH population group

WOMEN OF REPRODUCTIVE AGE	PREGNANT WOMEN	NEWBORNS AND INFANTS (BIRTH UP TO 1 YEAR OF AGE)	YOUNG CHILDREN (1 to 5 YEARS OF AGE)	CHILDREN (6 TO 11 YEARS OF AGE)	ADOLESCENTS /YOUNG ADULTS (12 TO 21 YEARS OF AGE)	CHILDREN WITH SPECIAL HEALTH CARE NEEDS (BIRTH TO 21 YEARS OF AGE)
Mental health (i.e., anxiety, depression, etc.) (49%)	Mental health (i.e., postpartum depression, anxiety, etc.) (39%)	Child abuse / neglect (43%)	Access to affordable childcare and/or pre-school (35%)	Overuse of technology/ excessive screen time (29%)	Mental health (i.e., anxiety, depression, etc.) (43%)	Mental health (i.e., anxiety, depression, etc.) (30%)
Equitable pay (20%)	Health care insurance (23%)	Not receiving developmental screenings (30%)	Child abuse / neglect (30%)	Physical activity (27%)	Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood (29%)	Health care insurance (24%)
Domestic or intimate partner violence (20%)	Postnatal care (22%)	Maternal substance use during or after pregnancy (29%)	Caregiver substance use or mother/father substance use. (23%)	Child abuse / neglect (26%)	Health care insurance (16%)	Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood (20%)
Illicit substance use (i.e., heroin, cocaine, etc.) (20%)						Navigation of the system of care for CYSHCN (20%)

Table 11. MCH Professionals and Provider's Three Most Important Health Problems/Health Issues in the Community, By MCH Population Group

WOMEN OF REPRODUCTIVE AGE	PREGNANT WOMEN	NEWBORNS AND INFANTS (BIRTH UP TO 1 YEAR OF AGE)	YOUNG CHILDREN (1 to 5 YEARS OF AGE)	CHILDREN (6 TO 11 YEARS OF AGE)	ADOLESCENTS /YOUNG ADULTS (12 TO 21 YEARS OF AGE)	CHILDREN WITH SPECIAL HEALTH CARE NEEDS (BIRTH TO 21 YEARS OF AGE)
Mental health (i.e., anxiety, depression, etc.) (61%)	Mental health (i.e., postpartum depression, anxiety, etc.) (48%)	Maternal substance use during or after pregnancy (37%)	Access to affordable childcare and/or pre-school (39%)	Obesity (27%)	Mental health (i.e., anxiety, depression, etc.) (36%)	Lack of adequate access to specialty medical care (36%)
Illicit substance use (i.e., heroin, cocaine, etc.) (24%)	Health care insurance (23%)	Not receiving developmental screenings (29%)	Caregiver substance use or mother/father substance use. (32%)	Poor eating habits (27%)	Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood (27%)	Navigation of the system of care for children and youth with special health care needs (27%)
Domestic or intimate partner violence (25%)	Prenatal Care (24%)	Low birth weight / Born before estimated due date (preterm birth) (28%)	Child abuse / neglect (22%)	Mental health (i.e., anxiety, depression, etc.) (27%)	E-cigarettes or vaping (16%)	Lack of social, ethical, emotional, physical and cognitive skills needed during adolescence and to transition into adulthood (26%)
Not receiving regular health screening (17%)		Child abuse / neglect (27%)				

