Maternal and Child Health Services Title V Block Grant

Nevada

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I. General Requirements

I.A. Letter of Transmittal

STATE OF NEVADA

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Governor

RICHARD WHITLEY, MS
Director

MARTA E. JENSEN
Acting Administrator

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July 7, 2015

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

Re: Maternal and Child Health Block Grant Submission
- Report FFY 2014, Application FFY 2016

Dear Ms. Lawler:

The Nevada State Division of Public and Behavioral Health, which administers the Title V Maternal and Child Health Block Grant, respectfully submits the FFY 2016 application and FFY 2014 Annual Report to the Health Resources and Services Administration.

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

Sincerely,

Marta Jensen

Marta E. Jensen
Acting Administrator

MJ:ch

Public Health: Working for a Safer and Healthier Nevada

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

The Nevada Division of Public and Behavioral Health (DPBH) Maternal and Child Health Action Plan covers the period October 1, 2016 to September 30, 2020 and is a draft strategic planning blueprint for activities to meet Nevada's priority needs. All activities undertaken (e.g., focus groups, surveys, etc.) involves diverse stakeholders (e.g., providers, coalition members, community-level advocates and family resource entities, legislators, etc.) and consumers. Stakeholders assisted in the identification of National Performance Measures (NPMs), the top priorities for each of the MCH populations as well as in developing the action plan. Consumers also provided input on NPMs and the quality of healthcare services they, their children and/or families received as well as their unmet needs. The information below provides a summary of accomplishments/progress and significant challenges relative to the priority needs.

Accomplishments and Priority Needs by Population Domain

1. Women/ Maternal Health

The emergent needs for this population domain were wellness screening, prenatal care, and substance use. These needs will be addressed through *priority 1: Improve preconception health among adolescents and women of childbearing age*.

Which corresponds to *NPM 1: The percent of women with a past year preventive medical visit*.

Data collection of maternal experiences, attitudes, and behaviors from preconception, through pregnancy and into the inter-conception period is on-going through the Baby BEARS project. Since this data is not available yet from other sources, it would be very helpful to MCH as well as other programs to identify groups of women and infants at high risk for health problems, to detect changes in health status, and to track progress towards the set indicators in improving the health of mothers and infants in Nevada. Plans are in place to continue administering Baby BEARS as well as solicitation of funding support from other programs that will benefit from the survey data.

Through the initiatives of the National Governors Association (NGA) Learning Network on Improving Birth Outcomes, MCH collaborated with Nevada's Office of the Governor, Nevada Medicaid, March of Dimes (Nevada Chapter) and other Nevada Department of Health and Human Services programs to improve birth outcomes by identifying modifiable risk factors for the incidence of preterm births, low birth weight and infant mortality and associated racial/ethnic health disparities. One of the State's goals in the NGA initiative is to expand access to health care for women, pregnant women, and infants; including educational outreach relating to the Affordable Care Act (ACA) and increased access to preventative care and public and private insurance. The activities of this initiative are currently being carried out by various workgroups around the State.

Title V collaborated with Nevada Women, Infants, and Children (WIC) Program to increase Gestational Diabetes Mellitus (GDM) messaging opportunities in relation to maternal type 2 diabetes risk. MCH has reached out to a type 2 diabetes expert from the community to provide training to WIC nutritionists on the need for screening as well as

raise awareness of the increased risk of type 2 diabetes postpartum. Other collaborations with WIC include identifying a pilot site(s) for collection of postpartum visit (PPV) data. A provider has been identified to speak on PPV-related issues for grand rounds presentation.

The SoberMomsHealthyBabies.org website to prevent substance use in pregnant women will continue to be promoted. The collaboration with the Substance Abuse Prevention and Treatment Agency (SAPTA) ensures materials and resources about substance use in pregnancy will reach the targeted audience. Continued participation of these initiatives is vital to Nevada Title V because their goals align very well with Nevada's MCH priorities and action plan for the next five years.

Priority 1: Improve preconception health among adolescents and women of childbearing age.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement efforts addressing the priorities and performance measures that pertain to this domain.

2. Perinatal /Infant Health

MCH is committed to improving birth outcomes in Nevada. As a result, MCH is currently involved in several statewide initiatives including the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality and NGA Learning Network on Improving Birth Outcomes, among others.

The Title V Program funds and collaborates with Washoe County Fetal Infant Mortality Review (WC FIMR) in Washoe County, Nevada, to assess the issues relating to fetal/infant loss with the goal of reducing fetal and infant mortality. The overall goal is the expansion of the FIMR project throughout Nevada.

Dignity Health oversees the Baby Safe Sleep Program and plans to continue with the program's activities in the coming years. Safe Kids Washoe County, the lead agency for Cribs for Kids (C4K) program in Nevada has over 38 active partner agencies statewide and will continue to leverage these partnerships to provide education and awareness on how to provide safe sleep environments to families in Nevada.

Nevada Breastfeeding Program continues to conduct statewide campaigns to improve infant feeding practices in hospitals, and increase community and business support for breastfeeding mothers. In addition, the breastfeeding program continues to support Women, Infants and Child (WIC) moms in breastfeeding by providing free professional lactation support, breast pumps, and an enhanced food package for moms who wish to breastfeed. Nevada WIC continues to oversee the *Loving Support Peer Counseling Program*. In addition, WIC will provide continued technical support for the remaining 15 maternity centers that have not achieved their Baby Friendly designation. WIC plans to again design and publish a Nevada Breastfeeds Calendar, and support and promote the 2016 "Liquid Gold" 5K Breastfeeding Awareness Run. Nevada WIC will continue to explore the use of the Electronic Benefit Transfer (EBT) system with Farmers Market vendors statewide to allow participants to use their $8-$10 monthly Cash Value Voucher (CVV) at any farmers market in order to potentially increase access to fresh fruits and vegetables, especially in rural areas.

The Clark County Healthy Start Program is committed to reducing racial disparities and improving perinatal health outcomes among African-American women by fostering continuous access to care for women who are pregnant or of child bearing age. The Program will continue providing outreach education and engaging the community members to obtain support.

Nevada received the March of Dimes Virginia Apgar Prematurity Campaign Leadership Award in 2014 for achieving the 8% reduction in premature birth rates from 13.8% in 2009 to 12.6% in 2013.

Priority 2: Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement existing efforts addressing this priority and the performance measures that pertain to this domain.

3. Child Health

Immunize Nevada ramped up its vaccination campaign and provided 78% more vaccines in 2014 than 2013. The campaigns were conducted at community and mobile food pantry sites in partnership with Walgreens. In addition, the state funded non-profit coalition developed several new projects to provide education, provider outreach, support

implementation of billing for public health services, and provide immunization training to healthcare providers. Nevada Home Visiting Program conducted parenting education and child wellness activities with the program's enrollees and will continue to offer these services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) continues to provide access to and receipt of the full range of screening, diagnostic, and treatment services. Language was added to Nevada's Medicaid Services Manual for the Healthy Kids Program (EPSDT) to clarify diagnostic and treatment services covered under EPSDT for children not dependent upon an EPSDT screening so that children get all medically necessary services. The Nevada Division of Health Care Financing and Policy is in the process of developing policy for coverage of Autism services for Medicaid and expects to start coverage in January 2016.

Priority 3: Increase the percent of children aged 10 through 71 months receiving developmental screening.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement efforts addressing this priority and performance measures that pertain to child health.

4. Adolescent Health

The Nevada Adolescent Health Program provides preventive services and ensures the needs of adolescents in Nevada are met. The program will continue to focus on youth development and health promotion for adolescents in Nevada and also continue to promote comprehensive sex education, adulthood preparation programs and abstinence education with the goal of preventing pregnancy and the spread of sexually transmitted infections (STIs) among adolescents. In addition, the Adolescent Health Program will continue to administer the Abstinence Education Grant Program (AEGP) and Personal Responsibility Education Program (PREP) in Nevada.

Priority 4. Increase the percent of children, adolescents and women of childbearing age who are physically active.

Priority 5: Increase the percent of adolescents and women of childbearing age who have access to healthcare services.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement efforts addressing these priorities and the performance measures that pertain to adolescent health.

5. Children and Youth with Special Health Care Needs

The MCH Program, in collaboration with the Department of Pediatrics, University of Utah Health Sciences Center, developed a Medical Home Portal to provide a comprehensive, coordinated and integrated state system for improving the care of CYSHCN in Nevada. The Medical Home portal will provide resources and educational materials in order to support, educate and empower families of CYSHCN throughout the state.

MCH will continue to collaborate with other agencies that provide services to CYSHCN including: Nevada Governor's Council on Developmental Disabilities (NGCDD), IDEA Part C/Early Intervention, Family TIES, Nevada Center For Excellence In Disabilities (NCED), Nevada Leadership Education in Neurodevelopment and Related Disabilities (NvLEND) among others.

Priority 6: Promote establishment of a medical home for children.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement efforts addressing this priority and the performance measures that pertain to this domain.

6. Cross Cutting/Life Course

MCH continues to work with March of Dimes in co-branding tobacco education and cessation materials as well as in distributing the March of Dimes pamphlet; *Smoking and Pregnancy* to WIC offices, MCH Coalitions, and Rural Community Health Nurses and at outreach events organized by Division of Public and Behavioral Health (DPBH) staff and/or MCH partners. MCH will also continue to work with the Substance Abuse Prevention and Treatment Agency (SAPTA) to oversee the *SoberMomsHealthyBabies.org* website to prevent substance use in pregnant women and provide information to women of childbearing age, providers, and concerned family and friends. The website provides the substance use help line (1-800-450-9530) and the Nevada tobacco quit line (1-800-784-8689) among other resources. The Tobacco Prevention and Cessation Program will continue to disseminate targeted Quit

line promotional material for pregnant and postpartum women who use tobacco, via Nevada providers, WIC clinics, early childhood educators, Nevada Head Starts and Safeway pharmacies. The Nevada Tobacco Quit line (NTQ) will continue to provide callers with up to five (5) scheduled personalized, culturally competent, coaching sessions, unlimited inbound calls, web and text support and Nicotine Replacement Therapies (NRTs) free of charge to callers ages 18 and up.

MCH will continue to collaborate with the Bureau of Behavioral Health, Wellness, and Prevention to implement mental health, behavioral health and substance use prevention strategies using a public health approach. Market plans offered in the Silver State Health Insurance Exchange will continue to offer mental health and substance use disorder services as part of the ten Essential Health Benefits stipulated in the ACA. In addition, qualified health plans offer a network of providers including those specializing in mental health and substance use, ensuring more Nevadans have access to quality health care that includes coverage for mental health and substance use disorder services.

The Office of Suicide Prevention (OSP) will continue to carry out various programmatic activities including: School-based screening for behavioral health or suicide risk, reducing access to lethal means of committing suicide such as firearms, training on suicide intervention and alertness training, increasing and enhancing suicide prevention efforts for service members, veterans and their families.

The Primary Care Office (PCO) will continue to expand recruitment and retention efforts of the healthcare workforce in Nevada by:

- Improving access to primary health care services for Nevada's underserved;
- Increasing availability of primary care providers in underserved areas;
- Increasing access to maternal and child health care service for underserved populations; and
- Improving provider access to health care financing resources.

Outreach and education of ACA and the Silver State Health Insurance Exchange (SSHIX) will continue to be targeted to uninsured individuals in the 138-400% Federal Poverty Level, younger families with children (ages 18-34) and predominantly young males (ages 21-29). Title V will continue to fund the Community Health Workers Program (CHW) to ensure the Hispanic population is reached through marketing and outreach campaigns. Other ACA-related outreach, education and referral coordination activities will involve collaborative efforts with MCH Coalitions, providers, state and local agencies, non-profit organizations and other stakeholders.

Priority 7: Prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age.

Priority 8: Increase the percent of adequately insured children.

The plan over the next year is for Title V, in conjunction with other programs, agencies, and community stakeholders to implement efforts addressing these priorities and the performance measures pertaining to this domain.

II. Components of the Application/Annual Report

II.A. Overview of the State

Nevada's Maternal and Child Health Title V program is dedicated to improving the health of families, with an emphasis on women, infants, and children, including children with special health care needs (CSHCN). Title V funding 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 MCH target populations.

1. Geography

Nevada is the seventh largest state in the U.S. with a land mass of approximately 110,000 square miles. The State's unique topography and vast distances separate Nevada's rural communities from the urban centers, so much so the distance between the two largest urban areas in the state is 450 miles. As defined by the State's Demographer, there are three urban counties (Carson City and Clark and Washoe), three rural counties (Douglas, Lyon, and Storey), with the remaining eleven considered frontier counties. Nevada's rural and frontier populations spreads over 95,421 square miles or 86.9% of the State's land mass. Approximately 83% of Nevada's land area is under the jurisdiction of the Federal Bureau of Land Management (BLM); the remaining 17% of the land is privately owned or within state, local, or tribal jurisdiction.

Nevada's urban areas struggle with many of the problems associated with urban living, but also with an unusually high cost of living relative to low wages and insecure work associated with service industries which constitute a large number of available jobs in these areas. The poverty level in rural and urban areas is comparable, however accessing medical and health care services is severely limited in rural and frontier counties due to geographical access barriers as well as difficulties in recruiting and retaining providers. This translates to low rates of routine preventive health services, such as recommended EPSDT screening and related childhood immunizations, and decreased access to preconception health services, including the screening and management of chronic conditions, counseling to achieve a healthy weight, and smoking cessation.

2. Population

Nevada's current population is 2,855,061, including 286,251 residents in the state's fourteen rural and frontier counties. According to 2014 population estimates prepared by the Nevada State Demographers Office, 2.5 million Nevadans or 89.9% of the state's population resides with in the urban counties. Over the last four years, Nevada's population has grown by 4.5% and is projected to grow by 9.5% over the next decade to become home for approximately 3.1 million residents. Some of the factors contributing to the population increase are births and increased immigration. As the economy rebounds, Nevada has seen an influx of new businesses such as the electric carmaker, Tesla which is building a "gigafactory" battery plant in Reno, Nevada and Switch, which has expanded beyond Las Vegas and is building a three million square foot SUPERNAP data center campus also in Reno. These companies, among others, play a major role in the projected population growth and will provide a huge economic boost to the State. The most densely populated area in the state is Clark County with 2,051,946 residents, followed by Washoe County where 437,580 people reside. In stark contrast to the urban areas, Esmeralda County and Eureka County are home to 912 and 2,056 residents, respectively. Currently 24.1% of Nevada's population is 17 years and younger, 62.2% are between 18 and 64 years of age, and 13.7% are 65 years and older.

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

In Nevada, according to the U.S. Census Bureau, there are 19.1% of foreign-born residents compared to the national

average of 12.9%. Immigrants comprised 25.1% of the state's workforce in 2011 or 348,671 workers. Latino immigrants comprised about 16% of the state's entire workforce in 2005, and an even higher share in select industries: 81% of the agricultural workforce, 47% of the construction and mining workforce, and 22% of the entertainment and tourist services workforce. The State's agricultural workforce is made up of migrant and seasonal farm workers where 61% of the farm workers (individual) and 50% with families are below the poverty level and suffer from a range of barriers which limit access to healthcare and achieving optimal health. Low educational attainment, illiteracy, language barriers, lack of transportation, insurance, and sick leave have all been identified as issues within Nevada, which limit positive health outcomes for this population. Additionally, fear of immigration penalties and a lack of knowledge about assistance programs continue to trouble this demographic.

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

In response to the problems that plague Nevada's mobile and immigrant population, efforts have been established to improve health outcomes, including supporting community health workers who create connections between vulnerable populations and healthcare systems. This lay health worker pool ensures cultural competence by providing culturally appropriate health education on topics related to chronic disease prevention, physical activity and nutrition, and advocating for underserved individuals to receive appropriate services. During the 2015 legislative session, SB 498 was passed requiring certification of community health worker pools to assure standardization of training, accountability, and regulation. It is expected that in the next six months, the Nevada Administrative Code (NAC) will be amended to address specific curriculum and certification requirements for the pools of community health workers.

The Division of Public and Behavioral Health along with the three other health authorities (Washoe, Clark, and Carson City Counties), and MCH partners employ bilingual staff and develop materials in English and Spanish.

3. Public Health System

Within Nevada, the lead public health agency is the Division of Public and Behavioral Health (DPBH). The division resides within Nevada's Department of Health and Human Services. DBPH has four (4) branches including Community Services, Clinical Services, Regulatory and Planning Services, and Administrative Services. Most health related programs in the state are joined together under the auspices of Nevada's Division of Public and Behavioral Health. Community Services programs include the State Immunization Program, Women, Infant, and Children (WIC) Program, Chronic Disease Prevention and Wellness Promotion Programs, HIV Prevention and Treatment Programs, Environmental Health, as well as the Substance Abuse Treatment Agency. Other supportive services such as the Office of Public Health Informatics and Epidemiology also reside within the Community Services Branch. The Maternal, Child and Adolescent Health (MCAH) Section is housed within the Bureau of Child, Family, and Community Wellness (BCFCW), where it is one of four sections addressing community health within Nevada. Currently, the MCAH section manages a portfolio of maternal and child health related programs, including the Title V MCH Block Grant; Maternal, Infant, and Early Childhood Home Visiting program; Adolescent Health and Teen Pregnancy Prevention; Early Hearing Detection and Intervention; Rape Prevention; and Children and Youth with Special Health Care Needs.

The State of Nevada Maternal, Child, and Adolescent Health Program addresses health issues amongst the population it serves by coordinating efforts with local health authorities, sister programs (Immunization, Wellness, and WIC), sister agencies (Medicaid/CHIP, Division of Child and Family Services, Family Services), Community Coalitions, MCH Coalitions, State of Nevada Office of Primary Care, Oral Health Coalitions, Crisis Call Center, Family Resource Centers, FQHC's, Planned Parenthood, and regional hospitals with their respective foundations.

4. Healthcare

The impact of the implementation of the Affordable Care Act (ACA) was substantial in Nevada. The estimated number of uninsured Nevadans in 2013 (Pre-ACA) was 20.7%. Based on the 2013 American Community Survey conducted by the U.S. Census Bureau, 14.8% of children under the age of 18 were uninsured, 27% of adults ages 18-64 were uninsured, 2.1% of the elderly 65 years and older were uninsured, and there was a 23.6% overall rate of uninsured among the non-elderly 64 years and under population. Currently, the estimated number of uninsured Nevadans, as of December 2014 was 11%. Specifically, 5.4% for children under 18, 15.2% for adults 18-64, 1.9% for the elderly 65 years and older and 12.5% overall for the non-elderly 64 and under. There has been an almost 10% decline in the uninsured and in Nevada during the ACA expansion, 6th best in the nation.

The 2014-2015 open enrollment period for the Silver State Health Insurance Exchange was moderately successful. As of February of 2015 there were 62,944 effectual enrollments. This was a 59% increase over the completed applications during the last open enrollment period.

Nevada's Medicaid and Children's Health Insurance Program (CHIP) are managed by the State of Nevada Division of Healthcare, Financing, and Policy. Contracts are in place with two managed care organizations, which provide healthcare to Medicaid eligible individuals. In Nevada during the 2014 calendar year, 573,874 individuals were enrolled in Medicaid compared to 399,971 during the previous year. In our state during the 2014 calendar year, 526,236 individuals were enrolled on one of two managed care plans provided by Medicaid and 47,638 were enrolled in the Medicaid *fee for service plan* available in the rural and frontier areas of Nevada. Nevada's CHIP program benefits children who are not eligible for Medicaid and may not otherwise have access to health insurance. Nevada's CHIP program had 32,825 children enrolled in during the 2014 year. As of January 2015, enrollment in Medicaid and CHIP increased by 65.7%. With this expansion came the opportunity to conduct outreach, increase health literacy, and facilitate accessing care for those new to insurance. The promotion of preventative benefits and screenings such as EPSDT under ACA, particularly as they relate to maternal and infant health, with an emphasis on Medicaid beneficiaries is a key priority in increasing maternal and infant health. In recognition that access to insurance isn't necessarily access to care, formulating current and future MCH programming and policy supporting access will be key to improving health amongst the MCH population Nevada serves. Nevada's Maternal, Child, and Adolescent Health Program will continue to monitor the impact of the ACA through programs such as the *Nevada Baby Birth Evaluation and Assessment of Risk Survey* (BabyBEARS), which is modeled after the Pregnancy Risk Assessment Monitoring System (PRAMS). This ongoing program captures prenatal and postnatal data that can be used as access and outcome indicators.

Nevada will also be monitoring Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings among its Medicaid eligible children (21 years of age and younger). Of the 311, 955 Medicaid Participants eligible for EPSDT screenings in 2014, there were a total of 227,937 screens received (73%). The EPSDT screening program is known as Healthy Kids in Nevada and offers a free well-child screening for children and youth who are enrolled in Medicaid and Nevada Check Up. Over the past few years Nevada's Maternal and Child Health (MCH) Program and Nevada Medicaid have worked together to educate providers and parents on Healthy Kids/EPSDT benefits available to children. A toolkit of Healthy Kids/EPSDT was produced in partnership between programs to increase outreach and utilization rates. It is important to expand this education and outreach in Nevada to ensure each Medicaid provider understands how to utilize the screening and parents/care-givers understand the benefit available to their children.

The Bright Futures project in Nevada targets advocates, parents, and schools with resources and information on healthy living for infants, children and, adolescents by promoting increased access to consistent well child healthcare visits. The Bright Futures Tools and Resource Kit has been distributed to medical providers, school staff, parent groups, family resource centers, home visiting staff, childcare health consultants, coalition memberships, and community leaders. These partnerships have increased the awareness of services available under Bright Futures, as well as increased awareness of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits to families as well.

A recent Health Effectiveness Data and Information Set (HEDIS) report for Medicaid Managed Care shows

significant improvement in rates of EPSDT in Nevada. MCH staff and community partners have actively recruited primary care providers to take the well child online curriculum. This curriculum was also included into the University of Nevada Medical School residency program.

Health Effectiveness Data and Information Set (HEDIS) measures will also assist Nevada in determining the ability of Medicaid participants to access timely services. Measures including immunization status; well child visits for the first 15 Months of Life (Six or More Visits); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Maternity related measures, and condition related measures are reviewed.

Attempting to address access to health for the remaining 11% of Nevada's uninsured is difficult. However, Nevada is home to a non-profit organization called *Access to Healthcare Network* (AHN). This organization offers a medical discount program which follows a Shared Responsibility Model. Members pay a small, income-based membership fee for access to the discounted provider network and participating healthcare providers receive a timely, yet reduced, payment. In addition to successfully negotiating lower costs of care, clients also receive case management. For clients who are unable to completely pay for their healthcare needs, a patient care fund also provides financial assistance. As the ACA has changed the insurance paradigm in Nevada, AHN has witnessed a transition as well and 82% of the medical discount program participants are the undocumented.

Additional safety nets for free health care is illustrated by the University of Nevada School Of Medicine's Student *Outreach Clinic* which is operated by medical students. The purpose of the clinic is to provide access to health care for those without medical insurance, providing them with medical care that they otherwise may not receive. The benefit to students is that they receive hands-on experience in treating patients from the first day of medical school. The Clinic is operated in cooperation with the Family Medicine Center and the University of Nevada School Of Medicine, and made possible by faculty and community physicians who donate their time to oversee the clinic. Services include general and acute medical care, gynecological exams, immunizations, and discounted laboratory services. Currently there are three separate clinics (General, Children's, and Women's) run by the Student Outreach Clinic. The clinic was founded in 1996 and provides health services to uninsured populations in Northern Nevada.

5. Employment

Currently there are 1.37 million Nevadans in the state's labor force, including 1.26 million who are employed and 112,617 who are unemployed. The annualized unemployment rate for 2014 in Nevada was 8.2% compared to the national average of 6.5%. The highest rate of unemployment in 2014 was in Lyon County (rural) at 15.2%, while the lowest rate was in Esmeralda County at 3.1%. Within the urban regions of Nevada, Carson City experienced the highest rate of unemployment at 8.8% and Washoe and Clark Counties were slightly lower at 8.3% and 8.0% respectively.

6. Housing

According the US Census Bureau in 2013 there were 1,186,879 housing units in Nevada and the home ownership rate was 56.7% compared to the national average of 64.9%. In 2014 Nevada ranked number two for foreclosure filings, with one in every 533 housing units was in some stage of the foreclosure process, which was two times the national average during that time period. In April of 2015, one in every 555 housing units was in some stage of foreclosure with Carson City at the highest rate at one in every 602 housing units.

When examining economic factors, it becomes clear Nevada has been slow to recover from the economic crisis, which can in part be attributed to the foreclosure crisis, and leads to greater risk of homelessness, although the extent of the relationship is unclear. In 2014, 1.9% of the total Nevada population was homeless. In 2015, this percentage decreased to 1.8%.

As expected, based on population, Southern Nevada (Clark County) maintains the largest number of the homeless population in the state. The 2015 annual estimate for the number of homeless people in Southern Nevada was 34,397. This represents a 0.01% decrease from the 2014. During the 2015 *Point in Time Count* 53.5% of the homeless survey respondents cited job loss as the primary cause of their homelessness, making it the primary cause of homelessness for the majority of this population. The second most commonly cited cause of homelessness was the category "*Other" at* 31.4%. This is the first year that this category has been included in the Top 6 Events leading to Respondents' Homelessness. In this same time frame, alcohol or drug use was the third most commonly

cited primary cause of homelessness in Southern Nevada.

7. Income

According to data provide by the Kaiser Family foundation 17% of Nevadans lived in poverty in 2013. The African American population bears the largest part of that percentage at 33%, followed by Hispanic groups at 27%, White at 12%, and "other" at 8%. Although poverty figures are not available for 2014, inferences can be drawn by reviewing the number of Nevadans participating in the *Supplemental Nutrition Program* (SNAP). In Nevada, 410,529 people or 14.5% of the state's population received SNAP benefits during 2014. Other indicators of poverty include the *Free and Reduced Lunch Program* in Schools and according to the most recent data available, 233,493 students qualified for the *Free and Reduced Lunch Program* in Nevada, which is 54.7% of the total student population. Nevada's urban areas maintain the highest poverty rates in Nevada with an average of 16.6% compared to the rural and frontier counties which maintain an average of 12.8%. Statewide, the U.S. Census Bureau reports that almost one quarter or 23.4% of Nevada's children through the age of 18 live in poverty.

Safeguards are offered to Nevadans through *Temporary Assistance for Needy Families* (TANF). Designed to help needy families, this financial support is aimed at providing assistance to cover a family's ongoing basic needs such as food, shelter, clothing, childcare, transportation, and other services.

8. Policy/Legislature

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

As a result of the budget shortfalls and Nevada's poor rankings on education, Governor Sandoval proposed a $1.3 billion dollar plan of new and extended taxes, which was passed by a republican controlled House and Senate and is the largest tax increase in state history. It is expected that the tax increase will support pre-K education, school readiness, full-day kindergarten, Zoom schools, funding for English-language learners, and opportunity grants for college students. There were a number of requests to support new public health initiatives, but with the current overall economic status, it prohibited funding of these initiatives. However, the Division of Public and Behavioral Health's (DPBH) budget was approved and included fee revenues to support funding the State's Dental Officer and Public Health Dental Hygienist. This demonstrates Nevada's commitment to address oral health issues within our state because this is the first time these positions will be funded and filled since they were created during the 2001 legislative session.

The 2015 legislative session was active with a number of bills relating to improving the health of Nevadans. SB79 was passed out of the Senate and Assembly and was signed into law by Nevada's Governor Brian Sandoval. The Nevada Legislature voted to pass SB79 to increase the state cigarette tax by $1 per pack. The tobacco tax increase is a win-win-win solution for Nevada – a health win that will reduce tobacco use and save lives and a financial win that will help to balance the state budget and invest in education.

The evidence is clear that increasing the cigarette tax is one of the most effective ways to reduce smoking, especially among kids. Nevada can expect the $1 cigarette tax increase to: prevent more than 10,200 Nevada kids from becoming smokers, spur more than 15,400 current adult smokers to quit, save more than 7,200 Nevada residents from premature, smoking-caused deaths, and save more than $474 million in future health care costs. The state projects that the $1 cigarette tax increase will raise more than $192 million in new revenue over the first two years.

AB 489 was also passed, supporting the certification of "Community Health Worker (CHW) Pools." This law will assist the State Chronic Disease Prevention and Wellness Program and Healthcare Quality and Compliance Bureau in assuring a competent and trained lay health workforce.

AB152 was passed as amended (without nutritional requirements) setting forth requirements relating to childcare

facilities to provide private space for breast feeding mothers and also requiring the childcare providers ensure children receive periods of moderate to vigorous activity. This law will limit the amount of sedentary activity other than meals, snack, and naps. It also prohibits childcare providers from limiting physical activity as a punishment. SB503 gives school districts the necessary funding to carry out a "*Breakfast After the Bell*" program, which is designed to provide low income students with breakfast in school so they can perform better and reduce health inequalities and disparities.

Beyond Nevada's biennial legislative period, Nevada relies on the MCH Advisory Board (MCHAB) to provide the State MCH program with direction and guidance on policy issues. This forum sets the stage for state priorities relating to the MCH populations served, and is used to guide the state's Needs Assessment as well as planning of interventions implemented by the State Maternal and Child Health Coalition, regional MCH coalitions, and Title V partners.

II.B. Five Year Needs Assessment Summary

II.B.1. Process

Introduction

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

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

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

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

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

Methodology

Qualitative Data

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

Quantitative Data

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

also utilized.