Appendix F. HRSA Indicators by Domain

Domain	Indicator	Indicator Definition
Socioeconomic Status (SES)	Poverty	% population living below %100 FPL
Socioeconomic Status (SES)	Unemployment	Unemployed percent of the civilian labor force
Socioeconomic Status (SES)	Highschool Dropout	% of 16-19 year olds not enrolled in school with no high school diploma
Socioeconomic Status (SES)	Highschool Dropout	% of 16-19 year olds not enrolled in school with no high school diploma
Socioeconomic Status (SES)	Highschool Dropout	% of 16-19 year olds not enrolled in school with no high school diploma
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 1 Yr Estimate
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 5 Yr Estimate
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks
Adverse Perinatal Outcomes	Low Birth Weight	% live births <2500 g
Substance Use Disorder	Alcohol	Prevalence rate: Binge alcohol use in past month
Substance Use Disorder	Marijuana	Prevalence rate: Marijuana use in past month
Substance Use Disorder	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month
Substance Use Disorder	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year
Crime	Crime Reports	# reported crimes/1000 residents
Crime	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17, 2015
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents

Appendix G. HRSA Needs Assessment Data

Simplified Method Overview

Indicators were selected in collaboration with HRSA/MCHB to match as closely as possible the statutorily-defined[866] criteria for identifying target communities for home visiting programs. We considered issues such as data availability and reliability of indicators at the county level when selecting the final indicator list. After selecting indicators, we grouped them according to five domains (Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment). The algorithm for identifying at-risk counties is as follows:

1. Obtain raw, county-level data for each indicator from the listed data source as defined in the Description of Indicators.

2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.).

3. Standardize indicator values (compute z-score) for each county so that all indicators have a mean of 0 and a SD of 1. Z-score = (county value - mean)/SD.

4. Using the resulting z-scores for each county, calculate the proportion of indicators within each domain for which that county's z-score was greater than 1, that is, the proportion of indicators for which a given county is in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains is identified as at-risk.

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[866] Not included are indicators for infant mortality and domestic violence. Infant mortality was excluded from the Adverse Perinatal Outcomes domain because the level of suppression at the county level for 5-year aggregate data was too high for meaningful inclusion (all but 13 states have >50% of counties with suppressed data). Preterm and low birth weight births together are the second largest cause of infant mortality. Given that the other two indicators in the domain are direct precursors of infant mortality, we evaluated the extent to which similar counties were identified when infant mortality rate was included or excluded (among counties with non-suppressed data). The level of suppression for preterm birth and low birthweight was also substantial for individual year data. Thus, we compiled 3-yr and 5-yr aggregated data to obtain reliable estimates for smaller counties. Domestic violence was excluded because there are no national sources available with county-level data for domestic violence.

Description of Indicators

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Notes	Next Update
Socioeconomic Status (SES)	Poverty	% population living below %100 FPL	Poverty	2016	Census Small Area Income and Poverty Estimates https://www.census.gov/data/datasets/2016/demo/saipe/2016-state-and-county.html	n/a	2017 data available in 2019
Socioeconomic Status (SES)	Unemployment	Unemployed percent of the civilian labor force	Unemployment	2016	Bureau of Labor Statistics https://www.bls.gov/lau/#cntyaa	n/a	2017 data available in 2019
Socioeconomic Status (SES)	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2016	American Community Survey https://factfinder.census.gov	1 year estimates used for counties with populations >65,000; 5 year estimate used for counties with populations <65,000	2017 data available in 2019
Socioeconomic Status (SES)	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2012-2016	American Community Survey https://factfinder.census.gov	1 year estimates used for counties with populations >65,000; 5 year estimate used for counties with populations <65,000	2017 data available in 2019
Socioeconomic Status (SES)	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	High school dropouts	2012-2016 OR 2016	American Community Survey https://factfinder.census.gov	1 year estimates used for counties with populations >65,000; 5 year estimate used for counties with populations <65,000	2017 data available in 2019
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 1 Yr Estimate	n/a	2016	n/a	n/a	n/a
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 5 Yr Estimate	n/a	2012-2016	n/a	n/a	n/a
Socioeconomic Status (SES)	Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate	n/a	2012-2016	n/a	n/a	n/a

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Notes	Next Update
				OR 2016			
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2012-2016	NVSS - Raw Natality File File received by HRSA	Births <10 were suppressed; the mean of counties was inputted for counties with missing data	2017 data available in 2019
Adverse Perinatal Outcomes	Low Birth Weight	% live births <2500 g	Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health	2012-2016	NVSS - Raw Natality File File received by HRSA	Births <10 were suppressed; the mean of counties was inputted for counties with missing data	2017 data available in 2019
Substance Use Disorder	Alcohol	Prevalence rate: Binge alcohol use in past month	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health https://www.samhsa.gov/data/population-data-nsduh/reports?tab=38	County estimates are inputted using the estimate for the Substance Abuse Treatment Planning Region in which they belong. Nonmedical use	2014-2016 available mid-2018; limited set only

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Notes	Next Update
						of pain relievers refer to any form of prescription pain relievers that were not prescribed for the person or that the person took only for the experience or feeling they caused.	
Substance Use Disorder	Marijuana	Prevalence rate: Marijuana use in past month	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health https://www.samhsa.gov/data/population-data-nsduh/reports?tab=38	County estimates are inputted using the estimate for the Substance Abuse Treatment Planning Region in which they belong. Nonmedical use of pain relievers refer to any form of prescription pain relievers that were not prescribed for the person or that the person took only for the experience or feeling they caused.	2014-2016 available mid-2018; limited set only
Substance Use Disorder	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health https://www.samhsa.gov/data/population-data-nsduh/reports?tab=38	County estimates are inputted using the estimate for the Substance Abuse Treatment Planning Region in which they belong. Nonmedical use of pain relievers refer to any form of prescription pain relievers that were	2014-2016 available mid-2018; limited set only

Domain	Indicator	Indicator Definition	Alignment with statute definition of at-risk communities	Year	Source	Source Notes	Next Update
						not prescribed for the person or that the person took only for the experience or feeling they caused.	
Substance Use Disorder	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	Substance abuse	2012-2014	SAMHSA - National Survey of Drug Use and Health https://www.samhsa.gov/data/population-data-nsduh/reports?tab=38	County estimates are inputted using the estimate for the Substance Abuse Treatment Planning Region in which they belong. Nonmedical use of pain relievers refer to any form of prescription pain relievers that were not prescribed for the person or that the person took only for the experience or feeling they caused.	2014-2016 available mid-2018; limited set only
Crime	Crime Reports	# reported crimes/1000 residents	n/a	2014	n/a	n/a	n/a
Crime	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17, 2015	n/a	2015	n/a	Used county population of 0-17 year olds from PEP	n/a
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	n/a	2016	n/a	n/a	n/a

Descriptive Statistics

Domain	Indicator	Indicator Definition	Year	Missing (n)	Missing (%)	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Population	Population	Population Estimate	2015	0	0.0	172,945	521,897	16,842	47,113	790	2,155,664	2,939,254
Socioeconomic Status	Poverty	% population living below %100 FPL	2016	0	0.0	13.1	2.8	13.0	2.8	7.8	18.2	14.1
Socioeconomic Status	Unemployment	Unemployed percent of the civilian labor force	2016	0	0.0	5.7	0.9	5.6	1.2	4.5	7.4	5.7
Socioeconomic Status	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma - 1 Yr Estimate	2016	15	88.2	0.5	0.1	0.5	0.1	0.4	0.6	7.2
Socioeconomic Status	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma - 5 Yr Estimate	2012-2016	0	0.0	4.4	3.8	5.0	6.9	0.0	11.1	5.6
Socioeconomic Status	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma - 1 Yr or 5 Yr Estimate	2012-2016 OR 2016	0	0.0	3.9	4.0	2.2	6.9	0.0	11.1	n/a
Socioeconomic Status	Income Inequality	Gini Coefficient - 1 Yr Estimate	2016	15	88.2	0.5	0.0	0.5	0.0	0.5	0.5	0.5
Socioeconomic Status	Income Inequality	Gini Coefficient - 5 Yr Estimate	2012-2016	0	0.0	0.4	0.0	0.4	0.1	0.4	0.5	0.5
Socioeconomic Status	Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate	2012-2016 OR 2016	0	0.0	0.4	0.0	0.4	0.1	0.4	0.5	n/a