Framework

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

Prioritization Process

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

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

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

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

1. Women’s/Maternal Health

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

Wellness screening

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

Research has shown that improving preconception health can result in improved reproductive health outcomes. Nevada Title V in collaboration with various agencies and programs has been conducting numerous activities to

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

Prenatal care

The percent of pregnant women who received prenatal care beginning in the first trimester in 2013 (68.4%) remained the same as 2012 (68.1%). More recent data (2014) indicates that this number slightly improved to 70% and this puts Nevada close to the Healthy People 2020 objective of 77.6%. In 2013, women with private insurance were the most likely to receive prenatal care in the first trimester (82.7%), followed by women with other type of public insurance (77.2%). Uninsured women (55.1%) and those enrolled in Medicaid (55.2%) were the least likely to receive prenatal care beginning in the first trimester. By race/ethnicity, White women were the most likely to receive prenatal care in the first trimester (77.2%) followed by Asian (76.3%), Hispanic (59.8%) and Black (59.6%).
Prenatal care was identified as a priority in the previous needs assessment (2011-2015) and will continue to be addressed in NPM 1. The Office of Public Health Informatics and Epidemiology, housed in DBPH will continue monitoring accurate reporting of prenatal care for all registered births in hospitals and birthing facilities in Nevada. Nevada tracks adequate reporting of prenatal care because research has shown that receiving early and regular prenatal care improves the chances of a healthy pregnancy and ensures that babies have better health outcomes. When hospitals provide complete information about prenatal care, DBPH can accurately allocate prenatal care resources where the needs are the greatest.
To address various aspects of prenatal and postnatal care, Amerigroup, a managed care organization in Nevada established Prenatal/Postpartum Quality Initiatives such as the OB Medical Record Review tool to monitor the providers' compliance with HEDIS and American Congress of Obstetricians and Gynecologists (ACOG) guidelines for prenatal and postpartum care. Amerigroup also oversees an intensive OB case management program for pregnant members known as *'Taking Care of Baby and Me*' which encourages members to optimize the outcome of their pregnancy.

2. Perinatal/Infant Health

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

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

Infant Mortality

Nevada's Infant Mortality Rate (IMR) in 2009 was 5.8 per 1,000 live births and significantly declined by 12 percent to 5.1 in 2014. This puts Nevada below the HP 2020 objective of 6.0. However, racial/ethnic disparities persist in infant mortality in our state. In 2012, Blacks (9.6) and American Indian/Alaska Natives (9.4) had the highest IMR while Asians had the lowest IMR (3.8). Hispanic IMR was 4.4 while White IMR was 5.2. Between 2011-2013, populations that participated in WIC had a lower IMR (4.7) compared to those who did not participate (5.5).
Nevada's Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births significantly declined (by 23 percent) from 93.1 in 2009 to 71.4 in 2013. In 2011-2013, Blacks had a significantly higher SUID rate (159.1) compared to Whites (84.1) and Hispanic (38.9). Infants born to moms with less than high school education experienced higher SUID rates (116.1) compared to infants born to moms with some college (40.1). Disparate SUID rates were seen in certain age groups with infants born to moms who were less than 20 years experiencing

higher SUID rates (162.0) compared to infants born to moms 30-34 years (89.9).
Approximately 4,000 infants in the United States die each year due to preventable and unsafe situations such as asphyxia, suffocation, and other undetermined sleep-related deaths. Title V closely works with Safe Kids Washoe County, the lead agency for the Cribs for Kids (C4K) program in Nevada to provide educational resources to parents and caregivers on the importance of practicing safe sleep behaviors. In 2014, C4K conducted seven statewide trainings (five in Washoe County and two in rural areas--Carson City and Ely) and as a result, acquired four new partner agencies in these areas. C4K conducted also conducted public awareness campaigns such as ABC's of safe sleep banner ads on various websites through a digital advertising campaign targeting new mothers across the state and 30 second radio PSA's on safe sleep were aired in rural areas. Baby Safe Sleep initiative is currently being implemented by Dignity Health System hospitals in Southern Nevada.
Title V collaborates with Maternal, Infant and Early Childhood Home Visiting Program, which houses the Healthy Start Program. Healthy Start was recently awarded federal funding to focus on reducing racial disparities and improving perinatal health outcomes among African-American women Clark County. The design and delivery of the program is to provide comprehensive, coordinated, health and social services that will foster continuous access to care for women who are pregnant or of childbearing age.

Breastfeeding

Nevada Title V has been doing significant work to improve the health and wellbeing of infants. One of the initiatives surrounding this domain includes breastfeeding promotion. In 2014, the percent of infants who were ever breastfed in Nevada (80.9%) was about the same as that of the nation (79.2%). The prevalence was even higher in moms enrolled in Nevada's Home Visiting Program (92.1%). However, the percent of infants breastfed exclusively through 6 months remained the same in 2010 (18.7%) and 2011 (18.8%). The high rates of breastfeeding initiation in our state are not surprising considering the significant contributions that have been made by the Nevada Breastfeeding Program and Nevada Home Visiting Program to support women who wish to breastfeed. Breastfeeding efforts will continue to be addressed through *priority 2: Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months.* This priority aligns with *NPM 4A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 month.*
Other efforts in Nevada that support breastfeeding include designation of a lactation room in one of two Department of Public and Behavioral Health buildings, and the "*Bring Your Baby to Work*" program which expanded from two to four Department of Health and Human Services Divisions – adding on the Division of Health Care Financing and Policy and the Division of Aging and Disabilities. These new developments were overseen by Nevada WIC in FY '14.

3. Child Health

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

Early Screening and Developmental Screening

MCH collaborates with entities across the state to ensure children are provided with appropriate screening, follow-up, testing, and timely treatment. Nevada Early Hearing Detection and Intervention (NV EHDI) Program, housed in the Maternal, Child and Adolescent Health section works to ensure that all children in Nevada are screened for hearing loss at birth and those identified with hearing loss receive timely and appropriate audiological, educational and medical intervention. However, Nevada faces a shortage of audiologists who routinely treat newborns and this

causes delays in diagnosis and increased loss to follow-up. Consequently, both parents and healthcare providers get frustrated. To deal with these issues, NV EHDI implemented the Guide By Your Side (GBYS) to address the Loss to Follow-up/Loss to Documentation Rate in Nevada. In addition, NV EHDI employs an audiologist to provide training on the correct newborn screening methods. The collaboration has led to improved screening and a reduction in the burden of conducting unnecessary diagnoses for audiologists.

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

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

Immunizations

CDC calls prevention of disease through vaccination as one of the 10 greatest public health achievements of the 20th century. However, immunization rates have dropped in the recent past in various populations, possibly attributed to nonmedical vaccine exemptions. MCH needs assessment findings found that parents and stakeholders were concerned about myths surrounding vaccines as well as the rising number of children in our community who were not vaccinated. To address these concerns, parents suggested that they would like to receive information to clear up misconceptions. Additionally, parents stated provision of immunizations at schools would lessen the burden of taking time off from work in order to have their child vaccinated.

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

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

Nutrition and Physical Activity

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

In 2011-12, 33.2% of percent of children and adolescents in Nevada were overweight or obese (BMI at or above the 85th percentile). However, more recent data (2013-2014) from Nevada's Student Height-Weight Study shows that the prevalence of overweight or obese children in our state has increased by 15 percent to 38.1%. Results from the needs assessment indicated a lack of education and services related to factors that lead to obesity, including adult

and child nutrition as well as physical activity. To address nutrition and physical activity, both parents and stakeholders suggested increasing regulation for foods serving children, promoting affordable sports, utilizing activity busses/tumble busses, and working with family resource centers to reach the populations they serve.
Plans are underway to create a Statewide Obesity Prevention Taskforce to look into ways to reduce overweight and obesity rates specifically through increased physical activity and physical education. The Comprehensive School Physical Activity Program (CSPAP) training has been provided to school staff and other partners and will be continued in urban areas, as well as rural and frontier Nevada.

4. Adolescent Health

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

Well-Visits

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

Immunizations

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

Nutrition and Physical Activity

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

Sexual and Reproductive Health

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

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

5. Children and Youth with Special Health Care Needs

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

Medical Home

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

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

6. Cross-Cutting/ Life Course

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

Mental Health

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

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

AB 164 was passed in 2013 to require all school administrators be trained in suicide and bullying prevention. As a result, the Office of Suicide Prevention (OSP) trained district superintendents and administrators in 5 counties: Lyon, Pershing, White Pine, Churchill, Lander and Humboldt in 2014. In addition, OSP collaborated with Nevada Coalition for Suicide Prevention to train over 8,334 Nevadans on suicide intervention and alertness training and has brought Suicide Awareness to 921,000 of our states population through media and news outlets. A recent behavioral health survey confirmed that Nevada is reducing the stigma and taboo around the subject of suicide.

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

Tobacco Cessation

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

Health Insurance

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

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

In 2013, 13.9 % of the children in Nevada did not have health insurance. This is a 23 percent reduction from 18.0 % in 2009. Even with the decline in children insurance rates, Nevada has not met the HP 2020 objective to increase the proportion of persons with health insurance to 100%. In 2013, children with the highest insurance rates were aged 12-17 (16.0%). By race/ethnicity, Native Hawaiian/other Pacific Islander children were the most likely to be uninsured (20.7%) while children of multiple race were the least likely to be uninsured (7.9%). Children born outside the U.S. were 2 times more likely to be uninsured than children born in the U.S. Nevada's MCH Program is aware of

these disparities and will continue with various efforts to increase health insurance coverage for the affected populations.

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

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II.B.2.b Title V Program Capacity

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

In Nevada's Executive Government, the elected Governor is the Head of State. Brian Sandoval, was elected Governor of Nevada on November 2, 2010 and is in his second four-year term. There are various departments, boards and commissions that make up the Executive Branch under the Governor. These include: Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch Includes: the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons.

The Nevada Department of Health and Human Services (DHHS) is the largest department, comprised of five divisions along with additional programs and offices overseen by the DHHS's Director's Office. Richard Whitley is the DHHS Director appointed by Governor Brian Sandoval. The five divisions under DHHS include: the state public health agency, known as the Division of Public and Behavioral Health (DPBH), Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS), Division of Health Care Financing and Policy (DHCFP), and Division of Welfare and Supportive Services (DWSS).

Various programs that help to promote MCH priorities in Nevada are also housed in DHHS. These include: *Nevada 2-1-1,* a free service that provides information about vital health and human service programs that are available throughout the State, *Office of Consumer Health Assistance,* provides information and advocacy to consumers to assist them manage any changes relating to the Health Care Reform. The *Nevada Governor's Council on Developmental Disabilities* engages in advocacy, system's change and capacity building activities for people with developmental disabilities and their families in order to promote equal opportunity, self-determination, and community inclusion. *The Office of Food Security* was established in September 2013 and strives to leverage regional and local community-based efforts to reduce hunger. The *Grants Management Unit* administers grants to local, regional, and statewide programs serving Nevadans. *The Office of Health Information Technology (HIT)* is responsible for administering Nevada's ARRA HITECH State Health Information Exchange (HIE) Cooperative Agreement, facilitating the core infrastructure and capacity that will enable statewide HIE and coordinating related

Health IT initiatives. *IDEA Part C Office* provides comprehensive, interagency, multidisciplinary, family-centered, and community-based services accessible to all infants and toddlers with disabilities and to many who are at risk for disabilities. *The Office of Minority Health's* mission is to improve the quality of health care services for members of minority groups; to increase access to health care services; and to seek ways to provide education, and to address, treat and prevent diseases and conditions that are prevalent among minority populations. *Tribal Liaisons*: DHHS is committed to partnering with the 27 Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the Tribal Governments as well as provides education and outreach. There is a network of Liaisons who represent each of the DHHS Divisions.
Nevada Revised Statute (NRS) 442 designates the DHHS through the DPBH to administer those parts of the Social Security Act which relate to Maternal and Child Health and Children with Special Health Care Needs. DBPH houses five bureaus including the 1). *Bureau of Child, Family and Community Wellness,* 2.) *Early Intervention Services*, 3). *Health care Quality and Compliance*, 4). *Preparedness, Assurance, Inspection and Statistics,* and 5). *Public Health and Clinical Services.* Title V/Maternal and Child Health Program is in the Bureau of Child, Family, and Community Wellness in the Maternal, Child and Adolescent Health section. Other programs in the section are: Maternal and Infant Health which includes Perinatal Substance use Prevention and SUID/SIDS, the Nevada Early Hearing Detection and Intervention (EHDI) Program, Adolescent Health Program; Rape Prevention and Education Program; and the Office of Suicide Prevention. The Section is headed by a Health Program Manager II and individual program managers range from Health Program Manager I to Health Program Specialist. The Bureau of Child, Family and Community Wellness under DBPH Administration is responsible for Title V MCH Block Grant oversight, management and reporting.
Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the State Board of Health from a list provided by the DPBH Administrator to two year terms, and two legislators are appointed by the Legislative Counsel. Its composition represents public health professionals, healthcare providers, legislators and a consumer to represent CYSHCN. The State Board of Health (SBOH) is a regulatory body that is staffed by the DPBH Administrator. The Advisory Board meets quarterly every year with the in person meeting in Carson City and via videoconference in Las Vegas and Elko. The MCH Advisory Board is staffed by the MCH Manager. Under NRS, MCHAB is charged to advise the DBPH Administration of the "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:
1. Ensuring the availability and accessibility of primary care health services;
2. Reducing the rate of infant mortality;
3. Reducing the incidence of preventable diseases and handicapping conditions among children;
4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;
5. Preventing the consumption of alcohol by women during pregnancy;
6. Reducing the need for inpatient and long-term care services;
7. Increasing the number of children who are appropriately immunized against disease;
8. Increasing the number of children from low-income families who are receiving assessments of their health;
9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and
10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);
11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and
12. Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."

Please see the organization chart under attachments.

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

The Division of Public and Behavioral Health strives to use its resources to promote and protect the health of all the six MCH population domains it serves. This is achieved by partnering and collaborating with multiple agencies and programs, both government and private, across the state.
Title V collaborates with state's public health community including the Southern Nevada Health District (SNHD), Washoe County Health District (WCHD) and Carson City Health Department to promote the health and wellbeing of the MCH/CYSHCN populations in those counties, as well as with the other Bureaus within DBPH. Title V funding provides funding for Community Health Nurses in Nevada's rural and frontier counties. In addition, Title V provides funds and also collaborates with WCHD to conduct the Fetal Infant Mortality Review (WC FIMR) Program. The purpose of WC FIMR is to assess the factors that affect the health of the mother, fetus and infant to learn more about how to reduce fetal and infant mortality.
Title V also collaborates with the DHHS Tribal Liaison to address the MCH-related needs of the Tribes in our state. The Liaison works closely with the 27 Tribes within the State of Nevada through a Tribal Consultation Process Agreement. This coordination establishes and strengthens ties and relationships with the Tribal Governments as well as provides education and outreach. This position has been vacant for several months and got filled in early July, 2015.

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

Title V supports 21 Full Time Employees (FTE) serving in various capacities such as bureau chief, program managers, program specialists, program coordinators, management analysts, health resource analysts, accounting assistants, office manager, community health nurses and administrative staff at DPBH.
Nevada's Title V/MCH program is managed through its main office in Carson City, Nevada. Christine Mackie, MPH, is the Bureau Chief and MCH Director. Beth Handler, MPH, is the Deputy Bureau Chief and oversees the section managers in the Bureau of Child, Family and Community Wellness. Andrea Rivers, BA, is the Maternal, Child and Adolescent Health Section Manager.
Laura Valentine, MS, is the Program Manager for the Title V/Maternal and Child Health (MCH) program and serves as the Children and Youth with Special Health care Needs (CYSHCN) Director. Ms. Valentine is responsible for the policy, program, evaluation, and fiscal administration of Title V activities.
Ingrid Mburia, MPH, Maternal and Child Health Epidemiologist, is responsible for the assessment and development of the Title V/MCH Block Grant and the MCH five-year needs assessment. Ms. Mburia is also responsible for developing, reviewing & evaluating program components such as performance measures and data trends for the population in the state as well as writing reports for federal, state and local use. In addition, Ms. Mburia employs appropriate epidemiologic and statistical methods in data analysis using SAS and other statistical software to manipulate, tabulate, and analyze datasets and also utilizes matching programs to link records using available identifiers.
The Maternal and Infant Health Coordinator position oversees the Perinatal Substance Use Prevention (PSAP) initiative among other duties. This position is currently vacant.
Debra Vieyra, Children and Youth with Special Health Care Needs (CYSHCN) Program Coordinator, collaborates with multiple state agencies and programs, as well as other MCH partners and stakeholders to provide CYSHCN Care Coordination management among other duties.
Deborah Duschesne, BA, is the Rape Prevention Education Program Coordinator and she manages and coordinates all aspects of this federally funded program. Ms. Duschesne collaborates with many state and community level entities that have a stake in prevention sexual violence and violence against women.
Perry Smith is the Program Coordinator for the Nevada Early Hearing Detection and Intervention Program. Mr.

Smith is responsible for the programmatic direction, operation, and evaluation of the state EHDI program. This involves writing and managing HRSA and CDC federal grants, working with collaborative partners through written agreements, writing reports for federal and state use, and supervising other EHDI staff.
Diane Miller, Au.D., CCC-A, is the EHDI Follow-up Coordinator and is a trained pediatric audiologist. Dr. Miller is responsible for working with the program data analyst to locate infants who are lost to follow-up and or lost to documentation and implementing processes and procedures to locate these infants. These procedures may include training of various professionals who may have had contact with these infants, making phone calls or sending letters to parents, and working with audiologists to appropriately test these infants.
Karli Dodge, EHDI Data Analyst, is responsible for overseeing accurate collection and analysis of demographic, hearing screening, diagnostic testing, and intervention services data through working with multiple data suppliers. Ms. Dodge also analyzes, compiles, and produces reports for state and federal users.
Evelyn Dryer, Health Program Manager, is responsible for managing MIECHV grants to include budget and scope of work development; supervising MIECHV staff; monitoring sub-recipient programs to include scope of work, budget and expenditures, program fidelity; developing Continuous Quality Improvement plans and overseeing the CQI process for the state team and for implementing agencies. Ms. Dryer is also responsible for reporting progress and performance to HRSA.
Melanie Lopez, Nevada Home Visiting (NHV) Program Coordinator, is responsible for developing training for home visitors, collaborating with agencies to build statewide systems, and networking with stakeholders to address the health of Nevada mothers, infants, and children.
Yucui Liu, MS, Health Resource Analyst for Nevada Home Visiting Program is responsible for ensuring compliance to Federal, State and DBPH policies and regulations, providing technical assistance on data collection, interpretation and reporting. Ms. Liu is also responsible for developing data collection instruments, building a data warehouse and maintaining and upgrading the database. Ms. Liu also manages, analyzes and reports on family health and wellness indicators for NHV.
Sarah Demuth, Adolescent Health Abstinence Education Grant Program Coordinator, manages the federally funded Title V State Abstinence Education Grant Program. Ms. Demuth is responsible for monitoring pass through funds for three sub-grantees located in northern Nevada by reviewing expenditure and scope of work, evaluating program effectiveness, facilitating program growth and community involvement, and generating federally mandated progress reports.
Sandra Ochoa, MPH, State Systems Development Initiative (SSDI)/Women, Infants, and Children (WIC) Biostatistician, provides data support to the MCH program and program's needs, including the 5-year needs assessment and MCH Block Grant. Supplementary to MCH Block Grant work, data are also provided to support ongoing efforts with the Collaborative Improvement and Innovation Network (COIIN) to reduce infant mortality and SSDI, and maintaining minimum and core data sets related to MCH.
Melissa Slayden, BS, Management Analyst, Office of Public Health Informatics and Epidemiology, is responsible for data collection from internal Division resources and from external State agencies in order to complete the Maternal Child Health Block Grant application. Additionally, Ms. Slayden is responsible for some data analysis, report writing, and report reviewing for the MCH program.
Nevada Title V/MCH program has significantly built its workforce capacity in the last five years. This was achieved through the development of additional/ new positions. Kristine Hughes, the current MCH fiscal support, was brought directly into the program to help in developing, implementing, monitoring, and controlling grant-in-aid projects and provide grants management oversight for incoming funding.
Nevada's DPBH faces numerous workforce challenges in recruiting and maintaining adequate public health professionals. Even though challenges such as difficulty adding new state positions and dependency on temporary staffing still remain, many positive changes affecting state employees were made in the 2015 Legislative session. Some of these include: Assembly Bill 489 was passed and will increase the Cost of Living Adjustment (COLA) by one percent effective July 1, 2015 and by two percent in FY 2017. In addition, Merit pay will be reinstated for classified employees, and State employees will no longer have to furlough.

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

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

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

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

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

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

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

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

- Increased preconception and inter-conception planning and educational outreach

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

In 2010-2012, the infant mortality rate (IMR) in Washoe County (6.0) was higher than the rest of the state (5.3) and the nation (5.1). To address this high IMR in the county, Nevada Title V/MCH program provided funding and collaborated with Washoe County Fetal Infant Mortality Review (WC FIMR) to carry out an in-depth process to uncover the patterns and risk factors associated with fetal and infant death. WC FIMR is currently a pilot project and it is hoped that the project will be expanded to the rest of the state in the near future.
Data linkage of Medicaid, WIC, Nevada Early Hearing Detection and Intervention (EHDI) datasets with Baby Birth Evaluation Assessment of Risk Survey (Baby BEARS) sample to extract mothers addresses and telephone number(s). This contact information is required because the Baby BEARS protocol combines two modes of data collection; a survey conducted by mailed questionnaire with multiple follow-up attempts, and a survey by telephone. Telephone follow-up begins after the mailing of the last questionnaire for survey participants that do not respond to the repeated mailings. A key aspect of his approach is to make several and varied contacts with sampled mothers. Baby BEARS fills a gap in Nevada's data needs by providing state-specific population-level data on maternal attitudes and experiences before, during, and after pregnancy to better understand birth outcomes in our state.
Title V collaborates with Substance Abuse Prevention & Treatment Agency (SAPTA) on various activities that provide community-based prevention and treatment to the MCH population. In 2013, SAPTA was awarded the Partnerships for Success grant to decrease substance abuse rates in Nevada. The Partnership for Success grant is designed to address two of the nation's top substance abuse prevention priorities:

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

In addition, Title V collaborates with SAPTA to meet the MCH-related objectives for their Block Grant as well as the Community Mental Health Services Block Grant, which includes activities to prevent and treat substance abuse and behavioral health issues respectively.
Governor Gibbons, through a September 2009 executive order, established the Nevada Early Childhood Advisory Council (ECAC) to strengthen state-level coordination and collaboration among the various sectors and settings of early childhood programs. The executive order empowers the Director's Office of the Department of Health and Human Services (DHHS) to establish and maintain the ECAC. Nevada Title V/MCH program collaborates with ECAC which supports MCH efforts through their vision, "Nevada's children will be safe, healthy, and thriving during the first eight years of life, and the system will support children and families in achieving their full potential."

II.C. State Selected Priorities

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

Prioritization Process

Nevada Title V utilized mixed methods to collect data and information for the needs assessment. Quantitative data was derived from data sources such as the state's vital records, BRFSS, YRBS, Census data among others. The electronic surveys and focus groups provided qualitative data. Needs assessments conducted by other entities in the state were gleaned for both qualitative and quantitative data. Some of the needs assessment reports utilized include: Nevada 2014 Statewide Community Needs Assessment, conducted on behalf of the Grants Management Advisory Committee by the Nevada Department of Health and Human Services (DHHS) Grants Management Unit, Nevada Title X, and the Renown Health Needs Assessment. Input from the needs assessment yielded over 30

priorities. As a result, the needs assessment planning committee used a prioritization process to narrow down these priorities to the current eight priorities. The following factors were put into consideration in selecting the final priorities:

Federal requirements- Title V guidance requires alignment of the selected priority with the state selected National Performance Measures and National Outcome Measures.

Incidence and prevalence- were both used to show the extent of disease or health condition among the MCH population in our state.

State and local capacity to collect data as well as ability to implement the strategies in the prioritization process was considered.

Evidence-based/informed strategies- Since Title V legislation promotes the use of evidence based/informed public health practices, our needs assessment team was conscientious about choosing priorities that will be addressed by prevention strategies that are supported by documented scientific evidence.

Measurability- In order to keep track of the priorities, it was necessary to develop priorities that Nevada MCH could make a significant difference in or “move the needle on.”

Cost of implementing the strategies and interventions to address the priorities was also taken into consideration.

Please see the Nevada Strategic Action Plan under supporting documents for more information on the activities, responsible parties, timeline and the resources that will be used to address the selected priorities.

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.0	64.0	66.0	68.0	70.0

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

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

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.0	25.0	27.0	29.0	31.0

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

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	16.0	18.0	20.0	22.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	72.0	74.0	76.0	78.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	36.0	39.0	42.0	45.0	48.0

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

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

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	76.0	79.0	82.0	85.0	88.0

Nevada selected eight (8) of the fifteen (15) National Performance Measures (NPMs) in accordance to the stipulations set in the Title V Maternal and Child Health Services Block Grant Guidance. The Guidance requires states and jurisdictions to select NPMs in which improvement in the baseline rate can be achieved. The eight NPMs chosen by Nevada for programmatic tracking and reporting was guided by the objectives and strategies identified for each of the priority needs. An NPM was chosen from each of the six population domains, and two additional NPMs were chosen from any of the domains to make a total of eight.

Setting targets for the new NPMs was conducted by the needs assessment planning committee who had a realistic consideration in the resources and capacities necessary to address the performance measures. Putting this into consideration, a target of 1.5, 2 or 3 percentage points was instituted as the target for various NPMs for the period of 2016 to 2020. The team felt that depending on the performance measure, these values were not only challenging but also attainable. These targets will serve as benchmarks and allow Title V/MCH Program to measure and track the progress of the new NPMs.

Women/ Maternal Health domain

The priority need for this domain is to improve preconception health among adolescents and women of childbearing age. Some of the corresponding objectives are to increase the percent of women ages 18-44 receiving routine check-ups in the last year, increasing the number of healthcare providers and public health professionals receiving SBIRT training each year, increase the percent of campaigns educating women on free preventive services available through Medicaid among others. NPM1, the percent of women 18-44 with a past year preventive medical visit provide an opportunity for women to discuss lifestyle habits with their health care provider, get screened for diseases, receive assessment for risk of future problems and keep vaccinations up to date. Ultimately, regular check-ups act as a prevention tool to aid in finding problems before they begin.

Perinatal/ Infant Health

The priority need for this domain is to increase the percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months. Some of the corresponding objectives are to increase the percent of children who are ever breastfed to 90% by 2020, increase the percent of children who are exclusively breastfed to 22% by 2018, increase the number of baby-friendly hospitals in Nevada by 2020 among others. Various strategies were developed to address this need and are provided in the action plan. Research has shown that breastfeeding provides numerous benefits for both the infant and mother. First, breast milk is a significant source of energy and nutrients to infants. Second, it provides protection against gastrointestinal infections and third, adults who were breastfed as babies are less likely to be overweight/obese (World Health Organization (WHO), 2014.) The NPM selected for this domain was the percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months.

Child Health

The priority need for this domain is to increase the percent of children aged 10 through 71 months receiving developmental screening. Some of the corresponding objectives are to increase the percent of children aged 10-35 months who have been screened for an Autism Spectrum Disorder and other developmental delays, increase the percent of children with a medical home by 2020, increase the annual number of referrals to Nevada Medical Home Portal resources among others. The American Academy of Pediatrics (AAP) policy statement, Identifying Infants

and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening, stipulates that developmental screening should be completed at every preventive visit and that a screening tool should be administered during the 9, 18, and 24-month visits. Also, in the Bright Futures Guidelines (3rd edition), the American Academy of Pediatrics (AAP) revised their recommended schedule to include three new well-child visits at 30 months, 7 years, and 9 years of age. The purpose of developmental screening is to ensure that a child is on the right developmental path during normal childhood development. The screening tool helps to identify a child's challenges which are then addressed or treated early. NPM 6, the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool was selected as a performance measure for this domain.

Adolescent Health

Two priority needs were developed to correspond with the two NPMs chosen for this domain. These are: 1. To increase the percent of children, adolescents and women of childbearing age who are physically active and 2. To increase the percent of adolescents and women of childbearing age who have access to healthcare services. The two NPMs chosen were 1. The percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day and 2. The percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. According to the U.S. Department of Health and Human Services (DHHS), physical activity is vital among adolescents because it aids in building and maintaining healthy bones and muscles, lowers the risk for developing obesity and chronic diseases and reduces feelings of depression and anxiety (DHHS, 2008). Further research has shown that physical activity could improve students' academic performance (CDC, 2010). Furthermore, in the recent decades, obesity has also become a major contributor of adolescent morbidity. The purpose of preventive services is to reduce serious morbidity and premature mortality. In adolescents, morbidity and mortality is linked to personal behavior which in turn is associated with intentional injuries such as homicide and suicide, reproductive health issues such as unintended pregnancy and sexually transmitted infections. Alcohol and drug use also contributes to some of the unintentional injuries such as automobile crashes.

Children and Youth with Special Health Care Needs

The priority need for this domain is to promote the establishment of a medical home for children including Children and Youth with Special Health Care Needs (CYSHCN). This priority need corresponds to the NPM that was chosen for this domain: The percent of children with and without special health care needs having a medical home. The concept of a medical home is promoted by both the American Academy of Pediatrics and the Affordable Care Act. A medical home has been found to be valuable in promoting health care utilization as well as in promoting healthy behaviors among children including those with special healthcare needs. A study by Long et al. (2012) found that a medical home among CYSHCN was significantly associated with increased preventive care visits, decreased outpatient sick visits, and decreased emergency department sick visits.

Cross-cutting/ Life Course

The priority need for this domain is two-fold: 1. To prevent and reduce tobacco use among adolescents, pregnant women and women of childbearing age and 2. To increase the percent of adequately insured children. These priorities correspond to the two NPMs chosen for this domain: 1. Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes and 2. Percent of children ages 0 through 17 who are adequately insured. A report of the Surgeon general indicated that women who smoke have a lower chance of getting pregnant. The same report also showed that smoking during pregnancy causes harm to an infant before and after birth and increases the risk for pregnancy complications such as miscarriages, problems with the placenta, premature birth, Sudden Infant Death Syndrome (SIDS) and birth defects (DHHS, 2010). Exposure to secondhand smoking during pregnancy is associated with preterm birth, low birth weight and SIDS. In addition, smoking is a risk factor for heart disease and cancer. (DHHS, 2006; DHHS, 2004).

The Affordable Care Act (ACA) has specific aspects that address the needs of children and youth, including

improved access to covered services, provision of age-appropriate benefits, and increased health insurance coverage. MCH realizes the importance of healthcare coverage especially for children and thus NPM 15 was chosen.

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

Although not required in FY 2016 Application/ 2014 Annual Report, Nevada Title V has begun considering three to five state performance measures that will be included in the FY 2017 Application/ 2015 Annual Report. These include:

State Priority Need: A. to promote oral health prevention and B. increase access and utilization of services

1. The percentage of women who had a dental visit during pregnancy, and B. The percentage of children, ages 1 through 17, who had a preventive dental visit in the last year.

Nevada does not have current data on the oral health status women during pregnancy. The Oral Health Program will work with key stakeholders and organizations to seek various sources from which this data can be obtained.

State Priority Need: To increase injury and violence prevention

1. Rate of hospitalization or mortality of women who experienced IPV or sexual assault and B. Rate of hospitalization or mortality of children who experienced IPV, or sexual assault.

The Rape Prevention and Education (RPE) Program is housed in the Maternal and Child Health Program and conducts various activities in the state to address intimate partner violence (IPV), domestic violence (DV) and sexual assault. Some of the IPV/DV-related initiatives that RPE is currently working on include: the statewide statutory rape awareness campaign to decrease sexual activity with underage girls, a sexual violence education website, and a bystander intervention website that identifies safe strategies for intervening in situations which may escalate to violence.

Selection of these state performance measures is based on the results of the MCH Needs Assessment.

II.F. Five Year State Action Plan

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

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improve preconception health among adolescents and women of childbearing age	Annual 2% increase women 18-44 receiving routine check-ups in last year (data collected as part of EHB) Increase by 25%, over 2013 baseline of 65.9%, by 2020, women receiving prenatal care in first trimester	Educational campaign on health and human services available – including informational discussions at provider level, brochures, etc. to communicate message. Educational campaign regarding preventive (e.g., diet modification) services through Medicaid in preconception	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			(34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

In 2016, Nevada Title V will carry out the strategic activities laid out in the five-year action plan as a foundation to track and measure the progress of the set national performance measure and national outcome measures for this domain.

- Annual 2% increase of women ages 18-44 receiving routine checks-up in the last year
- Increase the number of healthcare providers and public health professionals, applicable to preventative services for target population, receiving SBIRT training each year
- Provide current substance use educational information (ensure quarterly updates) available to women before, during and after pregnancy made available through the Sober Moms Health Babies website to increase unique visitors by 50%
- Increase by 25% (annually or over course of 5 years?) campaigns educating women on free preventive services available through Medicaid
- Increase by 25% women receiving prenatal care and postpartum visits

- Increase by 25%, over next five years, women receiving counseling, diet modification and tight glycemic control in the preconception period.

In addition, Nevada Title V in concert with other programs, agencies, and community stakeholders will continue to execute the existing efforts regarding the women/maternal health population. Information on the Affordable Care Act (ACA) and the essential health benefits (EHBs) will continue to be promoted. EHBs are a package of benefits that assure certain health plans offered in the state Health Insurance Exchange provide a baseline of coverage, benefits, and services to their enrollees. In order to be certified, most health plans are required to provide specific benefits. Some of the benefits that are of importance to MCH populations include maternity and newborn care, pediatric services, including oral and vision care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, preventive and wellness services and chronic disease management among others.

Data collection of maternal experiences, attitudes, and behaviors from preconception, through pregnancy and into the inter-conception period will continue to be collected through the Baby BEARS, a Title V-funded project. Ongoing monitoring of these maternal behaviors will help Title V to determine how to reduce infant deaths, decrease low birth weight and premature births and improve the overall health of the population in Nevada.

Title V will continue the work of the National Governors Association (NGA) Learning Network on Improving Birth Outcomes and the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). As the NGA Learning Network incorporates new participants in the planning process, implemented activities toward achieving birth outcome goals will be expanded. In 2014, NGA members met and developed an outline for strategies and activities to improve birth outcomes with measures and timeframes using multiple work groups. The work groups are excited to continue the work they started even though the set time for the learning collaborative expired in 2014. The outcomes that Nevada has set out to achieve by participating in the NGA Learning Network include: increased preconception and interconception planning and educational outreach, expanded tobacco and substance cessation programming targeted toward girls, women, and pregnant women, and decreased non-medically indicated early birth before 39 weeks. Nevada's CoIIN topic areas include Social Determinants of Health and Preconception and Interconception Care. Messaging on the importance of 17P and Long Acting Reversible Contraception (LARC) is also embedded in CoIIN's efforts. Pilot site(s) for collection of postpartum visit (PPV) data have been identified in WIC and a provider to speak on PPV-related issues has been identified for grand rounds presentation. Pilot Site data collection relating to the PPV is in the final approval and recruiting stages. The speaker will be funded by March of Dimes, Nevada Chapter. Continued participation of these initiatives is vital to Nevada Title V because their goals align very well with Nevada's MCH priorities and action plan for the next five years.

Title V will continue to fund the SoberMomsHealthyBabies.org website to prevent substance use in pregnant women and also continue to promote the website in collaboration with SAPTA. The collaboration will ensure that substance use in pregnancy materials and resources will reach the targeted audience.

Gestational diabetes mellitus (GDM) collaborations will continue with WIC to increase both targeted and general GDM messaging opportunities in relation to maternal type 2 diabetes risk. In addition, GDM informational posters will continue to be displayed at WIC sites to increase awareness of the increased risk of type 2 diabetes postpartum and the need for screening.

Title V will continue to participate in the Healthy Start initiatives, Fetal Infant Mortality Review (FIMR) Case Review Team (CRT) and Community Action Team (CAT), March of Dimes Campaigns, and Safe Haven education and information provision.

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Women/Maternal Health - Annual Report

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62	64	66	68	70

Nevada Title V/MCH Program continued its efforts to meet the needs of women/ maternal health populations in the state, including : infant mortality prevention activities, birth outcome improvement initiatives, Affordable Care Act (ACA) information promotion, substance use in pregnancy prevention, resource development and media campaigns on various MCH topics, PRAMS-like survey administration, among others. These efforts were carried out by the MCH program staff as well as through collaborative efforts with our partners and stakeholders in other programs, agencies as well as in the community.

Access to Health Care

Results from Nevada's Title V/MCH Needs Assessment indicated that many lower-income women in Nevada are faced with the burden of high health care costs along with little or no access to health services. Many consumer focus group attendees expressed concern that if they or a member of the family fell sick, they would face the risk of financial devastation. In 2014, Nevada expanded Medicaid under the guidelines laid out in the ACA and it is hoped that the expansion will lessen the health care cost burden on low income families, especially among racial/ethnic minorities. The Medicaid expansion covers the aged, blind, and disabled as well as households with income of up to 138% of Federal Poverty Level (FPL) (about $16,105 for a single person). For pregnant women, income can be up to 160%, and children are eligible for CHIP with household income up to 200% of FPL. Preliminary results indicate the total Nevada Medicaid enrollment in August 2014 included an additional 210,747 people compared with late 2013, an increase of more than 63 percent. In addition, in the first half of 2014, the uninsured rate in Nevada declined by 20 percent, going from 20 percent to 16 percent (Gallup Poll). Our state recognizes that Medicaid expansion has played a significant role in that decline.

Nevada Title V continued the activities of the National Governors Association (NGA) Learning Network on Improving Birth Outcomes. Nevada joined the Learning Network in 2013 and since then, the state has developed collaborative initiatives with key partners and stakeholders such as Nevada Medicaid, March of Dimes (Nevada Chapter) and the Bureau of Behavioral Health, Wellness, and Prevention to improve birth outcomes by identifying modifiable risk factors for the incidence of preterm births, low birth weight and infant mortality and associated racial/ethnic health disparities. One of the state's goals in the NGA initiative is to expand access to health care for women, pregnant women, and infants; including educational outreach relating to the ACA and increased access to preventative care and public and private insurance. To this end, MCH Program staff as well as our partners and stakeholders disseminated education materials and pamphlets regarding ACA. Navigator contact lists were distributed at the Nevada Transition Conference, Nevada Health Conference, and MCH staff made a presentation on the impact of the ACA on Maternal and Child Health providers at the March of Dimes Nevada Women's Health Symposium. MCH partners also posted links to the Silver State Health Insurance Exchange, Nevada's state-based marketplace exchange on their websites and social media sites. Prior to 2014, Nevada's Medicaid enrollment rates were low but the promotional campaigns and awareness materials surrounding it have encouraged more Medicaid-eligible individuals to get coverage.

Nevada Title V funds the Community Health Worker (CHW) Program housed in the same bureau to conduct outreach and provide information on the ACA to low-income women and racial/ethnic minorities. CHWs are particularly effective in reaching minority populations and socioeconomically disadvantaged populations in resource-poor neighborhoods where they help to address health disparities in both rural and urban settings. Currently, CHWs are

improving underserved Nevadans' access to health care by increasing health knowledge and self-sufficiency in this population through a range of activities. In CY 2014, the CHW program reached approximately 70, 000 individuals through outreach activities at health fairs, schools, and community events and established 252 case management cases. Title V recognizes that the goals of the MCH Program as well as those of the CHW program align well and the synergistic efforts will enable the two programs to reach some of the hard to reach populations in our state such Hispanics who are not skilled English speakers.

Senate Bill 498 was passed during the 2015 Legislative Session in Nevada. This bill will allow the Bureau of Health Care Quality and Compliance (HCQC) whose mission is to protect the safety and welfare of the public through the promotion and advocacy of quality health care through licensing, regulation enforcement and education to license agencies that want to provide certification to individuals who want to become community health workers. The law will establish guidelines and oversight on licensure of community health worker bodies and help establish standards for the qualifications, scope of work, and training of CHWs. By establishing guidelines and oversight on licensure of community health worker bodies, CHW roles and responsibilities will be communicated accurately between this workforce and employers, allowing the CHW workforce to expand and flourish.

Preconception, Inter-conception and postpartum Health

Increased preconception and inter-conception planning and educational outreach is another goal that Nevada set to address in the NGA Learning collaborative. In 2014, Nevada started conducting Baby Birth Evaluation and Assessment of Risk Survey (Baby BEARS). Baby BEARS is a statewide-representative survey of women residing in Nevada who have had a recent live birth. The survey collects self-reported information about maternal attitudes and experiences before, during, and shortly after pregnancy. Survey data are weighted to represent all eligible women in Nevada with a live birth and since the survey is still ongoing, results will be shared when they become available. Baby BEARS questionnaire and methods are mirrored after the Pregnancy Risk Assessment Monitoring System (PRAMS), a surveillance project of the Centers for Disease Control and Prevention (CDC) and state health departments. Nevada Title V MCH Block Grant currently funds the Baby BEARS project, however, the state will apply for funding when CDC announces expansion of PRAMS to the states that do not currently conduct the survey.

Nevada Title V partners with Nevada Home Visiting (NHV) Program which provides education on birth spacing and makes referrals for prenatal care if the woman has not found a health care provider. The Home Visiting curriculum is evidence-based and focuses on teaching expectant mothers about proper nutrition and exercise, what to expect during pregnancy, and how to care for themselves and the baby after the baby is born. NHV Program collects data regarding emergency room use, well-care visits, insurance status, and substance use. Women are screened for postpartum depression and domestic violence and if there is an identified need, appropriate referrals are made.

Title V collaborated with Nevada Women, Infants, and Children (WIC) Program to increase Gestational Diabetes Mellitus (GDM) messaging opportunities in relation to maternal type 2 diabetes risk. Title V staff sought a GDM expert to speak at a WIC nutritionist training. In addition, GDM informational posters were developed to increase awareness of the increased risk of type 2 diabetes postpartum and the need for screening. The posters were posted at various WIC sites in the state. Title V is currently seeking opportunities for partnership with Chronic Disease Prevention and Health Promotion Program and WIC to increase messaging on the need for women experiencing GDM to get type 2 diabetes screening postpartum.

Substance Use

Research findings indicate that smoking during pregnancy is dangerous to both mother and child. Smoking poses risks such as premature birth (being born too early), certain birth defects, bleeding during pregnancy, abruptio placentae, placenta previa, premature rupture of membranes, low birth weight newborns and sudden infant death syndrome (CDC, 2014; Trofor, Man & Miron 2009). Nevada Title V continued work with partners and MCH stakeholders to promote tobacco cessation especially among women of child bearing age. In 2013, Nevada Title V, Immunize Nevada, and Nevada Home Visiting Program collaborated in developing Nevada-specific messages and links for Text4baby enrollees in the State. This venture continued in 2014 and the customized Text4baby messages

continued to be sent to mothers who sign up for the service. The messages provide in-state links with information on how to quit using tobacco.

Title V continued to work with the Nevada March of Dimes on the March of Dimes Prematurity Campaign, co-branding tobacco education and cessation materials and supporting public and practitioner education to reduce pre-term births. The campaign conducted a statewide distribution of a March of Dimes pamphlet; *Smoking and Pregnancy* to WIC offices - including Intertribal Council WIC office, MCH Coalitions, and Rural Community Health Nurses as well as at several outreach events organized by the Division of Public and Behavioral (DPBH) staff and/or MCH partners. The pamphlet provides information on the risks of smoking to the baby's health, and gives tips and referrals to help pregnant women quit smoking. It is available in both English and Spanish. Nevada Title V continued to collaborate with other programs within DPBH to roll out various substance use prevention strategies.

Title V and the Substance Abuse Prevention and Treatment Agency (SAPTA) launched the *SoberMomsHealthyBabies.org* website to prevent substance use in pregnant women and provide information to women of childbearing age, providers, and concerned family and friends. The website provides resources to pregnant women who are facing substance use, resources on pregnancy, and where to get help through Nevada treatment centers. The website also provides the substance use help line (1-800-450-9530) and the Nevada tobacco quit line (1-800-784-8689.) Awareness of the new website was done through radio and television spots in Spanish and English through the Nevada Broadcasters Association. Sober Moms, Healthy Babies informational cards and branded magnets were distributed through various partners and additional links were added to the website. Focus groups were conducted in Reno and Las Vegas with pregnant women with a history of substance use and the feedback was used to review and refine campaign components. The media campaign included a provider outreach letter, branded magnets, distribution of business cards with website and phone number information, letter to Nevada 2-1-1 and Crisis Call Center staff. To create awareness of the website to the public and ensure the website received favorable coverage in the media, we did a press release in December, 2014 as well as produced and launched television and radio spots in Spanish and English. Information regarding the website launch was also posted on YouTube and social media. Google Analytics, an on-site web analytics service is currently being utilized to provide information on user engagement and utilization of the website. Title V and SAPTA is hopeful that the qualitative results derived from Google Analytics will assist the programs in improving the website as well as in developing targeted substance use prevention efforts to teen pregnancy-serving groups, substance use treatment providers, and others serving women during pregnancy and pre/inter-conception.

One of Nevada's NGA Learning Network to improve birth outcomes goals is to reduce negative birth outcomes resulting from substance abuse disorders including exposure to tobacco/nicotine for infants, children, women of child-bearing age and pregnant women. As part of the NGA collaborative, Nevada's work group participation relating to substance use in pregnancy has yielded partnerships with various agencies and Programs such as Medicaid. Through the new partnerships, Screening and Brief Intervention and Referral to Treatment (SBIRT) training will be conducted and resources will be developed in conjunction with the Children's Cabinet in Reno area. SBIRT is an early intervention strategy designed to identify those who present for medical or behavioral healthcare that are at particular risk due to alcohol or drug misuse or abuse. Research has shown that substance abuse is a risk factor for multiple illnesses including cardiovascular disease, cancer, liver problems, and damage to the nervous system. The primary goal of SBIRT is to screen and provide intervention before the problem becomes critical thereby alleviating possible health problems and societal issues. Nevada Title V will conduct awareness campaigns to providers in the state to inform them that reimbursement for screening and brief intervention is available through Medicaid.

State Action Plan Table						
Perinatal/Infant Health						

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Increase percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months	Increase to 90% babies ever breastfed Increase to 25% children exclusively breastfed at 6 months Increase to 50% baby-friendly hospitals in NV by 2020	Collaborate across Nevada stakeholders to increase provider use and general education (for both providers and moms) on: substance use (before, during & after pregnancy), Telemedicine, breastfeeding, safe sleep, post-partum care, etc.	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

Title V epidemiology staff will explore utilizing the Perinatal Periods of Risk (PPOR) approach to reduce infant mortality and to help identify critical periods to target interventions to reduce risk. PPOR brings community stakeholders together to build consensus and partnership based on local data. PPOR will be funded by Title V dollars and will provide an analytic framework as well as steps for investigating and addressing the disparities related to fetal and infant mortality in our state.

The Baby Safe Sleep Program at Dignity health developed several goals to accomplish in 2016. These include:

1. Assess existing policies/procedures relative to safe sleeping practices in eight hospitals in Clark County and provide consultation as needed
2. Develop preventative educational materials for new parents/caregivers to reduce child and infant deaths.
3. Reduce Clark County, NV child deaths from a baseline of 19 in 2009 due to unsafe sleep practices and inadequate child supervision

These goals will be realized through several objectives which have been clearly laid out by the Baby Safe Sleep Program and 2016 will be a time for continued program development, education, awareness, and evolving partner opportunities statewide. Cribs4Kids (C4K) program in Nevada would like the Baby Safe Sleep program to be streamlined into the REDCap System, making data entry more efficient and allowing the C4K coordinator more time to pursue other proactive approaches to safe sleep awareness activities. C4K would like to continue to work with first responders to educate and inform them on safe sleep tips to share with their communities. Currently, C4K is working with Reno Police Department and REMSA Paramedic crews on safe sleep education tip card dissemination. C4K has been approached by Sparks Police Department and the Washoe County Sheriff's Department for education of their staff as well. In addition, C4K would like to approach fire departments in Washoe County to provide education for their first responders. Through collaborative efforts, C4K believes we can target families right from the start or in their home during a visit from a first responder in 2016. C4K also plans to start approaching hospitals to encourage safe sleep education prior to discharge for families and to implement policy

change of institutions of a hospital's size, there is a need for passion within the organization. Cribs for Kids National has policies and procedures that have been used in other states and Nevada C4K will reach out to the national organization for technical assistance on how to tailor the policies to suit Nevada's needs. Southern Nevada Health District is also working with hospitals in Las Vegas to provide education and bring awareness to the safe sleep. FY'16 planned breastfeeding promotion activities and training for Nevada WIC includes the continuation of the *Loving Support Peer Counseling Program*, as well as both of our community support and improving hospital practices campaigns. In addition, Nevada WIC will provide continued technical support for the remaining 15 maternity centers that have not achieved their Baby Friendly designation. WIC plans to again design and publish a Nevada Breastfeeds Calendar, and support and promote the 2016 "Liquid Gold" 5K Breastfeeding Awareness Run. Nevada WIC will again be exploring the use of the Electronic Benefit Transfer (EBT) system with Farmers Market vendors statewide, allowing participants to use their $8-$10 monthly Cash Value Voucher (CVV) at any farmers market and other competitive WIC Farmers Market grant funds. This will potentially greatly increase access to fresh fruits and vegetables, especially in rural areas.

Perinatal/Infant Health - Annual Report

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

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

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

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

Breastfeeding

In 2014, Nevada Breastfeeding Program executed two statewide campaigns. One was aimed at improving infant feeding practices in hospitals, and the other at increasing community and business support for breastfeeding mothers. The breastfeeding program continues to support Women, Infants and Child (WIC) moms in breastfeeding by providing free professional lactation support, breast pumps, and an enhanced food package for moms who wish to breastfeed. In 2014 alone, MCH Title V purchased and distributed 36 breast pumps primarily to pregnant and parenting teen stakeholder organizations in our state and plans to distribute additional breast pumps in the future. According to the IOM, "research suggests that breastfeeding is associated with a reduced obesity risk for children". Nevada Title V partners with Nevada WIC program in various activities to improve the health and wellbeing of women and children in the state. In 2014, the Breastfeeding Coordinator spoke at four national public health conferences about the improvements in breastfeeding support in our state. A WIC Sponsored "Liquid Gold" 5K Breastfeeding Awareness Run was directly supported and held in Reno in August, 2014 for an estimated 350 participants. WIC continued to offer the USDA's Loving Support Breastfeeding Peer Counseling Program (BFPC), an evidence-based breastfeeding support program in 21 WIC clinics across the state to help support WIC mothers and babies in their breastfeeding relationship. Peer counselors are previous WIC participants who have had successful breastfeeding experiences and are passionate about helping other mothers meet their breastfeeding goals. Two of Nevada's 18

Maternity Centers had *Baby Friendly* designation in 2014 and a third, the St. Rose Siena campus just achieved this designation in 2015. Nevada WIC also published a 16-month (CY 2014-15) "Nevada Breastfeeds" promotional calendar.

The Inter-Tribal Council of Nevada (ITCN)

The Inter-Tribal Council of Nevada (ITCN) is a Tribal organization serving the member reservations and colonies in Nevada. The main goal of ITCN is to serve as a large political body for the small Nevada Tribes and plays a major role in promoting Health, Educational, Social, Economic, and Job Opportunity Programs. ITCN also manages Federal and State funded programs with the goal of improving the well-being of community members throughout the State of Nevada. Women, Infants and Children (WIC) is one of the programs administered by ITCN.

In the FY2014, ITCN WIC developed surveys for participants to complete every quarter. Each survey targets WIC services, WIC Food Benefits, nutrition education information, breastfeeding information, and family information. These surveys allowed ITCN WIC to target participant needs. ITCN WIC began conducting monthly baby behavior prenatal classes focusing on baby cues, feeding and sleeping patterns as well as FIT WIC nutrition classes such as *Step Away From the Screen, Take a Healthy Plate, Enjoy Being Active Together Daily,* and *Pass on Sugary Beverages. In addition, the* Breastfeeding Peer Counseling Program was also instituted and helped to increase breastfeeding rates through increased awareness.

Reducing Birth Outcomes: Preterm Birth, Low birth weight and Infant Mortality

Nevada continues to experience health disparities in various birth outcomes including preterm birth, low birth weight, and infant mortality.

Infant Mortality

CoIIN Initiative

To address issues relating to birth outcomes, MCH is currently involved in several initiatives. Title V staff as well as partner staff members attended the CoIIN Infant Mortality Summit in Washington DC in July, 2014 to develop Quality Improvement Aims, specify Strategies to achieve those Aims, and identify Measures that can be used to track progress.

Nevada Title V funds the Washoe County Fetal Infant Mortality Review (WC FIMR) in Washoe County. The WC FIMR pilot project was started in Washoe County because 2010-2012 data showed that the County had a higher Infant Mortality Rate (6.0) than the rest of the state (5.3) as well as the nation (5.1) (Nevada Division of Public and Behavioral Health, Office of Public Health and Informatics, 2013 ; National Vital Statistics System). WC FIMR is the first of its kind in our state and even though it is in its pilot phase, it is hoped that the project will be expanded to the rest of the state.

The goals of WC FIMR program are to:

- Enhance delivery systems and resources
- Understand how issues relate to fetal/infant loss
- Utilize information to reduce fetal and infant mortality

NAC 442.054 allows for review of certain records by State Health Officer or his designee and in 2014, WC FIMR was able to secure a letter from the State of Nevada granting authority for Washoe County to act on behalf of the State Health Officer to implement the Public Health Surveillance Project. WC FIMR has made several strides including developing a Policy and Procedure manual and has met with hospitals to implement data abstraction. Data abstraction has already been completed on 9 infant and 15 fetal deaths and case summaries have been written for 6 cases. The WC FIMR team has contacted National FIMR (NFIMR) for technical assistance with preparation as well as assistance with CRT and CAT. The NFIMR director and Program Specialist visited the team in November 2014. The WC FIMR team receives referrals from hospitals, vital statistics, and physicians and the data abstraction team reviews all medical records. Home interviewers then contact parents and conduct a maternal internal with consent from the family. Cases are summarized and information is presented to the Case Review Team (CRT) and the identified problems and recommendations from CRT are presented to the community Action Team (CAT).

Safe Sleep Initiative

One of the drivers for change in reducing infant mortality is promoting safe sleep. Data show that risk factors for Sudden Infant Death (SIDS) and infant mortality go beyond back sleeping and some of the identified risk factors include features in the sleep environment. In recognition of this, Dignity Health System hospitals are committed to providing safe sleep education through trainings to ensure that staff members have the most accurate information to pass on to parents and families with infants. Baby Safe Sleep implementation meetings with the Dignity Health System hospitals with maternity units began on February 5, 2014 and two months later, the Dignity Health System's hospital-wide infant safe sleep policy was approved. Dignity Health collaborated with Nevada Institute for Children's Research and Policy (NICRP) to conduct pre-training sleep position audits at the two Dignity Health hospitals with maternity units and completed the training in March, 2014.

Dignity Health recognizes the importance of developing strategic alliances and partnerships to promote safe sleep. As a result, ten WIC staff associated with the Dignity Health System hospitals were trained in September. The training was geared towards strengthening staff skills and building their confidence in their ability to provide safe sleep education to families with infants. In order to train more nurses and accommodate their varied schedules, an online Baby Safe Sleep staff training was conducted from March through June, 2014 and 117 staff were trained. The training included information on safe sleep, the importance of modeling safe sleep practices by hospital staff and program implementation. The hospital system did not make the training mandatory for nursing staff, however, the training has been incorporated into their skills fair that is conducted periodically with nursing staff.

Patient education on the Baby Safe Sleep Program was also provided at the two Dignity Health System hospitals in December, 2014 and 154 clients received information training on the Program. Patient education using the program continues at Dignity Health System's St. Rose-Siena and St. Rose-San Martin Hospitals. Several presentations showing support of the program were made to Nevada MCH Advisory Board in March, 2014. A webinar was also presented at the Children's Safety Network webinar in April, 2014 providing nationwide exposure for the project. Baby's Bounty, a local non-profit, began providing free infant safe sleep classes in collaboration with the local Head Start for the community on October 7, 2014 and the Baby Safe Sleep materials were selected for use with the classes.

Cribs for Kids

The mission of Cribs for Kids National is to prevent these deaths by educating parents and caregivers on the importance of practicing safe sleep behaviors and providing a safe sleep environment to families who otherwise could not afford a safe place for their baby to sleep. Safe Kids Washoe County is the lead agency for the Cribs for Kids (C4K) program in Nevada. C4K in Nevada has been in inception since 2011 and has accumulated more than 38 active partner agencies statewide. 2014 was another active and successful year for the C4K program in which a lot of activities were conducted and accomplishments achieved. C4K provides education and awareness on how to provide safe sleep environments to families in Nevada.

C4K is excited to partner with these agencies because they will help to provide more Safe Sleep survival kids and prevention education to residents in these areas. In 2014, 457 Babies received survival kits in Nevada along with over 38,000 English and 37,000 Spanish brochures. C4K is excited to have the new partners as they will help C4K reach even more families that would not have been reached otherwise.

C4K secured a $14,950 Public Awareness Grant from the Executive Committee to review the death of children in 2014. With funding from the grant, eight buses traveled Washoe County displaying messages on the *ABC's of safe sleep* from April 2014 through July 2014. In addition, the same messaging was placed in more than 130 buses from March through July 2014 in English and Spanish in both Washoe and Clark counties.

C4K collaborated with various programs and agencies around the state to provide information on safe sleep. One of the collaborative efforts included working with school nurses in Washoe County to provide safe sleep education to pregnant and parenting moms in high schools. C4K also joined the Fetal Infant Mortality Review team to understand the factors that affect the health of the mother, fetus and infant in an effort to reduce fetal and infant mortality in the

state. The Washoe County FIMR Program is the first in Nevada and will be implemented in 2014 by the Maternal, Child and Adolescent Health Program at the Washoe County Health District.

Preterm Birth and Low birth Weight

Nevada Title V is part of the Association of State and Territorial Health Officials (ASTHO) Healthy Babies Challenge, whose goal is to prevent premature births and reduce infant mortality. ASTHO and March of Dimes (MOD) challenged states to reduce premature births by 8% by 2014, with 2009 data serving as a baseline. In 2009, the percent of premature births in Nevada was 13.8% and declined to 12.6% in 2013, thus achieving the set 2014 goal in 2013. To honor this accomplishment, Nevada received the MOD Virginia Apgar Prematurity Campaign Leadership Award in 2014 for achieving the 8% reduction in premature birth rates. Despite the achievement, Nevada earned a "C" grade in the March of Dimes 2013 Premature Birth Report Card. The grading is based on several factors including the status of prevention strategies as well as the preterm birth rate by race/ethnicity of the mother. In 2013, race/ethnic minorities in Nevada had higher preterm birth rates compared to their White counterparts. Blacks had the highest preterm birth rates, 17.7%, followed by Native American, 16.9%, then Asian, 14.6% and Hispanic, 13.3%. Whites had the lowest preterm birth rate in the state at 11.0 %. These data indicate that that Nevada still has work to do to in regards to improving birth outcomes in the state especially among racial/ethnic minorities.

Clark County Healthy Start Program

Healthy Start is a Program within Maternal, Infant and Early Childhood Home Visiting Program that was developed to prevent infant mortality in communities with infant mortality rates that are at least 1.5 times the national average as well as areas with high rates of low birthweight, preterm birth, maternal mortality and maternal morbidity. The overall focus of the Clark County Healthy Start Program is to reduce racial disparities and improve perinatal health outcomes among African-American women through the design and delivery of a comprehensive, coordinated health and social service program that will foster continuous access to care for women who are pregnant or of child bearing age. The Healthy Start Program hired a senior health educator and two health educators in December 2014 and February 2015 respectively. In addition, a Medicaid Enrollment Specialist was hired to provide application assistance for enrolling Healthy Start recipients in Medicaid, The State Children's Health Insurance Program (SCHIP) or referrals to the Affordable Care Act (ACA). A Project Coordinator was also hired in 2014 to supervise program activities of four case managers and work with the project evaluation team at NICRP. The new staff is vital in helping to achieve the set benchmarks, required statistical reports and quarterly reports for the Healthy Start grant. In November 2014, the Clark County Healthy Start Program Manager and the Southern Nevada Health District (SNHD) Director of Clinical and Nursing Services attended HRSA Healthy Start EPIC conference. The gf the convention was to provide training and technical assistance to attendees in order to effectively plan and implement the new Healthy Start model that aims to maximize the impact of Healthy Start on the reduction of infant mortality through the integration of current and emerging evidenced-based approaches. The presentations at the conference were based on the four components of the Healthy Start EPIC model:

1. Evaluate need and impact
2. Partner for collective impact
3. Implement evidence-based practice and
4. Consider the client's context.

Clark County Healthy Start Program made several presentations in 2014 to various agencies and organizations in the community including the Southern Nevada Maternal and Child Health Coalition and the WIC Directors' meeting. Other presentations are planned for 2015. The purpose of these presentations was to raise awareness for the program, provide outreach education and obtain community support. The Healthy Start Program is now fully staffed and has begun the enrollment of participants. There are currently 13 participants enrolled and 44 referrals have been received since April, 2015. A Community Action Network Summit will be held in April 2015 and 70+ community partners are expected to be in attendance. The goal of the summit is to introduce the concept of collective impact, engage participants and obtain a commitment from 20-25 community partners to serve on the program's Community Action Network.