Domain	Indicator	Indicator Definition	Year	Missing (n)	Missing (%)	Mean of Counties	SD	Median	Interquartile Range	Min	Max	State Estimate
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	2012-2016	3	17.6	9.2	1.0	8.8	1.7	8.0	10.8	10.1
Adverse Perinatal Outcomes	Low Birth Weight	% live births <2500 g	2012-2016	3	17.6	8.2	1.3	7.9	2.0	5.9	10.7	8.3
Substance Use Disorder	Alcohol	Prevalence rate: Binge alcohol use in past month	2012-2014	0	0.0	24.5	0.6	24.5	0.0	23.9	26.6	24.6
Substance Use Disorder	Marijuana	Prevalence rate: Marijuana use in past month	2012-2014	0	0.0	8.0	0.5	7.8	0.0	7.6	9.6	7.9
Substance Use Disorder	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014	0	0.0	3.5	0.2	3.5	0.0	3.4	4.0	3.8
Substance Use Disorder	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014	0	0.0	4.8	0.1	4.8	0.0	4.7	5.4	5.2
Crime	Crime Reports	# reported crimes/1000 residents	2014	1	5.9	21.6	8.0	19.7	11.6	9.5	35.4	32.6
Crime	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17, 2015	2015	0	0.0	1756.1	1348.9	1513.9	1404.4	0.0	4246.3	1730.7
Child Maltreatment	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2014	0	0.0	5.2	2.9	6.7	3.1	0.0	8.7	7.3

Raw Indicators

County	Poverty	Unemployment	HS dropout	HS dropout 1 Yr	HS dropout 5 Yr	Income Inequality	Income Inequality 1 Yr	Income Inequality 5 Yr	Low Birth Weight	Preterm Birth
Churchill County	14.2	5.4	7.4	n/a	7.4	n/a	0.5	0.4	6.7	8.5
Clark County	14.6	5.8	0.4	0.4	5.7	0.5	0.5	0.5	8.4	10.4
Douglas County	9.7	5.6	5.0	n/a	5.0	n/a	0.5	0.5	8.0	8.3
Elko County	10.4	4.5	5.4	n/a	5.4	n/a	0.5	0.4	7.7	8.5
Esmeralda County	14.8	4.5	0.0	n/a	0.0	n/a	0.5	0.4	n/a	n/a
Eureka County	9.9	4.6	0.0	n/a	0.0	n/a	0.5	0.4	n/a	n/a
Humboldt County	11.9	5.4	10.2	n/a	10.2	n/a	0.5	0.4	7.5	8.4
Lander County	11.9	6.2	0.0	n/a	0.0	n/a	0.5	0.4	7.5	8.8
Lincoln County	14.1	5.1	6.2	n/a	6.2	n/a	0.5	0.5	5.9	9.5
Lyon County	11.9	7.4	9.0	n/a	9.0	n/a	0.5	0.4	8.6	10.1
Mineral County	18.2	6.6	0.0	n/a	0.0	n/a	0.5	0.4	10.7	8.7
Nye County	15.9	7.3	11.1	n/a	11.1	n/a	0.5	0.4	9.6	10.8
Pershing County	17.5	5.9	2.2	n/a	2.2	n/a	0.5	0.4	9.7	8.0
Storey County	7.8	6.3	0.0	n/a	0.0	n/a	0.5	0.4	n/a	n/a
Washoe County	12.5	5.0	0.6	0.6	4.5	0.5	0.5	0.5	7.7	9.6
White Pine County	14.7	4.6	1.8	n/a	1.8	n/a	0.5	0.4	9.5	10.7
Carson City	13.0	6.1	6.9	n/a	6.9	n/a	0.5	0.4	7.0	8.3
Mean	13.1	5.7	3.9	0.5	4.4	0.4	0.5	0.4	8.2	9.2
SD	2.8	0.9	4.0	0.1	3.8	0.0	0.0	0.0	1.3	1.0