National Governor's Association Learning Collaborative on Improving Birth Outcomes

Nevada developed several goals that relate to perinatal/infant health in the National Governor's Association Learning Collaborative on Improving Birth Outcomes:

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

Through this collaborative, Title V has been working with partners and stakeholders to identify modifiable risk factors for preterm births, low birth weight, infant mortality, and associated racial/ethnic health disparities. Specifically, workgroups have been formed around these goals and a lot of progress has been made in the state.
Nevada Title V joined the CoIIN initiative to reduce infant mortality and member partners include the Nevada Healthy Start grantee, the Southern Nevada Health District, Nevada Medicaid (Early and Periodic Screening, Diagnostic and Treatment (EPSDT)) and March of Dimes, Nevada Chapter. Nevada Title V will also leverage CoIIN infant mortality reduction efforts and membership in the Community Action Network.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase the percent of children aged 10 through 71 months receiving developmental screening	Increase 10% annually children 10-71 months screened with parent-completed screening tool. Increase 10% annually children 10-35 month who have been screened for an Autism Spectrum Disorder & other developmental delays.	Work with diverse community partner entities on a campaign to encourage and/or assist parents to complete developmental screening tool. Collaborate with health professionals using telehealth to reach rural/frontier populations. Partner with Learn the Signs Act Early, Bright Futures, Home Visiting	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) Percent of children in excellent or very good health	Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		and others on a campaign to educate parents on develop. Screening tool.				

Child Health

Child Health - Plan for the Application Year

In 2016, Immunize Nevada plans to expand the distribution of PINK Pregnancy and Baby Growth Charts, including a Spanish language version. In addition, outreach to new parents and parents of children under the age of three will be expanded by concentrating education efforts that enhance understanding of the infant immunization recommended schedule and improve access to vaccines, including eligibility for the *Vaccines for Children program*. Influenza education and outreach will continue to be promoted while targeting high risk groups such as pregnant women, seniors, children under the age of 5 and those with chronic health conditions.
Nevada Home Visiting will launch new expansion programs in Mineral and Nye Counties in 2016 to serve two of the neediest areas of the state. The previous needs assessment identified both these areas as very high risk. Programs in the other rural areas are expected to expand their service capacity and area.
Utilizing the results of the evaluation, workforce development will be a focus. NVH is actively seeking ways to better support our implementing agencies in staff retention and development. In addition, plans are in development to collaborate with other state agencies to create a more centralized system of entry and to cross-refer to appropriate services. Specific goals for NHV include:

- Collaboration with Nevada Early Childhood Comprehensive Systems (ECCS)
- Comprehensive Domestic Violence Training for each agency
- Breastfeeding Support training
- Collaboration with Nevada Web IZ (the Statewide Immunization Information System) to standardize records.
- Parents as Teachers in Mineral County to serve a minimum of ten families
- HIPPY in Nye County to serve a minimum of twenty-five families
- Expansion assessment in Lincoln, Humboldt, White Pine, Churchill and Lander Counties
- Collaborative meetings with WIC, Medicaid, Primary Care Office, Oral Health and Child Protective Services
- Publication of domestic violence handbook
- Professional development summit
- Specific program focus for teen parents

The Southern Nevada Health District (SNHD) Nurse-Family Partnership (NFP) Program has plans to increase the number of active clients served to 175 in 2016. SNHD's NFP program has and will continue to use management information systems (MIS), performance measurement data program improvement systems already in place and staff and client feedback to review overall program operations. The program will continue to work to meet program specific and MIECHV benchmarks. Specifically, the program will work to increase the percentage of children who

received the recommended schedule of immunizations, especially for the MIECHV funded families, and to decrease in the rate of subsequent pregnancies within 2 years of birth by women enrolled in the program.
The Nevada Division of Health Care Financing and Policy is in the process of developing policy for coverage of Autism services for Medicaid. The authority for these services will fall under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) with an anticipated start date for this coverage being January 1, 2016.
As per suggestions provided in the federal review, Title V will look into utilizing materials provided in the CDC Clear Communication Index to assess the communication materials that MCH Program is currently using (website, health education materials, targeted campaigns etc.)

Child Health - Annual Report

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

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

Immunization

Nevada Title V collaborates with Immunize Nevada, a diverse coalition of individual, business and organization partners committed to improving and protecting the health of children, teens, adults & seniors in Nevada. Immunize Nevada is the state's non-profit coalition that is funded primarily by the IZ Program of the Nevada Division of Public and Behavioral Health. In 2014, Immunize Nevada increased the website visitors by 352%, engaged 30% more Facebook followers, trained 80% more healthcare professionals and distributed 29% more PINK portfolios. In addition, 14,500 PINK Pregnancy and Baby Growth Charts were created and distributed to expectant moms through various community partners and outreach events. Immunize Nevada ramped up its vaccination campaign and provided 78% more vaccines than last year at community and mobile food pantry sites in partnership with Walgreens.
In addition to community outreach and activities, Immunize Nevada developed several new projects in 2014. *HPV: Closing the Vaccination Gap* project was developed to focus on increasing HPV vaccination through parent and adolescent education along with healthcare provider outreach. *Public Health Billing Implementation* project was also developed to support the implementation of billing for public health services at local health departments. *Cocooning in OB/GYN offices* is a special project through the Nevada State Immunization Program and is now being managed by the Adult Immunization Coordinator. *Immunizations 101 Online and Practicum Training* provides continuing education credits after the completion of three online modules and one live in-person practicum. While it focuses on training medical assistants, it is open to all healthcare professionals.
To honor the great work that Immunize Nevada has been doing, the organization was awarded the *Best Overall Influenza Season Activities* for the Walgreens/Food Bank of Northern Nevada pantry partnership by the CDC and the National Influenza Vaccination Disparities Partnership at the National Adult and Influenza Immunization Summit in May 2014. The summit focused on identifying specific barriers to adult vaccination and, most importantly, mitigation strategies to improve adult vaccine uptake and influenza vaccination for people of all ages.

Nevada Home Visiting Program

Parenting education and Child Wellness

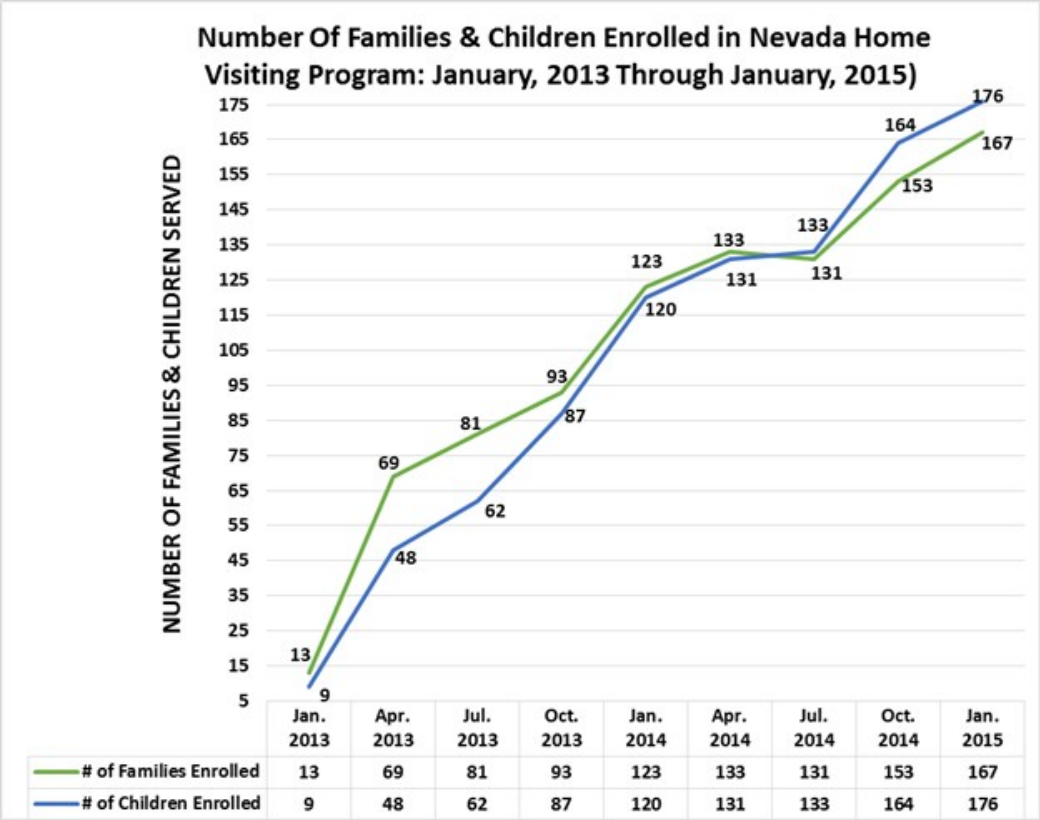
Nevada Title V collaborates with the Nevada Home Visiting (NHV) Program on various activities around the state. With the award of competitive grant funds in 2014, three new programs in NHV began serving families in rural

counties of Nevada. Early Head Start Home Based Option and the Children's Cabinet HIPPY (Home Instruction for Parents of Preschool Youngsters) opened for service in Elko, Nevada and Healthy Families America launched a program in Lyon and Storey Counties. The combined capacity of these three programs increased service from 135 families to 247 families. After consideration and analysis of the communities involved, Healthy Families America which has a very narrow opportunity for enrollment (enrollment in pregnancy or before an infant is two months old), was discontinued, and *Parents as Teachers* was implemented in its place in Storey and Lyon Counties. Parents as Teachers enrolls expectant mothers and families with children up through kindergarten entry. In small population areas, this opened up many more enrollment opportunities, and expanded the service availability to much more of the community.

NHV assumed the responsibility for continuous quality improvement, which had previously been contracted out. The continuous quality improvement program has brought dynamic new changes and progress. Utilizing the *Plan Do Study Act* method of improving processes, NHV identified several areas statewide that needed improvement. Small changes and studies are being made in the areas of immunization records, breastfeeding support, domestic violence screening, and birth-spacing education. The analysis of data related to these areas has indicated that some support and innovation was needed to improve the benchmark results. Once these PDSA cycles are complete, others will be identified for continuous quality improvement. A fishbone chart problem solving tool has been utilized in the development of the PDSA cycles. Training was provided to the program implementing agencies to introduce the fishbone chart and PDSA cycles. The agencies were also trained in creating SMART (Specific, Measurable, Achievable, Relevant, Time bonded) goals. These changes in the CQI process have led to more collaborative statewide meetings and better communication. Each agency has been identified as a subject matter expert in discrete topics, and are invited to present, one agency per meeting, on their topic of expertise. This has allowed the agencies to share their successes, learn from each other, and build on their strengths.

As a part of the improvement in communication, a quarterly newsletter has been developed and published, including articles pertinent to home visitors, parents and families, and the implementing agencies. A monthly check in call is held with each agency to discuss the training needs, technical assistance requests, or any other topics. These processes have created a friendlier, more open relationship between NVH and the program providers.

An evaluation is required by the funder on the expansion programs and as a result, an evaluation project relating to home visitor retention has been launched by Yale New Haven Health. The project is gathering very valuable information that can be utilized nationwide when approaching the topic of workforce development and personnel management/recruitment, particularly in rural areas. Home Visitors from each agency were afforded the opportunity to attend the Pew National Summit on Quality in Home Visiting in Washington, DC. This important national conference provided a broad perspective for home visitors on the success and innovation of programs nationwide.



Nurse Family Partnership (NFP)

The Southern Nevada Health District (SNHD) Nurse-Family Partnership Program, the first nurse family partnership unit in the state of Nevada, is one of the evidence based home visiting programs recognized by the Maternal Infant and Early Childhood Home Visiting Program. Research by the National Service Office of Nurse-Family Partnership and Southern Nevada Health District's contract with the National Office limits each nurse's caseload to twenty-five active clients. At present, the six Nurse Home Visitors are serving 142 clients. Fifty four clients are actively participating through the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program made available through the Nevada Division of Public and Behavioral Health under the Affordable Care Act (ACA).

The Southern Nevada Health District's Nurse-Family Partnership is one of the evidence-based home visiting program sites participating in the national Maternal and Infant Home Visiting Program Evaluation (MIHOPE) - Strong Start, a study designed to assess the effects of home visiting services on maternal and infant health. The Centers for Medicare and Medicaid Services (CMS) may use the results of the evaluation to help inform Medicaid reimbursement policies. Currently, 88 clients are enrolled in the Strong Start study. The District's Nurse-Family Partnership program is committed to enrolling 150 study participants through September 2015.

The current education and work status for active clients enrolled in the District's Nurse-Family Partnership Program is: 64 (50%) clients do not have a High School Diploma or GED while 62 (49%) clients have a High School Diploma or GED. One percent have vocational training, nine clients (14%) are enrolled in school, 20 clients (15.7%) are working full-time and 23 clients (18.1%) are working part-time. At intake, 26% of Southern Nevada Health District Nurse-Family Partnership clients were working and at 24 months post-delivery, 59% are working. These statistics indicate that the District's Nurse-Family Partnership is making great strides in ensuring participation of its clients in the workforce.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Nevada Division of Health Care Financing and Policy (DHCFP) submitted the CMS-416 to Centers for Medicare &

Medicaid Services (CMS) in April, 2015 for 2014. Once approved, that report will be made available. Language was added to Nevada's Medicaid Services Manual for our Healthy Kids program (EPSDT) to clarify that diagnostic and treatment services covered under EPSDT for children are not dependent upon an EPSDT screening (although the screenings are highly encouraged) so that children get all medically necessary services.

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Increase the percent of children, adolescents and women of child bearing age who are physically active	Increase 5% over baseline annually elementary & high school students physically active at least 60 minutes a day for 5 or more days a week. Increase 5% over baseline annually elementary & high school students who attend PE 1 or more days a week.	Collaborate with Chronic Disease Section of DPBH to conduct outreach to School Districts (including school-based health) to develop and implement obesity prevention activities for target population.	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		
Increase the percent of adolescents and women of child bearing age who have access to healthcare services	Increase to 78% by 2020 adolescents aged 12-17 with a preventive medical visit in the past year. Increase 25% within a year,	Educational campaign regarding preventive medical well-visits and abstinence.	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	with 2% annual increase by 2020, PREP & Abstinence program participants receiving education on well-visits. Increase 10% annually applicable Medicaid participants with well-visits (FFS & ACOs).		Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of			

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

Abstinence Education Grant Program (AEGP) will build on the new initiative “Parents talking with Teens” with the Nevada Broadcasters Association (NBA). In conjunction with the current non-sustaining commercial radio announcements, AEGP will provide funding to the non-sustaining television commercials to reflect the new initiative. These television spots will be aired both in the north as well as in south Nevada. Additionally, AEGP will continue to work with their current community partners: Quest Counseling, Carson City Health and Human Services (CCHHS) and the Elko Family Resource Center (FRC). Specifically, AEGP will work with CCHHS to broaden their program to include mentoring to prevent teen pregnancies.

Personal Responsibility Education Program (PREP) will continue working with their community partners: The Center, Planned Parenthood Mar Monte, Planned Parenthood of the Rocky Mountains, the Elko FRC and CCHHS. PREP will be focusing on conducting informal Technical Assistance visits to each subgrantee to monitor reporting and curriculum fidelity, as well as offering support on participant recruitment.

The Nevada State Immunization Program’s strategic plan states that by 12/31/2017, the Program will improve Nevada’s immunization rate to at or above the national average for children 19 – 35 months of age, improve adolescent immunization rates on recommended vaccines, and improve adult immunization rates for influenza and Tdap. In addition, the strategic plan will guide the program to focus its energy on their set goals and objectives.

The School Health Program will work toward implementing the Whole School, Whole Community, Whole Child model to ensure stakeholders understand the importance of physical education and physical activity and how it can be implemented into many non-traditional settings. Stakeholders will play a larger role in informing other partners and the general public about physical education and physical activity and why it is essential for health and why it should be mandated. Nevada Division of Public and Behavioral Health will assist school districts by providing technical

assistance to implement the school wellness policies and will also review School Improvement Plans (SIP) to customize physical activity recommendations that will help address issues outlined in the SIP.
Partnership with key physical education organizations, such as SHAPE Nevada will be formalized to provide professional development to school staff in order to help students reach the required 30 minutes of physical activity per day. Comprehensive School Physical Activity Program (CSPAP) training will be continued in urban areas, as well as rural and frontier Nevada. Additionally, DPBH will create a Statewide Obesity Prevention Taskforce composed of stakeholders, who will identify opportunities to decrease obesity in part, through increased physical activity and physical education.
By 2016 Nevada will have 14 operating SBHCs and Clark County (Southern Nevada), one of the largest school districts in the nation will house 11 of the 14 SBHCs. Three facilities will serve children in Northern Nevada. One in each respective county: Washoe, Lyon and Carson City. There is an increased desire to implement SBHCs into Nevada's rural/frontier regions, however, barriers exist due to lack of resources. Nevertheless, the youth mental health programs in three counties are committed to assisting in establishing programs.
In 2016 each of the School-Based Health Centers (SBHCs) in Nevada will have their billing systems established to accept Medicaid. Some facilities will be able to submit claims to private insurers. Historically most of Nevada's SBHCs have offered services free of charge with no reimbursement source to provide long-term sustainability. The incorporation of SBHC comprehensive services following the Bright Futures guidelines enables each facility to bill for services and generate income to build self-sustaining SBHCs.
In 2016, the You'N-I initiative will be implemented to engage the community on the shortages of mentors and the variety of opportunities for mentoring. January is national mentoring month and there are plans to hold a community wide event aimed at mentor recruitment. A recruitment fair with representation from all the youth mentoring organizations in town is planned and a keynote speaker will be invited to discuss the importance of mentoring. Community outreach activities will be continued through the Reno Youth Network www.renoyouthnetwork.com as well as support of the You'N-I initiative.
The Rape Prevention and Education (RPE) Program has the following goals set for 2016:

a. Develop the framework for a Sexual Assault Coalition. To achieve this goal, several ongoing meetings with sub-committees are being held to outline a framework for a Sexual Assault Coalition in Nevada.
b. Implement a bystander pilot program in one high school campus. Planning activities for the Green Dot pilot program at Incline High School will be continued.
c. Continue prevention activities targeted to teens and young adults. A Youth Summit in Las Vegas (summer 2015) for teen leaders will be held and YourSPACE educational sessions for youth will be conducted.
d. Build infrastructure for sexual assault awareness on college campuses. Green Dot trainings on UNR college campus will be provided.
e. Build infrastructure for evaluation of programs. This will be achieved by conducting Nevada YRBS surveillance, holding meetings for evaluation planning/training with RPE sub-grantees and annual planning for YourSPACE for 2015-16.
f. Attend required and support activities for RPE. Participate in Leadership Training and National Sexual Assault Conference in Los Angeles.
g. Provide trainings for professionals working within environments targeting teens and young adults. Ongoing bar/club trainings for alcohol awareness and bystander intervention will be provided in in Las Vegas.

Adolescent Health - Annual Report

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

Annual Objectives

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

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

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

Teen Pregnancy Prevention

The Nevada Adolescent Health Program housed in the Maternal, Child and Adolescent Health (MCAH) Section collaborates with the Title V Program as well as other community partners and agencies to provide preventive services and ensure the needs of adolescents in Nevada are met. Adolescent Health Program focuses on youth development and health promotion for adolescents in the state of Nevada and its efforts are to promote comprehensive sex education, adulthood preparation programs and abstinence education with the goal of preventing pregnancy and the spread of sexually transmitted infections among adolescents. The program administers the State Abstinence Education Grant Program (AEGP) and the State Personal Responsibility Education Program (PREP) of the Family and Youth Services Bureau (FYSB) of the Administration on Children, Youth and Families (ACYF).

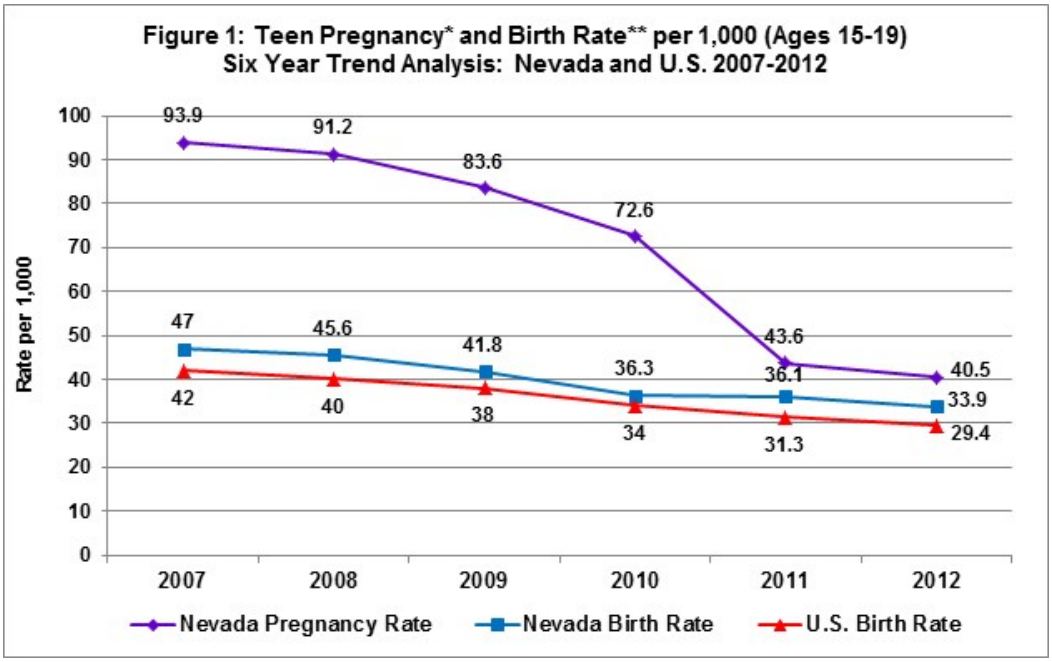
Abstinence Education Grant Program (AEGP)

AEGP supports decisions to abstain from sexual activity by providing abstinence education as defined by section 510(b) of the Social Security Act (42 U.S.C. § 710(b)) with a focus on those groups that are most likely to bear children out-of-wedlock, such as youth in or aging out of foster care. The target group for this program is comprised of youth, aged 9-12 years old, with priority enrollment given to children and adolescents in foster care. The evidence-based, medically accurate, educational program *Promoting Health Among Teens -Abstinence Only!* highlights goal setting and negotiation skills and is currently being implemented in seven counties in Nevada. A statewide media campaign promoting parent-child communication was inaugurated in 2014.

Personal Responsibility Education Program (PREP)

PREP supports personal responsibility education programs that replicate evidence-based effective program models that scientific research indicates changes behavior, by delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth. In Nevada, implementation of evidence-based, medically accurate, and culturally competent educational programming includes the following three adulthood preparation topics: Adolescent Development, Healthy Life Skills, and Healthy Relationships. The target group for this program is comprised of sexually experienced adolescents, aged 13-18 years old.

Nevada has seen a significant reduction in teen pregnancy and birth rates over the past two decades, but has consistently been above the national average. In 2010, Nevada ranked 44th among U.S. states due to its teen pregnancy rates (for comparison, the state with the lowest rate is ranked 1st and the state with the highest rate is ranked 50th). The Nevada teen birth rate has decreased by 28% between 2007 and 2012, while the national rate decreased 30% in that same time (see figure 1 below). Nevada's repeat teen birth rate is also higher than the national average. According to the Centers for Disease Control and Prevention National Vital Statistics System, 18.3% of teen births in the nation are repeat births while in Nevada, over 20% of teen births are repeat births.

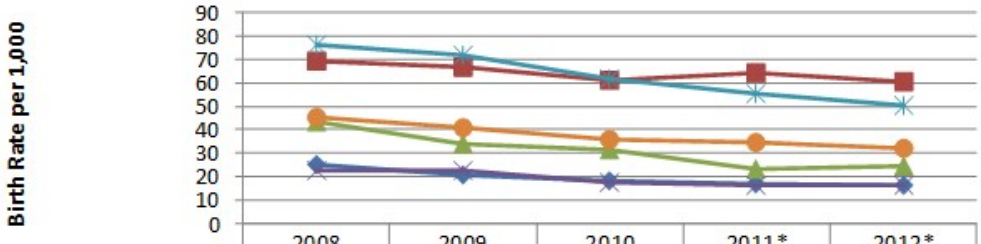


Source: Division of Public and Behavioral Health, CDC*Pregnancy Rates: Numerator (Abortions + Births) Denominator (Total Nevada female population 15-19) multiplied by 1,000**Birth Rates: Numerator (Total births) Denominator (Total Nevada and U.S. female population 15-9 respectively) multiplied by 1,000

Teen pregnancy and childbearing bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children. In 2010, the National Campaign to Prevent Teen and Unplanned Pregnancy ranked Nevada 36th in total costs associated with teen childbearing costs, with approximately $68 million dollars of state and federal funds spent on teen childbearing costs. There were approximately 73,470 teen births between 1991 and 2010, costing a total of $1.5 billion over that time period. Had it not been for significant declines in the teen birth rate in recent years, the costs to Nevada's taxpayers would have been even higher. However, on the bright side, the teen birth rate in Nevada declined by 48% between 1991 and 2010 and the progress Nevada made in reducing teen child-bearing saved taxpayers an estimated $84 million in 2010 alone compared to the costs they would have incurred had the rates not fallen. Total costs factor in the negative consequences sometimes experienced by the children of teen mothers during their childhood and their young adult years, and include costs associated with public health care (Medicaid and CHIP), increased risk of participating in child welfare, and, for children who have reached adolescence, increased risk of incarceration and lost tax revenue due to decreased earnings and spending.

Similar to the rest of the nation, there are race/ethnic disparities in Nevada with teen birth rates being consistently higher among Hispanic and African Americans teens than in the Asian, Native American and White counterparts (see figure 2 below).

Figure 2: Five year trend of Teen Birth Rate among Mothers in Nevada (Ages 15-19), By Race/Ethnicity



	2008	2009	2010	2011*	2012*
White	25.3	20.9	18.5	17.1	16.4
Black	69.3	66.7	61.2	64	60.2
Native American	43.6	34	31.3	23.1	24.5
Asian	22.8	22.8	17.8	16.2	16.2
Hispanic	76.2	71.7	61.6	55.6	50.2
Total	45.6	41.1	36	34.4	31.8

Source: Division of Public and Behavioral Health (2014)
* Preliminary Data

The Nevada Adolescent Health Program is excited that the Affordable Care Act extended the State Abstinence Education Program of Title V of the Social Security Act through fiscal year 2014 as well as amended Title V to include the Personal Responsibility Education Program (PREP). In 2014, the funding was extended through fiscal year 2016 and these funds will enable the program to continue providing services to adolescents in Nevada.

Physical Activity in Adolescents ages 12 through 17

In 2014, the Division of Public and Behavioral Health (DPBH), Chronic Disease Prevention and Health Promotion Section began working in the school health realm and hired a full time School Health Program Coordinator to focus on improving practices and policies related to the health of children in Nevada schools. Nevada created and adopted a Statewide School Wellness Policy to ensure local education agencies work toward meeting the Health Hunger Free Act's Smart Snack Standards and national physical activity recommendations. The School Health Coordinator worked with each of the 17 local education agency's school wellness coordinators to assist in the development or revision of a Local School Wellness Policies. Due to the school wellness policy, every school district within Nevada must ensure children are given the opportunity for at least 30 minutes of physical activity per day. Additionally, due to the school wellness policy, schools are now encouraged not to withhold physical activity as punishment, which has been a long standing practice.

In the 2015 legislative session, a bill was introduced requiring 30 minutes of physical education per day, from kindergarten through 11th grade. The introduction of this bill was important due to the fact that Nevada does not require physical education or activity in elementary and middle schools. DPBH was able to coordinate and educate key stakeholders about the bill and national best practices related to physical education and activity. Unfortunately, the physical education bill was not passed this session. However, DPBH and stakeholders will continue to work together in the interim to increase the understanding of the importance of physical education and activity. DPBH is hopeful that a physical education or activity law will successfully pass in the next legislative session. DBPH believes in the comprehensive approach to physical activity in the school setting. In 2015, the School Health Coordinator attended the Society of Health and Physical Educators (SHAPE) America training on Comprehensive School Physical Activity Program (CSPAP). The CSPAP program focuses on assessing the following for opportunities for physical activity:

Before and after school

- Family and community engagement
- Staff involvement

During school

- Physical education

Since attending the CSPAP training, the School Health Program Coordinator has provided two CSPAP professional development sessions to school staff and other partners potentially impacting 3,000 students.

Immunization

Nevada Title V closely works with Nevada Immunization Program to ensure adolescents receive the required vaccines. Using Nevada State Demographer estimates for the denominator, about 22.05% of children aged 6mos-17yrs were vaccinated for influenza during the 2013-2014 season. However, that number slightly declined to 20.92% for the 2014-2015 season. In 2013, the percent of adolescents aged 13 through 17 who received at least one dose of the HPV vaccine was 53.8% for girls and 31.9% for boys. 2014 data for HPV, Tdap and MCV4 will be available at the end of July, 2015.

In 2014, Nevada Immunization Program successfully launched a statewide Vaccines for Children (VFC) campaign in conjunction with National Infant Immunization Week. The campaign directs people to a VFC website vfcnevada.org, organized and maintained by Immunize Nevada. The website is designed for parents seeking a VFC provider and also serves as an informational resource for Nevada's VFC Providers. Spanish/English marketing for the campaign included radio, television, public relations, social media outreach and online advertising. In addition, VFC materials flyers and promotional giveaways were distributed throughout the state at health fair events, clinics and through the Immunize Nevada team as well as to dozens of partners.

With assistance from the Prevention and Public Health Fund (PPHF) HPV Improvement Grant, Immunize Nevada was able to launch a statewide HPV promotion campaign called HPV Free NV. The campaign includes a sustainable website and from Oct-Dec 2014, radio/TV/online ads were circulated across the state. The Immunization Program in collaboration with Immunize Nevada has been convening HPV Task Force meetings since October 2014 and even though the main focus is HPV, the campaign:

1) Encourages parents to ask for more information about adolescent immunization needs and;

2) Encourages providers to give a strong recommendation for the full scope of adolescent immunizations, rather than just those that may be school-required.

Health Promotion and Wellness among Adolescents

School-Based Health Centers (SBHCs) in Nevada have shifted their focus to provide comprehensive services to promote optimal physical, behavioral, emotional, and social health of its students. Personnel in the SBHCs use the evidence based practices outlined by Bright Futures to advance the quality of health promotion/preventive services for children. These SBHC comprehensive well-child visits will help Nevada reach its goals in improving the health and well-being of its children.

This allows SBHCs to integrate the essential components of the primary care medical home in their delivery of services to children, adolescents, and their families. At its core, the ideal SBHC model represents many key attributes of an advanced patient-centered primary care system for children and adolescents.

The need for access to affordable comprehensive care at SBHCs has been demonstrated in by the SBHCs operating in Southern Nevada. In the 2013-2014 school year, Clark County's ten SBHCs provided over 10,000 services to children, adolescents and their families from more than 100 schools.

The comprehensive model enables SBHCs to provide the services outlined in the Bright Futures guidelines for well-child visits. Standards of care have been established to reduce SBHC site-to-site variability, as well as to increase the utilization of evidence-based best practices. Policies and procedures developed outline minimum requirements for comprehensive services inclusive of: primary care, preventive health, screening and lab services, pharmacy, mental/behavioral health and social services, and oral health care.

Standards of care have permitted for the implementation of state certification by the Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness. Certification escalates the ability to study clinical outcomes, and increases the potential for insurance reimbursement. SBHCs that pass the state certification review are eligible to receive Medicaid reimbursements from the Division of Health Care Financing and Policy in a special category as a Provider Type 17 for billing purposes.

One SBHC became certified in December 2014. Others are ramping up their services to follow suit in this coming year. Certified SBHCs are required to submit data reports to the Division of Public and Behavioral Health, Bureau of Child, Family and Community Wellness. This enables the MCH Section to collect data on the number of well-child visits and other services provided such as: mental health screenings, oral health procedures, immunizations, etc.

A statewide community of interested parties created the Nevada School-Based Health Alliance. This state organization, affiliated with the National School-Based Health Alliance, is working to improve the health status of children and youth by advancing and advocating for school-based healthcare. The Nevada School-Based Health Alliance held its first meeting in September 2014, at the Nevada Health Conference. Topics discussed were: an overview of the newly formed organization, SBHC Certification, and the incorporation of SBHCs into the Medicaid Provider Type 17 specialty category for reimbursement.

Title V/MCH Block Grant funds have supported the development of comprehensive well-child visits for SBHCs in Clark County (Southern Nevada). Expertise was provided to develop community building and planning efforts for community partners interested in implementing a SBHC and to expand the care provided by operating SBHCs. The United Citizens Foundation (UCF), Inc. selected to conduct the planning process to initiate and establish a School Linked Health Center. Furthermore, the University Of Nevada School Of Medicine – Department of Pediatrics selected to utilize the consulting services to expand care into the comprehensive Bright Futures model.

Title V/MCH Block Grant funding was also provided for developing infrastructure, and policies and procedures to the Community Health Alliance, a Federally Qualified Health Center, to implement a SBHC at Wooster High School in Washoe County. Their SBHC which opened in January 2015 serves staff, students and families of the high school, four surrounding elementary schools, and one adjacent middle school.

Nevada Title V also collaborates with other partners in the state to promote health and wellness among adolescents. The Community Foundation of Western Nevada developed the Youth Network Initiative (*You'N-I*) project in the first quarter of 2014 to address the needs of youth who are homeless, runaways, or aging out of foster care. Prior to the project development, the Foundation hosted two public community meetings to get a full understanding of youth homelessness in Washoe County. The initiative's strategy was to connect with stakeholders to discover what resources were available or lacking and policies that created barriers for the youth. We also engaged the stakeholders to find out if they had any concerns or unmet needs.

The two needs that emerged from the public meetings were:

1. The need for an accurate resource guide to help youth find service providers and resources in the community and;
2. A resource center where youth could receive assistance.

To address the needs that came up from the public meetings, an online resource guide, *Reno Youth Network* was launched in September 2014. The website www.renoyouthnetwork.com allows users to narrow their search according to their age, gender, and specific needs to find relevant information. It also has a plethora of resources including food, shelter, education, healthcare, job among others. Information on the name of the agency/provider, address, phone, number, hours, services provided, keywords, directions and other information is also provided on the website. Users can provide a rating (based on five stars) and a review of the agency if they have received services previously. A four-minute video was created to provide information about the Youth Network http://bit.ly/1DHVuwQ. Since its launch in 2014, the Reno Youth Network has logged approximately 1,700 successful searches.

The Eddy House created the *YOUth Resource Center (the YOU).* The mission of Eddy House is to provide homeless, runaway, foster and other at-risk youth the opportunity to reach their full potential as healthy individuals

through a continuum of programs and services in Northern Nevada. You'N-I actively supports the Eddy House by helping promote the YOU and raising public awareness of youth homelessness. In 2014, Eddy House was connected with donors to solidify a location and initial funds for the YOU.
In fall 2014, the Community Foundation of Western Nevada conducted a survey and realized there was a shortage of mentors in Washoe County. The survey also indicated that most transient youth would value having a mentor in their life. To address this issue, a mentor recruitment subcommittee, comprised of a variety of youth mentoring organizations, was created. The purpose of forming such a network is to improve the quality and quantity of mentors throughout northern Nevada.

Rape Prevention Education

Nevada Title V collaborates with the Rape Prevention and Education (RPE) Program, housed within the MCH Program. *She's Not Old Enough*, a statewide statutory rape awareness campaign designed to decrease sexual activity with underage girls, received widespread acceptance and statewide media coverage. Public service announcements were heard over 318,258 times within a period of 15 months. In addition, two informative websites were completed for the prevention of sexual abuse and intimate partner violence in 2014. One of the websites is a sexual violence education website for youth defines sexual consent and the risks associated with power based personal relationships. The other website is a bystander intervention website that identifies safe strategies for intervening in situations which may escalate to violence.
YourSPACE educational curriculum was restructured to supplement current health educational standards for Nevada students. RPE projects that *YourSPACE* education sessions which define consent and identify the warning signs of relationship abuse will include presentations to over 20,000 Nevada middle and high school aged youth within a two year period. RPE provided trainings and seminars for professionals, to enhance teaching techniques and curriculum for building healthy dating relationships, increased 25% during 2013. Modules were rewritten to include appropriateness for LGBTQ youth and professionals working within Latino communities.
In November 2014, statewide stakeholders met to define plans for building a new state sexual assault coalition.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Promote establishment of a medical home for children	Increase 40% within a year, with 2% annual increase by 2020, children with and without special health care needs with a medical home in the past year. Increase 20% annually programs and	Educational campaign and access implementation regarding Medical Home.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health	Percent of children with and without special health care needs having a medical home		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	participants that receiving education on the Medical Home. Increase by 5% number of referrals to Nevada's medical home portal resources by 2020.		Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal			

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			conjugate vaccine			

Children with Special Health Care Needs

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

With the CYSHCN Program Coordinator position recently sustained, 2016 will bring forth more opportunities to develop, aimed at collaboration with partners to support programs and services related to CYSHCN, reaching federal, state and local levels.
The Medical Home Portal will be fully established with resources provided throughout the state that serve CYSHCN and their families. In an effort to promote outreach there will be collaboration with MCH partners. Educational trainings will be necessary for the CYSHCN, families, pediatricians, providers, professionals, schools and other services or agencies that serve this population. The resources will need to be maintained for reliability purposes and managed input of additional items in consideration of a standard of usefulness is anticipated.
MCH Title V dollars will allow a sub grant with CYSHCN and NCED for Sib workshops. This two day Sib workshop will be provided by Don Meyers. This will train and certify facilitators how to run a local Sib shop. The impact on a sibling can be overwhelming. The sib shop environment provides an opportunity for the sibling of the child that has special needs to be celebrated. The sibling is acknowledged individually and collectively in a positive setting that strongly connects with other siblings their age facing different but similar challenges. Building lifetime friendships and support not only benefits the sibling but is often reflected throughout the entire family. This training will be held in both locations, Reno, Fall 2015 shadowed by Las Vegas, Spring 2016.
Craniofacial Clinics in Northern and Southern Nevada will continue through calendar year 2016.
Critical Congenital Heart Disease (CCHD) for newborn screening will be reported to DPBH. Data records with a positive result will be located in a system within CYSHCN program.
NV PEP will continue to provide information, services and training to Nevada families of children with disabilities. NV PEP has a resource library available and they encourage parents who suspect that their child has a disability to utilize the books, videos and handouts. Personnel are supportive and compassionate because they have been impacted by disability in some way and are aware that navigating a challenging support system alone can be overwhelming.
NEIS will continue to increase parent engagement opportunities and support parents advocacy and training initiatives to link families using social media connections.
NCED will continue to hold Partners in Policy training classes.
NvLend will continue with the current activities into the application year.
TASCEI's plan for 2016 is to continue with current goals, objectives and activities.

Children with Special Health Care Needs - Annual Report

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

Annual Objectives					

	2016	2017	2018	2019	2020
Annual Objective	36	39	42	45	48

The CYSHCN Coordinator position had been vacant as of August 2013 until filled in January 2015. During the interim, other staff within the Maternal and Child Health program have been collaborating with agencies and organizations in order to meet the needs of CYSHCN and their families. Specific collaborations have been noted throughout this section.
Nevada has maintained a toll-free CYSHCN information line to provide a broad range of resources to families of CYSHCN across the state. Resource coordinators that assist callers are parents or family members of CYSHCN and are trained to provide appropriate information. Nevada 2-1-1 also continued to provide resources to callers. Users access resources by calling, texting or via internet. Nevada's 2-1-1 website is www.nevada211.org/. The operators are trained to provide relevant and accurate information to the caller. Nevada's 2-1-1 website is easy to navigate, and their texting service has staff members who respond via text messages. Some of the resources provided by Nevada 2-1-1 include: physical and mental health resources and support for children, youth and families, among others.
In alignment with the 2015 National Outcome Measure, Nevada's Title V Program included planning efforts in 2014 with the Department of Pediatrics, University of Utah Health Sciences Center to develop Nevada-specific components within their Medical Home Portal launched in 2002. The Medical Home Portal will serve as a key component of a comprehensive, coordinated and integrated state system for improving the care of CYSHCN, offering:

- Clinical decision support for primary care clinicians caring for children with chronic conditions;
- Information to support clinicians and parents responding to abnormal newborn screening tests;
- Information to support parents in caring for the CYSHCN, and for families, from birth or
- diagnosis through transition to adulthood;
- Information for clinicians to support their building a Medical Home, providing comprehensive care, integrating best practices, and partnering with families;
- Information about professional and community service providers to help CYSHCN and their families access services and to support robust referral practices; state information will be integrated into the content and will be searchable;
- Google translate will be available to translate the entire site; and
- Automatic creation of custom lists of services and resources for users, based on a diagnosis and zip code; these can be edited, printed, saved and shared.

Nevada's Title V Program, through this new partnership, will be better prepared to provide resources and educational materials in order to support, educate and empower families of CYSHCN throughout Nevada. In addition, Nevada's Title V Program will continue to collaborate with partners and stakeholders to ensure that activities that assist CYSHCN and their families continue.

Other State Agencies

Nevada Governor's Council on Developmental Disabilities (NGCDD)

MCH Title V continues to participate in collaboration with the NGCDD to assist with events and planning for CYSHCN, families and caretakers. Personnel encourage and support advocacy, capacity building, and systemic change activities that contribute to a coordinated, consumer driven, family-centered and family-directed, comprehensive system. The Council under their federal grant has funded the following projects during the 2014-2015 fiscal year:

- State Employment Leadership Network (SELN) Nevada is a member of this National Network under the

leadership of Nevada Developmental Services.

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

IDEA Part C/Early Intervention

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

Project ASSIST is Nevada's Central Directory for families of children with disabilities or special health care needs, as well as agencies, organizations, and programs that serve them. Information is available on a variety of subjects, including: parent support groups, therapies and other health and human services, financial and legal assistance, advocacy, etc. Personnel within Project ASSIST tracks incoming calls. Just in the month of August 2014, 77 calls for information and 20 referrals to Early Intervention.

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

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

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

With increased general funding authorized by the Nevada Legislature for new state and contracted positions, NEIS Reno provided timely services for all eligible children in March 2014. This goal has been maintained through the calendar year.

Referrals have increased from SFY 13 (1,406 children) to SFY (1,561 children), an increase of 11%. As a collaboration of NEIS and University of Nevada, School of Medicine the Title V Nevada sub grant with Craniofacial Clinics continued to be held both in Las Vegas and in Reno, Nevada. The clinics have a dedicated interdisciplinary team that is committed to caring for and treating children with cleft lip and palate and other craniofacial disorders. The Northern Nevada Craniofacial Clinic is housed within the Department of Speech Pathology and Audiology at the University of Nevada, Reno. The Southern Nevada Cleft Palate and Craniofacial Team is a cooperative effort between Nevada's Department of Health and Human Services (DHHS), Division of Public and Behavioral Health, and community healthcare professionals. The Southern Nevada Cleft Palate and Craniofacial team offers online resources including a cleft advocate, family-to-family connection, and medical financing options, as well as insurance assistance. In addition, the Southern Nevada Cleft Palate and Craniofacial team has a toll-free 24-hour Hotline: (888) 486-1209. The goal remains consistent for 2016.

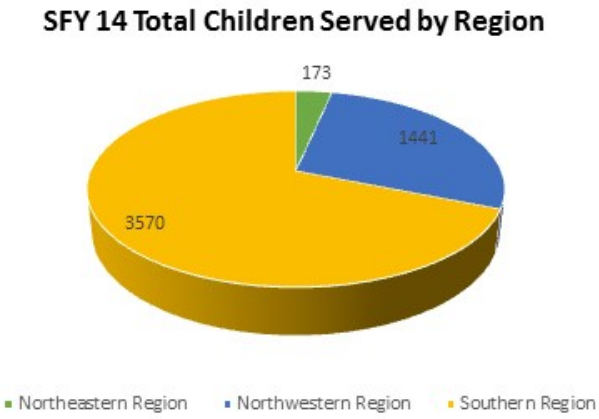
Project ASSIST, NEIS and the Medical Home Portal all have a distinctive role to play and will be complimentary to each other. Project ASSIST's directory provides information about foundations and other community groups, state and federal partners that have helpful information to the family and state provider entities. Unlike the Medical Home Portal, the directory does not contain a list of specific health care providers in each county.

Early Intervention community providers

Early Intervention services include private entities across Nevada including: Advanced Pediatric Therapies, The Continuum, Easter Seals, Baby Steps, Kideology, Therapy Management Group and Positively Kids.

One program offered by Positively Kids strives to embrace each child's unique needs while providing the services essential to their well-being and happiness. Vital to the success of every program we provide is its ability to achieve these goals:

- *Help children reach their full potential*
- *Create hope and foster inclusion*
- *Promote comfort and quality of life.*



Advanced Pediatric Therapies (APT) offers services to children from the ages of infancy through adolescence. The therapists are skilled in the areas of communication, feeding, sensory integration, self-help, gross motor, play/social, and fine motor skills. All of the therapists are also certified and highly skilled to treat children with a varying range of developmental, genetic and neurodevelopmental disabilities.

Regardless of the diagnosis, they work with the child and the family based on his/her areas of strength and areas of need. They have a vision that is for each individual to build positive social connections within his or her home and community using effective communication, self-help and gross motor skills. Although MCH Title V does not directly fund APT services, the Children and Youth with Special Health Care Needs program is collaborating to support APT's. This meets the National Performance standards moving in a direction to provide children with a Medical Home Portal that improves access to services through a one-stop shop for families.

Other statewide projects and activities

1. The Governor's Taskforce on Integrated Employment (herein referred to as "Taskforce") was established through Executive Order 2014-16 on July 21, 2014 by Governor Brian Sandoval to create a more diversified, inclusive and integrated workforce. There are 17 members representing state agencies, transportation, education, community training centers, the Governor's Council on Developmental Disabilities, the Nevada Disability Advocacy and Law Center, and an individual or parent of an individual with an intellectual or developmental disability. The Taskforce examines and evaluates current employment programs, resources, and funding, available training and employment opportunities for individuals with an intellectual/developmental disability.

2. Nevada Health Link (www.nevadahealthlink.com) has been instrumental in helping Nevadans to find a health insurance plan targeted to individual needs and budget. The online marketplace opened in October 2013 to enable individuals and businesses to shop for, compare and purchase health insurance. During the application process, if one person in a family qualifies for a public health insurance program, such as Medicaid or Nevada Check Up (Children's Health Insurance Program).

The current findings show that the percent of children with health insurance has increased by 6.9 percent when compared to 2008-2009 survey (81.59%). Despite this increase, Nevada still has the highest rate of uninsured children in the country (16.6%) compared to 7.2% in the nation (U.S. Census Bureau, 2012 American Community Survey). Similar to previous results, Hispanic children have the highest uninsured rates (48.4%) compared to Caucasian children (29.8%). Since Nevada has a large Hispanic population, concerted effort is needed to reach this population. With this in mind, the Silver State Health Insurance Exchange (SSHIX) hired Spanish-speaking Navigators and Enrollment Assisters.
SSHIX was aggressive in its outreach activities to inform the uninsured population in Nevada about the availability of affordable health coverage through the exchange, as well as of Medicaid Enrollment opportunities.
The marketplace was very helpful to families with CYSHCN because it provided in-person help through Navigators and Enrollment Assisters at various community locations and organizations. By the end of December 2014, the Nevada Health Link had appointed seventeen navigators, fifty-five enrollment assisters, and seventy-seven certified application counselors certified by Nevada Division of Insurance to enroll individuals and employers into the exchange. Navigators and Enrollment Assisters sat down with families with CYSHCN and walked them through the entire application and enrollment process in-person.
SSHIX has been vital in creating access, understanding and set a new standard for obtaining health insurance coverage, especially for families with CYSHCN. Nevada's Title V Program partners and stakeholders continued to keep their clients updated on any changes in enrollment at NevadaHealthLink.com. The statewide MCH Coalition and the regional MCH coalitions posted information about extensions in the enrollment period, especially targeting those who were unable to sign up due to technical difficulties.

1. In June, 2014, the Nevada Institute for Children's Research and Policy, a Sub grantee of Nevada's Title V Program, released the 2013-2014 Kindergarten Health Study Survey results. The findings show that approximately 87.2% of the respondents indicated that their child had some type of health insurance and 12.8% percent of respondents stated that their child did not have coverage.

2. Nevada Commission on Autism Spectrum Disorders (ASD) was initially created in 2008 by a Governor Executive Order and is comprised of five members. Earlier that year the 2008 Report of the Nevada Autism Task Force: An Action Plan for Nevada's Legislators and Policymakers indicating the need for this Commission. Due to the extent of recommendations, the Governor requested the Commission on ASD submit an Annual Report outlining the progress made on the report recommendations.

During the December 2013 meeting, and subsequent report to the Governor that month, the Commission on ASD indicating spending 2014 on meeting with experts, state agencies, advocates and others to develop a 5-year strategic plan to address the needs of individuals with Autism Spectrum Disorder across the lifespan, including

prioritizing the 146 recommendations made in 2008 Report.
To accomplish this task, the Commission developed a Steering Committee and four Subcommittees. The Chairs of the Subcommittees were part of the Steering Committee. The focus of the four Subcommittees was on: 1) Children 0-6 years of age, 2) Youth 7-21 years of age, 3) Adults, and 4) Rural communities. The Strategic Plan identified the following goals to accomplish between January 2015 and December 2019. They are: 1) Maximize public and private funding sources to support the full scope of services needed for all Nevadans with ASD, 2) Increase the system's capacity for diagnosis, treatment, services and supports for individuals with ASD across the lifespan, 3) Expand the number and quality of professionals providing services, and 4) Promote a well-informed, empowered and supportive Nevada population around the issues of ASD.

MCH COMMUNITY PARTNERS

Nevada Center for Excellence In Disabilities (NCED)

NCED is located in the College of Education at the University of Nevada, Reno and serves as Nevada's University Center for Excellence in Developmental Disabilities (UCEDD) as established by the Developmental Disabilities Rights Assistance and Rights Act (DD Act). The NCED is working on a multitude of programs/projects in service to people with disabilities, and the professionals in the field, across the lifespan, including: Nevada Leadership Education in Neurodevelopment and Related Disabilities (NvLEND), Partners in Policymaking, Technical Assistance Center on Social Emotional Intervention (TACSEI) for young children, Nevada Sibling Network, Positive Behavioral Supports (PBS) – Nevada, etc.
Twenty three participants completed the Partners in Policymaking Class which was taught one Saturday per month for nine months in Reno. Successful completion of the program gives Partners graduates these competencies:

- Describe the history of services for, and perceptions of, people with developmental disabilities.
- Describe significant contributions of the parents' movement.
- Describe the history of the self-advocacy and independent living movements.
- Describe the benefits and values of a quality, inclusive education for students with and without disabilities.
- Outline specific strategies to achieve a quality, inclusive education.
- Demonstrate knowledge of the service coordination system and what services may be available. Describe the importance of futures-planning and self-direction for people with developmental disabilities.
- Understand the principles of choice and control of resources in futures-planning.
- Understand the reasons for and the importance of proper positioning techniques for people with physical disabilities.
- Describe examples of state-of-the-art technologies for people with significant disabilities.
- Describe the importance of supported, competitive employment opportunities.
- Understand that a flexible, responsive system of supports for the families of children with disabilities is the cornerstone for a true system of community supports for people with developmental disabilities. Understand the need for all individuals to experience changes in lifestyle across the lifespan. Know/understand the importance of home ownership/control as one of the defining characteristics of adult life in our culture.
- Understand the basic principles and strategies being used to support people with developmental disabilities in their own homes across the lifespan.
- Create a vision for the year 2020 (and beyond) for people with disabilities.
- Understand how a bill becomes a law at the state and federal levels.
- Identify critical federal issues and the process by which participants can personally address their concerns.
- Demonstrate successful techniques for advocating for services to meet the needs of unserved and underserved individuals.
- Draft and deliver testimony for legislative hearings. Learn how to meet a public official and discuss issues. Identify strategies for beginning and sustaining grassroots-level organizing.
- Understand the role of when and how to use the media to effectively promote issues.

Demonstrate proper procedures for conducting a meeting. Gain a basic understanding of parliamentary procedure

and serving on boards.
The purpose of the NvLEND training program is to improve the health of infants, children, and adolescents with disabilities. They accomplish this by preparing trainees from diverse professional disciplines to assume leadership roles in their respective fields and by insuring high levels of interdisciplinary clinical competence. There are 43 LEND programs in 37 states across the nation. Collectively, they form a national network that shares information and resources and maximizes their impact. They work together to address national issues of importance to children with special health care needs and their families, exchange best practices and develop shared products. The program is funded by the Autism CARES Act and is administrated by the Health Resources and Service's Administration's (HRSA) Maternal and Child Health Bureau (MCHB).
Within LEND is Nevada State *Learn the Signs. Act Early* (*NvLTSAE*) project. NvLTSAE was formed in September 2011. Four statewide summits bringing together parents and professionals have been conducted. Primary outcomes established from the summits include: (1) children are identified earlier (reduce time between first concern and diagnosis), (2) individuals of all geographical locations have access to evidence-based, culturally competent, family centered services and care that assure optimal outcomes, and (3) professionals and families collaborate across disciplines, agencies, and a statewide system of care. NvLTSAE has been able to develop collaborations with several state, private, and public agencies. The Nevada Title V Program has provided funding and has been instrumental in providing not only funds, but also guidance about the needs of children in Nevada. Accomplishments and major activities for NvLTSAE in Calendar Year 2014 are as follows:

1. NvLTSAE website for professional and family education
2. Training of 11 interdisciplinary teams (approximately 55 professionals) from across the state in administration of the Autism Diagnostic Observation Schedule, 2nd Edition to conduct evidence based assessment for possible autism. Subsequent follow up on a monthly basis using Nevada's Project Echo was conducted to maintain contact and insure reliability. Project ECHO is an innovative health care delivery solution pioneered in New Mexico by Dr. Sanjeev Arora and has now been replicated by over 40 sites worldwide. The University of Nevada, School of Medicine was early to adopt Project ECHO, with only Washington, and urban Chicago replicating sooner. ECHO is a simple telehealth linkage connecting university-based faculty specialists to primary care providers in rural and under-served areas to extend specialty care to patients with chronic, costly, and complex medical illnesses.
3. Pilot project to develop an integrated online screening system in which childcare workers and parents will have access to the Ages and Stages Questionnaire and the Ages & Stages Social Emotional. Currently three childcare sites are participating in the pilot. Data indicates that the ASQ is effective in identifying children that require specialized services at 15% rate, which is comparable to the national average.
4. Develop eight training modules to be housed on the Nv*LTSAE* website for continuing education of childcare workers. We are working with Nevada Registry so childcare providers can get continuing education units. **(**50,000 Milestone Moment Booklets developed by the Centers for Disease Control were adapted for Nevada that included referral information for parents in 2013, with statewide distribution staring in 2014. Future improvements including working the Department of Education and the CDC to include Year Six.

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

Nevada Technical Assistance Center on Social Emotional Interventions for Young Children (Nevada TACSEI) is a statewide, collaborative initiative to enhance the ability of early care and education personnel and families to address the social, emotional and behavioral needs of all young children birth to 5 years. Using the Pyramid Model, a tiered prevention and intervention framework to prevent and address challenging behavior through evidence-based practices, Nevada TACSEI provides training and technical assistance for supporting social emotional competence and addressing challenging behaviors in young children at-risk for, or with identified developmental delays.
This project addresses National Performance measures 02 and 06 within the Federal Maternal and Child Health Block Grant sub granted through Children's Cabinet and Nevada MCH.
Outcomes in 2014:

1. Incorporate family perspectives and needs into project development, implementation and evaluation
    a. Created Family Engagement Subcommittee Strategic Plan, met with subcommittee, regularly reviewed and updated Strategic Plan
    b. Attended State Leadership Team meetings monthly
    c. Presented and had a resource table at the Nevada Association for the Education of Young Children (NevAEYC) State Conference
    d. Talked with administrators at multiple early care and education sites each month, providing materials for parents about the importance of social emotional skills in both English and Spanish and partnering with programs to increase/improve parent engagement practices
    e. Participated in Nevada PTA Conference and vendor exhibit, providing opportunities to speak to parents and professionals about family engagement practices
    f. Participated in Expanding Opportunities monthly meeting

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

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

Family TIES

Family TIES of Nevada is dedicated to providing culturally competent support, information, and assistance to achieve family-centered care for individuals with disabilities or special health care needs through family, community and professional partnerships as the Nevada Family-to-Family Healthcare Information and Education Center (F2FHIC). The Nevada F2FHIC is funded by the Maternal and Child Health Bureau to provide statewide support to families of children and youth with special health care needs by:

- Assisting families as they navigate public and private systems, including health systems and insurance plans.
- Assisting families in accessing services and resources for their children and in partnering with providers and caregivers.
- Listening to families as they describe their encounters with systems and helping guide them to possible solutions.
- Working with families, health care providers, public and private agencies, and advocacy or support groups to promote family-centered care and medical homes for children with special health care needs.
- Promoting discussion and linkages among families, providers, managed care programs, and government to better serve the health care and related needs of children and families in Nevada.

Family TIES of Nevada contracted with the Center for Program Evaluation (CPE) at the University of Nevada, Reno to assist with both the process and outcome evaluation associated with the F2FHIC project. The evaluation involved a partnership approach with Family TIES staff and administration throughout the state and was responsive to emerging needs and priorities in order to monitor progress toward the program's two goals: 1) Provide training,

information, emotional support and advocacy in the most family-centered, culturally competent manner to families of CYSHCN and 2)
Evaluate the cultural and linguistic competency of the Family TIES organization and its materials and implement a strategic plan to integrate competence in its project activities.
CPE partnered with the Family TIES project management team to track programming outputs (i.e., families provided information, education and/or training) and outcomes (i.e., access to care, partnering in CPE partnered with the Family TIES project management team to track programming outputs (i.e., families provided information, education and/or training) and outcomes (i.e., access to care, partnering in decision-making, advocacy), working to build capacity for enhance evaluation within Family TIES programming. The outcome evaluation focused on the short-term and intermediate outcomes listed in the logic model for each of the two programming goals and included: decision-making, advocacy), working to build capacity for enhanced evaluation within Family TIES programming. The outcome evaluation focused on the short-term and intermediate outcomes.

Outcomes were gathered and monitored through multiple modes, as well as integrated into in-depth follow-up inquiries with families and professionals served through Family TIES Family-to-Family Health Information Center. The outcomes evaluation triangulates data from these multiple sources to inform the process evaluation, as well as track programming impacts. Outcome evaluation measures include program documentation, organizational review, participant evaluations and follow-up questionnaires, professional surveys, and facilitated dialogues. CPE worked with Family TIES staff to track programming outputs, including number and demographics of families served, number of parents/caregivers and professionals trained, number of professionals served, number and type of services provided, number and type of agencies/programs served, and number and type of community-based organizations served tracked through Family TIES online database system.
In 2013-2014, evaluation methods included entry and analysis of Sales Force tracking system data; consumer demographics, needs, information, referral, and training outcomes, as well as the client impact questionnaire, presentation exit surveys, and follow-up surveys. Each of these strategies and their associated outcomes are summarized in the following evaluation bulletin In 2013-2014, Family TIES logged over 2,600 instances of support to Nevada families of CYSHCN—an 86% increase compared to 2013—and over 1,200 instances of support to professionals who work with families of CYSHCN—a 33% increase compared to 2013. Families and professionals were served through Family TIES' various programming strategies to provide support directly (i.e., one-to-one assistance or training, numbers are of known individual participants) or indirectly (i.e., collaborative presentation opportunities and informational mailings, numbers are estimates of individuals served with possible duplication) to support families of CYSHCN. During the 2013-2014 grant year:

- 960 families were served through direct one-to-one assistance and/or training (a 61% increase from the previous year)
- 266 professionals were served through direct one-to-one assistance and/or training.