County	Alcohol	Marijuana	Illicit Drugs	Pain Relievers	Crime Reports	Juvenile Arrests (2015)	Child Maltreatment
Churchill County	24.5	7.8	3.5	4.8	34.4	4246.3	7.5
Clark County	24.3	7.6	3.8	5.4	35.4	1341.9	7.4
Douglas County	23.9	8.3	3.4	4.7	17.7	3584.4	3.4
Elko County	24.5	7.8	3.5	4.8	27.6	1072.6	4.1
Esmeralda County	24.5	7.8	3.5	4.8	11.7	0.0	0.0
Eureka County	24.5	7.8	3.5	4.8	20.3	1727.9	0.0
Humboldt County	24.5	7.8	3.5	4.8	14.2	2363.2	7.1
Lander County	24.5	7.8	3.5	4.8	27.1	1169.6	5.3
Lincoln County	24.5	7.8	3.5	4.8	9.5	0.0	0.0
Lyon County	23.9	8.3	3.4	4.7	18.8	1655.0	4.2
Mineral County	24.5	7.8	3.5	4.8	n/a	1647.1	7.2
Nye County	24.5	7.8	3.5	4.8	21.2	900.8	6.7
Pershing County	24.5	7.8	3.5	4.8	17.6	1513.9	6.9
Storey County	24.5	7.8	3.5	4.8	30.3	202.0	7.5
Washoe County	26.6	9.6	4.0	4.8	27.4	3313.1	8.7
White Pine County	24.5	7.8	3.5	4.8	13.0	958.8	7.2
Carson City	23.9	8.3	3.4	4.7	19.2	4156.6	5.9
Mean	24.5	8.0	3.5	4.8	21.6	1756.1	5.2
SD	0.6	0.5	0.2	0.1	8.0	1348.9	2.9

Standardized Indicators

Low Birth Weight	Preterm Birth	Alcohol	Marijuana	Illicit Drugs	Pain Relievers	Crime Reports	Juvenile Arrests (2015)	Child Maltreatment
-1.09	-0.73	0.01	-0.39	-0.31	-0.05	1.61*	1.85*	0.78
0.17	1.23*	-0.33	-0.86	1.91*	3.63*	1.74*	-0.31	0.75
-0.13	-0.88	-1.09	0.68	-0.47	-0.97	-0.49	1.36*	-0.66
-0.38	-0.73	0.01	-0.39	-0.31	-0.05	0.75	-0.51	-0.39
n/a	n/a	0.01	-0.39	-0.31	-0.05	-1.24	-1.30	-1.83
n/a	n/a	0.01	-0.39	-0.31	-0.05	-0.16	-0.02	-1.83
-0.51	-0.83	0.01	-0.39	-0.31	-0.05	-0.93	0.45	0.64
-0.52	-0.36	0.01	-0.39	-0.31	-0.05	0.70	-0.43	0.03
-1.73	0.34	0.01	-0.39	-0.31	-0.05	-1.52	-1.30	-1.83
0.28	0.90	-1.09	0.68	-0.47	-0.97	-0.36	-0.07	-0.36
1.92*	-0.47	0.01	-0.39	-0.31	-0.05	n/a	-0.08	0.70
1.04*	1.70*	0.01	-0.39	-0.31	-0.05	-0.04	-0.63	0.51
1.15*	-1.21	0.01	-0.39	-0.31	-0.05	-0.50	-0.18	0.57
n/a	n/a	0.01	-0.39	-0.31	-0.05	1.09*	-1.15	0.79
-0.37	0.46	3.51*	3.48*	3.24*	-0.13	0.73	1.15*	1.21*
1.02*	1.51*	0.01	-0.39	-0.31	-0.05	-1.08	-0.59	0.67
-0.86	-0.93	-1.09	0.68	-0.47	-0.97	-0.30	1.78*	0.25