Of the families served, 58% were known to be Hispanic or Latino (an 11% increase from 2013) and 54% spoke Spanish as their primary language (a 12% increase from 2013). Considering all types of support, the majority of support instances for families was one-to-one assistance (49%), followed by indirect training (43%). For professionals the majority of support instances were indirect (75%), followed by direct trainings (18%). Support families and professionals received information or training that spanned six target outcomes for families of CYSHCN:

- Navigating Systems/Accessing Community Services (i.e., Child
- Care, Disability Awareness, Disaster Planning, Family Support, Home care, Hospitals, Housing, Legal Services, Parenting, Recreation, Respite, Schools, and Transportation)
- Financing for Needed Services (i.e., Medicaid, Public and Private Health Care, School-based and State-funded services)
- Accessing a Medical Home (i.e., Care Coordination, Child Development, Cultural Competence, DME, Medical

Sub specialty, Medications, Nutrition, Oral Health, Primary Care, Sexuality, Specialty Care, Testing, and Therapies)

- Partnering/Decision Making with Providers (i.e., Communicating with Each support instance was coded for the area of support.
- Adolescent Transition Issues (i.e., Adult Providers, Teen Council/Leadership, and Vocational/Employment)s, and
- Early and Continuous Screening (i.e., Genetic Testing, Newborn Hearing, and EI/IEP Screening).

In January 2014, Family TIES (as Family Voices FV State Affiliate Organization) was featured in National Family Voices *Friday's Child* January 2014 Publication: *Family Leadership in the States*. Family TIES Executive Director served on a Reactor Panel during *The Power of Partnerships - Family Voices Family Leadership Meeting*, representing all state affiliates, with the state perspective on key findings from the *Environmental Scan – a Family Voices* survey to assist states in meeting future challenges and guide the National Family Voices Board's strategic planning efforts. MCH has a sub grant with Family TIES to fund the statewide toll-free Information/Referral Line for Children with special health care needs was included as a valuable resource in Nevada's *Milestone Moments, Learn the Signs. Act Early* pamphlet.

Highlights of Family TIES Activities in 2013-2014

- Partnered with Dream Therapies and Grant-A-Gift Autism Foundation to create an autism awareness video featuring children with autism (Happy-Pharrell Williams).
- Developed *At A Glance: A Guide to Statewide Health Resources,* designed for people with disabilities or families with a child with special health needs, and distributed 2,225 sheets at 38 sites during 2013-2014.
- Developed *Taking Charge of Your Medical Care: The Youth Transition Checklist*, a tool to help teens take charge of their health care and support their independence as they transition from school to adulthood, and distributed 1,713 sheets at 38 sites during 2013-2014. The targeted distribution is middle and high schools (public and private), special ed. programs and teachers, counselors, and students; and other providers and sites across the state.
- A featured speaker at the NV Statewide Maternal and Child Health Coalition 2014 Spring Symposium, sharing available resources for Children and Youth with Special Health Care Needs – aimed at improving health outcomes of the maternal and child population in Nevada.

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

Title V continues to fund the toll-free CYSHCN bilingual helpline 1-866-326-8437 and collaborates with the organization to support services in local and statewide communities. Family TIES of Nevada uses the Title V funding to support Nevada's CYSHCN and their families by providing them with pertinent and accessible information including: maintaining a statewide toll-free line staffed by personnel with knowledge, skills, abilities and up-to-date information on resources to provide competent and compassionate support. Bilingual personnel are available to assist Spanish-speaking callers. Some of the topics often discussed with the helpline callers include: information on finding health care and dental providers, information and services available under government and community programs (sibling support group, Grant a Gift Autism Foundation, Katie Beckett, Medicaid etc), how to find services if relocating to Nevada, healthcare transitions for CYSHCN available in Nevada among others.

During the reporting year, Family TIES continued to provide culturally and linguistically competent services to support CYSHCN. As part of their outreach efforts, Family TIES maintains a Facebook and Twitter page with messages that raise awareness of the toll-free line, health fairs, trainings, upcoming conferences etc. The posts and other outreach materials are also available in Spanish. To ease cross posting, the link to the Twitter page is provided on the

Facebook page.

NV PEP

As the statewide Parent Training and Information (PTI) Center, Nevada PEP provides services to parents of children with special needs, and to professionals.

Nevada PEP offers the following services:

- Information, referral and technical assistance
- Individual assistance and support
- Specialized workshops on: Special Education Law, Due Process, Early Intervention Transition, and Parent/Professional Partnerships
- Newsletter and Resource Library
- Speakers

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Prevent and reduce tobacco use among adolescents, pregnant women and women of child bearing age	Decrease by 4% within a year, with 1% annual decrease by 2020, girls and women smoking in pregnancy. Decrease by 20% within a year, with 1% annual decrease by 2020, girls and women smoking during offspring's childhood. Increase by 10% annually Medicaid participant with smoking cessation counseling.	Educational campaign to prevent or reduce smoking (including e-cigarettes and medical marijuana) in target population, including pregnant women or children who live in a house with a smoker.	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			Percent of children in excellent or very good health			
Increase the percent of adequately insured children	Increase percent of adequately insured children by 5 percent in the next year. Increase the percent of statewide or local programs integrating insurance importance and accessibility in the next year Increase percent of parents who received education on insurance options by 5 percent in the next year. Increase number of eligible Medicaid enrollees with children.	Collaborate with MCH partners to identify uninsured and underinsured populations and develop and implement appropriate interventions.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children without health insurance	Percent of children ages 0 through 17 who are adequately insured		

Cross-Cutting/Life Course

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

The Tobacco Prevention and Cessation Program will continue to disseminate targeted Quit line promotional material for pregnant and postpartum women who use tobacco, via Nevada providers, WIC clinics, early childhood educators,

Nevada Head Starts and Safeway pharmacies.
In 2016, the Primary Care Office (PCO) will be continuing the work that began with the Behavioral Health Professional Pipeline Mapping Project. Recommendations to Medicaid, Licensing Boards, State Personnel and Nevada System of Higher Education will be followed up and expanded, based on Legislative direction. Following 2015 clean-up of our provider database, and a statewide needs assessment in partnership with the Maternal and Child Health program, Health Professional Shortage Area designations will be updated to reflect current needs and to leverage federal resources to recruit and retain health care professionals. Outreach for National Health Service Corps loan repayment and scholarship programs will be expanded to more private sector facilities, and we hope to engage managed care organizations contracted under state Medicaid.

Cross-Cutting/Life Course - Annual Report

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

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

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

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

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

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

Mental and Behavioral Health and Substance Use

In 2013, the Mental Health and Developmental Services Division merged with the State Health Division to become the Division of Public and Behavioral Health (DPBH). More recently, the Substance Abuse Prevention & Treatment Agency (SAPTA), Mental Health, and the HIV Prevention Program merged to form the Bureau of Behavioral Health, Wellness, and Prevention. These mergers have caused considerable change in the behavioral health and mental health services in Nevada. One such change is incorporating a public health approach to prevention of behavioral health conditions. The public health approach seeks prevention first, is data driven, incorporates policies that affect the environment in which the health or disease occurs, considers the structures that support government and community infrastructure and capacity, and provides access to the right services. Title V/MCH Program is excited about these changes because it realizes that investing in prevention, treatment and recovery of the MCH population with behavioral health problems will have a significant payoff in the long run.

Other new changes that have impacted mental health and substance use include the Affordable Care Act. Beginning in 2014, market plans are required to cover the ten Essential Health Benefits including mental health and substance use disorder services. In addition, qualified health plans (QHPs), health plans that can be sold through exchanges, are required to have a network of providers including those specializing in mental health and substance use. This statute will ensure that more Nevadans will have access to quality health care that includes coverage for mental health and substance use disorder services.

Children's Behavioral Health

In Nevada, the Division of Public and Behavioral Health (DPBH) is responsible for providing behavioral health services to children and adolescents to the rural areas of the state while the Division of Children and Family Services (DCFS) is responsible for providing services to the urban areas; Washoe and Clark County. The 2013 state-commissioned report on the status of Nevada's public mental health services indicated that Nevada had missed several opportunities over the years to strengthen its behavioral health system and to mitigate this, the state required a proactive, strategic plan to implement an integrated system of care approach to behavioral health (Watson et al, 2013.) Contrary to other states, Nevada's behavioral health system had been responding to adults with mental health crises rather than allocating funds to provide prevention and early intervention services for children and youth (Watson et al, 2013.)

Recent data indicates that Nevada is currently ranked as the worst state (51st) in providing access to mental and behavioral health care for its youth (Mental Health America, 2015--- The 2014 Annual Report of Mental Health America). The access ranking indicates how much access to mental health care a state has including access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. To address these issues, Nevada Title V has forged relationships to work with the three Children's Mental Health Consortiums in the state: Clark, Washoe, and Rural. Each consortium is tasked with creating and implementing a 10-Year Strategic Plan (plans created in 2010) that provides the vision, goals and strategies to implement an integrated system of care approach that will overcome the challenges identified in recent local, state, and national studies.

Rural Children's Mental Health Consortia has a plan in place for children in rural areas, which involves a seed grant that would offer sustainability, within two to four years. The plan involves schools collaborating with the rural regional clinics and nursing centers. Initial research indicates that a total of 29 facilities are accessible to partner with the schools. The system would be funded through a Medicaid type 14 provider and would allow the use of existing tele-health services through regional centers. It will also provide an opportunity to use targeted case management and display the ability to give wrap around services for issues that are within the school. It is expected that sustainability could be achieved through health clinics, or a type 60 provider under Medicaid in both Northern and Southern Nevada. The Consortium is working with Medicaid to secure affordable rates for these services so that taxpayers do not have to fund in full.

The Children's Behavioral Health Subcommittee has been working with representatives from the Clark County School District, Washoe County School District, and rural school districts to develop recommendations on school based mental health services. These recommendations include:

- Providing "block grant" type funding to school districts in the North, South, and rural regions that is administered through the Department of Child Welfare and Family Services (DCFS) and the Children's System of Care Behavioral Health Subcommittee.
- Providing Mental Health assessment with linkage to services.
- Providing school-based behavioral health interventions, such as positive behavior support interventions and bullying programs.

Youth Behavioral Health

To improve access to mental and behavioral health care for Nevada youth, the Nevada's National Governor's Association Medicaid Transformation Project developed screening tools and a screening process to ensure early identification.

Nevada will use the EPSDT authority and a comprehensive multi-part screening tool to identify the rising risk youth. EPSDT ensures that youth receive appropriate medical care, behavioral health services, and developmental services. The behavioral health screen will include a screening tool which includes; screening for trauma, behavioral health symptoms, suicide risk, and substance abuse. Nevada will leverage knowledge from nationally recognized tools commonly used in the field to develop its own screening tool. The rising risk determination will be determined based on the number of risk factors identified and the scores on the subsequent tools.

The screening will be conducted prior to entering the 7th grade. The state chose this entry point because there is a current school entry requirement for an immunization, and this mandate has been very successful in ensuring immunization compliance. This age is also when youth begin to display behaviors that may indicate early warning signs. Mandating screening would also de-stigmatize behavioral health screening among youth.

Adult Behavioral Health Services

The Division of Health Care Financing and Policy (DHCFP) works in partnership with the Centers for Medicare & Medicaid Services to provide quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up. Medicaid continues to work with CMS to get approval for change in methodology for the added behaviorally complex rate on top of the nursing rate for behavioral health care services. In addition, Medicaid continues to work with MCOs for patients who receive services through fee for service Medicaid. Medicaid also continues to do outreach in rural counties to assure residents that there is continuity of services as well as connection between the beneficiary, the primary care physician, the psychiatrist, the pharmacist, and the transportation provider.

Tobacco Prevention and Cessation Activities

The Nevada Tobacco Users Helpline (NTUH) closed its doors on July 31, 2014. However, the National Cancer Institute provided temporary telephonic cessation services for Nevada residents from August 1 through September 9, 2014 after which a new Quit line vendor was selected through a competitive process administered by Nevada State Purchasing Division. The Nevada Tobacco Quit line (NTQ) was launched on September 10, 2014 and provides callers with up to five scheduled personalized, culturally competent, coaching sessions, unlimited inbound calls, web and text support and Nicotine Replacement Therapies (NRTs) free of charge to callers ages 18 and up. NTQ is administered by National Jewish Health (NJH) and the medically-oriented services build on NJH's expertise as the leading respiratory center in the US for over 100 years. NJH and NTQ provide customized programs for pregnant and postpartum women and considers those who use tobacco during pregnancy to be a priority population for tobacco cessation. The Pregnancy/Post-Partum Program includes the standard services as well as dedicated coaching, NRTs or Quit medications (if approved by MD) during pregnancy and after giving birth, incentives for completing calls, and extra coaching calls.

TPCP is currently working with a marketing company to conduct focus groups for the Nevada Tobacco Prevention and Control Program (NTPCP) to research the tobacco-use habits, cessation motivations and cessation tactics of three target audiences: Lesbian, Gay, Bisexual and Transgender (LGBT); American Indian; and pregnant and postpartum mothers in northern Nevada. The goal of these focus groups is to determine effective ways to reach these audiences through future marketing communications tactics including collateral materials, outreach and other activities to raise awareness of the Quit line and to assist northern Nevadans with tobacco cessation.

Oral Health

Title V funds the program manager position within the Oral Health Program housed within the bureau of Child Family and Community Wellness. The MCH Program does not have direct oversight of the Oral Health Program, however, the two programs constantly collaborate. The new Oral Health Program Manager has worked with partners and stakeholders from across the state to create a roadmap for improving Nevadan's Oral Health. Nevada's oral health partnership has outlined several goals to achieve in the next five years. These include:

- Building the statewide oral health network –
    - By 2016, there will be a statewide oral health coalition that will join the American Network of Oral Health Coalitions (ANOHC).

    - By 2017, add at least 20 new members/stakeholders that are engaged in the statewide coalition.
- Changing public perception on the value of oral health –
    - Ongoing, seize opportunities to partner with other wellness organizations to incorporate oral health value into messaging for whole body wellness.
    - By 2020, 90% of entering Kindergartners will have had a dental visit in the past year. (Baseline 2014-15 School Year 74.8%)
- Eradicating dental disease in children –
    - Promote dental services in EPSDT, including primary care dental screenings, fluoride varnish and dental referrals.
    - Promote utilization of periodontal services available for pregnant women in Medicaid.
    - By 2020, 90% of Medicaid eligible children will have received dental services (prevention and/or treatment).
- Incorporating oral health into the primary education system –
    - By 2017, ensure school districts have adequate financial protections to encourage their inclusion of school-based/school-linked clinical health services, including dental.
    - By 2020, 50% of Title 1 schools have a school-based oral health program.
- Adding adult Medicaid dental care coverage and advocate for Medicare dental services at the national level –
    - By 2015, establish a dental Medicare advocacy group.
    - By 2017, Nevada Medicaid will have (at least) limited dental benefits for adults.
- Enhance Nevada's oral health measurement and surveillance system –
    - By 2016, establish a data dashboard for the oral health program.
    - In 2016-2017, conduct an open mouth survey (Basic Screening Survey) of Nevada's Head Start students.
    - By 2018, detailed data on Medicaid covered dental services provided through both FFS and MC will be collected and systematically disseminated.
    - By 2020, the state will allocate funding/staff to do a preschool and 3rd grade BSS every four years.
- Advancing inter-professional education and coordinated care –
    - Increase collaboration between medical, dental, dental hygiene, nursing and dental assistant training schools.
    - Increase opportunities for continuing education for children's primary care providers to enhance their comfort and implementation of protocols to conduct dental screenings, apply fluoride varnish, verify dental homes and make appropriate referrals as standard care.
    - By 2020, 100% of pediatricians will routinely refer children to a dentist.

During the 2015 Legislative Session, budgets were built for the next biennium. The Oral Health Program's budget was developed with one time money to fund two contract positions during the 2017 State Fiscal Year (July 1, 2016 – June 30, 2017). These positions are for a State Dental Health Officer and a State Public Health Dental Hygienist. During the coming year and when the funds for the positions are available, considerable planning will be done to identify additional funding opportunities and mechanisms to re-build the Oral Health Program and address this vital public health area. Position studies will be done to outline and justify duties for these two new positions.
The Oral Health Program is aware of the new Title V transformation and has included in its strategic plan how to address the new National Outcome Measures (NOMs) and National Performance Measures (NPMs) that relate to oral health. The new NPM for oral health is NPM 13 which is two-fold:
NPM 13A) the percentage of women who had a dental visit during pregnancy, and
NPM 13B) the percentage of children, ages 1 through 17, who had a preventive dental visit in the last year.
Data for NPM 13A will be derived from the Pregnancy Risk Assessment Monitoring System (PRAMS) and realizing that Nevada is not a PRAMS state, this performance measure was not chosen by the MCH Program. However, brainstorming sessions are underway to explore other sources that can be utilized to get data for this measure.
Nevada Title V is keen on implementing the new broad paradigm, the Life Course Perspective, as a framework for

which Nevada might reduce racial and ethnic disparities in oral health. In addition, Title V recognizes that oral disease has a significant impact on the health of MCH populations and talks between the MCH Program and the Oral Health Program are ongoing to make this NPM a State Performance Measure (SPM) in 2016 when states will be required to choose SPMs.

Health Care Access/ Health Care Workforce

The most recent, publicly available data for both children and adults in Nevada is from 2012. Thus, it will be a few more years before the state can fully evaluate the effects of the ACA on our population. Insurance coverage was expanded on January 1, 2014 when Nevada Medicaid and Nevada Checkup enrolled increased by 115,000. The Silver State Health Insurance Exchange had 73,000 enrollments. Nevada projects that by 2020, the insurance coverage expansion will yield an additional 197,000 Medicaid & Nevada Checkup enrollees, Silver State Health Insurance Exchange, 141,000 and Employer-Sponsored Plans & Medicare will have 256,000 enrollees (Griswold, 2015). However, these increases will have an upsurge in health workforce demand. Over the years, Nevada has faced persistent specialty shortages as well as geographic disparate distribution of physicians and the problem is compounded by an aging health workforce, a resultant ACA-related demand, and a rebounding economy.
Nevada Title V collaborates with the Primary Care Office (PCO) to fund a Coordinator position within the same bureau of the Title V Program. The PCO supports the Division of Public and Behavioral Health's mission to promote the health of Nevadans by expanding the use of J-1 Visa Waiver/Health Professionals in shortage areas across the state to:

- Improve access to primary health care services for Nevada's underserved;
- Increase availability of primary care providers in underserved areas;
- Increase access to maternal and child health care service for underserved populations; and
- Improve provider access to health care financing resources.

In 2014, the PCO Manager coordinated a statewide project to map requirements and challenges for behavioral health professionals throughout the pipeline, including: education and training, certification and licensure, Medicaid and Medicare reimbursement, state personnel classification, and eligibility for loan repayment and scholar programs. Over 50 participants were engaged from the Division of Public and Behavioral Health, Division of Health Care Financing and Policy (State Medicaid), Nevada System of Higher Education, multiple licensing boards and professional associations. All licensed behavioral health professionals were represented, including: Psychiatrists, Psychologists, Advance Practice Registered Nurses (APRNs), Psychiatric Nurses, Licensed Clinical Social Workers, Marriage and Family Therapists, Clinical Professional Counselors, and Licensed Alcohol and Drug Counselors.
A series of recommendations were developed and presented to multiple stakeholders throughout the state, including: State Medicaid, Governor's Workforce Investment Board/Health Care and Medical Services Sector Council, Nevada Division of Human Resources Management, and Individual Licensing Boards. Many recommendations have been implemented or are in progress, including the following:
1) Psychology intern program established under Division of Public and Behavioral Health (DPBH) with Western Interstate Commission for Higher Education (WICHE) to support four interns per year and develop accreditation
2) Partnership with Orvis School of Nursing and WICHE to support Registered Nurses (RNs) and APRNs at DPBH to advance training for Psychiatric Nursing
3) Medicaid rate increase for APRN's included in Governor's Recommended Budget
4) Policy drafted and under review for upgrade for Licensed Alcohol and Drug Counselors to improve Medicaid reimbursement
5) Expanded Medicaid reimbursement for tele-health to include urban-to-urban sessions
6) Provider listings are now available online on the state Medicaid website
7) Contact list expanded to licensing boards and additional training programs for notification of changes to Medicaid reimbursement; and
8) Ongoing work with licensing boards to expedite process and support health care workforce expansion.

A budget concept has been approved by the state Legislature to expand the PCO by 2 positions to continue this work and expand recruitment and retention efforts. Throughout 2014, the PCO updated dozens of Health Professional Shortage Area designations, and gained several new designations, including Medically Underserved Area/Population designations which supported applications for Federally Qualified Health Centers-New Access Points which were recently awarded. Dozens of site applications were reviewed and approved for National Health Service Corps, expanding eligibility for loan repayment and scholar programs.

References:

Griswold, T. (2015). Health Care Workforce Issues in Nevada. Office of Statewide Initiatives, University of Nevada School of Medicine.

Other Programmatic Activities

Title V funds the Suicide Prevention Coordinator position in the Office of Suicide Prevention (OSP) to carry out various programmatic activities including:

School-Based Screening: In 2014, OSP has established sustainable screening programs in Lyon, Washoe, Storey, Nye and Pershing counties through partnerships with the Children's Cabinet, Community Chest, Healthy Communities Coalition, Nye Community Coalition and the Frontier Community Coalition. These community coalitions have been funded and mentored to the point of sustaining their local screening programs annually with their local school districts. Served: 615 youth screened Achievement: 173 (28%) scored positive for behavioral health or suicide risk concerns; 74 (12%) referred to mental health services; Follow-up continues to occur but follow-up screening could not happen due to logistics of school schedules. Follow up continues one-on-one through phone calls or home visits.

Reducing Access to Lethal Means: OSP educated over 3,300 state firearm owners in firearm security and safety, to include gun shop and shooting ranges employees in Suicide Alertness and Intervention skills. We have also supplied electronic firearm securing and safety brochures to 85% of the states middle and high schools, in order to educate parents of at risk students about suicide-proofing their homes.

Training: OSP in collaboration with the Nevada Coalition for Suicide Prevention provided training on suicide intervention and alertness training to Nevadans. Training was done through media and news outlets.

The Nevada Department of Education received a Project Aware grant to bring school-based mental health and Youth Mental Health First Aid to Nevada. OSP will be coordinating the Youth Mental Health First Aid (YMHFA) component to increase mental health literacy and reduce stigma for youth and their families.

Title V funds the Suicide Hotline which is managed by Crisis Call Center. In 2014, through the expansion of text messaging and hotline awareness, the Office of Suicide Prevention increased awareness to promote help-seeking behaviors and access to suicide prevention information, resources and crisis intervention services for youth and adults, with 40,508 contacts to the hotline.13,064 of those were text messages. About 20% of all contacts are from youth under nineteen years.

Service Members, Veterans and their Families: OSP has partnered with the Nevada National Guard, the VA and the Office of Veterans Policy to greatly increase and enhance suicide prevention efforts for SMVF. In a unique collaboration of service member/civilian training teams, we have reached over 200 soldiers and airmen in *ASIST* or *safeTALK*, including the Adjutant General and over 80% of his leadership staff. We have also increased our training team to include 6 Nevada National Guard members and two VA staff members to work as military/veteran training teams.

In 2016, OSP plans to implement the following goals:

Goal 1: Strengthen and expand community-based suicide prevention and post-vention programs

Goal 2: Improve coordination and implementation of professional training programs for all healthcare providers due to passage of AB 93.

Goal 3: Coordinate and expand statewide monitoring capacity for suicide and non-fatal attempts.

Goal 4: Reduce access and greater awareness of lethal means.

Early Childhood Advisory Council (ECAC)

Nevada Expanding Opportunities (NEO), funded by the Nevada Department of Education officially created the Early Childhood Advisory Council (ECAC) subcommittee and brought an additional level of commitment and excitement to the initiative. Nevada's Early Childhood Advisory Council (ECAC) is one of 19 Councils, Committees and Commissions that is overseen by Nevada Department of Education,(NDE) the State Board of Education and Career and Technical Education. ECAC acts as an advisory body to the State Superintendent of Public Instruction, who may present any ECAC findings and recommendations concerning all things related to the Nevada's Early Childhood Comprehensive System to the Office of the Governor. ECAC continued to provide support for attendance at NEO meetings when other resources were unavailable.

II.F.2 MCH Workforce Development and Capacity

State and Division Staff Training

The State of Nevada has an Online Professional Development Center (https://nvelearn.nv.gov). Any State of Nevada agency, commission or board is able to create courses that serve the training needs of employees (including employees from other Divisions/Departments) or constituents on the website. The courses help to enhance the employee's professional careers as well as help them to further their education and job-related skills. Depending on licensure requirements of certain personnel, trainings can also be used to receive continuing education credit. Some courses offered on this website include an overview of various agency policies & procedures, domestic violence training, learning signs of Autism, analysis and tracking of assigned legislative bills, concepts of self-confidence and communication skills to deal with difficult behavior, how to recognize and identify ethical/unethical behavior among others.

DPBH employees participate in workforce development offered by federal agencies, academic institutions, and professional organizations, State Programs etc. DBPH also implements in-service trainings to keep its employees skills up to date.

MCAH Staff Training

Nevada MCAH staff participated in several workforce development opportunities in 2013-2014. The trainings were either local or national via different mechanisms such as in-person, conference calls, webinars, etc. Training and conferences were on various topics and the purpose was to increase knowledge and information in their respective job functions as well as to meet programmatic needs. Some of the trainings attended are highlighted below.

The Division of Public and Behavioral Health has two annual trainings on grant management and MCAH staff that attended gave rave reviews about the format as well as the value of the information they received from the training.

Several program staff attended a GIS webinar series. The GIS trainings covered topics such as *Geocoding Data and* making maps using *ArcGIS*. Staff were very appreciative of these trainings and are now able to use the skills from the training to create maps. In public health, maps are vital in helping users to visualize and interpret data which in turn leads to a better understanding of the relationships, patterns, and trends of diseases or health conditions.

Staff attended a workshop on, "*Census Data for Grant Writers Workshop- Using U.S. Census Data in Local Communities.*" In addition *Grant Writing or Grant Management Courses* were offered by the same agency. The primary goal of the training was to increase the understanding of U.S. Census data and tools available for researching local trends and elements in our community. The workshop was interactive and attendees were appreciative of the skills they gained from the training.

Program staff attended a series of virtual trainings hosted by AMCHP on Title V Five Year Needs Assessment. The trainings provided guidance on the needs assessment process. Some of the topics covered in the trainings included: an overview of the needs assessment process, Nuts and Bolts of the Five Year Needs Assessment, using data in the needs assessment process, how to engage stakeholders in the needs assessment process and selecting state priorities. The trainings also provided an opportunity for attendees to learn about other state's data strategies, resources and lessons learned from conducting the five-year needs assessment process.

Two MCH staff received scholarships to attend a two-part training the Maternal Mortality Review Data System

(MMRDS). The MMRDS standardizes information collected by maternal death reviews and defines a core set of information that all users collect using a free software package (Epi Info 7). The purpose of MMRDS is to:

- Serve as a data abstraction tool
- Support case summary development
- Document committee findings and recommendations
- Support analysis (internal to Epi Info and through exported data)

After the MMRDS training, MCH staff shared information with our partners in Washoe County FIMR team and Suicide Prevention Mortality Review team.

EHDI program staff participated in various training and workforce development opportunities discussed below:

Early Hearing Detection and Intervention Annual Meeting: The annual meeting is for all state EHDI programs, both federal grantors, the national EHDI technical assistance center, all players in the EHDI continuum (hospitals, audiologists, physicians, early interventionists), and parents of deaf or hard of hearing children. The purpose is to train and education all to raise the EHDI bar. Nevada EHDI presented at this conference on the topic: *EHDI Collaborative Activities that Support Timely and Appropriate Early Intervention*

American Academy of Pediatrics Conference - Nevada Chapter: Conference for Nevada pediatricians and other interested physicians and healthcare professionals which covers a variety of topics of local and/or national interest for pediatricians. Nevada EHDI presented at this conference on the topic: *Nevada EHDI overview and directions.*

SKI-HI Institute training: SKI-HI Institute provides a curriculum and staff training on how to work with infant/kids who are deaf or hard of hearing. This training is geared for those working in Early Intervention, IDEA Part C Offices, and EHDI services.

Webinar trainings on program quality improvement processes and program evaluation.

Training on the Web Enabled Vital Records Registry System (WEVRRS) which is Nevada's vital records database. Training was received on data importing, exporting, and table maintenance.

Statistical Analysis System (SAS): Training included: programming, essentials, data manipulation, statistical concepts, and statistics (ANOVA, regression, and logistic regression).

Home Visiting Staff attended the Tri-regional Joint Meeting in San Francisco to provide updates on MIECHV. The updates included data, reflective supervision, model updates among others. Staff also attended the Pew Summit on Quality in Home Visiting. The purpose was to receive information on MIHOPE evaluation initial findings, changes in Discretionary Grant Information System (DGIS) reporting and opportunities for collaboration. In addition, staff attended the Nevada Home Visiting fall summit conference and participated in weekly webinars from the technical assistance center for MIECHV programs.

Rape Prevention and Education (RPE) staff attended two consecutive conferences in 2014; RPE Leadership Conference and the National Sexual Assault Conference in Pittsburgh, Pennsylvania. In addition to annual conferences, webinars and conference calls provided ongoing technical assistance and training to RPE staff for developing, implementing, and evaluating statewide strategies for sexual and domestic violence prevention, and for the purpose of accomplishing objectives under the RPE cooperative agreement.

Cultural competence

MCAH staff attended training on *cultural competence in the primary care setting* in July, 2014. The training was organized by the Nevada Geriatric Education consortium in conjunction with Nevada AIDS education and Training center, University of Nevada School Of Medicine, UNLV Division of Health Sciences among others. The training was at no cost to attendees and CME and CE credits were offered.

The objectives of the training were to:

- Discuss the importance of cultural competence as a key service delivery tool in addressing health disparities in the primary care setting as it relates to disabilities, HIV and aging.
- Examine the culturally and linguistically appropriate services (CLAS) Standards, its components and relevance in the primary care setting as it relates to disabilities, HIV and aging.
- Identify applicable strategies that may be applied to specific service delivery in the primary care setting as it

relates to disabilities, HIV and aging.

II.F.3. Family Consumer Partnership

In the needs assessment process, MCH engaged stakeholders to brainstorm the top health concerns for Nevada's women, children, including children with special health care needs, solutions to those concerns, and to select National Performance Indicators to measure progress related to each of the MCH domains. Approximately 164 stakeholders responded to the needs assessment survey and 25 participated in focus groups held in different parts of the state. The stakeholders worked for a variety of non-profit, for-profit, and governmental agencies serving the needs of women and their children in their communities. MCH reached out to consumers and families to get feedback on their top health concerns, accessibility of services, interactions with providers, experience with health insurance, as well as awareness and experience with government funded service programs. Consumers included women with children who were primarily under or uninsured, had children with special needs, or utilized government funded social service programs such as WIC, SNAP or TANF. Approximately 105 consumers completed the needs assessment survey and 24 participated in focus groups.

The State Board of Health appoints a consumer to represent CYSHCN in the MCH Advisory Board. Inclusion of the CYSHCN consumer representative is imperative in providing information on various issues affecting CYSHCN such as family centered care, medical home, transition among others. This input is valuable in the planning, development and evaluation of programs targeting CYSHCN.

One of Title V partners, Nevada TACSEI, employs a Family Engagement Coordinator to facilitate parent involvement in the social emotional Pyramid Model activities.

II.F.4. Health Reform

Legislation and Governance

Governor Brian Sandoval signed SB 440 into law on June 16, 2011 establishing the Silver State Health Insurance Exchange (SSHIX) also known as Nevada Health Link www.nevadahealthlink.com. The Marketplace is governed by a 10-member board, including three ex officio, non-voting members (or their designees): the Director of the Department of Health and Human Services, the Director of the Department of Business and Industry, and the Director of the Department of Administration. The Governor appoints five of the voting members, while the Senate Majority Leader and the Speaker of the Assembly each appoint one voting member. According to the legislation, that voting members are required to have subject expertise in areas such as: individual or small employer health insurance markets; health care administration, financing, or information technology; health care delivery system administration; or experience of consumers that would benefit from the Exchange. Voting members cannot be Legislators or hold an elected office in Nevada state government, nor can they be affiliated with, have ownership interest in, or be a representative of a health insurer.

Contracting with Plans

In April 2013, the Board developed network adequacy ratios and travel standards congruent with county and provider specialty and in 2014, four carriers were offering Qualified Health Plans (QHPs) on Nevada Health Link. Individual market QHPs are required to be in place for one year and any changes to the plans can only be made before the open enrollment period. Carriers are allowed to use telemedicine to meet these accessibility requirements. In addition, Carriers are required to make their provider directories accessible to the Exchange for online publication and if requested, provide enrollees with a hard copy.

Eligibility Criteria

The following requirements must be fulfilled in order to enroll in a qualified health plan (QHP) in Nevada:

- Legal resident of Nevada
- Not incarcerated

To qualify for a tax credit the following is required:

- File taxes (if married, file jointly)
- Be enrolled in a QHP
- Income below 400% FPL

Consumer Assistance and Outreach

SSHIX was publicized to the target audience through various channels including TV and Cable Spots, digital media, radio and print. The target audiences were uninsured individuals in the 138-400% Federal Poverty Level including Hispanics (ages 18-54), younger families with children (ages 18-34) and predominantly young males (ages 21-29). Aggressive marketing of the exchange was from July 2013 through March 2014. Navigators, Enrollment Assisters, Certified Application Counselors (CACs) are on hand to assistance to consumers when applying for and choosing new insurance through the SSHIX Marketplace. SSHIX was also publicized by DPBH as well as MCH partners and stakeholders. In 2013, MCAH staff presented an overview of how ACA relates to MCH populations in Nevada at the March of Dimes Women's Health Symposium. The regional and Statewide MCH Coalitions displayed Affordable Care Act information on their websites and disseminated information on the locations and contact numbers of the Navigators, Enrollment Assisters and CACs widely.

Since Nevada implemented coverage in 2013 under the Affordable Care Act (ACA), the percentage of Nevadans that were still uninsured fell to 12% in July 2014 (Nevada Health and Human Services). By, December 2014, this percentage had further declined to 11%. This is a significant decrease from the second highest uninsured rate in the US at 20.7% in 2012. In addition, statewide Medicaid expansion enrollments increased by 71.5 percent to over 573,000 by the end 2014. This translates to over one-fifth (21.2%) of the state's population on Medicaid compared to approximately 10% in 2013.

This upsurge in the number of insured individuals creates higher demand for health care services and magnifies an already existing problem of workforce shortages. Title V is responding to these issues through various initiatives and collaborative ventures with partners and stakeholders.

To address Nevada's physician shortage, the state has developed recruitment and retention plans of critical health care providers. The Primary Care Office (PCO), housed in the Division of Public and Behavioral Health, provides support for National Health Service Corps (NHSC) loan repayment and scholar programs, and the J-1 Physician Visa Waiver and National Interest Waiver policies. In addition, the PCO maintains contact with all safety net providers to update information on the health care workforce, conduct outreach and technical assistance regarding program opportunities and requirements, and to ensure requirements are met.

Title V will continue to fund the Community Health Workers to ensure Hispanics with incomes between 138-400% FPL are reached through marketing and outreach campaigns. In addition, education on Nevada's Essential Health Benefits will be provided to this population. Other MCH-related outreach, education and referral coordination activities will involve collaborative efforts with MCH Coalitions, providers, state and local agencies, non-profit organizations and other stakeholders.

II.F.5. Emerging Issues

Mental Health

There is a growing need for mental and behavioral health services in Nevada. Gov. Brian Sandoval created a Nevada Behavioral Health and Wellness Council to develop recommendations to improve the system that might be acted on by the 2015 Legislature. Members of the council include members of law enforcement, judges, legislators, mental health and budget experts. Preliminary findings from the council indicate shortage of space to admit mentally ill individuals in Rawson-Neal, the state's largest Psychiatric Hospital as well as other hospitals. Plans are underway to add more beds to the Rawson-Neal psychiatric Hospital in Las Vegas as well as track other barriers to effectively meet the needs of people who are a danger to themselves or others. However, some Nevadans with mental and

behavioral health disorders are concerned about timely access to care and a lack of qualified providers.

Immigration

Nevada is becoming more and more diverse as immigrants from around the globe settle in the state. As a result, health outcomes and the associated medical issues may be influenced by social or cultural backgrounds. Thus cultural competency is vital in developing effective healthcare practices and policies. Most foreign-born Nevadans come from places like Latin American regions and countries such as Central America (52%), Mexico (44%), and the Caribbean (3.2%); Asian countries such as the Philippines (14%) and China (4%). Nevada's Hispanic/Latino population significantly increased (by 81.9 percent) from 393,970 in 2000 to 716,501 in 2010, (United States Census Bureau, 2012). This population is expected to continue to grow and is projected to increase to 838,788 by 2017 (Nevada State Demographer's Office, 2012). The 2014 Pew Research Center study showed that Nevada had the highest number of undocumented immigrants in 2012 at 7.6% of its total population compared to 3.6% nationally. In the same study, Nevada was estimated to have the highest number of undocumented immigrants in the nation constituting up to 10% of its labor force and with nearly one-fifth (18%) of students having at-least one undocumented parent.

Title V funds and works closely with Community Health Workers (CHWs) who provide outreach to the Hispanic population. The CHWs speak Spanish and because they come from the same communities, they are able to put various cultural aspects into perspective when implementing public health programs. In addition, program materials, resources, websites and PSA's are provided both in English and Spanish.

Health Care Access in Rural Nevada

In Nevada, 14 out of 17 counties are classified as rural and frontier and designated as federal shortage areas. Even though majority of the state's population lives in the urban areas (Clark and Washoe County), residents who live in the rural counties have poor access to public and health care services due to the vast distance from areas that provide services and a sheer lack of providers.

Some of the initiatives that MCH is currently involved in to address the need for providers in the rural areas include:

a. Telemedicine

The Nevada Broadband Telemedicine Initiative (NBTI) works in conjunction with University of Nevada Medical Center to brings videoconferencing, telemedicine applications, and other crucial tools to healthcare providers in the northern region of the state, where four hospitals do not currently have high-capacity broadband services, as well as bolster services to the south and east of Carson City. The project also partners with the Nevada System of Higher Education to bring enhanced capacity to two community colleges, six universities, and many K- 12 schools throughout Yerington, Fallon, Pahrump, and Hawthorne. The University of Nevada Medical Center cares for the largest percentage of poor and uninsured patients in the state, as well as the Indian Health Board of Nevada, which represents 13 tribal medical facilities.

Nevada Telemedicine Conference was held in September, 2014 and had the following objectives:

- Familiarize participants with need for telemedicine in improving patient care during patient transport or remote locations.
- Familiarize participants with available technologies for providing telemedicine during patient movement or remote locations.
- Present and discuss legislative issues related to telemedicine in remote/mobile applications of telemedicine.
- Present and discuss data needs and flows in telemedicine
- Familiarize participants with positive features of Nevada related to telemedicine development.
- Present comparison of Military and civilian patient management.
- Present and discuss issues related to the cross - sharing of telemedicine technology and processes between DoD and Civilian markets
- Establish telemedicine board.

b. Collaboration with Nevada Primary Care Office

Title V provides funding to some of the staff at the Primary Care Office (PCO) and also collaborates with the program

on various activities to increase health care access in the underserved areas of the state. PCO provides J-1 Physician Visa Waiver and National Interest Waiver programs to bring foreign-trained physicians to underserved areas in Nevada. This is of particular interest to MCH as more Nevadans are now insured with the implementation of the Affordable Care Act and Medicaid Expansion.

II.F.6. Public Input

Public input on the MCH Block Grant application and report was conducted similar to previous years. The initial draft and subsequent revisions of the MCH Block Grant was posted on the Division of Public and Behavioral Health website and public feedback was collected through an electronic survey mechanism provided on the same website. Specifically, Nevada's large network of MCH partners and stakeholders including the MCH Advisory Board, MCH regional and statewide coalitions, and the public were notified by email of the availability of the application/report and asked to provide feedback. In addition, announcements on the availability of the draft for review were made at conferences and subcommittee meetings convened with topic area experts. Also, ongoing feedback during quarterly meetings of the Nevada Maternal and Child Health Advisory Board is solicited to identify activities addressed in the MCH Block Grant. Nevada Title V/ MCH program strives to involve families and consumers in programmatic activities by collaborating with programs and agencies at the state and local level. Realizing they bring with them diverse backgrounds and expertise, MCH seeks feedback from families, consumers and stakeholders in the development and implementation of the program activities. Most of our partners reach consumers and families through emails sent via a listserv. The input received from partners and families is used to modify the application where necessary and to ensure quality and appropriateness of the strategies.
To expand upon the last needs assessment process, MCH utilized a planning committee to guide in the strategic planning process as well as in the implementation of the needs assessment. The current needs assessment used electronic surveys which were critical in reaching populations in the rural and frontier areas of the state as well as in reaching a large number of stakeholders and consumers. To avoid duplication and maximize efforts, needs assessments that had been recently conducted by various entities in the state were used to inform the MCH needs assessment.

II.F.7. Technical Assistance

Nevada is continually faced with inequitable disparities in health outcomes in its population. As a result, the MCH Program intends to employ population-based solutions that address the social, economic, environmental and cultural determinants that shape health-related behavior. A growing body of work has shown that the life course perspective can potentially address and improve persistent differences in health across the population. Thus, Nevada MCH welcomes technical assistance (TA) in developing Life Course Metrics to address social determinants of Health associated with racial/ethnic disparities in birth outcomes as well the associated risk factors. The TA will encompass assistance with staff training on data collection, evaluation and capacity building. Ultimately, these skills will supplement staff's ability to provide reliable and valid information to program managers, stakeholders and partners.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 1,747,990	$ 1,716,274	$ 1,752,177	$ 1,760,014
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 1,310,993	$ 1,287,206	$ 1,314,133	$ 1,320,011
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 3,058,983	$ 3,003,480	$ 3,066,310	$ 3,080,025
Other Federal Funds	$ 12,796,679	$ 12,796,679	$ 12,830,824	$ 12,830,824
Total	$ 15,855,662	$ 15,800,159	$ 15,897,134	$ 15,910,849

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 1,716,274	$ 1,998,800	$ 1,960,060	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 1,287,206	$ 1,499,100	$ 1,470,045	$
Local Funds	$ 0	$ 0	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 3,003,480	$ 3,497,900	$ 3,430,105	$
Other Federal Funds	$ 18,005,000		$ 76,074,243	$
Total	$ 21,008,480	$ 3,497,900	$ 79,504,348	$

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

	2016	
	Budgeted	Expended
Federal Allocation	$ 1,998,800	$
Unobligated Balance	$ 0	$
State Funds	$ 1,499,100	$
Local Funds	$ 0	$
Other Funds	$ 0	$
Program Funds	$ 0	$
SubTotal	$ 3,497,900	$
Other Federal Funds	$ 56,588,684	$
Total	$ 60,086,584	$

III.A. Expenditures

Federal Fiscal Year 2016 Application - Expenditure Narrative

In FFY 2014, the Nevada MCH program will expend $1,998,800 in federal funds and $1,499,100 in state match funds for a total of $3,497,900. The federal allotment of $1,998,800 exceeded the budget request of $1,716,274 by $282,526 (16.5%) requiring a proportionate increase in overall expenditures. The state match funds will be comprised of $1,192,843 from the State General Fund and $306,257 from the Fund for a Healthy Nevada. FFY 2014 state match funds expended will be adequate to meet Nevada's maintenance of effort amount of $853,034.

Budgeted vs. Expended by Types of Individuals Served:

The FFY 14 budget for Children 1 – 22 years old was 17.1% of the $1,716,274 award. Additional expenditures were required to meet the mandated 30% requirement for Preventative and Primary Care for Children. Expenditures for Pregnant Women, Infants < 1 yr old. and Others were reduced to make the appropriate level of funding available.

Pregnant Women:

Budget: $445,131
Expended: $263,197
Variance: Expenditures are 40.9% less than budget

Infants <1 year old:

Budget: $866,825
Expended: $724,940
Variance: Expenditures are 16.4% less than budget

Children 1 to 22 years old:

Budget: $514,882
Expended: $1,053,953
Variance: Expenditures are 104.7% more than budget

Children with Special Healthcare Needs:
Budget: $933,330
Expended: $1,077,742
Variance: Expenditures are 15.5% more than budget
Others: (Women of Childbearing Age):
Budget: $71,685
Expended: $52,019
Variance: Expenditures are 27.4% less than budget
Administration:
Budget: $171,627 (10% of $1,716,627)
Expended: $176,139 (8.8% of 1,998,800)
Variance: Expenditures are 2.6% more than budget
Budgeted vs. Expended by Types of Services:
In response to direction received, Nevada moved budgeted funds from Direct Health Care Services to Enabling Services increasing expenditures within that service level significantly and creating the following variances between budgeted and expended:
Direct Health Care Services:
Budget: $120,595
Expended: $0
Variance: Expenditures are 100% less than budget
Enabling Services:
Budget: $589,851
Expended: $1,330,459
Variance: Expenditures are 125.6% more than budget
Public Health Services and Systems:
Budget: $2,293,034 (combined Population-based & Infrastructure Services)
Expended: $2,167,441
Variance: Expenditures are 5.5% less than budget

III.B. Budget

Federal Fiscal Year 2016 Application – Budget Narrative
The total estimated Federal Fiscal Year FFY 2015 Maternal Child Health (MCH) budget is $3,497,900. As required, the state of Nevada's FFY 2016 application budget adheres to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget purposes, at $1,998,800. State matching funds are budgeted at $1,499,100 and are comprised of State General Funds, $1,192,843, and Funds for a Healthy Nevada, $306,257. The amount of state funds that will be used to support Maternal and Child Health programs in FFY 2016 is shown in the budget documentation of the state application. We assure that the $853,034 maintenance of effort requirement (FY89 level of state funding) will be satisfied.
For FFY 2016, $599,640, 30% of the federal Title V allocation, is budgeted for Preventive and Primary care of Children and Adolescents. An equal amount, 30% of the federal Title V allocation, is budgeted for Children and Youth with Special Healthcare Needs.Administrative costs for Federal Fiscal Year 2016 are budgeted at $199,880, 10% of the MCH allotment. Administrative expenditures will not exceed this amount.

The remaining FFY 2016 Federal Title V award is directed towards services for pregnant women, postpartum women and infants up to age 1 year as well as other activities supporting MCH populations throughout the state.

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

Other Federal Funds

Nevada's Title V Program is housed in the Bureau of Child, Family, and Community Wellness. The Bureau also administers the following federal grant programs/funding streams totaling $56,588,684 in FFY16. All federally funded programs referenced below provide indirect and direct services to the populations served by the Maternal and Child Health Block Grant Program.

Administration for Children and Families:

Abstinence Education
Personal Responsibility Education

Centers for Disease Control and Prevention:

Rape Prevention and Education
Early Hearing Detection
Diabetes
Tobacco
Cancer Prevention and Control Programs
Immunization

Preventative Health and Health Services

Sexual Assault

Health Resources and Services Administration

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

United Department of Agriculture

Women, Infants and Children

Budget by Types of Individuals Served

In FFY 2016, the Nevada MCH program is budgeting the following federal and state match funds towards the individuals served requirements:
Pregnant Women - $395,931
Infants < 1 year old - $663,376
Children 1 to 22 years old - $993,449
Children and Youth with Special Healthcare Needs - $988,675
Others - $106,679

Budget by Types of Services

Nevada no longer allocates funds to direct health care (DHC) services and only budgets for Enabling Services and Public Health Services and Systems.

In FFY 2016, the Nevada MCH program plans to allocate federal and state match funds as follows:
Direct Health Care Services - $0
Enabling Services - $1,439,392
Public Health Services and Systems - $2,058,508

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Updated MOA - final draft.pdf

V. Supporting Documents

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

Supporting Document #01 - Maternal, Child and Adolescent Health Organization Chart, June 2015.pdf

Supporting Document #02 - Nevada NPM NOM Narratives.pdf

Supporting Document #03 - NV MCH Title V Strategic Action Plan 16-20.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Nevada

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 1,998,800	$ 1,998,800
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 599,640	$ 604,926
B. Children with Special Health Care Needs	$ 599,640	$ 636,556
C. Title V Administrative Costs	$ 199,880	$ 176,139
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 1,499,100	$ 1,499,100
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 0	$ 0
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 1,499,100	$ 1,499,100
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 853,034	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 3,497,900	$ 3,497,900
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 56,588,684	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 60,086,584	$ 3,497,900
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 1,716,274
A. Preventive and Primary Care for Children	$ 514,882
B. Children with Special Health Care Needs	$ 514,882
C. Title V Administrative Costs	$ 171,627
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 1,287,206
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 1,287,206

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	$ 405,035
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program;	$ 428,321
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs;	$ 125,813
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant;	$ 396,046
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 1,050,524
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention;	$ 255,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and	$ 358,623

Education (RPE) Program;	
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations;	$ 2,083,359
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC);	$ 47,259,474
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Cancer Control;	$ 920,113
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Screening;	$ 500,785
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Home Visit Expan;	$ 1,126,895
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Tobacco Control;	$ 856,207
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Diabetes Control;	$ 48,865
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Billing Imp Project;	$ 488,999
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > III Enhancement;	$ 284,625

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Total award of $1,998,800 was 16.5% higher than the $1,716.274 we submitted for the FFY14 budget. This increased the target for Preventative and Primary Care for Children to $599,640.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Total award of $1,998,800 was 16.5% higher than the $1,716.274 we submitted for the FFY14 budget. This increased the target for Children with Special Healthcare Needs to $599,640.	
3.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: We requested $1,716,274 for FFY 14 with $1,287,206 (30%) budgeted for State MCH Funds. The amount awarded for FFY 14 was $1,998,800 which increased the required expenditures for this category to $1,499,100. We were able to satisfy the higher match requirement.	
4.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Total award of $1,998,800 was 16.5% higher than the $1,716.274 we submitted for the FFY14 budget. We were able to meet the increased target amount.	

Data Alerts:

None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Nevada

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 232,760	$ 178,751
2. Infants < 1 year	$ 323,706	$ 380,604
3. Children 1-22 years	$ 599,640	$ 604,926
4. CSHCN	$ 599,640	$ 636,556
5. All Others	$ 43,174	$ 21,824
Federal Total of Individuals Served	$ 1,798,920	$ 1,822,661
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 163,171	$ 84,446
2. Infants < 1 year	$ 339,670	$ 344,336
3. Children 1-22 years	$ 393,809	$ 449,028
4. CSHCN	$ 389,035	$ 441,187
5. All Others	$ 63,505	$ 30,194
Federal Total of Individuals Served	$ 1,349,190	$ 1,349,191
Federal State MCH Block Grant Partnership Total	$ 3,148,110	$ 3,171,852

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b

Budget and Expenditure Details by Types of Services

State: Nevada

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 799,520	$ 690,586
3. Public Health Services and Systems	$ 1,199,280	$ 1,308,214
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 0
Federal Total	$ 1,998,800	$ 1,998,800

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 639,873	$ 639,873
3. Public Health Services and Systems	$ 859,227	$ 859,227
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 0
Non-Federal Total	$ 1,499,100	$ 1,499,100

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Nevada

Total Births by Occurrence 35,074

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
3-Methylcrotonyl-CoA carboxylase deficiency	34,029 (97.0%)	8	1	1 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	34,029 (97.0%)	15	2	2 (100.0%)
Classic phenylketonuria	34,029 (97.0%)	7	2	2 (100.0%)
Tyrosinemia, type I	34,029 (97.0%)	3	1	1 (100.0%)
Primary congenital hypothyroidism	34,029 (97.0%)	276	20	20 (100.0%)
Congenital adrenal hyperplasia	34,029 (97.0%)	8	2	2 (100.0%)
S,S disease (Sickle cell anemia)	34,029 (97.0%)	11	10	9 (90.0%)
S,C disease	34,029 (97.0%)	9	8	2 (25.0%)
Biotinidase deficiency	34,029 (97.0%)	12	5	5 (100.0%)
Cystic fibrosis	34,029 (97.0%)	202	2	2 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	34,029 (97.0%)	7	2	2 (100.0%)
Hearing loss	34,032 (97.0%)	448	29	29 (100.0%)

1b. Secondary RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Short-chain acyl-CoA dehydrogenase deficiency	34,029 (97.0%)	15	1	1 (100.0%)
Tyrosinemia, type II	34,029 (97.0%)	6	2	2 (100.0%)

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	34,032 (97.0%)	448	29	29 (100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

Once a case is acknowledged, the primary care physician (PCP) is contacted. As soon as contact is made with the PCP, the American College of Medical Genetics ACTion Sheet, diagnostic test information, and specialist contact information are sent to the PCP. At the same time confirmatory testing is requested. The reference lab is called again until the diagnostic results are received. If results are normal they are faxed to the PCP and the determination is closed. If positive results are confirmed, the PCP is contacted again for applicable treatment information. Once treatment information is received the determination is closed.\r\n\r\nChildren confirmed to have metabolic disorders are referred specialty metabolic clinics conducted monthly in Reno and Las Vegas through Early Intervention Services. These are conducted by Dr. Longo (Pediatric Metabolic Specialist) from University of Utah School of Medicine, Salt Lake City.

Form Notes For Form 4:

On July 1, 2014, the first day of the State Fiscal Year in 2014 (SFY14) the State of Nevada changed the laboratory used to perform newborn screening from the Oregon Public Health Laboratory (OPHL) to the Nevada Public Health Laboratory (NPHL). From January 1, 2014 to June 30, 2014 the following methodology was used by OPHL to follow-up on presumptive positive cases: From July 1, 2014 to December 31, 2014 the method used by NPHL: According to the University of Nevada, Reno, Nevada Public Health Laboratory, Newborn Screening program, the following methodology guidelines are used in presumptive positive cases. Once a case is acknowledged, the primary care physician (PCP) is contacted. As soon as contact is made with the PCP the American College of Medical Genetics ACTion Sheet, diagnostic test information, and specialist contact information are sent to the PCP. At the same time the reference lab is called to get the

Field Level Notes for Form 4:

1.	**Field Name:**	**Tyrosinemia, type II - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Transient	
2.	**Field Name:**	**Tyrosinemia, type II - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Secondary RUSP Conditions - Newborn**
	Field Note: Transient	

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Nevada

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	7,031	25.0	1.0	33.0	36.0	5.0
2. Infants < 1 Year of Age	35,449	10.0	3.0	54.0	20.0	13.0
3. Children 1 to 22 Years of Age	44,058	46.0	3.3	17.7	31.0	2.0
4. Children with Special Health Care Needs	5,570	42.5	1.2	37.7	12.6	6.0
5. Others	3,245	25.0	1.0	24.0	46.0	4.0
Total	95,353					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

None

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

State: Nevada

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	7,031
2. Infants < 1 Year of Age	35,449
3. Children 1 to 22 Years of Age	44,058
4. Children with Special Health Care Needs	5,570
5. Others	3,245
Total	95,353

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

None

Form 6

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

State: Nevada

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	34,943	26,558	3,685	291	2,323	194	0	1,892
Title V Served	7,031	5,344	741	59	467	39	0	381
Eligible for Title XIX	26,086	19,827	2,751	217	1,734	145	0	1,412
2. Total Infants in State	35,449	26,943	3,738	296	2,356	197	0	1,919
Title V Served	35,449	26,943	3,738	296	2,356	197	0	1,919
Eligible for Title XIX	11,362	8,636	1,198	95	755	63	0	615

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	22,015	12,579	349	34,943
Title V Served	4,430	2,531	70	7,031
Eligible for Title XIX	16,434	9,391	261	26,086
2. Total Infants in State	22,333	12,762	354	35,449
Title V Served	22,333	12,762	354	35,449
Eligible for Title XIX	7,159	4,090	113	11,362

Form Notes For Form 6:

None

Field Level Notes for Form 6:

None

Form 7

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

State: Nevada

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 429-2669	(800) 429-2669
2. State MCH Toll-Free "Hotline" Name	MCH Campaign	MCH Campaign
3. Name of Contact Person for State MCH "Hotline"	Laura A. Valentine	Deborah Aquino
4. Contact Person's Telephone Number	(775) 684-5901	(775) 684-3479
5. Number of Calls Received on the State MCH "Hotline"		1,727
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	Nevada 2-1-1	Nevada 2-1-1
2. Number of Calls on Other Toll-Free "Hotlines"		1,727
3. State Title V Program Website Address		
	http://health.nv.gov/MCH.htm	http://health.nv.gov/MCH.htm
4. Number of Hits to the State Title V Program Website		0
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Nevada

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Laura Valentine
Title	Title V/Maternal and Child Health Program Manager
Address 1	4150 Technology Way Suite 210
Address 2	
City / State / Zip Code	Carson City / NV / 89706
Telephone	(775) 684-5901
Email	lvalentine@health.nv.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Laura Valentine
Title	Title V/Maternal and Child Health Program Manager
Address 1	4150 Technology Way Suite 210
Address 2	
City / State / Zip Code	Carson City / NV / 89706
Telephone	(775) 684-5901
Email	lvalentine@health.nv.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Nevada

Application Year 2016

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

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Nevada

Form Notes for Form 10a NPMs and NOMs:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	68.4 %	0.3 %	22,159	32,417
2012	68.1 %	0.3 %	21,698	31,869
2011	66.8 %	0.3 %	21,445	32,113
2010	65.9 %	0.3 %	20,999	31,884

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data

	2014
Annual Indicator	68.5
Numerator	24,017
Denominator	35,074
Data Source	Birth Certificate Data
Data Source Year	2014

NOM-1 Notes:

Percent of infants born to pregnant women receiving prenatal care in the first trimester. Multiple births are not unduplicated.

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	127.4	6.2 %	419	32,885
2011	106.2	5.7 %	353	33,252
2010	111.9	5.7 %	380	33,973
2009	103.8	5.4 %	370	35,660
2008	102.2	5.2 %	381	37,283

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	10.6	2.4 %	19	178,783
2008_2012	9.8	2.3 %	18	183,259

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.0 %	0.2 %	2,810	35,028
2012	8.0 %	0.1 %	2,781	34,903
2011	8.2 %	0.2 %	2,906	35,289
2010	8.3 %	0.2 %	2,965	35,931
2009	8.1 %	0.1 %	3,046	37,604

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	8.3
Numerator	2,897
Denominator	35,074
Data Source	Vital Records
Data Source Year	2014

NOM-4.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data

	2014
Annual Indicator	1.4
Numerator	502
Denominator	35,074
Data Source	Vital Records
Data Source Year	2014

NOM-4.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

State Provided Data

	2014
Annual Indicator	6.8
Numerator	2,395
Denominator	35,074
Data Source	Birth Certificates
Data Source Year	2014

NOM-4.3 Notes:

Data is provisional. Nevada resident births only.

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.8 %	0.2 %	3,437	34,937
2012	10.4 %	0.2 %	3,598	34,742
2011	10.5 %	0.2 %	3,694	35,187
2010	10.9 %	0.2 %	3,791	34,842
2009	10.8 %	0.2 %	3,981	36,710

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data

	2014
Annual Indicator	10.0
Numerator	3,515
Denominator	35,074
Data Source	Birth Certificates
Data Source Year	2014

NOM-5.1 Notes:

Provisional data. Nevada resident births only.

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data

	2014
Annual Indicator	2.8
Numerator	974
Denominator	35,074
Data Source	Birth Certificates
Data Source Year	2014

NOM-5.2 Notes:

Provisional data. Nevada resident births only.

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:

Indicator has a numerator <10 and is not reportable

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

State Provided Data

	2014
Annual Indicator	7.2
Numerator	2,541
Denominator	35,074
Data Source	Birth Certificate
Data Source Year	2014

NOM-5.3 Notes:

Provisional data. Nevada resident births only.

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

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

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

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

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	6.0 %			

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

NOM-7 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8	0.4 %	202	35,131
2012	6.0	0.4 %	209	35,037
2011	6.7	0.4 %	237	35,433
2010	5.9	0.4 %	212	36,054
2009	5.8	0.4 %	220	37,718

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2014
Annual Indicator	5.8
Numerator	206
Denominator	35,289
Data Source	Vital Records
Data Source Year	2014

NOM-8 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.4 %	186	35,030
2012	4.9	0.4 %	172	34,911
2011	5.7	0.4 %	201	35,296
2010	5.5	0.4 %	198	35,934
2009	5.8	0.4 %	219	37,612

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	5.1
Numerator	178
Denominator	35,074
Data Source	Vital Records
Data Source Year	2014

NOM-9.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

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

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	3.6
Numerator	127
Denominator	35,074
Data Source	Vital Statistics
Data Source Year	2014

NOM-9.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				

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

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	1.8
Numerator	64
Denominator	35,074
Data Source	Vital Records
Data Source Year	2014

NOM-9.3 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2013	171.3	22.1 %	60	35,030

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	128.9	19.2 %	45	34,911
2011	167.2	21.8 %	59	35,296
2010	125.2	18.7 %	45	35,934
2009	175.5	21.6 %	66	37,612

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	71.4	14.3 %	25	35,030
2012	85.9	15.7 %	30	34,911
2011	68.0	13.9 %	24	35,296
2010	58.4	12.8 %	21	35,934
2009	93.1	15.7 %	35	37,612

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

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

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

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

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

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

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	18.1	2.3 %	60	331,294
2012	18.6	2.4 %	62	332,660
2011	19.5	2.4 %	65	333,347
2010	19.2	2.4 %	64	334,050
2009	20.9	2.5 %	70	334,461

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	28.8	2.8 %	104	361,031
2012	29.1	2.8 %	105	360,693
2011	41.1	3.4 %	148	359,993
2010	34.2	3.1 %	125	365,773
2009	36.7	3.2 %	134	365,053

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	10.4	1.4 %	55	531,349
2010_2012	11.0	8.4 %	59	536,826
2009_2011	11.6	8.9 %	63	541,615
2008_2010	14.1	11.2 %	77	544,431
2007_2009	17.2	13.8 %	92	536,460

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	9.6	7.2 %	51	531,349
2010_2012	8.9	6.6 %	48	536,826
2009_2011	8.9	6.5 %	48	541,615
2008_2010	5.7	3.9 %	31	544,431
2007_2009	6.5	4.5 %	35	536,460

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	7.7
Numerator	14
Denominator	182,418
Data Source	Vital Records
Data Source Year	2014

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

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

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2011_2012	14.9 %	1.3 %	98,638	661,419

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	14.5 %	1.3 %	96,530	664,311
2003	15.1 %	0.9 %	87,423	579,030

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

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

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.8 %	0.5 %	10,018	551,374
2007	1.0 %	0.4 %	5,460	549,728

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	4.1 %	0.7 %	22,251	548,383
2007	3.6 %	0.8 %	19,576	547,910

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	49.3 %	7.0 %	21,051	42,702
2007	53.4 %	8.5 %	20,764	38,923
2003	53.0 %	5.0 %	20,160	38,048

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	79.0 %	1.5 %	522,315	661,375
2007	79.8 %	1.5 %	530,170	664,311
2003	79.6 %	1.1 %	460,820	579,030

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

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

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

Multi-Year Trend

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

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

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

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	26.0 %	1.7 %	32,999	126,805
2009	24.1 %	1.3 %	29,435	122,099

Year	Annual Indicator	Standard Error	Numerator	Denominator
2007	25.2 %	1.3 %	28,050	111,450

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

State Provided Data	
	2014
Annual Indicator	38.1
Numerator	39,109
Denominator	102,648
Data Source	Student Height-Weight Study
Data Source Year	2013-2014

NOM-20 Notes:

Data was collected from the Washoe County and Clark County School Districts 4th, 7th, and 10th grade students during the 2013-2014 school year. This is a weighted sample (N=9,595).

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	13.9 %	0.8 %	91,948	662,058
2012	16.6 %	0.8 %	110,085	663,964
2011	16.1 %	0.9 %	106,640	662,057
2010	17.9 %	0.7 %	118,672	664,484
2009	18.0 %	0.9 %	123,042	685,085

Year	Annual Indicator	Standard Error	Numerator	Denominator

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

State Provided Data	
	2014
Annual Indicator	17.8
Numerator	129,100
Denominator	724,800
Data Source	HKFF 2013 State Report
Data Source Year	2013

NOM-21 Notes:

http://kff.org/other/state-indicator/children-0-18/ Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2013.

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

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

Year	Annual Indicator	Standard Error	Numerator	Denominator

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	56.2
Numerator	60,155
Denominator	107,130
Data Source	Nevada State Immunization Program
Data Source Year	2014

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	50.1 %	2.0 %	310,104	619,540
2012_2013	51.1 %	2.1 %	315,349	617,143
2011_2012	45.5 %	3.3 %	288,232	632,828
2010_2011	49.9 %	4.4 %	72,959	135,359
2009_2010	26.9 %	1.9 %	67,497	145,468

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	45.5
Numerator	408,114
Denominator	897,345
Data Source	Nevada State Immunization Program
Data Source Year	2014

NOM-22.2 Notes:

Calculated with out accounting for the validity of the doses. The flu data were simply counted.

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	53.8 %	4.8 %	48,446	90,107
2012	62.5 %	4.9 %	56,019	89,569
2011	55.3 %	5.7 %	49,975	90,390
2010	47.4 %	4.5 %	40,065	84,455
2009	39.0 %	4.7 %	33,621	86,311

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-

width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	31.9 %	4.4 %	30,060	94,319
2012	11.6 %	2.8 %	10,828	93,680
2011	NR	NR	NR	NR

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data

	2014
Annual Indicator	33.1
Numerator	97,520
Denominator	294,603
Data Source	Nevada State Immunization Program
Data Source Year	2014

NOM-22.3 Notes:

The data provided did not contain break outs by sex.

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2013	88.3 %	2.1 %	162,824	184,426
2012	86.3 %	2.6 %	158,159	183,248
2011	80.2 %	2.9 %	148,616	185,214
2010	68.3 %	3.0 %	119,169	174,407
2009	64.0 %	3.2 %	113,692	177,632

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data	
	2014
Annual Indicator	90.5
Numerator	167,789
Denominator	185,322
Data Source	Nevada State Immunization Program - 2014 IIS Annual Report
Data Source Year	2014

NOM-22.4 Notes:

This data was taken from the 2014 IIS Annual Report submission question "How many adolescents aged 13 through 17 years (born from Jan 1, 1997 through Dec 31, 2001) that are both in your geopolitical area AND in your IIS have at least one dose of Tdap/Td?" Only valid doses are included.

Data Alerts:

None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	64.0 %	3.1 %	118,108	184,426
2012	66.4 %	3.2 %	121,579	183,248
2011	60.3 %	3.7 %	111,737	185,214
2010	54.3 %	3.2 %	94,611	174,407
2009	39.5 %	3.2 %	70,129	177,632

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

State Provided Data

	2014
Annual Indicator	50.8
Numerator	149,767
Denominator	294,603
Data Source	Nevada State Immunization Program
Data Source Year	2014

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Nevada

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	62.0	64.0	66.0	68.0	70.0

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

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

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	23.0	25.0	27.0	29.0	31.0

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

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	16.0	18.0	20.0	22.0	24.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	70.0	72.0	74.0	76.0	78.0

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

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	36.0	39.0	42.0	45.0	48.0

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

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

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

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

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

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objective	76.0	79.0	82.0	85.0	88.0

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Nevada

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Nevada

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Nevada

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	44	34	39	80	
Denominator	44	34	39	80	
Data Source	Oregon Public Health Lab	Oregon Public Health Lab	Oregon Public Health Lab	Oregon Public Health Lab and Nevada Public Health Lab	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: On July 1, 2014, the first day of the State Fiscal Year in 2014 (SFY14) the State of Nevada changed the laboratory used to perform newborn screening from the Oregon Public Health Laboratory (OPHL) to the Nevada Public Health Laboratory (NPHL). From January 1, 2014 to June 30, 2014 the following methodology was used by OPHL to follow-up on presumptive positive cases: From July 1, 2014 to December 31, 2014 the method used by NPHL: According to the University of Nevada, Reno, Nevada Public Health Laboratory, Newborn Screening program, the following methodology guidelines are used in presumptive positive cases. Once a case is acknowledged, the primary care physician (PCP) is contacted. As soon as contact is made with the PCP the American College of Medical Genetics ACTion Sheet, diagnostic test information, and specialist contact information are sent to the PCP. At the same time the reference lab is called to get the	
2.	**Field Name:**	**2013**
	Field Note: Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.	
3.	**Field Name:**	**2012**

Field Note:
Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.

4.	**Field Name:**	**2011**

Field Note:
Bureau of Child and Family Community Wellness, Newborn Screenings Program, Mary Pennington's number of positive screenings from Oregon Labs. Should match Form 11, NPM 1 total number.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	55.0	70.0	73.0	76.0
Annual Indicator	64.0	64.0	64.0	64.0	
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	51.0	51.0	51.0	53.0	57.0
Annual Indicator	36.8	36.8	36.8	36.8	
Numerator					

	2011	2012	2013	2014	2015
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	62.0	62.0	70.0	75.0	80.0
Annual Indicator	55.2	55.2	55.2	55.2	
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	90.0	90.0	60.0	63.0	66.0
Annual Indicator	57.2	57.2	57.2	57.2	
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording,

order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	33.0	37.0	41.0
Annual Indicator	31.7	31.7	31.7	31.7	
Numerator					
Denominator					
Data Source	2009 Natl Study	2009 Natl Study	2009 Natl Study	2009 Natl Study	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease

Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	70.0	71.0	65.0	65.0	70.0
Annual Indicator	60.2	55.9	57.9	60.8	

	2011	2012	2013	2014	2015
Numerator	67,905	64,235	68,077	64,453	
Denominator	112,813	114,854	117,652	106,053	
Data Source	NV Immunization	NV Immunization	NV Immunization	NV Immunization	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

2.	**Field Name:**	**2012**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

3.	**Field Name:**	**2011**

Field Note:
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records. Not all children of the specified cohort are enrolled in the registry.

The reported data is from the WebIZ Program, which was implemented in July, 2009. This data will always be provisional.

According to the Centers for Disease Control (CDC) the difference between 2010 and 2011 is based upon changes in measurement and definitions related to the Hib vaccine the CDC explanation is quoted below:

"4:3:1:3:3 series coverage reported in column B is based on the original definition for this series. We made it available in the 2009 web tables but not 2010; it is not recommended for comparison to years prior to 2009

because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples. We do recognize that some grantees use this measure, so we will be including it in future releases of the NIS data on our website. Column B relates to 2008 and previous years (remember though that the estimates are not directly comparable since they do not consider the brand type where some children may be counted as up to date with 3 doses but may require 4 doses to be up to date). Coverage estimates in column C are based on the new definition for Hib that takes into consideration the brand type (meaning some children only need 3 doses to be up to date, while others need 4 doses to be up to date), this began with the 2009 data. Column C can be compared with 2009 HIb estimates that are based on this new definition."

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	18.0	17.0	14.0	12.0	11.0
Annual Indicator	18.9	15.3	12.3	12.4	
Numerator	977	810	662	651	
Denominator	51,694	53,108	53,679	52,610	
Data Source	Vital Stats	Vital Stats	Vital Stats	Vital Stats	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: The 2014 data is provisional.	
2.	**Field Name:**	**2013**
	Field Note: The data for 2013 is preliminary. 2013 data will be available in December of 2015.	
3.	**Field Name:**	**2012**
	Field Note: The data for 2012 is preliminary. 2012 data will be available in December of 2014.	
4.	**Field Name:**	**2011**

Field Note:
Data entered is for 2011. The data is preliminary and will be available in December of 2013.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.0	40.0	42.0	42.0	42.0
Annual Indicator	37.0	37.0	37.0	37.0	
Numerator	13,321	13,321	13,321	13,321	
Denominator	36,003	36,003	36,003	36,003	
Data Source	BSS 2008	BSS 2008	BSS 2008	BSS 2008	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population. Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5. The numerator is based upon the Nevada Division of Public and Behavioral Health Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar. The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

2.	**Field Name:**	**2013**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Division of Public and Behavioral Health Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

3.	**Field Name:**	**2012**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Health Division's Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

4.	**Field Name:**	**2011**

Field Note:
The most recent data is based on a statewide Basic Screening Survey (BSS) of children enrolled in third grade conducted in 2008-09. Children were not resurveyed in school years 2009-10, 2010-11, 2011-12, or 2012-2013 with this population.

Due to oral health program (OHP) staff shortages and limited resources, funding has been re-appropriated to cycle OHP target populations and therefore beginning in 2011-2012 children in Head Start programs were assessed targeting ages 3, 4 and 5.

The numerator is based upon the Nevada Health Division's Oral Health Program estimate of 37% from the BSS 2008 for all 3rd Graders having received a dental sealant on at least one molar.

The denominator is from the Nevada Department of Education's Statewide NRS 387 303 Report.

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.9	1.8	1.7	1.4	1.3
Annual Indicator	1.8	1.7	1.5	1.9	
Numerator	9	9	9	11	

	2011	2012	2013	2014	2015
Denominator	512,943	527,473	586,919	568,512	
Data Source	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	ICD 10 codes-Cause of Death	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
Data entered is from 2013. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

2.	**Field Name:**	**2012**

Field Note:
Data entered is from 2012. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

3.	**Field Name:**	**2011**

Field Note:
Data entered is from 2011. The data is final.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	28.0	28.0	28.0	25.0	27.0
Annual Indicator	18.4	19.9	26.3	28.0	
Numerator			5,933	6,194	

	2011	2012	2013	2014	2015
Denominator			22,561	22,098	
Data Source	PedNSS	WIC	WIC	WIC	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Percent Nevada infants 6 to 24 months in WIC who were breastfed at least 6 months.	
2.	**Field Name:**	**2013**
	Field Note: Percent Nevada infants 6 to 24 months in WIC who were breastfed at least 6 months.	
3.	**Field Name:**	**2012**
	Field Note: NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extracted from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programmatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistency in the report. In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2012.	
4.	**Field Name:**	**2011**
	Field Note: NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extracted from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programmatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistency in the report.	

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	99.5	99.5	99.5	99.5	99.5
Annual Indicator	99.1	95.8	95.9	95.8	
Numerator	34,263	33,175	33,411	34,032	
Denominator	34,580	34,616	34,827	35,509	
Data Source	EHDI database	EHDI database	EHDI database	EHDI Database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: Nevada Early Hearing Detection and Intervention program's data systems, Nevada electronic birth records, and Nevada birthing hospitals & birthing facilities. Data matches Nevada submission to 2012 CDC annual EHDI survey. More accurate birth counts which include home births and births from a Federal hospital account for a slight decrease in percent screened. Accurate screening data from the Federal hospital will bring the percentage back up to the 99% level.	
2.	**Field Name:**	**2012**
	Field Note: From the state Early Hearing Detection & Intervention (EHDI) database.	
3.	**Field Name:**	**2011**
	Field Note: From the state Early Hearing Detection & Intervention (EHDI) database.	

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	15.0	15.0	12.0
Annual Indicator	17.5	19.3	20.0	17.8	
Numerator	117,196	134,300	139,405	129,100	

	2011	2012	2013	2014	2015
Denominator	668,200	694,600	697,026	724,800	
Data Source	U.S. Census Bureau 2011.	HKFF 2012 State Report	HKFF 2012 State Report	HKFF 2013 State Report	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: http://kff.org/other/state-indicator/children-0-18/ Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2013.	
2.	**Field Name:**	**2013**
	Field Note: http://kff.org/other/state-indicator/children-0-18/ Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2012.	
3.	**Field Name:**	**2012**
	Field Note: Data from the Henry J. Kaiser Family Foundation, State Health Facts for Nevada 2012.	
4.	**Field Name:**	**2011**
	Field Note: Niether the Great Basin Primary Care Association (GBPCA) annual report for 2011 nor the Kaiser Family State Health Facts for 2011 have been released, so U.S. Census Bureau 2011 data was utilized. Children are calculated for 0-17 years of age. Data Source: Number and Percent of Uninsured Children: U.S. Census Bureau. 2011. “Health Insurance Historical Tables - HIB Series,” Table HIB-5, data for 2010 for children under age 18 - Nevada listing. http://www.census.gov/hhes/www/hlthins/data/historical/files/hihistt5B.xls	

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	11.0	11.0	25.0	25.0	23.0

	2011	2012	2013	2014	2015
Annual Indicator	27.1	26.8	26.8	26.0	
Numerator					
Denominator					
Data Source	PedNSS tables	WIC	WIC	WIC	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
Using the CDC's 2013 Pediatric Nutrition Surveillance Nevada Summary of Demographic Data as reported by the Nevada Women, Infants and Children (WIC) Program.

In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2013.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

2.	**Field Name:**	**2012**

Field Note:
Using the CDC's 2012 Pediatric Nutrition Surveillance Nevada Summary of Demographic Data as reported by the Nevada Women, Infants and Children (WIC) Program.

In 2012 the CDC discontinued the PEDNSS report. The Nevada WIC Program developed a new report for 2012 data and beyond. The data reported is for 2012.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

3.	**Field Name:**	**2011**

Field Note:
Using the CDC's 2010 Pediatric Nutrition Surveillance
Nevada Summary of Demographic Indicators Table 2C.

In the past years until 2009, the percentage of children aged 2-5 years receiving WIC services with a Body Mass Index (BMI) >=85th to <95 percentile (overweight) were reported. The percentages have been corrected to include the percentage of children aged 2-5 years with a BMI >= 95th percentile (obese) from 2010 forward.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	6.0	4.0	3.0
Annual Indicator	6.7	6.9	4.3	3.8	
Numerator	2,354	2,398	1,488	1,330	
Denominator	35,196	34,526	34,371	35,074	
Data Source	vital stat/birth cert	vital stat/birth cert	vital stat/birth cert	Vital Stats	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: This data is addressing the third trimester smoking habits of the mother. Previous to 2013 the data includes all mothers who indicated tobacco use during pregnancy.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 is preliminary. Data will be finalized in December 2015. From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.	
3.	**Field Name:**	**2012**
	Field Note: 2012 reported data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator). Data for 2012 is preliminary. Data will be finalized in December 2014. From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.	

4.	**Field Name:**	**2011**

Field Note:
2011 reported data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2011 is preliminary. Data will be finalized in December 2013.

From 2004-2009 this question could not be answered correctly. The tobacco use question was :Tobacco use Yes/No throughout the pregnancy and average cigarette use per day. With the implementation of the 2003 version of the standard certificate the question is specific to the trimester tobacco use. The 2010 and following years' data reflects the tobacco use in the third trimester of pregnancy.

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	5.0	5.0	5.5	5.0	4.5
Annual Indicator	14.8	6.0	7.6	7.7	
Numerator	26	11	14	14	
Denominator	175,953	182,183	184,109	182,418	
Data Source	vital stats/ death cert	vital stats/ death cert	vital stats/ death cert	Vital Stats/Death Certs	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**

Field Note:
Data entered is from 2013. Data will be available in December, 2015. Data for 2013 is preliminary.

2.	**Field Name:**	**2012**

Field Note:
Data entered is from 2012. Data will be available in December, 2014. Data for 2012 is preliminary.

3.	**Field Name:**	**2011**

Field Note:

Data entered is from 2011. Data will be available in December, 2013. Data for 2011 is preliminary.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	97.0	97.0	98.0	98.0	99.0
Annual Indicator	90.9	90.6	90.6	92.6	
Numerator	432	403	378	465	
Denominator	475	445	417	502	
Data Source	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	Vital Stats/Birth Certs	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data for 2014 included level 3 only. Data for 2014 is preliminary.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 included level 3 only. Data for 2013 is preliminary. Data will be available in December, 2015.	
3.	**Field Name:**	**2012**
	Field Note: Data for 2012 included level 3 only. Data for 2012 is preliminary. Data will be available in December, 2014.	
4.	**Field Name:**	**2011**
	Field Note: Data for 2011 included level 3 only. Data for 2011 is preliminary. Data will be available in December, 2013.	

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	65.5	70.0	73.0
Annual Indicator	63.7	65.2	65.9	68.5	
Numerator	22,406	22,517	22,647	24,017	
Denominator	35,196	34,526	34,371	35,074	
Data Source	vital stats/ birth certs	vital stats/ birth certs	vital stats/ birth certs	Vital Stats/Birth Certs	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Data is provisional.	
2.	**Field Name:**	**2013**
	Field Note: Data for 2013 is preliminary. Data will be available in December, 2015.	
3.	**Field Name:**	**2012**
	Field Note: Data for 2012 is preliminary. Data will be available in December, 2014.	
4.	**Field Name:**	**2011**
	Field Note: Data for 2011 is preliminary. Data will be available in December, 2013.	

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Nevada

SPM 2 - The rate (per 1,000 MCH Medicaid population) of Medicaid dental providers.

	2011	2012	2013	2014	2015
Annual Objective	2.3	2.4	2.4	10.5	11.0
Annual Indicator	7.2	10.1	9.0	1.9	
Numerator	462	665	620	885	
Denominator	64,308	66,122	68,947	462,204	
Data Source	NV DHCFP	NV DHCFP	NV DHCFP	State of Nevada Medicaid	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: Extracted all children and women 15 to 44 (per month) then combined all months and removed duplicates for the year.	
2.	**Field Name:**	**2013**
	Field Note: Data is for federal fiscal year 2013. Numerator FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access. Data was not requested from Anthem for the first quarter of the fiscal year. Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database. Denominator All Children: All members age 0-18 during the reporting period (by birthdate). Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate). Note: Report counts all women 15-18 as children and does not duplicate them.	
3.	**Field Name:**	**2012**
	Field Note: Data is for federal fiscal year 2012. Numerator FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access. Data was not requested from Anthem for the first quarter of the fiscal year. Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database. Denominator All Children: All members age 0-18 during the reporting period (by birthdate).	

Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
Note: Report counts all women 15-18 as children and does not duplicate them.

4.	**Field Name:**	**2011**

Field Note:
Data is for federal fiscal year 2011.

Numerator
FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access.
Data was not requested from Anthem for the first quarter of the fiscal year.
Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database.
Denominator
All Children: All members age 0-18 during the reporting period (by birthdate).
Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
Note: Report counts all women 15-18 as children and does not duplicate them.

Data Alerts:

None

SPM 3 - The percent of women, ages 18 to 44, who are obese.

	2011	2012	2013	2014	2015
Annual Objective	16.0	16.0	21.0	21.0	19.0
Annual Indicator	24.6	23.9	24.2	24.2	
Numerator	107,104	104,368	103,095	103,235	
Denominator	436,178	436,061	426,014	426,592	
Data Source	BRFSS 2011	BRFSS 2012	BRFSS 2013	BRFSS 2014	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Denominator and numerator represent weighted frequencies from the 2014 Behavioral Risk Factor Surveillance System.

2.	**Field Name:**	**2013**

Field Note:

Information was produced by the Office of Public Health Informatics and Epidemiology from the BRFSS report.

Data Alerts:

None

SPM 5 - The number of public schools (K-12) that have access to a school based health center.

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	20.0	20.0	20.0
Annual Indicator			0.0	13.8	
Numerator			0	100	
Denominator			723	723	
Data Source			NSPF	NSPF	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: 100 schools were served by the 11 SBHC's that were operating in 2014. Nevada School Performance Framework shows 723 K-12 public schools in the state.	
2.	**Field Name:**	**2013**
	Field Note: Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County. Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and may contract with a sponsoring facility for the operation of the school-based health center, including, without limitation, for the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session. There is no 2013 data to report.	
3.	**Field Name:**	**2012**
	Field Note: Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County. Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and	

may contract with a sponsoring facility for the operation of
the school-based health center, including, without limitation, for
the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session.

There is no 2012 data to report.

4.	**Field Name:**	**2011**

Field Note:
Nevada Health Centers reported; 'Per our Board of Directors, effective November 1, 2010 all of our School-Based Health Centers are closed.' In 2009 and 2010 they served 10 schools in Clark County.

Senate Bill 247 would have enacted that the board of trustees of a school district or the governing body of a charter school may establish a school-based health center for a public school or consortium of public schools and may contract with a sponsoring facility for the operation of
the school-based health center, including, without limitation, for
the provision of medical services and care. The bill did not pass the 2011 State of Nevada Legislative session.

There is no 2011 data to report.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2013 SPM# 5. Please review your data to ensure this is correct

SPM 6 - The percent of positive hearing screening newborns who have received additional screening and diagnosis by 3 months.

	2011	2012	2013	2014	2015
Annual Objective	15.0	20.0	31.0	33.0	41.0
Annual Indicator	13.7	25.9	24.2	30.6	
Numerator	75	88	119	137	
Denominator	547	340	491	448	
Data Source	NB hearing database	NB hearing database	NB hearing database	NB hearing database	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**

Field Note:
Newborn Hearing Screening Program's data system, electronic birth records, Nevada Early Intervention Services data and other follow-up data received from clinical evaluations. Data matches Nevada submission to 2012 CDC annual EHDI survey.

Nevada's Universal newborn hearing screening program is successful with initial screening and is working to raise the screening percentage even higher by focusing on home births, Federal Hospital screening reporting and screener education. Strategies are in place to reduce the number of lost to rescreening and diagnostic follow-up with significant strides already realized.

2.	**Field Name:**	**2012**

Field Note:
Data for 2012 is from the Newborn Hearing database.

3.	**Field Name:**	**2011**

Field Note:
Data for 2011 is from the Newborn Hearing database.

Data Alerts:

None

SPM 8 - Percentage of Nevada public school students who are obese and overweight.

	2011	2012	2013	2014	2015
Annual Objective	22.0	22.0	22.0	22.0	22.0
Annual Indicator	24.1	24.1	25.8	38.1	
Numerator	478	478	977	3,652	
Denominator	1,982	1,982	3,783	9,595	
Data Source	YRBS 2009	YRBS 2009	YRBS 2013	Washoe/Clark School Districts	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Data is from student height weight data collected from the 2013-2014 Washoe County and Clark County school district Fourth, Seventh, and Tenth grade students. Total sample size was 9,595.

2.	**Field Name:**	**2013**

Field Note:
In 2013 the YRBS data was collected by the University of Nevada , Reno. This resulted in a much greater sample population. This data only includes high school aged students. The data can be viewed at http://chs.unr.edu/subpages/research/documents/2013NevadaYRBSReport.pdf. The pages are 104 and 105.

3.	**Field Name:**	**2012**

Field Note:
Reported dietary behavioral data is from 2009. The Youth Risk Behavior Survey (YRBS) is normally reported every other year, thus data is available for 2011 and 2012 which may not yet be reported. The Centers for Disease Control and Prevention's (CDC), Youth Risk Behavior Surveillance (YRBS) report has not been updated since 2009 as of July 9th, 2012.

YRBS only counts High School students, grades 9 through 12.

The YRBS survey at: http://apps.nccd.cdc.gov/youthonline/App/Default.aspx gives percentages and total respondents (the denominator) so you can determine the numerator by multiplying the percent times the total respondents.

Overweight = 13.2 percent and the denominator is 1,982;
The numerator is .132 X 1,982 = 261.6
Obese = 10.9% with the same denominator - 1,982.
The numerator is .109 X 1,982 = 216.0

Adding the two numerators together = 261.6 +216.0 = 478 (round up)

Therefore, to fill out the block grant form we used 478 as the numerator and 1982 as the denominator and the percent will automatically be calculated at (478 / 1982) X100 = 24.1%

4.	**Field Name:**	**2011**

Field Note:
Reported dietary behavioral data is from 2009. Youth Risk Behavior Survey (YRBS) is normally reported every other year, thus data is available for CY 2011 and 2012 which may not yet be reported. The Centers for Disease Control and Prevention's (CDC), Youth Risk Behavior Surveillance (YRBS) has not been updated since 2009 as of May 13th, 2012.

YRBS only counts High School students, grades 9 through 12.

The YRBS survey at: http://apps.nccd.cdc.gov/youthonline/App/Default.aspx gives percentages and total respondents (the denominator) so you can determine the numerator by multiplying the percent times the total respondents.

Overweight = 13.2 percent and the denominator is 1,982;
The numerator is .132 X 1,982 = 261.6
Obese = 10.9 percent with the same denominator - 1,982.
The numerator is .109 X 1,982 = 216.0

Adding the two numerators together = 261.6 +216.0 = 478 (round up)

Therefore, to fill out the block grant form we used 478 as the numerator and 1982 as the denominator and the

percent will automatically be calculated at (478 / 1982) X100 = 24.1 percent

Data Alerts:

None

SPM 9 - The percent of high school students who experience dating violence.

	2011	2012	2013	2014	2015
Annual Objective		0.0	0.0	10.0	10.0
Annual Indicator	0.0	0.0	11.3	11.3	
Numerator		0	310	310	
Denominator		1	2,747	2,747	
Data Source	Nevada Vital Stat	Nevada Vital Stat	Nevada YRBS	Nevada YRBS 2013	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: In 2013 there were 310 cases of dating violence out of sample size of 2747 which gives 11.3%. YRBS is conducted every other year on high school students 9-12.	
2.	**Field Name:**	**2013**
	Field Note: In 2013 there were 310 cases of dating violence out of sample size of 2747 which gives 11.3%. YRBS is conducted every other year on high school students grades 9-12.	
3.	**Field Name:**	**2012**
	Field Note: The Attorney General-Domestic Violence Fatality Review Statewide Team (AG-DVFRST) is appointed and is considered our primary source for the data. There were no fatal cases of domestic violence or intimate partner violence reported in 2012 for ICD-10 codes Z61.4, Z61.6-Z61.9, Z62.3, Z63.0-Z63.9, and T74.1-T74.9 listed as the underlying cause of death in 2012.	
4.	**Field Name:**	**2011**
	Field Note:	

Data are not currently available for this newly formed State Performance Measure around domestic and intimate partner violence. This is due to the fact that the Attorney General-Domestic Violence Fatality Review Statewide Team is newly appointed and is considered our primary source of the data. We anticipate a rich collection of data next year to report after cases of domestic violence and intimate partner violence are reviewed and reported on.

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2012 SPM# 9. Please review your data to ensure this is correct.

SPM 10 - The percent of live births weighing less than 2,500 grams among African Americans.

	2011	2012	2013	2014	2015
Annual Objective				12.5	12.5
Annual Indicator	12.9	13.5	12.5	25.3	
Numerator	471	496	485	733	
Denominator	3,642	3,678	3,880	2,897	
Data Source	Nevada Vital Stats	Nevada Vital Stats	Nevada vital Stats	Nevada Vital Stats	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Data is inclusive of all children born to either African American mothers or fathers, regardless of Hispanic ethnicity within 2,500 gram weight. Previous year's (2013) method does not seem to match the method moving forward from 2014.

Data Alerts:

None

Form 11
Other State Data

State: Nevada

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Nevada

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table